DEPARTMENT OF
Managed
Health Care

Health Care Service Plans' Provider Dispute Resolution Mechanisms

2018 Annual Report

April 11, 2019

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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 2018 Provider Dispute Resolution Mechanisms Report summarizes provider claim disputes by type of health plan, including full service and specialized health plans, from October 1, 2017 through September 30, 2018.

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 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 88 percent of all provider disputes processed by full service health plans were reported as being resolved within 45 working days.

[1] There were 78 licensed full service health plans at September 30, 2018. However, provider dispute information from 50 full service health plans are included in this report. Twenty-eight 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 direct enrollment in California.

- Approximately 91 percent of provider disputes filed with full service health plans involved claims payment issues.

- Providers prevailed in 38 percent of all disputes; health plans upheld their original determinations in 48 percent of the disputes. Fourteen 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 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 29 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 19,247 provider disputes for the reporting period.

- Specialized health plans reported 53 percent of all provider disputes were resolved in favor of the provider, 46 percent were upheld by the plans, and one percent of disputes were pending as of the September 30, 2018.

- Approximately 79 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 265 capitated providers or provider groups.

- Capitated providers processed approximately 76 million claims and received 651,752 provider disputes in the reporting period.

- Ninety-two 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, 2017 through September 30, 2018.

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

III. Full Service Health Plans

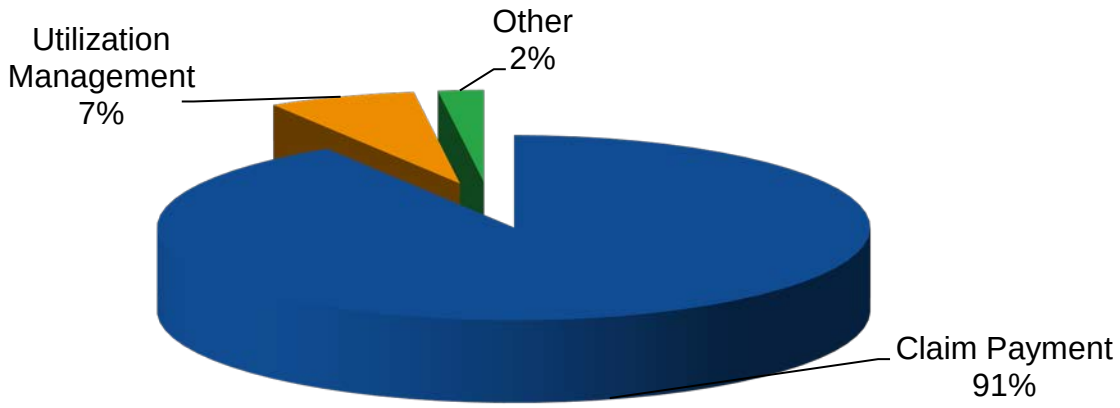
Of the 78 licensed full service health plans, data from 50 full service health plans is included in this report. Twenty-eight licensed full service health plans are excluded from the report because they are licensed only for Medicare products or operate as a county organized health system, exempt from Health and Safety Code section 1367(h), or they have no direct enrollment in California.

The 50 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. These full service health plans received 1,251,629 provider disputes during the 2018 reporting period. This represents a seven percent increase in disputes over the 2017 reporting period.

Claim payment disputes, which primarily involve claims of inadequate reimbursement, comprised of 91 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:	1,142,086
Total Number of Utilization Management Disputes:	83,752
Total Number of Other Disputes:	25,791

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 88 percent of all provider disputes were resolved within 45 working days. This is a seven percent decline from the prior year.

Eleven 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 factors include staffing issues, higher than expected claims volume, and claims system updates. Health plans have indicated that corrective action plans have been instituted to improve claims timeliness going forward. The corrective actions include reviewing daily reports to monitor processing timeliness, implementing system improvement audits to determine claim processing delays, and hiring additional staffing to eliminate dispute backlogs. Health plans collectively declined in their provider dispute resolution timeliness percentages by seven percentage points from 95 percent in 2017 to 88 percent 2018.

Provider Disputes Compared to Claims

Approximately 86 percent of provider claims processed were paid or adjusted by the health plans, and 14 percent were contested or denied. Nearly all claims (approximately 99 percent) were processed within 45 working days.

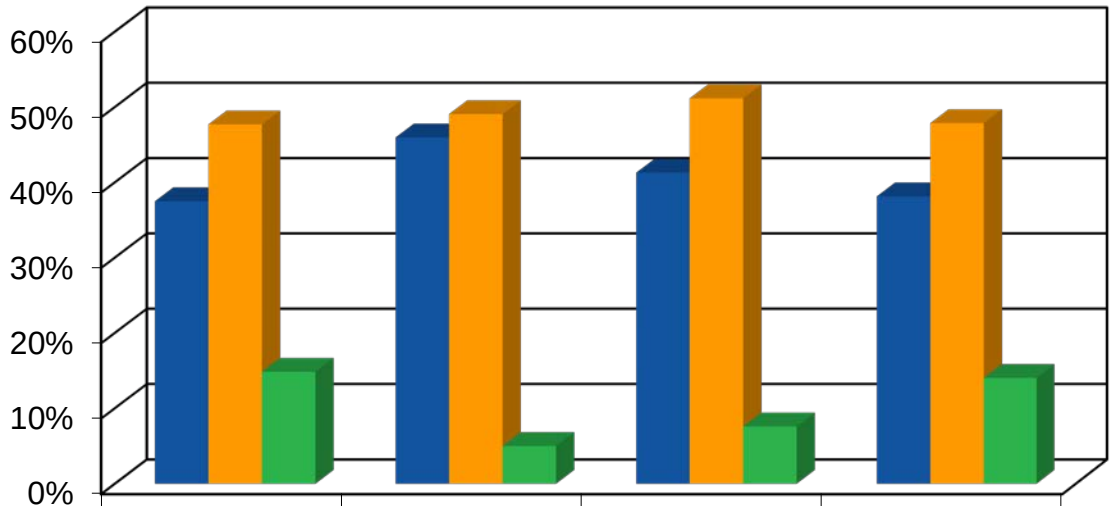
Approximately 152 million claims were processed during the reporting period. Over one million (1,251,629) claims were contested. This represents less than one percent (0.8 percent) of all claims processed by full service health plans.

Disposition of Full Service Health Plan Provider Disputes

For the 2018 reporting period, full service health plans reported that 38 percent of all disputes between providers and health plans were resolved in favor of the provider compared to 43 percent of provider disputes in 2017.

Of the 1,251,629 provider disputes submitted, 478,144 (38 percent) were resolved in favor of the provider, 598,382 (48 percent) in favor of the plan, and 175,103 (14 percent) were pending review as of September 30, 2018 (See Chart 2).

Chart 2
Resolution of Provider Disputes – Full Service Health Plans



	Claim Payment	Utilization Management	Other	Total
Provider	37%	46%	41%	38%
Plan	48%	49%	51%	48%
Pending	15%	5%	8%	14%

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 2018 reporting period, approximately 70 percent of provider disputes were filed with these seven plans. Collectively, they processed approximately 118 million claims, accounting for 78 percent 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 9/30/18	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	2,803,107	49,567,129	160,335	57,421 (36%)	84,875 (53%)	18,039 (11%)	96%
Blue Shield of California	2,625,140	20,709,295	212,799	75,099 (35%)	108,469 (51%)	29,231 (14%)	99%
Health Net Community Solutions, Inc.	1,445,741	17,884,839	61,618	34,617 (56%)	23,558 (38%)	3,443 (6%)	63%
Health Net of California, Inc.	662,496	4,296,364	77,493	39,352 (51%)	27,089 (35%)	11,052 (14%)	96%
Inland Empire Health Plan	1,245,177	8,070,070	43,138	20,505 (47%)	14,463 (34%)	8,170 (19%)	100%
Kaiser Permanente	8,158,216	3,705,199	193,702	29,713 (15%)	93,687 (49%)	70,302 (36%)	87%
L.A. Care Health Plan	2,187,392	14,185,146	127,883	43,676 (34%)	63,328 (50%)	20,879 (16%)	99%
Total - Seven Largest Health Plan	**19,137,269**	**118,418,042**	**876,968**	**300,383 (34%)**	**415,469 (48%)**	**161,116 (18%)**	**93%**
All Other Full Service Health Plans	**7,207,743**	**33,693,944**	**374,661**	**177,761 (47%)**	**182,913 (49%)**	**13,987 (4%)**	**77%**
Total - All Full Service Health Plans	**26,345,012**	**152,111,986**	**1,251,629**	**478,144 (38%)**	**598,385 (48%)**	**175,103 (14%)**	**88%**

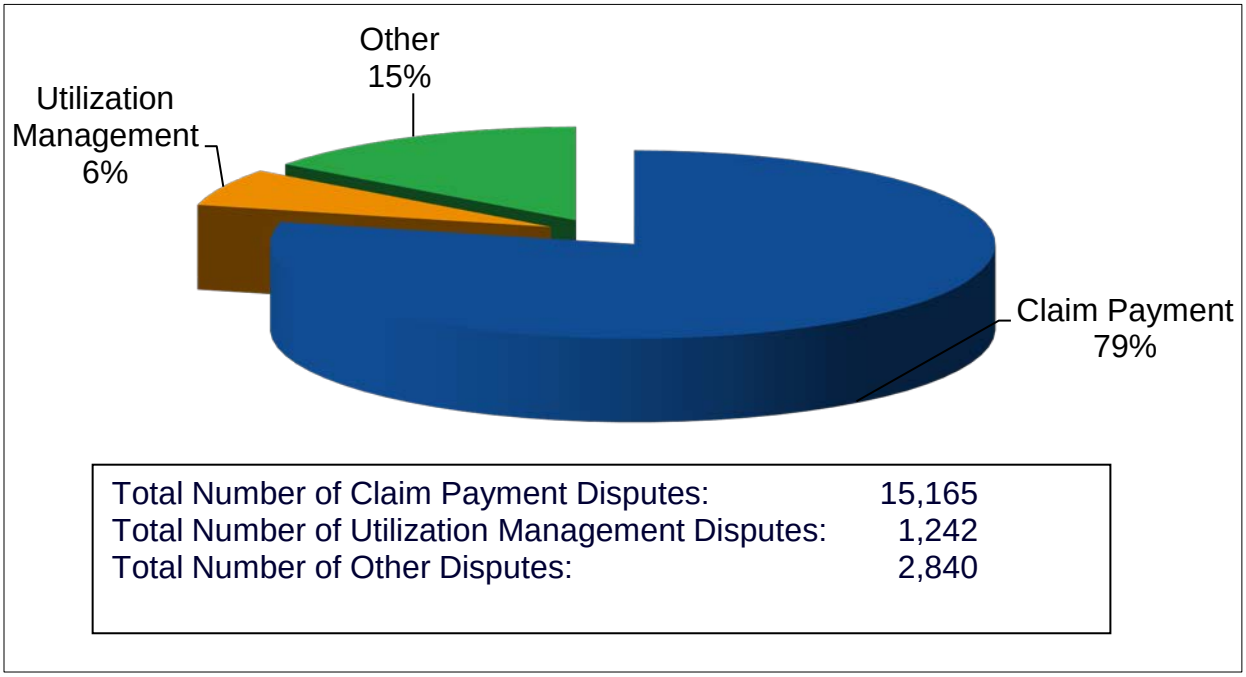
IV. Specialized Health Plans

Of the 47 licensed specialized health plans, data from 41 specialized health plans are included in this report. Three health plans are excluded because they are licensed only for Medicare, and therefore are exempt from Health and Safety Code section 1367(h), and three are discount health plans.

The 41 specialized health plans processed approximately 29 million provider claims and received 19,247 provider disputes. Specialized health plans had a six percent decrease in the number of disputes in the 2018 reporting period compared to 2017. Ninety-nine 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

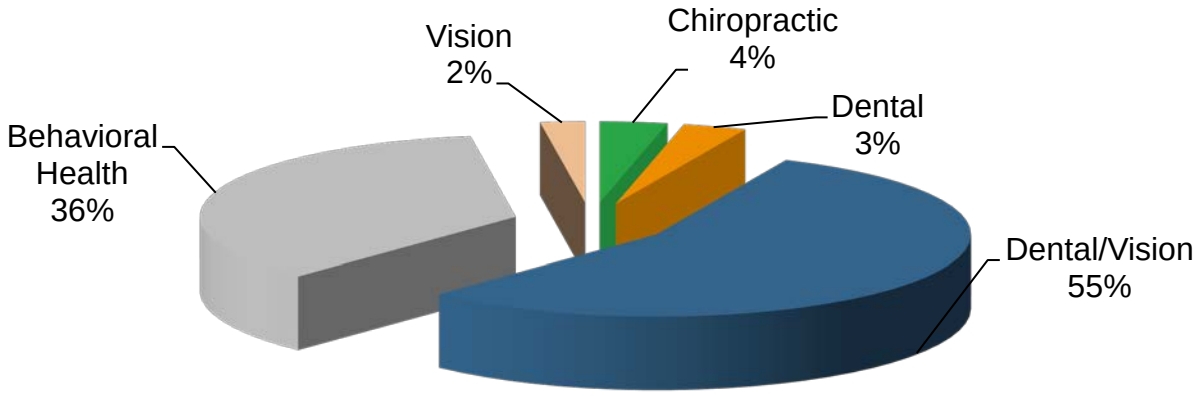


Total Number of Claim Payment Disputes:	15,165
Total Number of Utilization Management Disputes:	1,242
Total Number of Other Disputes:	2,840

Of the 19,247 total provider disputes submitted to specialized health plans during the 2018 reporting period, dental plans (including dental/vision plans) accounted for approximately 58 percent of the disputes, followed by behavioral health plans with 36 percent, chiropractic plans with four percent, and vision plans with two percent (See Chart 4). Dental plans accounted for approximately 40 percent of total enrollment for specialized health plans required to report.

Chart 4

Provider Disputes by Type of Specialized Health Plan



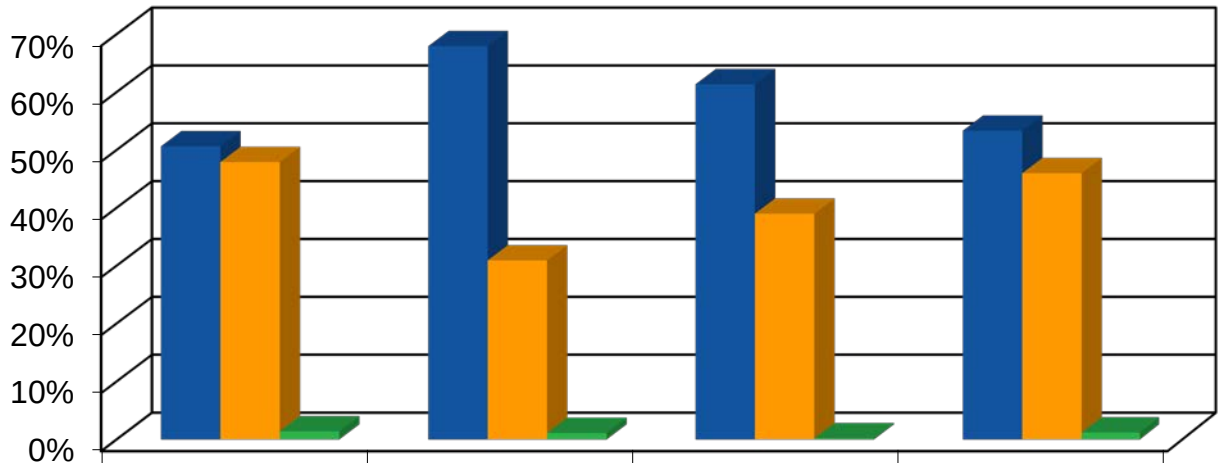
Total Disputes by Specialized Plan Type	2018
Dental/Vision	10,650
Behavioral Health	6,859
Dental	629
Chiropractic	667
Vision	442

Disposition of Specialized Health Plan Provider Disputes

Specialized health plans reported 53 percent of all provider disputes were resolved in favor of the provider, a five percent decrease from the prior year. Fifty-one percent of disputes involving claims payment issues were resolved in favor of the provider while 48 percent of disputes were resolved in favor of the plan, and the remaining one percent were pending at year-end. Utilization management disputes were resolved in favor of providers 68 percent of the time and 31 percent were in favor of the plan. One percent were pending at year-end. Other disputes were resolved in favor of providers 61 percent and 39 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	51%	68%	61%	53%
Plan	48%	31%	39%	46%
Pending	1%	1%	0%	1%

V. Capitated Providers

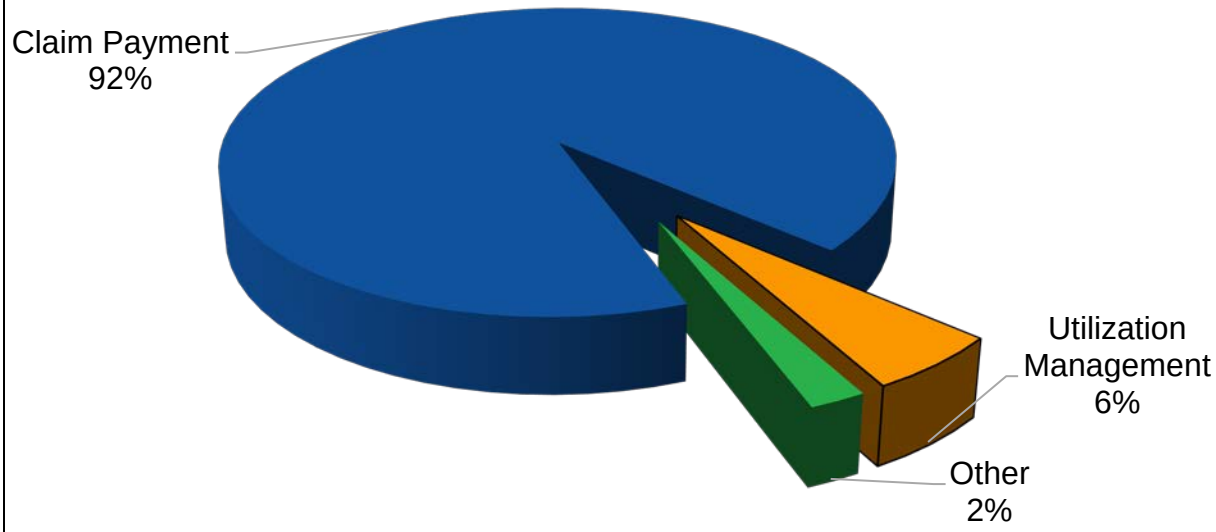
Generally, capitated providers fall within two main categories: (1) medical groups and Independent Practice Associations (IPAs); and (2) hospital systems that receive capitation from health plans, and in turn pay provider claims for health care services rendered to the plan's enrollees. Capitation is 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 265 capitated providers that were contracted with full service health plans.

Health plans report a total of 651,752 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 76 million claims in the 2018 reporting period. Ninety-two 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	600,331
Total Number of Utilization Management Disputes	36,498
Total Number of Other Disputes	14,923

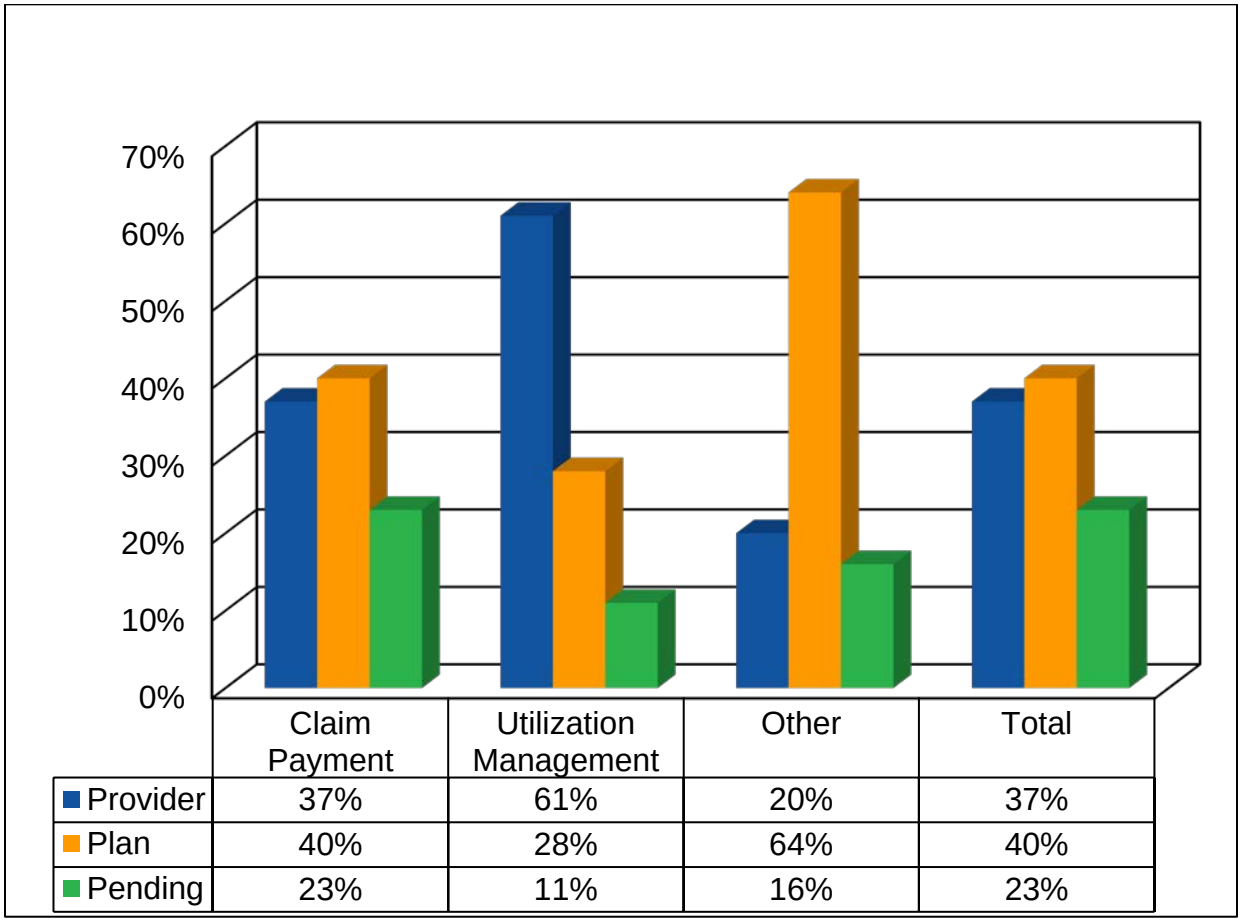
Approximately 85 percent of all claims processed were paid or adjusted and 15 percent of the claims processed were contested or denied. Capitated providers processed approximately 99 percent of claims within the 45-day statutory requirement.
For provider disputes not resolved within the prescribed timeframes, 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 12 percent in the 2018 reporting period compared to 2017. Of the 651,752 provider disputes submitted, 37 percent were resolved in favor of the provider, 40 percent were resolved in favor of the plan, and 23 percent were pending review as of September 30, 2018. 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	37%	61%	20%	37%
Plan	40%	28%	64%	40%
Pending	23%	11%	16%	23%

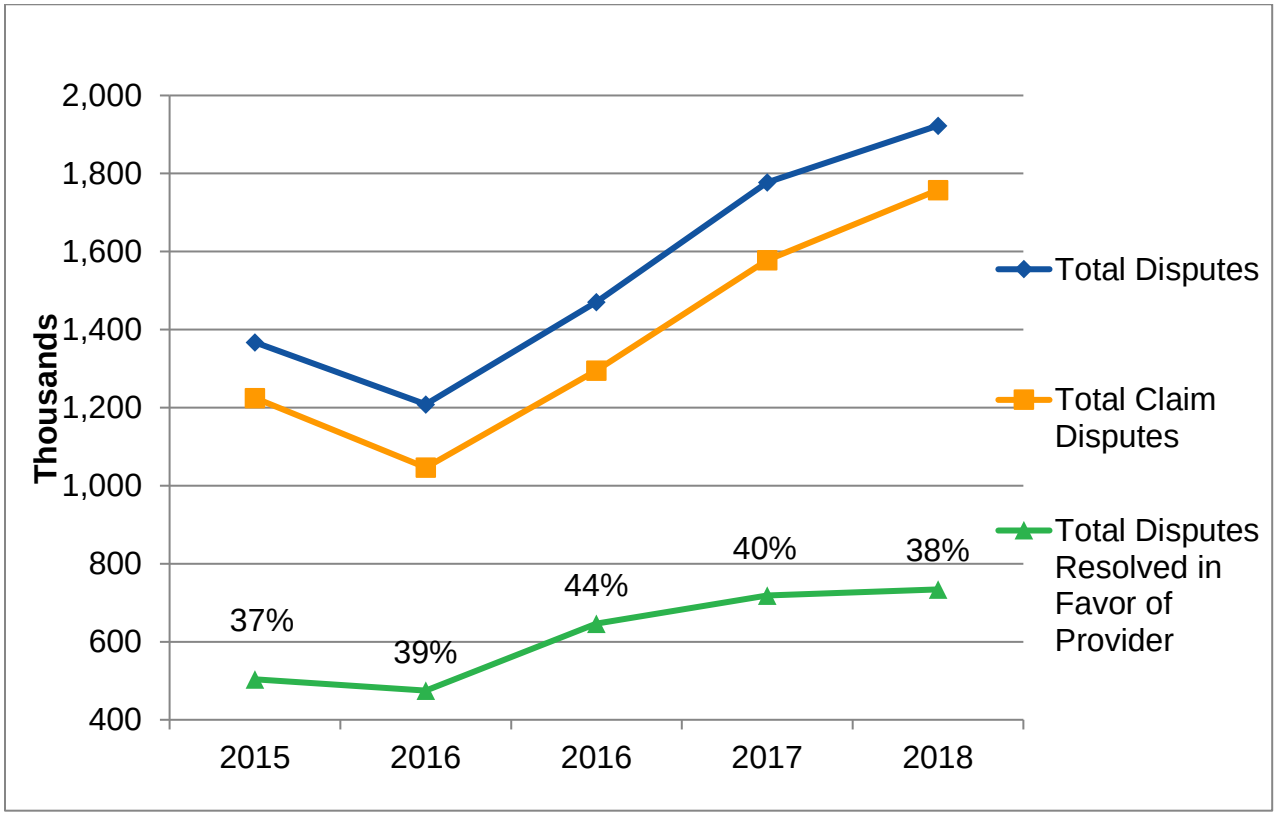
VI. Provider Dispute Trends

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 bar represents the total number of disputes reported, the red bar represents total claims disputes reported and the green bar represents the total number of disputes in favor of the provider.

From 2017 to 2018, provider disputes increased from 1.8 million to 1.9 million, an eight percent increase. The number of disputes resolved in favor of the provider has fluctuated between 37 and 44 percent over the five year period. For 2018, 38 percent of provider disputes were resolved in favor of the provider.

Chart 8

Five Year Provider Dispute Information



VII. Summary

In general, health plans reported resolving 88% of provider disputes within the required 45 day time frame, a 7% decline from the prior reporting period. Health plan provider disputes resolved in favor of the provider decreased by 5% in the 2018 reporting period compared to 2017. Providers prevailed in 38 percent of the disputes they filed with the health plans.

More than half (53%) of provider disputes filed with specialized plans 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 23% of these disputes pending as of September 30, 2018.

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.

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.