



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

**Department of Managed Health Care**  
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November 26, 2007

Via Federal Express Delivery & Email

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 ROUTINE EXAMINATION OF KAISER  
FOUNDATION HEALTH PLAN, INC.**

Dear Mr. Halvorson:

Enclosed is the Final Report of the Routine Examination of the fiscal and administrative affairs of Kaiser Foundation Health Plan, Inc. (the "Plan") for the quarter ended December 31, 2006. The examination was 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").<sup>1</sup> The Department issued a Preliminary Report to the Plan on August 3, 2007. The Plan filed responses to the Department on September 17, 2007 for its Northern California region and on September 24, 2007 for its Southern California region.

This Final Report includes a description of the compliance efforts included in the Plan's September 2007 responses, in accordance with Section 1382 (c).

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 September 2007 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.

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<sup>1</sup> 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.

If the Plan requests the Department to append a brief statement summarizing the Plan's September 2007 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://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. 20071557" 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 September 2007 responses did not fully resolve the deficiencies cited and the corrective actions required in the Preliminary Report issued by the Department on August 3, 2007. 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.

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. 20071557" 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](mailto:spedro@dmhc.ca.gov). You may also email inquiries to [wps@dmhc.ca.gov](mailto:wps@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](http://www.dmhc.ca.gov).

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

Sincerely,

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

ng:jn

cc: Maria Borje-Bonkowski, Director, Health Plan Licensing  
Mark Wright, Chief, Division of Financial Oversight  
Marcy Gallagher, Chief, Division of Plan Surveys  
Elizabeth Spring, Counsel, Division of Licensing  
Jamey Matalka, Examiner, Division of Financial Oversight  
Ned Gennaoui, Senior Examiner, Division of Financial Oversight

**CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE**

**DIVISION OF FINANCIAL OVERSIGHT**

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

**FILE NO. 933 0055**

**DATE OF FINAL REPORT: NOVEMBER 26, 2007**

**SUPERVISING EXAMINER: JANET NOZAKI**

**EXAMINER-IN-CHARGE: NED GENNAOUI**

**FINANCIAL EXAMINERS:**

**AGNES DOUGHERTY  
GALAL GADO  
MARIA MARQUEZ  
JAMEY MATALKA  
SUSAN MILLER**



## 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:	6,758,447
Service Area:	Major counties within California.
Date of Last Public Routine Financial Examination Report:	April 21, 2004

## **FINAL REPORT FOR THE ROUTINE EXAMINATION OF KAISER FOUNDATION HEALTH PLAN, INC.**

This is the Final Report of the Routine Examination of the fiscal and administrative affairs of Kaiser Foundation Health Plan, Inc. (the "Plan") for the quarter ended December 31, 2006. The examination was 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").<sup>1</sup> The Department issued a Preliminary Report to the Plan on August 3, 2007. The Plan filed responses with the Department on September 17, 2007 for its Northern California region and on September 24, 2007 for its Southern California region.

This Final Report includes a description of the compliance efforts included in the Plan's September 2007 responses to the Preliminary Report, in accordance with Section 1382 (c).

We performed a limited scope examination of the financial report filed with the Department for the quarter ended December 31, 2006, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions.

Our findings are presented in the accompanying attachment as follows:

Section I.	Financial Report
Section II.	Calculation of Tangible Net Equity
Section III.	Compliance Issues
Section IV.	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.***

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<sup>1</sup> 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. FINANCIAL REPORT**

Our examination resulted in no adjustments or reclassifications to the Plan's December 31, 2006 financial report filed with the Department.

A copy of the Plan's financial statements can be viewed at the Department's website by typing the link <http://wpso.dmhc.ca.gov/fe/search.asp> and selecting Kaiser Foundation Health Plan, Inc. on the first drop down menu.

**No response was required to this Section.**

## **SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)**

Net Worth per Examination as of December 31, 2006	\$10,332,225,000
Less: Receivables from officers, directors, and affiliates	50,000
Less: Intangibles	63,273,000
TNE	<u>\$10,268,902,000</u>
TNE required at December 31, 2006	<u>912,041,000</u>
Excess TNE per Examination as of December 31, 2006	<u>\$9,356,861,000</u>

As of December 31, 2006, the Plan was in compliance with the TNE requirements of Section 1376 and Rule 1300.76.

**No response was required to this Section.**

## **SECTION III. COMPLIANCE ISSUES**

### **A. 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.

Rule 1300.71 (a) (8) defines a "demonstrable and unjust payment pattern" or "unfair payment pattern" as any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims. Subsection (K) describes one of the payment patterns as the failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

**Northern California Region**

We selected a sample of fifty (50) potentially late claims to determine if interest and penalties were paid correctly in accordance with the Sections and Rule stated above. We initially reviewed fifteen (15) of these claims and found that five (5) or 33% of these claims were not paid the correct interest and penalties due. Prior to completing our review, the Plan acknowledged in writing that the Plan does not meet the 95 percent compliance rate regarding the payment of interest and penalty on late claims, and there were sufficient numbers of interest and penalty deficiencies requiring a corrective action plan for remediation. The review of late claims was discontinued as a result of the acknowledgement on February 16, 2007.

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

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 & Penalty Due	ER or Non- ER
L29	05/24/06	12/19/06	148	\$0	\$27.65	Non-ER
L32	08/29/06	11/14/06	16	\$0	\$25.00	ER
L36	05/11/05	11/27/06	504	\$24.25	\$25.73	Non-ER
L38	09/28/05	10/23/06	329	\$0	\$44.02	Non-ER
L39	08/03/06	11/01/06	29	\$0	\$16.64	Non-ER

**Southern California Region**

We selected a sample of fifty (50) potentially late claims to determine if interest and penalties were paid correctly in accordance with the Sections and Rule stated above.

We initially reviewed seven (7) of these claims and found that three (3) or 43% of these claims were not paid the correct interest and penalties due. Prior to completing our review, the Plan acknowledged in writing that the Plan does not meet the 95 percent compliance rate regarding the payment of interest and penalty on late claims, and there were sufficient numbers of interest and penalty deficiencies requiring a corrective action plan for remediation. The review of late claims was discontinued as a result of the acknowledgement on March 21, 2007.

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

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 & Penalty Due	ER or Non-ER
L09	07/19/06	12/07/06	76	\$0	\$145.15	ER
L15	03/13/06	12/12/06	207	\$3.06	\$10.26	Non-ER
L19	08/08/06	10/23/06	14	\$0	\$10.83	Non-ER

The failure to pay interest and penalties in the Northern and Southern California Regions was noted in the Final Report of the previous routine examination, dated April 26, 2004. In its response to the Preliminary Report for 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.

**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 it has failed to achieve the necessary levels of compliance with the Act and Regulations cited.

The Plan was also required to submit a Corrective Action Plan ("CAP") by Region 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, 2004 (the implementation date of Rule 1300.71) 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:
  - o Claim number
  - o 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 is completed.

### **Northern California Region**

*Northern California Claims Administration (“NCCA”) responded that it has experienced difficulty in achieving the necessary levels of compliance with Rule 1300.71 (a)(8), subsection (K) due to the following reason:*

*“The claims adjudication system is programmed to automatically calculate interest on claims processed past the 45 working day timeframe; however, there is a certain amount of manual intervention required from claims processors in order for the system to correctly apply interest and penalties on adjusted claims. Claims processors must determine the reason why a claim is being adjusted, input the correct receipt date for the claim if additional information was requested, and use the appropriate code to trigger the system to process the adjusted claim correctly. NCCA has identified that claims processors were inconsistent in following the required policies and procedures which has resulted in an unacceptable level of compliance.”*

*NCCA stated that all claims processors were in-serviced on April 17, 2007, July 27, 2007 and August 3, 2007 regarding the requirement for payment of interest and penalty on late claims and adjusted claims. Copies of the attendance sheets and training documents were included in the Plan’s September 17<sup>th</sup> response. The in-service sessions were conducted by NCCA’s department trainer, who has 5 years of training experience, 9 years of claims processing experience and is a certified trainer through Achieve Global. Additional in-service training sessions will be scheduled during the 4<sup>th</sup> quarter of 2007 and in 2008.*

*NCCA is monitoring correct payment of interest and penalties on adjusted claims through a monthly audit of a random sample of completed adjusted claims. Audit results are reviewed with the Operations Leader and Claims supervisors. Issues identified are addressed with the claims processor to ensure understanding of the procedure.*

*NCCA has identified the population of late and adjusted claims for the period January 1, 2004 to current that may require remediation. Each claim will be reviewed to determine if interest and penalty is owed. The total number of claims for the period is 40,469 claims.*

*NCCA stated that all remediation activities will be completed by March 31, 2008. The Plan will submit a monthly status report, including an electronic data file with required data elements, to demonstrate evidence that interest and penalties were paid on affected claims.*

*NCCA will monitor payment of interest and penalty on all claims processed beyond the required timeframes through an exception report that is automatically generated daily and weekly. A copy of a sample exception report was submitted with the Plan's September 17<sup>th</sup> response. NCCA identified the Operations Leader as the individual responsible for reviewing the report to ensure that appropriate interest and penalties are paid.*

*NCCA identified the Manager of Regulatory Compliance NCCA, the Manager of Quality Assurance and Provider Dispute Processing NCCA, the Operations Leader NCCA, and the Senior Operations Leader NCCA, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

**The Department acknowledges that NCCA's remediation on the 40,469 claims will be completed by March 31, 2008. Therefore, monthly status reports are due within 15 days following the close of each month. The first status report will be due on December 15, 2007 listing all interest and penalties paid up to November 30, 2007. The monthly status reports should be submitted through the Department's eFiling web portal, as described in the cover letter, until the remediation is completed.**

### **Southern California Region**

*Southern California Claims Administration ("SCAL") responded that it has experienced difficulty in achieving the necessary levels of compliance with Rule 1300.71 (a)(8), subsection (K) due to the following reason:*

*"The claims adjusters in the provider dispute unit were incorrectly changing the receive date on the claim to the dispute date rather than using the original claim receive date. The claims adjudication system is programmed to automatically calculate interest on claims processed past the 45 working day timeframe; however, there is a certain amount of manual intervention required from claims adjusters in order for the system to correctly apply interest. Claims adjusters must input the correct receipt date for the claim and use the appropriate code to trigger the system to process the claim correctly. SCAL Claims processors were inconsistent in following*

*the required policies and procedures which has resulted in an unacceptable level of compliance.”*

*SCAL stated its Interest Calculator was updated on May 29, 2007. The Interest Calculator is used to verify interest being calculated by the claims processing system and used to calculate interest when the system does not automatically calculate the interest on the claim.*

*The policy statement for processing interest on late claims was revised effective July 5, 2007 to ensure that interest and penalties on all late claims is calculated and processed accurately. Updated materials were included in the Plan’s September 24<sup>th</sup> response.*

*Training materials regarding interest and penalty were updated on May 22, 2007. All claims staff attended an in-service training conducted by the senior trainer on June 19, 20, and 21 of 2007 to review the updated missed interest training materials. An additional in-service training was to occur in October 2007 and will be conducted by the senior trainer to reinforce the policy and procedures associated with missed interest and penalties.*

*Claims adjusters have indicated confusion on how to identify emergency room claims; therefore, on some occasions are inappropriately applying the emergency claim interest calculation. An additional in-service training was scheduled for October 2007 to review how to identify emergency room claims.*

*Commercial claims are not paying interest with providers flagged with a letter of agreement (LOA) in the OCPS claim payment system. A system enhancement is in process and will be completed to correct this issue by December 2007. The remediation of these claims is included in the overall remediation plan.*

*Effective February 12, 2007, SCAL established a weekly missed interest remediation report. This report includes claims where interest was potentially due but no interest payment was made. The report is received by claims managers who review and monitor the report weekly to ensure that all impacted claims are adjusted by claims staff. The report was retroactive to January 1, 2007 and all claims from January 1, 2007 through September 8, 2007 have been adjusted. The report is used to ensure that all claims are adjusted weekly to pay any interest due as well as penalties.*

*Starting in April 2007, SCAL began remediation of late claims for which interest and penalties was due from January 1, 2004 through December 31, 2006. The interest and penalty payments for initial claims were identified and paid retroactively by May 2007. The total number of claims remediated from January 1, 2004 through December 31, 2006 was 1,906 claims. SCAL paid additional interest of \$37,464.42 and penalties of \$19,010.00 on the 1,906 claims.*

*Starting in February 2007, SCAL Claims began addressing all missed interest on late claims on a weekly basis. All identified late claims are adjusted each week to pay the appropriate interest and penalty. The total number of claims remediated from January 1,*

*2007 through September 8, 2007 was 47 claims. SCAL paid additional interest of \$374.68 and penalties of \$450 on the 47 claims. SCAL has not paid interest and penalties of \$21.59 on two claims.*

*Evidence on remediation for all identified late claims for which interest and penalties were due (for the period January 1, 2004 through December 31, 2006) was provided with the Plan's corrective action plan and was completed in May 2007.*

*Evidence on remediation for all identified late claims for which interest and penalties were due (for the period January 1, 2007 through the date the corrective action was implemented) was provided with the Plan's corrective action plan and was completed in September 2007.*

*SCAL identified the Compliance Manager, the Claims Operations Manager, and the Director of SCAL Claims Administration, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

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

## **B. CLAIMS DENIAL**

Sections 1371 and 1371.35 require that if the claim is contested or denied by the plan, the claimant shall be notified, in writing, that the claim is contested or denied within 45 working days after receipt of the claim by a health care service plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

Rule 1300.71 (a) (8) defines a "demonstrable and unjust payment pattern" or "unfair payment pattern" as any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims. Subsection (F) describes one of the payment patterns as the failure to provide a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section (d)(1) at least 95% of the time for the affected claims over the course of any three-month period.

### **Northern California Region**

#### **1. Denial for Taxpayer Identification Number**

Our examination disclosed that the Plan denied claims because they "did not receive the information requested." The information requested was the providers' taxpayer identification number ("TIN"). Although the TIN number was reported on the claim form, the Plan's procedure is to verify the TIN if it is a non-contracted provider that is billing the Plan for the first time. The Plan's policy is to make phone calls to providers, but these calls were not well-documented. In addition, our review disclosed that the Plan was sending several letters to the subscriber informing him that the claim was denied because of missing information. These procedures did not represent adequate attempts to verify the provider's TIN. Also, the Plan's denial letter did not provide a clear written explanation of the specific reason for the denial.

The Plan was required to implement a policy and procedures to address the verification of provider's TIN and to establish a record of communication with providers when obtaining additional information. In addition, the denial letter was to clearly state the specific reason for claims denial. Furthermore, the Plan was required to state the date of implementation of this policy and procedures and the management position responsible for implementation and compliance.

*NCCA responded that its policy and procedure were revised effective June 28, 2007 to clearly indicate how the staff must document communications with providers when obtaining additional information required when validating the provider's tax identification number, address, specialty, etc. The policy and procedure were revised on June 28 and 29, 2007. Staff was in-serviced on the revised policy and procedure on June 28 and 29, 2007. A copy of the attendance sheets was included in the Plan's September 17<sup>th</sup> response. NCCA stated that a minor revision was subsequently made to the policy and procedure on September 4, 2007. Staff was to be in-serviced on the updated policy and procedure by September 15, 2007.*

*NCCA stated that denial reasons and the corresponding text are automated within NCCA's claims adjudication system. A system change will be implemented by January 31, 2008 modifying language associated with the denial when a claim is denied because the Plan was unable to obtain required additional information.*

*NCCA identified the Manager of Regulatory Compliance NCCA and the Senior Operations Leader NCCA, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

**The Department finds that NCCA's compliance efforts are responsive to the deficiencies cited and the corrective actions required. However, the Plan is required to submit a copy of the revised policy and procedure mentioned in NCCA's response. In addition, the Plan is required to provide a written acknowledgement that it will provide a copy to the Department of the modified language used for denial letters regarding TIN numbers that NCCA will implement by January 31, 2008.**

### *Northern and Southern California Regions*

#### **2. Clear Explanation of Denial Reasons**

Our examination disclosed that the Plan does not consistently provide correct denial reasons on denial letters to providers. The denial letter should identify the missing information requested by the Plan to produce a Complete Claim.

The Plan was requested to implement a policy and procedures, and provide training to claims processors to ensure that denied claims letters identify the missing information necessary for claims reimbursement. In addition, the Plan was required to state the date of implementation of this policy and procedures, date of training, and the management position responsible for implementation and compliance.

### Northern California Region

*NCCA responded that it provides all claim processors a reference guide titled “Commercial Denials” which includes all denial codes and explanations, the corresponding text that is printed on denial letters when the code is used and specific instructions to indicate when the code should be used. A copy of the reference guide was included in the Plan’s September 17<sup>th</sup> response.*

*On September 26, 2007, NCCA stated that it in-serviced the claims processors on the appropriate use of the reference tool. A follow-up session was scheduled on November 6, 2007.*

*NCCA identified the Manager of Regulatory Compliance NCCA, the Manager of Quality Assurance, the Training and Provider Dispute Processing NCCA, the Operations Leader NCCA, and the Senior Operations Leader NCCA, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

**The Department finds that NCCAs compliance efforts are not fully responsive to the deficiencies cited and the corrective actions required. Denial Category “ER Hospital Bill” of the reference guide titled “Commercial Denials” is unreasonable since it requests the claimant to “...contact the hospital [where the patient was seen in the emergency room and then transferred to the hospital submitting the claim for payment] and request they [emergency room hospital] submit a completed UB-92 form and an itemized statement, with a complete list of all charges.” This code should be deleted from the guide since the Plan is responsible for requesting emergency room records.**

**The Plan is required to provide a written acknowledgment that Denial Category “ER Hospital Bill” was removed from the guide and the computerized claims payment processing system.**

### Southern California Region

*SCAL responded that it 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) effective November 19, 2007. This system is used by SCAL to compile documents and letters based on data from the claims processing system. The new system allows SCAL to track and address: letter issuance, letter content and letter language for all claim denial letters. The final implementation and policy statements were completed on July 2, 2007. In addition, any training materials associated with the revised policy statement were reviewed to assure accuracy and consistency with the newly revised policy statement. Updated materials, denied procedures and a matrix training aid were included in the Plan’s September 24<sup>th</sup> response.*

*SCAL stated that a report was created and is used to conduct monthly compliance and content reviews of each denial letter to ensure that it contains a clear explanation of the denial*

*reason. The report is reviewed by managers and the results are discussed with team supervisors who are responsible for direct feedback to claims staff for real-time training. Results of the error trends are tracked, reported and reviewed by managers to allow a timely response to any negative trends in errors. The claims supervisors provide feedback from those reports to the claims staff through Daily Dialogue sessions.*

*SCAL identified the Compliance Manager, the Claims Operations Manager, and the Director of SCAL Claims Administration, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

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

## **C. REIMBURSEMENT OF CLAIMS**

Rule 1300.71 (a)(8)(K) states that failure to reimburse at least 95 percent of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period constitutes a basis for a finding that the plan has engaged in a “demonstrable and unjust payment pattern.”

### **Northern and Southern California Regions**

#### **1. Retro-Active Enrollment**

Our examination disclosed that the Plan failed to reprocess previously denied claims for individuals with retroactive enrollment. These claims were previously denied due to member’s ineligibility. The Plan stated that it does not have policies and procedures for reprocessing these claims.

**The Plan’s failure to reprocess previously denied claims for members that are retroactively added to membership was referred to the Department’s Office of Enforcement for appropriate administrative action.**

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

- a. Identification of all claims denied due to member ineligibility during the period of January 1, 2004 through the date corrective action has been implemented by the Plan for members that were retroactively added to Plan membership.
- b. Evidence that these claims were reprocessed (paid or denied) and that interest and penalty were paid retroactively to the first calendar day after 45 working days from the member enrollment date. This evidence is 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 denied due to ineligibility
- Enrollment date
- Date new claim was received, if applicable
- 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 is to include the total number of claims and the total additional interest and penalty paid, as a result of remediation.

- c. Implementing a policy and procedures to ensure the reprocessing of previously denied claims for members that are retroactively added to membership.
- d. The date these policy and procedures were implemented, the management position responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing 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 is completed.

### **Northern California**

*NCCA responded that it has identified the claims denied due to member ineligibility but coverage was retroactively reinstated during the period January 1, 2004 through August 31, 2007. There are a total of 1,155 claims. Each claim will be reviewed to determine if coverage was effective on the date the service was incurred. If so, the claim will be re-processed.*

*NCCA stated that all remediation activities will be completed by November 30, 2007. NCCA will submit a monthly status report (including an electronic data file with required data elements) to demonstrate evidence that interest and penalties were paid on affected claims.*

*Effective September 5, 2007, NCCA implemented a policy and procedure to identify and reprocess denied claims for members who have been retroactively enrolled. A copy of the policy and procedure were submitted with the Plan's September 17<sup>th</sup> response.*

*NCCA will generate a monthly exception report with the list of affected claims that will need to be reviewed and reprocessed. The Operations Leader is responsible for ensuring that the claims listed on the report are reviewed and if appropriate, reprocessed by the 15th of each month.*

*NCCA identified the Manager of Regulatory Compliance NCCA and the Operations Leader NCCA, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

**The Department acknowledges that NCCA's remediation will be completed by November 30, 2007. The Plan is required to submit evidence, as described above, of its remediation with its response to the Final Report.**

**Southern California Region:**

*SCAL responded that it identified all claims that potentially meet the criteria of denial for ineligibility during the period of January 1, 2004 through July 31, 2007 and submitted a spreadsheet detailing these claims with its September 24, 2007 response. The Plan identified 31,231 claims for 2004, 25,786 claims for 2005, 24,542 claims for 2006, and 11,311 through July 31, 2007. The claims identified need to be reviewed against the eligibility system to identify the claims for members that were retroactively added to Plan membership. Upon completion of this review and remediation of this file, the Plan will identify all potential claims that meet the criteria for denial for ineligibility for the period from August 1, 2007 through December 31, 2007 with the results subject to the same review process noted above. A report will be generated to identify potential claims meeting the criteria on a monthly basis moving forward.*

*Evidence on remediation for all identified claims for which interest and penalties were due, will be completed by March 31, 2008. SCAL will submit a monthly status report, including an electronic data file with required data elements, to demonstrate evidence that interest and penalties were paid on affected claims until completed.*

*SCAL stated that it has a policy regarding eligibility. This policy has been revised to include a new section 6.0 Retroactive Member Activity and was submitted in the Plan's September 24, 2007 response. The revised policy will be implemented by December 31, 2007 upon approval of the proposed revisions.*

*In addition, SCAL is in the process of developing a monthly report by October 31, 2007 to identify all claims denied due to member ineligibility for members that were retroactively added to plan membership. The monthly report will be reviewed and monitored by claims managers and supervisors to ensure identified claims are being reprocessed.*

*SCAL identified the Compliance Manager, the Rework & Recovery Unit Manager, and the Director of SCAL Claims Administration, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

**The Department acknowledges that SCAL's remediation will be completed by March 31, 2008. Therefore, monthly status reports are due within 15 days following the close of each**

**month. The first status report will be due on December 15, 2007 listing all interest and penalties paid up to November 30, 2007. The monthly status reports should be submitted through the Department's eFiling web portal, as described in the cover letter, until the remediation is completed.**

### **Southern California Region**

## **2. Retro-Active Provider Contracts**

Our examination disclosed that the Plan failed to reprocess previously processed claims for providers with new negotiated compensation rates that were retroactively applied. The claims were previously paid based on prior provider compensation rates. The Plan stated that it does not have policies and procedures for reprocessing these claims that have retroactive provider compensation rates.

**The Plan's failure to reprocess claims from providers that entered into a new compensation arrangement with a retroactive application date was referred to the Department's Office of Enforcement for appropriate administrative action.**

The Plan was required to submit a Corrective Action Plan ("CAP") that includes the following:

- a. Identification of all claims processed incorrectly during the period of January 1, 2004 through the date corrective action has been implemented by the Plan for providers with new negotiated compensation rates that were retroactively applied.
- b. Evidence that these claims were reprocessed (paid or denied) and that interest and penalty were paid retroactively to the first calendar day after 45 working days from the execution date of the contract. 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
  - Total billed
  - Paid date (based on prior compensation rates)
  - Total paid (based on prior compensation rates)
  - Provider contract execution date
  - Total understatement or overstatement of amount paid
  - Amount paid (based on new compensation rates), if applicable
  - Date of additional payment (based on new compensation rates), if applicable
  - 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.

- c. The Plan was required to implement a policy and procedures to reprocess claims from providers that entered into a new compensation arrangement with a retroactive application date.
- d. In addition, the Plan was required indicate the date these policy and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

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 is completed.

*The Plan responded that, in fact, a process has been in place to track and correctly pay such claims to the satisfaction of affected providers. The Plan apologized for not clarifying the significance of the information provided during the course of the Department's on-site examination and requests an opportunity to further discuss this issue following submission of the Plan's response.*

*This process has been in place since 2003 (i.e., prior to January 1, 2004) and the Plan's intent has been to continuously improve the process, the most recent improvement being the implementation of a control element in October 2006. Although the process has been in place over that time period, it was not formalized into a written procedure until April 18, 2006. The Plan submitted a copy of the written procedure as evidence of this process in its September 24<sup>th</sup> response.*

*The Plan stated that it has been aware of the potential for incorrect claims payments in this context and as a result developed several approaches to deal with the problem as early as 2003. These approaches have evolved over time, and in recent times have been improved and further formalized. Rate negotiations requiring the retroactive application of new rates is not an uncommon occurrence. Frequently this issue is discussed during contract rate negotiations with providers and essentially made part of that negotiation. By attempting to resolve incorrect claims payment issues up-front during this negotiation period, the matter is handled pro-actively to the mutual satisfaction of both parties. All approaches attempt in some manner to approximate the dollar amount that would be due to the provider by estimating the claims volume that may be submitted during the negotiation period before a new contract rate is formalized and retroactively applied. These arrangements may take different forms, as follows:*

- *A settlement memorialized by letter to the provider, relating to an amendment to the agreement or the agreement itself, involving a lump sum payment settling claims for a specific date range.*
- *As above with a stand alone settlement agreement*
- *A claim-by-claim settlement (individual claim adjudication) with a settlement agreement settling all listed claims.*

*The Plan submitted an example of a redacted copy of a recent Extension Letter of Agreement and Term Sheet that includes a settlement of Kaiser Foundation Hospital liability for an 8% rate increase for the period June 1, 2007 to September 30, 2007. This involved a \$356,000 lump sum payment in lieu of claim-by-claim reconciliation and payment.*

*In those instances in which the provider elects to address claims payment issues after the conclusion of Plan-provider negotiations, the Plan works with the provider to identify affected claims so that they can be paid in a timely and accurate manner. In this alternative approach, a dedicated Claims unit will solicit precise information from the provider to facilitate this effort. The contracted provider might communicate its claims payment issues to either Claims or the Plan's Contracting Department. In either case, this process is typically a joint remediation effort of the Claims and Contracting Departments.*

*First, the Claims unit sends a formatted spreadsheet to the provider requesting specific information with respect to the claims at issue.*

*The provider is instructed to submit the requested information on the spreadsheet as directed back to the claims unit. This unit is responsible to research and adjust, as necessary, the claims identified by the provider. It is the responsibility of this claims unit to complete other fields on the spreadsheet to process the claim.*

*The Claims unit is also required to provide any comments to explain its action, as well as indicate any additional amount due and the code for the adjustment.*

*The information given Department examiners during the on-site examination should have clarified the existence and functioning of the process. Further, the Plan recognizes the need to better train appropriate personnel regarding this process and to develop a written policy and procedure that is up to date and clear. As mentioned, the Plan is currently engaged in improving its process and will document such improvements in a revised and updated policy and procedure. The Plan expects to submit that revised policy and procedure no later than November 30, 2007.*

*The Plan responded that its most recent improvement to the process was implemented in October 2006. At that time, Claims began to systematically log retroactively applied contract rates in order to better track claims that may be submitted during the negotiation period relating to such contracts. Further, Claims is currently developing a report that will provide the volume of affected claims identified by this control element, as well as the percentage of the claims identified that have been remediate to date. This report will include the requested*

*data elements in part b of the Required Action relating to remediation of the identified affected claims. The Plan stated that it will submit this report to the Department by October 8, 2007.*

*In bringing this deficiency to its attention, the Department has aided the Plan's efforts to further improve its process. The Plan respectfully requests further dialog with the Department on this matter after submission of the September 24<sup>th</sup> response to ensure that its efforts to continuously improve are properly focused.*

*SCAL identified the Compliance Manager, the Claims Operations Manager, and the Director of SCAL Claims Administration, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

**In a conference call with the Department on November 9, 2007, the Plan agreed to manually review all retro-contracts for 2006 and identify effective claims that need to be remediated and the amount of remediation per claim. The results of this review will be submitted to the Department with the Plan's response to the Final Report. After review the Plan's results, the Department will determine if the Plan needs to manually review retro-contracts and make remediation for effective claims in 2004 and 2005. The Department acknowledges that the Plan's revised policy and procedures will be submitted by November 30, 2007. The Plan acknowledged that it has not submitted a report that included the requested data elements in part b as stated in its September 24<sup>th</sup> response.**

### Southern California Region

#### **3. Retro-Active Authorizations**

Our examination disclosed that the Plan denied claims for lack of authorization. However, the Plan failed to reprocess those claims after a retroactive authorization was issued. The Plan stated that it does not have policies and procedures for reprocessing previously denied claims after authorizations have been issued for them.

The Plan was required to implement a policy and procedures to reprocess previously denied claims when retroactive authorizations are issued. In addition, the Plan was required indicate the date these policy and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

*SCAL responded that its policy statement for processing claims with a retroactive authorization was revised to include a new section, 6.0 Provisions/Procedures and 6.1 Retroactive Authorizations. This section addresses denied claims where the authorization was received subsequent to the claim. The revised policy will be implemented October 31, 2007. The revised policy and procedures were submitted with the Plan's September 24<sup>th</sup> response.*

*SCAL stated that it would develop a weekly report by October 31, 2007, to identify all claims denied for lack of authorization where a retroactive authorization was issued. The report will be retroactive to January 1, 2007 and all impacted claims will be remediated. Claims supervisors will review the weekly report for impacted claims to ensure claims are reprocessed, when appropriate. Claims Managers will monitor the report to ensure that claims are reprocessed.*

*SCAL identified the Compliance Manager, the Recovery Unit Manager and the Director of SCAL Claims Administration, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

**The Department finds that SCAL’s compliance efforts are responsive to the deficiencies cited and the corrective actions required. However, SCAL is required to submit a written acknowledgment that a weekly report was developed and implemented by October 31, 2007.**

#### **D. FORWARDING MISDIRECTED CLAIMS**

Rule 1300.71(b)(2)(A) states that failure to forward at least 95 percent of misdirected claims within ten (10) working days of receipt of the claim that was incorrectly sent to the plan over the course of any three-month period constitutes a basis for a finding that the plan has engaged in a “demonstrable and unjust payment pattern.”

##### **Southern California Region**

Claims incorrectly sent to the Plan for reimbursement that are not the financial responsibility of the Plan were not forwarded to the appropriate capitated provider within ten (10) working days of receipt by the Plan.

The following are examples of misdirected claims that were not forwarded within ten (10) working days (or 14 calendar days) by the Plan:

<b>Sample No.</b>	<b>Receipt Date</b>	<b>Denied Letter Date</b>	<b>Number of Calendar Days to Forward Misdirected Claims in Excess of 10 Working Days</b>
D 11	09/14/06	10/19/06	21
D13	09/20/06	10/12/06	8
D 27	09/05/06	10/06/06	17

The Plan was required to implement a policy and procedures to forward misdirected claims within ten (10) working days of receipt. The Plan was to state the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

*SCAL responded that it does not have a current policy or a systematic process for identifying misdirected claims, except for first responders. However, non-first responder claims represent only a small percentage of the overall misdirected claim population. SCAL is currently not able to consistently identify non-first responder misdirected claims in the front end claim unit (mail/scan/verify). SCAL is currently addressing the overall misdirected claims process and will create a revised process that will address all misdirected claims. The revised process and policy will be completed by December 31, 2007.*

*Currently, SCAL has a training aid regarding first responder misdirected claims. This population of misdirected claims represents the majority of the misdirected claims population. First responder misdirected claims are forwarded to a misdirected mail queue and the queue is monitored through a claims aging report by claims supervisors. The training aid was implemented January 11, 2005 and last revised on September 14, 2007. The New High Level Process Overview section of the training aid was revised by adding the requirement to forward misdirected claims within 10 working days of receipt of the claim. A copy of the training aid was submitted with the Plan's September 24<sup>th</sup> response.*

*Again on September 7, 2007, a review regarding the timely handling of first responder misdirected claims was performed by the operations manager with the claims supervisors that manage the misdirected mail report and queue. The supervisors were advised to forward all misdirected claims within ten working days of the receipt of the claim. SCAL stated that training would occur for managers and supervisors on the revised training aid on September 30, 2007.*

*SCAL also stated that it has a daily aging report to identify first responder claims that are not the financial responsibility of the Plan. A copy of the aging report was included in the Plan's September 24<sup>th</sup> response. SCAL states that claims managers will perform daily monitoring of the report for aging first responder misdirected claims to ensure that the claims are forwarded within 10 working days of receipt of the claim. SCAL will implement a weekly review of the turn around times associated with the misdirected activity report to allow timely feedback to claims adjusters to stay within required time frame by September 30, 2007.*

*SCAL identified the Compliance Manager, the Claims Operations Manager, and the Director of SCAL Claims Administration, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

**The Department finds that SCAL's compliance efforts are responsive to the deficiencies cited and corrective actions required. However, SCAL is required to submit a written acknowledgment that the revised process will be implemented on schedule by December 31, 2007.**

**E. 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.

**Northern California Region**

Our examination determined that interest was either not paid or underpaid on adjusted claim payments that resulted from provider disputes for 3 out of 50 (or 6%) of the provider disputes reviewed. The failure to pay interest correctly was due to the Plan incorrectly using the date of receipt of the dispute rather than the original receipt date of the claim to determine timeliness of the claim payment. The Plan is to use the original date of receipt because the original claim was incorrectly paid.

Examples of disputes resulting in adjusted claims for which interest was not paid or underpaid are as follows:

DMHC PDR Sample No.	Date of Receipt for Original Claim	Dispute Payment Date	Number of Days to Calculate Interest	Plan Calculated Interest Paid	DMHC Calculated Interest	Penalty Fee	Interest and Penalties Due
PD 06	08/09/06	12/22/06	71	\$0	\$15.00	\$10.00	\$25.00
PD 35	11/21/06	01/28/07	4	\$0	\$1.96	\$10.00	\$11.96
PD 54	08/31/06	01/14/07	72	\$338.08	\$421.82	\$0.00	\$93.74

**Southern California Region**

Our examination determined that interest was not paid, underpaid, or was paid after the Department provided the examination sample selection to the Plan on adjusted claim payments that resulted from provider disputes for 9 out of 50 (or 18%) of the provider disputes reviewed. The failure to pay interest correctly was due to the Plan incorrectly using the date of receipt of the dispute rather than the original receipt date of the claim to determine timeliness of the claim payment. The Plan is to use the original date of receipt because the original claim was incorrectly paid.

Examples of disputes resulting in adjusted claims for which interest was not paid, underpaid, or was paid after the Department provided the sample selection to the Plan are as follows:

DMHC PDR Sample No.	Date of Receipt for Original Claim	Dispute Payment Date	Number of Days to Calculate Interest	Plan Calculated Interest Paid	DMHC Calculated Interest	Penalty Fee	Interest and Penalties Due
PD 02	07/06/06	03/06/07	179	\$30.58	\$88.27	\$0	\$67.69
PD 05	07/05/06	12/07/06	91	\$25 .00 *	\$15.00	\$10.00	\$0
PD 26	07/31/06	01/06/07	95	\$0	\$15.00	\$10.00	\$25.00
PD 27	07/21/06	11/17/06	55	\$25.00 *	\$15.00	\$10.00	\$0

\* Interest and penalty were paid on March 8, 2007, after examination sample selection was provided to the Plan.

The failure to pay interest and penalties in the Northern and Southern California Regions on additional late claims payments resulted from provider disputes was noted in the Final Report of a provider dispute resolution mechanism examination, dated October 15, 2005. 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 these reports. This examination disclosed that the Plan's compliance efforts have not achieved the necessary levels of compliance with the Act and Regulations cited.

**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 the Plan has failed to achieve the necessary levels of compliance with the Act and Regulations cited.

The Plan was also required to submit a Corrective Action Plan ("CAP") by Region 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 and 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 September 1, 2005 (the date of the last remediation project) 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:
  - o Claim number
  - o Date of service
  - o Date original claim received
  - o Date new information received (date claim was complete)
  - o Total billed
  - o Total paid
  - o Paid date
  - o Interest amount paid
  - o 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 is required to submit a timeline with its response and monthly status reports until the CAP is completed.

### **Northern California Region**

*NCCA responded that it has experienced difficulty in achieving the necessary levels of compliance with Rule 1300.71.38 (g) due to the following reason.*

*“The claims adjudication system is programmed to automatically calculate interest on claims processed past the 45 working day timeframe; however, there is a certain amount of manual intervention required from claims processors in order for the system to correctly apply interest and penalties on adjusted claims. Claims processors must determine the reason why a claim is being adjusted, input the correct receipt date for the claim if additional information was requested, and use the appropriate code to trigger the system to process the adjusted claim correctly. NCCA has identified that claims processors were inconsistent in following the required policies and procedures which has resulted in an unacceptable level of compliance.”*

*NCCA stated that all claims processors were in-serviced on April 17, 2007, July 27, 2007 and August 3, 2007 regarding the requirement for payment of interest and penalty on late claims, and adjusted claims. Adjusted claims include claims where a payment is issued because of a provider dispute. Copies of the attendance sheets were submitted with the Plan’s September 17<sup>th</sup> response. Additional in-service training sessions will be scheduled during the 4<sup>th</sup> quarter of 2007 and in 2008.*

*NCCA is monitoring correct payment of interest and penalties on adjusted claims through a monthly audit of a random sample of completed adjusted claims. Audit results are reviewed with the Operations Leader and Claims supervisors. Errors identified are corrected and addressed with the claims processor to ensure understanding of the procedure. Also, an audit of a random sample of completed provider dispute cases is conducted monthly. A component of this audit is to validate that appropriate interest and penalty is applied and paid accurately on affected claims.*

*NCCA has identified the population of overturned claims resulting from a provider dispute for the period September 1, 2005 to current that may require remediation. Each claim will be reviewed to determine if interest and penalty is owed. The total number of overturned provider dispute cases for the period is 15,230.*

*All remediation activities will be completed by March 31, 2008. NCCA stated that it will submit a monthly status report, including an electronic data file with required data elements, to demonstrate evidence that interest and penalties were paid on affected claims.*

*NCCA identified the Manager of Regulatory Compliance NCCA, the Manager of Quality Assurance, the Training and Provider Dispute Processing NCCA, and the Senior Operations Leader NCCA, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

**The Department acknowledges that NCCA's remediation will be completed by March 31, 2008. Therefore, monthly status reports are due within 15 days following the close of each month. The first status report will be due on December 15, 2007 listing all interest and penalties paid up to November 30, 2007. The monthly status reports should be submitted through the Department's eFiling web portal, as described in the cover letter, until the remediation is completed.**

**Southern California Region:**

*SCAL responded that it has been unsuccessful in achieving the necessary levels of compliance with Rule 1300.71.38 (g) for the following reasons:*

*"The claims adjusters in the provider dispute unit were incorrectly changing the receive date on the claim to the dispute date rather than using the original claim receive date. The claims adjudication system is programmed to automatically calculate interest on claims processed past the 45 working day timeframe; however, there is a certain amount of manual intervention required from claims adjusters in the provider dispute unit in order for the system to correctly apply interest. Claims adjusters in the provider dispute unit must input the correct receipt date for the claim and use the appropriate code to trigger the system to process the claim correctly. SCAL Claims adjusters in the provider dispute unit were inconsistent in following the required policies and procedures which has resulted in an unacceptable level of compliance."*

*SCAL stated that training materials regarding interest and penalty were updated on May 22, 2007*

*The Interest Calculator was updated on May 29, 2007. The Interest Calculator is used to verify interest being calculated by the claims processing system and used to calculate interest when the system does not automatically calculate the interest on the claim.*

*All claims staff attended an in-service training on June 19, 20, and 21 of 2007 to review the updated training, updated interest calculator, training materials for Commercial Clean Claim Interest and updated policy statement. A copy of these update materials were submitted in the Plan's September 24<sup>th</sup> response.*

*An additional in-service training would occur in October 2007 to cover the July 5, 2007 revised policy statement and to address the correct payment of interest and penalties within five working days of issuance of the written determination of the provider dispute. All training was to be conducted by the senior trainer.*

*SCAL responded that its policy statement for processing interest on adjusted claims was revised effective July 5, 2007 to ensure that interest and penalties on all adjusted claims are calculated and processed accurately. The policy statement would be further revised by October 15, 2007, to address the correct payment of interest and penalties within five working days of the issuance of the written determination of the provider dispute. An additional in-service training would occur in October 2007 and would be conducted by the senior trainer to review the changes in the policy statement regarding processing interest and penalties on adjusted claim.*

*SCAL stated that claims adjusters in the provider dispute unit have indicated confusion on how to identify emergency room claims; therefore, on occasion they are inappropriately applying the emergency claim interest calculation. An additional in-service training was scheduled for October 2007 to review how to identify emergency room claims.*

*Additional training will be conducted to the claims adjusters to ensure the correct receive date is used when making adjustments and to address the correct payment of interest and penalties within five working days of issuance of the written determination of the provider dispute by December 2007.*

*Commercial claims are not paying interest with providers flagged with a letter of agreement (LOA) in the OCPS claim payment system. A system enhancement will be completed to correct this issue by December 2007. Remediation of these claims is included in the overall remediation plan.*

*SCAL stated that a report is currently being created and will be completed by September 30, 2007 to identify any adjusted claims where interest should have been paid, but no interest was paid for the period of January 1, 2007 through September 30, 2007. These claims will be remediated by December 31, 2007. Effective October 1, 2007, a weekly report will be generated to identify any adjusted claims where interest and penalties should have been paid, but no interest was paid. Adjustments will be made weekly to pay any interest due as well as penalties. Managers and supervisors will review and monitor these reports to ensure that all impacted claims receive the correct interest and penalty payments.*

*The interest and penalty payments for adjusted claims has been identified and paid retro-actively for claims from the universe dates January 1, 2006 through December 31, 2006, and was completed in August 2007. Evidence of the remediation effort was included in the Plan's September 24<sup>th</sup> response.*

*Further remediation for claims paid September 1, 2005 through December 31, 2005, will be completed by December 31, 2007. SCAL will submit a monthly status report, including an electronic data file with required data elements, to demonstrate evidence that interest and penalties were paid on affected claims until completed.*

*Evidence on remediation for all identified adjusted claims from September 1, 2005 through December 31, 2006, for which interest and penalties was due is provided with this corrective action plan and was completed in August 2007. Evidence on remediation for identified adjusted claims for 2007 will be completed by March 31, 2008. SCAL stated that it will submit a monthly status report, including an electronic data file with required data elements, to demonstrate evidence that interest and penalties were paid on affected claims until completed.*

*SCAL identified the Compliance Manager, the Rework and Recovery Unit Manager, and the Director of SCAL Claims Administration, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

**The Department acknowledges that SCAL's remediation will be completed by March 31, 2008. Therefore, monthly status reports are due within 15 days following the close of each month. The first status report will be due on December 15, 2007 listing all interest and penalties paid up to November 30, 2007. The monthly status reports should be submitted through the Department's eFiling web portal, as described in the cover letter, until the remediation is completed.**

#### **F. DISPUTE DETERMINATION - RIGHT OF APPEAL**

Rule 1300.71(e)(5) states that a provider submitting a claim dispute to the Plan involving an issue of medical necessity or utilization review shall have an unconditional right of appeal for that claim dispute to the primary plan's dispute resolution process for a de novo review and resolution for a period of 60 working days from the Plan's Date of Determination, pursuant to Rule 1300.71.38.

##### **Northern California Region**

The Plan contracts with The Permanente Medical Group ("TPMG") for the provision of medical services, and TPMG pays claims on behalf of the Plan. TPMG's determination letter does not indicate that the dispute determination was made by the Plan's dispute resolution committee.

The Plan was required to provide language in TPMG's dispute determination letter for the decision regarding the claim dispute that indicates the Plan's participation in the dispute determination. The Plan was required to provide a copy of TPMG's revised dispute determination letter.

The Plan was also required to state the date the use of this revised determination letter began, the Plan management position(s) responsible for overseeing TPMG's compliance with the corrective action, and a description of the monitoring system implemented to ensure continued compliance with this Rule.

Northern California Region:

*In Northern California, the Plan responded that the Provider Dispute Review Committee is a Health Plan function that reviews and decides provider disputes on behalf of both The Permanente Medical Group (TPMG) and the Plan. The committee charter from its inception reflects that the voting members of the committee who determine the resolution of the dispute are the Plan representatives.*

*In order to ensure that providers clearly understand that, while TPMG initially adjudicates appropriate claims, provider disputes related to those claims are decided by the Plan, the following changes have been made. The initial claim determination letter and remittance advice will include language that informs the provider that any dispute will be reviewed by the Plan and not by TPMG. Copies of the letter and remittance advice were included in the Plan's September 17<sup>th</sup> 2007 response. The provider dispute acknowledgement and resolution letters are being revised to accurately reflect that the dispute review decision is made by the Plan, which is signing the communications to the provider. These changes will be effective in their entirety by October 1, 2007.*

*The Plan will conduct a post implementation review of the above changes in November 2007 along with its annual claim provider dispute oversight audit in 2008.*

**The Department finds that the Plan's compliance efforts were responsive to the deficiencies cited and the corrective actions required.**

**G. FIDELITY BOND**

Section 1351 (q) and Rule 1300.76.3 requires each plan to at all times maintain a fidelity bond covering each officer, director, trustee, partner, and employee of the plan, whether or not they are compensated. The fidelity bond shall provide for 30 days notice to the Director prior to cancellation. The fidelity bond shall provide, at least, the minimum coverage for the plan, as required by the schedule in this Rule.

Our review of the fidelity bond disclosed that the Plan is covered under a blanket policy with its subsidiaries and related entities, and there was no evidence that the Plan has exclusive coverage of, at least, \$2 million that will not be eroded by claims made by subsidiaries and related entities covered under the policy.

The Plan was required to file a copy of the fidelity bond endorsement or rider that demonstrates that it has exclusive coverage that meets the requirements of Rule 1300.76.3. The Plan is also required to state the management position responsible for compliance and a description of the controls implemented to ensure continued compliance.

*The Plan responded that it obtained an endorsement to its Fidelity Bond that meets its coverage requirements under Rule 1300.76.3. This endorsement provides that a minimum of \$2,000,000 of the \$16,400,000 per occurrence limit of liability applicable to each insuring agreement shall be available solely for the loss of Kaiser Foundation Health Plan, Inc.*

*To ensure continued compliance, the Plan identified the Director of Corporate Risk Management as the individual responsible for reviewing Rule 1300.76.3 and ensuring that the requirements are met as a part of the procedures for renewing this policy or soliciting proposals from other insurance carriers for Fidelity Bond coverage.*

**The Department finds that the Plan's compliance efforts were responsive to the deficiencies cited and the corrective actions required.**

**SECTION IV. NONROUTINE EXAMINATION**

The Plan is 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 will be charged to the Plan in accordance with Section 1382 (b).

**No response was required to this Section.**

**KAISER FOUNDATION HEALTH PLAN, INC.**  
**Northern and Southern California Regions**

**Plan Addendum Response to Final Report of Routine Financial  
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**Exhibit FE-5**

**SUMMARY DESCRIPTION OF PLAN ORGANIZATION AND OPERATION**

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This acknowledges receipt of the Department's Final Report of Routine Financial Examination, issued November 26, 2007 (the "Final Report"). Pursuant to Section 1382 (d) of the Knox-Keene Act, the Plan hereby submits its modified response to be appended to the Final Report upon its public disclosure.

The Department's cover letter to the Final Report, from Supervising Examiner Janet Nozaki, instructs as follows:

Please indicate within ten (10) days whether the Plan requests the Department to append its September 2007 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.

The Plan made such request in writing on December 4, 2007 following a telephone discussion with Ms. Nozaki on November 30<sup>th</sup>. A copy of that written request is attached hereto.

The Department issued its Preliminary Report of Routine Financial Examination on August 3, 2007 and the Plan filed its responses on the 17<sup>th</sup> (Northern California) and 24<sup>th</sup> (Southern California) of September, 2007 (together, the "September responses"). The Final Report provides an accurate paraphrasing of the Plan's September responses to each deficiency found. This portion of the Final Report is in italicized type and describes the Plan's corrective actions taken as of the time of the September responses, as well as proposed future corrective action.

Given the Final Report's inclusion of the Plan's September responses, the Plan wishes only to add modifications to describe additional corrective actions taken, proposals for further corrective action, and clarifications of several points in the Final Report. The Plan wishes to append the statement that follows, in its entirety, to the Final Report upon its public disclosure.

## PLAN'S COMMENTS TO FINAL REPORT

Following is a shortened version of the Final Report that includes additional comments and clarifications of the Plan. An edited version of each remaining deficiency is followed by the Final Report's paraphrasing of the Plan's September responses (italicized portion). This is followed by the Department's statement regarding the sufficiency of the corrective actions already taken and guidance for further corrective action (bolded portion). The Plan's additional comments and clarifications follow the Department's statement (italicized bolded portion).

### **A. FAILURE TO PAY INTEREST DUE ON LATE CLAIMS PAYMENT - REPEAT DEFICIENCY**

Rule 1300.71 (a) (8) defines a "demonstrable and unjust payment pattern" or "unfair payment pattern" as any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims. Subsection (K) describes one of the payment patterns as the failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

#### **Northern California Region**

*Northern California Claims Administration ("NCCA") responded that it has experienced difficulty in achieving the necessary levels of compliance with Rule 1300.71 (a)(8), subsection (K) due to the following reason:*

*"The claims adjudication system is programmed to automatically calculate interest on claims processed past the 45 working day timeframe; however, there is a certain amount of manual intervention required from claims processors in order for the system to correctly apply interest and penalties on adjusted claims. Claims processors must determine the reason why a claim is being adjusted, input the correct receipt date for the claim if additional information was requested, and use the appropriate code to trigger the system to process the adjusted claim correctly. NCCA has identified that claims processors were inconsistent in following the required policies and procedures which has resulted in an unacceptable level of compliance."*

*NCCA stated that all claims processors were in-serviced on April 17, 2007, July 27, 2007 and August 3, 2007 regarding the requirement for payment of interest and penalty on late claims and adjusted claims. Copies of the attendance sheets and training documents were included in the Plan's September 17<sup>th</sup> response. The in-service sessions were conducted by NCCA's department trainer, who has 5 years of training experience, 9 years of claims processing experience and is a certified trainer through Achieve Global. Additional in-service training sessions will be scheduled during the 4<sup>th</sup> quarter of 2007 and in 2008.*

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*NCCA is monitoring correct payment of interest and penalties on adjusted claims through a monthly audit of a random sample of completed adjusted claims. Audit results are reviewed with the Operations Leader and Claims supervisors. Issues identified are addressed with the claims processor to ensure understanding of the procedure.*

*NCCA has identified the population of late and adjusted claims for the period January 1, 2004 to current that may require remediation. Each claim will be reviewed to determine if interest and penalty is owed. The total number of claims for the period is 40,469 claims.*

*NCCA stated that all remediation activities will be completed by March 31, 2008. The Plan will submit a monthly status report, including an electronic data file with required data elements, to demonstrate evidence that interest and penalties were paid on affected claims.*

*NCCA will monitor payment of interest and penalty on all claims processed beyond the required timeframes through an exception report that is automatically generated daily and weekly. A copy of a sample exception report was submitted with the Plan's September 17<sup>th</sup> response. NCCA identified the Operations Leader as the individual responsible for reviewing the report to ensure that appropriate interest and penalties are paid.*

*NCCA identified the Manager of Regulatory Compliance NCCA, the Manager of Quality Assurance and Provider Dispute Processing NCCA, the Operations Leader NCCA, and the Senior Operations Leader NCCA, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

**The Department acknowledges that NCCA's remediation will be completed by March 31, 2008. Therefore, monthly status reports are due within 15 days following the close of each month. The first status report will be due on December 15, 2007 listing all interest and penalties paid up to November 30, 2007. The monthly status reports should be submitted through the Department's eFiling web portal, as described in the cover letter, until the remediation is completed.**

**Plan's Additional Comment**

*Per telephone discussion with Supervising Examiner Janet Nozaki on November 30, 2007, the Plan will submit the first monthly status report on December 26, 2007 instead of December 15<sup>th</sup>. By December 26<sup>th</sup> the Plan must submit evidence of additional corrective action taken for those deficiencies where the Department has required such action. For any deficiency requiring monthly status reports, the December status report will be submitted December 26<sup>th</sup>.*

*To clarify the Plan's September response, in saying that the number of claims for the period totals 40,469, the Plan means that it must review that number of claims; however, not every such claim will require remediation.*

*The remediation process for the affected claims is in progress and on track for completion by March 31, 2008. The first monthly status report to be submitted December 26<sup>th</sup> will include a data file in Excel format of late and adjusted claims for the period January 1, 2004 to current that may require remediation, as well as the*

*result of the Plan's analysis of reviewed claims and interest and penalties paid up to November 30, 2007. Subsequent monthly reports will be submitted on January 15, February 15, and March 15, 2008. A final report will be submitted on April 15, 2008 to demonstrate evidence of full completion of the required remediation.*

**B. IMPROPER CLAIMS DENIAL DUE TO REASONS CITED BELOW**

**Northern California Region**

- 1. Improper Denial for Taxpayer Identification Number** -- Plan denied claims on basis that Plan "did not receive the information requested" when the information requested was the providers' taxpayer identification number ("TIN"). Plan's procedures for follow-up on this point deemed inadequate.

*NCCA responded that its policy and procedure were revised effective June 28, 2007 to clearly indicate how the staff must document communications with providers when obtaining additional information required when validating the provider's tax identification number, address, specialty, etc. The policy and procedure were revised on June 28 and 29, 2007. Staff was in-serviced on the revised policy and procedure on June 28 and 29, 2007. A copy of the attendance sheets was included in the Plan's September 17<sup>th</sup> response. NCCA stated that a minor revision was subsequently made to the policy and procedure on September 4, 2007. Staff was to be in-serviced on the updated policy and procedure by September 15, 2007.*

*NCCA stated that denial reasons and the corresponding text are automated within NCCA's claims adjudication system. A system change will be implemented by January 31, 2008 modifying language associated with the denial when a claim is denied because the Plan was unable to obtain required additional information.*

*NCCA identified the Manager of Regulatory Compliance NCCA and the Senior Operations Leader NCCA, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

**The Department finds that NCCA's compliance efforts are responsive to the deficiencies cited and the corrective actions required. However, the Plan is required to submit a copy of the revised policy and procedure mentioned in NCCA's response. In addition, the Plan is required to provide a written acknowledgement that it will provide a copy to the Department of the modified language used for denial letters regarding TIN numbers that NCCA will implement by January 31, 2008.**

**Plan's Additional Comment**

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*The Plan has developed a policy and procedure as required and it will submit a copy of it with the response required under Rule 1300.82 (response to show additional evidence of corrective action to resolve deficiencies cited, due December 26, 2007).*

## **2. Clear Explanation of Denial Reasons**

Plan did not consistently provide correct denial reasons on denial letters to providers and denial letter did not identify the missing information requested by the Plan to produce a complete claim. Plan requested to implement a policy and procedures, and provide training to claims processors to ensure that denied claims letters identify the missing information necessary for claims reimbursement.

### **Northern California Region**

*NCCA responded that it provides all claim processors a reference guide titled “Commercial Denials” which includes all denial codes and explanations, the corresponding text that is printed on denial letters when the code is used and specific instructions to indicate when the code should be used. A copy of the reference guide was included in the Plan’s September 17<sup>th</sup> response.*

*On September 26, 2007, NCCA stated that it in-serviced the claims processors on the appropriate use of the reference tool. A follow-up session was scheduled on November 6, 2007.*

*NCCA identified the Manager of Regulatory Compliance NCCA, the Manager of Quality Assurance, the Training and Provider Dispute Processing NCCA, the Operations Leader NCCA, and the Senior Operations Leader NCCA, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

**The Department finds that NCCA’s compliance efforts are not fully responsive to the deficiencies cited and the corrective actions required. Denial Category “ER Hospital Bill” of the reference guide titled “Commercial Denials” is unreasonable since it requests the claimant to “...contact the hospital [where the patient was seen in the emergency room and then transferred to the hospital submitting the claim for payment] and request they [emergency room hospital] submit a completed UB-92 form and an itemized statement, with a complete list of all charges.” This code should be deleted from the guide since the Plan is responsible for requesting emergency room records.**

**The Plan is required to provide a written acknowledgment that Denial Category “ER Hospital Bill” was removed from the guide and the computerized claims payment processing system.**

### **Plan’s Additional Comment**

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*The Plan's reference guide will be revised per the above guidance and the Category "ER Hospital Bill" will be removed from the computerized claims payment processing system. Evidence demonstrating this will be provided with the response required under Rule 1300.82 (response to show additional evidence of corrective action to resolve deficiencies cited, due December 26, 2007).*

**C. FAILURE TO REIMBURSE COMPLETE CLAIMS TIMELY AND WITH PROPER INTEREST, DUE TO REASONS CITED BELOW**

**Northern and Southern California Regions**

- 1. Retro-Active Enrollment** - Plan failed to reprocess previously denied claims for individuals with retroactive enrollment. These claims were previously denied due to member's ineligibility.

**Northern California**

*NCCA responded that it has identified the claims denied due to member ineligibility but coverage was retroactively reinstated during the period January 1, 2004 through August 31, 2007. There are a total of 1,155 claims. Each claim will be reviewed to determine if coverage was effective on the date the service was incurred. If so, the claim will be re-processed.*

*NCCA stated that all remediation activities will be completed by November 30, 2007. NCCA will submit a monthly status report (including an electronic data file with required data elements) to demonstrate evidence that interest and penalties were paid on affected claims.*

*Effective September 5, 2007, NCCA implemented a policy and procedure to identify and reprocess denied claims for members who have been retroactively enrolled. A copy of the policy and procedure were submitted with the Plan's September 17<sup>th</sup> response.*

*NCCA will generate a monthly exception report with the list of affected claims that will need to be reviewed and reprocessed. The Operations Leader is responsible for ensuring that the claims listed on the report are reviewed and if appropriate, reprocessed by the 15<sup>th</sup> of each month.*

*NCCA identified the Manager of Regulatory Compliance NCCA and the Operations Leader NCCA, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

**The Department acknowledges that NCCA's remediation will be completed by November 30, 2007. The Plan is required to submit evidence, as described above, of its remediation with its response to the Final Report.**

**Plan's Additional Comment**

***The Plan acknowledges that NCCA completed processing of all affected claims and will submit evidence of the remediation on December 26, 2007.***

**Southern California Region:**

*SCAL responded that it identified all claims that potentially meet the criteria of denial for ineligibility during the period of January 1, 2004 through July 31, 2007 and submitted a spreadsheet detailing these claims with its September 24, 2007 response. The Plan identified 31,231 claims for 2004, 25,786 claims for 2005, and 24,542 claims for 2006, and 11,311 through July 31, 2007. The claims identified need to be reviewed against the eligibility system to identify the claims for members that were retroactively added to Plan membership.*

*Evidence on remediation for all identified claims for which interest and penalties were due, will be completed by March 31, 2008. SCAL will submit a monthly status report, including an electronic data file with required data elements, to demonstrate evidence that interest and penalties were paid on affected claims until completed.*

*SCAL stated that it has a policy regarding eligibility. This policy has been revised to include a new section 6.0 Retroactive Member Activity and was submitted in the Plan's September 24, 2007 response. The revised policy will be implemented by December 31, 2007 upon approval of the proposed revisions.*

*In addition, SCAL is in the process of developing a monthly report by October 31, 2007 to identify all claims denied due to member ineligibility for members that were retroactively added to plan membership. The monthly report will be reviewed and monitored by claims managers and supervisors to ensure identified claims are being reprocessed.*

*SCAL identified the Compliance Manager, the Rework & Recovery Unit Manager, and the Director of SCAL Claims Administration, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

**Upon completion of this review, the Plan will identify all potential claims that meet the criteria for denial for ineligibility for the period from August 1, 2007 through October 31, 2007 with the results subject to the same process above. The Department acknowledges that SCAL's remediation will be completed by March 31, 2008. Therefore, monthly status reports are due within 15 days following the close of each month. The first status report will be due on December 15, 2007 listing all interest and penalties paid up to November 30, 2007. The monthly status reports should be submitted through the Department's eFiling web portal, as described in the cover letter, until the remediation is completed.**

**Plan's Additional Comment**

***The revised policy is on target to be fully implemented no later than December 31, 2007, as previously stated. In-service training on implementation of this policy is***

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*complete. The monthly report that was to be developed by October 2007 noted in the Plan's September response above will be submitted, along with any further evidence of additional corrective actions taken, with the response required under Rule 1300.82 (response to show additional evidence of corrective action to resolve deficiencies cited, due December 26, 2007). By agreement with the Department, the first monthly status report will be submitted with the December 26<sup>th</sup> response.*

*Please note that the September response indicated that the Plan had identified approximately 92,000 potential claims during the period from January 1, 2004 through July 2007. After running those results against the Plan's membership/eligibility system, the Plan determined that approximately 2,000 such claims required remediation. Although the Plan was able to create a report to identify impacted claims, it was an ad hoc report that has not yet been systematized. The Plan is in the process of developing the capability to generate this report on a regular monthly basis. Notwithstanding these challenges, the Plan has committed to completing remediation by March 31, 2008.*

### **Southern California Region**

#### **2. Retro-Active Provider Contracts**

Plan failed to reprocess previously processed claims for providers with new negotiated compensation rates that were retroactively applied. The claims were previously paid based on prior provider compensation rates.

*The Plan responded that, in fact, a process has been in place to track and correctly pay such claims to the satisfaction of affected providers. The Plan apologized for not clarifying the significance of the information provided during the course of the Department's on-site examination and requests an opportunity to further discuss this issue following submission of the Plan's response.*

*This process has been in place since 2003 (i.e., prior to January 1, 2004) and the Plan's intent has been to continuously improve the process, the most recent improvement being the implementation of a control element in October 2006. Although the process has been in place over that time period, it was not formalized into a written procedure until April 18, 2006. The Plan submitted a copy of the written procedure as evidence of this process in its September 24<sup>th</sup> response. The Plan stated that it has been aware of the potential for incorrect claims payments in this context and as a result developed several approaches to deal with the problem as early as 2003. These approaches have evolved over time, and in recent times have been improved and further formalized. Rate negotiations requiring the retroactive application of new rates is not an uncommon occurrence. Frequently this issue is discussed during contract rate negotiations with providers and essentially made part of that negotiation. By attempting to resolve incorrect claims payment issues up-front during this negotiation period, the matter is handled pro-actively to the mutual*

*satisfaction of both parties. All approaches attempt in some manner to approximate the dollar amount that would be due to the provider by estimating the claims volume that may be submitted during the negotiation period before a new contract rate is formalized and retroactively applied. These arrangements may take different forms, as follows:*

- *A settlement memorialized by letter to the provider, relating to an amendment to the agreement or the agreement itself, involving a lump sum payment settling claims for a specific date range.*
- *As above with a stand alone settlement agreement*
- *A claim-by-claim settlement (individual claim adjudication) with a settlement agreement settling all listed claims.*

*The Plan submitted an example of a redacted copy of a recent Extension Letter of Agreement and Term Sheet that includes a settlement of Kaiser Foundation Hospital liability for an 8% rate increase for the period June 1, 2007 to September 30, 2007. This involved a \$356,000 lump sum payment in lieu of claim-by-claim reconciliation and payment.*

*In those instances in which the provider elects to address claims payment issues after the conclusion of Plan-provider negotiations, the Plan works with the provider to identify affected claims so that they can be paid in a timely and accurate manner. In this alternative approach, a dedicated Claims unit will solicit precise information from the provider to facilitate this effort. The contracted provider might communicate its claims payment issues to either Claims or the Plan's Contracting Department. In either case, this process is typically a joint remediation effort of the Claims and Contracting Departments.*

*First, the Claims unit sends a formatted spreadsheet to the provider requesting specific information with respect to the claims at issue. The provider is instructed to submit the requested information on the spreadsheet as directed back to the claims unit. This unit is responsible to research and adjust, as necessary, the claims identified by the provider. It is the responsibility of this claims unit to complete other fields on the spreadsheet to process the claim.*

*The Claims unit is also required to provide any comments to explain its action, as well as indicate any additional amount due and the code for the adjustment.*

*The information given Department examiners during the on-site examination should have clarified the existence and functioning of the process. Further, the Plan recognizes the need to better train appropriate personnel regarding this process and to develop a written policy and procedure that is up to date and clear. As mentioned, the Plan is currently engaged in improving its process and will document such improvements in a revised and updated policy and procedure. The Plan expects to submit that revised policy and procedure no later than November 30, 2007.*

*The Plan responded that its most recent improvement to the process was implemented in October 2006. At that time, Claims began to systematically log retroactively applied contract rates in order to better track claims that may be submitted during the negotiation period relating to such contracts. Further, Claims is currently developing a report that will provide the volume of affected claims identified by this control element, as well as the percentage of the claims identified that have been remediate to date. This report will include the requested data elements in part b of the Required Action relating to remediation of the identified affected claims. The Plan stated that it will submit this report to the Department by October 8, 2007.*

*In bringing this deficiency to its attention, the Department has aided the Plan's efforts to further improve its process. The Plan respectfully requests further dialog with the Department on this matter after submission of the September 24<sup>th</sup> response to ensure that its efforts to continuously improve are properly focused.*

*SCAL identified the Compliance Manager, the Claims Operations Manager, and the Director of SCAL Claims Administration, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

**In a conference call with the Department on November 9, 2007, the Plan agreed to manually review all retro-contracts for 2006 and identify effective claims that need to be remediated and the amount of remediation per claim. The results of this review will be submitted to the Department with the Plan's response to the Final Report. After review the Plan's results, the Department will determine if the Plan needs to manually review retro-contracts and make remediation for effective claims in 2004 and 2005. The Department acknowledges that the Plan's revised policy and procedures will be submitted by November 30, 2007. The Plan acknowledged that it has not submitted a report that included the requested data elements in part b as stated in its September 24<sup>th</sup> response.**

#### **Plan's Additional Comment**

*The Plan acknowledges that a revised corrective action plan was developed in the November 9, 2007 telephone meeting with the Department. As the Plan explained in the November 9<sup>th</sup> meeting, because full remediation under this revised plan will require manual review of all retro-contracts for 2006 and the identification of all claims requiring adjustment by virtue of being subject to a retro contract, full remediation will take time. The Plan anticipates that full remediation will not be complete for at least several months. Accordingly, a detailed plan for accomplishing such remediation (and the time frame for accomplishing it) will be submitted, along with any evidence of corrective actions taken to date, with the response required under Rule 1300.82 (response to show additional evidence of corrective action to resolve deficiencies cited, due December 26, 2007).*

*Note that the revised policy and procedure that was to be submitted on November 30<sup>th</sup> is complete and the Plan will submit it with its December 26<sup>th</sup> response. The report the*

*Department notes as missing in the September 24<sup>th</sup> response was provided to the Department for the November 9<sup>th</sup> meeting. It was an excel spreadsheet that identified some claims subject to retro contracts, going back to January 1, 2004. The Plan acknowledged at the November 9<sup>th</sup> meeting that the report was flawed in that it did not include all data elements and may not have identified every affected claim. Because of the Plan's difficulty in complying with the Department's required corrective action as written in the Preliminary Report, the Department permitted the Plan to undertake the revised corrective action noted above.*

### **Southern California Region**

#### **3. Retro-Active Authorizations**

Plan denied claims for lack of authorization; however, Plan failed to reprocess those claims after a retroactive authorization was issued.

*SCAL responded that its policy statement for processing claims with a retroactive authorization was revised to include a new section, 6.0 Provisions/Procedures and 6.1 Retroactive Authorizations. This section addresses denied claims where the authorization was received subsequent to the claim. The revised policy will be implemented October 31, 2007. The revised policy and procedures were submitted with the Plan's September 24<sup>th</sup> response.*

*SCAL stated that it would develop a weekly report by October 31, 2007, to identify all claims denied for lack of authorization where a retroactive authorization was issued. The report will be retroactive to January 1, 2007 and all impacted claims will be remediated. Claims supervisors will review the weekly report for impacted claims to ensure claims are reprocessed, when appropriate. Claims Managers will monitor the report to ensure that claims are reprocessed.*

*SCAL identified the Compliance Manager, the Recovery Unit Manager and the Director of SCAL Claims Administration, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

**The Department finds that SCAL's compliance efforts are responsive to the deficiencies cited and the corrective actions required. However, SCAL is required to submit a written acknowledgment that a weekly report was developed and implemented by October 31, 2007.**

#### **Plan's Additional Comment**

*The Plan acknowledges that the weekly report was developed and implemented by October 31, 2007.*

#### **D. FORWARDING MISDIRECTED CLAIMS**

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Plan failed to forward at least 95 percent of misdirected claims within ten (10) working days of receipt.

### **Southern California Region**

Claims incorrectly sent to the Plan for reimbursement that are not the financial responsibility of the Plan were not forwarded to the appropriate capitated provider within ten (10) working days of receipt by the Plan. The Plan was required to implement a policy and procedures to forward misdirected claims within ten (10) working days of receipt. The Plan was to state the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

*SCAL responded that it does not have a current policy or a systematic process for identifying misdirected claims, except for first responders. However, non-first responder claims represent only a small percentage of the overall misdirected claim population. SCAL is currently not able to consistently identify non-first responder misdirected claims in the front end claim unit (mail/scan/verify). SCAL is currently addressing the overall misdirected claims process and will create a revised process that will address all misdirected claims. The revised process and policy will be completed by December 31, 2007.*

*Currently, SCAL has a training aid regarding first responder misdirected claims. This population of misdirected claims represents the majority of the misdirected claims population. First responder misdirected claims are forwarded to a misdirected mail queue and the queue is monitored through a claims aging report by claims supervisors. The training aid was implemented January 11, 2005 and last revised on September 14, 2007. The New High Level Process Overview section of the training aid was revised by adding the requirement to forward misdirected claims within 10 working days of receipt of the claim. A copy of the training aid was submitted with the Plan's September 24<sup>th</sup> response.*

*Again on September 7, 2007, a review regarding the timely handling of first responder misdirected claims was performed by the operations manager with the claims supervisors that manage the misdirected mail report and queue. The supervisors were advised to forward all misdirected claims within ten working days of the receipt of the claim. SCAL stated that training would occur for managers and supervisors on the revised training aid on September 30, 2007. SCAL also stated that it has a daily aging report to identify first responder claims that are not the financial responsibility of the Plan. A copy of the aging report was included in the Plan's September 24<sup>th</sup> response. SCAL states that claims managers will perform daily monitoring of the report for aging first responder misdirected claims to ensure that the claims are forwarded within 10 working days of receipt of the claim. SCAL will implement a weekly review of the turn around times associated with the misdirected activity report to allow timely feedback to claims adjustors to stay within required time frame by September 30, 2007.*

*SCAL identified the Compliance Manager, the Claims Operations Manager, and the Director of SCAL Claims Administration, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

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**The Department finds that SCAL's compliance efforts are responsive to the deficiencies cited and corrective actions required. However, SCAL is required to submit a written acknowledgment that the revised process will be implemented on schedule by December 31, 2007.**

**Plan's Additional Comment**

***The Plan acknowledges that the revised process will be implemented on schedule by December 31, 2007.***

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

Plan failed to comply with rule that states if the provider dispute or amended provider dispute involves a claim which is determined in whole or in part to be in favor of the provider, the plan or the plan's capitated provider shall pay any outstanding monies determined to be due, plus all interest and penalties required under law, within five (5) working days of the issuance of the Written Determination.

**Northern California Region**

Such interest was either not paid or underpaid on adjusted claim payments that resulted from provider disputes for 3 out of 50 (or 6%) of the provider disputes reviewed. The failure to pay interest correctly was due to the Plan incorrectly using the date of receipt of the dispute rather than the original receipt date of the claim to determine timeliness of the claim payment. The Plan is to use the original date of receipt because the original claim was incorrectly paid.

*NCCA responded that it has experienced difficulty in achieving the necessary levels of compliance with Rule 1300.71.38 (g) due to the following reason.*

*“The claims adjudication system is programmed to automatically calculate interest on claims processed past the 45 working day timeframe; however, there is a certain amount of manual intervention required from claims processors in order for the system to correctly apply interest and penalties on adjusted claims. Claims processors must determine the reason why a claim is being adjusted, input the correct receipt date for the claim if additional information was requested, and use the appropriate code to trigger the system to process the adjusted claim correctly. NCCA has identified that claims processors were inconsistent in following the required policies and procedures which has resulted in an unacceptable level of compliance.”*

*NCCA stated that all claims processors were in-serviced on April 17, 2007, July 27, 2007 and August 3, 2007 regarding the requirement for payment of interest and penalty on late claims, and adjusted claims. Adjusted claims include claims where a payment is issued because of a provider dispute. Copies of the attendance sheets were submitted with the Plan's September 17<sup>th</sup> response.*

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*Additional in-service training sessions will be scheduled during the 4<sup>th</sup> quarter of 2007 and in 2008.*

*NCCA is monitoring correct payment of interest and penalties on adjusted claims through a monthly audit of a random sample of completed adjusted claims. Audit results are reviewed with the Operations Leader and Claims supervisors. Errors identified are corrected and addressed with the claims processor to ensure understanding of the procedure. Also, an audit of a random sample of completed provider dispute cases is conducted monthly. A component of this audit is to validate that appropriate interest and penalty is applied and paid accurately on affected claims.*

*NCCA has identified the population of overturned claims resulting from a provider dispute for the period September 1, 2005 to current that may require remediation. Each claim will be reviewed to determine if interest and penalty is owed. The total number of overturned provider dispute cases for the period is 15,230.*

*All remediation activities will be completed by March 31, 2008. NCCA stated that it will submit a monthly status report, including an electronic data file with required data elements, to demonstrate evidence that interest and penalties were paid on affected claims.*

*NCCA identified the Manager of Regulatory Compliance NCCA, the Manager of Quality Assurance, the Training and Provider Dispute Processing NCCA, and the Senior Operations Leader NCCA, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

**The Department acknowledges that NCCA's remediation will be completed by March 31, 2008. Therefore, monthly status reports are due within 15 days following the close of each month. The first status report will be due on December 15, 2007 listing all interest and penalties paid up to November 30, 2007. The monthly status reports should be submitted through the Department's eFiling web portal, as described in the cover letter, until the remediation is completed.**

#### **Plan's Additional Comment**

*The remediation process for the affected claims is in progress and on track for completion by March 31, 2008. NCCA will submit the first monthly status report on December 26, 2007. The status report will include a data file in Excel format of late and adjusted claims for the period January 1, 2004 to current that may required remediation, the result of the analysis for those claims that have been reviewed and interest and penalties paid up to November 30, 2007. Subsequent monthly reports will be submitted on January 15, February 15, March 15, 2008. A final report will be submitted on April 15, 2008 to demonstrate evidence of full completion of the required remediation.*

#### **Southern California Region**

Such interest was not paid, underpaid, or was paid after the Department provided the examination sample selection to the Plan on adjusted claim payments that resulted from provider disputes for 9 out of 50 (or 18%) of the provider disputes reviewed. The failure to

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pay interest correctly was due to the Plan incorrectly using the date of receipt of the dispute rather than the original receipt date of the claim to determine timeliness of the claim payment. The Plan is to use the original date of receipt because the original claim was incorrectly paid.

The failure to pay interest and penalties in the Northern and Southern California Regions on additional late claims payments resulted from provider disputes was noted in the Final Report of a provider dispute resolution mechanism examination, dated October 15, 2005. 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 these reports. This examination disclosed that the Plan's compliance efforts have not achieved the necessary levels of compliance with the Act and Regulations cited.

The Plan was required to state the reasons why the Plan has failed to achieve the necessary levels of compliance with the Act and Regulations cited. The Plan was also required to submit a Corrective Action Plan ("CAP") by Region to address the deficiency cited above.

*SCAL responded that it has been unsuccessful in achieving the necessary levels of compliance with Rule 1300.71.38 (g) for the following reasons:*

*"The claims adjusters in the provider dispute unit were incorrectly changing the receive date on the claim to the dispute date rather than using the original claim receive date. The claims adjudication system is programmed to automatically calculate interest on claims processed past the 45 working day timeframe; however, there is a certain amount of manual intervention required from claims adjusters in the provider dispute unit in order for the system to correctly apply interest. Claims adjusters in the provider dispute unit must input the correct receipt date for the claim and use the appropriate code to trigger the system to process the claim correctly. SCAL Claims adjusters in the provider dispute unit were inconsistent in following the required policies and procedures which has resulted in an unacceptable level of compliance."*

*SCAL stated that training materials regarding interest and penalty were updated on May 22, 2007. The Interest Calculator was updated on May 29, 2007. The Interest Calculator is used to verify interest being calculated by the claims processing system and used to calculate interest when the system does not automatically calculate the interest on the claim.*

*All claims staff attended an in-service training on June 19, 20, and 21 of 2007 to review the updated training, updated interest calculator, training materials for Commercial Clean Claim Interest and updated policy statement. A copy of these update materials were submitted in the Plan's September 24<sup>th</sup> response.*

*An additional in-service training would occur in October 2007 to cover the July 5, 2007 revised policy statement and to address the correct payment of interest and penalties within five working days of issuance of the written determination of the provider dispute. All training was to be conducted by the senior trainer.*

*SCAL responded that its policy statement for processing interest on adjusted claims was revised effective July 5, 2007 to ensure that interest and penalties on all adjusted claims are calculated and processed accurately. The policy statement would be further revised by October 15, 2007, to*

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*address the correct payment of interest and penalties within five working days of the issuance of the written determination of the provider dispute. An additional in-service training would occur in October 2007 and would be conducted by the senior trainer to review the changes in the policy statement regarding processing interest and penalties on adjusted claim.*

*SCAL stated that claims adjusters in the provider dispute unit have indicated confusion on how to identify emergency room claims; therefore, on occasion they are inappropriately applying the emergency claim interest calculation. An additional in-service training was scheduled for October 2007 to review how to identify emergency room claims.*

*Additional training will be conducted to the claims adjusters to ensure the correct receive date is used when making adjustments and to address the correct payment of interest and penalties within five working days of issuance of the written determination of the provider dispute by December 2007.*

*Commercial claims are not paying interest with providers flagged with a letter of agreement (LOA) in the OCPS claim payment system. A system enhancement will be completed to correct this issue by December 2007. Remediation of these claims is included in the overall remediation plan.*

*SCAL stated that a report is currently being created and will be completed by September 30, 2007 to identify any adjusted claims where interest should have been paid, but no interest was paid for the period of January 1, 2007 through September 30, 2007. These claims will be remediated by December 31, 2007. Effective October 1, 2007, a weekly report will be generated to identify any adjusted claims where interest and penalties should have been paid, but no interest was paid. Adjustments will be made weekly to pay any interest due as well as penalties. Managers and supervisors will review and monitor these reports to ensure that all impacted claims receive the correct interest and penalty payments.*

*The interest and penalty payments for adjusted claims has been identified and paid retro-actively for claims from the universe dates January 1, 2006 through December 31, 2006, and was completed in August 2007. Evidence of the remediation effort was included in the Plan's September 24<sup>th</sup> response.*

*Further remediation for claims paid September 1, 2005 through December 31, 2005, will be completed by December 31, 2007. SCAL will submit a monthly status report, including an electronic data file with required data elements, to demonstrate evidence that interest and penalties were paid on affected claims until completed.*

*Evidence on remediation for all identified adjusted claims from September 1, 2005 through December 31, 2006, for which interest and penalties was due is provided with this corrective action plan and was completed in August 2007. Evidence on remediation for identified adjusted claims for 2007 will be completed by March 31, 2008. SCAL stated that it will submit a monthly status report, including an electronic data file with required data elements, to demonstrate evidence that interest and penalties were paid on affected claims until completed.*

*SCAL identified the Compliance Manager, the Rework and Recovery Unit Manager, and the Director of SCAL Claims Administration, as the individuals responsible for overseeing the CAP and ensuring ongoing compliance.*

**The Department acknowledges that SCAL's remediation will be completed by March 31, 2008. Therefore, monthly status reports are due within 15 days following**

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the close of each month. The first status report will be due on December 15, 2007 listing all interest and penalties paid up to November 30, 2007. The monthly status reports should be submitted through the Department's eFiling web portal, as described in the cover letter, until the remediation is completed.

**Plan's Additional Comment**

*The remediation process for the affected claims is in progress and on track for completion by March 31, 2008. SCAL will submit the first monthly status report on December 26, 2007. The status report will include a data file in Excel format of late and adjusted claims for the period January 1, 2004 to current that may required remediation, the result of the analysis for those claims that have been reviewed and interest and penalties paid up to November 30, 2007. Subsequent monthly reports will be submitted on January 15, February 15, March 15, 2008. A final report will be submitted on April 15, 2008 to demonstrate evidence of full completion of the required remediation. Please also note that the policy and procedure referenced in the September response will also be submitted with the December 26<sup>th</sup> response.*

**Additional Exhibits Included in this Filing**

Exhibit E-1, Attachment 1: Letter to Janet Nozaki - Dept of Managed Health Care