



Edmund G. Brown Jr., Governor
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Business, Transportation and Housing Agency

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April 15, 2011

Via Federal Express and E-mail
In Reply Refer to File No.: 933 0176

Beth Anderson, President
AETNA HEALTH OF CALIFORNIA, INC.
2625 Shadelands Drive
Walnut Creek, CA 94598

RE: FINAL REPORT OF THE ROUTINE EXAMINATION OF AETNA HEALTH OF CALIFORNIA, INC.'S CLAIMS SETTLEMENT PRACTICE AND PROVIDER DISPUTE RESOLUTION MECHANISM

Dear Ms. Anderson:

Enclosed is the Final Report of the routine examination of Aetna Health of California, Inc.'s ("the Plan") claims settlement practice and provider dispute resolution mechanism for the three month period ending June 30, 2009. 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").¹ The Department issued a Preliminary Report to the Plan on November 16, 2010. The Department accepted the Plan's electronically filed response on December 30, 2010.

This Final Report includes a description of the compliance efforts included in the Plan's response, 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 December 30, 2010 response to the Final Report. If so, please indicate which portions

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

of the Plan's response shall be appended, and electronically file copies of those portions of the Plan's response exclusive of information held confidential pursuant to Section 1382 (c), no later than ten (10) days from the date of the Plan's receipt of this letter.

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the Preliminary Report or wishes to modify any information provided to the Department in its December 30, 2010 response, please provide the 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 "Filing No. 20081993" assigned by the Department; 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, please select "Complete Amendment", complete "Execution" and then click "complete filing".

As noted in the attached Final Report, the Plan's response of December 30, 2010 was not fully responsive to the deficiencies raised in the Preliminary Report issued by the Department on November 16, 2010. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any request for additional corrective action contained in the attached Final Report, within 30 days after receipt of the report, unless an earlier date is requested. If the Plan fails to fully respond and/or resolve the deficiencies addressed in the Final Report, then a referral will be made to the Office of Enforcement for appropriate administrative action for any remaining, unresolved deficiencies.

Please file the Plan's response 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 "Filing No. 20081993" assigned by the Department; 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, please select “Complete Amendment”, complete “Execution” and then click “complete filing”.

Questions or problems related to the electronic transmission of the above responses should be directed to Rita Ultreras at (916) 255-2443 or email at rultreras@dmhc.ca.gov. You may also email inquiries to wpsso@dmhc.ca.gov.

The Department will make the attached Final Report available to the public in ten (10) days from the Plan’s receipt of this letter. The report will be located at the Department’s web site at www.dmhc.ca.gov.

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

Sincerely,

Original Signed By

JANET NOZAKI
Supervising Examiner
Office of Health Plan Oversight
Division of Financial Oversight
tr:jn

cc: Mary V. Anderson, Western Region General Counsel, Aetna Health of California, Inc.
Maureen McKennan, Acting Deputy Director, Plan and Provider Relations
Dennis Balmer, Acting Chief, Division of Financial Oversight
Marcy Gallagher, Chief, Division of Plan Survey
Lori Gilmore, Acting Assistant Deputy Director, Office of Provider Oversight
Crystal McElroy, Counsel, Division of Licensing
Susan Miller, Examiner, Division of Financial Oversight
Anna Kyumba, Examiner, Division of Financial Oversight

**STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE**

DIVISION OF FINANCIAL OVERSIGHT

AETNA HEALTH OF CALIFORNIA, INC.

FILE NO. 933-0176

DATE OF FINAL REPORT: APRIL 15, 2011

OVERSIGHT EXAMINER: JANET NOZAKI

EXAMINER-IN-CHARGE: SUSAN J. MILLER

FINANCIAL EXAMINERS:

**CANDICE HAW
SUHAG PATEL
THOMAS ROEDL
HONG TRUONG
ASHIKA VINOD**

BACKGROUND INFORMATION FOR AETNA HEALTH OF CALIFORNIA, INC.

Date Plan Licensed:	August 5, 1981
Organizational Structure:	Aetna Health of California Inc. (the “Company”) is a wholly-owned subsidiary of Aetna Health Holdings, LLC which is a wholly-owned subsidiary of Aetna Inc. The Company is incorporated in the State of California and commenced operations as a health maintenance organization (“HMO”) in 1981.
Type of Plan:	The Plan is a full service plan that arranges for comprehensive health care services to enrollees of commercial groups, point-of-service products, and MediCare beneficiaries.
Provider Network:	The Plan provides health care services by contracting with participating medical groups on a capitated basis, as well as direct contracts with individual physicians on a discounted fee-for-service basis. Hospitals are compensated on a capitated, per diem or case rate basis.
Plan Enrollment:	The Plan reported 486,443 enrollees as of June 30, 2009.
Service Area:	Statewide
Date of last Financial Routine Examination Final Report:	March 23, 2010

FINAL REPORT OF THE ROUTINE EXAMINATION OF AETNA HEALTH OF CALIFORNIA, INC.'S CLAIMS SETTLEMENT PRACTICE AND PROVIDER DISPUTE RESOLUTION MECHANISM

This is the Final Report of a routine examination of Aetna Health of California, Inc.'s ("the Plan") claims settlement practice and provider dispute resolution mechanism for the three month period ending June 30, 2009. The examination was conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382 of the Knox-Keene Health Care Plan Act of 1975.¹ The Department issued a Preliminary Report to the Plan on November 16, 2010. The Department accepted the Plan's electronically filed response on December 30, 2010.

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

Our findings are presented in this report as follows:

Section I.	Compliance Issues
Section II.	Non-Routine Examination

Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective action contained in this report, within 30 days after receipt of this report, unless an earlier date is requested.

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

SECTION I. COMPLIANCE ISSUES

A. PROVIDER DISPUTE VIOLATIONS

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

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

Deficiency	Total Sample Population	Total in the Sample	Number of Deficiencies Found	% of Compliance
Failure to reimburse claim accurately, including interest and penalty. <i>Repeat Deficiency</i>	2,746	92	16	83%
Dispute determination not accurate or not complete.	2,746	92	7	92%

The failure to reimburse claims accurately was previously reported in the 2004 examination's Final Report dated November 21, 2005. At that time, the Plan was notified that a referral for this violation was made to the Office of Enforcement for appropriate administrative action.

The following details the provider dispute mechanism violations by the Plan found during the Department's current examination:

1. PAYMENT ACCURACY OF PROVIDER DISPUTES – REPEAT DEFICIENCY

Section 1371 requires a health care service plan to reimburse uncontested claims no later than 45 working days after the date of receipt of the claim by the plan. 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 (j) 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 and Rule 1300.71 (i), which refer to claims for emergency services, require that if an uncontested claim is not reimbursed within 45 working days after the date of receipt of the claim by the plan, the plan shall automatically include the greater of \$15 for each

12-month period or portion thereof on a non-prorated basis, or interest at the rate of 15% per annum for the period of time that the payment is late.

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 of the Health and Safety Code and section 1300.71 of title 28.

Rule 1300.71(a)(8)(K) describes one unfair payment pattern 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.

The Department's examination noted that the Plan's policy is to pay late emergency claims at 15 percent and not more than \$15 per year. The Plan should have paid the greater of \$15 for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of 15 percent per annum for the period of time that the payment is late.

The examination also found that sixteen (16) out of 92 late claims resulting from provider disputes did not receive correct payments, including interest and penalties (a compliance rate of 82%). They included provider dispute sample numbers 20, 22, 47, 50, 61, 67, 72, 73, 76, 77, 78, 103, 104, 113, 115, and 118.

Examples of interest not paid correctly are as follows:

PDR Sample No.	Date of Receipt	Date Paid	Number of Days Late for Calculating Interest	Interest Paid by Plan	Interest Calculated by the DMHC	\$10 Fee	Additional Amount Owed by Plan
20	12-6-08	6-23-09	135	\$0	\$226.80	\$10.00	\$236.80
61	12-5-08	5-28-09	110	\$0	\$195.74	\$10.00	\$205.74
77	3-24-09	6-16-09	14	\$0.41	\$15.00	\$10.00	\$24.59

This repeat violation was referred to the Office of Enforcement for appropriate administrative action. The enforcement action resulted in a \$300,000 fine being assessed against the Plan.²

The Plan was required to explain why the corrective actions it implemented to resolve this deficiency in the prior routine examination were not effective in ensuring ongoing compliance.

² Letter of Agreement dated November 23, 2010 regarding Enforcement matter number 10-002.

The Plan was required to submit a detailed Corrective Action Plan (“CAP”) to bring the Plan into compliance with Section 1371, Section 1371.35, Rule 1300.71 and Rule 1300.71.38 (g) that was to include, but not be limited to, the following:

- a. Identification of all provider disputes paid from July 16, 2005³ to the present that resulted in late adjusted claim payments to the provider, due to incorrect payment of the initial claim.
- b. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in paragraphs “a” above. This evidence was to include an electronic data file/schedule (Excel or dBase) that identified the following:
 - Claim number
 - PDR tracking number
 - Date of service
 - Date original claim received
 - Date new information received (date claim was complete)
 - Total billed
 - Original total paid
 - Original paid date
 - Amount of adjustment paid (w/ check number)
 - Date adjustment paid
 - Amount of original interest paid
 - Original interest paid date
 - Number of days used to calculate interest
 - Amount of additional interest paid (with formula)
 - Date additional interest paid
 - Penalty paid
 - Date penalty paid
 - Check number for interest and/or penalty
 - Provider name
 - ER or Non-ER indicator

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

- c. Policies and procedures implemented to ensure that the payment of all late adjusted claims include interest and penalty, if applicable.

³ The remediation period for the prior routine examination was from January 1, 2004 to July 15, 2005. Therefore, the Plan’s remediation period for this examination will be from July 16, 2005.

- d. Date the policies 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 calendar days of receipt of the preliminary report, the Plan was required to submit a timeline (that did not exceed 180 calendar days from the receipt of the preliminary report) with its response. If the Plan was not able to meet this timeframe, it was to justify the reason for the delay. The Plan was also required to submit monthly status reports until the CAP is completed.

The Plan acknowledged that it failed to pay the greater of \$15 for each 12 month period at a non-prorated basis, or interest at the rate of 15 percent per annum for late claim payments of emergency services. However, the Plan disagreed that 17 of the 92 late claims examined failed to pay late claim interest correctly. The Plan submitted evidence which illustrates a valid methodology for the payment of interest and penalty, when applicable, for provider dispute sample numbers 20, 38, 47, 50, 73, 78 and 103, and respectfully requested that these sample numbers be removed from the Final Report.

The Plan agreed that it failed to pay appropriate interest and applicable penalty for provider dispute sample numbers 22, 61, 67, 72, 76, 77, 104, 113 and 115.

The Plan also acknowledged that its failure to pay applicable interest and penalties on Provider Disputes is a repeat deficiency. The corrective actions it implemented in 2005 failed to correct the deficiency because the problem in calculating emergency services late claim interest did not begin until September of 2008. The Plan has researched this issue and has traced the error back to a system enhancement made on September 12, 2008 and does not agree with the Department's request to make corrections back to July 16, 2005.

The Plan replied that it is taking action to correct its processes to pay ER late claim interest at the greater of 15% interest per annum or \$15 on a non-prorated basis. This project will be handled in three steps.

First, the Plan is making a change to a system rule in its HMO claim system to reflect the "non-prorated" requirement. This system change is scheduled to be implemented in February of 2011. Second, once the system change has been implemented, the Plan will pull reports to identify all claims that were underpaid interest from September 12, 2008 through the current date of the report. Third, the Plan will rework claims for which it has previously paid incorrect ER late claim interest. The Plan estimated that it can make processes corrections, complete re-training its staff and rework all underpaid claims resulting from provider disputes by no later than October 1, 2011.

Based on the Plan's representation that the problem for calculating interest on emergency service claims was a result of a system change implement in September 2008, the Department will accept the Plan's efforts to rework all emergency service claims that were underpaid interest from September 12, 2008 and forward. However, the Plan is required to go back to July 16, 2005 for all non-emergency service claims.

The Department finds that the Plan’s compliance efforts are not fully responsive to the deficiencies cited and the corrective actions required.

The following is the Department’s reply to the Plan’s response on the seven provider disputes that it disagrees with the Department’s findings:

Sample number 20 - The authorization provided by the Plan was for telemetry not for the “medical surgery” level. Therefore, this finding was not removed.

Sample number 38 – The Department accepts the Plan’s response. Therefore, this finding was removed.

Sample numbers 47, 50, 73, 78, and 103 - The Plan failed to provide copies of explanation of payments for these claims to support the Plan’s assertions.

The Plan is requested again to submit the information required in “c” and “d” above with its response to this report.

Furthermore, the Plan is required to submit monthly status reports with the information requested in “b” above starting May 15, 2011 until its CAP is completed on October 1, 2011.

2. DISPUTE DETERMINATION

Rule 1300.71.38 (f) requires a plan to issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute.

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 of the Health and Safety Code and section 1300.71 of title 28.

The Department’s examination found that the Plan’s dispute determinations were not correct in seven (7) out of 92 provider disputes reviewed (a non-compliance rate of 8 percent). They included provider dispute sample numbers 7, 34, 76, 87, 96, 98 and 106.

Examples of the type of incorrect determinations are as follows:

PDR Sample No.	Plan’s Determination	DMHC’s Determination
7	Original denial of IPA responsibility was overturned by the Plan.	Original denial should have been upheld since the IPA was financially responsible per the contract.

PDR Sample No.	Plan's Determination	DMHC's Determination
34	Original denial of IPA responsibility was upheld by the Plan.	Original denial should have been overturned since the Plan was financially responsible per the contract.

This repeat violation was referred to the Office of Enforcement for appropriate administrative action. The enforcement action resulted in a \$300,000 fine being assessed against the Plan.

The Plan was required to submit a detailed Corrective Action Plan (“CAP”) to bring the Plan into compliance with the above Sections and Rules that should include, but not be limited to, the following:

- a. Identification of all provider disputes, paid from July 16, 2005 through the date corrective actions were implemented by the Plan, where incorrect determination resulted in the provider not being paid accurately.
- b. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in paragraphs “a” above. This evidence was to include an electronic data file/schedule (Excel or dBase) that identified the following:
 - Claim number
 - PDR tracking number
 - Date of service
 - Date original claim received
 - Date new information received (date claim was complete)
 - Total billed
 - Original total paid
 - Original paid date
 - Amount of adjustment paid (w/check number)
 - Date adjustment paid
 - Amount of original interest paid
 - Original interest paid date
 - Number of days used to calculate interest
 - Amount of additional interest paid (with formula)
 - Date additional interest paid
 - Penalty paid
 - Date penalty paid
 - Check number for interest and/or penalty
 - Provider name
 - ER or Non-ER indicator

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

- c. Revised policies and procedures implemented to ensure that payments of late adjusted claims resulting from provider disputes include interest and penalty, if applicable, in compliance with the above Sections and Rules.
- d. Date the revised policies and procedures were implemented, the management position(s) 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 calendar days of receipt of the preliminary report, the Plan was required to submit a timeline (that did not exceed 180 calendar days from the receipt of the preliminary report) with its response. If the Plan was not able to meet this timeframe, it was to justify the reason for the delay. The Plan was also required to submit monthly status reports until the CAP is completed.

The Plan agreed that the seven provider disputes were incorrect in their final determinations. However, two of these (sample numbers 87 and 98) were the same issue with one IPA. This IPA had loaded Aetna's contract in their systems incorrectly which caused them to bill Aetna inappropriately. This issue has been corrected.

The Department finds that the Plan's compliance efforts are not responsive to the deficiency cited and the corrective actions required. The Plan failed to submit the information required in "a" through "d" above

The Plan is requested again to submit the required information with its response to this report. If the Plan is not able complete it CAP by May 16, 2011, it must file a timeline (broken down monthly showing the expected percentage of completion) with a specific date when its CAP will be completed.

Furthermore, the Plan is required to submit monthly status reports with the information requested in "b" above starting May 15, 2011 until its CAP is completed.

B. OTHER PROVIDER DISPUTE RESOLUTION DEFICIENCIES

The following details other provider dispute resolution deficiencies found during the Department's examination:

1. MANUAL PROCESSING ERRORS RELATED TO PROVIDER DISPUTES

Rule 1300.71 (a)(8)(K) describes one unfair payment pattern 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.

The examination found that the Plan did not routinely perform reworks to identify all claims for a provider whose claim was not paid correctly due to manual processing errors. This deficiency was noted in provider dispute sample numbers 34, 37, 47, 50, 61, 73, 76, 78, 79, 85, 86, 90, 92, 93, 100, 102, 104, 105, 111, 115, and 118 .

The Plan was required to take the following corrective actions to resolve the above deficiency:

- a. Evidence that correct payments were made to the providers associated with the claims identified above, including interest and penalties, as appropriate. This evidence was to include an electronic data file/schedule (Excel or dBase) that identified the following:
 - Claim number
 - PDR tracking number
 - Date of service
 - Date original claim received
 - Date new information received (date claim was complete)
 - Total billed
 - Original total paid
 - Original paid date
 - Amount of adjustment paid (w/ check number)
 - Date adjustment paid
 - Amount of original interest paid
 - Original interest paid date
 - Number of days used to calculate interest
 - Amount of additional interest paid (with formula)
 - Date additional interest paid
 - Penalty paid
 - Date penalty paid
 - Check number for interest and/or penalty
 - Provider name
 - ER or Non-ER indicator
- b. The data file was to provide the detail of all claims remediated; and, to include the total number of claims and the total additional interest and penalty paid, as a result of remediation.
- c. Revised policies and procedures implemented to ensure that reworks are routinely performed for a provider when manual processing errors are identified.
- d. Date the revised policies and procedures were implemented, the management position(s) 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 calendar days of receipt of the preliminary report, the Plan was required to submit a timeline (that did not exceed 180 calendar days from the receipt of the preliminary report) with its response. If the Plan was not able to meet this timeframe, it was to justify the reason for the delay. The Plan was also required to submit monthly status reports until the CAP is completed.

The Plan replied that it routinely performs claim reworks, either singly or for multiple claims, when warranted. The Plan agreed that provider sample numbers 38, 90, 92 and 102 are examples of situations which warrant claim rework, and the Plan has taken such action. These actions were taken prior to the examination and evidence of them was provided during the examination.

In those instances where a Plan processor made an error resulting in an incorrect payment, the Plan does not “sweep” the provider’s other claims as these instances are single unrelated events which do not affect other payments to that provider. The Plan’s claims are worked by multiple processors and provider disputes are handled by multiple analysts; the Plan does not believe these errors are systemic. Provider dispute sample numbers 34, 37, 61, 78, 79, 85, 86, 93, 100, 104, 105, 111, 115 and 118 are examples of such single error events.

In the spreadsheet of findings provided along with the Preliminary Report, the Department noted that it had retracted the findings in sample numbers 47 and 50 due to mishandling of a DOFR. The Plan believed that this negated the need for a “sweep” of that provider.

In the spreadsheet of findings provided along with the Preliminary Report, the Department does not note a need for reworking additional claims for the provide in sample No. 72, and No. 73. The Plan respectfully requested that all findings for this section be removed from the Final Report as the Plan does routinely perform reworks to identify all claims for a provider whose claim is not paid correctly due to manual processing errors, when warranted and as supported by the evidence presented here.

The Plan stated that there are no samples for which a “sweep” is warranted and these have not been implemented.

The following is the Department’s reply to the Plan’s response on individual provider dispute findings:

Sample numbers 38 and 72 – The Department accepts the Plan’s response. Therefore, these findings were removed.

Sample numbers 47 and 50 – The finding regarding the division of financial responsibility was removed. However, the finding regarding no interest paid was not removed. Therefore, the requirement to perform a sweep and pay interest is still warranted.

Sample number 73 – The Plan did not provide evidence of the new information it received to support that no interest was due to the provider. Therefore, the requirement to perform a sweep and pay interest is still warranted.

Sample number 90 - The revision to the provider contract and the initiation of the rework project were made after the Department selected the dispute for review. Therefore, this finding was not removed.

The Department acknowledges the human factor involved when manually processing claims. However, it does not absolve the Plan from implementing processes to improve the accuracy of payments made to providers.

Based on the unacceptable number of manual errors found by the Department, the Plan needs to implement a process to investigate and document that these manual errors are single unrelated events which do not affect other payments to the provider. This demonstration should include a review of a sample of other similar claims adjudicated for the provider; as well as, identification of the processor(s) that made the error(s) for retraining purposes.

The Department finds that the Plan’s compliance efforts are not fully responsive to the deficiencies cited and the corrective actions required. The Plan failed to submit the information required in “a” through “d” above.

The Plan is requested again to submit the required information with its response to this report. If the Plan is not able complete it CAP by May 16, 2011, it must file a timeline (broken down monthly showing the expected percentage of completion) with a specific date when its CAP will be completed.

Furthermore, the Plan is required to submit monthly status reports with the information requested in “a” above starting May 15, 2011 until its CAP is completed.

C. CLAIM SETTLEMENT PRACTICES – “UNFAIR PAYMENT PATTERN”

Section 1371.37 (a) prohibits a health care service plan from engaging in an unfair payment pattern. Subsection (c) includes the following claim settlement practices as “unfair payment patterns”:

- (1) Engaging in a demonstrable and unjust pattern, as defined by the department, of reviewing or processing complete and accurate claims that result in payment delays.
- (2) Engaging in a demonstrable and unjust pattern, as defined by the department, of reducing the amount of payment or denying complete and accurate claims.
- (4) Failing on a repeated basis to automatically include the interest due on claims pursuant to Section 1371.

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.

The Department’s examination found that the Plan is engaging in “unfair payment patterns” as summarized in the following table:

Deficiency	Type of Sample	Total Population	Total in the Sample	Number of Deficiencies Found	% of Compliance
Failure to reimburse claim accurately, including interest and penalty. <i>Repeat Deficiency</i>	Late Paid Claims	2,410	92	9	90%
Failure to forward the claim to the capitated provider in a timely manner.	Denied Claims	63,215	59	4	93%
Claim receipt date incorrectly entered into the claims system.	Emergency Non-contracted Claims	3,283	73	5	93%

The failure to reimburse claims accurately was previously reported in the Final Reports dated November 5, 2002 and November 21, 2005 for routine examinations conducted in 2002 and 2004, respectively. For both examinations, the Plan was notified that these violations were referred to the Office of Enforcement for appropriate administrative action.

The following details the unfair payment practices by the Plan found during the Department’s current examination:

1. CLAIM PAYMENT ACCURACY – REPEAT DEFICIENCY

Section 1371 requires a health care service plan to reimburse uncontested claims no later than 45 working days after the date of receipt of the claim by the plan. 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 (j) 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 and Rule 1300.71 (i), which refers to claims for emergency services, require that if an uncontested claim is not reimbursed within 45 working days after the date of receipt

of the claim by the plan, the plan shall automatically include the greater of \$15 for each 12-month period or portion thereof on a *non-prorated basis*, or interest at the rate of 15% per annum for the period of time that the payment is late.

Rule 1300.71 (a)(8)(K) describes one unfair payment pattern 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.

As previously stated, the Department’s examination noted that the Plan’s policy is to pay late emergency claims at 15 percent and not more than \$15 per year. The Plan should have paid the greater of \$15 for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of 15 percent per annum for the period of time that the payment is late.

The examination also found that 9 out of 92 (a non-compliance rate of 90%) late paid claims were not paid correctly. They include late claim sample numbers LP-3, LP-4, LP-10, LP-14, LP-20, LP-37, LP-39, LP-44, and LP-65.⁴

Examples of interest not paid correctly are as follows:

Late Claim Sample No.	Date of Receipt	Date Paid	Number of Days Late for Calculating Interest	Interest Paid by Plan	Interest Calculated by the DMHC	\$10 Fee	Additional Amount Owed by Plan
LP-13	10-1-08	6-18-09	196	\$1,754.00	\$1,809.39	\$10.00	\$65.39
LP-25	7-1-08	4-16-09	225	\$0	\$14.42	\$10.00	\$24.42
LP-39	1-7-09	6-25-09	105	\$4.39	\$15.00	\$10.00	\$20.61

This repeat violation was referred to the Office of Enforcement for appropriate administrative action. The enforcement action resulted in a \$300,000 fine being assessed against the Plan.

The Plan was required to explain why the corrective actions it implemented to resolve this deficiency in the prior routine examination were not effective in ensuring ongoing compliance.

The Plan was required to submit a detailed Corrective Action Plan (“CAP”) to bring the Plan’s into compliance with the above Sections and Rules that should include, but not be limited to, the following:

- a. Identification of all late claims, processed from July 16, 2005 through the date corrective actions were implemented by the Plan, that were not paid accurately, including interest and penalties.

⁴ Interest was underpaid on late claim sample numbers LP-10, LP-17, LP-20, LP- 44, LP-62 and LP-65 due to Plan using 3 days to mail payment instead of the actual 4 days to mail when calculating interest.

b. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in paragraph “a” above. This evidence was to include an electronic data file/schedule (Excel or dBase) that identified the following:

- Claim number
- Date of service
- Date original claim received
- Date new information received (date claim was complete)
- Total billed
- Original total paid
- Original paid date
- Amount of adjustment paid (w/ check number)
- Date adjustment paid
- Amount of original interest paid
- Original interest paid date
- Number of days used to calculate interest
- Amount of additional interest paid (with formula)
- Date additional interest paid
- Penalty paid
- Date penalty paid
- Check number for interest and/or penalty
- Provider name
- ER or Non-ER indicator

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

- c. Revised policies and procedures implemented to ensure that interest on claims is calculated and paid in compliance with the above Section and Rules.
- d. Date the revised policies and procedures were implemented, the management position(s) 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 calendar days of receipt of the preliminary report, the Plan was required to submit a timeline (that did not exceed 180 calendar days from the receipt of the preliminary report) with its response. If the Plan was not able to meet this timeframe, it was to justify the reason for the delay. The Plan was also required to submit monthly status reports until the CAP is completed.

The Plan acknowledged that it failed to pay the greater of \$15 for each 12 month period at a nonprorated basis, or interest at the rate of 15 percent per annum for late claim payments of emergency services. However, the Plan did not agree that 12 out of 92 late paid claims were not paid correctly.

The Plan submitted information to support its request that the Department's findings for sample numbers LP-13 and LP-25 be removed.

The Plan agreed that it failed to pay appropriate interest on sample numbers LP-3, LP-4, LP-10, LP-14, LP-20, LP-37, LP-39, LP-44, and LP-65.

The Plan acknowledged that its failure to pay applicable interest and penalties on Late Claims is a repeat deficiency. The corrective actions it implemented in 2005 failed to correct the deficiency because the problem in calculating Emergency Services late claim interest did not begin until 2008.

Interest was underpaid on late claim sample numbers LP-10, LP-17, LP-20, LP-44, LP-62 and LP-65 due to Plan using 3 days to mail payment instead of the actual 4 days to mail when calculating interest.

The Plan replied that it has researched this issue and has traced the error back to a system enhancement made on September 12, 2008 and does not agree with the Department's request to make corrections back to July 16, 2005.

The Plan is taking action to correct its processes to pay ER late claim interest at the greater of 15% interest per annum or \$15 on a non-prorated basis. This project will be handled in three steps.

First, the Plan is making a change to a system rule in its HMO claim system to reflect the "non-prorated" requirement. This system change is scheduled to be implemented in February of 2011. Second, once the system change has been implemented, the Plan will pull reports to identify all claims that were underpaid interest from September 12, 2008 through the current date of the report. Third, the Plan will rework claims for which it has previously paid incorrect ER late claim interest. The Plan estimates that it can make processes corrections, complete re-training its staff and rework all underpaid late claim interest by no later than October 1, 2011.

Based on the Plan's representation that the problem for calculating interest on emergency services claims was a result of a system change implement in September 2008, the Department will accept the Plan's efforts to rework all emergency service claims that were underpaid interest from September 12, 2008 and forward. However, the Plan is required to go back to July 16, 2005 for all non-emergency service claims.

The Department accepts the Plan's response to LP-13 and LP-25. Therefore, these findings were removed.

The Department finds that the Plan's compliance efforts are not fully responsive to the deficiencies cited and the corrective actions required. The Plan failed to submit the information required in "c" through "d" above.

The Plan is requested again to submit the information required in "c" and "d" above with its response to this report.

Furthermore, the Plan is required to submit monthly status reports with the information requested in "b" above starting May 15, 2011 until its CAP is completed on October 1, 2011.

2. MISDIRECTED CLAIMS

Rule 1300.71 (a)(8)(B) describes one unfair payment pattern as the failure to forward at least 95% of misdirected claims consistent with sections (b)(2)(A) & (B) over the course of any three-month period.

Rule 1300.71 (b)(2)(A) & (B) states that when a claim is sent to a health care service plan that has contracted with a capitated provider that is responsible for adjudicating the claim, the plan shall do the following:

If the claim involves emergency services, the plan must forward the claim to the appropriate capitated provider within ten (10) working days of receipt of the claim that was incorrectly sent to the plan.

For those claims that do not involve emergency service or care:

If the provider that filed the claim is contracted with the plan's capitated provider, the plan within ten (10) working days of the receipt of the claim must either send the claimant a notice of denial including instructions to bill the capitated provider or send the claim to the appropriate capitated provider.

For all other claims, the plan within ten (10) working days of the receipt of the claim incorrectly sent to the plan must forward the claim to the appropriate capitated provider.

The Department's examination found that the Plan failed to forward four (4) out of 59 denied claims that were the capitated provider's responsibility in a timely manner (a compliance rate of 93 percent).

The following claims were not forwarded within ten (10) working days during the three month period ending June 30, 2009:

Denied Sample No.	Date Received by Plan	Days in Excess of 10 Working Days
D-29	05/08/09	5
D-40	06/15/09	1
D-42	05/20/09	5
D-46	06/10/09	1

This repeat violation was referred to the Office of Enforcement for appropriate administrative action. The enforcement action resulted in a \$300,000 fine being assessed against the Plan.

The Plan was required to implement policies and procedures to forward misdirected claims within ten working days of receipt in compliance with Rule 1300.71(2)(A)&(B). The Plan was also required to provide the date of implementation, the management position(s) responsible for compliance, and a description of the monitoring system implemented to ensure continued compliance with this Rule.

The Plan acknowledged that it failed to forward four out of 59 denied claims to the capitated payer in a timely manner.

The Department finds that the Plan's compliance effort is not responsive to the deficiency cited and the corrective actions required. The Plan failed to submit the information required above.

The Plan is required again to submit its revised policies and procedures implemented to forward misdirected claims within ten working days of receipt. The Plan is also required to provide the date the revised policies and procedures were implemented, the management position(s) responsible for overseeing compliance, and a description of the monitoring system implemented to ensure ongoing compliance.

3. RECEIPT DATE OF CLAIMS

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

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

The Department's examination found that the correct receipt date was not used to calculate interest in five (5) out of 73 non-contracted emergency claims (a non-compliance rate of 7 percent). They included claim samples ERN-21, ERN-40, ERN-42, ERN-43, and ERN-44.

The Plan was required to submit a description of its process to ensure that the correct receipt date is being utilized in compliance with Rule 1300.71(a)(6). The Plan was also required to provide the management position(s) responsible for compliance and a description of the monitoring system implemented to ensure continued compliance with this Rule.

The Plan agreed that it failed to use the earliest claim received date to calculate interest due on sample No. ERN 21, No. ERN 42, No. ERN 43 and No. ERN 44. However, the Plan's systems captured the original claim received date, along with subsequent submission dates for these claims. The Plan respectfully requested that the finding be amended to acknowledge that the Plan does record claim received dates accurately.

The Department has amended its report to reflect that the Plan does record claim receive dates accurately as requested by the Plan.

The Department finds that the Plan's compliance effort is not responsive to the deficiency cited and the corrective actions required. The Plan failed to submit the information required above.

The Plan is required again to submit a description of its processes to ensure that the correct receipt date is being used to calculate interest. The Plan is also required to submit the management position(s) responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance.

D. OTHER CLAIMS SETTLEMENT DEFICIENCIES

The following are other claims settlement deficiencies identified during the Department's examination:

1. OVERSIGHT OF FORWARDED CLAIMS

Rule 1300.71 (e) states that a plan may contract with a claims processing organization for ministerial claims processing services or contract with capitated providers that pay claims, ("plan's capitated provider") subject to the following conditions:

- (1) The plan's contract with a claims processing organization or a capitated provider shall obligate the claims processing organization or the capitated provider to accept and adjudicate claims for health care services provided to plan enrollees.

The Department's examination noted that the Plan does not have policies and procedures in place to ensure that claims forwarded to plan's capitated providers are processed in compliance with the requirements of Rule 1300.71 (e). The Plan is required to incorporate

these procedures as part of its on-site and off-site monitoring of its capitated providers even if claims are forwarded correctly by the Plan to these capitated providers.

The Plan was required to submit its policies and procedures for ensuring that claims forwarded to capitated providers are received and processed in accordance with the above Rule. The Plan was to state the date the policies and procedures were implemented, the management position(s) responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

The Plan replied that it is in the process of revising its procedures to ensure that claims forwarded to its delegated claim entities are received and processed in accordance with Rule 1300.71(e). These process improvements will be implemented in the first quarter of 2011 within the Delegated Claim Oversight Department. Processes are being developed now and a description of those changes to processes will be provided to the Department by no later than April 1, 2011.

The Department finds that the Plan's compliance effort is not fully responsive to the deficiency cited and the corrective actions required.

The Plan failed to submit a description of the process improvements it was to implement by April 1, 2011 as indicated in its response.

The Plan is required again to submit its revised procedures for ensuring that claims forwarded to capitated providers are received and processed in accordance with the above Rule. The Plan is also required to state the date the policies and procedures were implemented, the management position(s) responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

2. EXPLANATION OF PAYMENT

Rule 1300.71 (a)(8)(F) defines an unfair payment pattern 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.

The Department's examination found that the Plan failed to correctly state that a claim was paid at the Plan's reasonable and customary rate. The explanation of payment incorrectly states "paid according to our fee schedule."

The Plan was required to revise its policies and procedures to ensure that the written explanations of payments are accurate. A copy of these revised policies and procedures were to be submitted with the Plan's response to this report. The Plan was also required to provide the date of implementation, the management position(s) responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure continued compliance with this Rule.

The Plan acknowledged that upon rare occasions a claim processor may use an incorrect message on a provider's explanation of payment. However, the Plan did not acknowledge that it is practicing an unfair payment pattern and emphasizes that this type of error is rare and caused by human error. The Plan requested that this finding be removed from the final report.

The Department finds that the Plan's compliance effort is not responsive to the deficiency cited and the corrective actions required. The Department disagrees that the error was due to the processor using the incorrect message. The findings were due to an incorrect explanation of payment to a non-contracted provider being programmed into the system.

The Plan is required again to submit its revised procedures for ensuring that the written explanations of payments are reviewed for accurate. The Plan is also required to state the date the policies and procedures were implemented, the management position(s) responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

3. REWORKS FOR MANUAL PROCESSING ERROR RELATED TO CLAIMS

The examination found that the Plan failed to routinely perform reworks to identify all claims for a provider whose claim was not paid correctly due to manual processing errors.

This issue was noted in paid claim sample number PD-25; paid emergency claim sample numbers ERR-21 and ERR-24; non-contracted emergency claim sample numbers ERN-21 and ERN-43; and denied claim sample number D-50.

The Plan was required to submit the following:

- a. Evidence that correct payments were made to the providers associated with the claims identified above, including interest and penalties, as appropriate. This evidence was to include an electronic data file/schedule (Excel or dBase) that identified the following:
 - Claim number
 - Date of service
 - Date original claim received
 - Date new information received (date claim was complete)
 - Total billed
 - Original total paid
 - Original paid date
 - Amount of adjustment paid (w/ check number)
 - Date adjustment paid
 - Amount of original interest paid
 - Original interest paid date

- Number of days used to calculate interest
 - Amount of additional interest paid (with formula)
 - Date additional interest paid
 - Penalty paid
 - Date penalty paid
 - Check number for interest and/or penalty
 - Provider name
 - ER or Non-ER indicator
- b. The data file was to provide the detail of all claims remediated; and, to include the total number of claims and the total additional interest and penalty paid, as a result of remediation
- c. Revised policies and procedures implemented to ensure that reworks are routinely performed for a provider when manual processing errors are found.
- d. Date the revised policies and procedures were implemented, the management position(s) 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 calendar days of receipt of the preliminary report, the Plan was required to submit a timeline (that did not exceed 180 calendar days from the receipt of the preliminary report) with its response. If the Plan was not able to meet this timeframe, it was to justify the reason for the delay. The Plan was also required to submit monthly status reports until the CAP is completed.

The Plan replied that it routinely performs claim reworks, either singly or for multiple claims, when warranted. The Plan agrees that sample number ERN 21 is an example of a situation which warrants a “sweep” of similar claims from the same provider and a rework project was conducted to ensure that all incorrectly paid claims were corrected. The project has been completed.

The Plan provided an explanation as to why it disagreed that sample numbers PD-24, PD- 25, PD- 28,PD- 44, ERR- 21, ERR- 24, ERR-43 and ERR-50 warrant claim rework or “sweep” projects.

The Plan requested that all findings for this section be removed from the Final Report as the Plan does routinely perform reworks to identify all claims for a provider whose claim is not paid correctly due to manual processing errors, when warranted and as supported by the evidence presented here. There are no samples for which a “sweep” is warranted and such “sweeps” have not been implemented.

The following is the Department’s reply to the Plan’s response on the seven claims that it disagrees with the Department’s findings:

Sample numbers PD-24, PD-28 and PD-55 – The Department accepts the Plan’s response. Therefore, these findings were removed.

Sample number PD-25 – The IPA authorization number was on the claim so it should have been paid. Therefore, this finding was not removed.

Sample number ERR-24 – This finding was related to the Plan not paying interest correctly on emergency claims. Therefore, this finding was not removed.

Sample number ERR-43 – The sample number identified by the Plan is not correct. The finding was related to an emergency claim from a non-contracted provider so the correct sample number is ERN-43. This findings was related to the Plan not paying interest correctly on emergency claims. Therefore, this finding was not removed.

Sample number D-50 – The sample number identified by the Plan is not correct. The finding was related to a claim that was denied so the correct sample number is D-50. Therefore, this finding was not removed.

The Department finds that the Plan’s compliance efforts are not fully responsive to the deficiencies cited and the corrective actions required.

The Plan is requested again to submit the information required in “a” to “d” above with its response to this report. If the Plan is not able complete it CAP by May 16, 2011, it must file a timeline (broken down monthly showing the expected percentage of completion) with a specific date when its CAP will be completed.

Furthermore, the Plan is required to submit monthly status reports with the information requested in “a” above starting May 15, 2011 until its CAP is fully completed.

E. ADMINISTRATIVE CAPACITY

Section 1367 (g) and Rule 1300.67.3 require that health care service plans maintain “the organizational and administrative capacity to provide services to subscribers and enrollees” and that a plan’s organization, administrative services, and policies must “result in the effective conduct of the plan’s business” and “provide effective controls.”

The Plan had not demonstrated “effective controls” over its claims processing functions and provider dispute resolution mechanism. In the claim questionnaire dated September 22, 2009 submitted to the Department, the Plan stated the following:

“There is no pre-designated timeframe for conducting claim audits. The most recent audit, CA HMO Prompt Pay Review, was completed in July 2006.”

The lack of a systematic timeframe for conducting claims audits and the repeated deficiencies found during the Department's current and past examinations demonstrate that the Plan's organization, administrative services and policies are insufficient to provide effective controls over the accurate processing of claims and provide disputes.

The Plan was required to submit a detailed Corrective Action Plan ("CAP") that demonstrates that it has the administrative capacity to ensure sustained compliance with the Knox-Keene Act and Title 28 Regulations at all times.

In addition, the Plan was required to file an undertaking that it will employ sufficient staff to correct the deficiencies cited in this report, as well as other deficiencies found by the Plan, and to ensure that the Plan maintains compliance with the Knox-Keene Act and Title 28 Regulations at all times.

The Plan replied that it disagrees that it lacks effective controls over its claim processing functions and provider dispute mechanisms. Formal internal audits are one tool used to provide such controls, but these are by no means the sole tool utilized by the Plan. Other tools used by the Plan include the following:

- *The Quality Review program*
- *Management reports to monitor claim accuracy and timeliness*
- *The Delegation Oversight processes*
- *System checks and balances to ensure that accurate records are maintained, claim payment authorization hierarchies are followed and that the integrity of the Plan's data is protected.*

Results from these monitoring tools are reviewed by the Plan's management, and by various committees and are rolled up to the Board of Directors.

Based on the unacceptable number of manual errors found in the Plan's claim settlement practice and provider dispute resolution mechanism, the Department disagrees that the tools used by the Plan were not adequate to ensure that provider claims are paid accurately.

Therefore, the Plan is required again to submit a detailed Corrective Action Plan ("CAP") that demonstrates that it has the administrative capacity to achieve sustained compliance with the Knox-Keene Act and Title 28 Regulations at all times.

In addition, the Plan is required to file an undertaking that it will employ sufficient staff to correct the deficiencies cited in this report, as well as other deficiencies found by the Plan, and to ensure that the Plan maintains compliance with the Knox-Keene Act and Title 28 Regulations at all times.

F. ACCESS TO BOOKS AND RECORDS

Section 1381 (a) requires all records, books, and papers of a plan shall be open to inspection during normal business hours by the director. Section 1381 (b) states that to the extent feasible,

all such records, books, and papers described in subdivision (a) shall be located in this state. This subsection further states that in examining such records outside this state, the Director shall consider the cost to the plan, consistent with the effectiveness of the Director's examination, and may upon reasonable notice require that such records, books and papers, or a specified portion thereof, be made available for examination in this state, or that a true and accurate copy of such records, books and papers, or a specified portion thereof, be furnished to the Director.

Section 1385 requires each plan to keep and maintain current such books of account and other records as the Director may by rule require. Rule 1300.85.1 requires that every plan preserve for a period of not less than five years, the last two years of which shall be in an easily accessible place at the offices of the plan, the books of account and other records required under the provisions of, and for the purpose of the Act. After such books and records have been preserved for two years, they may be warehoused or stored, or microfilmed, subject to their availability to the Director within not more than 5 days after request therefore.

The Plan failed to provide archived claims within 5 days. In some cases, it took the Plan three or more weeks to provide these claims to the Department. Examples included late claim sample numbers LP-68, LP-90; paid claim sample number 44; and non-contracted emergency claim sample number 68.

The Plan was required to submit a detailed Corrective Action Plan ("CAP") that demonstrates that it has the administrative capacity to ensure that books and records can be timely provided to the Department upon request.

The Plan acknowledged that the few claims listed above did take longer than five days to provide to the examination team. However, not all pieces of the claim samples were delayed. These samples were complicated re-worked claims with multiple claim submissions and re-works, some of which were more than three years old. Although the Plan worked diligently to provide all documentation promptly, it does acknowledge that it is not always possible to research and restore archived documents in such a tight time frame.

The Plan believed that any significant delay was due to prioritizing documentation provided during the examination to ensure that resources were used most efficiently rather than due to a lack of resources. The Plan respectfully requested that this deficiency be removed from the Final Report.

The Department acknowledges the difficulties that the Plan had in researching and restoring archived documents in the timely manner.

However, the Plan is required again to submit a CAP to the Department demonstrating that it has the administrative capacity to provide requested documents in a manner that meets the access requirements of the Act and Rule cited above.

SECTION II. NON-ROUTINE EXAMINATION

The Plan is advised that the Department will 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).

The Plan replied that it understands that the Department will conduct a non-routine examination to verify the representations contained in this response. The Plan requests that the time period of the examination be limited to the time period after its corrective action plans have been successfully implemented.