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May 16, 2008

via FedEx Delivery and eFile

John F. Schunhoff, Interim Director
COUNTY OF LOS ANGELES (d.b.a. COMMUNITY HEALTH PLAN)
313 North Figueroa Street, Room #912
Los Angeles, CA 90012

FINAL REPORT OF ROUTINE EXAMINATION OF COMMUNITY HEALTH PLAN

Dear Mr. Schunhoff:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of Community Health Plan (the "Plan"), conducted by the Department of Managed Health Care (the Department"), pursuant to Section 1382(a) of the Knox-Keene Health Care Plan Act of 1975.¹ The Department issued a Preliminary Report to the Plan on March 3, 2008. The Department accepted the Plan's electronically filed response on April 18, 2008.

This Final Report includes a description of the compliance efforts included in the Plan's April 18, 2008 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 electronically file 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 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 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.

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.

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the report or wishes to modify any information provided to the Department in its November 19, 2007 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 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. 20071750 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, then select "Complete Amendment", complete "Execution" and then click "complete filing".

As noted in the attached Final Report, the Plan's response of April 18, 2008 did not fully respond to one of the deficiencies raised in the Preliminary Report issued by the Department on March 3, 2008. 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.

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 "Filing No. 20071750" 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, then 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 Siniva Pedro at (916) 322-5393 or email at spedro@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

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

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

Sincerely,

ORIGINAL SIGNED BY

JOAN LARSEN

Supervising Examiner

Office of Health Plan Oversight

Division of Financial Oversight

cc: Teri Lauenstein, Director, County of Los Angeles
David Beck, Chief Financial Officer, County of Los Angeles
Mark Wright, Chief Examiner, Division of Financial Oversight
Thomas Roedl, Financial Examiner, Division of Financial Oversight
Maryam Tahriri, Monitoring Examiner, Division of Financial Oversight
Mike Punja, Counsel, Division of Licensing
Marcy Gallagher, Chief, Division of Plan Surveys

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

DIVISION OF FINANCIAL OVERSIGHT

COMMUNITY HEALTH PLAN

FILE NO. 933-0248

DATE OF FINAL REPORT: MAY 16, 2008



SUPERVISING EXAMINER: JOAN LARSEN

EXAMINER-IN-CHARGE: THOMAS ROEDL

FINANCIAL EXAMINERS: MARIA MARQUEZ

JAMEY MATALKA



BACKGROUND INFORMATION FOR COMMUNITY HEALTH PLAN

Date Plan Licensed:	December 30, 1985
Organizational Structure:	The Plan is the Medi-Cal health maintenance organization of the County of Los Angeles Department of Health Services.
Type of Plan:	Full service
Provider Network:	The Plan arranges for the provision of health care under an agreement with the Local Initiative Health Authority for the county of Los Angeles. The Plan also participates in the Healthy Families Program under a service agreement with the State of California.
Plan Enrollment:	As of June 30, 2007, the Plan had 165,656 enrollees, including 120,602 Medi-Cal enrollees, 19,675 Healthy Families members and 25,379 Medicare enrollees.
Service Area:	Los Angeles County
Date of last Final Report of Provider Dispute Resolution Examination:	July 8, 2005
Date of last Final Report of Routine Examination:	October 20, 2004

FINAL REPORT OF A ROUTINE EXAMINATION OF COMMUNITY HEALTH PLAN

This is the Final Report of a routine examination of the fiscal and administrative affairs of Community Health Plan (the “Plan”), conducted by the Department of Managed Health Care (the “Department”) pursuant to Section 1382(a) of the Knox-Keene Health Care Plan Act of 1975.¹ The Department issued a Preliminary Report to the Plan on March 3, 2008. The Department accepted the Plan’s electronically filed response on April 18, 2008.

This Final Report includes a description of the compliance efforts included in the Plan’s April 18, 2008 response to the Preliminary Report, in accordance with Section 1382(c).

We examined the financial report filed with the Department for the quarter ended June 30, 2007, as well as other selected accounting records and controls related to the Plan’s various fiscal and administrative transactions. Our findings are presented in this report as follows:

Section I.	Financial Report
Section II.	Calculation of Tangible Net Equity
Section III.	Compliance Issues
Section IV.	Non-routine Examination

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

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

SECTION I. FINANCIAL REPORT

Our examination resulted in no adjustments or reclassifications to the Plan’s June 30, 2007 financial statements filed with the Department. A copy of the Plan’s financial statements can be viewed at the Department’s website by typing the link <http://wps0.dmhc.ca.gov/fe/search.asp> and selecting Community Health Plan on the first drop down menu.

No response required to this Section.

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth as reported by the Plan as of the quarter ended June 30, 2007	\$ 18,699,076
Required TNE as of June 30, 2007	<u>3,745,373</u>
TNE Excess per Examination as of June 30, 2007	<u>\$ 14,953,703</u>

The Plan is in compliance with the TNE requirement of Section 1376 and Rule 1300.76 as of June 30, 2007.

No response required to this Section.

SECTION III. COMPLIANCE ISSUE

A. PROVIDER DISPUTE RESOLUTION

Rule 1300.71.38 states that all health care service plans that pay claims shall establish a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes.

The Department’s examination disclosed significant deficiencies (as presented below) in the Plan’s processing of provider disputes that would necessitate an expanded review of additional samples in accordance with the Department’s statistical sampling procedures. On November 28, 2007, the Department discontinued its review of provider disputes resolutions after the Plan requested the Department to discontinue its testing and agreed to acknowledge in writing that the Department found its processing of provider disputes to be in violation of Sections 1371, 1371.35 and Rule 1300.71.38. The Plan executed the acknowledgement on January 31, 2008.

1. **DETERMINATION LETTER NOT ISSUED**

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 forty-five working days after

date of receipt of the provider dispute or amended provider dispute (the Department allows sixty-four calendar days).

Rule 1300.71(a) (8) (S) sets forth practices, policies, and procedures that may constitute a basis for finding that a plan has engaged in a “demonstrable and unjust payment pattern”, if it fails to issue a written determination letter for at least 95% of the provider disputes it receives consistent with Rule 1300.71.38(e) over the course of any three month period.

The Department’s examination included a random selection of 188 provider disputes received during the period May 1 to July 31, 2007. Our examination disclosed that 83 out of the 188 disputes reviewed (or 44%) were overturned disputes which were resolved without the issuance of a dispute resolution letter. The Plan’s procedure for closing overturned disputes was to send an explanation of benefits (“EOB”) to the provider receiving payment without sending a determination letter. The Plan’s EOB did not provide an adequate explanation of the reason for payment (i.e. that the payment was the result of an overturned provider dispute).

The Plan was required to state the policies and procedures implemented to ensure that overturned dispute payments are explained through the issuance of a determination letter; the date of implementation of these policies; and, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.

The Plan acknowledges the Department’s examination deficiency finding regarding the issuance of a determination letter. The Plan represents it took immediate action, and, effective January 8, 2008, started issuing determination letters to its providers for all overturned dispute payments stating the pertinent facts and explaining the reasons for its determination within forty-five days after the date of receipt of the provider dispute.

The Plan provided in its response a specimen copy of its revised determination letter and revised Provider Dispute Resolution policies and procedures.

The Plan identified the Chief Financial Officer and Claims Processing Manager as the management positions responsible for monitoring the continued compliance.

The Department finds that the Plan’s compliance effort is responsive to the deficiency cited and corrective action required.

2. PAST DUE PAYMENT

Rule 1300.71.38(g) requires a plan to pay any outstanding funds that are due, and all interest and penalties required under Sections 1371 and 1371.35 and Rule 1300.71, within five working days of the date of the written determination. The accrual of interest and penalties for the payment of resolved provider disputes is to begin on the day following the expiration of the time for reimbursement as noted in Rule 1300.71(g).

The Department’s examination disclosed 80 (or 43%) of the 188 provider disputes reviewed were overturned disputes that were paid more than five working days (or seven calendar days) after the determination date. For overturned disputes, the determination date is the date on which the Plan’s staff completed processing of the dispute and made the decision to make a payment to the provider. As noted above, the Plan was not issuing determination letters, so the determination date cannot be documented with a letter of findings from the Plan to the provider.

Examples of overturned disputes in which the Plan took more than five working days to pay the dispute are shown below.

DMHC PDR Sample No.	Determination Date	Date Paid	Days over 5 working days
4	05/30/07	06/29/07	30
32	06/10/07	08/01/07	52
66	05/29/07	07/26/07	51
114	07/10/07	08/01/07	15
128	08/01/07	09/10/07	33
204	06/07/07	06/19/07	12

The Plan was also required to state the policies and procedures implemented to ensure that overturned dispute payments are made within five working days of the determination date; the date of implementation of these policies; and, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.

The Plan acknowledged that it was non-complaint with the requirement to issue payment within five working days of the issuance of the notice of determination letter. The Plan stated that the Department verified that it was fully compliant with issuing PDR payments within the forty-five working day statutory requirement. In order to achieve and ensure compliance with the five working day requirement, the Plan changed its practice to release the notice of determination letter after the Auditor-Controller warrant (check) is picked up by the Plan and ready for mailing to the provider.

The Plan provided a copy of its Provider Dispute Resolution policies and procedures revised on April 17, 2008.

The Plan identified the Chief Financial Officer and Claims Processing Manager as the Management positions responsible for monitoring continued compliance.

The Department finds that the Plan’s compliance effort is responsive to the deficiency cited and corrective action required.

3. DATE OF ACKNOWLEDGEMENT AND DETERMINATION

Rule 1300.71.38(e) requires a plan to acknowledge the receipt of each written provider dispute within fifteen working days of the date of receipt of the provider dispute by the plan office designated to receive provider disputes (the Department allows twenty-one calendar days to acknowledge disputes).

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 forty-five working days after date of receipt of the provider dispute or amended provider dispute (the Department allows sixty-four calendar days).

Rule 1300.71(a) (8) (R) sets forth practices, policies, and procedures that may constitute a basis for finding that a plan has engaged in a “demonstrable and unjust payment pattern”, if it fails to acknowledge the receipt of at least 95% of the provider disputes it receives consistent with Rule 1300.71.38(e) over the course of any three month period.

In 47 (or 25%) of the 188 provider disputes reviewed, the Department noted that the date of the acknowledgement letter in the provider dispute file did not match the date shown in the Plan’s provider dispute database.

In 19 (or 10%) of the 188 provider disputes reviewed, the Department noted that the date of the determination letter in the provider dispute file did not match the date shown in the Plan’s provider dispute database.

Examples of disputes in which the actual date of the acknowledgement letter or determination letter did not match the date in the provider dispute database are shown below.

DMHC PDR Sample No.	Date Acknowledged in database	Date of Acknowledgment Letter	Date of Determination in database	Date of Determination Letter
6			7/10/07	7/11/07
10			6/30/07	7/2/07
13	05/10/07	05/11/07		
21			6/07/07	6/08/08
42			6/30/07	7/2/07
46	05/30/07	06/01/07		
174	07/09/07	07/11/07		
183	06/04/07	06/05/07		
198	07/13/07	07/16/07		
199			5/27/07	5/25/07

The Plan was required to state the policies and procedures implemented to ensure that its database reflects the actual date of the acknowledgement letter and actual date of the determination; the date of implementation of these policies; and, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.

The Plan acknowledged that it took steps to ensure that its database reflects the actual date of the acknowledgement letter and the actual date of the determination letter. The Plan stated that it corrected this deficiency by ensuring that the date fields on the PDR database reflect the actual print date of the acknowledgement and determination letters generated by the Patient Management System.

The Plan provided a copy of its Provider Dispute Resolution policies and procedure, revised on April 17, 2008.

The Plan identified the Chief Financial Officer and Claims Processing Manager as the Management positions responsible for monitoring continued compliance.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and corrective action required.

4. PAYMENT OF INTEREST AND PENALTIES—Repeat Deficiency

Section 1371 requires a plan to reimburse uncontested claims no later than forty-five working days after receipt of the claim. This section also requires that if an uncontested claim is not reimbursed after forty-five working days after receipt, interest shall accrue at the rate of fifteen percent per annum beginning with the first calendar day after the forty-five working day period. This section requires 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 \$10 paid to the claimant. Section 1371 also requires that if the claim is contested or denied by the plan, the claimant shall be notified, in writing, that the claim is contested or denied with forty-five working days after receipt of the claim by the health plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

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

Rule 1300.71 sets forth various definitions and compliance requirements for claims settlement practices.

Rule 1300.71.38(g) states that if the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, the plan or the plan's capitated provider shall pay any outstanding monies determined to be due, and

all interest and penalties required under Sections 1371 and 1371.35 and Rule 1300.71, within five working days of the issuance of the written determination.

The Plan failed to pay the correct amount of interest and penalties on overturned disputes in 27 (or 14%) of the 188 provider disputes reviewed. In some cases, the Plan did not allow sufficient number of days between the closing of the dispute and the date the check is mailed, nor did the Plan pay the penalty required when interest was not paid automatically. In other cases, the Plan did not pay interest or penalties when due. Examples of disputes in which the Plan failed to pay the correct amount of interest and penalties are shown below.

DMHC PDR Sample No.	Amount of interest and penalties paid	Amount of interest and penalties owed	Difference	Number of days interest owed
5	\$ 6.41	\$ 10.49	\$ 4.08	42
20	\$ 00.00	\$ 13.35	\$ 13.35	60
52	\$ 00.00	\$236.68	\$236.68	125
167	\$ 29.99	\$ 34.61	\$ 4.62	15
170	\$ 00.00	\$ 64.85	\$ 64.85	131
190	\$ 00.00	\$ 35.91	\$ 35.91	82

This is a repeat violation. The Plan's failure to pay interest correctly was also addressed in the Final Report of the previous provider dispute resolution examination, dated July 8, 2005. In its response to this previous report, the Plan implemented corrective actions related to claims reimbursement that included remediation of interest payments for claims with date of receipt through May 2005. While these corrective actions were accepted by the Department at that time, this examination disclosed that the Plan's compliance efforts did not achieve the necessary levels of compliance with the Act and Regulations cited.

The Plan was required to state the reasons why its previous corrective actions failed to achieve the necessary levels of compliance with the Act and Regulations cited.

Additionally, the Plan was required to submit a Corrective Action Plan ("CAP") to address the above deficiency, to include the following:

- a. Audit procedures to ensure that the Plan is monitoring PDR requirements and correct payment of interest/penalty on late and/or adjusted claim payments that result from overturned PDR.
- b. Identification of all late paid, overturned provider disputes for which interest and penalties were omitted or not correctly paid after May 31, 2005 (the date of remediation from prior examination) through the date corrective action is implemented. The Plan was required to disclose the date of implementation in its response.

- c. Evidence that interest and penalties, as appropriate, were paid retroactively for the PDR claims identified in the paragraph “b” above. This evidence was to include an electronic data file (Excel or dBase) or schedule that identifies specific data fields required in the Preliminary Report. The data file was to also include the total number of provider disputes and the total additional interest and penalty paid, as a result of remediation.

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

The Plan acknowledged that it failed to pay the correct amount of interest and penalties on overturned disputes. The Plan stated that in some instances it overpaid interest. The Plan noted that it had not completed the analysis of the underpaid interest and penalties, but anticipates that the underpaid amounts will prove to be relatively immaterial.

The Plan developed and initiated a CAP to address the identified deficiencies and provided a timeline for completion. The timeline indicates that the CAP began on March 15, 2008. Identification of overturned provider disputes for period June 1, 2005 to December 31, 2007 was completed on March 15, 2008. Detailed review of these identified disputes will be completed in stages through September 30, 2008, with complete payment of interest/penalty by October 31, 2008.

The Plan’s Chief Financial Officer and Claims Manager are the positions accountable for overseeing the CAP. The CHP Compliance unit will perform regular periodic checks to independently validate and ensure continued compliance.

The Department finds that the Plan’s compliance effort is not fully responsive to the deficiency cited, as the Plan has not completed the corrective action required by the Department.

The Department did not find that the Plan’s response addressed the following requirements:

- a. **reason why its previous corrective action failed to achieve the necessary levels of compliance for payment of interest, pursuant with the Act and Regulations cited.**
- b. **audit procedures to ensure that the Plan is monitoring PDR requirements and correct payment of interest/penalty on late and/or adjusted claim payments that result from overturned PDR.**

The Plan is again required to provide a response.

In addition, the Department acknowledges the Plan’s CAP matrix timeline provided with its response. The Department requires the Plan to submit monthly status

updates as to its compliance with each action step. The first monthly status report for the month of April 2008 is due May 31, 2008. These monthly status reports are to continue each month thereafter until compliance is achieved no later than October 31, 2008. The monthly status report is to include an adequate narrative description of the action steps completed and the action steps still outstanding at each month end.

The Plan's CAP contained an action step regarding a proposal to the Department for consideration that should be directed to the Department's Office of Enforcement, as this repeat deficiency was referred for appropriate administrative action.

B. CLAIMS PAYMENT ACCURACY

Section 1371 states that a health care service plan shall reimburse claims or any portion of any claim, whether in state or out of state, as soon as practical, but no later than 45 working days after receipt of the claim by the health care service plan, unless the claim or portion thereof is contested by the plan in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 45 working days after receipt of the claim by the health care service plan.

Rule 1300.71 sets forth various definitions and compliance requirements for claim settlement practices.

The Department's examination included a review of 50 paid claims settled between June 1, 2007 and August 31, 2007 of which 5 (or 10%) were not paid correctly:

DMHC Paid Claim Sample No.	Claim Line No. or Procedure code	Overpayment <Underpayment>	Comments
14	3	<\$ 2.14>	Claim underpaid
15	90774	<\$10.25>	Claim paid at Medi-Cal basis rate instead of ER rate
27	J0886	\$ 1.17	Procedure code not in Plan's system, used rate for alternate code
36	90760	<\$ 9.61>	Claim paid at Medi-Cal basis rate instead of ER rate
42	4	<\$ 7.41>	Claim paid at Medi-Cal basis rate instead of child rate

Three of the claim payments identified above were corrected by the Plan during the examination.

The Plan was required to state the policies and procedures implemented to ensure that the Plan is paying claims accurately, a description of the monitoring system implemented to ensure compliance; the date of implementation of these policies; and, the management position(s) responsible for ensuring continued compliance. The procedures were to also address the steps to ensure an accurate rate is used when it is determined that a code is not in the Plan's system, as well as whether the Plan performs a retroactive sweep of all paid claims when it is determined that rates are not current for a particular procedure code.

The Plan noted that during the examination, it explained that part of this problem is due to the discrepancy between the Medi-Cal rate file that the Plan purchases from Electronic Data Systems (EDS) and the Medi-Cal rates posted by EDS on the Medi-Cal web site. The Plan noted that it continues to work with EDS to resolve this discrepancy. Furthermore, the Plan stated it implemented internal procedures where the Plan's staff is required to verify rates on the Medi-Cal web site when certain codes are not found on the Patient Management System (PMS) rate tables. The Plan represents that its staff was instructed to notify management immediately in order to ensure that necessary programming is conducted to update the rate tables in PMS with the new codes.

The Plan provided a copy of its revised claims handling and adjudication policies and procedures that was revised to include procedures to ensure accurate rate is used and a retroactive sweep of all paid claims is performed.

The Plan identified the Chief Financial Officer, the Claims Processing Manager, the Chief Information Officer, and the Compliance Officer as the management positions responsible for monitoring continued compliance.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and corrective action required.

C. STATUS OF CLAIMS

1. FAILURE TO ADJUDICATE DUPLICATE CLAIMS

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

Rule 1300.71 (a) (8) defines a "demonstrable and unjust payment pattern" or "unfair payment pattern" as any practice, policy or procedure that results in repeated delays in the adjudication

and correct reimbursement of provider claims. Subsection (F) describes one of the payment patterns as the failure to provide a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section (d)(1) at least 95% of the time for the affected claims over the course of any three-month period.

The examination disclosed that the Plan failed to acknowledge or adjudicate duplicate claims. Instead, such claims were discarded.

The Plan was required to state the policies and procedures implemented to ensure that the Plan is no longer discarding duplicate claims, a description of the monitoring system implemented to ensure compliance; the date of implementation of these policies; and, the management position(s) responsible for ensuring continued compliance.

The Plan acknowledged the deficiency finding that the Plan was discarding duplicate claims. The Plan stated that prior to the completion of the Department's examination the Plan took steps to record all claims received, including any duplicate claims. The Plan modified its Patient Management System (PMS) to include a comment at the bottom of the explanation of benefits explaining when a claim is denied as a duplicate.

The Plan provided a copy of its claims handling and adjudication policies and procedures revised on April 17, 2008.

The Plan identified the Chief Financial Office, and the Claims Processing Manager as the management positions responsible for monitoring continued compliance.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and corrective action required.

2. FAILURE TO FORWARD MISDIRECTED CLAIMS IN A TIMELY MANNER

Rule 1300.71 (b)(2) requires that if a claim is sent to a plan that has contracted with a capitated provider that is responsible for adjudicating the claim, then the plan shall do the following:

- (A) For a provider claim involving emergency service and care, the plan shall forward the claim to the appropriate capitated provider within (10) working days of receipt of the claim that was incorrectly sent to the plan.
- (B) For a provider claim that does not involve emergency services or care: (i) 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 claims shall either: (1) send the claimant a notice of denial, with instructions to bill the capitated provider or (2) forward the claim to the appropriate capitated provider; (ii) in all other cases, the plan within ten (10) working days of the receipt of the claim incorrectly sent to the plan shall forward the claim to the appropriate capitated provider.

Our examination included a review of 25 claims denied between June 1, 2007 and August 31, 2007 which included 3 (or 12% of the 25 reviewed) misdirected claims that were not forwarded within ten days as shown below:

DMHC Denied Sample No.	Date received	Date forwarded	Days to redirect
84	08/10/07	08/31/07	17
87	08/15/07	08/30/07	11
97	08/06/07	08/21/07	11

The Plan was required to state the policies and procedures implemented to ensure that the Plan is forwarding misdirected claims in a timely manner, a description of the monitoring system implemented to ensure compliance; the date of implementation of these policies; and, the management position(s) responsible for ensuring continued compliance.

The Plan acknowledged the Department's finding that the Plan was not forwarding misdirected claims in a timely manner. The Plan represented that immediately after screening and identifying the misdirected claims, the data entry clerks forward them to the mail room for copying (for US Mail distribution) or scanning (for e-mail distribution) to ensure that all misdirected claims are sent out in a timely manner.

The Plan provided a copy of its claims handling and adjudication policies and procedure revised on April 17, 2008.

The Plan identified the Chief Financial Office, and the Claims Processing Manager as the management positions responsible for monitoring continued compliance.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and corrective action required.

D. CLAIMS SETTLEMENT REQUIREMENTS – CAPITATED PROVIDERS

Rule 1300.71(a)(8) and 1300.71(b) through (q) outline the Plan's responsibility to have in place policies and procedures to ensure that the claims settlement practices of the Plan's capitated providers are in compliance with the claim settlement requirements.

The Department's examination included a review of the Plan's policies and procedures relating to the Plan's oversight of capitated providers for compliance with claim settlement requirements. The Plan failed to include the following requirements in its policies and procedures:

Rule	Compliance Issue
1300.71 (b)	Claim filing deadline
1300.71(c)	Acknowledgement of claims
1300.71 (d)	Denying, adjusting, or contesting a claim and reimbursement of overpayments
1300.71 (e)	Contracts for claims payments
1300.71(g)	Time for disbursements of claims
1300.71 (h)	Time lines in contesting or denying claims
1300.71 (i)	Late claims interest requirements
1300.71 (j)	Pay penalties for failure to automatically include interest on late claims
1300.71 (k)	Frivolous requests or late notices when processing claims
1300.71 (l)	Provide provider dispute information for their contracted providers
1300.71 (m)	Provide modifications to the required information to their contracting providers, including fee schedules and other required information
1300.71 (o)	Provide fee schedules and other required information to their contracted providers

The Plan was required to submit a copy of its revised policies and procedure to confirm that the Plan's oversight includes a determination as to the capitated provider's compliance with the required provisions presented above. The Plan was also required to state the date of implementation of these policies; the management position(s) responsible for ensuring continued compliance; and, a description of the monitoring system implemented to ensure continued compliance.

The Plan acknowledged the Department's finding that its policy and procedures did not include all required provisions. The Plan modified its existing policies and procedures on April 17, 2008 and provided a copy with its response. The Plan also included a copy of its audit tool used by its Centralized Contract Monitoring Division.

The Plan identified the Compliance Officer as the management position responsible for monitoring continued compliance.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and corrective action required.

SECTION IV. NON-ROUTINE EXAM

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

No response required to this Section.