Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
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Sacramento, CA 95814
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August 19, 2020 **Via eFile**

Mr. Brian Ternan
President and Chief Executive Officer
California Health and Wellness Plan
21281 Burbank Blvd.
Woodland Hills, CA 91367

FINAL REPORT OF A NONROUTINE EXAMINATION OF CALIFORNIA HEALTH AND WELLNESS PLAN

Dear Mr. Ternan:

Enclosed is the final report (Final Report) of a nonroutine examination for the quarter ended September 30, 2019, of the claims settlement practices and dispute resolution mechanism of California Health and Wellness Plan (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 April 22, 2020. The Department accepted the Plan's electronically filed responses on June 5, 2020, July 16, 2020, July 30, 2020, and August 11, 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 no 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(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 # S20-N-493."
- 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 April 22, 2020. The Plan is required to respond to any request for corrective actions contained within the attached Final Report within 30 days of receipt, unless indicated otherwise therein. 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-N-493."
- 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, California Health and Wellness Plan
Pritika Dutt, CPA, Deputy Director, Office of Financial Review
Jennifer Clark, Supervising Examiner, Division of Financial Oversight
Eri Fukuda, 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 NONROUTINE EXAMINATION

OF

CALIFORNIA HEALTH AND WELLNESS PLAN

FILE NO. 933 0493

DATE OF FINAL REPORT: AUGUST 19, 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 CALIFORNIA HEALTH AND WELLNESS PLAN

Date Plan Licensed:	October 26, 2013
Organizational Structure:	California Health and Wellness Plan (Plan) is a wholly owned subsidiary of Centene Corporation, a publicly traded company. The Plan was incorporated for the purpose of providing comprehensive Medi-Cal managed health care services to California enrollees.
Type of Plan:	The Plan is a full-service health care service plan.
Provider Network:	The Plan contracts with its affiliate, Celtic Insurance Company, for a provider network. The Plan contracts with various healthcare providers for the provision of medical care to its members. The Plan compensates providers on a fee-for-service and capitation basis. Hospital services are compensated on a per diem basis and/or fee-for-service basis. Pharmaceutical services are compensated on a fee-for-service basis.
Plan Enrollment:	As of September 30, 2019, the Plan reported enrollment of 196,816.
Service Area:	Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba Counties.
Date of Prior Final Routine Examination Report:	May 8, 2019

FINAL REPORT OF A NONROUTINE EXAMINATION OF CALIFORNIA HEALTH AND WELLNESS PLAN

This is the final report (Final Report) for the quarter ended September 30, 2019, of a nonroutine examination of the claims settlement practices and dispute resolution mechanism of California Health and Wellness Plan (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 April 22, 2020. The Department accepted the Plan's electronically filed responses on June 5, 2020, July 16, 2020, July 30, 2020, and August 11, 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 purpose of this nonroutine examination was to review the Plan's processing of claims and provider disputes for the quarter ended September 30, 2019, to determine compliance with the Sections and Rules. The Department's findings are presented in this Final Report as follows:

Part I. Compliance Issues

Unless indicated otherwise, 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.

1. PAYMENT ACCURACY, INCLUDING INTEREST AND PENALTY – 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.

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 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 the Plan failed to reimburse claims accurately, including interest and penalties in:

- Three out of 50 paid claims (a compliance rate of 94 percent). This deficiency was noted in the following paid claims sample numbers: 15, 42, and 50. This

deficiency was caused by the Plan failing to reimburse claims using rates outlined in the corresponding contracts.

- Six out of 50 late paid claims (a compliance rate of 88 percent). This deficiency was noted in the following late paid claims sample numbers: 7, 22, 29, 33, 49, and 56. The deficiency was caused by the Plan using the incorrect date to calculate interest on reprocessed claims and failing to reimburse a claim using rates outlined in the corresponding contract.

- Two out of 30 high dollar claims. This deficiency was noted in the following high dollar claims sample numbers: 4 and 25. This deficiency was caused by the Plan failing to update its diagnosis-related group calculator.

- Eight out of 50 claims resulting from provider dispute resolutions (PDRs) (a compliance rate of 84 percent). This deficiency was noted in the following PDR claim sample numbers: 4, 7, 10, 24, 27, 48, 49, and 52. The deficiency was primarily caused by the Plan using the incorrect date to calculate interest on overturned PDRs.

The Plan's failure to reimburse claims accurately, including automatic payment of interest and penalty, is a repeat deficiency, as this issue was previously noted in the Department's final report dated May 8, 2019, for the quarter ended June 30, 2018. 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 Sections and Rules cited.

During the course of the exam, the Plan reprocessed high dollar claim samples 4 and 25 and paid an additional $10,950.43 in principal and interest.

The Plan was required to explain why the corrective actions implemented to resolve the deficiency of failure to reimburse claims accurately, including automatic payment of interest and penalty, 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 Sections and Rules.

d. Identification of all claims paid inaccurately, including interest and penalties, from June 30, 2018 (date of prior examination period), 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
   - Penalty 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 the total number of claims, total original claim payments, additional claim payments, and the total additional interest and penalties paid as a result of remediation.

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

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

The Plan responded by acknowledging that multiple repeat deficiencies were identified in this nonroutine examination and provided the following explanation for the repeat deficiencies identified in the Preliminary Report:

Following the Department's prior examination conducted in 2018, the Plan assessed its claims operations and the actions required to achieve ongoing compliance. As a result, the Plan developed an approach that would address the overall health of claims processing, including several required action steps. As part of this effort, the Plan identified two primary plans of action.

The first plan of action involved a transition of Claims Management and Claims Processing staff to California from Great Falls, Montana. While this involved a level of ramp up to ensure all staff was adequately trained and equipped on the use of the Plan's claims adjudication system and other associated processes, the California-based team is overall more knowledgeable of California claims processing rules and regulations, as well as more familiar with California provider contracts and configuration requirements.

The second plan of action involved an overall end to end claims processing review. As a result of this review, multiple initiatives were identified that required system configuration updates related to providers, facilities, benefits, and other system updates required to accurately and effectively process claims going forward. System and configuration updates required a significant amount of claims review to ensure historical claims were processed accurately.

This entire effort took a greater length of time than initially anticipated, and was not completed prior to third quarter of 2019, which was the exam period for this nonroutine examination.

The Plan provided the following policies and procedures related to interest and pricing as part of the Plan's CAP:

- *"Timely Payment of Claims" revised on May 21, 2020.*
- *"Determining Interest Date for Medicaid Scenario" with effective date of January 28, 2019. This policy was reviewed on May 21, 2020 and did not require any revisions.*
- *"By Report Pricing" with effective date of June 1, 2020.*

The Plan conducted trainings on the above policies on May 11, 2020 and June 4, 2020.

The Plan will complete its review of the claims for the period of June 30, 2018 through May 31, 2020, including all necessary adjustments, by November 6, 2020. The total number of claims requiring review is 139,227.

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

The Plan's monitoring of the overall performance is outlined in the provided "Timely Payment of Claims" and "Oversight and Corrective Action Plan for Non Routine Audit" policies approved on May 21, 2020.

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

The Department approves the Plan's proposed date of November 6, 2020 for submission of the claims remediation as identified in the Preliminary Report.

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

2. INCORRECT CLAIM DENIALS – Repeat Deficiency

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.

The Department's examination disclosed that claims were improperly denied or adjusted in:

- Three out of 50 paid claims (a compliance rate of 94 percent). This deficiency was noted in the following paid claims sample numbers: 1, 4, and 15. The deficiency was primarily caused by the Plan incorrectly denying claims for invalid Current Procedural Terminology codes due to errors in system configuration.
- Four out of 50 denied claims (a compliance rate of 92 percent). This deficiency was noted in the following denied claims sample numbers: 8, 34, 35, and 43. The deficiency was primarily caused by the Plan incorrectly denying claims due to system configuration errors.
- One out of 30 high dollar claims. This deficiency was noted in high dollar claims sample number 13. The deficiency was caused by the Plan incorrectly denying a claim for missing authorization due to retro enrollment.

The Plan's incorrect denial of claims is a repeat deficiency, as this issue was previously reported in the Department's final report of routine examination dated May 8, 2019, for the quarter ended June 30, 2018. 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 Rules cited.

During the course of the exam, the Plan reprocessed high dollar claim sample 13 and paid an additional $53,976.61 in principal and interest.

The Plan was required to explain why the corrective actions implemented to resolve the deficiency of incorrectly denying claims, 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 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 June 30, 2018 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
- Penalty 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: the total number of claims; total original claim payments; additional claim payments; and the total additional interest and penalties paid as a result of remediation.

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

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

The Plan responded by providing the following policies and procedures:

- *"Code Editing Overview" implemented on January 1, 2013 and recirculated to the Coding Analytics team on June 5, 2020, with a follow-up training conducted on June 11, 2020.*

- *"Payment Integrity Prepay Code Auditing Management Review Manual" implemented on April 25, 2016 and recirculated to the Coding Analytics team on June 5, 2020, with a follow-up training conducted on June 11, 2020.*

- *"Prior Authorization" implemented on February 1, 2019.*

The Plan submitted evidence that on July 28, 2020, it completed the required remediation resulting in the additional payment of $212,456.83, including interest of $27,362.55 and penalty of $640.00, on 620 claim payments.

Vice President of Claims Operations and the Senior Vice President, Operations, along with the Claims Department Management teams will be responsible for overseeing the CAP. In addition, the Payment Integrity Leadership team is responsible for ensuring appropriate coding analytic setup and review.

The Plan's monitoring of the overall performance is outlined in the provided "Oversight and Corrective Action Plan for Non Routine Audit" policy.

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

3. REIMBURSEMENT OF CLAIM OVERPAYMENTS

Rule 1300.71(b)(5) prohibits a plan or a plan's capitated provider to request reimbursement for the overpayment of a claim, unless the plan or the plan's capitated provider sends a written request for reimbursement to the provider within 365 days of the date of payment on the overpaid claim.

Rule 1300.71(d)(3) states if a plan or a plan's capitated provider determines that it has overpaid a claim, it shall notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the date of service and including clear explanation of the basis upon which the plan or the plan's capitated provider believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

The Department's examination disclosed that the Plan failed to send a written request for overpayment reimbursement to the provider, instead automatically offset the overpayment of a claim against a provider's current claim submission, per provider agreements that allowed the Plan to immediately offset or recoup overpaid amounts. This deficiency was noted in late paid claim sample number 4 and PDR claim sample number 47.

The Plan was required to revise its provider agreements to ensure a written request for overpayment reimbursement is sent to providers pursuant to the above Rules. The Plan was then required to electronically file the revised agreements with the Department. The cover page for the filing was to state that it was filed as a result of the recent financial examination. The Plan was required to provide evidence in its response to the Preliminary Report that the filing was submitted to the Department.

The Plan was also required to describe to the Department the corrective actions implemented to ensure a written request for overpayment reimbursement is sent to the provider pursuant to the above Rules, provide clean and redlined versions, when applicable, of relevant policies and procedures, state the date of implementation and identify the management positions responsible for ensuring ongoing compliance.

The Department's examination also disclosed that the Plan conducted multiple claim recoupment projects in violation of the aforementioned Rules and recouped claim overpayments after the allowable timeframe in one out of 50 PDRs reviewed. This deficiency was noted in PDR claim sample number 27.

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 recoupment of claim overpayments are done 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. Identification of all claims where recoupment of overpayments were made outside of the 365-day time limit from June 30, 2018 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
- Penalty 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 the total number of claims, total original claim payments, additional claim payments, and the total additional interest and penalties paid as a result of remediation.

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

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

The Plan responded that it revised its provider agreements and filed the revised template with the Department on June 5, 2020.

The Plan provided the following policies that went into effect on May 22, 2020:

- *"CHW Recovery Overpayments Timely Filing" policy related to timeliness and notification periods.*

- *"Post Pay Audits of CHW Recoveries" policy related to auditing and monitoring.*

The Plan provided attestations of the overpayment training conducted on May 21, 2020.

The Plan submitted evidence that on August 6, 2020, it completed the required remediation resulting in the additional payment of $286,142.32, including interest of $28,130.74 and penalty of $240.00, on 1,229 claim payments.

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

Monitoring of this deficiency is incorporated in the provided "Oversight and Corrective Action Plan for Non Routine Audit" policy as well as the "Post Pay Audits of CHW Recoveries" policy.

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 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 that the Plan failed to timely acknowledge receipt of 18 out of 50 provider disputes reviewed (a compliance rate of 64 percent). This deficiency was noted in the following PDR claim sample numbers: 3, 5, 6, 7, 8, 11, 12, 14, 15, 19, 23, 28, 30, 33, 35, 38, 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 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 by providing its "CHW AB1455 Provider Dispute Policy" revised on May 21, 2020, which includes the acknowledgement requirement. The training on the revised policy was conducted on May 27, 2020.

The Plan also provided training materials titled "CenPas Provider Dispute Acknowledgement Process for CHW", as well as the corresponding attestations of the training completed on May 20, 2020.

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

The Plan's monitoring of this deficiency is incorporated in the provided "Oversight and Corrective Action Plan for Non Routine Audit" policy.

The Department finds that the Plan's compliance efforts are responsive to the corrective actions 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 that the Plan failed to issue a written determination letter within 45 working days of receipt in:

- 15 out of 50 provider disputes reviewed (a compliance rate of 70 percent). This deficiency was noted in the following PDR claim sample numbers: 1, 4, 8, 10, 11, 18, 19, 23, 25, 26, 29, 39, 43, 49, and 52.

- Two out of 50 late paid claims. This deficiency was noted in late paid claims sample numbers 33 and 61.

The Plan's failure to issue a timely written determination letter is a repeat deficiency, as this issue was previously reported in the Department's final report of routine examination dated May 8, 2019, for the quarter ended June 30, 2018. 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 Rules cited.

The Plan was required to explain why the corrective actions implemented to resolve the deficiency of failing 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 by providing its "CHW AB1455 Dispute Policy" revised on May 21, 2020. The policy outlines the timely resolution requirement and includes a reference to an additional weekly check cycle to negate future delays. Training on the policy was provided on May 27, 2020.

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

The Plan's monitoring of this deficiency is incorporated in the provided "Oversight and Corrective Action Plan for Non Routine Audit" policy.

The Department finds that the Plan's compliance efforts are responsive to the corrective actions 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 the Plan incorrectly upheld its original decision on claim reimbursements in three out of 50 PDRs reviewed (a compliance rate of 94 percent). This deficiency was noted in the following PDR claim sample numbers: 1, 7, and 30.

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

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

b. Date the policies and procedures were implemented.

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

d. Identification of all provider disputes incorrectly denied from June 30, 2018 through the date the corrective action was implemented by the Plan.

e. Evidence that 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 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 positions responsible for overseeing the CAP and a description of the monitoring system implemented to ensure ongoing compliance.

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

The Plan responded by providing its "CHW AB1455 Dispute Policy" revised on May 21, 2020. The policy outlines the resolution and determination requirement and was used for training of the Plan's Provider Dispute team. All training was conducted on or before May 27, 2020.

In addition, the "Code Editing Overview" and "Payment Integrity Prepay Code Auditing Management Review Manual" policies were recirculated to the Coding Analytics team on June 5, 2020 and a follow-up training was conducted on June 11, 2020.

The Plan submitted evidence that on July 21, 2020, it completed the required remediation resulting in the additional payment of $76,053.70, including interest of $3,691.79 and penalty of $10.00, on nine claim payments.

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

The Plan's monitoring of this deficiency is incorporated in the provided "Oversight and Corrective Action Plan for Non Routine Audit" policy.

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

4. ACCURACY OF WRITTEN DETERMINATION – Repeat Deficiency

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 nine out of 50 PDRs reviewed had inaccurate information (a compliance rate of 82 percent). The deficiency was noted in the following PDR claim sample numbers: 4, 7, 18, 19, 28, 37, 39, 47, and 50.

The Plan's failure to provide an accurate written PDR determination letter is a repeat deficiency, as this issue was previously noted in the Department's final report dated May 8, 2019, for the quarter ended June 30, 2018. 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 Rule cited.

The Plan was required to explain why the corrective actions implemented to resolve the deficiency of failing to provide an accurate written PDR determination letter 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 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 positions responsible for overseeing the CAP and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan responded by providing its "CHW AB1455 Dispute Policy" revised on May 21, 2020, which outlines the requirement of a written determination, and "Letter Writing Guidelines - PDR Desktop Procedure" created on May 1, 2020. These policies were used for training of the Provider Dispute team, which was conducted on May 6 2020, May 7, 2020 and May 27, 2020.

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

The Plan's monitoring of this deficiency is incorporated in the provided "Oversight and Corrective Action Plan for Non Routine Audit" policy.

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

5. TIMELY PAYMENT OF PDRS

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 of the issuance of the determination letter in seven out of 50 PDRs reviewed (a compliance rate of 86 percent). The deficiency was noted in the following PDR claim sample numbers: 3, 7, 10, 11, 24, 34, and 42.

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 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. 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 positions 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 the response to deficiency III.B.2 Timely Resolution of Provider Disputes.

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

6. REJECTED CLAIMS

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

Rule 1300.71.38 requires health plans to establish a fast, fair, and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes and outlines notification, submission and reporting requirements, as well as the associated timelines. Rule 1300.71.38(a) defines a contracted provider dispute as a contracted provider's written notice to the plan or the plan's capitated provider challenging, appealing or requesting reconsideration of a claim that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute.

The Department's examination disclosed that the Plan employs a claims rejection process that does not afford providers appeal rights required by Rule 1300.71.38. Per the Plan, "A rejection (contested claim) is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system." Also, per the Plan, "A denial is defined as a claim that has passed edits and is entered into the claims system, however has been billed with invalid or inappropriate information causing the claim to deny." In the event of an inappropriate or incorrect rejection, the Plan's existing process does not allow providers access to its PDR mechanism to remedy the dispute, as the claim never enters the Plan's claims adjudication system. In addition, upon review of the Plan's lists of rejection and denial codes/explanations, it appears that multiple items are on both lists. As such, a standard claim denial may be categorized as a rejection, thereby avoiding claims settlement requirements for denied claims.

The Plan was required to describe to the Department the corrective actions implemented to ensure providers are afforded the appeal rights required by Rule 1300.71.38 for rejected claims, provide clean and redlined versions of policies and procedures when applicable, state the date of implementation and identify the management positions responsible for ensuring ongoing compliance.

The Plan responded that provider appeal rights will be incorporated into the existing rejected claims letters explaining the Plan's PDR processes, where to obtain a PDR form, and how and where to submit a PDR.

The rejected claims letters will include this information by July 31, 2020.

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

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