REPORT OF HEALTH CARE SERVICE PLANS' PROVIDER DISPUTE RESOLUTION MECHANISMS

2011 ANNUAL REPORT

April 3, 2012

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Executive Summary

The Department of Managed Health Care (DMHC) licenses and regulates health care service plans in California and in so doing, protects the rights of consumers and health care providers while maintaining the financial stability of the managed health care system.

State law requires health care service plans (health plans) to pay health care providers accurately and in a timely fashion for services provided and to maintain a fast, fair, and cost-effective system for processing and resolving provider claim disputes (California Health and Safety Code section 1367 (h)). Health plans are required to annually report the number, type, and summaries of provider claim payment disputes, describe the resolutions including terms and timeliness, and explain how plans are addressing trends or patterns in disputes.

The DMHC annually summarizes the health plans' self-reported provider dispute data for the Governor and the Legislature pursuant to Health and Safety Code section 1375.7(e). The 2011 Provider Dispute Resolution Mechanisms Report summarizes provider claim disputes by type of plan, including full service health plans and specialized health plans, from October 1, 2010 through September 30, 2011. The report includes provider dispute data from health plans' capitated providers such as hospital systems and medical groups.[1]

KEY STATISTICS:

Full Service Health Plans:

Full Service Health Plans are health plans that provide all of the basic health care services and mandated benefits requirement under the Knox-Keene Act.

- There are 37 licensed full service health plans in California subject to the reporting requirements of Section 1375.7(e).
- Full service health plans processed approximately 103 million claims in the reporting period.
- Full service health plans received 820,229 provider disputes for the reporting period.
- California's seven largest full service health plans[2] provide health care benefits to over 16 million (76%) of the approximately 22 million enrollees.

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[1] Generally, capitated providers fall within two main categories: (1) medical groups and Independent Practice Associations (IPAs); and (2) hospital systems that receive capitation from health plans, and in turn pay provider claims for health care services rendered to the plan's enrollees. Capitation is a set amount of prepaid money received or paid out, based on the number of enrollees assigned to an organization, rather than on the level of services delivered. This arrangement is usually expressed in units of PMPM (per member per month).

[2] California's seven largest full service plans are Aetna Health of California, Blue Cross of California, California Physicians' Services (Blue Shield of California), Cigna HealthCare of California, Health Net of California, Kaiser Foundation Health Plan, and United Health Care of California.

- Approximately 82 percent of the reported provider disputes were filed with the seven largest full service health plans.

- The seven largest full service health plans processed more than 91 million claims, accounting for 89 percent of all claims filed by full service health plans in California.

- Approximately 95 percent of all provider disputes processed by full service health plans were reported as being resolved within 45 working days from the date of receipt.

- Ninety-one percent of provider disputes with full service health plans involved claims payment and/or billing problems.

- Providers prevailed in 38 percent of all disputes; plans prevailed in 53 percent of the disputes.

- Less than one-percent (0.79%) of all claims processed by full service health plans resulted in a claim payment/billing dispute.

Specialized Health Plans:

Specialized Health Plans are health plans that provide coverage in a single specialized area of care such as vision, dental, behavioral health and chiropractic health plans.

- There are 44 licensed specialized health plans subject to the provider dispute reporting requirements.

- Specialized health plans processed approximately 24 million claims in the 2011 reporting period.

- Specialized health plans received 16,547 provider disputes for the reporting period.

- Specialized health plans reported that 47 percent of all provider disputes were resolved in favor of the provider, a decrease of four percent from the 2010 reporting period.

- Fifty percent of disputes involving claims payment and billing issues resolved are in favor of the plan versus 44 percent in favor of the provider. This is a shift from 2010 which showed 50 percent of disputes resolved in favor of the provider and 42 percent in favor of the plan.

- Dental plans reported nearly half (49.4%) of all specialized health plan provider disputes. Dental plan enrollment made up 57 percent of the total enrollment for specialized health plans required to report.

- Nearly three-quarters (71%) of provider disputes with specialized plans involved claims payment and/or billing problems.

Capitated Providers:

Capitated Providers are providers that have contracted with a health plan to assume the financial risk for the provision of health care services to the plan's enrollees. Capitated providers include hospitals and medical groups.

- Plans reported data on 299 capitated providers.
- Capitated providers processed approximately 31 million claims and received 456,788 provider disputes in the 2011 reporting period.
- Ninety-five percent of disputes involved claims payment and/or billing problems.
- Thirty-five percent of all reported provider disputes with capitated providers were resolved in favor of the provider.

II.

Introduction/Background

In 2003, the DMHC issued regulations regarding the timely and accurate payment of provider claims and required health plans to establish a fast, fair and cost-effective dispute resolution process. These regulations, known as the Claims Settlement Practice and Dispute Resolution Mechanism Regulations, require all health plans, and their capitated providers that pay claims, to fully implement specific standards and safeguards[3] for payment of provider claims for services rendered on or after January 1, 2004.

In addition to defining the basic concepts relevant to all dispute resolution mechanisms, the regulations require plans to submit to the DMHC the Annual Plan Dispute Resolution Mechanism Report, which is public information, and contains the following:

(1) Information on the number and types of providers utilizing the dispute resolution mechanism;

(2) a summary of the disposition of all provider disputes, including an informative description of the type, term, and resolution;

(3) the timeliness of dispute resolution determinations; and

(4) a detailed information statement disclosing any emerging or established patterns of provider disputes, and how that information has been used to improve administrative capacity, plan/provider relations, claims payment procedures, quality assurance systems, and the quality of patient care, and are required to report dispute results.

Plans summarized their provider dispute results in three categories:

- Claims Payment/Billing Disputes -- Provider complaints relating to the plan's failure to reimburse complete claims with the correct payment, including the automatic payment of all interest and penalties.

- Utilization Management Disputes -- Provider complaints relating to medical necessity and authorization determinations.

- Other Disputes -- Provider complaints relating to non-monetary issues, such as enrollee eligibility and assignment matters, and provider credentialing and certification.

This report reflects information reported by health plans for October 1, 2010, through September 30, 2011.

III.

Full Service Health Plans

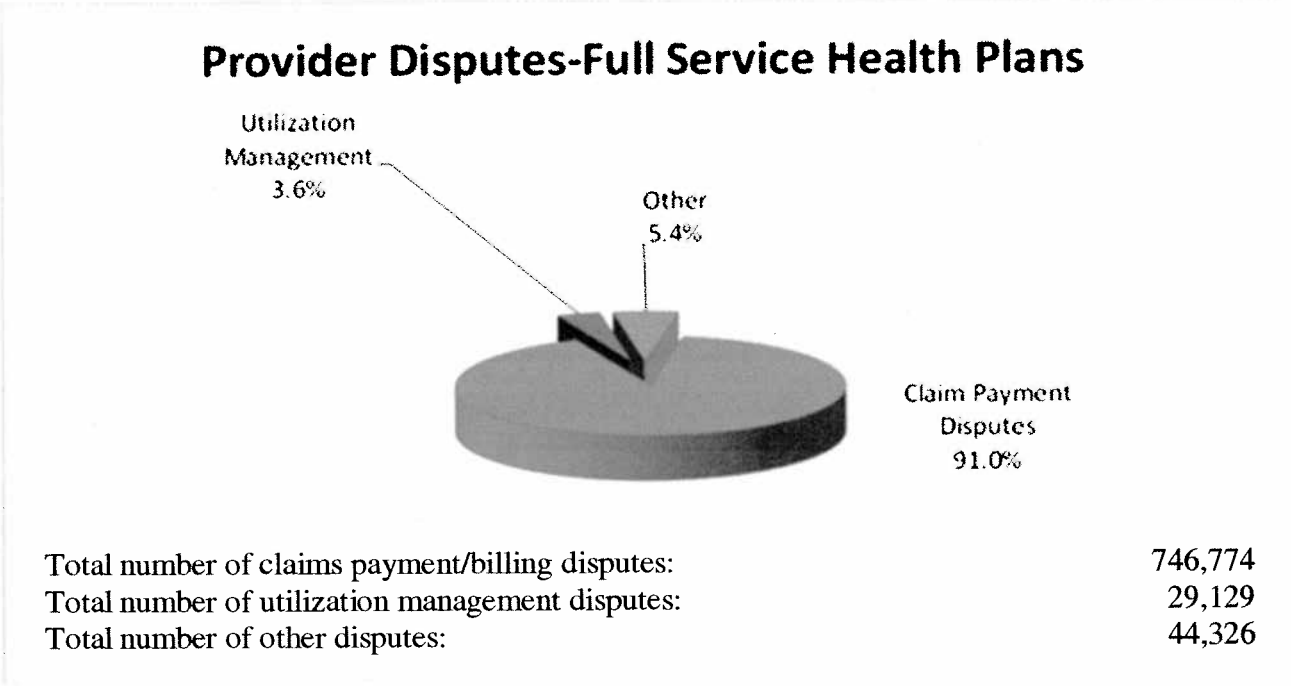
Of the 55 licensed full service health plans, data from 37 is included in this report. Eighteen licensed, full service health plans are excluded because they provide only Medicare products, and are therefore exempt from Health and Safety Code section 1367(h).

The 37 full service health plans reported a total of 103 million claims processed during the reporting period. A claim is considered processed when the health plan adjudicates and classifies the claim as paid, adjusted, contested or denied.

The full service health plans received 820,229 provider disputes during the 2011 reporting period. This represents an increase of 23 percent in disputes over the 2009 reporting period.

Claims payment/billing disputes, which primarily involve claims of inadequate reimbursement, comprised 91 percent of the full service health plan provider disputes.

Chart 1



Total number of claims payment/billing disputes:	746,774
Total number of utilization management disputes:	29,129
Total number of other disputes:	44,326

Approximately 99 percent of all provider disputes processed by full service health plans were reported as resolved within 45 working days from the date of receipt. This falls within the timeframes set forth in the regulation. In 2010, 96 percent of provider disputes were resolved within 45 days.

For provider disputes not resolved within the prescribed timeframe, some health plans described corrective action measures that were instituted to ensure future compliance with the timeliness standard. Examples of self-reported corrective actions included regular oversight committee meetings to discuss claims processing performance and emerging trends, partnering with provider groups to find collaborative solutions to claims processing issues, and assigning specialized quality coaches to work with claims and dispute processors.

Additionally, some health plans undertook evaluations of the top drivers of grievances, appeals and provider disputes and investigated high volumes of appeals with an overturn rate. Further, some plans implemented internal compliance oversight processes to review dispute timeliness and hired more claims research specialists. Per regulation 1300.71 (b)(1), contracted providers have 90 days and non-contracted providers have 180 days to submit claims to health plans for processing. In an effort to minimize the number disputes received, the health plans educated providers on timely filing requirements, implemented meetings with clinical personnel to review individual dispute cases, improved tracking tools, restructured provider dispute departments and retooled grievance and appeals review systems.

The DMHC monitors the health plans' corrective actions through its financial examinations and by analyzing complaints received by the department's Provider Complaint Unit. Additionally, reports on quarterly corrective action plans for capitated providers are created by the capitated provider and monitored by the health plans, to ensure corrective action plans are competed/fulfilled within required

time frames. The department's continued outreach and monitoring of corrective action plans has improved health plan compliance with processing claims and disputes within regulatory timeframes.

Provider Disputes Compared to Claims

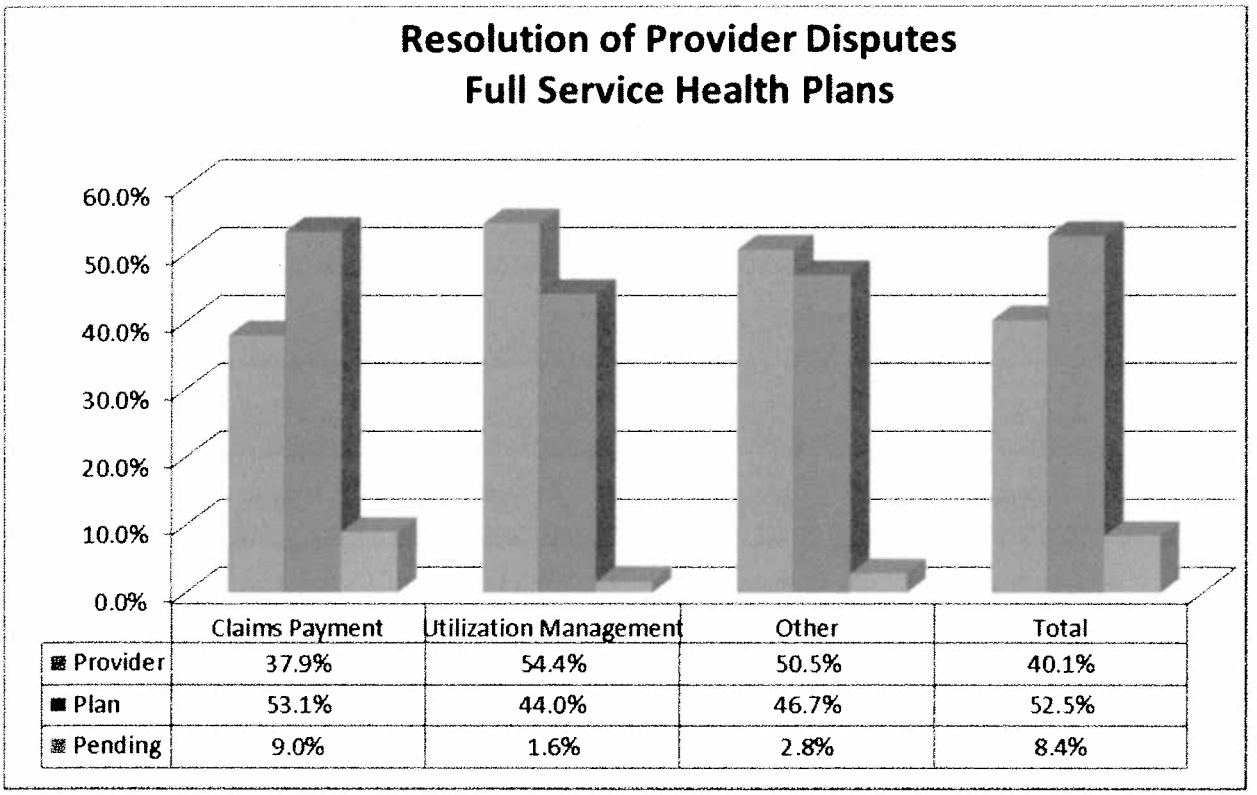
Of the 103 million claims processed during the reporting period, there were approximately 750,000 provider disputes of the plans' reimbursement determinations. This represents less than one percent (0.79%) of all claims processed by full service health plans.

Approximately 83 percent of provider claims processed were paid or adjusted, and 17 percent were contested or denied. Nearly all claims (approximately 99%) were processed within 45 working days from the date of receipt.

Disposition of Full Service Health Plan Provider Disputes

In 2011, the full service health plans reported 38 percent of all disputes between providers and health plans were resolved in favor of the provider, a decrease of one percent (1%) from 2010. Of the 820,229 provider disputes submitted, 321,225 (39%) were determined in favor of the provider, 430,394 (53%) in favor of the plan, and 68,610 (8%) were pending review as of September 30, 2011. (See Chart 2).

Chart 2



	Claims Payment	Utilization Management	Other	Total
Provider	37.9%	54.4%	50.5%	40.1%
Plan	53.1%	44.0%	46.7%	52.5%
Pending	9.0%	1.6%	2.8%	8.4%

Seven Largest Full Service Health Plans

California's seven largest full service health plans provide health care benefits to over 16 million enrollees, representing 76 percent of the approximately 22 million enrollees enrolled in health plans licensed by the DMHC. In 2011, 82 percent of provider disputes were filed with these seven plans. They processed more than 91 million claims, accounting for 89 percent of all claims filed by full service health plans in California. (See Table 1).

Table 1
Provider Disputes by Plan

Name of Health Plan	Enrollment	Approximate Number of Claims Processed	Number of Disputes Received	Resolved Disputes in Favor of the Provider	Resolved Disputes in Favor of the Health Plan	Disputes Pending	Percentage of Disputes Resolved in Favor of Provider	Percentage of Disputes Resolved Within 45 Working Days
Kaiser Foundation Health Plan, Inc.	6,910,222	1,913,449	78,716	16,975	58,770	2,971	22%	100%
Anthem Blue Cross	3,317,728	54,589,428	319,016	123,733	188,608	6,675	39%	89%
Blue Shield (California Physicians Service)	2,439,352	11,060,039	99,505	46,253	40,629	12,623	88%	96%
Health Net of California, Inc.	2,096,409	19,294,247	128,916	41,672	48,564	38,680	32%	99%
United Health Care of California	863,716	873,824	26,210	15,044	11,166	0	57%	100%
Aetna Health of California, Inc.	795,043	3,265,668	9,375	4,976	4,399	0	53%	99%
Cigna Healthcare of California, Inc.	232,060	584,520	10,275	6,622	3,653	0	64%	98%
Total - Seven Largest Health Plans	**16,654,530**	**91,581,175**	**672,013**	**255,275**	**355,789**	**60,949**	**38%**	**95%**
All Other Full Service Health Plans	5,107,408	11,805,809	148,216	65,950	74,605	7,661	44%	99%
Total - All Full Service Health Plans	**21,761,938**	**103,386,984**	**820,229**	**321,225**	**430,394**	**68,610**	**39%**	**95%**

Health plans that fall below the 95 percent compliance requirement are required to file and implement a corrective action plan that will be monitored on a quarterly basis by the DMHC and reviewed as part of the health plan's routine examination.

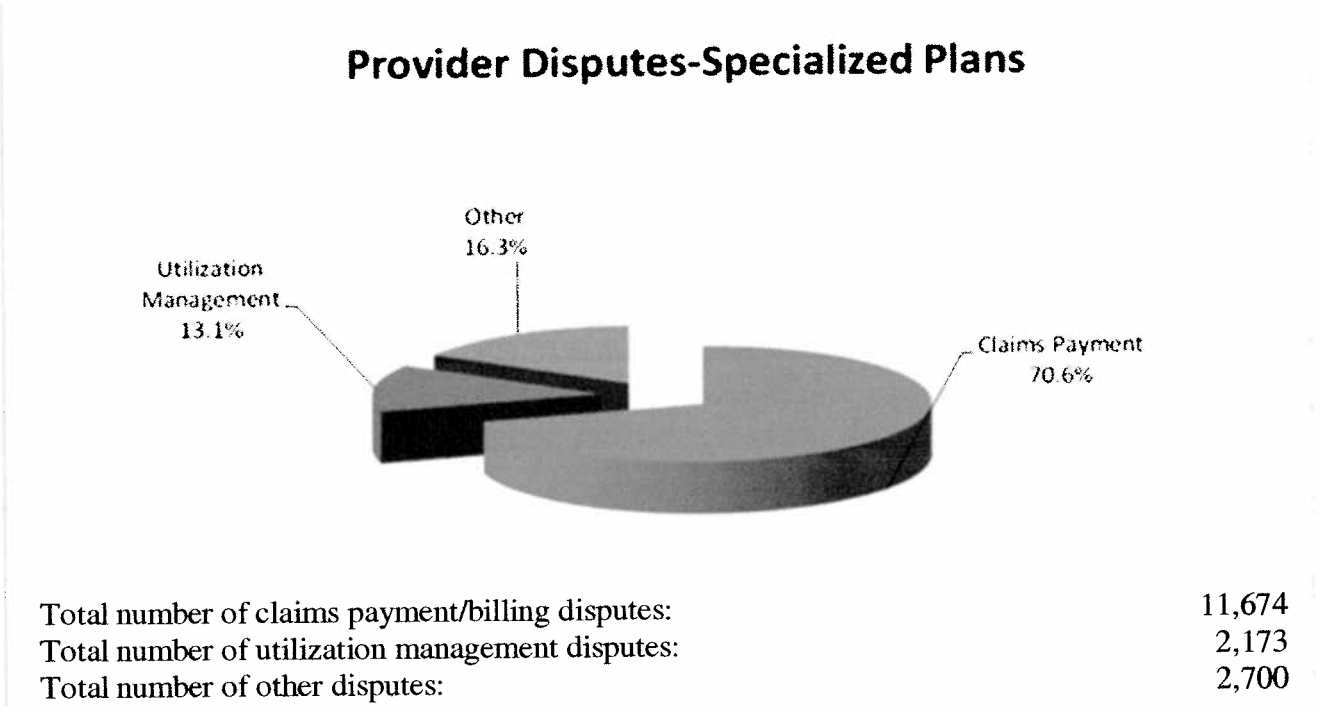
Anthem Blue Cross self-reported noncompliance with the provider dispute resolution timeliness requirement. A corrective action plan was submitted to the DMHC with their filing and it is being monitored by the DMHC.

IV.

Specialized Health Plans

California's 44 licensed, specialized health plans processed approximately 23 million health care claims and reported receiving 16,547 provider disputes during the 2011 reporting period, a 21 percent increase from 2010[2]. Similar to full service health plan reporting results, the majority of provider disputes (71 %) submitted to specialized health plans are claims payment/billing disputes. Chart 3 shows the breakdown of provider disputes.

Chart 3



Total number of claims payment/billing disputes:	11,674
Total number of utilization management disputes:	2,173
Total number of other disputes:	2,700

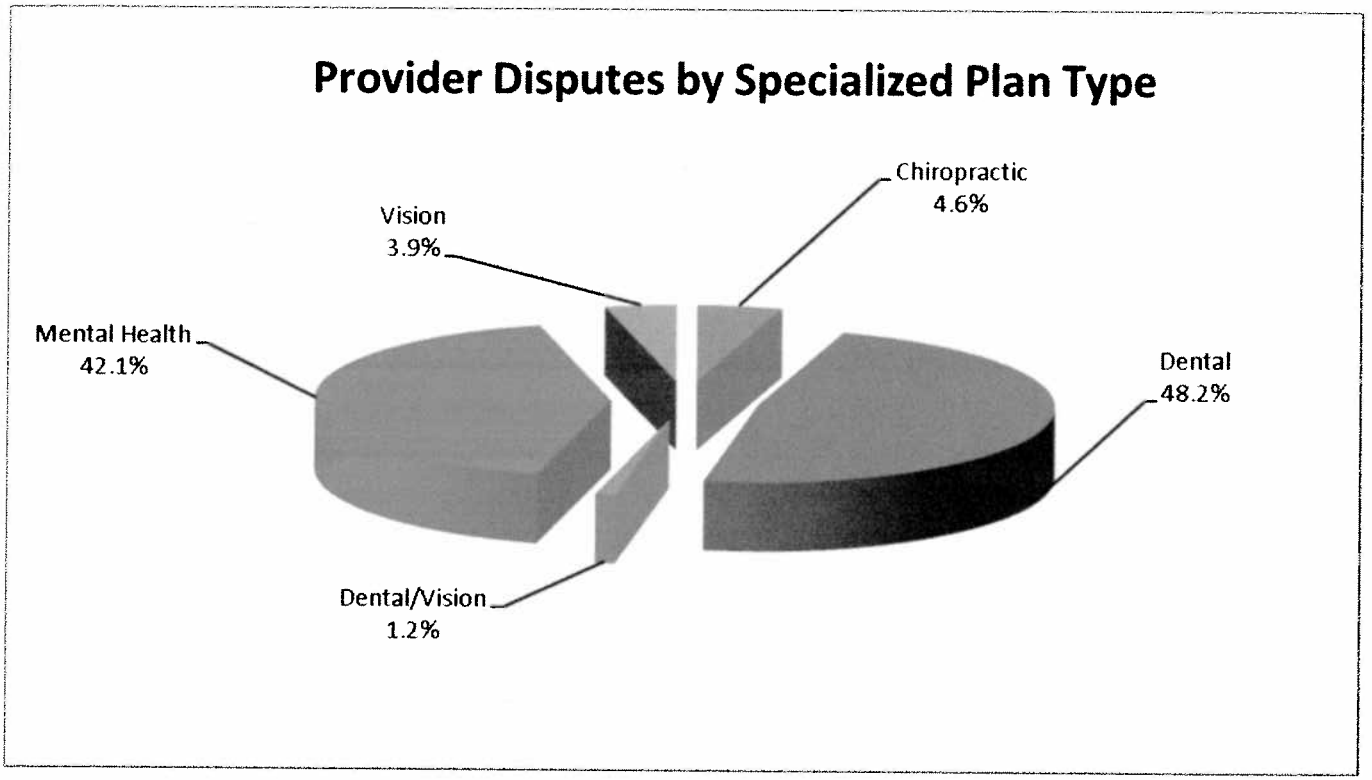
Specialized health plans reported that 99 percent of all provider disputes were resolved within 45 working days from the date of receipt. Several specialized health plans noted an increase in the number of disputes received this year. Specialized health plans have begun to enforce claims submission deadlines. In an effort to minimize the number disputes received, the health plans educated providers

[4] There are a total of 54 licensed specialized health plans; however, 10 specialized health plans are not subject to the provider dispute resolution reporting requirements because these include four discount health and six pharmacy plans.

on timely filing requirements, implemented meetings with clinical personnel to review individual dispute cases, improved tracking tools, restructured provider dispute departments and retooled grievance and appeals review systems.

Of the 16,547 total provider disputes submitted to specialized health plans during the 2011 reporting period, dental plans (including dental/vision plans) accounted for nearly half of the disputes (8,163), followed by mental health plans with 42 percent (6,968), chiropractic plans at 4.6 percent (769), and vision plans at 4 percent (647). (See Chart 4). This is the second year dental plans have reported the largest number of disputes in the specialized health plan category. Dental plan enrollment is significantly higher than all other specialized health plans; correlating to a higher number of provider disputes.

Chart 4

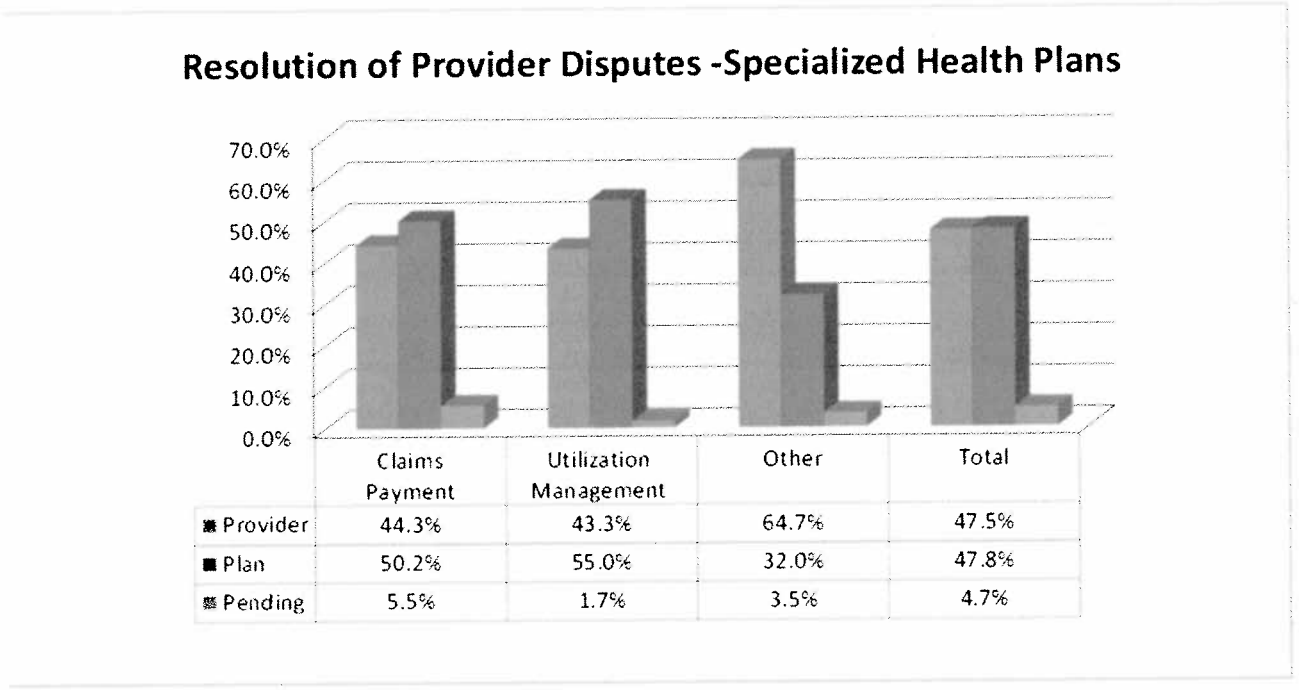


Disposition of Specialized Health Plan Provider Disputes

Specialized health plans reported that 47 percent of all provider disputes were resolved in favor of the provider, a decrease of four percent from the 2010 reporting period. Fifty percent of disputes involving claims payment and billing issues were resolved in favor of the plan versus 44 percent in favor of the provider. This is a shift from 2010 which showed disputes involving claims payment and billing issues at 50 percent in favor of the provider and 42 percent in favor of the plan. Utilization management disputes are resolved in favor of plans slightly more than half (55%) the time and other disputes are more often resolved in favor of the provider. (See Chart 5).

As noted earlier, specialized health plans have started enforcing claims submission timeliness for providers. This may have led to an overall increase in the number of disputes providers submit and an increase in the number of disputes now in favor of the plan.

Chart 5



	Claims Payment	Utilization Management	Other	Total
Provider	44.3%	43.3%	64.7%	47.5%
Plan	50.2%	55.0%	32.0%	47.8%
Pending	5.5%	1.7%	3.5%	4.7%

V.

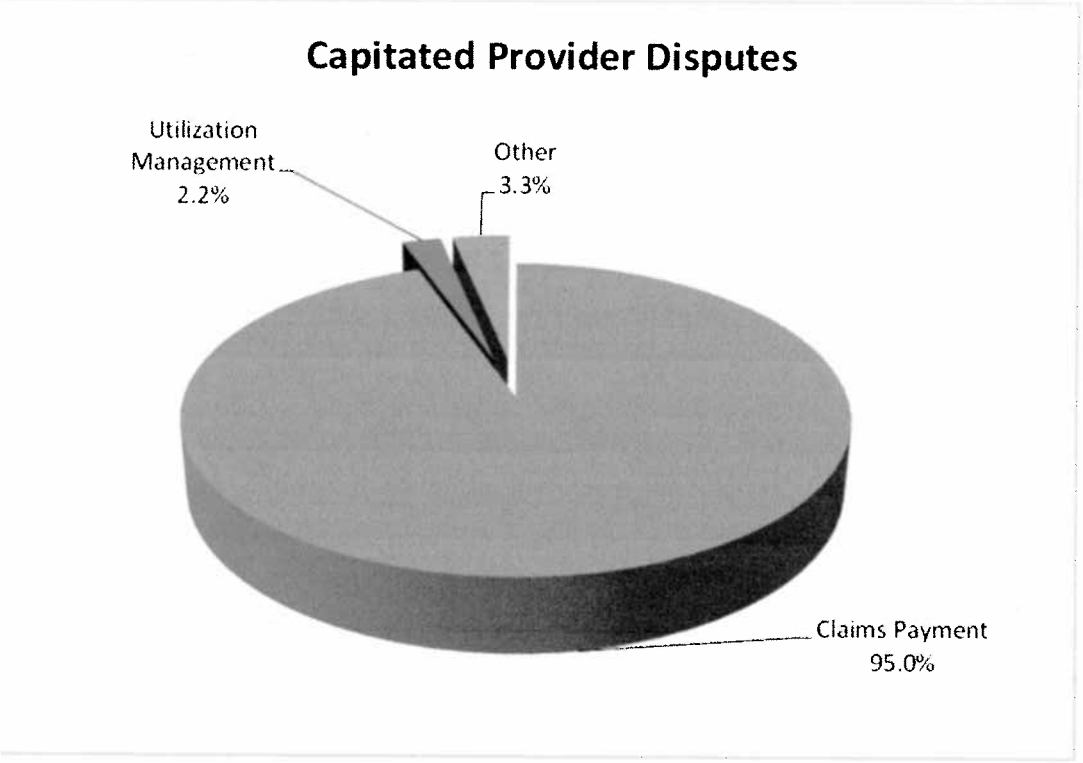
Capitated Providers

All health plans are required to compile and provide a dispute resolution report for each capitated provider with whom they contract. Based upon the number of filings received, the DMHC has identified 299 capitated providers that are contracted with full service health plans.

Health plans report a total of 456,788 provider disputes filed with capitated providers during the reporting period. Any capitated provider that is non-compliant with Health and Safety Code section 1371 and California Code of Regulations, Title 28, section 1300.71 criteria must report to the health plan on a quarterly basis. The contracted capitated providers must also file annually to health plan. The reporting requirements for capitated providers are similar to full service and specialized health plan reporting.

Capitated providers processed approximately 31 million claims in 2011. Nearly all provider disputes (95%) received by capitated providers involved claim payment and billing issues. Chart 6 reflects the breakdown of provider complaints with capitated providers.

Chart 6



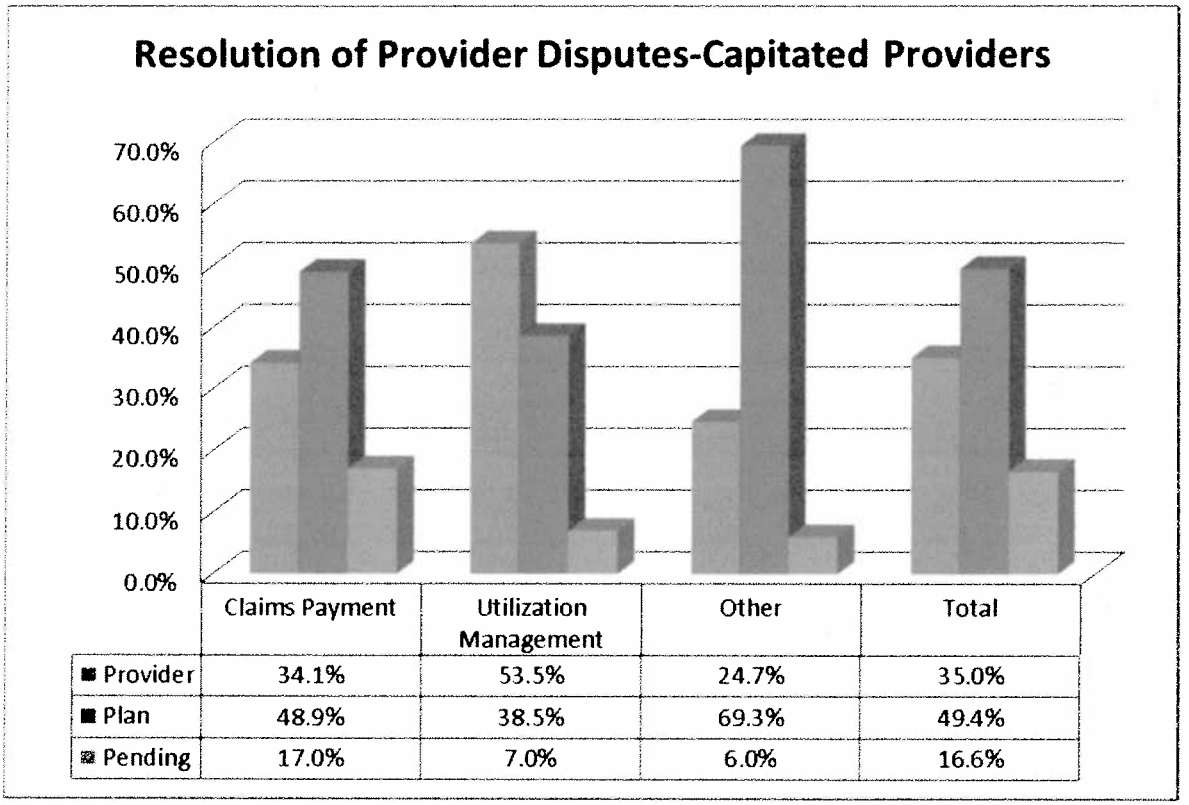
Total number of claims payment/billing disputes:	431,655
Total number of utilization management disputes:	10,217
Total number of other disputes:	14,916

Approximately 90 percent of claims processed were paid or adjusted and ten percent of the claims processed were contested or denied. In addition, capitated providers processed approximately 99 percent of claims within regulatory time frames.

Disposition of Capitated Providers' Provider Disputes

In 2011, the number of capitated provider disputes increased 29 percent from 2010. Of the 456,788 provider disputes submitted in 2011, 35 percent were resolved in favor of the provider submitting the dispute, 49 percent were resolved in favor of the capitated provider, and 16 percent were pending review as of September 30, 2011. Chart 7 illustrates the breakdown by percentages for each category of dispute compared to the total number of disputes.

Chart 7



	Claims Payment	Utilization Management	Other	Total
Provider	34.1%	53.5%	24.7%	35.0%
Plan	48.9%	38.5%	69.3%	49.4%
Pending	17.0%	7.0%	6.0%	16.6%

VI.

Summary

The provider dispute resolution data summarized in this report is self-reported by plans and capitated providers, and may not include all provider disputes occurring throughout the managed care industry in California. Further, there are substantive differences in the way plans identify, quantify and track provider disputes. The quality and accuracy of this self-reported data is evaluated through the DMHC's regular onsite auditing activities, and review of quarterly and annual claims payment and dispute resolution reports. If the DMHC finds deficiencies, the plans and capitated providers are required to promptly institute appropriate corrective action which the DMHC monitors. In addition, the DMHCs' Provider Complaint Unit continues to monitor the industry's compliance efforts in achieving claims payment standards required by Health and Safety Code section 1371 and California Code of Regulations, Title 28, section 1300.71.