Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency
**DEPARTMENT OF MANAGED HEALTH CARE**
**980 9th Street, Suite 500, Sacramento, CA 95814**
**Telephone: 916-255-2444 | Fax: 916-255-2280**

**Via USPS Delivery and eFile**

October 20, 2017

Mr. Jeffrey M. Conklin
President and Chief Executive Officer
**Adventist Health Plan, Inc.**
2100 Douglas Boulevard
Roseville, CA 95661

**FINAL REPORT OF ROUTINE EXAMINATION OF ADVENTIST HEALTH PLAN, INC.**

Dear Mr. Conklin:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of Adventist Health Plan, Inc. (Plan), conducted by the Department of Managed Health Care (Department), pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on July 28 2017. The Department accepted the Plan's electronically filed responses on September 11, 2017, September 28, 2017, October 4, 2017 and October 5, 2017.

This Final Report includes a description of the compliance efforts included in the Plan's September 11, 2017, September 28, 2017, October 4, 2017 and October 5, 2017 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 ten (10) days from the date of the Plan's receipt of this letter whether the Plan requests the Department to append its responses to the Final Report. If so, please indicate which portions of the Plan's responses shall be appended, and

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the California Health and Safety Code, Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Chapter 2 of Division 1, Title 28, of the California Code of Regulations, beginning with Section 1300.43.

electronically file copies of those portions of the Plan's responses excluding information held confidential pursuant to Section 1382(c). If the Plan requests the Department to append a brief statement summarizing the Plan's responses to the Report or wishes to modify any information provided to the Department in its September 11, 2017, September 28, 2017, October 4, 2017 and October 5, 2017 responses, please provide the electronically filed documentation no later than ten (10) days from the date of the Plan's receipt of this letter through the eFiling web portal. Please file this addendum electronically via the Corrective Action Plan system (CAP system) within the Online Forms Section of the Department's eFiling web portal https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "Online Forms".
- From the Existing Online Forms menu, click on the "Details" for the DFO Corrective Action Plan S16-R2-508.
- Go to the "Messages" tab
    - Select "Addendum to Final Report" (note this option will only be available for 10 days after the Final Report has been issued)
    - 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"

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

Questions or problems related to the electronic transmission of the response should be directed to Vijon Morales at 916-255-2447 or email at Vijon.Morales@dmhc.ca.gov. You may also email inquiries to wpso@dmhc.ca.gov.

**The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter through the eFiling system. The Report will be located at the Department's web site at View Financial Examination Reports.**

If there are any questions regarding this Report, please contact me at 916-255-2444 or email: Steven.Alseth@dmhc.ca.gov.

Sincerely,

Orginial Signed By

Steven J. Alseth
Senior Examiner (Supervisor)
Office of Financial Review
Division of Financial Oversight

cc: Dan Rhodes, Compliance Officer, Adventist Health Plan, Inc.
Pritika Dutt, CPA, Deputy Director, Office of Financial Review
Eri Fukuda Examiner, Division of Financial Oversight
Jasdeep Atwal, Examiner, Division of Financial Oversight
Terence Sharp, Attorney III, Office of Plan Licensing
Laura Dooley-Beile, Chief, Division of Plan Surveys
Paula Hood, Staff Services Manager I, Help Center

# STATE OF CALIFORNIA
# DEPARTMENT OF MANAGED HEALTH CARE

## DIVISION OF FINANCIAL OVERSIGHT

## FINAL REPORT OF ROUTINE EXAMINATION

## OF

## ADVENTIST HEALTH PLAN, INC.

## FILE NO. 933-0508

## DATE OF FINAL REPORT: OCTOBER 20, 2017

## OVERSIGHT EXAMINER: STEVEN ALSETH

## EXAMINER-IN-CHARGE: ERI FUKUDA

## FINANCIAL EXAMINERS: ANNA BELMONT, NINA MOUA AND ERICA SHORT

## BACKGROUND INFORMATION FOR ADVENTIST HEALTH PLAN, INC.

| | |
|---|---|
| Date Plan Licensed: | February 14, 2014. |
| Organizational Structure: | Adventist Health Plan, Inc. (Plan), a jointly owned subsidiary of Adventist Health Systems/West (AH) and Fresno Community Hospital and Medical Center, is a restricted-licensed health plan domiciled in the State of California. The Plan began operations in January 2016. The Plan has two administrative services agreements. The first agreement is with AH for the provision of the Plan's executive management team; and the second agreement is with SynerMed, Inc. for the performance of claim and provider dispute functions of the Plan. |
| Type of Plan: | The Plan was licensed as a full service Medicare Advantage (MA) plan. The Plan was subsequently licensed as a restricted full service plan and provides health care services to Medi-Cal enrollees as a subcontractor to Health Net Community Solutions, Inc., a fully licensed Medi-Cal plan. |
| Provider Network: | The Plan contracts with and delegates financial risk to: Employee Health Systems Medical Group, Inc. and Adventist Medical Center – Hanford, for the arrangement and provision of professional and institutional health care services, respectively, for covered members. |
| Plan Enrollment: | As of December 31, 2016, the Plan reported 15,832 enrollees. |
| Service Area: | Fresno, Tulare (partial), Kings, Mendocino and Tuolumne counties. |
| Date of Prior Final Routine Examination Report: | Not Applicable. |

# FINAL REPORT OF A ROUTINE EXAMINATION OF ADVENTIST HEALTH PLAN, INC.

This is the Final Report of a routine examination of the fiscal and administrative affairs of Adventist Health Plan, Inc. (Plan), conducted by the Department of Managed Health Care (Department) pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on July 28, 2017. The Department accepted the Plan's electronically filed responses on September 11, 2017, September 28, 2017, October 4, 2017 and October 5, 2017.

This Final Report includes a description of the compliance efforts included in the Plan's September 11, 2017, September 28, 2017, October 4, 2017 and October 5, 2017 responses to the Preliminary Report, in accordance with Section 1382(c). The Plan's responses are noted in *italics*.

The Department examined the Plan's financial report filed with the Department for the quarter ended December 31, 2016, 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 Report as follows:

| | |
|---|---|
| Section I. | Financial Statements |
| Section II. | Calculation of Tangible Net Equity |
| Section III. | Compliance Issues |
| Section IV. | Non-Routine Examination |

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

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the California Health and Safety Code, Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Chapter 2 of Division 1, Title 28, of the California Code of Regulations, beginning with Section 1300.43.

## SECTION I. FINANCIAL REPORT

The Department's examination did not result in any adjustments or reclassifications to the Plan's financial statements for the quarter ended December 31, 2016, as filed with the Department. A copy of the Plan's financial statements can be viewed at the Department's website by typing the link http://wpso.dmhc.ca.gov/fe/search/#top and selecting Adventist Health Plan, Inc. on the second drop-down menu.

**No response was required to this Section.**

## SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

| | |
|---|---|
| Net Worth as reported by the Plan as of quarter ended December 31, 2016 | $1,787,235 |
| Add: Subordinated debt and accrued interest | 264,829 |
| Tangible Net Equity | 2,052,064 |
| Required TNE | 1,000,000 |
| TNE Excess per Examination | $1,052,064 |

The Plan was in compliance with the TNE requirement of Section 1376 and Rule 1300.76 as of December 31, 2016.

**No response was required to this Section.**

## SECTION III. COMPLIANCE ISSUES

The Plan has entered into agreements with Independent Physician Association (IPA) and Capitated Hospital. These entities are bearing the risk and paying all claims. Rule 1300.71(e)(8) does not relieve the Plan of its responsibility to comply with Sections1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 and Rule 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4.

The Department's review of claims being processed by the delegated entities disclosed:

### A. PENALTY ON LATE PAID CLAIMS

Section 1371, and Rules 1300.71(g) and 1300.71(i)(2) require a health care service plan to reimburse uncontested claims no later than 45 working days after receipt of the claim. This section also requires that if an uncontested claim is not reimbursed within 45 working days after receipt, interest shall accrue at the rate of 15 percent

per annum beginning with the first calendar day after the 45 working-day period.

Section 1371.35 and Rule 1300.71(i)1 require that late payment on a complete claim for emergency services and care, which is neither contested nor denied, shall automatically include the greater of $15 for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of 15 percent per annum for the period of time that the payment is late.

Rule 1300.71(j) states the penalty for failure to comply with the interest requirements of Rule 1300.71(i) shall be a fee of $10 payable to the claimant.

The Department reviewed seven (7) late paid claims, which was the entire population of late paid claims for the three-month period ended December 31, 2016. The Department's examination disclosed that the Plan did not pay the greater of $15 for each 12-month period or portion thereof on a non-prorated basis for late emergency claims payment. Prior to the examination's commencement, the Plan paid additional interest to bring total interest to $15; however, the Plan did not pay the $10 penalty for underpaying the interest. The deficiencies were noted in late claim samples: L-1, L-2, L-3, L-4, L-5, L-6, and L-7.

The Plan was required to submit a Corrective Action Plan (CAP) to address the deficiencies cited above, and to include the following:

a. Training procedures to ensure that claim processors are properly trained to determine the amount of interest and penalty due in compliance with the requirements of the above Sections and Rules.

b. Audit procedures to ensure that the Plan is monitoring the correct payment of interest and penalties on late adjusted claim payments.

c. Identification of all late paid claims for which interest and penalties were not correctly paid, from January 1, 2016 through the date corrective action is implemented by the Plan.

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

    - Claim number
    - Date of service
    - Date original claim received
    - Date new information received
    - Date complete claim received
    - Total billed
    - Total paid

- Paid date (mailed date)
- Number of days late used to calculate interest
- Interest amount paid (include formula)
- Date interest paid
- Penalty amount paid
- Additional interest amount paid, if applicable
- Date additional interest paid, if applicable
- Check number for additional interest and penalty paid amount
- Provider name
- Emergency or non-emergency indicator

The data file was to include the total number of claims and the total additional interest and penalty paid as a result of remediation.

e. Policies and procedures implemented to ensure that interests and penalties on late claims are calculated and paid in compliance with the above Sections and Rules.

f. Date the additional training, auditing procedures, and policies and procedures were implemented and the management position(s) responsible for ensuring continued compliance.

*The Plan responded that it reviewed the seven cases cited above by the Department and agrees with the Department's assessment that the Plan did not pay the $10 penalty for underpaying interest on all of the seven late claims.*

*The Plan provided a report to identify all emergency claims paid between January 1, 2016 and February 21, 2017 where either no interest was paid or interest below $15 was paid. The report identified 13 claims that warranted further examination. Of those 13 claims, seven (7) claims needed to be corrected to include the $10 penalty. For any identified claims that were not paid correctly, the correct interest and penalty amount was calculated and paid. The Plan paid an additional interest of $96.97 and penalty of $70.*

*The Plan contracts with SynerMed for claim processing. SynerMed's Claims Department held a training session on February 17, 2017. The Claims Examiners and Claims Auditors responsible for processing the Plan's claims were trained on the differences between the payment requirements for late emergency claims and the payment requirements for other claims.*

*SynerMed Claims Department also reviewed SynerMed's Interest Policy and Procedure with each of the Claims Examiners and Claims Auditors, and each Claims Examiner and Claims Auditor was given a copy of the SynerMed Policy and Procedure for ease of reference at his/her desk.*

*SyneMed's Claims Auditors review 100% of all paid and denied claims to ensure accurate interest payment. In addition, SynerMed implemented a post-payment report to capture any claim in which interest is owed for emergency and non-emergency services, but which has not been paid or paid incorrectly because of the lag time between when the claim is adjudicated and when it is paid. The post-payment report is generated after each check run to ensure that interest was paid accurately for the claim if the claim was identified as being late. This post-payment report is reviewed by the Claims Auditor. If the Claims Auditor detects that a Claims Examiner is consistently calculating interest and/or penalties incorrectly, he or she would report it to his or her manager. The manager would in turn implement re-training for the Claims Examiner.*

*The Plan conducted an on-site audit of SynerMed's Claims Department on September 20, 2017 and September 21, 2017. The claims audit included examination of any late paid emergency claims to confirm interest or penalty was paid correctly. The Plan's Director of Compliance was in charge of the audit.*

*The Plan's Director of Compliance and SynerMed's Claims Director are responsible for ensuring continued compliance.*

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

## B. CLEAR AND ACCURATE DENIAL EXPLANATION

Rule 1300.71(d)(1) states that a plan or a plan's capitated provider shall not improperly deny, adjust, or contest a claim. For each claim that is either denied, adjusted or contested, the plan or the plan's capitated provider shall provide an accurate and clear written explanation of the specific reasons for the action taken within the timeframes specified in sections (g) and (h).

The Department's examination of denied claims disclosed that the Plan did not provide a clear denial explanation on three (3) out of 50 denied claims for the three-month period ended December 31, 2016. Requests for additional information that were sent to providers stated that the provider had 14 days to submit additional information. However, claims were denied before the 14 day deadline. The deficiencies were noted in denied claims samples: D-10, D-12 and D-14.

The Plan was required to submit a detailed CAP to bring the Plan into compliance with the above rule that should include the following:

a. Policies and procedures implemented to ensure that claims are not incorrectly denied and evidence that claims, which are correctly denied are denied with a clear and accurate explanation.

b. Training procedures to ensure that claim processors follow the policies and procedures.

c. Audit procedures to confirm with Rule 1300.71(d)(1).

d. Date the additional training, auditing procedures, and policies and procedures were implemented and the management position(s) responsible for ensuring continued compliance.

*The Plan responded that SynerMed's Claims Department no longer has a practice of pending claims. Claims are now closed as a contested claim and additional information is requested.*

*As of May 15, 2017, SynerMed's Claims Department implemented the use of Adjustment Code "16 – Claim lacking information" and provided detailed information directly on the provider explanation of benefits (EOB). Claims are no longer kept in a "pend" status. Each claim is closed and is considered contested until the provider submits the additional information needed to adjudicate the claim.*

*Additionally, when SynerMed's Claims Department implemented the new adjustment code, an e-mail was sent by SynerMed's Claims Department management to all claims staff explaining the change and the effective date. Each Claims Lead gathered the Claims Examiners and Claims Auditors on his/her team in a training meeting to discuss the implementation of the new adjustment code, and how it would affect claims processing. The Claims Department held a training on May 15, 2017 to implement Adjustment Code "16". On May 16, 2017, the Claims Lead held a training meeting with Claims Auditors and Claims Examiners on the implementation of the new adjustment code "16."*

*SynerMed established Pre-check Run Audit Procedure. Once each Claims Examiner adjudicates a claim, it goes to the Claims Auditor. The Claims Auditor reviews 100% of adjudicated claims for adherence to SynerMed policy and procedure, to include the appropriate use of adjustment codes such as the newly implemented adjustment code "16". If any of the adjudicated claims with adjustment code "16" appear to be improperly coded, the Claims Auditor returns it to the Claims Examiner for correction. If a Claims Examiner continues to use the adjustment code incorrectly, the Claims Auditor will re-train the Claims Examiner and require the Claims Examiner to sign-off that they have received the re-training and understand the process.*

*SynerMed also established Post-Check Run Audit Procedure. On a bi-monthly and monthly basis, a SynerMed Claims Analyst reviews all paid claims for timeliness and appropriate coding. Any claims that the Claims Analyst suspects were inappropriately coded are sent to the Claims Compliance Manager for review. If the Claims Compliance Manager determines that a claim was*

*inappropriately coded, he/she sends it back to the Claims Auditor for re-processing. Additionally, SynerMed re-trains the Claims Examiner and Claims Auditor to determine the root cause of the use of the inappropriate adjustment code.*

*The Plan conducted an on-site audit of SynerMed's Claims Department on September 20, 2017 and September 21, 2017. The claims audit included examination of denied claims related to Rule 1300.71(d)(1). The Plan's Director of Compliance was in charge of the audit.*

*The Plan's Director of Compliance and SynerMed's Claims Director are responsible for ensuring continued compliance.*

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

## C. PROVIDER DISPUTE VIOLATIONS

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.

The Department's examination found that the Plan failed to comply with the requirements of a fast, fair and cost-effective resolution mechanism for the three-month period ended December 31, 2016, as follows:

### 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 one 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% of the time over the course of any three-month period.

The Department's examination disclosed that the Plan did not provide a written determination within 45 working days of receipt for 13 out of 50 provider disputes reviewed (a compliance rate of 74 percent). This deficiency was noted in provider dispute (PDR) sample numbers: PDR-1, PDR-5, PDR-10, PDR-15, PDR-17, PDR-18, PDR-20, PDR-44, PDR-61, PDR-63, PDR-89, PDR-110, and PDR-117.

The Plan was required to submit a detailed CAP to bring the Plan into compliance with the above rules that should include the following:

a. Training procedures to ensure that the determination letter on provider disputes are issued timely.
b. Audit procedures to confirm the timely resolution of provider disputes in compliance with Rule 1300.71.38(f)

c. The date of training and implementation of the audit procedures and the management position(s) responsible for ensuring ongoing compliance.

*The Plan responded that SynerMed's Claims Department increased its staffing levels to ensure timely completion of written determinations. Additionally, SynerMed's Claims Department provided monthly training sessions to all Claims staff to discuss adherence to policies and procedures, including timely completion of written determinations.*

*As of January 1, 2017, SynerMed implemented audit procedures for both during PDR processing and post-processing to ensure timely written determination. On a daily basis, all "open" PDRs are reported within a daily aging report. The daily aging report is reviewed by the PDR Manager to ensure that the determinations of the PDRs are processed timely. The PDR Manager may re-assign PDRs and/or add PDR processing resources to ensure the timely completion of PDRs. If it is determined that a PDR will fall out of compliance before the next check run, an on-demand check run will be requested. PDR Manager runs a preliminary timeliness report for PDRs each month. This report shows PDRs that have been processed by staff member. If the PDR Manager determines that a staff member is not processing PDRs timely, she will initiate a meeting with the PDR Coordinator to review possible reasons for not meeting timeliness standards.*

*The Plan conducted an on-site audit of SynerMed's Claims Department on September 20, 2017 and September 21, 2017. The claims audit included examination of the timely resolution of provider disputes in compliance with Rule 1300.71.38(f). The Plan's Director of Compliance was in charge of the audit.*

*The Plan's Director of Compliance and SynerMed's PDR Manager are responsible for ensuring ongoing compliance.*

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

## SECTION IV. NON-ROUTINE EXAMINATION

The Plan is advised that the Department may conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this Report. The cost of such examination will be charged to the Plan in accordance with Section 1382(b).

**No response was required to this Section.**