



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

Department of Managed Health Care
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July 30, 2015

SENT VIA FACSIMILE ONLY TO: (818) 676-8097

Douglas Schur
 Health Net of California
 21650 Oxnard Street, Suite 1560
 Woodland Hills, CA 91367

RE: ENFORCEMENT MATTER NUMBER: 11-506

LETTER OF AGREEMENT

Dear Mr. Schur:

The Office of Enforcement within the Department of Managed Health Care (the "Department") is conducting an ongoing investigation of the regulatory performance of Accountable Health Care IPA (AHC). AHC is contracted by Health Net of California ("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")¹, 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 from 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.

¹ 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). 21 of the 64 violations are attributable to the Plan, and the remaining 43 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), and 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). 25 of the 103 violations are attributable to the Plan, and the remaining 78 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). 4 of these 41 violations are attributable to the Plan, and the remaining 37 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.

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 \$50,000 are warranted. The Department has accepted the corrective action proposed by the Plan, which requires the Plan to perform the following:

- Require that Accountable contract with MedPoint Management to process claims and provider disputes commencing May 1, 2015;
- Require that Accountable enhance its utilization management policy to better ensure that:
 - 1) provider requests for referrals or authorizations are submitted to Accountable with sufficient information to allow Accountable to render a determination in a timely manner; and
 - 2) Accountable notifies contracted providers of Accountable's decisions to approve prospective or concurrent authorization requests within 24 hours of the decisions;
- Conduct claims and utilization management audits of MedPoint Management and Accountable during the third and fourth quarters of 2015, with copies of all results provided to the Department by November 1, 2015, and February 1, 2016, respectively. During the third quarter of 2015, the Plan will conduct monthly audits. Sample size will be double the number of files historically subject to an audit; and

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- Require that Accountable contract with MedPoint management to perform utilization management functions if third quarter audit results indicate substantial non-compliance with audited regulatory standards for utilization management.

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: August 17, 2015


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

CBL: kj

Accepted by Health Net of California, Inc.

Dated: 8/4/15


 Douglas Schur
 Vice President
 Health Net of California, Inc.

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