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
L.A. Care Health Plan Joint Powers Authority
1055 West 7th Street, 10th floor
Los Angeles, CA 90017

FINAL REPORT OF A ROUTINE EXAMINATION OF L.A. CARE HEALTH PLAN JOINT POWERS AUTHORITY

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 L.A. Care Health Plan Joint Powers Authority (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 25, 2022, August 2, 2022, August 8, 2022, August 9, 2022, August 12, 2022 and August 24, 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 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

[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.

Plan requests the Department to append a brief statement summarizing the Plan's Responses or wishes to modify any information provided to the Department in its Responses, please provide an addendum no later than 10 days from the date of the Plan's receipt of this letter. Please file this addendum electronically via the corrective action plan (CAP) system within the Department's eFiling web portal at https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling."
- From the eFiling menu, select "Online Forms."
- From the Online Forms menu, select "Details" for "CAP #L22-R-504."
- 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://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling."
- From the eFiling menu, select "Online Forms."
- From the Online Forms menu, click on the "Details" for "CAP #L22-R-504."
- 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 wpso@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, L.A. Care Health Plan Joint Powers Authority
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

L.A. CARE HEALTH PLAN JOINT POWERS AUTHORITY

FILE NO. 933 0504

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
LINDSAY GONZALES
ZAW OO

BACKGROUND INFORMATION FOR L.A. CARE HEALTH PLAN JOINT POWERS AUTHORITY

Date Plan Licensed:	December 6, 2013
Organizational Structure:	L.A. Care Health Plan Joint Powers Authority (Plan) is a public entity, separate and apart from the County of Los Angeles (County), and it is not an agency, division, or department of the County. Local Initiative Health Authority for Los Angeles County (L.A. Care) entered into a joint exercise of powers agreement with the County to establish the Plan in July 2012. L.A. Care and the Plan are under common management and control.
Type of Plan:	The Plan is a full-service health care service plan providing services to In-Home Supportive Services (IHSS) workers. In February 2013, the IHSS product was renamed the Homecare Workers Health Care Plan (PASC-SEIU). The PASC-SEIU program provides health care services to IHSS workers in Los Angeles County.
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 50,938 IHSS enrollees at September 30, 2021.
Service Area:	The Plan operates in Los Angeles County.
Date of Prior Final Routine Examination Report:	January 24, 2017

FINAL REPORT OF A ROUTINE EXAMINATION OF L.A. CARE HEALTH PLAN JOINT POWERS AUTHORITY

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 L.A. Care Health Plan Joint Powers Authority (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 25, 2022, August 2, 2022, August 8, 2022, August 9, 2022, August 12, 2022 and August 24, 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 "L.A. Care Health Plan Joint Powers Authority" on the second drop-down menu of the Department's financial statement database available at http://wpso.dmhc.ca.gov/fe/search/#top.

No response is required to this Part.

PART II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

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

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. ACCURACY OF CLAIM PAYMENT TO NONCONTRACTED PROVIDERS

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 claims were not reimbursed accurately in six out of 50 paid claims reviewed (a compliance rate of 88 percent). The deficiency was caused by the Plan incorrectly reimbursing claims from noncontracted providers at Medi-Cal rates, rather than the Plan's usual and customary rates. This deficiency was noted in paid claim sample numbers: 6, 7, 15, 34, 38 and 47.

The Preliminary Report required the Plan to submit a corrective action plan (CAP) to address the deficiency cited above, and to include the following:

a. Policies and procedures implemented, and date of implementation, to ensure claim payments to noncontracted providers were reimbursed accurately.

b. Training procedures implemented, and date of implementation, to ensure processors pay claims to noncontracted providers accurately.

c. Audit procedures implemented, and date of implementation, to ensure that the Plan was monitoring the accurate payment of claims to noncontracted providers.

d. Identification of all claims from noncontracting providers that were not correctly paid from October 1, 2019 through the date corrective action was implemented by the Plan.

e. Evidence that claim payments to noncontracting providers were paid correctly. In addition, late payments were to include interest and penalties, as appropriate, for the claims identified in paragraph "d" 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 additional payment

- Payment 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, total additional amount of payments, and total additional interest and penalties paid as a result of remediation.

f. 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:

<u>Root Causes</u>:

- *The Plan stated that paid claim sample numbers 7, 15, 34 and 38 were processed with incorrect reimbursement rates because, at the time of conversion to a new claim system, some contracts were loaded with inaccurate reimbursement rates.*

- *In addition, paid claim sample numbers 6 and 74 were not processed correctly by claim examiner in accordance with AB 72 regulations. This processing was not in line with the Plan's AB 72 policy.*

- *The Plan acknowledged a lack of policies and procedures for paying noncontracted providers for the Plan's PASC-SEIU line of business.*

- *Also, the Plan determined that the current oversight and monitoring required enhancements.*

Remediation:

- *On July 14, 2022, the Plan implemented a new policy and procedure, "PASC-SEIU Non-Par Provider Reimbursement," to reimburse noncontracting provider claims accurately.*

- *In addition, the Plan indicated that it would correct the reimbursement rates for the contracts affected by the system change. The Plan's configuration team would review all affected contracts. The Plan's claim analyst would run a report and validate the accuracy of the loaded contracts. After validation, the Plan's claim analyst would conduct a second level review to validate the report and findings. Afterward, tests would be conducted before applying the updates. The claim analyst would make sure that the system updates were capturing the correct reimbursement rates. The Plan updated its standard operating procedures to ensure contracts are uploaded correctly. This updated standard operating procedures would be implemented on August 29, 2022.*

- *On July 12, 2022, the Plan provided training to its staff on accurately processing and reimbursing noncontracting provider claims. the Plan submitted the list of attendees.*

- *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 capture the accuracy of noncontracted provider claims reimbursement.*

- *The Plan identified claims processed from October 1, 2019 through June 16, 2022 that required remediation, include interest on late payments. The Plan anticipates completing the remediation 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, 3022, which is due to the Department by

October 17, 2022. The monthly status and final remediation reports should include the information required by paragraph "e" of the required CAP above.

In addition, the Plan is required to confirm that the new audit and standard operating procedures were implemented by the Plan and provide the actual implementation dates.

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. ACKNOWLEDGMENT OF PROVIDER DISPUTES - REPEAT DEFICIENCY

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 it receives consistent with Rule 1300.71.38(e) over the course of any three-month period.

The Department's examination disclosed that the Plan failed to timely acknowledge the receipt of 11 out of 50 paper provider disputes reviewed (a compliance rate of 78 percent). This deficiency was noted in provider dispute sample numbers: 3, 8, 10, 12, 19, 22, 28, 30, 43, 45 and 47. The Plan represented to the Department that this deficiency was the result of staff absenteeism during the unprecedented COVID-19 pandemic.

The Plan's failure to acknowledge the receipt of the paper provider disputes or amended paper provider disputes within 15 working days is a repeat deficiency, as this issue was previously reported in the Department's final report of routine examination dated January 24, 2017, for the quarter ended December 31, 2015. The reasons for this deficiency in the current examination are different from the reasons for the previous examination.

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 requirements for acknowledging paper provider disputes.

b. Training procedures implemented, and date of implementation, to ensure that paper provider disputes were acknowledged within 15 working days of receipt.

c. Audit procedures implemented, and date of implementation, to confirm the timely acknowledgment of paper provider disputes.

d. Management position responsible for ensuring continued compliance.

The Plan responded as follows:

Root Cause:

- *The Plan's provider dispute department had staffing shortage due to leaves of absence during the months of May, June, and July of 2021. 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 acknowledgment of provider disputes. 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 96 percent compliance rate for the timely acknowledgment of paper provider disputes.*

- *On July 20, 2022, the Plan provided training to its staff on the timely acknowledgment requirements of 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 responsive to the deficiency cited and 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 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 determination letter had inaccurate resolution language in three out of 50 provider disputes reviewed (a compliance rate of 94 percent). Although the resolution decision was correct, the pertinent facts and reasons supporting the determination were not accurate. This deficiency was noted in provider dispute sample numbers: 8, 29 and 41.

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

a. Policies and procedures implemented, and date of implementation, to ensure that the facts and reasons supporting the determination on provider disputes were accurate.

b. Training procedures implemented, and date of implementation, to ensure that determinations were properly supported by the pertinent facts and reasons.

c. Audit procedures implemented, and date of implementation, to ensure accurate determinations.

d. Management position responsible for ensuring continued compliance.

The Plan responded as follows:

Root Cause:

- *The Plan indicated that a lack of staff training resulted in inaccurate determination letters.*

- *In addition, there was insufficient management oversight to ensure that cases were handled correctly, and that the provider dispute determination letter language was accurate.*

- *Also, the Plan acknowledged that the provider dispute determination letter script was incorrect. The script for the mass closure process was not clear as it used the total claim paid amount, rather than the additional amount being paid to the provider for the dispute submitted. The mass closure process was created for efficiency to respond to claims already adjusted, without examiner review.*

Remediation:

- *The Plan submitted a copy of its updated provider dispute procedure, "Provider Dispute Resolution," indicating an implementation date of November 1, 2022. The updated procedure indicated that every written determination would state all pertinent facts of the provider dispute and explain the reasons for the Plan's determination.*

- *On July 20, 2022, the Plan provided training to its staff to ensure that provider dispute determinations were accurate. The Plan submitted the list of attendees.*

- *In addition, the Plan provided a copy of its audit procedures, which were implemented on August 1, 2022. As an enhancement to the audit procedures, the Plan implemented weekly monitoring and oversight of provider disputes to validate accuracy of the determination letters. The Plan provided a copy of the audit results for the period of August 1, 2022 through August 12, 2022.*

- *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 Plan is required to confirm that the updated provider dispute 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 Health Plan Joint Powers Authority, L.A. Care would like to submit the following clarification:

1) In the summary of L.A. Care's Remediation for Finding A1 (Accuracy of Claim Payment to Non-Contracted Providers), the Final Report provides in part:

> *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 capture the accuracy of noncontracted provider claims reimbursement.*

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 non-contracted provider claims reimbursement.*