



Edmund G. Brown Jr., Governor  
State of California  
Health and Human Services Agency

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**Department of Managed Health Care**  
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July 24, 2014

via USPS Delivery and eFile

Dr. Thomas Horowitz, Chair of the Board of Governors  
**LOCAL INITIATIVE HEALTH AUTHORITY FOR LOS ANGELES COUNTY**  
1055 West 7<sup>th</sup> Street  
Los Angeles, CA 90017

**FINAL REPORT OF ROUTINE EXAMINATION OF LOCAL INITIATIVE  
HEALTH AUTHORITY FOR LOS ANGELES COUNTY**

Dear Dr. Horowitz:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of Local Initiative Health Authority for Los Angeles County (the "Plan"), conducted by the Department of Managed Health Care (the "Department"), pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.<sup>1</sup> The Department issued a Preliminary Report to the Plan on April 14, 2014. The Department accepted the Plan's electronically filed response on May 29, 2014.

This Final Report includes a description of the compliance efforts included in the Plan's May 29, 2014 response, 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 ten (10) days from the date of the Plan's receipt of this letter whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and

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<sup>1</sup> References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

electronically file copies of those portions of the Plan's response 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 to the report or wishes to modify any information provided to the Department in its May 29, 2014 response, please provide the electronically filed documentation no later than ten (10) days from the date of the Plan's receipt of this letter through the eFiling web portal. Please file this addendum electronically via the Corrective Action Plan system ("CAP system") within the Online Forms Section of the Department's eFiling web portal <https://wpsso.dmhc.ca.gov/secure/login/>, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "Online Forms".
- From the Existing Online Forms menu click on the "Details" for the DFO Corrective Action Plan **L14-R-355**
- Go to the "Messages" tab
  - Select "Addendum to Final Report" (note this option will only be available for 10 days after the Final Report has been issued)
  - 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"
  - Click "Send Message"

As noted in the attached Final Report, the Plan's response of May 29, 2014 did not fully respond to the deficiencies raised in the Preliminary Report issued by the Department on April 14, 2014. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any request for additional corrective action contained within the attached Final Report, within 30 days after receipt of the 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 Office of Enforcement for appropriate administrative action for any remaining, unresolved deficiencies.

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

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "Online Forms".
- From the Existing Online Forms menu click on the "Details" for the DFO Corrective Action Plan **L14-R-355**
- Go to the "Data Requests" tab
  - 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 send the Plan an e-mail(s) requesting those 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 the response should be directed to Susan Levitt at (916) 255-2443 or email at [Susan.Levitt@dmhc.ca.gov](mailto:Susan.Levitt@dmhc.ca.gov). You may also email inquiries to [wpsso@dmhc.ca.gov](mailto:wpsso@dmhc.ca.gov).

**The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter through the eFiling system. The report will be located at the Department's web site at [View Department Issued Final Examination Reports](#).**

If there are any questions regarding this report, please contact me.

Sincerely,

**ORIGINAL SIGNED BY**

NED GENNAOUI  
Senior Examiner (Supervisor)  
Office of Financial Review  
Division of Financial Oversight

cc: Augustavia J. Haydel, Chief Legal Officer, Local Initiative Health Authority for Los Angeles County  
Gil Riojas, Deputy Director, Office of Financial Review  
Joan Larsen, Supervising Examiner, Division of Financial Oversight  
Thomas Roedl, Examiner, Division of Financial Oversight  
Dayana Joseph, Monitoring Examiner, Division of Financial Oversight  
Melissa Moon, Senior Counsel, Office of Plan Licensing  
Laura Dooley Beile, Chief, Division of Plan Surveys

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

**DIVISION OF FINANCIAL OVERSIGHT**

**FINAL REPORT OF THE ROUTINE EXAMINATION  
OF  
LOCAL INITIATIVE HEALTH AUTHORITY FOR LOS ANGELES  
COUNTY**

**FILE NO. 933 0355**

**DATE OF FINAL REPORT: JULY 24, 2014**

**OVERSIGHT EXAMINER: NED GENNAOUI**

**EXAMINER-IN-CHARGE: THOMAS ROEDL**

**FINANCIAL EXAMINERS:**

**JULIANA ASABOR  
GALAL GADO**

**BACKGROUND INFORMATION FOR  
LOCAL INITIATIVE HEALTH AUTHORITY FOR LOS ANGELES COUNTY**

Date Plan Licensed:	April 1, 1997
Organizational Structure:	Local Initiative Health Authority for Los Angeles County (the “Plan” or “L.A. Care”) is an independent local public agency created to serve Medi-Cal beneficiaries in Los Angeles County. The County Board of Supervisors established the Local Initiative Health Authority for Los Angeles County in 1994. A thirteen member Board of Governors sets policy for the Plan and oversees its planning, development and administration. The Department of Health Care Services pays the Plan a fixed per-member, per-month payment for each Medi-Cal member. The Plan provides health care services to Medi-Cal beneficiaries primarily through contracts with its Plan Partners, including Anthem Blue Cross of California, Care 1st Health Plan and Kaiser Foundation Health Plan.
Type of Plan:	The Plan is a full service health plan providing services primarily to Medi-Cal beneficiaries through various programs. Healthy Families program members were transitioned to Medi-Cal starting March 2013 and completed February 2014. In-Home Supportive Services (“IHSS”) membership was transferred from Community Health Plan to the Plan in February 2012 and subsequently renamed Homecare Workers Health Care Plan. In addition, the Plan participates in the Healthy Kids and the Medicare Advantage Special Needs Programs.
Provider Network:	The Plan subcontracts the delivery of health care services through its Plan Partners provider network and contracts directly with participating physician provider groups, hospitals, and ancillary professionals. The Plan compensates the providers on a capitated or per diem payment basis.
Plan Enrollment:	As of September 30, 2013, the Plan reported total enrollment of 1,197,442 members consisting of 1,147,142 Medi-Cal Risk; 43,048 IHSS; 3,107 Medicare Risk; 3,051 Medi-Medi; 1,082 Healthy Kids; and 12 Healthy Families enrollees.
Service Area:	Los Angeles County
Date of last Final Routine Examination Report:	February 22, 2010

**FINAL REPORT OF A ROUTINE EXAMINATION OF  
LOCAL INITIATIVE HEALTH AUTHORITY FOR LOS ANGELES COUNTY**

This is the Final Report of a routine examination of the fiscal and administrative affairs of Local Initiative Health Authority for Los Angeles County (the “Plan” or “L.A. Care”), conducted by the Department of Managed Health Care (the “Department” or “DMHC”) pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.<sup>1</sup> The Department issued a Preliminary Report to the Plan on April 14, 2014. The Department accepted the Plan’s electronically filed response on May 29, 2014.

This Final Report includes a description of the compliance efforts included in the Plan’s May 29, 2014 response to the Preliminary Report, in accordance with Section 1382(c). The Plan’s response is noted in *italics*.

The Department examined the financial report filed with the Department for the quarter ended September 30, 2013, 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 report as follows:

Section I.	Financial Report
Section II.	Calculation of Tangible Net Equity
Section III.	Compliance Issues

***Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective action contained within this report, within 30 days after receipt of this report.***

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<sup>1</sup> References throughout this report to “Section” are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the California Health and Safety Code Section 1340, et seq. References to “Rule” are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

**SECTION I. FINANCIAL REPORT**

The Department's examination did not result in any adjustments or reclassifications to the Plan's financial statements for the quarter ended September 30, 2013, as filed with the Department. A copy of the Plan's financial statements can be viewed at the Department's website by typing the link <http://wpsso.dmhc.ca.gov/fe/search.asp> and selecting Local Initiative Health Authority for Los Angeles County from the first drop down menu.

**No response was required to this Section.**

**SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)**

Net Worth and TNE as reported by the Plan as of the Quarter Ended September 30, 2013	\$175,943,053
Required TNE	<u>34,075,114</u>
TNE Excess per Examination	<u>\$141,867,939</u>

The Plan is in compliance with the TNE requirement of Section 1376 and Rule 1300.76 as of September 30, 2013.

**No response was required to this Section.**

**SECTION III. COMPLIANCE ISSUES**

**A. CLAIM 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 a "demonstrable and unjust payment pattern" or "unfair 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 “unfair payment patterns” for the three-month period ending September 30, 2013, as follows:

**1. PAYMENT ACCURACY OF INTEREST ON LATE CLAIMS – *Repeat Deficiency***

Section 1371 and Rule 1300.71(i)(2) and (j) require a health care service plan to reimburse uncontested claims no later than 45 working days after the date of receipt of the claim by the plan and require that if an uncontested claim is not reimbursed within 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first

calendar day after the 45 working day period. The penalty for failure to comply with this requirement shall be a fee of ten (\$10) dollars paid to the claimant.

Section 1371.35 and Rule 1300.71 (i)(1), which refer to claims resulting from emergency services, require that if an uncontested claim is not reimbursed within 45 working days after receipt, the plan shall pay the greater of \$15.00 or interest at the rate of 15% per annum, beginning with the first calendar day after the 45 working day period. The penalty for failure to comply with this requirement shall be a fee of ten (\$10) dollars.

Rule 1300.71(a)(2) states a “Complete Claim” means a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides reasonably relevant information and information necessary to determine payer liability.

Rule 1300.71(a)(8)(K) describes one unfair payment pattern as the failure to reimburse at least 95% 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 found that seven (7) out of the 73 late claims reviewed had interest that was not paid or was underpaid (a compliance rate of 90 percent). The incorrect payment of interest was the result of the Plan not selecting the correct date of receipt of a Complete Claim to calculate the number of days used in determining the amount of interest payable on these late claims. Therefore, the Plan demonstrated an unfair payment pattern according to Section 1371.37 (c)(4) for failing to automatically include the interest due on late claim payments during the three-month period ended September 30, 2013. They included late claim sample numbers 4, 15, 17, 20, 49, 71 and 73.

The Plan’s failure to pay interest correctly on late claim payments was a repeat deficiency, as this issue was previously noted in the Department’s Final Report of Examination dated February 22, 2010, for the quarter ended December 31, 2008. This examination disclosed that the Plan’s compliance efforts in response to the prior report had not achieved the necessary levels of compliance with the Act and Regulations cited.

**This repeat violation may be referred to the Office of Enforcement for appropriate administrative action upon resolution of all deficiencies addressed in this Final Report.**

The Preliminary Report required the Plan to explain why the corrective actions implemented by the Plan to resolve the deficiency of not paying interest correctly on late claim payments, found in the Department’s prior examination, were not effective in ensuring ongoing compliance.

In addition, the Plan was required to submit a Corrective Action Plan (“CAP”) to address the deficiency cited above. The CAP was to include the following:

- a. Policy and procedures implemented to ensure that the date of receipt of a Complete Claim was used to determine whether interest and penalty, if applicable, were required to be included with payments on late claims in compliance with the above Sections and Rules.
- b. Training procedures to ensure that claim processors were properly trained on interest and penalty requirements.
- c. Audit procedures to ensure that the Plan was monitoring correct payment of interest and penalties on late and late adjusted claims payments.
- d. Identification of all late claims for which interest and penalties were not correctly paid from June 1, 2009 (the date after the last remediation date of the prior examination) through the date corrective action has been implemented by the Plan.
- e. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in the paragraph immediately above. This evidence was to include an electronic data file (Excel or Access) or schedule that identified the following:
  - Claim number
  - Date of service
  - Date original claim received
  - Date of receipt of new information
  - Date of receipt for complete claim
  - Total billed
  - Total paid
  - Paid date (mail date)
  - Amount of original interest paid
  - Date interest paid
  - Penalty amount originally paid
  - Number of late days used to calculate interest (with formula)
  - Total interest owed per claim (with formula)
  - Amount of additional interest paid in remediation (Total interest owed minus previous interest paid)
  - Penalty amount paid
  - Date additional interest and penalty paid, if applicable
  - Check number for additional interest and penalty paid amount
  - Provider name
  - ER or Non-ER indicator

The data file was to provide the detail of all claims remediated, and to include the total number of claims and the total additional interest and penalty paid as a result of remediation.

- f. Date the revised policy and procedures, training and auditing procedures were implemented and the management position(s) responsible to oversee the CAP and to ensure ongoing compliance.

*The Plan responded that in its efforts to ensure that claims are forwarded timely, in February 2013, L.A. Care contracted with a vendor for optical character recognition (“OCR”) services. The contract with that vendor was implemented in April 2013. During the implementation process for the OCR claims vendor, L.A. Care implemented a change in the process which caused the incorrect date of receipt of claim to be assigned. In mid-July 2013, L.A. Care discovered that claims were being loaded into L.A. Care’s systems using the date received at L.A. Care rather than the first date stamp date which created date of receipt discrepancies for claims loaded into L.A. Care systems from the scanning vendor. Upon discovery of the error, the Plan stated their claims examiners were instructed to manually review the date of receipt for all scanned claims and to update as necessary. The issue was reported to L.A. Care’s electronic data interchange team who implemented corrective action to remediate the error on August 6, 2013. The Plan indicated their audit review tool was updated to include a specific task of reviewing the claim date of receipt to ensure accuracy.*

*The Plan responded that the cause of the inaccurate interest payments is related to the use by L.A. Care of an incorrect date of receipt of claims that originated during the Plan’s transition to a new claims scanning vendor and resulted in the use of an incorrect date of receipt field during the claims load process at L.A. Care. The Plan represented that the incorrect receipt date is limited to April 15, 2013 through August 6, 2013. The Plan indicated that the process in place for the loading of claims prior to April 15, 2013 utilized a different methodology for the loading of the date of receipt into the Plan’s claims systems which precluded the possibility of an incorrect date assignment. The Plan believes that it was in compliance with the required compliance standard prior to and after the time period set forth above.*

*The Plan summarized the scope and extent of the use of the incorrect receipt of claim date, as follows:*

- *For claims received from July 1, 2009 until approximately April 15, 2013, the correct date of receipt was used during all claims load process;*
- *For claims received from April 15, 2013 through August 6, 2013, claims were loaded with the incorrect date of receipt. The error was identified in mid-July 2013 and claims loaded into L.A. Care’s system after July 16, 2013 were updated to reflect the correct date of receipt;*
- *For claims received after August 6, 2013, the correct date of receipt was used and no updates or changes to the claims received dates were required.*

*The Plan believes that an equitable resolution and appropriate CAP is for L.A. Care to reprocess those claims for the limited time period during which the discrepancies in the date of receipt used created a situation where interest may now be due on claims where no interest was paid, as well as those situations where interest was paid but additional interest is now payable. The Plan recognizes that it shall pay penalties for claims during this time period. The Plan respectfully requested that the Department permit L.A. Care to remediate this*

*deficiency for claims improperly paid for the period April 15, 2013 through August 6, 2013, rather than from June 1, 2009 to the present. The Plan stated that the anticipated remediation date for the payment of interest and penalty is July 15, 2014.*

*The Plan submitted details of a CAP which included enhanced training for claims department staff on the correct received date conducted on May 23, 2014, revised policy and procedures on the same subject titled "Claims Received Date Guidelines" drafted on May 23, 2014, and audit procedures to ensure compliance with the correct payment of interest on late claims, implemented on May 27, 2014.*

*The Plan's Compliance Officer was identified as the management position responsible for ongoing compliance.*

**The Department finds that the Plan's compliance efforts are not fully responsive to the deficiency cited and the corrective actions required because the Plan did not complete the required actions set forth in the Preliminary Report.**

**The Department approves the Plan's proposal to limit its review and remediation to late paid claims received during the period of April 15, 2013 through August 6, 2013, and the Department anticipates that the evidence of remediation will be filed with the Plan's response to this Final Report.**

**The Plan is again required to submit evidence of the identification and remediation payment of interest and penalty, as described above in paragraphs d. and e., with its response to this Report. In addition, the Plan is required to file a final version of the policy document titled "Claims Received Date Guidelines" dated November 4, 2013, as the copy provided was watermarked as a draft document.**

## **2. FORWARDING MISDIRECTED CLAIMS – Repeat Deficiency**

Rule 1300.71(b)(2)(A) and (B) states that when a claim is sent to a health care service plan that has contracted with a capitated provider that is responsible for adjudicating the claim, the plan shall do the following:

- If the claim involves emergency services, the plan must forward the claim to the appropriate capitated provider within ten (10) working days of receipt of the claim that was incorrectly sent to the plan.

For those claims that do not involve emergency service or care:

- If the provider that filed the claim is contracted with the plan's capitated provider, the plan must, within ten (10) working days from receipt of the claim, either send the claimant a notice of denial including instructions to bill the capitated provider or send the claim to the appropriate capitated provider.

- For all other claims, the plan must, within ten (10) working days from receipt of the incorrectly sent claim, forward the claim to the appropriate capitated provider.

Rule 1300.71 (a)(8)(B) describes one unfair payment pattern as the failure to forward at least 95% of misdirected claims consistent with Rule 1300.71(b)(2)(A) and (B) over the course of any three-month period.

The Department's examination found that nine (9) out of 87 denied claims reviewed were not forwarded to the appropriate capitated provider by the Plan within ten (10) working days from receipt (a compliance rate of 90 percent). They included denied claim sample numbers 14, 22, 23, 40, 44, 47, 52, 59 and 60.

The Plan's failure to forward misdirected claims timely was a repeat deficiency, as this issue was previously noted in the Department's Final Report of Examination dated February 22, 2010, for the quarter ended December 31, 2008. This examination disclosed that the Plan's compliance efforts in response to the prior report had not achieved the necessary levels of compliance with the Regulation cited.

**This repeat violation may be referred to the Office of Enforcement for appropriate administrative action upon resolution of all deficiencies addressed in this Final Report.**

The Preliminary Report required the Plan to explain why the corrective actions implemented by the Plan to resolve the deficiency of not forwarding misdirected claims timely, found in the Department's prior examination, were not effective in ensuring ongoing compliance.

In addition, the Plan was required to submit a detailed CAP to bring the Plan into compliance with the above Rule that included, but was not limited to, the following:

- a. Training procedures to ensure that claim processors were properly trained on forwarding misdirected claims timely;
- b. Audit procedures to confirm that misdirected claims were processed in compliance with Rule 1300.71(b)(2)(A) and (B); and
- c. The date of training and implementation of the audit procedures and the management position(s) responsible for ensuring ongoing compliance.

*The Plan responded that it took substantial steps to ensure that claims received are forwarded in a timely manner to the financially-responsible downstream capitated providers. In August 2012, L.A. Care embarked on a project to improve forwarding by bringing the claims scanning function in-house. Prior to August 2012, the Plan indicated its practice was to ship all paper claims to a scanning vendor via two (2) day air shipping. By bringing the scanning function in-house, L.A. Care was able to shave two days off of the claims intake process. The*

*project was completed on May 15, 2013, and resulted in a consistent 2-day improvement in forwarding misdirected claims.*

*L.A. Care believes that the root cause for the late forwarded claims currently identified by the Department is related to: 1) Claims where recent changes in the member's enrollment occurred and the member's information was not yet updated or the member could not be identified using the criteria supplied by the billing provider (i.e., "MNF" or member not found claims); or 2) Claims received from the contracted provider groups with early receipt date stamps.*

*L.A. Care believes that migration to a new core claims system, which is scheduled to occur in the 2<sup>nd</sup> half of 2014, will address both of these issues. The Plan described the structures that will be present in the new system include:*

- *All claims forwarding functions to and from L.A. Care and its contracted provider groups will be done via electronic data interchange ("EDI") utilizing the HIPAA-compliant "837" claims EDI interfaces. The 837 EDI format will be used for both professional and institutional claims.*
- *MNF claims will be managed in a real time environment.*

*The steps that L.A. Care states were taken since the Department's previous audit to ensure that misdirected claims are timely forwarded include:*

- *In November 2012, additional staffing was added to the Mail Forwarding Department.*
- *In April 2013, an increase in the lag days in forwarding claims was identified and further additional staffing was added to ensure that the process remained timely. No appreciable increase in lag time in claims forwarding was identified since that time. Claims are forwarded within two (2) business days of load into L.A. Care's systems.*
- *In January 2014, the Claims Quality Audit Department identified an issue with the timeliness of forwarding claims where the member listed on the claim was not immediately identifiable by L.A. Care's systems. The timeframe to review and resolve claims with membership issues was immediately addressed, with the result that MNF claims are consistently processed within two (2) business days.*
- *Additionally, L.A. Care claims mailroom is in the process of developing a proposal to purchase limited functionality OCR software. This software will allow the claims mailroom to read the member information listed on the claim form and compare it against membership lists immediately to identify any potential issue in matching the member to the Plan's eligibility databases. The Plan states the implementation of this solution will allow the MNF process to move from a retrospective, batch process to a proactive, real time activity which will rapidly identify member information.*

*The Plan avers that the activities it has taken to bring the misdirected claims forwarding processes into compliance have been substantial, and the Plan believes that it has met the intent of the corrective action plan filed with the Department as a result of its previous audit. The Plan responded that the activities undertaken by L.A. Care demonstrate a consistent*

*pattern of monitoring forwarded claims, identification of any issues or concerns found with the forwarding process, development of remediation program(s) to address these issues, and implementation of solutions that remove the underlying cause of the problem, thereby allowing the Plan to continue to timely forward claims. Additionally, the significant efforts the Plan has undertaken as part of our core system replacement project demonstrate a deep understanding of the business needs and technical requirements associated with effectively forwarding claims and demonstrate the Plan's continued effort to ensure that it is utilizing tools that allow it to remain compliant with the Department's requirements.*

*The Plan submitted details of a CAP implemented on May 23, 2013 which included enhanced training for claims department staff on misdirected claims and audit procedures to ensure timely forwarding of misdirected claims.*

*The Plan's Compliance Officer was identified as the management position responsible for ongoing compliance.*

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

### **3. INCORRECT CLAIM DENIALS**

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 one unfair payment pattern as the failure to reimburse at least 95% 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 seven (7) out of 87 denied claims reviewed were improperly denied and should have been paid (a compliance rate of 92 percent). These improper denials were due to various processor errors. They included denied claim sample numbers 4, 27, 30, 31, 38, 52 and 85.

**This violation may be referred to the Office of Enforcement for appropriate administrative action upon resolution of all deficiencies addressed in this Final Report.**

The Preliminary Report required the Plan to submit a CAP to address the deficiency cited above. The CAP was to include the following:

- a. Evidence that correct payments were made to the seven providers associated with the claim samples identified above, including interest and penalties, as appropriate. In addition, the Plan was required to reprocess all claims for these seven providers, from January 1, 2009 (the date after the balance sheet date of the

prior examination) through the date of corrective action, that were denied for the same reasons identified as incorrect denials in the examination denied sample. 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 total paid
- Original paid date
- Amount of adjustment paid (with check number)
- Date adjustment paid/mailed
- Amount of original interest paid
- Original interest paid date
- Number of days used to calculate interest
- Amount of additional interest paid (with formula)
- Date additional interest paid
- Penalty paid
- Date penalty paid
- Check number for interest and/or penalty
- Provider name
- ER or Non-ER indicator

The data file was to provide the detail of all claims remediated, and to include the total number of claims, total additional payments, and total additional interest and penalty paid as a result of remediation.

- b. Training procedures to ensure that claims were properly processed, and denied or paid, in accordance with provider contracts.
- c. Audit procedures to ensure that the Plan was monitoring proper denial of claims in accordance with Rule 1300.71(d)(1).
- d. The date of training and implementation of the audit procedures and the management position(s) responsible to oversee the CAP and to ensure ongoing compliance.

*The Plan responded that it took significant action to address the issue of inaccurate claim denials. The Plan stated it identified a lack of consistent and well-structured training materials as one of the reasons for the inaccurate adjudication of claim denials.*

*In December 2013, the Plan indicated it awarded a contract for the development of claims training materials which was completed on May 22, 2014. L.A. Care will use the materials to*

*train its claims examiners as set forth in the CAP for this deficiency. Training was conducted as materials were developed, and claim processor needs were identified.*

*L.A. Care has been rotating staff through training sessions on the new materials as materials are completed. Each training session includes a pre-training assessment, training materials, and a post-training assessment. L.A. Care believes that the activities it has undertaken to remediate its training program are sufficient to address this deficiency going forward.*

*The Plan stated that it expects to have 6,500 claims associated with the seven identified providers reprocessed within the 90 day time period specified by the Department.*

*The Plan submitted additional policies and procedures titled “Coordination of Benefits” and “Misdirected Claims Processing” that became effective May 28, 2014. In addition, the Plan implemented audit procedures on May 23, 2014.*

*The Plan’s Compliance Officer was identified as the management position responsible for ongoing compliance.*

**The Department finds that the Plan’s compliance efforts are not fully responsive to the deficiency cited and the corrective actions required because the Plan did not complete the required actions set forth in the Preliminary Report. The Department anticipates that the evidence of remediation will be filed with the Plan’s response to this Final Report.**

**The Plan is again required to submit evidence of remediation payment, as described above in paragraph a., with its response to this Report.**

#### **4. UNTIMELY DENIAL OF CLAIMS**

Section 1371 and Rule 1300.71 (h) require a health care service plan to contest or deny claims no later than 45 working days after the date of receipt of the claim by the plan.

Section 1371.35, which refers to claims for emergency services, requires a health care service plan to contest or deny claims no later than 45 working days after the date of receipt of the claim by the plan.

Rule 1300.71(a)(8)(L) describes one unfair payment pattern as the failure to contest or deny a claim within the timeframes of Rule 1300.71(h) and Section 1371 or 1371.35 at least 95% of the time for the affected claims over the course of any three-month period.

The Department’s examination found that nine (9) out of 87 denied claims reviewed were not contested or denied within 45 working days after the date of receipt by the Plan (a compliance rate of 90 percent). They included denied claim sample numbers 11, 16, 41, 48, 60, 63, 69, 75 and 83.

**This violation may be referred to the Office of Enforcement for appropriate administrative action upon resolution of all deficiencies addressed in this Final Report.**

The Preliminary Report required the Plan to submit a detailed CAP to bring the Plan into compliance with the above Sections and Rule that included, but was not limited to, the following:

- a. Training procedures to ensure that claim processors were properly trained on the timely denial of claims;
- b. Audit procedures to confirm that denied claims were processed timely; and
- c. The date of training and implementation of the audit procedures and the management position(s) responsible for ensuring ongoing compliance.

*The Plan responded that the Claims Director will communicate with the Claims Trainer to ensure that Claim Timelines are incorporated into the training program. In addition, the Claims Director will work weekly with the Claims Management Team to review the claims aging and identify if additional temporary employees need to be hired. Additionally, based on current staff, the Claims Director will review the department's structure and make sure that all positions are filled.*

*The Plan submitted policies and procedures titled "Claims Timeliness" and "Oversight of Claims Timeliness". In addition, the Plan represented it conducted training and implemented audit procedures on May 27, 2014.*

*The Plan's Compliance Officer was identified as the management position responsible for ongoing compliance.*

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

## **B. OTHER CLAIMS DEFICIENCY**

### **1. RECEIPT DATE OF CLAIMS**

Rule 1300.77.4 requires all plans to institute procedures whereby all claims received by the plan are maintained and accounted for in a manner which permits the determination of date of receipt of any claim, the status of any claim, the dollar amount of unpaid claims at any time and the rapid retrieval of any claim.

Rule 1300.71 (a)(6) defines the date of receipt as the working day when a claim is delivered to either the plan's specified claims payment site, post office box, or to its designated claims processor.

The Department's examination disclosed that the date of receipt entered into the Plan's claims payment processing system was significantly different from the actual date of receipt stamped on the claim image. An incorrect date of receipt can result in late claim payments, interest not being calculated correctly, and incorrect determination of claims payable balance. This deficiency was noted in 21 denied claims including sample numbers 1, 6, 9, 22, 24, 28, 41, 43, 44, 47, 56, 60, 63, 64, 68, 69, 71, 72, 76, 79 and 81; four (4) late claims including sample numbers 5, 15, 17 and 20; and four (4) paid claims including sample numbers 9, 13, 40 and 43.

The Preliminary Report required the Plan to submit a detailed CAP to bring the Plan into compliance with the above Rules that included, but was not limited to, the following:

- a. Training procedures to ensure that claim processors were properly trained on verifying that the correct date of receipt was input into the claims payment processing system;
- b. Audit procedures to confirm that the date of receipt on claim image matched the date of receipt input into the claims payment processing system to determine payment timeliness and the correct amount of interest on late and late adjusted claim payments; and
- c. The date of training and implementation of the audit procedures and the management position(s) responsible for ensuring ongoing compliance.

*The Plan responded that in addition to the CAP implemented for Section III.A.1. above, the Plan implemented the following:*

- *The Claims Director reviewed/revised/created policies to ensure that claim images are reviewed and compared to the Claims Adjudication system in order to validate the integrity of the claim.*
- *The Claims Director incorporated the policies with the training program for new and existing employees.*
- *The Claims Department added additional auditing functions to ensure data accuracy, as well as financial accuracy, relating to each claim adjudicated. This includes reviewing the claim image Received Date compared to the claims processing system Received Date in order to ensure the proper received date is being utilized (data accuracy).*
- *Existing and new staff will continue to be monitored through the actions identified above by the Claims Manager and the Claims Auditing Manager, with oversight from the Claims Director,*

*The Plan represented that the training for claims department staff was conducted on May 23, 2014, and audit procedures were implemented on May 27, 2014.*

*The Plan's Compliance Officer was identified as the management position responsible for ongoing compliance.*

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

### **C. PROVIDER DISPUTE VIOLATIONS**

Rule 1300.71.38 requires all health care service plans that pay claims to establish a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes.

The Department's examination found that the Plan failed to comply with the requirements of a fast, fair and cost-effective resolution mechanism for the three-month period ending September 30, 2013, as follows:

#### **1. PAYMENT ACCURACY OF INTEREST ON LATE CLAIMS RESULTING FROM PROVIDER DISPUTES – *Repeat Deficiency***

Rule 1300.71.38 (g) states that if the provider dispute or amended provider 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 required under Sections 1371 and 1371.35 and Rule 1300.71, within five (5) working days of the issuance of the written determination.

Rule 1300.71(a)(8)(K) describes one unfair payment pattern as the failure to reimburse at least 95% 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 the Plan did not pay or underpaid the amount of interest on late adjusted claim payments resulting from provider disputes for eight (8) out of 93 provider disputes reviewed (a compliance rate of 91 percent). They included provider dispute sample numbers 38, 42, 46, 49, 52, 59, 64 and 73.

This deficiency was mainly the result of not selecting the correct date of receipt of a Complete Claim as defined by Rule 1300.71(a)(2) to determine the timeliness of claim payments.

The Plan's failure to pay interest correctly on late claim payments resulting from provider disputes was a repeat deficiency, as this issue was previously noted in the Department's Final Report of Examination dated February 22, 2010, for the quarter ended December 31, 2008. This examination disclosed that the Plan's compliance efforts in response to the prior report had not achieved the necessary levels of compliance with the Regulations cited.

**This repeat violation may be referred to the Office of Enforcement for appropriate administrative action upon resolution of all deficiencies addressed in this Final Report.**

The Preliminary Report required the Plan to explain why the corrective actions implemented by the Plan to resolve the deficiency of not paying interest correctly on late claim payments resulting from provider disputes, found in the Department's prior examination, were not effective in ensuring ongoing compliance.

In addition, the Plan was required to submit a CAP to address the deficiency cited above. The CAP was to include the following:

- a. Training procedures to ensure that claim processors were properly trained on interest and penalty requirements, including the proper application of the date of receipt of a Complete Claim as defined by Rule 1300.71(a)(2).
- b. Audit procedures to ensure that the Plan was monitoring correct payment of interest and penalties on late adjusted claims payments resulting from provider disputes.
- c. Identification of all provider disputes that resulted in late adjusted claim payments from June 1, 2009 (the date after the last remediation date of the prior examination) through the date corrective action has been implemented by the Plan.
- d. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in the paragraph immediately above. This evidence was to include an electronic data file (Excel or Access) or schedule that identified the following:
  - Claim number
  - PDR tracking number
  - Date of service
  - Date original claim received
  - Date new information received
  - Total billed
  - Original total paid
  - Original paid date
  - Amount of adjustment paid (with check number)
  - Date adjustment paid/mailed
  - Amount of original interest paid
  - Original interest paid date
  - Number of days used to calculate interest
  - Amount of additional interest paid (with formula)
  - Date additional interest paid
  - Penalty paid
  - Date penalty paid
  - Check number for interest and/or penalty

- Provider name
- ER or Non-ER indicator

The data file was to provide the detail of all claims remediated, and to include the total number of claims and the total additional interest and penalty paid as a result of remediation.

- e. Revised policy and procedures implemented to ensure that provider dispute payments of late claims included interest and penalty, if applicable, in compliance with the above Sections and Rules.
- f. Date the revised policy and procedures, training and auditing procedures were implemented and the management position(s) responsible to oversee the CAP and to ensure ongoing compliance.

*The Plan responded that the root cause for the ineffectiveness of L.A. Care's prior corrective actions was the lack of follow-through in implementing existing policies and ineffective training.*

*The Plan's response referenced the issue with the date of receipt for claims received from April 2013 through August 2013, as described above in Section III.A.1 of this Report. The Plan respectfully requested that the Department permit L.A. Care to remediate this deficiency for claims, resulting from provider disputes, improperly paid for the period of April 15, 2013 through August 6, 2013, rather than from June 1, 2009, to the present.*

*In order to remedy this deficiency going forward, the Plan indicated that it developed additional policies and procedures and enhanced training procedures to ensure that the PDR team has a deep understanding of claim interest, penalty, and date of receipt criteria. L.A. Care stated it is evaluating the PDRs and shall complete all reprocessing of adjusted interest and penalties by July 15, 2014.*

*The Plan submitted details of a CAP which included training procedures titled "Interest Payments for Provider Dispute Resolutions" and "Claims Received Date for Provider Dispute Resolutions". The Plan represented the training was conducted on May 27, 2014. Revised policy and procedure titled "Interest Payment Policy and Procedure-PDR" became effective May 28, 2014, and audit procedures to ensure compliance with the correct payment of interest on late claim payments resulting from provider disputes were implemented on May 27, 2014.*

*The Plan's Compliance Officer was identified as the management position responsible for ongoing compliance.*

**The Department finds that the Plan's compliance efforts are not fully responsive to the deficiency cited and the corrective actions required because the Plan did not complete the required actions set forth in the Preliminary Report.**

**The Department approves the Plan's proposal to limit its review and remediation to payments resulting from provider disputes for late paid claims received during the period of April 15, 2013 through August 6, 2013, and the Department anticipates that the evidence of remediation will be filed with the Plan's response to this Final Report.**

**The Plan is again required to submit evidence of remediation payment of interest and penalty, as described above in paragraphs c. and d., with its response to this Report.**

## **2. RECEIPT ACKNOWLEDGEMENT OF PROVIDER DISPUTES**

Rule 1300.71.38(e)(2) requires a plan to acknowledge the receipt of each paper provider dispute within fifteen (15) working days of the date of receipt of the provider dispute by the plan office designated to receive provider disputes.

Rule 1300.71(a)(8)(R) describes one unfair payment pattern as the failure to acknowledge the receipt of at least 95% of the provider disputes it receives consistent with Rule 1300.71.38(e) over the course of any three-month period.

The Department's examination disclosed that the Plan failed to issue timely acknowledgement of receipt for 19 out of 93 provider disputes reviewed (a compliance rate of 80 percent). They included provider dispute sample numbers 1, 12, 16, 17, 21, 26, 27, 39, 47, 48, 52, 54, 61, 72, 80, 81, 82, 89 and 92.

**This violation may be referred to the Office of Enforcement for appropriate administrative action upon resolution of all deficiencies addressed in this Final Report.**

The Preliminary Report required the Plan to submit a detailed CAP to bring the Plan into compliance with the above Rule that included, but was not limited to, the following:

- a. Training procedures to ensure that paper provider disputes were acknowledged timely;
- b. Audit procedures to confirm that paper provider disputes were acknowledged in compliance with Rule 1300.71.38(e)(2); and
- c. The date of training and implementation of the audit procedures and the management position(s) responsible for ensuring ongoing compliance.

*The Plan responded that it recognized that provider disputes were not timely acknowledged and remediated this situation during February 2014, with all PDRs acknowledged timely since that time. The Plan submitted a CAP that included direct oversight of the provider dispute acknowledgement process by the Claims Department management, and training was provided on May 27, 2014. Additionally, the Plan stated that the quality audit department developed an audit tool with an implementation date of*

*May 23, 2014 that was used to ensure that all provider disputes were timely acknowledged.*

*The Plan's Compliance Officer was identified as the management position responsible for ongoing compliance.*

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

### **3. RESOLUTION OF PROVIDER DISPUTES**

Rule 1300.71.38 (f) requires a plan to 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 one 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% of the time over the course of any three-month period.

The Department's examination disclosed that the Plan failed to send the written determination letter within 45 working days of receipt on 30 out of 93 provider disputes reviewed (a compliance rate of 68 percent). They included provider dispute sample numbers 1, 3, 6, 7, 10, 12, 16, 17, 21, 27, 30, 33, 39, 40, 45, 47, 53, 56, 57, 58, 60, 64, 68, 72, 74, 77, 78, 82, 87 and 92.

**This violation may be referred to the Office of Enforcement for appropriate administrative action upon resolution of all deficiencies addressed in this Final Report.**

The Plan was required to submit a detailed CAP to bring the Plan into compliance with the above Rule that included, but was not limited to, the following:

- a. Training procedures to ensure that the determination letters on provider disputes were issued timely;
- b. Audit procedures to confirm the timely resolution of provider disputes in compliance with Rule 1300.71.38(f); and
- c. The date of training and implementation of the audit procedures and the management position(s) responsible for ensuring ongoing compliance.

*The Plan responded that the processing of provider disputes had not been in compliance with dispute resolution timeframes. The Plan included a description of the corrective actions taken to ensure compliance, including a description of training and audit procedures, and indicated that the date of their implementation was May 27, 2014.*

*The Plan's Compliance Officer was identified as the management position responsible for ongoing compliance.*

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

#### **D. AMENDMENTS TO PLAN APPLICATION**

Section 1352(a) and Rule 1300.52 require all plans to file an amendment with the director within thirty (30) days after any changes in the information contained in its application, other than financial or statistical information. Rule 1300.52.4 sets forth standards for amendment filings.

Section 1367 (h)(1) states that contracts with subscribers and enrollees, providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair reasonable, and consistent with the objectives of this chapter.

The Department's examination disclosed that the Plan failed to comply with the filing requirements of the above Section and Rules. The Plan did not file the Service Agreements with CDR Associates, LLC, DataMetrix, Inc. and Firstsource Transaction Services, LLC for claims processing.

On February 21, 2014, the Plan filed an amendment which included the three Service Agreements referenced above (eFile #20140485). The filing included a description of the administrative arrangements to monitor the proper performance of the agreements and the provisions included in the agreements to protect the Plan, its plan business, and its enrollees and providers in the event of a failure of performance or termination of the Agreements.

The Preliminary Report required the Plan to state the policies and procedures implemented to ensure that contracts relating to claims processing are filed with the Department, the date of implementation, and the management position(s) responsible for ensuring continued compliance with the Sections and Rules stated above.

*The Plan provided a draft Policy and Procedure Titled "DMHC Knox-Keene Act Filing of Claims Related Administrative Services Agreements" to address this deficiency and ensure that contracts related to claims processing are timely filed with the Department. The Plan stated that given the approval process necessary for new policies and procedures, L.A. Care will immediately implement this Policy and Procedure on an interim basis and will file an executed Policy and Procedure with DMHC by August 15, 2014. The Plan stated that the management in L.A Care's Legal and Compliance Departments will be responsible for ensuring continued compliance with the requirements of the rules and the Policy and Procedure.*

**The Department finds the Plan's compliance efforts are responsive to the deficiency cited and the corrective actions required. However, the Plan is required to file the executed Policy and Procedure Titled "DMHC Knox-Keene Act Filing of Claims**

**Related Administrative Services Agreements” with the Plan’s response to this Final Report.**

Final Report of Routine Examination

of

Local Initiative Health Authority for Los Angeles County (L.A. Care Health Plan)

Request to Append a Supplemental Response to Preliminary Report

to the

Final Report of Routine Examination Issued July 24, 2014 (Final Report)

Pursuant to Section 1382(d) of the Knox-Keene Health Care Service Plan Act of 1975, L.A. Care requests that the Department append to the Final Report a supplemental response to the Preliminary Report of Routine Examination of Local Initiative Health Authority for Los Angeles County (Preliminary Report) filed by L.A. Care Health Plan on May 29, 2014, as follows:

Please append the following supplemental response to the Final Report at the portions of the Final Report listed below:

Deficiencies Remediated.

1. Section III. Compliance Issues. A.1. Payment Accuracy of Interest on Late Claims.
2. Section III. Compliance Issues. A.3. Incorrect Claims Denials.
3. Section III. Compliance Issues. C.1. Payment Accuracy of Interest on Late Claims Resulting From Provider Disputes.

In response to the Required Action for the deficiencies in the Preliminary Report set forth above, L.A. Care Health Plan identified all late claims and retroactively paid interest and penalties for the claims identified. In order to demonstrate that the above remedial actions were taken, L.A. Care created data files evidencing the remediation of all claims required to be remediated and evidencing additional interest and penalties paid. L.A. Care was prepared to file the data file with the Department on July 15, 2014. However, on July 15, 2014, the Department instructed L.A. Care not to file any further corrective action plan documents until after the Final Report was issued. In accordance with the Department's instruction, L.A. Care will file the data files as part of its CAP response to the Final Report.