Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
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Sacramento, CA 95814
Phone: 916-324-8176 | Fax: 916-255-5241
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February 2, 2021 **Via eFile**

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

FINAL REPORT OF A ROUTINE EXAMINATION OF HEALTH NET COMMUNITY SOLUTIONS, 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 Community Solutions, 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, January 7, 2021, and January 22, 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

[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-426."
- 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-426."
- 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 Community Solutions
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 COMMUNITY SOLUTIONS, INC

FILE NO. 933 0426

DATE OF FINAL REPORT: FEBRUARY 2, 2021

SUPERVISING EXAMINER: JENNIFER CLARK

OVERSIGHT EXAMINER: ANNA BELMONT

EXAMINER-IN-CHARGE: ERICA SHORT

FINANCIAL EXAMINERS:

NEETU BHANGU

ERI FUKUDA

NINA MOUA

DANIIL RYBALKO

BACKGROUND INFORMATION FOR HEALTH NET COMMUNITY SOLUTIONS, INC.

Date Plan Licensed:	June 13, 2005
Organizational Structure:	Health Net Community Solutions, Inc. (Plan) is a for-profit, wholly owned subsidiary of Health Net, LLC., which is a wholly owned subsidiary of Centene Corporation. The Plan provides health care services to individuals through government-subsidized programs, including Medicare through its contract with the Centers for Medicare and Medicaid, Medi-Cal through its contracts with the California Department of Health Care Services, and subcontractor agreements
Type of Plan:	The Plan is a full service health care plan.
Provider Network:	The Plan contracts with various providers, including medical groups, hospitals, and other providers of health care services. Professional providers receive capitation for their services on a per member per month basis, and institutional providers are reimbursed on a capitation, discounted fee-for-service, hospital per diem, and case rate basis.
Plan Enrollment:	The Plan reported 1,699,335 enrollees as of March 31, 2020.
Service Area:	The Plan's service area consists of Alameda, Fresno, Imperial, Kern, Kings, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Stanislaus, and Tulare Counties.
Date of Prior Final Routine Examination Report:	August 27, 2019

FINAL REPORT OF A ROUTINE EXAMINATION OF HEALTH NET COMMUNITY SOLUTIONS, 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 Community Solutions, 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, January 7, 2021, and January 22, 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:

- Four out of 50 late paid claims (a compliance rate of 92 percent). This deficiency was noted in the following late paid claims samples numbers: 17, 22, 35, and 37. The deficiency was primarily caused by the Plan failing to pay interest correctly due to using the incorrect date of receipt on reprocessed claims.

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 Managed Health Network:

- 13 out of 50 late paid claims (a compliance rate of 74 percent). This deficiency was noted in the following late paid claims sample numbers: 1, 3, 4, 7, 8, 9, 13, 16, 18, 21, 29, 36, and 43. This deficiency was primarily caused by the Plan underpaying interest due to using the date the claim was finalized in the claim system and not the date the check was mailed and using the incorrect date of receipt on reprocessed claims.

- Three out of 50 paid claims (a compliance rate of 94 percent). This deficiency was noted in the following paid claims sample numbers: 16, 34, and 39. The deficiency was caused by the Plan using incorrect rates to reimburse the claims.

- Five out of 50 claims resulting from provider dispute resolutions (PDRs) (a compliance rate of 90 percent). This deficiency was noted in the following PDR sample numbers: 9, 19, 20, 39, and 45. This deficiency was primarily caused by the Plan underpaying interest due to using the date the claim was finalized in the claim system and not the date the check was mailed.

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 16, 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 16, 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 is completed.

The Plan responded by acknowledging a repeat deficiency previously noted in the Department's final report of claims examination dated February 16, 2018, for the quarter ended June 30, 2017. The Plan stated that it has seen improvement from the last audit

which indicates incremental success due to the measures that were employed for the Automated Benefit Services (ABS) claims adjudication system. The Plan will continue with the measures currently in place in addition to the processes described below.

The Plan implemented post pay audits on late paid and late adjusted claims. It will conduct refresher training for its claims processing employees as it relates to the elements of payment accuracy including payment of interest and penalties. Due to the repeat finding surrounding payment of interest and the number of errors identified, it is necessary for training material to undergo a complete review. The Plan is developing a new training curriculum. Training of all claims processing staff will be completed by January 31, 2021. The Plan provided a draft of the training in its current form. It will submit the revised training curriculum and evidence of staff training attendance to the Department by February 15, 2021.

During the DMHC audit of MHN in March 2020, a deficiency was identified specific to MHN's interest calculations. 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; revised "Oversight and Corrective Action Plan for Routine Audit" policy implemented in September 2020; and redlined and final versions of MHN's "New Day Claims monetary level assignment and audit process" updated on November 27, 2020.

MHN also 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 attestations for the associated training completed on November 30, 2020.

The Plan stated that it will review claims for remediation for the period of June 30, 2017 through November 30, 2020. The total number of claims identified requiring review is 3,668. 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 claims remediation and interest payment training.

The Department approves the Plan's proposed date of February 28, 2021, for submission of the final claims remediation and February 15, 2021, for submission of the revised interest payment training curriculum and evidence of staff attendance.

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

2. FAILURE TO PROVIDE NOTICE BEFORE CHANGING PROVIDER FEE SCHEDULES

Rule 1300.71(m) requires a plan to provide a minimum of 45 days prior written notice before instituting any changes, amendments or modifications to fee schedules and other required information.

The Department's examination disclosed that 45 days prior written notice was not provided before instituting changes to the provider's fee schedule in three out of 50 paid claims processed by the Managed Health Network. This deficiency was noted in the following paid claims sample numbers: 16, 34, and 39.

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 providers receive a minimum of 45 days prior written notice before any changes to fee schedules are instituted. 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 claims processors are aware of and comply with the requirements of the above Rule.

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

The Plan responded that the MHN's Provider Relations Department implemented a new policy that requires management approval before any changes to fee schedules are implemented. The policy will require a minimum of 45 days prior written notice to the provider. The MHN Provider Relations Department Auditor will also audit the Symphony system to ensure that the provider information was loaded correctly. The audit will verify that the providers on the distribution list or on the Contract Load Form have been entered correctly.

The Plan provided its "Universal or Line of Business Rate Change Notification" policy, implemented November 23, 2020, and attestations for the associated training conducted on November 23, 2020.

The Senior Director of Provider Relations for MHN will be 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. FORWARDING MISDIRECTED CLAIMS

Rule 1300.71(b)(2)(A) and (B) state that when a claim is sent to a health care service plan that has contracted with a capitated provider that is responsible for adjudicating the claim, the plan shall do the following:

- If the claim involves emergency services, the plan must forward the claim to the appropriate capitated provider within 10 working days of receipt of the claim that was incorrectly sent to the plan.

- If the claim does not involve emergency services or care and if the provider that filed the claim is contracted with the plan's capitated provider, the plan must, within 10 working days from receipt of the claim, either send the claimant a notice of denial including instructions to bill the capitated provider or send the claim to the appropriate capitated provider.

- For all other claims, the plan must, within 10 working days from receipt of the incorrectly sent claim, forward the claim to the appropriate capitated provider.

Rule 1300.71(a)(8)(B) describes an "unfair payment pattern" as the failure to forward at least 95 percent of misdirected claims consistent with Rule 1300.71(b)(2)(A) and (B) over the course of any three-month period.

The Department's examination disclosed that the Plan did not deny or forward misdirected claims within 10 working days of receipt in three out of 30 high dollar claims processed by the Plan. This deficiency was noted in the following high dollar sample numbers: 6, 20, and 37.

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 misdirected claims are denied or forwarded in accordance with the above Rules. 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 claims 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 follows an internal "Signature of Approval" process to ensure that high dollar claims, which is any claim with a billed amount greater than $50,000, that is not auto adjudicated, receives a secondary review prior to being forwarded to a delegated entity. This allows the Plan to validate that claims are being forwarded correctly based upon the Division of Financial Responsibility Agreement. Claims meeting this criteria are reviewed and approved by various levels of management prior to finalization. The Plan submitted "Signature Authority for Denying Charges – Full and Partial Claim Denials" policy that modifies the signature process to expedite the review of high dollar claims by removing unnecessary levels of review and approval. The policy was originally implemented in May 2004 and updated on November 25, 2020. The Plan will measure its success in meeting this standard over the next 120 days using existing timely forwarding reports.

The Plan also noted that during the audit period 99.33 percent of all misdirected claims were forwarded within 10 working days.

There was no training component of this CAP.

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 responsive to the corrective action required. Therefore, no further response is required.

B. 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. 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 the receipt of five out of 50 PDR samples (a compliance rate of 90 percent) processed by Managed Health Network. This deficiency was noted in the following PDR sample numbers: 9, 15, 27, 39, and 49.

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 initiated monthly audits of all elements of PDR processing in November 2020, including timely acknowledgement, beginning with 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, MHN implemented weekly random audits of cases on a more real time basis. Cases are selected as they are closed and the Supervisor audit all elements of those selected cases according to the regulatory requirements. Current day audits began with cases closed during the first week of December 2020.

Additionally, the provider dispute mailing address was changed to a dedicated P.O. Box specifically for receipt of PDRs, preventing PDR receipts to be mixed with member correspondence.

The Plan stated that the internal monitoring of MHN's provider dispute acknowledgement timeliness performance metrics reflects consistent results of greater than 95 percent since the third quarter of 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 20, 2020.

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 responsive to the corrective action required. Therefore, no further response is required

2. TIMELY RESOLUTION OF PROVIDER DISPUTES – Repeat Deficiency

Rule 1300.71.38(f) requires a plan to issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute or amended provider dispute.

Rule 1300.71(a)(8)(S) describes an "unfair payment pattern" as the failure to comply with the time period for resolution and written determination pursuant to Rule 1300.71.38(f) at least 95 percent of the time over the course of any three-month period.

The Department's examination disclosed the failure to issue a written determination letter within 45 working days of receipt in three out of 50 PDR samples (a compliance rate of 94 percent) processed by the Plan. This deficiency was noted in the following PDR sample numbers: 9, 40, and 43.

The Plan's failure to issue a written determination letter timely is a repeat deficiency, as this issue was previously noted in the Department's final report of examination dated February 16, 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 Rules cited.

The Plan was required to explain why the corrective actions implemented to resolve the deficiency of failure to issue a written determination letter timely, 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 CAP that included the following:

a. Policies and procedures, including internal claims audit procedures, implemented to ensure determination letters for provider disputes are issued 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 regularly monitors the timeliness of the resolution of PDRs to assess performance. The Plan began monthly audits of all elements of PDR processing, including the timely resolution of provider disputes and will compile a quarterly report with the audit results. In addition, the Plan is 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 against the regulatory requirements. Current day audits began with cases closed during the first week of December 2020.

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

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 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 15 out of 50 PDR samples processed by Managed Health Network (a compliance rate of 70 percent). This deficiency was noted in the following PDR claims sample numbers**:** 1, 6, 7, 14, 16, 22, 23, 29, 31, 35, 40, 42, 43, 44, and 48.

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 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 upheld in error 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 is completed.

The Plan responded that all errors within the deficiency were manual errors due to incorrect uphold decisions made by two specific examiners. The Plan conducted focused education related to the desktop policies and procedures as part of the training with the analysts responsible for making the incorrect case decisions. All upholds by these examiners will be reviewed for accuracy and corrections will be made where

incorrect decisions occurred. If additional errors are found, additional steps will be taken to address.

The Plan provided redlined and final versions of "Medi-Cal Rules for Entering Coordination of Benefits with a Primary Carrier" procedures revised on December 9, 2020; "Medi-Cal Burgess Pricer-1" with an effective date of January 29, 2017; and "Autism and Applied Behavioral Analysis (ABA) Service Claims-15" with an effective date of December 5, 2019.

The Plan provided attestation for trainings completed on November 24, 2020 and December 9, 2020.

The Plan will review the uphold decisions for the two examiners who made the 15 errors for the period of June 30, 2017 through November 30, 2020. The total number of cases requiring review is 188. 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.

4. FAILURE TO PROVIDE CLEAR PDR DETERMINATION

Rule 1300.71.38(f) requires a plan to resolve each provider dispute or amended provider dispute and issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute or amended provider dispute.

The Department's examination disclosed that the determination letter in six out of 50 PDR samples processed by Managed Health Network did not provide a clear explanation for upholding the determination (a compliance rate of 88 percent). The deficiency was noted in the following PDR claims sample numbers: 8, 10, 12, 21, 26, and 36.

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 the accuracy of written PDR determination letters. 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 Rule.

d. Management position(s) 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 the clear and correct communication of decisions and underlying rationale for said decisions, utilizing 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, MHN is 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 against the regulatory requirements. Current day audits began with cases closed during the first week of December 2020.

In addition to these audits, the letter writing training materials were reviewed and updated on November 30, 2020. All PDR staff have been trained on the elements and requirements of compliant communications.

The Plan provided its "Letter Writing Guidelines" updated on November 30, 2020, and attestations for the associated training completed on December 10, 2020.

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 responsive to the corrective action required. Therefore, no further response is required.

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.