

SONIA R. FERNANDES  
Deputy Director | Chief Counsel, Bar Number 232932  
SHEILA F. GONZALEZ  
Assistant Chief Counsel, Bar Number 192510  
ANGELA M. LAI  
Assistant Chief Counsel, Bar Number 237616  
HEATHER R. MESSENGER  
Assistant Chief Counsel, Bar Number 240442  
JENNIFER E. MARSH  
Attorney III, Bar Number 272546  
RAMAKRISHNA NARAYAN  
Attorney III, Bar Number 294579  
OWEN R. ZION  
Attorney III, Bar Number 300620  
CALIFORNIA DEPARTMENT OF  
MANAGED HEALTH CARE  
980 9<sup>th</sup> Street, Suite 500  
Sacramento, CA 95814-2725  
916-323-0435 - Phone  
916-323-0438 - Fax

Attorneys for the Department of Managed Health Care

BEFORE THE DEPARTMENT OF MANAGED HEALTH CARE  
OF THE STATE OF CALIFORNIA

In The Matter of:

LOCAL INITIATIVE HEALTH AUTHORITY  
FOR LOS ANGELES COUNTY AND L.A.  
CARE HEALTH PLAN JOINT POWERS  
AUTHORITY,  
Respondents.

Enforcement Matter Numbers: 18-799,  
20-063, 21-428, 21-509, 21-680

**ACCUSATION**

(Health & Safety Code section 1340 et  
seq.)

**I. INTRODUCTION**

The California Department of Managed Health Care (the Department) brings the present action to assess administrative penalties against Local Initiative Health Authority for Los Angeles County and L.A. Care Health Plan Joint Powers Authority (Respondents, collectively) pursuant to the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended (the Act) (Health and Safety Code section 1340 et seq.). Respondents are health care service plans licensed under and regulated by the Act.

1 Respondents have repeatedly violated numerous provisions of the Act and the  
2 implementing regulations found in title 28 of the California Code of Regulations, including  
3 but not limited to violations concerning the handling of enrollee grievances, the  
4 processing of requests for authorization (utilization review or utilization management),  
5 overseeing and adequately supervising its contracted entities regarding timely access,  
6 and the processing of claims. The widespread, systemic, and unrelenting nature of these  
7 violations is unprecedented and has caused harm to Respondents' enrollees. As the  
8 regulator of California health care service plans, the Department brings the instant  
9 disciplinary action against Respondents seeking a monetary penalty to ensure these  
10 violations do not recur, to protect California's health plan enrollees, and to ensure a stable  
11 health care delivery system.

## 12 II. PARTIES

13 1. Sonia R. Fernandes (Complainant) is the Deputy Director and Chief  
14 Counsel of the Department's Office of Enforcement. Complainant brings this Accusation  
15 solely in her official capacity as Deputy Director and Chief Counsel of the Office of  
16 Enforcement for the Department. The Department protects consumers health care rights  
17 and ensures a stable health care delivery system.

18 2. At all times pertinent to the allegations herein, Respondents have been full-  
19 service health care plans as defined by Health and Safety Code section 1345, subdivision  
20 (f), and are subject to the regulatory provisions of the Act.

21 3. Respondent Local Initiative Health Authority for Los Angeles County  
22 (Respondent L.A. Care) is the holder of health care service plan license number 933 0355  
23 which was issued on April 1, 1997, by the Commissioner of the Department of  
24 Corporations, predecessor to the Director of the Department. Respondent's principal  
25 corporate office is located at 1055 West 7<sup>th</sup> Street, Los Angeles, CA 90017.

26 4. Respondent L.A. Care Health Plan Joint Powers Authority (Respondent L.A.  
27 Care JPA) is the holder of health care service plan license number 933 0504 which was  
28 issued on December 6, 2013, by the Director of the Department. Respondent's principal

1 corporate office is located at 1055 West 7<sup>th</sup> Street, 10<sup>th</sup> Floor, Los Angeles, CA 90017.

### 2 **III. JURISDICTION**

3 5. This Accusation is brought before the Director of the Department (Director)  
4 under the authority conferred in the Act and Title 28 of the California Code of Regulations,  
5 as specified below.

6 6. The Department is charged with the task of regulating managed care in the  
7 State of California and ensuring that the entities that sell managed care products in  
8 California, known as health care service plans, are in compliance with their obligations  
9 under the Act and the rules and regulations promulgated thereunder. (Health & Saf.  
10 Code, §§ 1341, subd. (a), and 1345, subd. (f).)

11 7. The Director is responsible for the performance of all duties and  
12 responsibilities vested by law in the Department, including the administration and  
13 enforcement of the Act and the rules and regulations promulgated thereunder. (Health &  
14 Saf. Code, §§ 1341, subd. (c), and 1346, subd. (a)(5).)

15 8. Health and Safety Code section 1386, subdivision (a),<sup>1</sup> authorizes the  
16 Director to take disciplinary action against a health care service plan under the  
17 appropriate circumstances. The Director is authorized to assess administrative penalties  
18 against the plan if the Director determines, after appropriate notice and opportunity for a  
19 hearing, that the plan has committed any of the acts or omissions enumerated in Section  
20 1386, subdivision (b), which constitute grounds for disciplinary action.

21 9. Section 1386, subdivision (b)(6), states the grounds for disciplinary action  
22 include instances where a plan has violated or attempted to violate any provision of the  
23 Act, or any rule or regulation adopted by the Director pursuant to the Act or any order  
24 issued by the Director.

25 ///

---

27 <sup>1</sup> For convenience, a section of the Health and Safety Code is hereinafter referred  
28 to as "Section," followed by the section number.

10. All hearings before the Director are to be held in accordance with the Administrative Procedure Act, and the Director has all of the powers granted under that Act. (Health & Saf. Code, § 1397, subd. (a).) The factors for determining an appropriate penalty for violations of the Knox-Keene Act are set forth in California Code of Regulations, title 28, section 1300.86.<sup>2</sup>

#### IV. FACTUAL ALLEGATIONS

11. As full-service health plans, Respondents are charged with arranging for basic health care services of its enrollees. An enrollee is a person who is enrolled in a health plan, and who is a recipient of services from the plan. (Health & Saf. Code, § 1345, subd. (c).)

12. Between April 1, 2021, and June 30, 2021, Respondent L.A. Care reported its total membership to be 2,376,673, of which 2,279,569 enrollees were in its Medi-Cal Risk line of business, and 97,104 enrollees were in its individual commercial line of business.

13. Between April 1, 2021, and June 30, 2021, Respondent L.A. Care JPA reported its total membership to be 51,209 enrollees, in its In-Home Supportive Services line of business.

#### Department investigation into utilization management (Enforcement matters 21-509 and 21-680)

14. On June 23, 2021, Respondents notified the Department that on March 29, 2021, Respondents had discovered that they were experiencing “an issue processing authorizations timely” in their internal Utilization Management (UM) operation, which handles inpatient authorizations (including concurrent requests) and pre-service/retrospective authorization requests.

15. Between April 6, 2021, and June 17, 2021, Respondents reported a total of 9,125 authorization requests in its backlog, for Medi-Cal, Cal Medi-Connect, L.A. Care

---

<sup>2</sup> For convenience, a section of the title 28 of the California Code of Regulations is hereinafter referred to as “Rule,” followed by the section number.

1 Covered, and PASC SEIU lines of business. Respondents explained that the  
2 authorizations include situations in which the members have received services and that  
3 Respondents were continuing to investigate the number of enrollees awaiting services to  
4 address those requests as expeditiously as possible.

5 16. Respondents identified several root causes for this problem, including:  
6 changes to a new UM system that launched on April 6, 2021, and required extensive staff  
7 trainings that took place between March 2 – April 27, 2021; receipt of a high volume of  
8 non-actionable requests consisting of requests for services that do not require  
9 authorization and repeat requests as a result of untimely processing of initial requests;  
10 staffing shortages due to attrition and absences, including absences due to COVID-19;  
11 and increased inpatient requests due to a high prevalence of COVID-19 in the  
12 community.

13 17. Respondents identified the steps they were taking to remediate the UM  
14 backlog. Respondents' June 23, 2021, letter stated that they were taking steps to address  
15 the timeliness issue by hiring supplemental staff to improve processing time, prioritizing  
16 urgent requests, and prioritizing requests based on clinical acuity and member needs,  
17 such as oncology or other urgent health care needs.

18 18. Respondents reported in discovery responses to the Department that, in  
19 September 2020, Respondents' own intentional administrative actions compounded their  
20 staffing shortage: "Due to budget cuts for FY 2020-2021, UM was required to cut \$1.3  
21 million from its staffing budget. This was achieved by not funding temporary labor by First  
22 Source (provided consistent non-clinical staffing to UM for >3 years) and eliminating 11  
23 permanent full-time UM positions (pcns) - both clinical and non-clinical roles." This  
24 number was later reported by Respondents to be 14 full-time positions.<sup>3</sup> These cuts were  
25 made as the scope of the pandemic was steadily increasing and reducing UM staffing

26  
27 <sup>3</sup> In discovery responses, Respondents stated that their overall UM budget grew  
28 from \$14,110,497 in FY 2019/2020 to \$15,253,323 in FY 2020/2021. This is true, but  
while the overall budget grew, Respondents reduced their UM staff by 11 positions, later  
reported to be 14 positions, and did not fund temporary staffing.

1 was patently counterintuitive. In response to administrative discovery, Respondents  
2 stated that after additional consultation with its finance and UM Department, Respondents  
3 concluded that there were no budget cuts to the UM department's staffing budget.  
4 Respondents provided financial spreadsheets that appear to indicate that the UM staffing  
5 budget for Fiscal Year (FY) 19-20 increased from 123 full time employees to 128 for FY  
6 20-21. However, there was a significant variance between what was budgeted for UM  
7 staffing versus what was actually spent on UM staffing. For example, while Respondents  
8 budgeted for 128 full-time equivalent (FTE) positions for FY 20-21, Respondents only  
9 used the budget on 114 FTE positions.

10 19. Respondents' administrative decisions resulted in the direct loss of 11 full-  
11 time positions in its UM staffing budget. As a result, Respondents were unable to maintain  
12 a level of staffing sufficient to process authorization requests that caused a backlog of  
13 9,125 authorization requests. Respondents' staffing shortages in all areas of business,  
14 including the Grievance and Appeals Department, impacted the timely resolution of at  
15 least 67,717 grievances, as reported by Respondents to the Department on December  
16 17, 2021. Although Respondents blamed their backlogs on staffing shortages related to  
17 the COVID-19 pandemic, Respondents admitted that their own staffing decisions were a  
18 cause.

19 20. At the time Respondents made the decision to cut their UM staffing  
20 spending, its financial assets were vast. Between April 1, 2021, to June 30, 2021, the time  
21 period where Respondents informed the Department that uncovered their severe UM and  
22 grievance system backlogs, Respondents' financial statements indicate they were flush  
23 with cash.

24 21. Respondent L.A. Care filed its Quarterly Financial Reporting Form for the  
25 quarter ending June 30, 2021, with the Department. Respondent L.A. Care reported  
26 \$658,479,837 in cash and cash equivalents. Respondent L.A. Care reported its total  
27 current assets to be \$ 4,417,172,200. Respondent L.A. Care reported its total current  
28 liabilities to be \$3,506,973,916. Respondent L.A. Care reported its tangible net equity to

1 be \$1,019,609,441, an amount that was \$863,689,926 greater than the minimum tangible  
2 net equity required by law. Respondent L.A. Care reported its current total revenue (year  
3 to date) to be \$7,009,384,436.

4 22. Respondents' systemic failure to timely process authorizations for health  
5 care services delayed consumers' access to medically necessary health care services  
6 and had a detrimental impact on their enrollees. This UM system failure presents  
7 substantial harm to Respondents' enrollees whose health conditions continue to  
8 deteriorate while awaiting authorization for treatment. Enrollee harm is further  
9 exacerbated by Respondents' systemic failure to timely and adequately resolve consumer  
10 complaints regarding delays in authorization. Below are a few examples based on  
11 consumer complaints to the Department's Help Center, which illustrate delays which  
12 continued even after Respondents began to work through its authorization backlog.

13 Enrollee A

14 23. An enrollee (Enrollee A) with stomach cancer diagnosed in September  
15 2020, underwent a computerized tomography (CT) scan in August 2021, which revealed  
16 a progression of the cancer, including metastasis to the liver and lungs with growth of  
17 nodules. Enrollee A's doctor changed treatment to a more advanced treatment with  
18 infusions and submitted a request for authorization of this treatment to Respondent L.A.  
19 Care on September 10, 2021. Health plans are obligated to expedite urgent requests  
20 such as this, where the enrollee's health is rapidly declining. The enrollee requested the  
21 authorization be expedited several times without success. Unfortunately, Respondent L.A.  
22 Care did not authorize the request. The enrollee's health continued to decline. The  
23 enrollee came to the Help Center on September 13, 2021. Respondent L.A. Care did not  
24 provide the authorization for the infusion treatment until September 16, 2021. The  
25 enrollee stated in his Help Center complaint that his health was deteriorating daily, and  
26 this deterioration was caused by Respondent L.A. Care's delay of urgent treatment by six  
27 days. Respondent L.A. Care should have expedited this urgent request, and issued its  
28 decision in a timely fashion appropriate for the nature of Enrollee A's medical condition,

1 not to exceed 72 hours, in accordance with Health and Safety Code section 1367.01,  
2 subdivision (h)(2), which would have been no later than September 12, 2021. Instead,  
3 Enrollee A was forced to seek assistance from the DMHC Help Center, and did not  
4 receive authorization until September 16, 2021.

5 Enrollee B

6 24. An enrollee (Enrollee B) suffered extreme pain in both ears, throat, and right  
7 side of the head. Enrollee B requested an authorization from Respondent L.A. Care to  
8 see an otolaryngologist and was told by Respondent L.A. Care that the authorization  
9 would be finalized on August 27, 2021. On September 10, 2021, the authorization was  
10 still not finalized, and Respondent L.A. Care told the enrollee it would be completed on  
11 September 13, 2021. The authorization was approved on September 14, 2021. Due to the  
12 delay, the enrollee suffered extreme pain over a period of more than two weeks.  
13 Respondent L.A. Care should have expedited this urgent request, and issued its decision  
14 in a timely fashion appropriate for the nature of Enrollee A's medical condition, not to  
15 exceed 72 hours, in accordance with Health and Safety Code section 1367.01,  
16 subdivision (h)(2), which would have been no later than September 12, 2021. Instead, the  
17 Enrollee had to wait two additional days with extreme ear pain, until September 14, 2021,  
18 for the authorization.

19 Enrollee C

20 25. An enrollee (Enrollee C) stated that a December 2020 colonoscopy  
21 revealed the possibility of a B-Cell Lymphoma diagnosis, which could have a life  
22 expectancy of six to nine months if confirmed and required treatment from an oncologist  
23 and a gastrointestinal (GI) specialist. Respondent L.A. Care had no in-network  
24 oncologists available for several months, so the enrollee requested authorization to see  
25 an out-of-network oncologist and GI specialist. Respondent L.A. Care initially denied the  
26 Enrollee C's request to see the out-of-network oncologist, and "significantly" delayed the  
27 approval of the out-of-network GI specialist by taking over a month to process the Letter  
28 of Agreement between the out-of-network provider's medical group and the enrollee's in-



1 network medical group. Enrollee C emphasized, “with being told that I may have less than  
2 a year to live, and then being forced to wait an unreasonable amount of time for the care  
3 and testing I need to survive, I felt like if I didn’t go to the ER I might die.” Furthermore,  
4 Enrollee C stated that when Enrollee C would contact Respondent L.A. Care to file  
5 grievances, representatives recommended multiple times that Enrollee C seek  
6 emergency room (ER) care in the interim until Enrollee C was permitted to see both GI  
7 and oncology specialists. Enrollee C disclosed Enrollee C had been to the ER three times  
8 since December 2020, due to Enrollee C’s increased symptoms.

9       26. After approximately two months of experiencing consistent denials and  
10 delays from Respondent L.A. Care, Enrollee C disenrolled from Respondent L.A. Care  
11 and was approved for Medi-Cal fee-for-service (FFS), effective February 28, 2021. Since  
12 enrolling in Medi-Cal FFS, Enrollee C reports that Enrollee C has not experienced any  
13 issues with receiving care. Enrollee C states that Enrollee C has been contacted by  
14 Respondent L.A. Care twice, requesting Enrollee C drop the unresolved grievances  
15 related to Respondent L.A. Care’s failure to timely process Enrollee C’s requests for  
16 authorizations.

17       **Department investigation into grievance system problems (Enforcement**  
18 **matters 21-428 and 21-680)**

19       27. On May 28, 2021, Respondents disclosed a systemic failure to issue  
20 grievance resolution letters, stating that in April 2021 they had discovered thousands of  
21 resolution letters were not sent to enrollees from 2017 to 2021, with most issues occurring  
22 in 2020 and 2021.

23       28. As of June 25, 2021, Respondents reported a backlog of 1,792 appeals and  
24 12,147 grievances waiting to be resolved.

25       29. Prior to the systemic issue being identified (on or around April 2021), a  
26 total of 55,295 grievances (including appeals) received by Respondents had not  
27 been issued timely resolutions. After discovery of the issue until about December 17,  
28 2021, an additional 12,422 grievances (including appeals) received by Respondents

1 were not issued timely resolutions.

2 30. Through researching the grievance resolution issue, Respondents also  
3 discovered that 8,722 complaints were transmitted but not initiated by Respondents'  
4 grievance division.

5 31. Altogether, as of December 17, 2021, Respondents failed to provide timely  
6 resolution to a total of 67,717 grievances, with the total number of grievances not  
7 resolved timely continuing to grow. Below are examples of enrollee harm based on  
8 consumer complaints to the Department's Help Center.

9 Enrollee D

10 32. An enrollee (Enrollee D) filed grievances with Respondent L.A. Care on four  
11 separate occasions (May 8, 2019, July 5, 2019, August 16, 2019, and October 2, 2019)  
12 concerning emergency room bills for services received in March 2019 that Respondent  
13 L.A. Care did not pay. Respondent L.A. Care incorrectly asserted that Enrollee D had  
14 alternate coverage notwithstanding the enrollee providing evidence on May 13, 2019, that  
15 the alternate coverage had terminated in 2017. Despite having the necessary information  
16 to appropriately resolve the enrollee's grievances, Respondent L.A. Care failed to  
17 appropriately rectify the issue in four separate resolutions, requiring Enrollee D to seek  
18 aid from the Department in February 2020. Respondent L.A. Care paid the claims for  
19 emergency services on February 25, 2020, after the Department's intervention.

20 Enrollee E

21 33. An enrollee (Enrollee E) filed a grievance on May 18, 2020, concerning a  
22 hospital bill. Before the resolution was due by Respondent L.A. Care, Enrollee E provided  
23 supporting documents on June 11, 2020. According to the enrollee, the enrollee followed  
24 up with Respondent L.A. Care on July 16, 2020, August 4, 2020, August 5, 2020, and  
25 September 5, 2020. After receiving notice of being sent to collections, Enrollee E filed a  
26 complaint with the Department in November 2020. During the Department's investigation,  
27 Respondent L.A. Care conceded it failed to resolve Enrollee E's May 18 grievance.

28 ///

1        Enrollee F

2        34.     Between January 23, 2020, and March 19, 2021, an enrollee (Enrollee F)  
3 filed three grievances regarding a claim for emergency services, resulting in Enrollee F's  
4 account being sent to collections. Respondent L.A. Care purportedly "resolved" the  
5 grievances on February 20, 2020, January 29, 2021, and April 16, 2021. Each time,  
6 rather than rectifying Enrollee F's grievances, Respondent L.A. Care advised the enrollee  
7 it needed a copy of the bill. It took Respondent L.A. Care 15 months to determine that its  
8 delegated medical group received the claim at issue in September 2019 – before the  
9 enrollee submitted the initial grievance. Respondent L.A. Care purportedly "resolved" the  
10 matter by determining the claim was properly processed by the medical group with a  
11 check issued in October 2019. It was only after the Department's intervention when  
12 Respondent L.A. Care determined Enrollee F's claim was sent to collections in error.

13        Enrollee G

14        35.     An enrollee (Enrollee G) filed a grievance on October 27, 2020, regarding  
15 an authorization and referral request for wound care. The enrollee, who had an open  
16 wound, complained she attempted to call the referral department several times but was  
17 having difficulty getting through. On November 30, 2020, Respondent L.A. Care sent the  
18 enrollee a Member Grievance Extension Letter. The letter advised Enrollee G it was  
19 unable to complete its review by November 26, 2020, but would respond by December  
20 10, 2020. Enrollee G filed a complaint with the Department on December 10, 2020.  
21 Respondent L.A. Care responded to the Department on December 21, 2020, and stated  
22 that resolution of Enrollee G's grievance was still pending.

23        Enrollee H

24        36.     An enrollee (Enrollee H) with stomach cancer and metastatic liver and lung  
25 cancer contacted Respondent L.A. Care on February 3, 2021, dissatisfied with a delay in  
26 determination of eligibility for Social Security Disability Benefits. Respondent L.A. Care  
27 responded to Enrollee H's grievance on October 14, 2021, – 223 days late and only after  
28 the Department's involvement. On March 31, 2021, Enrollee H contacted Respondent

1 L.A. care regarding transportation issues for chemotherapy treatments. Respondent L.A.  
2 Care's response to Enrollee H's grievance was 143 days late and only after the  
3 Department's intervention.

4 Enrollee I

5 37. An enrollee (Enrollee I) filed a grievance with Respondent L.A. Care by  
6 phone on February 18, 2021, regarding a bill from a collection agency for imaging  
7 services. Enrollee I followed up with Respondent L.A. Care on the grievance in February,  
8 March, and June 2021, but received no response from Respondent L.A. Care. In August  
9 2021, Enrollee I filed a complaint with the Department. After Department intervention,  
10 Respondent L.A. Care resolved the grievance on September 2, 2021 – 166 days late – by  
11 confirming that the enrollee had no financial responsibility for the claims at issue.

12 Enrollee J

13 38. An enrollee (Enrollee J) called Respondent L.A. Care on April 8, 2021, and  
14 complained about appointments cancelled by her PCP. Respondent L.A. Care sent the  
15 enrollee a written grievance response letter on December 1, 2021 – 207 days late.

16 39. Respondents' ongoing backlog continues to add additional cases with  
17 untimely resolutions. As of February 14, 2022, in addition to new case, Respondents'  
18 backlog included 2,044 grievances and 0 appeals from the original backlog reported as of  
19 June 25, 2021.

20 40. Respondents' Appeals and Grievances Director (who resigned in January  
21 2021) did not retrieve reports indicating cases were not properly closed during her tenure.  
22 This Director was responsible for continuously reviewing the operation of Respondents'  
23 grievance system to identify any emergent patterns of grievances pursuant to Rule  
24 1300.68, subdivision (b)(1).

25 41. Since the beginning of 2017 until the end of October 2021, Respondents'  
26 written grievance record compiled pursuant to Rule 1300.68, subdivision (b)(5), was  
27 reviewed by the following on the following dates by the listed entities:

28 ///

1. Compliance & Quality Committee of the Board (governing body)
  - a. March 19, 2020
  - b. September 15, 2020
2. Executive Consumer Advisor Committee (ECAC) (public policy committee)<sup>4</sup>
  - a. May 19, 2019
  - b. October 19, 2019
  - c. January 8, 2020
3. Board of Governors Meeting (governing body)
  - a. June 6, 2019
  - b. November 7, 2019

**Department investigation into delegate oversight (Enforcement Matter 20-063)**

**A. Action Regarding Respondent L.A. Care's Grievance System**

42. The Department reviewed all grievance and appeals files provided by Respondent L.A. Care for the years 2016 to 2020 relating to complaints by enrollees regarding compliance to timely access standards by Los Angeles County, Department of Health Services (LA DHS), a delegate of Respondent L.A. Care. The Department concluded that Respondent L.A. Care failed to consistently process enrollee grievances pursuant to the Knox-Keene Act statutes and regulations.<sup>5</sup> Below are the facts of a few examples.

///

///

---

<sup>4</sup> This committee name and dates were provided by L.A. Care in response to discovery requests. The public policy committee may go by the name Executive Community Advisory Committee, or another name.

<sup>5</sup> In the interest of judicial efficiency, these matters are being prosecuted as a group. This group prosecution is not intended to represent the universe of violations during the relevant time period.

1 a. Enrollee K had a case of suspected basal cell carcinoma skin cancer.  
2 The enrollee filed a grievance with Respondent L.A. Care, complaining that  
3 he had to wait seven weeks to obtain a dermatology appointment and  
4 another seven weeks to obtain a biopsy. Respondent L.A. Care's grievance  
5 response stated that it forwarded the enrollee's concerns to his medical  
6 group "so they can internally investigate all events and make necessary  
7 corrective action(s) . . . ." Respondent L.A. Care downplayed the enrollee's  
8 complaint as a "dissatisfaction" with the specialist and suggested that the  
9 enrollee reach out to his PCP to request a new doctor. During the medical  
10 group's investigation, the dermatologist confirmed the enrollee's condition  
11 was very suggestive of basal cell carcinoma skin cancer but stated, "We are  
12 a very busy clinic and the wait for an appointment is usually 2 months. We  
13 also do a lot of surgical procedures and likewise the wait for a biopsy  
14 appointment is also around 2 months. That is the way it has been in this  
15 clinic for the past 35 years." The medical group's conclusion was that "a  
16 potential quality issue has not been identified . . . . No actions at [sic]  
17 needed at this time . . . ."

18 b. Enrollee L needed an urgent procedure due to a mass in his stomach  
19 but experienced delays in scheduling a colonoscopy. The enrollee's  
20 colonoscopy appointment was cancelled after the enrollee started to  
21 prepare for the colonoscopy. Respondent L.A. Care's grievance response  
22 merely stated that it forwarded the enrollee's concerns to LA DHS "so they  
23 can internally investigate all events and take any necessary actions."  
24 Respondent L.A. Care then suggested that the enrollee contact his PCP  
25 "and obtain a new authorization for colposcopy [sic]." Because the  
26 grievance was actually against a non-LA DHS facility, LA DHS asked  
27 Respondent L.A. Care to retract the grievance from LA DHS. There was no  
28 further action noted in this grievance file.

1 c. Enrollee M's authorized eye surgery was repeatedly rescheduled –  
2 from February 2019, to March 2019, to April 2019, to May 2019 – and the  
3 provider did not proactively notify the enrollee ahead of the cancellations. By  
4 the time of the grievance, the authorization for surgery had expired.  
5 Respondent L.A. Care's grievance response merely stated that the  
6 enrollee's concerns "have been carefully noted and forwarded to  
7 [Respondent L.A. Care's delegated medical group] for confidential review  
8 and follow up." Respondent L.A. Care offered no assistance in locating  
9 another ophthalmologist, or extending the authorization, or obtaining a  
10 surgery for the enrollee. The medical group reviewed the case and  
11 concluded that "No quality of care issue identified" and "No actions at [sic]  
12 needed at this time . . . ."

13 43. In all the examples above, the enrollee grievances did not reach a final  
14 conclusion; thus, Respondent L.A. Care's grievance responses were not true resolutions  
15 or rectifications of the enrollees' grievances.

16 44. During the Department's investigation, Respondent L.A. Care stated that it  
17 considered an enrollee grievance "adequately considered" under Section 1368,  
18 subdivision (a)(1), so long as the enrollee was "able to submit a grievance to Respondent  
19 L.A. Care under Respondent L.A. Care's grievance system."

20 *B. Action Regarding Respondent L.A. Care's Failure to Ensure Utilization Review*  
21 *Requirements Are Followed*

22 45. The Department reviewed documents provided by Respondent L.A. Care  
23 regarding its delegate LA DHS' use of a system known as the eConsult system.

24 46. Documents provided by Respondent L.A. Care set forth the eConsult  
25 system as used by LA DHS is a system that reviews and approves, modifies, or denies  
26 requests by providers prior to the provision of health care services to enrollees – a  
27 process that mimics the utilization review system described in Section 1367.01. The  
28 eConsult process can be summarized as follows:

- “DHS requests that all non-urgent consults begin with an eConsult exchange between the PCP and specialists . . . .”
- “When a PCP believes a patient may require a specialty referral . . . the PCP will consult with the relevant specialist through eConsult, and the eConsult specialist will determine whether a face-to-face specialist visit is indicated, or if the patient requires testing, imaging, etc. Prior to an in-person specialist visit, the member’s PCP completes an eConsult, and the specialist reviews the referral and informs the scheduler to outreach to the patient when a face-to-face visit is indicated or requested.”
- LA DHS instructs its providers “Do NOT tell your patient they are getting a ‘referral’ . . . . Instead tell your patient that you will be communicating with an expert specialist about their case and will contact them with their recommendations. Save your patient a visit to the specialist by maximizing what you offer the patient in the clinic.”
- “If the specialist reviewing the eConsult decides that the patient needs to be seen for a face-to-face visit, then eConsult activity may be limited to triage, as the patient is then scheduled for a visit with a specialist who may or may not be the same person as the eConsult specialist.”
- If a patient is referred for a face-to-face visit, the specialist will have to select the appropriate time frame. “If Next available is selected, the scheduling timeframe of scheduling will have a start date of one month from close date up to 6 months.”
- “If an eConsult case decision results in closure where no face-to-face with a specialist is needed, then the patient will continue his/her care with the patient’s primary care provider.”

47. Documents provided by Respondent L.A. Care suggest there are no built-in timeframes for the various stages of the eConsult process, no written notification to enrollees (unless the PCP challenges the eConsult case decision through the formal



second opinion process), and no oversight by Respondent L.A. Care.

48. Documents provided by Respondent L.A. Care also set forth a three-level decision-making/appeal system within the eConsult system as used by LA DHS, which can be summarized as follows:

- If the PCP disagrees with specialist reviewing the eConsult, “the provider can bring this to the attention of their Medical Director who can review it.”
- “The PCP may choose to request a formal second opinion by following the eConsult Second Opinion Dialogue process.”
- “When a provider or patient requests a second opinion, the provider will send a request by e-mail to the eConsult team ( [REDACTED] and [REDACTED] ). The subject line of the e-mail should be ‘SECOND OPINION.’ The eConsult Director will designate an initial reviewer. If the initial reviewer can make a decision based on a review of the existing eConsult . . . the decision will be sent to the PCP.”
- “If the PCP or the patient still disagrees with the outcome of this review . . . the provider will send a request by e-mail to the eConsult team. ( [REDACTED] and [REDACTED] ).”
- “For DHS-assigned managed care patients . . . The request will be forwarded to the Chief Medical Officer of Managed Care Services (MCS CMO) or designee to review the case. The MCS CMO or designee will notify the PCP and patient of the outcome of this review in writing, including reasons for the denial (if applicable) and information on his/her right to file a grievance with the health plan. The notification will comply with California *Health and Safety Code* Section 1368.02(b).”

49. Respondent L.A. Care provided to the Department a document that suggests the enrollees receive written notification of the outcome of eConsult “second opinion” review and notification of Respondent L.A. Care’s grievance system.

1 Notwithstanding numerous requests from the Department, however, Respondent L.A.  
2 Care could not provide any template notice or sample notice or any evidence that notice  
3 is being sent to the enrollees. Respondent L.A. Care also could not provide any  
4 information regarding the process, timing, measuring, monitoring, or oversight of its  
5 delegate's issuance of such notification, or what information is provided in such  
6 notification.

7 50. While documents provided by Respondent L.A. Care suggest that the  
8 eConsult system as used by LA DHS utilizes a process that mimics the utilization review  
9 system described in Section 1367.01, the documents also suggest that the eConsult  
10 system does not provide key consumer protections as required under Section 1367.01,  
11 including timely decisions, timely notification of decisions that contain a clear and concise  
12 reason, a description of the clinical guidelines or criteria used, and the clinical reasons for  
13 the decisions regarding medical necessity, and an opportunity to file a grievance with  
14 Respondent L.A. Care or request an administrative hearing.

15 51. Documents provided by Respondent L.A. Care suggest that there is no  
16 oversight by Respondent L.A. Care of LA DHS' use of the eConsult system. During the  
17 Department's investigation, Respondent L.A. Care conceded it does not have any policies  
18 specific to eConsult.

19 C. Action Regarding Respondent L.A. Care's Failure to Measure and Monitor the  
20 Adequacy of its Contracted Provider Network to Provide Enrollees with Timely  
21 Access to Health Care Services

22 52. During the Department's investigation, Respondent L.A. Care conceded that  
23 its delegate, LA DHS, requires that non-urgent appointments begin with the eConsult  
24 process. As Respondent L.A. Care explained: "DHS requests that all non-urgent consults  
25 begin with an eConsult exchange between the PCP and specialists . . . ."

26 53. For Respondent L.A. Care to satisfy its obligation to properly measure and  
27 monitor the adequacy of its contracted provider network to provide enrollees with timely  
28 access to needed health care services, pursuant to Rule 1300.67.2.2, subdivision (a)(4),

1 at minimum, Respondent L.A. Care needs to ensure that its contracted provider network  
2 accurately tracks all relevant data points – most importantly, the date of the initial request  
3 for health care service by an enrollee or the enrollee’s treating provider.

4 54. During the Department’s investigation, Respondent L.A. Care conceded that  
5 its evaluation of compliance with timely access standards occurs “only after the PCP and  
6 eConsult specialist determine that a specialty referral is indicated, which would be outside  
7 of the eConsult process.”

8 55. As such, Respondent L.A. Care’s measuring and monitoring of timely  
9 access compliance does not take into consideration the date of which an enrollee  
10 requests an appointment, or the PCP requests an appointment on behalf of the enrollee.

11 56. Respondent L.A. Care’s measuring and monitoring of timely access  
12 compliance does not take into consideration the eConsult process that LA DHS requires  
13 contracting providers to complete when requesting a non-urgent appointment on behalf of  
14 enrollees. Documents provided by Respondent L.A. Care suggest that there are no built-  
15 in timeframes for the various stages of the eConsult process, and Respondent L.A. Care  
16 maintains no guidance, oversight, or tracking of how long this eConsult process can take.

17 57. Without proper tracking of the “date of request for appointment” for the  
18 purpose of measuring and monitoring of timely access compliance, Respondent L.A. Care  
19 does not have reliable data to oversee its delegate’s timely access compliance.

20 **Department Financial Examination findings (Enforcement Matter 18-799)**

21 **A. The Routine Financial Examination of Respondent L.A. Care for the Quarter Ending**  
22 **June 30, 2017, Raised Significant Concerns Regarding Respondent L.A. Care’s**  
23 **Claims Payment Processes**

24 58. The Department conducted a routine financial examination of Respondent  
25 L.A. Care for the quarter ending June 30, 2017 (Routine Examination) and issued a final  
26 report on August 1, 2018.

27 59. The Routine Examination raised significant concerns regarding Respondent  
28 L.A. Care’s compliance with California law with regards to the processing of claims for

1 medical services. This resulted in the untimely and inaccurate payment of claims on a  
2 systemic basis.

3 60. The Routine Examination uncovered 21 instances where Respondent L.A.  
4 Care failed to accurately pay late claims, including interest and penalties where  
5 applicable.

- 6 - Respondent L.A. Care failed to include interest in 13 of 50 of late claims  
7 reviewed in Respondent L.A. Care's MHC system.
- 8 - Respondent L.A. Care used the wrong payment date for interest  
9 calculations or failed to apply interest for reprocessed claims in 2 of the  
10 50 paid claims reviewed in Respondent L.A. Care's MHC system.
- 11 - Respondent L.A. Care incorrectly denied claims for missing  
12 authorizations, and then reprocessed them without including interest in 3  
13 out of 30 high dollar claims reviewed in Respondent L.A. Care's MHC  
14 system.
- 15 - Respondent L.A. Care failed to include interest when Respondent L.A.  
16 Care reprocessed an incorrectly denied claim in 1 out of 50 claims  
17 reviewed in Respondent L.A. Care's QNXT system.
- 18 - Respondent L.A. Care incorrectly denied claims for missing  
19 authorizations, and then reprocessed them without including  
20 interest in 2 out of 30 high dollar claims reviewed in Respondent  
21 L.A. Care's QNXT system.

22 61. The Routine Examination uncovered 11 instances where Respondent L.A.  
23 Care incorrectly denied claims.

- 24 - Respondent L.A. Care incorrectly denied claims in 4 out of 50 claim  
25 denials reviewed in Respondent L.A. Care's MHC system.
- 26 - Respondent L.A. Care incorrectly denied claims in 2 out of 30 high dollar  
27 claims reviewed in Respondent L.A. Care's MHC system.
- 28 - Respondent L.A. Care incorrectly denied 4 out of 50 claims reviewed in

Respondent L.A. Care's QNXT system.

- Respondent L.A. Care incorrectly denied 1 out of 30 high dollar claims reviewed in Respondent L.A. Care's QNXT system.

62. The Routine Examination uncovered 11 instances where Respondent L.A. Care failed to timely forward misdirected claims.

- Respondent L.A. Care failed to timely forward misdirected claims in 7 of 50 denied claims processed in Respondent L.A. Care's MHC system.
- Respondent L.A. Care failed to timely forward misdirected claims in 3 of 50 denied claims in Respondent L.A. Care's QNXT system.
- Respondent L.A. Care failed to timely forward misdirected claims in 1 of 30 high dollar claims processed in Respondent L.A. Care's QNXT system.

63. The Routine Examination uncovered four instances where Respondent L.A. Care failed to contest or deny claims in a timely manner.

- Respondent L.A. Care failed to timely contest or deny 3 out of 50 claims in Respondent L.A. Care's MHC system.
- Respondent L.A. Care failed to timely contest or deny 1 out of 30 high dollar claims processed in Respondent L.A. Care's QNXT system.

64. Respondent L.A. Care's total remediation to rectify all deficient claims for the Routine Examination was \$2.9 million.

*B. The Non-Routine Financial Examination of Respondent L.A. Care for the Quarter Ending March 31, 2019, Raised Significant Concerns Regarding Respondent L.A. Care's Claims Payment Processes*

65. The Department conducted a Non-Routine financial examination of Respondent L.A. Care for the quarter ending March 31, 2019 (Non-Routine Examination), and issued a final report on December 26, 2019.

66. The Non-Routine Examination was conducted due to significant deficiencies in the claims payment process that were uncovered in the earlier Routine Examination.

1           67.    The Non-Routine Examination uncovered 21 instances where Respondent  
2 L.A. Care failed to accurately pay late claims, including interest and penalties where  
3 applicable.

- 4               - Respondent L.A. Care failed to include penalty and interest payments in  
5               5 out of 50 paid claims reviewed.
- 6               - Respondent L.A. Care failed to include penalty and interest payments in  
7               4 out of 50 late claims reviewed.
- 8               - Respondent L.A. Care failed to include penalty and interest payments in  
9               6 out of 30 high dollar claims reviewed.
- 10              - Respondent L.A. Care failed to include penalty and interest payments in  
11              6 out of 50 provider dispute resolution claims reviewed.

12           68.    The Non-Routine Examination uncovered 13 instances where Respondent  
13 L.A. Care incorrectly denied claims.

- 14              - Respondent L.A. Care incorrectly denied 8 out of 50 denied claims  
15              reviewed.
- 16              - Respondent L.A. Care incorrectly denied 5 out of 30 high dollar  
17              claims reviewed.

18           69.    The Non-Routine Examination uncovered 38 instances where Respondent  
19 L.A. Care failed to provide a clear and accurate explanation when denying, adjusting, or  
20 contesting a claim.

- 21              - Respondent L.A. Care failed to provide a clear and accurate explanation  
22              in 11 out of 50 denied claims reviewed.
- 23              - Respondent L.A. Care failed to provide a clear and accurate explanation  
24              in 5 out of 50 paid claims reviewed.
- 25              - Respondent L.A. Care failed to provide a clear and accurate explanation  
26              in 8 out of 50 late claims reviewed.
- 27              - Respondent L.A. Care failed to provide a clear and accurate explanation  
28              in 4 out of 30 high dollar claims reviewed.

- 1                   - Respondent L.A. Care failed to provide a clear and accurate explanation  
2                   in 10 out of 50 provider dispute resolution claims reviewed.

3           70.     Respondent L.A. Care's total remediation to rectify all deficient claims for  
4 the Non-Routine Examination was \$6.6 million. Combined with the remediation required  
5 to rectify all deficient claims for the Routine Examination, the total remediation required  
6 was \$9.5 million.

7           **Respondents' Financial Statutes**

8           71.     Respondent L.A. Care filed its Quarterly Financial Reporting Form for the  
9 quarter ending December 31, 2021, with the Department. As of December 31, 2021,  
10 Respondent L.A. Care reported its cash and cash equivalents to be \$676,492,659.  
11 Respondent L.A. Care reported its total current assets to be \$4,405,930,548. Respondent  
12 L.A. Care reported total current liabilities to be \$3,471,430,183. Respondent L.A. Care  
13 reported its tangible net equity to be \$1,077,010,894, an amount that was \$923,434,625  
14 greater than the minimum tangible net equity required by law. Respondent L.A. Care  
15 reported its total revenue (year to date) to be \$2,429,602,874.

16          72.     Respondent L.A Care JPA filed its Quarterly Financial Reporting Form for  
17 the quarter ending December 31, 2021, with the Department. As of December 31, 2021,  
18 Respondent L.A Care JPA reported its cash and cash equivalents to be \$23,054,978.  
19 Respondent L.A Care JPA reported its total current assets to be \$69,396,480.  
20 Respondent L.A Care JPA reported total current liabilities to be \$27,434,298. Respondent  
21 L.A Care JPA reported its tangible net equity to be \$5,984,952, an amount that was  
22 \$1,611,912 greater than the minimum tangible net equity required by law. Respondent  
23 L.A Care JPA reported its total revenue (year to date) to be \$ 48,024,696.

24                   **V.   FIRST CAUSE FOR DISCIPLINE**

25           (Failure to respond to requests for health care services within five business days  
26 of Respondents' receipt of information reasonably necessary to make a determination;  
27 failure to timely respond to requests for post-service authorization.)

28                   [Health & Saf. Code, § 1367.01, subds. (a) & (h)(1).]

73. Complainant re-alleges all matters set forth in paragraphs 1 through 72 and incorporates them herein.

74. Health care service plans that violate any portion of the Act or the rules and regulations promulgated thereunder are subject to discipline by the Department. (Health & Saf. Code, § 1386, subd. (b)(6).)

75. Health plans and any entity with which they contract for services that include utilization review or utilization management functions or that delegates utilization review or utilization management functions are required to comply with timely access requirements under Section 1367.01. (Health & Saf. Code, § 1367.01, subd. (a).)

76. Section 1367.01, subdivision (h)(1), requires a health plan to make decisions to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, not to exceed five business days from the health plan's receipt of the information reasonably necessary and requested by the health plan to make the determination.

77. Respondents' reported backlog of 9,125 authorization requests demonstrates that Respondents failed to respond to enrollee requests for services within five business days. (Health & Saf. Code § 1367.01, subd. (h)(1).)

78. Respondents are therefore subject to discipline pursuant to Section 1386, subdivision (b)(6), for violations of Health and Safety Code section 1367.01, subdivisions (a) and (h)(1).

## **VI. SECOND CAUSE FOR DISCIPLINE**

(Failure to make timely decisions based on medical necessity  
when the enrollee faces a serious and imminent threat to the enrollee's health.)

[Health & Saf. Code, § 1367.01, subds. (a) & (h)(2).]

79. Complainant re-alleges all matters set forth in paragraphs 1 through 78 and incorporates them herein.

///



1        80. Health care service plans that violate any portion of the Act or the rules and  
2 regulations promulgated thereunder are subject to discipline by the Department. (Health &  
3 Saf. Code, § 1386, subd. (b)(6).)

4        81. Health plans and any entity with which they contract for services that include  
5 utilization review or utilization management functions or that delegates utilization review  
6 or utilization management functions are required to comply with timely access  
7 requirements under Section 1367.01. (Health & Saf. Code, § 1367.01, subd. (a).)

8        82. Section 1367.01, subdivision (h)(2), requires a health plan to make  
9 decisions to approve, modify, or deny requests by providers prior to, retrospectively, or  
10 concurrent with the provision of health care services to enrollees, based in whole or in  
11 part on medical necessity, not to exceed 72 hours after the health plan's receipt of the  
12 information reasonably necessary and requested by the health plan to make the  
13 determination when an enrollee's condition is such that the enrollee faces an imminent  
14 and serious threat to his or her health, including, but not limited to, the potential loss of  
15 life, limb, or other major bodily function, or the normal timeframe for the decision process  
16 as described in Section 1367.01, subdivision (h)(1), would be detrimental to the enrollee's  
17 life or health or could jeopardize the enrollee's ability to regain maximum function.

18        83. Respondents' reported backlog of 9,125 authorization requests  
19 demonstrates that Respondents failed to respond to enrollee requests for services within  
20 72 hours in cases where the enrollee faced a serious and imminent threat to their health.  
21 (Health & Saf. Code § 1367.01, subd. (h)(2).)

22        84. Respondents are therefore subject to discipline pursuant to Section 1386,  
23 subdivision (b)(6), for violations of Health and Safety Code section 1367.01, subdivisions  
24 (a) and (h)(2).

## 25                    **VII. THIRD CAUSE FOR DISCIPLINE**

26 (Failure to communicate a decision to approve, modify, or deny requests for treatment  
27 authorization to the requesting provider within 24 hours of the health plan's decision.)

28                    [Health & Saf. Code § 1367.01, subds. (a) & (h)(3).]

1           85.    Complainant re-alleges all matters set forth in paragraphs 1 through 84 and  
2 incorporates them herein.

3           86.    Health care service plans that violate any portion of the Act or the rules and  
4 regulations promulgated thereunder are subject to discipline by the Department. (Health &  
5 Saf. Code, § 1386, subd. (b)(6).)

6           87.    Health plans and any entity with which they contract for services that include  
7 utilization review or utilization management functions or that delegates utilization review  
8 or utilization management functions are required to comply with timely access  
9 requirements under Section 1367.01. (Health & Saf. Code, § 1367.01, subd. (a).)

10          88.    Section 1367.01, subdivision (h)(3), requires that decisions to approve,  
11 modify, or deny requests by providers for authorization prior to, or concurrent with, the  
12 provision of health care services to enrollees be communicated to the requesting provider  
13 within 24 hours of the decision.

14          89.    Respondents' reported backlog of 9,125 authorization requests  
15 demonstrates that Respondents failed to communicate decisions to approve, modify, or  
16 deny treatment requests to the requesting provider within 24 hours of Respondents'  
17 decision. (Health & Saf. Code § 1367.01, subd. (h)(3).)

18          90.    Respondents are therefore subject to discipline pursuant to Section 1386,  
19 subdivision (b)(6), for violations of Health and Safety Code section 1367.01, subdivisions  
20 (a) and (h)(3).

21                               **VIII.    FOURTH CAUSE FOR DISCIPLINE**

22 (Failure to maintain the organizational and administrative capacity to provide contracted  
23 services to subscribers/enrollees including staffing in medical and other health services,  
24 and in fiscal and administrative services sufficient to result in the effective conduct of  
25 Respondents' business.)

26                               [Health & Saf. Code, § 1367, subd. (g), and  
27 Cal. Code of Regs., tit. 28, § 1300.67.3, subd. (a)(2).]  
28

1           91. Complainant re-alleges all matters set forth in paragraphs 1 through 90 and  
2 incorporates them herein.

3           92. Health care service plans that violate any portion of the Act or the rules and  
4 regulations promulgated thereunder are subject to discipline by the Department. (Health &  
5 Saf. Code, § 1386, subd. (b)(6).)

6           93. Health care service plans shall have the organizational and administrative  
7 capacity to provide services to subscribers and enrollees. (Health & Saf. Code, § 1367,  
8 subd. (g).)

9           94. The organization of each health plan is required to provide the capability to  
10 furnish, in a reasonable and efficient manner, the health care services for which  
11 subscribers and enrollees have contracted, including staffing in medical and other health  
12 services, and in fiscal and administrative services sufficient to result in the effective  
13 conduct of the plan's business. (Cal. Code Regs., tit. 28, § 1300.67.3, subd. (a)(2).)

14           95. Respondents' reported backlog of 9,125 authorization requests  
15 demonstrates Respondents failed to maintain the organizational and administrative  
16 capacity to provide contracted services to subscribers/enrollees, including but not limited  
17 to, failing to maintain sufficient staffing in its UM department. (Health & Saf. Code, § 1367,  
18 subd. (g), Cal. Code Regs., tit. 28, § 1300.67.3, subd. (a)(2).)

19           96. Respondents' failure to adequately process enrollee grievances, as  
20 described above, including but not limited to Respondents' reported back log of 67,717  
21 grievances as of December 17, 2021, and failure to maintain sufficient staffing to timely  
22 process grievances, further demonstrate a lack of administrative capacity on the part of  
23 Respondents.

24           97. Respondent L.A. Care's failure to properly measure and monitor the  
25 adequacy of its contracted provider network to provide enrollees with timely access to  
26 needed health care services by accurately tracking all relevant data points further  
27 demonstrates Respondent L. A. Care's lack of administrative capacity. (Cal. Code Regs.,  
28 tit. 28, § 1300.67.2.2, subds. (a)(4), (c)(5)(D) & (c)(5)(F).) Failing to maintain an adequate

1 contracted provider network undercuts enrollees' ability to receive timely access to health  
2 care services.

3 98. Respondent L.A. Care's failure to ensure its delegate follows all  
4 requirements under Section 1367.01 for the prospective, retrospective, or concurrent  
5 review and approval, modification, delay, or denial, based in whole or in part on medical  
6 necessity, requests by providers prior to, retrospectively, or concurrent with the provision  
7 of health care services to enrollees further demonstrates a lack of administrative capacity  
8 on the part of Respondent L.A. Care. Failing to ensure enrollees are afforded key  
9 consumer protections guaranteed under Section 1367.01 undercuts enrollees' ability to  
10 receive medically necessary services covered by Respondent L.A. Care's contract with  
11 the enrollees.

12 99. Respondent L.A. Care's inability to timely process claims, to the extent  
13 Respondent L.A. Care had to remediate \$9.5 million in claims (combined totals from both  
14 the Routine and Non-Routine Examinations), further demonstrates Respondent L.A.  
15 Care's lack of administrative capacity. Failing to pay claims properly undercuts a stable  
16 health care delivery system, and can also disrupt care for enrollees.

17 100. By failing to maintain a level of administrative capacity sufficient to provide  
18 services to enrollees and subscribers, Respondents failed to perform a basic obligation of  
19 health plans. Respondents are therefore subject to discipline pursuant to Section 1386,  
20 subdivision (b)(6), for violations of Health and Safety Code, section 1367, subdivision (g)  
21 and Rule 1300.67.3, subdivision (a)(2).

## 22 **IX. FIFTH CAUSE FOR DISCIPLINE**

23 (Failure to maintain a sufficient ratio of staff to enrollees to reasonably assure  
24 that all services offered by Respondents will be accessible to enrollees  
25 without delays detrimental to the health of the enrollees.)

26 [Cal. Code Regs., tit. 28, § 1300.67.2, subd. (d).]

27 101. Complainant re-alleges all matters set forth in paragraphs 1 through 100  
28 and incorporates them herein.

102. Health care service plans that violate any portion of the Act or the rules and regulations promulgated thereunder are subject to discipline by the Department. (Health & Saf. Code, § 1386, subd. (b)(6).)

103. A health plan is required to maintain a sufficient ratio of enrollees to staff such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. (Cal. Code Regs., tit. 28, § 1300.67.2, subd. (d).)

104. Respondents' backlog of 9,125 authorization requests was due in part to insufficient UM staffing and caused delays detrimental to the health of enrollees. (Cal. Code Regs., tit. 28 § 1300.67.2, subd. (d).)

105. Respondents are therefore subject to discipline pursuant to Section 1386, subdivision (b)(6), for violations of Rule 1300.67.2, subdivision (d).

#### **X. SIXTH CAUSE FOR DISCIPLINE**

(Failure to meet the standards for timely access of care.)

[Cal. Code Regs., tit. 28, §§ 1300.67.2 and 1300.67.2.2, subd. (a)(1).]

106. Complainant re-alleges all matters set forth in paragraphs 1 through 105 and incorporates them herein.

107. Health care service plans that violate any portion of the Act or the rules and regulations promulgated thereunder are subject to discipline by the Department. (Health & Saf. Code, § 1386, subd. (b)(6).)

108. Health plans must make basic and specialty health care services readily available and accessible to each of the plan's enrollees. (Cal. Code Reg., tit. 28 § 1300.67.2.) Health plans that provide or arrange for the provision of hospital or physician services are required to comply with timely access requirements under Rule 1300.67.2.2. (Cal. Code Regs., tit. 28, § 1300.67.2.2, subd. (a)(1).)

109. Respondents' reported backlog of 9,125 authorization requests demonstrates that Respondents failed to meet the standards for timely access to care as required under these sections. (Cal. Code Regs., tit. 28 § 1300.67.2.2, subd. (a)(1).)

110. Respondents are therefore subject to discipline pursuant to Section 1386, subdivision (b)(6), for violations of Rule 1300.67.2.2, subdivision (a)(1).

**XI. SEVENTH CAUSE FOR DISCIPLINE**

(Failure to provide or arrange for the provisions of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice.)

[Cal. Code Regs., tit. 28, § 1300.67.2.2, subd. (c)(1).]

111. Complainant re-alleges all matters set forth in paragraphs 1 through 110 and incorporates them herein.

112. Health care service plans that violate any portion of the Act or the rules and regulations promulgated thereunder are subject to discipline by the Department. (Health & Saf. Code, § 1386, subd. (b)(6).)

113. Health plans that provide or arrange for the provision of hospital or physician services are required to comply with timely access requirements under Rule 1300.67.2.2. (Cal. Code Regs., tit. 28, § 1300.67.2.2, subd. (a)(1).)

114. Rule 1300.67.2.2, subdivision (c)(1), requires health plans to provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice.

115. Rule 1300.67.2.2, subdivision (c)(1), further requires health plans to establish and maintain provider networks, policies, and procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with the clinical appropriateness standard.

116. Respondents' backlog of 9,125 authorization requests demonstrate that Respondents failed to provide or arrange for the provisions of covered health care services in a timely manner. (Cal. Code Regs., tit. 28, § 1300.67.2.2, subd. (c)(1).)

117. Respondents are therefore subject to discipline pursuant to Section 1386, subdivision (b)(6), for violations of Rule 1300.67.2.2, subd. (c)(1).

///

1                                   **XII.     EIGHTH CAUSE FOR DISCIPLINE**

2 (Failure to ensure that all plan and provider processes necessary to obtain covered health  
3 care services, including but not limited to, prior authorization processes, are completed in  
4 a manner that ensures enrollees receive health care services in a timely manner.)

5                                   [Cal. Code Regs., tit. 28, § 1300.67.2.2, subd. (c)(2).]

6             118.   Complainant re-alleges all matters set forth in paragraphs 1 through 117  
7 and incorporates them herein.

8             119.   Health care service plans that violate any portion of the Act or the rules and  
9 regulations promulgated thereunder are subject to discipline by the Department. (Health &  
10 Saf. Code, § 1386, subd. (b)(6).)

11            120.   Health plans that provide or arrange for the provision of hospital or  
12 physician services are required to comply with timely access requirements under Rule  
13 1300.67.2.2. (Cal. Code Regs., tit. 28, § 1300.67.2.2, subd. (a)(1).)

14            121.   Rule 1300.67.2.2, subdivision (c)(2), requires health plans to ensure that all  
15 plan and provider processes necessary to obtain covered health care services, including  
16 but not limited to prior authorization processes, are completed in a manner that assures  
17 the provision of covered health care services to enrollees in a timely manner appropriate  
18 for the enrollee's condition and in compliance with the requirements of Rule 1300.67.2.2.

19            122.   Respondents' backlog of 9,125 authorization requests and insufficient UM  
20 staffing demonstrate that Respondents' prior authorization processes failed to ensure that  
21 enrollees received health care services in a timely manner. (Cal. Code Regs., tit. 28 §  
22 1300.67.2.2, subd. (c)(2).)

23            123.   Respondents are therefore subject to discipline pursuant to Section 1386,  
24 subdivision (b)(6), for violations of Rule 1300.67.2.2, subdivision (c)(2).

25                                   **XIII.     NINTH CAUSE FOR DISCIPLINE**

26                                   (Failure to accurately pay claims including penalty and interest.)

27                                   [Health & Saf. Code, § 1371, subd. (a)(1);

28                                   Cal. Code Regs., tit. 28, § 1300.71, subds. (i)(1), (i)(2), & (j).]

1           124. Complainant re-alleges all matters set forth in paragraphs 1 through 123  
2 and incorporates them herein.

3           125. Any act or omission which constitutes a violation of the Knox-Keene Act or  
4 regulations is grounds for disciplinary action against a health care service plan. (Health &  
5 Saf. Code, § 1386, subd. (b)(6).)

6           126. The Director shall conduct an examination of the fiscal and administrative  
7 affairs of health care service plans as often as deemed necessary to protect the interest  
8 of subscribers or enrollees, but not less frequently than once every five years. (Health &  
9 Saf. Code, § 1382, subd. (a).)

10          127. Health care service plans shall contest, deny, or reimburse claims no later  
11 than 30 working days after receipt of a complete claim, or in the case of health  
12 maintenance organizations, no later than 45 working days after receipt. (Health & Saf.  
13 Code, § 1371, subd. (a)(1).)

14          128. A "complete claim" means a claim which provides reasonably relevant  
15 information and/or information necessary to determine payer liability. (Cal. Code Regs.,  
16 tit. 28, § 1300.71, subds. (a)(2), (a)(10), & (a)(11).)

17          129. Late payment on a complete claim shall automatically include interest at the  
18 rate of 15 percent per annum for the period of time that the payment is late. (Health & Saf.  
19 Code, § 1371, subd. (a)(4); Cal. Code Regs., tit. 28, § 1300.71, subds. (i)(1 & (2).)

20          130. A health plan or health plan's capitated provider that fails to automatically  
21 include the interest due on a late claim payment shall pay the provider \$10 for the late  
22 claim in addition to any interest payments made pursuant to subdivisions (i)(1) and (2).  
23 (Cal. Code Regs., tit. 28, § 1300.71, subd. (j).)

24          131. Respondent L.A. Care failed to accurately pay claims in 21 samples  
25 reviewed in the Routine Examination and 21 samples reviewed in the Non-Routine  
26 Examination, for a total of 42 instances. This deficiency on the part of Respondent L.A.  
27 Care was not adequately addressed after the Routine Examination, as evidenced by the  
28 continued inaccuracies in the payment of claims in the Non-Routine Examination.



132. Respondent L.A. Care is therefore subject to discipline pursuant to Section 1386, subdivision (b)(6), for violations of Section 1371, subdivision (a)(1), and Rule 1300.71, subdivisions (i)(1), (i)(2), and (j).

**XIV. TENTH CAUSE FOR DISCIPLINE**

(Incorrect claim denials.)

[Cal. Code Regs., tit. 28, § 1300.71, subd. (d)(1).]

133. Complainant re-alleges all matters set forth in paragraphs 1 through 132 and incorporates them herein.

134. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Health & Saf. Code, §§ 1386, subd. (b)(6).)

135. A health plan or a health plan's capitated provider shall not improperly deny, adjust, or contest a claim. (Cal. Code Regs., tit. 28, § 1300.71, subd. (d)(1).)

136. Respondent L.A. Care incorrectly denied claims in 11 samples reviewed in the Routine Examination and in 13 samples reviewed in the Non-Routine Examination, for a total of 24 instances. This deficiency was not adequately addressed by Respondent L.A. Care after the Routine Examination as evidenced by the continued improper claim denials in the Non-Routine Examination.

137. Respondent L.A. Care is therefore subject to discipline pursuant to Section 1386, subdivision (b)(6), for violations of Rule 1300.71, subdivision (d)(1).

**XV. ELEVENTH CAUSE FOR DISCIPLINE**

(Failure to forward misdirected claims.)

[Cal. Code Regs., tit. 28, § 1300.71, subds. (b)(2)(A) & (b)(2)(B).]

138. Complainant re-alleges all matters set forth in paragraphs 1 through 137 and incorporates them herein.

139. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Health & Saf. Code, § 1386, subd. (b)(6).)

1 140. For a provider claim involving emergency service or care, a health plan shall  
2 forward the claim to the appropriate capitated provider within 10 working days of receipt  
3 of the claim that was incorrectly sent to the health plan. (Cal. Code Regs., tit. 28, §  
4 1300.71, subd. (b)(2)(A).)

5 141. For a provider claim that does not involve emergency service or care, if the  
6 provider that filed the claim is contracted with the health plan's capitated provider, the  
7 health plan within 10 working days of receipt shall either: (1) send the claimant a notice of  
8 denial, with instructions to bill the capitated provider; or (2) forward the claim to the  
9 appropriate capitated provider. In all other cases, the plan within 10 working days of  
10 receipt of the claim incorrectly sent to the plan shall forward the claim to the appropriate  
11 capitated provider. (Cal. Code Regs., tit. 28, § 1300.71, subd. (b)(2)(B).)

12 142. Respondent L.A. Care failed to forward misdirected claims on 11 samples  
13 reviewed in the Routine Examination, in violation of Rule 1300.71, subdivisions (b)(2)(A)  
14 and (b)(2)(B).

15 143. Respondent L.A. Care is therefore subject to discipline pursuant to Section  
16 1386, subdivision (b)(6).

17 **XVI. TWELVETH CAUSE FOR DISCIPLINE**

18 (Untimely claim denials.)

19 [Cal. Code Regs., tit. 28, § 1300.71, subds. (b)(2)(A) & (b)(2)(B).]

20 144. Complainant re-alleges all matters set forth in paragraphs 1 through 143  
21 and incorporates them herein.

22 145. Any act or omission which constitutes a violation of the Knox-Keene Act or  
23 regulations is grounds for disciplinary action against a health care service plan. (Health &  
24 Saf. Code, § 1386, subd. (b)(6).)

25 146. For a provider claim involving emergency service or care, a health plan shall  
26 forward the claim to the appropriate capitated provider within 10 working days of receipt  
27 of the claim that was incorrectly sent to the health plan. (Cal. Code Regs., tit. 28, §  
28 1300.71, subd. (b)(2)(A).)

1 147. Health care service plans shall contest, deny, or reimburse claims no later  
2 than 30 working days after receipt of a complete claim, or in the case of health  
3 maintenance organizations, no later than 45 working days after receipt. (Health & Saf.  
4 Code, § 1371, subd. (a)(1).)

5 148. A “complete claim” means a claim which provides reasonably relevant  
6 information and/or information necessary to determine payer liability. (Cal. Code Regs.,  
7 tit. 28, § 1300.71, subds. (a)(2), (a)(10), & (a)(11).)

8 149. Respondent L.A. Care failed to timely deny claims in four samples reviewed  
9 in the Routine Examination, in violation of Rule 1300.71, subdivisions (b)(2)(A) and  
10 (b)(2)(B).

11 150. Respondent L.A. Care is therefore subject to discipline pursuant to Section  
12 1386, subdivision (b)(6).

13 **XVII. THIRTEENTH CAUSE FOR DISCIPLINE**

14 (Failure to provide a clear and accurate explanation  
15 for denied, adjusted, or contested claims.)

16 [Cal. Code Regs., tit. 28, § 1300.71, subd. (d)(1).]

17 151. Complainant re-alleges all matters set forth in paragraphs 1 through 150  
18 and incorporates them herein.

19 152. Any act or omission which constitutes a violation of the Knox-Keene Act or  
20 regulations is grounds for disciplinary action against a health care service plan. (Health &  
21 Saf. Code, § 1386, subd. (b)(6).)

22 153. A health plan or a health plan’s capitated provider shall not improperly deny,  
23 adjust, or contest a claim. For each claim that is either denied, adjusted, or contested, the  
24 health plan or health plan’s capitated provider shall provide an accurate and clear written  
25 explanation of the specific reasons for the action taken. (Cal. Code Regs., tit. 28, §  
26 1300.71, subd. (d)(1).)

27 ///

28 ///

1 154. Respondent L.A. Care failed to provide an accurate and clear explanation  
2 when denying, adjusting, or contesting a claim in 38 samples reviewed in the Non-  
3 Routine Examination, in violation of Rule 1300.71, subdivision (d)(1).

4 155. Respondent L.A. Care is therefore subject to discipline pursuant to Section  
5 1386, subdivision (b)(6).

6 **XVIII. FOURTEENTH CAUSE FOR DISCIPLINE**

7 (Systemic failure to timely resolve and respond to grievances.)

8 [Health & Saf. Code, § 1368.01, subd. (a);

9 Cal. Code Regs., tit. 28, § 1300.68, subd. (d)(3).]

10 156. Complainant re-alleges all matters set forth in paragraphs 1 through 155  
11 and incorporates them herein.

12 157. Any act or omission which constitutes a violation of the Knox-Keene Act or  
13 regulations is grounds for disciplinary action against a health care service plan. (Health &  
14 Saf. Code, § 1386, subd. (b)(6).)

15 158. Respondents are required to resolve grievances within 30 days and send a  
16 written resolution. (Health & Saf. Code, § 1368.01, subd. (a); Cal. Code Regs., tit. 28, §  
17 1300.68, subd. (d)(3).)

18 159. "Grievance" means a written or oral expression of dissatisfaction regarding  
19 a health plan and/or provider, including quality of care concerns, and shall include a  
20 complaint, dispute, request for reconsideration or appeal made by an enrollee or the  
21 enrollee's representative. (Cal. Code Regs., tit. 28, § 1300.68, subd. (a)(1).)

22 160. "Resolved" in the context of a grievance means that the grievance has  
23 reached a final conclusion with respect to the enrollee's submitted grievance, and there  
24 are no pending enrollee appeals within a health plan's grievance system, including  
25 entities with delegated authority. (Cal. Code Regs., tit. 28, § 1300.68, subd. (a)(4).)

26 161. Respondents failed to timely respond to over 67,717 grievances, with the  
27 number increasing as Respondents reportedly continue to work through their backlog and  
28 additional issues are identified. This number includes the over 8,000 grievances that were

not initiated by Respondents. Respondents systemically failed, and continue to fail, to timely respond to enrollee grievances in violation of Section 1368.01, subdivision (a) and Rule 1300.68, subdivision (d)(3).

162. Respondents are therefore subject to discipline pursuant to Section 1386, subdivision (b)(6).

### **XIX. FIFTEENTH CAUSE FOR DISCIPLINE**

(Systemic failure to ensure adequate consideration and rectification of grievances.)

[Health & Saf. Code, § 1368, subd. (a)(1).]

163. Complainant re-alleges all matters set forth in paragraphs 1 through 162 and incorporates them herein.

164. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Health & Saf. Code, § 1386, subd. (b)(6).)

165. Respondents are required to maintain a grievance system that ensures adequate consideration and appropriate rectification of enrollee grievances. (Health & Saf. Code, § 1368, subd. (a)(1).)

166. "Grievance" means a written or oral expression of dissatisfaction regarding a health plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative. (Cal. Code Regs., tit. 28, § 1300.68, subd. (a)(1).)

167. Respondents' systemic failure to timely respond to thousands of grievances for a prolonged period, their repeated failure to initiate the grievance process and to identify these deficiencies earlier, all demonstrate that Respondents' grievance program systemically fails to operate as it should, namely, to adequately consider and rectify enrollee grievances, in violation of Section 1368, subdivision (a)(1).

168. Respondents are therefore subject to discipline pursuant to Section 1386, subdivision (b)(6).

///

1                                   **XX.    SIXTEENTH CAUSE FOR DISCIPLINE**

2                   (Systemic failure of Respondents' governing body and public policy body  
3                   to periodically review the written grievance record.)

4                   [Cal. Code Regs, tit. 28, § 1300.68, subd. (b)(5).]

5           169.   Complainant re-alleges all matters set forth in paragraphs 1 through 168  
6 and incorporates them herein.

7           170.   Any act or omission which constitutes a violation of the Knox-Keene Act or  
8 regulations is grounds for disciplinary action against a health care service plan. (Health &  
9 Saf. Code, § 1386, subd. (b)(6).)

10          171.   A written record shall be made for each grievance received by a health plan,  
11 including the date received, the health plan representative recording the grievance, a  
12 summary or other document describing the grievance, and its disposition. The written  
13 record of grievances shall be reviewed periodically by the governing body of a health  
14 plan, the public policy body created pursuant to Rule 1300.69, and by an officer of the  
15 health plan or his designee. This review must be thoroughly documented. (Cal. Code  
16 Regs, tit. 28, §1300.68, subd. (b)(5).)

17          172.   Since the beginning of 2017 until the end of October 2021, Respondents'  
18 written grievance record compiled pursuant to Rule 1300.68, subdivision (b)(5), was  
19 periodically reviewed by the following on the following dates by the listed entities:

- 20                   1.    Compliance & Quality Committee of the Board (governing body)  
21                           a.    March 19, 2020  
22                           b.    September 15, 2020  
23                   2.    Executive Consumer Advisor Committee (ECAC) (public policy  
24                           committee)<sup>6</sup>  
25                           a.    May 19, 2019

26  
27                   <sup>6</sup> This committee name and dates were provided by Respondent L.A. Care in  
28 response to discovery requests. The public policy committee may go by the name  
Executive Community Advisory Committee, or another name.

1 b. October 19, 2019

2 c. January 8, 2020

3 3. Board of Governors Meeting (governing body)

4 a. June 6, 2019

5 b. November 7, 2019

6 173. For calendar years 2017, 2018 and 2021, Respondents failed to have their  
7 written record of grievances reviewed periodically by Respondents' governing body and  
8 the public policy body created pursuant to Rule 1300.69. This is in violation of Rule  
9 1300.68, subdivision (b)(5).

10 174. Respondents are therefore subject to discipline pursuant to Section 1386,  
11 subdivision (b)(6).

12 **XXI. SEVENTEENTH CAUSE FOR DISCIPLINE**

13 (Failure of the designated health plan officer with primary responsibility for Respondents'  
14 grievance system to continuously review the operation of the system to identify any  
15 emergent patterns of grievances.)

16 [Cal. Code Regs, tit. 28, § 1300.68, subd. (b)(1).]

17 175. Complainant re-alleges all matters set forth in paragraphs 1 through 174  
18 and incorporates them herein.

19 176. Any act or omission which constitutes a violation of the Knox-Keene Act or  
20 regulations is grounds for disciplinary action against a health care service plan. (Health &  
21 Saf. Code, § 1386, subd. (b)(6).)

22 177. An officer of a health plan shall be designated as having primary  
23 responsibility for the health plan's grievance system and shall continuously review the  
24 operation of the grievance system to identify any emergent patterns of grievances. (Cal.  
25 Code Regs, tit. 28, §1300.68, subd. (b)(1).)

26 178. Respondents' Appeals and Grievances Director (who resigned in January  
27 2021) did not retrieve reports indicating cases were not properly closed during her tenure.  
28 This Director was responsible for continuously reviewing the operation of Respondents'

grievance system to identify any emergent patterns of grievances pursuant to Rule 1300.68, subdivision (b)(1).

179. The failure of Respondents' designated officer to review reports identifying that grievance matters were not being properly closed represents a violation on the part of Respondents of having an officer who continuously reviews the operation of their grievance system to identify emergent patterns. (Cal. Code Regs, tit. 28, §1300.68, subd. (b)(1).)

180. Respondents are therefore subject to discipline pursuant to Section 1386, subdivision (b)(6).

## **XXII. EIGHTEENTH CAUSE FOR DISCIPLINE**

(Failure to establish and maintain a grievance system that consistently ensures adequate consideration of enrollee grievances.)

[Health & Saf. Code, § 1368, subd. (a)(1).]

181. Complainant re-alleges all matters set forth in paragraphs 1 through 180 and incorporates them herein.

182. Any act or omission which constitutes a violation of the Knox-Keene Act or regulations is grounds for disciplinary action against a health care service plan. (Health & Saf. Code, § 1386, subd. (b)(6).)

183. Section 1368, subdivision (a)(1), requires health plans to establish and maintain a grievance system that provides reasonable procedures that shall ensure *adequate* consideration of enrollee grievances and rectification when appropriate.

184. Rule 1300.68, subdivision (a), requires that grievances be reviewed and resolved within 30 calendar days of receipt. A grievance is considered "resolved" if the grievance has reached a final conclusion with respect to the enrollee's submitted grievance. (Cal. Code Regs., tit. 28, § 1300.68, subd. (a)(4).)

185. As discussed above, the Department reviewed all grievance and appeals files provided by Respondent L.A. Care for the years 2016 to 2020 relating to complaints by enrollees regarding compliance to timely access standards by Los Angeles County,



1 Department of Health Services (LA DHS), a delegate of Respondent L.A. Care. The  
2 Department concluded that Respondent L.A. Care failed to consistently reach a true  
3 resolution or rectification of enrollees' grievances, in violation of Section 1368, subdivision  
4 (a)(1).

5 186. Respondent L.A. Care is therefore subject to discipline pursuant to Section  
6 1386, subdivision (b)(6).

### 7 **XXIII. NINETEENTH CAUSE FOR DISCIPLINE**

8 (Failure to consistently oversee the health plan's delegate to ensure that  
9 all utilization review requirements are followed.)

10 [Health & Saf. Code, § 1367.01.]

11 187. Complainant re-alleges all matters set forth in paragraphs 1 through  
12 186 and incorporates them herein.

13 188. Any act or omission which constitutes a violation of the Knox-Keene Act or  
14 regulations is grounds for disciplinary action against a health care service plan. (Health &  
15 Saf. Code, § 1386, subd. (b)(6).)

16 189. Health care service plans are required to ensure that they and their  
17 delegates follow all requirements under Section 1367.01 for the prospective,  
18 retrospective, or concurrent review and approval, modification, delay, or denial, based in  
19 whole or in part on medical necessity, requests by providers prior to, retrospectively, or  
20 concurrent with the provision of health care services to enrollees.

21 190. Rule 1300.68, subdivision (a), requires that the grievances be reviewed and  
22 resolved within 30 calendar days of receipt.

23 191. Respondent L.A. Care conceded its awareness that its delegate, LA DHS,  
24 uses the eConsult system to provide services to Respondent L.A. Care's enrollees.

25 192. Respondent L.A. Care is in possession of LA DHS documents that provide  
26 that the eConsult system as used by LA DHS is a system that reviews and approves,  
27 modifies, or denies requests by providers prior to the provision of health care services to  
28 enrollees, and a three-level decision-making/appeal system – making the process one

1 that mimics the utilization review system described in Section 1367.01. Yet, the  
2 documents also suggest that the eConsult system does not provide key consumer  
3 protections as required under Section 1367.01, including timely decision, timely  
4 notification of the reasons for decisions regarding medical necessity, opportunity to file a  
5 grievance with Respondent L.A. Care or request an administrative hearing, and  
6 Respondent L.A. Care's oversight.

7 193. Respondent L.A. Care is in possession of LA DHS documents that provide  
8 that there are no built-in timeframes for the various stages of the eConsult process, no  
9 written notification to enrollees (unless the Primary Care Physician challenges the  
10 eConsult case decision through the formal second opinion process), and no oversight by  
11 Respondent L.A. Care.

12 194. Respondent L.A. Care cannot provide any template notice, sample notice,  
13 or any evidence, that notice is being sent to the enrollees when a decision to modify or  
14 deny a requested treatment or service is based on medical necessity. Respondent L.A.  
15 Care also cannot provide any information regarding the process, timing, measuring,  
16 monitoring, or oversight of its delegate's issuance of such notification, or what information  
17 is provided in such notification. Such notices are required pursuant to Section 1367.01,  
18 subd. (h), to inform enrollees and treating providers of the basis of any modification or  
19 denial, and appeal rights.

20 195. During the Department's investigation, Respondent L.A. Care conceded it  
21 does not have any policies or procedures specific to its oversight on how the eConsult  
22 system is utilized.

23 196. Respondent L.A. Care's failure to consistently oversee its delegate to  
24 ensure that all utilization review requirements under Section 1367.01 are followed subject  
25 Respondent L.A. Care to discipline pursuant to Section 1386, subdivision (b)(6).

26 ///

27 ///

28 ///

1 **XXIV. TWENTIETH CAUSE FOR DISCIPLINE**

2 (Failure to measure and monitor the adequacy of

3 the health plan's contracted provider network

4 to provide enrollees with timely access to needed health care service.)

5 [Cal. Code Regs., tit. 28, § 1300.67.2.2, subds. (a)(4), (c)(5)(D) & (c)(5)(F).]

6 197. Complainant re-alleges all matters set forth in paragraphs 1 through 196  
7 and incorporates them herein.

8 198. Any act or omission which constitutes a violation of the Knox-Keene  
9 Act or regulations is grounds for disciplinary action against a health care service  
10 plan. (Health & Saf. Code, § 1386, subd. (b)(6).)

11 199. A health plan is required to provide or arrange for the provision of access to  
12 health care services in a timely manner, and establish metrics for measuring and  
13 monitoring the adequacy of a plan's contracted provider network to provide enrollees with  
14 timely access to needed health care services. (Cal. Code Regs., tit. 28, § 1300.67.2.2,  
15 subd. (a)(4).)

16 200. The obligation of a health plan to comply with timely access standards "shall  
17 not be waived" when the plan delegates to its medical groups, independent practice  
18 associations, or other contracting entities any services or activities that the plan is  
19 required to perform. (Cal. Code Regs., tit. 28, § 1300.67.2.2, subd. (a)(3).)

20 201. A health plan is required to ensure that its contracted provider network has  
21 adequate capacity and availability of licensed health care providers to offer enrollee  
22 appointments that meet the following timeframes:

- 23 - Non-urgent appointments with specialist physicians: within 15 business  
24 days of the request for appointment (Cal. Code Regs., tit. 28,  
25 § 1300.67.2.2, subd. (c)(5)(D)); and  
26 - Non-urgent appointments for ancillary services for the diagnosis or  
27 treatment of injury, illness, or other health condition: within 15 business  
28 days of the request for appointment. (Cal. Code Regs., tit. 28, §

1300.67.2.2, subd. (c)(5)(F).)

202. “Appointment waiting time” is defined to mean “the time from the initial request for health care service by an enrollee or the enrollee’s treating provider to the earliest date offered for the appointment for services *inclusive of time for obtaining authorization from the plan or completing any other condition or requirement of the plan or its contracting providers.*” (Cal. Code Regs., tit. 28, § 1300.67.2.2, subd. (b)(2).) (Emphasis added.)

203. For Respondent L.A. Care to satisfy its obligation to properly measure and monitor the adequacy of its contracted provider network to provide enrollees with timely access to needed health care services, pursuant to Rule 1300.67.2.2, subdivision (a)(4), at minimum, Respondent L.A. Care must ensure that its contracted provider network accurately tracks all relevant data points – most importantly, the date of the initial request for health care service by an enrollee or the enrollee’s treating provider.

204. Respondent L.A. Care is aware that its delegate requires providers to, when an enrollee requests or requires non-urgent appointments to specialists or ancillary services, begin with the eConsult process.

205. Respondent L.A. Care admitted to the Department that its evaluation of compliance with timely access standards occurs “only after the PCP and eConsult specialist determine that a specialty referral is indicated, which would be outside of the eConsult process.” In essence, Respondent L.A. Care’s measuring and monitoring of timely access compliance does not take into consideration the date of which an enrollee requests an appointment, or the PCP requests an appointment on behalf of the enrollee. Yet, as discussed above, Respondent L.A. Care is in possession of LA DHS documents that provide that there are no built-in timeframes for the various stages of the eConsult process.

206. Without accurately tracking the “appointment waiting time” pursuant to Rule 1300.67.2.2, subdivision (b)(2), Respondent L.A. Care is not consistently ensuring that its contracted provider network has adequate capacity and availability of licensed health care

1 providers to offer enrollee appointments that meet the timeframes prescribed in Rule  
2 1300.67.2.2, subdivisions (c)(5)(D) and (c)(5)(F). As such, Respondent L.A. Care is not  
3 consistently and accurately measuring and monitoring the adequacy of its contracted  
4 provider network to provide enrollees with timely access to needed health care services,  
5 pursuant to Rule 1300.67.2.2, subdivision (a)(4). These violations subject Respondent  
6 L.A. Care to discipline pursuant to Section 1386, subdivision (b)(6).

7  
8 **PRAYER**

9 **WHEREFORE**, Complainant prays that a decision be rendered by the Director of  
10 the Department of Managed Health Care assessing an administrative penalty against the  
11 Respondents, in the amount of \$35,000,000 for the violations of the Knox-Keene Act and  
12 the accompanying rules and regulations they have committed as alleged in this  
13 Accusation.

14 **WHEREFORE**, Complainant also prays for such other and further relief, as the  
15 Director deems proper.

16 Dated: 3/4/2022

/Original/Signed/  
SONIA R. FERNANDES  
Deputy Director | Chief Counsel  
Office of Enforcement