Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
Phone: 916-324-8176 | Fax: 916-255-5241
www.HealthHelp.ca.gov

May 11, 2020 **Via eFile**

Mr. Ron Rosenberger
Chief Executive Officer and President
Premier Health Plan Services, Inc.
1901 Avenue of the Stars, Ste. 1750
Los Angeles, CA 90067

FINAL REPORT OF A ROUTINE EXAMINATION OF PREMIER HEALTH PLAN SERVICES, INC.

Dear Mr. Rosenberger:

Enclosed is the final report (Final Report) of a routine examination for the quarter ended March 31, 2019 of the fiscal and administrative affairs of Premier Health Plan Services, 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 December 24, 2019. The Department accepted the Plan's electronically filed responses on February 7, 2020, March 16, 2020, March 25, 2020, March 27, 2020, April 1, 2020 and April 6, 2020 (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 copies of those portions excluding information held confidential pursuant to Section

---

[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.

1382(c). If the Plan requests the Department to append a brief statement summarizing the Plan's response(s) 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 # S19-R-473."
- 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 December 24, 2019. 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 # S19-R-473."
- 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,

ORIGINAL SIGNED BY

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

cc: Carmela Camino, Director, Health Plan Accounting and Reporting, Premier Health Plan Services, Inc.
Pritika Dutt, CPA, Deputy Director, Office of Financial Review
Jennifer Clark, Supervising Examiner, Division of Financial Oversight
Eri Fukuda, Examiner, Division of Financial Oversight
Benbin Feng, Examiner, Division of Financial Oversight
Brianne Burkart, 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

PREMIER HEALTH PLAN SERVICES, INC.

FILE NO. 933 0473

DATE OF FINAL REPORT: MAY 11, 2020

SUPERVISING EXAMINER: JENNIFER CLARK

OVERSIGHT EXAMINER: ANNA BELMONT

EXAMINER-IN-CHARGE: ERI FUKUDA

FINANCIAL EXAMINERS:

NINA MOUA

DANIIL RYBALKO

ERICA SHORT

BACKGROUND INFORMATION FOR PREMIER HEALTH PLAN SERVICES, INC

Date Plan Licensed:	June 25, 2009
Organizational Structure:	Premier Health Plan Services, Inc. (Plan) is a for-profit, wholly owned subsidiary of Tenet California, Inc., which is an indirect, wholly owned subsidiary of Tenet Healthcare Corporation (Tenet), a publicly traded company. The Plan owns and operates four independent physician associations (IPAs): Alamitos IPA, Brookshire IPA, Lakewood IPA and St. Mary IPA. The Plan receives administrative and operational support services from Coast Healthcare Management, LLC, a Plan affiliate, and Tenet pursuant to administrative services agreements.
Type of Plan:	The Plan is authorized to engage in business as a restricted license, full service health care service plan providing health care services to Medicare Advantage enrollees through contracts with other full service Knox-Keene licensed health care plans. The Plan's IPAs also provide professional health care services to commercial enrollees through contracts with other full service Knox-Keene licensed health care plans.
Provider Network:	The Plan contracts with medical groups, independent physicians, hospitals and ancillary providers, including affiliate entities, for the provision of medical services to its members. Providers are reimbursed on a capitated, per diem or fee-for-service basis.
Plan Enrollment:	The Plan reported 30,007 enrollees as of March 31, 2019.
Service Area:	The Plan operates in Los Angeles and Orange Counties.
Date of Prior Final Routine Examination Report:	February 13, 2017

FINAL REPORT OF A ROUTINE EXAMINATION OF PREMIER HEALTH PLAN SERVICES, INC.

This is the final report (Final Report) for the quarter ended March 31, 2019 of a routine examination of the fiscal and administrative affairs of Premier Health Plan Services, 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 December 24, 2019. The Department accepted the Plan's electronically filed responses on February 7, 2020, March 16, 2020, March 25, 2020, March 27, 2020, April 1, 2020, and April 6, 2020 (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 examined the Plan's financial report filed with the Department for the quarter ended March 31, 2019, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions. The Department's findings are presented in this Final Report as follows:

Part I.	Financial Statements
Part II.	Calculation of Tangible Net Equity
Part III.	Compliance Issues
Part IV.	Internal Control Issue
Part V.	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. FINANCIAL STATEMENTS

The Department's examination did not result in any adjustments or reclassifications to the Plan's financial statements for the quarter ended March 31, 2019, as filed with the Department. A copy of the Plan's financial statements can be viewed by selecting "Premier Health Plan Services, Inc." on the second drop-down menu of the Department's financial statement database available at http://wpso.dmhc.ca.gov/fe/search/#top.

No response is required to this Part.

PART II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth and TNE as reported by the Plan as of quarter ended March 31, 2019	$15,923,774
Required TNE	4,428,992
TNE Excess per Examination	$11,494,782

The Plan was in compliance with the TNE requirements of Rule 1300.76 as of March 31, 2019.

No response is required to this Part.

PART III. 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.

1. PAYMENT ACCURACY, INCLUDING INTEREST AND PENALTY

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.

Section 1371.35 and Rule 1300.71(i)(1) and (j), which refer to claims resulting from emergency services, require a health care service plan, if the plan is a health maintenance organization, to reimburse uncontested claims for emergency services within 45 working days after the date of receipt of the claim by the plan. If an uncontested claim for emergency services is not reimbursed within 45 working days after receipt, the plan shall pay the greater of $15 per year or interest at the rate of 15 percent per annum beginning with the first calendar day after the 45-working-day period. 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.

The Department's examination disclosed that the Plan failed to reimburse claims accurately, including interest and penalties in the following claims samples processed by the management service organization (MSO) Coast HealthCare Management, LLC (Coast):

- Eight out of 50 late paid claims (a compliance rate of 84 percent). The deficiency was noted in the following late paid claims sample numbers: 4, 5, 11, 21, 27, 29, 35 and 48. This deficiency was primarily caused by the Plan using the incorrect date to calculate interest on improperly denied and reprocessed claims, not paying interest at the greater of $15 or 15 percent per annum on emergency claims, or failing to pay interest when interest should have been paid.

- Three out of 50 paid claims (a compliance rate of 94 percent). The deficiency was noted in the following paid claims sample numbers: 1, 2 and 14. This deficiency was caused by the Plan failing to process a retro authorization request timely and pay the resultant interest, failing to pay interest at the greater of $15 or 15 percent per annum on emergency claims, or processor error.

- Three out of 30 high dollar claims. The deficiency was noted in the following high dollar claims sample numbers: 1, 16 and 23. This deficiency was caused by the Plan failing to reimburse a claim using rates outlined in the corresponding contract, using the incorrect date to calculate interest, or processor error.

- Two out of 50 claims resulting from provider dispute resolutions (PDRs). The deficiency was noted in PDR claims sample numbers 27 and 33. This deficiency was caused by the Plan using the incorrect date to calculate interest or incorrectly applying the member's copay. During the course of the examination, the Plan reprocessed and paid outstanding amounts due, including interest and penalty.

The Department's examination disclosed that the Plan failed to reimburse claims accurately, including interest and penalties in the following claims samples processed by the MSO Conifer Value-Based Care, LLC (Conifer):

- 19 out of 50 late paid claims (a compliance rate of 62 percent). The deficiency was noted in the following late paid claims sample numbers: 6, 9, 10, 12, 13, 17, 23, 25, 28, 30, 33, 36, 37, 39, 41, 45, 47, 48 and 53. This deficiency was primarily caused by the Plan using the incorrect date to calculate interest on improperly denied and reprocessed claims, not paying interest at the greater of $15 or 15 percent per annum on emergency claims, or failing to pay interest when interest should have been paid.

- Two out of 50 paid claims. The deficiency was noted in paid claims sample numbers 6 and 42. This deficiency was caused by the Plan having an incorrect provider reimbursement rate uploaded in the system or processor error.

- Six out of 31 claims resulting from PDRs. The deficiency was noted in the following PDR claims sample numbers: 2, 6, 9, 13, 19 and 28. This deficiency was primarily caused by the Plan failing to pay interest on reprocessed claims that were initially denied as capitated.

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 penalty. 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 penalty, from February 13, 2017 (date of prior final report) through the date the corrective action was implemented by the Plan.

e. Evidence that interest and penalty, 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 identifies 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
- Penalty amount paid, if applicable
- Number of late days used to calculate interest
- Check number for interest and penalty paid
- Provider name
- ER or Non-ER indicator

The data file was to provide the details of all claims remediated, including 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 position(s) 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.

In response to the payment accuracy deficiency identified in claims processed by Coast, the Plan noted that Coast's claims department was going through a full claims review and remediation prior to the Department's examination and provided the following responses to the specific deficiencies:

- *With regard to the deficiency caused by failing to pay the correct amount of interest, the Plan stated that Coast updated its interest calculator on July 2, 2019 and added a pre-check run audit to ensure interest payment accuracy. The Plan provided Coast's "AB1455 Claims Interest" policy, approved on July 29, 2019, and Interest Calculator Worksheet, which included a minimum $15 interest payment on emergency claims.*

- *With regard to the deficiency caused by failing to process retro authorization requests, the Plan stated that Coast made updates to its processing of retro*

authorization requests that route to medical review, which were documented in a new policy "Mailroom End to End Process" approved on July 29, 2019.

- *With regard to the deficiency caused by failing to reimburse a claim using rates outlined in the corresponding contract, the Plan stated that the system was properly configured to pay at the contracted rates.*

- *With regard to the deficiency found in PDR samples, the Plan stated that it identified the staff responsible for the deficiency and performance-managed these staff appropriately. PDRs are now being tightly managed through dashboards and oversight reports. Managerial performance expectations, including following PDR Audit policies and ensuring timely dispute processes through consistent and close monitoring of PDR dashboards, have been clearly outlined. The Plan provided its "PDR Audit" policy, approved on June 30, 2019, and "AB1455 Provider Disputes" policy approved on May 10, 2019.*

The Plan also provided its "Quality and Audit Process" policy approved on August 16, 2019 that describes Coast's monitoring system to ensure ongoing compliance with payment accuracy requirements and includes procedures for a pre-check run audit.

Coast implemented weekly Coast Senior Leadership Team Meetings, during which departmental dashboards are reviewed and collaboratively worked to remediate deficiencies as a team.

Coast's department leaders conduct routine training on an ongoing basis and use examiner accuracy trend reports for focused education and training. Coast conducted claim and PDR trainings on December 5, 2019, December 20, 2019 and January 17, 2020.

The Plan submitted evidence that on April 16, 2020, Coast completed the required remediation resulting in the additional payment of $15,759.78, including interest of $4,906.16 and penalty of $2,300.00, on 287 claims.

The Coast Director of Claims is responsible for overseeing the CAP. The Coast Director of Claims reports to the Coast Chief Executive Officer (CEO) who reports to and is responsible for bringing issues to the Board.

The Department finds that the Plan's compliance efforts with regard to deficiencies identified in claims processed by Coast are not responsive to the corrective actions required for the following reasons:

- **The Plan did not adequately respond to the deficiency caused by failing to process retro authorization requests, as the "Mailroom End to End Process" policy does address the processing of retro authorization requests that route to medical review.**

- **The Plan did not adequately respond to the deficiency caused by failing to reimburse a claim using rates outlined in the corresponding contract, as the Plan did not provide a description of the corrective actions implemented to resolve the deficiency.**

The Plan is required to submit the following:

- **Policies and procedures, including internal claims audit procedures, implemented to ensure retro authorization requests are processed timely. When applicable, clean and redlined versions must be submitted to clearly identify revisions made to policies and procedures as a result of the examination.**

- **Description of the corrective actions implemented to resolve the deficiency caused by failing to reimburse a claim using rates outlined in the corresponding contract.**

- **Date the corrective actions were implemented.**

In response to the payment accuracy deficiency identified in claims processed by Conifer, the Plan indicated that the deficiency was caused by the unusually short turnaround time resulting from the transition of the claims processing function from Coast to Conifer on October 1, 2018, and provided the following responses to the specific deficiencies:

- *With regard to the deficiency caused by failing to pay interest on claims incorrectly denied for no authorization, the Plan stated that the root cause of the deficiency was that authorizations issued prior to October 1, 2018 were not uploaded in the claims system and linked to claims. Authorizations are now processed in Conifer's claims system and linked properly to claims. This prevents the claim from being forwarded to the health plan for processing under the point of service benefit.*

  The Conifer Operations Director and Conifer Quality Control Manager are responsible for the accurate processing of claims. They report to the Conifer Vice President (VP) of Finance and Operations, who reports to the Coast CEO, who reports to and is responsible for bringing issues to the Board.

- *With regard to the deficiency caused by failing to pay interest on claims incorrectly denied as capitated, the Plan stated that the root cause for the deficiency was that Conifer did not receive the related provider contracts at the time of transition. The Plan stated that the contracts have since been uploaded in Conifer's claims system and are being routinely audited against configuration.*

  The Plan submitted Conifer's "Provider Contract and Fee Schedule Audit" policy revised on August 9, 2019.

Coast contracting staff create incidents and track contracts through implementation grids and Conifer's Provider Practice has an intake process that creates an incident for contract configuration. Dashboard reports that track the aging of incidents are provided to the Board.

- *With regard to the deficiency caused by having an incorrect provider reimbursement rate uploaded in the system, the Plan's response was the same as its response to the deficiency caused by failing to pay interest on claims incorrectly denied as capitated.*

- *With regard to the deficiency found in PDR samples, the Plan stated that Conifer identified a gap in its claims system configuration. Conifer updated the implementation checklist and reconciled set up to an independent line of business plan table.*

  The Plan provided Conifer's "Claims Interest" policy last updated in January 2019 and "Interest Configuration" job aid revised on February 6, 2020.

  The Conifer Senior Director of Business reports to the Conifer VP of Finance and Operations, who reports to the Coast CEO, who reports to and is responsible for bringing issues to the Board.

The Plan submitted evidence that on April 10, 2020, Conifer completed the required remediation resulting in the additional payment of $3,003.26, including interest of $1,669.78 and penalty of $400.00, on 80 claims.

The Department finds that the Plan's compliance efforts with regard to deficiencies identified in claims processed by Conifer are not fully responsive to the corrective actions required for the following reasons:

- **The Plan did not adequately respond to the deficiency caused by Conifer having incorrect provider reimbursement rates uploaded in the system.**

- **The Plan did not provide training materials and the dates training was conducted to ensure claim processors are aware of and comply with the requirements of the above rules.**

- **The Plan did not provide remediation for late paid claims sample numbers, 28, 30 and 36, and paid claims sample numbers 6 and 42.**

- **The Plan did not identify and provide remediation for all claims paid inaccurately due to the incorrect provider reimbursement rates being uploaded in the system from October 1, 2018 (transition date) through the date the corrective action was implemented by the Plan.**

Within 30 days of receipt of this Final Report, the Plan is required to submit a detailed CAP that must include the following:

- **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.**

- **Evidence of completion of remediation for late paid claims sample numbers 28, 30 and 36, and paid claims sample numbers 6 and 42.**

- **Identification of all claims paid inaccurately, including interest and penalty, due to having the incorrect provider reimbursement rate uploaded in the system from October 1, 2018 through the date the corrective action was implemented by the Plan.**

- **Evidence that interest and penalty, as appropriate, were paid retroactively for the claims identified in the above paragraph. This evidence is to include an electronic data file/schedule (Excel or Access) that identifies 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**
    - **Penalty amount paid, if applicable**
    - **Number of late days used to calculate interest**
    - **Check number for interest and penalty paid**
    - **Provider name**
    - **ER or Non-ER indicator**

    The data file is to provide the details of all claims remediated, including 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.

If the Plan is not able to meet this timeframe, it must provide a justification for the delay and request approval by the Department for the proposed timeline for completion of the CAP. The Plan is also required to submit monthly status reports to the Department until the CAP is completed

2. REIMBURSEMENT OF NONCONTRACTING PROVIDER CLAIMS

Section 1371.31(a)(1) requires health plans to reimburse noncontracting individual health professionals rendering services subject to Section 1371.9 the greater of the average contracted rate or 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered.

Rule 1300.71.31(a)(1) defines average contracted rate as the claims-volume weighted average of the contracted commercial rates paid for the same or similar services in the geographic region, in the applicable calendar year.

Rule 1300.71(a)(8)(U) describes an "unfair payment pattern" as the failure to pay noncontracting health professionals the reimbursement described in Rule 1300.71.31 and required pursuant to Section 1371.31.

The Department's examination disclosed that the Plan failed to reimburse the greater of the average contracted rate or 125 percent of the amount of Medicare in one out of five noncontracting individual provider claims processed by Coast. The deficiency was noted in noncontracting provider claims sample number 5. In addition, the Department was not able to verify payment accuracy in two out of five noncontracting provider claims due to the Plan not providing its average contracted rate data. The deficiency was noted in noncontracting provider claims sample numbers 3 and 4.

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

a. Average contracted rate data calculated pursuant to Section 1371.31 and Rule 1300.71.31.

b. Policies and procedures, including internal claims audit procedures, implemented to ensure noncontracting individual health professional claims are paid the greater of the average contracted rate or 125 percent of the Medicare reimbursement amount.

c. Date the policies and procedures were implemented.

d. 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.

e. Identification of all noncontracting individual health professional claims paid inaccurately with the date of service from July 1, 2017 through the date the corrective action was implemented by the Plan.

f. Evidence that interest and penalty, as appropriate, were paid retroactively for the claims identified in paragraph "e" above. This evidence was to include an electronic data file/schedule (Excel or Access) that identifies 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
- Penalty amount paid, if applicable
- Number of late days used to calculate interest
- Check number for interest and penalty paid
- Provider name
- ER or Non-ER indicator

The data file was to provide the details of all claims remediated, including 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.

g. Management position(s) 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 the root cause for the deficiency was that its Average Contracted Rate policy was not updated. The policy was updated and filed with the Department on November 22, 2019. The Plan confirmed that claim sample numbers 3 and 4 were paid accurately at 125 percent of Medicare, as 125 percent of Medicare was greater than the Plan's average contracted rate. Claim sample number 5 was erroneously underpaid at 100 percent of Medicare due to an examiner error. The claim was adjusted and paid at the average contracted rate of $38 per unit. The examiner was coached and re-educated.

Coast also implemented weekly Coast Senior Leadership Team Meetings, during which departmental dashboards are reviewed and collaboratively worked to remediate deficiencies as a team.

The Plan's response in regards to the claim processor training was the same as provided in Part III.A.1.

The Coast Director of Claims is responsible for overseeing the CAP. The Coast Director of Claims reports to the Coast CEO, who reports to and is responsible for bringing issues to the Board.

The Plan submitted evidence that on April 10, 2020, Coast completed the required remediation resulting in the additional payment of $4,033.64, including interest of $646.89, on 51 claims.

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

3. INCORRECT CLAIM DENIALS

Rule 1300.71(d)(1) states that a plan shall not improperly deny, adjust, or contest a claim. For each claim that is denied, adjusted or contested, the plan shall provide an accurate and clear written explanation of the specific reasons for the action taken.

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(b)(1) states that the plan shall not impose a deadline for the receipt of a claim that is less than 90 days for contracted providers and 180 days for noncontracting providers after the date of service.

Rule 1300.71(a)(8)(A) states that the imposition of a claims filing deadline inconsistent with Rule 1300.71(b)(1) in three or more claims over the course of any three-month period is an unfair payment pattern.

The Department's examination disclosed that claims were improperly denied and should have been paid in the following claims samples processed by Coast:

- Four out of 50 denied claims (a compliance rate of 92 percent). This deficiency was noted in the following denied claims sample numbers: 4, 5, 41 and 42. The deficiency was primarily caused by the claims being improperly denied due to the system erroneously reflecting contracted providers as noncontracted, or being incorrectly contested due to the absence of medical records when medical records were provided. After being contacted by the providers, claim sample numbers 41 and 42 were reprocessed and paid prior to the examination.

The Department's examination disclosed that claims were improperly denied and should have been paid in the following claims samples processed by Conifer:

- 18 out of 50 denied claims (a compliance rate of 64 percent). This deficiency was noted in the following denied claims sample numbers: 1, 2, 9, 21, 28, 29, 31, 39, 40, 42, 45, 51, 71, 77, 78, 80, 96 and 100. The deficiency was primarily caused by claims being improperly denied as untimely, capitated, not financially responsible, or for additional information when no additional information was needed.

- 47 out of 50 late paid claims. This deficiency was noted in the following late paid claims sample numbers: 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 25, 26, 27, 28, 30, 32, 33, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 52 and 53. The deficiency was caused by a system configuration error, resulting in 34 claims from two providers being improperly denied as capitated, and 13 claims from two providers being improperly denied as not financially responsible. After receiving provider disputes, the Plan reprocessed and paid the improperly denied claims, but failed to correct its system configuration timely and remediate the affected claims.

- One out of 31 PDR claims. This deficiency was noted in PDR claim sample number 10. The deficiency was caused by the original claim and resultant PDR being incorrectly denied as capitated due to a system configuration error.

- Two out of 29 encounter claims. This deficiency was noted in encounter claims sample numbers 35 and 36. The deficiency was caused by the claims being incorrectly recorded as encounter claims and denied as capitated due to a system configuration error.

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 claims are not improperly denied. 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 claims improperly denied from February 13, 2017 through the date the corrective action was implemented by the Plan.

e. Evidence that interest and penalty, 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 identifies 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
- Penalty amount paid, if applicable
- Number of late days used to calculate interest
- Check number for interest and penalty paid
- Provider name
- ER or Non-ER indicator

The data file was to provide the details of all claims remediated, including 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 position(s) 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.

In response to the incorrect claim denials deficiency identified in claims processed by Coast, the Plan noted that Coast's claims department was going through a full claims review and remediation prior to the Department's examination. As part of the review, Coast implemented a pre-check run audit that includes a report of denied claims reviewed on a daily basis. The monitoring system to ensure ongoing compliance is referenced in the provided "Quality and Audit Process" policy.

The Plan's response in regards to the claim processor training was the same as provided in Part III.A.1.

The Plan submitted evidence that on April 16, 2020, Coast completed the required remediation resulting in the additional payment of $16,579.47, including interest of $1,666.71, on 34 claims.

The Coast Director of Claims is responsible for overseeing the CAP. The Coast Director of Claims reports to the Coast CEO who reports to, and is responsible for bringing issues to the Board.

The Department finds that the Plan's compliance efforts with regard to deficiencies identified in claims processed by Coast are responsive to the corrective actions required.

In response to the incorrect claim denials deficiency identified in claims processed by Conifer, the Plan provided the following responses to the specific deficiencies:

- *With regard to the deficiency identified in the denied claims sample, Conifer's Quality Control (QC) team has a tool to review claims denials for appropriateness prior to check run. QC flags claims with errors back to the claims department for correction.*

  Department leaders conduct routine training on an ongoing basis and use examiner accuracy trend reports for focused education and training. Conifer conducted training on contested claim errors on February 5, 2020.

  The Plan submitted evidence that Conifer made additional payment of $418.81, including interest of $5.79, on denied claims sample numbers: 21, 96 and 100.

  The Conifer Operations Director and the Conifer Quality Control Manager are responsible for the accurate processing of these claims. They report to the Conifer VP of Finance and Operations, who reports to the Coast CEO, who reports to and is responsible for bringing issues to the Board.

- *With regard to the deficiency identified in the late paid, PDR and encounter claims samples, the Plan stated that the root cause for the deficiency was that Conifer did not receive the related provider contracts at the time of transition. The Plan stated that the contracts have since been uploaded in Conifer's claims system and are being routinely audited against configuration.*

  The Plan submitted Conifer's "Provider Contract and Fee Schedule Audit" policy revised on August 9, 2019.

  Coast contracting staff create incidents and track contracts through implementation grids and Conifer's Provider Practice has an intake process that creates an incident for contract configuration. Dashboard reports that track the aging of incidents are provided to the Board.

The Department finds that the Plan's compliance efforts with regard to deficiencies identified in claims processed by Conifer are not fully responsive to the corrective actions required as the Plan did not provide the following:

- **Policies and procedures, including internal claim audit procedures, implemented to ensure claims are not improperly denied as untimely or for additional information when no additional information was needed.**

- **Proof of remediation of denied sample numbers 1, 2, 9, 28, 29, 31, 39, 40, 42, 45, 51, 71, 77, 78 and 80.**

- **Identification of all claims improperly denied from October 1, 2018 through the date the corrective action was implemented by the Plan.**

The Plan is required to submit the following within 30 days of receipt of this Final Report:

- **Policies and procedures, including internal claim audit procedures, implemented to ensure claims are not improperly denied as untimely or for additional information when no additional information was needed.**

- **Date the policies and procedures were implemented.**

- **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.**

- **Identification of all claims that were improperly denied from October 1, 2018 through the date the corrective action was implemented by the Plan.**

- **Evidence that interest and penalty, as appropriate, was paid retroactively for the claims identified in the above paragraph. This evidence is to include an electronic data file/schedule (Excel or Access) that identifies 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**

- **Penalty amount paid, if applicable**
- **Number of late days used to calculate interest**
- **Check number for interest and penalty paid**
- **Provider name**
- **ER or Non-ER indicator**

The data file is to provide the details of all claims remediated, including 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.

If the Plan is not able to meet this timeframe, it must provide a justification for the delay and request approval by the Department for the proposed timeline for completion of the CAP. The Plan is also required to submit monthly status reports to the Department until the CAP is completed.

4. FAILURE TO PROCESS A CLAIM

Section 1371 and Rule 1300.71(h) require a health care service plan, if the plan is a health maintenance organization, to contest or deny claims no later than 45 working days after the date of receipt of the claim by the plan.

Rule 1300.71(a)(8)(L) describes an "unfair payment pattern" as the failure to contest or deny a claim within the timeframes of Rule 1300.71(h) and Sections 1371 or 1371.35 for at least 95 percent of the affected claims over the course of any three-month period.

The Department's examination disclosed that, due to a systemic issue, the Plan failed to contest or deny, within 45 working days of receipt, one out of 50 denied claims processed by Conifer. This deficiency was noted in denied claim sample number 12 and was caused by the system being configured to reject claims when the Tax ID was missing or incorrect, and not send a remittance advice to the providers for such claims.

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 that claims missing or having an incorrect Tax ID are processed and remittance advices sent to providers. When applicable, clean and redlined versions must be submitted to clearly identify revisions made to policies and procedures as a result of the examination.

b. Training procedures to ensure that claim processors are aware of the revised policy and procedures.

c. Date of implementation of the new policy and procedures.

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 the claim was flagged in error by the system. The analyst should have reached out to provider to validate information billed prior to contesting the claim for valid Tax ID.

The Application Configuration Analyst was coached and re-educated on the process. Conifer's department leaders conduct routine training on an ongoing basis and use claims accuracy trend reports for focused education and training.

The Conifer Senior Director of Business reports to the Conifer VP of Finance and Operations, who reports to the Coast CEO, who reports to and is responsible for bringing issues to the Board.

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

B. PDR MECHANISM

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 RESOLUTION OF PROVIDER DISPUTES

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 that the Plan failed to issue a written determination letter within 45 working days of receipt in 19 out of 50 provider disputes processed by Coast (a compliance rate of 62 percent). This deficiency was noted in the following provider dispute sample numbers: 5, 6, 7, 8, 9, 13, 14, 15, 20, 24, 25, 31, 32, 34, 37, 40, 42, 47 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 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. Training procedures to ensure that claim processors are aware of the revised policy and procedures.

c. Date of implementation of the new policy and procedures.

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 Coast's claims department performed a full claims review and remediation prior to the Department's examination. Coast identified the staff responsible for the deficiency and performance-managed these staff appropriately. PDRs are now being tightly managed through dashboards and oversight reports. Managerial performance expectations, including following PDR Audit policies and ensuring timely dispute processes through consistent and close monitoring of PDR dashboards, have been clearly outlined. The Plan provided its "PDR Audit" policy, approved on June 30, 2019, and "AB1455 Provider Disputes" policy approved on May 10, 2019.

Coast implemented weekly Coast Senior Leadership Team Meetings, during which PDR dashboards are reviewed by the Coast Claims Director. The Coast Claims Director discusses any current or anticipated deficiencies and the plan for remediating these deficiencies.

Coast's department leaders conduct routine training on an ongoing basis and use examiner accuracy trend reports for focused education and training. Staff re-training and re-education was performed on December 20, 2019.

The Coast Claims Manager reports to the Coast Director of Claims, who is responsible for all claims activity. The Coast Director of Claims reports to the Coast CEO, who reports to and is responsible for bringing issues to the Board.

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

2. LATE PAYMENT ON 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 the Plan did not pay additional amounts due to providers within five working days from the issuance of the determination letter on three out of 50 PDRs processed by Coast (a compliance rate of 94 percent). This deficiency was noted in the following PDR sample numbers: 18, 31 and 40.

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 that the Plan pays additional amounts due to providers 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. Training procedures to ensure that claim processors are aware of the revised policy and procedures.

c. Date of implementation of the new policy and procedures.

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

The Plan's response to this deficiency was the same as provided in Part III.B.1.

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

C. FIDELITY BOND – Repeat Deficiency

Rule 1300.76.3 requires each plan to maintain at all times a fidelity bond covering each officer, director, trustee, partner, and employee of the plan, whether or not they are compensated. The fidelity bond must provide at least the prescribed minimum coverage for the plan and may contain a provision for a deductible amount. However, the deductible amount must not be in excess of 10 percent of the required minimum bond coverage and must not to exceed $100,000.

The Department's examination disclosed that the Plan is covered under a fidelity bond policy naming its parent, Tenet Healthcare Corporation (Tenet), as the insured party and does not provide the Plan with the "exclusive right" to the minimum required coverage.

In addition, the fidelity bond policy has a deductible of $2,500,000, which exceeds the maximum allowable deductible of $100,000, and does not include the required 30-day cancellation notice.

The Plan's failure to maintain a fidelity bond meeting the requirements of Rule 1300.76.3 is a repeat deficiency, as this deficiency was previously noted in the Department's final report of routine examination dated February 13, 2017, for the quarter ended December 31, 2015. The Plan's corrective actions in response to the prior final report did not achieve the necessary levels of compliance with the Rule cited.

On November 26, 2019, the Plan provided a revised fidelity bond policy complying with the requirements of Rule 1300.76.3.

The Plan was required to explain why the corrective actions implemented to resolve the fidelity bond deficiencies, as identified in the Department's prior examination, were not effective in ensuring ongoing compliance.

The Plan was also required to describe to the Department the corrective actions implemented to ensure its fidelity bond complies with all requirements of Rule 1300.76.3 upon annual renewal, provide clean and redlined versions of policies and procedures when applicable, state the date of implementation and identify the management position(s) responsible for ensuring ongoing compliance.

The Plan acknowledged that actions taken to correct deficiencies identified in the prior examination did not result in continued compliance at the date of the current examination. The Plan determined the root cause for non-compliance with fidelity bond requirements was reliance upon a single individual to ensure compliance with all fidelity bond filing requirements. The Plan previously contracted with an outside Chief Financial Officer (CFO) who has been replaced by an employed CFO. In addition to the CFO, processes now include the Director of Health Plan Finance and the Plan's Controller. Tracking logs are maintained to ensure timely and accurate completion of fidelity bond requirements. The Plan's CFO is responsible for reporting issues directly to the Board.

In order to prevent this from reoccurring and to ensure continuous compliance with Rule 1300.76.3, the Plan implemented the following procedures, effective February 15, 2020:

1. *The Plan will review Rule 1300.76.3 at least 60 days prior to renewal of its fidelity bond policy to ensure it remains in full compliance.*

2. *To the extent that the current insurance policy is in full compliance, the Plan's CFO will advise the VP Risk Management of Tenet that the policy may be renewed with the current provisions unchanged.*

3. *To the extent that the current policy requires changes in order to comply with the Rule, the Plan's CFO will advise the VP of Risk Management of Tenet that the policy requires revision and set forth those revisions for review and discussion.*

4. *At least 30 days prior to renewal, the proposed fidelity bond policy will be returned to the CFO for review and comparison to the Rule. After determining that the policy is in compliance with the Rule, the CFO will approve issuance of the new policy.*

5. *Once issued, the new policy will be provided to the Department.*

The Director of Health Plan Finance reports directly to the CFO, who is responsible for reporting to the CEO and to the Board of Directors.

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

D. AMENDMENTS TO PLAN APPLICATION – Repeat Deficiency

Section 1352(a) and Rule 1300.52 require all plans to file an amendment with the director within 30 days after any change in the information contained in its application,

other than financial or statistical information. Rule 1300.52.4 sets forth the standards for filing amendments.

The Department's examination disclosed that the Plan failed to file with the Department an administrative services agreement with Conifer for claims processing, with an effective date of September 1, 2018.

The Plan's failure to file the administrative services agreement was a repeat deficiency, as this deficiency was previously noted in the Department's final report of routine examination dated February 13, 2017, for the quarter ended December 31, 2015. This examination disclosed that the Plan's corrective actions in response to the prior final report had not achieved the necessary levels of compliance with the Section and Rules cited.

On November 7, 2019, the Plan filed with the Department the administrative services agreement with Conifer.

The Plan was required to explain why the corrective actions implemented to resolve this deficiency, as identified in the Department's prior examination, were not effective in ensuring ongoing compliance.

The Plan was required to describe to the Department the corrective actions implemented to ensure amendments will be filed pursuant to the above Section and Rules, provide clean and redlined versions of policies and procedures when applicable, state the date of implementation and identify the management position(s) responsible for ensuring ongoing compliance.

The Plan responded that because the Plan, Coast and Conifer are all subsidiaries of Tenet, the Plan determined that moving the claims processing function from Coast to Conifer was not a material modification to the Plan's license. Tenet recognizes that subsidiaries may adopt different processes and that the Department in such cases would want to evaluate those processes prior to future transitions.

Transitions of the Plan's operating functions are reviewed and approved by the Board prior to filing any material modification with the Department.

The Department finds that the Plan's compliance efforts are not responsive to the corrective actions required as the Plan did not describe corrective actions implemented to ensure amendments will be filed pursuant to the above Section and Rules.

Within 30 days of receipt of this Final Report, the Plan is required to describe to the Department the corrective actions implemented to ensure amendments will be filed pursuant to the above Section and Rules, provide clean and redlined versions of policies and procedures when applicable, state the date of implementation and identify the management position(s) responsible for ensuring ongoing compliance.

E. ANTIFRAUD REPORT FILING

Section 1348(c) requires every health care service plan that established an antifraud plan to provide to the director an annual written report describing the plan's efforts to deter, detect, and investigate fraud, and to report cases of fraud to a law enforcement agency. For those cases that are reported to law enforcement agencies by the plan, this report must include the number of cases prosecuted to the extent known to the plan. The report may also include recommendations by the plan to improve efforts to combat health care fraud.

The Department's examination disclosed that the Plan did not file annual antifraud reports with the Department for years 2017 and 2018.

The Plan was required to describe to the Department the corrective actions implemented to ensure antifraud reports are filed annually, provide clean and redlined versions of policies and procedures when applicable, state the date of implementation and identify the management position(s) responsible for ensuring continued compliance.

The Plan acknowledged that annual antifraud reports have not been filed with the Department in accordance with Section 1348(c). The Plan believed that it was only responsible for reporting compliance concerns to its contracted full service Knox-Keene health plans (Plan Sponsors) and/or law enforcement agencies, and the Plan Sponsors were responsible for annual antifraud reporting to the Department. The Plan routinely reports incidents of substantiated fraud, waste and abuse to Plan Sponsors as contractually required.

The Plan's annual antifraud report for calendar year 2019 and updated antifraud plan were filed with the Department on January 31, 2020. The antifraud plan includes the submission of the annual antifraud report to the Department no later than January 31 of each calendar year.

The Plan's Compliance Officer is responsible for submitting the antifraud report on an annual basis. The Compliance Officer reviews the annual plan report with the Board prior to submission to the Department.

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

F. METHODOLOGY FOR DETERMINING AVERAGE CONTRACTED RATE FILING

Rule 1300.71.31(f)(1) requires health plans to electronically file with the Department the policies and procedures used to determine the average contracted rates in accordance with Rule 1300.71.31 by August 15, 2019, and thereafter when the policies and procedures are amended.

The Department's examination disclosed that the Plan did not file its policies and procedures used to determine the average contracted rates with the Department.

On November 22, 2019, the Plan filed its policies and procedures used to determine the average contracted rates with the Department.

The Plan was required to describe to the Department the corrective actions implemented to resolve the deficiency, state the date of implementation and identify the management position(s) responsible for ensuring ongoing compliance with the above Rule.

The Plan responded that the “AB72 Average Contracted Rate Methodology Determination” policy was filed with the Department on November 22, 2019. The Coast Director of Managed Care is responsible for timely submission of the average contracted rate filing to the Department. In addition, the Plan’s Compliance Officer and the Coast Director of Managed Care each maintain tracking logs which are reviewed weekly with the Coast CEO to ensure all Department filings are submitted in a timely manner.

The Coast Director of Managed Care reports to the Coast CEO who reports to, and is responsible for bringing issues to the Plan’s Board of Directors. Backup support is provided by the Plan’s Compliance Officer to ensure filing deadlines are routinely monitored and filings are submitted to the Department in a timely manner. The Plan’s Board of Directors has the ultimate responsibility and oversight over the Plan.

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

G. INVESTMENT POLICY

Section 1346(a)(11) requires a plan to invest in assets meeting the requirements of Section 1376.

The Department’s examination disclosed that the Plan did not have investment policies and procedures in place to ensure the Plan’s assets are invested in accordance with the Section above.

The Plan was required to submit an investment policy that complies with the above Section, state the date of implementation and identify the management position(s) responsible for ensuring ongoing compliance with the above Section.

The Plan stated that Tenet maintains a written investment policy for its subsidiaries and provided the referenced policy. The Plan’s investments have been in compliance with the above Sections, comprised almost exclusively of conservative investments, such as certificates of deposit, other cash deposits and U.S. Treasury Bills. As of the examination date, such investments totaled $27,224,855, or 99.6 percent of total invested assets.

In order to ensure that its investments always remain in compliance with the relevant statutes, the Plan implemented the following additional policy, effective February 15, 2020:

1. *In order to ensure compliance with Section 1346(a)(11) requiring the Plan's invested assets to be in compliance with Section 1376 and other referenced statutes and regulations, at least 45 days before the maturity of an existing investment or the intent to purchase a new investment, the Plan will engage in a discussion with the Tenet Treasury Department to identify investment opportunities and to evaluate compliance with the applicable guidance of the proposed purchase.*

2. *Once a compliant investment has been identified, the Plan CFO will advise the Treasurer of Tenet that the recommended investment is in compliance and to proceed.*

3. *The Treasury Department will provide the Plan's finance department with trade tickets and other documentation necessary for the finance team to record the new investment and to account for it properly.*

4. *Investment decisions made during the preceding quarter will be presented to the Plan's Board of Directors for retroactive approval.*

The Director of Health Plan Finance reports directly to the CFO, who is responsible for reporting to the CEO and to the Board of Directors.

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

H. ADMINISTRATIVE CAPACITY – Repeat Deficiency

Section 1367(g) and Rule 1300.67.3 require every plan to have the organizational and administrative capacity to provide services to subscribers and enrollees. This includes sufficient staffing in administrative services and written procedures for effective controls that result in the effective conduct of the plan's business.

The Department's examination disclosed that the Plan lacked sufficient staffing and written procedures for effective controls as demonstrated by the following:

- The Plan did not provide requested documents in a timely manner, prolonging the examination. The insurance policies and questionnaires were provided four months after the submission due date, despite multiple reminders from the Department.

- The Plan did not have adequate oversight over claims processed by the Plan's MSO, Conifer.

- The Plan did not provide average contracted rate data to demonstrate compliance with noncontracting individual health professional reimbursement requirements.

- The Plan did not have investment policies and procedures in place to ensure the Plan's assets are invested in accordance with Section 1346(a)(11).

- The Plan did not have an escheatment policy for stale-dated checks.

- The Plan failed to comply with the fidelity bond requirements of Rule 1300.76.3.

- The Plan failed to file with the Department its master services agreement with Conifer to process claims.

The lack of administrative capacity is a repeat deficiency, as this issue was previously reported in the Department's final report of routine examination dated February 13, 2017, for the quarter ended December 31, 2015.

The Plan was required to implement a CAP to resolve the aforementioned deficiencies and ensure adequate administrative capacity to provide services to subscribers and enrollees. The Plan was required to provide the policies and procedures implemented (clean and redlined versions when applicable), state the date of implementation and identify the management position(s) responsible for ensuring ongoing compliance with the above Section and Rule.

The Plan responded that Tenet and the Plan recognize ongoing executive leadership issues and operational concerns. Beginning January 2019, the Plan began implementing significant changes to address operational and performance deficiencies, which resulted in the change of leadership and development of a CAP that included the following:

- *Replacement of senior level staff, including the Coast CEO and Coast CFO. Both the Coast CEO and CFO were previously employed by Tenet and are well experienced in health plan operations. Additionally, the Coast CEO and CFO are both members of, and participate in, the Plan's Board of Directors meetings and report operational items as appropriate to the Plan's Board of Directors.*

- *The adoption of a new Plan Board of Directors and Officers.*

- *New management oversight reporting for key operational areas.*

- *Regular meetings with the executive team and directors.*

In addition to other corrective actions implemented during 2019, the Plan focused its efforts on project management and transparency in all communications related to the Plan's operational activities.

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

PART IV. INTERNAL CONTROL ISSUE

Section 1384 requires financial statements be submitted to the Department. Section 1345(s) requires the financial statements be prepared in accordance with generally accepted accounting principles (GAAP). Rule 1300.45(q) states that authoritative pronouncements should be used to determine GAAP.

The Auditing Standards – Clarified (AU-C), which is issued by the Auditing Standards Board of the American Institute of Certified Public Accountants, is considered a source of authoritative pronouncements.

AU-C section 315.04 states that internal control is "a process effected by those charged with governance, management, and other personnel that is designed to provide reasonable assurance about the achievement of the entity's objectives with regard to the reliability of financial reporting, effectiveness and efficiency of operations, and compliance with applicable laws and regulations."

AU-C section 265.11 states, "The auditor should communicate in writing to those charged with governance on a timely basis significant deficiencies and material weaknesses identified during the audit, including those that were remediated during the audit."

A. UNCLAIMED PROPERTY

Section 1500 et seq. of the California Code of Civil Procedure, title 10, Chapter 7, also known as the Unclaimed Property Law, sets forth the requirements for submitting unclaimed funds to the California State Controller. Funds unclaimed for three years or more should be escheated to the State Controller's Office.

The Department's examination disclosed that the Plan did not have an escheatment policy and had outstanding checks dated back to 2007 that have not been escheated to the California State Controller's Office.

The Plan was required to provide evidence of escheatment of outstanding checks aged more than three years to the California State Controller's Office in accordance with the applicable unclaimed property laws and regulations.

In addition, the Plan was required to provide the policy and procedures implemented to ensure stale-dated checks are transferred to the California State Controller's Office appropriately, state the date of implementation and identify the management position(s) responsible for ensuring ongoing compliance.

The Plan responded that the current finance team became involved in closing the Plan's books in August 2019, at which time it discovered that stale-dated checks had not been

identified nor the escheatment process undertaken for several years. In early September 2019, Tenet engaged Crowe LLP (Crowe), a third-party vendor, to perform the escheatment process for all hospital and health plan payments to providers. Crowe is provided various data elements for the stale-dated checks and is responsible for performing the notification diligence to payees (templates for the first and second notices to payees were provided to the Department with the Plan's response); advising the Plan of which checks should be reissued to the original payee; and, ultimately, to escheat funds to the State for payees who could not be located. The first database, comprised of provider checks issued through December 31, 2018, was provided to Crowe on September 25, 2019. Subsequently, a database comprised of checks issued during the period January 1, 2019 through June 30, 2019 was provided to Crowe on January 7, 2020. Going forward, during the process of closing each month's books, a new database will be compiled for quarterly submission to Crowe.

In addition to working with Crowe with respect to provider payments issued from the EZCap system, the Plan also instituted a robust process for checks issued from the Sage system. In this case, the Plan performs the end-to-end process, which began in late December 2019. Going forward, during the process of closing each month's books, the spreadsheet will be updated to add the next month and diligence will begin.

The Director of Health Plan Finance reports directly to the CFO, who is responsible for reporting to the CEO and to the Board of Directors.

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

PART V. NONROUTINE EXAMINATION

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