



Edmund G. Brown Jr., Governor  
State of California  
Health and Human Services Agency

Department of Managed Health Care  
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July 7, 2015

**SENT VIA FACSIMILE ONLY TO: (916) 447-0911**

Terry German  
Blue Cross of California  
1121 L Street, Suite 500  
Sacramento, CA 95814

**RE: ENFORCEMENT MATTER NUMBER: 11-506**

**LETTER OF AGREEMENT**

Dear Mr. German:

The Office of Enforcement within the Department of Managed Health Care (hereafter Department) is conducting an ongoing investigation of the regulatory performance of Accountable Health Care IPA (AHC). AHC is contracted by Blue Cross of California (hereafter Plan) to perform claims processing, utilization management (UM), and other administrative functions on behalf of the Plan. AHC is also contracted with other health care service plans. Pursuant to the Knox-Keene Health Care Service Plan Act of 1975, as amended, and California Code of Regulations, title 28 (collectively, the "Knox-Keene Act")<sup>1</sup>, the contracting health care service plan maintains regulatory liability for compliance with the Knox-Keene Act.

Pursuant to a stipulated agreement between AHC and the Department, Berkeley Research Group (BRG) is tasked with investigating and evaluating AHC's compliance with the Knox-Keene Act. BRG conducted an audit of AHC which examined AHC's claims processing timeliness, claims payment accuracy, and UM timeliness. The audit reviewed claims and UM decisions made in July through September 2014.

Based on the audit, the Department has found the following violations of the Knox-Keene Act:

**1. Failure to timely identify and acknowledge claims. (Rule 1300.71(c).)**

Under Rule 1300.71(c), a health plan must identify and acknowledge the receipt of each claim. For electronically received claims, a plan must identify and acknowledge the receipt of the claim within two business days. For claims received on paper, a plan must identify and acknowledge the receipt of the claim within fourteen business days.

<sup>1</sup> Citations to a "Section" herein refer to the Health and Safety Code. Citations to a "Rule" refer to Title 28 of the California Code of Regulations.

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In order to identify and acknowledge the receipt of a claim, a plan must input the claim into the system. Inputting the claim into the claims system permits the plan to identify the claim and track its status through the claims process. Therefore, the date of entry into the system must be within the timeframes noted above.

The BRG audit found that 64 out of 800 sampled claims were not acknowledged timely. Each failure to timely acknowledge a claim constitutes a violation of Rule 1300.71(c). 23 of the 64 violations are attributable to the Plan, and the remaining 41 violations are attributable to other health plans contracted with AHC.

**2. Failure to timely process claims. (Section 1371; Rule 1300.71(g) & (h).)**

Under Section 1371 and Rule 1300.71(g) and (h), an uncontested HMO claim must be paid or denied within 45 working days. Under Section 1371 and Rule 1300.71(g), an HMO plan may contest a submitted claim, but must do so within 45 working days. A plan violates this provision when it fails to pay a claim within the mandated period of time.

The BRG audit found that 103 out of 800 sampled claims were processed beyond the 45-working-day requirement (87.1% compliance). Each failure to process the claim within the 45 working-day requirement constitutes a violation of Section 1371 and Rule 1300.71(g). 41 of the 103 violations are attributable to the Plan, and the remaining 62 violations are attributable to other health plans contracted with AHC.

**3. Failure to include proper interest and penalties on late-paid claims. (Section 1371; Rule 1300.71(i) & (j).)**

Under Section 1371 and Rule 1300.71(i) and (j), in the event that a plan fails to pay a claim within 45 working days (a "late-paid" claim), it must reimburse the claim, including interest, at the rate of 15% per annum. For emergency claims not timely processed, it must include the greater of a \$15 penalty for each 12-month period that the payment is late, or interest at the rate of 15% per annum. Failure to automatically include this late payment results in an additional payment of \$10 per claim. BRG conducted a statistically valid sampling of AHC's 29,411 late-paid claims and tested the accuracy of the interest and penalty payments. BRG found that 41 of 400 late-paid claims did not include sufficient interest and penalties (89.8% compliance). Each failure to include proper interest and penalties constitutes a violation of Section 1371 and Rule 1300.71(i) or (j). 15 of these 41 violations are attributable to the Plan, and the remaining 26 violations are attributable to other health plans contracted with AHC.

**4. Failure to record the date of receipt of paper claims. (Rule 1300.71(a)(6) & (c).)**

Under Rule 1300.71(c), a plan must identify the recorded date of receipt, meaning the working day when the claim was delivered to the plan's capitated medical group. (Rule 1300.71(a)(6).) BRG reports that AHC maintains no mechanism to affirmatively determine the actual date of receipt of a paper claim because the paper claims are not date stamped when they are received.

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Instead, AHC relies on the date of receipt that is manually entered into the system. The scanned versions of the paper claims contain no date stamp, and AHC has provided no explanation to BRG as to how the actual date of the paper claim can be tracked and verified. Without a mechanism for tracking the actual date of receipt of these paper claims, AHC cannot independently verify the actual date of receipt for these claims. The failure to maintain a system for verifying the date of receipt of paper claims constitutes a systemic violation of Rule 1300.71(c).

**5. Failure to make timely utilization management decisions. (Section 1367.01(h).)**

Section 1367.01(h) sets forth timeliness standards for utilization management review. For retrospective reviews, a plan has 30 days to make a decision. (Section 1367.01(h)(1).) For prospective or concurrent reviews, the plan has five days to make a decision. (Section 1367.01(h)(1).) For urgent reviews, the plan has no more than 72 hours to make a decision. (Section 1367.01(h)(2).) It is critical for health plans to make determinations within these time frames because enrollees are unable to obtain coverage for these services until AHC makes this determination.

BRG conducted an audit of 383 of AHC's 75,254 utilization management decisions made during the third quarter of 2014 and found that 17 of the 383 utilization management decisions were not made timely. This demonstrates that AHC continues to have some difficulty in consistently making utilization management decisions within regulatory timeframes. Each of these failures to make a utilization management decision within the regulatory timeframe constitutes a violation of Section 1367.01(h). 6 of these 17 violations are attributable to the Plan, and the remaining 11 violations are attributable to other health plans contracted with AHC.

**6. Failure to provide notification of decisions to approve prospective or concurrent authorization requests to providers within 24 hours of the decision. (Section 1367.01(h)(3).)**

Under Section 1367.01(h)(3), a health plan must notify a provider of a decision to approve a request for prior or concurrent authorization within 24 hours. The BRG report indicates that it is the regular business practice of AHC to specifically *not* provide providers with notification that a service has been authorized when the request is a concurrent (in-patient) authorization request. AHC's practice is confirmed by BRG's review of UM decisions, which contains no indication that providers were given any notification of authorization. Consequently, all 51 concurrent review files reviewed as part of the BRG audit failed to demonstrate proper notice of the UM decision to the provider. This practice constitutes a systemic violation of Section 1367.01(h)(3).

The Plan has acknowledged its failure to comply with the Knox-Keene Act in this enforcement matter. The Department determined that a corrective action plan and an administrative penalty of \$40,000 are warranted. The Department has accepted the corrective action plan proposed by the Plan, which includes the following:

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- AHC claims processing will be handled by MedPoint Management, Inc., for claims with dates of service after May 1, 2015. The Plan will track the run off claims, including remediation of non-compliant claims found in the BRG audit.
- The Plan will monitor the monthly claims and utilization management timeliness reports from AHC and MedPoint.
- The Plan will be performing claims and utilization management audits on both entities for claims handled by each during the third and fourth quarter of 2015. A copy of all results of these audits will be delivered to the Department by November 2015 and February 2016, respectively.

The Department agrees that performance of the corrective action plan to the Department's satisfaction and payment of the penalty will settle all presently-known issues, accusations, and claims pertaining to this enforcement matter. This Letter of Agreement may not be used as an admission by the Plan in any other civil or criminal proceedings; however, it may be used by the Department in future administrative proceedings.

Sincerely,

Dated: 7/23/15

Carol L. Ventura  
Carol L. Ventura  
Deputy Director | Chief Counsel  
Office of Enforcement

CBL: klj

**Accepted by Blue Cross of California**

Dated: 7/7/15

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Terry German  
Associate General Counsel  
Blue Cross of California

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