Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
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January 29, 2021 **Via eFile**

Mr. Brian Ternan
Chair of the Board of Directors
Health Net of California, Inc.
21281 Burbank Blvd.
Woodland Hills, CA 91367

FINAL REPORT OF A ROUTINE EXAMINATION OF HEALTH NET OF CALIFORNIA, INC.

Dear Mr. Ternan:

Enclosed is the final report (Final Report) of a routine examination for the quarter ended March 31, 2020, of the claims settlement practices and dispute resolution mechanism of Health Net of California, Inc. (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a preliminary report (Preliminary Report) to the Plan on October 29, 2020. The Department accepted the Plan's electronically filed responses on December 14, 2020 and January 7, 2021 (Responses).

The Final Report includes a description of the compliance efforts included in the Plan's Responses, in accordance with Section 1382(c).

Section 1382(d) states, "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within 10 days from the date of the Plan's receipt of this letter whether the Plan requests the Department to append its response(s). If so, please indicate which portions of the Plan's response(s) should be appended, and electronically file

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[1] References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in Health and Safety Code Section 1340 et seq.

copies of those portions excluding information held confidential pursuant to Section 1382(c). If the Plan requests the Department to append a brief statement summarizing the Plan's response or wishes to modify any information provided to the Department in its Responses, please provide an addendum no later than 10 days from the date of the Plan's receipt of this letter. Please file this addendum electronically via the corrective action plan (CAP) system within the Department's eFiling web portal at https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling."
- From the eFiling menu, select "Online Forms."
- From the Online Forms menu, select "Details" for "CAP # S20-R-300."
- Go to the "Messages" tab, then:
  - Select "Addendum to Final Report" (note this option will only be available for 10 days after the issuance of the Final Report).
  - Select the deficiency(ies) that are applicable.
  - Create a message for the Department.
  - Attach and upload all documents with the name "Addendum to Final Report."
  - Select "Send Message."

As noted in the attached Final Report, the Plan's Responses did not adequately respond to the deficiencies raised in the Preliminary Report issued by the Department on October 29, 2020. The Plan is required to respond to any request for corrective actions contained within the attached Final Report within 30 days of receipt of the Final Report. If the Plan fails to fully respond and/or resolve the deficiencies addressed in the Final Report, then a referral will be made to the Department's Office of Enforcement for appropriate administrative action.

Please file the Plan's response electronically via the CAP system within the Department's eFiling web portal at https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling."
- From the eFiling menu, select "Online Forms."
- From the Online Forms menu, click on the "Details" for "CAP # S20-R-300."
- Go to the "Data Requests" tab, then:
  - Click on the "Details" for each data request that does not have a status of "Complete."
  - Follow the instructions and/or use the form shown to add the requested data (depending on the type of data requested: New Filing, Document Request, Claims Data, or Financial Statement Refile).

The Department will also e-mail the Plan requesting all items that are still outstanding. The e-mail(s) will contain a link to the CAP system for the Plan to file the response electronically.

Questions or problems related to the electronic transmission of any addendum should be directed to Vijon Morales at 916-255-2447, or by e-mail at Vijon.Morales@dmhc.ca.gov. You may also e-mail inquiries to wpso@dmhc.ca.gov.

The Department will make the Final Report available to the public in 10 days from the Plan's receipt of this letter. The Final Report will be located at the Department's web site at http://www.dmhc.ca.gov/LicensingReporting/ViewFinancialExaminationReports.aspx.

The Plan is hereby advised that any violations listed in the Final Report may be referred to the Department's Office of Enforcement for appropriate administrative action.

If there are any questions regarding the Final Report, please contact me at 916-255-2425, or by e-mail at Anna.Belmont@dmhc.ca.gov.

Sincerely,

SIGNED BY

Anna Belmont
Corporation Examiner IV, Supervisor
Office of Financial Review
Division of Financial Oversight

cc: Christy K Bosse, Vice President of Compliance, Health Net of California, Inc.
Pritika Dutt, CPA, Deputy Director, Office of Financial Review
Jennifer Clark, Supervising Examiner, Division of Financial Oversight
Erica Short, Examiner, Division of Financial Oversight
Ping Han, Examiner, Division of Financial Oversight
John Lai, Attorney III, Office of Plan Licensing
Laura Dooley-Beile, Supervising Health Care Service Plan Analyst, Office of Plan Monitoring
Ben Carranco, Assistant Deputy Director, Help Center
Chad Bartlett, Staff Services Manager II, Help Center

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

OFFICE OF FINANCIAL REVIEW
DIVISION OF FINANCIAL OVERSIGHT

FINAL REPORT OF A ROUTINE EXAMINATION

OF

HEALTH NET OF CALIFORNIA, INC.

FILE NO. 933 0300

DATE OF FINAL REPORT: JANUARY 29, 2021

SUPERVISING EXAMINER: JENNIFER CLARK

OVERSIGHT EXAMINER: ANNA BELMONT

EXAMINER-IN-CHARGE: ERICA SHORT

FINANCIAL EXAMINERS:

BENBIN FENG

ERI FUKUDA

NINA MOUA

DANIIL RYBALKO

BACKGROUND INFORMATION FOR HEALTH NET OF CALIFORNIA, INC.

Date Plan Licensed:	March 7, 1991
Organizational Structure:	Health Net of California, Inc. (Plan) is a for-profit, wholly owned subsidiary of Health Net, LLC (HN), which is a wholly owned subsidiary of Centene Corporation. The Plan wholly owns the following subsidiaries: Health Net Life Insurance Company, Health Net Life Reinsurance Company, and MEB Ventures, II. The Plan is a party to several administrative service agreements with HN and its affiliates, which authorize certain services to be performed on behalf of the Plan and vice versa.
Type of Plan:	The Plan is a full service health care plan that provides access to health care services through its commercial, Medicare, Medi-Cal dental, and Knox-Keene Point-of-Service (POS) products.
Provider Network:	The Plan contracts with various providers, including medical groups, hospitals, and other providers of health care services. Professional providers are reimbursed on a capitation basis, and institutional providers are reimbursed on a discounted fee-for-service, hospital per diem, case rate, and capitation basis.
Plan Enrollment:	The Plan reported 971,019 enrollees at March 31, 2020.
Service Area:	Alameda, Contra Costa, El Dorado, Fresno, Kern, Kings, Los Angeles, Madera, Marin, Merced, Napa, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Sutter, Tulare, Ventura, Yolo, and Yuba Counties.
Date of Prior Final Routine Examination Report:	February 9, 2018

FINAL REPORT OF A ROUTINE EXAMINATION OF HEALTH NET OF CALIFORNIA, INC.

This is the final report (Final Report) for the quarter ended March 31, 2020, of a routine examination of the claims settlement practices and dispute resolution mechanism of Health Net of California, Inc. (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975.[1]

The Department issued a preliminary report (Preliminary Report) to the Plan on October 29, 2020. The Department accepted the Plan's electronically filed responses on December 14, 2020 and January 7, 2021 (Responses).

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

The Plan is hereby advised that any violations listed in the Final Report may be referred to the Department's Office of Enforcement for appropriate administrative action.

The Department's findings are presented in this Final Report as follows:

Part I. Compliance Issues
Part II. Nonroutine examination

The Plan is required to respond to any request for corrective actions contained herein within 30 days of receipt of this Final Report.

[1] References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in Health and Safety Code Section 1340 et seq. References to "Rule" are to regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act of 1975, contained within title 28 of the California Code of Regulations.

PART I. COMPLIANCE ISSUES

A. CLAIMS SETTLEMENT PRACTICES- "UNFAIR PAYMENT PATTERN"

Section 1371.37 prohibits a health care service plan from engaging in an unfair payment pattern and defines certain claims settlement practices as "unfair payment patterns."

Rule 1300.71(a)(8) defines an "unfair payment pattern" as any practice, policy, or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims.

The Plan contracts with its affiliate Managed Health Network (MHN) to process behavioral claims. The Department examined two sets of claims samples, one processed by the Plan and one processed by MHN.

1. PAYMENT ACCURACY, INCLUDING INTEREST AND PENALTIES – Repeat Deficiency

Section 1371 and Rule 1300.71(i)(2) and (j) require a health care service plan, if the plan is a health maintenance organization, to reimburse uncontested claims no later than 45 working days after the date of receipt of the claim by the plan. If an uncontested claim is not reimbursed within 45 working days after receipt, interest accrues at the rate of 15 percent per annum, beginning with the first calendar day after the 45-working-day period. A plan that fails to automatically include any interest due in its payment of the claim must pay a fee of $10 to the claimant.

Rule 1300.71(a)(8)(K) describes an "unfair payment pattern" as the failure to reimburse at least 95 percent of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

Rule 1300.71.38(g) states if the provider dispute or amended dispute involves a claim and is determined in whole or in part in favor of the provider, the plan shall pay any outstanding monies determined to be due, and all interest and penalties within five working days of the issuance of the written determination.

The Department's examination disclosed that claims were not reimbursed accurately, including automatic payment of interest and penalties, in the following claims samples processed by the Plan:

- 12 out of 50 late paid claims (a compliance rate of 76 percent). This deficiency was noted in the following late paid claims sample numbers: 14, 17, 21, 24, 26, 30, 31, 39, 40, 43, 44, and 54. The deficiency was caused by the Plan underpaying interest due to using the date the claim was finalized in the claim system instead of the date the check was mailed, and using the incorrect date of receipt on reprocessed claims.

- Four out of 30 high dollar claims. This deficiency was noted in the following high dollar claims sample numbers: 6, 15, 25, and 32. The deficiency was caused by the Plan not paying or underpaying interest due to using the incorrect date of receipt on reprocessed claims.

- Four out of 50 claims resulting from provider dispute resolutions (PDRs) (a compliance rate of 92 percent). This deficiency was noted in the following PDR sample numbers: 14, 20, 28, and 48. The deficiency was caused by the Plan failing to pay interest due to using the PDR date of receipt instead of the claim date of receipt.

The Department's examination disclosed that claims were not reimbursed accurately, including automatic payment of interest and penalties, in the following claims samples processed by MHN:

- 10 out of 50 late paid claims (a compliance rate of 80 percent). This deficiency was noted in the following late paid claims sample numbers: 3, 6, 19, 23, 24, 25, 30, 38, 40, and 50. The deficiency was caused by the underpayment of interest due to using the date the claim was finalized in the claim system instead of the date the check was mailed, and using the incorrect date of receipt on reprocessed claims.

- Five out of 50 PDRs (a compliance rate of 90 percent). This deficiency was noted in the following PDR sample numbers: 26, 49, 50, 53, and 66. The deficiency was caused by the Plan underpaying interest due to using the date the claim was finalized in the claim system instead of the date the check was mailed, and using the incorrect date of receipt on reprocessed claims to calculate interest.

The Plan's failure to reimburse claims accurately, including interest and penalties is a repeat deficiency, as this issue was previously noted in the Department's final report of examination dated February 9, 2018, for the quarter ended June 30, 2017. This examination disclosed that the Plan's compliance efforts in response to the prior final report had not achieved the necessary levels of compliance with the Section and Rules cited.

The Plan was required to explain why the corrective actions implemented to resolve the deficiency of failure to reimburse claims accurately, including payment of interest and penalties, as identified in the Department's prior examination, were not effective in ensuring ongoing compliance.

In addition, the Plan was required to submit a detailed corrective action plan (CAP) that included the following:

a. Policies and procedures, including internal claims audit procedures, implemented to ensure claims are paid accurately, including interest and penalties. When

applicable, clean and redlined versions were to be submitted to clearly identify revisions made to policies and procedures as a result of the examination.

b. Date the policies and procedures were implemented.

c. Training materials and the date(s) training was conducted to ensure claim processors are aware of and comply with the requirements of the above Section and Rules.

d. Identification of all claims paid inaccurately, including interest and penalties, from February 9, 2018 (date of prior final report), through the date the corrective action was implemented by the Plan.

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

- Claim number
- Date of service
- Date original claim received
- Date new information received
- Total billed
- Original amount paid
- Date original amount paid
- Additional amount paid as a result of remediation
- Date additional amount paid
- Amount of original interest paid
- Amount of additional interest paid as a result of remediation
- Date additional interest paid
- Penalties amount paid, if applicable
- Number of late days used to calculate interest
- Check number for interest and penalties paid
- Provider name
- ER or Non-ER indicator

The data file was to provide the details of all claims remediated, including claims corrected during the course of the examination, and was to include the total number of claims, total original claim payments, additional claim payments, and the total additional interest and penalties paid as a result of remediation.

f. Management positions responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan was required to provide a response to the Department within 45 days of receipt of the Preliminary Report. If the Plan was not able to complete the CAP or portions of the CAP within 45 days, the Plan was required to submit a timeline with its

response that committed the Plan to complete the CAP within 90 calendar days of receipt of the Preliminary Report. If the Plan was not able to meet this timeframe, it was required to provide a justification for the delay and request approval by the Department for the proposed timeline for completion of the CAP. The Plan was also required to submit monthly status reports to the Department until the CAP was completed.

The Plan responded by acknowledging a repeat deficiency previously noted in the Department's final report of claims examination dated February 9, 2018 for the quarter ended June 30, 2017. Following the Department's prior examination conducted in 2017, the Plan assessed its claims operations and the actions required to achieve ongoing compliance. As a result, the Plan developed an approach that would address the overall health of claims processing, including several required actions.

The Plan provided refresher training for its associates and conducted audits to cure the deficiencies identified. The Plan contends that these actions were successful on the platform that they were targeted to address, which was the singular processing platform, Automated Benefit Services (ABS), used for claims adjudication in 2017. The current 2020 exam included claims processed on the ABS system, as well as on the AMISYS Managed Care Systems (AMISYS) platform. Although this is a repeat finding, the Plan sees improvement from the last exam which indicates incremental success of the measures implemented for the ABS adjudication system, for which the prior CAP intended to address. While acknowledging that some deficiencies in the 2020 exam were in the ABS system, the Plan was encouraged by the improvement seen there and will continue with the measures put in place for ABS.

The Plan stated that since the majority of the errors identified in the 2020 exam were related to claims processed within the AMISYS claims processing system, corrective actions described below focus on the AMISYS system and will be implemented in addition to corrective actions that are currently in force for the ABS system.

The Plan stated that it is developing a new training curriculum related to interest payments. Training of all claims processing staff will be completed by January 31, 2021. The Plan provided a draft of the training curriculum in its current form. The Plan will submit the revised training curriculum and evidence of staff attendance to the Department by February 15, 2021.

With regard to underpaying claims due to member copay overcharges, the Plan implemented several enhancements related to tracking members' out of pocket maximum (OOPM) responsibility. On May 1, 2020, a process was put in place to notify members when they have met their OOPM and have no further financial obligations. This will prevent members continuing to pay copays at the time of service after the maximum responsibility has been satisfied. Also, effective May 1, 2020, a process to expedite member refunds as a result of excess payments made by members was implemented. When delegated provider groups (PPGs) are identified as owing excess copays to members, the Plan reaches out to the PPG to inform them of their obligation to the member. The PPG is given the opportunity to reimburse the member within 15

days. If payment is not made within 15 days, the Plan will make the payment on behalf of the PPG with deduction of that payment from the group's capitation payment. The Plan added a page on its website for PPGs that identifies members who have already met their OOPM, thereby providing a method of avoidance of copay overcharges to the member. A longer term solution of Explanation of Benefits enhancements is planned which will include additional OOPM accumulation communications to members. This enhancement is currently scheduled to go live in July 2021. The Plan provided its audit OOPM Audit Process workflow and "OOPM Member Met Letter" implemented on May 1, 2020.

With regard to the incorrect interest start date being used on returned checks that are reissued, the returned check void/reissue process for CA Marketplace was reviewed and revised to provide clear instructions on how to identify the correct start date for the interest calculation. The Plan provided its "Reissuing a Returned Check for California Marketplace" policy outlining its returned check process, which was approved on November 25, 2020. In addition, the Plan provided staff sign in sheets for "Return Check Training – When to Apply Interest," which was conducted on December 3, 2020.

With regard to the incorrect application of copayments on outpatient claims where the provider's contract bundles the payment amount to one line, the Plan has implemented a manual pricing tool where examiners can manually calculate the payment amount that applies to each individual service line. This break out of payment by line will allow the system to recognize where a member has a copayment responsibility for each applicable date of service. The Plan provided the Outpatient Pricing Template it implemented on May 8, 2020 and a roster for the associated training completed on May 8, 2020.

With regard to interest underpayments due to not adding mailing days in the AMISYS adjudication system, the Plan responded that it will modify the interest obligation start date by two days earlier going forward. The expected implementation date is February 14, 2021.

With regard to underpaying interest on behavioral claims processed by MHN, the Plan stated that the deficiency was due to the system configuration surrounding holidays and use of the check issue date versus posting date. MHN updated both the system configuration and its Policy and Procedures in July 2020 to reflect modifications to the interest calculation methodology. The updates require a separate job for claim lines requiring payment of interest to add an extra day for generation and mailing of the remittance advice. MHN established internal audits in September 2020 to validate that the Plan's actions have corrected this deficiency. The Plan provided written confirmation that MHN's Symphony interest updates were completed on July 6, 2020. In addition, the Plan provided redlined and final versions of MHN's "Interest Payment" procedures updated on June 2, 2020, and revised "Oversight and Corrective Action Plan for Routine Audit" policy implemented in September 2020. MHN interest training was conducted in multiple training sessions held from June 5, 2020 through July 1, 2020.

In addition, MHN updated its Policy and Procedures for adjustments. The Plan provided redlined and final versions of MHN's "Adjustments" policy revised on November 25, 2020, and attestation for the associated training completed on November 30, 2020.

MHN enhanced its high dollar claims process. All claims with an allowable amount of greater than $10,000 will be incorporated into a daily prepayment review. Actual claim submission will be viewed and compared to all data elements in the adjudication system and signed off by the appropriate level of leadership prior to release. The Plan provided redlined and final versions of MHN's "New Day Claims monetary level assignment and audit process" updated November 27, 2020.

The Plan stated that it will review claims for the period of February 9, 2018 through November 30, 2020, including paper checks to determine mailing date. The total number of claims requiring review is 44,843. When the interest configuration in the AMISYS system is complete, a review will be done to identify additional claims that need to be remediated.

The review of the claims, including all necessary adjustments, will be completed as follows: 3,789 non-interest related claims by February 28, 2021; and 41,054 interest related claims by April 30, 2021.

The Vice President of Claims Operations and the Senior Vice President, Operations, along with the Claims Management teams will be responsible for overseeing the CAP.

The Department finds that the Plan's compliance efforts are not fully responsive to the corrective action required since the Plan did not complete the claims remediation, implementation of the interest obligation start date configuration, and interest payment training.

The Department approves the following dates proposed by the Plan:

- **February 14, 2021 to modify the interest obligation start date in AMISYS and provide evidence of the modification.**
- **February 15, 2021 for submission of the revised interest payment training curriculum and evidence of staff attendance.**
- **April 30, 2021 for submission of the final claims remediation.**

The Plan is required to submit monthly status reports to the Department until the CAP is completed.

PDR MECHANISM

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

Rule 1300.71.38(m)(2) states that the failure of a plan to comply with the requirements of a fast, fair, and cost-effective dispute resolution mechanism shall be a basis for disciplinary action against the plan.

1. TIMELY PAYMENT OF PROVIDER DISPUTES

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 must 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 Department's examination disclosed that additional amounts due to providers were not paid or were paid after five working days of the issuance of an overturn determination in nine out of 50 PDR samples (a compliance rate of 82 percent) processed by the Plan. This deficiency was noted in the following PDR sample numbers: 4, 5, 10, 12, 14, 43, 46, 48, and 50.

The Plan was required to submit a detailed CAP that included the following:

a. Policies and procedures, including internal claims audit procedures, implemented to ensure additional amounts due to providers are paid within five days of issuance of an overturn determination. When applicable, clean and redlined versions were to be submitted to clearly identify revisions made to policies and procedures as a result of the examination.

b. Date the policies and procedures were implemented.

c. Training materials and the date(s) training was conducted to ensure claim processors are aware of and comply with the requirements of the above Rules.

d. Identification of all provider disputes where additional amounts were not paid after issuance of an overturn determination from June 30, 2017 (date of prior examination period) through the date the corrective action was implemented by the Plan.

e. Evidence that additional amounts, including interest and penalties, as appropriate, were paid retroactively for the provider disputes identified in paragraph "d" above. This evidence was to include an electronic data file/schedule (Excel or Access) that identified the following:

- Claim number
- PDR number
- Date of service
- Date original claim received
- Date new information received
- Total billed
- Total paid
- Paid date (mail date)
- Amount of interest paid
- Date interest paid
- Penalty amount paid, if applicable
- Number of late days used to calculate interest
- Total interest owed per claim
- Check number for interest and penalties paid
- Provider name
- ER or Non-ER indicator

The data file was to provide the details of all claims remediated, including claims corrected during the course of the examination, and was to include the total number of claims, total original claim payments, additional claim payments, and the total additional interest and penalties paid as a result of remediation.

f. Management positions responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan was required to provide a response to the Department within 45 days of receipt of the Preliminary Report. If the Plan was not able to complete the CAP or portions of the CAP within 45 days, the Plan was required to submit a timeline with its response that committed the Plan to complete the CAP within 90 calendar days of receipt of the Preliminary Report. If the Plan was not able to meet this timeframe, it was required to provide a justification for the delay and request approval by the Department for the proposed timeline for completion of the CAP. The Plan was also required to submit monthly status reports to the Department until the CAP was completed.

The Plan responded that in order to facilitate timely payments of overturned provider disputes in the AMISYS claims adjudication system, it implemented a special identifier, code EXYz, on November 10, 2020. This code will assist in timely payment in two ways. It will allow PDR adjustments to be identified and prioritized in the check release process, and will prevent certain coding edits from being reapplied after the PDR is released which could essentially influence the final PDR disposition.

The Plan stated that it implemented two new PDR audits; the timely payment of overturned disputes and the correctness of the claim as processed in the adjudication system. Monthly audits of all regulatory elements of completed PDRs began in November 2020 beginning with the Plan's and MHN's October 2020 PDR data. The

monthly audits will be used to compile quarterly results. In addition, the Plan and MHN will be implementing weekly random audits of current cases. Cases will be selected as they are closed and the Supervisor will audit all of the same elements of those selected cases consistent with the regulatory requirements. Current day audits began with cases closed within the first week of December 2020.

The Plan provided its "DMHC Regulatory Requirements" policy updated on June 17, 2020; "Quarterly Claims Audit" policy finalized on November 17, 2020; PDR Monthly Audit Template; and Supervisor PDR Audit Log effective December 1, 2020.

In addition, the Plan provided attestations for the DMHC Regulatory Requirements training completed on December 10, 2020.

The Plan stated that it did not begin processing claims in the AMISYS system until January 1, 2018, therefore, the Plan will review the PDR claim adjustments for the period January 1, 2018 through November 30, 2020. The total number of claims requiring review is 5,796. The review of the claims, including all necessary adjustments, will be completed by April 30, 2021.

The Vice President of Claims Operations and the Senior Vice President, Operations, along with the Claims Management teams will be responsible for overseeing the CAP.

The Department finds that the Plan's compliance efforts are not fully responsive to the corrective action required since the Plan did not complete the remediation required by the Department.

The Department approves the Plan's proposed date of April 30, 2021 for submission of the final claims remediation.

The Plan is required to submit monthly status reports to the Department until the CAP is completed.

2. ACKNOWLEDGEMENT OF PROVIDER DISPUTES

Rule 1300.71.38(e)(2) requires a plan to acknowledge the receipt of each paper provider dispute within 15 working days of the date of receipt of the provider dispute by the office designated to receive provider disputes.

Rule 1300.71(a)(8)(R) describes an "unfair payment pattern" as the failure to acknowledge the receipt of at least 95 percent 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 disclosed the failure to timely acknowledge receipt of 11 out of 50 PDR samples (a compliance rate of 78 percent) processed by MHN. This deficiency was noted in the following PDR sample numbers: 2, 7, 11, 21, 25, 30, 40, 53, 55, 56, and 77.

The Plan was required to submit a detailed CAP that included the following:

a. Policies and procedures, including internal claims audit procedures, implemented to ensure provider disputes are acknowledged timely. When applicable, clean and redlined versions were to be submitted to clearly identify revisions made to policies and procedures as a result of the examination.

b. Date the policies and procedures were implemented.

c. Training materials and the date(s) training was conducted to ensure claim processors are aware of and comply with the requirements of the above Rules.

d. Management positions responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan responded that it began monthly audits of all elements of PDR processing, including timely acknowledgement, in November starting with the Plan's and MHN October 2020 PDR data. The results will be used to compile a quarterly report for progress monitoring. In addition, both the Plan and MHN will be implementing weekly random audits of cases on a more real time basis. Cases will be selected as they are closed and the Supervisor will audit all elements of those selected cases according to the regulatory requirements. Weekly audits began with cases closed within the first week of December 2020.

The Plan stated that internal monitoring of the Plan's and MHN's provider dispute acknowledgement timeliness performance metrics reflected consistent results of greater than 95 percent compliance since May 2020.

The Vice President of Claims Operations and the Senior Vice President, Operations, along with the Claims Management teams are responsible for overseeing the CAP.

The Department finds that the Plan's compliance efforts are responsive to the corrective action required. Therefore, no further response is required.

3. INCORRECT PDR DETERMINATION

Rule 1300.71(d)(1) states a plan shall not improperly deny, adjust, or contest a claim.

Rule 1300.71(a)(8)(F) states that the plan's 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 Rule 1300.71(d)(1) at least 95 percent of the time for the affected claims over the course of any three-month period constitutes an unfair payment pattern.

The Department's examination disclosed that an original decision was incorrectly upheld on claim reimbursements in 10 out of 50 PDR samples processed by the Plan.

This deficiency was noted in the following PDR sample numbers: 3, 16, 21, 22, 26, 29, 34, 37, 45, and 47.

The Plan was required to submit a detailed CAP that included the following:

a. Policies and procedures, including internal claims audit procedures, implemented to ensure PDR determinations are accurate. When applicable, clean and redlined versions were to be submitted to clearly identify revisions made to policies and procedures as a result of the examination.

b. Date the policies and procedures were implemented.

c. Training materials and the date(s) training was conducted to ensure claim processors are aware of and comply with the requirements of the above Rules.

d. Identification of all provider disputes incorrectly denied from June 30, 2017 (date of prior examination period), through the date the corrective action was implemented by the Plan.

e. Evidence that additional amounts, including interest and penalties, as appropriate, were paid retroactively for the provider disputes identified in paragraph “d” above. This evidence was to include an electronic data file/schedule (Excel or Access) that identified the following:

   - Claim number
   - PDR number
   - Date of service
   - Date original claim received
   - Date new information received
   - Total billed
   - Total paid
   - Paid date (mail date)
   - Amount of interest paid
   - Date interest paid
   - Penalty amount paid, if applicable
   - Number of late days used to calculate interest
   - Total interest owed per claim
   - Check number for interest and penalties paid
   - Provider name
   - ER or Non-ER indicator

   The data file was to provide the details of all claims remediated, including claims corrected during the course of the examination, and was to include the total number of claims, total original claim payments, additional claim payments, and the total additional interest and penalties paid as a result of remediation.

f. Management positions responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan was required to provide a response to the Department within 45 days of receipt of the Preliminary Report. If the Plan was not able to complete the CAP or portions of the CAP within 45 days, the Plan was required to submit a timeline with its response that committed the Plan to complete the CAP within 90 calendar days of receipt of the Preliminary Report. If the Plan was not able to meet this timeframe, it was required to provide a justification for the delay and request approval by the Department for the proposed timeline for completion of the CAP. The Plan was also required to submit monthly status reports to the Department until the CAP was completed.

The Plan responded that it and MHN are implementing two additional audits of PDRs in order to monitor the accuracy of PDR case decisions, which will include a review of the correctness of the decision. Monthly audits of all regulatory elements of completed PDRs began in November 2020 with the Plan's and MHN's October 2020 PDR data. The results of the monthly audits will be used to compile a quarterly report for progress monitoring. In addition, the Plan and MHN will implement weekly random audits of cases on a more real time basis. Cases will be selected as they are closed and the Supervisor will audit all elements of those selected cases according to the regulatory requirements. Weekly audits began in December 2020 with cases closed within the first week of December 2020.

The Plan will review all similar provider disputes incorrectly denied from June 30, 2017 through November 30, 2020. The total number of PDR cases to be reviewed is 671. The review of the claims, including all necessary adjustments, will be completed by February 28, 2021.

The Vice President of Claims Operations and the Senior Vice President, Operations, along with the Claims Management teams will be responsible for overseeing the CAP.

The Department finds that the Plan's compliance efforts are not fully responsive to the corrective action required since the Plan did not complete the remediation required by the Department.

The Department approves the Plan's proposed date of February 28, 2021 for submission of the final claims remediation.

The Plan is required to submit monthly status reports to the Department until the CAP is completed.

PART II. NONROUTINE EXAMINATION

The Plan is advised that the Department may conduct a nonroutine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by

the Plan in response to the Preliminary Report. The cost of said examination will be charged to the Plan in accordance with Section 1382(b).

No response is required to this Part.