



Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
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Via USPS Delivery and eFile

August 1, 2018

Mr. John Baackes
Chief Executive Officer
LOCAL INITIATIVE HEALTH AUTHORITY FOR L.A. COUNTY
DBA L.A. CARE HEALTH PLAN
1055 West 7th Street
Los Angeles, CA 90017

**FINAL REPORT OF ROUTINE EXAMINATION OF LOCAL INITIATIVE HEALTH
AUTHORITY FOR L.A. COUNTY**

Dear Mr. Baackes:

Enclosed is the final report (Final Report) of a routine examination for the quarter ended June 30, 2017 of the fiscal and administrative affairs of Local Initiative Health Authority for L.A. County (Plan). The examination was conducted by the Department of Managed Health Care (Department), pursuant to Section 1382(a) 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 20, 2018. The Department accepted the Plan's electronically filed responses on June 4, 2018, June 14, 2018, July 16, 2018, and July 23, 2018 (Responses).

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

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

Please indicate within 10 days from the date of the Plan's receipt of this letter whether the Plan requests the Department to append its Responses to the Final Report. If so,

¹ References throughout this Final 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 of 1975 found within Title 28 of the California Code of Regulations.

please indicate which portions of the Plan's Responses should be appended, and electronically file copies of those portions of the Plan's Responses 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 to the Final Report or wishes to modify any information provided to the Department in its Responses, please provide the electronically filed documentation no later than 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 at <https://wpsd.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 S18-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 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."
 - Select "Send Message."

As noted in the attached Final Report, the Plan's Responses did not adequately respond to the deficiencies raised in the Preliminary Report issued by the Department on April 20, 2018. According to Rule 1300.82, the Plan is required to respond to any request for additional corrective action 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 Office of Enforcement for appropriate administrative action.

The Plan is hereby advised that any violations listed in this Final Report may be referred to the Office of Enforcement for appropriate administrative action upon the completion of all remediation addressed in this Final Report.

Questions or problems related to the electronic transmission of the response should be directed to Vijon Morales at 916-255-2447 or by email at Vijon.Morales@dmhc.ca.gov. You may also email inquiries to wpsd@dmhc.ca.gov.

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

If there are any questions regarding this Final Report, please contact me at 916-255-2425 or email me at: Anna.Belmont@dmhc.ca.gov.

Sincerely,

Anna Belmont, CPA
Senior Examiner (Supervisor)
Office of Financial Review
Division of Financial Oversight

cc: Elysse Palomo, Senior Manager, Regulatory Audits and Governance, Local Initiative Health Authority for L.A. County
Augustavia J. Haydel, Chief Legal Officer, Local Initiative Health Authority for L.A. County
Pritika Dutt, CPA, Deputy Director, Office of Financial Review
Ashika Chiu, Examiner, Division of Financial Oversight
Carrie Ramage, Attorney III, Office of Plan Licensing
Laura Dooley Beile, Chief, Division of Plan Surveys
Paula Hood, Staff Services Manager I, Help Center

STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

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

FINAL REPORT OF ROUTINE EXAMINATION

OF

**LOCAL INITIATIVE HEALTH AUTHORITY for L.A.
COUNTY**

FILE NO. 933-0355

DATE OF FINAL REPORT: AUGUST 1, 2018

OVERSIGHT EXAMINER: STEVEN ALSETH

EXAMINER-IN-CHARGE: ANNA BELMONT

FINANCIAL EXAMINERS

JOHN ATAMIAN

ERI FUKUDA

NINA MOUA

ERICA SHORT

BACKGROUND INFORMATION FOR LOCAL INITIATIVE HEALTH AUTHORITY FOR L.A COUNTY

Date Plan Licensed:	April 1, 1997
Organizational Structure:	Local Initiative Health Authority for L. A. County (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 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.
Type of Plan:	Full Service Health Plan
Provider Network:	The Plan subcontracts the delivery of health care services through health maintenance organizations and contracts directly with various health care providers.
Plan Enrollment:	As of June 30, 2017, the Plan's enrollment was 2,116,991 which consisted of 2,043,532 Medi-Cal Risk, 24,390 Individual, and 49,069 IHSS enrollees.
Service Area:	Los Angeles County
Date of Prior Final Routine Examination Report:	July 24, 2014

FINAL REPORT OF A ROUTINE EXAMINATION OF LOCAL INITIATIVE HEALTH AUTHORITY FOR L.A. COUNTY

This is the final report (Final Report) for the quarter ended June 30, 2017 of a routine examination of the fiscal and administrative affairs of Local Initiative Health Authority for L.A. County (Plan), conducted by the Department of Managed Health Care (Department) pursuant to Section 1382(a) 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 20, 2018. The Department accepted the Plan's electronically filed responses on June 4, 2018, June 14, 2018, July 16, 2018 and July 23, 2018 (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.

The Plan is hereby advised that any violations listed in this Final Report may be referred to the Office of Enforcement for appropriate administrative action upon the completion of all corrective actions required in response to this Final Report.

The Department examined the Plan's financial report filed with the Department for the quarter ended June 30, 2017, 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:

Section I.	Financial Statements
Section II.	Calculation of Tangible Net Equity
Section III.	Compliance Issues
Section IV.	Internal Control
Section V.	Non-Routine Examination

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 Final Report, within 30 days of receipt of this Final Report.

¹ References throughout this Final 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 of 1975 found within Title 28 of the California Code of Regulations.

SECTION 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 June 30, 2017, as filed with the Department. A copy of the Plan's financial statements can be viewed on the Department's website by typing the link <http://wpsso.dmhc.ca.gov/fe/search/#top> and selecting "Local Initiative Health Authority for L.A. County" on the second drop-down menu.

No response is required to this section.

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth and TNE as reported by the Plan as of quarter ended June 30, 2017	\$ 630,646,132
Required TNE	<u>149,592,413</u>
TNE Excess per Examination	<u>\$ 481,053,719</u>

The Plan was in compliance with the TNE requirements of Section 1376 and Rule 1300.76 as of June 30, 2017.

No response is 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.

In 2017, the Plan transitioned from the old claims processing system, "MHC," to the new claims processing system, "QNXT." The Department examined both systems since the Plan currently processes claims with service date prior to November 1, 2016 on MHC, and other claims with service date after that date on QNXT.

The Department's examination found that the Plan engaged in "unfair payment patterns" for the three-month period ended June 30, 2017, 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 \$10 paid to the claimant for each late claim.

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 or interest 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 \$10 paid to the claimant for each late claim.

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

The Department’s examination disclosed that the Plan failed to reimburse claims accurately including interest and penalties in:

- 13 out of 50 late claims processed in the MHC system (a compliance rate of 74 percent). This deficiency was noted in the following MHC late paid claims sample numbers: 1, 4, 9, 11, 14, 22, 24, 26, 29, 31, 36, 43, and 50. The deficiency was primarily caused by the Plan’s error of sending check payments to incorrect addresses and then reissuing checks without paying additional interest.
- Three out of 30 high dollar claims processed in the MHC system. This deficiency was noted in the following MHC high dollar claims sample numbers: 10, 29, and 30. The deficiency was primarily caused by the Plan incorrectly denying claims for missing authorization or eligibility and then reprocessing them without interest.
- Two out of 50 paid claims processed in the MHC system. This deficiency was noted in MHC paid claims sample numbers 16 and 35. The deficiency was caused by processors using wrong payment date for interest calculation or not applying interest on reprocessed claims.
- Two out of 30 high dollar claims processed in the QNXT system. This deficiency was noted in QNXT high dollar claims sample numbers 12 and 13. The deficiency was caused by the Plan incorrectly denying claims for missing authorization and then reprocessing them without interest.

- One out of 50 late claims processed in the QNXT system. This deficiency was noted in QNXT late paid claims sample number 13 and was due to processor error.
- One out of 50 denied claims processed in the QNXT system. This deficiency was noted in QNXT denied claims sample number 21. This claim was incorrectly denied. Subsequent to payment, the Plan's self-audit determined that this claim should have been paid. The Plan paid the previously incorrectly denied claim, but the Plan failed to include interest on this claim.

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 July 24, 2014, for the quarter ended September 30, 2013. Thus, this examination disclosed that the Plan's compliance efforts in response to the prior final 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 by the Plan to resolve the deficiency of not paying interest correctly on late claim payments, found in the Department's previous examination, were not effective in ensuring ongoing compliance.

In addition, the Plan was required to submit a detailed Corrective Action Plan (CAP) to bring the Plan into compliance with the above Sections and Rules that included the following:

- a. Policy and procedures implemented to ensure that claims are paid accurately including interest and penalties.
- b. Audit procedures to confirm claims are paid accurately including interest and penalties.
- c. Training procedures to ensure that claim processors are aware of and comply with the requirements of the above Sections and Rules;
- d. Date the policy and procedures were implemented.
- e. Identification of all claims processed from July 24, 2014 through the date the corrective action was implemented by the Plan, where interest was not paid or underpaid.
- 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 of receipt for original claim
- Date of receipt of new information
- Date of receipt for complete claim
- Total billed
- Total paid
- Date of payment (mail date)
- Amount of interest paid
- Date of payment of interest
- Penalty amount paid, if applicable
- Number of late days used to calculate interest (with formula)
- Total interest owed per claim (with formula)
- Check number for interest and penalty paid amount
- Provider name
- ER or Non-ER indicator

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

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

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

The Plan stated that in the previous examination, the accuracy of interest on late claims was due to a date stamp issue. The corrective actions did address the date stamp issue, however, the deficiency that occurred in the current examination has a different root cause: finalized claims were re-opened in order to void a check that was previously issued to a provider. The Plan stated that it did not have a process in place to address stale dated checks and incorrect addresses in the old Legacy system, MHC. This is not related to the previous date stamp issue and the process put in place to correct it.

The Plan added that the following action plan addresses the new root causes for the deficiency identified in the audit period:

In regards to the Plan's error of sending check payments to incorrect addresses and then reissuing checks without paying additional interest, the Plan stated the following:

The Plan created a cross-functional work flow and process between Medical Payment System Services (MPSS), Claims, and Provider Data Unit (PDU) to ensure the Plan sends payments to the correct addresses. This includes a process to research returned and stale checks to ensure they are being re-sent to the correct address and with interest, if required. Many of the payments in question during the audit were reissued due to stale dated checks. The reasons for stale dated checks can vary and the Plan has an existing policy on how to handle stale dated checks. All payments that resulted in stale dated checks because they were sent to the wrong addresses would become returned mail and thus fall into the newly developed return mail work flow. The Plan attached to its Responses "Return Mail Work Flow" procedures which would be implemented on June 4, 2018.

The Plan stated that once the Return Mail Work Flow and Policy and Procedures have been finalized and approved, the Provider Network Management Engagement and Strategy training team will launch the associated training, provide Frequently Asked Questions (FAQ) documentation and any necessary reference materials to support the network. All business units impacted by this change (including but not limited to the Customer Solutions Center/Call Center representatives, Provider Contract/Relations Account Managers, PDU staff, MPSS staff) will also be trained on the new work flow.

In regards to the Plan incorrectly denying claims for missing authorization or eligibility and then reprocessing them without interest, the Plan stated the following:

The Plan's examiners were not reviewing the claim image for an authorization tracking number. On May 24, 2017, the Plan updated the Utilization Management Auto Authorization process to instruct examiners to move forward if an authorization tracking number was included in the claim image. Additionally, the procedure was updated to allow examiners to automatically pay the claim without looking for an authorization. The Plan attached "Auto Authorization Process" procedures. The claim examiners completed training on this new process on May 26, 2017. The Plan attached to its Responses interest training sign-in sheets dated March 14, 2018 and March 16, 2018.

In regards to the Plan's claim processors using wrong payment date for interest calculation or not applying interest on reprocessed claims, the Plan stated the following:

On February 1, 2018, interest guidelines were updated and revised to include the revised formula for manually calculating interest. To ensure applicable interest was automatically included in the provider's payment, the Plan automated the payment of interest in MHC system on December 12, 2016. The Plan attached "Interest and Payment Calculations for Claims Reimbursement" procedures with the last review date of February 1, 2018. The Plan stated that interest training was completed on March 16, 2018. The Plan attached to its Responses interest training sign in sheets dated March 14, 2018 and March 16, 2018.

In regards to denied claims, where Plan though self-audit determined that the claim was incorrectly denied, then paid the claim, but failed to include interest on the reprocessed claim, the Plan stated the following:

MPSS and Claims unit will review sample cases that were found to be incorrectly denied and interest was not paid accurately. Based on the results of this review, the Plan will develop a policy and workflow to address this issue.

The Plan stated that it will have the following monitoring system for returned checks work flow: the Plan's MPSS and PDU will pull a quarterly monitoring report to ensure returned mail is sent to the updated addresses. This report will be submitted to and also monitored by the Compliance department. This monitoring will start in July 2018 for the third quarter of 2018 reporting.

The Plan stated that its Claims department conducts ongoing monitoring to ensure interest is paid accurately. The Plan attached to its Responses "Claim Auditing and Monitoring" procedures, which were implemented on April 17, 2018.

The Management position responsible for overseeing the CAP is the Director of Claims.

The Plan stated that it identified all claims processed from July 24, 2014 to present where interest may be required. The Plan is in the process of reviewing the entire universe to validate whether or not interest is due and if so, the amount due. The Plan can provide the Department with the identification and evidence that interest penalties were paid on an excel spreadsheet as requested in the Final Report by March 30, 2019.

The Plan stated that it can provide a universe of claims that may potentially require interest. The Plan is in the process of analyzing each line item to validate if interest is actually owed. The Plan is able to provide status updates on an ongoing basis to the Department, if requested. This validation of interest amount owed will not be completed until March 30, 2019.

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required, since the Plan has not completed the remediation of previously processed claims where interest was not paid or underpaid and has not developed a policy and procedures to ensure that interest is paid on the reprocessed claims which were previously incorrectly denied.

The Plan is required to submit the following:

- **Policy and procedures implemented to ensure that interest is paid on the reprocessed claims which were previously incorrectly denied.**
- **Identification of all claims processed from July 24, 2014 through the date the corrective action was implemented by the Plan, where interest was not paid or underpaid.**

- **Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in the previous paragraph. This evidence is to include an electronic data file/schedule (Excel or Access) that identifies the following:**
 - **Claim number**
 - **Date of service**
 - **Date of receipt for original claim**
 - **Date of receipt of new information**
 - **Date of receipt for complete claim**
 - **Total billed**
 - **Total paid**
 - **Date of payment (mail date)**
 - **Amount of interest paid**
 - **Date of payment of interest**
 - **Penalty amount paid, if applicable**
 - **Number of late days used to calculate interest (with formula)**
 - **Total interest owed per claim (with formula)**
 - **Check number for interest and penalty paid amount**
 - **Provider name**
 - **ER or Non-ER indicator**

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

- **The Plan is required to justify the reason for the delay of the remediation and request approval from the Department for the proposed extended timeframe. The Plan also has to submit monthly status reports until the CAP is completed.**

2. INCORRECT CLAIM DENIALS – Repeat Deficiency

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

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

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

- Four out of 50 denied claims processed in the MHC system (a compliance rate of 92 percent). This deficiency was noted in the following MHC denied claims sample numbers: 10, 12, 18, and 42. The deficiency was primarily caused by claims being incorrectly denied for eligibility. The Plan had systematic issues with their eligibility system.
- Four out of 50 denied claims processed in the QNXT system (a compliance rate of 92 percent). This deficiency was noted in the following QNXT denied claim sample numbers: 21, 26, 27, and 31. The deficiency was primarily caused by the Plan incorrectly determined that there was no amount due from the Plan because the Medicare payment was higher than the allowable amount for the procedure. However, according to the Plan's claims procedures, the Plan reimburses providers at the higher of the Medicare or Medi-Cal rate. The Plan reimbursed the claims at the Medicare rate; however, the Medi-Cal rate was higher. Therefore, the claims should have been paid at the Medi-Cal rate instead of the Medicare rate.
- Two out of 30 high dollar claims processed in the MHC system. This deficiency was noted in MHC high dollar claims sample numbers 14 and 22. The deficiency was caused by the Plan incorrectly denying claims for missing authorization when the authorization was issued by an independent physician association (IPA). However, claims processors did not have access to it at time of claim processing.
- One out of 50 paid claims processed in the MHC system. This deficiency was noted in MHC paid claims sample number 18. The deficiency was caused by a claim processor incorrectly denying the claim as the Medicare rate paid was higher than the maximum allowable for this claim. However, the Plan was responsible for paying the coinsurance portion of the claim.
- One out of 30 high dollar claims processed in the QNXT system. This deficiency was noted in QNXT high dollar claim sample number 11. The deficiency was caused by the Plan incorrectly denying the claim for invalid billing, due to error in system configuration.

The Plan's incorrect denial of claims was a repeat deficiency, as this issue was previously noted in the Department's final report of examination dated July 24, 2014, for the quarter ended September 30, 2013. 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 Rule cited.

The Preliminary Report required the Plan to explain why the corrective actions implemented by the Plan to resolve the deficiency of incorrectly denying claims, 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 Rules that included, but not be limited to, the following:

- a. Policies and procedures implemented to ensure that claims are processed correctly.
- b. Training procedures implemented to ensure that claim processors are aware of and comply with the requirements of the above Rules.
- c. Audit procedure to confirm claims are paid accurately including interest and penalties with the above Rules.
- d. Date the policy and procedures were implemented.
- e. Identification of all claims incorrectly denied that should have been paid, from July 24, 2014 through the date the corrective action was implemented by the Plan.
- f. Evidence that interest and penalties, as appropriate, were paid retroactively for the denied claims identified in paragraph "e" above. This evidence was to include an electronic data file (Excel or Access) that identified the following:
 - Claim number
 - Date of service
 - Date of receipt for original claim
 - Date of receipt of new information
 - Date of receipt for complete claim
 - Total billed
 - Total paid
 - Date of payment (mail date)
 - Amount of interest paid
 - Date of payment of interest
 - Penalty amount paid, if applicable
 - Number of late days used to calculate interest (with formula)
 - Total interest owed per claim (with formula)
 - Check number for interest and penalty paid amount
 - Provider name
 - ER or Non-ER indicator

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

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

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

The Plan responded that in the previous CAP, the Plan added trainers who were subject matter experts on claims adjudication. This included training material created by Cambria that was implemented on May 22, 2014. However, the Plan realized that there were still gaps in the training program; therefore, the Plan implemented the STAR training program on June 15, 2017 to address gaps in the training process.

The Plan indicated that it identified additional root causes related to this deficiency. The following action plan addresses the new root causes for the deficiency identified in the audit:

In regards to the claims being incorrectly denied for eligibility, that Plan stated it had systematic issues with their eligibility system. The Plan transitioned their Member Enrollment from the legacy system MHC's Member Eligibility Program (MEP) to QNXT on May 5, 2018. QNXT is now the system of record for all claims and membership. The incorrect member denials were the result of the splitter not working correctly. The splitter determined if the claims should go into MHC or QNXT, and may have directed the claim to the incorrect system based on eligibility. The transition of MEP to QNXT ensures that claims are entered into the correct system and thus ensures claims are not incorrectly denied for eligibility.

In regards to the Plan incorrectly determining that there was no amount due from the Plan because the Medicare payment was higher than the allowable amount, although the Plan should have paid at a higher Medi-Cal rate instead of the Medicare rate or should have paid coinsurance portion of the claim, the Plan stated that the Coordination of Benefits (COB) training material was revised to include details on All Plan Letter (APL) 13-03 requirements. Examiners were re-trained on COB processing. The Plan attached to its Responses "COB training sign-in sheets" dated May 14, 2018, May 16, 2018 and May 17, 2018 and "Coordination of Benefits Process", which was implemented on May 11, 2018.

In regards to incorrect denial of claims for missing authorization when the authorization was issued by an IPA, the Plan stated that the claims processors did not have access to the authorization at the time of claims processing. The Plan's claims system QNXT did not have the capability to display related authorizations. On May 24, 2017, the Plan revised the UM Auto Authorization process and the system was updated to allow examiners to locate the authorizations in QNXT and move forward with approval. Claims examiners completed training on this new process on May 26, 2017. The Plan

attached to its Responses "UM Auto Authorization Guidelines," which were implemented on May 26, 2017. The Training took place on May 26, 2017. The Plan attached to its Responses the training log dated May 26, 2017.

In regards to incorrect denial of claim for invalid billing, due to error in the system configuration, the Plan stated that this was due to a scanning issue with the Plan's clearinghouse HealtheConnex. The Plan changed their Optical Character Recognition (OCR)/scanning vendor from HealtheConnex to ImageNet on June 26, 2017. The Plan attached to its Responses "ImageNet Guidelines," which were completed on June 6, 2017, and rolled out to examiners on June 30, 2017. The workflow was created on May 17, 2018, but the process was in place as of June 20, 2017.

The Plan stated that the Claims department will conduct ongoing monitoring for incorrect denials, and the management position responsible for overseeing the CAP is the Director of Claims.

The Plan has identified all claims processed from July 24, 2014 to present where claims may have been incorrectly denied. The Plan is in the process of reviewing the entire universe to validate incorrect denial and if so, the amount due. The Plan will provide the Department with the identification and evidence that interest penalties were paid on an Excel spreadsheet by March 30, 2019.

The Plan added that it will provide a universe of claims that were potentially denied incorrectly. The Plan is in the process of analyzing each line item to validate if interest is actually owed. The Plan is able to provide status updates on an ongoing basis to the Department, if requested. This validation of interest amount owed will not be completed until March 30, 2019.

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required, since the Plan has not completed the remediation of previously incorrectly denied claims.

The Plan is required to submit the following:

- **Identification of all claims processed from July 24, 2014 through the date the corrective action was implemented by the Plan, that were incorrectly denied.**
- **Evidence that additional claims payment, interest and penalties, as appropriate, were paid retroactively for the denied claims identified in paragraph above. This evidence is to include an electronic data file/schedule (Excel or Access) that identifies the following:**
 - **Claim number**
 - **Date of service**
 - **Date of receipt for original claim**

- **Date of receipt of new information**
- **Date of receipt for complete claim**
- **Total billed**
- **Total paid**
- **Date of payment (mail date)**
- **Amount of interest paid**
- **Date of payment of interest**
- **Penalty amount paid, if applicable**
- **Number of late days used to calculate interest (with formula)**
- **Total interest owed per claim (with formula)**
- **Check number for interest and penalty paid amount**
- **Provider name**
- **ER or Non-ER indicator**

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

- **The Plan is required to justify the reason for the delay of the remediation and request approval from the Department for the proposed extended timeframe. The Plan also has to submit monthly status reports until the CAP is completed.**

3. ACKNOWLEDGEMENT OF CLAIMS

Rule 1300.71(c) states that the plan and the plan's capitated provider shall identify and acknowledge the receipt of each claim. In the case of an electronic claim, identification and acknowledgement shall be provided within two working days of the date of receipt of the claim by the office designated to receive the claim, or in the case of a paper claim, identification and acknowledgement shall be provided within 15 working days of the date of receipt of the claim by the office designated to receive the claim.

Rule 1300.71(a)(8)(E) describes an "unfair payment pattern" as the failure to acknowledge the receipt of at least 95 percent of claims consistent with Rule 1300.71(c) over the course of any three-month period.

The Department's examination disclosed that the Plan failed to timely input, and, therefore, acknowledge:

- Three out of 50 late claims in the MHC system (a compliance rate of 94 percent). This deficiency was noted in the following MHC late claims sample numbers: 2, 3, and 32.
- Two out of 30 high dollar claims in the MHC system. This deficiency was noted

in MHC high dollar claims sample numbers 8 and 10.

- Two out of 30 high dollar claims in the QNXT system. This deficiency was noted in QNXT high dollar claims sample numbers 16 and 25.

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

- a. Policy and procedures implemented to ensure that claims are timely entered in the system in compliance with the above Rules.
- b. Training procedures to ensure that claims processors are aware of the policy and procedures.
- c. Audit procedures to confirm claims are timely entered in the system in compliance with the above Rules.
- d. Date of implementation of the new policy and procedures.
- e. Management position responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan responded that the root cause for the deficiency was mailroom backlog. The Plan outsourced its mailroom process to ImageNet on June 26, 2017. The Plan attached to its Responses "ImageNet Guidelines" and "ImageNet Processing and Monitoring Workflow" procedures, which were implemented on May 23, 2018. Examiners were provided the ImageNet Guidelines via email on September 22, 2017.

The Plan's Claims department conducts ongoing monitoring to ensure acknowledgement of claims. The Plan attached to its Responses ImageNet Processing and Monitoring Workflow with the Implementation date of May 23, 2018. In addition, the Plan attached to its Responses new policy and procedures for Internal Auditing and Monitoring with implementation date of April 17, 2018.

The Plan stated that the management position responsible for overseeing the CAP is the Director of Claims.

The Department finds that the Plan's compliance effort is responsive to the corrective action required. Therefore, no further response is required.

4. FORWARDING MISDIRECTED CLAIMS – Repeat Deficiency

Rule 1300.71(b)(2)(A) and (B) state 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 10 working days of receipt of the claim that was incorrectly sent to the plan.
- If the claim does not involve emergency services or care and if the provider that filed the claim is contracted with the plan's capitated provider, the plan must, within 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 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 an "unfair payment pattern" as the failure to forward at least 95 percent 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 disclosed that the Plan did not forward misdirected claims within 10 working days of receipt in:

- Seven out of 50 denied claims processed in the MHC system (a compliance rate of 86 percent). This deficiency was noted in the following MHC denied claims sample numbers: 1, 13, 18, 20, 31, 32, and 50.
- Three out of 50 denied claims processed in the QNXT system (a compliance rate of 94 percent). This deficiency was noted in the following QNXT denied claims sample numbers: 11, 16, and 20.
- One out of 30 high dollar claims processed in the QNXT system. This deficiency was noted in QNXT high dollar claim sample number 5.

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 July 24, 2014, for the quarter ended September 30, 2013. 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 Rules cited.

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 not be limited to, the following:

- a. Policy and procedures implemented to ensure that misdirected claims are

forwarded timely in compliance with above Rules.

- b. Training procedures to ensure that claim processors are properly trained on forwarding misdirected claims timely.
- c. Audit procedures to confirm misdirected claims are forwarded timely in compliance with the above Rules.
- d. Date of implementation of the new policy and procedures.
- e. Management position responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan responded that they added additional staffing and OCR software. However, due to the increase in volume of claims received, the Plan had to develop a better solution to ensure that claims department consistently met the 10 working day requirement. The manual process did not consistently keep the Plan in compliance and, therefore, the Plan created an automated forwarding process using a database created to automate and track claims forwarded. This was implemented for electronic claims on June 18, 2017 and for paper claims on June 26, 2017. The Plan attached to its Responses "Business Requirements for Misdirected Claims", which were implemented on May 2, 2017.

The Plan stated that its claims department conducts ongoing monitoring to ensure misdirected claims are forwarded timely, and the management position responsible for overseeing the CAP is the Director of Claims.

The Department finds that the Plan's compliance effort is responsive to the corrective action required. Therefore, no further response is required.

5. CLEAR AND ACCURATE 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 for the specific reasons for the action taken.

The Department's examination disclosed that the Plan failed to send a remittance advice to providers, or provided an explanation that was unclear or incorrect, in four out of 50 denied claims processed in the MHC system (a compliance rate of 92 percent). This deficiency was noted in the following MHC denied claims sample numbers: 10, 15, 16, and 32.

The Department's examination also indicated that the Plan provided an explanation that was unclear or incorrect, in one out of 30 high dollar claims processed in the MHC system. This deficiency was noted in MHC high dollar claims sample number 4.

Furthermore, the Department's examination found that the Plan provided an explanation that was unclear or incorrect, in one out of 50 denied claims processed in the QNXT system. This deficiency was noted in QNXT denied claims sample number 43.

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

- a. Policy and procedures implemented to ensure that all remittance advices are prepared with complete and accurate denial information in compliance with above Rule.
- b. Training procedures to ensure that claim processors are properly trained on including complete and accurate denial information in all remittance advices.
- c. Audit procedures to confirm all remittance advices are prepared with complete and accurate denial information in compliance with the above Rule.
- d. Date of implementation of the new policy and procedures.
- e. Management position responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan responded that the root cause for the deficiency was that claim adjustment reason codes (CARCs) and remittance advise remark codes (RARCs) mapping was not correct in the Plan's legacy claims system (MHC).

CARCs and RARCs were mapped to the new claims system, QNXT, with custom edit codes. This was implemented on October 13, 2016. Due to the voided check issue, when check was voided, the system created a new paid check date which pulled old claims into the audit period.

The Plan attached to its Responses "Function Requirements Documents for QNXT Super Remittance Advice for all LOBs".

The Plan stated that the second cause for the deficiency was an examiner error – claims should have been processed as coordination of benefits (COB).

The COB training material was revised to include detail on APL 13-03 requirements. Examiners were re-trained on COB processing. The Plan attached to its Responses "Coordination of Benefits Process" procedures, which were implemented on May 15, 2018 and training sign-in sheets dated May 14, 2018 and May 17, 2018.

The Plan stated that the claims department conducts ongoing monitoring to ensure denials are correct, and the management position responsible for overseeing the CAP is the Director of Claims.

The Department finds that the Plan's compliance effort is responsive to the corrective action required. Therefore, no further response is required.

6. UNTIMELY DENIAL OF CLAIMS – Repeat Deficiency

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 an “unfair payment pattern” as the failure to contest or deny a claim within the timeframes of Rule 1300.71(h) and Sections 1371 or 1371.35 for at least 95 percent of the affected claims over the course of any three-month period.

The Department's examination disclosed that the Plan failed to contest or deny, within 45 working days of receipt, three out of 50 denied claims processed in the MHC system (a compliance rate of 94 percent). This deficiency was noted in the following MHC denied claims sample numbers: 3, 21, and 31.

In addition, the Department's examination found that the Plan failed to contest or deny, within 45 working days of receipt, one out of 30 high dollar claims processed in the QNXT system. This deficiency was noted in QNXT high dollar claim sample number 25.

The Plan's failure to deny claims timely was a repeat deficiency, as this issue was previously noted in the Department's final report of examination dated July 24, 2014, for the quarter ended September 30, 2013. 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 Sections and Rule cited.

The Preliminary Report required the Plan to explain why the corrective actions implemented by the Plan to resolve the deficiency of untimely denying claims, 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 Sections and Rule that included, but not be limited to, the following:

- a. Policy and procedures implemented to ensure that denials of claims are made in a timely manner in compliance with the above Sections and Rules.
- b. Training procedures to ensure that claims processors are aware of the revised policy and procedures.

- c. Audit procedures to confirm timely denial of claims in compliance with the above Sections and Rules.
- d. Date of implementation of the new policy and procedures.
- e. Management position responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan responded that as indicated in the previous CAP, the claims management team review aging reports on a daily basis. Effective June 23, 2017, the Plan engaged the service of ImageNet, a complete mailroom service, data capture services and generation of electronic files vendor in order to decrease processing times and reduce operating costs around claims. In addition, as indicated in the previous CAP, the Plan added Trainers who were subject matter experts on claims adjudication. This included training material created by Cambria that was implemented on May 22, 2014. However, the Plan realized that there were still gaps in the training program. Therefore, it implemented the STAR training program on June 15, 2017 to address gaps in the training process.

The Plan stated that effective June 23, 2017, it engaged the service of ImageNet, a complete mailroom service, data capture services and generation of electronic files vendor in order to decrease processing times and reduce operating costs around claims. The Plan outsourced mailroom process to ImageNet. The Plan determined that outsourcing the mailroom processes would ensure that claims were entered into the claims system promptly and eliminate backlog in the mailroom.

The Plan stated that its Claims department conducts ongoing monitoring for untimely denial of claims, and the management position responsible for overseeing the CAP is the Director of Claims.

The Department finds that the Plan's compliance effort is responsive to the corrective action required. Therefore, no further response is required.

B. PROVIDER DISPUTE RESOLUTION (PDR) MECHANISM

Rule 1300.71.38(m)(2) states that the failure of a plan to comply with the requirements of a fast, fair and cost-effective dispute resolution mechanism shall be a basis for disciplinary action against the plan.

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 ended June 30, 2017, as follows:

1. TIMELY 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 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 Plan failed to issue a written determination letter within 45 working days of receipt in five out of 50 provider disputes reviewed (a compliance rate of 90 percent). This deficiency was noted in the following provider dispute sample numbers: 9, 14, 24, 44, and 45.

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

- a. Policy and procedures implemented to ensure that determination letters on provider disputes are issued timely in compliance with the above Rules.
- b. Training procedures to ensure that claims processors are aware of the revised policy and procedures.
- c. Audit procedures to confirm determination letters on provider disputes are issued timely in compliance with the above Rules.
- d. Date of implementation of the new policy and procedures.
- e. Management position responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan responded that the root cause for the deficiency was a lack of audit to ensure cases are resolved within 45 working days.

The Plan added that on December 18, 2017, it implemented a database query setup, which enables the PDR team to capture all pending cases to ensure cases are resolved timely. The Plan maintains an inventory at 30-lag days or under to monitor the timeliness of the PDRs. All cases over 35 days are submitted to the Plan’s department that is causing the delay. The Plan’s department has three days to respond. If no response is received, the PDR Lead will escalate. The Plan attached to its Responses an existing “Provider Dispute Resolution procedures” and “New Dispute Resolution Tool examiner guidelines desktop procedure,” which was implemented on December 18, 2017.

The Plan stated that on May 10, 2018, it retrained its PDR examiners on the forwarding and pending case process. The Plan attached to its Responses training sign-in sheet dated May 10, 2018. The PDR team has reinforced existing audit procedures to confirm determination letters on provider disputes are issued timely.

The Plan stated that the management position responsible for overseeing the CAP is the Manager of PDR.

The Department finds that the Plan's compliance effort is responsive to the corrective action required. Therefore, no further response is required.

2. ACCURACY OF WRITTEN DETERMINATION

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.

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 five out of 50 provider disputes reviewed had inaccurate information (a compliance rate of 90 percent). Four out of the five provider disputes determination letters had an incorrect payable amount. The amount that was eventually paid on these provider disputes was different than the amount stated in the determination letters. This deficiency was noted in provider dispute sample numbers: 6, 23, 27, 31, and 47.

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

- a. Policy and procedures implemented to ensure that determination letters clearly explain the decision made by the Plan in compliance with the above Rules.
- b. Training procedures to ensure that claims processors are aware of the revised policy and procedures.
- c. Audit procedures to confirm determination letters clearly explain the decision made by the Plan in compliance with the above Rules.
- d. Date of implementation of the new policy and procedures.
- e. Management position responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan stated that the root cause for the deficiency was that letter scripts were not modified to reflect the new claims system QNXT payment methodology.

The Plan stated that in the previous overturned letter script, the amount adjusted was not clearly communicated to the provider on the resolution letter. It was indicating amount paid versus amount adjusted. The Plan modified the overturned letter script to indicate the amount the Plan is adjusting versus the total amount paid.

The Plan stated that the training was conducted on the resolution letter script changes on May 9, 2018. The Plan attached to its Responses "training sign-in sheets" and "Revised Overturned Letter Script".

The Plan stated that the second root cause was a lack of audit to ensure correct letter script was being used. The Plan added that the PDR team has reinforced existing audit procedures to confirm determination letters on provider disputes are issued timely, and the management position responsible for overseeing the CAP is the Manager of PDR.

The Department finds that the Plan's compliance effort is responsive to the corrective action required. Therefore, no further response is required.

3. FAILURE TO ESTABLISH FAST, FAIR AND COST-EFFECTIVE PDR MECHANISM

Rule 1300.71.38(m)(2) states that the failure of a plan to comply with the requirements of a fast, fair and cost-effective dispute resolution mechanism shall be a basis for disciplinary action against the plan.

Section 1371.4(b) states that a plan shall reimburse providers for emergency services to its enrollees, until the care results in stabilization of the enrollee.

The Department's examination disclosed that the Plan failed to establish a fast and cost effective PDR mechanism for claims when it delegates utilization management to an IPA. This deficiency was found in PDR sample 44, which pertains to an out of state emergency services claim. The claim was the financial responsibility of the Plan. It was denied for medical necessity and the remittance advice (RA) included instructions to the provider to submit the PDR to the Plan. The provider submitted the PDR to the Plan and it was denied instructing the provider to submit the PDR to the IPA for the first level appeal and determination of medical necessity.

The Preliminary Report required the Plan to establish a fast, fair and cost effective PDR mechanism for claims when it delegates utilization management to an IPA. The Plan was required to perform first level appeal review by itself or forward the appeal for review and determination to the IPA.

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

- a. Policy and procedures implemented to ensure that the Plan performs first level appeal review by itself or forward the appeal for review and determination to the IPA in compliance with the above Rule.
- b. Training procedures to ensure that claims processors are aware of the revised policy and procedures.
- c. The date of implementation of the new policy and procedures.
- d. Management position responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance

The Plan responded that it is working on addressing the required actions set forth in the Preliminary Report to improve its PDR process and remediate the deficiencies. The Plan stated that one change in operations that has been made, that will have an impact on improving the PDR process is that all claims examiners now have direct access to the Plan's authorization database called CCA (Authorization Database). This will allow claims examiners to have access to the CCA database to validate authorizations and better coordinate the financially responsible party.

The Plan stated that the above mentioned claim has been reprocessed and paid.

The Plan stated that currently the Plan's RA directs providers to file a formal dispute to the Plan's Appeals and Grievances unit. Claims that were processed in the Legacy System generated an old version of the RA template. The Plan stated that RAs will be modified to include second level dispute guidance and information, as well as information on the documentation needed for review. Anticipated implementation date is August 17, 2018.

The Plan added that the Plan's PDR team has enhanced existing audit procedures to monitor all PDR cases. Cases are reviewed to ensure they were resolved correctly. The Plan attached with its response a policy "CLM-NEW Claim Auditing and Monitoring" with implementation date of June 4, 2018.

The Plan stated that the management position responsible for overseeing the CAP is Nancy Villaneda, Manager, PDR.

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required. The Department acknowledges that the Plan paid PDR sample 44 with interest on July 9, 2018.

The Plan is required to submit a detailed CAP to bring the Plan into compliance with the above Section and Rule that should include, but not be limited to, the following:

- a. Policy and procedures implemented to ensure compliance with Section 1371.4(b) and Rule 1300.71.38(m)(2).**
- b. Training procedures to ensure that claims processors are aware of the revised policy and procedures.**
- c. The date of implementation of the new policy and procedures.**
- d. Management position responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.**

C. FIDELITY BOND

Rule 1300.76.3 requires each plan to maintain, at all times, a fidelity bond covering each officer, director, trustee, partner, and employee of the plan, whether or not they are compensated. In addition, the fidelity bond shall provide for a 30-day notice to the director prior to cancellation, and it shall provide at least the minimum coverage for the plan, as required by the schedule in the Rule. The fidelity bond may contain a provision for a deductible amount. However, the deductible amount shall not be in excess of 10 percent of the required minimum bond coverage, not to exceed \$100,000.

The Department's examination disclosed that the Plan's fidelity bond policy had a deductible of \$1 million, which exceeds the maximum allowed deductible of \$100,000.

The Preliminary Report required the Plan to file, with its response, an evidence of a fidelity bond that corrects the above noted deficiency.

The Plan was also required to provide the policy and procedures implemented to ensure that the fidelity bond complies with all of the requirements of Rule 1300.76.3, the date of implementation, and the management position(s) responsible for ensuring continued compliance with Rule 1300.76.3.

The Plan responded that currently, it has a crime coverage policy that serves as a fidelity bond. However, due to the Plan's size and complexity, acquiring a crime or fidelity bond policy with a \$100,000 deductible is not feasible in the insurance market in which the Plan purchases its insurance coverage.

The Plan stated that it worked with its insurance broker and came up with a proposal for meeting the requirements of Rule 1300.76.3. To satisfy the maximum deductible, the Plan is proposing to obtain an endorsement rider to its crime coverage policy from its insurer that documents a \$100,000 retention (i.e., deductible) under specific indemnification terms as set forth in the endorsement rider. The Plan attached to its Responses "indemnification endorsement."

The Plan stated that on May 29, 2018 it acquired a formal statement from its insurance broker about how the commercial insurance marketplace will not accommodate a deductible at this low level. The Plan attached excerpt from the broker statement. On May 31, 2018, the Plan contacted the Department to inquire about whether the endorsement rider approach would be acceptable to the Department. The Department instructed the Plan to file the proposal and a copy of the endorsement rider for the Department's review and consideration.

The Plan stated that, if acceptable, the Plan will implement the endorsement within 30 days.

The Plan stated that it will develop a policy and procedures to address the requirements of Rule 1300.76.3 on July 27, 2018.

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required, since the Plan has not implemented the endorsement rider to its fidelity bond policy that provides for \$100,000 deductible amount. Therefore, the Plan is required to file evidence of a fidelity bond that corrects the above noted deficiency.

The Plan is also required to provide the policy and procedures implemented to ensure that the fidelity bond complies with all of the requirements of Rule 1300.76.3, the date of implementation, and the management position(s) responsible for ensuring continued compliance with Rule 1300.76.3.

D. ENROLLMENT NOTICE OF CANCELLATION

Section 1365(a)(1)(A) states that enrollment can be cancelled for nonpayment of the required premiums if the individual, employer, or contract holder has been duly notified and billed for the charge and at least a 30-day grace period has elapsed since the date of notification.

Rule 1300.65(c)(3)(B)(ii) states that the notice of cancellation for nonpayment of premiums and grace period shall include the following language:

"You are receiving this notice of cancellation because your [Plan] coverage is being cancelled or not renewed because you have not paid your premium.

Even though you have not paid your premiums, you are being provided a "grace period" to allow you time to make your past due premiums payment(s) without losing your health care coverage.

"Grace period" means a period of at least 30 days beginning no sooner than the first day after the last day of paid coverage and lasts at least 30 days. Your grace period ends on (insert month, day, year).

You may avoid losing your coverage if you pay the premium(s) owed to [Plan] before the end of the grace period. If you do not pay the required premium amount by the end of the grace period, your coverage will be terminated effective the day

after the last day of the grace period. Your grace period ends on (insert month, day, year).

Coverage will continue during the grace period; however, you are still responsible to pay unpaid premiums and any copayments, coinsurance or deductible amounts required under the plan contract.”

The Department’s examination disclosed that the Plan’s notice of cancellation did not state that the Plan shall continue to provide coverage during a 30-day grace period after the last day of paid coverage, as required by the above Rule.

The Preliminary Report required the Plan to submit a CAP including a revised policy and procedures, and a copy of the revised cancellation letter, to comply with the above Rule. In addition, the Plan was required state the CAP implementation date and the management position responsible for ensuring ongoing compliance.

The Plan responded that on May 16, 2018, it revised the “One Month Grace Period Member Notice” to include the required language and revised the “Three Month Grace Period Member Notice” to include required language and provide a timeline narrative describing steps and consequences with the three month grace period. The Plan attached to its Responses “One Month Grace Period Member Notice” and “Three Month Grace Period Member Notice”.

The Plan stated that on June 15, 2018, it will submit the revised letters to Covered California for review and approval. The Plan will implement the new letters upon approval.

The Plan stated that it will develop a policy and procedures to address revision of letters and include annual letter review by its commercial product group management team. The Plan stated that it will incorporate letter review into the annual cycle process to ensure review takes place as part of the annual renewal process. Expected policy and procedures implementation date is July 27, 2018.

The management position responsible for overseeing the CAP is the Senior Manager of Commercial Product Group Management.

The Department finds that the Plan’s compliance effort is not fully responsive to the corrective action required, since the Plan has not completed the implementation of the revised policy and procedures. The Plan is required to submit a revised policy and procedures, and a copy of the revised cancellation letter, to comply with the above Rule.

E. MONITORING FINANCIAL VIABILITY OF CAPITATED PROVIDERS

Rule 1300.75.4.3(e) requires each plan to have adequate procedures in place to ensure that the plan notifies the Department or its designated agent no later than five business

days from discovering that any of its contracting organizations experienced any event which materially alters the organization's financial situation, or threatens its solvency.

Rule 1300.75.4.5(a)(5) requires each plan to advise the Department and the organization in writing within five days of becoming aware that a contracting organization is not in compliance with the requirements of a final CAP, or that an organization's conduct may cause the plan to be subject to disciplinary action.

The Department's examination disclosed that the Plan did not have adequate policies and procedures in place to ensure compliance with Rules 1300.75.4.3(e) and 1300.75.4.5(a)(5).

The Preliminary Report required the Plan to submit the revised policy and procedures, and the date of their implementation, to demonstrate compliance with Rules 1300.75.4.3(e) and 1300.75.4.5(a)(5). In addition, the Plan was required to state the management position(s) responsible for ensuring continued compliance.

The Plan responded that there are processes in place to ensure that the Plan is compliant with Rules 1300.75.4.3(e) and 1300.75.4.5(a)(5), but it failed to formally document these Rules in its policy and procedures.

The Plan stated that it updated the policy for "Minimum Financial Solvency and Risk Management Requirements for Plan Partners and Participating Provider Groups" to include provisions of Rules 1300.75.4.3(e) and 1300.75.4.5(a)(5). This policy is expected to be finalized by September 30, 2018. The process is in place, but the policy is still going through the Plan's approval process. The Plan attached to its Responses a draft copy of the policy.

The management position responsible for overseeing the CAP is the Director of Financial Compliance.

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required, since the Plan has not finalized its revised policy and procedures to demonstrate compliance with Rules 1300.75.4.3(e) and 1300.75.4.5(a)(5).

The Plan is required to submit the revised policy and procedures, and the date of their implementation, to demonstrate compliance with Rules 1300.75.4.3(e) and 1300.75.4.5(a)(5).

SECTION IV. INTERNAL CONTROL

Sections 1384 and 1345(s), and Rule 1300.45(q) include requirements for filing financial statements in accordance with Generally Accepted Accounting Principles (GAAP) and other authoritative pronouncements of the accounting profession.

AICPA Statement on Auditing Standards (SAS) No. 78 states: "Internal control is a process, effected by an entity's board of directors, management, and other personnel, designed to provide reasonable assurance regarding the achievement of objectives in the following categories: (a) reliability of financial reporting, (b) effectiveness and efficiency of operations, and (c) compliance with applicable laws and regulations."

SAS No. 115 requires an auditor to communicate reportable conditions noted during the examination to appropriate personnel. "Reportable conditions" involve matters coming to the auditor's attention relating to significant deficiencies in the design or operation of the internal control structure, which could adversely affect the organization's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements.

Rule 1300.67.3(a)(3) requires a licensed health care service plan to have written procedures for the conduct of the business of the plan so as to provide effective controls.

The Department's examination disclosed the following weaknesses in internal controls:

A. MAILING CLAIM PAYMENTS TO INCORRECT ADDRESSES

The Department's examination disclosed that five claim payment checks were sent to incorrect addresses, or were not sent at all, because the address was missing on the check. Review of claims processed in the MHC system revealed that 31 out of 50 late claims for the quarter ended June 30, 2017 had stale-dated checks that have never been cashed by providers and which later had to be reissued. The Plan was requested to research whether original checks were sent to the correct addresses or not. The research showed that 12 out of 50 late claims had checks sent to incorrect addresses or were not sent at all. Later, all these checks were reissued. One of the reissued checks has never been cashed and is still outstanding.

The deficiency concerning the checks that were sent to incorrect address or never sent at all and later reissued was noted in the following MHC late claims sample numbers: 1, 2, 5, 9, 11, 14, 22, 24, 29, 43, and 50.

The deficiency concerning the check that was sent to incorrect address, later reissued, and is still outstanding was found in MHC late claims sample number 26.

The Preliminary Report required the Plan to research remaining claims with reissued checks to determine whether the original checks were sent to the correct addresses. If not, the Plan was required to reprocess those claims payments and include interest.

The Plan was also required to submit the policy and procedures implemented to ensure that checks are mailed to correct addresses. The Plan was required to research stale-dated checks to determine whether the checks had been mailed to the correct addresses. In addition, the Plan was to state the date these policy and procedures were

implemented, the management position(s) responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

The Plan stated that the root cause for the deficiency is the lack of a cross-functional process to research returned checks and apply interest, if required.

The Plan added that it created a cross-functional work flow and process between MPSS, Claims, and PDU to ensure the Plan sends payments to the correct addresses. This includes a process to research returned and stale checks to ensure the checks are re-sent to the correct address and with interest, if required. During the onsite examination, many of the payments in question were reissued due to stale dated checks. The reasons for stale dated checks can vary and the Plan has an existing policy on how to handle stale dated checks.

The Plan explained that all payments that result in stale checks due to being sent to the wrong address would become returned mail and thus fall into the newly developed return mail work flow. The Plan attached to its Responses "Return Mail Work Flow" procedures, which were implemented on June 4, 2018.

The Plan stated that once the Return Mail Work Flow and Policy and Procedures have been finalized and approved, the Provider Network Management Engagement and Strategy training team will launch the associated training, provide FAQ documentation and any necessary reference materials to support the network. All business units impacted by this change (including but not limited to the Customer Solutions Center/Call Center representatives, Provider Contract/Relations Account Managers, PDU staff, MPSS staff) will also be trained on the new work flow.

The Plan indicated that MPSS and PDU will pull a quarterly monitoring report to ensure returned mail is sent to the updated addresses. This report will be submitted to and also monitored by the compliance department. This monitoring will start in July 2018 for third quarter of 2018 reporting.

The management positions responsible for overseeing the CAP are the Senior Director of MPSS, the Director of Claims and the Director of Provider Data Unit.

The Plan disclosed that it identified all claims processed from July 24, 2014 to present where claims may have been sent to incorrect addresses. The Plan is in the process of reviewing the entire universe to validate whether the claims payments were sent to the incorrect address and the amount due, if applicable. The Plan can provide the Department with the identification and evidence that interest and penalties were paid on an Excel spreadsheet by March 30, 2019.

The Plan stated that it can provide a universe of claims that may potentially require interest due to being sent to the incorrect address. The Plan is in the process of analyzing each line item to validate if interest is actually owed. The Plan is able to provide status updates on an ongoing basis to the Department, if requested. This validation of interest amount owed will be completed by March 30, 2019.

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required, since the Plan has not completed its research of the remaining claims with reissued checks to determine whether the original checks were sent to the correct addresses.

The Plan is also required to research the remaining claims with reissued checks to determine whether the original checks were sent to the correct addresses. If not, the Plan is required to reprocess those claims payments and include interest. The Plan is required to research stale-dated checks to determine whether the checks had been mailed to the correct addresses.

B. FAILURE TO RESEARCH COMPLAINTS ABOUT MEDICAL GROUPS

The Department's examination disclosed that the Plan failed to respond to a complaint filed by a provider about the Plan's various contracted medical groups. The provider submitted a provider dispute to the Plan stating that he submitted 363 claims to the Plan's medical groups that have neither been paid nor denied. The provider submitted the list of claims with members' numbers, dates of service, billed amounts and dates the claims were sent to the medical groups. According to the provider, all these claims were sent to the medical groups twice and have been pending for more than six months. The Plan denied provider's provider dispute for missing first and second level appeal letters, a copy of the complete medical records, a copy of the claim form, a copy of the explanation of benefit, and a copy of the first level resolution letter. The Plan did not appear to have contacted its medical groups and researched the status of these claims. During the examination, the Plan was requested to research whether the members mentioned in the complaint belong to any of the Plan's medical groups. The Plan responded that 60 of the claims were for Plan's members belonging to various medical groups.

The Preliminary Report required the Plan to contact its medical groups and research the status of the claims mentioned in the noted provider complaint.

The Plan was also required to submit the policy and procedures implemented to ensure that complaints about its medical groups are researched and appropriate measures are taken to process claims. The Plan was to state the date these procedures were implemented, the management position(s) responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan disagreed with this deficiency. The Plan stated that the provider dispute did not have the required information to proceed with the case review. The provider did not attach claims or IPA information. The Plan attempted to research the claims with the information provided. The claims were not found in the claims system. The Plan was unable to contact the appropriate medical groups due to lack of sufficient claims information. The Plan sent the provider a letter requesting additional information. No response was received from provider.

Based on the lack of sufficient information and the regulations cited below, the Plan believes its actions were appropriate. According to Rule 1300.71.38(d)(2), the Plan or the Plan's capitated provider may return any provider dispute lacking the information enumerated in either Rule 1300.71.38(a)(1) or (a)(2), if the information is in the possession of the provider and is not readily accessible to the Plan or the Plan's capitated provider. Along with any returned provider dispute, the Plan or the Plan's capitated provider shall clearly identify in writing the missing information necessary to resolve the dispute consistent with sections 1300.71(a)(10) and (11) and 1300.71(d)(1), (2) and (3). Except in situation where the claim documentation has been returned to the provider, no Plan or a Plan's capitated provider shall request the provider to resubmit claim information or supporting documentation that the provider previously submitted to the Plan or the Plan's capitated provider as part of the claims adjudication process.

The Department finds that the Plan's compliance effort is not responsive to the corrective action required, since the Plan failed to research the status of the claims mentioned in the noted provider complaint. Again, the Plan is required to research the provider's complaint.

The Plan is required to submit the policy and procedures implemented to ensure that complaints about its medical groups are researched and appropriate measures are taken to process claims. The Plan is to state the date these procedures were implemented, the management position(s) responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance.

SECTION V. NON-ROUTINE EXAMINATION

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

No response is required to this section.