



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

Department of Managed Health Care
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November 12, 2015

SENT VIA FACSIMILE ONLY TO: (213) 438-5724

Augustavia J. Haydel
 Chief Legal Officer
 Local Initiative Health Authority for L.A. County
 DBA: L.A. Care Health Plan,
 L.A. Care Plan de Salud
 1055 West 7th Street
 Los Angeles, CA 90017

RECEIVED
 MANAGED HEALTH CARE
 ACCOUNTING OFFICE
 2015 DEC 11 AM 10:25

RE: ENFORCEMENT MATTER NUMBER: 14-243

LETTER OF AGREEMENT

Dear Ms. Haydel:

The Office of Enforcement within the Department of Managed Health Care (the Department) has concluded its investigation of Local Initiative Health Authority for L.A. County (L.A. Care or the Plan) concerning the above matter. This investigation concerned the Plan's violations of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and regulations promulgated thereunder. The relevant facts are fully set forth below.

The Department's Division of Financial Oversight (DFO) conducted a routine examination of the Plan for the quarter ending September 30, 2013. In its Final Report issued July 24, 2014, DFO found numerous deficiencies and related violations, including several repeat violations. The violations, outlined below, are separated into two main categories – Claims Settlement and Provider Dispute Resolution (PDR) Mechanisms.

Claims Settlement Violations

Section 1371.37(a) of the Health and Safety Code prohibits health plans from engaging in unfair payment patterns.¹ More specifically, Section 1371.37(c) defines "unfair payment patterns" as:

- (1) Engaging in a demonstrable and unjust pattern, as defined by the Department, of reviewing or processing complete and accurate claims that result in payment delays.

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

Augustavia J. Haydel
Letter of Agreement
Page 2 of 4

- (2) Engaging in a demonstrable and unjust pattern, as defined by the Department, of reducing the amount of payment or denying complete and accurate claims.
- (3) Failing on a repeated basis to pay the uncontested portions of a claim within the timeframes specified in Sections 1371, 1371.1 or 1371.35.
- (4) Failing on a repeated basis to automatically include the interest due on claims pursuant to Section 1371.

Rule 1300.71(a)(8) defines "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.

DFO identified repeat deficiencies in the Plan's claims settlement practices in this most recent examination and in the Final Report (for the previous examination for the period ending December 31, 2008) issued February 22, 2010. They include:

1. Failure to Pay Interest Correctly on Late Paid Claims (Repeat Deficiency)
Sections 1371 and 1371.35 and Rules 1300.71(i) and (j)

The Plan used the incorrect date for receipt of the complete claim to calculate the number of days for interest payments. In 7 of the 73 late claims reviewed, the Plan underpaid or failed to pay interest (compliance rate of 90%). DFO previously identified this deficiency in its February 22, 2010 report. According to the Plan, its processes had improved — during the period from July 1, 2009, until April 15, 2013, it had used the correct receipt date for its claims load process. However, from April 15, 2013, through August 6, 2013, the Plan incorrectly loaded the claims receipt dates due to a change in their process when they contracted with a new vendor for optical character recognition ("OCR") services. The Plan discovered the error in mid-July 2013, performed a manual review of all scanned claims, and remediated the error. The Plan's remediation (completed by August 25, 2014) resulted in payments of \$27,281 in interest and \$14,115 in penalties on 2,551 claims. DFO found the Plan's compliance efforts and Corrective Action Plan ("CAP") acceptable.

2. Failure to Forward Misdirected Claims to the Appropriate Capitated Provider Within Ten (10) Working Days from Receipt (Repeat Deficiency)
Rule 1300.71(b)(2)(A) and (B)

DFO found that in 9 out of 87 denied claims reviewed, the Plan failed to forward the denied claims to the appropriate capitated provider within 10 working days from receipt (compliance rate of 90%). DFO previously identified this deficiency in its February 22, 2010 report. The Plan responded that it had taken substantial steps to ensure that claims are forwarded in a timely manner to the financially-responsible downstream capitated providers. It brought the claims scanning function in-house (resulting in a 2-day improvement); implemented a new core claims system in the latter-half of 2014, including electronic data interchange and management of claims in a real time environment; and increased staffing in the mail forwarding department. DFO found the Plan's compliance efforts and CAP acceptable.

Augustavia J. Haydel
Letter of Agreement
Page 3 of 4

3. Improper Denial, Adjustment or Contest of a Claim
Rule 1300.71(d)(1)

DFO determined that the Plan improperly denied 7 of the 87 claims reviewed (a compliance rate of 92%). DFO required the Plan to submit a CAP for this deficiency that included reprocessing all claims for the 7 providers associated with the claims samples DFO identified, as well as training and audit procedures, and identification of management position(s) responsible to ensure ongoing compliance. The Plan's remediation (completed by August 25, 2014) resulted in additional claim payments of \$575,245 and interest of \$8,606 on 346 claims. DFO found the Plan's compliance efforts and CAP acceptable.

4. Failure to Contest or Deny Claims within 45 Working Days of Receipt
Section 1371 and Rule 1300.71(h)

In 9 of the 87 denied claims reviewed, DFO found that the Plan failed to contest the claim within 45 working days of the receipt (compliance rate of 90%). The Plan's corrective action included training and audit procedures, and identification of management position(s) responsible to ensure ongoing compliance. In addition, the Plan submitted policies and procedures for oversight and compliance to ensure claims timeliness. DFO found the Plan's compliance efforts and CAP acceptable.

Provider Dispute Resolution Mechanism Violations

DFO's examination concluded that the Plan failed to comply with the requirements of Rule 1300.71.38 which requires all health care service plans that pay claims to have a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. The deficiencies and respective violations include:

1. Payment Accuracy of Interest on Late Claims Resulting from Provider Disputes
(Repeat Deficiency).
Sections 1371 and 1371.35 and Rules 1300.71(i) and (j), 1300.71.38(g)

DFO found that in 8 of the 93 provider disputes reviewed, the Plan underpaid or did not pay the amount of interest on late adjusted claims payments (compliance rate of 91%). DFO noted this was a repeat deficiency previously identified in the February 22, 2010 report and required the Plan to explain why its previous corrective actions had failed. The Plan responded that the lack of follow-through in implementing policies and ineffective training resulted in the repeat deficiencies. The Plan said it developed additional policies and procedures, along with enhanced training to ensure its personnel had better understanding and knowledge. The Plan also committed to reprocess interest and penalties. It also identified management personnel responsible for ongoing compliance.

Augustavia J. Haydel
Letter of Agreement
Page 4 of 4

2. Failure to Acknowledge Receipt of Provider Disputes.
Rule 1300.71.38(e)(2) and 1300.71(a)(8)(R)

DFO found the Plan failed to issue timely acknowledgements of receipt in 19 of the 93 provider disputes reviewed (compliance rate of 80%). The Plan's corrective action included improvements to oversight, training, and the implementation of a quality audit tool to ensure timely acknowledgement. The Plan also identified management personnel responsible for ongoing compliance. DFO found the Plan's compliance efforts and CAP acceptable.

3. Time Period for Resolution and Written Determination of Provider Disputes.
Rules 1300.71.38(f) and 1300.71(a)(8)(S)

DFO concluded the Plan failed to send written determinations within 45 working days of receipt in 30 of the 93 provider disputes DFO reviewed (compliance rate of 68%). The Plan's corrective action included training and audit procedures, and identification of management personnel responsible for ongoing compliance. DFO found the Plan's compliance efforts and CAP acceptable.

The Plan has acknowledged its failure to comply with the Knox-Keene Act and title 28 of the California Code of Regulations in this enforcement matter. The Department determined that an administrative penalty of \$150,000.00 is warranted. The Department further determined that the Plan completed its corrective action. The Department agrees that payment of the penalty will settle all issues, accusations, and claims pertaining to this enforcement matter. This Letter of Agreement may not be used as an admission by the Plan in any other civil or criminal proceedings; however, it may be used by the Department in future administrative proceedings.

Sincerely,

Dated: December 16, 2015



Carol L. Ventura
Deputy Director | Chief Counsel
Office of Enforcement

SMT:rmt

Accepted by Local Initiative Health Authority for L.A. County

Dated: December 8, 2015



Augustavia J. Haydel
Chief Legal Officer
Local Initiative Health Authority for L.A. County