DMHC and DHCS Fine L.A. Care $55 Million in Enforcement Actions

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The California Department of Managed Health Care (DMHC) on March 4, 2022, assessed the largest penalty against a health plan in the Department's history. DMHC and the California Department of Health Care Services (DHCS) jointly announced the results of enforcement actions against Local Initiative Health Authority for Los Angeles County, more commonly known as *L.A. Care*. The penalties assessed by DMHC and DHCS against L.A. Care include $55 million in fines, which consist of a $35 million fine from DMHC and a $20 million sanction from DHCS. The amount is by far the largest penalty by DMHC, outstripping the previous record fine of $10 million imposed in 2008.

According to the joint statement issued by the two Departments, "[t]he magnitude of L.A. Care's violations, which has resulted in harm to its members, requires immediate action. Our investigations found several operational failures at L.A. Care, which have significantly impacted the health and safety of some of the state's most vulnerable health care consumers. This action is necessary to protect the plan's members, and to get L.A. Care to make serious changes to repair the plan's operations."

L.A. Care has indicated that they intend to appeal the fines.

What are the allegations against L.A. Care?

L.A. Care is a full-service health plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and under the oversight of DMHC. L.A. Care also contracts with DHCS to provide managed care services to Medi-Cal beneficiaries.

During the investigations, DMHC and DHCS reportedly found multiple violations of the Knox-Keene Act and DHCS contract requirements by L.A. Care, including its handling of enrollee grievances, the processing of requests for authorization and inadequate oversight and supervision of its contracted entities regarding

timely access.

The Departments identified and alleged:

- A systemic failure to issue and to timely issue grievance resolution letters. "L.A. Care reported to the DMHC that it had failed to timely respond to more than 67,000 grievances for several lines of business, including Medi-Cal. L.A. Care reported to DHCS 41,500 instances in which L.A. Care failed to timely issue a resolution letter for a grievance or appeal from January 2019 through October 2021."
- A systemic failure to timely process prior authorizations for health care services, delaying members' access to medically-necessary health care services that had a detrimental impact on its members. "L.A. Care reported a backlog of 9,125 authorization requests to the DMHC and 8,517 to the DHCS for a three-month period in 2021. Upon further inquiry, L.A. Care further disclosed to the DHCS an identified 92,854 instances in which prior authorization requests were not processed timely from January 1, 2019 through October 13, 2021."
- A failure to consistently and adequately measure, monitor and correct its delegates, including contracted providers, compliance with timely access standards.
- A failure to maintain sufficient organizational and administrative capacity to provide services to members, including a failure to adequately fund or staff L.A. Care's utilization management department.

What can health plans do in response to the enforcement actions?

Health plans and certain of their delegated entities (*i.e.*, those delegated grievances, utilization management and timely access compliance) should take these allegations and the fines seriously, as it likely signals that the Departments will focus on these areas of compliance in the near future to ensure the alleged violations are not occurring elsewhere. Any plan applicant to DHCS's Medi-Cal Managed Care RFP should also look for ways to incorporate in its response its relevant compliance programs in these areas.

Also, plans should consider taking the following steps to ensure compliance:

- Conduct a third-party audit of their grievances, appeals and utilization management processes and statistics including, for example, turn-around-times. These audits should not be limited to reviewing the "paperwork" and should instead allow the auditors access to plans' internal systems to ensure the integrity of the information in the "paperwork."
- Compare plans' utilization management budgets and full-time equivalents with similarly-situated health plans and other industry standards to ensure low to no variance.
- Review the effectiveness of their delegation oversight program. If plans do not have an oversight program, they should create a robust delegation oversight program that includes clear accountability, lines of communication and corrective actions. The delegation program should also ensure all parties understand the applicable compliance and contractual requirements.
- Review their current timely access surveys and reporting to ensure such reports comply with the DMHC's current methodology and demonstrate the appropriate follow-ups and corrective actions.

Additionally, delegated entities that provide services in the areas of grievances, appeals and utilization management should seriously consider a third-party audit of their processes and statistics. All timely access grievances and noncompliance should be taken seriously, dealt with swiftly, and appropriately documented.