ANTHONY MANZANETTI
Deputy Director | Chief Counsel, Bar No. 119384
CAROL L. VENTURA
Assistant Chief Counsel, Bar No. 99570
HEIDI L. LEHRMAN
Senior Counsel, Bar No. 210062
CALIFORNIA DEPARTMENT OF
MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814-2725
916-323-0435 -Phone
916-323-0438 -Fax

FILED
APR 24, 2013
DEPARTMENT OF MANAGED HEALTH CARE
By Susan Ball
Filing Clerk

BEFORE THE DEPARTMENT OF MANAGED HEALTH CARE

OF THE STATE OF CALIFORNIA

IN THE MATTER OF: Blue Cross of California, Respondent.	Enforcement Matter No.: 11-542 **SETTLEMENT AGREEMENT AND ORDER**

This Settlement Agreement is made by and between BLUE CROSS OF CALIFORNIA, also known as ANTHEM BLUE CROSS (hereafter the "Plan"), and the DEPARTMENT OF MANAGED HEALTH CARE (hereafter "Department"), with regard to the Routine Examination of Blue Cross of California's Claims Settlement Practice and Provider Dispute Resolution mechanism by the Department and subsequent Order of the Director dated January 12, 2012.

I. VIOLATIONS.

The Plan acknowledged the following language, verbatim, in signed acknowledgements dated July 19, 2010, and October 6, 2010:

A. Claim Payment Accuracy

In an acknowledgement dated October 6, 2010, the Plan acknowledged the following:

Blue Cross of California (the "Plan") acknowledges that it has certain deficiencies in its claims payment procedures, operations, and related finalization processes which have resulted in the Plan incorrectly denying and incorrectly paying on a number of claims as described below. The Plan has requested that the Department of Managed Health Care ("the Department") discontinue its testing on late ISG and WGS claims, denied WGS claims, and non-contracted emergency ISG claims in light of the Plan's acknowledgement of these deficiencies and the Plan acknowledges that the Department agreed to do so in reliance upon this document. The Plan further acknowledges its commitment to correcting these deficiencies in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.

The Plan acknowledges that these deficiencies have resulted in its violations of Health and Safety Code sections 1371, 1371.35, 1371.37 and 1371.8; and California Code of Regulations, Title 28, sections 1300.71(a)(8), 1300.71(i) and 1300.71(j). For purposes of assessing a penalty for these violations, the Plan agrees that there was a deficiency rate of 24 percent found in the sample of 25 late WGS claims, 8 percent found in the sample of 25 late ISG claims, 6 percent found in the sample of 50 denied WGS claims, and 8 percent found in the sample of 50 non-contracted emergency ISG claims that are evidence of the percentages of deficiencies present in the entire universe of late claims, denied WGS claims, and non-contracted emergency ISG claims that were manually adjudicated during the time frame defined by the Department's examination, specifically July 1, 2008, to September 30, 2008.

B. Date of Receipt

In an acknowledgement dated October 6, 2010, the Plan acknowledged the following:

The Plan acknowledges that it had certain deficiencies in its claims payment procedures, operations, and related finalization processes which have resulted in the recording of incorrect dates of receipt on a number of emergency claims as described below. The Plan has requested

that the Department discontinue its testing on emergency claims in light of the Plan's acknowledgement of this deficiency and the Plan acknowledges that the Department agreed to do so in reliance upon this document. The Plan further acknowledges its commitment to correcting this deficiency in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.

The Plan acknowledges that this deficiency resulted in its violations of California Code of Regulations, Title 28, section 1300.71(a)(6). For purposes of assessing a penalty for this violation, the Plan agrees that the deficiency rates of 50 percent found in the sample of 50 emergency ISG claims, 18 percent found in the sample of 50 non-contracted emergency ISG claims, 20 percent found in the sample of 50 non-contracted emergency WGS claims, and 12 percent found in the sample of 50 emergency WGS claims are conclusive evidence of the percentages of deficiencies present in the entire universe of emergency ISG claims and emergency WGS claims received between 2:01 pm and 11:59 pm Pacific Standard time and adjudicated during the time frame defined by the Department's examination, specifically July 1, 2008, through September 30, 2008.

C. Accurate Written Explanation

In an acknowledgement dated October 6, 2010, the Plan acknowledged the following:

The Plan acknowledges that it has deficiencies in its claims payment procedures, operations and related finalization processes which have resulted in the lack of accurate or complete written explanation of denial for a number of denied WGS claims. The Plan has requested that the Department discontinue its review of denied WGS claims in light of the Plan's acknowledgement of these deficiencies and the Plan acknowledges that the Department agreed to do so in reliance upon this document. The Plan further acknowledges its commitment to correcting this deficiency in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.

The Plan acknowledges that this deficiency has resulted in its violation of California Code of Regulations, Title 28, sections 1300.71(a)(8)(F) and 1300.71(d)(1). For purposes of assessing a penalty for this violation, the Plan agreed that the deficiency rates of 10 percent found in the sample of 50 denied WGS claims is conclusive evidence of the percentages of deficiency present in the entire universe of misdirected claims mailed back to the medical group for processing and adjudication during the time frame defined by the Department's examination, specifically July 1, 2008, through September 30, 2008.

D. Provider Disputes

In an acknowledgement dated July 19, 2010, the Plan acknowledged the following:

The Plan acknowledges that it has deficiencies in its provider dispute resolution procedures, operations and related finalization processes which have resulted in untimely processing of provider disputes, inaccurate or incomplete written determination letters of pertinent fact(s), untimely acknowledgement of the disputes; requests for additional information that was unnecessary or the plan had the information on an unacceptable number of provider disputes. The Plan has requested that the Department discontinue its testing of provider disputes in light of the Plan's acknowledgment of these deficiencies in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.

The Plan acknowledges that these deficiencies have resulted in its violations of California Code of Regulations, title 28, section 1300.71.38. For purposes of assessing a penalty for these violations, the Plan agrees that the deficiency rates of 14 percent for untimely processing of provider disputes: 6 percent for inaccurate or incomplete determination letters; 10 percent for untimely acknowledgement of provider disputes; and 8 percent for requesting unnecessary information found in the sample of 50 provider disputes constituted conclusive evidence of the percentage of deficiencies present in the entire universe of provider disputes adjudicated during

the time frame defined by the Department's examination, specifically July 1, 2008, through September 30, 2008.

II. CORRECTIVE ACTION and REMEDIATION

SECTION A. Corrective Action: The Plan shall, no later than 90 days from the date this agreement is executed, submit a Corrective Action Plan ("CAP"), as follows:

1. With regard to the violations of Health and Safety Code sections 1371, 1371.35, and 1371.37, subdivision (a) and (c)(4), and California Code of Regulations, title 28, sections 1300.71 and 1300.71.38, subdivision (g), reported in section I.A.5 of the Final Report, the CAP must include the following:

   a. Training procedures to ensure that claim processors have been properly trained on interest and penalty requirements regarding additional payments resulting from provider disputes due to incorrect payment of the initial claim,

   b. Audit procedures to ensure that the Plan is monitoring correct payment of interest and penalties on late adjusted claim payments resulting from provider disputes.

   c. Revised policies and procedures implemented to ensure that payments of late adjusted claims resulting from provider disputes include interest and penalty, if applicable, in compliance with the above statutes and regulations, and

   d. Date the revised policies and procedures were implemented, the management position(s) responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

2. With regard to the violations of California Code of Regulations, title 28, section 1300.71, subdivision (a)(8)(K), reported in section I.B.6 of the Final Report, the CAP must include the following:

   a. Evidence that correct payments were made to the providers associated with the claims identified in the Final Report on page 17, including interest and penalties, as appropriate,

   b. Revised policies and procedures implemented to ensure that reworks are routinely performed for a provider when manual processing errors are identified, and

c. Date the revised policies and procedures were implemented, the management position(s) responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

3. With regard to the violations of Health and Safety Code section 1371 and California Code of Regulations, title 28, section 1300.71, subdivision (j),(a)(8)(K), and (g)(1), reported in section I.C.1 of the Final Report, the CAP shall include, for each claim system (ISG and WGS), the following:

a. Training procedures to ensure that claim processors have been properly trained on interest and penalty requirements,

b. Audit procedures to ensure that the Plan is monitoring correct payment of interest and penalties on late and late adjusted claims payments,

c. Revised policies and procedures implemented to ensure that payments of late adjusted claims include interest and penalty, if applicable, in compliance with the above statute and regulation, and

d. Date the revised policies and procedures were implemented, the management position(s) responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

4. With regard to the violations of Health and Safety Code section 1371.35 and California Code of Regulations, title 28, section 1300.71, subdivision (i) and (a)(8)(K), reported in section I.C.2 of the Final Report, the CAP shall include the following:

a. Revised policy and procedures for ensuring that non-contracted emergency claims are paid correctly, and

b. Date revised policy and procedures were implemented, the management position(s) responsible for compliance, and the controls implemented for monitoring continued compliance.

5. With regard to the violations of California Code of Regulations, title 28, section 1300.71, subdivision (d) and (a)(8)(K), reported in section I.C.3 of the Final Report, the CAP shall include the following:

a. Policies and procedures implemented to ensure that claims are paid in compliance with the above regulation, and

b. Date the policies and procedures were implemented, the management position(s) responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

6. With regard to the violations of California Code of Regulations, title 28, section 1300.71, subdivision (d) and (a)(8)(K), reported in section I.C.4 of the Final Report, the CAP shall include the following:

a. Revised policy and procedures for ensuring that the providers of denied claims are given a clear and accurate denial reason, and

b. Date revised policy and procedures were implemented, the management position(s) responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure continued compliance.

7. With regard to the violations of California Code of Regulations, title 28, section 1300.71, subdivision(d) and (a)(8)(K), reported in section I.D.2 of the Final Report, the CAP shall include the following:

a. Evidence that correct payments were made to the providers associated with the claims identified in the Final Report on page 33 including interest and penalties, as appropriate,

b. Revised policies and procedures implemented to ensure that reworks are routinely performed for a provider when manual processing errors are found, and

c. Date the revised policies and procedures were implemented, the management position(s) responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

SECTION B. Remediation: For purposes of remediation the following terms are used:

1. A "Late Paid Claim" is defined as:

A claim that was reimbursed more than 64 calendar days for all HMO product types, including, without limitation Medi-Cal claims ("HMO") or 43 calendar days for all other claims ("non-HMO") from the date of receipt of a complete claim.

2. "Interest Paid" is defined as:

The total interest and penalty paid which appear as one total on the Plan's claims system.

3. The "date of receipt of a complete claim" is defined as:

The date when all the information necessary to process a claim is received by the Plan. The date of receipt entered on the Plan's claims system will be presumed accurate.

4. The "Claims Resolution Period" is defined as:

The period July 1, 2007, through April 30, 2011.

5. The Plan shall, no later than 120 days from the date this agreement is executed:

A. For the Claims Resolution Period, the Plan will carry out the following methodology systematically and without manual adjudication:

1. Days to Pay the Claim:

For each claim payment processing event (which shall be defined as both original claim processing and adjustment processing in which the Plan issues a payment, the Plan will calculate the number of "Days to Pay the Claim." This calculation will be performed by subtracting the date of receipt from the mail date of payment on the claim (which shall be the completion date of the claim from the Plan's claims system plus three (3) days for claims for services performed in California and five (5) days for claims for services performed outside of California). For purposes of this calculation, ITS Host Paid Home Claims will not be counted. ITS Host Paid Home Claims are defined to mean those claims for which: (1) services were provided to a member in a state other than California; (2) the Blue Cross or Blue Shield plan in such state was the payor on the claim on behalf of the Plan; and (3) the Plan reimbursed the payor on the claim.

2. Late Days:

The Plan will determine the number of "Late Days" on each claim processing event by subtracting 64 calendar days for HMO claims, or 43 calendar days for non-HMO claims from the total number of days calculated pursuant to the Days to Pay the Claim calculations.

3. Interest Owed:

The Plan will determine the Interest Owed on each of the Late Paid Claims by multiplying the number of Late Days by the amount paid on the claim for services rendered for each claim event by the interest rate of:

a. Fifteen percent (15%) per annum; or

b. If an emergency claim, the greater of fifteen dollars ($15) for each 12-month period or portion thereof on a non-prorated basis or the interest rate of fifteen percent (15%) per annum.

4. Remediation Amount:

The Plan will determine the Remediation Amount as follows: The Plan will subtract the Interest Paid on the claim event from the calculated Interest Owed for the claim event. Any resulting negative difference equals the amount of an Overpayment. Any resulting positive difference equals the Underpayment Amount. A $10 late payment penalty will be added to each Underpayment Amount. This new amount will be the Total Underpayment Amount. For purposes of this section, any Overpayments may be offset against any Underpayments for the same provider only. The Remediation Amount for each provider shall be the total amount of the Total Underpayments minus the total amount of the Overpayments.

B. Data Fields: The data fields needed to audit this automated calculation of interest and penalties are defined in Exhibit A. These fields will be provided in an electronic format (text delimited or Excel format) for all claim events in which the recalculated interest owed does not match the previously paid interest amount.

C. The Plan will provide reporting data that includes the date of the original claim payment so that data can be segregated by year and by quarter within each year, in addition to providing a summary for all time periods.

D. The Plan will report compliance with this Section B as set forth in Exhibit A.

III. TERMS

A. Performance of the corrective actions and remediation agreed to and in a manner described by this Settlement Agreement as set forth in Paragraph II, above, will release the Plan and its affiliates, successors and assigns from any further allegations, accusation or other regulatory action based on a claim of violation of any finding as stated in the Final Report dated April 12, 2011, with the

1 exception of seeking and/or compelling payment, including without limitation, by administrative and/or
2 judicial means, from the Plan of the suspended penalty amount referenced in the Letter of Agreement
3 dated November 29, 2010, for Enforcement Matter Numbers 10-002 and/or 10-642. Performance of the
4 corrective actions and remediation as set forth herein will conclude and settle the deficiencies
5 encompassed within the scope of the Claims Resolution Period and the Department may not pursue any
6 other action against the Plan for any claims processed within the Claims Resolution Period, with the
7 exception of seeking and/or compelling payment, including without limitation, by administrative and/or
8 judicial means, from the Plan of the suspended penalty amount referenced in the Letter of Agreement
9 dated November 29, 2010, for Enforcement Matter Numbers 10-002 and/or 10-642. The parties
10 understand and agree that, except as herein described, nothing in this Agreement limits or in any way
11 affects the Department's right and authority under Health and Safety Code sections 1386 and 1387, and
12 regulations 28 C.C.R. sections 1300.86 and 1300.87.

13 B. Binding Effect. The terms set forth herein shall be binding on the Plan and its respective
14 successors and permitted assigns and on the Department. The parties agree that the terms of this
15 Agreement are more than a mere contract and that they are additionally an order of the Director, and the
16 Department may exercise any and all aspects of its enforcement authority to enforce the Plan's
17 compliance with any and/or all of the Plan's obligations under this Agreement, and that any remedy
18 available to the Director is not exclusive, and may be sought and employed in any combination with
19 civil, criminal, and other administrative remedies deemed warranted by the Director to enforce this
20 Agreement. If the Plan fails to fulfill its obligations to the Department as provided under the terms set
21 forth herein, the Plan stipulates and agrees that the Department shall have the authority to enforce the
22 provisions of this Agreement in the Superior Court of California for the County of Sacramento.

23 C. Assignment. No term set forth herein may be assigned by the Plan in whole or part
24 without the prior written consent of the Department.

25 D. Amendment. This Agreement may not be altered, amended, or otherwise changed or
26 modified, except in writing signed by both of the parties.

27 E. Good Faith. The parties understand and agree that this Settlement Agreement represents
28 their good faith efforts to resolve difficult issues.

F. No Inducement. The parties declare and represent that no promises, inducements, or other agreements not expressly contained herein have been made and that this release contains the entire agreement between the parties and the terms of this Settlement Agreement are contractual and not recitals only.

G. Authority of Signatories. All parties covenant that they possess the necessary capacity and authority to sign and enter into this Settlement Agreement.

H. Further Documents. The parties agree to execute and deliver such other additional documents as reasonably may be required to effectuate each of the terms of this Settlement Agreement.

I. Advice of Attorney. Each party warrants and represents that, in executing this Settlement Agreement, they have relied upon legal advice from the attorney of their choice; that the terms of this Settlement Agreement have been read, and its consequences (including, but not limited to, risks, complications, and costs) have been completely explained to them by that attorney; that adequate time has been given for them to consult with their attorney, to ask any questions concerning this Settlement Agreement, to receive responses to those questions, and to contemplate the attorney's advice concerning this Settlement Agreement; and that the parties fully understand the terms of this Settlement Agreement. The parties to this Settlement Agreement acknowledge, warrant, and represent that, in executing this Settlement Agreement, they have not relied on any inducements, promises, or representations made by any other party to this Settlement Agreement or any person or entity representing or serving another party, except for those expressly stated in this Settlement Agreement.

J. Integration. This Agreement is the complete, final and exclusive statement of the terms of the Agreement and supersedes prior or contemporaneous negotiations, representations, statements, writings, and/or agreements (with the exclusive exception being the Letter of Agreement dated November 29, 2010, for Enforcement Matter Numbers 10-002 and/or 10-642), whether written or oral, which relate to the subject matter of this Agreement.

K. Attorneys' Fees Arising Out of This Settlement Agreement. If any party to this Settlement Agreement becomes involved in a dispute or controversy, including, but not limited to, arbitration or litigation, arising out of this Settlement Agreement, or the performance of it, then the prevailing party in such dispute or controversy, or in a separate suit, shall be entitled to its reasonable

costs and expenses incurred in connection with such dispute or controversy, including expert witness fees and attorneys' fees. The parties agree that the prevailing party shall recover the reasonable amount of all such expenses and fees incurred.

L. Enforceable Settlement Agreement. The parties specifically entered into this Settlement Agreement with the understanding that it is enforceable by either party to the fullest extent under the laws of the State of California. In the event any party fails to perform the conditions or terms required therein, any court may enforce the terms of this Settlement Agreement.

M. Construction. As used in this Settlement Agreement, the masculine, feminine, or neuter gender, the singular or plural numbers, and the conjunctive or disjunctive shall each be deemed to include the other whenever the context so indicates. This Settlement Agreement shall be construed in accordance with its fair meaning, the captions being for the convenience of the parties only and not intended to describe or define the provisions in the portions of the Settlement Agreement to which they pertain. The parties have freely negotiated the terms of this Settlement Agreement, and this Settlement Agreement shall not be construed against the drafter, as these drafting services have been performed as a courtesy to the other parties to this Settlement Agreement. In the event that any provision of this Settlement Agreement is held to be ineffective or invalid, the remaining provisions will nevertheless be given full force and effect.

N. Counterparts. For the convenience of the parties, this document may be executed in counterparts, which shall together constitute the agreement of the parties. If an original signature is affixed by a party to a counterpart of this Agreement and a facsimile, or copy, of such originally executed counterpart signature is thereafter sent to a party or a party's attorneys of record, the facsimile, or copy, shall be afforded the same validity as the originally executed counterpart, and may be relied upon by all parties for any and all purposes relating to this Agreement.

\\\

\\\

\\\

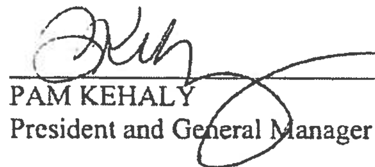
O. Effective Date of Agreement. This Settlement Agreement shall take effect immediately upon execution by the Director of the Department of Managed Health Care.

IT IS SO AGREED:

The parties hereby execute this Settlement Agreement by the signatures of their respective duly authorized agents. This Agreement is also, on the signature of Brent Barnhart an Order of the Department of Managed Health Care, effective the date shown immediately next to the signature of Brent Barnhart, and contemporaneously operates to lift and terminate the Order of the Director dated January 12, 2012.

Dated: April _____, 2013

ANTHEM BLUE CROSS

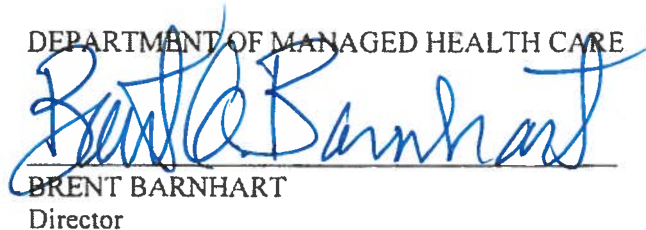


PAM KEHALY
President and General Manager

IT IS SO AGREED AND ORDERED:

Dated: April 24, 2013

DEPARTMENT OF MANAGED HEALTH CARE



BRENT BARNHART
Director

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

Exhibit A

Compliance Report for Remediation

The documentation for the Plan shall include:

1) A claim event detail level electronic data file (in text delimited or Excel format) that provides the following data fields for all claim events where the recalculated interest amount was different from the original interest payment. This documentation is to be submitted within 90 days from the date the settlement agreement is executed.

	Field Name & Description	Field Property
a.	Claim number (The value to identify a unique claim. A claim number may appear multiple times if adjusted for additional payment.)	Text
b.	Line of business (HMO and non-HMO)	Text
c.	Company Codes 200C and 210C	
d.	Indicator for ER or non-ER claims Value will be "Y" or "N*". ER indicator is "Y" when one of the following CPT or Revenue codes exists on the claim: 99281, 99282, 99283, 99284, 99285, 99288, 450, 451, 452, 453, 454, 455, 457, 458, or 459. (For ER claims, the Plan is required to pay interest at the greater of 15% or $15 per annum.)	Text
e.	Original Receipt Date (Date the claim was received the first time by the Plan)* The date entered on the Plan's claims system will be presumed accurate.	Date (YYYYMMDD)
f.	Date Additional Information Received (Date entered	Date

	by the processor that indicates when additional information was received.)* The date entered on the Plan's claims system will be presumed accurate.	(YYYYMMDD)
g.	Date of receipt for Interest Recalculation (Represents date of receipt of a complete claim – value will be either the Date Additional Information Received or Original Receipt Date)*	Date (YYYYMMDD)
h.	Original amount paid on the claim not including interest	Currency/Numeric
i.	Amount of interest originally paid	Currency/Numeric
j.	Date of Original Claim Payment (Claim Completion date plus mailing days of three (3) days when the claim is for services performed in California and five (5) days when the claim is for services performed outside of California.)	Date (YYYYMMDD)
k.	Recalculated Number of Late Days	Numeric
l.	Recalculated Interest Owed Amount	Currency/Numeric
m.	Amount of Underpayment/Overpayment (Difference between Recalculated Interest Owed Amount and the Amount of Interest originally paid)	Currency/Numeric
n.	Provider Tax ID	Text
o.	Remediation Amount (Includes the $10 late payment penalty for underpayments.)	Currency/Numeric

*For claim events where no claim dollars were paid but only claim interest dollars, these fields may be blank as they are not needed for the recalculation process.

2) A provider tax ID level summary electronic data file (in text delimited or Excel format) that provides the following data fields for all claim events where the recalculated interest amount was not the same

as the original interest payment. This documentation is to be submitted within 90 days from the date the settlement agreement is executed.

	Field Name & Description	Field Property
a.	Provider Tax ID	Text
b.	Count of Underpaid Interest Claim Events	Numeric
c.	Total Underpaid Interest Dollar Amount	Currency/Numeric
d.	Count of Overpaid Interest Claim Events	Numeric
e.	Total Overpaid Interest Dollar Amount	Currency/Numeric
f.	Total Provider Remediation Amount	Currency/Numeric

3) A provider tax ID level summary (in text delimited or Excel format) that provides the remediation payment information. This information will be provided to the Department subsequent to the provision of the reporting data in (1) and (2) above. This documentation is to be submitted within 120 days from the date the settlement agreement is executed.

	Field Name & Description	Field Property
a.	Provider Tax ID	Text
b.	Check Date of Remediation Payment	YYYYMMDD
c.	Check Number of Remediation Payment	Numeric
d.	Amount of Remediation Payment per check	Currency/Numeric
e.	Provider Name	Text

4) A sample of the notation or explanation that contains a clear explanation of the remediation payment and will be included with the remediation payment to each provider.

~~o0o~~