



Arnold Schwarzenegger, Governor
State of California
Business, Transportation and Housing Agency

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September 24, 2009

In reply refer to file No. 933 0055
Via Federal Express and E-Mail

George Halvorson, Chairman of the Board & Chief Executive Officer
Kaiser Foundation Health Plan, Inc.
One Kaiser Plaza
Oakland, CA 94612

**RE: FINAL REPORT OF THE NON-ROUTINE EXAMINATION OF KAISER
FOUNDATION HEALTH PLAN, INC.**

Dear Mr. Halvorson:

Enclosed is the Final Report of the Non-Routine Examination of Kaiser Foundation Health Plan, Inc. (the "Plan") conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").¹ The Department issued a Preliminary Report to the Plan on February 24, 2009. The Plan filed responses with the Department on April 10, 2009, April 14, 2009 and September 15, 2009. In addition, the Plan filed a progress report regarding its corrective actions on July 29, 2009.

The purpose of the examination was to verify representations made to the Department by the Plan in response to the Department's Preliminary Report of the Routine Examination, dated August 3, 2007, and Final Report dated November 26, 2007. The Department accepted the Plan's electronically filed responses on September 17, 2007, September 24, 2007, October 26, 2007, December 6, 2007, December 24, 2007, January 18, 2008, February 15, 2008, March 17, 2008, April 16, 2008, September 15, 2008, December 26, 2008 and July 2, 2009.

This examination involved reviewing the Plan's corrective action plan to resolve deficiencies found in claim reimbursements, claim denials, interest payments on late claims and late provider dispute payments identified in the prior routine examination.

This Final Report includes a description of the compliance efforts included in the Plan's April 10, 2009, April 14, 2009 and September 15, 2009 responses, in accordance with Section 1382 (c).

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

Section 1382 (d) states “If requested in writing by the plan, the director shall append the plan’s response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public.”

Please indicate within ten (10) days whether the Plan requests the Department to append its April 10, 2009, April 14, 2009 and September 15, 2009 responses to the Final Report. If so, please indicate which portions of the Plan’s responses shall be appended and provide a copy (electronically) of those portions of the Plan’s responses exclusive of information held confidential pursuant to Section 1382 (c), no later than ten (10) days from the date of the Plan’s receipt of this letter.

If the Plan requests the Department to append a brief statement summarizing the Plan’s April 10, 2009, April 14, 2009 and September 15, 2009 responses to the report or wishes to modify any information provided to the Department in its responses, please provide the electronically filed documentation no later than ten (10) days from the date of the Plan’s receipt of this letter through the eFiling web portal.

Please file this addendum electronically via the Department's eFiling web portal <https://wps0.dmhc.ca.gov/secure/login/>, as follows:

- From the main menu, select “eFiling”.
- From the eFiling (Home) menu, select “File Documents”.
- From the File Documents Menu for:
 - 1) File Type; select “Amendment to prior filing”;
 - 2) Original Filing, select the Department’s assigned “Filing No. 20081267” by clicking on the down arrow; and
 - 3) Click “create filing”.
- From the Original Filing Details Menu, click “Upload Amendments”; select # of documents; select document type: “Plan addendum response to Final Report (FE5)”; then “Select File” and click “Upload”.
- Upload all documents then upload a cover letter as Exhibit E-1 that references to your response. After upload, then select “Complete Amendment”,
- Select a “Signatory,”
- Complete “Execution” and then click “complete filing”.

As noted in the attached Final Report, the Plan’s April 10, 2009, April 14, 2009 and September 15, 2009 responses did not fully resolve the deficiencies cited and the corrective actions required in the Preliminary Report issued by the Department on February 24, 2009. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for these unresolved issues, within thirty (30) days of receipt of this report. If the Plan fails to fully respond and/or resolve the deficiencies addressed in the Final Report, a referral will be made to the Office of Enforcement for appropriate administrative action for any remaining, unresolved deficiencies.

Please file the Plan's response to the Final Report electronically via the Department's eFiling web portal <https://wpsso.dmhc.ca.gov/secure/login/>, as follows:

- From the main menu, select “eFiling”.
- From the eFiling (Home) menu, select “File Documents”.
- From the File Documents Menu for:
 - 1) File Type; select “Amendment to prior filing”;
 - 2) Original Filing, select the Department’s assigned “Filing No. 20081267” by clicking on the down arrow; and
 - 3) Click “create filing”.
- From the Original Filing Details Menu, click “Upload Amendments”; select # of documents; select document type: " Plan’s Response to Final Report (FE10)"; then “Select File” and click “Upload”.
- Upload all documents then upload a cover letter as Exhibit E-1 that references to your response. After upload, then select “Complete Amendment”,
- Select a “Signatory,”
- Complete “Execution” and then click “complete filing”.

Questions or problems related to the electronic transmission of the response should be directed to Siniva Pedro at (916) 322-5393 or email at spedro@dmhc.ca.gov. You may also email inquiries to wpsso@dmhc.ca.gov.

The Department will make the attached Final Report available to the public in ten (10) days from the Plan’s receipt of this letter.

The Executive Summary to the Department’s most recent Plan Survey Report is located at the Department’s web site at www.dmhc.ca.gov.

If there are any questions regarding this report, please contact me.

Sincerely,

ORIGINAL SIGNED BY

JANET NOZAKI
Supervising Examiner
Office of Health Plan Oversight
Division of Financial Oversight

ng:jn

cc: Tim Le Bas, Assistant Deputy Director, Office of Health Plan Oversight
Amy Dobberteen, Assistant Deputy Director, Office of Enforcement
Marcy Gallagher, Chief, Division of Plan Surveys
Elizabeth Spring, Counsel, Division of Licensing
Sang Le, Senior Examiner, Division of Financial Oversight
Ned Gennaoui, Senior Examiner, Division of Financial Oversight



DIVISION OF FINANCIAL OVERSIGHT

**FINAL REPORT OF
THE NON-ROUTINE EXAMINATION OF
KAISER FOUNDATION HEALTH PLAN, INC.**

FILE NO. 933 0055

DATE OF FINAL REPORT: SEPTEMBER 24, 2009

SUPERVISING EXAMINER: JANET NOZAKI

EXAMINER-IN-CHARGE: NED GENNAOUI

FINANCIAL EXAMINERS:

**JAMEY MATALKA
SUSAN MILLER
GALAL GADO
SANG LE**

BACKGROUND INFORMATION FOR KAISER FOUNDATION HEALTH PLAN, INC.

Date Plan Licensed: October 27, 1977

Organizational Structure: Kaiser Foundation Health Plan, Inc. (“Plan”) is a nonprofit, public benefit corporation, licensed as a Knox-Keene plan and as a federally qualified HMO. The Plan is one of the organizations that comprise the Kaiser Permanente Medical Care Program. The other organizations are Kaiser Foundation Hospitals, The Permanente Medical Group, and Southern California Permanente Medical Group.

Type of Plan: A health care service plan providing the full range of health benefits, including hospital, medical and pharmacy, to commercial, Medicare and Medi-Cal members.

Provider Network: Integrated care model offering health care services through a network of hospitals and physician practices operating under the Kaiser Permanente name. Compensation arrangements include capitation, discounted fee for service, per diem and case rate basis.

Plan Enrollment: 6,754,938 as of June 30, 2009

Service Area: Major counties within California.

Date of Last Final Routine Financial Examination Report: November 26, 2007

**FINAL REPORT OF THE NON-ROUTINE EXAMINATION OF
KAISER FOUNDATION HEALTH PLAN, INC.**

This is the Final Report of the Non-Routine Examination of Kaiser Foundation Health Plan, Inc. (the "Plan") conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").¹ The Department issued a Preliminary Report to the Plan on February 24, 2009. The Plan filed responses with the Department on April 10, 2009, April 14, 2009 and September 15, 2009. In addition, the Plan filed a progress report regarding its corrective actions on July 29, 2009.

This Final Report includes a description of the compliance efforts included in the Plan's April 10, 2009, April 14, 2009 and September 15, 2009 responses, in accordance with Section 1382 (c). The Plan's responses are noted in *italics*.

The purpose of the examination was to verify representations made to the Department by the Plan in response to the Department's Preliminary Report of the Routine Examination, dated August 3, 2007, and Final Report dated November 26, 2007. The Department accepted the Plan's electronically filed responses on September 17, 2007, September 24, 2007, October 26, 2007, December 6, 2007, December 24, 2007, January 18, 2008, February 15, 2008, March 17, 2008, April 16, 2008, September 15, 2008, December 26, 2008 and July 2, 2009.

This examination involved reviewing the Plan's corrective action plan to resolve deficiencies found in claim reimbursements, claim denials, interest payments on late claims and late provider dispute payments identified in the prior routine examination.

Our findings are presented in the accompanying attachment as follows:

Section I.	Compliance Issues
Section II.	Internal Control
Section III.	Non-Routine Examination

Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for the corrective actions requested in this report, within 30 days after receipt of this report

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

SECTION I. COMPLIANCE ISSUES

A. PROVIDER DISPUTE VIOLATIONS

Rule 1300.71.38 (m)(2) states that the failure of a plan to comply with the requirements of a fast, fair and cost-effective dispute resolution mechanism shall be a basis for disciplinary action against the plan.

The Department's examination found that the Plan failed to comply with the requirements of a fast, fair and cost-effective dispute resolution mechanism as summarized in the table below:

SOUTHERN CALIFORNIA REGION

Deficiency	Section/Rule Violated	Type of Claim in Sample	Total Claims in the Sample Population	Total Claims in the Sample	Number of Deficiencies Found	% of Compliance
Interest and penalties not paid on late claims payments resulting from provider disputes	Sections 1371 and 1371.35 and Rules 1300.71 and 1300.71.38 (g)	Overtured Late PDR	6,509	50	8	84%

On February 20, 2009, the Plan filed a signed acknowledgement with the Department that stated the following:

“Kaiser Foundation Health Plan, Inc. (the Plan) acknowledges that it has deficiencies in its provider dispute resolution procedures, operations and related finalization processes which have resulted in the incorrect payment of interest and penalties on an unacceptable number of late claim payments resulting from provider disputes. The Plan has requested that the Department of Managed Health Care (the Department) discontinue its testing for interest and penalty payments on late claim payments resulting from provider disputes in light of the Plan’s acknowledgement of these deficiencies and the Plan acknowledges that the Department agreed to do so in reliance upon this document. The Plan further acknowledges its commitment to correcting the deficiencies cited herein in accordance with requirements set forth in applicable provisions of the Knox-Keene Act and regulations promulgated thereunder, and as further delineated in Department reports issued to the Plan pursuant to Health and Safety Code section 1382.

The Plan acknowledges that these deficiencies have resulted in its violations of Health and Safety Code sections 1371 and 1371.35 and California Code of Regulations, Title 28, section 1300.71.38(g). For purposes of assessing a penalty for these violations, the Plan agrees that the deficiency rate of 16 percent found in the sample of 50 late claim payments resulting from provider disputes is conclusive evidence of the percentage of deficiencies present in the entire universe of late claim payments resulting from provider disputes adjudicated during the time

frame defined by the Department's examination, specifically March 1, 2008 through May 31, 2008."

The following details the provider dispute resolution mechanism violations found during our examination:

1. INTEREST ON LATE CLAIMS PAYMENTS RESULTED FROM PROVIDER DISPUTES – REPEAT DEFICIENCY

Rule 1300.71.38 (g) states that if the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, the plan or the plan's capitated provider shall pay any outstanding monies determined to be due, and all interest and penalties required under Sections 1371 and 1371.35 and Rule 1300.71, within five (5) working days of the issuance of the written determination.

Southern California Region

The failure of the Southern California Region to pay interest correctly on additional late claims payments resulting from provider disputes was noted in the Final Report of the previous routine examination, dated November 26, 2007. In response to the Preliminary Report for that examination, the Plan described various corrective action plans which included policy and procedure changes and the remediation of interest and penalties for the time periods specified in the report. This examination disclosed that the Plan's compliance efforts have not achieved the necessary levels of compliance with the Act and Regulations cited in the following respect:

Interest was not paid, underpaid, or paid after the Department provided the examination sample selection to the Plan on adjusted claim payments that resulted from provider disputes for ten (10) out of fifty (50), or 20 percent, of the provider disputes reviewed. The failure to pay interest correctly was due to the following:

- The Plan used an incorrect date of receipt (i.e. the claim scan date, eligibility update date, or the date of receipt of last information) when calculating interest instead of the date of receipt of a "Complete Claim" as defined by Rule 1300.71 (a)(2). The following are examples:

DMHC PDR Sample No.	Receipt Date used to Calculate Interest	Receipt Date of a "Complete Claim"	Interest Paid by the Plan	Interest That Should Have Been Paid	Penalty for Interest Underpayment	Amount of Interest Underpayment Including Penalty
S-PD 7	01/21/08	11/23/07	\$1.16	\$1.21	\$10.00	\$10.05
S-PD 9	03/03/08	05/10/07	\$.01	\$3.07	\$10.00	\$13.06
S-PD 31	01/10/08	12/19/07	\$10.80	\$16.98	\$10.00	\$16.18

- The Plan had a policy of not paying interest on claim adjustments due to retro-active contracts or contractual cost-of-living adjustments (“COLA”). This issue was cited in the Final Report of the prior routine examination. At the time of this examination, the Plan was in the process of resolving this issue. Therefore, this issue will be handled separately under the Plan’s corrective action plan for the prior routine examination. Examples are provider disputes sample numbers 3 and 19.
- Errors made by claim processors included provider disputes sample numbers 20, 24, 26, 35 and 49.

The Plan’s repeated failure to comply with the interest requirements of Sections 1371 and 1371.35 and Rule 1300.71.38 (g) was referred to the Department’s Office of Enforcement for appropriate administrative action.

The Plan was required to state the reasons why its compliance efforts have not achieved the necessary levels of compliance with the Act and Regulations cited.

In addition, the Plan was required to submit a Corrective Action Plan (“CAP”) to address the deficiency cited above. The CAP was to include the following:

- a. Training procedures to ensure that claim processors have been properly trained on interest and penalty requirements regarding additional payments resulting from provider disputes due to incorrect payment of the initial claim.
- b. Audit procedures to ensure that the Plan is monitoring correct payment of interest and penalties on late adjusted claim payments resulting from provider disputes.
- c. Identification of all late claims resulting from provider disputes for which interest and penalties were not correctly paid from January 1, 2007 (the date after the last examination) through the date corrective action has been implemented by the Plan.
- d. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in the paragraph immediately above. This evidence was to include an electronic data file (Excel or Access) or schedule that identified the following:
 - Claim number
 - Date of service
 - Date original claim received
 - Date new information received (date claim was complete)
 - Total billed
 - Total paid
 - Paid date
 - Interest amount paid
 - Date interest paid
 - Penalty amount paid

- Additional Interest amount paid if applicable
- Date additional interest paid if applicable
- Check number for additional interest and penalty paid amount
- Provider name
- ER or Non-ER indicator
- Number of late days used to calculate interest

The data file was to include the total number of claims and the total additional interest and penalty paid, as a result of remediation.

In addition, the Plan was required to state the management position(s) responsible for overseeing the CAP and a description of the monitoring system implemented to ensure continued compliance. If the Plan was not able to complete the CAP or portions of the CAP within 45 days of receipt of this report, the Plan was required to submit a timeline with its response and monthly status reports until the CAP was completed.

In its response, the Plan acknowledged that there had been shortcomings in calculating the correct interest. The Plan stated that it is identifying and, where necessary, remediating these claims for the period beginning January 1, 2007 through March 31, 2009. SCAL will submit a monthly status report of cases remediated, to be completed by August 30, 2009. Additionally, the Plan will be implementing increased training regarding correct calculation of interest and will be conducting regular audits to ensure the correct calculation of interest.

In response to the 2007 Routine Financial Examination, Southern California Claims Administration (SCAL Claims) took immediate actions to correct the failure to pay interest correctly on late claims resulting from provider disputes. Those actions included:

- *In October 2007 SCAL Claims began using a weekly report to identify any adjusted claims where interest and penalties should have been paid, but no interest was paid.*
- *Revised the interest policies and procedures to ensure clarity of process for paying interest.*
- *Conducted two in-service trainings for all staff (June 2007 and October 2007).*

The actions outlined above did not prove fully successful in achieving the necessary levels of compliance with Rule 1300.71.38 (g) for the following reasons:

- *Calculation of interest for provider disputes and adjusted claims is a process dependent on the manual entry of an appropriate receipt date of the claim and/or additional information. The additional staff training conducted in October 2007 did not fully address the issues associated with staff utilizing the dispute date rather than the original received date in the interest calculation.*

- *The weekly control report created on October 1, 2007 to identify any adjusted claims where interest and penalties should have been paid, but no interest was paid was implemented. The intent of these reports was to ensure adjustments were being made weekly when interest, as well as penalty, was due. However, full monitoring and control of these reports was not adhered to resulting in continued missed interest payments.*

Additional corrective actions to address the deficiency cited include the following:

- *A review and update of the department policy and procedure and related desk-level training materials outlining interest payments on PDR claims were completed on March 31, 2009.*
- *Staff training on the revised policy and training material will be completed by April 30, 2009. To ensure continued awareness of defined policies and procedures, annual interest application training will be scheduled. Additional training will be provided as needed.*
- *A daily process audit will be implemented on April 17, 2009 to ensure interest and penalties are paid on late adjusted claim payments. The daily audits will consist of process control reporting:*

PDR Interest Mismatch– reporting to identify adjusted claims where interest and penalty payments do not match automated interest logic. This includes all claims where interest paid is any amount less than the report calculation. Claims identified by the daily reporting will be distributed and tracked for adjustment within 10 day(s) of identification.

- *17,708 PDR claims were identified with improper interest payments for a period of January 1, 2007 to March 31, 2009. As of August 30, 2009, all remediation of these claims will be complete for payment of claim amount, interest and penalty.*
- *Evidence on remediation for all identified PDR claims from January 1, 2007 through March 31, 2009 will be completed by August 30, 2009. SCAL Claims will provide a monthly status report, including an electronic data file with the required data elements, to demonstrate evidence that interest and penalties were paid on affected claims until completed.*

The Plan identified the Director, SCAL Business Excellence, the Compliance Manager and the Director, SCAL, as the responsible parties for overseeing the CAP and ensuring ongoing compliance.

The Plan submitted the following documents: Quality Audit Policy Statements regarding Interest, High Level Process – End to End for Interest Remediation Flow Chart, Provider

Dispute Resolution Policy, Training Update #9, Interest and Penalty Payment on Adjusted Claims, and a list of claims that potentially need remediation.

The Department finds that the Plan’s compliance efforts are not fully responsive to the deficiency cited and the corrective actions required. The Plan is requested to revise the following:

- **Section 6.3, Cal-Optima Interest and Penalty Language, of the Quality Audit Policy Statements regarding Interest to indicate that interest applies to contracted providers. In addition, the Plan is required to file a copy of the revised Quality Audit Policy Statements regarding Interest with its response to this report.**
- **The response to Question 3 of Training Update #9, Interest and Penalty Payment on Adjusted Claims, to indicate penalty is due if the interest underpayment was the result of the Plan’s error. In addition, the Plan is required to file a copy of a revised Training Update #9 with its response to this report.**

The Department acknowledges that the Plan’s CAP will be completed by August 30, 2009. The first status report was filed on July 29, 2009 detailing all interest and penalties paid up to July 14, 2009. The last status report (due by October 15, 2009) is required to include the detail of all claims remediated, the total number of claims, and the total additional interest and \$10 fee paid, as a result of the remediation. This report should be filed through the Department’s eFiling web portal.

2. DETERMINATION LETTER

Rule 1300.71.38 (f) states that the Plan shall issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute or amended provider dispute.

Southern California Region

Our examination of overturned provider disputes found that the Plan did not accurately disclose the pertinent facts and reasons for its determination to make additional payments on seven (7) out of fifty (50), or 14 percent, of disputes reviewed.

The following were examples of inaccurate facts and reasons found in provider dispute determination letters:

DMHC PDR Sample No.	Determination Letter Date	Inaccurate Facts and Reasons on Determination Letter	Actual Facts and Reasons for Plan’s Determination
S-PD 1	05/01/08	Upholding original payment	Payment under protest
S-PD 10	05/14/08	Inappropriate contract rate	Additional information received
S-PD 24	03/07/08	No additional payment	Additional payment issued

DMHC PDR Sample No.	Determination Letter Date	Inaccurate Facts and Reasons on Determination Letter	Actual Facts and Reasons for Plan's Determination
S-PD 33	03/05/08	Paid according to contract	Payment under protest
S-PD 45	03/11/08	Reevaluation of member eligibility	Payment under protest

The Plan was required to submit a Corrective Action Plan (“CAP”) that included:

- Training procedures implemented to ensure that processors are properly trained to accurately disclose the facts and reasons for provider disputes determination.
- Audit procedures implemented to ensure compliance and to identify the need for additional training.
- Date of implementation of the training and audit procedures.
- The management position responsible for compliance.

The Plan responded that it would be implementing enhanced training procedures to ensure that processors are properly trained to accurately disclose the facts and reasons for the Plan's determination. In addition, the Plan would undertake an audit process to ensure that letters contain adequate explanation for the Plan's determination. The letter selection process on PDR claims for accurate letter determination would be completed by April 30, 2009. An established process for letter audit was implemented in June 2007. Currently, this audit is under review and controls would be put in place by May 30, 2009 to validate letter selection. Training and audit procedures would begin May 30, 2009.

The Plan identified the Senior Operations Leader, the Compliance Manager and the Director, SCAL, as the responsible parties for overseeing the CAP and ensuring ongoing compliance.

The Plan submitted SCAL Claims Training calendar for April 2009.

The Department finds that SCAL Claims' compliance efforts are responsive to the deficiencies cited and the corrective actions required.

B. CLAIM SETTLEMENT PRACTICES – “UNFAIR PAYMENT PATTERN”

Rule 1300.71 (s)(2) states that the failure of a plan to comply with the requirements of Sections 1371 and 1371.35 may constitute a basis for disciplinary action against the plan.

Section 1371.37 (a) states each plan is prohibited from engaging in an unfair payment pattern. Section 1371.37 (c)(4) defines an "unfair payment pattern," as failing on a repeated basis to automatically include the interest due on claims pursuant to Section 1371.

The Department’s examination found that the Plan engaged in “unfair payment patterns” as summarized in the following tables:

NORTHERN CALIFORNIA REGION

Deficiency	Section/Rule Violated	Type of Claim in Sample	Total Claims in the Sample Population	Total Claims in the Sample	Number of Deficiencies Found	% of Compliance
Plan failed to reopen and reprocess claims once additional information is received.	Sections 1371 and 1371.35	Denied	18,727	50	7	86%

SOUTHERN CALIFORNIA REGION

Deficiency	Section/Rule Violated	Type of Claim in Sample	Total Claims in the Sample Population	Total Claims in the Sample	Number of Deficiencies Found	% of Compliance
Interest and penalties not paid correctly on late claims	Sections 1371 & 1371.35 & Rule 300.71	Late	14,919	50	10	80%

On February 20, 2009, the Plan filed a signed acknowledgement with the Department that stated the following:

Northern California Region

“Kaiser Foundation Health Plan, Inc. (the Plan) acknowledges that it has deficiencies in its claims payment procedures, operations and related finalization processes which have resulted in the Plan failing to reopen and/or reprocess claims after receipt of additional information after the claim was initially processed, causing untimely processing of an unacceptable number of claims. The Plan has requested that the Department discontinue its testing of denied claim payments in light of the Plan’s acknowledgement of these deficiencies. The Plan further acknowledges its commitment to correcting the deficiencies cited herein in accordance with requirements set forth in applicable provisions of the Knox-Keene Act and regulations promulgated thereunder, and as further delineated in Department reports issued to the Plan pursuant to Health and Safety Code section 1382.

The Plan acknowledges that these deficiencies have resulted in its violations of Health and Safety Code sections 1371 and 1371.35. For purposes of assessing a penalty for these violations, the Plan agrees that the deficiency rate of 14 percent found in the sample of 50 claims for which additional information was received after the claim was initially processed is conclusive evidence of the percentage of deficiencies present in the entire universe of claims for which additional information was received after the claim was initially processed during the

time frame defined by the Department's examination, specifically March 1, 2008 through May 31, 2008."

Southern California Region

"The Plan acknowledges that it has deficiencies in its claims payment procedures, operations and related finalization processes which have resulted in the incorrect payment of interest and penalties on an unacceptable number of late claim payments. The Plan has requested that the Department discontinue its testing for interest and penalty payments on late claim payments in light of the Plan's acknowledgement of these deficiencies and the Plan acknowledges that the Department agreed to do so in reliance upon this document. The Plan further acknowledges its commitment to correcting the deficiencies cited herein in accordance with requirements set forth in applicable provisions of the Knox-Keene Act and regulations promulgated thereunder, and as further delineated in Department reports issued to the Plan pursuant to Health and Safety Code section 1382.

The Plan acknowledges that these deficiencies have resulted in its violations of California Code of Regulations, Title 28, section 1300.71 and Health and Safety Code sections 1371 and 1371.35. For purposes of assessing a penalty for these violations, the Plan agrees that the deficiency rate of 20 percent found in the sample of 50 late claim payments is conclusive evidence of the percentage of deficiencies present in the entire universe of late claim payments adjudicated during the time frame defined by the Department's examination, specifically March 1, 2008 through May 31, 2008."

The following details the unfair payment practices and other claim settlement deficiencies found during our examination:

1. INCORRECT INTEREST ON LATE CLAIMS PAYMENT - REPEAT DEFICIENCY

Section 1371 requires a health care service plan to reimburse uncontested claims no later than 45 working days after receipt of the claim. This section also requires that if an uncontested claim is not reimbursed within 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 45 working day period.

Section 1371 and Rule 1300.71 require that all interest that has accrued shall be automatically included in the claim payment. The penalty for failure to comply with this requirement shall be a fee of ten (\$10) dollars paid to the claimant.

Section 1371.35, which refers to claims resulting from emergency services, requires that if an uncontested claim is not reimbursed within 45 working days after receipt by a health care service plan, the plan shall pay the greater of \$15 per year or interest at the rate of 15 percent per annum, beginning with the first calendar day after the 45 working-day period.

Section 1371.37 (a) states each plan is prohibited from engaging in an unfair payment pattern. Section 1371.37 (c)(4) defines an "unfair payment pattern," as failing on a repeated basis to automatically include the interest due on claims pursuant to Section 1371.

Southern California Region

The failure to pay interest and penalties in the Southern California Region was noted in the Final Report of the previous routine examination, dated November 26, 2007. In its response to the Preliminary Report of that examination, the Plan proposed corrective actions in response to findings related to claims reimbursement interest payment and calculation deficiencies. These corrective actions were implemented by the Plan. While these corrective actions were reviewed and accepted by the Department at that time, this examination disclosed that the Plan’s compliance efforts have not achieved the necessary levels of compliance with the Act and Regulations cited.

We selected a sample of fifty (50) claims paid late during the three-month period ended May 31, 2008 to determine if interest and penalties were paid correctly in accordance with the Sections and Rules stated above.

Our examination found that ten (10) out of the fifty (50) late claims reviewed, or 20 percent of these claims, did not pay or underpaid the amount of interest due. The incorrect payment of interest was the result of the Plan not selecting the correct date of receipt of a complete claim to calculate the number of days used in determining the amount of interest payable on these late claims. Therefore, the Plan demonstrated an unfair payment pattern according to Section 1371.37 (c)(4) for failing to automatically include the interest due on late claims payments during the three-month period ending May 31, 2008.

Examples of late claims where interest and penalty were not paid or underpaid are as follows:

DMHC Late Claim Sample No.	Date of Receipt of Original Claim or New Information	Date Claim Paid	Number of Days Late for Calculating Interest	Interest Paid by Plan	Interest That Should Have Been Paid	Penalty for No Interest Paid or Interest Underpayment	Amount of Interest Underpayment Including Penalty
S-L 5	08/15/06	03/26/08	525	\$631.97	\$662.15	\$0*	\$30.18
S-L 17	12/17/07	05/29/08	100	\$7.26**	\$7.19	\$10.00	\$9.93
S-L 20	01/03/08	05/26/08	80	\$3.67	\$4.08	\$10.00	\$10.41
S-L 32	11/23/07	04/24/08	89	\$0	\$34.98	\$10.00	\$44.98
S-L 36	03/05/08	05/13/08	5	\$0	\$.08	\$10.00	\$10.08

* Penalty was previously paid for interest underpayment.

** Interest was paid after the claim was selected by the Department for review.

The Plan's repeated failure to comply with the interest requirements of Sections 1371 and 1371.35 and Rule 1300.71 was referred to the Department's Office of Enforcement for appropriate administrative action.

The Plan was required to state the reasons why its compliance efforts had not achieved the necessary levels of compliance with the Act and Regulations cited.

In addition, the Plan was required to submit a Corrective Action Plan ("CAP") to address the deficiency cited above. The CAP was to include the following:

- a. Training procedures to ensure that claim processors have been properly trained on interest and penalty requirements.
- b. Audit procedures to ensure that the Plan is monitoring correct payment of interest and penalties on late and late adjusted claim payments.
- c. Identification of all late claims for which interest and penalties were not correctly paid from January 1, 2007 through the date corrective action has been implemented by the Plan.
- d. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in the paragraph immediately above. This evidence was to include an electronic data file (Excel or Access) or schedule that identifies the following:
 - Claim number
 - Date of service
 - Date original claim received
 - Date new information received (date claim was complete)
 - Total billed
 - Total paid
 - Paid date
 - Interest amount paid
 - Date interest paid
 - Penalty amount paid
 - Additional Interest amount paid if applicable
 - Date additional interest paid if applicable
 - Check number for additional interest and penalty paid amount
 - Provider name
 - ER or Non-ER indicator
 - Number of late days used to calculate interest

The data file was to include the total number of claims and the total additional interest and penalty paid, as a result of remediation.

In addition, the Plan was required to state the management position(s) responsible for overseeing the CAP and a description of the monitoring system implemented to ensure continued compliance. If the Plan was not able to complete the CAP or portions of the CAP within 45 days of receipt of this report, the Plan was required to submit a timeline with its response and monthly status reports until the CAP was completed.

The Plan acknowledged that there had been shortcomings in calculating the correct interest. The Plan stated that it is identifying and, where necessary, remediating these claims for the period beginning January 1, 2007 through March 31, 2009. SCAL will submit a monthly status report of cases remediated, to be completed by August 30, 2009. Additionally, the Plan will be implementing increased training regarding correct calculation of interest and will be conducting regular audits to ensure the correct calculation of interest.

In response to the 2007 Routine Financial Examination, Southern California Claims Administration (SCAL Claims) took immediate actions to correct the failure to pay interest correctly on late claims. Those actions included:

- In October 2007 SCAL Claims began using a weekly report to identify any adjusted claims where interest and penalties should have been paid, but no interest was paid.*
- Revised interest policies and procedures to ensure clarity of process for paying interest.*
- Conducted two in-service trainings for all staff (June 2007 and October 2007).*

The actions outlined above did not prove fully successful in achieving the necessary levels of compliance for the following reasons:

- System enhancements completed in October 2007 focused on and corrected issues associated with automated interest application on first-pass or initial claim payments. Findings in this audit exposed (49 of 50 of the reviewed claims were adjustments) the deficiency in the adjusted claims interest calculation process that relies on the manual entry by a user of a correct receipt date.*
- The additional staff training conducted in December 2007 did not fully address the issues associated with staff utilizing the additional information receipt date rather than the original received date in the interest calculation process.*
- The weekly control report to identify adjusted claims where interest and penalties were incorrectly applied was developed and implemented on October 1, 2007. However, full monitoring and validation that the appropriate remediation action was being taken was not adhered to which resulted in continued missed interest payments.*

Additional corrective actions to address the deficiency cited included the following:

- *A review and update of the policy and procedures and related desk-level training material outlining interest payments on late claims was completed on March 31, 2009.*
- *Staff training on the revised policy and training material would be completed by April 30, 2009. To ensure continued awareness of defined policies and procedures, annual interest application training would be scheduled.*
- *A daily process audit would be implemented on April 17, 2009 to ensure interest and penalties are paid on late adjusted claim payments. The daily audits will consist of process control reporting:*

Late Interest Mismatch – reporting to identify late claims where interest and penalty payments do not match automated interest logic. This includes all claims where interest paid is any amount less than the report calculation. Claims identified by the daily reporting will be distributed and tracked for adjustment within 10 day(s) of identification.

- *30,894 late claims were identified with improper interest payments for a period of January 1, 2007 to March 31, 2009. As of August 30, 2009, all remediation of these claims will be complete for payment of claim amount, interest and penalty.*
- *Evidence on remediation for all identified late claims from January 1, 2007 through March 31, 2009 will be completed by August 30, 2009. SCAL Claims will provide a monthly status report, including an electronic data file with the required data elements, to demonstrate evidence that interest and penalties were paid on affected claims until completed. The data file will be submitted on a CD due to file size.*
- *The Plan identified the Director, SCAL Business Excellence, the Compliance Manager and the Director, SCAL, as the responsible parties for overseeing the CAP and ensuring ongoing compliance.*
- *The Plan submitted the following documents: Quality Audit Policy Statements, High Level Process – End to End for Interest Remediation Flow Chart, Provider Dispute Resolution Policy, Training Update #9, Interest and Penalty Payment on Adjusted Claims, and a list of claims that potentially need remediation.*

The Department acknowledges that the Plan's CAP will be completed by August 30, 2009. The first status report was filed on July 29, 2009 detailing all interest and penalties paid up to July 14, 2009. The last status report (due by October 15, 2009) is required to include the detail of all claims remediated, the total number of claims, and the total additional interest and \$10 fee paid, as a result of the remediation. This report should be submitted through the Department's eFiling web portal.

2. TIME LIMITS FOR REIMBURSEMENT, CONTEST, OR DENIAL OF CLAIMS

Sections 1371 and 1371.35 states each plan shall reimburse claims or any portion of any claim, whether in state or out of state, as soon as practical, but no later than 45 working days after receipt of the claim, unless the claim or portion thereof is contested by the plan in which case the claimant shall be notified, in writing, that the claim is contested or denied within 45 working days after receipt of the claim. Section 1371.35 refers to claims resulting from emergency services.

Section 1371.37 (a) states each plan is prohibited from engaging in an unfair payment pattern. Section 1371.37 (c)(3) defines an "unfair payment pattern," as failing on a repeated basis to pay the uncontested portions of a claim within the timeframes specified in Sections 1371 and 1371.35.

Northern California Region

The Plan sends several requests to providers for additional information when the Plan receives incomplete claims. The claims are denied on the fifty-fifth (55th) calendar day after receipt if the requested additional information is not received.

Our examination found that the Plan failed to reopen and reprocess the claims once additional information was received from the providers. Examples included denied sample numbers 2, 6, 19, 23, 42, 46 and 47. In provider dispute sample number 3, the claim was even denied as a duplicate submission of a previously processed claim when the provider submitted the requested information. Receiving information or additional information as a result of the Plan's request necessitates the reprocessing of the related claim to determine whether the information received completes the claim as defined in Rule 1300.71(a)(2). In addition, it requires the Plan to reimburse, contest or deny the claim within 45 working days after receipt of the requested information or additional information pursuant to Sections 1371 and 1371.35.

The Plan's failure to comply with the requirements of processing claims timely pursuant to Sections 1371 and 1371.35 demonstrated an unfair payment pattern, and was referred to the Department's Office of Enforcement for appropriate administrative action.

The Plan was required to submit a Corrective Action Plan ("CAP") to address the deficiency cited above. The CAP was to include the following:

- a. Policy and procedures implemented and the date of their implementation to ensure that the Plan reopens and reprocesses claims when additional information is received as a result of Plan request.

- b. Training procedures to ensure that claim processors have been properly trained to reopen and reprocess claims within 45 working days of the date of receipt of additional information.
- c. Audit procedures to ensure that the Plan's implemented policy and procedures are working as intended.
- d. Identification and review of all claims that were denied due to not receiving the requested information from January 1, 2007 through the date corrective action has been implemented by the Plan. The review was to include a determination of whether the requested information was received and whether it resulted in a complete claim that needed to be reprocessed.
- e. Evidence that claims, where providers submitted additional information as a result of the Plan request, had been reprocessed, and claims payments made included interest pursuant to the requirements of Sections 1371 and 1371.35. This evidence was to include an electronic data file (Excel or Access) or schedule that identified the following:
 - Claim number
 - Date of service
 - Date original claim received
 - Date requested information received (date claim was complete)
 - Total billed
 - Total paid
 - Paid/denied date
 - Interest amount paid
 - Date interest paid
 - Penalty amount paid, if applicable
 - Additional Interest amount paid, if applicable
 - Date additional interest paid, if applicable
 - Check number for additional interest and penalty paid amount
 - Provider name
 - ER or Non-ER indicator
 - Number of late days used to calculate interest

The data file was to include the total number of claims and the total additional claims amount and interest and penalty paid, as a result of remediation.

In addition, the Plan was required to state the management position(s) responsible for overseeing the CAP and a description of the monitoring system implemented to ensure continued compliance. If the Plan was not able to complete the CAP or portions of the CAP within 45 days of receipt of this report, the Plan was required to submit a timeline with its response and monthly status reports until the CAP was completed.

The Plan acknowledged that it had not routinely been re-opening claims that had been closed for lack of sufficient information when additional information is received. The Plan responded that it is implementing Policies and Procedures to ensure that such claims are re-opened. The Plan stated that it is identifying and, where necessary, remediating these claims for the period beginning January 1, 2007 through March 11, 2009. NCAL will submit a monthly status report of cases remediated, to be completed by September 30, 2009. Additionally, the Plan will be implementing increased training regarding the re-opening of claims upon receipt of additional information and will be conducting regular audits to ensure that the process is being followed.

The Plan added that effective March 11, 2009, Northern California Claims Administration (NCCA) implemented a policy and procedure to reopen and reprocess closed denied claims upon receipt of requested information. The Claims processors were trained on the policy and procedure on March 11, 2009. Additional training sessions will be scheduled monthly, beginning in April, 2009.

Beginning in April, 2009, NCCA will monitor the new process through a monthly focused audit of a random sample of closed denied claims. The claim will be reviewed to determine if the requested information has not been received and the claim continues to be denied correctly. Audit results will be reviewed with the Operations Leader and Claim Supervisors. Errors identified will be corrected and addressed with the claims processor to ensure understanding of the procedure. The monthly focused audit will be discontinued when NCCA has achieved an accuracy rate of 95% or better for 3 consecutive months.

NCCA has identified the population of claims that were denied due to not receiving the requested information for the period January 1, 2007 through March 11, 2009. There are a total of approximately 35,000 claims. Each claim will be reviewed to determine if the requested information has been received. If so, the claim will be re-processed. Claim payments will include the applicable interest payments pursuant to the requirements of Sections 1371 and 1371.35. Remediation activities will begin in April, 2009; completion date is targeted for September 30, 2009. Beginning in May, 2009, NCCA will submit an electronic data file with all of the requested data elements. The electronic data file will be submitted monthly until the remediation is complete.

The Plan identified the Compliance Manager, the Operations Leader and the Director, NCCA, as the responsible parties for overseeing the CAP and ensuring ongoing compliance.

The Plan submitted the following documents: Policy Regarding Additional Information Received in Response to a Request for Information after a Claim is Closed, Sign-in Sheet for Training and a list of claims that potentially need remediation.

The Department acknowledges that the Plan's CAP will be completed by September 30, 2009. The first status report was filed on July 29, 2009 detailing all remediation up to July 1, 2009. The last status report (due by October 15, 2009) is required to include the detail of all claims remediated, the total number of claims, and the total additional

interest and \$10 fee paid, as a result of the remediation. This monthly status report should be submitted through the Department's eFiling web portal.

3. INCORRECT CLAIMS DENIAL REASONS – REPEAT DEFICIENCY

Rule 1300.71 (d)(1) states that a plan or a plan's capitated provider shall not improperly deny, adjust, or contest a claim. For each claim that is denied, adjusted or contested, the plan or the plan's capitated provider shall provide an accurate and clear written explanation of the specific reasons for the action taken.

Southern and Northern California Region

The failure by the Southern and Northern California Regions to provide correct denial reasons in claim denial letters was noted in the Final Report of the previous routine examination, dated November 26, 2007. In response to the Preliminary Report for that examination, the Plan described various corrective action plans which included providing a Commercial Denials reference guide to all claim processors. This examination disclosed that the Plan's compliance efforts have not achieved the necessary levels of compliance with the Act and Regulations cited.

Our examination found that the Plan does not consistently provide accurate denial reasons on denial letters to providers. An inaccurate denial reason on the denial letter does not allow a provider to submit the correct information to result in a complete claim.

The following are examples of wrong denial reasons:

DMHC Denied Claims Sample No.	Denial Letter Date	Inaccurate Denial Reasons per Plan	Actual Denial Reasons per Examination
S-D 27	04/14/08	Not authorized	Forwarded to California Children Services
S-D 38	04/23/08	Invalid date of service	Invalid place of service
S-D 40	03/14/08	Untimely filing	Duplicate
N-D 1	03/24/08	Untimely filing	Should had been paid *
N-D 33	04/18/08	Untimely filing	Duplicate

* Timely claim filing requirements do not apply to claims submitted by members.

The Plan was required to state the reasons why its compliance efforts had not achieved the necessary levels of compliance with the Act and Regulations cited.

The Plan was required by Region to submit a Corrective Action Plan ("CAP") that included:

- Training procedures implemented to ensure that claim processors were continually trained to provide correct claims denial reasons.

- Audit procedures implemented to ensure that the Plan was monitoring processors for using correct claims denial reasons.
- Date of implementation of the training and audit procedures.
- The management position responsible for compliance.

The Plan responded that it will implement enhanced training procedures to ensure that processors are properly trained to accurately disclose the facts and reasons for the Plan's determination. In addition, the Plan stated that it would undertake an audit process to ensure that letters contain adequate explanation for the Plan's determination. The Plan would review overall letter selection process for first pass claims for accurate letter determination. This will be completed by April 30, 2009. The current letter quality audit is under review for improvement and controls will be put in place by May 30, 2009 to validate correct letter selection with training and audit procedures to begin May 30, 2009.

Southern California Claims Administration (SCAL Claims), in response to the 2007 Routine Financial Examination, took immediate actions to correct the failure to provide correct denial reasons in the claim denial letter. Those actions included:

- *In June 2007, the monthly letter quality audit report that identifies issues with denial codes was revised to allow better line of sight to the potential errors. The monthly audit report was used by the Claims Supervisor's to identify incorrect denial selection by claims adjuster and to provide feedback.*
- *In November 2004, SCAL Claims has transitioned from requesting and creating claim letters in the claim processing system (OCPS) to the implementation of separately supported letter generation system (the Aurora Data System). The system was enhanced in July 2007 and again in November 2008 to achieve more consistency in letter selection.*

The actions outlined above did not prove fully successful in achieving the necessary levels of compliance with Rule 1300.71 (d) (1). SCAL Claims Department will review the end-to-end process for letter selection for claim denial determination. SCAL Claims will take the following actions to achieve compliance:

- *Review overall letter selection process for first pass claims for accurate letter determination. This would be completed by April 30, 2009 and trained to appropriate staff.*
- *The current letter quality audit is under review for improvement and controls would be put in place by May 30, 2009 to validate correct letter selection.*
- *Training and audit procedures will be implemented by May 30, 2009.*

The Plan identified the Compliance Manager, Claims Operations Manager, Senior Operations Leader and the Director, SCAL Claims, as the responsible parties for overseeing the CAP and ensuring ongoing compliance.

The Plan submitted SCAL Claims Training calendar for April 2009.

Northern California Claims Administration (NCCA), following the 2007 Routine Financial Examination, updated the denial reason guide that claims processors utilize to identify appropriate denial reason codes. An in-service training session was held for claims processors to review the denial reason guide. Monthly team meetings were also held in 2008 to review errors identified from the monthly retrospective audits. However, NCCA has determined that claims processors have been inconsistent in following established policies and procedures.

To ensure continued improvement, NCCA would implement the following controls:

- *Effective in April 2009, focused training will be conducted monthly to review all denial codes and reasons for denials.*
- *Effective April 2009, the sampling methodology that is used to extract claims for the monthly retrospective audit will be enhanced to capture a higher percentage of denied claims. Audit results will be reviewed with the Operations Leader and Claims Supervisors. Errors identified will be corrected and addressed with the claims processor to ensure understanding of the procedures.*

The Plan identified the Compliance Manager, the Operations Leader and the Director, NCCA, as the responsible parties for overseeing the CAP and ensuring ongoing compliance.

The Department finds that SCAL Claims and NCCA compliance efforts are responsive to the deficiencies cited and the corrective actions required.

4. INCORRECT CLAIMS DENIALS FOR LACK OF AUTHORIZATION

Rule 1300.71 (d)(1) states that a plan or a plan's capitated provider shall not improperly deny, adjust, or contest a claim. For each claim that is denied, adjusted or contested, the plan or the plan's capitated provider shall provide an accurate and clear written explanation of the specific reasons for the action taken.

Northern California Region

Our examination found some instances where claims authorized by the Southern California Region (where services were provided) were incorrectly denied when these claims were processed by the Northern California Region (where the member was enrolled). Examples included denied claims sample numbers 21 and 43.

The Plan was required to implement and submit to the Department a policy and procedures to review authorizations issued by the Region where services were provided in addition to checking the authorizations issued by the Region in which the enrollee was a member prior to denying a claim for lack of authorization. The Plan was to indicate the date of implementation and the management position responsible for compliance.

The Plan responded that two claims cited for this deficiency represented errors that were made by claims processors. To ensure that authorized claims are processed correctly, NCCA will implement the following controls:

- The policy and procedure has been updated to explicitly outline the processes that a claims processor must follow to identify an authorization. Claims processors would be trained on the updated policy and procedure by April 10, 2009.*
- As an additional safeguard, effective April 2009, the sampling methodology that is used to pull claims for audits will be enhanced to capture a higher percentage of denied claims. This will validate that the processor errors found in these two claims are not systemic problems. Audit results will be reviewed with the Operations Leader and Claims Supervisors. Errors identified will be corrected and addressed with the claims processor to ensure understanding of the procedures.*

The Plan identified the Compliance Manager, the Operations Leader and the Director, NCCA, as the responsible parties for overseeing the CAP and ensuring ongoing compliance.

The Plan submitted a policy regarding Authorized/Referral Claims with its response.

The Department finds that NCCA's compliance efforts are responsive to the deficiencies cited and the corrective actions required.

5. INCORRECT CLAIMS DENIALS DUE TO INCORRECT ELIGIBILITY DETERMINATION

Rule 1300.71 (d)(1) states that a plan or a plan's capitated provider shall not improperly deny, adjust, or contest a claim. For each claim that is denied, adjusted or contested, the plan or the plan's capitated provider shall provide an accurate and clear written explanation of the specific reasons for the action taken.

Southern California Region

Our examination found that the Plan was incorrectly denying claims due to member ineligibility when in fact the member was an enrollee of the Plan. This can occur when a member receives service in a California Region that he is not assigned to. For example, the member is assigned to the Southern California Region but receives service in the Northern California Region. Since both the Southern and Northern California Regions are part of the Plan, a claim for this member should not have been denied for member ineligibility. Each Region should verify the member's

eligibility with the other California Region before denying a claim for member ineligibility. An example was denied sample number S-D 31.

The Plan was required to submit a Corrective Action Plan (“CAP”) to address the deficiency cited above. The CAP was to include the following:

- a. Policy and procedures implemented and the date of their implementation to ensure that the Plan verified eligibility with the other California Region before denying a claim for member ineligibility with the Plan.
- b. Identification of all claims that were denied due to member ineligibility with the Plan while the member was an enrollee of the other California Region for the period of January 1, 2007 through the date corrective action has been implemented by the Plan.
- c. Evidence that the claims identified in the immediate paragraph above were reprocessed (paid or denied) and that interest and penalty, if applicable, were paid on late claims processed beyond 45 working days after the original receipt of the claim pursuant to the requirements of Sections 1371 and 1371.35. This evidence was to include an electronic data file (Excel or Access) or schedule that identified the following:
 - Claim number
 - Date of service
 - Date original claim received
 - Date requested information received (date claim was complete)
 - Total billed
 - Total paid
 - Paid/denied date
 - Interest amount paid
 - Date interest paid
 - Penalty amount paid, if applicable
 - Additional Interest amount paid, if applicable
 - Date additional interest paid, if applicable
 - Check number for additional interest and penalty paid amount
 - Provider name
 - ER or Non-ER indicator
 - Number of late days used to calculate interest

The data file was to include the total number of claims and the total additional claims amount and interest and penalty paid, as a result of remediation.

In addition, the Plan was required to state the management position(s) responsible for overseeing the CAP and a description of the monitoring system implemented to ensure continued compliance. If the Plan was not able to complete the CAP or portions of the CAP within 45 days of receipt of this report, the Plan was required to submit a timeline with its response and monthly status reports until the CAP was completed.

The Plan responded that Southern California Claims Administration (SCAL Claims) department process for a visiting member was contained in SCAL policy and it was updated on October 6, 2008. There was one (1) claim issue during the audit that led to this finding. The error was a “human” error made by the claims adjuster. The claims adjuster did not follow all the required steps to check member eligibility. This was an isolated error for one claim.

Our current process outlines the steps needed to validate member eligibility for visiting members to the SCAL Region:

- *Training Update # 18 entitled Terminated and Visiting Member was updated October 6, 2008. The update was delivered to staff through a communication sent via e-mail distribution and refresher training for claims staff would be completed by April 30, 2009. SCAL Claims’ current process and procedure requires verification of eligibility of any affected member.*
- *Claim #X13747954 was the single claim identified during the audit.*
- *Claim #X13747954 was reprocessed on August 13, 2008. The Policy and Procedures for processing interregional claims and identifying membership status has always been in place and was not changed. The one outlier claim identified by the surveyors which was processed incorrectly is attributable to human error and is not indicative of a systemic claims processing deficiency. Imposition of a CAP for the purpose of attempting to identify the presence of additional, similar outliers would be burdensome and unproductive.*

The Plan identified the Senior Claims Operations Leader, the Operations Manager, the Compliance Manager and the Director, SCAL Claims, as the responsible parties for overseeing the CAP ensuring ongoing compliance.

The Plan submitted Quality Audit Policy Statements regarding Eligibility with its response.

The Department finds that SCAL Claims’ compliance efforts are not fully responsive to the deficiency cited and the corrective actions required.

Section 4.3, Shared Medical Record Numbers (“MRNs”) of Quality Audit Policy Statements regarding Eligibility defines Shared MRNs as, “Medical record numbers that have been recycled or reassigned to a “new” or different member by Foundation System.” The Plan is requested to file the methodology used to prevent confusion in medical records of members who have the same MRNs in its response to this report.

6. TREATMENT CODE MODIFIER

Rule 1300.71 (d)(1) states that a plan or a plan's capitated provider shall not improperly deny, adjust, or contest a claim. For each claim that is denied, adjusted or contested, the plan or the

plan's capitated provider shall provide an accurate and clear written explanation of the specific reasons for the action taken.

Southern California Region

Our examination disclosed that the Plan's claims payment processing system, OCPS, was unable to automatically read multiple modifiers on claims treatment lines beyond the first modifier. The Plan adjusted claim payments based on these modifiers once it receives a dispute from providers. An example was paid sample number S-P 16.

The Plan was required to implement a policy and procedures to adjust claim payments based on modifiers beyond the first modifier on claims. In addition, the Plan was requested to submit its policy and procedures to the Department, and indicate the date of implementation and the management position responsible for compliance.

The Plan responded that Southern California Claims Administration (SCAL Claims) will develop the requested policy and procedure related to the processing of claim payments based on modifiers beyond the first modifier on claims by April 15, 2009. The implementation of procedures and controls to ensure compliance with this policy will be completed by May 15, 2009. Due to the system limitation of Outside Claims Processing System (OCPS), controls include detect and remediate measures and additional preventive methods built through systems other than OCPS.

The Plan identified the Director, Business Excellence, the Compliance Manager and the Director, SCAL Claims, as the responsible parties for overseeing the CAP and ensuring ongoing compliance.

The Plan submitted a policy regarding Multiple Modifiers with its response.

The Department finds that SCAL Claims' compliance efforts are responsive to the deficiency cited and the corrective actions required.

C. RECEIPT DATE FOR CLAIMS

Rule 1300.77.4 requires all plans to institute procedures whereby all claims received by the plan are maintained and accounted for in a manner which permits the determination of the date of receipt of any claim, the status of any claims, the dollar amount of unpaid claims at any time and the rapid retrieval of any claim.

Rule 1300.71 (a)(6) defines the date of receipt as the working day when a claim is delivered to either the plan's specified claims payment site, post office box, or to its designated claims processor.

Southern California Region

Our examination disclosed that the Plan did not consistently capture the actual date of receipt of claims. We found that claims scan date or receipt date of additional information was used as the receipt date of claims. This practice could result in the incorrect calculation of interest paid on late claims to providers.

The following were examples of claims where the Plan input the wrong date of receipt:

DMHC PDR Sample No.	Actual Receipt Date	Input Receipt Date
S-PD 2	09/18/07	01/18/08
S-PD 31	08/27/07	01/10/08

Northern California Region

Our examination disclosed a similar deficiency in the Northern Region. In some instances, we found that the Plan incorrectly captured the claim denial date as the receipt date, or the receipt date of the Region who handled the claim last when the claim was received by both Regions instead of the earliest receipt date. In other instances, the Plan incorrectly captured the second submission date or the receipt date of a claim submitted by the provider instead of the earlier receipt date of the same claim submitted by the member.

The following were examples of claims where the Plan input the wrong date of receipt:

DMHC Denied Sample No.	Actual Receipt Date Per Exam	Receipt Date Captured Per Plan
N-D 1	02/29/08	05/13/08
N-D 18	03/05/08	03/07/08
N-D 27	01/17/08	03/11/08
N-D 33	08/06/07	03/21/08

In addition, the Northern California Region did not consistently stamp the date of receipt on each claim. The practice of stamping the date of receipt on each claim provides evidence of the actual receipt date that should be captured. Examples included paid sample numbers 5, 34 and 47.

For each Region, the Plan was required to provide additional training to claims processors to ensure that the actual receipt date was captured and to file evidence of this training. In addition, the Plan was requested to submit additional policies, procedures and oversight processes implemented to ensure actual receipt date was input in the Plan's claims payment processing systems, and provide the date of implementation of these policies, procedures and processes and the management position responsible for ensuring compliance.

Furthermore, the Northern California Region was required to implement additional procedures to ensure that the date of receipt was stamped on each claim. The Plan was requested to submit a copy of these procedures, the date of their implementation and the management position responsible for ensuring compliance.

The Plan responded that both regions are updating relevant policies and procedures; enhancing training relative to recording the first date of entry into the system; and implementing additional quality controls. SCAL will have completed the needed training enhancements by April 30, 2009. NCAL will have completed the enhanced training by April 15, 2009.

Southern California Claims Administration (SCAL Claims) would provide additional instruction and training to staff on the appropriate procedures for identifying, capturing and entering correct claims receipt dates into the transaction system. Training and the filing of evidence of the training will be completed by April 30, 2009.

Finalized policies and procedures were completed on March 31, 2009. The documentation included a fully mapped claims process diagram throughout the process and the remediation controls that ensure compliance with Rules 1300.77.4 and 1300.71 (a)(6).

Additional oversight controls to ensure compliance with the defined process would be implemented by May 4, 2009. These controls include:

- A weekly supervisor inspection audit that will involve a physical comparison of batch coversheets information to data entered into the transaction system. Evidence of the audit will be maintained in the compliance office.*
- Daily automated data integrity reporting that compares the receipt date information entered into the batch staging system (Work in Process) and the core transaction system. The control will detect receipt date changes made throughout the process and trigger a validation audit to ensure compliance with department policies and procedures.*

The Plan identified the Director, Business Excellence, the Compliance Manager and the Director, SCAL Claims, as the responsible parties for overseeing the CAP and ensuring ongoing compliance.

The Plan submitted the following documents: Quality Audit Policy Statements regarding Clerical Work, SCAL Mailroom Process Flow, and SCAL Claims Training Calendar for April 2009.

By April 15, 2009 Northern California Claims Administration ("NCCA) will complete the update and training on the department policy and procedure that will instruct staff on the appropriate procedures for identifying, capturing and entering of correct claims receipt dates into the transaction system.

On March 31, 2009, NCCA completed the required updates to the policy and procedures for the correct identification, selection and system entry of claims receipt dates. The staff would be trained on the policy and procedure by April 15, 2009. Additionally, a monthly in-service session would be scheduled beginning May 2009.

The policy and procedures referenced above include procedures to ensure that the date of receipt is stamped on each claim.

Beginning with April 2009, a quality control process will be implemented to ensure that the date of receipt is stamped on each claim. Each day, a random sample of 8 batches of claim documents will be reviewed within 24 hours after the documents are scanned into the system. The reviewer will check the image of the documents to ensure that date of receipt is stamped and that the stamp date is legible.

The Plan identified the Compliance Manager, Operations Leader, Manager NCCA Support and the Director, NCCA, as the responsible parties for overseeing the CAP and ensuring ongoing compliance.

The Plan submitted the following documents: Policies for Receipt Date and Alternative Receipt Date, SCAN Room Operations, and New Information Date.

The Department finds that SCAL Claims and NCCA compliance efforts are responsive to the deficiencies cited and the corrective actions required.

D. CLAIMS PAYMENT AT CONTRACTUAL RATES

Rule 1300.67.8 states written contracts must be executed between the plan and each provider of health care services which regularly furnishes services under the plan. The written contract shall set forth, among other things, reimbursement rates for services provided.

Southern California Region

Our examination found that the Plan paid claims at the lower of billed charges or contracted rates. The Plan was required to reimburse claims at contractual rates unless the contract had a written provision allowing the Plan to pay at the lower of billed charges or contracted rates. Examples included paid sample number 31 and late sample number 39.

The Plan was required to submit a policy and procedures implemented to ensure that claims would be reimbursed at contractual rates and that contractual rates would not be reduced to billed charges unless the provider agreement had a written provision allowing the reduction. In addition, the Plan was requested to indicate the date of implementation and the management position responsible for compliance.

The Plan responded that the Department identified two claims that had been paid at the billed rate rather than the contractual rate. The Plan has updated its policies and procedures to ensure

that a claim is paid at the contracted rate, even if it exceeds the billed rate, unless the contract provides otherwise.

In January 2009 Southern California Claims Administration (SCAL Claims) updated the department policy for payments to contracted providers as well as the associated training documents to reflect proper processing guidelines for payment at contracted rates.

The claim files that are the identified errors for this deficiency were instances of incorrect contract adjudication by the claims adjuster. The policy and procedure for processing using contracted rates for case rates was updated and finalized by January 21, 2009. As an additional safeguard, a Control Plan would be added to the Southern California Claims Administration Performance Management effective April 30, 2009.

The Plan identified the Compliance Manager, Claims Operations Manager, Senior Claims Operations and the Director, SCAL Claims, as the responsible parties for overseeing the CAP and ensuring ongoing compliance.

The Plan submitted the following documents: Quality Audit Policy Statements regarding Payments to Contracted and Non-Contracted Providers.

The Department finds that SCAL Claims compliance efforts are responsive to the deficiencies cited and the corrective actions required.

E. PAYMENT UNDER PROTEST DISCLOSURE

Southern California Region

Our examination found that the Plan paid non-contracting providers at reasonable and customary rates. To keep the member from being balance-billed, the Plan paid the difference between billed charges and reasonable and customary rates. However, the Plan was not consistently disclosing to providers that the payment for the difference was made under protest (or as goodwill). Consequently, no interest was required on this type of late claim payments. Examples included late sample numbers 3, 8, 19, 22, 23 and 30; as well as, paid sample numbers 17 and 27.

The Plan was required to implement a policy and procedures to communicate payments under protest clearly and consistently to providers to prevent the application of the interest requirements on late claims payments pursuant to Sections 1371 and 1371.35. In addition, the Plan was required to submit a copy of its implemented policy and procedures, indicate the date of implementation and the management position responsible for compliance.

The Plan responded that the Department determined that, in order to prevent members from being balanced billed, the Plan was paying claims under protest or as goodwill. The Department has stated that this should be clear in the payment communication so that it will be clear that there is no interest owing on those claims. The Plan's policies and procedures have been updated to require such documentation to providers in these situations.

In March 2009 Southern California Claims Administration (SCAL Claims) updated the current Interest policy with the appropriate documentation regarding interest payment to reflect appropriate reasons for paying under protest including the proper documents to use to communicate to providers. The policy and procedure Training Update #9 - Interest & Penalty Payment on Adjusted Claims was updated on March 27, 2009. The training would occur by April 30, 2009. Interest monitoring controls have been updated to include pay under protest letters as a monitored data point as of April 1, 2009. The Plan's policy and procedures, Provider Dispute Resolution, is also submitted in draft form, currently going through the Plans final approval process.

The Plan identified the Compliance Manager, Claims Operations Leader and the Director, SCAL Claims, as the responsible parties for overseeing the CAP and ensuring ongoing compliance.

The Plan submitted the following documents: Provider Dispute Resolution Policy and Training Update #9, Interest and Penalty Payment on Adjusted Claims.

The Department finds that SCAL Claims compliance efforts are responsive to the deficiencies cited and the corrective actions required.

SECTION II. INTERNAL CONTROL

Sections 1384, 1345 (s) and Rule 1300.45 (q) include requirements for filing financial statements in accordance with generally accepted accounting principles ("GAAP") and other authoritative pronouncements of the accounting profession.

Statement on Auditing Standards (SAS) No. 78 states "Internal control is a process—effected by an entity's board of directors, management, and other personnel—designed to provide reasonable assurance regarding the achievement of objectives in the following categories: (a) reliability of financial reporting, (b) effectiveness and efficiency of operations, and (c) compliance with applicable laws and regulations."

SAS 60 requires an auditor to communicate reportable conditions noted during the examination to appropriate personnel. Reportable conditions involve matters coming to the auditor's attention relating to significant deficiencies in the design or operation of the internal control structure, which could adversely affect the organization's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements.

A. TRACKING OF RECEIPT OF ADDITIONAL CLAIM INFORMATION

Northern California Region

The Department's examination disclosed that the Plan populated the "Date of Receipt of Additional Information" field in the Northern Region's claims payment processing system, CATS, with a denial date when the requested information was not received in order to allow

CATS to close the claim and issue a denial letter. Populating a date in the “Date of Receipt of Additional Information” that was not accurate resulted in CATS indicating that additional information was received when none was received. Examples included denied sample numbers 1, 2, 6, 9, 13, 16, 19, 23, 24, 26, 30, 42, 43, 46, 47, 48 and 49.

The Plan was requested to implement a system change to CATS to stop populating the “Date of Receipt of Additional Information” field when no additional information was received. Furthermore, the Plan was requested to indicate the date of implementation of the system change and the management position responsible for compliance. If the Plan was not able to complete the system change within 45 days of receipt of this report, the Plan was required to submit a monthly status report until the system change was implemented.

The Plan responded that NCCA was reviewing the required specifications that must be used to change the existing logic in the Claims Adjudication and Tracking System (CATS). The change would allow a claims processor to close a claim when requested information was not received without requiring entry of a date in the new information date field of the CATS bill screen. NCCA would work with the KPIT systems team to implement the systems changes. The targeted implementation date is November 30, 2009. NCCA will submit a monthly status report until the system change is implemented.

The Plan identified the Compliance Manager, Senior Operations Leader and the Director, NCCA, as the responsible parties for overseeing the CAP and ensuring ongoing compliance.

The Department acknowledges that NCCA’s claims payment processing system changes will be completed by November 30, 2009. Therefore, monthly status reports are due within 15 days following the close of each month. The first status report (due on October 15, 2009) should indicate NCCA’s implementation progress toward achieving the necessary system changes. The last status report (due by December 15, 2009) is required to summarize all the system changes and indicate the date of their implementation. The monthly status reports should be submitted through the Department’s eFiling web portal.

SECTION III. NON-ROUTINE EXAMINATION

The Plan was advised that the Department may conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this report. The cost of such examination would be charged to the Plan in accordance with Section 1382 (b).

No response was required for this Section.