October 10, 2013

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

FINAL REPORT OF THE ROUTINE EXAMINATION OF AETNA HEALTH OF CALIFORNIA, INC.

Dear Ms. Anderson:

Enclosed is the Final Report of the routine examination of the claims settlement practice and dispute resolution mechanism of Aetna Health of California, Inc. (the “Plan”) for the three month period ending September 30, 2012. The examination was conducted by the Department of Managed Health Care (the “Department”), pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.\(^1\) The Department issued a Preliminary Report to the Plan on July 17, 2013. The Department accepted the Plan’s electronically filed response on September 5, 2013.

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 from the date of the Plan’s receipt of this letter whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan’s response shall be appended, and electronically file copies of those portions of the Plan’s response excluding information held confidential pursuant to Section 1382(c). If the Plan requests the Department to append a brief statement summarizing the Plan’s

\(^1\) References throughout this report to “Section” are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the 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.
response to the report or wishes to modify any information provided to the Department in its response, 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 Corrective Action Plan system (“CAP system”) within the Online Forms Section of the Department's eFiling web portal https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select “eFiling”.
- From the eFiling (Home) menu, select “Online Forms”.
- From the Existing Online Forms menu click on the “Details” for the DFO Corrective Action Plan L13-R-176.
- Go to the “Messages” tab
  - Select “Addendum to Final Report” (note this option will only be available for 10 days after the Final Report has been issued)
  - Select the deficiency(ies) that are applicable
  - Create a message for the Department
  - Attach and Upload all documents with the name “Addendum to Final Report”
  - Click “Send Message”

As noted in the attached Final Report, the Plan’s response did not fully respond to the deficiencies raised in the Preliminary Report issued by the Department on July 17, 2013. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any request for additional corrective action contained within the attached Final Report, within 30 days after receipt of the report. 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 CAP system within the Online Forms Section of the Department's eFiling web portal https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select “eFiling”.
- From the eFiling (Home) menu, select “Online Forms”.
- From the Existing Online Forms menu click on the “Details” for the DFO Corrective Action Plan L13-R-176.
- Go to the “Data Requests” tab
  - Click on the “Details” for each data request that does not have a status of “Complete”
  - Follow the Instructions and/or use the form shown to add the requested data (depending on the type of data requested: New Filing, Document Request, Claims Data, or Financial Statement refile)

The Department will also send the Plan an e-mail(s) requesting those items that are still outstanding. The e-mail(s) will contain a link to the CAP system for the Plan to file the response electronically.
Questions or problems related to the electronic transmission of the above responses should be directed to Ted Zimmerman at (916) 255-2429 or email at tzimmerman@dmhc.ca.gov. You may also email inquiries to wpso@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 through the eFiling system. The report will be located at the Department’s web site at View Department Issued Final Examination Reports.

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

Sincerely,

ORIGINAL SIGNED BY

JOAN LARSEN
Supervising Examiner
Office of Financial Review
Division of Financial Oversight

cc: Mary V. Anderson, Western Region General Counsel, Aetna Health of California, Inc.
    Suzanne Goodwin-Stenberg, Chief, Division of Financial Oversight
    Laura Dooley-Beile, Chief, Division of Plan Surveys
    Amal Abu-Rahma, Senior Counsel, Office of Plan Licensing
    Stephen Babich, Supervising Examiner, Division of Financial Oversight
    Ashika Vinod, Examiner, Division of Financial Oversight
    Ned Gennaoui, Senior Examiner, Division of Financial Oversight
STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

DIVISION OF FINANCIAL OVERSIGHT

FINAL REPORT OF THE ROUTINE EXAMINATION
OF
AETNA HEALTH OF CALIFORNIA, INC.

FILE NO. 933 0176

DATE OF FINAL REPORT: OCTOBER 10, 2013

SUPERVISING EXAMINER: JOAN LARSEN
EXAMINER-IN-CHARGE: NED GENNAOUI
FINANCIAL EXAMINERS:
FRANCISCO GARCIA
SUHAG PATEL
**BACKGROUND INFORMATION FOR AETNA HEALTH OF CALIFORNIA, INC.**

<table>
<thead>
<tr>
<th>Date Plan Licensed:</th>
<th>August 6, 1981</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational Structure:</td>
<td>Aetna Health of California, Inc. (the “Plan”) is a wholly-owned subsidiary of Aetna Health Holdings, LLC, which is a wholly-owned subsidiary of Aetna Inc. The Company was incorporated in the State of California, and commenced operations as a health maintenance organization (“HMO”) in 1981.</td>
</tr>
<tr>
<td>Type of Plan:</td>
<td>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.</td>
</tr>
<tr>
<td>Provider Network:</td>
<td>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.</td>
</tr>
<tr>
<td>Plan Enrollment:</td>
<td>The Plan reported 856,242 enrollees as of September 30, 2012.</td>
</tr>
<tr>
<td>Service Area:</td>
<td>Major counties within California</td>
</tr>
<tr>
<td>Date of last Final Routine Examination Report:</td>
<td>April 15, 2011</td>
</tr>
</tbody>
</table>
This is the Final Report of the routine examination of the claims settlement practice and dispute resolution mechanism of Aetna Health of California, Inc. (the “Plan”) for the three month period ending September 30, 2012. The examination was conducted by the Department of Managed Health Care (the “Department”), pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975. The Department issued a Preliminary Report to the Plan on July 17, 2013. The Department accepted the Plan’s electronically filed response on September 5, 2013.

This Final Report includes a description of the compliance efforts included in the Plan’s response to the Preliminary Report, in accordance with Section 1382(c). The Plan’s response is noted in italics.

Our findings are presented in this report as follows:

- **Section I.** Compliance Issues
- **Section II.** Nonroutine 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 within this report, within 30 days after receipt of this report.

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1. References throughout this report to “Section” are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the 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 dispute resolution mechanism for the three month period ending September 30, 2012 as summarized below:

<table>
<thead>
<tr>
<th>Deficiency</th>
<th>Type of Sample</th>
<th>Total Sample Population</th>
<th>Total in the Sample</th>
<th>Number of Deficiencies Found</th>
<th>% of Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to reimburse claims accurately, including paying interest and penalty. Repeat Deficiency</td>
<td>PDR</td>
<td>2,439</td>
<td>93</td>
<td>16</td>
<td>83%</td>
</tr>
<tr>
<td>Failure to pay disputes within five (5) working days from determination date.</td>
<td>PDR</td>
<td>2,439</td>
<td>93</td>
<td>12</td>
<td>87%</td>
</tr>
</tbody>
</table>

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

1. PAYMENT ACCURACY OF INTEREST ON LATE CLAIMS RESULTING FROM PROVIDER DISPUTES – Repeat Deficiency

Section 1371 and Rule 1300.71 (i)(2) require 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. 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)(1), which refer to claims resulting from emergency services, require that if an uncontested claim is not reimbursed within 45 working days after receipt, the plan shall pay the greater of $15.00 or interest at the rate of 15% per annum, beginning with the first calendar day after the 45 working day period. The penalty for failure to comply with this requirement shall be a fee of ten ($10) dollars.

Rule 1300.71(j) requires a plan or a plan's capitated provider that fails to automatically include the interest due on a late claim payment shall pay the provider $10 for that late claim in addition to any amounts due pursuant to Rule 1300.71(i).
Rule 1300.71.38(g) states, “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, within five (5) working days of the issuance of the Written Determination.”

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 disclosed that the Plan did not pay or underpaid the amount of interest on late adjusted claim payments resulting from provider disputes for 16 out of 93 provider disputes reviewed (a non-compliance rate of 17 percent). They included provider dispute sample numbers 5, 10, 30, 38, 43, 48, 50, 58, 61, 70, 74, 79, 86, 87, 91 and 93.

This deficiency was mainly the result of not selecting the correct date of receipt of a Complete Claim as defined by Rule 1300.71(a)(2) to determine the timeliness of claim payments.

For claims incorrectly denied as capitated provider’s financial responsibility, the Plan improperly used the date of receipt of the capitated provider’s denial letter, submitted with the provider dispute, to determine the timeliness of claim payment. The Plan was required to use the date of receipt of the original claim, rather than the date of receipt of the capitated provider’s remittance advice, since the Plan should have processed the claim correctly when it was originally submitted based on the contractual division of financial responsibility. This deficiency was noted in provider dispute sample number 61.

In addition, the Plan was required to use the original receipt date by the Plan when the Plan was paying on behalf of capitated providers, rather than the date of receipt by the Plan of the capitated provider’s remittance advice denying the claim. The claimant should not be penalized for the capitated provider’s failure to pay its claims. The receipt of the capitated provider’s remittance advice was not considered required information to result in a Complete Claim as defined by Rule 1300.71(a)(2). This deficiency was noted in provider dispute sample numbers 5, 38, 48, 58, 74, 79, 91 and 93.

The Plan’s failure to pay interest correctly on late claim payments resulting from provider disputes was a repeat deficiency, as this issue was previously noted in the Department’s Final Report of Examination dated April 15, 2011, for the quarter ended June 30, 2009. The Plan was notified that this violation was referred to the Office of Enforcement for appropriate administrative action. This examination disclosed that the Plan’s compliance efforts in response to this prior report had not achieved the necessary levels of compliance with the Regulations cited.

This repeat violation was referred to the Office of Enforcement for appropriate administrative action.
The Plan was required to explain why the corrective actions implemented by the Plan to resolve the deficiency of not paying interest correctly on late claim payments resulting from provider disputes, found in the Department’s prior examination, were not effective in ensuring ongoing compliance.

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

a. Training procedures to ensure that claim processors had been properly trained on interest and penalty requirements, including the proper application of the date of receipt of a Complete Claim as defined by Rule 1300.71(a)(2).

b. Audit procedures to ensure that the Plan was monitoring correct payment of interest and penalties on late adjusted claims payments resulting from provider disputes.

c. Identification of all provider disputes that resulted in late adjusted claim payments from March 1, 2011 (date of system change) through the date corrective action had been implemented by the Plan that were either:

   1. Incorrectly denied as capitated provider responsibility to pay, and the Plan did not use the original date of receipt of the incorrectly denied claim; or
   2. Paid on behalf of capitated providers, that were at risk for these claims, and the Plan did not use the original date of receipt of the claim to determine claim timeliness.

d. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in the paragraph immediately above. This evidence was to include an electronic data file (Excel or Access) or schedule that identified the following:

   - Claim number
   - PDR tracking number (if resulted from PDR process)
   - 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 (with check number)
   - Date adjustment paid
   - Amount of original interest paid
   - Original interest paid date
   - Number of 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.

e. Revised policies and procedures implemented to ensure that provider dispute payments of late claims included interest and penalty, if applicable, in compliance with the above Sections and Rules. In addition, these revised policies and procedures should instruct claim processors to use the original date of receipt on claims denied incorrectly as capitated provider’s financial responsibility and claims paid on behalf of capitated providers.

f. Date the revised policies and procedures, training and auditing procedures were implemented and the management position(s) responsible to oversee the CAP and 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 with its response to this report a timeline that committed the Plan to completion of the CAP within 180 calendar days from the receipt of the Preliminary report. If the Plan was not able to meet this timeframe, it must justify the reason for the delay. The Plan was also required to submit monthly status reports until the CAP was completed.

The Plan responded and acknowledged that it did not pay or underpaid the amount of interest on six (6) late adjusted claim payments resulting from provider dispute samples 5, 38, 43, 58, 70 and 74. The Plan further stated that remediation of interest and penalty for each of these samples was paid at the time of the Department’s examination and/or the Plan provided evidence of subsequent payment in its response.

However, the Plan also responded that it disagrees that 10 out of 93 provider disputes reviewed did not pay or underpaid the amount of interest on the related late adjusted claim payments for provider dispute samples 10, 30, 48, 50, 61, 79, 86, 97, 91 and 93. The Plan’s response included additional explanations or documentation for their position on each of these claims and demonstrated that interest was previously paid and no additional interest is due.

The Plan responded that it is taking the following actions to correct its processes to pay appropriate interest and applicable penalty for claim payments.
1. Supplemeting claim payment policies and procedures to ensure that claim processors have specific tools to understand the requirement for determining the correct received date to use for interest and penalty requirements. The update and implementation will occur by November 1, 2013.

2. Developing a Learning Center course that will ensure that Claim Processors are properly trained on interest and penalty requirements, the proper application of the original date of receipt of claims when additional payments are made as a result of a provider dispute decision, and to ensure that such payments are issued within 5 working days of the determination letter date. Claim Processors will be required to complete this course by December 31, 2013.

   This course is still in the development stage. When it is ready for release, the Plan will provide the Department with a copy of the course materials. Upon completion of the course, the Plan will also provide the Department with a list of the names of all participants and dates of completion for each.

3. The Claim Quality Review team will conduct monthly reports to monitor correct payment of interest and penalties on late adjusted claims payments resulting from provider disputes.

4. The Plan requested reports to identify all claims that were underpaid interest from March 1, 2011 through the current date of the report.

   The Plan stated that it will then perform a manual review of those identified claims to determine which require adjustment. The Plan will provide evidence that interest and penalties, were paid for those claims in an electronic data file in Excel format to include the total number of claims and total additional interest and penalty paid from the result of remediation.

   The Plan estimates that all policy/processes corrections, re-training and adjustments to underpaid claims resulting from provider disputes can be completed by no later than December 31, 2013.

   The Plan also responded that the deficiency noted in the Department’s final Report of Examination dated April 15, 2011 was for failure to pay late claim interest accurately. This deficiency was due to a specific systemic issue related to the $15 Emergency Services rate of late claim interest. The corrective actions taken as a result of this deficiency did correct that issue. Although the deficiencies noted in this report are also for failure to accurately pay late claim interest, the reasons behind the failure as outlined in this report are not related to the previous issue.

   The Department finds that the Plan’s compliance efforts are responsive to the deficiencies cited but the corrective actions required are not complete, as follows:
a. The Department reviewed the Plan's response regarding its disagreement over the underpayment of interest and penalty relating to provider dispute sample numbers 10, 30, 48, 50, 61, 79, 86, 87, 91 and 93.

The Department agrees with the Plan that no additional interest or penalty is owed on these sample claims because the Plan paid the additional interest and penalty on these disputes either after the Department pointed out to the Plan that interest was not paid correctly during the examination, or after these disputes were selected as a sample, but before they were reviewed by the Department. Therefore, the interest payment deficiency regarding these provider disputes was noted properly by the Department.

Provider Dispute Sample Number 61

The Plan is requested to provide documentation of payment of interest of $42.91 plus penalty of $10 in response to this report.

b. The Department acknowledges that the Plan’s CAP will be completed by December 31, 2013. Therefore, monthly status reports are due within 15 days following the close of each month to disclose the Plan’s progress in supplementing the claim payment policies and procedures; developing the Learning Center Course; the anticipated or completion training dates; the identification of the total number of disputes that resulted in late adjusted claim payments from March 1, 2011 to CAP implementation date; and, evidence of the amount of interest and penalty payments on late claims resulting from provider disputes. The first status report is due by October 15, 2013, and the final status report (due by January 15, 2014) is required to include the detail of all claims remediated, the total number of claims, and the total interest and penalty paid, as a result of the remediation. In addition, the Plan is requested to submit a copy of the Learning Center Course and a list of the names of all participants in the training upon completion. The Plan is also required to indicate the date of implementation of the new policy/process corrections and the management position(s) responsible to oversee the CAP and to ensure ongoing compliance.

c. The Plan is required to submit a written confirmation, in response to this report, that the identification and remediation will include all provider dispute payments that resulted in late adjusted claim payments relating to claims that were either:

i. Incorrectly denied as capitated provider responsibility to pay, and the Plan did not use the original date of receipt of the incorrectly denied claim; or

ii. Paid on behalf of capitated providers, that were at risk for these claims, and the Plan did not use the original date of receipt of the claim to determine claim timeliness.
2. LATE CLAIM PAYMENT ON PROVIDER DISPUTES

Rule 1300.71.38(g) states, “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, within five (5) working days of the issuance of the Written Determination.”

The Department’s examination found that the Plan failed to pay additional amounts due to providers within five (5) working days from the determination letter date in 12 out of 93 provider disputes reviewed (a non-compliance rate of 13 percent). They included provider dispute sample numbers 5, 23, 42, 43, 44, 58, 65, 74, 77, 79, 86 and 87.

This violation was referred to the Office of Enforcement for appropriate administrative action.

The Plan was required to submit its revised policy and procedures for ensuring that additional payments resulting from a provider dispute were issued within five (5) working days of the determination letter date in compliance with the above Rule. The Plan was also required to provide the date of implementation and the management position(s) responsible to ensure ongoing compliance with this Rule.

The Plan responded that it agreed that it failed to pay additional amounts to providers within five (5) working days from the determination letter for the provider dispute samples cited above.

The Plan stated it is developing a Learning Center course that will ensure that our Claim Processors are properly trained on interest and penalty requirements, the proper application of the original date of receipt of claims when additional payments are made as a result of a provider dispute decision, and to ensure that such payments are issued within five (5) working days of the determination letter date. The Plan represented that Claim Processors will be required to complete the course by December 31, 2013.

The Department finds that the Plan’s compliance efforts are not fully responsive as the corrective actions required are not complete.

The Department acknowledges that the Plan’s CAP will be completed by December 31, 2013. Therefore, monthly status reports are due within 15 days following the close of each month to disclose the Plan’s progress in developing the Learning Center Course and to perform the training. The first status report is due by October 15, 2013, and the final status report is due by January 15, 2014. In addition, the Plan is required to submit to the Department a copy of the Learning Center Course and a list of the names of all participants in the training upon completion. The Plan is also required to indicate the date of implementation of the new policy/process corrections and the management position(s) responsible to oversee the CAP and to ensure ongoing compliance.
B. 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.

3. Failing on a repeated basis to pay the uncontested portions of a claim within the timeframes specified in Section 1371, 1371.1, or 1371.35.

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 engaged in “unfair payment patterns” for the three month period ending September 30, 2012 as summarized in the following table:

<table>
<thead>
<tr>
<th>Deficiency</th>
<th>Type of Claim</th>
<th>Total Claims in the Sample Population</th>
<th>Total Claims in the Sample</th>
<th>Number of Deficiencies Found</th>
<th>% of Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to reimburse claim accurately, including paying interest and penalty.</td>
<td>Late</td>
<td>2,719</td>
<td>93</td>
<td>12</td>
<td>87%</td>
</tr>
<tr>
<td>Failure to reimburse claims accurately. Claims were denied incorrectly.</td>
<td>Denied</td>
<td>60,152</td>
<td>50</td>
<td>3</td>
<td>94%</td>
</tr>
</tbody>
</table>

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

1. PAYMENT ACCURACY OF INTEREST ON LATE CLAIMS

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 Rules 1300.71 (i) and (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.

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 found that the Plan did not pay interest on twelve (12) out of the 93 late claims reviewed (a non-compliance rate of 13 percent). Therefore, the Plan demonstrated an unfair payment pattern according to Section 1371.37 (c)(4) for failing to automatically include the interest due on late claim payments during the three-month period ending September 30, 2012. The failure to pay interest on late claims was the result of:

a. The Plan’s claim system improperly required an admission date for outpatient claims. An admission date was not applicable to outpatient claims. In order to allow processing of outpatient claims, the processor input the admission date as the date of receipt of new information, which was then considered the date of receipt of a complete claim. The processor should have input the original date of receipt of the claim when the claim system requested the admission date. Inputting a date other than the original date of receipt resulted in underpayment of interest. This deficiency was noted in late claim sample numbers 9, 17, 34, 40, 64, 86, 91, 110, 113 and 117.

b. The Plan not paying a claim when there was an overpayment on a different claim due from the same provider. The Plan withheld claim payments when an overpayment was due from the provider until all the overpayment was eliminated. When the overpayment was eliminated, the Plan released the claim payments which resulted in claim payment delays, and required the payment of interest on late claim payments. The Plan also did not issue an explanation of benefit to the provider to indicate the reimbursable amount when an overpayment existed.

The Plan was required to pay interest on late claims, and indicate the amount of interest paid on the explanation of payment sent to the provider, regardless of whether an overpayment was due from the provider. Overpayments should be handled in accordance with Rule 1300.71(d)(3) through (6), and the Plan was required to give the provider a detailed written explanation identifying the specific overpayments or payments that had been offset against the specific current claim payments, including interest on late claims. This deficiency was noted in late claim sample numbers 17, 51 and 86.

c. The Plan incorrectly used the date of receipt of the capitated provider’s denial letter to determine the timeliness of claim payment. The Plan was required to use the date of receipt of the original claim, rather than the date of receipt of the capitated provider’s remittance advice, since the Plan should have processed the claim correctly when it was
originally submitted based on the contractual division of financial responsibility. In addition, the Plan was required to use the original receipt date by the Plan when the Plan was paying on behalf of capitated providers, rather than the date of receipt by the Plan of the capitated provider’s remittance advice denying the claim. The claimant should not be penalized for the capitated provider’s failure to pay its claims. The receipt of the capitated provider’s remittance advice was not considered required information to result in a Complete Claim as defined by Rule 1300.71(a)(2). This deficiency was noted in late claim sample numbers 34 and 54.

This violation was referred to the Office of Enforcement for appropriate administrative action.

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

a. Revised policies and procedures implemented to correct the noted deficiencies above and to ensure that payments on late claims included interest and penalty, if applicable, in compliance with the above Sections and Rules.

b. Training procedures to ensure that claim processors had been properly trained on interest and penalty requirements.

c. Audit procedures to ensure that the Plan was monitoring correct payment of interest and penalties on late and late adjusted claims payments.

d. Identification of all late claims for which interest and penalties for the above three deficiency reasons that were not correctly paid from March 1, 2011 through the date corrective action had been implemented by the Plan.

e. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in the paragraph immediately above. This evidence was to include an electronic data file (Excel or Access) or schedule that identified the following:

- Claim number
- Date of service
- Date original claim received
- Date of receipt of new information
- Date of receipt for complete claim
- Total billed
- Total paid
- Paid date (mail date)
- Amount of original interest paid
- Date interest paid
- Penalty amount originally paid
- Number of late days used to calculate interest (with formula)
Total interest owed per claim (with formula)
- Amount of additional interest paid in remediation (Total interest owed minus previous interest paid)
- Penalty amount paid
- Date additional interest and penalty paid, if applicable
- Check number for additional interest and penalty paid amount
- Provider name
- ER or Non-ER indicator

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

f. Date the revised policies and procedures, training and auditing procedures were implemented and the management position(s) responsible to oversee the CAP and 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 with its response to this report a timeline that committed the Plan to completion of the CAP within 180 calendar days from the receipt of the Preliminary report. If the Plan was not able to meet this timeframe, it must justify the reason for the delay. The Plan was also required to submit monthly status reports until the CAP was completed.

The Plan responded regarding each category of the above noted deficiencies as follows:

a. The Plan stated it agrees that this claims field affected interest payments for the samples listed above.

The results of the Plan’s research into this problem indicate that a system rule in the HMO claim system requires that all facility claims (claims billed on a UB92 or equivalent form) must contain certain criteria, or that claim would either reject or be labeled unclean. A claim processor would then attempt to obtain the correct code and process the claim appropriately.

The rule in question is imperfect in that it requires an Admit date to be populated on all UB92 claims, including those for outpatient services. An Admit date is not applicable to outpatient services. These claims do not reject at the clearing house; they enter the Plan’s HMO claim system as an unclean claim. The claim processor reviews the claim and can override the requirement for an Admit date. The claim is then processed and is usually not delayed because of the unnecessary rule.

However, a problem does occur if and when that claim ever requires rework. At that point the processor performing the rework notes that the claim was unclean and only applies late claim interest back to the date that new information was received (usually the
The Plan represented that it successfully implemented a system change on August 26, 2013. The Plan is in the process of pulling reports that will identify all impacted claims. As the issue only affects payment of late claim interest on a claim that required adjustment, the Plan will limit this report to identifying facility claims for outpatient services, where an admit date was blank and to those claims that were reworked. The Plan will advise the Department when the report is complete and then will provide status at regular intervals as it researches each claim to determine if late claim interest is due.

b. The Plan disagrees that it withholds payments from providers when an overpayment is due from the provider until the overpayment is eliminated and that it does not issue an explanation of benefit to the provider to indicate the reimbursable amount when an overpayment exists, unless the provider’s contract language allows such action or if a non-contracted provider authorizes such action. The Plan’s response provided additional explanation and documentation for late claim sample numbers 17, 51, and 86.

c. The Plan agrees that interest was due on late claim samples 34 and 54.

The Department finds that the Plan’s compliance efforts are not fully responsive to the deficiencies cited and corrective actions required because it did not comply with the required actions set forth in the Preliminary Report.

The following corrective actions are again required of the Plan in response to this report:

**Late Outpatient Claim Payments:**

The Department acknowledges that the Plan’s CAP regarding outpatient claims was implemented on August 26, 2013 and that the Plan is in the process of preparing a report of all possible claims to be remediated. Therefore, the Plan’s is required to submit monthly status reports to the Department which are due within 15 days following the close of each month, disclosing the Plan’s progress in the remediation process and the amount of interest and penalty payments on these late claims. The first status report is due October 15, 2013 (15 days following the end of the reported month), and the final status report is required to include the detail of all claims remediated, the total number of claims, and the total interest and penalty paid, as a result of the remediation.

In addition, the Plan is required to indicate the anticipated completion date of the remediation, which should be within 180 calendar days from the receipt of the Preliminary report (or January 15, 2014). If the Plan is not able to meet this timeframe, it must justify the reason for the delay.
The Plan is again required to provide the policy and procedures, training of staff and the audit procedures implemented to monitor correct payment of interest and penalties on outpatient claims, the date of implementation, and the management position(s) responsible for the corrective action and to ensure ongoing compliance.

**Late Claim Payments to Providers with Overpayments:**

The Plan did not submit to the Department a copy of the explanation of benefit sent to the provider indicating the timely processing of late claim sample numbers 17, 51 and 86, and informing the provider that payments were withheld pursuant to the contractual agreement, since an overpayment was due from the provider.

The Plan is again required to provide a policy and procedure to issue an explanation of benefits indicating that the amount owed to the provider for the processed claim was not made in accordance with the contractual agreement between the Plan and the provider, where an overpayment is due from the provider. The Plan is also required to state, the training, the audit procedures, the date of implementation, and the management position(s) responsible for the corrective action and to ensure ongoing compliance.

**Late Claim Payment Resulting from Previous Incorrect Claim Denials as Capitated Provider Responsibility or Late Claim Payments on Behalf of Capitated Providers:**

The Plan is again required to submit a CAP that includes the following:

a. Policy and procedures implemented to use the date of receipt of the original claim when (1) the Plan pays a claim that was previously incorrectly denied as capitated provider’s responsibility; and, (2) the Plan pays a claim that is the financial responsibility of the Plan, rather than the date of receipt by the Plan of the capitated provider’s remittance advice denying the claim.

b. Training procedures to ensure that claim processors are properly trained on the proper selection of the original date of receipt of claims paid on behalf of capitated providers or previously denied as capitated provider responsibility for the correct calculation of interest on late claim payments.

c. Audit procedures to ensure that the Plan is monitoring correct payment of interest and penalties on late adjusted claims payments.

d. Identification of all late claims for which interest and penalties were not correctly paid from March 1, 2011 through the date corrective action had been implemented by the Plan.

e. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in the paragraph immediately above. This evidence is to include
an electronic data file (Excel or Access) or schedule that identifies the specific data fields as described above.

f. Date the revised policies and procedures, training and auditing procedures were implemented and the management position(s) responsible to oversee the CAP and to ensure ongoing compliance.

2. INCORRECT CLAIM DENIALS

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.

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

The Department’s examination disclosed that three (3) out of 50 denied claims were improperly denied and should have been paid (a non-compliance rate of 6 percent). These improper denials were due to processor errors: denied sample number 16 was incorrectly denied as duplicate; denied sample number 17 was incorrectly denied as capitated provider responsibility; and denied sample number 20 was incorrectly denied as capitated provider responsibility due to unique provider contract terms.

This violation was referred to the Office of Enforcement for appropriate administrative action.

The Plan was required to submit a CAP to address the deficiency cited above. The CAP shall include the following:

a. Evidence that correct payments were made to the three providers associated with the claim samples identified above, including interest and penalties, as appropriate. The Plan was required to reprocess all claims for these three providers, from March 1, 2011 through the date of corrective action, that were denied for the same reasons identified as incorrect denials in the examination samples. This evidence was to include an electronic data file/schedule (Excel or Access) 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 (with check number)
The data file was to provide the detail of all claims remediated; and, to include the total number of claims, total additional payments, and the total additional interest and penalty paid, as a result of remediation.

b. Audit procedures to ensure that the Plan was monitoring proper denial of claims in accordance with Rule 1300.71(d)(1).

c. Date the audit procedures were implemented and the management position(s) responsible to oversee the CAP and 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 must justify the reason for the delay. The Plan was also required to submit monthly status reports until the CAP was completed.

The Plan responded that it agreed that Denied Sample #16, #17 and #20 were denied inappropriately and should have been paid.

The Plan represented it is taking the following actions to ensure that claims are denied appropriately and to correct any payments, plus applicable interest and penalties, for the three (3) providers in the claim sample:

1. The Claim Quality Review team will conduct monthly reviews to monitor proper denial of claims.

2. The Plan requested reports to identify all claims for the three (3) providers that may have been incorrectly denied from March 1, 2011 through the current date of the report.

3. The Plan will provide evidence that correct payments were made to the three (3) impacted providers, including interest and applicable penalties, for the claims identified, in an electronic data file in Excel format which will include the total number of claims and total additional interest and penalty paid from the result of remediation.
The Plan estimates that it can complete all rework no later than December 31, 2013.

The Department finds that the Plan’s compliance efforts are not fully responsive to the corrective actions required as they are not complete.

The Department acknowledges that the Plan’s CAP will be completed by December 31, 2013. Therefore, monthly status reports are due within 15 days following the close of each month, disclosing the Plan’s progress in reviewing identified claims, the additional amount paid, and the amount of interest and penalty payments on remediated claims. The first status report is due by October 15, 2013, and the final status report (due by January 15, 2014) is required to include the detail of all claims remediated, the total number of claims, the total additional amount and the total interest and penalty paid, as a result of the remediation. The Plan is also again required to indicate the audit procedures implemented, the date of their implementation and the management position(s) responsible for compliance.

SECTION II. NONROUTINE EXAMINATION

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

No response was required to this Section.
October 24, 2013

Department of Managed Health Care  
Ms. Joan Larsen  
Supervising Examiner  
Division of Financial Oversight  
320 West Fourth Street, Suite 880  
Los Angeles, CA 90013  

Re: RESPONSE TO FINAL REPORT OF THE ROUTINE EXAMINATION OF AETNA HEALTH OF CALIFORNIA INC.’S CLAIM SETTLEMENT PRACTICE AND PROVIDER DISPUTE MECHANISM (“ROUTINE EXAMINATION”)

Dear Ms. Larsen:

Aetna Health of California Inc. (the “Plan”) has completed its review of the Final Report of the Routine Examination of the Plan’s Claims Settlement Practices and Provider Disputes Mechanism, issued by the Department of Managed Health Care (“Department”) on October 10, 2013 (the “Final Report”). The Final Report covers the exam period from July 1, 2012 through September 30, 2012, and it includes the Department’s findings and requests for corrective actions.

The Plan considers the corrective actions it committed to undertake in its September 5, 2013 response to the Preliminary Report and the actions addressed below to demonstrate its commitment to meeting or exceeding legal and regulatory compliance standards.

In response to the Final Report, the Plan will voluntarily take the following corrective action steps:

1. PAYMENT ACCURACY OF INTEREST ON LATE CLAIMS RESULTING FROM PROVIDER DISPUTES

   a. The Plan has taken, or will take, the steps to pay appropriate interest and applicable penalty for late adjusted claim payments.

   b. The Plan is revising its claim payment policies and procedures to ensure that claim processors have specific tools to understand the requirement for determining the correct received date to use for interest and penalty requirements. The estimated implementation date is November 22, 2013.

   c. The Plan has released a Learning Center course entitled HMO Non-Texas Determining RCD, CUC, and ALT RCD Dates Training #157248 on September 25, 2013. Completion of this course is mandatory on an annual basis for all Claim Processors. The Learning Center course will ensure that our Claim Processors have been properly trained on interest and penalty requirements, the proper application of the original date of receipt of claims when additional payments are made as a result of a provider dispute decision, and to ensure that such payments are issued within 5 working days of the determination letter date. Claim Processors will be required to complete course by December 31, 2013.

   d. The Claim Quality Review team will conduct monthly reports to monitor correct payment of interest and penalties on late adjusted claims payments resulting from provider disputes.
e. The Plan has pulled reports that identified all claims that potentially were underpaid interest from March 1, 2011 through July 31, 2013.

f. The Plan will analyze the reports to identified claims to determine which require adjustment. The Plan will provide evidence that interest and penalties, were paid for those to include the total number of claims and total additional interest and penalty paid from the result of remediation.

g. The Plan will research each of those claims, re-work them if the Plan has not already done so, and pay any applicable interest plus the $10 penalty.

h. Upon completion of the re-work project, the Plan will provide the Department with a report which will contain the relevant data elements.

2. LATE CLAIM PAYMENT ON PROVIDER DISPUTES

Please refer to the Plan’s response provided above in Section 1 (c), Payment Accuracy of Interest on Late Claims Resulting from Provider Dispute.

3. CLAIM SETTLEMENT PRACTICES – “UNFAIR PAYMENT PATTERN” - PAYMENT ACCURACY OF INTEREST ON LATE CLAIMS

Please refer to the Plan’s response provided above in Section 1 (a) – (h), Payment Accuracy of Interest on Late Claims Resulting from Provider Dispute.

4. INCORRECT CLAIM DENIALS

a. The Plan is taking the following actions to ensure that claims are being denied appropriately and to correct any payments, plus applicable interest and penalties, for these providers. The Plan has pulled reports that identified all claims that potentially were incorrectly identified from March 1, 2011 through July 31, 2013.

b. The Plan will analyze the reports to identified claims to determine which require adjustment. The Plan will provide evidence that correct payments were paid for these providers’ claims to include the total number of claims and total additional interest and penalty paid from the result of remediation. The estimated completion date to analyze the reports is November 30, 2013.

c. A re-work project will be implemented to research each of those claims, re-work them if the Plan has not already done so, and pay the applicable interest rate plus the $10 penalty. The estimated completion date is December 31, 2013. Upon completion of the re-work project, the Plan will provide the Department with a report which will contain the relevant data elements. The estimated date of delivery is December 31, 2013.

The Plan appreciates the opportunity to respond to the Final Report, and requests that this response be appended to the Final Report that is posted on the Department’s website.

Sincerely,

Lesa Paige Bentley
Regulatory Compliance Manager