Health Care Service Plans' Provider Dispute Resolution Mechanisms

2019 Annual Report

April 13, 2020

Contents

I. Executive Summary 2
II. Introduction 4
III. Full Service Health Plans 6
IV. Specialized Health Plans 9
V. Capitated Providers 12
VI. Provider Dispute Trends 15
VII. Summary 16

Tables and Charts

Chart 1. Provider Disputes – Full Service Health Plans 6
Chart 2. Resolution of Provider Disputes – Full Service Health Plans 8
Table 1. Seven Largest Full Service Health Plans 8
Chart 3. Provider Disputes – Specialized Health Plans 9
Chart 4. Provider Disputes by Type of Specialized Health Plan 10
Chart 5. Resolution of Provider Disputes – Specialized Health Plans 11
Chart 6. Provider Disputes – Capitated Providers 13
Chart 7. Resolution of Provider Disputes – Capitated Providers 14
Chart 8. Five Year Provider Dispute Information 15

I. Executive Summary

The California Department of Managed Health Care (DMHC) protects consumers' health care rights and ensures a stable health care delivery system. As part of this mission, the DMHC licenses and regulates health care service plans (health plans) while maintaining the financial stability of the managed health care system.

State law requires health plans to pay health care providers accurately and in a timely fashion for services provided and to maintain a fast, fair, and cost-effective system for processing and resolving provider claim disputes (Health and Safety Code section 1367(h).) Health plans are required to annually report the number, type, and summaries of provider claim payment disputes, describe the resolutions including terms and timeliness, and explain how health plans are addressing trends or patterns in disputes. The report includes provider dispute data from health plans' capitated providers such as hospital systems and medical groups.

As required by Health and Safety Code section 1375.7(f), the DMHC annually summarizes the health plans' self-reported provider dispute data in a report to the Governor and the Legislature. The 2019 Provider Dispute Resolution Mechanisms Report summarizes provider claim disputes by type of health plan, including full service and specialized health plans, from October 1, 2018 through September 30, 2019.

Key Findings

Full Service Health Plans

Full Service Health Plans are health plans that provide all of the basic health care services and mandated benefits required under the Knox-Keene Act.

- There are 54 licensed full service health plans in California subject to the reporting requirements of section 1375.7(f).[1]
- Health plans processed approximately 152 million claims in the reporting period. Less than one-percent (0.8 percent) of these claims resulted in claims disputes.
- Full service health plans received more than 1.2 million provider disputes for the reporting period.
- Approximately 96 percent of all provider disputes processed by full service health plans were reported as being resolved within 45 working days.

[1] There were 81 licensed full service health plans at September 30, 2019. However, twenty-seven licensed full service health plans are excluded from the report because they are licensed only for Medicare products or are operating as county organized health systems which are exempt from Health and Safety Code section 1367(h), or they do not have direct enrollment in California.

- Approximately 92 percent of provider disputes filed with full service health plans involved claims payment issues.

- Providers prevailed in 35 percent of all disputes; health plans upheld their original determinations in 53 percent of the disputes. Twelve percent of the disputes were pending at the time the plans reported this data to the DMHC.

Specialized Health Plans

Specialized Health Plans are health plans that provide coverage in a specialized area of care such as vision, dental, behavioral health, and chiropractic care.

- There are 41 licensed specialized health plans subject to the provider dispute reporting requirements of section 1375.7(f).

- Specialized health plans processed approximately 30 million claims in the reporting period. Less than one-half of one percent (0.07 percent) of these claims were the subject of a claim payment dispute.

- Specialized health plans received 21,623 provider disputes for the reporting period.

- Specialized health plans reported 48 percent of all provider disputes were resolved in favor of the provider, 50 percent were upheld by the plans, and two percent of disputes were pending as of the September 30, 2019.

- Approximately 72 percent of provider disputes with specialized health plans involved claims payment issues.

Capitated Providers

Capitated Providers are providers such as hospitals, risk bearing organizations, or provider groups that have contracted with a full service health plan to assume the financial risk and pay claims for the provision of health care services to the enrollees.

- Full service health plans reported data on 260 capitated providers or provider groups.

- Capitated providers processed approximately 74 million claims and received 640,128 provider disputes in the reporting period. Less than one percent (0.82 percent) of these claims were the subject of a claim payment dispute.

- Ninety-five percent of disputes involved claims payment.

- Thirty-six percent of all reported provider disputes with capitated providers were resolved in favor of the provider.

II. Introduction

In 2003, the DMHC issued regulations regarding the timely and accurate payment of provider claims and required health plans to establish a fast, fair and cost-effective dispute resolution process. These regulations, known as the Claims Settlement Practice and Dispute Resolution Mechanism Regulations, require all health plans, and their capitated providers that pay claims, to fully implement specific standards and safeguards for payment of provider claims for services rendered on or after January 1, 2004.[2]

In addition to defining the basic concepts relevant to all dispute resolution mechanisms, the regulations require health plans to submit to the DMHC the Annual Plan Dispute Resolution Mechanism Report, which is public information, and contains the following:

(1) Information on the number and types of providers utilizing the dispute resolution mechanism;

(2) A summary of the disposition of all provider disputes, including an informative description of the type, term, and resolution;

(3) The timeliness of dispute resolution determinations;

(4) A detailed information statement disclosing any emerging or established patterns of provider disputes, and how that information has been used to improve administrative capacity, plan/provider relations, claims payment procedures, quality assurance systems, and the quality of patient care, as well as dispute results.

The provider dispute resolution data summarized in this report is self-reported by health plans and capitated providers. There may be substantive differences in the way health plans and capitated providers identify, quantify and track provider disputes. The DMHC is currently working with the health plans and capitated providers to improve the reporting and quality of the data.

Health plans are required to summarize their provider dispute results in three categories:

- Claim Payment Disputes -- Provider complaints relating to the health plan's failure to reimburse complete claims with the correct payment, including the automatic payment of all interest and penalties.

- Utilization Management Disputes -- Provider complaints relating to medical necessity and authorization determinations.

[2] See California Code of Regulations, Title 28, sections 1300.71 and 1300.71.38.

- Other Disputes -- Provider complaints relating to non-monetary issues, such as enrollee eligibility and assignment matters, and provider credentialing and certification.

The DMHC conducts regular onsite auditing activities, and reviews quarterly and annual claims payment and dispute resolution reports to monitor the industry's compliance with claims payment standards required by Health and Safety Code section 1371 and California Code of Regulations, Title 28, section 1300.71. The DMHC implements appropriate corrective actions for any identified claims payment deficiencies and monitors them accordingly.

Providers who are not satisfied with the resolution of their disputes may contact the DMHC Provider Complaint Unit. Additional information regarding the provider complaint process can be found in the DMHC's Provider Complaint Section: http://www.dmhc.ca.gov/FileaComplaint/ProviderComplaintAgainstaPlan/SubmitaProviderComplaint.aspx.

The claim and provider dispute examination results are located in the DMHC's Financial Examination Reports Section: http://dmhc.ca.gov/LicensingReporting/ViewFinancialExaminationReports.aspx.

III. Full Service Health Plans

This report reflects information reported by health plans for October 1, 2018 through September 30, 2019.

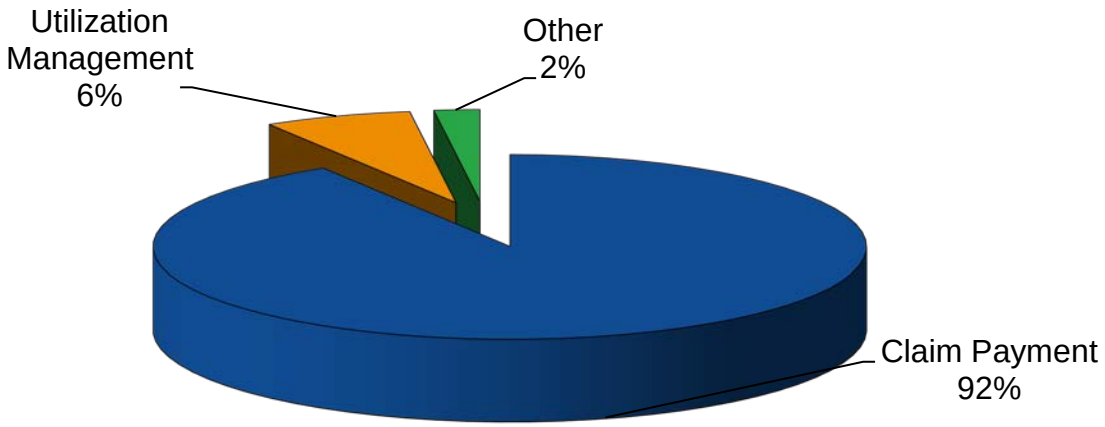
Of the 81 licensed full service health plans, data from 54 full service health plans is included in this report. Twenty-seven licensed full service health plans are excluded from the report because they met one or more of the following criteria: are licensed only for Medicare products or operate as county organized health systems which are exempt from Health and Safety Code section 1367(h), or they have no direct enrollment in California.

The 54 full service health plans reported approximately 152 million claims processed during the reporting period. A claim is considered processed when the health plan adjudicates and classifies the claim as paid, adjusted, contested or denied. The health plans received 1,278,641 provider disputes during the 2019 reporting period. This represents a two percent increase in disputes over the 2018 reporting period.

Claim payment disputes, which primarily involve claims of inadequate reimbursement, comprised of 92 percent of the full service health plan provider disputes (See Chart 1).

Chart 1

Provider Disputes – Full Service Health Plans



Total Number of Claim Payment Disputes:	1,180,490
Total Number of Utilization Management Disputes:	76,438
Total Number of Other Disputes:	21,713

Regulations require the health plans to resolve 95 percent of all complete provider disputes within 45 working days. Collectively, the full service health plans reported that 96 percent of all provider disputes were resolved within 45 working days.

Seven health plans reported noncompliance with the 45 working day requirement to resolve disputes. Health plans that fall below the 95 percent compliance requirement are required to file and implement a corrective action plan that is monitored by the DMHC quarterly and reviewed as part of the health plan's routine financial examination.

Deficient health plans reported that timeliness standards were not met due to a variety of factors. These include staffing issues, higher than expected claims volume that shifted resources from processing disputes to processing claims, and system configuration issues.

Health plans have indicated that corrective action plans have been instituted to improve claims timeliness going forward. The corrective actions include reviewing reports to monitor processing timeliness, changing claim vendors, and hiring additional staffing to eliminate dispute backlogs.

Health plans collectively improved in their provider dispute resolution timeliness percentages by eight percentage points from 88 percent in 2018 to 96 percent in 2019.

Provider Disputes Compared to Claims

Approximately 85 percent of provider claims processed were paid or adjusted by the health plans, and 15 percent were contested or denied. Nearly all claims (approximately 98 percent) were processed within 45 working days.

Approximately 152 million claims were processed during the reporting period. Over one million (1,278,641) claims were contested. This represents less than one percent (0.8 percent) of all claims processed by full service health plans.

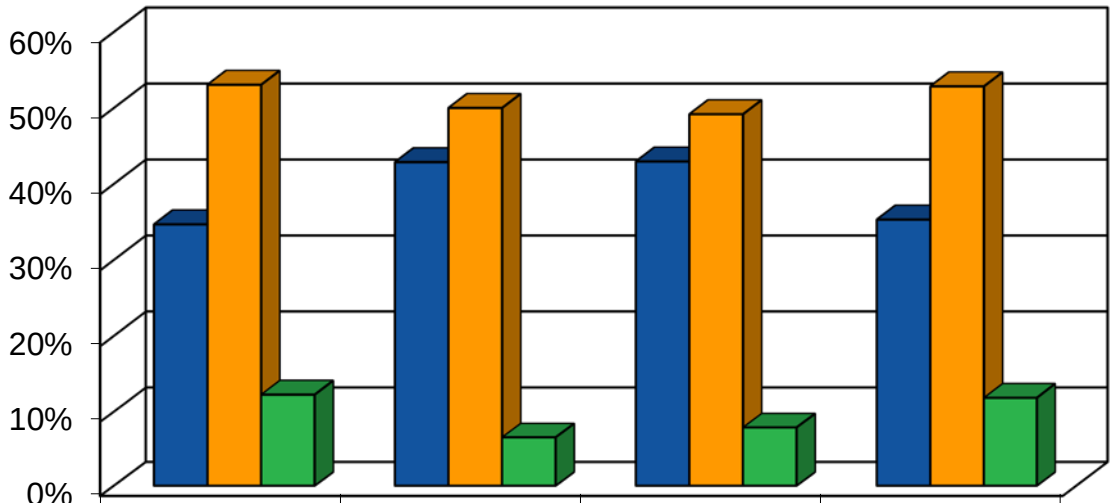
Disposition of Full Service Health Plan Provider Disputes

For the 2019 reporting period, full service health plans reported that 35 percent of all disputes between providers and health plans were resolved in favor of the provider compared to 38 percent of provider disputes in 2018.

Of the 1,278,641 provider disputes submitted, 451,481 (35 percent) were resolved in favor of the provider, 675,648 (53 percent) in favor of the plan, and 151,512 (12 percent) were pending review as of September 30, 2019 (See Chart 2).

Chart 2

Resolution of Provider Disputes – Full Service Health Plans



	Claim Payment	Utilization Management	Other	Total
Provider	35%	43%	43%	35%
Plan	53%	50%	49%	53%
Pending	12%	7%	8%	12%

Seven Largest Full Service Health Plans

California's seven largest full service health plans[3] provide health care benefits to approximately 19 million enrollees, representing 73 percent of the approximately 26 million enrollees enrolled in health plans licensed by the DMHC. For the 2019 reporting period, approximately 72 percent of provider disputes were filed with these seven plans. Collectively, they processed approximately 118 million claims, accounting for 77 percent of all claims processed by full service health plans in California (See Table 1).

Of note, the health plans with the highest percentage of disputes resolved in favor of the provider were Medi-Cal managed care plans – IEHP (46 percent), LA Care (40 percent) and Health Net Community Solutions, Inc. (39 percent).

[3] California's seven largest full service health plans are Blue Cross of California (Anthem Blue Cross), California Physicians' Service (Blue Shield of California), Health Net Community Solutions, Inc., Health Net of California, Inc., Inland Empire Health Plan (IEHP), Kaiser Foundation Health Plan (Kaiser Permanente), and Local Initiative Health Authority of L.A. County (L.A. Care Health Plan).

Table 1

Seven Largest Full Service Health Plans

Health Plan	Enrollment as of 9/30/19	Number of Claims Processed	Number of Disputes Received	Resolved Disputes in Favor of the Provider	Resolved Disputes in Favor of the Health Plan	Disputes Pending	Percentage of Disputes Resolved Within 45 Working Days
Anthem Blue Cross	3,110,988	48,815,547	176,775	52,325 (30%)	111,463 (63%)	12,987 (7%)	94%
Blue Shield of California	2,742,848	19,965,379	218,450	72,979 (34%)	109,761 (50%)	35,710 (16%)	97%
Health Net Community Solutions, Inc.	1,393,133	17,263,471	60,388	23,868 (39%)	28,772 (48%)	7,748 (13%)	97%
Health Net of California, Inc.	634,807	3,374,164	37,119	9,601 (26%)	25,775 (69%)	1,743 (5%)	91%
Inland Empire Health Plan	1,219,170	9,127,757	71,418	32,955 (46%)	30,956 (43%)	7,507 (11%)	98%
Kaiser Permanente	8,266,430	4,074,805	186,142	32,553 (18%)	102,734 (55%)	50,855 (27%)	98%
L.A. Care Health Plan	2,143,890	14,711,882	168,341	68,027 (40%)	88,415 (53%)	11,899 (7%)	97%
Total - Seven Largest Health Plan	**19,511,266**	**117,333,005**	**918,633**	**292,308 (32%)**	**497,876 (54%)**	**128,449 (14%)**	**97%**
All Other Full Service Health Plans	**7,057,209**	**34,935,829**	**360,008**	**159,173 (44%)**	**177,772 (49%)**	**23,063 (7%)**	**96%**
Total - All Full Service Health Plans	**26,568,475**	**152,268,834**	**1,278,641**	**451,481 (35%)**	**675,648 (53%)**	**151,512 (12%)**	**96%**

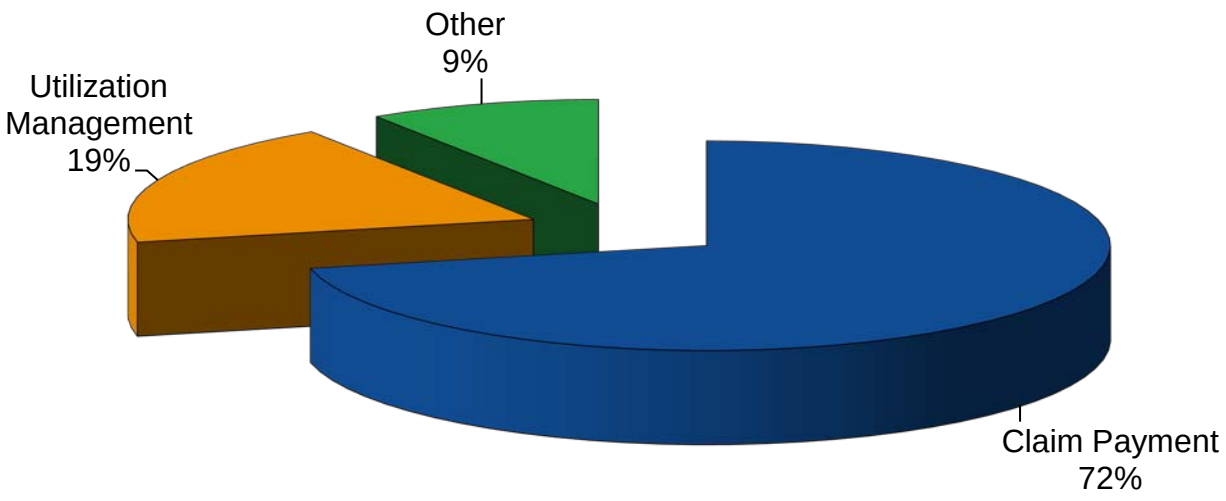
IV. Specialized Health Plans

Of the 45 licensed specialized health plans, data from 41 specialized health plans are included in this report. Four health plans are excluded from the report because they are exempt from Health and Safety Code section 1367(h): two health plans are licensed only for Medicare Part D and two are discount health plans.

The 41 specialized health plans processed approximately 30 million provider claims and received 21,623 provider disputes. Specialized health plans had a twelve percent increase in the number of disputes in the 2019 reporting period compared to 2018. Ninety-eight percent of the provider disputes were resolved within 45 working days. The majority of provider disputes submitted to specialized health plans involved claim payment disputes. Chart 3 shows the breakdown of provider disputes.

Chart 3

Provider Disputes – Specialized Health Plans

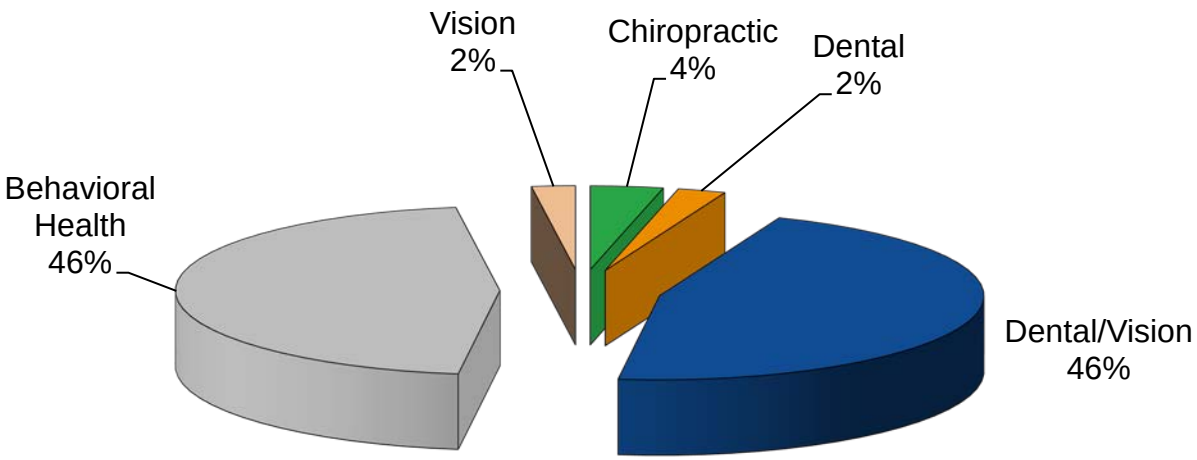


Total Number of Claim Payment Disputes:	15,460
Total Number of Utilization Management Disputes:	4,167
Total Number of Other Disputes:	1,996

Of the 21,623 total provider disputes submitted to specialized health plans during the 2019 reporting period, dental plans (including dental/vision plans) accounted for approximately 48 percent of the disputes, followed by behavioral health plans with 46 percent, chiropractic plans with four percent, and vision plans with two percent (See Chart 4).

Chart 4

Provider Disputes by Type of Specialized Health Plan



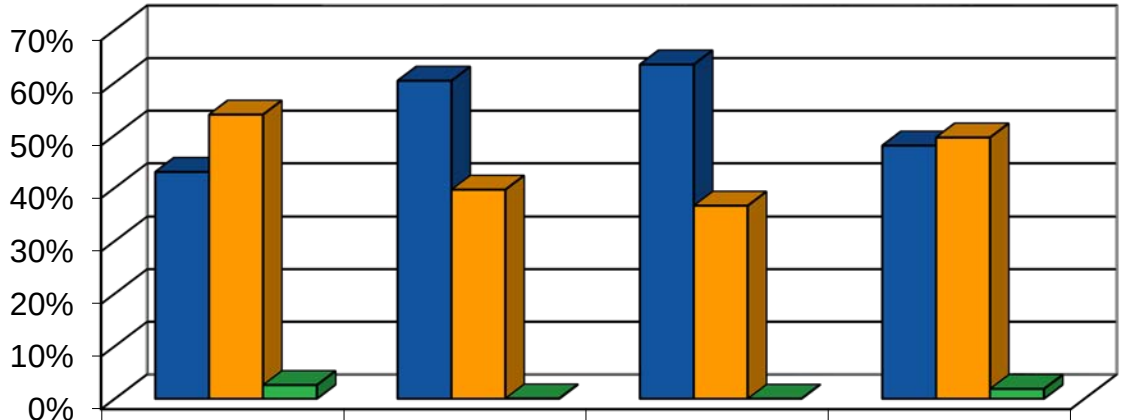
Total Disputes by Specialized Plan Type	2019
Dental/Vision	9,951
Behavioral Health	9,900
Dental	518
Chiropractic	784
Vision	470

Disposition of Specialized Health Plan Provider Disputes

Specialized health plans reported 48 percent of all provider disputes were resolved in favor of the provider, a nine percent decrease from the prior year. Forty-three percent of disputes involving claims payment issues were resolved in favor of the provider while 54 percent of disputes were resolved in favor of the plan, and the remaining three percent were pending at year-end. Utilization management disputes were resolved in favor of providers 60 percent of the time and 40 percent were in favor of the plan. Other disputes were resolved in favor of providers 63 percent and 37 percent in favor of the plan (See Chart 5).

Chart 5

Resolution of Provider Disputes - Specialized Health Plans



	Claim Payment	Utilization Management	Other	Total
Provider	43%	60%	63%	48%
Plan	54%	40%	37%	50%
Pending	3%	0%	0%	2%

V. Capitated Providers

Generally, capitated providers fall within two main categories: (1) medical groups and Independent Practice Associations (IPAs); and (2) hospital systems that receive capitation from health plans, and in turn pay provider claims for health care services rendered to the plan's enrollees. Capitation is a prepaid amount received or paid out, based on the number of enrollees assigned to an organization. This arrangement is usually expressed in units or per member per month (PMPM) payments.

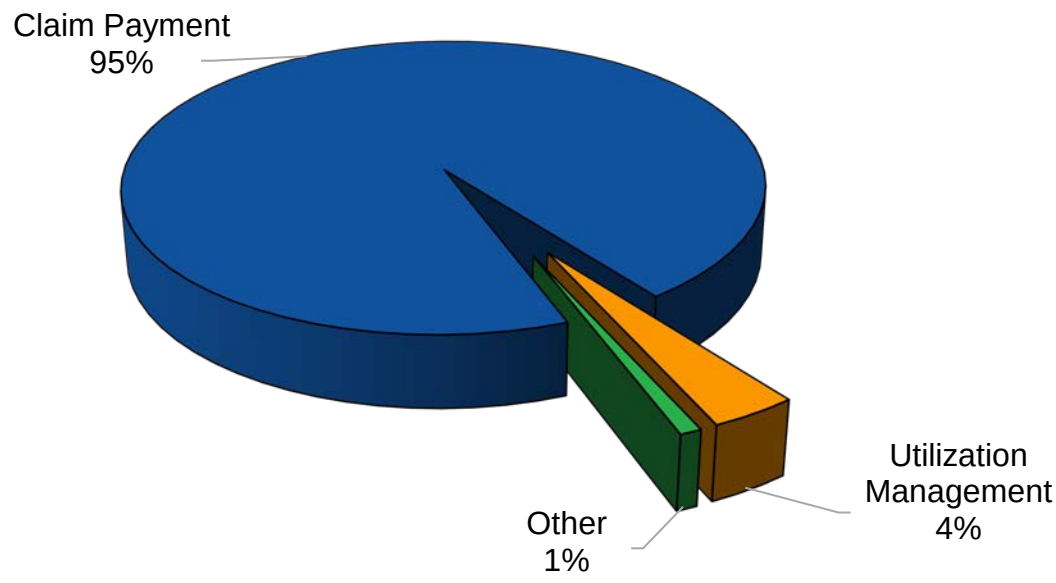
All health plans are required to compile and provide a dispute resolution report for each capitated provider or provider group. Based upon the number of filings received, the DMHC has identified 260 capitated providers that were contracted with full service health plans.

Health plans reported a total of 640,128 provider disputes filed with capitated providers during the reported period. Any capitated provider that is non-compliant with Health and Safety Code section 1371 and California Code of Regulations, Title 28, section 1300.71 criteria must report to the health plan on a quarterly basis. Capitated providers must also file an annual provider dispute report with each of its contracting health plans. Capitated providers are required to follow the same reporting elements as full service and specialized health plans.

Capitated providers processed over 74 million claims in the 2019 reporting period. Ninety-five percent of provider disputes involved claims payment issues. Chart 6 reflects the breakdown of provider disputes.

Chart 6

Provider Disputes – Capitated Providers



Total Number of Claim Payment Disputes	610,468
Total Number of Utilization Management Disputes	23,730
Total Number of Other Disputes	5,930

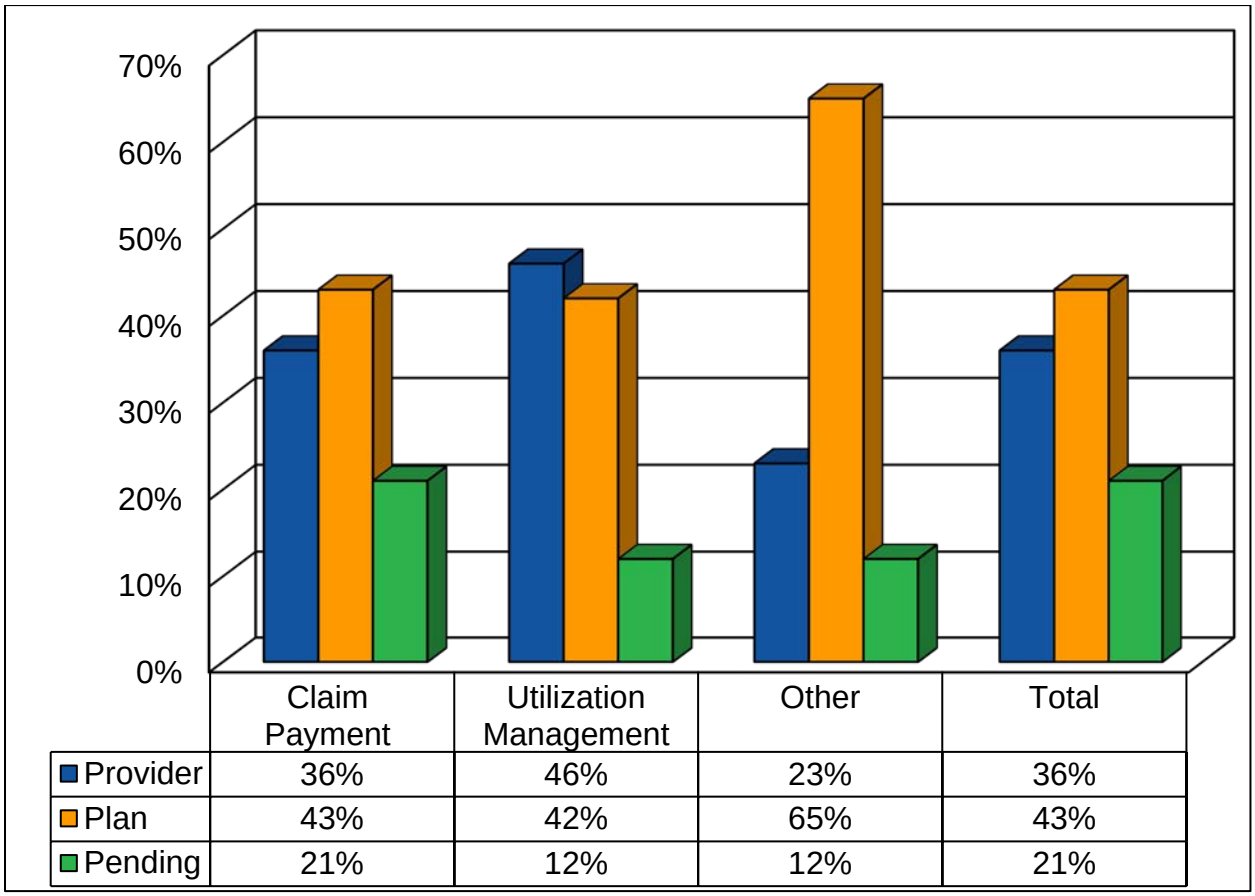
Approximately 85 percent of all claims processed were paid or adjusted and 15 percent of the claims processed were contested or denied. Capitated providers processed approximately 99 percent of claims within the 45-day statutory requirement. For provider disputes not resolved with the prescribed timeframes, the capitated providers self-initiate corrective action plans. These corrective action plans are monitored by the health plans to ensure compliance with the required timeframes.

Disposition of Capitated Providers' Provider Disputes

The number of capitated provider disputes decreased two percent in the 2019 reporting period compared to 2018. Of the 640,128 provider disputes submitted, 36 percent were resolved in favor of the provider, 43 percent were resolved in favor of the plan, and 21 percent were pending review as of September 30, 2019. Chart 7 illustrates the breakdown by percentages for each category of dispute compared to the total number of disputes.

Chart 7

Resolution of Provider Disputes – Capitated Providers



	Claim Payment	Utilization Management	Other	Total
Provider	36%	46%	23%	36%
Plan	43%	42%	65%	43%
Pending	21%	12%	12%	21%

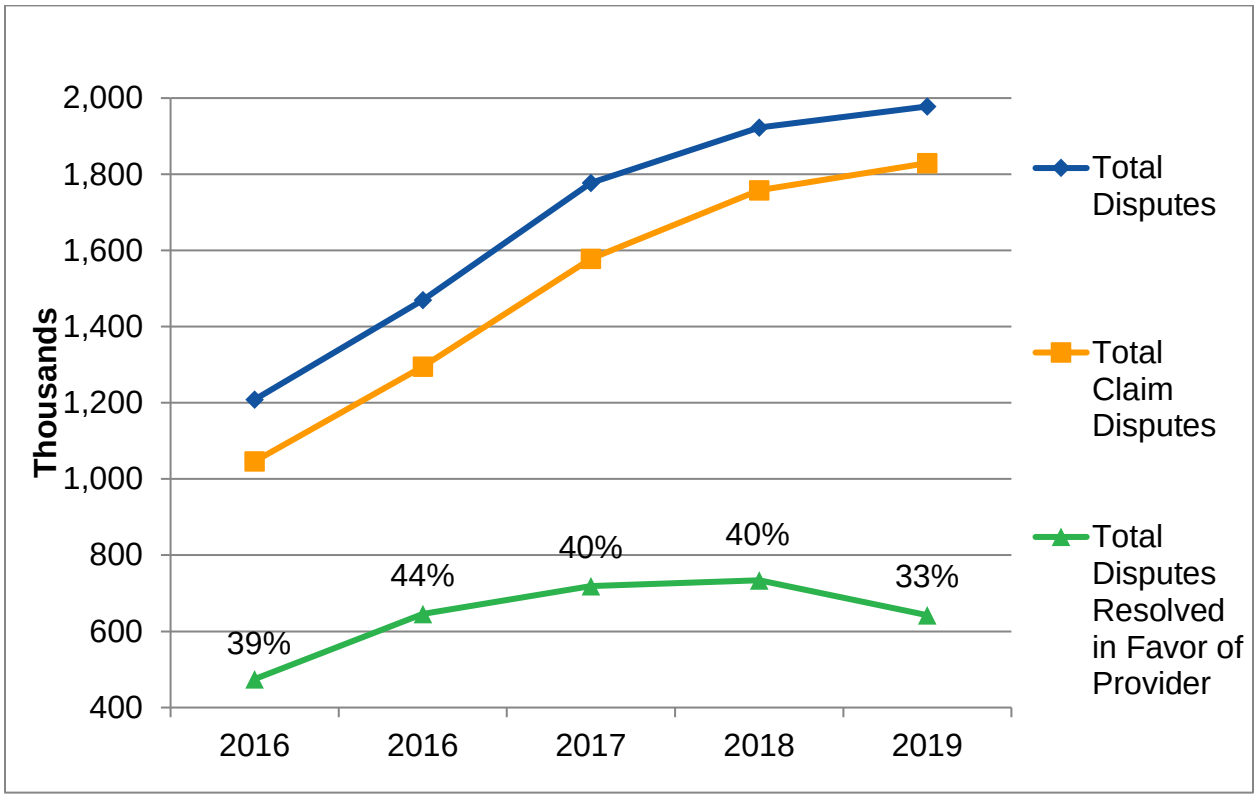
VI. Provider Dispute Trends

Chart 8 displays the trend for the volume of disputes reported by Full Service Plans, Specialized Plans, and Capitated Providers over a five year period. The blue line represents the total number of disputes reported, the orange line represents total claims disputes reported and the green line represents the total number of disputes in favor of the provider.

From 2018 to 2019, provider disputes increased from 1.92 million to 1.94 million, representing a one percent increase. The number of disputes resolved in favor of the provider has fluctuated between 33 percent and 44 percent over the five year period. For 2019, 33 percent of provider disputes were resolved in favor of the provider.

Chart 8

Five Year Provider Dispute Information



VII. Summary

For the 2019 reporting period, health plans reported resolving 96 percent of provider disputes within the required 45 day time frame, a nine percent increase from the prior reporting period.

Health plan provider disputes resolved in favor of the provider decreased by 17 percent in the 2019 reporting period compared to 2018. Providers prevailed in 33 percent of the disputes they filed with the health plans.

Almost half (48 percent) of provider disputes filed with specialized plans were resolved in favor of the provider.

Approximately 36 percent of provider disputes filed with capitated providers were resolved in favor of the provider with approximately 21 percent of these disputes pending as of September 30, 2019.