August 18, 2016

Pratibha Patel, Chair of the Board
DaVita Healthcare Partners Plan
2175 Park Place
El Segundo, CA 90245

FINAL REPORT OF ROUTINE EXAMINATION OF DAVITA HEALTHCARE PARTNERS PLAN

Dear Ms. Patel:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of DaVita Healthcare Partners Plan (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 June 3, 2016. The Department accepted the Plan’s electronically filed response on July 22, 2016.

This Final Report includes a description of the compliance efforts included in the Plan’s July 22, 2016 response, in accordance with Section 1382(c).

Section 1382(d) states, “If requested in writing by the plan, the director shall append the plan’s response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public.”

Please indicate within ten (10) days from the date of the Plan’s receipt of this letter whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan’s response 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 response 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 to the Report or wishes to modify any information provided to the Department in its July 22, 2016 response, 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-R-498.
- 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.

The Department will also send the Plan an e-mail(s) requesting those 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 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 916-255-2441 or email: bill.chang@dmhc.ca.gov.

Sincerely,

Bill Chang, CPA
Supervising Examiner
Office of Financial Review

cc: Christy L. Naylor, Assistant General Counsel, DaVita Healthcare Partners Plan
Gil Riojas, Deputy Director, Office of Financial Review
Steve Alseth, Examiner IV (Supervisor), Division of Financial Oversight
Nina Moua, Examiner, Division of Financial Oversight
Ping Han, Examiner, Division of Financial Oversight
Danielle Cavallini, Attorney, Office of Plan Licensing
Laura Dooley-Beile, Chief, Division of Plan Surveys
Dan Southard, Health Program Manager III, Help Center
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

DAVITA HEALTHCARE PARTNERS PLAN

FILE NO. 933-0498

DATE OF FINAL REPORT: AUGUST 18, 2016

SUPERVISING EXAMINER: Bill Chang

OVERSIGHT EXAMINER: Steven Alseth

EXAMINER-IN-CHARGE: Nina Moua

FINANCIAL EXAMINERS: Anna Belmont, Eri Fukuda
BACKGROUND INFORMATION FOR DAVITA HEALTHCARE PARTNERS PLAN

Date Plan Licensed: December 31, 2013

Organizational Structure: DaVita HealthCare Partners Plan, Inc. (Plan) is a for-profit corporation, organized under the laws of the State of Delaware. The Plan is wholly-owned by HealthCare Partners Holdings, LLC which is wholly-owned by DaVita HealthCare Partners, Inc., the ultimate parent company.

Type of Plan: The Plan is a restricted full service health care service plan authorized to provide and arrange health care to the Medicare Advantage, commercial and Cal Medi-Connect enrollees of other Knox-Keene licensed plans through contractual arrangements. The Plan does not have the power to enter into plan contracts (within the meaning of Section 1345(g)) directly with employer groups or members of the general public.

Provider Network: The Plan contracts directly with two risk-bearing medical group entities - HealthCare Partners Affiliates Medical Group and Arta Health Network. The Plan also contracts for specialty services and hospitals. The Plan reimburses these providers on a capitated and fee-for-service basis.

Plan Enrollment: As of September 30, 2015, the Plan reported plan-to-plan enrollment of 523,150 enrollees.

Service Area: Greater Los Angeles and Orange counties.

Date of prior Final Routine Examination Report: N/A
This is the Final Report of a routine examination of the fiscal and administrative affairs of DaVita Healthcare Partners Plan (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. The Department issued a Preliminary Report to the Plan on June 3, 2016. The Department accepted the Plan’s electronically filed response on July 22, 2016.

This Final Report includes a description of the compliance efforts included in the Plan’s July 22, 2016 response to the Preliminary Report, in accordance with Section 1382(c). The Plan’s response is noted in *italics*.

The Department examined the Plan’s financial report filed with the Department for the quarter ended December 31, 2015, 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

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.

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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, 2015, 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](http://wpso.dmhc.ca.gov/fe/search/#top) and selecting DaVita Healthcare Partners Plan on the second drop down menu.

*No response is required to this Section.*

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Worth as reported by the Plan as of quarter ended December 31, 2015</td>
<td>$43,154,036</td>
</tr>
<tr>
<td>Less: Unsecured Affiliate Receivables</td>
<td>$271,516</td>
</tr>
<tr>
<td>Tangible Net Equity</td>
<td>$42,882,520</td>
</tr>
<tr>
<td>Required TNE</td>
<td>$16,080,120</td>
</tr>
<tr>
<td>TNE Excess per Examination</td>
<td>$26,802,400</td>
</tr>
</tbody>
</table>

The Plan is in compliance with the TNE requirement of Section 1376 and Rule 1300.76 as of December 31, 2015.

*No response is required to this Section.*

**SECTION III. COMPLIANCE ISSUES**

**A. CLEAR AND ACCURATE DENIAL EXPLANATION**

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)(F) describes one unfair payment pattern as the failure to provide a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim at least 95% of the time over the course of any three-month period.
The Department’s review of denied claims disclosed that the Plan sent letters to providers requesting additional documentation to process the claim on three (3) out of twelve (12) claims. The Plan’s letters requested the provider provide additional documentation (medical records) within 15 days, and the Plan would process the claim after receiving the additional records. The Plan then denied the claims for not having medical records before the 15 day expiration date. Since the Plan denied the claim shortly after the request letter for additional documents, and did not allow the provider the stated time to provide the records, the request letter is inaccurate. The Plan is not allowing the provider the stated time to provide requested information before denial of the claim.

The Plan was required to implement policies and procedures to ensure that communications to providers on claims are prepared with complete and accurate information for compliance with Rule 1300.71(d)(1). The Plan was also required to provide the date of implementation, and the management position(s) responsible to ensure continued compliance.

**PLAN RESPONSE**

The Plan responded that the Plan has implemented the required action. Effective June 20, 2016, the Plan implemented a new template that is explicit in stating the claim is denied and additional information can be submitted for reconsideration of the claim. The Plan’s Vice President in Medical Groups Operations Management, Shirley Calloway, is responsible to ensure continued compliance.

The Department finds that the Plan’s compliance effort is responsive to the corrective action required.

**B. PROVIDER DISPUTE RESOLUTION MECHANISM**

1. **FAILURE TO RECORD PROVIDER DISPUTES**

Rule 1300.71.38 (a)(1) and (2) defines a contracted and non-contracted provider dispute as a provider’s written notice to the plan 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 or disputing a request for reimbursement of an overpayment of a claim.

Rule 1300.71.38 requires all health care service plans and their capitated providers to establish a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes.

The Department’s review of late claims disclosed that one (1) out of five (5) late claims had provider’s notes submitted through the provider portal disputing the
Plan’s determination of the claim. The provider’s dispute was not recorded as a PDR or processed in accordance with Rule 1300.71.38, by the Plan.

The Plan was required to submit revised policies and procedures implemented to process all correspondence from the providers disputing paid amounts as PDRs in accordance with Rule 1300.71.38. In addition, the Plan was required to state the date of implementation, the management position(s) responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure continued compliance with these Rules.

**PLAN RESPONSE**

The Plan responded that the Plan has determined this non-reporting of a PDR submitted through the provider portal resulted from an incidental human error in the report logic, i.e., the PDR report criteria contained a variable for original claim number instead of PDR claim number. This was an unusual occurrence as normally the reports are validated prior to submission. Accordingly, respectfully, the Plan does not believe a revision in policies and procedures is required.

The Department finds that the Plan’s compliance effort is responsive to the corrective action required.

2. **DISCLOSURE OF GOODWILL PAYMENTS**

Rule 1300.71(a)(8)(f) states that the Plan’s failure to inform a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section (d)(1) at least 95% of the time for the affected claims over the course of any three-month period is an unfair payment pattern.

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.

The Department’s examination disclosed that one (1) out of one (1) PDR was paid as goodwill, and the Plan was not financially responsible. Goodwill payments are not required to include interest and penalties if they are paid late. The Plan’s determination letter included language that the plan had overturned their original decision and is paying the claim. The claim was paid late and did not include interest. The use of the term “overturned” indicates that the plan is overturning its original decision as not being correct and is making payment on the claim so that the provider would be due interest because the claim is paid late.
The Plan should have revised its determination letter for a goodwill payments to clearly state that payment is being made as a gesture of goodwill, and that the original decision to deny the claim is not being overturned. A copy of the revised goodwill letter should have been provided in the Plan’s response to the Preliminary Report. The Plan was also required to state the date of implementation of the corrective action, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.

**PLAN RESPONSE**

The Plan responded that the Plan has revised its determination letter template for a goodwill payment to clearly state payment is being made as a gesture of goodwill, and the original decision to deny the claim is not being overturned. The implementation date of the revised template is July 19, 2016. The Plan’s appeal resolution tool has been updated to implement the processing of goodwill payments.

The Plan’s Vice President in Medical Groups Operations Management, Shirley Calloway, is responsible to ensure continued compliance. Continued compliance with these requirements will be overseen by Ms. Calloway and the Plan’s VP of Compliance, Ms. Erin Mills.

The Department finds that the Plan’s compliance effort is responsive to the corrective action required.

### 3. FIDELITY BOND

Section 1351(q) and Rule 1300.76.3 require each plan to maintain, at all times, a fidelity bond. The fidelity bond shall provide for thirty (30) days’ notice to the Director prior to cancellation. The fidelity bond shall provide at least the minimum coverage for the plan, as required by the schedule in this Rule, and may contain a provision for a deductible amount that is not in excess of 10 percent of the required minimum bond coverage, but in no event shall the deductible amount be in excess of $100,000.

The Department’s examination disclosed that the Plan’s fidelity bond is not in compliance with above Section and Rule, as follows:

- The policy provides for a deductible amount of $250,000, which is in excess of the allowed deductible of $100,000.

- The policy does not provide for a 30-days’ notice to the director prior to cancellation.
The Plan was required to provide evidence of exclusive fidelity bond coverage for the Plan in the amount of at least $2,000,000, with a deductible amount not in excess of $100,000. The Plan was required to file a copy of the fidelity bond endorsement or rider that demonstrates compliance with the 30-day notice to the Department prior to cancellation. The Plan was also required to state the date of implementation of the corrective action, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.

**PLAN RESPONSE**

The Plan responded that the Plan has implemented the required action. It has obtained the described fidelity bond coverage with a deductible of $100,000. Also, the Plan has secured the fidelity bond coverage required by section 1351(q) and Rule 1300.76.3 that requires the carrier to provide thirty (30) days’ notice to the Department prior to termination. A copy of the applicable Endorsement was provided to the Department on April 7, 2016. This endorsement was made effective back to the beginning of the current renewal period, which is November 30, 2015. The executive responsible for ensuring compliance is the Vice President of Finance, Leslie Olson-Collins. Continued compliance with these requirements will be overseen by Ms. Collins and the Plan’s VP of Compliance, Ms. Erin Mills.

The Department finds that the Plan’s compliance effort is responsive to the corrective action required.

**SECTION IV. NONROUTINE 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 required to this Section.