Health Care Service Plans' Provider Dispute Resolution Mechanisms

2020 Annual Report

March 30, 2021

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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 2020 Provider Dispute Resolution Mechanisms Report summarizes provider claim disputes by type of health plan, including full service and specialized health plans, from October 1, 2019 through September 30, 2020.

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 50 licensed full service health plans in California subject to the reporting requirements of section 1375.7(f).[1]
- Health plans processed approximately 155 million claims in the reporting period. Less than 1% (0.9%) of these claims resulted in disputes.
- Full service health plans received more than 1.4 million provider disputes for the reporting period.
- Approximately 97% of all provider disputes processed by full service health plans were reported as being resolved within 45 working days.

[1] There were 87 licensed full service health plans at September 30, 2020. However, 37 licensed full service health plans are excluded from the report because they are licensed only for Medicare products or are operating as a county organized health system, exempt from Health and Safety Code section 1367(h), or they do not have enrollment in California.

- Approximately 90% of provider disputes filed with full service health plans involved claims payment issues.

- Providers prevailed in 38% of all disputes and health plans upheld their original determinations in 53% of the disputes. Nine percent of the disputes were pending at the time the full service health 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 health plans.

- There are 38 licensed specialized health plans subject to the provider dispute reporting requirements of section 1375.7(f).

- Specialized health plans processed over 27 million claims in the reporting period. Less than half of 1% (0.07%) of these claims were the subject of a payment dispute.

- Specialized health plans received 19,323 provider disputes for the reporting period.

- Specialized health plans reported 50% of all provider disputes were resolved in favor of the provider, 49% were upheld by the plans, and 1% of disputes were pending as of the September 30, 2020.

- Approximately 55% 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 254 capitated providers or provider groups.

- Capitated providers processed approximately 69 million claims and received 662,791 provider disputes in the reporting period.

- Ninety-four percent of disputes involved claims payment.

- Thirty-seven 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.

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.

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

This report reflects information reported by health plans for October 1, 2019 through September 30, 2020.

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

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.

The claim and provider dispute examination results are located in the DMHC's Financial Examination Reports Section.

Full Service Health Plans

This report reflects information reported by health plans for October 1, 2019 through September 30, 2020.

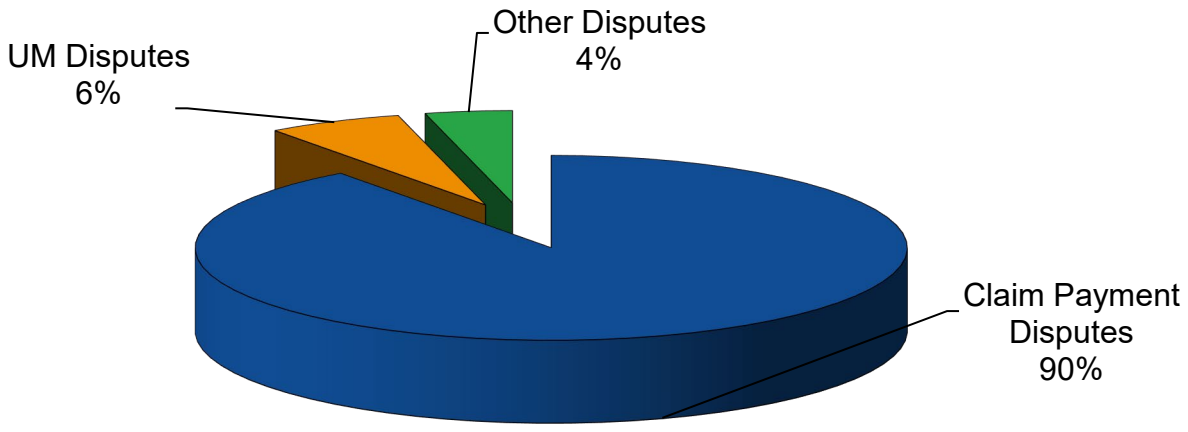
Of the 87 licensed full service health plans, data from 50 full service health plans is included in this report. Thirty-seven licensed full service health plans are excluded from the report because they met one or more of the following criteria: are licensed only for Medicare products, operate as a County Organized Health System (COHS), exempt from Health and Safety Code section 1367(h), or have no enrollment in California.

The 50 full service health plans reported approximately 155 million claims processed during the reporting period, an increase of 2% from the 2019 reporting period. A claim is considered processed when the health plan adjudicates and classifies the claim as paid, adjusted, contested or denied. The reporting full service health plans received 1,419,434 provider disputes during the 2020 reporting period. This represents an 11% increase in disputes over the 2019 reporting period.

Claim payment disputes, which primarily involve claims of inadequate reimbursement, comprised of 90% 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:	1,279,656
Total Number of Utilization Management Disputes:	86,750
Total Number of Other Disputes:	53,028

Regulations require the health plans to resolve 95% of all completed provider disputes within 45 working days. Collectively, the full service health plans reported that 97% 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% 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 factors include system configuration changes and the impact of COVID-19 on staffing and business functions such as processing mail and printing. 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 staff to eliminate dispute backlogs. Health plans collectively improved in their provider dispute resolution timeliness percentages by one percentage point from 96% in 2019 to 97% in 2020.

Provider Disputes Compared to Claims

Approximately 77% of provider claims processed were paid or adjusted by the health plans, and 23% were contested or denied. Nearly all claims (approximately 97%) were processed within 45 working days.

Approximately 155 million claims were processed during the reporting period. Over one million (1,419,434) claims were contested. This represents less than 1% (0.9%) of all claims processed by full service health plans.

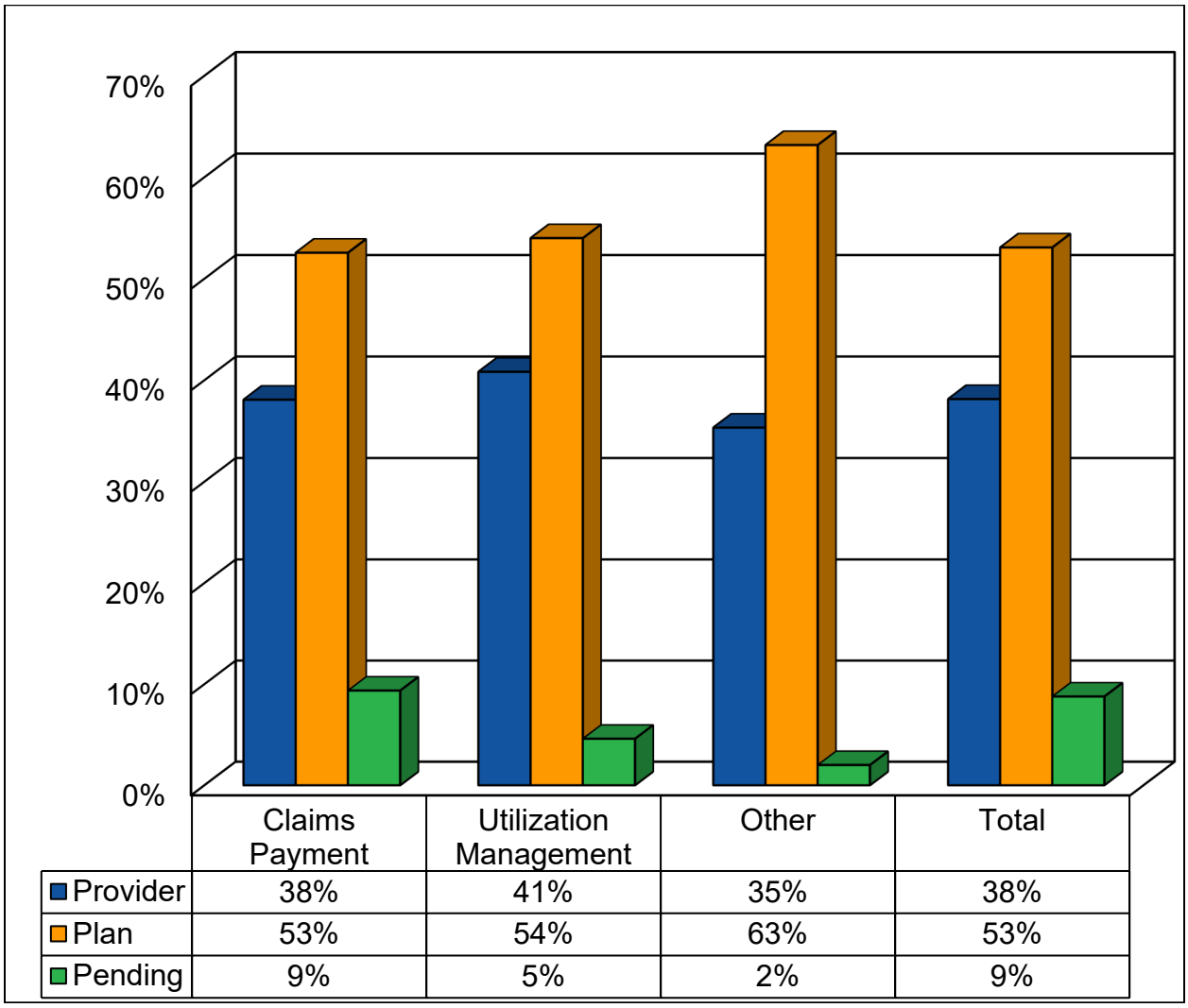
Disposition of Full Service Health Plan Provider Disputes

For the 2020 reporting period, full service health plans reported that 38% of all disputes between providers and health plans were resolved in favor of the provider compared to 35% of provider disputes in 2019.

Of the 1,419,434 provider disputes submitted, 541,432 (38%) disputes were resolved in favor of the provider, 753,400 (53%) in favor of the plan, and 124,602 (9%) were pending review as of September 30, 2020 (See Chart 2).

Chart 2

Resolution of Provider Disputes – Full Service Health Plans



	Claims Payment	Utilization Management	Other	Total
Provider	38%	41%	35%	38%
Plan	53%	54%	63%	53%
Pending	9%	5%	2%	9%

Seven Largest Full Service Health Plans

California's seven largest full service health plans[3] provide health care benefits to approximately 18 million enrollees, representing 67% of the over 27 million enrollees enrolled in health plans licensed by the DMHC. For the 2020 reporting period, approximately 67% of provider disputes were filed with these seven plans. Collectively, they processed approximately 119 million claims, accounting for roughly 76% of all claims processed by full service health plans in California (See Table 1).

[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 9/30/20	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	3,008,305	52,142,385	190,939	62,753 (32%)	127,834 (67%)	352 (1%)	96%
Blue Shield of California	2,618,713	17,466,600	199,730	64,496 (32%)	118,802 (60%)	16,432 (8%)	98%
Health Net Community Solutions, Inc.	1,401,480	17,540,794	91,752	33,452 (37%)	52,642 (57%)	5,658 (6%)	96%
Health Net of California, Inc.	580,719	3,392,250	50,180	16,486 (33%)	24,339 (48%)	9,355 (19%)	97%
Inland Empire Health Plan	1,294,668	8,993,991	57,553	23,978 (42%)	31,121 (54%)	2,454 (4%)	100%
Kaiser Permanente	7,184,020	4,856,569	155,782	30,317 (20%)	100,295 (64%)	25,170 (16%)	100%
L.A. Care Health Plan	2,263,843	14,479,494	207,562	84,572 (41%)	69,658 (33%)	53,332 (26%)	97%
Total - Seven Largest Health Plan	**18,351,748**	**118,872,083**	**953,498**	**316,054 (33%)**	**524,691 (55%)**	**112,753 (12%)**	**98%**
All Other Full Service Health Plans	**9,170,234**	**36,544,800**	**465,936**	**225,378 (48%)**	**228,709 (49%)**	**11,849 (3%)**	**96%**
Total - All Full Service Health Plans	**27,521,982**	**155,416,883**	**1,427,149**	**541,432 (38%)**	**753,400 (53%)**	**124,602 (9%)**	**97%**

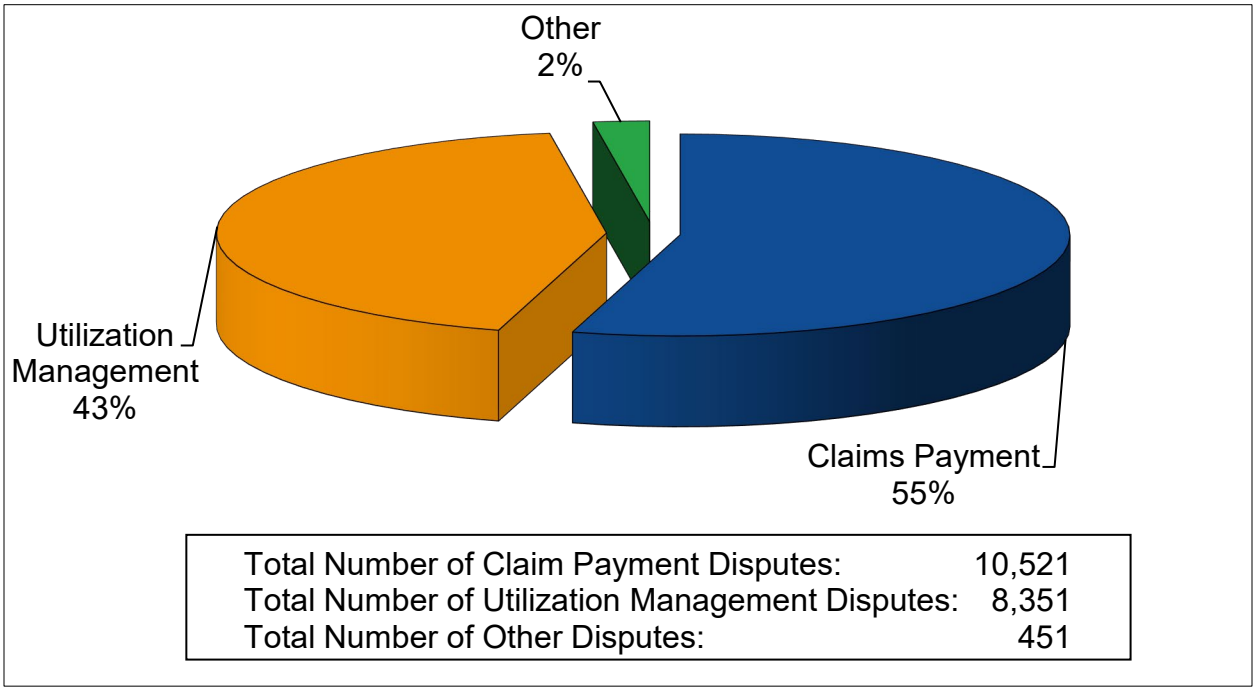
III. Specialized Health Plans

Of the 45 licensed specialized health plans, data from 38 specialized health plans are included in this report. Seven licensed specialized health plans are excluded from the report because they met one or more of the following criteria: are licensed only for Medicare products, are licensed as discount plans, were considered to be in pre-operations for the reporting year, or they have no enrollment in California.

The 38 specialized health plans processed approximately 27 million provider claims and received 19,323 provider disputes. Specialized health plans had an 11% decrease in the number of disputes in the 2020 reporting period compared to 2019. Ninety-three 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

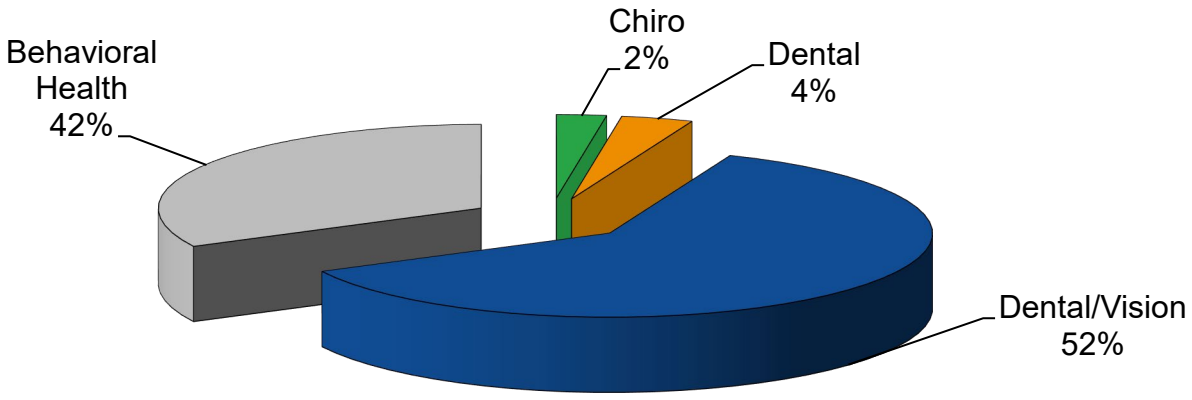
Provider Disputes – Specialized Health Plans



Of the 19,323 total provider disputes submitted to specialized health plans during the 2020 reporting period, dental plans (including dental/vision plans) accounted for approximately 56% of the disputes, followed by behavioral health with approximately 42% of the disputes, and chiropractic plans with 2% (See Chart 4). Dental plans accounted for approximately 42% of total enrollment for specialized health plans required to report.

Chart 4

Provider Disputes by Type of Specialized Health Plan



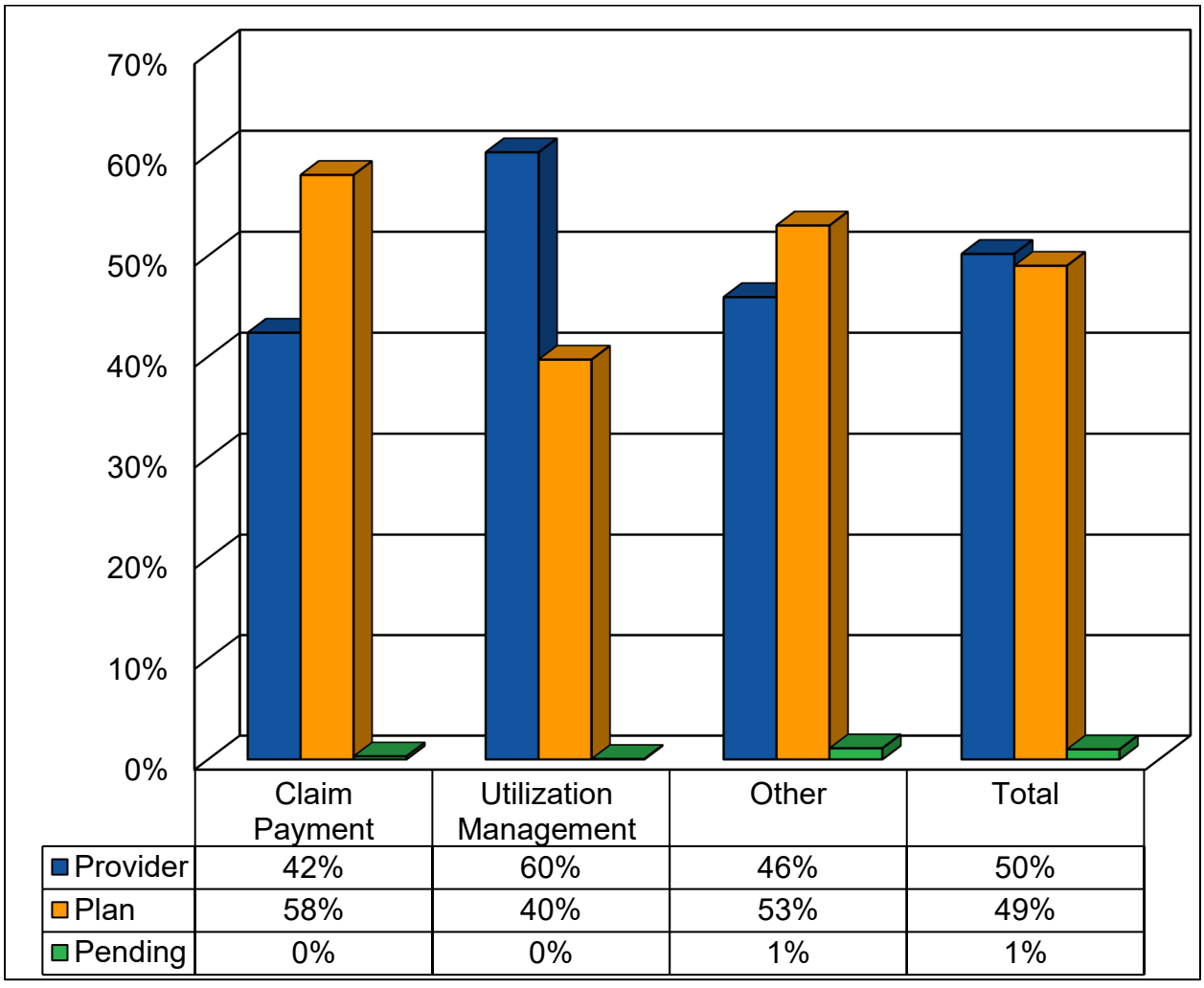
Total Disputes by Specialized Plan Type	2020
Dental/Vision	10,076
Behavioral Health	8,100
Dental	756
Chiropractic	363
Vision	28

Disposition of Specialized Health Plan Provider Disputes

Specialized health plans reported 50% of all provider disputes were resolved in favor of the provider, an increase of 4% from the prior year. Forty-two percent of disputes involving claims payment issues were resolved in favor of the provider while 58% of disputes were resolved in favor of the plan. Sixty percent of utilization management disputes were resolved in favor of providers, while 40% were in favor of the plan. Forty-six percent of Other disputes were resolved in favor of providers, 53% were resolved in favor of the plan 53%, and 1% were pending at year-end (See Chart 5).

Chart 5

Resolution of Provider Disputes - Specialized Health Plans



	Claim Payment	Utilization Management	Other	Total
Provider	42%	60%	46%	50%
Plan	58%	40%	53%	49%
Pending	0%	0%	1%	1%

IV. 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.

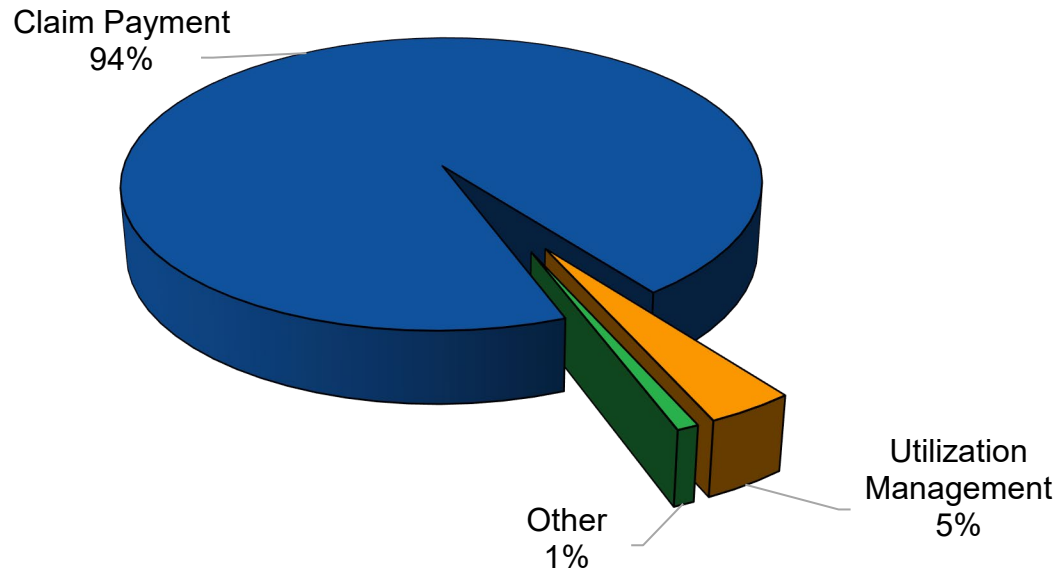
All health plans are required to compile and provide a dispute resolution report for each capitated provider or provider group. Based upon the number of filings received, the DMHC has identified 254 capitated providers that were contracted with full service health plans.

Health plans reported a total of 662,791 provider disputes filed with capitated providers during the reporting 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 approximately 69 million claims in the 2020 reporting period. Ninety-four 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:	622,723
Total Number of Utilization Management Disputes:	33,232
Total Number of Other Disputes:	6,836

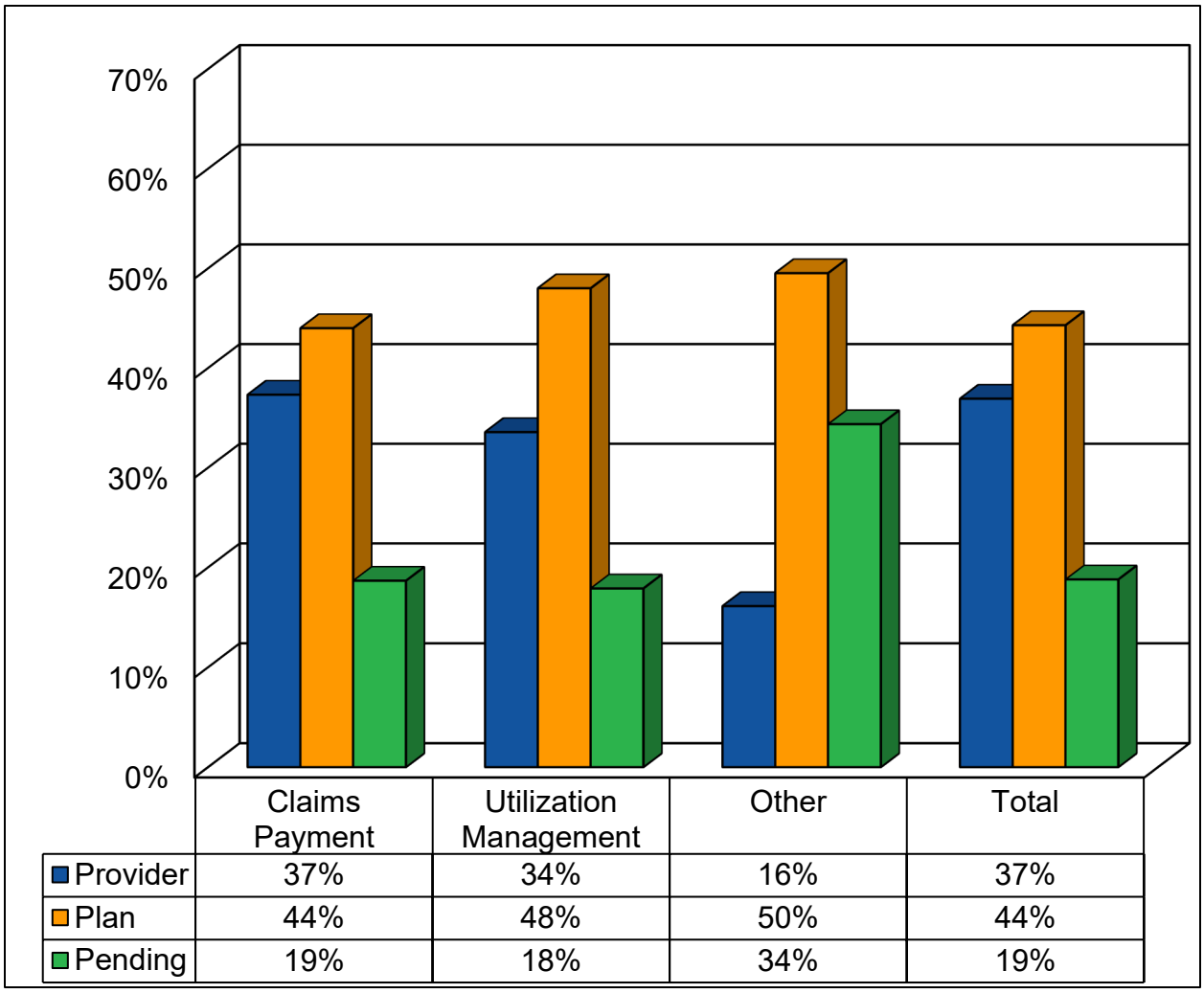
Approximately 84% of all claims processed were paid or adjusted and 16% of the claims processed were contested or denied. Capitated providers processed approximately 99% of claims within the 45-day statutory requirement. For provider disputes not resolved within the prescribed timeframes, the capitated providers self-initiate corrective action plans. These corrective action plans are monitored by the health plans to ensure compliance within the required timeframes.

Disposition of Capitated Providers' Provider Disputes

The number of capitated provider disputes increased 4% in the 2020 reporting period compared to 2019. Of the 662,791 provider disputes submitted, 37% were resolved in favor of the provider, 44% were resolved in favor of the plan, and 19% were pending review as of September 30, 2020. 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



	Claims Payment	Utilization Management	Other	Total
Provider	37%	34%	16%	37%
Plan	44%	48%	50%	44%
Pending	19%	18%	34%	19%

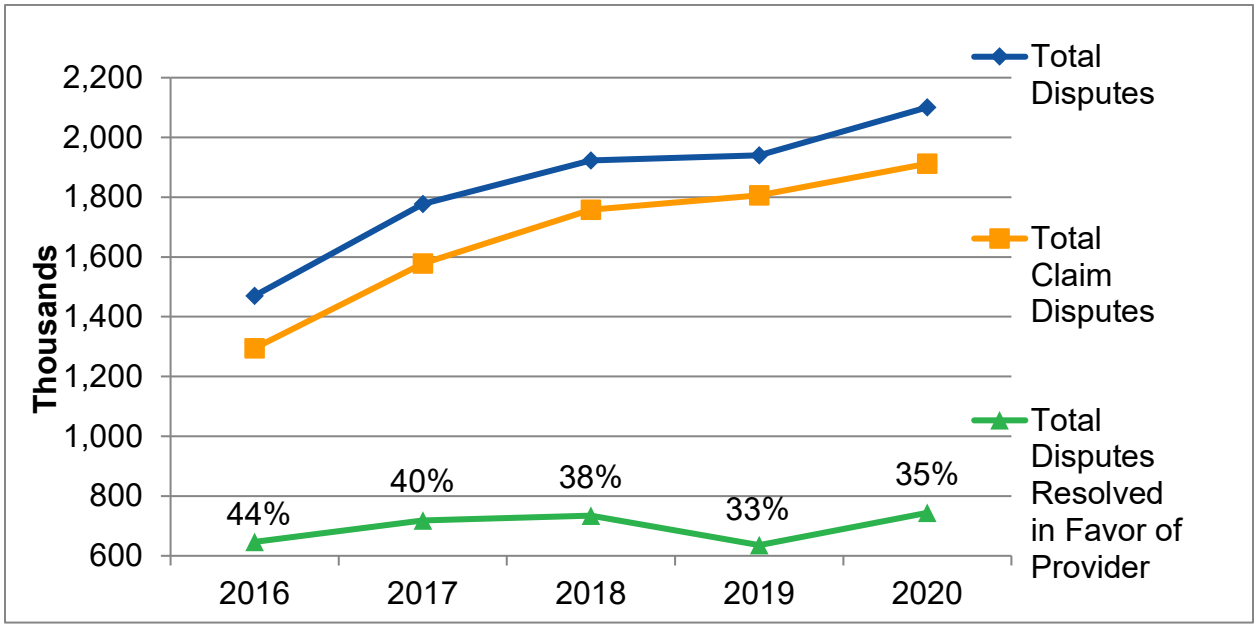
V. Provider Dispute Trends

Chart 8 displays the trend for the volume of disputes reported by full service health plans, specialized health plans, and capitated providers over a five year period.

From 2019 to 2020, the total number of provider disputes increased from 1.94 million to 2.1 million, an 8% increase. The number of disputes resolved in favor of the provider has fluctuated between 33% and 44% over the five-year period. For 2020, 35% of provider disputes were resolved in favor of the provider.

Chart 8

Five Year Provider Dispute Information



VI. Summary

In general, health plans reported resolving 97% of provider disputes within the required 45-day time frame, a 1% increase from the prior reporting period. The number of provider disputes resolved by health plans in favor of the provider increased by 17% in the 2020 reporting period compared to 2019. Providers prevailed in 35% of the disputes they filed with the health plans.

There was an 11% decrease in provider disputes received by specialized health plans. Half (50%) of the provider disputes filed were resolved in favor of the provider.

Approximately 37% of provider disputes filed with capitated providers were resolved in favor of the provider with approximately 19% of these disputes pending as of September 30, 2020.

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. For the 2020 reporting period, the DMHC updated the reporting instructions for the claims and provider dispute reports to improve consistency in the reporting by health plans and capitated providers.