Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
Phone: 916-324-8176 | Fax: 916-255-5241
www.DMHC.ca.gov

June 24, 2026 **Via eFile**

Ms. Martha Santana-Chin
Chief Executive Officer
Local Initiative Health Authority for Los Angeles County
DBA: L.A. Care Health Plan
1200 W. 7th Street
Los Angeles, CA 90017

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

Dear Ms. Santana-Chin:

Attached is the final report (Final Report) of a routine examination for the quarter ended December 31, 2024 of the fiscal and administrative affairs, including the claims settlement practices and provider 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 April 8, 2026. The Department accepted the Plan's electronically filed responses on May 29, 2026, June 3, 2026 and June 15, 2026 (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."

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

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 Responses. If so, please indicate which portions of the Plan's Responses 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 Responses 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://wpso.dmhc.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 # S25-R-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 fully respond to the deficiencies raised in the Preliminary Report issued by the Department on April 8, 2026. 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://wpso.dmhc.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 # S25-R-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 the Office of Financial Review administrative support team at 916-255-2345 or by e-mail at ofr_admin@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 will be referred to the Department's Office of Enforcement for appropriate administrative actions.

If there are any questions regarding the Final Report, please contact me at 915-255-2425 or by e-mail at anna.belmont@dmhc.ca.gov.

Sincerely,

SIGNED BY

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

cc: Graham Floro, Compliance Advisor III, Local Initiative Health Authority for Los Angeles County
Michelle Yamanaka, Deputy Director, Office of Financial Review
Jennifer Clark, Supervising Examiner, Division of Financial Oversight
Michael Cen, Examiner, Division of Financial Oversight
Daniel Flores, Examiner, Division of Financial Oversight
Carrie Ramage, Attorney IV, Office of Plan Licensing
Chris Wordlaw, Manager II, Office of Plan Monitoring
Chad Bartlett, Supervisor II, Help Center

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

OFFICE OF FINANCIAL REVIEW
DIVISION OF FINANCIAL OVERSIGHT

FINAL REPORT OF A ROUTINE EXAMINATION

OF

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

FILE NO. 933 0355

DATE OF FINAL REPORT: JUNE 24, 2026

SUPERVISING EXAMINER: ANNA BELMONT

OVERSIGHT EXAMINER: JENNIFER CLARK

EXAMINER-IN-CHARGE: MICHAEL CEN

FINANCIAL EXAMINERS:

TOM BRAZIL

ERI FUKUDA

AGLAEE LOPEZ

NINA MOUA

ERICA SHORT

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 created to serve Medi-Cal beneficiaries in Los Angeles County. The Plan entered into a Joint Exercise of Powers Agreement with Los Angeles County (County) to establish L.A Care Health Plan Joint Powers Authority (JPA), a licensed health maintenance organization. L.A. County's Board of Supervisors established the JPA in July 2012. The JPA is a public entity, separate and apart from the County and is not an agency, division, or department of the County. The Plan and the JPA are under common management and control, however, the JPA is a separate entity and was approved to retain its QIF License by the Department on August 16, 2021.
Type of Plan:	The Plan is a full-service health care service plan.
Provider Network:	The Plan contracts directly with participating physician provider groups, hospitals, primary care and specialty care physicians, and other ancillary professionals for health care services.
Plan Enrollment:	The Plan reported 2,570,226 enrollees at December 31, 2024.
Service Area:	Los Angeles County
Date of prior Final Non-Routine Examination Report:	August 25, 2022

FINAL REPORT OF A ROUTINE 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 December 31, 2024 of a routine examination of the fiscal and administrative affairs, including the claims settlement practices and provider 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 April 8, 2026. The Department accepted the Plan's electronically filed responses on May 29, 2026, June 3, 2026 and June 15, 2026 (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 response is noted in italics within this Final Report.

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

The Department examined the Plan's financial report filed with the Department for the quarter ended December 31, 2024, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions.

The Department's findings are presented in this Final Report as follows:

Part I.	Financial Statements
Part II.	Calculation of Tangible Net Equity
Part III.	Compliance Issues

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 California 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. FINANCIAL STATEMENTS

The Department's examination did not result in any adjustments or reclassifications to the Plan's financial statements for the quarter ended December 31, 2024, as filed with the Department. A copy of the Plan's financial statements can be viewed by selecting "Local Initiative Health Authority for Los Angeles County" on the second drop-down menu of the Department's financial statement database available at http://wpso.dmhc.ca.gov/fe/search/#top.

No response is required to this Part.

PART II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth as reported by the Plan as of quarter ended December 31, 2024	$2,301,577,022
Required TNE	$202,193,429
TNE Excess per Examination	$2,099,383,593

The Plan was in compliance with the TNE requirements of Rule 1300.76 as of December 31, 2024.

No response is required to this Part.

PART III. 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 claims settlement practices as "unfair payment patterns."

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

The Department's examination found that the Plan engaged in demonstrable and unjust payment patterns and unfair payment patterns for the three-month period ended December 31, 2024, as follows:

1. PAYMENT ACCURACY, INCLUDING INTEREST AND PENALTIES – 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 also pay a fee of $10 to the claimant.

Rule 1300.71(a)(8)(K) describes a demonstrable and unjust 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 the 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.

Section 1371.35 and Rule 1300.71(i)(1) and (j), which refer to claims resulting from emergency services, require a health care service plan, if the plan is a health maintenance organization, to reimburse uncontested claims for emergency services within 45 working days after the date of receipt of the claim by the plan. If an uncontested claim for emergency services is not reimbursed within 45 working days after receipt, the plan shall pay the greater of $15 per year or interest 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 also pay a fee of $10 to the claimant.

The Department's examination disclosed that claims were not reimbursed accurately, including the automatic payment of interest and penalties in the following claim samples:

- In 23 out of 104 provider dispute resolutions (PDRs). This deficiency was noted in the following PDR sample numbers: 14, 15, 20, 21, 22, 23, 25, 28, 29, 31, 51, 55, 58, 59, 65, 67, 74, 83, 91, 96, 99, 100, and 102. The Department infers with 90 percent confidence that the true compliance rate is between 70.53 percent and 83.82 percent, with the upper bound being less than the required 95 percent compliance rate.

  The deficiency was caused by the following processor errors:

  - Failure to pay interest or underpaying interest on overturned PDRs. This issue was identified in PDR sample numbers 15, 55, and 67.

  - Incorrectly upholding PDRs that should have been overturned. This issue was identified in PDR sample numbers 20, 59, 91, and 96.

- Denying claims as the medical group's responsibility in error. This issue was identified in PDR sample numbers 22 and 29.

This deficiency was also caused by the following system configuration errors:

- The system was not configured accurately to reimburse CPT code G2023, which was terminated by DHCS for dates of service on or after May 12, 2023. The Plan was denying this CPT code for claims with the date of service prior to May 12, 2023. The issue was identified in PDR sample number 21.

- The system was configured to pay physician claims using Medi-Cal rates plus the applicable Proposition 56 supplemental payment. However, the Proposition 56 program ended December 31, 2023 and was replaced with targeted rate increases (TRI). The Plan is required to pay the higher of the Medi-Cal rate plus Proposition 56 supplemental payment or TRI rate. The issue was identified in PDR sample numbers 58 and 65.

- The system was not updated to pay current Fair Health rates on non-contracted provider claims. The issue was identified in PDR sample number 51.

- The system was not configured to automatically add the Ground Emergency Medical Transport (GEMT) Quality Assurance Fee (QAF) on ambulance claims. The supplemental payments were paid each month based on reports of processed ambulance claims. The sample claim was not captured on the monthly report because, as explained by the Plan, "the logic did not pick up the claim that was adjusted due to the line level vs header level. The header level of the claim is showing a "paid" status." The issue was identified in PDR sample number 83.

- The Medicare Ambulatory Surgical Center (ASC) rates were not uploaded in the system accurately. Per the Plan, the system has since been updated to price accordingly. The issue was identified in PDR sample number 102.

In addition, the deficiency was caused by the Plan's non-compliant policy of not reimbursing Medi-Cal emergency room rates for services provided in a hospital emergency room billed on a UB04 claim form. The issue was identified in PDR sample numbers 14, 23, 25, 28, 31, 74, 99, and 100.

- In seven out of 30 high dollar claims. The deficiency was noted in the following high dollar claim sample numbers: 2, 6, 7, 11, 19, 25, and 30.

  The deficiency was caused by the following processor errors:

- Incorrectly recouping payment on a claim instead of denying it for the primary payer reimbursing more than the Plan's allowed amount. The issue was identified in high dollar sample number 6.

- Failure to pay interest on a reprocessed claim. The issue was identified in high dollar sample number 19.

- Failure to accurately reimburse a claim using the APR-DRG calculator. The issue was identified in high dollar sample number 25.

- Failure to pay interest on a claim due to using the incorrect claim clean date. The issue was identified in high dollar sample number 30.

In addition, this deficiency was caused by the following system configuration errors:

- Incorrect configuration of the provider contract preventing outlier payments from being calculated for members assigned to a specific region. The issue was identified in sample high dollar number 11. The configuration was corrected by the Plan effective July 1, 2024, but because this claim admission date pre-dated the July 1, 2024 update, this claim was not reimbursed accurately.

- Incorrect configuration of the APR-DRG calculator. The contractual percentage allowance was applied to the APR-DRG base rate instead of the APR-DRG payment amount. The issue was identified in sample numbers 2 and 7.

The Plan's failure to reimburse claims accurately, including automatic payment of interest and penalties, is a repeat deficiency. This issue was previously noted in the Department's final report of examination dated August 25, 2022 for the quarter ended September 30, 2021. The examination disclosed that the Plan's compliance efforts in response to the prior report had not achieved the necessary levels of compliance with the Sections and Rules cited.

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

In addition, the Preliminary Report required the Plan 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 penalties. When

applicable, clean and redlined versions were to 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. Evidence that applicable changes were made to the Plan's claims processing system.

d. Training materials and the date(s) training was conducted to ensure claim processors are aware of and comply with the requirements of the above Sections and Rules.

e. Identification of all claims paid inaccurately, including interest and penalties, from September 30, 2021 through the date the corrective action was implemented by the Plan.

f. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in paragraph "e" 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
- Penalties amount paid, if applicable
- Number of late days used to calculate interest
- Check number for interest and penalties paid
- Provider name
- ER or Non-ER indicator

The data file was to provide the details of all claims remediated, including claims corrected during the course of the examination, and was to include 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.

g. Management position(s) responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

The Preliminary Report required the Plan 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, the Plan was required to submit a timeline with its response 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 responded that as part of the prior corrective action, the Claims Integrity Compliance team enhanced the monitoring process to conduct targeted audits for interest payments made on late paid claims, which has been successful in identifying and addressing inaccurate payments for late claims. However, the Plan has identified a gap in its reporting: the current report is only targeting late claims based on the claims' clean date in the system. Therefore, it would not identify the claims in which the clean date was manually brought forward in error and the interest was due, which aligns with the recent audit findings. In order to further strengthen its monitoring processes, the Plan will create a new report and validation process focused on claims with modified clean dates to identify cases where the clean date was brought forward in error and take necessary actions.

The deficiency resulted from the following root causes:

- *Variability in claims examiners' interpretation of interest calculation logic and when to apply. To remediate this root cause, the Plan will conduct targeted re-training sessions for claims teams on interest calculation, adding clear memos and regulatory requirements. The anticipated completion date is December 31, 2026. The Plan provided its revised "Interest and Penalty Calculations for claims reimbursement" policy aligned with APL 25-007 Assembly Bill 3275 guidance. The Plan also provided its PDR policy that outlines interest payment requirements on overturned PDRs. In addition, the Plan provided proof that interest calculation training was conducted in August 2024, along with related training materials "DMHC Financial Audit Findings" and "Clean Date and Memo."*

- *Gaps in validation processes to confirm correct application of interest and penalties. To remediate this root cause, the Plan implemented or is currently implementing the following corrective actions:*

    - *Established a quarterly mock-audit process and provided Claims Compliance Regulatory Mock Audits Desktop Procedure dated November 21, 2025 to the Department.*

- *Implemented the current interest payment targeted report used for generating the dashboard that displays the number of claims where interest was not applied correctly, and provided it to the Department.*

- *The Plan is creating a new report and validation process for claims with manually modified clean dates. The anticipated completion date of the new reporting implementation is December 31, 2026.*

- *The Plan is enhancing reporting capabilities to provide comprehensive oversight of claims adjudication accuracy, denial trends, and provider dispute resolution performance to identify patterns and trends for remediation, with anticipated implementation date of December 31, 2026.*

- *Limited monitoring and reporting capabilities to proactively identify and address claims and PDR payment accuracy issues. To remediate this root cause, the Plan performed or is currently performing the following system updates:*

  - *Deployed Medi-Cal Targeted Rate Increase updates on May 8, 2026. The Plan provided a screenshot demonstrating Medi-Cal TRI Fee table configuration.*

  - *Enhanced Fair Health rate upload process to 4 times a year per schedule. The Plan provided a screenshot demonstrating Fair Health Rates upload history, with the latest update on March 1, 2026.*

  - *Updated CPT Code G2023 to reflect the correct termination date of May 12, 2023. The system update and remediation were completed on June 17, 2025. The Plan provided a System Screenshot demonstrating CPT Code G2023 termination date of May 12, 2023.*

  - *Updated provider type for Medicare ASC rates to pay at correct ASC rate and applicable claims were remediated on November 17, 2025. The Plan provided backend screenshot demonstrative provider type change from "miscellaneous" to "surgical clinic."*

  - *Configured the system with "Custom" APR DRG contract to allow outlier payments with July 1, 2024 effective date. The system was reviewed on July 11, 2025.*

  - *The Plan is updating GEMT reporting to line level reporting.*

  - *The Plan will update its Core Claims System Configuration where the 26 and TC modifiers will be aligned with the Medi-Cal Fee Schedule tables. The anticipated implementation date of July 1, 2026.*

- *The examiners were trained on inpatient claims that include instructions to apply the contractual percentage allowance to the APR-DRG payment amount and not the APR-DRG base rate. The training was conducted on July 9, 2025. The Plan provided inpatient training PowerPoint presentation.*

- *The Plan will identify all claims where inaccurate interest and penalties were paid, from September 30, 2021, through the date the corrective action was implemented. The Plan expects report to be generated by July 30, 2026 and validation and remediation completed by December 31, 2026.*

The Plan's Senior Manager, Claims Administration, Claims Integrity, and Business Analyst III, Claims Data and Support Services, will be responsible for the implementation of corrective action plan.

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required since the Plan did not complete implementation of its internal audit and reporting procedures to ensure accurate claim payments, including applicable interest and penalties, and did not complete the claims remediation required by the Department. In addition, the Plan did not address the Plan's non-compliant policy of not reimbursing Medi-Cal emergency room rates for services provided in a hospital emergency room billed on a UB04 claim form.

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

2. ACCURACY OF WRITTEN PDR DETERMINATION

Rule 1300.71.38 requires a health care service plan to establish a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes in accordance with Section 1371 and Rule 1300.71.

Rule 1300.71.38(f) requires a plan to resolve each provider dispute or amended 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.

Rule 1300.71(a)(8)(S) describes an "unfair payment pattern" as the failure to comply with the time period for resolution and written determination pursuant to Rule 1300.71.38(f) at least 95 percent of the time over the course of any three-month period.

The Department's examination disclosed that the determination letter in 17 out of 104 PDRs reviewed were incomplete, contained inaccurate information, or provided incorrect reasons for upholding the original denial. The deficiency was noted in the following PDR sample numbers: 3, 4, 6, 14, 23, 25, 26, 28, 31, 49, 57, 60, 70, 73, 80,

81, and 90. The Department infers with 90 percent confidence that the true compliance rate is between 76.85 percent and 88.75 percent, with the upper bound being less than the required 95 percent compliance rate.

The primary cause for the deficiency was the Plan's failure to instruct providers to bill according to Medicare guidelines instead of Medi-Cal guidelines. Although the Plan is a Medi-Cal Plan, it requires providers to bill according to Medicare guidelines. When providers bill laboratory codes with modifier "TC", the Plan denies them for having an inappropriate modifier. When providers dispute the denial, no guidance is given on the appropriate billing of the laboratory codes.

The Preliminary Report required the Plan to submit a detailed CAP that included the following:

a. When applicable, policies and procedures, including internal claims audit procedures, implemented to ensure the accuracy and completeness of written PDR determination letters. Clean and redlined versions were to 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. Management position(s) responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan responded that the deficiency resulted from the following root causes:

- *Inconsistent system configuration and claims adjudication logic, resulting in pricing discrepancies. To remediate this root cause, the Plan will update its Core Claims System Configuration where the 26 and TC modifiers will be aligned with the Medi-Cal Fee Schedule tables from the Department of Health Care Services. The anticipated completion date of the system update is July 1, 2026. In addition, the Plan will conduct targeted training for claims teams on updated split billing logic with anticipated completion date of July 30, 2026.*

- *Inconsistent monitoring of validation for completeness of written determination. The Plan revised its Internal Claims Auditing and Monitoring policy to include review of the claim image, system edits, system and manual pricing, authorizations, and denial accuracy and clarity. The policy was revised on May 21, 2026 and provided to the Department.*

- *Gaps in reporting and audit processes to demonstrate compliance with clarity of dispute resolutions. To remediate this root cause, the Plan is in the process of*

implementation of enhanced audit processes to ensure that all dispute resolutions include clear and complete written determinations. The anticipated completion date of phase one is July 30, 2026 and phase 2 is December 31, 2026.

The Plan's Business Analyst III, Claims Data and Support Services, and Business Analyst II, Claims Data and Support Services, will be responsible for implementation of the CAP.

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required since the Plan did not complete the system configuration to align with the Medi-Cal fee schedule, did not conduct the specified training, and did not complete implementation of its internal audit and reporting procedures to ensure all dispute resolutions include clear and complete written determinations.

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

B. ACCURATE AND CLEAR DENIAL EXPLANATION

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 of the specific reasons for the action taken.

The Department's examination disclosed that the Plan did not provide an accurate and clear denial explanation in nine out of 104 PDRs when the original remittance advice was issued on the claim. The deficiency was noted in the following PDR sample numbers: 37, 40, 46, 54, 65, 67, 72, 79, and 84.

In addition, six out of 30 high dollar claims did not provide an accurate and clear denial explanation. The deficiency was noted in the following high dollar claims sample numbers: 1, 12, 21, 23, 26, and 28.

The Preliminary Report required the Plan 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 were to 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. Evidence that applicable changes were made to the Plan's claims processing system.

d. 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.

e. Management position(s) responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan responded that the deficiency resulted from the following root causes:

- *Inconsistent application of denial criteria and documentation standards across claims examiners. To remediate this root cause, the Plan conducted targeted training sessions for claims teams on incorrect claim denials and provided training material "DMHC Audit Findings – Incorrect Claim Denials" to the Department.*
- *Inconsistent application of denial reason codes and selection logic within the claims adjudication system. To remediate this root cause, Plan is in the process of enhancing and standardizing Claims and PDR Core Processing systems denial reasons and application logic, The anticipated completion date of phase one is July 30, 2026 and phase 2 is December 31, 2026.*
- *Limited quality assurance validation focused specifically on clarity and completeness of denial explanation. To remediate this root cause the Plan implemented or is currently implementing the following corrective actions:*
    - *Implementing a daily reporting and supporting process to identify and remediate incomplete denial reasons. The anticipated implementation date is July 30, 2026.*
    - *Implementing enhanced audit processes to ensure that all denied claims and PDRs have accurate and clear denial explanations. The anticipated implementation date is December 31, 2026.*
    - *Revised its Internal Claims Auditing and Monitoring policy to include review of the claim image, system edits, system and manual pricing, authorizations, and denial accuracy and clarity. The policy was revised on May 21, 2026 and provided to the Department.*

The Plan's Senior Manager, Claims Administration, Claims Integrity, and Business Analyst III, Claims Data and Support Services, will be responsible for implementation of the CAP.

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required since the Plan did not complete the standardization

of its Claims and PDR Core Processing systems denial reason and did not complete implementation of its internal audit and reporting procedures to ensure that all denied claims and PDRs have accurate and clear denial explanations.

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

C. ENROLLMENT CANCELLATION NOTICE

Section 1352(a) and Rule 1300.52 require all plans to file an amendment within thirty days after any changes in the information contained in its application, other than financial or statistical information. Section 1352 and Rule 1300.52.4 set forth the standards for filing amendments.

Rules 1300.65 through 1300.65.5 outline requirements relating to cancellations, rescissions, and nonrenewals of an enrollment or subscription, including notice requirements.

The Department's examination disclosed that the Plan revised its enrollment cancellation notices, including "Notice of Grace Period" and "Notice of End of Coverage", but did not file the revised templates with the Department.

During the course of the exam, the Plan filed its updated templates of "Notice of Grace Period" and "Notice of End of Coverage" with the Department.

The Preliminary Report required the Plan to implement corrective actions to ensure changes to previously submitted exhibits are filed with the Department pursuant to the above Section and Rules, provide clean and redlined versions of related policies and procedures when applicable, state the date of implementation, and identify the management position(s) responsible for ensuring ongoing compliance.

The Plan responded that the deficiency resulted from the following root causes:

- *Currently, materials are submitted through Podio by business units, and Legal reviews and tags materials requiring the Department's filing. In this case, there was inadequate oversight of the process/system due to the heavy workload, staffing concerns and high volume of Podio entries received during that period. This resulted in Legal inadvertently failing to submit the relevant Podio submission to the Department after it was tagged in Podio for the Department's filing. To remediate this root cause, Legal will continue to advise submitters in the Podio comments section of the determination that certain materials should be filed with the Department. However, the business unit (BU) will be required to submit a request in Legal's Legal Matter Management (LMM) system to actually trigger Legal's Department submission process and will provide the final version of the subject documents in that process.*

- *Excluding Podio, there is no other current protocol that provides additional notice and tracking support for the BUs and Legal team of materials that have been identified for Department's filing. Unlike other requests for legal analysis and support, requests for legal review of Podio materials for the Department's filing are not submitted by the BU into Legal's LMM system. Podio should not be the only process for requesting Legal submit a document for the Department's filing due to the high volume of Podio entries, most of which do not require Department's filing. To remediate this root cause, Legal will provide the BU with instructions for submitting Department filling requests of Podio materials into LMM.*

- *Legal's review of Podio documents is often complicated in that the document presented in Podio is not assured to be the final version which may necessitate multiple reviews, and the business need for the document may change or be delayed resulting in reviews that are no longer needed or applicable. To remediate this root cause, Legal recommended Compliance to revise the Podio training materials available on Laci (and elsewhere if applicable) to include instructions to submitters to enter documents requiring Department's filing into LMM.*

Legal Services is in the process of drafting procedures to address this issue. The anticipated completion date for the above corrective actions is September 30, 2026.

The Plan's Associate Counsel III, Senior Director, Health Care Legal Services, Legal Services Department will be responsible for implementation of the CAP.

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required since the Plan did not complete the development and implementation of the policies and procedures to ensure that changes to previously submitted exhibits are filed with the Department.

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

D. CHANGES IN PLAN PERSONNEL

Section 1352(c) and Rule 1300.52.2 state, in part, that a plan shall, within five days, file an amendment when there are changes in personnel of the plan. Changes in personnel refer to the addition or deletion of a director, trustee, principal officer, general partner, general manager or principal management persons, or persons occupying similar positions, or performing similar functions, or a substantial and material change in the duties of any such person.

The Department's examination disclosed that the Plan did not timely file the key personnel changes indicated in the table below with the Department.

Position Title	Reason	Effective Date	Filing Date	Days Late
Board of Governors	Election	4/4/2023	4/11/2023	2
Board of Governors	Election	12/6/2022	12/20/2022	9
Director of DPSS and Board of Governors	Resigned	5/20/2022	6/14/2022	20

The Preliminary Report required the Plan to implement corrective actions to ensure changes in key personnel are filed with the Department within five days pursuant to the above Section and Rule, provide clean and redlined versions of related policies and procedures when applicable, state the date of implementation, and identify the management position(s) responsible for ensuring ongoing compliance.

The Plan responded that the deficiency resulted from the following root causes:

- *For the matter involving the departure of Director of DPSS, the Plan did not submit notification timely due to an error. To remediate the root cause, the Plan will ensure that Legal obtains notice of departures timely from Board Services and/or Human Resources, will calendar the filing due date, and will include Legal administrative staff to track compliance.*

- *For the matter involving submission of filings of new Officers, the Plan believed that filings due on Saturday (per the Code of Civil Procedure) could be submitted on the following Monday; The Plan has been informed that the Department believes that filings that are due on Saturdays are due on the preceding Friday. To remediate the root cause, the Plan will review appropriate timing for submission of filings based on the Knox-Keene Health Care Service Plan Act of 1975 in detail to obtain fuller knowledge of the requirements related to changes in key personnel, including timing of filings.*

- *For the matter involving the late submission of an Officer filing, the root cause was that the Plan did not receive all required documentation in a timely manner from relevant departments and/or the new Officer so it delayed the filing until the information was received. To remediate the root cause, the Plan will submit filings even if there is incomplete/missing documentation to meet the timing requirement and will escalate noncompliance to obtain appropriate documentation timely for the filing.*

The Plan's Legal Services is in the process of drafting procedures to address this issue. The anticipated completion date for the above corrective actions is September 30, 2026.

The Plan's Associate Counsel III, Senior Director, Health Care Legal Services, will be responsible for implementation of the CAP.

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required since the Plan did not complete the development and implementation of the policies and procedures to ensure changes in key personnel are filed with the Department within five days.

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