Health Care Service Plans' Provider Dispute Resolution Mechanisms

2016 Annual Report

April 28, 2017

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I.

Executive Summary

The California Department of Managed Health Care (DMHC) protects consumers' health care rights and ensures a stable health care delivery system. As part of this mission, the DMHC licenses and regulates health care service plans (health plans) while maintaining the financial stability of the managed health care system.

State law requires health plans to pay health care providers accurately and in a timely fashion for services provided and to maintain a fast, fair, and cost-effective system for processing and resolving provider claim disputes (California Health and Safety Code section 1367(h).) Health plans are required to annually report the number, type, and summaries of provider claim payment disputes, describe the resolutions including terms and timeliness, and explain how health plans are addressing trends or patterns in disputes. The report includes provider dispute data from health plans' capitated providers such as hospital systems and medical groups.[1]

As required by Health and Safety Code section 1375.7(f), the DMHC annually summarizes the health plans' self-reported provider dispute data in a report to the Governor and the Legislature. The 2016 Provider Dispute Resolution Mechanisms Report summarizes provider claim disputes by type of health plan, including full service health plans and specialized health plans, from October 1, 2015 through September 30, 2016.

KEY STATISTICS:

<u>Full Service Health Plans</u>:

Full Service Health Plans are health plans that provide all of the basic health care services and mandated benefits required under the Knox-Keene Act.

- There are 49 licensed full service health plans in California subject to the reporting requirements of section 1375.7(f). Twenty-three licensed, full service health plans are excluded from the report because they are licensed only for Medicare products, and therefore are exempt from Health and Safety Code section 1367(h).

- Health plans processed approximately 154 million claims in 2016. Less than one-percent (0.73 percent) of these claims resulted in claims disputes.

[1] Generally, capitated providers fall within two main categories: (1) medical groups and Independent Practice Associations (IPAs); and (2) hospital systems that receive capitation from health plans, and in turn pay provider claims for health care services rendered to the plan's enrollees. Capitation is a set amount of prepaid money received or paid out, based on the number of enrollees assigned to an organization, rather than on the level of services delivered. This arrangement is usually expressed in units of PMPM (per member per month).

- Full service health plans received more than one million (1,112,573) provider disputes for the reporting period.

- California's seven largest full service health plans[2] provide health care benefits to approximately 18 million (74 percent) of the approximately 24 million full service health plan enrollees.

- Approximately 69 percent of the reported provider disputes were filed with the seven largest full service health plans.

- The seven largest full service health plans processed more than 126 million claims, accounting for 82 percent of all claims filed by full service health plans in California.

- Approximately 85 percent of all provider disputes processed by full service health plans were reported as being resolved within 45 working days from the date of receipt.

- Roughly 84 percent of provider disputes filed with full service health plans involved claims payment and/or billing problems.

- Providers prevailed in 37 percent of all disputes; health plans upheld their original determinations in 44 percent of the disputes, with 19 percent of the disputes pending at the time the plans reported this data to the DMHC.

Specialized Health Plans:

Specialized Health Plans are health plans that provide coverage in a specialized area of care such as vision, dental, behavioral health, and chiropractic health plans.

- There are 42 licensed specialized health plans subject to the provider dispute reporting requirements.

- Specialized health plans processed approximately 26 million claims in the 2016. Less than one-half of one percent (0.04 percent) of these claims were the subject of a claim payment/billing dispute.

- Specialized health plans received 17,663 provider disputes for the reporting period.

[2] California's seven largest full service health plans are Blue Cross of California (Anthem Blue Cross), California Physicians' Services (Blue Shield of California), Health Net of California, Inland Empire Health Plan, Kaiser Foundation Health Plan, Local Initiative Health Authority of L.A. County (LA Care), and Health Net Community Solutions.

- Specialized health plans reported that 50 percent of all provider disputes were resolved in favor of the provider, a decrease of 3 percent from the 2015 reporting period.

- Specialized health plans upheld their original determination in 54 percent of the claims payment and billing disputes, an increase of 2 percent from the 2015 reporting period.

- Dental plans reported more than half (56 percent) of all specialized health plan provider disputes.

- Dental plan enrollment accounted for 60 percent of the total enrollment for specialized health plans required to report.

- Approximately 63 percent of provider disputes with specialized health plans involved claims payment and/or billing problems.

Capitated Providers:

Capitated Providers are providers that have contracted with a full service health plan to assume the financial risk and pay claims for the provision of health care services to the plan's enrollees.

- Full service health plans reported data on 289 capitated providers. This includes risk bearing organizations (RBO), capitated hospitals, and certain other provider groups that do not meet the definition of an RBO.

- Capitated providers processed approximately 64 million claims and received 552,499 provider disputes in the 2016 reporting period.

- 89 percent of disputes involved claims payment and/or billing problems.

- 36 percent of all reported provider disputes with capitated providers were resolved in favor of the provider.

II.

Introduction/Background

In 2003, the DMHC issued regulations regarding the timely and accurate payment of provider claims and required health plans to establish a fast, fair and cost-effective dispute resolution process. These regulations, known as the Claims Settlement Practice and Dispute Resolution Mechanism Regulations, require all health plans, and their capitated providers that pay claims, to fully implement specific standards and safeguards for payment of provider claims for services rendered on or after January 1, 2004.[3]

In addition to defining the basic concepts relevant to all dispute resolution mechanisms, the regulations require health plans to submit to the DMHC the Annual Plan Dispute Resolution Mechanism Report, which is public information, and contains the following:

> (1) Information on the number and types of providers utilizing the dispute resolution mechanism;
>
> (2) A summary of the disposition of all provider disputes, including an informative description of the type, term, and resolution;
>
> (3) The timeliness of dispute resolution determinations;
>
> (4) A detailed information statement disclosing any emerging or established patterns of provider disputes, and how that information has been used to improve administrative capacity, plan/provider relations, claims payment procedures, quality assurance systems, and the quality of patient care, as well as dispute results.

Health plans are required to summarize their provider dispute results in three categories:

- Claims Payment/Billing Disputes -- Provider complaints relating to the health plan's failure to reimburse complete claims with the correct payment, including the automatic payment of all interest and penalties.

- Utilization Management Disputes -- Provider complaints relating to medical necessity and authorization determinations.

- Other Disputes -- Provider complaints relating to non-monetary issues, such as enrollee eligibility and assignment matters, and provider credentialing and certification.

This report reflects information reported by health plans for October 1, 2015 through September 30, 2016.

[3] See California Code of Regulations, title 28, sections 1300.71 and 1300.71.38.

III.

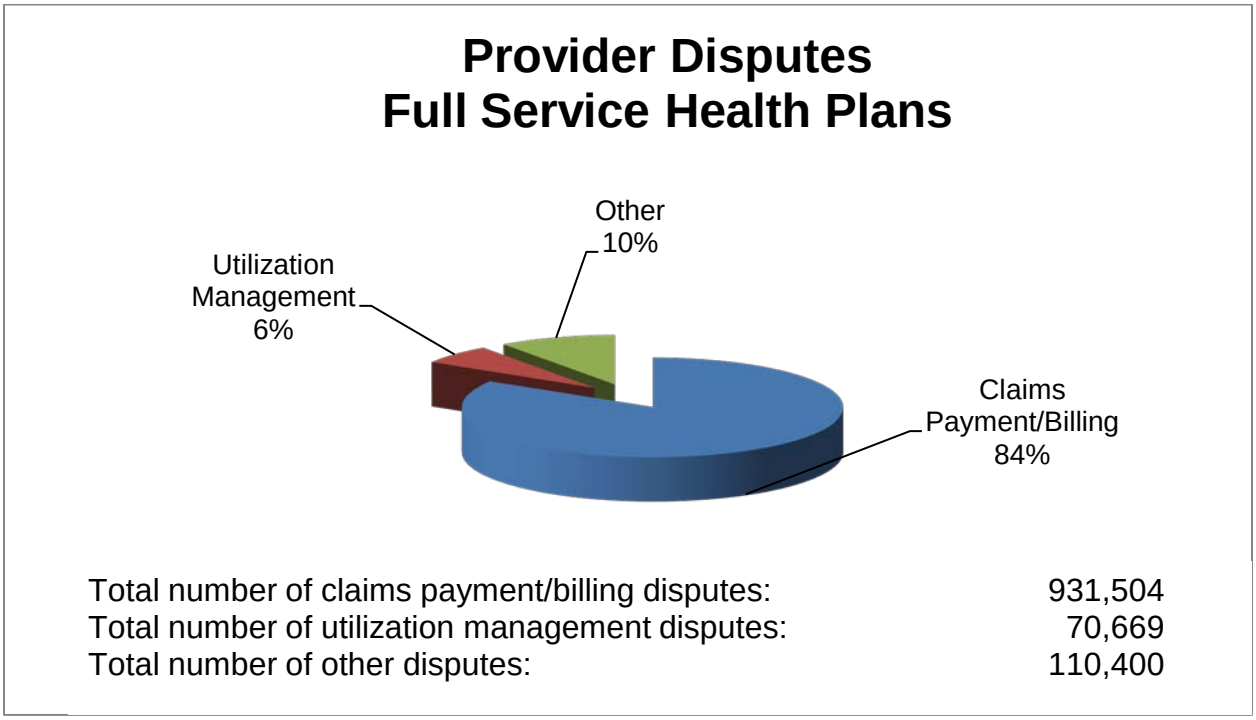
Full Service Health Plans

Of the 72 licensed full service health plans, data from 49 full service health plans are included in this report. Twenty-three licensed, full service health plans are excluded because they are licensed only for Medicare products, and therefore are exempt from Health and Safety Code section 1367(h).

The 49 full service health plans reported more than 154 million claims processed during the reporting period. A claim is considered processed when the health plan adjudicates and classifies the claim as paid, adjusted, contested, or denied. The reporting full service health plans received 1,112,573 provider disputes during the 2016 reporting period. This represents a 21 percent increase in disputes over the 2015 reporting period.

Claims payment/billing disputes, which primarily involve claims of inadequate reimbursement, comprised 84 percent of the full service health plan provider disputes (See Chart 1).

Chart 1



Total number of claims payment/billing disputes:	931,504
Total number of utilization management disputes:	70,669
Total number of other disputes:	110,400

Regulations require the health plans to resolve 95 percent of all complete provider disputes within 45 working days. Approximately 85 percent of all provider disputes processed by full service health plans were reported as resolved within the required 45 working days from the date of receipt. Collectively, full service health plans did not meet the timeliness requirements for resolving timeliness disputes. In 2015, 87 percent of provider disputes were resolved within 45 days.

Health plans attributed the declining provider dispute resolution timeliness to a variety of factors. These factors include staffing issues, unexpected claims backlog, and claims system updates. Health plans have indicated that corrective action plans have been instituted to improve timeliness going forward. The corrective actions include reviewing daily reports to monitor processing timeliness, implementing system improvement audits to determine claim processing delays, and hiring additional staffing to eliminate dispute backlogs.

The DMHC monitors the health plans' corrective actions through its financial examinations and by analyzing provider complaints received by the DMHC's Provider Complaint Unit.

Provider Disputes Compared to Claims

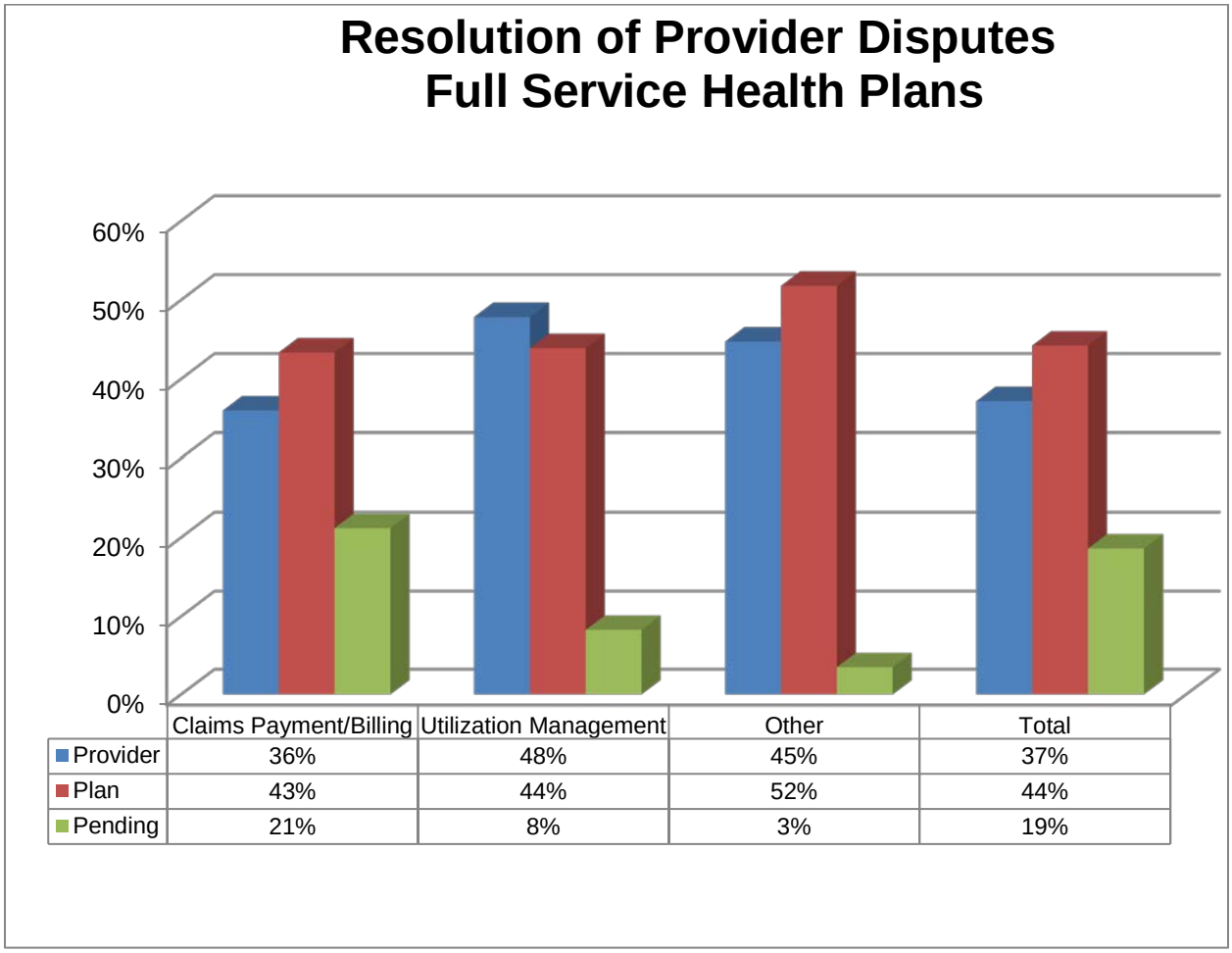
Approximately 85 percent of provider claims processed were paid or adjusted, while 15 percent were contested or denied. Nearly all claims (approximately 98 percent) were processed within 45 working days from the date of receipt.

Over 154 million claims were processed during the reporting period, which resulted in 1,112,573 provider disputes contesting the full service health plans' reimbursement determinations. This represents less than 1 percent (0.73 percent) of all claims processed by full service health plans.

Disposition of Full Service Health Plan Provider Disputes

For the 2016 reporting period, full service health plans reported that 37 percent of all disputes between providers and health plans were resolved in favor of the provider. This was a decrease of 11 percent of disputes resolved in favor of the provider from the 2015 reporting period. Of the 1,112,573 provider disputes submitted 413,623 (37 percent) were resolved in favor of the provider, 491,962 (44 percent) in favor of the plan, and 206,988 (19 percent) were pending review as of September 30, 2016 (See Chart 2). There was an increase of 12 percent to pending disputes compared to 2015. The increase in pending claims this year is due primarily to one health plan that reported a backlog and staffing issues.

Chart 2



	Claims Payment/Billing	Utilization Management	Other	Total
Provider	36%	48%	45%	37%
Plan	43%	44%	52%	44%
Pending	21%	8%	3%	19%

Seven Largest Full Service Health Plans

California's seven largest full service health plans provide health care benefits to approximately 18 million enrollees, representing 74 percent of the approximately 24 million enrollees enrolled in health plans licensed by the DMHC. For the 2016 reporting period, approximately 69 percent of provider disputes were filed with these seven plans. Collectively, they processed more than 126 million claims, accounting for 82 percent of all claims processed by full service health plans in California (See Table 1).

Table 1

Provider Disputes by Plan

Name of Health Plan	Enrollment as of September 30, 2016	Number of Claims Processed	Number of Disputes Received	Resolved Disputes in Favor of the Provider	Resolved Disputes in Favor of the Health Plan	Disputes Pending	Percentage of Disputes Resolved Within 45 Working Days
Anthem Blue Cross	3,238,092	63,565,396	209,964	78,930 (37%)	125,220 (60%)	5,814 (3%)	95%
Blue Shield of California	2,565,906	18,343,462	143,545	45,651 (32%)	73,947 (51%)	23,947 (17%)	96%
Health Net Community Solutions	1.476,544	16,150,546	89,880	31,839 (35%)	22,170 (25%)	35,871 (40%)	66%
Health Net of California, Inc.	995,250	7,255,594	59,851	27,553 (46%)	28,445 (48%)	3,853 (6%)	98%
Inland Empire Health Plan (IEHP)	1,216,646	6,142,714	19,850	7,638 (38%)	10,684 (54%)	1,528 (8%)	99%
Kaiser Foundation Health Plan, Inc.	6,467,723	2,674,629	90,855	23,305 (26%)	42,011 (46%)	25,539 (28%)	77%
LA Care	1,983,145	11,945,599	151,504	16,370 (11%)	47,309 (31%)	87,825 (58%)	22%
Total - Seven Largest Health Plans	**17,943,306**	**126,077,940**	**765,449**	**230,874 (30%)**	**350,198 (46%)**	**184,377 (24%)**	**80%**
All Other Full Service Health Plans	6,369,594	27,826,288	347,124	182,749 (52%)	141,764 (41%)	22,611 (7%)	96%
Total - All Full Service Health Plans	**24,312,900**	**153,904,228**	**1,112,573**	**413,623 (37%)**	**491,550 (44%)**	**206,988 (19%)**	**86%**

In 2016, nine health plans reported noncompliance with the 45 working day requirement to resolve disputes. These health plans provided information on emerging or established patterns payment deficiencies and demonstrated specific actions taken to improve dispute timeliness.

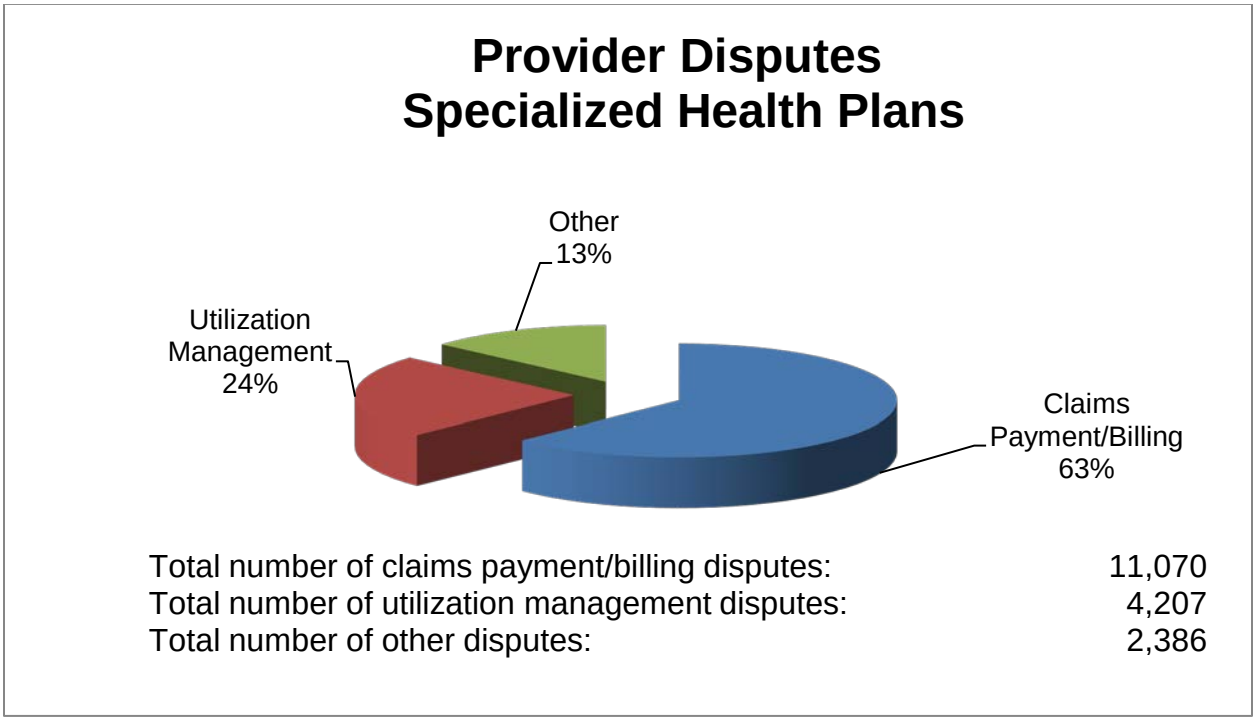
Health plans that fall below the 95 percent compliance requirement are required to file and implement a corrective action plan that is monitored on a quarterly basis by the DMHC and reviewed as part of the health plan's routine financial examination.

IV.

Specialized Health Plans

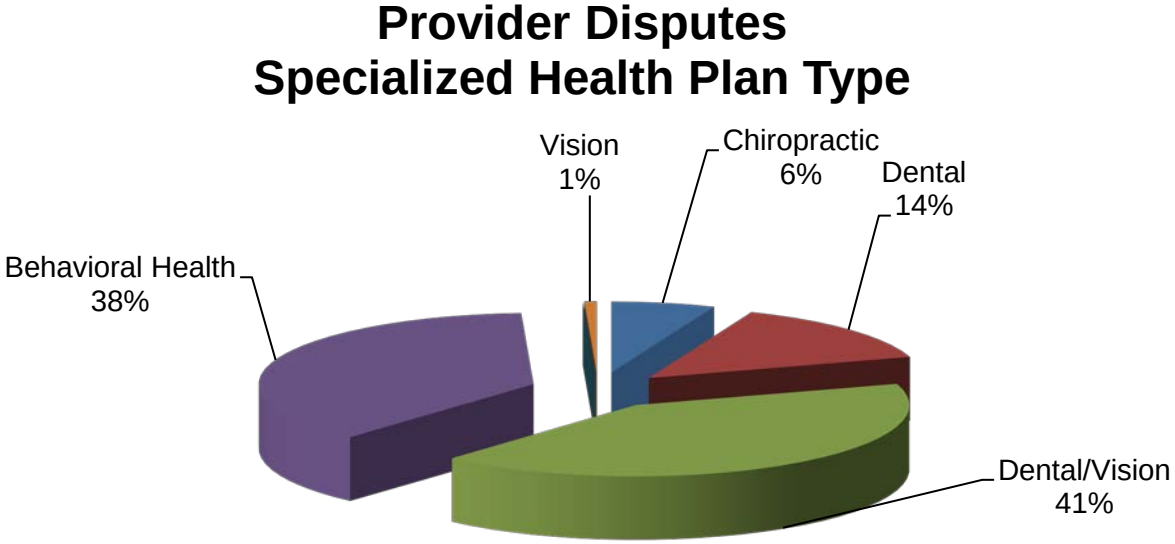
During the 2016 reporting period, California's 42 specialized health plans processed more than 26 million provider claims and received 17,663 provider disputes. Specialized health plans noted a decrease in the number of disputes with 17,663 disputes in 2016 versus 18,182 disputes in 2015. This represents a 3 percent decrease compared to the 2015 reporting period. Of these disputes, 99 percent were resolved within 45 working days from the date of receipt. The majority of provider disputes (63 percent) submitted to specialized health plans involved claims payment/billing disputes. Chart 3 shows the breakdown of provider disputes.

Chart 3



Of the 17,663 total provider disputes submitted to specialized health plans during the 2016 reporting period, dental plans (including dental/vision plans) accounted for more than 56 percent of the disputes, followed by behavioral health plans with 38 percent, chiropractic plans at 6 percent, and vision plans at 1 percent (See Chart 4). The dental plan disputes accounted for 9,805 disputes followed by 6,653 behavioral health disputes.

Chart 4

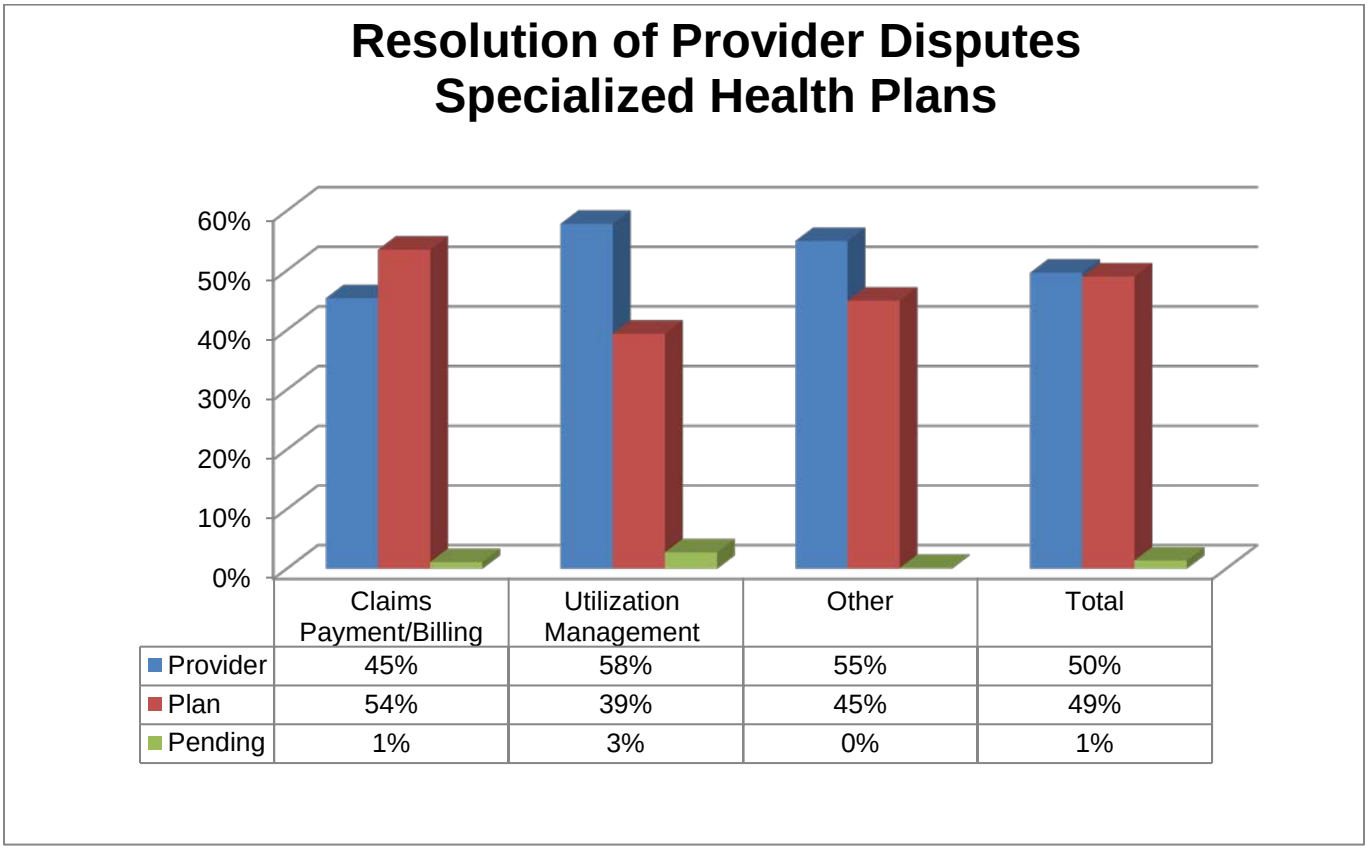


Total disputes by Specialized Plan Type	2016
Dental/Vision	7,320
Behavioral Health	6,653
Dental	2,485
Chiropractic	1,078
Vision	127

Disposition of Specialized Health Plan Provider Disputes

Specialized health plans reported that 50 percent of all provider disputes were resolved in favor of the provider, a three percent decrease from the 2015 reporting period. Forty-five percent of disputes involving claims payment and billing issues were resolved in favor of the provider while 54 percent of disputes were resolved in favor of the plan. Utilization management disputes were resolved in favor of providers 58 percent of the time (See Chart 5).

Chart 5



	Claims Payment/Billing	Utilization Management	Other	Total
Provider	45%	58%	55%	50%
Plan	54%	39%	45%	49%
Pending	1%	3%	0%	1%

V.

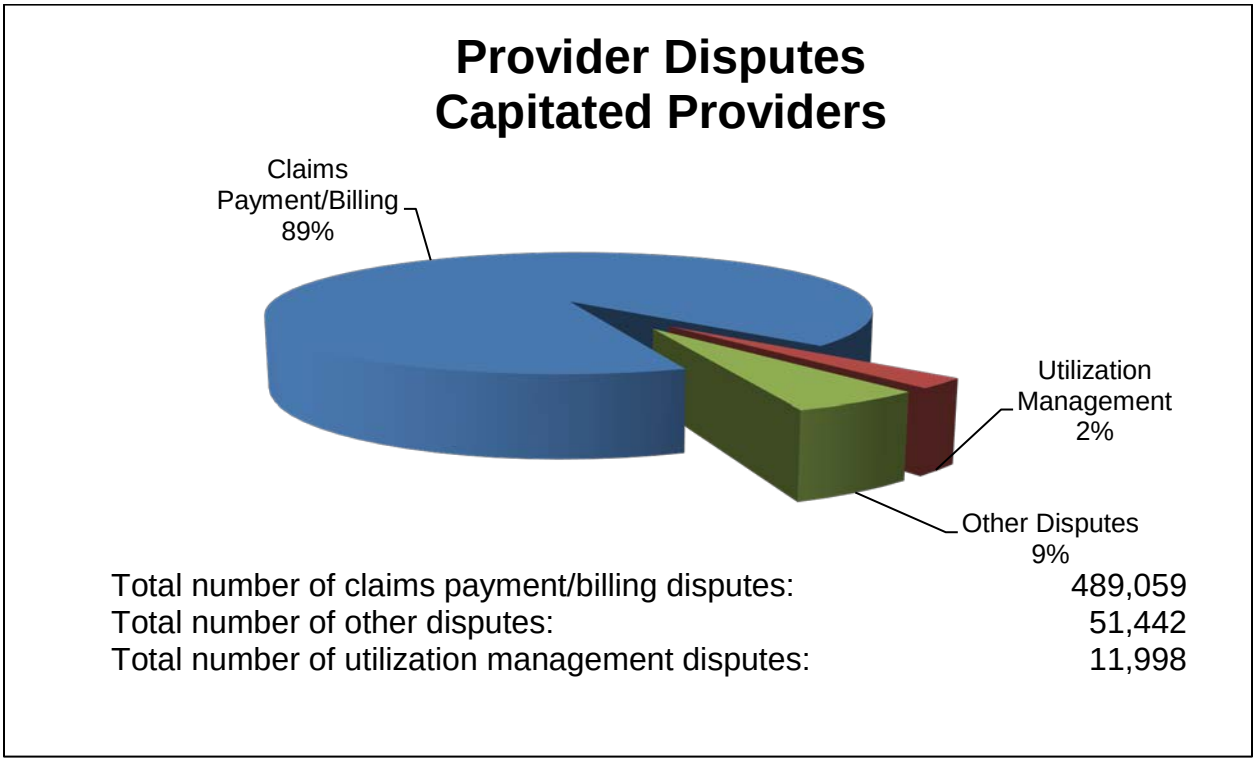
Capitated Providers

All health plans are required to compile and provide a dispute resolution report for each capitated provider. Based upon the number of filings received, the DMHC has identified 289 capitated providers that contracted with full service health plans.

Health plans report a total of 552,499 provider disputes filed with capitated providers during the reporting period. Any capitated provider that is non-compliant with Health and Safety Code section 1371 and California Code of Regulations, Title 28, section 1300.71 criteria must report to the health plan on a quarterly basis. The capitated providers must also file an annual provider disputes report with each of their contracting health plans. Capitated providers are required to follow the same reporting elements as full service and specialized health plans.

Capitated providers processed approximately 64 million claims in 2016. Nearly all provider disputes (89 percent) received by capitated providers involved claim payment and billing issues. Chart 6 reflects the breakdown of provider complaints with capitated providers.

Chart 6



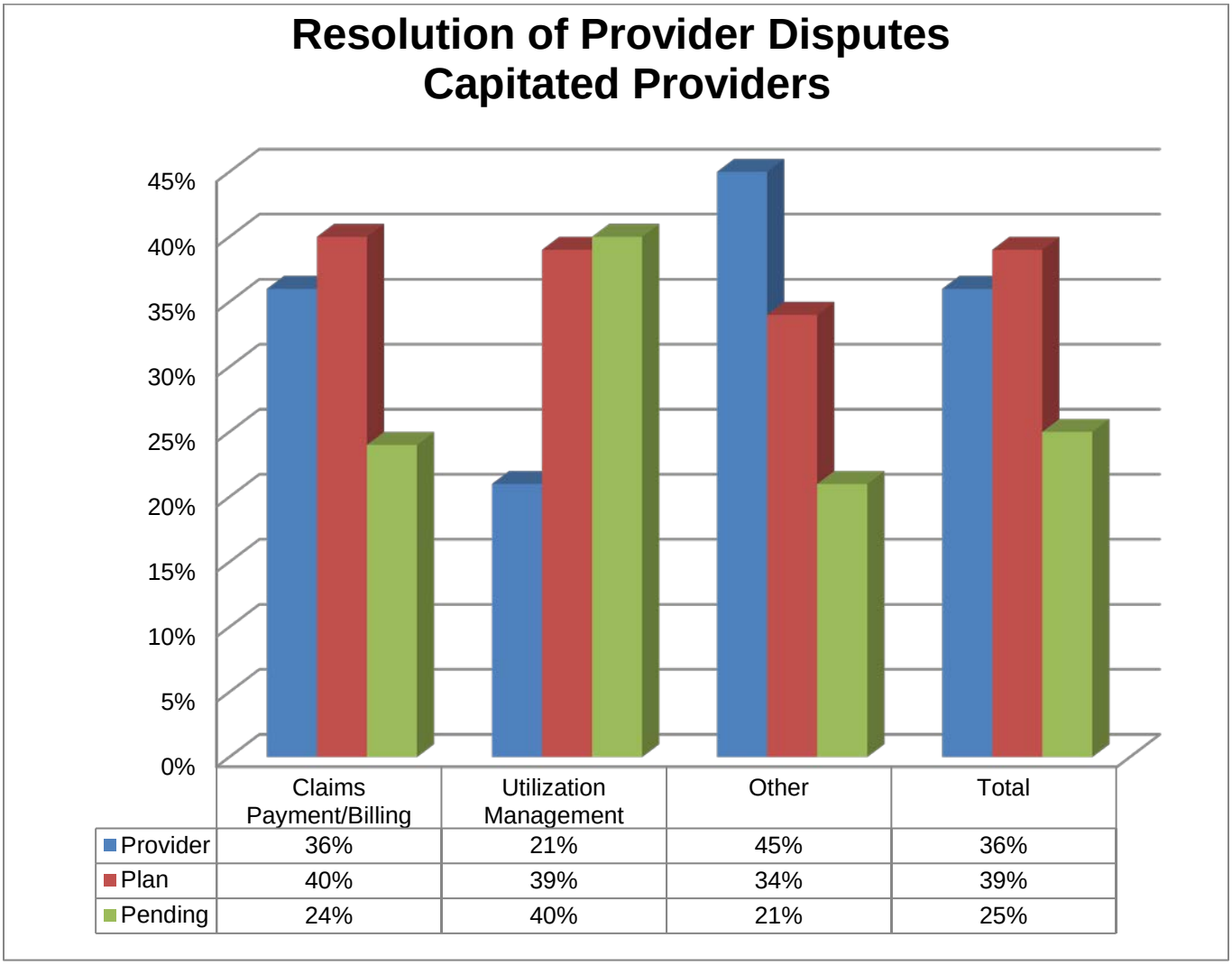
Approximately 92 percent of claims processed were paid or adjusted and 8 percent of the claims processed were contested or denied. In addition, capitated providers processed approximately 99 percent of claims within the 45-day statutory requirement.

For provider disputes not resolved within the prescribed timeframes, the capitated providers self-initiate corrective action plans. These corrective action plans are monitored by the health plans to ensure compliance within the required timeframes.

Disposition of Capitated Providers' Provider Disputes

In 2016, the number of capitated provider disputes increased 4 percent from 2015. Of the 552,499 provider disputes submitted, 36 percent were resolved in favor of the provider submitting the disputes, 39 percent were resolved in favor of the plan, and 25 percent were pending review as of September 30, 2016. Chart 7 illustrates the breakdown by percentages for each category of dispute compared to the total number of disputes.

Chart 7



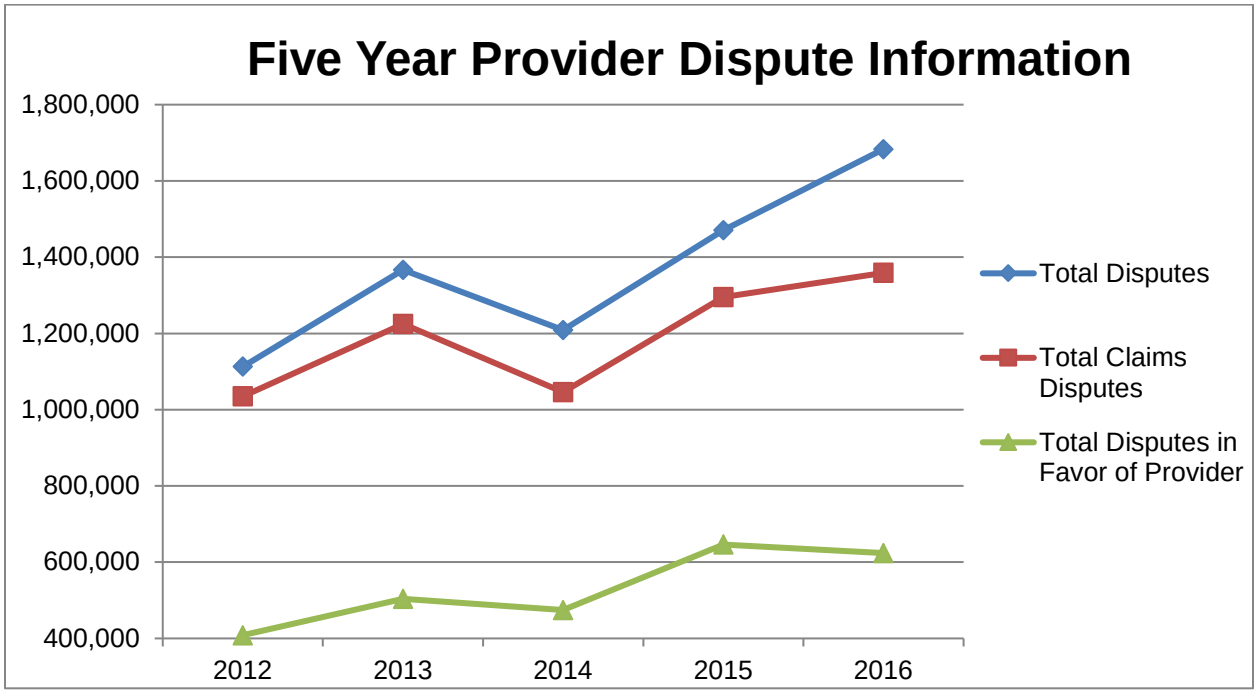
	Claims Payment/Billing	Utilization Management	Other	Total
Provider	36%	21%	45%	36%
Plan	40%	39%	34%	39%
Pending	24%	40%	21%	25%

VI.

Provider Dispute Trends – All Plan Types

Chart 8 displays the trend for the volume of disputes reported by Full Service Plans, Specialized Plans, and Capitated Providers over a five year period. The blue bar represents the total number of disputes reported, the red bar represents total claims disputes reported and the green bar represents the total number of disputes in favor of the provider reported. From 2015 to 2016, the chart shows increases in total disputes, total claims disputes and a minor decrease in total disputes in favor of the provider. In 2012, 37 percent of the disputes received were decided in favor of the provider in contrast to 44 percent in 2015. The trend from 2012 to 2016 shows fluctuation between 37 and 44 percent in the number of overturned provider disputes.

Chart 8



VII.

Summary

The provider dispute resolution data summarized in this report is self-reported by health plans and capitated providers, and may not include all provider disputes. In addition, there are substantive differences in the way health plans identify, quantify and track provider disputes. The DMHC is currently working with the health plans and capitated providers to improve the reporting and quality of the data.

The DMHC conducts regular onsite auditing activities, and reviews quarterly and annual claims payment and dispute resolution reports to monitor the industry's compliance with claims payment standards required by Health and Safety Code section 1371 and California Code of Regulations, title 28, section 1300.71. The DMHC implements appropriate corrective actions for any identified claims payment deficiencies and monitors them accordingly.

The claim and provider dispute examination results are located on the DMHC's website: http://dmhc.ca.gov/LicensingReporting/ViewFinancialExaminationReports/hmoPlan/318.aspx#.WOfawE2gtQs