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

Department of Managed Health Care
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Via: UPS

July 8, 2005

David Beck, Acting Director
COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
(DBA: COMMUNITY HEALTH PLAN)
1000 S. Freemont, Building A-9, East 2nd Floor
Alhambra, CA 91803

RE: FINAL REPORT FOR THE REVIEW OF THE PROVIDER DISPUTE RESOLUTION MECHANISM OF COMMUNITY HEALTH PLAN

Dear Mr. Beck:

Enclosed is the Final Report for the review of the Provider Dispute Resolution Mechanism of Community Health Plan ("the Plan") for the period January 1, 2004 to December 31, 2004. The Department of Managed Health Care (the "Department") conducted the review pursuant to Rule 1300.71.38 (m) (1) and Section 1382 (a) of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").[1] The Department issued a Preliminary Report to the Plan on April 27, 2005. The Department accepted the Plan's response electronically on June 16, 2005.

This Final Report includes a description of the compliance efforts included in the Plan's June 16 2005 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."

[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.

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 provide copies (hardcopy and electronically) 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 report or wishes to modify any information provided to the Department in its response, please provide the documentation (hardcopy and electronically) no later than ten (10) days from the date of the Plan's receipt of this letter.

As noted in the attached Final Report, the Plan's response did not fully resolve some of the deficiencies raised in the Preliminary Report issued by the Department on April 27, 2005. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for the corrective actions requested in the Final Report, within thirty (30) days after receipt of the report.

Please file the Plan's response electronically, just as you do for regular licensing filings via the Department's web portal (<https://wp.dmhc.ca.gov/efile>) under Report/Other, subfolder NRXAM and barcode NR004. Do not file an Execution Page or Exhibit E-1 (Summary of Filing). Please note this process is separate from the electronic financial reporting and is specifically for the response to this final report only. Questions or problems related to the electronic transmission of the response should be directed to Angie Rodriguez at (916) 324-9048 e-mail at arodriguez@dmhc.ca.gov. You may also email inquiries to helpfile@dmhc.ca.gov.

In order to expedite the review process, please email an electronic copy of your response directly to me at jnozaki@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

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

Sincerely,

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

cc: Mark Wright, Chief, Division of Financial Oversight
Marcy Gallagher, Chief, Division of Plan Surveys
John Puente, Assistant Chief Counsel, Division of Licensing
Kim Malme, Senior Examiner, Division of Financial Oversight
Maryam Tahriri, Examiner, Division of Financial Oversight

CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE

DIVISION OF FINANCIAL OVERSIGHT

FINAL REPORT FOR THE REVIEW OF THE PROVIDER DISPUTE RESOLUTION MECHANISM OF COUNTY OF LOS ANGELES – DEPARTMENT OF HEALTH SERVICES (DBA: COMMUNITY HEALTH PLAN)

FILE NO. 933 0248

DATE OF FINAL REPORT: JULY 8, 2005

SUPERVISING EXAMINER: JANET NOZAKI

EXAMINER-IN-CHARGE: KIM MALME

FINANCIAL EXAMINERS:

SURRENDER BHATIA
GALAL GADO
LISA MEDINA

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 (DHS).
Type of Plan:	The County of Los Angeles, Department of Health Services (dba: Community Health Plan) is a federally qualified HMO and is licensed as a full service health care service plan. The Plan arranges for the provision of health care for Medi-Cal beneficiaries under an agreement with the Local Initiative Health Authority for the County of Los Angeles (L.A. Care). The Plan also participates in the Healthy Families Program under a service agreement with the State of California and provides healthcare services for In-Home-Supportive Service Workers (IHSS) and County Temporary Employees.
Plan Enrollment:	160,981 enrollees for the quarter ended December 31, 2004.
Service Area:	Approved areas in Los Angeles County
Date of Last Public Report for Routine Financial Examination:	October 20, 2004

FINAL REPORT FOR THE REVIEW OF THE PROVIDER DISPUTE RESOLUTION MECHANISM OF COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES (DBA: COMMUNITY HEALTH PLAN)

This is the Final Report for the review of the Provider Dispute Resolution Mechanism of Community Health Plan ("the Plan") for the period January 1, 2004 to December 31, 2004. The Department of Managed Health Care (the "Department") conducted the review pursuant to Rule 1300.71.38 (m) (1) and Section 1382 (a) of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").[1] The Department issued a Preliminary Report to the Plan on April 27, 2005. The Department accepted the Plan's response electronically on June 16, 2005.

This Final Report includes a description of the compliance efforts included in the Plan's June 16, 2005 response to the Preliminary Report, in accordance with Section 1382 (c).

We performed a limited review of the Plan's Provider Dispute Resolution Mechanism for the period January 1, 2004 to December 31, 2004. Our findings are presented in the accompanying attachment as "Compliance Issues."

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

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

COMPLIANCE ISSUES

A. BOOKS AND RECORDS

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

During our review, the Plan was unable to locate written provider disputes or provide evidence that provider disputes were accepted verbally by the Plan for 24 of the 68 disputes reviewed. The following are examples of provider disputes that were not adequately documented:

Sample No.	Receipt Date	Paid Date/Denied
21	7/20/04	Unable to determine
23	7/28/04	8/31/04
24	8/18/04	9/17/04
25	8/18/04	9/17/04
49	9/02/04	Unable to determine
68	9/20/04	10/19/04

The Plan was required to submit a Corrective Action Plan ("CAP") that outlines in detail how the Plan will correct this deficiency. The CAP was to include the policies and procedures implemented to ensure that provider disputes are adequately documented. The CAP was also to state the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

The Plan responded that prior to the start of the review, it had drafted and implemented procedures to ensure that written disputes are retained and verbal disputes are documented by the Call Center staff. The Plan stated that the draft policy is projected to be finalized by July 2005. The Plan identified the Claims Processing Manager as the management position responsible for overseeing the corrective action.

The Department finds that the Plan's compliance efforts are responsive to the deficiency cited and the corrective actions required. However, the Plan is required to submit a finalize policy with its response to this report.

B. PAST DUE PAYMENTS

Rule 1300.71.38 (g) requires a plan to pay any outstanding monies and all interest and penalties required under Sections 1371 and 1371.35, that results from a provider dispute involving a claim, to be paid within five (5) working days of the issuance of the written determination.

Our review found that additional payments were not made timely on 17 of the 68 disputes reviewed. The delay in payment is due to all disbursements by the Plan being issued by the County of Los Angeles. The following is a sample of payments made more than five (5) working days after the written determination date:

Sample No.	Determination Letter Date	Paid Date	Days Over 5 Working Days
4	4/28/04	5/18/04	13
5	4/14/04	5/4/04	13
17	6/18/04	7/7/04	12
18	7/28/04	8/17/04	13
22	9/10/04	9/28/04	11
41	9/7/04	9/28/04	14

The Plan was required to submit a CAP that outlines the action that the Plan has taken or is in the process of taking to correct this deficiency.

The Plan provided a copy of the letter sent to Kevin Donohue, Senior Counsel, requesting a waive to the five (5) working day requirement and allow the Plan ten (10) working days from the date of the written determination for payment on provider disputed resolutions, due to the limitations of the Plan's payment process.

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

C. LATE CLAIM PAYMENTS

Section 1371 requires a 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. 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 ten ($10) dollars 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 within 45 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 45 working days after receipt, the plan shall pay the greater of $15 per year or interest at the rate of 15 percent per annum, beginning with the first calendar day after the 45 working-day period.

Our review disclosed that claims or portions of claims were not paid within the timeframes required by Sections 1371 and 1371.35. In addition, our review noted that the Plan had incorrectly interpreted Section 1371.35 to mean that the aggregate amount of interest paid to a single provide for late claims per year was $15.

Therefore, our review disclosed that the Plan had not paid interest on individual late claims (including additional payments result from a provider dispute) when the aggregate interest payment of $15 per year to a provider was reached. The Plan stated that its interpretation had not been questioned by the Department during the prior two routine examinations. Furthermore, no issue related to interest payments on late claims was raised in the recent examination conducted as of March 31, 2004.

Our review noted 17 out of 68 provider disputes reviewed did not receive interest in accordance with the above requirements, for additional payments made. The following are examples of these disputes:

Sample No.	Dispute Payment Date	Number of Days to Calculate Interest	DMHC Calculated Interest	$10 Fee	Underpaid Interest and Penalties Due
4	5/18/04	31	$1.17	$10.00	$11.77
17	7/7/04	46	$2.70	$10.00	$12.70
18	8/17/04	49	$1.19	$10.00	$11.19
22	9/28/04	48	$15.00	$10.00	$25.00
45	10/19/04	137	$3.55	$10.00	$13.55
46	10/19/04	124	$3.21	$10.00	$13.21
47	10/19/04	192	$4.20	$10.00	$14.20
48	10/19/04	161	$3.53	$10.00	$13.53
54	9/28/04	132	$49.60	$10.00	$59.60
55	9/28/04	116	$42.07	$10.00	$52.07

The Plan was required to implement a CAP to bring the Plan into compliance with the above Sections. The CAP was to include, but not be limited to, the following:

- Revise its interest calculation for non-emergency late claims to be 15% per claim. (Section 1371)

- Revise its interest calculation for emergency late claims to be a minimum of $15 per claim and per year or 15% whichever is the greater amount. For example, if an emergency claim is paid 385 days late, the amount of interest would be $30 ($15 for the full year and $15 for the partial year). (Section 1371.35)

- Identify all late claims paid on or after April 1, 2004 to the present where interest was either underpaid or not paid because the aggregate interest of $15 per year to the provider had been reached. In addition, the Plan is required to submit evidence in its response that the correct amount of interest and the $10 fee, if applicable, were paid for all claims identified.

- Identify all provider disputes (with dates of service after January 1, 2004) on or after April 1, 2004 to the present where additional payments were made and required interest was either underpaid or not paid because the aggregate interest of $15 per year to the provider had been reached. In addition, the Plan is required to submit evidence in its response that the correct amount of interest and the $10 fee, if applicable, were paid for all disputes identified.

The Plan was also to state the date its revised policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

The Plan responded that it has revised the software programming for interest calculation for non-emergency late claims to 15% per year and emergency late claims to be a minimum of $15 per claim per year or 15%, whichever is the greater amount. The revision was effective with new claims processed as of May 3, 2005.

The Plan stated that software programming to correct the interest calculation on previously processed claims is in development and is projected to be operational by September 1, 2005. Therefore, the Plan projects the underpaid and required interest on late claims and provider disputes from April 1, 2004 to May 3, 2005 will be correctly paid by October 1, 2005. The Plan identified the Claims Processing Manager as the management position responsible for overseeing the corrective action.

The Department acknowledges the Plan's anticipated completion date for interest and penalty payments on late claims and provider disputes from April 1, 2004 to May 3, 2005. Accordingly, the Plan is required to submit as evidence a schedule that includes: claim number, date of service, receipts dates, paid amounts, paid dates, provider name, number of days late, amount of interest paid, penalty paid, and check number for each late claim and provider dispute identified.

D. MONITORING FINANCIAL CAPACITY OF CAPITATED PROVIDERS

Rule 1300.67.8 (c) requires a health plan to monitor the financial capacity of providers when they are compensated on a capitated basis. Section 1375.1 (a) (3) and (b) requires a health plan to demonstrate a procedure for prompt payment or denial of provider claims and the financial soundness of the Plan's arrangements for health care services. Health plans that capitate provider groups and delegate claims payment functions to these provider groups must have procedures in place to ensure that these groups

comply with Sections 1371, 1371.35 and 1375.1 (a) (3) and (b). In addition, Rule 1300.71.38 (h) requires that the Plan and its capitated provider shall each designate a principal officer to be primarily responsible for the maintenance of their respective provider dispute resolution mechanism(s), for the review of its operations and for noting any emerging patterns of provider disputes to improve administrative capacity, plan-provider relations, claim payment procedures and patient care.

Our review noted that the Plan has delegated this function to the County's Fiscal and Financial Compliance Auditors. On March 4, 2005, the auditors started conducting reviews of the provider dispute mechanisms of the Plan's capitated providers. No reviews were performed during the calendar year 2004.

The Plan was required to submit a summary of the results of these reviews. In addition, the Plan was required to submit a copy of all reports issued to its capitated providers where corrective action plans were required. If these reports are not completed by the date that the Plan's response to this preliminary report was filed, the Plan was required to submit a timeline of when such reports will be provided to the Department.

The Plan responded that none of the fiscal audit with PDR monitoring reports issued thus far, have required CAPs. The Plan submitted the Centralized Contract Monitoring Division's ("CCMD") Financial Solvency Oversight Report of CHP Providers for the quarter ending December 31, 2004 and stated that future formats will be revised to reflect the PDR results.

The Department finds that the Plan's compliance effort is not fully responsive to the deficiency cited and the corrective action required. The Plan is required to submit CCMD's report of CHP Providers for the quarter ending March 31, 2005 that includes the PDR results.