



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

August 25, 2022

Via eFile

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

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

Dear Mr. Baackes:

Enclosed is the final report (Final Report) of a routine examination for the quarter ended September 30, 2021, of the fiscal and administrative affairs of Local Initiative Health Authority for Los Angeles County, dba: L.A. Care Health Plan (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975.¹ The Department issued a preliminary report (Preliminary Report) to the Plan on May 31, 2022. The Department accepted the Plan's electronically filed responses (Responses) on July 15, 2022, July 21, 2022, August 2, 2022, August 8, 2022, August 9, 2022 and August 12, 2022.

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

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

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

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

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

- From the main menu, select "eFiling."
- From the eFiling menu, select "Online Forms."
- From the Online Forms menu, select "Details" for "CAP #L22-R-355."
- Go to the "Messages" tab, then:
 - Select "Addendum to Final Report" (note this option will only be available for 10 days after the issuance of the Final Report).
 - Select the deficiency(ies) that are applicable.
 - Create a message for the Department.
 - Attach and upload all documents with the name "Addendum to Final Report."
 - Select "Send Message."

As noted in the attached Final Report, the Plan's Responses did not adequately respond to the deficiencies raised in the Preliminary Report issued by the Department on May 31, 2022. The Plan is required to respond to any request for corrective actions contained within the attached Final Report within 30 days of receipt of the Final Report. If the Plan fails to fully respond and/or resolve the deficiencies addressed in the Final Report, then a referral will be made to the Department's Office of Enforcement for appropriate administrative action.

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

- From the main menu, select "eFiling."
- From the eFiling menu, select "Online Forms."
- From the Online Forms menu, click on the "Details" for "CAP #L22-R-355."
- Go to the "Data Requests" tab, then:
 - Click on the "Details" for each data request that does not have a status of "Complete."
 - Follow the instructions and/or use the form shown to add the requested data (depending on the type of data requested: New Filing, Document Request, Claims Data, or Financial Statement Refile).

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

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

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

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

If there are any questions regarding the Final Report, please contact me at 213-620-2057 or by e-mail at Suhag.Patel@dmhc.ca.gov.

Sincerely,

SIGNED BY

Suhag Patel
Corporation Examiner IV, Supervisor
Office of Financial Review
Division of Financial Oversight

cc: Augustavia J. Haydel, General Counsel, Local Initiative Health Authority for Los Angeles County
Pritika Dutt, CPA, Deputy Director, Office of Financial Review
Ned Gennaoui, Supervising Examiner, Division of Financial Oversight
Francisco Garcia, Senior Examiner, Division of Financial Oversight
Lorena Meza, Examiner, Division of Financial Oversight
Linda Kam, Assistant Chief Counsel, Office of Plan Licensing
Laura Dooley-Beile, Supervising Health Care Service Plan Analyst, Office of Plan Monitoring
Chad Bartlett, Staff Services Manager II, Help Center

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

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

FINAL REPORT OF A ROUTINE EXAMINATION

OF

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

FILE NO. 933 0355

DATE OF FINAL REPORT: AUGUST 25, 2022

SUPERVISING EXAMINER: NED GENNAOUI

OVERSIGHT EXAMINER: SUHAG PATEL

EXAMINER-IN-CHARGE: FRANCISCO GARCIA

FINANCIAL EXAMINERS:

**SEBAS ALEX
JULIANA ASABOR
JOHN ATAMIAN
CHANTE BIAGAS
ZAW OO**

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

Date Plan Licensed:	April 1, 1997
Organizational Structure:	Local Initiative Health Authority for Los Angeles County, dba: L.A. Care Health Plan, (Plan) is an independent local public agency that provides managed health care services to Medi-Cal beneficiaries in Los Angeles County.
Type of Plan:	The Plan is a full-service health care service plan providing services to Medi-Cal beneficiaries in accordance with contracts with the Department of Health Care Services.
Provider Network:	The Plan subcontracts the delivery of health care services through its network of contracted health plans. In addition, the Plan contracts directly with participating physician groups, hospitals, primary care and specialty care physicians and other ancillary professionals for health care services.
Plan Enrollment:	The Plan reported total enrollment of 2,467,223 members at September 30, 2021.
Service Area:	The Plan operates in Los Angeles County.
Date of Prior Final Routine Examination Report:	August 1, 2018

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

This is the final report (Final Report) for the quarter ended September 30, 2021, of a routine examination of the fiscal and administrative affairs of Local Initiative Health Authority for Los Angeles County, dba: L.A. Care Health Plan (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975.¹ The Department issued a preliminary report (Preliminary Report) to the Plan on May 31, 2022. The Department accepted the Plan's electronically filed responses (Responses) on July 15, 2022, July 21, 2022, August 2, 2022, August 8, 2022, August 9, 2022 and August 12, 2022.

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

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

The Department examined the Plan's financial report filed with the Department for the quarter ended September 30, 2021, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions.

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

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

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

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

PART I. FINANCIAL STATEMENTS

The Department's examination did not result in any adjustments or reclassifications to the Plan's financial statements for the quarter ended September 30, 2021, as filed with the Department. A copy of the Plan's financial statements can be viewed by selecting "Local Initiative Health Authority for Los Angeles County" on the second drop-down menu of the Department's financial statement database available at <http://wpsso.dmhc.ca.gov/fe/search/#top>.

No response is required to this Part.

PART II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth and TNE as reported by the Plan as of quarter ended September 30, 2021	\$1,049,455,062
Required TNE	<u>154,423,468</u>
TNE Excess per Examination	<u>\$895,031,594</u>

The Plan was in compliance with the TNE requirements of Rule 1300.76 as of September 30, 2021.

No response is required to this Part.

PART III. COMPLIANCE ISSUES

A. CLAIM SETTLEMENT PRACTICES – “UNFAIR PAYMENT PATTERNS”

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

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

The Department's examination found that the Plan engaged in “unfair payment patterns” for the three-month period ended September 30, 2021, as follows:

1. PAYMENT ACCURACY OF INTEREST ON LATE CLAIMS - REPEAT DEFICIENCY

Section 1371 and Rule 1300.71(i)(2) 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.

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.

Rule 1300.71(j) states that the penalty for failure to comply with the requirements of Rule 1300.71(i)(1) and (2) shall be a fee of \$10 paid to the claimant for each late claim.

Rule 1300.71(a)(8)(K) describes one 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 pay or underpaid interest on three out of 50 late paid claims reviewed (a compliance rate of 94 percent). This deficiency was noted in late paid claim sample numbers: 6, 12 and 49. This deficiency was also noted in provider dispute sample numbers 32 and 37. The deficiency was caused by claim processors not using the date of receipt of a complete claim to determine the amount of interest due.

The Plan's failure to reimburse claims accurately, including automatic payment of interest and penalties, was a repeat deficiency, as this issue was previously reported in the Department's final report of nonroutine examination dated December 26, 2019, for the quarter ended March 31, 2019. This examination disclosed that the Plan's corrective actions in response to the previous 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 to resolve the deficiency of failure to reimburse claims accurately, including payment of interest and penalties, as identified in the Department's previous 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, and to include the following:

- a. Training procedures implemented, and date of implementation, to ensure that claims processors pay interest, and penalties if applicable, on all late claim payments.
- b. Audit procedures implemented, and date of implementation, to ensure that the Plan is monitoring the accurate payment of interest and penalties on all late claim payments.
- c. Identification of all late paid claims for which interest and penalties were not correctly paid from October 1, 2019 (the remediation completion date of the

previous nonroutine examination) through the date corrective action was implemented by the Plan.

- d. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in paragraph “c” of the required CAP. 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
- 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
- Emergency or non-emergency indicator

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

- e. Management position responsible for ensuring continued compliance.

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

The Plan responded as follows:

In the previous examination, the interest issues occurred due to a system rounding error, during the automatic interest table coding to account for the leap year. The Plan updated the system and received confirmation on August 9, 2019 that the rounding error was resolved. The current exceptions were due to examiners not going back to the original complete claim receipt date when adjusting claims for additional payments.

Root Causes:

- Late paid claim sample numbers 6, 12 and 49 and provider dispute sample numbers 32 and 37 were incorrectly processed by claim examiners. These claims were previously reprocessed to make an additional payment to providers. The claim processors used the incorrect date of receipt to process these claims. When adjusting these claims, the claim processors should have used the original date of receipt. This incorrect processing was not in line with the Plan's policy for paying interest and penalties accurately.*
- The Plan acknowledged that the current oversight and monitoring process required enhancements.*

Remediation:

- On July 12, 2022, the Plan provided training to its staff on the accurate reimbursement of claims including paying interest and penalties. The Plan submitted the list of attendees.*
- In addition, the Plan submitted a copy of its audit procedures, "Internal Claims Auditing and Monitoring," indicating an implementation date of September 1, 2022. As an enhancement to the audit procedures, the Plan created daily monitoring and oversight to verify that interest and penalties were accurately paid on all late paid claims.*
- Also, the Plan identified claims processed from October 1, 2019 through June 13, 2022 where interest was not paid and/or underpaid. The Plan anticipates completing the remediation, by paying interest and penalties due, by September 30, 2022. The Plan will file evidence of remediation completion with the Department.*
- The Plan's Claims Integrity Compliance Manager is the management position responsible for ensuring continued compliance.*

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

remediation. The Department acknowledges the Plan's representation that the required CAP will be completed by September 30, 2022.

The Plan is required to file a monthly status report indicating the Plan's progress toward completing the required remediation, until the remediation is completed. The first status report should indicate all remediated claims up to August 31, 2022 and is required to be filed with the Department by September 15, 2022. The final remediation report should indicate all remediated claims up to the remediation completion date of September 30, 2022, which is due to the Department by October 17, 2022. The monthly status and final remediation reports should include the information required by paragraph "d" of the required CAP above.

In addition, the Plan is required to confirm that the new audit procedures, with an implementation date of September 1, 2022, was implemented by the Plan and provide the actual implementation date.

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 one "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 reviewed (a compliance rate of 92 percent). This deficiency was noted in denied claim sample numbers: 12, 18, 25 and 50. The deficiency was caused by claim processors incorrectly denying claims as delegated provider financial responsibility to pay.

The Plan's incorrect denial of claims was a repeat deficiency, as this issue was previously reported in the Department's final report of nonroutine examination dated December 26, 2019, for the quarter ended March 31, 2019. This examination disclosed that the Plan's corrective actions in response to the previous final 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 incorrectly denying claims, found in the Department's previous examination, were not effective in ensuring ongoing compliance.

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

- a. Training procedures implemented, and date of implementation, to ensure that claim processors accurately determine the entity responsible for claim payment prior to denying claims.
- b. Audit procedures implemented, and date of implementation, to confirm the accurate denial of claims.
- c. Identification of all claims incorrectly denied, as the financial responsibility of delegated providers to pay, that should have been paid, from October 1, 2019 through the date the corrective action was implemented by the Plan.
- d. Evidence that interest and penalties, as appropriate, were paid retroactively for the denied claims identified in “c” of the required CAP. This evidence was to include an electronic data file (Excel or Access) that identified the following:
 - Claim number
 - Date of service
 - Date original claim received
 - Date new information received
 - Date claim was complete
 - Total billed
 - Total paid
 - Paid date (mail date)
 - Number of days late used to calculate interest
 - Interest amount paid
 - Date interest paid
 - Penalty amount paid, if applicable
 - Check number for claim payment and interest, and penalty, if applicable
 - 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 penalties paid, as a result of remediation.

- e. Management position responsible for ensuring continued compliance.

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

The Plan responded as follows:

The previous examination findings were due to edits in the claims system that were not linked to the correct claim adjustment reason codes and remittance advice remark codes. As a result, claims were denied incorrectly. The related system issue was corrected on June 8, 2019. The current exceptions are due to examiners incorrectly forwarding claims.

Root Causes:

- Denied claim sample numbers 18 ,25 and 50 were incorrectly denied as the financial responsibility of the Plan's delegated providers. The claim processors did not review and verify the division of financial responsibility (DOFR) prior to adjudicating the claims. Therefore, the claims were incorrectly denied as delegated provider financial responsibility. This incorrect processing was not in line with the Plan's DOFR training.*
- Denied claim sample number 12 was incorrectly denied by claim processors, due to member ineligibility. However, this was incorrect as the member was eligible on the date of service.*
- The Plan acknowledged that the current oversight and monitoring process required enhancements.*

Remediation:

- On July 12, 2022, the Plan provided training to its staff to accurately apply DOFR on each claim, and to determine member eligibility prior to denying claims. The Plan submitted the list of attendees.*
- In addition, the Plan submitted a copy of its audit procedures, "Internal Claims Auditing and Monitoring," indicating an implementation date of September 1, 2022. As an enhancement to the audit procedures, the Plan created daily monitoring and oversight to review the accuracy of denied claims.*
- Also, the Plan identified claims processed from October 1, 2019 through June 16, 2022 where claims may have been denied incorrectly. The Plan anticipates completing the review and remediation by September 30, 2022, including interest on late payments. The Plan will file evidence of remediation completion with the Department.*
- The Plan's Claims Integrity Compliance Manager is the management position responsible for ensuring continued compliance.*

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required since the Plan did not complete the required remediation. The Department acknowledges the Plan's representation that the required CAP will be completed by September 30, 2022.

The Plan is required to file a monthly status report indicating the Plan's progress toward completing the required remediation, until the remediation is completed. The first status report should indicate all remediated claims up to August 31, 2022, and is required to be filed with the Department by September 15, 2022. The final remediation report should indicate all remediated claims up to the remediation completion date of September 30, 2022, which is due to the Department by October 17, 2022. The monthly status and final remediation reports should include the information required by paragraph "d" of the required CAP above.

In addition, the Plan is required to confirm that the new audit procedures, with an implementation date of September 1, 2022, was implemented by the Plan and provide the actual implementation date.

B. PROVIDER DISPUTE RESOLUTION 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 September 30, 2021, as follows:

1. TIMELY RESOLUTION OF PROVIDER DISPUTES – REPEAT DEFICIENCY

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 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 three out of 50 provider disputes reviewed (a compliance rate of 94 percent). This deficiency was noted in provider dispute sample numbers: 15, 29 and 32.

The Plan's failure to issue a written determination within 45 working days of receipt of the provider dispute or amended provider dispute was a repeat deficiency, as this issue

was previously reported in the Department's final report of routine examination dated August 1, 2018, for the quarter ended June 30, 2017. This examination disclosed that the Plan's corrective actions in response to the previous final 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 issuing a written determination within 45 working days of receipt, found in the Department's previous examination, were not effective in ensuring ongoing compliance.

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

- a. Plan representation of current compliance rate and the start and end dates of noncompliance with the timeliness requirement for resolution of provider disputes. If the Plan had not reached the minimum compliance rate, the Plan was required to indicate the anticipated date of achieving the required compliance rate.
- b. Training procedures implemented, and date of implementation, to ensure that a written determination was issued within 45 working days of receipt of the provider dispute or amended provider dispute.
- c. Audit procedures implemented, and date of implementation, to confirm the timely issuance of written determination letters.
- d. Management position responsible for ensuring continued compliance.

The Plan responded as follows:

Although there was a fix implemented in 2017 to correct the deficiency noted in the previous examination, the Plan found that there was insufficient management oversight due to staffing shortage in the provider dispute (PDR) department. In May 2021, there was a reorganization of the claims operations unit to resolve the lack of oversight required to identify risk of non-compliance. The new leadership team conducted a staffing analysis that identified the need for additional resources for meeting the compliance requirements. The additional resources have been approved and the leadership team is working to recruit skilled individuals to ensure ongoing compliance.

Root Cause:

- *The Plan's PDR department had staffing shortage due to leaves of absence during the months of May, June, and July of 2021. Provider disputes were backlogged during the review period due to a high rate of absenteeism related to COVID and other issues. At the same time, the Plan experienced an increase in the number of provider disputes. The absenteeism in conjunction with the*

increase in the number of provider disputes impacted resolution timeliness of provider disputes. The provider dispute database implemented in 2017 was able to report inventory aging, and the Plan attempted to bring additional resources to reduce the provider dispute inventory. Due to the additional resources not having sufficient provider dispute experience, they were not sufficient to achieve compliance with the timely resolution requirements.

Remediation:

- *The Plan provided a current compliance report, as of June 30, 2022, that indicated a 44 percent compliance rate for the timely resolution of provider disputes. The Plan anticipates achieving at least 95 percent compliance rate by September 30, 2022.*
- *On July 20, 2022, the Plan provided training to its staff on the requirements of timely resolution for provider disputes. The Plan submitted the list of attendees.*
- *In addition, the Plan indicated that it already has an audit process in place that was implemented on February 1, 2021. As an additional enhancement to the audit procedures, the Plan created daily monitoring and oversight of the aging report to determine the timely issuance of written determination letters. Also, to meet the provider dispute resolution timeliness requirements, the Plan started allowing overtime to its current staff and hired additional staff.*
- *The Plan's Director of Payment Remediation is the management position responsible for ensuring continued compliance.*

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required since the Plan did not complete the required remediation. The Department acknowledges the Plan's representation that the required CAP will be completed by September 30, 2022.

The Plan is required to file a monthly status report indicating the Plan's progress toward completing the required remediation, until the remediation is completed. The first status report should indicate the compliance rate for provider dispute resolution timeliness as of August 31, 2022, and is required to be filed with the Department by September 15, 2022. The final remediation report should indicate a compliance rate of at least 95 percent for resolution timeliness, as of the remediation completion date of September 30, 2022, which is due to the Department by October 17, 2022.

2. ACKNOWLEDGMENT OF PROVIDER DISPUTES

Rule 1300.71.38(e)(2) requires a plan to acknowledge the receipt of each paper provider dispute within 15 working days of the date of receipt of the provider dispute by the 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 percent of the provider disputes a plan 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 timely acknowledge the receipt of 18 out of 50 paper provider disputes reviewed (a compliance rate of 64 percent). This deficiency was noted in provider dispute sample numbers: 1, 7, 8, 9, 10, 12, 15, 17, 20, 21, 23, 26, 31, 33, 36, 38, 39 and 47.

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

- a. Plan representation of current compliance rate and the start and end dates of noncompliance with the timeliness requirement for acknowledging paper provider disputes. If the Plan had not reached the minimum compliance rate, the Plan was required to indicate the anticipated date of achieving the required compliance rate.
- b. Policies and Procedures implemented, and date of implementation, to ensure paper provider disputes were acknowledged timely.
- c. Training procedures implemented, and date of implementation, to ensure that paper provider disputes were acknowledged within 15 working days of receipt.
- d. Audit procedures implemented, and date of implementation, to confirm the timely acknowledgment of paper provider disputes.
- e. Management position responsible for ensuring continued compliance.

The Plan responded as follows:

Root Cause:

- *The PDR department had staffing shortage due to leaves of absence during the months of May, June, and July of 2021. The provider dispute acknowledgments were backlogged during the review period due a high rate of absenteeism related to COVID and other issues. At the same time, the Plan had an increase in the number of provider disputes. The absenteeism in conjunction with the increase in*

the number of provider disputes impacted timely acknowledgement. Also, the entire hiring process for temporary staff took over a month.

Remediation:

- *The Plan provided a current compliance report, as of June 30, 2022, that indicated a 93 percent compliance rate for the timely acknowledgment of paper provider disputes. The Plan anticipates achieving at least 95 percent compliance rate by September 30, 2022.*
- *Also, the Plan submitted a copy of its revised policy and procedure, "Provider Dispute Resolution," indicating an implementation date of November 1, 2022. The revised policy and procedure indicated that the Plan, or the Plan's capitated provider, shall acknowledge provider disputes within 15 working days of receipt of the paper provider disputes or within two working days of receipt of the electronic provider disputes.*
- *On July 20, 2022, the Plan provided training to its staff on the timely acknowledgement requirement for paper provider disputes. The Plan submitted the list of attendees.*
- *In addition, the Plan indicated that it already had an audit process in place that was implemented on February 1, 2021. As an additional enhancement to its audit procedures, the Plan created daily monitoring and oversight of its aging report to determine timely acknowledgment of paper provider disputes. Also, to meet the provider dispute acknowledgment timeliness requirements, the Plan started allowing overtime to its current staff and hired additional staff.*
- *The Plan's Director of Payment Remediation is the management position responsible for ensuring continued compliance.*

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required since the Plan did not complete the required remediation. The Department acknowledges the Plan's representation that the required CAP will be completed by September 30, 2022.

The Plan is required to file a monthly status report indicating the Plan's progress toward completing the required remediation, until the remediation is completed. The first status report should indicate the compliance rate for provider dispute acknowledgment timeliness as of August 31, 2022, and is required to be filed with the Department by September 15, 2022. The final remediation report should indicate a compliance rate of least 95 percent for acknowledgment timeliness, as of the remediation completion date of September 30, 2022, which is due to the Department by October 17, 2022.

In addition, the Plan is required to confirm that the revised policy and procedure, with an implementation date of November 1, 2022, was implemented by the Plan and provide the actual implementation date.



2021 DMHC Routine Examination (Financial Audit) Narrative
Final Report – Clarification

With regard to the 2021 DMHC Routine Examination (Financial Audit) Final Report for L.A. Care Local Initiative Health Authority for Los Angeles County, L.A. Care would like to submit the following clarifications:

- 1) In the summary of L.A. Care’s Remediation for Finding A1 (Payment Accuracy of Interest on Late Claims), the Final Report provides in part:

In addition, the Plan submitted a copy of its audit procedures, “Internal Claims Auditing and Monitoring,” indicating an implementation date of September 1, 2022. As an enhancement to the audit procedures, the Plan created daily monitoring and oversight to verify that interest and penalties were accurately paid on all late paid claims.

L.A. Care would like to clarify that the above statement should instead provide:

In addition, the Plan submitted a copy of its previous audit procedures, “Internal Claims Auditing and Monitoring,” indicating an implementation date of March 1, 2004. Effective September 1, 2022, as an enhancement to these audit procedures, the Plan created a monthly monitoring and oversight process to verify that interest and penalties were accurately paid on all late paid claims.

- 2) In the summary of L.A. Care’s Remediation for Finding A2 (Incorrect Claim Denials), the Final Report provides in part:

In addition, the Plan submitted a copy of its audit procedures, “Internal Claims Auditing and Monitoring,” indicating an implementation date of September 1, 2022. As an enhancement to the audit procedures, the Plan created daily monitoring and oversight to review the accuracy of denied claims.

L.A. Care would like to clarify that the above statement should instead provide:

In addition, the Plan submitted a copy of its previous audit procedures, “Internal Claims Auditing and Monitoring,” indicating an implementation date of March 1, 2004. Effective September 1, 2022, as an enhancement to these audit procedures, the Plan created a monthly monitoring and oversight process to verify the accuracy of denied claims.