REPORT OF HEALTH CARE SERVICE PLANS' PROVIDER DISPUTE RESOLUTION MECHANISMS

2015 ANNUAL REPORT

June 3, 2016

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I.

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 health plans are addressing trends or patterns in disputes. The report includes provider dispute data from health plans' capitated providers such as hospital systems and medical groups[1].

As required by Health and Safety Code section 1375.7(f), the DMHC annually summarizes the health plans' self-reported provider dispute data in a report to the Governor and the Legislature. The 2015 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, 2014 through September 30, 2015.

KEY STATISTICS:

<u>Full Service Health Plans</u>:

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 47 licensed full service health plans in California subject to the reporting requirements of section 1375.7(f). Twenty-five licensed, full service health plans are excluded from the report because they are in pre-operations or provide Medicare products, therefore exempt from Health and Safety Code section 1367(h).

- Health Plans processed approximately 141 million claims in 2015. Less than one-percent (0.64 percent) of these claims resulted in claims disputes.

- Full service health plans received 921,236 provider disputes for the reporting period.

[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).

- California's seven largest full service health plans[2] provide health care benefits to over 22 million (88 percent) of the approximately 25 million full service health plan enrollees.

- Approximately 60 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 116 million claims, accounting for 82 percent of all claims filed by full service health plans in California.

- Approximately 87 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.

- Roughly 86 percent of provider disputes filed with full service health plans involved claims payment and/or billing problems.

- Providers prevailed in 48 percent of all disputes; plans upheld their original determinations in 45 percent of the disputes, with 7 percent of the disputes pending.

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 47 licensed specialized health plans subject to the provider dispute reporting requirements.

- Specialized health plans processed approximately 25 million claims in the 2015. Less than one-percent (0.07 percent) of these claims resulted in claim payment/billing dispute.

- Specialized health plans received 18,182 provider disputes for the reporting period.

- Specialized health plans reported that 53 percent of all provider disputes were resolved in favor of the provider, an increase of two percent of provider dispute resolved in favor of the provider from the 2014 reporting period.

- Plans upheld their original determination in 52 percent of the claims payment and billing disputes. This remains unchanged from the 2014 reporting period.

- Dental plans reported more than half (52 percent) of all specialized health plan provider disputes.

[2] California's seven largest full service plans are Anthem Blue Cross of California, California Physicians' Services (Blue Shield of California), Health Net of California, Inland Empire Health Plan, Kaiser Foundation Health Plan, Local Initiative Health Authority of L.A. County, and Health Net Community Solutions.

- Dental plan enrollment accounted for 62 percent of the total enrollment for specialized health plans required to report.

- Approximately 72 percent of provider disputes with specialized plans involved claims payment and/or billing problems.

Capitated Providers:

Capitated Providers are providers that have contracted with a full service health plan to assume the financial risk and pay claims for the provision of health care services to the plan's enrollees.

- Full Service health plans reported data on 296 capitated providers. This includes risk bearing organizations (RBOs), capitated hospitals, and certain other provider groups that do not meet the definition of an RBO.

- Capitated providers processed approximately 57 million claims and received 530,881 provider disputes in the 2015 reporting period.

- Ninety-two percent of disputes involved claims payment and/or billing problems.

- Thirty-six 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 for payment of provider claims for services rendered on or after January 1, 2004.[3]

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 are required to summarize 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, 2014 through September 30, 2015.

[3] See California Code of Regulations, title 28, sections 1300.71 and 1300.71.38.

III.

Full Service Health Plans

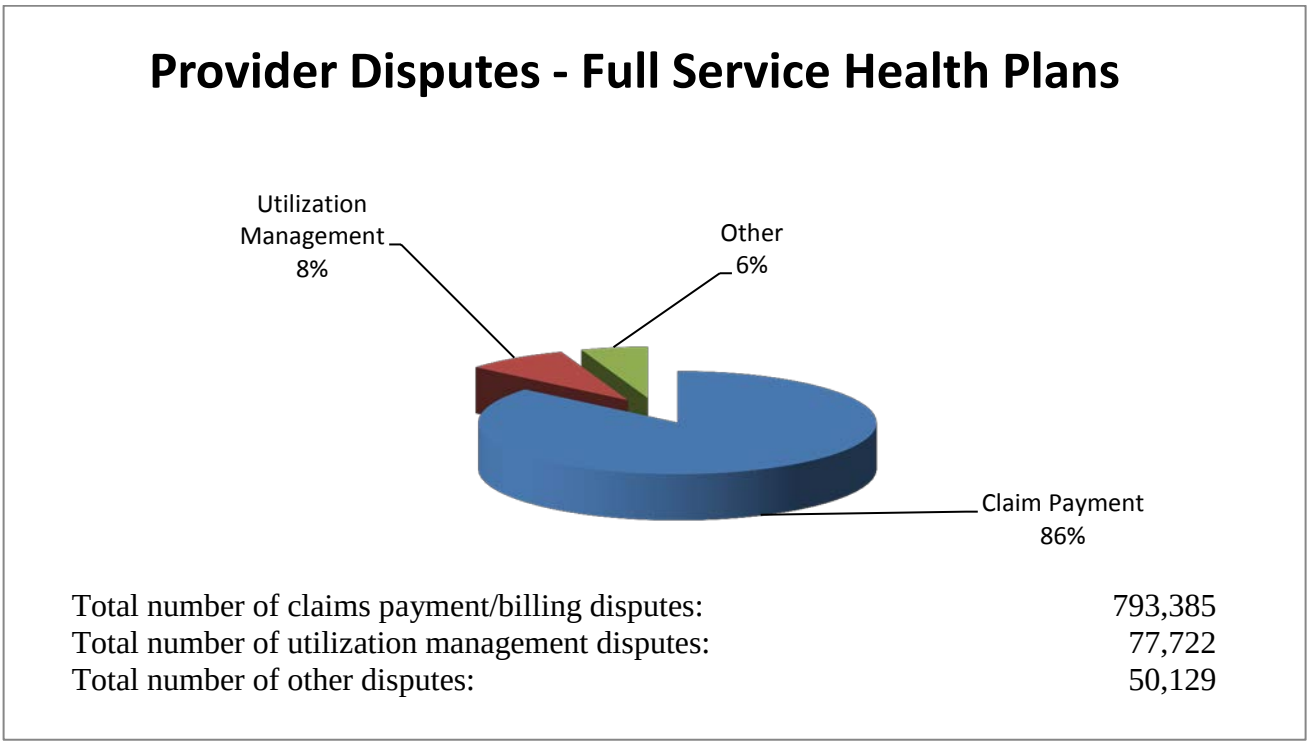
Of the 72 licensed full service health plans, data from 47 full service health plans are included in this report. Twenty-five licensed, full service health plans are excluded because they are in pre-operations or provide only Medicare products, therefore are exempt from Health and Safety Code section 1367(h).

The 47 full service health plans reported more than 141 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 reporting full service health plans received 921,236 provider disputes during the 2015 reporting period. This represents a 35 percent increase in disputes over the 2014 reporting period.

Claims payment/billing disputes, which primarily involve claims of inadequate reimbursement, comprised 86 percent of the full service health plan provider disputes (See Chart 1).

Chart 1



Total number of claims payment/billing disputes:	793,385
Total number of utilization management disputes:	77,722
Total number of other disputes:	50,129

Regulations require the health plans to resolve 95 percent of all complete provider disputes within 45 working days. Approximately 87 percent of all provider disputes processed by full service health plans were reported as resolved within the required 45 working days from the date of receipt. Collectively, full service health plans did not meet the timeliness requirements for resolving timeliness disputes. In 2014, 93 percent of provider disputes were resolved within 45 days.

Health plans attributed the declining provider dispute resolution timeliness to a variety of factors. These factors include large increases in unanticipated health plan enrollment, staffing issues, and claims system updates. Health plans are required to report to the Department any corrective action plans that have been instituted to improve timeliness going forward. Corrective action plans in 2015 included weekly reports to monitor processing timeliness, system improvements to determine dispute causes, educational guidance to billers and providers, and additional staffing to eliminate dispute backlog.

The DMHC monitors the health plans' corrective actions through its financial examinations and by analyzing provider complaints received by the DMHC's Provider Complaint Unit.

Provider Disputes Compared to Claims

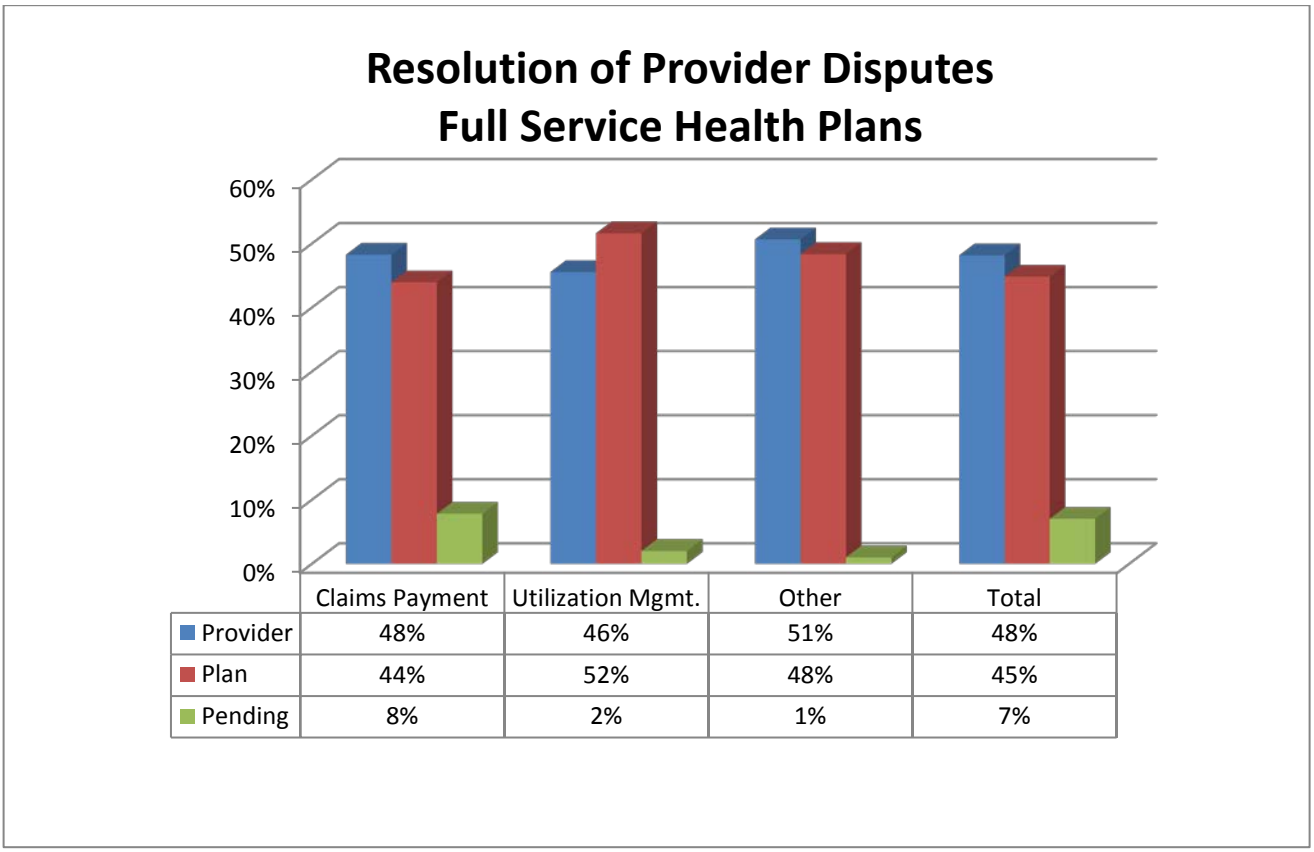
Approximately 87 percent of provider claims processed were paid or adjusted, while 13 percent were contested or denied. Nearly all claims (approximately 99 percent) were processed within 45 working days from the date of receipt.

Over 141 million claims were processed during the reporting period, which resulted in 921,236 provider disputes contesting the full service health plans' reimbursement determinations. This represents less than one percent (0.65 percent) of all claims processed by full service health plans.

Disposition of Full Service Health Plan Provider Disputes

For the 2015 reporting period, full service health plans reported that 48 percent of all disputes between providers and health plans were resolved in favor of the provider. This was an increase of 7 percent of disputes resolved in favor of the provider from the 2014 reporting period. Of the 921,236 provider disputes submitted, 443,607 (48 percent) were resolved in favor of the provider, 412,930 (45 percent) in favor of the plan, and 64,699 (7 percent) were pending review as of September 30, 2015 (See Chart 2).

Chart 2



	Claims Payment	Utilization Mgmt.	Other	Total
Provider	48%	46%	51%	48%
Plan	44%	52%	48%	45%
Pending	8%	2%	1%	7%

Seven Largest Full Service Health Plans

California's seven largest full service health plans provide health care benefits to over 22 million enrollees, representing 88 percent of the approximately 25 million enrollees enrolled in health plans licensed by the DMHC. For the 2015 reporting period, 60 percent of provider disputes were filed with these seven plans. Collectively, they processed more than 116 million claims, accounting for 82 percent of all claims processed by full service health plans in California (See Table 1).

Table 1

Provider Disputes by Plan

Name of Health Plan	Enrollment[4]	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.	7,522,054	2,238,391	55,161	17,421	29,537	8,203	32%	99%
Blue Cross of California (Anthem Blue Cross)	3,402,322	59,451,623	206,903	75,634	126,267	5,002	37%	94%
California Physicians' Service (Blue Shield of California)	3,269,516	17,758,686	109,652	52,158	53,476	4,018	48%	97%
Health Net of California, Inc.	3,080,412	7,429,339	51,671	21,238	24,786	5,647	41%	97%
Local Initiative Health Authority for LA County (L.A. Care Health Plan)	1,841,788	9,755,244	38,992	10,229	8,963	19,800	26%	33%
Health Net Community Solutions	1,800,934	14,553,187	19,000	11,865	4,464	2,671	62%	95%
Inland Empire Health Plan (IEHP)	1,123,253	5,049,592	70,974	29,610	34,504	6,860	42%	98%
Total - Seven Largest Health Plan[5]	**22,040,279**	**116,236,062**	**552,353**	**218,155**	**281,997**	**52,201**	**39%**	**92%**
All Other Full Service Health Plans	3,366,189	25,498,992	368,883	225,452	130,933	12,498	61%	79%
Total - All Full Service Health Plans	**25,406,468**	**141,735,054**	**921,236**	**443,607**	**412,930**	**64,699**	**48%**	**87%**

In 2015, eleven health plans reported noncompliance with the 45 working day requirement to resolve disputes. These health plans provided information on emerging or established patterns payment deficiencies and demonstrated specific actions taken to improve dispute timeliness.

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

[4] Total health plan enrollment reported at the quarter ended 9/30/15.

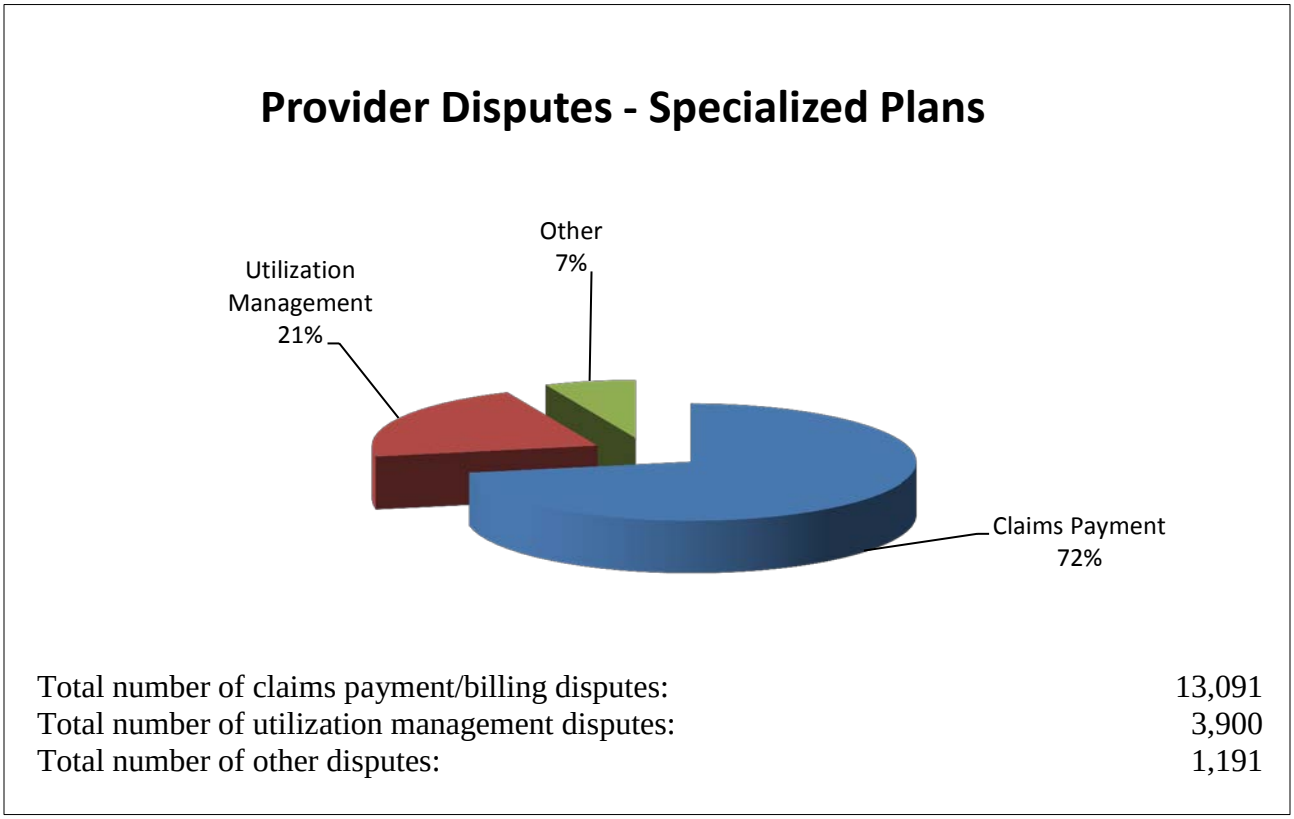
[5]Health Net Community Solutions, Local Initiative Health Authority for L.A. County (L.A. Care Health Plan), and Inland Empire Health Plan are Medi-Cal plans included in the top seven largest health plans, a change from the previous year.

IV.

Specialized Health Plans

During the 2015 reporting period, California's 47 specialized health plans processed more than 25 million provider claims and received 18,182 provider disputes. Specialized health plans noted an increase in the number of disputes with 18,182 disputes in 2015 versus 15,544 disputes in 2014. This represents a 17 percent increase over the 2014 reporting period. Of these disputes, 96 percent were resolved within 45 working days from the date of receipt. The majority of provider disputes (72 percent) submitted to specialized health plans involved claims payment/billing disputes. Chart 3 shows the breakdown of provider disputes.

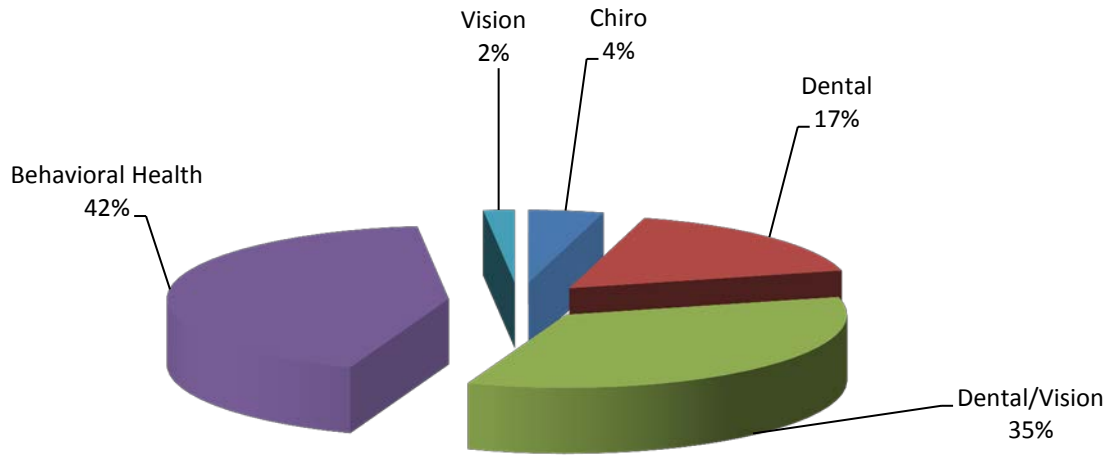
Chart 3



Total number of claims payment/billing disputes:	13,091
Total number of utilization management disputes:	3,900
Total number of other disputes:	1,191

Of the 18,182 total provider disputes submitted to specialized health plans during the 2015 reporting period, dental plans (including dental/vision plans) accounted for more than 52 percent of the disputes, followed by behavioral health plans with 42 percent, chiropractic plans at four percent, and vision plans at two percent (See Chart 4). Dental plans continue to report the largest number of disputes. The dental plan disputes accounted for 9,338 disputes followed by 7,735 behavioral health disputes.

Chart 4

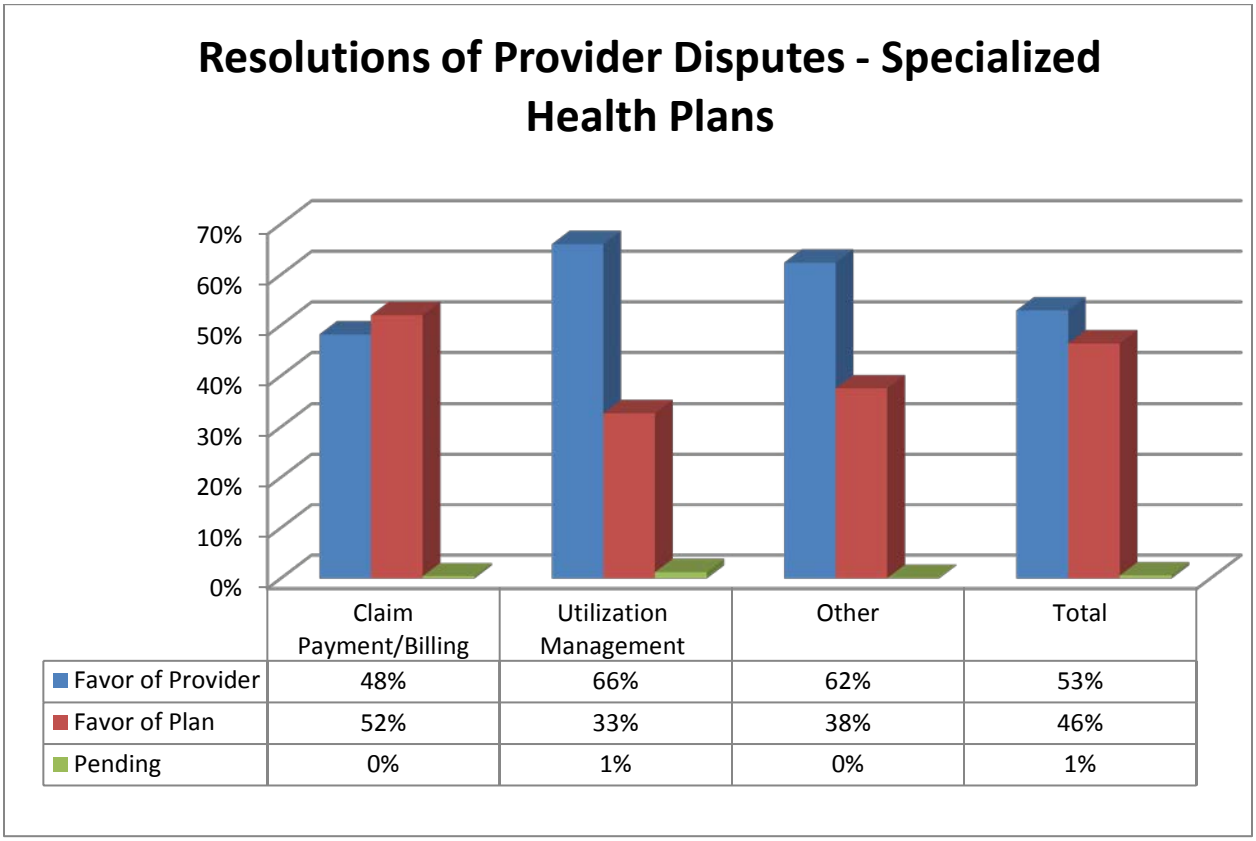


Total disputes by Specialized Plan Type	2015
Behavioral Health	7,735
Vision	326
Chiropractic	783
Dental	3,051
Dental/Vision	6,287

Disposition of Specialized Health Plan Provider Disputes

Specialized health plans reported that 53 percent of all provider disputes were resolved in favor of the provider, a two percent increase in the number of provider dispute resolved in favor of the provider from the 2014 reporting period. Forty-eight percent of disputes involving claims payment and billing issues were resolved in favor of the provider while 52 percent of disputes were resolved in favor of the plan. Utilization management disputes were resolved in favor of providers 66 percent of the time (See Chart 5).

Chart 5



	Claim Payment/Billing	Utilization Management	Other	Total
Favor of Provider	48%	66%	62%	53%
Favor of Plan	52%	33%	38%	46%
Pending	0%	1%	0%	1%

V.

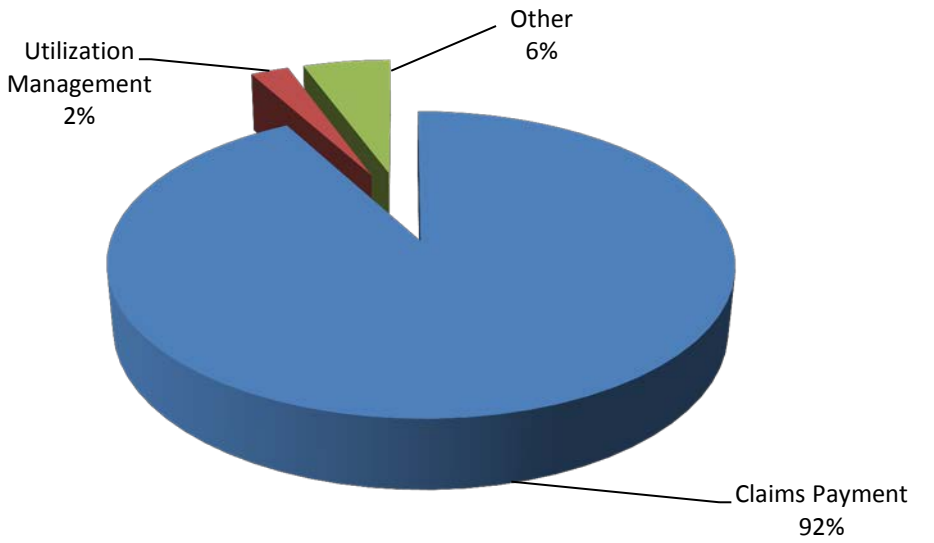
Capitated Providers

All health plans are required to compile and provide a dispute resolution report for each capitated provider. Based upon the number of filings received, the DMHC has identified 296 capitated providers that contracted with full service health plans.

Health plans report a total of 530,881 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 capitated providers must also file an annual provider disputes report with each of their contracting health plans. Capitated providers are required to follow the same reporting elements as full service and specialized health plans.

Capitated providers processed approximately 57 million claims in 2015. Nearly all provider disputes (92 percent) 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:	488,469
Total number of utilization management disputes:	12,901
Total number of other disputes:	29,511

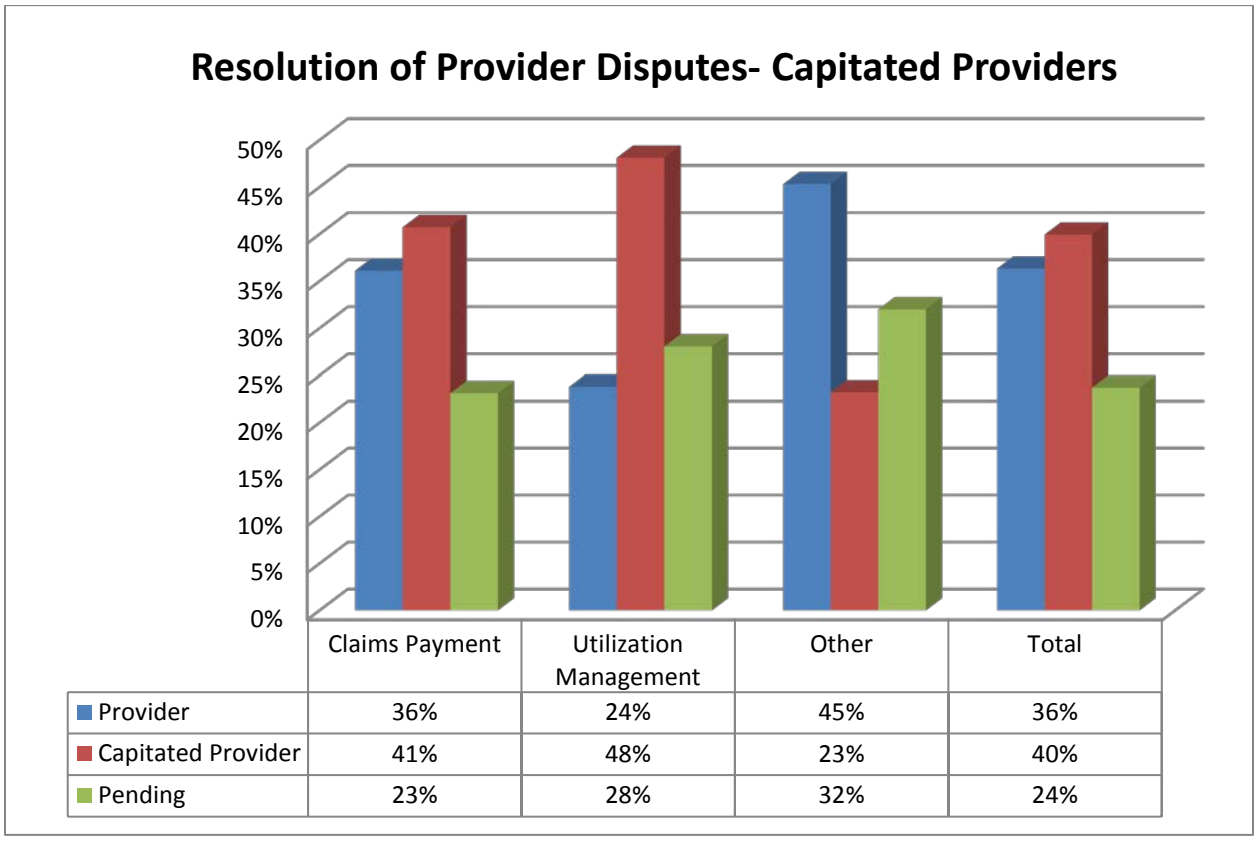
Approximately 86 percent of claims processed were paid or adjusted and 14 percent of the claims processed were contested or denied. In addition, capitated providers processed approximately 99 percent of claims within the 45-day statutory requirement.

For provider disputes not resolved within the prescribed timeframes, the capitated providers self-initiate corrective action plans. These corrective action plans are monitored by the health plans to ensure compliance within the required timeframes. The Department tracks these corrective actions to confirm the health plans are appropriately monitoring their contracted capitated provider for compliance.

Disposition of Capitated Providers' Provider Disputes

In 2015, the number of capitated provider disputes increased four percent from 2014. Of the 530,881 provider disputes submitted, 36 percent were resolved in favor of the provider submitting the disputes, 40 percent were resolved in favor of the plan, and 24 percent were pending review as of September 30, 2015. The increase in provider disputes with capitated providers is consistent with the overall increase in disputes received by full service health plans. Chart 7 illustrates the breakdown by percentages for each category of dispute compared to the total number of disputes.

Chart 7



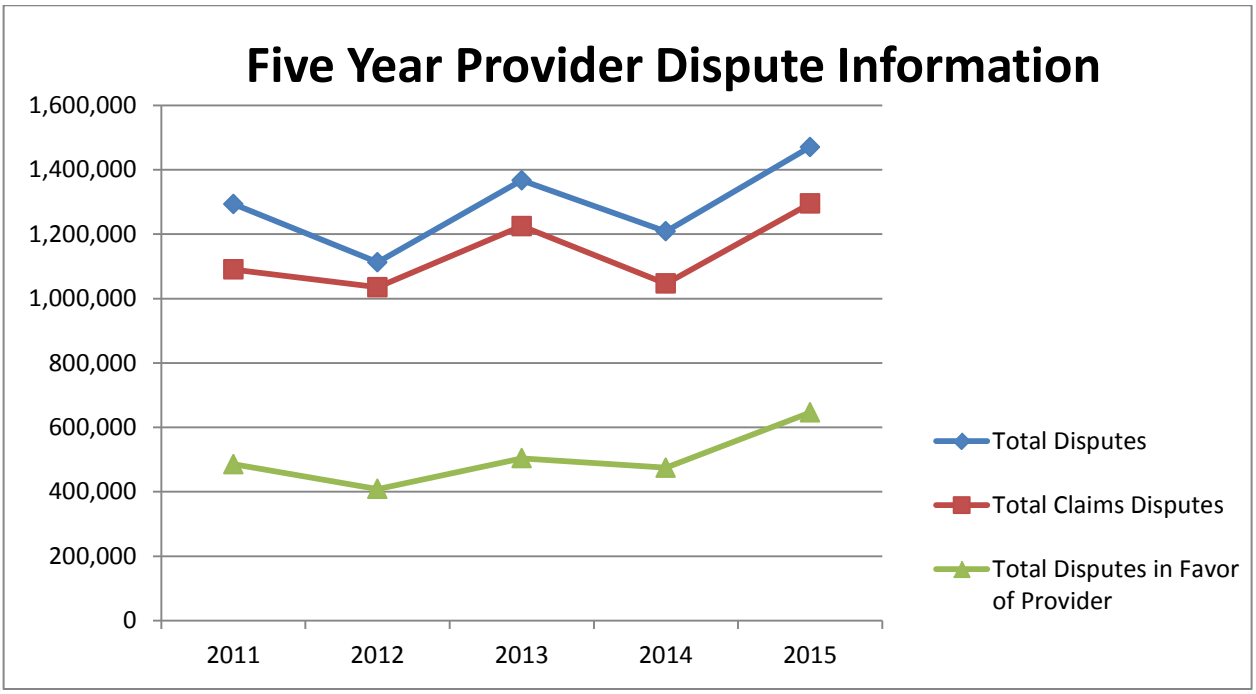
	Claims Payment	Utilization Management	Other	Total
Provider	36%	24%	45%	36%
Capitated Provider	41%	48%	23%	40%
Pending	23%	28%	32%	24%

VI.

Provider Dispute Trends – All Plan Types

Chart 8 displays the trend for the volume of disputes reported by Full Service Plans, Specialized Plans, and Capitated Providers over a five year period. The blue bar represents the total number of disputes reported, the red bar represents total claims disputes reported and the green bar represents the total number of disputes in favor of the provider reported. From 2014 to 2015, the chart shows increases in total disputes, total claims disputes and total disputes in favor of the provider. In 2011, 38 percent of the disputes received were decided in favor of the provider in contrast to 44 percent in 2015. This trend indicates a gradual increase in the number of overturned provider disputes over the five year period.

Chart 8



VII.

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. In addition, there are substantive differences in the way plans identify, quantify and track provider disputes. The DMHC is currently working with the health plans and capitated providers to review the underlying data included in the reports. This data verification process should improve the quality of the data and will assist in enhancing the reporting instructions by identifying common reporting errors and addressing them through clarification of expectations in the instructions.

The DMHC conducts regular onsite auditing activities, and reviews quarterly and annual claims payment and dispute resolution reports to monitor the industry's compliance with claims payments standards required by Health and Safety Code section 1371 and California Code of Regulations, title 28, section 1300.71. The DMHC implements appropriate corrective actions for any identified claims payment deficiencies and monitors them accordingly.