Health Care Service Plans' Provider Dispute Resolution Mechanisms

2017 Annual Report

May 10, 2018

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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.

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 2017 Provider Dispute Resolution Mechanisms Report summarizes provider claim disputes by type of health plan, including full service and specialized health plans, from October 1, 2016 through September 30, 2017.

KEY FINDINGS

Full Service Health Plans

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 48 licensed full service health plans in California subject to the reporting requirements of section 1375.7(f).[1]

- Health plans processed approximately 156 million claims in the reporting period. Less than one-percent (0.8 percent) of these claims resulted in claims disputes.

- Full service health plans received more than one million provider disputes for the reporting period.

- Approximately 95 percent of all provider disputes processed by full service health plans were reported as being resolved within 45 working days.

[1] There were 74 licensed full service health plans at September 30, 2017. However, provider dispute information from 48 full service health plans are included in this report. Twenty-six licensed full service health plans are excluded from the report because they are licensed only for Medicare products or are operating as a county organized health system, exempt from Health and Safety Code section 1367(h), or recently licensed health plans that do not currently have enrollment.

- Approximately 87 percent of provider disputes filed with full service health plans involved claims payment issues.

- Providers prevailed in 43 percent of all disputes; health plans upheld their original determinations in 47 percent of the disputes. Ten percent of the disputes were 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 of section 1375.7(f).

- Specialized health plans processed approximately 28 million claims in the reporting period. Less than one-half of one percent (0.04 percent) of these claims were the subject of a claim payment dispute.

- Specialized health plans received 20,566 provider disputes for the reporting period.

- Specialized health plans reported 52 percent of all provider disputes were resolved in favor of the provider and 49 percent were upheld by the plans.

- Approximately 61 percent of provider disputes with specialized health plans involved claims payment issues.

Capitated Providers

Capitated Providers are providers such as hospitals, risk bearing organzations (RBOs), or other provider groups, 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 266 capitated providers or provider groups.

- Capitated providers processed approximately 67 million claims and received 584,184 provider disputes in the reporting period.

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

- Thirty-five 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.[2]

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 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, 2016 through September 30, 2017.

[2] See California Code of Regulations, Title 28, sections 1300.71 and 1300.71.38.

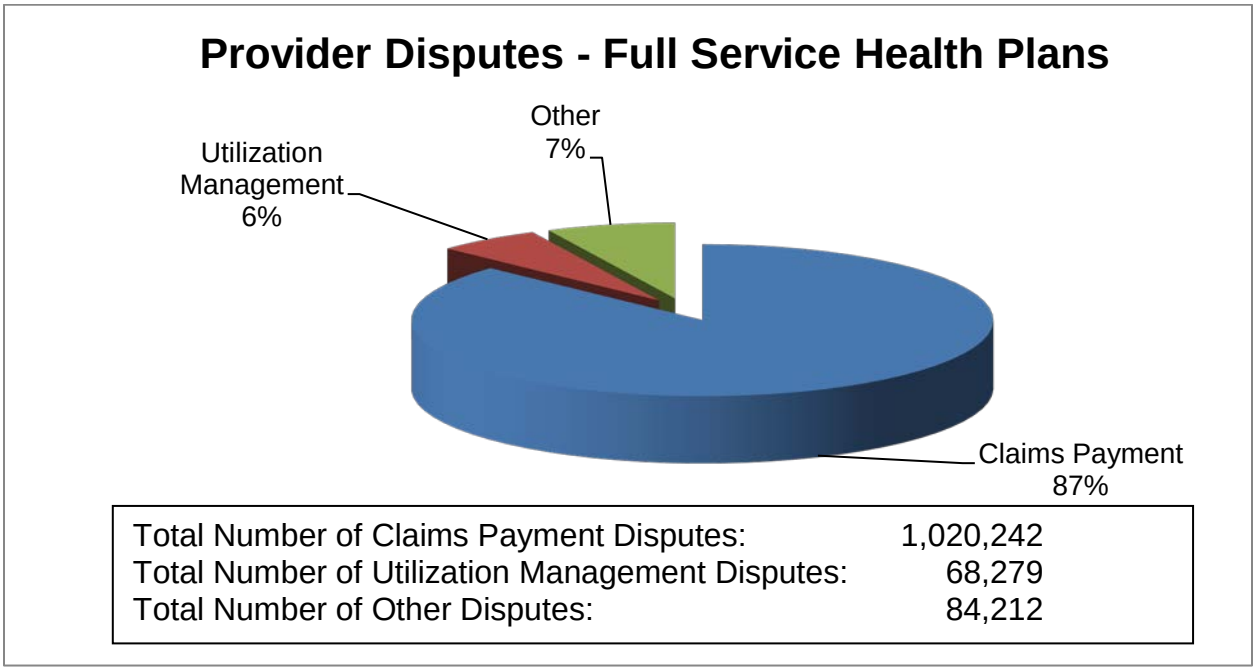
III. Full Service Health Plans

Of the 74 licensed full service health plans, data from 48 full service health plans are included in this report. Twenty-six licensed full service health plans are excluded from the report because they are licensed only for Medicare products or are operating as a county organized health system, exempt from Health and Safety Code section 1367(h), or recently licensed health plans that do not currently have enrollment.

The 48 full service health plans reported approximately 156 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 1,172,733 provider disputes during the 2017 reporting period. This represents a five percent increase in disputes over the 2016 reporting period.

Claims payment/billing disputes, which primarily involve claims of inadequate reimbursement, comprised 87 percent of the full service health plan provider disputes (See Chart 1).

Chart 1



Regulations require the health plans to resolve 95 percent of all complete provider disputes within 45 working days. Collectively, the full service health plans reported that 95 percent of all provider disputes were resolved within 45 working days. This is a nine percent improvement from the prior year.

Eight health plans reported noncompliance with the 45 working day requirement to resolve disputes. Health plans that fall below the 95 percent compliance requirement

are required to file and implement a corrective action plan that is monitored by the DMHC quarterly and reviewed as part of the health plan's routine financial examination.

Deficient health plans reported that timeliness standards were not met due to a variety of factors. These factors include staffing issues, higher than expected claims volume, and claims system updates. Health plans have indicated that corrective action plans have been instituted to improve claims 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. Corrective action plans appear to be working as health plans collectively improved their timeliness standards from 86 percent in 2016 to 95 percent in 2017.

Provider Disputes Compared to Claims

Approximately 85 percent of provider claims processed were paid or adjusted by the health plans, and 15 percent were contested or denied. Nearly all claims (approximately 98 percent) were processed within 45 working days.

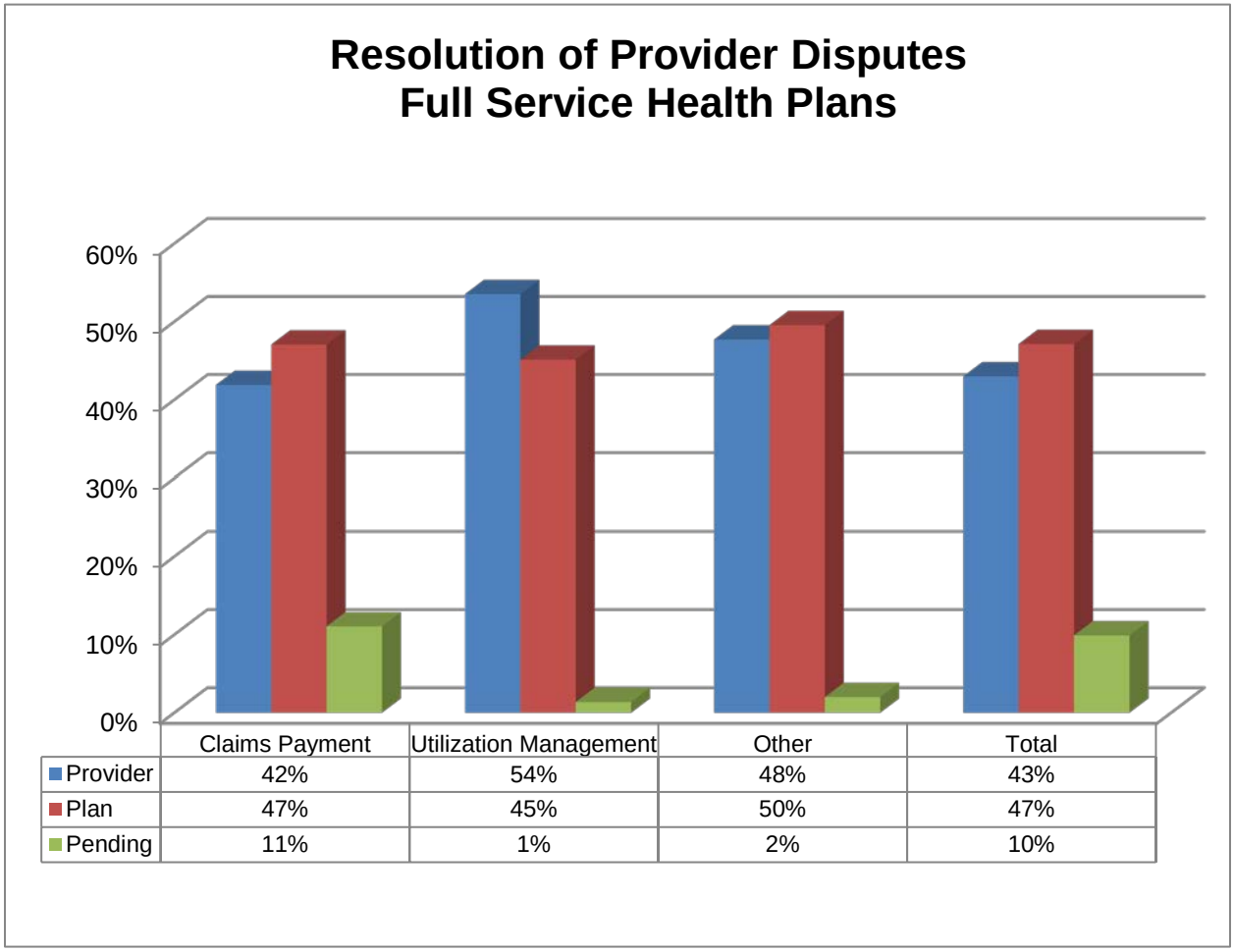
Approximately 156 million claims were processed during the reporting period. Over one million (1,172,733) claims were contested. This represents less than one percent (0.8 percent) of all claims processed by full service health plans.

Disposition of Full Service Health Plan Provider Disputes

For the 2017 reporting period, full service health plans reported that 43 percent of all disputes between providers and health plans were resolved in favor of the provider. This was an increase of six percent from the 2016 reporting period.

Of the 1,172,733 provider disputes submitted 504,043 (43 percent) were resolved in favor of the provider, 552,653 (47 percent) in favor of the plan, and 116,037 (10 percent) were pending review as of September 30, 2017 (See Chart 2). There was a nine percent decrease in pending disputes at the end of the 2017 reporting period compared to 2016.

Chart 2



	Claims Payment	Utilization Management	Other	Total
Provider	42%	54%	48%	43%
Plan	47%	45%	50%	47%
Pending	11%	1%	2%	10%

Seven Largest Full Service Health Plans

California's seven largest full service health plans[3] provide health care benefits to approximately 19 million enrollees, representing 73 percent of the approximately 26 million enrollees enrolled in health plans licensed by the DMHC. For the 2017 reporting period, approximately 64 percent of provider disputes were filed with these seven plans. Collectively, they processed approximately 121 million claims, accounting for 78 percent of all claims processed by full service health plans in California (See Table 1).

[3] California's seven largest full service health plans are Blue Cross of California (Anthem Blue Cross), California Physicians' Service (Blue Shield of California), Health Net Community Solutions, Inc., Inland Empire Health Plan (IEHP), Kaiser Foundation Health Plan (Kaiser Permanente), Local Intiative Health Authority of L.A. County (L.A. Care Health Plan), and UHC of California (UnitedHealthCare of California).

Table 1

Provider Disputes by Health Plan

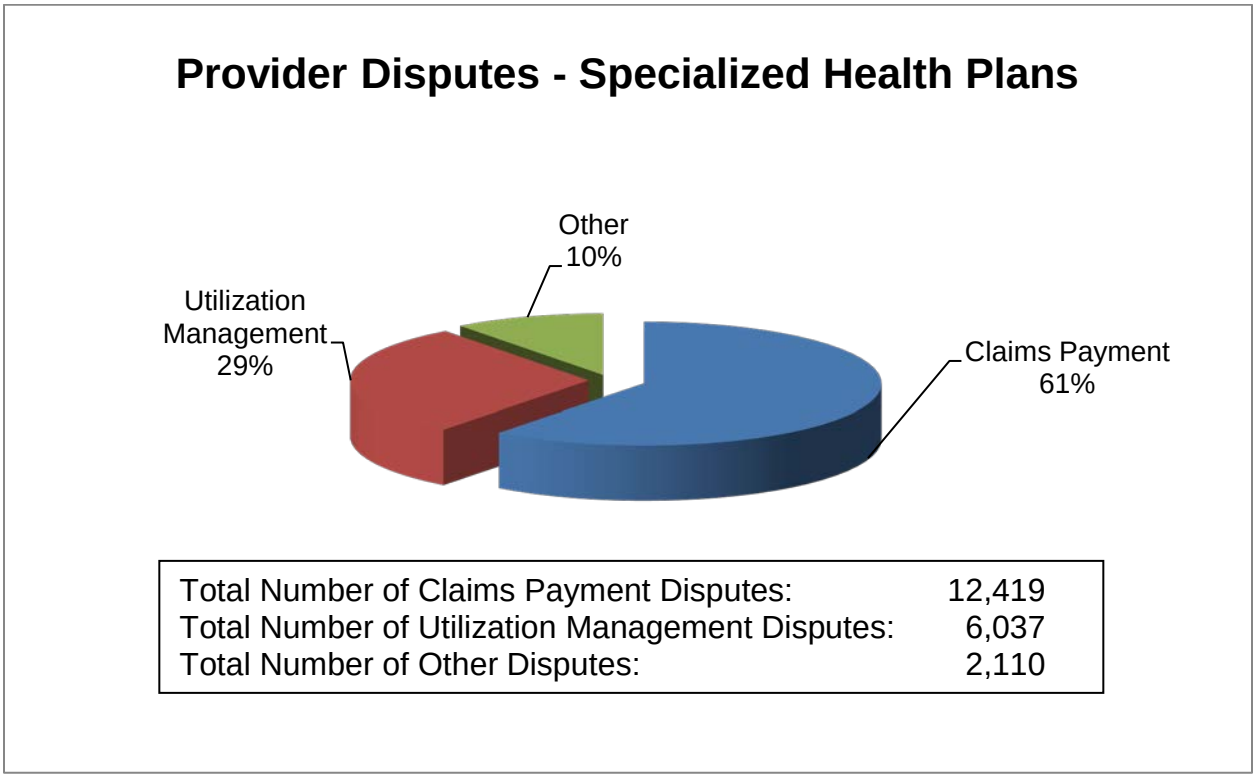
Health Plan	Enrollment as of 9/30/17	Number of Claims Processed	Number of Disputes Received	Resolved Disputes in Favor of the Provider	Resolved Disputes in Favor of the Health Plan	Disputes Pending	Percentage of Disputes Resolved Within 45 Working Days
Anthem Blue Cross	2,923,566	59,064,466	190,805	88,390 (46%)	101,966 (53%)	449 (1%)	91%
Blue Shield of California	2,358,623	18,817,508	204,515	63,625 (31%)	113,637 (56%)	27,253 (13%)	98%
Health Net Community Solutions, Inc.	1,518,268	17,175,538	59,146	33,331 (56%)	17,975 (31%)	7,840 (13%)	96%
Inland Empire Health Plan (IEHP)	1,429,298	7,172,114	40,400	22,979 (57%)	16,366 (40%)	1,055 (3%)	99%
Kaiser Foundation Health Plan, Inc.	7,868,869	3,156,523	128,503	23,930 (19%)	65,432 (51%)	39,141 (30%)	87%
LA Care Health Plan	2,130,419	14,527,964	109,628	46,544 (42%)	46,716 (43%)	16,368 (15%)	97%
UHC of California	872,233	752,424	12,918	6,496 (50%)	6,418 (49%)	4 (1%)	96%
Total - Seven Largest Health Plan	19,101,276	120,666,537	745,915	285,295 (38%)	368,510 (50%)	92,110 (12%)	94%
All Other Full Service Health Plans	7,222,189	35,002,620	426,818	218,748 (51%)	184,143 (43%)	23,927 (6%)	95%
Total - All Full Service Health Plans	26,323,465	155,669,157	1,172,733	504,043 (43%)	552,653 (47%)	116,037 (10%)	95%

IV. Specialized Health Plans

Of the 46 licensed specialized health plans, data from 42 specialized health plans are included in this report. Four health plans are excluded because three are licensed only for Medicare, and therefore are exempt from Health and Safety Code section 1367(h), and one health plan ceased operations in 2017.

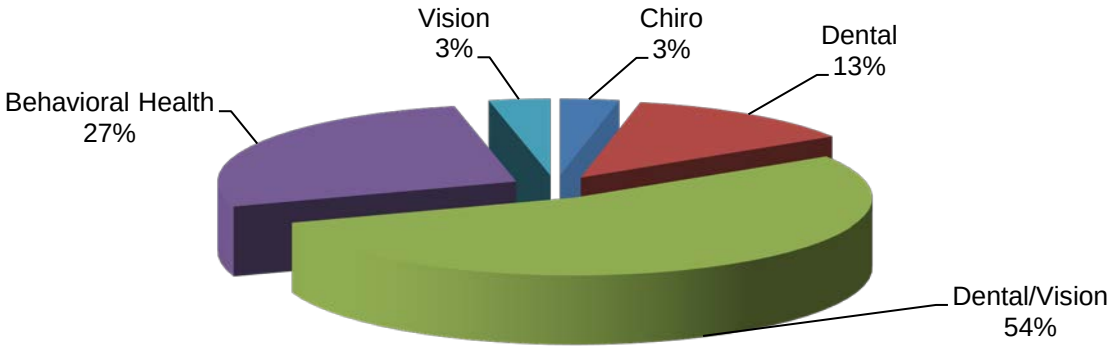
The 42 specialized health plans processed approximately 28 million provider claims and received 20,566 provider disputes. Specialized health plans had a 16 percent increase in the number of disputes in the 2017 reporting period compared to 2016. Ninety-nine percent of the provider disputes were resolved within 45 working days. The majority of provider disputes submitted to specialized health plans involved claims payment disputes. Chart 3 shows the breakdown of provider disputes.

Chart 3



Of the 20,566 total provider disputes submitted to specialized health plans during the 2017 reporting period, dental plans (including dental/vision plans) accounted for approximately 67 percent of the disputes, followed by behavioral health plans with 27 percent, chiropractic plans with three percent, and vision plans with three percent (See Chart 4). Dental plans accounted for approximately 60 percent of total enrollment for specialized health plans required to report.

Chart 4

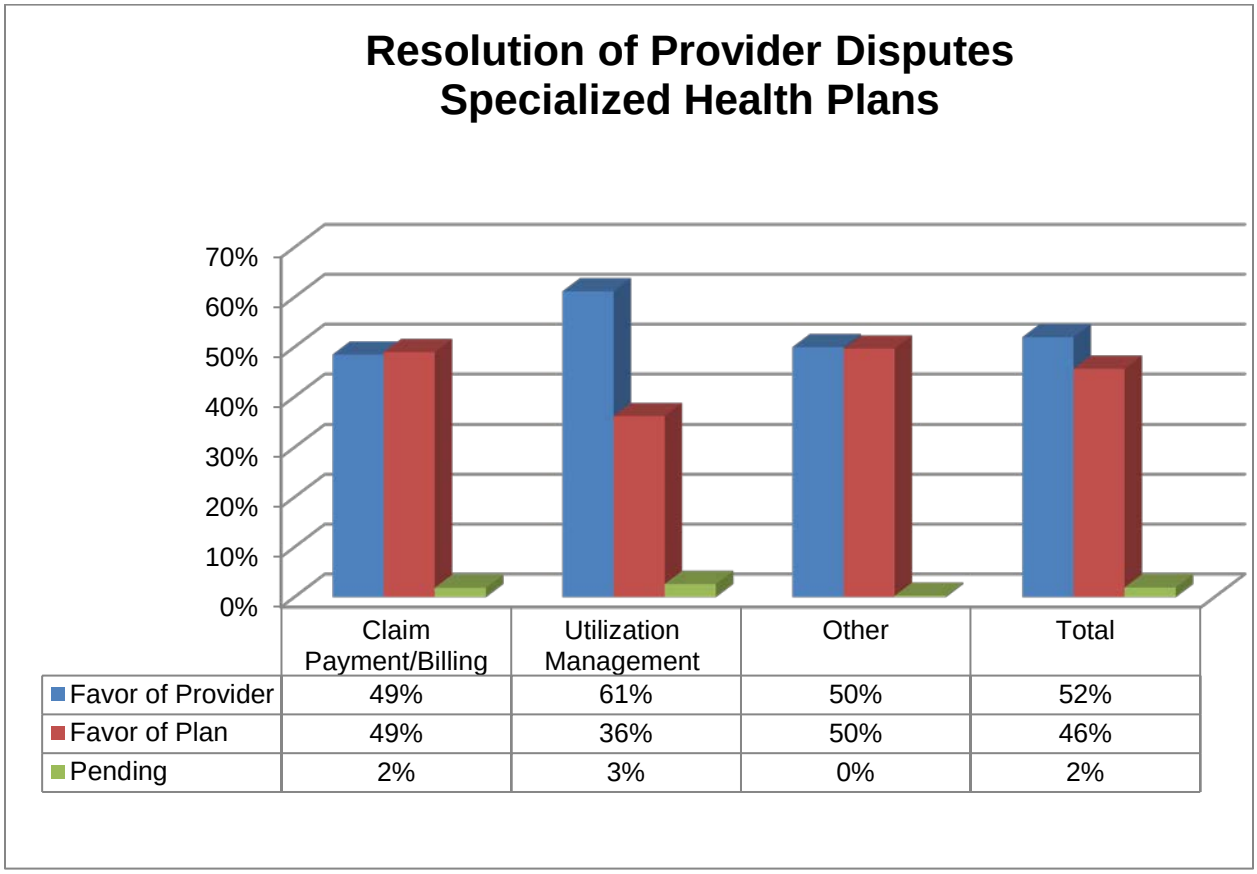


Total Disputes by Specialized Plan Type	2017
Dental/Vision	11,047
Behavioral Health	5,542
Dental	2,633
Chiropractic	659
Vision	685

Disposition of Specialized Health Plan Provider Disputes

Specialized health plans reported 52 percent of all provider disputes were resolved in favor of the provider, a two percent increase from the prior year. Forty-nine percent of disputes involving claims payment and billing issues were resolved in favor of the provider while 49 percent of disputes were resolved in favor of the plan, and the remaining two percent were pending at year-end. Utilization management disputes were resolved in favor of providers 61 percent of the time and 36 percent were in favor of the plan. Three percent were pending at year-end. Other disputes were split with 50 percent in favor of the provider and 50 percent in favor of the plan (See Chart 5).

Chart 5



	Claim Payment/Billing	Utilization Management	Other	Total
Favor of Provider	49%	61%	50%	52%
Favor of Plan	49%	36%	50%	46%
Pending	2%	3%	0%	2%

V. Capitated Providers

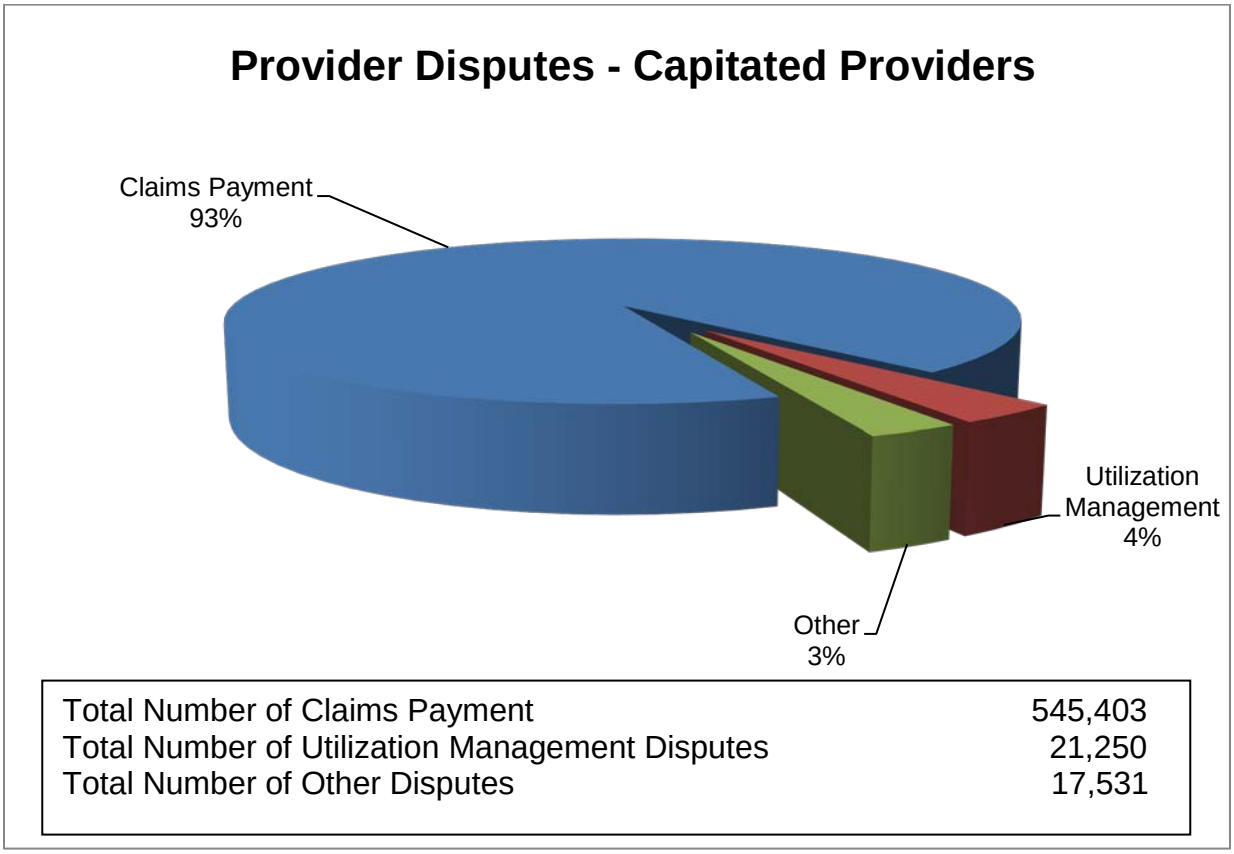
Generally, capitated providers fall within two main categories: (1) medical groups and Independent Practice Associations (IPAs); and (2) hospital systems that receive capitation from health plans, and in turn pay provider claims for health care services rendered to the plan's enrollees. Capitation is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

All health plans are required to compile and provide a dispute resolution report for each capitated provider or provider group. Based upon the number of filings received, the DMHC has identified 266 capitated providers that were contracted with full service health plans.

Health plans report a total of 584,184 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. Capitated providers must also file an annual provider dispute report with each of its contracting health plans. Capitated providers are required to follow the same reporting elements as full service and specialized health plans.

Capitated providers processed approximately 67 million claims in the 2017 reporting period. Ninety-three percent of provider disputes involved claim payment and billing issues. Chart 6 reflects the breakdown of provider disputes.

Chart 6



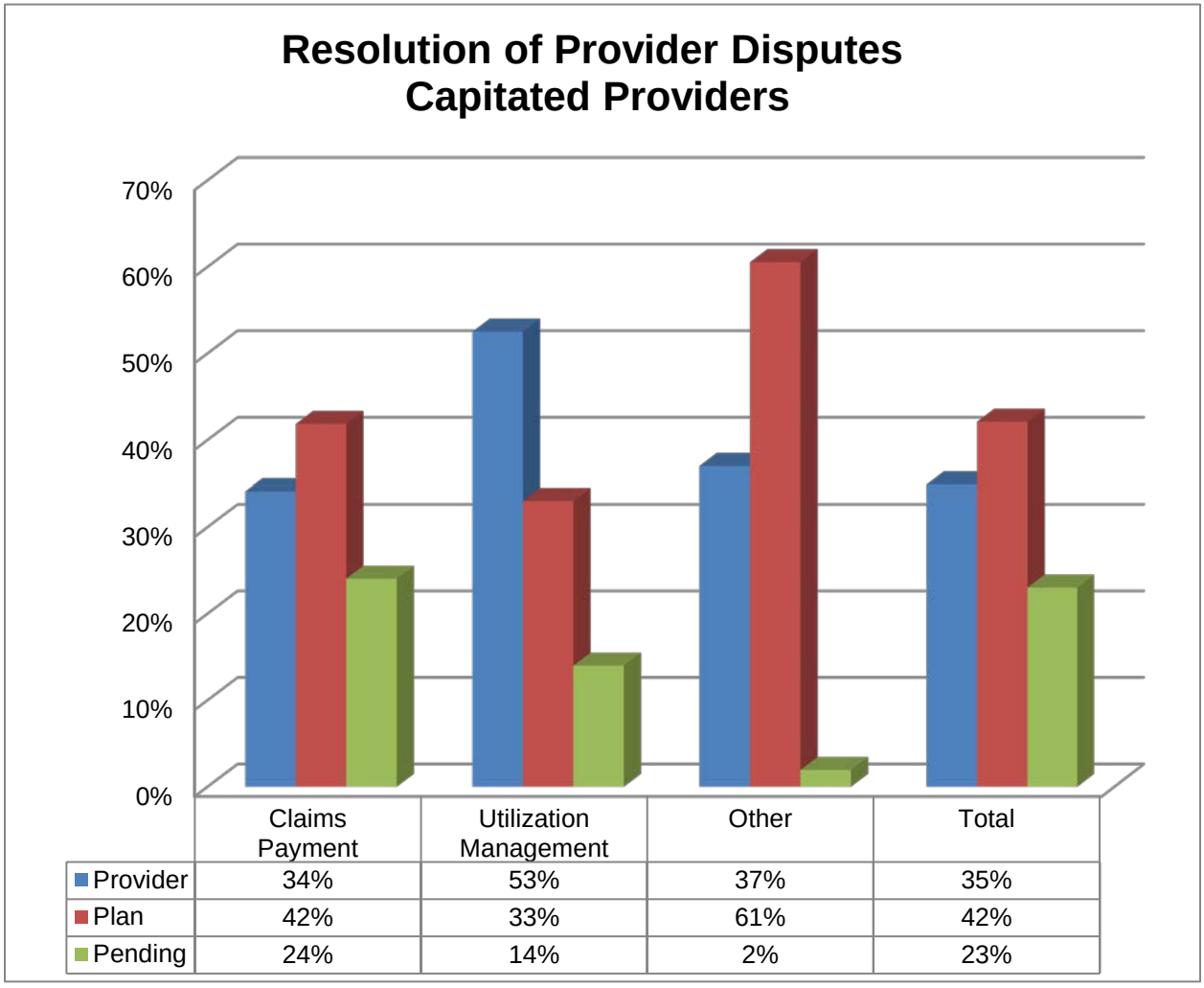
Total Number of Claims Payment	545,403
Total Number of Utilization Management Disputes	21,250
Total Number of Other Disputes	17,531

Approximately 87 percent of all claims processed were paid or adjusted and 13 percent of the claims processed were contested or denied. 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

The number of capitated provider disputes increased six percent in the 2017 reporting period compared to 2016. Of the 584,184 provider disputes submitted, 35 percent were resolved in favor of the provider, 42 percent were resolved in favor of the plan, and 23 percent were pending review as of September 30, 2017. Chart 7 illustrates the breakdown by percentages for each category of dispute compared to the total number of disputes.

Chart 7



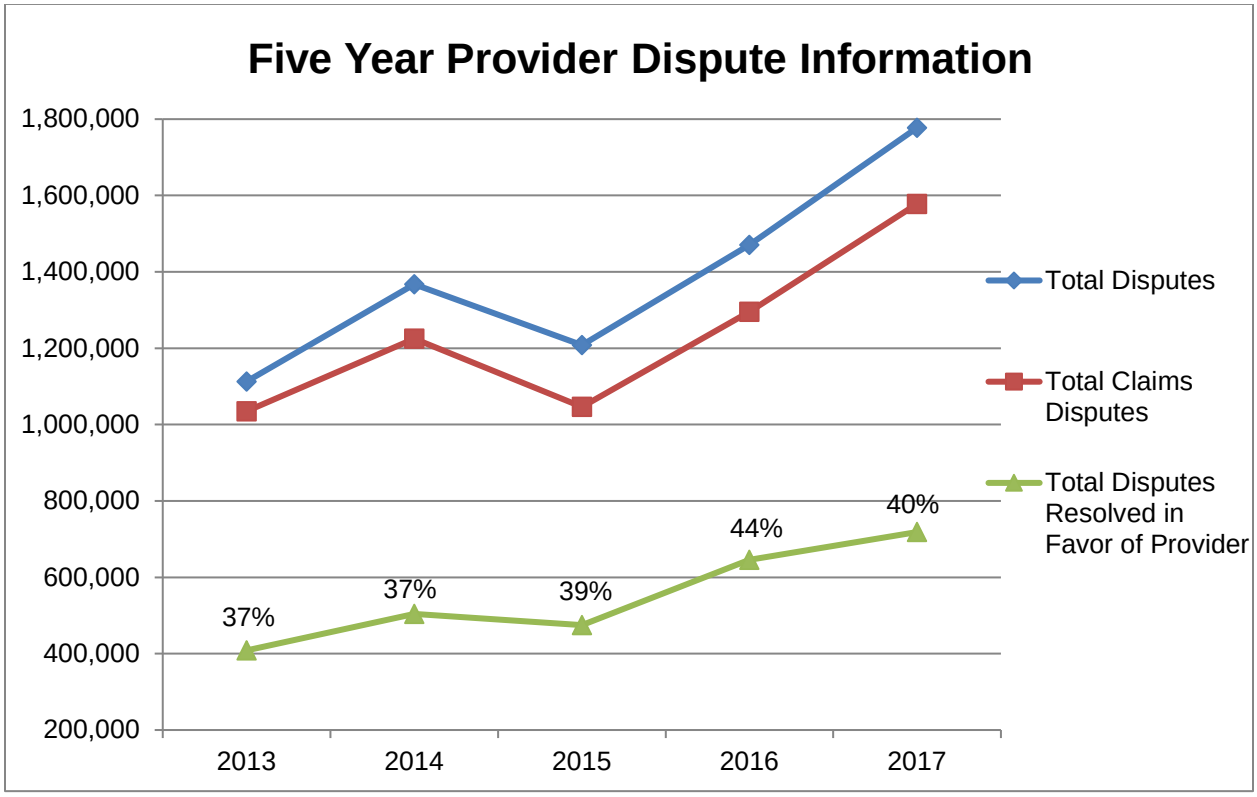
	Claims Payment	Utilization Management	Other	Total
Provider	34%	53%	37%	35%
Plan	42%	33%	61%	42%
Pending	24%	14%	2%	23%

VI. Provider Dispute Trends

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.

From 2016 to 2017, provider disputes increased from 1.5 million to 1.8 million, a 21 percent increase. The number of disputes resolved in favor of the provider has fluctuated between 37 and 44 percent over the five year period. For 2017, 40 percent of provider disputes were resolved in favor of the provider.

Chart 8



VII. Summary

In general, health plans report resolving most provider disputes (95%) within the required 45 day time frame, a 9% improvement over the prior reporting period. Health plan provider disputes resolved in favor of the provider increased by 6% in the 2017 reporting period compared to 2016. Providers prevailed in 43 percent of the disputes they filed with the health plans.

More than half (52%) of provider disputes filed with specialized plans were resolved in favor of the provider.

Approximately 35% of provider disputes filed with capitated providers were resolved in favor of the provider with approximately 23% of these disputes pending as of September 30, 2017.

The provider dispute resolution data summarized in this report is self-reported by health plans and capitated providers. There may be substantive differences in the way health plans and capitated providers 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.

Providers who are not satisfied with the resolution of their disputes may contact the DMHC Provider Complaint Unit. Additional information regarding the provider complaint process can be found on the DMHC's website: http://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan/SubmitaProviderComplaint.aspx.

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