



Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
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December 26, 2019

Via USPS Delivery and eFile

Mr. John Baackes
Chief Executive Officer
Local Initiative Health Authority for Los Angeles County
DBA: L.A. Care Health Plan
1055 West 7th Street
Los Angeles, CA 90017

**FINAL REPORT OF A NONROUTINE EXAMINATION OF LOCAL INITIATIVE
HEALTH AUTHORITY FOR LOS ANGELES COUNTY, DBA: L.A. CARE HEALTH
PLAN**

Dear Mr. Baackes:

Enclosed is the final report (Final Report) of a nonroutine examination for the quarter ended March 31, 2019 of the claims settlement practice and dispute resolution mechanism of Local Initiative Health Authority for Los Angeles County, dba: L.A. Care Health Plan (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975.¹ The Department issued a preliminary report to the Plan on September 30, 2019. The Department accepted the Plan's electronically filed response on November 14, 2019 and December 16, 2019 (Responses).

The Final Report includes a description of the compliance efforts included in the Plan's Responses, in accordance with Section 1382(c).

Section 1382(d) states, "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within 10 days from the date of the Plan's receipt of this letter whether the Plan requests the Department to append its response(s). If so, please indicate

¹ References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in Health and Safety Code Section 1340 et seq.

which portions of the Plan's response(s) should be appended, and electronically file copies of those portions excluding information held confidential pursuant to Section 1382(c). If the Plan requests the Department to append a brief statement summarizing the Plan's response or wishes to modify any information provided to the Department in its Responses, please provide an addendum no later than 10 days from the date of the Plan's receipt of this letter. Please file this addendum electronically via the corrective action plan (CAP) system within the Department's eFiling web portal at <https://wpsso.dmhca.ca.gov/secure/login/>, as follows:

- From the main menu, select "eFiling."
- From the eFiling menu, select "Online Forms."
- From the Online Forms menu, select "Details" for "CAP # S19-N-355."
- Go to the "Messages" tab, then:
 - Select "Addendum to Final Report" (note this option will only be available for 10 days after the issuance of the Final Report).
 - Select the deficiency(ies) that are applicable.
 - Create a message for the Department.
 - Attach and upload all documents with the name "Addendum to Final Report."
 - Select "Send Message."

As noted in the attached Final Report, the Plan's Responses did not adequately respond to the deficiencies raised in the Preliminary Report issued by the Department on September 30, 2019. The Plan is required to respond to any request for corrective actions contained within the attached Final Report within 30 days of receipt of the Final Report. If the Plan fails to fully respond and/or resolve the deficiencies addressed in the Final Report, then a referral will be made to the Department's Office of Enforcement for appropriate administrative action.

Please file the Plan's response electronically via the CAP system within the Department's eFiling web portal at <https://wpsso.dmhca.ca.gov/secure/login/>, as follows:

- From the main menu, select "eFiling."
- From the eFiling menu, select "Online Forms."
- From the Online Forms menu, click on the "Details" for "CAP # S19-N-355."
- Go to the "Data Requests" tab, then:
 - Click on the "Details" for each data request that does not have a status of "Complete."
 - Follow the instructions and/or use the form shown to add the requested data (depending on the type of data requested: New Filing, Document Request, Claims Data, or Financial Statement Refile).

The Department will also e-mail the Plan requesting all items that are still outstanding. The e-mail(s) will contain a link to the CAP system for the Plan to file the response electronically.

Questions or problems related to the electronic transmission of any addendum should be directed to Vijon Morales at 916-255-2447 or by e-mail at Vijon.Morales@dmhc.ca.gov. You may also e-mail inquiries to wps@dmhc.ca.gov.

The Department will make the Final Report available to the public in 10 days from the Plan's receipt of this letter. The Final Report will be located at the Department's web site at <http://www.dmhc.ca.gov/LicensingReporting/ViewFinancialExaminationReports.aspx>.

The Plan is hereby advised that any violations listed in the Final Report may be referred to the Department's Office of Enforcement for appropriate administrative action.

If there are any questions regarding the Final Report, please contact me at 919-255-2425 or by e-mail at Anna.Belmont@dmhc.ca.gov.

Sincerely,

ORIGINAL SIGNED BY

Anna Belmont
Corporation Examiner IV, Supervisor
Office of Financial Review
Division of Financial Oversight

cc: Surah Alsawaf, Compliance Advisor, Local Initiative Health Authority for Los Angeles County
Augustavia J. Haydel, Chief Legal Officer, Local Initiative Health Authority for Los Angeles County
Pritika Dutt, CPA, Deputy Director, Office of Financial Review
Jennifer Clark, Supervising Examiner, Division of Financial Oversight
Erica Short, Examiner, Division of Financial Oversight
Ashika Chiu, Examiner, Division of Financial Oversight
Carrie Ramage, Attorney III, Office of Plan Licensing
Laura Dooley-Beile, Supervising Health Care Service Plan Analyst, Office of Plan Monitoring
Ben Carranco, Assistant Deputy Director, Help Center
Chad Bartlett, Staff Services Manager II, Help Center

**STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE**

**OFFICE OF FINANCIAL REVIEW
DIVISION OF FINANCIAL OVERSIGHT**

FINAL REPORT OF A NONROUTINE EXAMINATION

OF

**LOCAL INITIATIVE HEALTH AUTHORITY FOR
LOS ANGELES COUNTY
DBA: L.A. CARE HEALTH PLAN**

FILE NO. 933 0355

DATE OF FINAL REPORT: DECEMBER 26, 2019

SUPERVISING EXAMINER: JENNIFER CLARK

OVERSIGHT EXAMINER: ANNA BELMONT

EXAMINER-IN-CHARGE: ERICA SHORT

FINANCIAL EXAMINERS:

ERI FUKUDA

NINA MOUA

DANIIL RYBALKO

**BACKGROUND INFORMATION FOR
LOCAL INITIATIVE HEALTH AUTHORITY FOR LOS ANGELES COUNTY
DBA: L.A. CARE HEALTH PLAN**

Date Plan Licensed:	April 1, 1997
Organizational Structure:	Local Initiative Health Authority for Los Angeles County, dba: L.A. Care Health Plan (Plan) is an independent local public agency that provides managed health care services to Medi-Cal beneficiaries in Los Angeles County.
Type of Plan:	The Plan is a full service health care service plan providing services to Medi-Cal beneficiaries in accordance with contracts with the Department of Health Care Services. The Plan also participates in the Cal MediConnect program and provides services to members that are dually eligible for both Medicare and Medi-Cal. In addition, the Plan provides health care services to the In-Home Supportive Services (IHSS) workers in Los Angeles County and offers HMO Individual products through Covered California.
Provider Network:	The Plan has direct contracts with various health care providers and subcontracts the delivery of health care through contracts with three licensed health care service plans.
Plan Enrollment:	As of March 31, 2019, the Plan reported total enrollment of 2,157,912, consisting of 2,024,444 Medi-Cal, 83,067 individual and 50,401 IHSS enrollees.
Service Area:	Los Angeles County
Date of Prior Final Routine Examination Report:	August 1, 2018

**FINAL REPORT OF A NONROUTINE EXAMINATION OF
LOCAL INITIATIVE HEALTH AUTHORITY FOR LOS ANGELES COUNTY
DBA: L.A. CARE HEALTH PLAN**

This is the final report (Final Report) for the quarter ended March 31, 2019 of a nonroutine examination of the claims settlement practice and dispute resolution mechanism of Local Initiative Health Authority for Los Angeles County, dba: L.A. Care Health Plan (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975.¹

The Department issued a preliminary report (Preliminary Report) to the Plan on September 30, 2019. The Department accepted the Plan's electronically filed responses on November 14, 2019 and December 16, 2019 (Responses).

This Final Report includes a description of the compliance efforts included in the Plan's Responses to the Preliminary Report, in accordance with Section 1382(c). The Plan's responses are noted in italics within this Final Report

The Plan is hereby advised that any violations listed in the Final Report may be referred to the Department's Office of Enforcement for appropriate administrative action.

The purpose of this nonroutine examination was to review the Plan's processing of claims and provider disputes for the quarter ended March 31, 2019 to determine compliance with the Sections and Rules. The Department's findings are presented in this Final Report as follows:

Part I.	Compliance Issues
Part II.	Nonroutine Exam

The Plan is required to respond to any request for corrective actions contained herein within 30 days of receipt of this Final Report.

¹ References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in Health and Safety Code Section 1340 et seq. References to "Rule" are to regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act of 1975 contained within title 28 of the California Code of Regulations.

PART I. COMPLIANCE ISSUES

A. CLAIMS SETTLEMENT PRACTICES – “UNFAIR PAYMENT PATTERN”

Section 1371.37 prohibits a health care service plan from engaging in an unfair payment pattern, and defines certain claim settlement practices as “unfair payment patterns.”

Rule 1300.71(a)(8) defines an “unfair payment pattern” as any practice, policy, or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims.

1. PAYMENT ACCURACY, INCLUDING AUTOMATIC PAYMENT OF INTEREST AND PENALTY - Repeat Deficiency

Section 1371 and Rule 1300.71(i)(2) and (j) require a health care service plan, if the plan is a health maintenance organization, to reimburse uncontested claims no later than 45 working days after the date of receipt of the claim by the plan. If an uncontested claim is not reimbursed within 45 working days after receipt, interest accrues at the rate of 15 percent per annum beginning with the first calendar day after the 45-working-day period. A plan that fails to automatically include any interest due in its payment of the claim must pay a fee of \$10 to the claimant.

Rule 1300.71(a)(8)(K) describes an “unfair payment pattern” as the failure to reimburse at least 95 percent of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

Rule 1300.71.38(g) states if a provider dispute or amended dispute involves a claim and is determined in whole or in part in favor of the provider, the plan shall pay any outstanding monies determined to be due, and all interest and penalties within five working days of the issuance of the written determination.

The Department’s examination disclosed that the Plan failed to reimburse claims accurately, including automatic payment of interest and penalty in:

- Five out of 50 paid claims (a compliance rate of 90 percent). This deficiency was noted in the following paid claims sample numbers: 20, 23, 24, 32 and 48. The deficiency was caused by the Plan using the incorrect contracted rate to reimburse claims.
- Four out of 50 late claims (a compliance rate of 92 percent). This deficiency was noted in the following late claims sample numbers: 2, 5, 24 and 45. The

deficiency was caused by the Plan underpaying interest and improperly denying procedures that should have been paid.

- Six out of 30 high dollar claims. This deficiency was noted in the following high dollar claims sample numbers: 1, 5, 15, 17, 20 and 22. This deficiency was primarily caused by the following:
 - Incorrect Diagnosis-Related Group pricing configuration.
 - Paying dual eligible claims as primary payer when the Plan should have been secondary.
 - Not paying interest on claims improperly denied for missing authorization. Independent practice associations (IPAs) authorized services but did not forward authorizations to the Plan, resulting in the Plan denying claims for missing authorization. Providers submitted a provider dispute resolution (PDR) with proof of authorization during the time of service, prompting the Plan to overturn its original decision and pay the claims. However, the Plan did not pay interest on the claims that were paid after 45 working days.
- Six out of 50 claims resulting from PDRs (a compliance rate of 88 percent). This deficiency was noted in the following PDR claims sample numbers: 1, 8, 17, 18, 31 and 47. The deficiency was primarily caused by the Plan not paying interest on overturned PDRs.

The Plan's failure to reimburse claims accurately, including automatic payment of interest and penalty is a repeat deficiency, as this issue was previously reported in the Department's final report of routine examination dated August 1, 2018, for the quarter ended June 30, 2017. This examination disclosed that the Plan's corrective actions in response to the prior final report had not achieved the necessary levels of compliance with the Section and Rules cited.

The Plan was required to explain why the corrective actions implemented to resolve the deficiency of failing to reimburse claims accurately, including automatic payment of interest and penalty, as identified in the Department's prior examination, were not effective in ensuring ongoing compliance.

In addition, the Plan was required to submit a detailed corrective action plan (CAP) that included the following:

- a. Policies and procedures, including internal claims audit procedures, implemented to ensure claims are paid accurately, including interest and penalty. When applicable, clean and redlined versions must be submitted to clearly identify revisions made to policies and procedures as a result of the examination.

- b. Date the policies and procedures were implemented.
- c. Training materials and the date(s) training was conducted to ensure claim processors were aware of and comply with the requirements of the above Section and Rules.
- d. Identification of all claims paid inaccurately, including interest and penalty, from August 1, 2018 (date of prior final report) through the date the corrective action was implemented by the Plan.
- e. Evidence that interest and penalty, as appropriate, were paid retroactively for the claims identified in paragraph "d" above. This evidence was to include an electronic data file/schedule (Excel or Access) that identified the following:
 - Claim number
 - Date of service
 - Date original claim received
 - Date new information received
 - Total billed
 - Original amount paid
 - Date original amount paid
 - Additional amount paid as a result of remediation
 - Date additional amount paid
 - Amount of original interest paid
 - Amount of additional interest paid as a result of remediation
 - Date additional interest paid
 - Penalty amount paid, if applicable
 - Number of late days used to calculate interest
 - Check number for interest and penalty paid
 - Provider name
 - ER or Non-ER indicator

The data file was to provide the details of all claims remediated, including the total number of claims, total original claim payments, additional claim payments, and the total additional interest and penalties paid as a result of remediation.

- f. Management positions responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan was required to provide a response to the Department within 45 days of receipt of the Preliminary Report. If the Plan was not able to complete the CAP or portions of the CAP within 45 days of receipt of the Preliminary Report, the Plan was required to submit with its response a timeline that committed the Plan to complete the CAP within 90 calendar days of receipt of the Preliminary Report. If the Plan was not

able to meet this timeframe, it was required to provide a justification for the delay and request approval by the Department for the proposed timeline for completion of the CAP. The Plan was also required to submit monthly status reports to the Department until the CAP was completed.

The Plan summarized the previous examination findings related to payment accuracy and stated that the corrective actions implemented as a result of the last examination did not resolve the current deficiency because the root causes resulting in the 2017 deficiency were different from the root causes identified during this examination.

With regard to using the incorrect contracted rate to reimburse claims, the Plan stated the following:

The turnaround time for the Plan to update its claims system is 14-30 days from the day the Medi-Cal fee schedules are published and become effective. Due to the time it takes to update its system, the Plan has to remediate claims that may have been paid during the 14-30 day window. The Plan provided a "Medi-Cal Fee Table Business Rules Job Aid" revised on May 14, 2019.

The Plan created a Claims and PDR Monitoring Program to validate, on a quarterly basis, that the correct contracted rate is used. The monitoring will begin the first quarter of 2020 and results will be reported to the Internal Compliance Committee quarterly. The Plan provided the Claims and PDR Monitoring Program guidelines to the Department.

The Plan stated that claims examiners completed a training class on October 29, 2019 and November 1, 2019 to address all examiner errors identified during the examination. The Plan provided the associated training materials and sign-in sheets.

With regard to paying dual eligible claims as primary payer when the Plan should have been secondary, the Plan stated the following:

The cause of the deficiency was the system tied the payments to the incorrect reimbursement methodology. The Plan updated its system with coordination of benefits (COB) payment guidelines in July 2018 and provided its "Medi-Cal Reimbursement for COB" procedures.

With regard to underpaying interest, the Plan stated the following:

The incorrect interest rate calculation was due to a system rounding error made during the automatic interest table build to account for the leap year. The Plan updated the system on August 9, 2019 and the rounding issue was resolved.

Claims examiners completed a training class addressing claims processing errors on October 29, 2019 and November 1, 2019.

With regard to using the incorrect Diagnosis-Related Group pricing configuration, the Plan stated the following:

The 3M application used by the Plan contained incorrect hospital characteristics, which resulted in the overpayment of claims. When this issue was raised during the examination, the Plan immediately transitioned to using the State Grouper/Pricer. Claims examiners completed a training class on the State calculator, which took place from July 2, 2019 through July 16, 2019. The Plan provided the associated training materials and sign-in sheets.

With regard to the authorization/tracking number issue, the Plan stated the following:

The Plan revised its authorization validation process on August 1, 2019. The new process extends the timeframe for receiving authorizations from the delegates. The Plan will also hold its delegates accountable for submitting authorizations timely per their contractual obligation. The Plan provided its "Standard Delegated Process Workflow" dated October 29, 2019, "Extended Delegated Process Workflow" dated October 25, 2019 and "Claims Desktop Procedure-Utilization Management Auto Authorization Guidelines" revised on July 30, 2019.

The Plan also stated that it will be exploring various options to enforce delegates' compliance as it is the responsibility of the Plan's delegated participating provider groups to ensure a copy of the authorization is submitted to the Plan in a timely manner.

The Plan identified claims processed from August 1, 2018 to October 1, 2019 where claims did not include the automatic payment of interest. The Plan will provide to the Department a list of claims where interest was not paid or underpaid and claims where the incorrect fee schedule was used. These spreadsheets will be updated once validation has been completed and the claims have been re-processed. A final report of the remediated claims will be sent to the Department by September 30, 2020.

Ann Reaves, Claims Compliance Manager, and Nancy Villaneda, Senior Manager PDR, will be responsible for overseeing the CAP.

The Department finds that the Plan's compliance efforts are not fully responsive to the corrective action required, as the Plan did not complete the remediation required by the Department. The Plan is required to identify all claims paid inaccurately, including interest and penalty, from August 1, 2018 through the date the corrective action was implemented by the Plan.

The Plan is also required to submit evidence that interest and penalty, as appropriate, were paid retroactively for the claims identified in paragraph "d" above. This evidence is to include an electronic data file/schedule (Excel or Access) that identifies the following:

- **Claim number**
- **Date of service**
- **Date original claim received**
- **Date new information received**
- **Total billed**
- **Original amount paid**
- **Date original amount paid**
- **Additional amount paid as a result of remediation**
- **Date additional amount paid**
- **Amount of original interest paid**
- **Amount of additional interest paid as a result of remediation**
- **Date additional interest paid**
- **Penalty amount paid, if applicable**
- **Number of late days used to calculate interest**
- **Check number for interest and penalty paid**
- **Provider name**
- **ER or Non-ER indicator**

The data file is to provide the details of all claims remediated, including the total number of claims, total original claim payments, additional claim payments, and the total additional interest and penalties paid as a result of remediation.

The Plan is required to submit monthly status reports to the Department until the CAP is completed.

2. INCORRECT CLAIM DENIALS – Repeat Deficiency

Rule 1300.71(d)(1) states that a plan shall not improperly deny, adjust, or contest a claim. For each claim that is denied, adjusted or contested, the plan shall provide an accurate and clear written explanation of the specific reasons for the action taken.

Rule 1300.71(a)(8)(K) describes an “unfair payment pattern” as the failure to reimburse at least 95 percent of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

The Department’s examination disclosed that claims were improperly denied and should have been paid in:

- Eight out of 50 denied claims (a compliance rate of 84 percent). This deficiency was noted in the following denied claims sample numbers: 3, 11, 14, 25, 32, 34, 39 and 48.
- Five out of 30 high dollar claims. This deficiency was noted in the following high

dollar claims sample numbers: 5, 10, 15, 20 and 22. Prior to the Department's examination, the Plan reprocessed and paid the aforementioned high dollar claims after receiving PDRs from providers.

The deficiency was caused by the Plan incorrectly denying claims as misdirected, due to processor errors and due to IPAs authorizing services but not forwarding the authorizations to the Plan.

The Plan's incorrect denial of claims is a repeat deficiency, as this issue was previously reported in the Department's final report of routine examination dated August 1, 2018, for the quarter ended June 30, 2017. This examination disclosed that the Plan's corrective actions in response to the prior final report had not achieved the necessary levels of compliance with the Rules cited.

The Plan was required to explain why the corrective actions implemented to resolve the deficiency of incorrectly denying claims, as identified in the Department's prior examination, were not effective in ensuring ongoing compliance.

In addition, the Plan was required to submit a detailed CAP that included the following:

- a. Policies and procedures, including internal claims audit procedures, implemented to ensure claims are not improperly denied. When applicable, clean and redlined versions must be submitted to clearly identify revisions made to policies and procedures as a result of the examination.
- b. Date the policies and procedures were implemented.
- c. Training materials and the date(s) training was conducted to ensure claim processors are aware of and comply with the requirements of the above Rules.
- d. Identification of all claims improperly denied, from August 1, 2018 through the date the corrective action was implemented by the Plan.
- e. Evidence that interest and penalty, as appropriate, were paid retroactively for the claims identified in paragraph "d" above. This evidence was to include an electronic data file/schedule (Excel or Access) that identified the following:
 - Claim number
 - Date of service
 - Date original claim received
 - Date new information received
 - Total billed
 - Original amount paid
 - Date original amount paid
 - Additional amount paid as a result of remediation

- Date additional amount paid
- Amount of original interest paid
- Amount of additional interest paid as a result of remediation
- Date additional interest paid
- Penalty amount paid, if applicable
- Number of late days used to calculate interest
- Check number for interest and penalty paid
- Provider name
- ER or Non-ER indicator

The data file was to provide the details of all claims remediated, including the total number of claims, total original claim payments, additional claim payments, and the total additional interest and penalties paid as a result of remediation.

- f. Management positions responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan was required to provide a response to the Department within 45 days of receipt of the Preliminary Report. If the Plan was not able to complete the CAP or portions of the CAP within 45 days of receipt of the Preliminary Report, the Plan was required to submit with its response a timeline that committed the Plan to complete the CAP within 90 calendar days of receipt of the Preliminary Report. If the Plan was not able to meet this timeframe, it was required to provide a justification for the delay and request approval by the Department for the proposed timeline for completion of the CAP. The Plan was also required to submit monthly status reports to the Department until the CAP is completed.

The Plan summarized the previous examination findings related to incorrect denial of claims and stated that the corrective actions implemented as a result of the last examination did not resolve the current deficiency because the root causes resulting in the 2017 deficiency were different from the root causes identified during this examination.

With regard to IPAs authorizing services but not forwarding the authorizations to the Plan, the Plan described the corrective actions taken in Part I.A.1 above.

With regard to denying claims as misdirected and processor errors the Plan stated the following:

It was discovered during the examination that certain edits in the claims system were not cross-walked to the correct Claim Adjustment Reason Codes (CARCs) and/or Remittance Advice Remark Codes (RARCs), resulting in claims being incorrectly denied, and claims examiners were inappropriately denying claims for invalid

modifiers when the Plan was the secondary payer. The system issue was corrected on June 8, 2019 and the Plan provided its "CARC/RARC Updates Workflow".

The Plan stated that claims examiners completed training on October 29, 2019 and November 1, 2019 to address all examiner errors identified during the examination.

The Plan identified claims processed from August 1, 2018 to October 1, 2019 where claims may have been incorrectly denied for no authorization. The Plan will provide to the Department a list of claims denied incorrectly. These spreadsheets will be updated once validation has been completed and the claims have been re-processed. A final report of the remediated claims will be sent to the Department by September 30, 2020.

Ann Reaves, Claims Compliance Manager, and Nancy Villaneda, Senior Manager PDR, will be responsible for overseeing the CAP.

The Department finds that the Plan's compliance efforts are not fully responsive to the corrective action required, as the Plan did not complete the remediation required by the Department. The Plan is required to identify all claims that were improperly denied from August 1, 2018 through the date the corrective action was implemented by the Plan.

The Plan is also required to provide evidence that interest and penalty, as appropriate, were paid retroactively for the claims identified in paragraph "d" above. This evidence is to include an electronic data file/schedule (Excel or Access) that identifies the following:

- **Claim number**
- **Date of service**
- **Date original claim received**
- **Date new information received**
- **Total billed**
- **Original amount paid**
- **Date original amount paid**
- **Additional amount paid as a result of remediation**
- **Date additional amount paid**
- **Amount of original interest paid**
- **Amount of additional interest paid as a result of remediation**
- **Date additional interest paid**
- **Penalty amount paid, if applicable**
- **Number of late days used to calculate interest**
- **Check number for interest and penalty paid**
- **Provider name**
- **ER or Non-ER indicator**

The data file is to provide the details of all claims remediated, including the total number of claims, total original claim payments, additional claim payments, and the total additional interest and penalties paid as a result of remediation.

The Plan is required to submit monthly status reports to the Department until the CAP is completed.

3. CLEAR AND ACCURATE DENIAL EXPLANATION – Repeat Deficiency

Rule 1300.71(d)(1) states that a plan or a plan's capitated provider shall not improperly deny, adjust, or contest a claim. For each claim that is denied, adjusted or contested, the plan or the plan's capitated provider shall provide an accurate and clear written explanation for the specific reasons for the action taken.

Rule 1300.71(a)(8)(F) states that the plan's failure to provide a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with Rule 1300.71(d)(1) at least 95 percent of the time for the affected claims over the course of any three-month period constitutes an unfair payment pattern.

Rule 1300.71.38(f) requires a plan to resolve each provider dispute and issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute or amended provider dispute.

The Department's examination disclosed that the Plan failed to provide a denial explanation or provided an explanation that was unclear or incorrect in:

- 11 out of 50 denied claims (a compliance rate of 78 percent). This deficiency was noted in the following denied claims sample numbers: 1, 3, 6, 9, 11, 16, 18, 32, 37, 43 and 45.
- Five out of 50 paid claims (a compliance rate of 90 percent). This deficiency was noted in the following paid claims sample numbers: 3, 8, 18, 29 and 34.
- Eight out of 50 late claims (a compliance rate of 84 percent). This deficiency was noted in the following late claims sample numbers: 6, 11, 20, 23, 24, 35, 43 and 47.
- Four out of 30 high dollar claims. This deficiency was noted in the following high dollar claim sample numbers: 1, 11, 16 and 25.
- 10 out of 50 claims that resulted in PDRs (a compliance rate of 80 percent). This deficiency was noted in the following PDR claim sample numbers: 4, 19, 27, 30, 31, 32, 35, 37, 43 and 49.

The Plan's failure to provide clear and accurate denial explanations is a repeat deficiency, as this issue was previously noted in the Department's final report of routine examination dated August 1, 2018, for the quarter ended June 30, 2017. This examination disclosed that the Plan's corrective actions in response to the prior final report had not achieved the necessary levels of compliance with the Rules cited.

The Plan was required to explain why the corrective actions implemented to resolve the deficiency of failure to provide an accurate and clear denial explanation, as identified in the Department's prior examination, were not effective in ensuring ongoing compliance.

In addition, the Plan was required to submit a detailed CAP that included the following:

- a. Policies and procedures, including internal claims audit procedures, implemented to ensure that all remittance advices are prepared with complete and accurate denial information. When applicable, clean and redlined versions must be submitted to clearly identify revisions made to policies and procedures as a result of the examination.
- b. Date of implementation of the new policy and procedures.
- c. Training materials and the date(s) training was conducted to ensure claim processors are aware of and comply with the requirements of the above Rules.
- d. Management positions responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan responded that the previous examination found that the root cause of the finding was due to a voided check issue. However, during this examination the root cause was due to certain system edits not being cross-walked to the correct CARCs and/or RARCs. This was corrected during the examination.

The Plan stated that it corrected a rule program setting which caused CARC 128 (newborn services covered under mother's allowance) to appear in the system and on the remittance advice in February 2019. A quarterly monitoring program was created to ensure this deficiency is corrected. Monitoring will begin the first quarter of 2020 and results will be reported to the Internal Compliance Committee quarterly. The Plan provided its "CARC/RARC Updates Workflow" and stated that this issue was addressed during the aforementioned claims examiner training.

On June 20, 2019, the Plan implemented custom logic for COB claims that were paid at zero dollars. The Plan provided its "COB Claims Paid at \$0 Business Requirements Document" created on April 2, 2019.

Ann Reaves, Claims Compliance Manager, and Nancy Villaneda, Senior Manager PDR, will be responsible for overseeing the CAP.

The Department finds the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required. Therefore, no further response is required.

PART II. NONROUTINE EXAMINATION

The Plan is advised that the Department may conduct a nonroutine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to the Preliminary Report. The cost of said examination will be charged to the Plan in accordance with Section 1382(b).