Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
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May 3, 2023 **Via eFile**

Mr. Brian Ternan
Chair of the Board of Directors
Health Net of California, Inc.
21281 Burbank Blvd.
Woodland Hills, CA 91367

FINAL REPORT OF A NONROUTINE EXAMINATION OF HEALTH NET OF CALIFORNIA, INC.

Dear Mr. Ternan:

Enclosed is the final report (Final Report) of a nonroutine examination for the quarter ended June 30, 2022 of the claims settlement practices and provider dispute resolution mechanism of Health Net of California, Inc. (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 and Rule 1300.82.1 of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a preliminary report (Preliminary Report) to the Plan on February 1, 2023. The Department accepted the Plan's electronically filed response on March 17, 2023.

The Final Report includes a description of the compliance efforts included in the Plan's March 17, 2023 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."

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[1] References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in California Health and Safety Code section 1340 et seq. References to "Rule" are to regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act of 1975 contained within title 28 of the California Code of Regulations.

Please indicate within 10 days from the date of the Plan's receipt of this letter whether the Plan requests the Department to append its response. If so, please indicate which portions of the Plan's response should be appended, and electronically file copies of those portions 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 or wishes to modify any information provided to the Department in its March 17, 2023 response, please provide an addendum no later than 10 days from the date of the Plan's receipt of this letter. Please file this addendum electronically via the corrective action plan (CAP) system within the Department's eFiling web portal at https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling."
- From the eFiling menu, select "Online Forms."
- From the Online Forms menu, select "Details" for "CAP S22-N-300."
- Go to the "Messages" tab, then:
  - Select "Addendum to Final Report" (note this option will only be available for 10 days after the issuance of the Final Report).
  - 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."

As noted in the attached Final Report, the Plan's response of March 17, 2023 did not adequately respond to the deficiencies raised in the Preliminary Report issued by the Department on February 1, 2023. The Plan is required to respond to any request for corrective actions contained within the attached Final Report within 30 days of receipt of the Final Report. If the Plan fails to fully respond and/or resolve the deficiencies addressed in the Final Report, then a referral will be made to the Department's Office of Enforcement for appropriate administrative action.

Please file the Plan's response electronically via the CAP system within the Department's eFiling web portal at https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling."
- From the eFiling menu, select "Online Forms."
- From the Online Forms menu, click on the "Details" for "CAP S22-N-300."
- Go to the "Data Requests" tab, then:
  - Click on the "Details" for each data request that does not have a status of "Complete."
  - Follow the instructions and/or use the form shown to add the requested data (depending on the type of data requested: New Filing, Document Request, Claims Data, or Financial Statement Refile).

The Department will also e-mail the Plan requesting all 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 any addendum should be directed to the Office of Financial Review administrative support team at 916-255-2345 or by e-mail at ofr_admin@dmhc.ca.gov.

The Department will make the Final Report available to the public in 10 days from the Plan's receipt of this letter. The Final Report will be located at the Department's web site at http://www.dmhc.ca.gov/LicensingReporting/ViewFinancialExaminationReports.aspx.

The Plan is hereby advised that any violations listed in the Final Report may be referred to the Department's Office of Enforcement for appropriate administrative actions.

If there are any questions regarding the Final Report, please contact me at 916-255-2425 or by e-mail at Anna.Belmont@dmhc.ca.gov.

Sincerely,

SIGNED BY

Anna Belmont
Examiner IV, Supervisor
Office of Financial Review
Division of Financial Oversight

cc: Christy Bosse, Senior Vice President and CA Compliance Officer, Health Net of California, Inc.
Pritika Dutt, CPA, Deputy Director, Office of Financial Review
Jennifer Clark, Supervising Examiner, Division of Financial Oversight
Erica Short, Examiner, Division of Financial Oversight
Lorilee Ambrosini, Examiner, Division of Financial Oversight
John Lai, Attorney III, Office of Plan Licensing
Laura Dooley-Beile, Supervising Health Care Service Plan Analyst, Office of Plan Monitoring
Chad Bartlett, Staff Services Manager II, Help Center

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

OFFICE OF FINANCIAL REVIEW
DIVISION OF FINANCIAL OVERSIGHT

FINAL REPORT OF A NONROUTINE EXAMINATION

OF

HEALTH NET OF CALIFORNIA, INC.

FILE NO. 933 0300

DATE OF FINAL REPORT: MAY 3, 2023

SUPERVISING EXAMINER: JENNIFER CLARK

OVERSIGHT EXAMINER: ANNA BELMONT

EXAMINER-IN-CHARGE: ERICA SHORT

FINANCIAL EXAMINERS:

MICHAEL CEN

BENBIN FENG

DEREK JANG

NINA MOUA

BACKGROUND INFORMATION FOR HEALTH NET OF CALIFORNIA, INC.

Date Plan Licensed:	March 7, 1991
Organizational Structure:	Health Net of California, Inc. (Plan) is a for-profit, wholly owned subsidiary of Health Net, LLC (HNLLC). Effective March 24, 2016, HNLLC became an indirect wholly owned subsidiary of Centene Corporation, a publicly traded company. The Plan wholly owns the following subsidiaries: Health Net Life Insurance Company, Health Net Life Reinsurance Company, and MEB Ventures II. The Plan is a party to several administrative service agreements with HNLLC and its affiliates, which authorize certain services to be performed on behalf of and by the Plan.
Type of Plan:	The Plan is a full service health care plan that provides access to health care services through its commercial, Medicare, Medi-Cal, and Knox-Keene Point-of-Service products.
Provider Network:	The Plan contracts with various providers, including medical groups, hospitals, and other providers of health care services. Professional providers receive capitation for their services on a per member per month basis, and institutional providers are reimbursed on a capitation, discounted fee-for-service, hospital per diem, or case rate basis. Capitation contracts often contain provisions for shared risk.
Plan Enrollment:	As of June 30, 2022, the Plan reported total enrollment of 914,785.
Service Area:	The majority of counties in California.
Date of Prior Final Routine Examination Report:	January 29, 2021

FINAL REPORT OF A NONROUTINE EXAMINATION OF HEALTH NET OF CALIFORNIA, INC.

This is the final report (Final Report) of a nonroutine examination for the quarter ended June 30, 2022 of the claims settlement practices and provider dispute resolution mechanism of Health Net of California, Inc. (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 and Rule 1300.82.1 of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a preliminary report (Preliminary Report) to the Plan on February 1, 2023. The Department accepted the Plan's electronically filed response on March 17, 2023.

This Final Report includes a description of the compliance efforts included in the Plan's March 17, 2023 response to the Preliminary Report, in accordance with Section 1382(c). The Plan's response is noted in italics within this Final Report.

The Plan is hereby advised that any violations listed in the Final Report may be referred to the Department's Office of Enforcement for appropriate administrative action.

The Department's findings are presented in this Final Report as follows:

Part I. Compliance Issues

The Plan is required to respond to any request for corrective actions contained herein within 30 days of receipt of this Final Report.

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[1] References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in California Health and Safety Code section 1340 et seq. References to "Rule" are to regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act of 1975 contained within title 28 of the California Code of Regulations.

PART I. COMPLIANCE ISSUES

A. CLAIMS SETTLEMENT PRACTICES - “UNFAIR PAYMENT PATTERN”

Section 1371.37 prohibits a health care service plan from engaging in an unfair payment pattern, and defines certain claims settlement practices as “unfair payment patterns.”

Rule 1300.71(a)(8) defines an “unfair payment pattern” as any practice, policy, or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims.

1. PAYMENT ACCURACY, INCLUDING INTEREST AND PENALTIES – Repeat Deficiency

Rule 1300.71(a)(8)(K) describes an “unfair payment pattern” as the failure to reimburse at least 95 percent of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

Section 1371 and Rule 1300.71(i)(2) and (j) require a health care service plan, if the plan is a health maintenance organization, to reimburse uncontested claims no later than 45 working days after the date of receipt of the claim by the plan. If an uncontested claim is not reimbursed within 45 working days after receipt, interest accrues at the rate of 15 percent per annum, beginning with the first calendar day after the 45-working-day period. A plan that fails to automatically include any interest due in its payment of the claim must also pay a fee of $10 to the claimant.

Rule 1300.71.38(g) states if a provider dispute or amended dispute involves a claim and is determined in whole or in part in favor of the provider, the plan shall pay any outstanding monies determined to be due, and all interest and penalties within five working days of the issuance of the written determination.

The Department’s examination disclosed that claims were not reimbursed accurately, including automatic payment of interest and penalties, in ten out of 80 provider dispute samples. The deficiency was noted in the following provider dispute sample numbers: 2, 4, 5, 9, 11, 13, 32, 39, 41, and 55. This deficiency was primarily caused by the system redenying the claims after the provider disputes were approved for payment and claim processors using the dispute date of receipt instead of the claim date of receipt to calculate interest.

The Department infers with 90% confidence that the true compliance rate is between 80.17% and 92.38%, with the upper bound being less than the required 95% compliance rate.

The Plan’s failure to pay claims accurately, including interest and penalties, is a repeat deficiency, as this issue was previously reported in the Department’s final report of examination dated January 29, 2021, for the quarter ended March 31, 2020. This examination disclosed that the Plan’s corrective actions in response to the prior

examination report were ineffective at achieving compliance with the Sections and Rules cited.

The Preliminary Report required the Plan to explain why the corrective actions implemented to resolve the deficiency of failure to reimburse claims accurately, including automatic payment of interest and penalties, as identified in the Department's prior examination, were not effective in ensuring ongoing compliance.

In addition, the Preliminary Report required the Plan to submit a detailed corrective action plan (CAP) that included the following:

a. Policies and procedures, including internal claims audit procedures, implemented to ensure claims are paid accurately, including interest and penalties. When applicable, clean and redlined versions were to be submitted to clearly identify revisions made to policies and procedures as a result of the examination.

b. Date the policies and procedures were implemented.

c. Evidence that applicable changes were made to the Plan's claims processing system.

d. Training materials and the date(s) training was conducted to ensure claim processors are aware of and comply with the requirements of the above Sections and Rules.

e. Identification of all claims paid inaccurately, including interest and penalties, from January 29, 2021 (date of prior final report) through the date the corrective action was implemented by the Plan.

f. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in paragraph "e" above. This evidence was to include an electronic data file/schedule (Excel or Access) that identified the following:

- Claim number
- Date of service
- Date original claim received
- Date new information received
- Total billed
- Original amount paid
- Date original amount paid
- Additional amount paid as a result of remediation
- Date additional amount paid
- Amount of original interest paid
- Amount of additional interest paid as a result of remediation
- Date additional interest paid

- Penalties amount paid, if applicable
- Number of late days used to calculate interest
- Check number for interest and penalties paid
- Provider name
- ER or Non-ER indicator

The data file was to provide the details of all claims remediated, including claims corrected during the course of the examination, and was to include the total number of claims, total original claim payments, additional claim payments, and the total additional interest and penalties paid as a result of remediation.

g. Management position(s) responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

The Plan was required to provide a response to the Department within 45 days of receipt of the Preliminary Report. If the Plan was not able to complete the CAP or portions of the CAP within 45 days, the Plan was required to submit a timeline with its response that committed the Plan to complete the CAP within 90 calendar days of receipt of the Preliminary Report. If the Plan was not able to meet this timeframe, it was required to provide a justification for the delay and request approval by the Department for the proposed timeline for completion of the CAP. The Plan was also required to submit monthly status reports to the Department until the CAP was completed.

The Plan responded that it acknowledges the overall accuracy of the finding related to provider dispute sample numbers 2, 4, 5, 9, 11, 13, 32, 39, 41, and 55.

In reviewing the prior CAP against the current findings, Claims Operations identified that the training curriculum did not have enough specificity and scenarios to ensure the examiners can identify the multiple scenarios they may encounter while processing PDRs. Additionally, based on the audit findings, the Claims Operations team believes multiple refresher trainings on interest start date determination throughout the calendar year will close any potential knowledge gaps.

Therefore, the Plan updated its interest training materials to provide additional scenarios for appropriate interest start date selection and interest calculations. This will provide the examiner additional context and scenarios to appropriately select the correct interest start date during the adjudication process. Also, beginning with the first quarter of 2023, the Plan will require training on a quarterly basis for all examiners, supervisors, and managers.

With respect to denials surrounding lack of authorizations from delegated Physician Provider Groups (PPGs) submitted to the Plan for adjudication purposes, the Claims Operations team will coordinate with the Medical Management team to obtain a disposition of any missing authorizations from the PPG before finalizing the claim to avoid incorrect denials.

Additional actions taken by Claims Operations in fourth quarter of 2022, was the review of claims that had $500 of potential interest underpayment or overpayment. Other established safeguards already in place include, but are not limited to, potential denial and reject reviews, random and focused audits and internal audit activities. In those scenarios where a correction is needed, the information is shared with the individual associate for educational and training purposes.

The Claims Operations team will continue to perform monthly audits against the various Departmental audit elements and will report out quarterly. Going forward, Claims Operations will perform 10 individual monthly audits for each examiner who has an error identified through the monthly audit review process, regardless of error type (interest, keying, failure to adjust, etc.) The audits will continue for the individual examiner until the examiner can demonstrate proficiency surrounding interest start date selection and calculations. The examiner will remain on audit until they have demonstrated 100% accuracy for three consecutive months.

The Plan also recognizes the opportunity to minimize manual interest errors through automation opportunities. The Plan's corporate parent started reviewing potential system enhancements and will be providing periodic updates to the Plan on the feasibility of any future automation.

The Claims Operations team will review the respective audit results and report to the Plan's executive leadership monthly. Should other trends be identified, modifications to the CAP will be made and shared accordingly with the Plan's executive leadership.

The Plan provided the following documents to the Department:

- *"DMHC Requirements and Compliance Standards" policy, implemented on May 11, 2006 and last revised on October 5, 2022.*
- *"DMHC Quarterly Claims and PDR Audit Pull" policy implemented on February 20, 2023 to reflect specific examiner focus audits that will continue until the examiner meets compliance for 3 consecutive months.*
- *PDR, High Dollar, Late Pay monthly audit templates, implemented on February 1, 2023.*
- *Updated interest training materials and attestation for training held in March 2023. Claims processors will be required to review the interest training materials and have interest training on a quarterly basis, beginning with the first quarter of 2023.*
- *"Supervisor PDR Audit Log and Reporting" policy implemented on March 13, 2023 to reflect singular focus audits for examiners who have received one or more audit errors.*

- *"Signature Authority for Interest Payments" policy for high dollar claims implemented on February 3, 2005 and revised on February 22, 2023.*

The Plan reviewed and remediated claims where errors related to the audit findings were identified. The Plan found that all errors were human in nature and there was no systemic issue requiring modification. It was identified that one individual accounted for five out of the nine errors. The Plan is in process of reviewing 2,012 adjustments performed by this individual from January 29, 2021 through January 31, 2022. The review will be completed by April 30, 2023 and evidence of remediation will be provided by May 15, 2023.

The individual singular errors are being addressed as educational opportunities.

Vice President of Claims Operations, the Claims Department Management teams, and Plan's Senior Vice President of Operations will be responsible for overseeing the CAP.

The Department finds that the Plan's compliance efforts are not fully responsive to the corrective action required since the Plan did not complete the remediation required by the Department.

The Department approves the Plan's proposed date of May 15, 2023, for submission of the final claims remediation.

The Plan is required to submit monthly status reports to the Department until the CAP is completed.