No. S274927

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

COUNTY OF SANTA CLARA,

Petitioner,

v.

THE SUPERIOR COURT OF SANTA CLARA,

Respondent,

DOCTORS MEDICAL CENTER OF MODESTO, et al.

Real Parties in Interest.

After a Decision by the Court of Appeal,
Sixth Appellate District
Case No. H048486

REQUEST FOR JUDICIAL NOTICE; DECLARATION OF SUSAN P. GREENBERG; [PROPOSED] ORDER

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COUNTY OF SANTA CLARA

MOTION AND NOTICE OF MOTION

The County of Santa Clara (the County) respectfully moves for judicial notice of the documents identified below pursuant to California Rules of Court 8.252(a), 8.520(g), and 8.630(h). These documents are judicially noticeable under Evidence Code sections 452 and 459 and are relevant in responding to contentions made in the Opening Brief. The Motion is based on the attached Memorandum of Points and Authorities and Declaration of Susan P. Greenberg.

The County seeks judicial notice of the following documents:

Exhibit A – Governor's Executive Order No. S-13-06 (July 25, 2006) (included in the record, Appendix of Exhibits in Support of Petition for Writ of Mandate (App.) 19–20).

Exhibit B – Consent Agreement, In the Matter of Health Net of California, Inc., Department of Managed Health Care (DMHC), No. 04-300 (App. 693–700).

Exhibit C – California Department of Managed Health Care, Health Care Service Plans' Provider Dispute Resolution Mechanisms, 2017 Annual Report (App. 675–691).

Exhibit D – California Department of Managed Health Care 2020 Annual Report (attached).

Exhibit E – California Department of Managed Health Care 2021 Annual Report (attached).

Exhibit F – Letter Brief, *Bell v. Blue Cross of California*, 2005 WL 2236533 (Cal.App. 2 Dist. Jul. 8, 2005) (attached).

Exhibit G – Respondents' Hearing Brief in Opposition to Petitioners' Writ of Mandate, *California Medical Assn. v. DMHC*, 2008 WL 5818770 (Cal. Superior Nov. 7, 2008) (attached).

Exhibit H – California Department of Managed Health Care Notice of Rulemaking Action (Mar. 11, 2015) (attached).

Exhibit I –Summary Individual Disclosure Report for Doctors Medical Center of Modesto for the period of January 1 through December 31, 2016 (attached).

Exhibit J – Summary Individual Disclosure Report for Doctors Medical Center of Modesto for the period of January 1 through December 31, 2017 (attached).

Exhibit K – Summary Individual Disclosure Report for Doctors Hospital of Manteca for the period of January 1 through December 31, 2016 (attached).

Exhibit L – Summary Individual Disclosure Report for Doctors Hospital of Manteca for the period of January 1 through December 31, 2017 (attached).

DATED: December 12, 2022

Respectfully submitted,

JAMES R. WILLIAMS
County Counsel

DocuSigned by:
Susan Greenberg
F6B0E7284644468...

By: _____
SUSAN P. GREENBERG
Deputy County Counsel

Attorneys for Petitioner
COUNTY OF SANTA CLARA

MEMORANDUM OF POINTS AND AUTHORITIES

INTRODUCTION

Pursuant to California Rules of Court 8.252(a), 8.520(g), and 8.630(h) and California Evidence Code sections 452 and 459, Petitioner the County of Santa Clara (the County) requests that this Court take judicial notice of documents published on websites operated by the State of California, as well as legal briefs filed by the California Department of Managed Health Care (DMHC). These documents are relevant in assessing various new contentions, and expanded or revised public policy arguments, made by the Real Parties in Interest Doctors Medical Center of Modesto and Doctors Hospital of Manteca (Plaintiffs) in the Opening Brief, should the Court consider those arguments by Plaintiffs.

The Court may take judicial notice of each of these documents as official acts of the California state executive branch. (Evid. Code, § 452, subd. (c).) In addition, these materials are either published on official state websites or, in the case of the attached legal briefs (Exhibits E and F), available from court records and published on Westlaw. Thus, the proposition that the documents are published as the stated positions of DMHC or the Governor, or information reported by Plaintiffs to a state agency (Exhibits E–L), is "not reasonably subject to dispute and . . . capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy." (Evid. Code, § 452, subd. (h).)

This Court may, moreover, take judicial notice of briefs filed by DMHC as records from state court proceedings. (Evid. Code § 452, subd. (d).) Exhibit B, a DMHC consent agreement, may also be judicially noticed as a "legally operative" contract. (See, e.g., *Scott v. JPMorgan Chase Bank, N.A.* (2013) 214 Cal.App.4th 743, 754.)

A. Executive Order and DMHC Brief Addressing Balance Billing (Exhibits A and G)

In the Opening Brief on the Merits, Plaintiffs argue that the Court of Appeal's immunity ruling would "eliminate a key justification for the ban on balance billing." (Opening Brief (OB) at 41.)[1] This is a new argument that is, the County respectfully submits, more appropriately directed to the Legislature. But to the extent that Plaintiffs' new argument is considered, the County asks that this Court take judicial notice of two documents relevant in assessing Plaintiffs' argument.

Exhibit A is relevant in demonstrating that, contrary to Plaintiffs' new contention to this Court, the rationale for the prohibition against balance billing does not depend on an assumption that public entities operating health care plans can be sued for civil damages by providers. Rather, the prohibition originates in grave health policy concerns about the impact of balance billing on patients and, to the extent relevant, was also supported by the Governor's explicit expectation that provider concerns

[1] Balance billing is a prohibited billing practice defined and addressed in Section I(B) of the County's Answering Brief on the Merits (AB).

about reimbursement rates would be effectively resolved through mechanisms *other* than litigation—i.e., DMHC response to complaints via the Provider Complaint Unit and an independent dispute resolution process (IDRP) developed by DMHC.

Exhibit A is publicly available at <https://www.library.ca.gov/wp-content/uploads/GovernmentPublications/executive-order-proclamation/3382-3383.pdf> [as of December 12, 2022]. The Court may take judicial notice of Exhibit A as an official act of the California state executive branch. (Evid. Code, § 452, subd. (c).)

The County sought judicial notice of Exhibit A in the Superior Court, but for a different reason. When this litigation began, Plaintiffs did not acknowledge that balance billing was prohibited but, rather, asserted tort claims against the County for allegedly interfering with the Plaintiffs' ability to balance bill patients. (App. 476–77, 492–94.) The County asked the Court to take judicial notice of the Executive Order in seeking dismissal of these common law claims, as the document was relevant in demonstrating that the County had no common law duty not to interfere with Plaintiffs' ability to balance bill VHP enrollees. Ultimately, the Superior Court did not take judicial notice of the Executive Order because the Court determined that dismissal was proper because the County was immune from liability for these tort claims (a ruling not challenged by Plaintiffs on appeal). (App. 513–14.)

Exhibit G, a legal brief filed by DMHC in litigation challenging the validity of a regulation prohibiting balance billing, provides additional information regarding the numerous public policy concerns prompting the prohibition against balance billing and the State's staunch opposition to the practice—points relevant to assessing Plaintiffs' new argument about balance billing. The County did not seek judicial notice of this document in the trial court.

Exhibit G also provides background regarding DMHC's regulatory and enforcement roles relevant in evaluating Plaintiffs' other predictive assertions concerning the potential consequence of the Court of Appeal's ruling, including Plaintiffs' contention that the requirements of the Knox-Keene Act would purportedly have no force if Plaintiffs cannot sue public entities for damages via civil litigation. (E.g., OB 39.) This Court may take judicial notice of any records from state court proceedings. (Evid. Code, § 452, subd. (d).)

B. Other Documents Addressing DMHC Oversight and Enforcement (Exhibits B through E)

Exhibits B through E provide additional relevant information regarding DMHC oversight and enforcement over health plans' treatment of payment disputes. Plaintiffs contend that absent reversal of the Court of Appeal's ruling, the County would have "carte blanche" to systematically underpay providers for emergency services provided to plan enrollees. (OB

39.) As explained in the County's Answer Brief on the Merits (section I(C)), however, the County is required to pay providers a "reasonable and customary" rate pursuant to Health and Safety Code section 1371.4 and DMHC regulations—a requirement subject to enforcement by DMHC. Any quarrels with the Legislature's chosen mode of enforcement do not supply a basis for recognizing a new statutory cause of action for damages against public entities, where the Legislature afforded none. But to the extent that the Court considers Plaintiffs' contentions, the County asks the Court to take judicial notice of these documents relevant in assessing Plaintiffs' contention.

Exhibits B and C: Exhibit B is a consent agreement between DMHC and a health plan, which states that DMHC found that the plan was not utilizing a compliant reimbursement rate methodology and provides that the plan will reopen claims and provide additional reimbursement. (App. 693–95.) Exhibit B is publicly available at <https://wpso.dmhc.ca.gov/enfactions/docs/346/1208359079064.pdf> [as of December 12, 2022].

Exhibit C is a DMHC report to the Legislature reflecting the agency's oversight over provider dispute resolutions. Exhibit C is publicly available at <https://www.dmhc.ca.gov/Portals/0/Docs/DO/2017DRM.PDF> [as of December 12, 2022].

The County sought judicial notice of Exhibits B and C in the Superior Court, but the Court denied the request because it found the scope of DMHC's enforcement authority to be irrelevant (App. 730)—reasoning that was not adopted by the Court of Appeal in reversing. The Court may take judicial notice of both the reports and the consent agreement as official acts of the California state executive branch. (Evid. Code, § 452, subd. (c); *Gong v. City of Rosemead* (2014) 226 Cal.App.4th 363, 376 [taking judicial notice under Evid. Code, § 452, subd. (c) of government entity records]; see also *Scott v. JPMorgan Chase Bank, N.A.*, *supra*, 214 Cal.App.4th at pp. 752–753 ["official acts" is to be construed expansively].) Their publication on state websites purporting to describe agency activities is, moreover, "not reasonably subject to dispute and . . . capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy." (Evid. Code, § 452, subd. (h).)

In addition, courts routinely take judicial notice of the "legally operative" effects of government contracts, such as the consent agreement. (See, e.g., *Scott v. JPMorgan Chase Bank, N.A.*, *supra*, 214 Cal.App.4th at p. 754, citing *Fontenot v. Wells Fargo Bank, N.A.* (2011) 198 Cal.App.4th 256, 265 ["Where, as here, judicial notice is requested of a legally operative document—like a contract—the court may take notice not only of the fact of the document and its recording or publication, but also facts that clearly derive from its legal effect."].)

Exhibits D and E: Exhibits D and E, DMHC Annual Reports for 2020 and 2021, are relevant in responding to Plaintiffs' contention, not advanced in the Superior Court or the Court of Appeal, that DMHC does not report to the Legislature regarding claims payment disputes for "county-operated health plans." (OB 14.) Exhibits D and E each contain charts at the end of the document which detail various aspects of plans' response to disputes and claims, which include VHP among other county-operated plans.

Exhibits D and E also provide additional background regarding DMHC's Provider Complaint Unit and IDRP, including explaining that these are available for both individual complaints and disputes over multiple claims, and cover disputes over both emergency and non-emergency services. (E.g., Ex. D, at p. 17; Ex. D, at p. 8.)

Exhibits D and E are publicly available at <https://www.dmhc.ca.gov/Portals/0/Docs/DO/2020ARAccessible.pdf> [as of December 12, 2022] and <https://www.dmhc.ca.gov/Portals/0/Docs/DO/2021ARFinalAccessible.pdf > [as of December 12, 2022]. They are official state records; and their authenticity, and publication by DMHC via an official state website, are not reasonably subject to dispute, and therefore these exhibits are judicially noticeable. (Evid. Code, § 452, subds. (c) and (h).). The County did not seek judicial notice of these documents in the Superior Court but, as noted

above, the Superior Court in any event denied the County's other requests for judicial notice of documents reflecting DMHC oversight and enforcement.

C. DMHC Amicus Letter Brief in *Bell v. Blue Cross* (Exhibit F)

Plaintiffs cite to an amicus brief submitted by DMHC in *Bell v. Blue Cross of California* (2005) 131 Cal.App.4th 211, albeit without making a formal request for judicial notice, to argue that DMHC supports providers' right to bring civil litigation against health plans over reimbursement disputes. (OB 21.) The County asks this Court to take judicial notice of an additional amicus letter brief submitted by DMHC in that case, to provide a fuller picture of the Agency's concerns and views. As reflected in Exhibit F, DMHC asserted that providers could sue plans under a common law, quantum meruit theory or under the Unfair Competition Law and noted that the same remedies might not lie against public entities. (Ex. F, at pp. 2–3, 5.)

This Court may take judicial notice of briefs filed by DMHC as records from state court proceedings. (Evid. Code, § 452, subd. (d).) Moreover, the Court may take judicial notice of each of these documents as official acts of the California state executive branch. (Evid. Code, § 452, subd. (c).)

D. DMHC Denial of Request for Rulemaking (Exhibit H)

Plaintiffs argue for the first time to this Court that they seek to vindicate a purely statutory duty under section 1371.4 of the Knox-Keene Act (Section 1371.4) that was "unknown at common law." (OB 10.) Exhibit H is a Notice of Denial of Request for Rulemaking that addresses the relationship between Section 1371.4, its implementing regulations, and cases addressing common law claims for reimbursement. Among other points, in Exhibit H DMHC asserts that the implementing regulations set forth the minimum criteria for compliance with the reimbursement obligation and identifies non-exclusive factors which may be considered by, but do not limit, courts adjudicating common law claims for reimbursement.

E. Plaintiffs' Reported Cost-to-Charge Ratios (Exhibits I through L)

Plaintiffs also suggest for the first time to this Court that, in asserting damages claims against the County seeking reimbursement of full-billed charges, Plaintiffs merely seek to recoup their costs. (E.g., OB 15; Petn. 13 ["a claim for reimbursement seeks no more than recompense for the claimant's expenditures on the health plan's behalf"].) The data in Exhibits I through L includes Plaintiffs' reported cost-to-charge ratio (i.e., the ratio of reported costs to billed charges) for the two years relevant to the claims at issue in this case. The County asks the Court to take judicial notice of

these documents because they reflect that, according to Plaintiffs' disclosures to regulators, Plaintiffs' billed charges were about ten times their costs. The County does not offer these for the truth of the matter asserted, but rather to demonstrate that *Plaintiffs* have represented that their billed charges are approximately ten times their costs.

As explained in the accompanying declaration, Exhibits I through L are reports published on the California Department of Health Care Access and Information (HCAI) website, summarizing financial data submitted by Plaintiffs as part of required regulatory disclosures. HCAI has several divisions, including the Information Services Division from which these reports were retrieved, which collects detailed quarterly and annual financial information from California hospitals in order to help the public assess the financial status and service volume of the hospitals. (See, e.g., 22 C.C.R. §§ 97040-45.)

The Court may take judicial notice of the reports as official acts of the California state executive branch. (Evid. Code, § 452, subd. (c); *Gong v. City of Rosemead, supra,* 226 Cal.App.4th at p. 376.) Their publication on a state website purporting to summarize data submitted by Plaintiffs is, moreover, "not reasonably subject to dispute and . . . capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy." (Evid. Code, § 452, subd. (h).)

Plaintiffs did not suggest in the trial court that they sought to assert claims for costs and the County did not seek judicial notice of these materials in the trial court.

CONCLUSION

For the reasons stated above, Petitioner respectfully requests that this Court take judicial notice of Exhibits A through L.

DATED: December 12, 2022

Respectfully submitted,

JAMES R. WILLIAMS
County Counsel

By: DocuSigned by: Susan Greenberg F6B0E7284644468...
SUSAN P. GREENBERG
Deputy County Counsel

Attorneys for Petitioner
COUNTY OF SANTA CLARA

DECLARATION OF SUSAN P. GREENBERG

I, Susan P. Greenberg, declare as follows:

1. I am an attorney licensed to practice in the state of California and an attorney of record for Petitioner County of Santa Clara in this matter. I make this declaration based upon personal knowledge.

2. **Exhibit A** is a true and correct copy of California Governor's Executive Order No. S-13-06 (July 25, 2006); included in the record at Appendix of Exhibits in Support of Petition for Writ of Mandate (App.) 19-20 and publicly available at <https://www.library.ca.gov/wp-content/uploads/GovernmentPublications/executive-order-proclamation/3382-3383.pdf> [as of December 12, 2022].

3. **Exhibit B** is a true and correct copy of a Consent Agreement entered into between California Department of Managed Health Care (DMHC) and Health Net of California, Inc., in the DMHC Enforcement Matter captioned: In the Matter of Health Net of California, Inc., Department of Managed Health Care, No. 04-300; included in the record at App. 693-700 and publicly available at <https://wpso.dmhc.ca.gov/enfactions/docs/346/1208359079064.pdf [as of December 12, 2022].

4. **Exhibit C** is a true and correct copy of a DMHC report titled, Health Care Service Plans' Provider Dispute Resolution Mechanisms, 2017 Annual Report, included in the record at App. 675-91 and publicly

available at <https://www.dmhc.ca.gov/Portals/0/Docs/DO/2017DRM.PDF> [as of December 12, 2022].

5. Attached hereto as **Exhibit D** is a true and correct copy of DMHC's 2020 Annual Report, publicly available at <https://www.dmhc.ca.gov/Portals/0/Docs/DO/2020ARAccessible.pdf> [as of December 12, 2022].

6. Attached hereto as **Exhibit E** is a true and correct copy of DMHC's 2021 Annual Report, publicly available at <https://www.dmhc.ca.gov/Portals/0/Docs/DO/2021ARFinalAccessible.pdf> [as of December 12, 2022].

7. Attached hereto as **Exhibit F** is a true and correct copy of a letter brief filed by DMHC in *Bell v. Blue Cross of California*, 2005 WL 2236533 (Cal.App. 2 Dist. Jul. 8, 2005).

8. Attached hereto as **Exhibit G** is a true and correct copy of DMHC's Respondents' Hearing Brief in Opposition to Petitioners' Writ of Mandate, *California Medical Assn. v. DMHC*, 2008 WL 5818770 (Cal. Superior Nov. 7, 2008).

9. Attached hereto as **Exhibit H** is a true and correct copy of DMHC notice dated March 11, 2015, titled "Notice of Decision on Petition for Rulemaking Action." This document is publicly available at

<https://dmhc.ca.gov/Portals/0/LawsAndRegulations/PublicReports/fdcapgp032015.pdf> [as of December 12, 2022].

10. Attached hereto as **Exhibit I** is a true and correct copy of a report titled "Summary Individual Disclosure Report" for Doctors Medical Center of Modesto, for the period January 1 through December 31, 2016. This report was generated on the website for the California Department of Health Care Access and Information (HCAI) formerly known as the Office of Statewide Planning and Development (OSHPD), based on publicly available information, by <visiting http://hcai.ca.gov> [as of December 9, 2022] and: (a) selecting the "Data & Reports" link; (b) selecting the "Request Data" link; (c) selecting the link in the sentence "You can search for Annual Reports for individual health facilities on SIERA"; (d) searching for "DOCTORS MEDICAL CENTER – MODESTO (106500852)" in the search bar; (e) selecting "Go"; (f) selecting the "Annual Financials" link; (g) selecting the "Reports" link; (h) selecting "Show All…"; and (i) selecting the "Audited Summary" link under the date "12-31-2016."

11. Attached hereto as **Exhibit J** is a true and correct copy of a report titled "Summary Individual Disclosure Report" for Doctors Medical Center of Modesto, for the period January 1 through December 31, 2017. This report was generated on HCAI's website using publicly available information, by visiting <http://hcai.ca.gov> [as of December 9, 2022] and: (a) selecting the "Data & Reports" link; (b) selecting the "Request Data"

link; (c) selecting the link in the sentence "You can search for Annual Reports for individual health facilities on SIERA"; (d) searching for "DOCTORS MEDICAL CENTER – MODESTO (106500852)" in the search bar; (e) selecting "Go"; (f) selecting the "Annual Financials" link; (g) selecting the "Reports" link; (h) selecting "Show All…"; and (i) selecting the "Audited Summary" link under the date "12-31-2017."

12. Attached hereto as **Exhibit K** is a true and correct copy of a report titled "Summary Individual Disclosure Report" for Doctors Medical Center of Modesto, for the period January 1 through December 31, 2016. This report was generated on HCAI's website using publicly available information, by visiting <http://hcai.ca.gov> [as of December 9, 2022] and: (a) selecting the "Data & Reports" link; (b) selecting the "Request Data" link; (c) selecting the link in the sentence "You can search for Annual Reports for individual health facilities on SIERA"; (d) searching for "Doctors Hospital of Manteca (106392287)" in the search bar; (e) selecting "Go"; (f) selecting the "Annual Financials" link; (g) selecting the "Reports" link; (h) selecting "Show All…"; and (i) selecting the "Audited Summary" link under the date "12-31-2016."

13. Attached hereto as **Exhibit L** is a true and correct copy of a report titled "Summary Individual Disclosure Report" for Doctors Medical Center of Modesto, for the period January 1 through December 31, 2017. This report was generated on HCAI's website using publicly available

information, by visiting <http://hcai.ca.gov> [as of December 9, 2022] and: (a) selecting the "Data & Reports" link; (b) selecting the "Request Data" link; (c) selecting the link in the sentence "You can search for Annual Reports for individual health facilities on SIERA"; (d) searching for "Doctors Hospital of Manteca (106392287)" in the search bar; (e) selecting "Go"; (f) selecting the "Annual Financials" link; (g) selecting the "Reports" link; (h) selecting "Show All…"; and (h) selecting the "Audited Summary" link under the date "12-31-2017."

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on December 12, 2022 at San José, California.

DocuSigned by:
Susan Greenberg
F6B0E7284644468...

SUSAN P. GREENBERG

EXHIBIT D

2020 ANNUAL REPORT

CELEBRATING 20 YEARS OF CONSUMER PROTECTION

DEPARTMENT OF Managed Health Care

Gavin Newsom
Governor
State of California

Mark Ghaly MD, MPH
Secretary
Health and Human Services Agency

Mary Watanabe
Director
Department of Managed Health Care

DMHC MISSION, VALUES & GOALS

MISSION

The Department of Managed Health Care protects consumers' health care rights and ensures a stable health care delivery system.

CORE VALUES

- Integrity
- Leadership
- Commitment to Service

GOALS

- Educate and assist California's diverse health care consumers
- Cultivate a coordinated and sustainable health care marketplace
- Regulate fairly, efficiently and effectively
- Foster a culture of excellence throughout the organization

MESSAGE FROM THE SECRETARY

This year we celebrate the 20th anniversary of the creation of the Department of Managed Health Care. Over the past 20 years, the Department has protected the health care rights of millions of Californians. This includes saving consumers hundreds of millions of dollars through the rate review program, ensuring consumers receive needed care under the Independent Medical Review program, and holding health plans accountable to provide timely and accessible health care to consumers.

In the face of the unprecedented events brought on by the COVID-19 pandemic over the last year, the Department has demonstrated its commitment to serving California's health care consumers. The Department worked closely with the California Health and Human Services Agency and its other departments to reduce the spread and mitigate impacts of the virus, to protect California's most vulnerable populations. The Department took actions to expand access to health care during this time, such as creating and extending special enrollment periods for uninsured Californians to gain health care coverage, directing health plans to cover the cost of vaccines, requiring health plans cover testing, and expanding the coverage of telehealth services.

In addition to the 20th anniversary of the Department, we also celebrate the 45th anniversary of the Knox-Keene Act and the 10th anniversary of the Affordable Care Act. California enacted the strongest patient protection health care laws in the nation when the Knox-Keene Act was established in 1975, which set the foundation for the Department's regulation of health plans. In 2000, the Department was created as the first state agency in the nation exclusively dedicated to protecting consumers' health care rights. After the Affordable Care Act was passed in 2010, California was the first

state in the nation to enact legislation creating a health benefit exchange, which we know as Covered California. Today, California continues to be a leader as we work together to create a system to provide accessible, affordable, and equitable health care for all.

Since its inception, the Department has continued to uphold a strong regulatory program to meet the needs of California's diverse population. I congratulate the Department and its employees for their dedication to our great state and the Department's mission.

Mark Ghaly MD, MPH

Secretary

California Health and Human Services Agency

MESSAGE FROM THE DIRECTOR

The year 2020 reminded us that regardless of the challenges we may encounter, the Department of Managed Health Care (DMHC) will always remain committed to protecting consumers' health care rights and ensuring a stable health care delivery system. In 2020, the DMHC responded to the COVID-19 pandemic by working tirelessly to ensure that the health care rights of consumers were not compromised during this public health emergency. We also celebrated the 45th anniversary of the Knox-Keene Act, the 20th anniversary of the DMHC and the 10th anniversary of the Affordable Care Act (ACA). It is an honor to be a part of these important milestones and present the accomplishments the Department has achieved over the past 20 years.

The DMHC worked to respond to changes brought on by COVID-19 in 2020, all while also adjusting to the new way of operating in our daily lives. DMHC employees quickly transitioned to work remotely to adhere to stay at home orders and continued providing important services to support health care consumers, health plans and providers. With all of these changes, the DMHC continued to be productive and had a number of record accomplishments, including issuing a record-breaking number of All Plan Letters (APLs) to health plans, reviewing the highest number of health plan rate filings in one year as well as reviewing new financial filings, and staying on top of all of the many changes that happened in the health care industry during a world-wide pandemic.

We worked closely with state and local leaders, health plans, providers, consumer advocates and other stakeholders in supporting actions to respond to COVID-19. The Department issued many APLs providing guidance and information to health plans. This included notifying health plans to cover the administration of qualifying COVID-19 vaccines with no cost-sharing for health plan enrollees. The DMHC remained focused on ensuring affordability and continued access to care for health plan enrollees. More information on the Department's actions and guidance is included later in this report.

The Department also implemented new laws and took enforcement action against health plans that violated consumers' health care rights. Significant enforcement actions included penalizing health plans that failed to timely authorize medically necessary services for enrollees, stopping the improper denials of emergency room claims and violations of state and federal mental health parity laws.

I am personally committed to ensuring that health plan enrollees have access to appropriate and needed behavioral health care services and this will continue to be a focus for the DMHC in the years ahead. The COVID-19 pandemic and resulting stay at home orders, job losses and virtual learning for students have caused significant stress on individuals and families. The need for behavioral health services has never been greater. Specifically, the Department is focused on implementing Senate Bill (SB) 855 (Wiener, 2020), which strengthened California's mental health parity statute to help improve consumers' access to quality mental health and substance use disorder services. In addition, the DMHC is also working on conducting focused behavioral health investigations of all full-service commercial health plans to assess whether enrollees have consistent access to medically necessary behavioral health care services. These investigations will begin in 2021.

The DMHC Help Center is a valuable resource to anyone facing issues with their health plan, including access to services or care. The DMHC Help Center can be reached at 1-888-466-2219 or www.HealthHelp.ca.gov and always offers free assistance in all languages.

The DMHC has made tremendous progress over the past 20 years, and you can see many of the highlights of these accomplishments in this report. As we look forward, the Department will continue to focus on the COVID-19 response, how we can better hold health plans accountable for reducing health disparities and improving health outcomes for enrollees, and continuing to improve equal and affordable health care access for all Californians.

As we celebrate our 20th anniversary, I remain impressed by the DMHC's dedicated employees who have relentlessly continued to work hard to achieve our mission during a very challenging year.

Mary Watanabe

Director
Department of Managed Health Care

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TABLE OF CONTENTS

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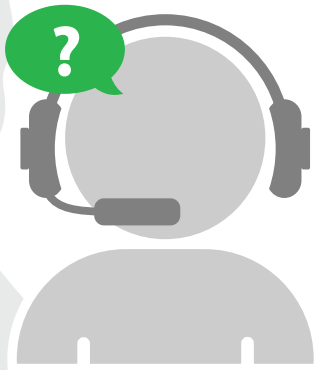
DEPARTMENT OF
Managed Health Care

2020
20 YEARS
of Consumer Protection



2.5 MILLION
CONSUMERS ASSISTED

The DMHC Help Center educates consumers about their rights, resolves consumer complaints, helps consumers navigate and understand their coverage, and ensures access to health care services.

27.7 MILLION
CALIFORNIANS' HEALTH CARE RIGHTS ARE PROTECTED BY THE DMHC

95% of state-regulated commercial and public health plan enrollment is regulated by the DMHC

132
LICENSED HEALTH PLANS

87 FULL SERVICE

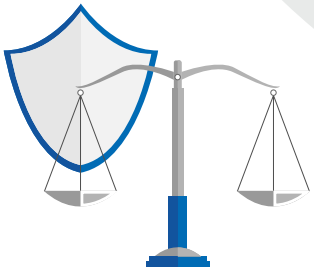
45 SPECIALIZED

$36.1 MILLION
dollars recovered from health plans on behalf of consumers

$296.1 MILLION
dollars saved on Health Plan Premiums through the Rate Review Program since 2011

$40.3 MILLION in 2020

$165.1 MILLION
dollars in payments recovered to physicians and hospitals



INDEPENDENT MEDICAL REVIEW (IMR)

Approximately **68%** of consumer appeals (IMRs) to the DMHC resulted in the consumer receiving the requested service or treatment from their health plan.

$83.6 MILLION
dollars assessed against health plans that violated the law

DEPARTMENT OF
Managed Health Care

KNOW YOUR HEALTH CARE RIGHTS

In California, health plan members have the right to:

- basic health care services
- choose your primary doctor
- an appointment when you need one (timely access to care)
- see a specialist when medically necessary
- receive treatment for all mental health and substance use conditions
- get a second doctor's opinion
- know why your plan denies a service or treatment
- understand your health problems and treatments
- translation and interpreter services
- give informed consent when you have a treatment
- file a complaint and ask for an Independent Medical Review (an external appeal of your plan's denial of services or treatment)
- a copy of your medical records (you may be charged)
- continue to see your doctor, even if they no longer participate in your plan (under certain circumstances)
- be notified of an unreasonable rate increase
- not be illegally balance billed by a health care provider
- see a written diagnosis (description of your health problem)

The California Department of Managed Health Care protects consumers' health care rights and ensures a stable health care delivery system.

How can you get help from the DMHC?

The DMHC protects you by making sure your health plan follows the law and ensures health plans are spending money in a way that helps you.

Most people who live in California are enrolled in a health plan regulated by the DMHC. Because of this, the DMHC Help Center is a good place to start if you have a problem with your health plan.

The DMHC Help Center assists consumers with understanding their health care rights, benefits and to resolve health plan issues.

If you are having issues with your health plan, you should file a grievance with your plan. If you are not satisfied with your health plan's resolution of the grievance or have been in your plan's grievance system for 30 days, you should contact the DMHC Help Center for assistance. If your issue is urgent, you should contact the DMHC Help Center immediately.

The DMHC Help Center provides help in all languages. Help is available by calling 1-888-466-2219 (TDD: 1-877-688-9891) or at www.HealthHelp.ca.gov. ALL SERVICES ARE FREE.

Celebrating Significant Anniversaries

In 2020, we celebrated the 20th anniversary of the DMHC, along with the 10th anniversary of the enactment of the Affordable Care Act (ACA), and the 45th anniversary of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). Some of the important health care accomplishments achieved over the years are highlighted below each significant anniversary.

20 Years

The DMHC was created in 2000 as the first agency in the country dedicated solely to the regulation of managed health care plans and consumer assistance. Today, the Department continues to protect consumers' health care rights and ensures a stable health care delivery system.

- More than 2.5 million consumers have received assistance and support through the Help Center which offers complaint resolution through telephone and online assistance
- 132 health plans (45 specialized and 87 full service) provide health coverage to nearly 27.7 million Californians
- More than $165.1 million in payments owed to physicians and hospitals have been recovered
- More than $83.6 million in fines and penalties have been assessed on health plans that violated the law, and the DMHC has imposed changes in health plan operations to protect consumer rights
- More than $296 million have been saved on health plan premiums through the Department's Rate Review Program
- Approximately 68% of consumer appeals (Independent Medical Reviews) to the DMHC have resulted in the consumer receiving the requested service or treatment from their health plans

10 Years

Enacted on March 23, 2010, the ACA has reshaped the nation's health care landscape.

- As soon as the ACA passed, the DMHC provided leadership and support to craft and implement new laws and regulations
- The DMHC received $9.2 million in federal ACA grants to enhance consumer assistance and created strategic partnerships to help California consumers prepare for and understand ACA coverage options
- Under strict timelines, the DMHC conducted focused reviews of dozens of new health plan products and provider networks to ensure compliance with state and federal laws and consumer protections
- Enrollment in DMHC-licensed health plans has increased nearly 44% over 2013 enrollment, the last year before the ACA was fully implemented

45 Years

California's groundbreaking managed care law, the Knox-Keene Act, laid the foundation for robust regulation and consumer protections. The DMHC works with a large array of partners, including policymakers, other state agencies and stakeholders to continuously improve Knox-Keene Act standards as the managed care industry and the needs of consumers evolve.

20 YEARS

of Consumer Protection

Introduction

Twenty years ago, the DMHC was created as the first state department in the country solely dedicated to regulating managed health care plans and assisting consumers to resolve disputes with their health plans. The creation of the Department in 2000 capped decades of California's leadership in consumer protection in the oversight of managed health care.

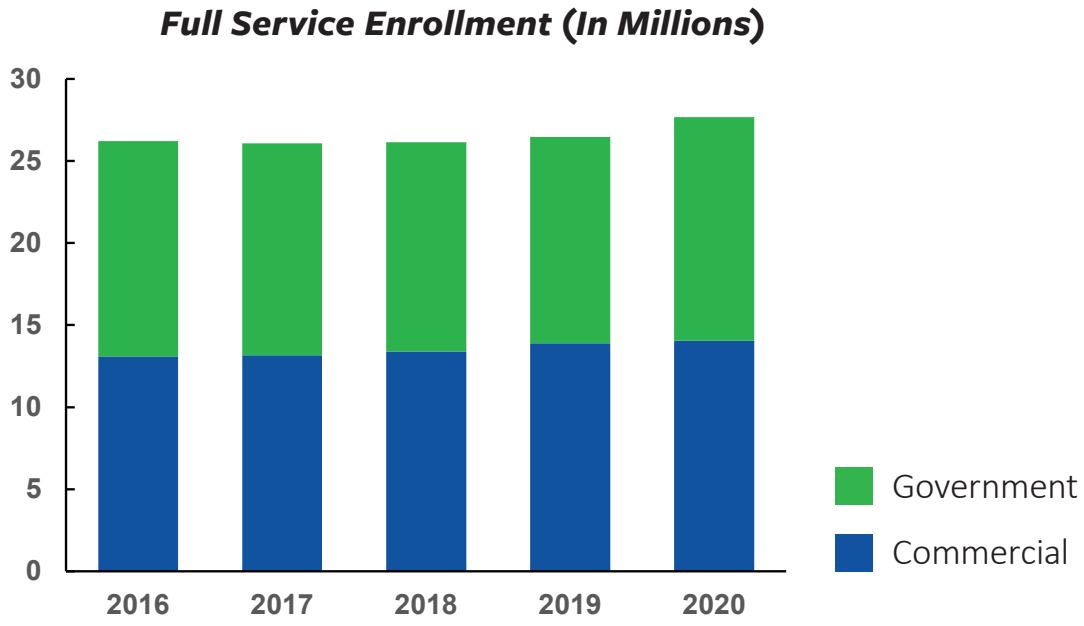
With the enactment of the Knox-Keene Act 45 years ago, California took an early lead in regulating and helping to shape the managed health care industry. The Knox-Keene Act has been refined, strengthened and improved over the years adjusting to market shifts and changing consumer needs and expectations. Further enhanced through enactment of federal health care reforms, the Knox-Keene Act continues to provide a comprehensive framework for consumer rights and health plan standards unparalleled in other states. The many protections included in the Knox-Keene Act set the stage for the DMHC to effectively implement health care reform under the ACA in California. Enacted in 2010, the ACA changed the fundamental rules of health insurance markets making it easier for consumers to obtain coverage regardless of age, health status or income. The DMHC continues to work with policymakers, other state agencies, health plans, stakeholders and enrolled consumers to implement the ACA.

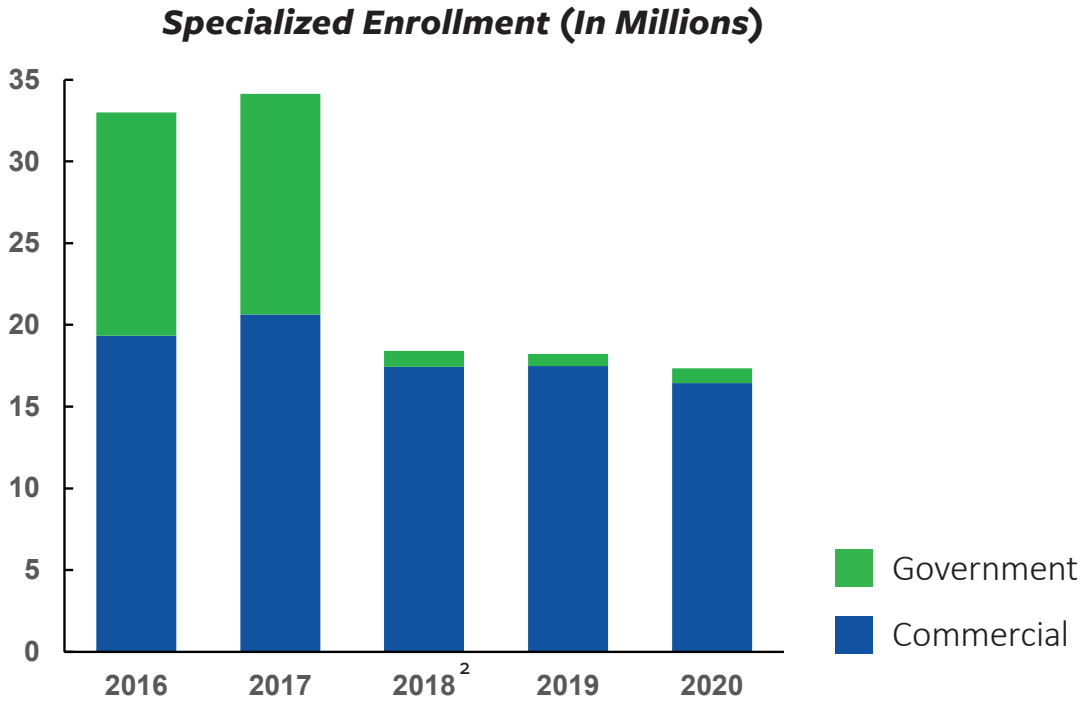
Over the Department's 20-year history, California has launched several initiatives to improve and expand access to health care for all Californians. As an ongoing effort to achieve our mission, the Department continues to implement new laws and regulations, takes action against health plans that violated consumers' health care rights and offers direct assistance to consumers through the DMHC Help Center. As of the end of 2020, the Department has directly assisted approximately 2.5 million consumers through the DMHC Help Center.

The DMHC now regulates the majority of state-regulated health care coverage in California including 95% of commercial and government health plan enrollment. In 2020, 87 full-service health plans licensed by the DMHC provided health care services to more than 27.7 million Californians. This included more than 14 million commercial enrollees and approximately 13.6 million government enrollees[1]. In addition to full-service health plans, the DMHC oversees 45 specialized health plans including chiropractic, dental, vision, behavioral health (psychological) and pharmacy. In 2020, the DMHC's budget was $92,485,000 with 505 positions. The DMHC is funded by assessments on its regulated health plans.

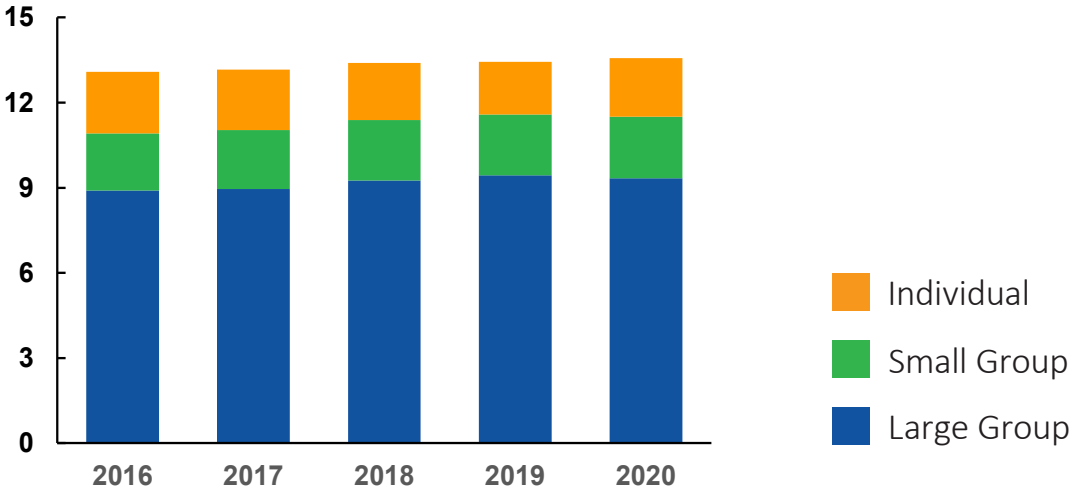
As California celebrates the many historic managed health care milestones, this report highlights current accomplishments, the regulatory history of the Knox-Keene Act and the emerging challenges and opportunities facing the Department and the managed health care industry. The DMHC remains committed to protecting consumers' health care rights and ensuring a stable health care delivery system.

Enrollment Overview

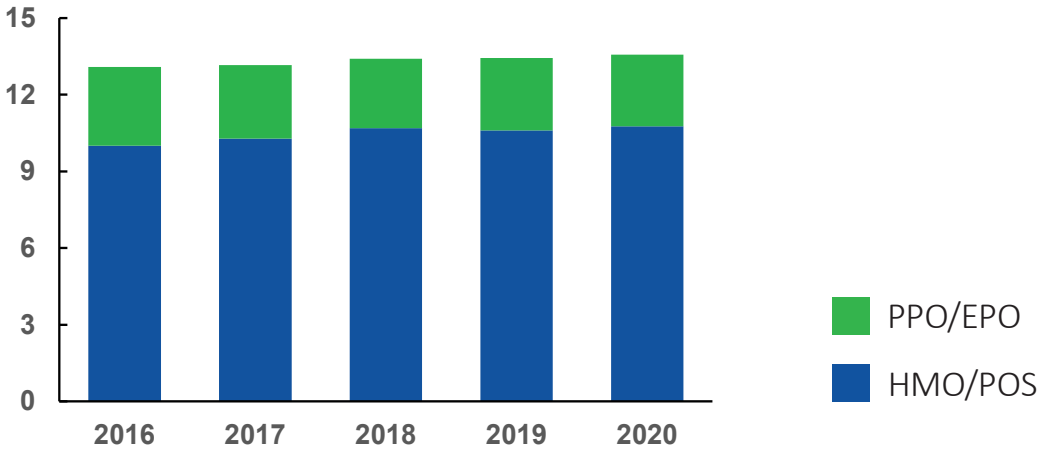




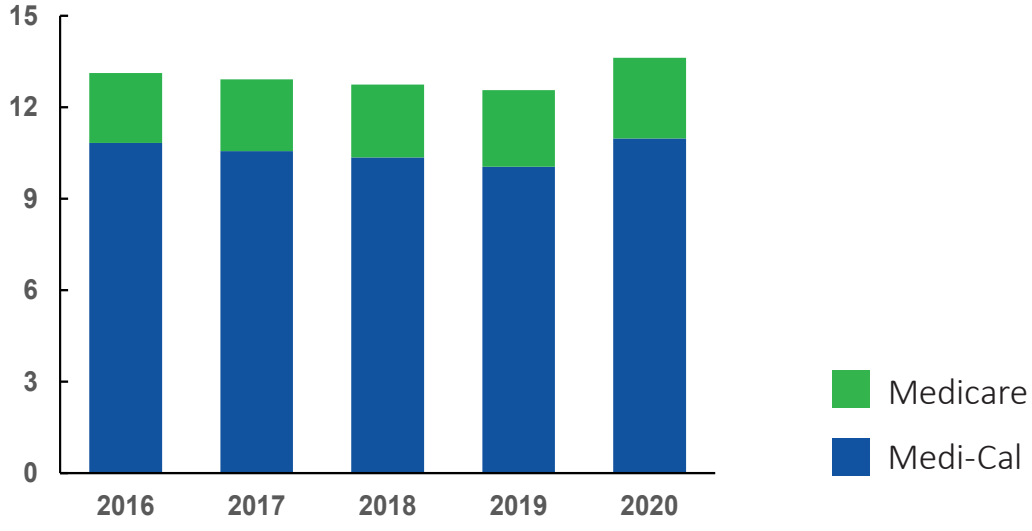
Commercial Enrollment by Market (In Millions)



Commercial Enrollment by Product (In Millions)



Government Enrollment by Type (In Millions)



TIMELINE OF 20 YEARS OF CONSUMER PROTECTION

1999-2000

DMHC Established

The DMHC is created as the first stand-alone state department in the nation dedicated solely to the regulation of health care plans and the provision of consumer assistance to resolve problems with health plans. (AB 78, 1999)

1999

Financial Solvency Standards Board (FSSB)

The FSSB is established with eight-members—the Director and seven members appointed by the Director. The board is the first of its kind in the country. The FSSB advises the Director on matters of financial solvency affecting the delivery of health care services. In the early years, the board focused on how to develop and implement a standardized set of financial solvency benchmarks that all providers and health plans would be required to follow. (SB 260, 1999)

2000

Consumer Assistance

The newly created consumer focused DMHC opens the Help Center. The DMHC Help Center's trained staff assists consumers to resolve issues with health plans and monitors complaints for evidence of systemic health plan regulatory compliance problems.

2001

Independent Medical Review

California establishes the Independent Medical Review program, a legally binding system for external review of health plan denials of care. Since the program's inception, the DMHC has overseen nearly 40,000 reviews of plan denials (including overturned, reversed and upheld decisions). (AB 55, 1999)

2003

Continuity of Care

Following disruptive transfers of more than three million Californians affected by provider contract terminations, the DMHC works to secure legislation to provide continuity of care to at-risk patients. This allows terminally ill and pregnant consumers, and others with scheduled surgeries or procedures, to continue care with a terminated provider under specified circumstances. (AB 1286, 2003)

Timely Claims Payment

The DMHC issued regulations requiring health plans to establish a fast, fair and cost-effective dispute resolution process with providers. These regulations require health plans to pay provider claims timely and accurately pursuant to specific regulatory criteria. (AB 1455, 2003)

2004-2005

Community Investments

In 2004, WellPoint and Anthem Blue Cross corporations merge, affecting control of Blue Cross of California. In 2005, PacifiCare of California merges with UnitedHealth Group. The DMHC conducts a thorough review of the mergers and potential impacts on consumers, and negotiates concessions associated with the corporate changes, including more than $450 million in community benefits for California consumers (including commitments from related companies regulated by California Department of Insurance).

2005

Provider Solvency

In the wake of several high-profile failures of medical groups contracted with health plans, legislation imposes stricter financial responsibilities on risk-bearing organizations (RBOs) and requires health plans to report on risk arrangements. After engaging external stakeholders and the FSSB in an extensive regulatory review process to establish appropriate financial survey reporting requirements and criteria, the DMHC establishes the Provider Solvency Unit to oversee and monitor RBO financial filings.

2008

Balance Billing Prohibition

The practice of billing patients for disputed balances above what the health plan pays is commonly referred to as "balance billing." The DMHC enacts regulations protecting consumers from balance billing by emergency providers. The courts repeatedly affirm the balance billing prohibition.

Cancellations and Rescissions

The DMHC investigates and achieves a groundbreaking settlement with California's five largest health plans, including fines totaling nearly $14 million, for rescinding coverage after enrollees sought treatment or filed a claim. The Department requires the health plans to make major system changes and to contact more than 3,000 consumers with an offer of coverage and the opportunity to submit claims for out-of-pocket expenses.

2010

Timely Access to Care

The DMHC implements landmark regulations to ensure Californians get timely access to care when they need it. The regulations make California the first state in the nation to provide patients with predictable wait times for appointments, timeliness of referrals and response times for health plan telephone triage. It took eight years of negotiations, but the DMHC emerged with a strong, direct way to eliminate unnecessary delays for consumers. (AB 2179, 2010)

2010-2014

ACA Implementation

The DMHC provides early leadership and technical expertise to support enactment of state legislation implementing the ACA and works diligently to update health plan standards and regulatory practices in advance of full implementation in 2014.

2011

Consumer Assistance Program

The DMHC receives the first of several federal ACA grants to work with the Office of the Patient Advocate, the California Department of Insurance and local community-based legal services advocates to enhance and expand consumer education and assistance. Additionally, the DMHC was designated California's Consumer Assistance Program, receiving federal grants to enhance consumer assistance and education efforts in the state.

Provider Claims Payment

Routine financial examinations for the claims payment practices and provider dispute resolution mechanism requirements of the seven largest full-service health plans result in $1.6 million in penalties, $1.8 million in additional paid provider claims and $4.4 million in interest and penalties paid to providers.

Rate Review Program

The DMHC establishes a premium rate review program to provide the public with information to enhance consumer understanding about rate changes in the individual and small group markets and promote more accountability within the health care industry. (SB 1163, 2010)

2012

Autism Advisory Task Force

The DMHC convenes the Autism Advisory Task Force. The Task Force developed recommendations regarding medically necessary behavioral health treatment for individuals with autism or pervasive developmental disorder, as well as the appropriate qualifications, training and education for providers of such treatment.

2013

Coverage for Medical Therapies

The DMHC takes action against six large health plans for improper denials of medically necessary therapies, such as speech and occupational therapy, and requires the health plans to reimburse enrollees for out-of-pocket costs incurred.

ACA Compliance

The DMHC works under tight timelines to review health plan products, provider networks and rate filings ensuring 2014 coverage meets new federal and state requirements.

2014

Access to Mental Health Care

The Department conducts a routine survey of behavioral health services in Kaiser Foundation Health Plan (Kaiser Permanente) and assesses $4 million in penalties for deficiencies in timely access to care. The DMHC later reached a landmark 3-year agreement with the health plan to ensure enrollees receive timely access to behavioral health services.

2015

Accurate Provider Directories

The DMHC imposed a combined $600,000 penalty against California Physicians' Service (Blue Shield of California) and Blue Cross of California (Anthem Blue Cross) for inaccurate provider

directories, which limited enrollee access to care and resulted in an unacceptable consumer experience. Both plans were required under the agreement to improve the accuracy of their provider directories and to reimburse enrollees who may have been negatively impacted by inaccuracies in the published provider directories.

Health Plan Merger

The DMHC approved Blue Shield of California's acquisition of Care1st Health Plan. The Department's approval included several conditions requiring Blue Shield to improve access in the Medi-Cal program as the plan entered this new market segment. Blue Shield also agreed to invest $200 million to help strengthen the health care delivery system and support consumer assistance programs. As part of these investments, the plan was required to develop an industry-led solution to improve the accuracy of health plan provider directories.

2016

Health Plan Dashboard

As part of its commitment to transparency, the DMHC launched the Health Plan Dashboard, an online tool that aggregates public data sets reported by health plans and the DMHC.

Health Plan Merger

The DMHC approved Centene's acquisition of Health Net and applied several conditions to improve access and quality of care. This included investing $140 million to improve health outcomes and support California's health care infrastructure for underserved groups. The plan also agreed to keep key operations in California including building a service center in the state.

Provider Directory Standards

The DMHC released Uniform Provider Directory Standards. These uniform standards were developed to help ensure consistency in how information is displayed across provider directories. (SB 137, 2015)

2017

Surprise Billing

The DMHC implemented AB 72 which protects consumers against out-of-network providers from balance billing consumers when the consumer did everything right and went to an in-network facility, commonly known as "surprise billing." (AB 72, 2016)

Independent Dispute Resolution Process

To remove consumers from the middle of billing disputes, AB 72 created a default reimbursement rate for these out-of-network or non-contracted providers. The DMHC Help Center launched an Independent Dispute Resolution Process (IDRP) as a mechanism for non-contracted providers or health plans to dispute the default reimbursement amount.

2018

Mental Health Parity

The Department completed its comprehensive review of 25 full-service commercial health plans' benefit designs and methodologies for providing mental health services and focused medical surveys to assess whether plans implemented Mental Health Parity and Addiction Equity Act (MHPAEA) compliant benefit designs into practice. As a result of this focused

compliance review, many health plans were required to update their policies and procedures and/or revise cost-sharing for services and treatment. Several plans were also required to reimburse enrollees because the plans had inappropriately applied cost-sharing out of compliance with MHPAEA.

Prescription Drug Cost Transparency

The DMHC issued the first Prescription Drug Cost Transparency Report, for Measurement Year 2017. In accordance with newly enacted legislation, the DMHC must prepare an annual report summarizing the findings and the impact of prescription drug costs on health care premiums. (SB 17, 2017)

Health Plan Mergers

The DMHC approved CVS's acquisition of Aetna, Inc., Optum, Inc.'s acquisition of DaVita Health Plan of California, and Cigna Corporation's acquisition of Express Scripts. The Department's approval of these mergers included important conditions to improve plan performance and access to care for enrollees. As a part of the conditions imposed by the DMHC, a combined total of $358 million was committed to be invested to support California's health care delivery system.

2019

Pharmacy Benefit Management

The DMHC convened a Task Force on Pharmacy Benefit Management (PBM) Reporting to determine what information, related to pharmaceutical costs, health plans or their contracted pharmacy benefit managers should report to the DMHC. The DMHC submitted the Task Force's recommendations to the Legislature. (AB 315, 2018)

Delegate Oversight

The DMHC took enforcement action against 12 DMHC-regulated health plans, including $1.9 million in fines, for the plans' lack of oversight of a delegated medical group. The poor oversight led to the improper denials and delays of enrollees' care. In addition to the fines, the health plans agreed to corrective actions to improve plan oversight of delegated entities.

Enrollee Grievances

The DMHC reached an agreement with Anthem Blue Cross to correct the plan's repeated failures to properly identify and handle enrollee grievances and appeals, including a $2.8 million fine and an $8.4 million investment in the plan's consumer grievances and appeals process. The plan also agreed to several corrective actions to make important consumer-protective improvements to how the plan handles consumer grievances and appeals.

Emergency Response

After the earthquakes, wildfires and power shutoffs that occurred throughout California, the Governor declared a State of Emergency in the affected areas. In response to the declarations, the DMHC took action including sending out All Plan Letters reminding health plans of their obligations under a declared state of emergency. A non-emergency hotline was established to help medically vulnerable Californians and health care facilities find additional resources in their communities during the power shutoffs.

2020

COVID-19 Response

The DMHC took action to protect consumers' health care rights and ensure a stable health care delivery system during the COVID-19 pandemic. The Department worked closely with state and local leaders, health plans, providers and other stakeholders in supporting actions and providing guidance to health plans to mitigate the spread and severity of COVID-19, and ensure enrollees had continued access to health care services. More information on the DMHC's actions can be found in the next section of this report.

Upholding Consumer Protections

The DMHC took enforcement actions against health plans that violated important consumer protections. This includes $1.2 million in fines against Blue Cross of California Partnership Plan, Inc. (Blue Cross) for the plan's failure to timely implement two Independent Medical Review (IMR) determinations to authorize coverage for medically necessary services. The Medi-Cal managed care plan had failed to timely authorize the enrollees' services after receiving the IMR decisions.

2020

Annual Report

Response to COVID-19

The DMHC, along with the rest of the state, the nation and the world, faced unprecedented challenges brought on by the COVID-19 pandemic. The Department continued to prioritize its mission as it worked to address all of the changes brought on by this once in a lifetime emergency. The DMHC worked closely with many stakeholders including state and local leaders, health plans, providers and others, as the Department focused on ensuring enrollees continued to receive needed health care services, providers could continue to provide care, and health plans continued to cover and offer medically necessary services.

The DMHC took several actions in 2020 to support the state's response efforts. This included providing guidance to health plans through many All Plan Letters (APLs). Some of the key issues the DMHC issued guidance on included:

- directing health plans to cover the administration of qualifying COVID-19 vaccines with no cost-sharing for health plan enrollees,
- directing health plans to remove administrative burdens on hospitals during the COVID-19 surge,
- ensuring stability in health plan provider networks,
- ensuring health plans provided continued and safe access to care for health plan enrollees through telehealth, and requiring plans to reimburse providers for telehealth services at the same rate as if the services were delivered in-person,
- requiring health plans to offer a special enrollment period to make sure Californians had an available path to affordable health care coverage,
- reminding health plans to comply with California non-discrimination requirements, and about resources to help mitigate negative health outcomes to members due to the COVID-19 emergency, and
- enacting new reporting requirements on health plans to ensure health plans sufficiently support providers with Personal Protective Equipment (PPE) and other COVID-19 supplies to safely deliver services to plan enrollees.

The DMHC created a new COVID-19 web page on the Department's website to make it easy for the public and stakeholders to find information, resources and guidance. The Department also created several consumer-friendly fact sheets, including on the topics of vaccines, testing and health care coverage.

The COVID-19 pandemic caused many changes in the health care industry and within the DMHC. In March 2020, the Department transitioned nearly all employees to telework to adhere to new stay at home orders and state guidance. The Department also made adjustments to how it conducted its work, including changing all on-site financial exams and medical surveys to be completed remotely. In addition, some employees were redirected to support the state's COVID-19 response, including working with local counties on contact tracing.

DMHC Help Center

The DMHC Help Center educates consumers about their health care rights, resolves consumer complaints, helps consumers navigate and understand their coverage and assists consumers in getting timely access to appropriate health care services. The DMHC Help Center provides direct assistance in all languages to health care consumers through the Department's website, www.HealthHelp.ca.gov, and a toll-free phone number, 1-888-466-2219.

If a consumer is experiencing an issue with their health plan, they can file a grievance with their plan. If they are not satisfied with their health plan's resolution of the grievance or if the grievance has not been resolved after 30 days, they should contact the DMHC Help Center for assistance. If a consumer is experiencing an imminent or serious threat to their health, they should contact the DMHC Help Center immediately.

Through a team of health care analysts, nurses and attorneys, the DMHC Help Center uses a variety of mechanisms to assist consumers. Most consumer problems are resolved through the standard complaint process. Common complaints include cancellation of coverage, billing issues, quality of service, coverage disputes and access complaints.

The Department's Quick Resolution process addresses consumer issues through a three-way call between the DMHC, the consumer and the health plan. Complaints involving serious or urgent medical issues are routed to nurses who provide immediate assistance 24 hours a day, seven days a week.

The Independent Medical Review (IMR) program is available to consumers if a health plan denies, modifies or delays a request for a service as not medically necessary or as experimental or investigational. Doctors independent of the health plan review these matters and make an independent determination about whether the requested service should be provided. If an IMR is decided in the consumer's favor, the health plan must provide the requested service or treatment promptly. All IMR decisions are reported on the DMHC's website with a summary of the issue and outcome for each case.

Consumers with plans and issues outside of the DMHC's jurisdiction who contact the Help Center are transferred or referred to the appropriate agency for assistance. In addition to providing direct consumer assistance, the DMHC also contracts with community-based organizations under the Consumer Assistance Program to provide consumers with local, in-depth assistance.

WHAT IS THE DMHC HELP CENTER?

The DMHC provides assistance to all California health care consumers through the Help Center. The DMHC Help Center assists consumers with understanding their health care rights and benefits, and helps to resolve complaints and coverage issues between health plan enrollees and health plans.

The DMHC Help Center provides these services for free and help is available in all languages. To contact the DMHC Help Center for assistance call 1-888-466-2219 (TDD: 1-877-688-9891) or visit www.HealthHelp.ca.gov.

2020 Highlights

In 2020, the DMHC Help Center assisted 119,760 health care consumers, and handled 10,570 complaints and 3,793 IMRs. Approximately 68% of consumers who submitted an IMR request to the DMHC Help Center received the service or treatment they requested[3].

The community-based Consumer Assistance Program served 9,394 consumers and conducted 1,319 outreach events throughout California despite many impacts under the COVID-19 emergency. Through these Consumer Assistance Program outreach events, the Department reached 61,658 consumers to educate consumers about their health care rights.

AB 72 (2016), which prohibits providers from surprise balance billing health plan enrollees, also required the DMHC to create an Independent Dispute Resolution Process (IDRP) as a mechanism for non-contracted, non-emergency providers or health plans to dispute the default provider payment amount. In 2020, the DMHC received 23 IDRP applications, and one IDRP was carried over from 2019. Of those, 11 were incomplete, ineligible, non-jurisdictional or non-responsive; one completed the process with a determination letter issued; and, 12 were pending as of December 31, 2020.

In addition to providing consumer assistance, the DMHC Help Center assists providers with claims payment disputes with health plans. The DMHC Help Center received 6,767 provider complaints and recovered $11,627,333 in payments for providers.

2020 BY THE NUMBERS

HELP CENTER

119,760 CONSUMERS ASSISTED[4]

103,830 TELEPHONE INQUIRIES

10,570 CONSUMER COMPLAINTS[5]

3,793 IMRs CLOSED[6]

$2 M RECOVERED FOR CONSUMERS

1,567 NON-JURISDICTIONAL REFERRALS

6,767 PROVIDER COMPLAINTS

$11.6 M RECOVERED PROVIDER PAYMENTS

1 AB 72 IDRP CASES COMPLETED

On average, approximately 68% of enrollees that submitted IMR requests to the DMHC received the requested service or treatment.

Behavioral Health Coverage Changes

California health plan enrollees have the right to treatment for all medically necessary mental health and substance use disorder conditions. SB 855 (2020) strengthened California's mental health parity laws by requiring commercial health plans to provide full coverage for the treatment of all mental health conditions and substance use conditions, under the same terms and conditions applied to other medical conditions. The law also establishes specific standards for what is considered a medically necessary treatment and creates criteria for clinical guidelines for assessing medical necessity.

Under this new law, health plans must cover the full spectrum of all medically necessary treatment in all settings for enrollees. This includes the following settings, when medically necessary:

- Sessions with a therapist
- Medication to manage enrollees' condition
- Out-patient Intensive Treatment
- In-patient Residential treatment

The law also mandates that if an enrollee cannot find an appropriate mental health provider in their health plan network, the health plan must arrange and pay for out-of-network services at no additional cost to the enrollee.

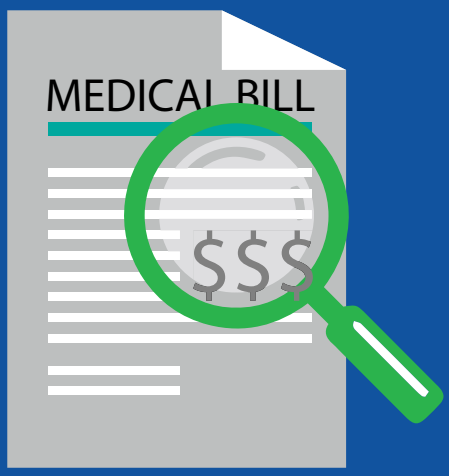
Additionally, the law includes financial protections. Health plans cannot charge more for mental health and substance use disorder services than for physical health conditions. This includes enrollee cost-sharing obligations, such as co-pays, deductibles, maximum annual and lifetime benefits and other out-of-pocket expenses.

Health plan enrollees having trouble accessing behavioral health care treatment or services, should first contact their health plan at the member services phone number on their health plan member card. Their health plan will review the grievance and should ensure the enrollee is able to timely access medically necessary care.

If the enrollee does not agree with their health plan's response, they should contact the DMHC Help Center at www.HealthHelp.ca.gov or by calling 1-888-466-2219. Contact the DMHC Help Center immediately for urgent issues, such as a facility trying to discharge the enrollee, but the enrollee disagrees that they are ready to be discharged.

DMHC HELP CENTER PROVIDER COMPLAINT UNIT

The DMHC recognizes that it is important for hospitals, doctors and other providers to receive accurate payments in a timely manner. The DMHC Help Center's Provider Complaint Unit is responsible for processing complaints from providers to ensure prompt and accurate payment according to the law. The Provider Complaint Unit handles individual complaints, complaints with multiple claims, emergency service complaints and non-emergency service complaints.

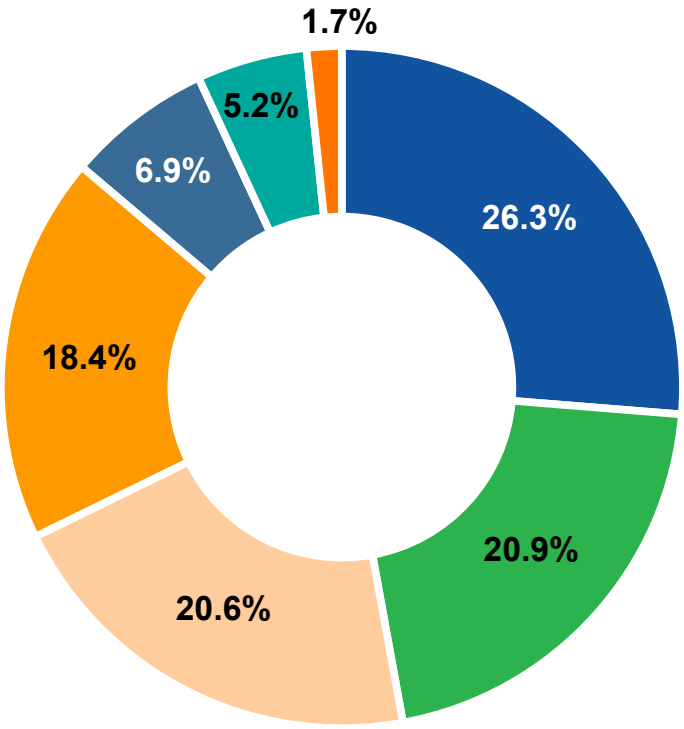


The DMHC established an Independent Dispute Resolution Process (IDRP) for emergency and non-emergency services. An IDRP allows providers and payors to dispute whether payment of a specified rate was appropriate. An external reviewer goes over the claim and determines which rate is justified.

DMHC Help Center staff perform analyses on unfair payment patterns and emerging trends on all provider complaints. The Department uses this information to help identify criteria for audits of health plans and their delegated entities.

Providers looking for more information or to dispute a payment can visit the DMHC website at www.HealthHelp.ca.gov.

CONSUMER COMPLAINTS RESOLVED IN 2020

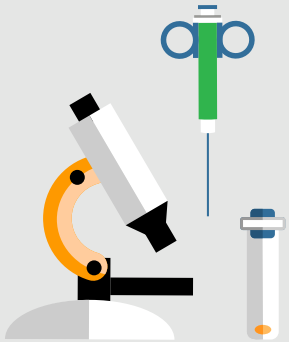


- **1.7% -** Coordination of Benefits[7]
- **5.2% -** Enrollment
- **6.9% -** Access to Care
- **18.4% -** Provider Customer Service
- **20.6% -** Health Plan Customer Service
- **20.9% -** Benefits/Coverage
- **26.3% -** Claims/Financial

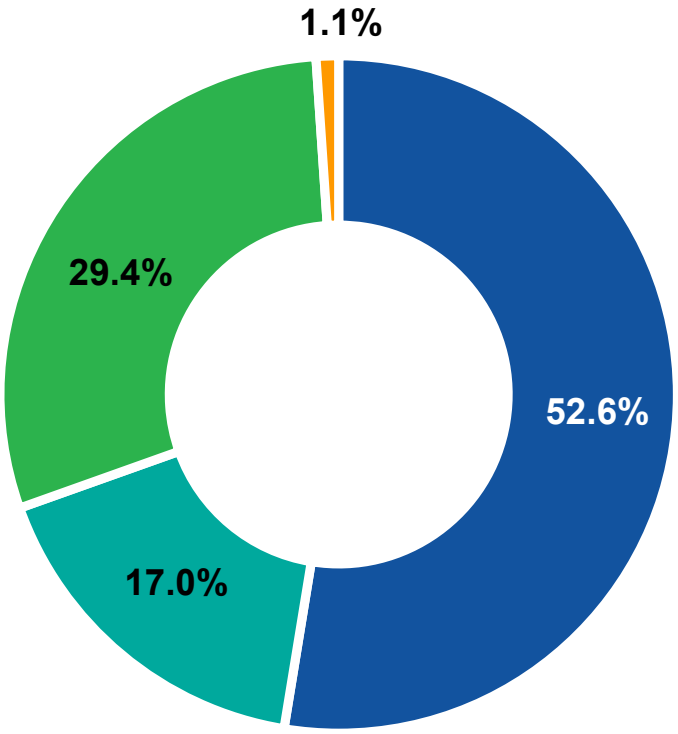
Interspersed throughout this report are consumer stories of assistance the DMHC Help Center provided during 2020. The names of enrollees have been changed to protect their identities.

DMHC HELP CENTER ASSISTANCE: CLAIMS/FINANCIAL DISPUTE

Jesse, a Small Group HMO plan member, needed either a Magnetic Resonance Imaging (MRI) procedure or a biopsy performed. He called his health plan's member services center to compare the cost of the MRI and biopsy. He was told the cost of an MRI was over $2,000 and a biopsy was $800. Jesse decided to have a biopsy expecting a bill for $800. However, he received a bill for almost $4,000. He appealed to his health plan, but the plan upheld their denial. He then filed a complaint with DMHC Help Center. The DMHC requested the phone recordings between the health plan and Jesse. The health plan responded saying Jesse was charged for services in addition to the biopsy which caused the total charges to be different, and the health plan agreed to waive Jesse's cost share amount that exceeded the $800.

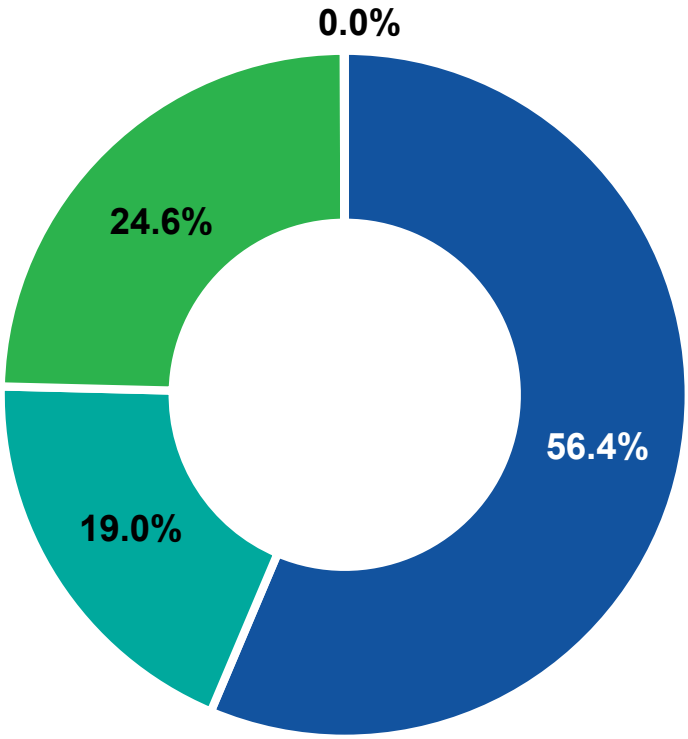


CONSUMER COMPLAINTS RESOLVED IN 2020 BY COVERAGE TYPE



- **1.1% -** Medicare
- **17.0% -** Medi-Cal
- **29.4% -** Individual
- **52.6% -** Employment Based

IMRs RESOLVED IN 2020 BY COVERAGE TYPE



- **0.0% -** Medicare
- **19.0% -** Medi-Cal
- **24.6% -** Individual
- **56.4% -** Employment Based

DEPARTMENT OF Managed Health Care

Timely Access to Care

In California, health care consumers have the right to an appointment when needed.

The law requires health plans licensed by the DMHC to make primary care providers and hospitals available within specific geographic and time-elapsed standards. Health plans must ensure their network of providers, including doctors, can provide enrollees with an appointment within a specific number of days or hours.

Urgent Care

prior authorization not required by health plan
2 days

prior authorization required by health plan
4 days

Non-Urgent Care

Doctor Appointment

PRIMARY CARE PHYSICIAN
10 business days

SPECIALTY CARE PHYSICIAN
15 business days

Mental Health Appointment
(non-physician[1])
10 business days

Appointment
(ancillary provider[2])
15 business days

[1] Examples of non-physician mental health providers include counseling professionals, substance abuse professionals and qualified autism service providers.

[2] Examples of non-urgent appointment for ancillary services include lab work or diagnostic testing, such as mammogram or MRI, and treatment of an illness or injury such as physical therapy.

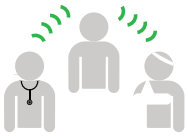
Timely Access to Care Requirements

DISTANCE

Provide access to a primary care provider or a hospital within 15 miles or 30 minutes from where enrollees live or work.

AVAILABILITY

Your health plan should have telephone services available on a 24/7 basis.



INTERPRETER

Interpreter services must be coordinated with scheduled appointments for health care services to ensure interpreter services are provided at the time of the appointment.

Unable to get an Appointment Within the Timely Access Standard?

If you are not able to get an appointment within the timely access standard, you should first contact your health plan for assistance at the toll-free number listed on your health plan card.

The DMHC Help Center is available at 1-888-466-2219 (TDD: 1-877-688-9891) or www.HealthHelp.ca.gov to assist you if your health plan does not resolve the issue. The DMHC Help Center will work with you and your health plan to ensure you receive timely access to care.

If you believe you are experiencing a medical emergency, dial 9-1-1 or go to the nearest hospital. If your health issue is urgent, but not an emergency, and does not require prior approval or authorization from your health plan, you have the right to get care within 48 hours.

The waiting time for an appointment may be extended if a qualified health care provider has determined and made record that a longer waiting time will not be harmful to the enrollee's health.

Plan Licensing

Health plans in California must be licensed by the DMHC. As part of the licensing process, the DMHC reviews all aspects of the health plan's operations, including benefits and coverage (e.g., Evidences of Coverage), template contracts with doctors and hospitals, provider networks, mental health parity and complaint and grievance systems.

After licensure, the DMHC monitors health plans and any changes made to plan operations, including changes in service areas, contracts, benefits or systems. Health plans are required to file changes as amendments or material modifications, depending on the scope of the change. The DMHC also periodically identifies specific licensing issues for focused examination or investigation.

2020 Highlights

The DMHC issues All Plan Letters (APLs) to provide guidance and information to health plans. The Department issued a record 43 APLs in 2020. A large number of APLs issued in 2020 were focused on the state's response to the COVID-19 pandemic. This includes issuing guidance to health plans to cover the administration of qualifying COVID-19 vaccines with no cost-sharing for health plan enrollees, requiring health plans to remove administrative burdens on hospitals during the COVID-19 surge, ensuring stability in health plan provider networks, and enacting new reporting requirements to ensure health plans are sufficiently supporting providers with Personal Protective Equipment (PPE) and other COVID-19 supplies to safely deliver services to plan enrollees.

Additionally, the Department issued guidance on preventive health services coverage for Human Immunodeficiency Virus (HIV) preexposure prophylaxis (PrEP) with no cost sharing, and continued to provide guidance to health plans regarding the obligation to provide enrollees access

2020 BY THE NUMBERS

PLAN LICENSING

7 NEW LICENSES ISSUED

4,993 EVIDENCES OF COVERAGE REVIEWED

1,161 ADVERTISEMENTS REVIEWED

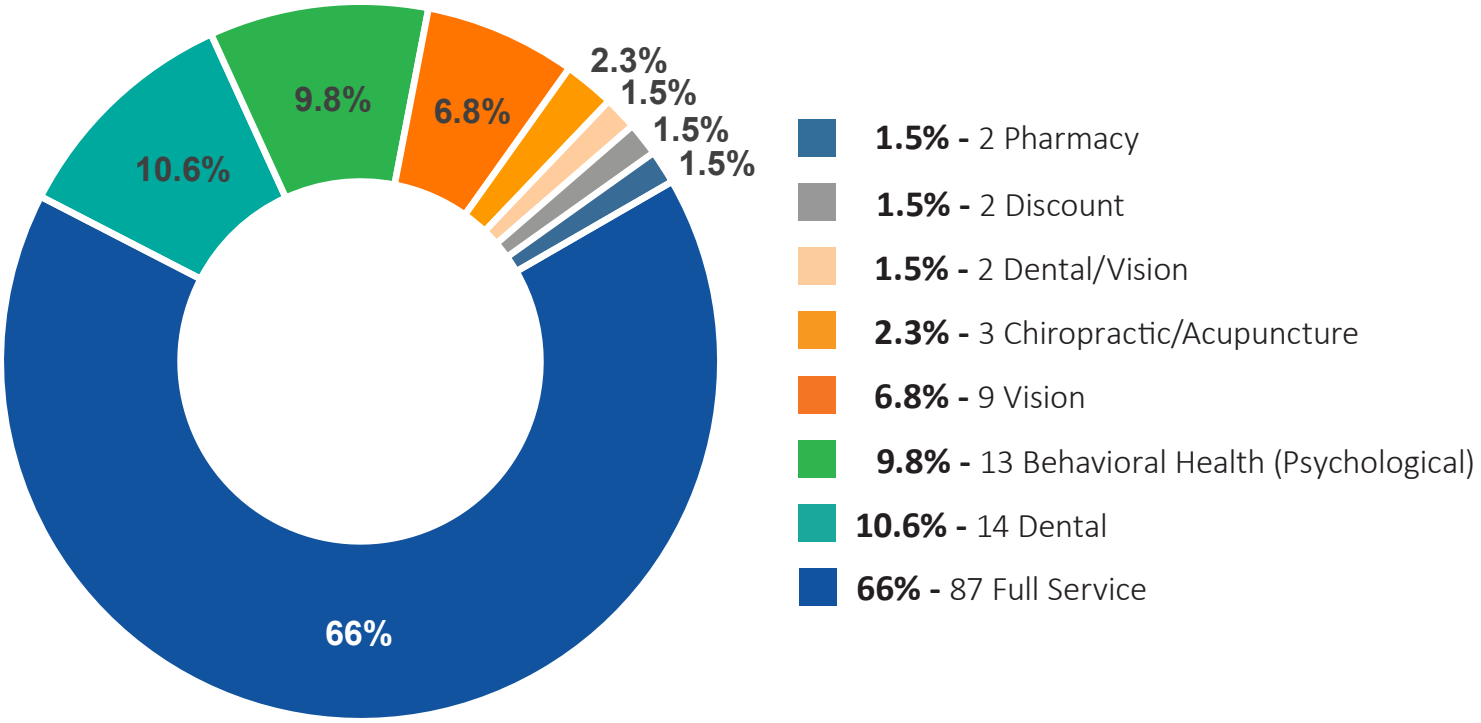
44 COVERED CALIFORNIA FILINGS REVIEWED[8]

43 ALL PLAN LETTERS

195 MATERIAL MODIFICATIONS (SIGNIFICANT CHANGES) RECEIVED

"Health plans in California must be licensed by the DMHC."

LICENSED PLANS IN 2020



to health services when impacted by natural disasters under a declared state of emergency, such as wildfires and extreme weather.

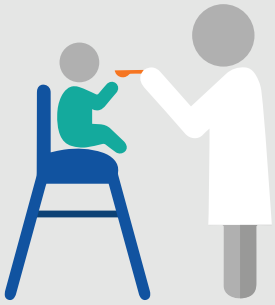
Following the passage of SB 855 (2020), the Department met with stakeholders including the bill's sponsors, behavioral health providers, consumer advocacy groups, health plans, the California Association of Health Plans, the Association of California Life and Health Insurance Companies and California Department of Insurance to discuss implementation to ensure health plans comply with the amendments made by this new law to California's mental health parity law. The law requires commercial health plans and insurers to provide full coverage for the treatment of all mental health conditions and substance use disorders. It also establishes specific standards for what constitutes medically necessary treatment and criteria for the use of clinical guidelines. The DMHC created a consumer fact sheet to help educate enrollees on the new law, and will be working on regulations in 2021.

On an annual basis, the DMHC reviews all Qualified Health Plans (QHP) and Qualified Dental Plans (QDP) applying to offer benefits for the upcoming plan year through Covered California, the state's Health Benefits Exchange. This process involves the review of each plan for compliance with Covered California's Patient Centered Benefit Plan Designs, including cost sharing, actuarial value compliance, and contract amendments between full service and specialized health care service plans. The DMHC reviewed 44 QHP and QDP filings in 2020 to ensure compliance with the consumer protections in both the ACA and Knox-Keene Act.

AB 315 (2018) established various contracting requirements between pharmacy benefit managers (PBMs) and health plans. The bill created a new requirement requiring PBMs that contract with health plans to administer drug benefits to register with the DMHC. In 2019, the Department established a PBM registration process. Since then, the DMHC has received 29 applications and registered 16 PBMs by the end of 2020. Many PBMs that applied for registration did not qualify because they did not contract with a DMHC-regulated health plan.

The DMHC also continued to monitor and review plan compliance with the Uniform Provider Directory Standards established by SB 137 (2015). Health plans must publish and maintain accurate, complete and up-to-date provider directories. All health plans must have publicly available provider directories on their website, make weekly updates to those directories and provide consumers with simple ways to report directory errors.

DMHC HELP CENTER ASSISTANCE: COORDINATION OF CARE (CONTINUITY OF CARE)



Jessica, a minor with an Individual plan PPO coverage, was diagnosed with feeding difficulties, developmental delay, gross motor delay, speech delay, and other serious medical conditions. Her mother asked her health plan to cover her twice weekly oral-motor feeding therapy with an out-of-network provider that had been treating Jessica since birth. Jessica's health plan denied the request and redirected her back to an in-network provider. After unsuccessfully going through the health plan's appeal process, Jessica's mother filed a complaint with the DMHC Help Center. The DMHC Help Center was able to demonstrate that the identified in-network providers were only treating patients via telehealth, and due to the severity of Jessica's condition, in-person services were required. Jessica's health plan agreed to authorize continued oral-motor feeding therapy with the requested out-of-network provider.

Plan Monitoring

The DMHC assesses and monitors health plan networks and delivery systems for compliance with the Knox-Keene Act. The Department evaluates compliance through surveys of health plan operations. A routine survey of each licensed health plan is performed every three years. The DMHC also conducts non-routine surveys when a specific issue or problem requires a focused review of a health plan's operations. The surveys are like audits, and examine health plan practices related to access and availability of services, utilization management, quality improvement, continuity and coordination of care, language access, and enrollee grievances and appeals.

When a survey identifies deficiencies, the DMHC requires corrective actions and may refer deficiencies to the Office of Enforcement for further investigation. Enforcement referrals typically occur when there are repeat deficiencies or when the health plan's corrective actions do not adequately correct the deficiencies. Survey findings, including corrective actions, are issued in public reports posted to the DMHC website.

The DMHC monitors health plan provider networks and the accessibility of services to enrollees by reviewing the geographic proximity of in-network providers to enrollee residences or work locations, provider-to-patient ratios and timely access to care. For some provider types, health plans must meet specific time and distance standards. Health plans networks are required to have an adequate number of providers to deliver care to enrollees in a timely manner. This includes a requirement that plans ensure their network of providers can offer enrollees an appointment within a specific number of days or hours.

When a contract terminates between a health plan and a hospital or provider group, the DMHC assesses how the enrollees affected by the termination will continue to receive care. Health plans must submit a "Block Transfer Filing" to the DMHC when a contract termination with a hospital or provider group affects 2,000 or more enrollees. The DMHC ensures the health plan's remaining network adequately supports the affected enrollee population and requires the health plan to timely notify its affected enrollees, in writing, of the contract termination. The DMHC also requires health plans to notify affected enrollees that they may qualify for "continuity of care," where they can continue to see their doctor or hospital, under certain circumstances, for a limited time after the termination.

DMHC HELP CENTER ASSISTANCE: ENROLLMENT/HEALTH PLAN CUSTOMER SERVICE

Monica, and her husband, Joe, Exclusive Provider Organization (EPO) health plan members, discovered their health plan had canceled their coverage when Joe attempted to get a prescription filled just days before his scheduled surgery. Monica and Joe had been paying their monthly premiums through auto payment and said they never received notice there was a problem with the payments. Monica and Joe were prepared to pay any past due premiums, but their health plan refused to reinstate their coverage. Monica contacted the DMHC Help Center for assistance. The DMHC Help Center discovered a problem with the health plan's notices of cancellation to Monica and Joe. The health plan agreed to reinstate their coverage, allowing Joe to reschedule his surgery.

2020 Highlights

Ensuring access to timely and appropriate behavioral health care treatment and services, including compliance with state and federal mental health parity laws continues to be a high priority for the DMHC. The DMHC received approval in the 2020-21 state budget to conduct focused investigations of all full-service commercial health plans regulated by the Department to further evaluate health plan compliance with parity and assess whether enrollees have consistent access to medically necessary behavioral health care services. To prepare for the focused investigations that will begin in 2021, the DMHC hired two, full-time permanent staff, selected an external consultant and began drafting the scope of work and compliance tools that will be utilized throughout the focused investigations.

On June 12, 2020, the DMHC submitted the amended timely access regulation to the Office of Administrative Law. The purpose of this regulation is to set a standardized methodology for how health plans report timely access to care requirements and annual network requirements to the DMHC. This regulation will help the DMHC ensure health plans are meeting timely access to care requirements, and allow for meaningful comparisons of timely access to care information across health plans. Once the regulation is adopted, the DMHC will be able to better hold health plans accountable.

The DMHC conducted a non-routine survey of Aetna Health of California Inc. (Aetna) following one of Aetna's former Medical Directors stating that he did not independently review relevant medical records and relied solely on information provided by nurses when performing utilization management (UM) review. This information raised questions about whether Aetna's other Medical Directors were making similar UM determinations without conducting an appropriate medical assessment. The non-routine survey report was issued in 2020 with the DMHC's findings which identified two uncorrected deficiencies around the plan's UM oversight. The Department required Aetna to submit additional information around its corrective action efforts to address the deficiencies, and will assess the plan's progress in making corrections to comply with UM oversight at the follow-up survey.

2020 BY THE NUMBERS

PLAN MONITORING

27 ROUTINE SURVEYS

18 FOLLOW-UP SURVEYS

2 NON-ROUTINE SURVEYS[9]

3 MHPAEA FOCUSED FOLLOW-UP SURVEYS

121 UNIQUE HEALTH PLAN NETWORKS REVIEWED[10]

44 TIMELY ACCESS COMPLIANCE REPORTS REVIEWED[11]

301 BLOCK TRANSFERS RECEIVED

65 MATERIAL MODIFICATIONS RECEIVED

> ***"The DMHC assesses and monitors health plan networks and delivery systems for compliance with the Knox-Keene Act."***

Financial Oversight

The DMHC works to ensure stability in California's health care delivery system by actively monitoring the financial status of health plans and provider groups, known as Risk Bearing Organizations (RBOs), to make sure they can meet their financial obligations to consumers and other purchasers.

The DMHC reviews health plan financial statements and filings, and analyzes health plan reserves, financial management systems and administrative arrangements. To monitor and corroborate reported information, the DMHC conducts routine financial examinations of each health plan every three to five years and initiates non-routine financial examinations as needed. Routine examinations focus on health plan compliance with financial and administrative requirements that include reviewing the plan's claims payment practices and provider dispute resolution processes.

The DMHC does not license provider organizations but monitors the financial solvency of RBOs. An RBO is a physician-owned provider group that, in its contracts with health plans, pays claims and assumes financial risk for the cost of all health care services (inpatient and outpatient) for each enrolled person assigned to the RBO by accepting a fixed monthly payment. This arrangement is typically referred to as "capitation."

RBOs are subject to financial solvency requirements and regular financial reporting. The DMHC monitors the financial stability of RBOs by analyzing financial filings, conducting financial and/or claims examinations, reviewing claims payment practices and monitoring corrective action plans. As of December 31, 2020, the DMHC had 199 registered RBOs.

The DMHC annually reviews health plans compliance with Medical Loss Ratio (MLR) requirements of 85% in the large group market and 80% in the individual and small group markets. MLR is the percentage of health plan premiums that a health plan spends on medical services and activities that improve quality of care. If a health plan does not meet the minimum MLR threshold, it must provide rebates to consumers and other purchasers, such as employers.

The DMHC reviews the financial status of all licensed health plans and registered RBOs at the Financial Solvency Standards Board (FSSB) public meetings. The FSSB meets quarterly and advises the Director on matters of financial solvency that affect the delivery of health care services. FSSB members offer a broad range of experience and expertise including perspectives from actuaries, hospital and provider executives, health plan executives and consumer advocates.

2020 Highlights

Due to an increase in provider complaints involving Anthem Blue Cross Medicare Supplement claims, the DMHC imposed a Corrective Action Plan (CAP) to address the plan's unfair claims payment practices. The DMHC required Anthem Blue Cross to remediate all impacted Medicare Supplement claims from January 1, 2017 going forward. As part of the CAP that was completed in November 2020, Anthem Blue Cross processed approximately 120,000 claims and providers received claims payments of $26.3 million and nearly $9.2 million in interest.

The DMHC conducted a non-routine financial examination of California Health and Wellness Plan due to several claims processing deficiencies identified during the DMHC's 2019 routine financial examination. The DMHC imposed a CAP on the plan to correct claims denials and payment accuracy issues. As a result, the plan remediated more than 18,000 claims and paid providers an additional $793,000 in claims payments and $501,000 in interest and penalties, as of December 2020.

In 2020, six health plans were required to issue rebate checks totaling $102.6 million to enrollees for failing to meet the minimum MLR for 2019:

- Aetna Health of California, Inc. reported a MLR of 77.7% and paid rebates of $2.3 million in the small group market.
- Anthem Blue Cross reported a MLR of 77.8% and paid rebates of $53.3 million in the small group market.
- Blue Shield of California reported a MLR of 79% and paid $34.9 million in rebates in the small group market.
- Health Net of California, Inc. reported a MLR of 77.8% and paid $9.9 million in rebates in the small group market.
- Community Care Health Plan, Inc. reported a MLR of 82.6% and paid rebates of $1.3 million in the large group market.
- U.S. Behavioral Health Plan, California (OptumHealth Behavioral Solutions of California) reported a MLR of 57.8% and paid rebates of $859,350 in the large group market.

The updated regulation for RBOs went into effect on October 1, 2019, and the first financial filings were received on February 15, 2020. The updated regulation requires plans to file detailed financial statements and supplemental information on a quarterly and annual basis. In addition, the updated regulation made changes to the Department's grading criteria in financial oversight that went into effect on October 2, 2020. As part of these changes, RBOs must now maintain tangible net equity based on premium revenues or medical expenses, whichever is higher.

2020 BY THE NUMBERS

FINANCIAL OVERSIGHT

70 FINANCIAL EXAMINATIONS COMPLETED[12]

2,677 FINANCIAL STATEMENTS REVIEWED[13]

$102.6 M MLR REBATES[14]

$27.9 M CLAIM AND DISPUTED PAYMENTS REMEDIATED

$10.4 M INTEREST AND PENALTIES PAID

"The DMHC works to ensure stability in California's health care delivery system."

Rate Review

Since January 2011, the DMHC has saved Californians nearly $300 million in health care premiums through the premium rate review program for individual and small group health plans. Under state law, proposed premium rate changes for individual or small group health plans must be filed with the DMHC. Actuaries perform an in-depth review of the health plan's proposed changes and require health plans to demonstrate the proposed rate changes are supported by data, including underlying medical costs and trends. The DMHC does not have the authority to approve or deny rate increases; however, the Department's rate review efforts hold health plans accountable through transparency, ensure consumers get value for their premium dollar and save Californians money.

If the DMHC finds a health plan rate change is not supported, the DMHC negotiates with the health plan to reduce the rate, called a modified rate. If the health plan refuses to modify its rate, the Department can find the rate to be unreasonable. When the DMHC finds a proposed rate change to be unreasonable, the health plan must notify impacted members of the unreasonable finding.

Additionally, health plans that offer large group coverage must file annual aggregated rate information with the DMHC. The DMHC holds a public meeting in accordance with statute to increase transparency of large group rate changes. Starting July 1, 2020, health plans with large group products had to file information regarding the methodology, factors, and assumptions used to determine rates with the DMHC. Reviewing the methodology, factors and assumptions used by these plans in developing the rates provides greater transparency and assurance to large group contract holders that the methods the plans are using to develop rates are reasonable.

Health plans in the commercial market must also file certain prescription drug cost information with the DMHC. The DMHC summarizes the data and the impact of prescription drug costs on health care premiums into an annual report and shares this information at the public meeting on large group rates. The annual report is also available on the DMHC website.

REVIEW & COMMENT ON HEALTH PLAN PROPOSED RATE CHANGES

The DMHC makes it easy for the public to view and comment on health plan proposed rates. Visit **www.RateReview.DMHC.ca.gov** for more information and to review and submit comments.

2020 Highlights

In 2020, the DMHC reviewed 54 individual and small group rate filings. As a result of the Department's review and negotiations with health plans, the DMHC saved consumers $40.3 million in premiums. Anthem Blue Cross agreed to reduce both its proposed small group and grandfathered individual rate increases, saving consumers approximately $36.6 million. Health Net of California, Inc. also reduced its small group rate increase, saving consumers approximately $3.7 million.

Health plans submitted their first annual large group filings under AB 731 (2019) to the DMHC on September 2, 2020. The DMHC reviewed 37 filings from 23 health plans.

In October 2020, the DMHC received 25 prescription drug cost filings from commercial health plans for Measurement Year (MY) 2019. The DMHC includes this information in an annual report on the impact of the cost of prescription drugs on health plan premiums. Among other findings, the MY 2019 report revealed that health plans paid an increase of $1 billion on prescription drugs since 2017, including an increase of $600 million in 2019.

In March 2020, the DMHC held a public meeting to discuss the 2019 large group aggregate rate data, as well as the prescription drug costs reported by health plans in the large group rate market.

2020 BY THE NUMBERS

RATE REVIEW

91 RATE FILING REVIEWS COMPLETED[15]

25 PRESCRIPTION DRUG COST FILINGS REVIEWED

158 RATE FILINGS RECEIVED[16]

0 RATES FOUND UNREASONABLE

3 REDUCED (MODIFIED) RATES

$40.3 M CONSUMER SAVINGS THROUGH NEGOTIATED MODIFIED RATES

$296.1 M CONSUMER SAVINGS THROUGH NEGOTIATED MODIFIED RATES SINCE 2011

> ***Since January 2011, the DMHC has saved Californians $296.1 million in health care premiums.***

Enforcement

To protect consumers, the DMHC takes timely action against health plans that violate the law. The primary purpose of enforcement action is to change plan behavior to comply with the law. Enforcement actions include issuing cease and desist orders, imposing administrative penalties (fines), freezing enrollment and requiring corrective actions. When necessary, the DMHC may pursue litigation to ensure health plans follow the law.

In 2020, the first $1 million in fines collected by the DMHC was transferred to the Steven M. Thompson Physician Corps Loan Repayment Program to be used to encourage physicians to practice in medically underserved areas. The remaining funds were transferred to the Health Care Services Plan Fines and Penalties Fund to support the Medi-Cal program.

2020 Highlights

In 2020, the DMHC assessed $3,720,750 in fines for enforcement actions taken against health plans. The Department's enforcement actions in 2020 involved many diverse legal issues, including failures to timely implement IMR decisions, wrongfully denying emergency services claims payment, violations of state and federal mental health parity laws and improperly denying basic health care services.

Some of the significant enforcement actions taken by the DMHC in 2020 are described below:

The DMHC imposed fines totaling $1.2 million against Blue Cross of California Partnership Plan, Inc. (Blue Cross) for its failure to timely implement two IMR decisions adopted by the DMHC. California law requires health plans to authorize the services within five working days of receiving an IMR determination accepted by the Department. After the DMHC Help Center intervened, the enrollees were able to get the services they needed. In one case, the service was not authorized until 200 days after the plan was legally required to authorize the service. Due to this delay, the plan was fined $1 million. In the second case, the service was not authorized for 41 days after the legal requirement and the plan was fined $205,000 for that violation. Blue Cross acknowledged its failure to comply with the law and agreed to pay the fine and complete a CAP to settle the issue. The plan updated their internal policies to ensure proper IMR handling in the future and paid the imposed penalty.

DMHC HELP CENTER ASSISTANCE: INDEPENDENT MEDICAL REVIEW (IMR): MEDICAL NECESSITY

Helene, a Large Group HMO plan member, was diagnosed with Stage 3 breast cancer. She filed a complaint with the DMHC regarding an interruption in her immunotherapy infusions due to a contract change between her health plan and provider. Helene requested to continue receiving treatment from her existing oncologist. Her health plan denied her request for continuity of care and referred her to an in-network oncologist, but the in-network oncologist was unable to arrange timely treatment. The DMHC Help Center reached out to the plan and the plan agreed to cover the remaining infusions with the out-of-network oncologist, consistent with completion of covered services.

The DMHC ordered Aetna Health of California, Inc. (Aetna) to stop wrongfully denying payment for emergency medical services and fined the plan $500,000. The Department's order also required Aetna to review and remediate claims wrongfully denied since February 1, 2017. The Department previously took enforcement action against Aetna for improperly denying coverage for enrollees' emergency medical services. Aetna entered into settlement agreements with the DMHC in 2015 and 2016 and paid $135,000 in fines, in addition to implementing CAPs requiring training for employees handling claims for emergency services and reimbursement for emergency services.

The DMHC also imposed a $120,000 penalty against Aetna for its continued failure to cover speech therapy services. In September 2014, Aetna and the DMHC entered into a settlement agreement that required the plan to provide speech therapy services as a basic health care service, regardless of whether an enrollee's speech impediment or developmental disability had a physical cause. In 2017, the DMHC's medical survey of the plan found the plan continued to cite to a national clinical policy in support of its denials of speech therapy services that contradicted the terms of the September 2014 settlement agreement with the DMHC. The Department concluded that Aetna violated both the law and settlement agreement by failing to cover basic health care services. The plan acknowledged its failure by implementing a CAP and paying the penalty.

The DMHC imposed a $65,000 penalty against Community Health Group for its failure to provide basic health care services by improperly denying medically necessary speech therapy to treat autism in violation of the California Mental Health Parity Act. The enrollee was a minor with a developmental disability, cerebral palsy, autism spectrum disorder, intractable epilepsy, chromosomal abnormalities and abnormal speech. The enrollee's primary care physician provided a referral for an evaluation to

2020 BY THE NUMBERS

ENFORCEMENT

706 CASES OPENED

146 CASES CLOSED WITH A PENALTY

$3.7 M PENALTIES ASSESSED

"To protect consumers, the DMHC takes timely action against health plans that violate the law."

receive speech therapy services in addition to the services received once a week at the enrollee's school. Community Health Group improperly denied the provider's request. The DMHC determined the speech therapy services legally qualified as ambulatory care services. In denying speech therapy, the plan denied a basic health care service. The plan acknowledged its failure by paying a fine and implementing a CAP including training staff to recognize Medi-Cal managed care plans may not impose service limitations on Early and Periodic Screening, Diagnostic and Treatment benefits, including speech therapy.

The DMHC imposed a $25,000 penalty against Ventura County Health for its failure to correct deficiencies identified in a focused survey regarding compliance with MHPAEA. Ventura County Health failed to calculate financial requirements in accordance with the MHPAEA regulations. In addition to paying the penalty, Ventura County Health provided proof that all enrollees who were charged incorrect cost-sharing amounts for mental health or substance use disorder services were reimbursed directly by the providers and, in some instances, by the plan.

DMHC HELP CENTER ASSISTANCE: CLAIMS/FINANCIAL/ COVERAGE OF FERTILITY PRESERVATION

Serena, a Large Group HMO plan member, was diagnosed with lymphoma. She required chemotherapy treatment that could cause infertility. She underwent fertility preservation procedures before starting chemotherapy. Her health plan covered the treatments, but charged her copayments based on the infertility benefits of her Evidence of Coverage. Serena submitted a complaint to the DMHC Help Center, because she thought her copayments should be calculated under her benefits for basic health care services. After the DMHC Help Center intervened, Serena's health plan agreed to reprocess her copayments under her benefits for basic health care services.

Celebrating 10 Years of the Affordable Care Act (ACA)

California has been a national leader in the implementation of ACA. As a result, California's uninsured rate has fallen from 17% to 7.1%. The number of uninsured Californians has dropped by 3.7 million[17]. The DMHC has played an active role in California's implementation of the ACA since its passage in 2010, working as a partner with other state agencies, legislators, health plans, providers and stakeholders. As a result, California has remained ahead of the curve in executing health reform. This section briefly highlights ACA implementation activities of the DMHC to date.

Statutory Changes and Regulatory Guidance

The DMHC provided technical expertise for updating California laws to make them consistent with the ACA. California passed legislation to guarantee availability of coverage for children and to allow them to stay on their parents' policy until age 26[18]. State legislation ensured coverage for preventive health care services without cost sharing, eliminated annual and lifetime dollar limits on benefits and established California's benchmark for essential health benefits as minimum coverage in the individual and small group markets[19]. California's chosen Essential Health Benefits benchmark plan is a Knox-Keene licensed benefit plan, Kaiser Small Group HMO 30. Each state's benchmark plan sets the minimum benefits requirements for all coverage under individual and small group coverage. As such, the Knox-Keene Act's comprehensive approach to benefits became the standard for all coverage in the individual and small group markets in California.

The state Legislature also authorized the DMHC to review premium rate filings and enforce MLR requirements[20]. Market reforms for individual and small employer coverage guaranteed availability of coverage without preexisting condition limitations and imposed standard rating rules, prohibiting rates based on expected claims use or health status. California had already enacted many of these market reforms, including guaranteed availability and renewal for small employers and guaranteed renewability for individuals.

The additional ACA protections also paved the way for individuals to have guaranteed coverage at reasonable rates due to the individual health coverage mandate. In 2019, the U.S. Congress eliminated the penalty for the ACA's individual mandate and California enacted an individual mandate in state law, imposing a tax penalty on Californians who go without health coverage that became effective on January 1, 2020. California also enacted new and expanded subsidies to increase coverage and promote affordability. The individual mandate, along with the state subsidy improved access for low-income and middle-income Californians to purchase affordable coverage, and ensures a healthy risk pool and more stable health insurance market.

As illustrated by the following chart, which offers a comparison of the standards required by the Knox-Keene Act prior to the passage of the ACA, California was a national leader in providing health plan enrollees robust health care protections even before the enactment of the ACA.

Following passage of ACA-related reforms, the DMHC developed detailed rules, guidance and regulatory review procedures. Leading up to 2014, the first year of full implementation of the ACA, the DMHC reviewed a significant increase of health plan products and rate filings, including filings for Qualified Health Plans selected to participate in Covered California as well for products offered off the exchange. Now the DMHC reviews these filings annually. The DMHC's review includes network adequacy, standard benefit designs, essential health benefits, and benefit and rate change notices for individual and small employer contracts.

Health Plan Standards in Knox-Keene Act and the ACA

	Knox-Keene Act Pre-ACA	ACA Provision
Minimum Benefits	For individual, small group, and large group coverage, mandates basic health care services as a minimum, if medically necessary	For individual and small group coverage, mandates essential health benefits as a minimum
Comprehensive Coverage	Prohibits denial based on fixed dollar or service limits	Prohibits annual and lifetime dollar limits on essential health benefits
Preventive Health Care Services	For individual, small group, and large group coverage, mandates coverage of preventive health care services as a basic health care service	For individual and small group coverage, mandates coverage of preventive health care services as essential health benefit; requires coverage for certain preventive services without any enrollee cost sharing
Emergency Services	For individual, small group, and large group coverage, mandates coverage of emergency services as a basic health care service, including out-of-area emergencies Requires uniform cost sharing for out-of-network and in-network emergency services	For individual and small group coverage, mandates coverage of emergency services as an essential health benefit Prohibits higher deductibles, co-payments and co-insurance for out-of-network emergency services than those charged for in-network emergency services
Provider Choice	For individual, small group, and large group coverage, allows enrollees to select any available participating primary care provider Allows enrollees to access care from a participating obstetrician-gynecologist (OB-GYN) providers without a referral	For individual, small group, and large group coverage, allows enrollee to select any available participating primary care provider Allows enrollees to access care from a participating OB-GYN provider without a referral
Network Adequacy	Requires readily available and accessible primary, specialty, institutional and ancillary services, subject to specific time and distance standards, physician-enrollee ratios and appointment waiting time standards	For individual and small group coverage offered through the Exchange, requires qualified health plans to offer a sufficient choice of providers in number and type to ensure that all services will be accessible without unreasonable delay

	Knox-Keene Act Pre-ACA	ACA Provision
Independent External Review	Establishes the Independent Medical Review (IMR) program (1999), allowing enrollees to request binding independent review of health plan decisions that deny, modify or delay coverage of requested services based on medical necessity	Requires issuers to have an independent external review process much like IMR. CMS determined the Knox-Keene Act IMR program complies with the ACA
Guaranteed Availability	Guaranteed availability for small group coverage (1992) Limited guaranteed availability in the individual market: HIPAA coverage, conversion coverage, continuation coverage, Cal-COBRA	Guaranteed availability for individual, small group, and large group coverage
Pre-existing Condition Exclusions	For small group coverage, limited the pre-existing condition exclusion period to six months For individual and large group coverage, limited pre-existing condition exclusion periods to six or twelve months, depending on the number of enrollees	For individual, small group, and large group coverage, prohibits all pre-existing condition exclusions
Guaranteed Renewability	For individual, small group, and large group coverage, guaranteed renewability except in cases of nonpayment, fraud or good cause	For individual, small group, and large group coverage, guaranteed renewability, with limited exceptions, including nonpayment, fraud, or issuer ceases to offer product/exits market

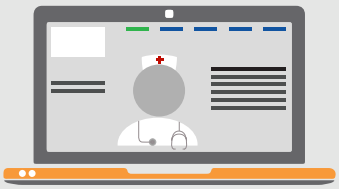
ACA Education and Information

Starting in 2010, the DMHC Help Center received federal ACA Consumer Assistance Program grant funds to develop statewide media materials, enhance the consumer facing website, and expand the Help Center's capacity to help educate and inform consumers about the coverage opportunities and changes in the ACA. The Department developed toolkits including resource guides and fact sheets for individuals, families and small businesses to help them understand their rights to keep coverage, gain new coverage or file a grievance or appeal. In addition, the DMHC awarded a portion of the grant funds to the Health Consumer Alliance, a network of nine community-based legal services organizations, to provide local, one-on-one assistance to individuals and families navigating the post-ACA health coverage market. As part of the grant, the DMHC worked with experts and stakeholders to develop accessible educational materials for individuals with physical, developmental, intellectual and sensory disabilities.

The DMHC no longer receives federal grant funding for ACA education and outreach. However, the Department has maintained its Consumer Assistance Program beyond the federal funding and continues to help consumers understand their rights and receive the care they need. Through the Consumer Assistance Program, the DMHC contracts with community-based organizations to provide consumers with local, in-depth assistance. Over the last five years, the DMHC's Consumer Assistance Program has served 63,788 consumers and conducted 9,847 outreach events. Through these outreach events, the Department has reached more than 633,000 consumers.

DMHC HELP CENTER ASSISTANCE: BENEFITS / COVERAGE – INACCURATE PROVIDER DIRECTORY

Paul, a Large Group PPO health plan member, obtained heath care services from a provider that he found on his employer group's health plan website. Paul's health plan denied the provider's claims because the provider was not contracted with Paul's health plan. After making several unsuccessful appeals to his health plan, Paul filed a complaint with the DMHC Help Center. The DMHC Help Center worked with Paul to get proof the provider was listed incorrectly on his employer's health plan website. Based on this information, Paul's health plan agreed to cover the services due to the inaccurate information on his employer group's heath plan website.



Creation of the DMHC Emphasizes Consumer Protection

The Department of Corporations administered a comprehensive regulatory framework through the Knox-Keene Act. However, as enrollment in managed care plans in California accelerated throughout the 1990s, policymakers and others began to question whether health plans were effectively balancing access, care and quality with costs. Managed care plans in the state kept California premiums historically among the lowest in the country but the growing national focus on quality brought a new level of scrutiny to health plan policies and management strategies. The resulting "managed care backlash" led to a wave of more stringent legislative and regulatory requirements imposed on health plans.

It was in this environment that the DMHC was created. Legislation to transfer oversight of health plans from the Department of Corporations to a new "state agency devoted exclusively to the licensing and regulation of managed health care" came as part of a sweeping package of bills sponsored by consumer advocacy organizations, dubbed the Patient Bill of Rights. AB 78 (1999) required the new DMHC to establish a consumer-focused Help Center and amended the original legislative intent of the Knox-Keene Act to reinforce the DMHC's role in addressing consumer complaints.

The new consumer-focused DMHC opened in July 2000 to assist consumers and ensure the accessibility and the quality of health care services offered by the health plans it licenses.

THE PATIENT BILL OF RIGHTS

- Guaranteed coverage for second opinions
- Time limits for utilization review and mandated disclosure of the criteria health plans use in denying coverage
- Independent external medical review to resolve disputes related to denials, delays, or modifications of coverage for health services
- Improvements in the external review system for coverage of experimental treatments
- Consumer right to sue an HMO for damages related to denials or delays in care
- Standards to assure the solvency of medical groups under contract with health plans, and
- Additional mandated benefits, including mental health parity, contraception, hospice, cancer screening, and coverage for diabetic supplies

Historical Timeline of the Knox-Keene Act[21]

1929-1945

Early prepaid health plan models emerge in California (Ross-Loos, Permanente Health Plan and Blue Shield of California).

1946

California Supreme Court rules that Blue Shield of California and other prepaid health plans are not in the business of insurance and are not subject to the jurisdiction of the Insurance Commissioner. (*California Physicians' Service v. Garrison* (1946) 28 Cal.2d 790)

1965

Knox-Mills Health Plan Act requires health care service plans to register with the California Attorney General (AB 419, 1965). More than 100 health plans register including Ross-Loos, Kaiser Permanente, Blue Shield of California and Family Health Plan, along with specialized dental and mental health plans.

1972

California Waxman-Duffy Prepaid Health Plan Act (AB 1496, 1972) sets standards for the growing number of prepaid health plans in Medi-Cal under the oversight of the Department of Health Services.

1973

Congress passes the Federal Health Maintenance Organization Act and coins the term "HMO" for the first time. The Act establishes comprehensive benefits, community rating, financial reserve standards and other requirements.

1975

Knox-Keene Health Care Service Plan Act of 1975 transfers health care service plans from the Attorney General to the Commissioner of Corporations (AB 138, 1975) and establishes a comprehensive framework of regulatory oversight and consumer protections.

1982

Legislature authorizes disability insurers to selectively contract with health care providers, paving the way for the Insurance Commissioner to also license and regulate PPOs, as health insurance products (AB 3480, 1982).

1993

Legislature authorizes Knox-Keene plans to develop point-of-service (POS) contracts (SB 1221, 1993).

1995

Legislature requires the Department of Corporations (DOC) to establish a toll-free number to receive consumer complaints and inquiries (SB 689, 1995).

1996

Legislation creates the Managed Health Care Improvement Task Force to report on the status of health coverage and make recommendations on the appropriate role for government oversight and regulation of managed care (AB 2343, 1996). Legislation requires the DOC to establish an HMO Ombudsperson to resolve and respond to consumer complaints (SB 1936, 1996).

1998

Managed Care Task Force recommends the creation of a new state department to regulate health care service plans and to phase in regulation of medical groups and other provider entities that bear substantial risk for health care services.

1999

Legislature passes 21-bill package known as the Patient Bill of Rights, which establishes the DMHC and transfers responsibility of regulating health care service plans under the Department (AB 78, 1999).

DMHC HELP CENTER ASSISTANCE: COORDINATION OF CARE (CONTINUITY OF CARE) / HEALTH PLAN CUSTOMER SERVICE

Miguel, a minor enrolled in a Medi-Cal Managed Care health plan, was diagnosed with autism and language impairment. His mother contacted the DMHC Help Center because his health plan would not authorize continued speech therapy services from the provider after the provider's contract with the plan was terminated. The DMHC Help Center informed Miguel's health plan that the speech therapy services from the newly terminated provider qualified for completion of covered services under California law, and the health plan authorized continued services from the provider.

Looking Ahead

The Department has a proud history of consumer-protective achievements and a consumer-focused approach to the regulation of health plans in California. For over 20 years, the DMHC has continued to build on California's leadership and regulation of managed health care delivery systems. Much has happened over these two decades, including significant changes brought on by the passage of the ACA ten years ago.

Looking forward, the Department will continue to provide consumer assistance and regulatory enforcement activities while staying on top of the emerging challenges facing the health care delivery system. This includes a continued focus on the changes and challenges presented by the COVID-19 pandemic, and supporting the state's ongoing recovery efforts. As California moves on to a new normal, the DMHC will play an important role in ensuring the enduring stability of the health care delivery system and consumer access to needed and delayed care caused by the pandemic.

Additionally, the Department remains focused on ensuring all health care enrollees can obtain timely and appropriate access to care. This includes making sure that health plan enrollees can access appropriate behavioral health care services when they need them.

The DMHC will also continue ongoing efforts to achieve the Department's overall mission including implementing new laws and regulations, ensuring the financial stability of health plans and risk bearing organizations, conducting health plan surveys and financial examinations, assessing the adequacy of plan networks to ensure timely access to care, taking action against health plans that violate consumers' health care rights and providing direct assistance to consumers through the DMHC Help Center.

Notes

1 The enrollment charts include the following enrollment types reported by plans and searchable in the Health Plan Financial Summary Report: Point of service - Large Group, PPO - Large Group, Group (Commercial), Point of Service - Small Group, PPO - Small Group, Small Group, PPO - Individual, Point of Service - Individual, Individual, IHSS, Medi-Cal Risk, Medicare Risk (Medicare Advantage), Medicare Cost (Fee For Service) and Medicare Supplement. Healthy Families and AIM enrollment were also reported in previous years when those programs were active.

2 Delta Dental of California and the Department of Health Care Services made a change in their contractual arrangement in January 2018, whereby Delta Dental of California was no longer the fiscal intermediary of the Medi-Cal dental program. As a result, Delta Dental of California's Medi-Cal enrollment declined by approximately 13 million lives.

3 Enrollees received the requested services in nearly 68% of the cases qualified by the Department for the IMR program in 2020.

4 This includes consumers who may have received more than one form of assistance throughout the year.

5 Consumer complaints are comprised of standard complaints (10,061), quick resolutions (440), and urgent cases (69) in 2020. 8,286 of the standard complaints were resolved by the DMHC and are included in the complaint report in the Appendix. Of the remaining cases, most were sent back to the health plan to address through the grievance process.

6 IMRs closed are comprised of cases that were resolved by the DMHC or closed for any reason other than non-jurisdictional in 2020. 2,592 of the IMRs were resolved by the DMHC and are included in the IMR report in the Appendix. The remaining cases were closed because the consumer had not yet gone through the health plan grievance process, the consumer did not respond to requests for information, or the case was ineligible for IMR.

7 The category "Coordination of Benefits" has also been previously referred to as "Quality of Care."

8 Includes review of Qualified Health Plan filings and Qualified Dental Plan filings.

9 The non-routine surveys released in 2020 were for Aetna Health of California, Inc. and Anthem Blue Cross (Dental).

10 Networks reviewed in 2020 were for Measurement Year 2019.

11 Timely Access compliance reports reviewed in 2020 were for Measurement Year 2019.

12 43 Health Plan Financial Examinations, 3 Health Plan Medical Loss Ratio Exams and 24 RBO Financial Examinations.

13 1,445 Health Plan Financial Statements Reviewed and 1,232 RBO Financial Statements Reviewed.

14 Rebates for calendar year 2019, paid in 2020.

15 This includes 14 individual market health plan premium rate filings, 40 small group rate filings, and 37 large group rate filings. The total number of rate filings increased from previous years as a result of AB 731 (2019), which required health plans to file large group rate filings with the DMHC starting in 2020.

16 The DMHC does not review annual aggregate rate filings.

17 How Many In Your Area Are Covered by the Affordable Care Act?, California HealthCare Foundation, 2020. Available online at: https://www.chcf.org/publication/how-many-your-area-are-covered-affordable-care-act/#easy-footnote-bottom-2-43290.

18 Guaranteed Coverage for Children (AB 2244, 2010) and Dependent Coverage up to age 26 (SB 1088, 2010).

19 Preventive services (AB 2345, 2010) and Essential health benefits (AB 1453, 2012; SB 951, 2012).

20 Premium rate review (SB 1163, 2010) and Medical Loss Ratios, Annual and Lifetime Benefit Limits (SB 51, 2011).

21 Excerpted from Making Sense of Managed Care Regulation in California, California HealthCare Foundation, 2001. Available online at: https://www.chcf.org/publication/making-sense-of-managed-care-regulation-in-california/

2020 Independent Medical Review Summary Report

Report Overview

68%
of enrollee cases that qualified for the Department's IMR program received the requested services they needed.*

15%
of IMR cases were reversed by the health plan after the DMHC received the IMR application.

53%
of cases previously denied by health plans were overturned by the IMRO.

32%
of cases were upheld by the IMRO.

The Annual Independent Medical Review (IMR) Summary Report displays the number and types of IMRs resolved during the 2020 calendar year, by health plan. The Department resolved 2,592 IMRs.

The Report identifies each health plan's enrollment during the year, the number of IMRs resolved for each health plan, the number of IMRs per 10,000 enrollees, the number of IMRs upheld or overturned by the Independent Medical Review Organization (IMRO), and the number of IMRs that the health plan reversed.

The health plan enrollment figures were provided to the Department by the health plans in their quarterly financial filings. Enrollment reflects the enrollment figures provided for the fourth quarter of 2020 for the population of enrollees within the DMHC Help Center's jurisdiction. Plans with zero enrollment as of December 31, 2020, may have had enrollment earlier in the year or received a license during 2020.

Data represents resolved IMRs which were determined to be within the Department's jurisdiction, eligible for review, and resolved (closed) within calendar year 2020. Cases pending at the end of 2020 and resolved (closed) in the following year are reported in the subsequent year's Annual Report.

Health plans are listed according to their business names during 2020. In instances where a health plan is known by more than one name, the legal name is shown first with the additional name(s) in parentheses. For health plans that are involved in plan-to-plan arrangements, the data is reported by the primary plan only.

The number of IMRs per 10,000 enrollees is displayed to illustrate the volume of IMRs for a plan in a manner that considers the wide variations in plan enrollment. When comparing plans, a lower number of IMRs per 10,000 enrollees indicates fewer IMRs were resolved per capita. As a result, a plan with a higher overall number of resolved IMRs may still show fewer IMRs per 10,000 enrollees than another plan with fewer overall resolved IMRs.

* Enrollees received the requested services in 67.9% of the cases qualified by the Department for the IMR program in 2020.

California Department of Managed Health Care

2020 Independent Medical Review by Health Plan

Plan Type and Name	Enrollees*	Total IMRs Resolved	IMRs per 10,000	EXPERIMENTAL / INVESTIGATIONAL IMR							MEDICAL NECESSITY IMR							ER REIMBURSEMENT IMR						
				Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%
FULL SERVICE – ENROLLMENT OVER 400,000																								
Blue Cross of California (Anthem Blue Cross)	2,236,665	534	2.39	136	54	39.7%	74	54.4%	8	5.9%	397	109	27.5%	253	63.7%	35	8.8%	1	0	0.0%	0	0.0%	1	100.0%
Blue Cross of California Partnership Plan, Inc.	808,082	56	0.69	2	0	0.0%	1	50.0%	1	50.0%	54	12	22.2%	22	40.7%	20	37.0%	0	0	0.0%	0	0.0%	0	0.0%
California Physicians' Service (Blue Shield of California)	2,596,281	969	3.73	192	90	46.9%	79	41.1%	23	12.0%	774	188	24.3%	503	65.0%	83	10.7%	3	1	33.3%	2	66.7%	0	0.0%
Health Net Community Solutions, Inc.	1,425,909	80	0.56	5	3	60.0%	2	40.0%	0	0.0%	75	25	33.3%	29	38.7%	21	28.0%	0	0	0.0%	0	0.0%	0	0.0%
Health Net of California, Inc.	570,069	88	1.54	15	5	33.3%	7	46.7%	3	20.0%	72	18	25.0%	28	38.9%	26	36.1%	1	1	100.0%	0	0.0%	0	0.0%
Inland Empire Health Plan (IEHP)	1,326,955	75	0.57	3	1	33.3%	2	66.7%	0	0.0%	72	45	62.5%	18	25.0%	9	12.5%	0	0	0.0%	0	0.0%	0	0.0%
Kaiser Foundation Health Plan, Inc. (Kaiser Permanente)	7,098,996	251	0.35	3	3	100.0%	0	0.0%	0	0.0%	248	123	49.6%	96	38.7%	29	11.7%	0	0	0.0%	0	0.0%	0	0.0%
Local Initiative Health Authority for Los Angeles County (L.A. Care Health Plan)	2,316,497	93	0.40	4	3	75.0%	0	0.0%	1	25.0%	88	30	34.1%	41	46.6%	17	19.3%	1	0	0.0%	0	0.0%	1	100.0%
Molina Healthcare of California	501,613	15	0.30	0	0	0.0%	0	0.0%	0	0.0%	15	6	40.0%	4	26.7%	5	33.3%	0	0	0.0%	0	0.0%	0	0.0%
UHC of California (UnitedHealthcare of California)	405,397	64	1.58	8	5	62.5%	3	37.5%	0	0.0%	56	15	26.8%	25	44.6%	16	28.6%	0	0	0.0%	0	0.0%	0	0.0%
Total Full Service - Enrollment Over 400,000:	**19,286,464**	**2,225**	**1.15**	**368**	**164**	**44.6%**	**168**	**45.7%**	**36**	**9.8%**	**1851**	**571**	**30.8%**	**1019**	**55.1%**	**261**	**14.1%**	**6**	**2**	**33.3%**	**2**	**33.3%**	**2**	**33.3%**
FULL SERVICE – ENROLLMENT UNDER 400,000																								
Access Senior HealthCare, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Adventist Health Plan, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Aetna Better Health of California Inc.	30,071	5	1.66	1	1	100.0%	0	0.0%	0	0.0%	4	1	25.0%	1	25.0%	2	50.0%	0	0	0.0%	0	0.0%	0	0.0%
Aetna Health of California Inc.	197,414	12	0.61	1	1	100.0%	0	0.0%	0	0.0%	11	3	27.3%	5	45.5%	3	27.3%	0	0	0.0%	0	0.0%	0	0.0%
AIDS Healthcare Foundation (Positive Healthcare)	691	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Alameda Alliance For Health	275,726	11	0.40	0	0	0.0%	0	0.0%	0	0.0%	11	6	54.5%	2	18.2%	3	27.3%	0	0	0.0%	0	0.0%	0	0.0%
Alignment Health Plan**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
AltaMed Health Network, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
AmericasHealth Plan, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Arcadian Health Plan, Inc.**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Aspire Health Plan**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Astiva Health, Inc.**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Bay Area Accountable Care Network, Inc. (Canopy Health)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Blue Shield of California Promise Health Plan	103,414	6	0.58	0	0	0.0%	0	0.0%	0	0.0%	6	1	16.7%	2	33.3%	3	50.0%	0	0	0.0%	0	0.0%	0	0.0%
Brandman Health Plan**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Brown & Toland Health Services, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
California Health and Wellness Plan (California Health and Wellness)	206,031	7	0.34	0	0	0.0%	0	0.0%	0	0.0%	7	1	14.3%	4	57.1%	2	28.6%	0	0	0.0%	0	0.0%	0	0.0%
Care Improvement Plus South Central Insurance Company**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
CareMore Health Plan	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Central Health Plan of California, Inc.**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
CHG Foundation (Community Health Group Partnership Plan)	276,672	4	0.14	0	0	0.0%	0	0.0%	0	0.0%	4	2	50.0%	2	50.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Children's Health Plan of California	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Chinese Community Health Plan	8,713	2	2.30	1	0	0.0%	1	100.0%	0	0.0%	1	0	0.0%	1	100.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Choice Physicians Network, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Cigna HealthCare of California, Inc.	150,432	17	1.13	6	3	50.0%	0	0.0%	3	50.0%	11	2	18.2%	6	54.5%	3	27.3%	0	0	0.0%	0	0.0%	0	0.0%
Clever Care of Golden State Inc. (Clever Care of California)**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Community Care Health Plan, Inc.	11,496	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Community Health Group	6,979	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Contra Costa County Medical Services (Contra Costa Health Plan)	202,017	11	0.54	1	1	100.0%	0	0.0%	0	0.0%	10	7	70.0%	3	30.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
County of Ventura (Ventura County Health Care Plan)	12,117	1	0.83	0	0	0.0%	0	0.0%	0	0.0%	1	0	0.0%	1	100.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Dignity Health Provider Resources, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
EPIC Health Plan	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
For Your Benefit, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Fresno-Kings-Madera Regional Health Authority (CalViva Health)	374,982	34	0.91	0	0	0.0%	0	0.0%	0	0.0%	34	13	38.2%	15	44.1%	6	17.6%	0	0	0.0%	0	0.0%	0	0.0%
Global Health Plan, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%

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Plan Type and Name	Enrollees*	Total IMRs Resolved	IMRs per 10,000	EXPERIMENTAL / INVESTIGATIONAL IMR							MEDICAL NECESSITY IMR							ER REIMBURSEMENT IMR						
				Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%
Golden State Medicare Health Plan (Golden State Health Plan)**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Health Net Health Plan of Oregon, Inc. (Health Net Medicare of California)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Heritage Provider Network, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Hill Physicians Care Solutions, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Humana Health Plan of California, Inc.**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Imperial Health Plan of California, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Inter Valley Health Plan, Inc.**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Kern Health Systems	277,452	26	0.94	0	0	0.0%	0	0.0%	0	0.0%	26	5	19.2%	9	34.6%	12	46.2%	0	0	0.0%	0	0.0%	0	0.0%
Medcore HP	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Medi-Excel, S.A. de C.V. (MediExcel Health Plan)	14,062	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
MemorialCare Select Health Plan	230	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Meritage Health Plan	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Monarch Health Plan, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
On Lok Senior Health Services	381	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Optum Health Plan of California	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Orange County Health Authority (CalOptima)***	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Oscar Health Plan of California	103,833	44	4.24	4	2	50.0%	1	25.0%	1	25.0%	39	6	15.4%	17	43.6%	16	41.0%	1	1	100.0%	0	0.0%	0	0.0%
Partnership HealthPlan of California***	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Premier Health Plan Services, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
PRIMECARE Medical Network, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Prospect Health Plan, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Providence Health Assurance**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Providence Health Network	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
San Francisco Health Authority (San Francisco Health Plan)	150,634	3	0.20	1	0	0.0%	0	0.0%	1	100.0%	2	0	0.0%	1	50.0%	1	50.0%	0	0	0.0%	0	0.0%	0	0.0%
San Joaquin County Health Commission (Health Plan of San Joaquin)	364,077	13	0.36	1	0	0.0%	1	100.0%	0	0.0%	12	5	41.7%	5	41.7%	2	16.7%	0	0	0.0%	0	0.0%	0	0.0%
San Mateo Health Commission (Health Plan of San Mateo)	122,943	31	2.52	2	0	0.0%	2	100.0%	0	0.0%	29	6	20.7%	21	72.4%	2	6.9%	0	0	0.0%	0	0.0%	0	0.0%
Santa Barbara San Luis Obispo Regional Health Authority (CenCal Health)***	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Santa Clara County (Valley Health Plan)	44,602	5	1.12	0	0	0.0%	0	0.0%	0	0.0%	5	1	20.0%	3	60.0%	1	20.0%	0	0	0.0%	0	0.0%	0	0.0%
Santa Clara County Health Authority (Santa Clara Family Health Plan)	271,107	19	0.70	1	0	0.0%	1	100.0%	0	0.0%	18	3	16.7%	10	55.6%	5	27.8%	0	0	0.0%	0	0.0%	0	0.0%
Santa Cruz-Monterey-Merced Managed Medical Care Commission (Central California Alliance for Health)***	540	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Scan Health Plan	13,966	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Scripps Health Plan Services, Inc.	15,253	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Sequoia Health Plan, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Sharp Health Plan	138,970	41	2.95	2	1	50.0%	1	50.0%	0	0.0%	38	9	23.7%	17	44.7%	12	31.6%	1	0	0.0%	1	100.0%	0	0.0%
Sistemas Medicos Nacionales, S.A.de C.V. (SIMNSA Health Plan)	48,484	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Stanford Health Care Advantage**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Sutter Health Plan (Sutter Health Plus)	96,692	20	2.07	2	1	50.0%	1	50.0%	0	0.0%	18	3	16.7%	11	61.1%	4	22.2%	0	0	0.0%	0	0.0%	0	0.0%
UnitedHealthcare Benefits Plan of California	162,829	8	0.49	0	0	0.0%	0	0.0%	0	0.0%	8	3	37.5%	5	62.5%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
UnitedHealthcare Community Plan of California, Inc.	19,851	1	0.50	0	0	0.0%	0	0.0%	0	0.0%	1	0	0.0%	0	0.0%	1	100.0%	0	0	0.0%	0	0.0%	0	0.0%
Universal Care, Inc. (Brand New Day)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Vitality Health Plan of California, Inc.**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
WellCare of California, Inc.**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Western Health Advantage	101,791	42	4.13	3	2	66.7%	0	0.0%	1	33.3%	39	6	15.4%	23	59.0%	10	25.6%	0	0	0.0%	0	0.0%	0	0.0%
Total Full Service - Enrollment Under 400,000:	**3,804,452**	**363**	**0.95**	**26**	**12**	**46.2%**	**8**	**30.8%**	**6**	**23.1%**	**335**	**83**	**24.8%**	**164**	**49.0%**	**88**	**26.3%**	**2**	**1**	**50.0%**	**1**	**50.0%**	**0**	**0.0%**
Total All Full Service Plans:	**23,090,916**	**2,588**	**1.12**	**394**	**176**	**44.7%**	**176**	**44.7%**	**42**	**10.7%**	**2,186**	**654**	**29.9%**	**1,183**	**54.1%**	**349**	**16.0%**	**8**	**3**	**37.5%**	**3**	**37.5%**	**2**	**25.0%**
CHIROPRACTIC																								
ACN Group of California, Inc. (OptumHealth Physical Health of California)	73,948	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%

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				Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%
American Specialty Health Plans of California, Inc. (ASHP)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Landmark Healthplan of California, Inc.	67,027	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Chiropractic:	**140,975**	**0**	**0.00**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
DENTAL																								
Access Dental Plan	317,441	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Aetna Dental of California Inc.	121,251	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
California Dental Network, Inc.	75,170	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Cigna Dental Health of California, Inc.	209,840	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Consumer Health, Inc. (Newport Dental Plan)	6,194	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Dedicated Dental Systems, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Dental Benefit Providers of California, Inc.	161,201	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Dental Health Services	71,684	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Golden West Health Plan, Inc. (Golden West Dental & Vision Plan)	10,071	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Liberty Dental Plan of California, Inc. (Personal Dental Services)	384,551	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Managed Dental Care	100,538	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Starmount Managed Dental of California, Inc. (Unum Dental HMO Plan)	1,229	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
UDC Dental California, Inc. (United Dental Care of California, Inc.)	26,279	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
United Concordia Dental Plans of California, Inc.	85,288	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Western Dental Services, Inc. (Western Dental Plan)	144,429	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Dental:	**1,715,166**	**0**	**0.00**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
DENTAL/VISION																								
Delta Dental of California	5,062,584	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
SafeGuard Health Plans, Inc. (MetLife)	245,894	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Dental/Vision:	**5,308,478**	**0**	**0.00**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
DISCOUNT																								
First Dental Health	28,546	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
The CDI Group, Inc.	36,000	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Discount:	**64,546**	**0**	**0.00**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
PHARMACY																								
SilverScript Insurance Company	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
WellCare Prescription Insurance, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Pharmacy:	**0**	**0**	**0.00**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
BEHAVIORAL HEALTH (PSYCHOLOGICAL)																								
Beacon Health Options of California, Inc. (Beacon of California)	713,228	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Cigna Behavioral Health of California, Inc.	137,629	1	0.07	0	0	0.0%	0	0.0%	0	0.0%	1	0	0.0%	0	0.0%	1	100.0%	0	0	0.0%	0	0.0%	0	0.0%
Claremont Behavioral Services, Inc. (Claremont EAP)	50,882	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
CONCERN: Employee Assistance Program	144,184	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Empathia Pacific, Inc. (LifeMatters)	148,945	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Health Advocate West, Inc.	81,719	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Health and Human Resource Center, Inc. (Aetna Resources for Living)	1,481,951	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Holman Professional Counseling Centers	120,849	1	0.08	0	0	0.0%	0	0.0%	0	0.0%	1	0	0.0%	1	100.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Human Affairs International of California (HAI-CA)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Humana EAP and Work-Life Services of California, Inc.	28,610	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Magellan Health Services of California, Inc. - Employer Services	847,574	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%

California Department of Managed Health Care

2020 Independent Medical Review by Health Plan

Plan Type and Name	Enrollees*	Total IMRs Resolved	IMRs per 10,000	EXPERIMENTAL / INVESTIGATIONAL IMR							MEDICAL NECESSITY IMR							ER REIMBURSEMENT IMR						
				Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%
Managed Health Network	652,249	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
U. S. Behavioral Health Plan, California (OptumHealth Behavioral Solutions of California)	795,646	2	0.03	0	0	0.0%	0	0.0%	0	0.0%	2	0	0.0%	1	50.0%	1	50.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Behavioral Health (Psychological):	**5,203,466**	**4**	**0.01**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**4**	**0**	**0.0%**	**2**	**50.0%**	**2**	**50.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
VISION																								
Envolve Vision, Inc. (Envolve Benefit Options)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
EyeMax Vision Plan, Inc.	99	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
EYEXAM of California, Inc.	325,512	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
FirstSight Vision Services, Inc. (America's Best Vision Plan)	191,695	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Medical Eye Services, Inc.	47,937	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Premier Eye Care, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Vision Plan of America	14,912	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Vision Service Plan	4,040,009	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Visique Vision Solutions of California, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Vision:	**4,620,164**	**0**	**0.00**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
Total Specialty Plans:	**17,052,795**	**4**	**0.00**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**4**	**0**	**0.0%**	**2**	**50.0%**	**2**	**50.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
Grand Totals:	**40,143,711**	**2,592**	**0.65**	**394**	**176**	**44.7%**	**176**	**44.7%**	**42**	**10.7%**	**2,190**	**654**	**29.9%**	**1,185**	**54.1%**	**351**	**16.0%**	**8**	**3**	**37.5%**	**3**	**37.5%**	**2**	**25.0%**

THIS INFORMATION IS PROVIDED FOR STATISTICAL PURPOSES ONLY. THE DIRECTOR OF THE DEPARTMENT OF MANAGED CARE HAS NEITHER INVESTIGATED NOR DETERMINED WHETHER THE GRIEVANCES COMPILED WITHIN THIS SUMMARY ARE REASONABLE OR VALID.

"Upheld by IMR" means that the review organization upheld the health plan's denial.

"Overturned by IMR" means that the review organization overturned the health plan's denial and the plan is required to authorize the requested service.

"Rev. by Plan" means that the health plan reversed its denial prior to the review organization making a determination and the plan decided to authorize the requested service.

Grey shading indicates that the plan surrendered its license in 2020.

*Enrollees reflect only the number of enrollees under DMHC Help Center jurisdiction.

**The DMHC Help Center does not have jurisdiction over Medicare Advantage health plan consumer complaints. Refer to: www.medicareappeal.com, www.Medicare.gov and www.CMS.gov.

***County Organized Health Systems (COHS) Medi-Cal lines of business are exempt from DMHC licensure under Welfare and Institutions Code section 14087.95, and the DMHC Help Center does not have jurisdiction over these consumer complaints. Although not required by the law, San Mateo Health Commission (Health Plan of San Mateo) has a DMHC license over its Medi-Cal line of business and these enrollees can file a complaint or IMR with the DMHC Help Center. COHS may have other lines of business subject to DMHC jurisdiction, such as In-Home Supportive Services (IHSS). Enrollees in these lines of business can file a complaint or IMR with the DMHC Help Center.

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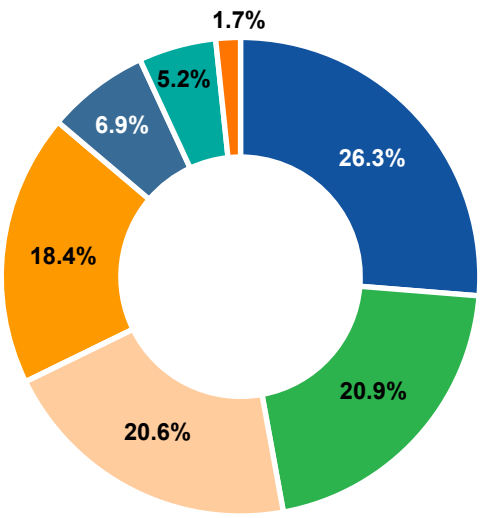
2020 Consumer Complaint Summary Report

Report Overview



1.7% - Coordination of Benefits

5.2% - Enrollment

6.9% - Access to Care

18.4% - Provider Customer Service

20.6% - Health Plan Customer Service

20.9% - Benefits/Coverage

26.3% - Claims/Financial

The Annual Complaint Summary Report displays the numbers and types of complaints, by health plan, resolved by the Department during the 2020 calendar year. An enrollee's complaint may include more than one issue. A complaint consisting of multiple distinct issues is counted as one resolved complaint. Specific complaint issues are categorized in seven categories: Access to Care, Benefits/Coverage, Claims/Financial, Enrollment, Coordination of Benefits, Health Plan Customer Service, and Provider Customer Service.

The Report identifies the number of complaints resolved for each health plan, the health plan's enrollment during 2020, the number of complaints per 10,000 members, and the number of issues for each complaint category.

The health plan enrollment figures were provided to the Department by the health plans in their quarterly financial filings. Enrollment reflects the enrollment figures provided for the fourth quarter of 2020 for the population of enrollees within the DMHC Help Center's jurisdiction. Plans with zero enrollment as of December 31, 2020, may have had enrollment earlier in the year or received a license during 2020.

Data represents resolved complaints which were determined to be within the Department's jurisdiction, eligible for review by the Department, and resolved (closed) within calendar year 2020. Cases pending at the end of the calendar year and resolved (closed) in the following year are reported in the subsequent year's Annual Report.

Health plans are listed according to their business names during 2020. In instances where a health plan is known by more than one name, the legal name is shown first with the additional name(s) in parentheses. For health plans that are involved in plan-to-plan arrangements, the data is reported by the primary plan only.

The number of complaints per 10,000 enrollees is displayed to illustrate the volume of complaints for a plan in a manner that considers the wide variations in plan enrollment numbers. When comparing plans, a lower number of complaints per 10,000 enrollees indicates fewer complaints were resolved per capita. As a result, a plan with a higher overall number of resolved complaints may still show fewer complaints per 10,000 enrollees than another plan with fewer overall resolved complaints.

California Department of Managed Health Care

2020 Complaints by Health Plan and Category

Plan Type and Name	Complaints Resolved	% of Complaints Resolved	Enrollees*	Complaints per 10,000	ACCESS TO CARE		BENEFITS/ COVERAGE		CLAIMS/ FINANCIAL		ENROLLMENT		COORDINATION OF BENEFITS		HEALTH PLAN CUSTOMER SERVICE		PROVIDER CUSTOMER SERVICE	
					Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000
FULL SERVICE – ENROLLMENT OVER 400,000																		
Blue Cross of California (Anthem Blue Cross)	1,104	15.3%	2,236,665	4.94	42	0.19	285	1.27	691	3.09	83	0.37	21	0.09	419	1.87	102	0.46
Blue Cross of California Partnership Plan, Inc.	100	1.4%	808,082	1.24	33	0.41	52	0.64	11	0.14	4	0.05	3	0.04	28	0.35	39	0.48
California Physicians' Service (Blue Shield of California)	1,922	26.7%	2,596,281	7.40	105	0.40	693	2.67	949	3.66	254	0.98	64	0.25	687	2.65	162	0.62
Health Net Community Solutions, Inc.	333	4.6%	1,425,909	2.34	108	0.76	120	0.84	26	0.18	3	0.02	15	0.11	116	0.81	190	1.33
Health Net of California, Inc.	358	5.0%	570,069	6.28	41	0.72	98	1.72	175	3.07	36	0.63	8	0.14	154	2.70	59	1.03
Inland Empire Health Plan (IEHP)	142	2.0%	1,326,955	1.07	32	0.24	56	0.42	14	0.11	5	0.04	7	0.05	38	0.29	66	0.50
Kaiser Foundation Health Plan, Inc. (Kaiser Permanente)	2,317	32.2%	7,098,996	3.26	244	0.34	583	0.82	832	1.17	202	0.28	18	0.03	588	0.83	1279	1.80
Local Initiative Health Authority for Los Angeles County (L.A. Care Health Plan)	520	7.2%	2,316,497	2.24	115	0.50	143	0.62	181	0.78	16	0.07	26	0.11	166	0.72	142	0.61
Molina Healthcare of California	62	0.9%	501,613	1.24	13	0.26	13	0.26	20	0.40	5	0.10	2	0.04	28	0.56	17	0.34
UHC of California (UnitedHealthcare of California)	337	4.7%	405,397	8.31	20	0.49	191	4.71	119	2.94	5	0.12	15	0.37	118	2.91	40	0.99
Total Full Service – Enrollment Over 400,000:	**7,195**	**100.0%**	**19,286,464**	**3.73**	**753**	**0.39**	**2,234**	**1.16**	**3,018**	**1.56**	**613**	**0.32**	**179**	**0.09**	**2,342**	**1.21**	**2,096**	**1.09**
FULL SERVICE – ENROLLMENT UNDER 400,000																		
Access Senior HealthCare, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Adventist Health Plan, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Aetna Better Health of California Inc.	11	1.3%	30,071	3.66	7	2.33	7	2.33	1	0.33	0	0.00	0	0.00	4	1.33	4	1.33
Aetna Health of California Inc.	57	6.8%	197,414	2.89	6	0.30	25	1.27	25	1.27	2	0.10	3	0.15	19	0.96	4	0.20
AIDS Healthcare Foundation (Positive Healthcare)	0	0.0%	691	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Alameda Alliance For Health	37	4.4%	275,726	1.34	10	0.36	13	0.47	3	0.11	1	0.04	2	0.07	10	0.36	15	0.54
Alignment Health Plan**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
AltaMed Health Network, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
AmericasHealth Plan, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Arcadian Health Plan, Inc.**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Aspire Health Plan**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Astiva Health, Inc.**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Bay Area Accountable Care Network, Inc. (Canopy Health)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Blue Shield of California Promise Health Plan	23	2.7%	103,414	2.22	6	0.58	7	0.68	2	0.19	0	0.00	1	0.10	9	0.87	12	1.16
Brandman Health Plan**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Brown & Toland Health Services, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
California Health and Wellness Plan (California Health and Wellness)	16	1.9%	206,031	0.78	6	0.29	3	0.15	5	0.24	0	0.00	0	0.00	6	0.29	6	0.29
Care Improvement Plus South Central Insurance Company**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
CareMore Health Plan	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Central Health Plan of California, Inc.**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
CHG Foundation (Community Health Group Partnership Plan)	11	1.3%	276,672	0.40	2	0.07	8	0.29	0	0.00	0	0.00	0	0.00	3	0.11	3	0.11
Children's Health Plan of California	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Chinese Community Health Plan	9	1.1%	8,713	10.33	0	0.00	2	2.30	5	5.74	2	2.30	0	0.00	5	5.74	0	0.00
Choice Physicians Network, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Cigna HealthCare of California, Inc.	36	4.3%	150,432	2.39	4	0.27	22	1.46	9	0.60	1	0.07	3	0.20	5	0.33	3	0.20
Clever Care of Golden State Inc. (Clever Care of California)**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Community Care Health Plan, Inc.	0	0.0%	11,496	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Community Health Group	1	0.1%	6,979	1.43	0	0.00	1	1.43	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Contra Costa County Medical Services (Contra Costa Health Plan)	24	2.9%	202,017	1.19	9	0.45	7	0.35	4	0.20	0	0.00	3	0.15	11	0.54	12	0.59
County of Ventura (Ventura County Health Care Plan)	5	0.6%	12,117	4.13	0	0.00	1	0.83	4	3.30	0	0.00	0	0.00	1	0.83	2	1.65
Dignity Health Provider Resources, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
EPIC Health Plan	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
For Your Benefit, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Fresno-Kings-Madera Regional Health Authority (CalViva Health)	50	5.9%	374,982	1.33	17	0.45	16	0.43	3	0.08	2	0.05	1	0.03	12	0.32	25	0.67
Global Health Plan, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Golden State Medicare Health Plan (Golden State Health Plan)**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Health Net Health Plan of Oregon, Inc. (Health Net Medicare of California)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00

California Department of Managed Health Care

2020 Complaints by Health Plan and Category

Plan Type and Name	Complaints Resolved	% of Complaints Resolved	Enrollees*	Complaints per 10,000	ACCESS TO CARE		BENEFITS/ COVERAGE		CLAIMS/ FINANCIAL		ENROLLMENT		COORDINATION OF BENEFITS		HEALTH PLAN CUSTOMER SERVICE		PROVIDER CUSTOMER SERVICE	
					Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000
Heritage Provider Network, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Hill Physicians Care Solutions, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Humana Health Plan of California, Inc.**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Imperial Health Plan of California, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Inter Valley Health Plan, Inc.**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Kern Health Systems	19	2.3%	277,452	0.68	2	0.07	9	0.32	3	0.11	1	0.04	1	0.04	7	0.25	6	0.22
Medcore HP	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Medi-Excel, S.A. de C.V. (MediExcel Health Plan)	1	0.1%	14,062	0.71	0	0.00	0	0.00	1	0.71	0	0.00	0	0.00	0	0.00	0	0.00
MemorialCare Select Health Plan	0	0.0%	230	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Meritage Health Plan	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Monarch Health Plan, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
On Lok Senior Health Services	0	0.0%	381	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Optum Health Plan of California	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Orange County Health Authority (CalOptima)***	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Oscar Health Plan of California	142	16.9%	103,833	13.68	5	0.48	61	5.87	63	6.07	13	1.25	4	0.39	42	4.04	11	1.06
Partnership HealthPlan of California***	1	0.1%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	1	0.00
Premier Health Plan Services, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
PRIMECARE Medical Network, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Prospect Health Plan, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Providence Health Assurance**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Providence Health Network	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
San Francisco Health Authority (San Francisco Health Plan)	17	2.0%	150,634	1.13	5	0.33	6	0.40	2	0.13	1	0.07	0	0.00	2	0.13	12	0.80
San Joaquin County Health Commission (Health Plan of San Joaquin)	23	2.7%	364,077	0.63	7	0.19	11	0.30	1	0.03	0	0.00	0	0.00	6	0.16	12	0.33
San Mateo Health Commission (Health Plan of San Mateo)	24	2.9%	122,943	1.95	13	1.06	8	0.65	0	0.00	0	0.00	1	0.08	4	0.33	5	0.41
Santa Barbara San Luis Obispo Regional Health Authority (CenCal Health)***	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Santa Clara County (Valley Health Plan)	25	3.0%	44,602	5.61	2	0.45	12	2.69	9	2.02	1	0.22	1	0.22	7	1.57	8	1.79
Santa Clara County Health Authority (Santa Clara Family Health Plan)	43	5.1%	271,107	1.59	11	0.41	17	0.63	5	0.18	3	0.11	4	0.15	8	0.30	21	0.77
Santa Cruz-Monterey-Merced Managed Medical Care Commission (Central California Alliance for Health)***	0	0.0%	540	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Scan Health Plan	0	0.0%	13,966	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Scripps Health Plan Services, Inc.	5	0.6%	15,253	3.28	2	1.31	2	1.31	1	0.66	0	0.00	0	0.00	0	0.00	0	0.00
Sequoia Health Plan, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Sharp Health Plan	78	9.3%	138,970	5.61	8	0.58	33	2.37	33	2.37	4	0.29	1	0.07	23	1.66	18	1.30
Sistemas Medicos Nacionales, S.A.de C.V. (SIMNSA Health Plan)	12	1.4%	48,484	2.48	0	0.00	2	0.41	10	2.06	0	0.00	0	0.00	0	0.00	0	0.00
Stanford Health Care Advantage**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Sutter Health Plan (Sutter Health Plus)	61	7.3%	96,692	6.31	2	0.21	25	2.59	29	3.00	4	0.41	3	0.31	14	1.45	14	1.45
UnitedHealthcare Benefits Plan of California	17	2.0%	162,829	1.04	0	0.00	6	0.37	11	0.68	0	0.00	0	0.00	9	0.55	0	0.00
UnitedHealthcare Community Plan of California, Inc.	1	0.1%	19,851	0.50	0	0.00	1	0.50	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Universal Care, Inc. (Brand New Day)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Vitality Health Plan of California, Inc.**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
WellCare of California, Inc.**	2	0.2%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	3	0.00	0	0.00
Western Health Advantage	90	10.7%	101,791	8.84	6	0.59	44	4.32	33	3.24	5	0.49	6	0.59	20	1.96	16	1.57
Total Full Service – Enrollment Under 400,000:	**841**	**100.0%**	**3,804,452**	**2.21**	**130**	**0.34**	**349**	**0.92**	**262**	**0.69**	**40**	**0.11**	**34**	**0.09**	**230**	**0.60**	**210**	**0.55**
Total All Full Service Plans:	**8,036**		**23,090,916**	**3.48**	**883**	**0.38**	**2,583**	**1.12**	**3,280**	**1.42**	**653**	**0.28**	**213**	**0.09**	**2,572**	**1.11**	**2,306**	**1.00**
CHIROPRACTIC																		
ACN Group of California, Inc. (OptumHealth Physical Health of California)	1	100.0%	73,948	0.14	0	0.00	1	0.14	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
American Specialty Health Plans of California, Inc. (ASHP)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Landmark Healthplan of California, Inc.	0	0.0%	67,027	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Total Chiropractic:	**1**	**100.0%**	**140,975**	**0.07**	**0**	**0.00**	**1**	**0.07**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**

California Department of Managed Health Care

2020 Complaints by Health Plan and Category

Plan Type and Name	Complaints Resolved	% of Complaints Resolved	Enrollees*	Complaints per 10,000	ACCESS TO CARE		BENEFITS/ COVERAGE		CLAIMS/ FINANCIAL		ENROLLMENT		COORDINATION OF BENEFITS		HEALTH PLAN CUSTOMER SERVICE		PROVIDER CUSTOMER SERVICE	
					Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000
DENTAL																		
Access Dental Plan	5	9.6%	317,441	0.16	2	0.06	2	0.06	2	0.06	0	0.00	0	0.00	2	0.06	2	0.06
Aetna Dental of California Inc.	10	19.2%	121,251	0.82	0	0.00	3	0.25	6	0.49	0	0.00	0	0.00	1	0.08	5	0.41
California Dental Network, Inc.	6	11.5%	75,170	0.80	1	0.13	1	0.13	2	0.27	3	0.40	0	0.00	1	0.13	1	0.13
Cigna Dental Health of California, Inc.	1	1.9%	209,840	0.05	0	0.00	1	0.05	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Consumer Health, Inc. (Newport Dental Plan)	0	0.0%	6,194	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Dental Benefit Providers of California, Inc.	0	0.0%	161,201	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Dental Health Services	0	0.0%	71,684	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Golden West Health Plan, Inc. (Golden West Dental & Vision Plan)	0	0.0%	10,071	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Liberty Dental Plan of California, Inc. (Personal Dental Services)	23	44.2%	384,551	0.60	0	0.00	16	0.42	5	0.13	1	0.03	0	0.00	3	0.08	5	0.13
Managed Dental Care	3	5.8%	100,538	0.30	0	0.00	2	0.20	1	0.10	1	0.10	0	0.00	2	0.20	2	0.20
Starmount Managed Dental of California, Inc. (Unum Dental HMO Plan)	0	0.0%	1,229	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
UDC Dental California, Inc. (United Dental Care of California, Inc.)	0	0.0%	26,279	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
United Concordia Dental Plans of California, Inc.	0	0.0%	85,288	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Western Dental Services, Inc. (Western Dental Plan)	4	7.7%	144,429	0.28	1	0.07	3	0.21	0	0.00	0	0.00	0	0.00	1	0.07	3	0.21
Total Dental:	**52**	**100.0%**	**1,715,166**	**0.30**	**4**	**0.02**	**28**	**0.16**	**16**	**0.09**	**5**	**0.03**	**0**	**0.00**	**10**	**0.06**	**18**	**0.10**
DENTAL/VISION																		
Delta Dental of California	178	98.9%	5,062,584	0.35	3	0.01	73	0.14	93	0.18	17	0.03	2	0.00	80	0.16	51	0.10
SafeGuard Health Plans, Inc. (MetLife)	2	1.1%	245,894	0.08	0	0.00	2	0.08	0	0.00	0	0.00	0	0.00	0	0.00	1	0.04
Total Dental/Vision:	**180**	**100.0%**	**5,308,478**	**0.34**	**3**	**0.01**	**75**	**0.14**	**93**	**0.18**	**17**	**0.03**	**2**	**0.00**	**80**	**0.15**	**52**	**0.10**
DISCOUNT																		
First Dental Health	0	0.0%	28,546	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
The CDI Group, Inc.	0	0.0%	36,000	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Total Dental/Vision:	**0**	**0.0%**	**64,546**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**
PHARMACY																		
SilverScript Insurance Company	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
WellCare Prescription Insurance, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Total Pharmacy:	**0**	**0.0%**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**
BEHAVIORAL HEALTH (PSYCHOLOGICAL)																		
Beacon Health Options of California, Inc. (Beacon of California)	0	0.0%	713,228	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Cigna Behavioral Health of California, Inc.	1	8.3%	137,629	0.07	0	0.00	0	0.00	1	0.07	0	0.00	0	0.00	0	0.00	0	0.00
Claremont Behavioral Services, Inc. (Claremont EAP)	0	0.0%	50,882	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
CONCERN: Employee Assistance Program	0	0.0%	144,184	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Empathia Pacific, Inc. (LifeMatters)	0	0.0%	148,945	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Health Advocate West, Inc.	0	0.0%	81,719	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Health and Human Resource Center, Inc. (Aetna Resources for Living)	0	0.0%	1,481,951	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Holman Professional Counseling Centers	2	16.7%	120,849	0.17	1	0.08	0	0.00	0	0.00	0	0.00	0	0.00	1	0.08	0	0.00
Human Affairs International of California (HAI-CA)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Humana EAP and Work-Life Services of California, Inc.	0	0.0%	28,610	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Magellan Health Services of California, Inc. - Employer Services	0	0.0%	847,574	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Managed Health Network	0	0.0%	652,249	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
U. S. Behavioral Health Plan, California (OptumHealth Behavioral Solutions of California)	9	75.0%	795,646	0.11	1	0.01	7	0.09	1	0.01	0	0.00	0	0.00	3	0.04	3	0.04
Total Behavioral Health (Psychological):	**12**	**100.0%**	**5,203,466**	**0.02**	**2**	**0.00**	**7**	**0.01**	**2**	**0.00**	**0**	**0.00**	**0**	**0.00**	**4**	**0.01**	**3**	**0.01**
VISION																		
Envolve Vision, Inc. (Envolve Benefit Options)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
EyeMax Vision Plan, Inc.	0	0.0%	99	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
EYEXAM of California, Inc.	0	0.0%	325,512	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00

California Department of Managed Health Care

2020 Complaints by Health Plan and Category

Plan Type and Name	Complaints Resolved	% of Complaints Resolved	Enrollees*	Complaints per 10,000	ACCESS TO CARE		BENEFITS/ COVERAGE		CLAIMS/ FINANCIAL		ENROLLMENT		COORDINATION OF BENEFITS		HEALTH PLAN CUSTOMER SERVICE		PROVIDER CUSTOMER SERVICE	
					Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000
FirstSight Vision Services, Inc. (America's Best Vision Plan)	0	0.0%	191,695	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Medical Eye Services, Inc.	0	0.0%	47,937	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Premier Eye Care, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Vision Plan of America	0	0.0%	14,912	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Vision Service Plan	5	100.0%	4,040,009	0.01	0	0.00	0	0.00	3	0.01	2	0.00	0	0.00	0	0.00	0	0.00
Visique Vision Solutions of California, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Total Vision:	**5**	**100.0%**	**4,620,164**	**0.01**	**0**	**0.00**	**0**	**0.00**	**3**	**0.01**	**2**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**
Total Specialty Plans:	**250**		**17,052,795**	**0.15**	**9**	**0.01**	**111**	**0.07**	**114**	**0.07**	**24**	**0.01**	**2**	**0.00**	**94**	**0.06**	**73**	**0.04**
Grand Totals:	**8,286**		**40,143,711**	**2.06**	**892**	**0.22**	**2,694**	**0.67**	**3,394**	**0.85**	**677**	**0.17**	**215**	**0.05**	**2,666**	**0.66**	**2,379**	**0.59**

THIS INFORMATION IS PROVIDED FOR STATISTICAL PURPOSES ONLY. THE DIRECTOR OF THE DEPARTMENT OF MANAGED CARE HAS NEITHER INVESTIGATED NOR DETERMINED WHETHER THE GRIEVANCES COMPILED WITHIN THIS SUMMARY ARE REASONABLE OR VALID.

Grey shading indicates that the plan surrendered its license in 2020.

*Enrollees reflect only the number of enrollees under DMHC Help Center jurisdiction.

**The DMHC Help Center does not have jurisdiction over Medicare Advantage health plan consumer complaints. Refer to: www.medicareappeal.com, www.Medicare.gov and www.CMS.gov.

***County Organized Health Systems (COHS) Medi-Cal lines of business are exempt from DMHC licensure under Welfare and Institutions Code section 14087.95, and the DMHC Help Center does not have jurisdiction over these consumer complaints. Although not required by the law, San Mateo Health Commission (Health Plan of San Mateo) has a DMHC license over its Medi-Cal line of business and these enrollees can file a complaint or IMR with the DMHC Help Center. COHS may have other lines of business subject to DMHC jurisdiction, such as In-Home Supportive Services (IHSS). Enrollees in these lines of business can file a complaint or IMR with the DMHC Help Center.

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DEPARTMENT OF
Managed
Health Care

Published June 2021

EXHIBIT E

2021 ANNUAL REPORT

DEPARTMENT OF
Managed
Health Care

Gavin Newsom
Governor
State of California

Mark Ghaly MD, MPH
Secretary
Health and Human Services Agency

Mary Watanabe
Director
Department of Managed Health Care

DMHC MISSION, VALUES & GOALS

MISSION

The Department of Managed Health Care protects consumers' health care rights and ensures a stable health care delivery system.

CORE VALUES

- Integrity
- Leadership
- Commitment to Service

GOALS

- Educate and assist California's diverse health care consumers
- Cultivate a coordinated and sustainable health care marketplace
- Regulate fairly, efficiently and effectively
- Foster a culture of excellence throughout the organization

MESSAGE FROM THE DIRECTOR

The Department of Managed Health Care (DMHC) now protects the health care rights of more than 28 million Californians. This is a job I take very seriously, and I am honored to be directing the work of the Department during this historic time.

The DMHC continued to respond to the COVID-19 pandemic in 2021, while achieving our mission to protect consumers' health care rights and ensure a stable health care delivery system. The Department worked closely with the California Health and Human Services Agency (CalHHS), California Department of Public Health (CDPH) and with state and local leaders, health plans, providers, consumer advocates and others to support the state's ongoing response to the COVID-19 pandemic, including expanding access to vaccinations and testing, and supporting the state's hospitals and other parts of the health care delivery system. You can visit the COVID-19 page[1] on the Department's website to find information about the DMHC's actions, consumer fact sheets and guidance to health plans.

The COVID-19 pandemic has caused significant stress on individuals and families and the growing need for behavioral health services has never been greater. The DMHC remains committed to ensuring health plan enrollees have access to appropriate behavioral health care services, and this will continue to be a focus for the Department in the years ahead. The DMHC began conducting focused behavioral health investigations of commercial health plans in 2021. The goal of the behavioral health investigations is to identify and understand the challenges and barriers enrollees may face in obtaining behavioral health care treatment and services, and to identify systemic changes that can be made to improve the delivery of care. These investigations will be critical to better understand the barriers consumers face with accessing behavioral health care.

The DMHC also worked to establish a Health Equity and Quality Committee with the goal of improving health outcomes and reducing health care disparities for Californians. The Committee will make recommendations for standard health equity and quality measures, including annual benchmark standards for assessing equity and quality in health care delivery. While I look forward to the Committee's work and receiving their recommendations in the fall of 2022, the DMHC will continue to focus on ensuring access to quality health care for all Californians.

The Department also implemented several new laws in 2021 and took enforcement actions against health plans that violated consumers' health care rights. Significant enforcement actions included penalizing health plans that failed to address enrollee grievances, timely implement Independent Medical Review (IMR) decisions, maintain financial solvency and deliver basic health care services in compliance with the law.

The DMHC Help Center continues to be a valuable resource to assist health care consumers. If you are having a problem with your health plan, such as getting access to care or are being denied treatment, I encourage you to contact the DMHC Help Center for assistance at 1-888- 466-2219 or www.HealthHelp.ca.gov.

I also want to express my gratitude to the Department's dedicated staff for their commitment to our mission as we continue to navigate through these uncertain times. I am very proud of the work the DMHC has accomplished over this last year.

Mary Watanabe

Director
Department of Managed Health Care

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DEPARTMENT OF
Managed Health Care

2021

2.6 MILLION
CONSUMERS ASSISTED

The DMHC Help Center educates consumers about their rights, resolves consumer complaints, helps consumers navigate and understand their coverage, and ensures access to health care services.

28.4 MILLION
CALIFORNIANS' HEALTH CARE RIGHTS ARE PROTECTED BY THE DMHC

96% of state-regulated commercial and public health plan enrollment is regulated by the DMHC

$86.3 MILLION

dollars assessed against health plans that violated the law

140
LICENSED HEALTH PLANS

- **94** FULL SERVICE
- **46** SPECIALIZED

$296.1 MILLION

dollars saved on Health Plan Premiums through the Rate Review Program since 2011

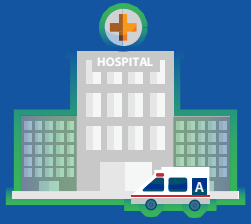
Approximately

68%

of consumer appeals (IMRs) to the DMHC resulted in the consumer receiving the requested service or treatment from their health plan

$38.5 MILLION

dollars recovered from health plans on behalf of consumers



$177.8 MILLION

dollars in payments recovered to physicians and hospitals

KNOW YOUR HEALTH CARE RIGHTS

In California, health plan members have the right to:

- basic health care services
- choose your primary doctor
- an appointment when you need one (timely access to care)
- see a specialist when medically necessary
- receive treatment for all mental health and substance use conditions
- get a second doctor's opinion
- know why your plan denies a service or treatment
- understand your health problems and treatments
- know your out-of-pocket costs & if you met your deductible or out-of-pocket max
- see a written diagnosis (description of your health problem)
- give informed consent when you have a treatment
- file a complaint and ask for an Independent Medical Review (an external appeal of your plan's denial of services or treatment)
- a copy of your medical records (you may be charged)
- translation and interpreter services
- continue to see your doctor, even if they no longer participate in your plan (under certain circumstances)
- be notified of an unreasonable rate increase
- not be illegally balance billed by a health care provider
- not be excluded from health plan coverage because of a pre-existing condition
- guaranteed availability to renew or purchase commercial health plan coverage

The California Department of Managed Health Care protects consumers' health care rights and ensures a stable health care delivery system.

How can you get help from the DMHC?

The DMHC protects you by making sure your health plan follows the law and ensures health plans are spending money in a way that helps you.

Most people who live in California are enrolled in a health plan regulated by the DMHC. Because of this, the DMHC Help Center is a good place to start if you have a problem with your health plan.

The DMHC Help Center assists consumers with understanding their health care rights, benefits and to resolve health plan issues.

If you are having issues with your health plan, you should file a grievance with your plan. If you are not satisfied with your health plan's resolution of the grievance or have been in your plan's grievance system for 30 days for non-urgent issues, you should contact the DMHC Help Center for assistance. If your issue is urgent, you should contact the DMHC Help Center immediately.

The DMHC Help Center provides help in all languages.
Help is available by calling 1-888-466-2219 (TDD: 1-877-688-9891)
or at www.HealthHelp.ca.gov. ALL SERVICES ARE FREE.

DEPARTMENT OF Managed Health Care

Introduction

Created by consumer-sponsored legislation in 1999, the DMHC regulates the majority of health care coverage in California including 96% of commercial and public enrollment in state-regulated health plans. In 2021, the DMHC's budget was $103,396,000 with 516 positions. The DMHC is funded by assessments on the Department's regulated health plans.

The DMHC began operations in 2000 as the first state department in the country dedicated solely to regulating managed health care plans and assisting consumers to resolve disputes with those plans. The Department educates consumers about their health care rights, helps them resolve complaints with their health plans, assists consumers in navigating their health coverage and ensures consumers can access necessary health care services. The Department does this through licensing health plans that operate in California, conducting medical surveys of licensed health plans and actively monitoring the financial stability of health plans and medical groups to ensure consumers are able to get the care they need. The DMHC also reviews proposed health plan premium rates to protect consumers from unreasonable or unjustified increases. The Department's efforts improve transparency and accountability in health plan rate setting; however, the DMHC does not have the authority to deny rate increases. As of the end of 2021, the DMHC has assisted approximately 2.6 million consumers.

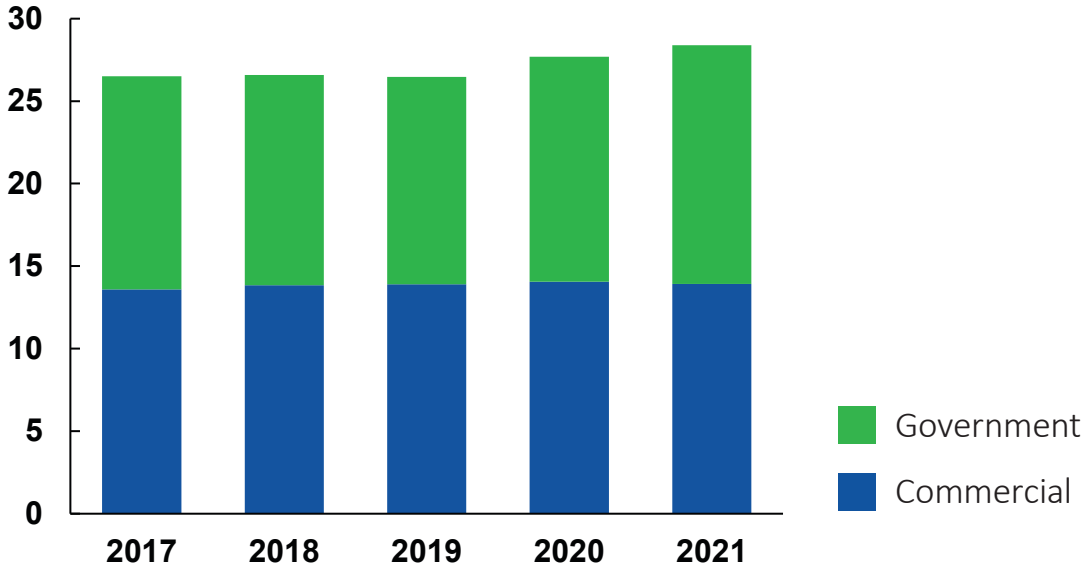
In 2021, 94 full service health plans licensed by the DMHC provided health care services to 28.4 million Californians. This included approximately 13.9 million commercial enrollees and approximately 14.5 million government enrollees. In addition to full-service health plans, the DMHC oversees 46 specialized health plans including chiropractic, dental, vision, behavioral health (psychological), and pharmacy.

Over the Department's 21-year history, California has launched several initiatives to improve and expand access to health care for all Californians. The Department continues to implement new laws and regulations, hold health plans accountable and offer direct assistance to consumers through the DMHC Help Center.

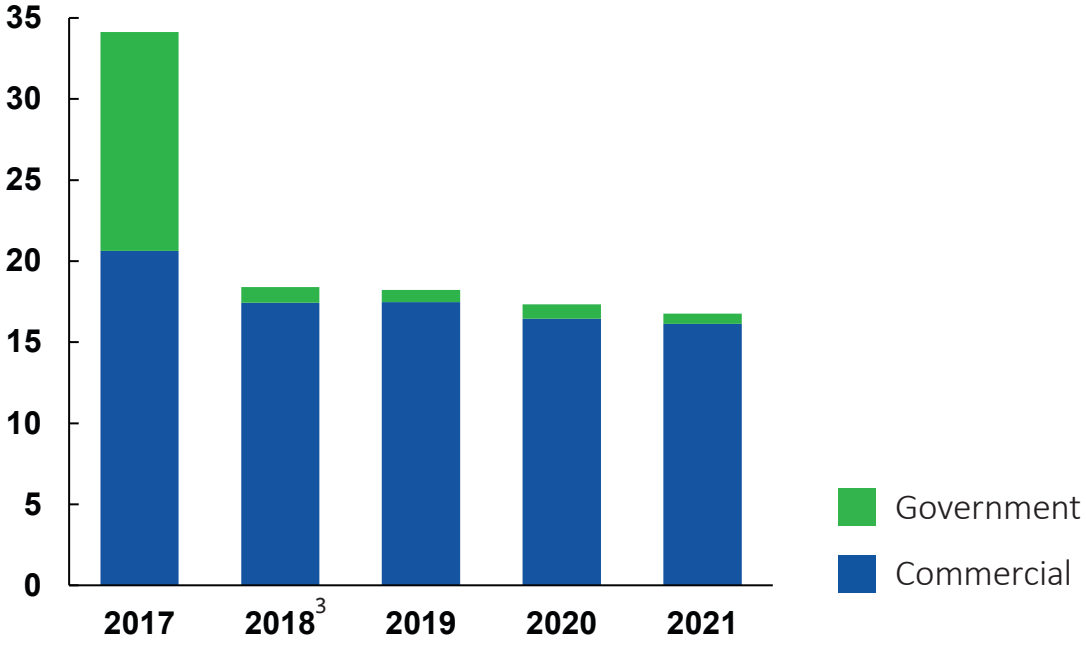
The DMHC licenses and regulates the full scope of managed care models, including all Health Maintenance Organizations (HMO) in California, as well as Preferred Provider Organizations (PPO), Exclusive Provider Organizations (EPO), Point-of-Service (POS) products and Medi-Cal managed care plans. The Department also licenses and conducts financial reviews of Medicare Advantage and Part D plans. The enrollment overview charts[2] on the next two pages illustrate how enrollment under the DMHC is distributed between commercial and government enrollment.

Enrollment Overview

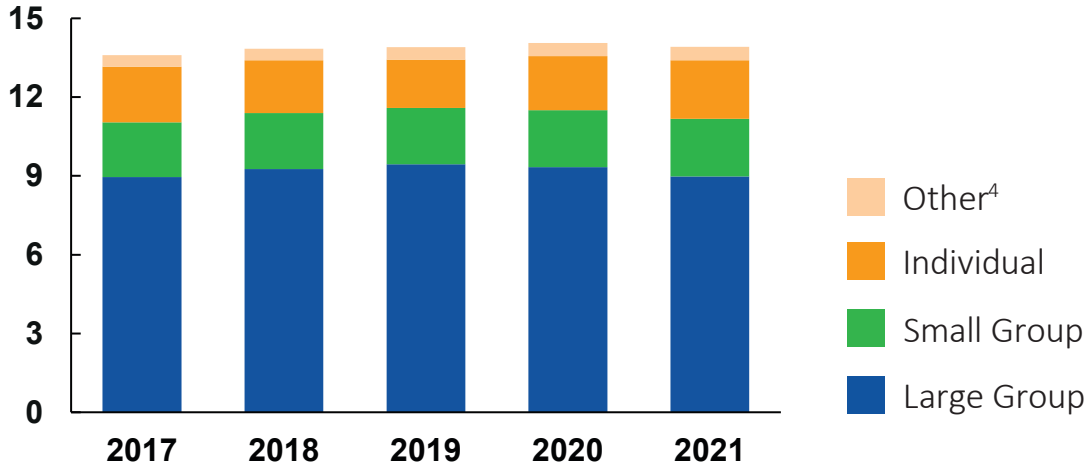
Full Service Enrollment (In Millions)



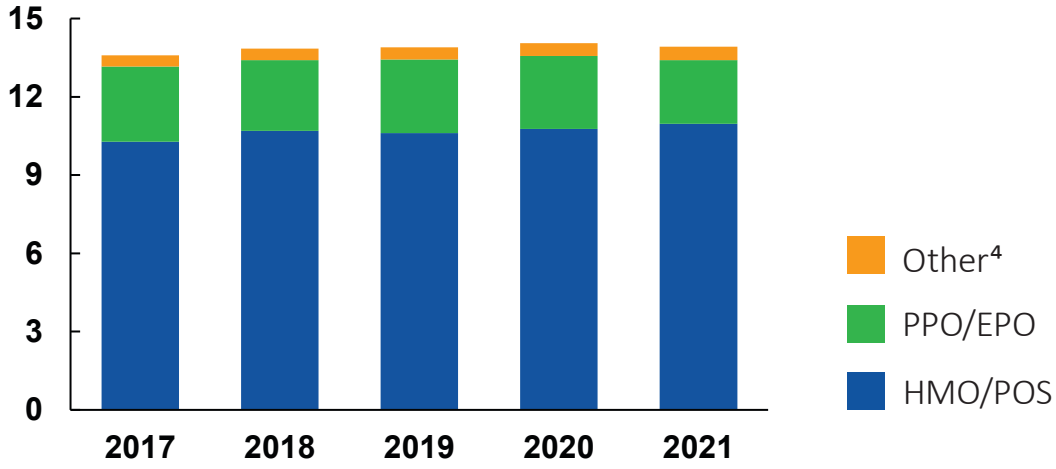
Specialized Enrollment (In Millions)



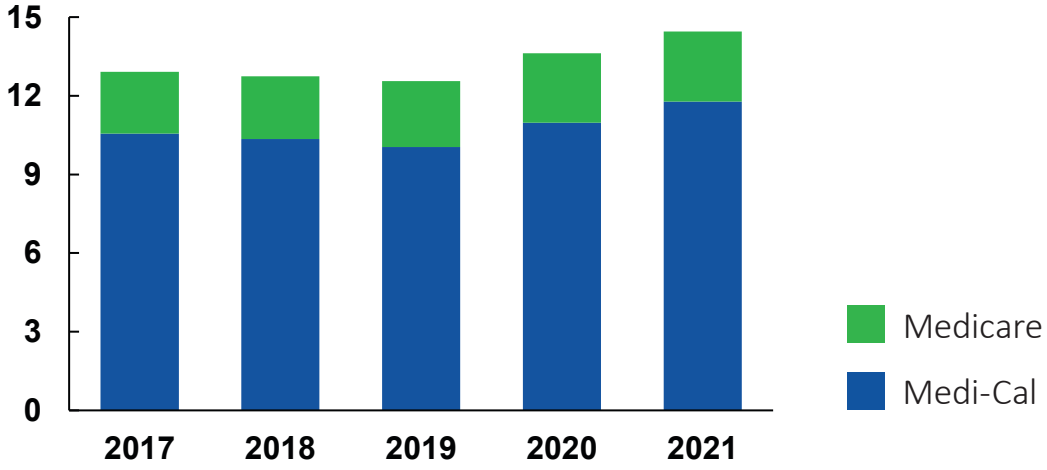
Commercial Enrollment by Market (In Millions)



Commercial Enrollment by Product (In Millions)



Government Enrollment by Type (In Millions)



Response to COVID-19

The Department worked closely with federal, state and local partners, health plans, providers, consumer advocates and others to support the state's ongoing response to the COVID-19 pandemic.

The DMHC took several actions in 2021 to support the state's response efforts, including providing guidance to health plans through All Plan Letters (APLs). This included issuing guidance to health plans regarding COVID-19 testing with no cost-sharing for health plan enrollees, the administration of vaccinations, and ensuring continued stability in the health care delivery system.

In late 2020 and early 2021, the state was experiencing a surge in COVID-19 positive cases and hospitalizations. This surge caused many hospitals in the state to meet or exceed their usual capacity to serve patients. Accordingly, to provide care to all patients in need, the state worked with these facilities to maximize their capacity by allowing for the expeditious transfer of patients from the most highly impacted hospitals to hospitals with more available capacity.

On December 28, 2020, CDPH issued "All Facilities Letter 20-91" to California hospitals, and, on January 5, 2021, CDPH issued a State Public Health Officer Order (Order) to help ensure California hospitals and other health care facilities could prioritize services and resources. Following the CDPH Order, the DMHC issued guidance to health plans to not prevent or delay the transfer of a plan enrollee and to cover the medically necessary costs associated with the transfer of their enrollees. Because health plan prior authorization requirements for transfers between hospitals can cause unnecessary delays in effectuating such transfers, health plans were not allowed to require prior authorization or impose any other requirements on a hospital's transfer of plan enrollees under the Order.

On February 26, 2021, the federal Centers for Medicare & Medicaid Services (CMS), in conjunction with the U.S. Department of Labor and the Department of the Treasury, issued new guidance making it easier for enrollees to obtain diagnostic COVID-19 testing. The new federal guidance clarified health plans must cover COVID-19 diagnostic testing for all health plan enrollees by any provider with no cost-sharing. The DMHC issued an APL providing an overview of the new federal guidance, and explaining how the federal guidance and the DMHC's emergency regulation regarding COVID-19 testing work together to ensure enrollees could access COVID-19 testing.

As COVID-19 vaccines became more widely available throughout 2021, the DMHC worked closely with health plans to ensure enrollee access to vaccines. The DMHC issued guidance to ensure health plans take all appropriate steps to help enrollees at the very highest risk receive COVID-19 vaccinations in a timely and efficient manner. The DMHC required health plans to engage in outreach to high-risk enrollees to ensure those enrollees were aware they were eligible to receive COVID-19 vaccines. The DMHC also directed health plans to arrange for vaccines for homebound enrollees including transportation services. In anticipation of the Centers for Disease Control and Prevention (CDC) Emergency Use Authorization for the COVID-19 vaccine for children ages 5 to 11, the DMHC instructed health plans to take immediate steps to ensure eligible pediatric enrollees could access COVID-19 vaccines.

Additionally, the Department expanded the opportunity for coverage by requiring plans to offer a special enrollment period to individuals negatively impacted by COVID-19. The Department also continued to monitor health

plan support of providers and expanded plans' reporting requirements to include dentists, given the impact of the pandemic upon dental providers and networks.

The DMHC created a COVID-19 webpage located on the Department's website to make it easy for the public and stakeholders to find information, resources and guidance. The Department also created several consumer-friendly fact sheets, including on the topics of vaccines, testing and health care coverage.

The COVID-19 pandemic caused many changes in the health care industry and within the DMHC. The Department continued to telework, and follow public safety and state guidance through 2021. The Department remains focused on ensuring enrollees continue to receive appropriate health care services and will continue to quickly address new issues and changes that arise from the pandemic.

DMHC Help Center

The DMHC Help Center educates consumers about their health care rights, resolves consumer complaints, helps consumers navigate and understand their coverage and assists consumers in getting timely access to appropriate health care services. The DMHC Help Center provides direct assistance in all languages to health care consumers through the Department's website, www.HealthHelp.ca.gov, and toll-free phone number, 1-888-466-2219.

If a health plan enrollee is experiencing an issue with their health plan, they can file a grievance with their plan. If they are not satisfied with their health plan's resolution of the grievance or if the grievance has not been resolved after 30 days for non-urgent issues, they should contact the DMHC Help Center for assistance. If an enrollee is experiencing an urgent threat to their health, they should contact the DMHC Help Center immediately.

Through a team of health care analysts, nurses and attorneys, the DMHC Help Center uses a variety of mechanisms to assist health plan enrollees. Most problems are resolved through the standard complaint process. Common complaints include cancellation of coverage, billing issues, quality of service, coverage disputes and access complaints.

The Department's Quick Resolution process addresses issues through a three-way call between the DMHC, the enrollee and the health plan. Complaints involving serious or urgent medical issues are routed to nurses who provide immediate assistance 24 hours a day, seven days a week.

The Independent Medical Review (IMR) program is available to enrollees if a health plan denies, modifies or delays a request for a service as not medically necessary or as experimental or investigational. Doctors independent of the health plan review these matters and make an independent determination about whether the requested service should be provided. If an IMR is decided in the enrollee's favor, the health plan must provide the requested service or treatment promptly. All IMR decisions are reported on the DMHC's website with a summary of the issue and outcome for each case.

Consumers with plans and issues outside of the DMHC's jurisdiction who contact the Help Center are transferred or referred to the appropriate agency for assistance. In addition to providing direct consumer assistance, the DMHC also contracts with community-based organizations under the Consumer Assistance Program to provide consumers with local, in-depth assistance.

WHAT IS THE DMHC HELP CENTER?

The DMHC provides assistance to all California health care consumers through the Help Center. The DMHC Help Center assists consumers with understanding their health care rights and benefits, and helps to resolve complaints and coverage issues between health plan enrollees and health plans.

The DMHC Help Center provides these services for free and help is available in all languages. To contact the DMHC Help Center for assistance call 1-888-466-2219 (TDD: 1-877-688-9891) or visit www.HealthHelp.ca.gov.

2021 Highlights

In 2021, the DMHC Help Center assisted 122,666 health care consumers, and handled 10,771 complaints and 3,747 IMRs. Approximately 68% of consumers who submitted an IMR request to the DMHC Help Center received the service or treatment they requested[5].

As the COVID-19 pandemic went into a second year in 2021, the DMHC Help Center continued to protect consumers' health care rights and ensured enrollees received needed health care services. The DMHC Help Center assisted health plan enrollees with COVID-19 related issues, including ensuring that enrollees were not liable for unlawful balance billing or administrative cost-sharing for COVID-19 vaccinations and telehealth services. Additionally, enrollees were provided information about where to get tested and vaccinated for COVID-19.

The community-based Consumer Assistance Program served 8,333 consumers and conducted 1,452 outreach events throughout California despite the many challenges caused by the COVID-19 pandemic. Through these outreach events, the Department reached 46,240 consumers to educate consumers about their health care rights.

Health plan enrollees are protected from surprise medical bills for non-emergency services rendered by out-of-network providers at contracted facilities. Billing disputes between health plans and out-of-network providers in these cases are resolved through a binding Independent Dispute Resolution Process (IDRP) administered by the DMHC. In 2021, the DMHC received 45 IDRP applications, and an additional 12 IDRP applications were carried over from 2020. Of the total 57 IDRPs handled in 2021, 13 were incomplete, ineligible, non-jurisdictional or non-responsive; 22 completed the process with a determination letter issued; and 22 were pending as of December 31, 2021.

The DMHC Help Center also assists providers with claims payment disputes with health plans. The DMHC Help Center closed 6,350 provider complaints and recovered $10,218,208 in payments for providers in 2021.

2021 BY THE NUMBERS

HELP CENTER

122,666 CONSUMERS ASSISTED[6]

106,641 TELEPHONE INQUIRIES

10,771 CONSUMER COMPLAINTS[7]

3,747 IMRs CLOSED[8]

$2.4 M RECOVERED FOR CONSUMERS

1,507 NON-JURISDICTIONAL REFERRALS

6,350 PROVIDER COMPLAINTS

$10.2 M RECOVERED PROVIDER PAYMENTS

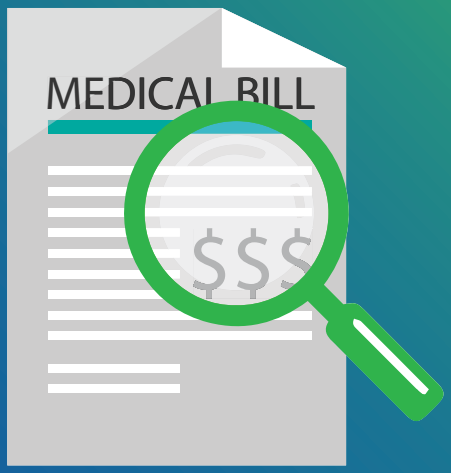
22 NON-EMERGENCY SERVICES IDRP CASES COMPLETED

On average, approximately

68%

of enrollees that submitted IMR requests to the DMHC received the requested service or treatment.

DMHC HELP CENTER PROVIDER COMPLAINT UNIT



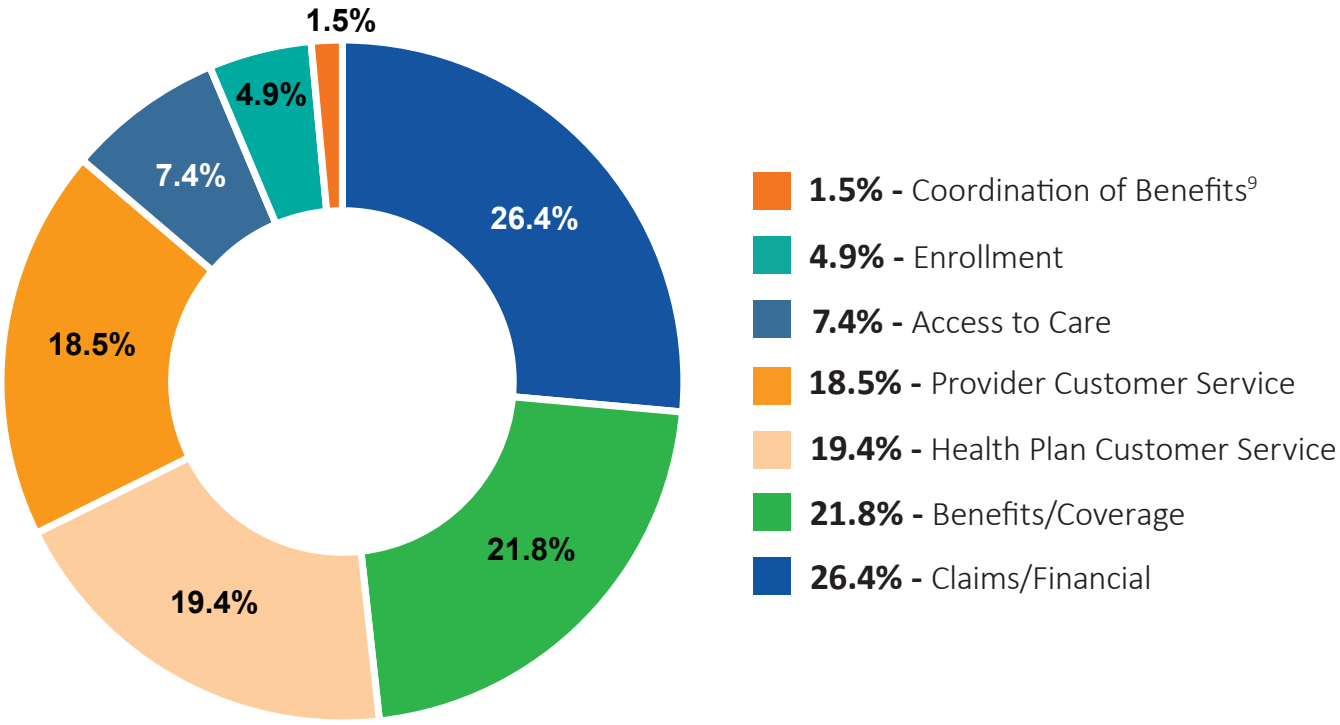
To ensure the health care delivery system can continue to provide services to consumers, it is important for hospitals, doctors and other providers to receive accurate payments from health plans in a timely manner. The DMHC Help Center's Provider Complaint Unit is responsible for processing complaints from providers to ensure prompt and accurate payment according to the law. The Provider Complaint Unit handles individual complaints, complaints with multiple claims, emergency service complaints and non-emergency service complaints.

The DMHC established an Independent Dispute Resolution Process (IDRP) for emergency and non-emergency services. An IDRP allows providers and health plans to dispute whether payment of a specified rate was appropriate. An external reviewer goes over the claim and determines which rate is justified.

DMHC Help Center staff perform analyses on unfair payment patterns and emerging trends on all provider complaints. The Department uses this information to help identify criteria for audits of health plans and their delegated entities.

Providers looking for more information or to dispute a payment can visit the DMHC website at www.HealthHelp.ca.gov.

CONSUMER COMPLAINTS RESOLVED IN 2021

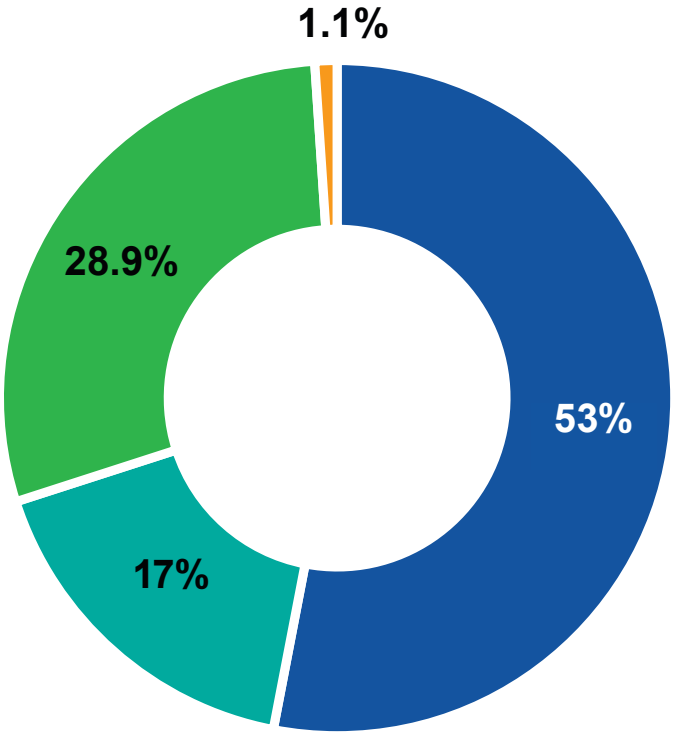


Interspersed throughout this report are consumer stories of assistance the DMHC Help Center provided during 2021. The names of enrollees have been changed to protect their identities, and the outcomes are specific to the circumstances and details of each individual case.

DMHC HELP CENTER ASSISTANCE: INDEPENDENT MEDICAL REVIEW (IMR) – EXPERIMENTAL/INVESTIGATIONAL

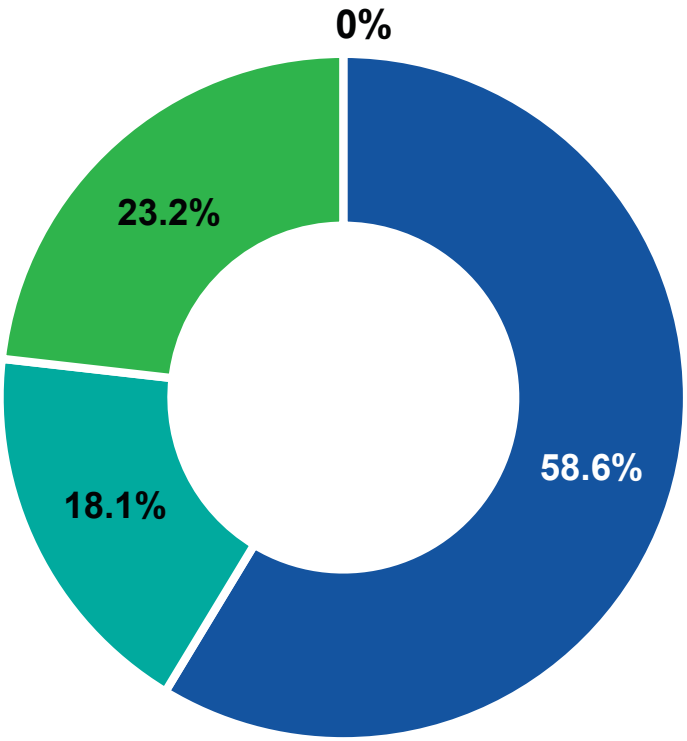
Yesenia, a Large Group HMO plan member, was diagnosed with Lymphedema in her arm due to complications after she had a mastectomy. Yesenia requested Lymphedema surgery to reduce the severity of her condition, but her health plan denied the services as Experimental/Investigational. She then applied for an IMR at the DMHC Help Center asking for help to get her health plan to authorize and cover surgical treatment. After completing the IMR process, Yesenia's surgery was deemed more beneficial than any available standard therapy, and her health plan was required to cover her Lymphedema surgery.

CONSUMER COMPLAINTS RESOLVED IN 2021 BY COVERAGE TYPE



- **1.1% -** Medicare
- **17% -** Medi-Cal
- **28.9% -** Individual
- **53% -** Employment Based

IMRs RESOLVED IN 2021 BY COVERAGE TYPE



- **0% -** Medicare
- **18.1% -** Medi-Cal
- **23.2% -** Individual
- **58.6% -** Employment Based

Behavioral Health Care Coverage

California health plan enrollees have the right to treatment for all medically necessary mental health conditions and substance use disorders. A new law that took effect in 2021 strengthened California's mental health parity laws by requiring commercial health plans to provide full coverage for the treatment of all mental health conditions and substance use disorders, under the same terms and conditions applied to other medical conditions.

Health plans must cover the full spectrum of all medically necessary treatment in all settings for enrollees. This includes the following settings, when medically necessary:

- Sessions with a therapist
- Medication to manage enrollees' condition
- Outpatient Intensive Treatment
- Inpatient Residential treatment

The law also mandates that if an enrollee cannot find an appropriate mental health provider in their health plan network, the health plan must arrange and pay for out-of-network services at no additional cost to the enrollee.

Additionally, the law includes financial protections. Health plans cannot charge more for mental health and substance use disorder services than for physical health conditions. This includes enrollee cost-sharing obligations, such as co-pays, deductibles, maximum annual and lifetime benefits and other out-of-pocket expenses.

Health plan enrollees having trouble accessing behavioral health care treatment or services, should first contact their health plan at the member services phone number on their health plan member card. Their health plan will review the grievance and should ensure the enrollee is able to timely access medically necessary care.

If the enrollee does not agree with their health plan's response, they should contact the DMHC Help Center at www.HealthHelp.ca.gov or by calling 1-888-466-2219. Contact the DMHC Help Center immediately for urgent issues.

Plan Licensing

Health plans in California must be licensed by the DMHC. As part of the licensing process, the DMHC reviews all aspects of the health plan's operations, including benefits and coverage (e.g., Evidences of Coverage), template contracts with doctors and hospitals, provider networks, mental health parity, and complaint and grievance systems.

After licensure, the DMHC monitors health plans and any changes made to plan operations, including changes in service areas, contracts, benefits or systems. Health plans are required to file changes as amendments or material modifications, depending on the scope of the change. The DMHC also periodically identifies specific licensing issues for focused examination or investigation.

2021 Highlights

The DMHC issues APLs to provide guidance and information to health plans. The Department issued 25 APLs in 2021. Of these, 15 APLs provided guidance and information regarding the state's response to the COVID-19 pandemic.

Following the passage of Senate Bill (SB) 855 (2020), the Department worked to ensure health plans complied with this new law which made amendments to California's mental health parity law and requires commercial health plans to provide full coverage for the treatment of all mental health conditions and substance use disorders. It also establishes specific standards for what constitutes medically necessary treatment and criteria for the use of clinical guidelines. The DMHC issued an APL directing health plans to demonstrate compliance with the new law. Health plans were required to submit updated contracts, policies and procedures, and clinical guidelines showing how the plans would provide full coverage for the treatment of all mental health conditions and substance use

2021 BY THE NUMBERS

PLAN LICENSING

7 NEW LICENSES ISSUED

4,813 EVIDENCES OF COVERAGE REVIEWED

1,005 ADVERTISEMENTS REVIEWED

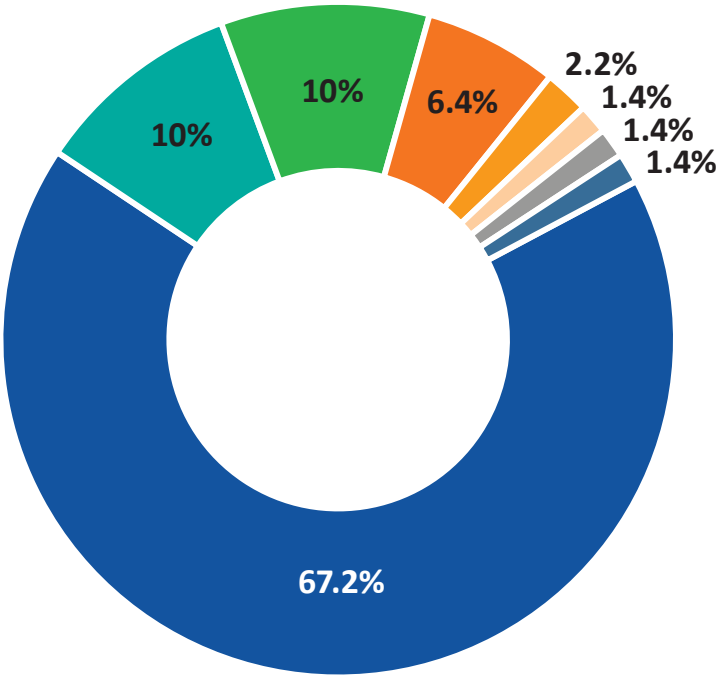
45 COVERED CALIFORNIA FILINGS REVIEWED[10]

25 ALL PLAN LETTERS

289 MATERIAL MODIFICATIONS (SIGNIFICANT CHANGES) RECEIVED

"Health plans in California must be licensed by the DMHC."

LICENSED PLANS IN 2021



- **1.4% -** 2 Pharmacy
- **1.4% -** 2 Discount
- **1.4% -** 2 Dental/Vision
- **2.2% -** 3 Chiropractic/Acupuncture
- **6.4% -** 9 Vision
- **10% -** 14 Behavioral Health (Psychological)
- **10% -** 14 Dental
- **67.2% -** 94 Full Service

disorders as well as adopt specific criteria and guidelines for determining when services and treatments are medically necessary.

On an annual basis, the DMHC reviews all Qualified Health Plans (QHP) and Qualified Dental Plans (QDP) applying to offer benefits for the upcoming plan year through Covered California, the state's Health Benefits Exchange. This process involves the review of each plan for compliance with Covered California's Patient Centered Benefit Plan Designs, including cost sharing, actuarial value compliance, and contract amendments between full service and specialized health care service plans. The DMHC reviewed 45 QHP and QDP filings in 2021 to ensure compliance with the consumer protections in federal and state law.

Health plans intending to merge or consolidate with any entity, including another health plan, must obtain prior approval from the DMHC. Under a law passed in 2018 (Assembly Bill (AB) 595), the Department's authority over the review of health plan mergers was expanded to include the ability to disapprove a merger, or change of control transaction, that may substantially lessen competition or doesn't meet the strong consumer protections in the law. Additionally, the Department must review change of control transactions and determine if it is a "major transaction" which requires the Department obtain an independent analysis and hold a public meeting. Since this law took effect on January 1, 2019, the DMHC has reviewed 24 different change of control transactions, including 11 in 2021.

The most significant transaction in 2021 was Centene Corporation's (Centene) acquisition of Magellan Health, Inc. (Magellan). For the first time since AB 595 took effect, the Department determined this change of control transaction met the requirements of a major transaction in the law. This required the Department to hold a public meeting and obtain an independent impact analysis on the merger. The DMHC held a public meeting on October 27, 2021 and approved the merger on December 30, 2021, including conditions

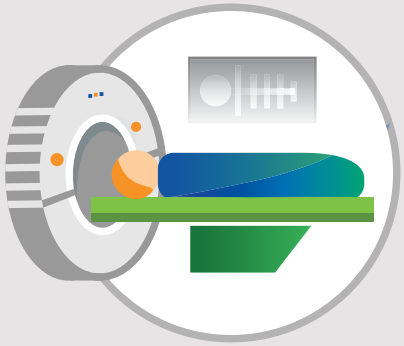
to ensure the merger would not adversely impact enrollees or the stability of California's health care delivery system.

Pharmacy Benefit Managers (PBMs) that contract with DMHC-licensed health plans to administer drug benefits are required to register with the Department. In 2021, the DMHC received eight amended applications, and nine new applications from PBMs. Only one of the nine new applications qualified to register with the DMHC. Many PBMs that applied for registration did not qualify because they did not contract with a DMHC-licensed health plan. Additionally, one registered PBM surrendered its registration with the Department in 2021.

The DMHC also continued to monitor and review plan compliance with the Uniform Provider Directory Standards. Health plans must publish and maintain accurate, complete and up-to-date provider directories. All health plans must have publicly available provider directories on their website, make weekly updates to those directories and provide consumers with simple ways to report directory errors.

DMHC HELP CENTER ASSISTANCE: CLAIMS/FINANCIAL – EMERGENCY SERVICES

Booker, a Small Group PPO plan member, went to see his primary care doctor, who referred him to get a computerized tomography (CT) scan at the hospital next door. Booker then went to the hospital next to his doctor's office and explained he was only there to get a CT scan. Though he told the hospital staff to check his doctor's order, he was given more services in the emergency department than he needed or that his doctor ordered. He later received a bill from the hospital's emergency department for more than $1,000. He filed an appeal and asked his health plan to waive the cost of the extra services because he said he told the emergency department staff many times he was only there for a CT scan per his doctor's orders. After unsuccessfully going through the health plan's appeal process, Booker filed a complaint with the DMHC Help Center. Following the DMHC Help Center's investigation, the plan approved Booker's request to waive the emergency department fees.



KNOW YOUR HEALTH CARE RIGHTS

Timely Access to Care

Health plans must ensure their network of providers, including doctors, can provide enrollees with an appointment within a specific number of days or hours.

A qualified health care provider may extend the waiting time for an appointment if they determine a longer waiting time will not be harmful to the enrollee's health.

Urgent Care

prior authorization **not required** by health plan
2 days

prior authorization **required** by health plan
4 days

Non-Urgent Care

Doctor Appointment

PRIMARY CARE PHYSICIAN
10 business days

SPECIALTY CARE PHYSICIAN
15 business days

Mental Health Appointment
(non-physician[1])
10 business days

Appointment
(ancillary provider[2])
15 business days

Follow-Up Care

Mental Health / Substance Use Disorder Follow-Up Appointment
(non-physician)
10 business days from prior appointment
(effective July 1, 2022)

Timely Access to Care Requirements

DISTANCE

A primary care provider / hospital within 15 miles or 30 minutes from where enrollees live or work

AVAILABILITY 24/7

Telephone services to talk to your health plan should be available 24/7

INTERPRETER

Interpreter services must be coordinated and provided with scheduled appointments for health care services

Unable to get an Appointment Within the Timely Access Standard?

If you are not able to get an appointment within the timely access standard, you should first contact your health plan for assistance at the toll-free number listed on your health plan card. The DMHC Help Center is available at 1-888-466-2219 (TDD: 1-877-688-9891) or www.HealthHelp.ca.gov to assist you if your health plan does not resolve the issue. The DMHC Help Center will work with you and your health plan to ensure you receive timely access to care. If you believe you are experiencing a medical emergency, dial 9-1-1 or go to the nearest hospital.

DEPARTMENT OF Managed Health Care

[1] Examples of non-physician mental health providers include counseling professionals, substance abuse professionals and qualified autism service providers.

[2] Examples of ancillary services include lab work or diagnostic testing, such as mammogram or MRI, or treatment such as physical therapy.

Plan Monitoring

The DMHC assesses and monitors health plan networks and delivery systems for compliance with the Knox-Keene Act. The Department evaluates compliance through surveys of health plan operations. A routine survey of each licensed health plan is performed every three years. The DMHC also conducts non-routine surveys when a specific issue or problem requires a focused review of a health plan's operations. The surveys are like audits, and examine health plan practices related to access and availability of services, utilization management, quality improvement, continuity and coordination of care, language access, and enrollee grievances and appeals.

When a survey identifies deficiencies, the DMHC requires corrective actions and may refer deficiencies to the Office of Enforcement for further investigation. Enforcement referrals typically occur when there are repeat deficiencies or when the health plan's corrective actions do not adequately correct the deficiencies. Survey findings, including corrective actions, are issued in public reports posted to the DMHC website.

The DMHC monitors health plan provider networks and the accessibility of services to enrollees by reviewing the geographic proximity of in-network providers to enrollee residences or work locations, provider-to-patient ratios and timely access to care. For some provider types, health plans must meet specific time and distance standards. Health plan networks are required to have an adequate number of providers to deliver care to enrollees in a timely manner. This includes a requirement that plans ensure their networks of providers can offer enrollees an appointment within a specific number of days or hours.

When a contract terminates between a health plan and a hospital or provider group, the DMHC assesses how the enrollees affected by the termination will continue to receive care. Health plans must submit a "Block Transfer Filing" to the DMHC when a contract termination with a hospital or provider group affects 2,000 or more enrollees. The DMHC ensures the health plan's remaining network adequately supports the affected enrollee population and requires the health plan to timely notify its affected enrollees, in writing, of the contract termination. The DMHC also requires health plans to notify affected enrollees that they may qualify for "continuity of care," where they can continue to see their doctor or hospital, under certain circumstances, for a limited time after the termination.

DMHC HELP CENTER ASSISTANCE: INDEPENDENT MEDICAL REVIEW (IMR) – EXPERIMENTAL/INVESTIGATIONAL

Ivan, an Individual PPO plan member on the state's exchange, Covered California, requested to join a clinical trial for a new vaccine to treat neuroblastoma. His health plan denied the treatment as Experimental and Investigational. Ivan then applied for an IMR with the DMHC Help Center. The IMR determined the clinical trial for the new vaccine to treat neuroblastoma qualified to be covered under the law on "approved clinical trials" (California Health and Safety Code §1370.6). Following the DMHC Help Center's decision, the health plan authorized coverage.

2021 Highlights

Ensuring access to timely and appropriate behavioral health care treatment and services, including compliance with state and federal mental health parity laws continues to be a high priority for the DMHC. The DMHC received approval in the 2020-21 state budget to conduct focused investigations of all full-service commercial health plans regulated by the Department to further evaluate health plan compliance with parity and assess whether enrollees have consistent access to medically necessary behavioral health care services.

In 2021, the DMHC began the focused behavioral health investigations of the first five plans. The Department anticipates an average of five investigations will be conducted per year over approximately five years.

The DMHC amended the timely access regulation and submitted the final regulation package to the Office of Administrative Law (OAL) on August 2, 2021. The purpose of the amendments to this regulation is to set a standardized methodology for how health plans report timely access to care requirements and annual network requirements to the DMHC. This regulation will help the DMHC ensure health plans are meeting timely access to care requirements, allow for meaningful comparisons of timely access to care information across health plans, and allow the DMHC to better hold health plans accountable.

In 2021, the DMHC received approval to form a Health Equity and Quality Committee to help reduce health care disparities for Californians. The Committee will make recommendations by September 30, 2022, for standard health equity and quality measures, including annual benchmark standards for health plans to assess equity and quality in health care delivery.

Additionally, to streamline the process of evaluating health plan networks following provider group and hospital terminations, the DMHC made enhancements to health plan reporting of Block Transfers.

2021 BY THE NUMBERS

PLAN MONITORING

16 ROUTINE SURVEYS

22 FOLLOW-UP SURVEYS

1 NON-ROUTINE SURVEY[11]

127 UNIQUE HEALTH PLAN NETWORKS REVIEWED[12]

46 TIMELY ACCESS COMPLIANCE REPORTS REVIEWED[13]

338 BLOCK TRANSFERS RECEIVED

130 MATERIAL MODIFICATIONS RECEIVED

> ***The DMHC assesses and monitors health plan networks and delivery systems for compliance with the Knox-Keene Act.***

Financial Oversight

The DMHC works to ensure stability in California's health care delivery system by actively monitoring the financial status of health plans and provider groups, known as Risk Bearing Organizations (RBOs), to make sure they can meet their financial obligations to consumers and other purchasers.

The DMHC reviews health plan financial statements and filings, and analyzes health plan reserves, financial management systems and administrative arrangements. To monitor and corroborate reported information, the DMHC conducts routine financial examinations of each health plan every three to five years and initiates non-routine financial examinations as needed. Routine examinations focus on health plan compliance with financial and administrative requirements that include reviewing the plan's claims payment practices and provider dispute resolution processes.

The DMHC annually reviews health plan compliance with Medical Loss Ratio (MLR) requirements of 85% in the large group market and 80% in the individual and small group markets. MLR is the percentage of health plan premiums that a health plan spends on medical services and activities that improve quality of care. If a health plan does not meet the minimum MLR threshold, it must provide rebates to consumers and other purchasers, such as employers.

The DMHC does not license provider organizations but monitors the financial solvency of RBOs. An RBO is a physician-owned provider group that, in its contracts with health plans, pays claims and assumes financial risk for the cost of all health care services (inpatient and outpatient) for each enrolled person assigned to the RBO by accepting a fixed monthly payment. This arrangement is typically referred to as "capitation." RBOs are subject to financial solvency requirements and regular financial reporting. The DMHC monitors the financial stability of RBOs by analyzing financial filings, conducting financial and/or claims examination, reviewing claims payment practices, and monitoring corrective action plans. As of December 31, 2021, the DMHC had 209 registered RBOs.

The DMHC reviews the financial status of all licensed health plans and registered RBOs at the Financial Solvency Standards Board (FSSB) public

DMHC HELP CENTER ASSISTANCE: ACCESS TO CARE

Ebony, a Medi-Cal Managed Care plan member, was diagnosed with breast cancer. Her treating health care provider recommended she obtain genetic testing to determine the most effective treatment plan for her condition. The health plan denied the services as not a covered benefit, stating genetic testing is only approved under Medi-Cal for newborns and pregnant women. The DMHC Help Center investigated Ebony's complaint and her health plan's policies. With the DMHC Help Center's assistance, the health plan agreed to overturn their previous denial. Ebony was able to have a consultation with a genetic counselor and genetic testing to determine the most effective plan to treat her breast cancer.

meetings. The FSSB meets quarterly and advises the Director on matters of financial solvency that affect the delivery of health care services. The FSSB members offer a broad range of experience and expertise including perspectives from actuaries, hospital and provider executives, health plan executives and consumer advocates.

2021 Highlights

In January 2021, the DMHC completed the routine financial examination of Health Net of California, Inc. (Health Net). The DMHC imposed a Corrective Action Plan (CAP) requiring Health Net to remediate provider claims due to inaccurate claims payments, untimely payment of Provider Dispute Resolutions (PDR), and incorrect PDR determinations. Health Net reprocessed almost 35,000 claims and paid nearly $1.3 million to providers, including interest and penalties.

Blue Cross of California (Anthem Blue Cross) notified the DMHC in 2020 the plan had overcharged premiums paid by Medicare Supplement enrollees. The plan was required to complete a CAP including remediating all impacted premiums, including refunding enrollees. As part of the CAP that was completed in 2021, Anthem Blue Cross reimbursed $3.7 million in premiums going back to 2011, including $1.3 million in interest.

In 2021, six health plans were required to issue rebate checks totaling $89.9 million for failing to meet the minimum MLR requirement for 2020:

- Local Initiative Health Authority for Los Angeles County (L.A. Care Health Plan) reported an MLR of 77.8% for 2020 and paid rebates of $9.6 million in the individual market.
- Molina Healthcare of California reported an MLR of 78.6% for 2020 and paid rebates of $3.4 million in the individual market.
- Anthem Blue Cross reported an MLR of 77.3% for 2020 and paid rebates of $66.6 million in the small group market.

2021 BY THE NUMBERS

FINANCIAL OVERSIGHT

67 FINANCIAL EXAMINATIONS COMPLETED[14]

2,751 FINANCIAL STATEMENTS REVIEWED[15]

$89.9 M MLR REBATES[16]

$1.45 M CLAIM AND DISPUTED PAYMENTS REMEDIATED

$1.04 M INTEREST AND PENALTIES PAID

The DMHC works to ensure stability in California's health care delivery system.

- Health Net reported an MLR of 78.3% for 2020 and paid $7.6 million in rebates in the small group market.
- Holman Professional Counseling Centers reported an MLR of 84.6% for 2020 and paid rebates of $19,794 in the large group market.
- U.S. Behavioral Health Plan, California (OptumHealth Behavioral Solutions of California) reported an MLR of 65.8% for 2020 and paid rebates of $2.3 million in the large group market.

DMHC HELP CENTER ASSISTANCE: CLAIMS/FINANCIAL—DENTAL

Fatima, a Large Group HMO dental plan member, was incorrectly billed for several dental procedures that should have been covered with no cost-share by her dental plan. Fatima received an evaluation, dental cleaning, x-rays, dental crown, and a cavity filling from a dental provider contracted with her plan and was charged $1,092 by the provider. After paying for the charges, she filed a grievance with her dental plan because the evaluation, dental cleaning and x-rays should have been covered with no cost-share according to her Evidence of Coverage. Unfortunately, the plan could not resolve her grievance within 30 days. Fatima filed a complaint with the DMHC Help Center, which contacted her plan about the complaint. Following the DMHC Help Center's intervention, the plan reprocessed Fatima's claims and she was reimbursed $900.

Rate Review

Since January 2011, the DMHC has saved Californians nearly $300 million in health care premiums through the premium rate review program for individual and small group health plans. Under state law, proposed premium rate changes for individual or small group health plans must be filed with the DMHC. Additionally, health plans that offer large group products must provide information regarding the methodology, factors, and assumptions used to determine rates to the DMHC. Actuaries perform an in-depth review of the health plan's proposed changes and requires health plans demonstrate how the proposed changes are supported by data, including underlying medical costs and trends. The DMHC does not have the authority to approve or deny rate increases; however, the Department's rate review efforts hold health plans accountable through transparency, and ultimately has saved consumers hundreds of millions of dollars.

If the DMHC finds a health plan rate change is not supported, the DMHC negotiates with the health plan to reduce the rate, called a modified rate.

If the health plan refuses to modify its rate, the Department can find the rate to be unreasonable. When the DMHC finds a proposed rate change to be unreasonable, the health plan must notify impacted enrollees of the unreasonable finding.

Additionally, health plans that offer individual, small group, and large group coverage must file annual aggregate rate information with the DMHC. The DMHC holds a public meeting every other year to increase transparency of health plan premium rate changes.

Health plans in the commercial market must file certain prescription drug cost information with the DMHC on an annual basis. The DMHC analyzes the data and the impact of prescription drug costs on health care premiums and produces an annual report that is presented at the public meeting on large group rates.

The Department has an informative and user-friendly premium rate review section on its public website that makes it easy for the public to view and comment on health plan proposed rate changes.

REVIEW & COMMENT ON HEALTH PLAN PROPOSED RATE CHANGES

The DMHC makes it easy for the public to view and comment on health plan proposed rates. Visit www.RateReview.DMHC.ca.gov for more information and to review and submit comments.

2021 Highlights

The DMHC reviewed 51 individual and small group rate filings in 2021. The DMHC reviewed health plans' proposed rate changes to ensure that the rate changes were supported by data, including underlying medical costs and trends. The Department did not find any unreasonable or unjustified rate changes.

The DMHC implemented Assembly Bill (AB) 2118 (2020), which requires health plans that offer commercial products in the individual and small group markets to annually report information to the DMHC, including premiums, cost sharing, benefits, enrollment, and trend factors. The DMHC reviewed aggregate rate filings for 12 individual and 15 small group health plans and published the Individual and Small Group Aggregate Premium Rate Report for Measurement Year 2021.

Also in 2021, the Department reviewed 37 filings from 23 health plans related to large group aggregate rate and prescription drug cost information. The DMHC aggregated the information across all reporting plans and published the Large Group Aggregate Rates and Prescription Drug Costs Report for Measurement Year 2021. The report summarizes the large group aggregate rate information and analyzes the impact of the cost of prescription drugs on health plan premiums in the large group market. Additionally, effective July 1, 2021, a large group contract holder with coverage that is experience rated can request the DMHC to review a rate change. The DMHC released an online form for large group contract holders to request the Department's review of a rate change.

The DMHC published the Prescription Drug Cost Transparency Report for Measurement Year 2020, which looks at the impact of the cost of prescription drugs on commercial health plan premiums. Among other findings, the report reveals that health plans paid an increase of $1.5 billion on prescription drugs since 2017, including an increase of almost $500 million in the last reporting year.

2021 BY THE NUMBERS

RATE REVIEW

88 RATE FILING REVIEWS COMPLETED[17]

25 PRESCRIPTION DRUG COST FILINGS REVIEWED

50 ANNUAL AGGREGATE RATE FILINGS REVIEWED

$296.1 M CONSUMER SAVINGS THROUGH NEGOTIATED MODIFIED RATES SINCE 2011

> ***Since January 2011, the DMHC has saved Californians $296.1 million in health care premiums.***

Enforcement

To protect consumers, the DMHC takes timely action against health plans that violate the law. The primary purpose of enforcement actions are to change plan behavior to comply with the law. Enforcement actions include issuing cease and desist orders, imposing administrative penalties (fines), freezing enrollment and requiring corrective actions. When necessary, the DMHC may pursue litigation to ensure health plans follow the law.

In 2021, the first $1 million in fines collected by the DMHC was transferred to the Steven M. Thompson Physician Corps Loan Repayment Program to be used to encourage physicians to practice in medically underserved areas. The remaining funds were transferred to the Health Care Services Plan Fines and Penalties Fund to support the Medi-Cal program.

2021 Highlights

In 2021, the DMHC assessed $2,688,750 in fines for enforcement actions taken against health plans. The Department's enforcement actions involved many diverse legal issues, including failures to address enrollee grievances, timely implement IMR decisions, maintain financial solvency, and deliver basic health care services in compliance with the law.

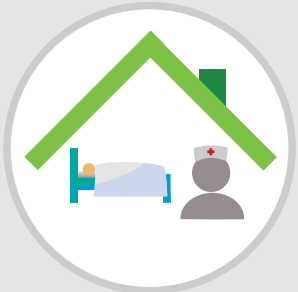
Some of the significant enforcement actions taken by the DMHC in 2021 are described below.

The DMHC imposed penalties totaling $173,500 against L.A. Care Health Plan for multiple enrollee grievance enforcement actions. In the first action, the plan failed to timely and accurately respond to the Department's requests for necessary information to resolve complaints for eight enrollees, and the Department determined the plan had a lack of administrative capacity to provide services to its enrollees. In the second action, the plan failed to timely resolve 20 enrollee grievances within 30 days of receipt as required by law. The plan took corrective actions and paid the penalties.

The DMHC imposed a $150,000 penalty against California Physicians' Service (Blue Shield of California) for the plan's failure to timely implement an IMR decision adopted by the DMHC. California law requires health plans to authorize the services within five working days of receiving an IMR determination accepted by the Department. After the DMHC Help Center intervened, the enrollee was able to get the residential treatment center services adopted through the IMR. However, the service was not authorized until 22 days after the plan was legally required to authorize the service. The plan acknowledged its

DMHC HELP CENTER ASSISTANCE: INDEPENDENT MEDICAL REVIEW (IMR) – MEDICAL NECESSITY

Kaoru, a minor with Large Group HMO plan coverage, was diagnosed with acute lymphoblastic leukemia, and needed home skilled nursing services from a registered nurse. Her father submitted an appeal to the health plan but the services were denied as not medically necessary. Kaoru's father applied for an IMR with the DMHC Help Center. The IMR determined Kaoru's request for skilled nursing services from a registered nurse were medically necessary and the health plan was required to cover the services.



failure to comply with the law, paid the penalty, and agreed to corrective actions to settle the issue.

The DMHC imposed a total of $130,000 in penalties against Premier Health Plan Services, Inc., for its failure to maintain the minimum required tangible net equity (TNE) and for various claims payment and provider dispute resolution violations identified in a financial audit of the plan. The plan failed to reimburse claims accurately, including automatic payment of interest and penalty, issued incorrect claim denials and failed to timely resolve provider complaints. The Plan completed remediation on claims totaling $45,147.99, including interest and fees.

The DMHC filed a Cease-and-Desist Order to freeze enrollment and then filed an Accusation to revoke the license of Vitality Health Plan of California, Inc. (CCA Health Plans of California, Inc.) due to the plan's chronic TNE deficiencies impacting Medicare enrollees. Under the law, health plans are required to have a minimum TNE to ensure financial solvency in order to pay health care claims for enrollees. The plan filed for Chapter 11 bankruptcy to reorganize its debts and continue operating. The Department withdrew its Accusation based on the stipulation between the parties agreeing that the Accusation was put on hold by the bankruptcy filing and that the Cease-and-Desist Order would continue in effect until approval of a change in control request. The Department granted approval of a change in control to a new buyer, Commonwealth Care Alliance. The plan then resolved the TNE deficiency.

The DMHC filed an Accusation to revoke the license of Golden State Health Plan, and issued a Cease-and-Desist Order to freeze enrollment due to the plan's chronic TNE deficiencies impacting Medicare enrollees. The DMHC and the plan later entered into a settlement agreement, which requires the plan to voluntarily surrender its license if it fails to secure funding to cure its TNE deficiency.

2021 BY THE NUMBERS

ENFORCEMENT

884 CASES OPENED

233 CASES CLOSED WITH A PENALTY

$2.7 M PENALTIES ASSESSED

"To protect consumers, the DMHC takes timely action against health plans that violate the law."

The DMHC imposed an $85,000 penalty against Aetna Dental of California, Inc., for its failure to cure nine deficiencies identified in a routine survey. The uncorrected deficiencies included the plan's quality assurance program, including failing to document all statutorily required quality-of-care criteria; multiple failures with the plan's grievance system, including failure to adequately consider enrollee grievances; failure to maintain grievance-related records; improperly processing coverage disputes as exempt grievances; failure to track and monitor grievances submitted online; failure to consistently and timely make utilization management decisions and convey those decisions in writing; and failure to meet the statutory requirements for language assistance programs. The plan paid the penalty and agreed to corrective actions.

The DMHC imposed a $35,000 penalty against Health Net for its failure to pay claims for medically necessary and authorized services, failure to timely pay claims, and failure to adequately consider the enrollee's grievance. The plan acknowledged its failure to timely and accurately pay the claim, paid the penalty, and agreed to corrective actions.

The DMHC also imposed a $25,000 penalty against Health Net Community Solutions, Inc. for imposing an impermissible referral requirement for OB/GYN care and for its repeated failure to initiate a grievance on three occasions over a three-month period. The misinformation provided and the failures to initiate a grievance contributed to the enrollee's failure to find timely prenatal services. The plan acknowledged its failure to timely and accurately pay the claim, paid the penalty, and agreed to a CAP.

Notes

1 www.dmhc.ca.gov/COVID-19

2 The enrollment charts include the following enrollment types reported by plans and searchable in the Health Plan Financial Summary Report: Point of service - Large Group, PPO - Large Group, Group (Commercial), Point of Service - Small Group, PPO - Small Group, Small Group, PPO - Individual, Point of Service - Individual, Individual, IHSS, Medi-Cal Risk, Medicare Risk (Medicare Advantage), Medicare Cost (Fee For Service) and Medicare Supplement. Healthy Families and AIM enrollment were also reported in previous years when those programs were active.

3 Delta Dental of California and the Department of Health Care Services made a change in their contractual arrangement in January 2018, whereby Delta Dental of California was no longer the fiscal intermediary of the Medi-Cal dental program. As a result, Delta Dental of California's Medi-Cal enrollment declined by approximately 13 million lives.

4 "Other" enrollment consists of Medicare Supplement enrollment.

5 Enrollees received the requested services in 67.5% of the cases qualified by the Department for the IMR program in 2021.

6 This includes consumers who may have received more than one form of assistance throughout the year.

7 Consumer complaints are comprised of standard complaints (10,352), quick resolutions (371), and urgent cases (48) in 2021. 8,282 of the standard complaints were resolved by the DMHC and are included in the complaint report in the Appendix. Of the remaining cases, most were sent back to the health plan to address through the grievance process.

8 IMRs closed are comprised of cases that were resolved by the DMHC or closed for any reason other than non-jurisdictional in 2021. 2,570 of the IMRs were resolved by the DMHC and are included in the IMR report in the Appendix. The remaining cases were closed because the consumer had not yet gone through the health plan grievance process, the consumer did not respond to requests for information, the case was withdrawn by the consumer or the case was ineligible for IMR.

9 The category "Coordination of Benefits" has also been previously referred to as "Quality of Care."

10 Includes review of Qualified Health Plan filings and Qualified Dental Plan filings.

11 The non-routine survey released in 2021 was for Human Affairs International of California (HAI-CA).

12 Networks reviewed in 2021 were for Measurement Year 2020 Annual Network Reporting.

13 Timely Access compliance reports reviewed in 2021 were for Measurement Year 2020.

14 45 Health Plan Financial Examinations and 22 RBO Financial Examinations.

15 1,473 Health Plan Financial Statements Reviewed and 1,278 RBO Financial Statements Reviewed.

16 Rebates for calendar year 2020 were paid in 2021.

17 This includes 14 individual market health plan premium rate filings, 37 small group rate filings, and 37 large group rate filings.

2021 Independent Medical Review Summary Report

Report Overview

68%
of enrollee cases that qualified for the Department's IMR program received the requested services they needed.*

17%
of IMR cases were reversed by the health plan after the DMHC received the IMR application.

51%
of cases previously denied by health plans were overturned by the IMRO.

32%
of cases were upheld by the IMRO.

The Annual Independent Medical Review (IMR) Summary Report displays the number and types of IMRs resolved during the 2021 calendar year, by health plan. The Department resolved 2,570 IMRs.

The Report identifies each health plan's enrollment during the year, the number of IMRs resolved for each health plan, the number of IMRs per 10,000 enrollees, the number of IMRs upheld or overturned by the Independent Medical Review Organization (IMRO), and the number of IMRs that the health plan reversed.

The health plan enrollment figures were provided to the Department by the health plans in their quarterly financial filings. Enrollment reflects the enrollment figures provided for the fourth quarter of 2021 for the population of enrollees within the DMHC Help Center's jurisdiction. Plans with zero enrollment as of December 31, 2021 may have had enrollment earlier in the year, received a license in 2021 or did not have enrollment within the DMHC Help Center's jurisdiction.

Data represents resolved IMRs which were determined to be within the Department's jurisdiction, eligible for review, and resolved (closed) within calendar year 2021. Cases pending at the end of 2021 and resolved (closed) in the following year are reported in the subsequent year's Annual Report.

Health plans are listed according to their business names during 2021. In instances where a health plan is known by more than one name, the legal name is shown first with the additional name(s) in parentheses. For health plans that are involved in plan-to-plan arrangements, the data is reported by the primary plan only.

The number of IMRs per 10,000 enrollees is displayed to illustrate the volume of IMRs for a plan in a manner that considers the wide variations in plan enrollment. When comparing plans, a lower number of IMRs per 10,000 enrollees indicates fewer IMRs were resolved per capita. As a result, a plan with a higher overall number of resolved IMRs may still show fewer IMRs per 10,000 enrollees than another plan with fewer overall resolved IMRs.

* Enrollees received the requested services in 67.5% of the cases qualified by the Department for the IMR program in 2021.

California Department of Managed Health Care

2021 Independent Medical Review by Health Plan

Plan Type and Name	Enrollees*	Total IMRs Resolved	IMRs per 10,000	EXPERIMENTAL / INVESTIGATIONAL IMR							MEDICAL NECESSITY IMR							ER REIMBURSEMENT IMR						
				Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%
FULL SERVICE – ENROLLMENT OVER 400,000																								
Blue Cross of California (Anthem Blue Cross)	2,096,787	614	2.93	156	68	43.6%	83	53.2%	5	3.2%	457	116	25.4%	297	65.0%	44	9.6%	1	0	0.0%	1	100.0%	0	0.0%
Blue Cross of California Partnership Plan, Inc.	876,321	60	0.68	1	0	0.0%	0	0.0%	1	100.0%	59	20	33.9%	23	39.0%	16	27.1%	0	0	0.0%	0	0.0%	0	0.0%
California Physicians' Service (Blue Shield of California)	2,421,076	807	3.33	164	78	47.6%	64	39.0%	22	13.4%	636	164	25.8%	378	59.4%	94	14.8%	7	3	42.9%	3	42.9%	1	14.3%
Health Net Community Solutions, Inc.	1,495,990	69	0.46	7	4	57.1%	2	28.6%	1	14.3%	61	16	26.2%	28	45.9%	17	27.9%	1	1	100.0%	0	0.0%	0	0.0%
Health Net of California, Inc.	503,507	111	2.20	15	4	26.7%	10	66.7%	1	6.7%	96	27	28.1%	39	40.6%	30	31.3%	0	0	0.0%	0	0.0%	0	0.0%
Inland Empire Health Plan (IEHP)	1,418,544	55	0.39	2	2	100.0%	0	0.0%	0	0.0%	53	37	69.8%	12	22.6%	4	7.5%	0	0	0.0%	0	0.0%	0	0.0%
Kaiser Foundation Health Plan, Inc. (Kaiser Permanente)	7,144,640	274	0.38	1	1	100.0%	0	0.0%	0	0.0%	270	132	48.9%	108	40.0%	30	11.1%	3	2	66.7%	0	0.0%	1	33.3%
Local Initiative Health Authority for Los Angeles County (L.A. Care Health Plan)	2,446,634	107	0.44	1	1	100.0%	0	0.0%	0	0.0%	106	39	36.8%	41	38.7%	26	24.5%	0	0	0.0%	0	0.0%	0	0.0%
Molina Healthcare of California	544,318	12	0.22	0	0	0.0%	0	0.0%	0	0.0%	12	5	41.7%	1	8.3%	6	50.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Full Service - Enrollment Over 400,000:	**18,947,817**	**2,109**	**1.11**	**347**	**158**	**45.5%**	**159**	**45.8%**	**30**	**8.6%**	**1750**	**556**	**31.8%**	**927**	**53.0%**	**267**	**15.3%**	**12**	**6**	**50.0%**	**4**	**33.3%**	**2**	**16.7%**
FULL SERVICE – ENROLLMENT UNDER 400,000																								
Access Senior HealthCare, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Adventist Health Plan, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Aetna Better Health of California Inc.	41,666	1	0.24	0	0	0.0%	0	0.0%	0	0.0%	1	0	0.0%	1	100.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Aetna Health of California Inc.	195,661	14	0.72	1	0	0.0%	1	100.0%	0	0.0%	13	1	7.7%	7	53.8%	5	38.5%	0	0	0.0%	0	0.0%	0	0.0%
AIDS Healthcare Foundation (Positive Healthcare)	747	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Alameda Alliance For Health	296,873	9	0.30	0	0	0.0%	0	0.0%	0	0.0%	9	3	33.3%	3	33.3%	3	33.3%	0	0	0.0%	0	0.0%	0	0.0%
Align Senior Care California, Inc.**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Alignment Health Plan**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
AltaMed Health Network, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
AmericasHealth Plan, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Arcadian Health Plan, Inc.**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Aspire Health Plan**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Astiva Health, Inc.**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Bay Area Accountable Care Network, Inc. (Canopy Health)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Blue Shield of California Promise Health Plan	119,190	6	0.50	1	1	100.0%	0	0.0%	0	0.0%	5	1	20.0%	4	80.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Brandman Health Plan**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Brown & Toland Health Services, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
California Health and Wellness Plan (CA Health and Wellness)	222,630	14	0.63	2	0	0.0%	2	100.0%	0	0.0%	12	2	16.7%	7	58.3%	3	25.0%	0	0	0.0%	0	0.0%	0	0.0%
Care Improvement Plus South Central Insurance Company	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
CareMore Health Plan	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
CCA Health Plans of California, Inc. (CCA Health California)**^	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Central Health Plan of California, Inc.**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Central Valley Health Plan, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
CHG Foundation (Community Health Group Partnership Plan)	303,710	5	0.16	1	0	0.0%	1	100.0%	0	0.0%	4	2	50.0%	1	25.0%	1	25.0%	0	0	0.0%	0	0.0%	0	0.0%
Children's Health Plan of California	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Chinese Community Health Plan	7,515	1	1.33	0	0	0.0%	0	0.0%	0	0.0%	1	0	0.0%	1	100.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Choice Physicians Network, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Cigna HealthCare of California, Inc.	139,517	14	1.00	7	3	42.9%	2	28.6%	2	28.6%	7	2	28.6%	3	42.9%	2	28.6%	0	0	0.0%	0	0.0%	0	0.0%
Clever Care of Golden State Inc. (Clever Care of California)**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Community Care Health Plan, Inc.	11,653	1	0.86	0	0	0.0%	0	0.0%	0	0.0%	1	0	0.0%	0	0.0%	1	100.0%	0	0	0.0%	0	0.0%	0	0.0%
Community Health Group	7,048	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Contra Costa County Medical Services (Contra Costa Health Plan)	221,277	2	0.09	0	0	0.0%	0	0.0%	0	0.0%	2	1	50.0%	0	0.0%	1	50.0%	0	0	0.0%	0	0.0%	0	0.0%
County of Ventura (Ventura County Health Care Plan)	12,012	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Dignity Health Provider Resources, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
EPIC Health Plan	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%

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Plan Type and Name	Enrollees*	Total IMRs Resolved	IMRs per 10,000	EXPERIMENTAL / INVESTIGATIONAL IMR							MEDICAL NECESSITY IMR							ER REIMBURSEMENT IMR						
				Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%
Essence Healthcare of California, Inc. (Essence Healthcare)**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
For Your Benefit, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Fresno-Kings-Madera Regional Health Authority (CalViva Health)	393,125	17	0.43	1	1	100.0%	0	0.0%	0	0.0%	16	4	25.0%	8	50.0%	4	25.0%	0	0	0.0%	0	0.0%	0	0.0%
Global Health Plan, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Golden State Medicare Health Plan (Golden State Health Plan)**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Healthy Valley Provider Network, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Heritage Provider Network, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Hill Physicians Care Solutions, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Humana Health Plan of California, Inc.**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Humana Health Plan of Texas, Inc.**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Imperial Health Plan of California, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Innovative Integrated Health Community Plans, Inc.**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Inter Valley Health Plan, Inc.**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Kern Health Systems	298,205	34	1.14	1	0	0.0%	1	100.0%	0	0.0%	33	9	27.3%	13	39.4%	11	33.3%	0	0	0.0%	0	0.0%	0	0.0%
L.A. Care Health Plan Joint Powers Authority	50,614	5	0.99	0	0	0.0%	0	0.0%	0	0.0%	5	1	20.0%	3	60.0%	1	20.0%	0	0	0.0%	0	0.0%	0	0.0%
MedCare Partners, Inc. (MedCare Partners Health Plan)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Medcore HP	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Medi-Excel, S.A. de C.V. (MediExcel Health Plan)	13,529	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
MemorialCare Select Health Plan	248	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Meritage Health Plan	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Monarch Health Plan, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
On Lok Senior Health Services	1,671	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Optum Health Plan of California	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Orange County Health Authority (CalOptima)***	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Oscar Health Plan of California	96,831	61	6.30	6	0	0.0%	3	50.0%	3	50.0%	55	8	14.5%	20	36.4%	27	49.1%	0	0	0.0%	0	0.0%	0	0.0%
Partnership HealthPlan of California***	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
PIH Health Care Solutions	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Premier Health Plan Services, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
PRIMECARE Medical Network, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Prospect Health Plan, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Providence Health Assurance**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Providence Health Network	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
San Francisco Health Authority (San Francisco Health Plan)	165,138	4	0.24	0	0	0.0%	0	0.0%	0	0.0%	4	1	25.0%	3	75.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
San Joaquin County Health Commission (Health Plan of San Joaquin)	388,170	16	0.41	0	0	0.0%	0	0.0%	0	0.0%	16	8	50.0%	6	37.5%	2	12.5%	0	0	0.0%	0	0.0%	0	0.0%
San Mateo Health Commission (Health Plan of San Mateo)	1,205	22	182.57	1	1	100.0%	0	0.0%	0	0.0%	21	0	0.0%	11	52.4%	10	47.6%	0	0	0.0%	0	0.0%	0	0.0%
Santa Barbara San Luis Obispo Regional Health Authority (CenCal Health)***	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Santa Clara County (Valley Health Plan)	44,962	6	1.33	1	0	0.0%	1	100.0%	0	0.0%	5	2	40.0%	1	20.0%	2	40.0%	0	0	0.0%	0	0.0%	0	0.0%
Santa Clara County Health Authority (Santa Clara Family Health Plan)	291,097	27	0.93	0	0	0.0%	0	0.0%	0	0.0%	27	7	25.9%	14	51.9%	6	22.2%	0	0	0.0%	0	0.0%	0	0.0%
Santa Cruz-Monterey-Merced Managed Medical Care Commission (Central California Alliance for Health)***	517	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Scan Health Plan	14,475	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Scripps Health Plan Services, Inc.	15,908	1	0.63	0	0	0.0%	0	0.0%	0	0.0%	1	0	0.0%	0	0.0%	1	100.0%	0	0	0.0%	0	0.0%	0	0.0%
Sequoia Health Plan, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Sharp Health Plan	134,308	28	2.08	2	1	50.0%	1	50.0%	0	0.0%	26	6	23.1%	12	46.2%	8	30.8%	0	0	0.0%	0	0.0%	0	0.0%
Sistemas Medicos Nacionales, S.A.de C.V. (SIMNSA Health Plan)	49,272	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Sutter Health Plan (Sutter Health Plus)	100,466	9	0.90	3	2	66.7%	1	33.3%	0	0.0%	6	2	33.3%	1	16.7%	3	50.0%	0	0	0.0%	0	0.0%	0	0.0%
UHC of California (UnitedHealthcare of California)	389,230	52	1.34	9	7	77.8%	2	22.2%	0	0.0%	42	9	21.4%	13	31.0%	20	47.6%	1	0	0.0%	1	100.0%	0	0.0%
UnitedHealthcare Benefits Plan of California	370,381	69	1.86	20	9	45.0%	11	55.0%	0	0.0%	49	8	16.3%	26	53.1%	15	30.6%	0	0	0.0%	0	0.0%	0	0.0%

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				Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%
UnitedHealthcare Community Plan of California, Inc.	26,406	2	0.76	0	0	0.0%	0	0.0%	0	0.0%	2	0	0.0%	1	50.0%	1	50.0%	0	0	0.0%	0	0.0%	0	0.0%
Universal Care, Inc. (Bright HealthCare)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
WellCare of California, Inc.**	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Western Health Advantage	101,258	38	3.75	3	2	66.7%	1	33.3%	0	0.0%	35	10	28.6%	21	60.0%	4	11.4%	0	0	0.0%	0	0.0%	0	0.0%
Total Full Service - Enrollment Under 400,000:	**4,526,515**	**458**	**1.01**	**59**	**27**	**45.8%**	**27**	**45.8%**	**5**	**8.5%**	**398**	**87**	**21.9%**	**180**	**45.2%**	**131**	**32.9%**	**1**	**0**	**0.0%**	**1**	**100.0%**	**0**	**0.0%**
Total All Full Service Plans:	**23,474,332**	**2,567**	**1.09**	**406**	**185**	**45.6%**	**186**	**45.8%**	**35**	**8.6%**	**2,148**	**643**	**29.9%**	**1,107**	**51.5%**	**398**	**18.5%**	**13**	**6**	**46.2%**	**5**	**38.5%**	**2**	**15.4%**
Chiropractic																								
ACN Group of California, Inc. (OptumHealth Physical Health of California)	76,174	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
American Specialty Health Plans of California, Inc. (ASHP)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Landmark Healthplan of California, Inc.	67,996	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Chiropractic:	**144,170**	**0**	**0.00**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
Dental																								
Access Dental Plan	305,124	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Aetna Dental of California Inc.	113,738	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
California Dental Network, Inc.	71,788	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Cigna Dental Health of California, Inc.	199,095	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Consumer Health, Inc. (Newport Dental Plan)	6,193	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Dental Benefit Providers of California, Inc.	157,156	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Dental Health Services	62,931	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Golden West Health Plan, Inc. (Golden West Dental & Vision Plan)	7,856	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Liberty Dental Plan of California, Inc. (Personal Dental Services)	402,905	2	0.05	0	0	0.0%	0	0.0%	0	0.0%	2	1	50.0%	0	0.0%	1	50.0%	0	0	0.0%	0	0.0%	0	0.0%
Managed Dental Care	92,698	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Starmount Managed Dental of California, Inc. (Unum Dental HMO Plan)	550	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
UDC Dental California, Inc. (United Dental Care of California, Inc.)	22,872	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
United Concordia Dental Plans of California, Inc.	73,629	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Western Dental Services, Inc. (Western Dental Plan)	158,970	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Dental:	**1,675,505**	**2**	**0.01**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**2**	**1**	**50.0%**	**0**	**0.0%**	**1**	**50.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
DENTAL/VISION																								
Delta Dental of California	4,190,502	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
SafeGuard Health Plans, Inc. (MetLife)	209,160	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Dental/Vision:	**4,399,662**	**0**	**0.00**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
DISCOUNT																								
First Dental Health	27,694	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
The CDI Group, Inc.	24,389	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Discount:	**52,083**	**0**	**0.00**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
PHARMACY																								
SilverScript Insurance Company	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
WellCare Prescription Insurance, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Pharmacy:	**0**	**0**	**0.00**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
BEHAVIORAL HEALTH (PSYCHOLOGICAL)																								
Beacon Health Options of California, Inc. (Beacon of California)	615,947	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Claremont Behavioral Services, Inc. (Claremont EAP)	93,436	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
CONCERN: Employee Assistance Program	87,975	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Empathia Pacific, Inc. (LifeMatters)	130,591	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%

California Department of Managed Health Care

2021 Independent Medical Review by Health Plan

Plan Type and Name	Enrollees*	Total IMRs Resolved	IMRs per 10,000	EXPERIMENTAL / INVESTIGATIONAL IMR							MEDICAL NECESSITY IMR							ER REIMBURSEMENT IMR						
				Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%	Total IMRs	Upheld by IMR	%	Over-turned by IMR	%	Rev. by Plan	%
Evernorth Behavioral Health of California, Inc.	115,818	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Health Advocate West, Inc.	86,712	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Health and Human Resource Center, Inc. (Aetna Resources for Living)	1,906,860	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Holman Professional Counseling Centers	88,836	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Human Affairs International of California (HAI-CA)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Humana EAP and Work-Life Services of California, Inc.	32,066	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Magellan Health Services of California, Inc. - Employer Services	831,576	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Managed Health Network	591,221	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Morneau Shepell (California) Limited (LifeWorks by Morneau Shepell)	21,986	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
U. S. Behavioral Health Plan, California (OptumHealth Behavioral Solutions of California)	786,374	1	0.01	0	0	0.0%	0	0.0%	0	0.0%	1	0	0.0%	0	0.0%	1	100.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Behavioral Health (Psychological):	**5,389,398**	**1**	**0.00**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**1**	**0**	**0.0%**	**0**	**0.0%**	**1**	**100.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
VISION																								
Envolve Vision, Inc. (Envolve Benefit Options)	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
EyeMax Vision Plan, Inc.	428	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
EYEXAM of California, Inc.	435,236	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
FirstSight Vision Services, Inc. (America's Best Vision Plan)	226,579	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Medical Eye Services, Inc.	47,726	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Premier Eye Care, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Vision Plan of America	14,196	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Vision Service Plan	4,367,397	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Visique Vision Solutions of California, Inc.	0	0	0.00	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%	0	0	0.0%	0	0.0%	0	0.0%
Total Vision:	**5,091,562**	**0**	**0.00**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
Total Specialty Plans:	**16,752,380**	**3**	**0.00**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**	**3**	**1**	**33.3%**	**0**	**0.0%**	**2**	**66.7%**	**0**	**0**	**0.0%**	**0**	**0.0%**	**0**	**0.0%**
Grand Totals:		**2,570**	**0.64**	**406**	**185**	**45.6%**	**186**	**45.8%**	**35**	**8.6%**	**2,151**	**644**	**29.9%**	**1,107**	**51.5%**	**400**	**18.6%**	**13**	**6**	**46.2%**	**5**	**38.5%**	**2**	**15.4%**

THIS INFORMATION IS PROVIDED FOR STATISTICAL PURPOSES ONLY. THE DIRECTOR OF THE DEPARTMENT OF MANAGED CARE HAS NEITHER INVESTIGATED NOR DETERMINED WHETHER THE GRIEVANCES COMPILED WITHIN THIS SUMMARY ARE REASONABLE OR VALID.

"Upheld by IMR" means that the review organization upheld the health plan's denial.

"Overturned by IMR" means that the review organization overturned the health plan's denial and the plan is required to authorize the requested service.

"Rev. by Plan" means that the health plan reversed its denial prior to the review organization making a determination and the plan decided to authorize the requested service.

Grey shading indicates that the plan surrendered its license in 2021.

*Enrollees reflect only the number of enrollees under DMHC Help Center jurisdiction.

**The DMHC Help Center does not have jurisdiction over Medicare Advantage health plan consumer complaints. Refer to: www.medicareappeal.com, www.Medicare.gov and www.CMS.gov.

***County Organized Health Systems (COHS) Medi-Cal lines of business are exempt from DMHC licensure under Welfare and Institutions code section 14087.95, and the DMHC Help Center does not have jurisdiction over these consumer complaints. Although not required by the law, San Mateo Health Commission (Health Plan of San Mateo) has a DMHC license over its Medi-Cal line of business and these enrollees can file a complaint or IMR with the DMHC Help Center. COHS may have other lines of business subject to DMHC jurisdiction, such as In-Home Supportive Services (IHSS). Enrollees in these lines of business can file a complaint or IMR with the DMHC Help Center.

^This plan was previously known as Vitality Health Plan of California, Inc.

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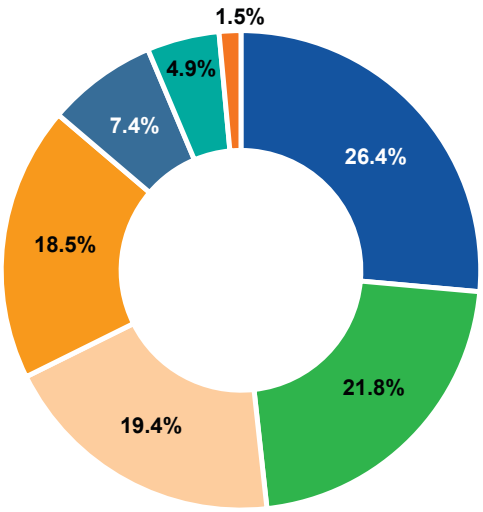
2021 Consumer Complaint Summary Report

Report Overview



1.5% - Coordination of Benefits

4.9% - Enrollment

7.4% - Access to Care

18.5% - Provider Customer Service

19.4% - Health Plan Customer Service

21.8% - Benefits/Coverage

26.4% - Claims/Financial

The Annual Complaint Summary Report displays the numbers and types of complaints, by health plan, resolved by the Department during the 2021 calendar year. An enrollee's complaint may include more than one issue. A complaint consisting of multiple distinct issues is counted as one resolved complaint. Specific complaint issues are categorized in seven categories: Access to Care, Benefits/Coverage, Claims/Financial, Enrollment, Coordination of Benefits, Health Plan Customer Service, and Provider Customer Service.

The Report identifies the number of complaints resolved for each health plan, the health plan's enrollment during 2021, the number of complaints per 10,000 members, and the number of issues for each complaint category.

The health plan enrollment figures were provided to the Department by the health plans in their quarterly financial filings. Enrollment reflects the enrollment figures provided for the fourth quarter of 2021 for the population of enrollees within the DMHC Help Center's jurisdiction. Plans with zero enrollment as of December 31, 2021 may have had enrollment earlier in the year, received a license in 2021 or did not have enrollment within the DMHC Help Center's jurisdiction.

Data represents resolved complaints which were determined to be within the Department's jurisdiction, eligible for review by the Department, and resolved (closed) within calendar year 2021. Cases pending at the end of the calendar year and resolved (closed) in the following year are reported in the subsequent year's Annual Report.

Health plans are listed according to their business names during 2021. In instances where a health plan is known by more than one name, the legal name is shown first with the additional name(s) in parentheses. For health plans that are involved in plan-to-plan arrangements, the data is reported by the primary plan only.

The number of complaints per 10,000 enrollees is displayed to illustrate the volume of complaints for a plan in a manner that considers the wide variations in plan enrollment numbers. When comparing plans, a lower number of complaints per 10,000 enrollees indicates fewer complaints were resolved per capita. As a result, a plan with a higher overall number of resolved complaints may still show fewer complaints per 10,000 enrollees than another plan with fewer overall resolved complaints.

California Department of Managed Health Care

2021 Complaints by Health Plan and Category

Plan Type and Name	Complaints Resolved	% of Complaints Resolved	Enrollees*	Complaints per 10,000	ACCESS TO CARE		BENEFITS/ COVERAGE		CLAIMS/ FINANCIAL		ENROLLMENT		COORDINATION OF BENEFITS		HEALTH PLAN CUSTOMER SERVICE		PROVIDER CUSTOMER SERVICE	
					Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000
FULL SERVICE – ENROLLMENT OVER 400,000																		
Blue Cross of California (Anthem Blue Cross)	1,199	17.8%	2,096,787	5.72	63	0.30	349	1.66	673	3.21	138	0.66	16	0.08	396	1.89	122	0.58
Blue Cross of California Partnership Plan, Inc.	96	1.4%	876,321	1.10	31	0.35	43	0.49	17	0.19	3	0.03	4	0.05	23	0.26	17	0.19
California Physicians' Service (Blue Shield of California)	1,736	25.7%	2,421,076	7.17	63	0.26	672	2.78	915	3.78	164	0.68	32	0.13	519	2.14	124	0.51
Health Net Community Solutions, Inc.	297	4.4%	1,495,990	1.99	119	0.80	119	0.80	35	0.23	5	0.03	7	0.05	88	0.59	151	1.01
Health Net of California, Inc.	369	5.5%	503,507	7.33	37	0.73	128	2.54	153	3.04	30	0.60	13	0.26	134	2.66	69	1.37
Inland Empire Health Plan (IEHP)	115	1.7%	1,418,544	0.81	33	0.23	44	0.31	6	0.04	1	0.01	1	0.01	29	0.20	63	0.44
Kaiser Foundation Health Plan, Inc. (Kaiser Permanente)	2,203	32.6%	7,144,640	3.08	312	0.44	587	0.82	646	0.90	163	0.23	45	0.06	585	0.82	1255	1.76
Local Initiative Health Authority for Los Angeles County (L.A. Care Health Plan)	645	9.6%	2,446,634	2.64	131	0.54	160	0.65	274	1.12	24	0.10	18	0.07	212	0.87	180	0.74
Molina Healthcare of California	89	1.3%	544,318	1.64	17	0.31	22	0.40	23	0.42	22	0.40	1	0.02	57	1.05	17	0.31
Total Full Service – Enrollment Over 400,000:	**6,749**	**100.0%**	**18,947,817**	**3.56**	**806**	**0.43**	**2,124**	**1.12**	**2,742**	**1.45**	**550**	**0.29**	**137**	**0.07**	**2,043**	**1.08**	**1,998**	**1.05**
FULL SERVICE – ENROLLMENT UNDER 400,000																		
Access Senior HealthCare, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Adventist Health Plan, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Aetna Better Health of California Inc.	12	1.0%	41,666	2.88	7	1.68	4	0.96	2	0.48	0	0.00	0	0.00	7	1.68	6	1.44
Aetna Health of California Inc.	35	2.9%	195,661	1.79	6	0.31	17	0.87	9	0.46	1	0.05	0	0.00	10	0.51	5	0.26
AIDS Healthcare Foundation (Positive Healthcare)	2	0.2%	747	26.77	0	0.00	1	13.39	0	0.00	0	0.00	0	0.00	1	13.39	2	26.77
Alameda Alliance For Health	28	2.3%	296,873	0.94	7	0.24	9	0.30	3	0.10	1	0.03	0	0.00	13	0.44	11	0.37
Align Senior Care California, Inc.**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Alignment Health Plan**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
AltaMed Health Network, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
AmericasHealth Plan, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Arcadian Health Plan, Inc.**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Aspire Health Plan**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Astiva Health, Inc.**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Bay Area Accountable Care Network, Inc. (Canopy Health)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Blue Shield of California Promise Health Plan	25	2.1%	119,190	2.10	4	0.34	11	0.92	4	0.34	1	0.08	0	0.00	6	0.50	8	0.67
Brandman Health Plan**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Brown & Toland Health Services, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
California Health and Wellness Plan (CA Health and Wellness)	31	2.6%	222,630	1.39	9	0.40	9	0.40	6	0.27	0	0.00	0	0.00	10	0.45	9	0.40
Care Improvement Plus South Central Insurance Company	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
CareMore Health Plan	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
CCA Health Plans of California, Inc. (CCA Health California)**^	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Central Health Plan of California, Inc.**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Central Valley Health Plan, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
CHG Foundation (Community Health Group Partnership Plan)	16	1.3%	303,710	0.53	2	0.07	5	0.16	1	0.03	0	0.00	4	0.13	4	0.13	10	0.33
Children's Health Plan of California	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Chinese Community Health Plan	7	0.6%	7,515	9.31	0	0.00	2	2.66	5	6.65	0	0.00	0	0.00	3	3.99	2	2.66
Choice Physicians Network, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Cigna HealthCare of California, Inc.	34	2.8%	139,517	2.44	3	0.22	20	1.43	10	0.72	1	0.07	0	0.00	8	0.57	6	0.43
Clever Care of Golden State Inc. (Clever Care of California)**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Community Care Health Plan, Inc.	0	0.0%	11,653	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Community Health Group	2	0.2%	7,048	2.84	0	0.00	2	2.84	0	0.00	0	0.00	0	0.00	1	1.42	0	0.00
Contra Costa County Medical Services (Contra Costa Health Plan)	23	1.9%	221,277	1.04	6	0.27	11	0.50	1	0.05	0	0.00	0	0.00	9	0.41	13	0.59
County of Ventura (Ventura County Health Care Plan)	5	0.4%	12,012	4.16	2	1.67	3	2.50	1	0.83	0	0.00	0	0.00	1	0.83	1	0.83
Dignity Health Provider Resources, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
EPIC Health Plan	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Essence Healthcare of California, Inc. (Essence Healthcare)**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
For Your Benefit, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Fresno-Kings-Madera Regional Health Authority (CalViva Health)	31	2.6%	393,125	0.79	15	0.38	17	0.43	0	0.00	0	0.00	0	0.00	9	0.23	10	0.25

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2021 Complaints by Health Plan and Category

Plan Type and Name	Complaints Resolved	% of Complaints Resolved	Enrollees*	Complaints per 10,000	ACCESS TO CARE		BENEFITS/ COVERAGE		CLAIMS/ FINANCIAL		ENROLLMENT		COORDINATION OF BENEFITS		HEALTH PLAN CUSTOMER SERVICE		PROVIDER CUSTOMER SERVICE	
					Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000
Global Health Plan, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Golden State Medicare Health Plan (Golden State Health Plan)**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Healthy Valley Provider Network, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Heritage Provider Network, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Hill Physicians Care Solutions, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Humana Health Plan of California, Inc.**	2	0.2%	0	0.00	1	0.00	1	0.00	1	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Humana Health Plan of Texas, Inc.**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Imperial Health Plan of California, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Innovative Integrated Health Community Plans, Inc.**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Inter Valley Health Plan, Inc.**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Kern Health Systems	9	0.7%	298,205	0.30	1	0.03	5	0.17	0	0.00	1	0.03	0	0.00	3	0.10	2	0.07
L.A. Care Health Plan Joint Powers Authority	47	3.9%	50,614	9.29	2	0.40	6	1.19	37	7.31	0	0.00	0	0.00	10	1.98	11	2.17
MedCare Partners, Inc. (MedCare Partners Health Plan)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Medcore HP	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Medi-Excel, S.A. de C.V. (MediExcel Health Plan)	4	0.3%	13,529	2.96	1	0.74	0	0.00	3	2.22	0	0.00	0	0.00	1	0.74	1	0.74
MemorialCare Select Health Plan	0	0.0%	248	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Meritage Health Plan	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Monarch Health Plan, Inc.	1	0.1%	0	0.00	1	0.00	0	0.00	0	0.00	0	0.00	0	0.00	1	0.00	0	0.00
On Lok Senior Health Services	1	0.1%	1,671	5.98	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	3	17.95
Optum Health Plan of California	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Orange County Health Authority (CalOptima)***	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Oscar Health Plan of California	145	12.0%	96,831	14.97	3	0.31	48	4.96	85	8.78	10	1.03	1	0.10	44	4.54	19	1.96
Partnership HealthPlan of California***	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
PIH Health Care Solutions	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Premier Health Plan Services, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
PRIMECARE Medical Network, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Prospect Health Plan, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Providence Health Assurance**	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Providence Health Network	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
San Francisco Health Authority (San Francisco Health Plan)	19	1.6%	165,138	1.15	4	0.24	11	0.67	1	0.06	0	0.00	0	0.00	4	0.24	13	0.79
San Joaquin County Health Commission (Health Plan of San Joaquin)	20	1.7%	388,170	0.52	3	0.08	10	0.26	0	0.00	2	0.05	4	0.10	1	0.03	10	0.26
San Mateo Health Commission (Health Plan of San Mateo)	8	0.7%	1,205	66.39	2	16.60	3	24.90	0	0.00	1	8.30	1	8.30	2	16.60	1	8.30
Santa Barbara San Luis Obispo Regional Health Authority (CenCal Health)***	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Santa Clara County (Valley Health Plan)	24	2.0%	44,962	5.34	2	0.44	14	3.11	6	1.33	2	0.44	2	0.44	6	1.33	2	0.44
Santa Clara County Health Authority (Santa Clara Family Health Plan)	49	4.0%	291,097	1.68	6	0.21	27	0.93	1	0.03	2	0.07	4	0.14	20	0.69	13	0.45
Santa Cruz-Monterey-Merced Managed Medical Care Commission (Central	0	0.0%	517	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Scan Health Plan	0	0.0%	14,475	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Scripps Health Plan Services, Inc.	7	0.6%	15,908	4.40	0	0.00	4	2.51	3	1.89	0	0.00	0	0.00	1	0.63	0	0.00
Sequoia Health Plan, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Sharp Health Plan	56	4.6%	134,308	4.17	1	0.07	26	1.94	25	1.86	2	0.15	1	0.07	11	0.82	11	0.82
Sistemas Medicos Nacionales, S.A.de C.V. (SIMNSA Health Plan)	14	1.2%	49,272	2.84	0	0.00	7	1.42	7	1.42	0	0.00	0	0.00	2	0.41	1	0.20
Sutter Health Plan (Sutter Health Plus)	103	8.5%	100,466	10.25	6	0.60	42	4.18	31	3.09	3	0.30	25	2.49	22	2.19	16	1.59
UHC of California (UnitedHealthcare of California)	287	23.7%	389,230	7.37	23	0.59	139	3.57	125	3.21	7	0.18	3	0.08	74	1.90	40	1.03
UnitedHealthcare Benefits Plan of California	88	7.3%	370,381	2.38	1	0.03	27	0.73	58	1.57	5	0.13	1	0.03	21	0.57	4	0.11
UnitedHealthcare Community Plan of California, Inc.	7	0.6%	26,406	2.65	5	1.89	2	0.76	1	0.38	0	0.00	0	0.00	1	0.38	0	0.00
Universal Care, Inc. (Bright HealthCare)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
WellCare of California, Inc.**	1	0.1%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	1	0.00	0	0.00
Western Health Advantage	67	5.5%	101,258	6.62	6	0.59	29	2.86	27	2.67	5	0.49	1	0.10	10	0.99	14	1.38
Total Full Service - Enrollment Under 400,000:	**1,210**	**100.0%**	**4,526,515**	**2.67**	**129**	**0.28**	**512**	**1.13**	**453**	**1.00**	**44**	**0.10**	**47**	**0.10**	**317**	**0.70**	**244**	**0.54**
Total All Full Service Plans:	**7,959**	**100.0%**	**23,474,332**	**3.39**	**935**	**0.40**	**2,636**	**1.12**	**3,195**	**1.36**	**594**	**0.25**	**184**	**0.08**	**2,360**	**1.01**	**2,242**	**0.96**

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Plan Type and Name	Complaints Resolved	% of Complaints Resolved	Enrollees*	Complaints per 10,000	ACCESS TO CARE		BENEFITS/ COVERAGE		CLAIMS/ FINANCIAL		ENROLLMENT		COORDINATION OF BENEFITS		HEALTH PLAN CUSTOMER SERVICE		PROVIDER CUSTOMER SERVICE	
					Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000
Chiropractic																		
ACN Group of California, Inc. (OptumHealth Physical Health of California)	1	100.0%	76,174	0.13	1	0.13	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	2	0.26
American Specialty Health Plans of California, Inc. (ASHP)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Landmark Healthplan of California, Inc.	0	0.0%	67,996	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Total Chiropractic:	**1**	**100.0%**	**144,170**	**0.07**	**1**	**0.07**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**2**	**0.14**
DENTAL																		
Access Dental Plan	6	12.8%	305,124	0.20	2	0.07	2	0.07	3	0.10	0	0.00	0	0.00	2	0.07	0	0.00
Aetna Dental of California Inc.	3	6.4%	113,738	0.26	0	0.00	1	0.09	2	0.18	0	0.00	0	0.00	1	0.09	3	0.26
California Dental Network, Inc.	4	8.5%	71,788	0.56	1	0.14	0	0.00	2	0.28	0	0.00	0	0.00	3	0.42	1	0.14
Cigna Dental Health of California, Inc.	3	6.4%	199,095	0.15	0	0.00	1	0.05	1	0.05	0	0.00	0	0.00	1	0.05	0	0.00
Consumer Health, Inc. (Newport Dental Plan)	0	0.0%	6,193	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Dental Benefit Providers of California, Inc.	0	0.0%	157,156	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Dental Health Services	2	4.3%	62,931	0.32	0	0.00	0	0.00	1	0.16	2	0.32	0	0.00	0	0.00	1	0.16
Golden West Health Plan, Inc. (Golden West Dental & Vision Plan)	0	0.0%	7,856	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Liberty Dental Plan of California, Inc. (Personal Dental Services)	20	42.6%	402,905	0.50	0	0.00	12	0.30	7	0.17	0	0.00	1	0.02	4	0.10	7	0.17
Managed Dental Care	1	2.1%	92,698	0.11	0	0.00	1	0.11	0	0.00	0	0.00	0	0.00	0	0.00	1	0.11
Starmount Managed Dental of California, Inc. (Unum Dental HMO Plan)	0	0.0%	550	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
UDC Dental California, Inc. (United Dental Care of California, Inc.)	0	0.0%	22,872	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
United Concordia Dental Plans of California, Inc.	2	4.3%	73,629	0.27	0	0.00	0	0.00	1	0.14	0	0.00	0	0.00	0	0.00	5	0.68
Western Dental Services, Inc. (Western Dental Plan)	6	12.8%	158,970	0.38	1	0.06	1	0.06	4	0.25	0	0.00	0	0.00	4	0.25	6	0.38
Total Dental:	**47**	**100.0%**	**1,675,505**	**0.28**	**4**	**0.02**	**18**	**0.11**	**21**	**0.13**	**2**	**0.01**	**1**	**0.01**	**15**	**0.09**	**24**	**0.14**
DENTAL/VISION																		
Delta Dental of California	255	99.2%	4,190,502	0.61	2	0.00	114	0.27	123	0.29	19	0.05	0	0.00	83	0.20	83	0.20
SafeGuard Health Plans, Inc. (MetLife)	2	0.8%	209,160	0.10	0	0.00	1	0.05	1	0.05	0	0.00	0	0.00	1	0.05	0	0.00
Total Dental/Vision:	**257**	**100.0%**	**4,399,662**	**0.58**	**2**	**0.00**	**115**	**0.26**	**124**	**0.28**	**19**	**0.04**	**0**	**0.00**	**84**	**0.19**	**83**	**0.19**
DISCOUNT																		
First Dental Health	0	0.0%	27,694	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
The CDI Group, Inc.	3	100.0%	24,389	1.23	0	0.00	0	0.00	2	0.82	1	0.41	0	0.00	0	0.00	0	0.00
Total Discount:	**3**	**100.0%**	**52,083**	**0.58**	**0**	**0.00**	**0**	**0.00**	**2**	**0.38**	**1**	**0.19**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**
PHARMACY																		
SilverScript Insurance Company	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
WellCare Prescription Insurance, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Total Pharmacy:	**0**	**0.0%**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**
BEHAVIORAL HEALTH (PSYCHOLOGICAL)																		
Beacon Health Options of California, Inc. (Beacon of California)	0	0.0%	615,947	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Claremont Behavioral Services, Inc. (Claremont EAP)	0	0.0%	93,436	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
CONCERN: Employee Assistance Program	0	0.0%	87,975	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Empathia Pacific, Inc. (LifeMatters)	0	0.0%	130,591	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Evernorth Behavioral Health of California, Inc.	0	0.0%	115,818	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Health Advocate West, Inc.	0	0.0%	86,712	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Health and Human Resource Center, Inc. (Aetna Resources for Living)	0	0.0%	1,906,860	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Holman Professional Counseling Centers	0	0.0%	88,836	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Human Affairs International of California (HAI-CA)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Humana EAP and Work-Life Services of California, Inc.	0	0.0%	32,066	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Magellan Health Services of California, Inc. - Employer Services	0	0.0%	831,576	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Managed Health Network	0	0.0%	591,221	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00

California Department of Managed Health Care

2021 Complaints by Health Plan and Category

Plan Type and Name	Complaints Resolved	% of Complaints Resolved	Enrollees*	Complaints per 10,000	ACCESS TO CARE		BENEFITS/ COVERAGE		CLAIMS/ FINANCIAL		ENROLLMENT		COORDINATION OF BENEFITS		HEALTH PLAN CUSTOMER SERVICE		PROVIDER CUSTOMER SERVICE	
					Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000	Count	Per 10,000
Morneau Shepell (California) Limited (LifeWorks by Morneau Shepell)	0	0.0%	21,986	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
U. S. Behavioral Health Plan, California (OptumHealth Behavioral Solutions of California)	2	100.0%	786,374	0.03	0	0.00	0	0.00	2	0.03	0	0.00	1	0.01	0	0.00	0	0.00
Total Behavioral Health (Psychological):	**2**	**100.0%**	**5,389,398**	**0.00**	**0**	**0.00**	**0**	**0.00**	**2**	**0.00**	**0**	**0.00**	**1**	**0.00**	**0**	**0.00**	**0**	**0.00**
VISION																		
Envolve Vision, Inc. (Envolve Benefit Options)	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
EyeMax Vision Plan, Inc.	0	0.0%	428	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
EYEXAM of California, Inc.	0	0.0%	435,236	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
FirstSight Vision Services, Inc. (America's Best Vision Plan)	0	0.0%	226,579	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Medical Eye Services, Inc.	0	0.0%	47,726	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Premier Eye Care, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Vision Plan of America	0	0.0%	14,196	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Vision Service Plan	13	100.0%	4,367,397	0.03	0	0.00	2	0.00	8	0.02	3	0.01	0	0.00	3	0.01	2	0.00
Visique Vision Solutions of California, Inc.	0	0.0%	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Total Vision:	**13**	**100.0%**	**5,091,562**	**0.03**	**0**	**0.00**	**2**	**0.00**	**8**	**0.02**	**3**	**0.01**	**0**	**0.00**	**3**	**0.01**	**2**	**0.00**
Total Specialty Plans:	**323**	**100.0%**	**16,752,380**	**0.19**	**7**	**0.00**	**135**	**0.08**	**157**	**0.09**	**25**	**0.01**	**2**	**0.00**	**102**	**0.06**	**111**	**0.07**
Grand Totals:	**8,282**	**100%**		**2.06**	**942**	**0.23**	**2,771**	**0.69**	**3,352**	**0.83**	**619**	**0.15**	**186**	**0.05**	**2,462**	**0.61**	**2,353**	**0.58**

THIS INFORMATION IS PROVIDED FOR STATISTICAL PURPOSES ONLY. THE DIRECTOR OF THE DEPARTMENT OF MANAGED CARE HAS NEITHER INVESTIGATED NOR DETERMINED WHETHER THE GRIEVANCES COMPILED WITHIN THIS SUMMARY ARE REASONABLE OR VALID.

Grey shading indicates that the plan surrendered its license in 2021.

*Enrollees reflect only the number of enrollees under DMHC Help Center jurisdiction.

**The DMHC Help Center does not have jurisdiction over Medicare Advantage health plan consumer complaints. Refer to: www.medicareappeal.com, www.Medicare.gov and www.CMS.gov.

***County Organized Health Systems (COHS) Medi-Cal lines of business are exempt from DMHC licensure under Welfare and Institutions Code section 14087.95, and the DMHC Help Center does not have jurisdiction over these consumer complaints. Although not required by the law, San Mateo Health Commission (Health Plan of San Mateo) has a DMHC license over its Medi-Cal line of business and these enrollees can file a complaint or IMR with the DMHC Help Center. COHS may have other lines of business subject to DMHC jurisdiction, such as In-Home Supportive Services (IHSS). Enrollees in these lines of business can file a complaint or IMR with the DMHC Help Center.

^This plan was previously known as Vitality Health Plan of California, Inc.

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DEPARTMENT OF
Managed
Health Care

Published June 2022

EXHIBIT F

2005 WL 2236533 (Cal.App. 2 Dist.) (Appellate Brief)
Court of Appeal, Second District, California.

BELL,

v.

BLUE CROSS OF CALIFORNIA.

No. B174131.
July 8, 2005.

Letter Brief

***1** *Hand-Delivered*

Vaino H. Spencer, Presiding Justice

Miriam A. Vogel, Associate Justice

Frances Rothschild, Associate Justice

California Court of Appeal

Second Appellate District - Division One

300 South Spring Street, 2nd Floor

Los Angeles, CA 90013

Your Honors:

On June 27, 2005, the Court granted Amicus Department of Managed Health Care's (”“Department‘’ or ”“DMHC‘’) request for leave to respond to Blue Cross's additional letter brief. Pursuant to that Order, the Department submits the following response for the Court's consideration.

I. *INTRODUCTION*

The issue in this case is whether emergency physicians have the ability to bring a lawsuit to contest whether the amount Blue Cross, or any other health plan, chooses to reimburse for emergency services represents the reasonable and customary value of the services rendered. The cause of emergency room bankruptcies in California, and what Blue Cross sets forth in its Evidence of Coverage to its enrollees concerning the payment of non-contracted emergency provider claims are of no consequence in this appeal. In determining whether emergency physicians have the ability to sue, the court must look to who is best suited to determine the ”“reasonable and customary value‘’ of an emergency physician's services. If Blue Cross prevails, health plans will continue to make this determination unilaterally and emergency providers will have no direct means to challenge the appropriateness of the plans' determinations or to protect their financial interests. Denying emergency room providers a means to redress reimbursement disputes will encourage providers to ”“balance bill‘’ enrollees for services that should be paid by the

health plan. This later scenario would completely obliterate the purpose of ***2** Health and Safety Code section 1371.4[1] which was intended to shift financial responsibility for reimbursing the cost of emergency services from the enrollee to the health plan.

II. *ARGUMENT*

A. The Department Cannot Adjudicate Factual Disputes Between Health Plans and Emergency Physicians.

The Department does have the authority to determine whether a health plan has engaged in a demonstrable and unjust payment pattern and to take action accordingly, as it did in the Health Net case to which Blue Cross has repeatedly referred.[2] Such a determination is expressly authorized by statute and regulations and the Department has consistently maintained that the ability to find a demonstrable and unjust payment pattern is within its exclusive jurisdiction. (Health & Saf. Code, § 1371.37; 28 C.C.R. § 1300.71; *see also* DMHC's Amicus Brief, at p.1). While the Department has the power to require a health plan to re-adjudicate claims paid pursuant to a deficient reimbursement methodology, this authority is not equivalent to rendering a judicial determination between two parties disputing over what constitutes the reasonable and customary value of a specific physician's services. Blue Cross ignores this distinction in arguing that the Department's recent regulatory actions suggest that the Department has exclusive powers relating to claim reimbursement.

While the Department did direct Health Net to modify its reimbursement methodology and recalculate the reimbursement owed to emergency room providers, the Department did not adjudicate any claim individually or direct Health Net as to the specific amount each provider was due. (RJN Ex 2:2.) The Department simply determined that the mechanism by which Health Net was calculating its reimbursement levels violated California Code of Regulations, title 28, section 1300.71 and therefore its reimbursement methodology constituted a demonstrable and unjust payment pattern. (RJN Ex 2:1.) The Department directed Health Net to re-adjudicate affected claims based upon a payment methodology consistent with the requirements of 1300.71. (RJN Ex 2:3.)

As the Department explained in its amicus brief, the Knox-Keene Act does not authorize the Department to set specific reimbursement levels or to exercise jurisdiction over providers by adjudicating individual payment disputes that arise between providers and health plans. Should the Department attempt to adjudicate such claims, its decisions would not be binding upon the individual providers or upon health plans that contest the Department's authority to set reimbursement rates.

Note: Page 3 missing in original document ***4** no later than 30 working days after receipt of the claim, or if the plan is an HMO, no later than 45 working days after receipt of the claim.

In analogizing the language in section 1371.35 to the language in section 1371.4, Blue Cross quotes section 1371.4: ”“the plan “shall reimburse providers for emergency services and care provided to its enrollees, until care results in the stabilization of the enrollee' ....‘’ (Letter brief, at 6.) This quoted language has nothing to do with the time a health plan has to reimburse an emergency provider. On the contrary, it defines the services to be reimbursed by the health plan as those necessary to stabilize the enrollee in an emergency.

Because the language of these two sections cannot be analogized, and because the fourth district offered no rationale for determining that section 1371.35 is purely regulatory, *Cohen* has no application to this court's decision as to whether a violation of section 1371.4 may serve as the basis for a UCL claim.

D. Equitable Principles of *Quatum Meruit* are Applicable to Non-Contracting Physicians Seeking Restitution.

Blue Cross also argues that the principles of equity do not apply to this situation because no California court has previously based a decision relating to a reimbursement dispute between a health plan and a provider based on equitable principles. The

principles of equity, however, are not so limited. Equitable principles will support a cause of action, unless a court has previously found that they do not apply. While courts have not previously recognized a non-contracting physician's right to recover directly against health plans based on *quantum meruit,* these cases involved different factual circumstances distinguishable from the case at hand. (e.g., *Calif. Med. Assoc. v. Aetna U.S. Healthcare of Calif.* (2001) 94 Cal.App.4th 151, 172 (finding no quasi-contract action for unjust enrichment exists where an express agreement defines the parties rights).)

To support its argument that the Appellants cannot bring a claim in quantum meruit, Blue Cross cites *Calif. Emergency Physicians Med. Group v. PacifiCare of Calif.* (2003) 111 Cal.App.4th 1127 (”“*PacifiCare*‘’). However, Blue Cross only points out that section 76 of the Restatement of Restitution is footnoted in that case and implies that section 76 does not support the Appellants' claim in this case. Blue Cross ignores the fact that the Fourth District's refusal to grant restitution in that case resulted from PacifiCare's delegation of payment responsibility for emergency services under section 1371.4 to a capitated medical group. Based on this delegation, PacifiCare was relieved of any liability regardless of the medical group's subsequent bankruptcy. The court did not find any flaw in the physicians' reliance on the Restatement. Furthermore, the court found that common law causes of action could be brought against a health plan so long as the wrongful conduct alleged was not specifically authorized by any provision of the Knox-Keene Act. (*Id.* at 1134.) *PacifiCare* simply does not support Blue Cross's position in this case.

Blue Cross's reliance on *Union of American Physicians and Dentists v. County of Santa Clara* (1983) 149 Cal.App.3d 45 is equally flawed. In that case, the physicians relied on sections 113 ***5** and 114 of the Restatement of Restitution in bringing their *quantum meruit* claim. The problem with the claim in that case, however, did not lie with the physicians' reliance on the Restatement as Blue Cross implies. Rather, the court refused to grant restitution because the physicians invoked equity to recover from a county government. (*Union of American Physicians and Dentists v. County of Santa Clara* (1983) 149 Cal.App.3d 45, 50 (”“*American Physicians*‘’).) The court found that a county was not liable to pay a claim for services rendered to indigent residents unless the county had the specific legal authority to pay. (*Id.* at 50-51.) Because no specific statutory authority authorized the county to pay claims submitted by non-contracted physicians, the county was not obligated to reimburse the physicians. (*Id.* at 52.) Had the physicians sought to recover from a private entity, rather than a county, they would have been able to move forward with a claim for restitution.

In this case, the emergency physicians are seeking restitution from Blue Cross-a private corporation-not a county government. The limitations that apply to a governmental entity's ability to reimburse a private party have no application to a for-profit, private corporation. Furthermore, Blue Cross, as a health plan, has a ”“mandatory duty to pay for emergency medical services under section 1371.4‘’ of the Knox-Keene Act. (See *Calif. Emergency Physicians Med. Group, supra,* 111 Cal.App.4th 1127, 1131.) Even Blue Cross does not contest this point.

Appellants in this case have a cause of action under section 114 of the Restatement of Restitution, cited in *American Physicians*. Section 114 provides:
a person who has performed the duty of another by supplying a third person with necessaries, although acting without the other's knowledge or consent, is entitled to restitution from the other therefor if

(a)he acted unofficiously and with intent to charge therefor, and

(b)the things or services supplied were immediately necessary to prevent serious bodily harm to or suffering by such person.‘’

(Rest. 1st of Restitution, § 114.)

The Appellants performed Blue Cross's contractual and statutory duty to arrange and pay for emergency medical care (§1345; §1371.4) by treating Blue Cross's enrollees with when they presented themselves in the hospital emergency room. Although acting without Blue Cross's specific knowledge or consent,[4] the Appellants did not act officiously, having provided services

pursuant to their EMTALA obligation. As emergency room physicians they had the intent and right to charge for their services. And because they provided stabilizing emergency medical care, they were supplying services immediately necessary to prevent serious bodily harm and suffering. The Appellants fulfilled all the requirements of Restatement section 114.

***6** Based on these equitable principles and the factual circumstances of this case, the Appellants are entitled to bring a claim for restitution and challenge Blue Cross's unilateral determination of the value of their services in a court of law.

E. Non-Contracted Physicians are Entitled to the Reasonable and Customary Value of their Services.

Blue Cross does not contest that it is obligated to pay for emergency services under section 1371.4. Furthermore, Blue Cross acknowledges that non-contracting physicians are ”“entitled to that which the subscriber would be entitled under his or her contract.‘’ Blue Cross's EOC, in effect prior to the filing of this lawsuit, states that Blue Cross is responsible for a portion of the ”“customary and reasonable‘’ or billed charges, whichever is less. In seeking restitution under the UCL, non-contracting providers are simply seeking a determination of what constitutes the reasonable and customary value of their services that they are entitled to under law and equitable principles.

According to section 1300.71 of the California Code of Regulations, title 28, the reimbursement of the ”“reasonable and customary value‘’ for the health care services rendered by a non-contracted provider must be based upon statistically credible information that is updated at least annually and takes into consideration several factors including: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services; (iii) the provider's usual fee for these services; (iv) the prevailing rates charged by other providers in the same general geographic area; (v) other relevant economic aspects of the provider's practice; and (vi) any other unusual circumstances. (28 C.C.R. §1300.71(a)(3)(B).)

Blue Cross asserts that although it is following this regulation, it disagrees with the interpretation of the term ”“reimburse‘’ as set forth in the statute and therefore the Court is not bound by the standard in the regulation for the purposes of this case. But until Blue Cross directly (and successfully) challenges this regulation in a court of law, the regulation has the force of law, notwithstanding Blue Cross's opinion. (See *Tomlinson v. Qualcomm, Inc.* (2002) 97 Cal.App.4th 934 (”“[T]he administrative agency's action comes before the court with a presumption of correctness and regularity.‘’).)

By allowing non-contracted emergency providers to bring a claim for the reasonable and customary value of their services, the Court is not required to shift the burden of uncompensated and under compensated care from one party to another. Nor must it authorize ”“balance billing‘’ against health plans as Blue Cross warns. These physicians are only seeking an independent adjudication of the reasonable and customary value of their services based on established criteria.

F. Blue Cross's Admonition Against the Unpredictable Situation that Would Arise from Litigation is Irrational.

Blue Cross warns that unless exclusive jurisdiction over payment disputes lies with the Department, different rates of reimbursement will result depending upon the county or the ***7** particular court within a county that hears a dispute. This argument, however, ignores the fact that reimbursement will likely be different from county to county if the current regulatory formula for calculating reimbursement is properly implemented by a health plan. The current prevailing rate in a particular geographic area is one of the six factors a health plan must consider in calculating the reimbursement value. (28 C.C.R. §1300.71 (a)(3)(B).) The plan should also be considering the provider's training, qualifications, and experience and the service provided. (*Id.*) This means that providers in different counties may be entitled to different levels of reimbursement. Different reimbursement levels are the natural result of the required methodology, not a risk created by the possibility of ”“piecemeal‘’ litigation. Courts are well versed in applying multi-factored, fact-specific formulas to reach a fair result.

When you peel back Blue Cross's arguments, you are left with the realization that providers must be granted some method to challenge a health plan's specific determination relating to the reasonable and customary value of emergency services. Blue Cross

realizes that the Knox-Keene Act only sets forth a standard for an acceptable payment methodology, but falls short of setting specific rates. It hopes that courts will decline to entertain legitimate disputes between health plans and emergency providers so that its individual claims adjudication decisions can avoid both regulatory and judicial scrutiny. Providing a health plan with unfettered discretion to determine the specific reimbursement amounts for emergency services is an invitation for abuse.

III. *CONCLUSION*

The Department's jurisdiction over the Knox-Keene Act does not preempt the Appellants' claims in this case. The emergency physicians' right to bring a UCL claim predicated on a violation of a statute that makes Blue Cross's practices unlawful, as well as a common law claim for restitution are supported by California case law. For this reason, the Court should overturn the trial court's order sustaining Blue Cross's demurrer without leave to amend.

Appendix not available.

Footnotes

1 All subsequent statutory references are to the Health and Safety Code unless otherwise stated.

2 The Court can find a copy of the Department's Press Release and the Consent Agreement entered into by the Department and Health Net as Exhibits 1 and 2 to Blue Cross's Request for Judicial Notice filed on May 2, 2005 (RJN).

4 The Department is of the opinion that Blue Cross, based on its obligation to arrange for and provide emergency services to all of its enrollees, implicitly authorizes emergency room physicians to provide those services since it has no other means to arrange for the delivery of emergency care.

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EXHIBIT G

2008 WL 5818770 (Cal.Superior) (Trial Motion, Memorandum and Affidavit)
Superior Court of California.
Sacramento County

CALIFORNIA MEDICAL ASSOCIATION, California Hospital Ass'n, California Chapter of the American College of Emergency Physicians, California Orthopaedic (sic) Ass'n, California Radiological Society of Anesthesiologists, Petitioners & plaintiffs,

v.

DEPARTMENT OF MANAGED HEALTH CARE, State of California; Lucinda Ehnes, in her official capacity as Director of the Department of Managed Health Care; and Does 1 through 100, inclusive, Respondents & defendants.

No. 34-2008-80000059.

November 7, 2008.

Date: November 21, 2008
Time: 9:00 a.m.
Dept.31
Action Filed: September 26, 2008
(Unlimited jurisdiction)
Exempt from Fees (Gov. Code § 6103)

Respondents' Hearing Brief in Opposition to Petitioners' Writ of Mandate

Amy L. Dobberteen, Assistant Deputy Director, Bar No. 155111.

California Department of, Managed Health Care, 980 Ninth Street, Suite 500, Sacramento, CA 95814-7243, Telephone: (916) 323-0435.

Attorneys for Respondents/Defendants, Department of Managed Health Care.

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Michael D. McClelland, Senior Counsel, Bar No. 204223.

Assigned for All Purposes: Hon. Michael Kenny.
Judge: Hon. Michael Kenny.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

STATE CASES

I. INTRODUCTION

This case presents a meritless challenge to an administrative regulation properly promulgated by the California Department of Managed Health Care (the Department) in accordance with the Administrative Procedures Act (APA). Petitioners present no credible theories in support of their allegation that the Regulation at issue exceeded the Department's authority to conduct rulemaking, an authority which was explicitly delegated by the Legislature in Health and Safety Code sections 1344 and 1371.39.[1] Instead, Petitioners' challenge is supported only by their own displeasure with the Regulation. Their case fails because the evidence shows the Department acted pursuant to a specific delegation from the Legislature and undertook that task with substantial evidence supporting its actions.

The Regulation simply defines a malicious business practice known commonly as balance billing to be an unfair billing pattern under the law. *Balance billing* describes a non-network emergency health care provider's attempt to collect from a health plan enrollee any balance due on an emergency bill when a health plan has paid what it contends is a reasonable and customary amount, but the provider seeks all of its billed charges. It is an unfair practice because the enrollee prepaid for all of their emergency care. (Health & Saf. Code, §§ 1345(b)(6), 1367(i), 1371.4, 1375.1(a)(2).) Instead, it is the responsibility of health plans and providers to reach a resolution on the reasonable value of the services. (Health & Saf. Code, §§ 1345(b)(6), 1367(i), 1371.4(b), 1371.38; Cal. Code Regs., tit. 28, § 1300.78.) As set forth herein, the enrollee has no place in the middle of such a dispute because he has prepaid for his emergency care.

II. FACTS AND BACKGROUND

A. The Department's Mission.

Pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act or the Act), the Department is the agency responsible for the execution of the laws of this state relating to health care service plans and the health care service plan business. (Health & Saf. Code, §§ 1340 et seq., 1341.) The phrase *health care service plans* (health plans or plans) is not a broad reference to health insurance, but instead is a term used under the Knox-Keene Act to specifically describe business entities

which sell managed care products to consumers in California. (Health & Saf. Code, § 1345(f).) Put simply, the Department is the regulator of managed care in this State.

The Knox-Keene Act was created to foster and protect managed care through a:

...comprehensive system of licensing and regulation (formerly under the jurisdiction of the Department of Corporations (DOC) and presently within the jurisdiction of the Department of Managed Health Care (DMHC) [citation]. All aspects of the regulation of health plans are covered, including financial stability, organization, advertising and capability to provide health services. (*Viola v. Dept. Managed Health Care* (2005) 133 Cal.App.4th 299, 307 [quoting, *Van de Kamp v. Gumbiner* (1990) 221 Cal.App.3d 1260, 1284; and citing, *Coast Plaza Doctors Hospital v. UHP Healthcare* (2002) 105 Cal.App.4th 693, 700; and *California Medical Assn. v. Aetna U.S. Healthcare of California, Inc.* (2001) 94 Cal.App.4th 151, 155, fn. 31.)

Though managed care is often generically described as health insurance, this tends to create confusion because of the large variety of very different health insurance products available. Rather, a health plan is more precisely a form of prepaid health care coverage called a Health Maintenance Organization (HMO) or managed care organization.[2]

B. Managed Care in California.

The term "managed care" refers to a prepaid healthcare delivery and payment system under which a health plan agrees to provide, or arrange for the provision of, all basic healthcare services for a population of enrollees. Practically speaking, the enrollee pays a monthly premium and is then fully covered for all basic healthcare services. (Health & Saf. Code, §§ 1345(b), 1367(i), 1375.1.) Of course, a plan could not offer a prepaid product if it had no way of protecting itself against the liabilities created if enrollees had unrestricted access to care outside the network at the plan's expense. Thus, managed care necessarily involves a defined network of providers who have agreed to see the plan's enrollees at a fixed cost. (See Health & Saf. Code, §§ 1363(a)(8), 1367(i), 1371.4(j), 1373.3, 1379.)

The network providers prospectively contract to render care to the plan's enrollees on either a capitated or discounted fee-for-service basis. (*Ochs v. PacifiCare of California* (2004) 115 Cal.App.4th 782, 787.) In California, plans commonly establish the largest pieces of their networks by contracting with organizations of physicians, rather than individuals.[3] These organizations are commonly compensated on a capitated basis. Under a capitated system, a plan makes a periodic payment to a provider based on the population of enrollees assigned to that provider during the defined period, regardless of whether the enrollees actually access healthcare services. The contracting medical group or IPA then assumes, by contract, the duty of the health plan to provide, or arrange for the provision of, all necessary medical services to a population of enrollees. In doing so the health plan shifts its risk to the medical group or IPA, which then has the expertise to manage the care and keep the enrollees healthy so they utilize their prepaid care at a level commensurate with expectations and the available resources. In contrast, specialty physicians and hospitals are often contracted on a discounted fee-for-service basis and then paid according to the negotiated rates when those services are used.

From the enrollee's perspective, the managed care bargain involves reduced choice of provider in exchange for improved financial predictability of health care costs (as compared to traditional indemnity insurance), an organized system of coordinated care, and an expanded range of covered or preventive care services. Other than co-payments at the time of treatment, managed care enrollees are not billed by providers unless they go out of network for unauthorized, non-emergency services. (See, *The Promise and Perils of Managed Health Care: Consumers' Search for a Level Playing Field* (1996) 18 Whittier L.Rev. 3. 5 (hereinafter *Promise and Perils of Managed Health Care*).)

A health plan is unique from other health coverage in that it is a prepaid plan. Health plans are not traditional indemnity policies which make their insureds whole only after they have incurred out-of-pocket costs to a third party. As a result, much of Petitioners' analysis fails because of their reliance upon an inappropriate analogy to traditional indemnity policies. (e.g., Petitioners' Opening Brief (POB) at p. 2, fn. 2.) Instead, the purchase of a health plan is an actual prepayment for services. (Health & Saf. Code, §§ 1345(f)(1), 1367(i), 1375.1.) In exchange for the premiums, the enrollee receives services, not indemnity. This is the essential function of the health plans authorized under the Knox-Keene Act and balance billing is inimical this function.

C. The Critical Exception: Emergency Services Under Managed Care.

In order to guarantee that the managed care bargain is a meaningful one, the Knox-Keene Act includes various requirements as to the health care services which plans must provide. Most importantly, plans must assume full financial risk on a prospective basis for the provision of all "basic healthcare services," as that term is defined in section 1345(b). (Health & Saf. Code, §§ 1367(i), 1375.1(a)(2).) The list of "basic healthcare services" in section 1345(b) specifically includes "[e]mergency health care services." (Health & Saf. Code, § 1345(b)(6).) Thus, plans must assume full financial risk.for emergency services.

However, this mandate creates tension between the necessity of a defined network of providers and the unpredictable nature of medical emergencies. The law resolved this issue in favor of the enrollee by confirming that plans must assume the full financial risk associated with emergency services, *even if those services are rendered by a provider outside the plan's network.* (Health & Saf. Code, §§ 1371.4(a),(b) and (c), 1375.1.) Specifically, the Legislature required plans to "reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee." (Health & Saf. Code, § 1371.4(b).) In doing so, the Legislature created a critical exception for emergency cases to the enforcement of the managed care network. At the same time, it also yielded two important consequences. First, it resulted in a statutory scheme which was so comprehensive with regard to the intersection of managed care and emergency medicine that the Knox-Keene Act thereby preempted common law on the enrollee/non-network emergency provider relationship. (*See Van De Kamp v. Gumbiner, supra,* 221 Cal.App.3d 1260, 1283-1284; *Cal. Emer. Phys. Med. Group v. PacifiCare of California* (2003) 111 Cal.App.4th 1127, 1134.) Thus, a traditional common law analysis which might impart on the patient/enrollee a duty to pay an emergency provider for services rendered was preempted by a specific statute in the Act- Section 1371.4. Requiring the plan to pay the emergency provider directly, even the non-network provider, was necessary to harmonize the Act and vindicate the prepaid nature of the enrollee's benefits. Second, section 1371.4 conclusively brought non-network emergency providers under the jurisdiction of the Department to the extent they participated in the delivery of managed care. (Health & Saf. Code, § 1371.4 [applies to all providers].) It is illogical to conclude that the Legislature intended for those providers to reap the benefits of the Act, without being subject to the reach of its burdens.

D. The Crisis of Balance Billing Demanded Action.

When an enrollee visits a hospital emergency room which is within the plan's network, the plan pays the hospital's rates as set forth in the written contract between the two. If, instead, the enrollee visits a non-network hospital for an emergency - or more commonly, the physicians staffing a network hospital are not themselves within the plan's network - a different resolution of the bill is necessary. In that event, the provider generates a bill for the medical services at a rate of their choosing, known as billed charges. The plan remains obligated to provide full coverage to the enrollee for their emergency services and has a duty to remit payment directly to the provider. (Health & Saf. Code, §§ 1345(b)(6), 1367(i), 1371.4(b), 1375.1; *Bell v. Blue Cross* (2005) 131 Cal.App.4th 211, 220.) However, the plan is not necessarily obligated to pay the full amount of the bill, but rather the reasonable and customary value of the services. (*Ibid;* Health & Saf. Code, § 1371.4(b); and Cal. Code Regs., tit. 28, § 1300.71(a)(3)(B).)[4]

A problem results when the plan's payment to the provider is less than the billed charges, either because the charges were in excess of the reasonable and customary value of the services or the payment was below that value. In those situations, there is a balance remaining on the enrollee's account with the provider.[5] Some providers attempt to collect this balance directly from

the enrollee in a practice known in the healthcare industry as balance billing. From the enrollee's perspective, *balance billing* represents a double billing because he has already paid for his emergency care by purchasing a prepaid health plan. Further, if the plan has met its obligation to pay the reasonable and customary value of the service rendered, then the balance left owing is necessarily uncustomary and unreasonable. In any event, allowing an emergency healthcare provider to seek payment directly from an enrollee for a covered healthcare service is entirely inconsistent with the objective of a *prepaid* health plan.

Providers are already entitled to full reimbursement from health plans for all reasonable charges associated with a medical emergency and have the right to seek recovery for those charges directly from the plans either in court or through dispute resolution systems. (Health & Saf. Code, §§ 1371.4, 1371.38; Cal. Code Regs., tit. 28, § 1300.78; *Bell v. Blue Cross, supra,* 131 Cal.App.4th 211, 219-220.) Notwithstanding these avenues for resolution, some providers continue to use their patients as inexpensive leverage in an effort to elicit higher payments from plans, often turning the enrollees into an additional source of revenue in the process. The providers argue vehemently in support of the practice, claiming it is.the.only way they can even the bargaining power between themselves and health plan's. However, their argument ignores the most contemptible aspect of balance billing, which is the harm it causes to their patients, who.unquestionably have far less bargaining power than either the plan or provider. The enrollee, when faced with collection proceedings relative to medical care for which they prepaid, is left with two miserable choices: pay a bill they do not owe, or risk severe harm to their credit while waiting for their doctor to obtain further satisfaction, often in excess of the reasonable value, from their health plan.

Petitioners tragically minimize both the prevalence and malice of balance billing. Recently, the Department was forced to intervene when a Southern California hospital chain balance billed as many as 6.000 enrollees as part of a campaign against a specific health plan, demanding payment on health care services for which they had already paid. The provider followed those bills with thousands of collection letters, threatening to ruin their credit ratings if the provider was not paid its billed charges, despite the fact their health plan had already paid the provider a reasonable and customary amount for the services. (Respondent's Request for Judicial Notice (RRFJN) at Exh. A, Declaration of Michael McClelland at Exh. A thereto.)

Balance billing is so inconsistent with managed care and such a malignant and unjust practice that the Governor directed the Department to eliminate the practice. (RRFJN at Exh. B.) It is important to note that the harm of balance billing is not simply the attempt to collect from the enrollee a sum he does not owe, but also that the practice shields those few providers charging exorbitant and unreasonable rates, thereby raising the cost of healthcare. Consider the example of two enrollees, A and B, with identical plans. Both enrollees have paid identical premiums, co-pays and deductibles. Both are faced with an emergency, but A is taken to an in-network hospital and B to an out-of-network hospital. While both have purchased identical plans for the same price, and bargained for the same level of prepaid services, including emergency services, B is balance billed by the non-network hospital and consequently has dramatically different costs than A. Thus, based on the randomness of where an ambulance might take an enrollee during an emergency, a balance billing provider rips asunder the plan product. Petitioners therefore reduce the prepaid plan sought to be promoted by the Legislature to the vagaries of whether the ambulance turned right to a network provider or left to a non-network provider. Such a result is completely anomalous to the point of a prepaid health plan.

With such aggressive tactics, a provider can elicit unreasonable rates, distort the market, and drive up the price of health care, all discouraging future care. Additionally, a provider armed with balance billing has no incentive to contract with a plan, defeating the managed care purpose sought by the Legislature. (Health & Saf. Code, § 1342.) The Legislature specifically intended to facilitate health plan products, providing California consumers with an option that gives them greater predictability over their health care finances. (Health & Saf. Code, §§ 1342, et seq., 1345(f)(1), 1367(i).) To permit balance billing is to foster random inequities in emergency care coverage, thereby eviscerating the Legislature's intent to protect and facilitate a prepaid health product. For these reasons, and pursuant to an express legislative delegation, the Department defined “unfair billing pattern” to include the harmful practice of balance billing.

Specifically, the Legislature delegated to the Department the authority to make law by issuing regulations as necessary to carry out the provisions of the Knox-Keene Act. (Health & Saf. Code, § 1344.) In section 1371.39(b)(1), the Legislature specifically

instructed the Department to further define the term "unfair billing pattern."[6] The Department did so by promulgating California Code of Regulations, title 28, section 1300.71.39.[7] The Regulation reads as follows:

§ 1300.71.39 Unfair Billing Patterns:

(a) Except for services subject to the requirements of Section 1367.11 of the Act, "unfair billing pattern" includes the practice, by a provider of emergency services, including but not limited to hospitals and hospital-based physicians such as radiologists, pathologists, anesthesiologists, and on-call specialists, of billing an enrollee of a health care service plan for amounts owed to the provider by the health care service plan or its capitated provider for the provision of emergency services.

(b) For purposes of this section:

(1) "Emergency services" means those services required to be covered by a health plan pursuant to Health & Safety Code sections 1345(b)(6), 1367(i), 1371.4, 1371.5 and Title 28, California Code of Regulations, sections 1300.67(g) and 1300.71.4. (2) Co-payments, coinsurance and deductibles that are the financial responsibility of the enrollee are not amounts owed the provider by the health care service plan. (3) "The plan's capitated provider" shall have the same meaning as that provided in section 1300.71(a).

This Regulation was properly promulgated by the Department to achieve the necessary goal of protecting enrollees and preserving the managed care bargain.

III. THE REGULATION IS VALID.

Petitioners challenge the exercise of rulemaking authority expressly delegated to the Department in the Act. (Health & Saf. Code, §§ 1344, 1371.39(b)(1).) The lawfulness of an agency's regulation is subject to a well-worn test. In reviewing a legislative rule a court is free to make three inquiries: (1) whether the rule is within the delegated authority; (2) whether it is reasonably necessary; and (3) whether it was issued pursuant to proper procedure. (Gov. Code, § 11342.1; *Moore v. California State Bd. of Accountancy* (1992) 2 Cal.4th 999, 1014-1015; *Ralphs Grocery Co. v. Reimel* (1968) 69 Cal.2d 172, 175, fn. 2 [citing, 1 Davis, Administrative Law Treatise (1958) § 5:05; *cf. Whitcomb Hotel, Inc. v. California Emp. Com.* (1944) 24 Cal.2d 753, 756, 759].)

A. Evidentiary Standard of Review.

On judicial review of the validity of an administrative regulation, the burden of proof is on the party challenging the regulation, since the administrative agency's action comes before the court with a presumption of correctness and regularity. (Credit Ins. Gen Agents Assn. v. Payne (1976) 16 Cal.3d. 651, 657.) A reviewing court's role in examining the validity of regulations promulgated pursuant to an agency's legislative power is limited. "Our function is to inquire into the legality of the regulations, not their wisdom." (*Morris v. Williams* (1967) 67 Cal.2d 733, 737, see also, *Moore v. California State Bd. of Accountancy, supra,* 2 Cal.4th 999, 1014.)[8]

The law in this District is clear. In the absence of an express legislative command, the decision as to whether administrative regulations are necessary or appropriate is a matter entrusted to the discretion of the administrative agency. (*Alfaro v. Terhune* (2002) 98 Cal.App.4th 492, 500, 503 [citing, *Agricultural Labor Relations Bd. v. Superior Court*(1976) 16 Cal. 3d 392, 413].) The agency's decision, which is legislative in character, comes to the court with a strong presumption of correctness, and the court must defer to the agency's expertise unless its decision is arbitrary and capricious. (*Ibid.* [citations omitted].)

Lastly, the Supreme Court has rejected similar arguments which sought to cavil an agency's authority. An administrative agency is not limited to the exact provisions of a statute in adopting regulations to enforce its mandate. The absence of any specific [statutory] provisions regarding the regulation of [an issue] does not mean that such a regulation exceeds statutory authority..." (*Ford Dealers Association v. DMV* (1982) 32 Cal.3d 347, 362.)

A challenge to an agency regulation is reviewed for substantial evidence. (Gov. Code, § 1350(b)(1).) Substantial evidence is an extremely deferential standard meaning any evidence in the record, whether controverted or not. (*e.g., In re S.C.* (2006) 138 Cal.App.4th 396, 415.) The administrative agency, not the judicial branch, is charged with weighing the evidence and making a determination. (*Western States Petroleum Assn. v. Superior Court* (1995) 9 Cal.4th 559, 572-574.) As the Supreme Court there held:

...administrative agencies to which the Legislature has delegated regulatory authority in particular areas often develop a high degree of expertise in those areas and the body of law that governs them. In recognition of this expertise, the United States Supreme Court has regularly given a high degree of deference to the regulatory decisions of federal executive agencies. (See, e.g., *Chevron U.S.A. v. Natural Res. Def. Council* (1984) 467 U.S. 837, 844-845 ["We have long recognized that considerable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer, and the principle of deference to administrative interpretations 'has been consistently followed by this Court whenever decision as to the meaning or reach of a statute has involved reconciling conflicting policies, and a full understanding of the force of the statutory policy in the given situation has depended upon more than ordinary knowledge respecting the matters subjected to agency regulations.' "], fn. omitted.) This court has also recognized the propriety of such deference. (See *California Hotel & Motel Assn. v. Industrial Welfare Com., supra* 25 Cal.3d 200, 212 [judicial review of quasi-legislative administrative decisions limited "out of deference ... to the presumed expertise of the agency within its scope of authority"].)

Additionally, when pursuing a claim for injunctive relief, as here, Petitioners are also bound by the procedural and substantive requirements applicable to an action for injunctive relief. These include Code of Civil Procedure section 526, subdivision (b)(4), which provides that an injunction cannot be granted "[t]o prevent the execution of a public statute by officers of the law for the public benefit." (*Alfaro v. Terhune, supra.* 98 Cal.App.4th 492, 500 [citations omitted].)

The rules of review applicable here are vital because Petitioners cannot meet their burdens and overcome the presumptions favoring the Department. Petitioners committed a fatal mistake in questioning the wisdom of the Regulation, not its lawfulness. (*Moore v. Bd. of Accountancy, supra,* 2 Cal.4th 999, 1014 [judiciary only examines legality not wisdom].) As discussed below, on each and every issue raised by the Petitioners, there is substantial evidence in the record supporting the Department's rulemaking. Because this court is estopped from an inquiry into the Regulation's wisdom and must defer to the Department's expertise, the Petition is without any support and should be denied.

B. Application of the APA Test.

Each of the three prongs from the APA test is satisfied in this case and thus under the Supreme Court's precedents the Regulation is valid. Such a showing alone is sufficient to defeat the Petitioners' challenge.

1. The Knox-Keene Act Unmistakably Delegated Specific Authority for the Regulation. The Legislature clearly vested the Department with the exclusive authority to enforce the Act. (Health & Saf. Code, § 1341; *Viola v. Dept. Managed Health Care, supra.* 133 Cal.App.4th 299, 307 [quoting, *Van de Kamp v. Gumbiner, supra,* 221 Cal.App.3d 1260, 1284; and citing; *Coast Plaza Doctors Hospital v. UHP Healthcare, supra,* 105 Cal.App.4th 693, 700; and *California Medical Assn. v. Aetna U.S. Healthcare of California. Inc., supra,* 94 Cal.App.4th 151, 155, fn. 3].) Further, the Act delegates extensive lawmaking ability to the Department:

The director may from time to time adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of this chapter, including rules governing applications and reports, and defining any terms, whether or not used in this chapter, insofar as the definitions are not inconsistent with the provisions of this chapter. For the purpose of rules and forms,

the director may classify persons and matters within the director's jurisdiction, and may prescribe different requirements for different classes. The director may waive any requirement of any rule or form in situations where in the director's discretion such requirement is not necessary in the public interest or for the protection of the public, subscribers, enrollees, or persons or plans subject to this chapter. The director may adopt rules consistent with federal regulations and statutes to regulate health care coverage supplementing Medicare. (Health & Saf. Code, § 1344(a).)

The Third District Court of Appeal has upheld agency regulations solely based on just this sort of broad, general delegation of rulemaking authority. (See, *Cal. Med. Ass'n v. Lackner* (1981) 124 Cal.App.3d 28.) Specifically, the Department defined an "unfair billing pattern" to include balance billing pursuant to the explicit authority granted in section 1371.39(b)(1):
"Unfair billing pattern" means engaging in a demonstrable and unjust pattern of unbundling of claims, upcoding of claims, ***or other demonstrable and unjustified billing patterns, as defined by the department.*** [emphasis supplied.]

A closer inspection of the statute only reinforces the Department's authority. With the enactment of sections 1371.37 and 1371.39, the Legislature sought to restrain unfair billing patterns and unfair payment patterns by providers and plans alike. (See, Health & Saf. Code, §§ 1371.37, 1371.39; Note, Stats 2000 ch 825 §§ 6, 8 (SB 1177); ch 827 §§ 6, 8 (AB 1455).) The Legislature defined two instances of unfair billing patterns (unbundling of claims and upcoding of claims) and specifically delegated to the Department the task of defining additional "demonstrable and unjustified billing patterns." (Health & Saf. Code, § 1371.39(b)(1).) Further, such a provision is consistent with the Act's general rulemaking delegation giving the Department broad rulemaking power for definitional purposes. (Health & Saf. Code, § 1344(a).) Rule 1300.71.39 is therefore an exercise of rulemaking authority delegated expressly by the Legislature, twice. Thus, the authority for the Regulation is even more specific and greater than that approved by the Third District. (*Cal. Med. Ass'n v. Lackner, supra,* 124 Cal.App.3d 28, 38.) Hence, Petitioners' arguments on the subject of authority are without merit.

Section 1371.39(b)(1) directs the Department to define further unfair billing patterns. The only way an agency may permissibly define any term, definition, or rule is through the official process of rulemaking pursuant to the APA. (*Tidewater Marine W. v. Bradshaw* (1996) 14 Cal.4th 557, 568.) Thus, the meaning of the phrase "...or other demonstrable and unjustified billing patterns, 'as defined by the department'," is not subject to any reasonable dispute and is unambiguous. (Health & Saf. Code, § 1371.39(b)(1).) In light of the unmistakable authority conveyed by the Act, the entirety of Petitioners' reliance on committee reports and vetoed legislation is irrelevant. No extrinsic evidence is needed to interpret an unambiguous statute. (e.g., People v. Otto (1992) 2 Cal.4th 1088, 1100 [citations omitted]; *Community Development.Com. v. County of Ventura* (2007) 152 Cal.App.4th 1470, 1482.) Because the statute is unambiguous, it needs no construction and consequently, any challenge to the Department's authority to promulgate the Regulation must fail. (*Catholic Mutual Relief Society v. Superior Court* (2007) 42 Cal.4th 358, 369.)

The California Supreme Court addressed an identical issue in *Moore v. Board of Accountancy, supra,* ultimately concluding the agency's rulemaking was valid. (*Moore v. Bd. of Accountancy, supra,* 2 Cal.4th 999, 1014-1016.) There, an executive agency, the Board of Accountancy, promulgated a regulation interpreting provisions of the Business and Professions Code which the Legislature had entrusted to the agency's oversight and enforcement-specifically the titles from which unlicensed accountants were prohibited from using in advertisements. There, as did the Legislature in section 1371.39(b)(1), the statute enumerated a few specific prohibitions, but added a catch-all "any" provision. The Board of Accountancy properly promulgated a regulation interpreting the statute, adding an additional definition to the list of prohibited advertising terms.

The Supreme Court upheld the Board's regulation on several grounds applicable here. First, the Court held that the Board's general rulemaking and enforcement authority permitted that agency to issue a regulation interpreting and making more specific (i.e., definitional rulemaking) the prohibitions codified in the statute. (*Moore v. Bd. of Accountancy, supra,* 2 Cal.4th 999, 1013-1014.) Notably, the Department has identical rulemaking and enforcement authority over the Knox-Keene Act. (Health & Saf. Code, §§ 1344 [rulemaking], 1386-87, 1390-1392 [enforcement]; *Van de Kamp v. Gumbiner. supra, Cal. Med. Ass'n v. Aetna, supra.*) But perhaps more strongly, the Supreme Court upheld the Board of Accountancy's authority to supplement the

Business and Professions Code's language generally. In contrast, the same result is even more compelled in the present case where the Legislature directed the Department to define further unfair billing patterns. (Health & Saf. Code, § 1371.39(b)(1).)

Second, the Moore Court recognized that a narrow construction of the Board's authority would negate the intent of the statutes at issue. (*Moore v. Bd. of Accountancy, supra,* 2 Cal.4th 999, 1014.) As the Supreme Court has oft-noted, a court's role is to choose the construction that comports most closely with the apparent intent of the lawmakers, with a view to promoting rather than defeating the general purpose of the statute. (*Allen v. Sully-Miller Contracting Co.* (2002) 28 Cal.4th 222, 227.) Here, the Legislature's intent that the Department define further unfair billing patterns is express. (Health & Saf. Code, § 1371.39(b)(1).) Petitioners' construction therefore does violence to the stated legislative intent and defeats the general purpose of section 1371.39.

Lastly, the *Moore* court unequivocally recognized the imperative importance of deferring to agency expertise:
Moreover, "these issues do not present a matter for the independent judgment of an appellate tribunal; rather, both come to this court freighted with the strong presumption of regularity accorded administrative rules and regulations." (*Ralphs Grocery Co. v. Reimel, supra,* 69 Cal.2d 172, 175.) And in considering whether the regulation is "reasonably necessary" under the foregoing standards, the court will defer to the agency's expertise and will not "superimpose its own policy judgment upon the agency in the absence of an arbitrary and capricious decision." [citations] (*Moore v. Bd. of Accountancy, supra,* 2 Cal.4th 999, 1015.)

The Department is the sole agency with rulemaking and enforcement authority over the Knox-Keene Act, the sole agency with the expertise and familiarity with the satellite legal and regulatory issues concerning balance billing. (*See, Sara M. v. Sup. Ct.* (2008) 36 Cal.4th 998, 1012 [deference to agency w/ familiarity].) Nothing in the Regulation is extraordinary or inapposite to the everyday rulemaking authority enjoyed by sister agencies and routinely granted deference by the c ourts. Moreover, the interpretation of a consumer protection statute such as the Act is necessarily one of broad construction. (*People ex rel Lungren v. Sup. Ct.* (1996) 14 Cal.4th 294, 313.) Petitioners' contentions seek a restrictive interpretation of Section 1371.39, one inimical to the Department's consumer protection mission. (Health & Saf. Code, §§ 1341-1342.) Consequently, the Petition should be dismissed.

2. The Regulation is Reasonably Necessary: the Rule Defines a Billing Practice which is Manifestly Unfair as an Unfair Billing Pattern.

In determining whether regulations are reasonably necessary to effectuate the statutory purpose, the courts are once again compelled to accord significant deference to the rulemaking agency and are not to intervene in the absence of an arbitrary or capricious decision. (*Cal. Ass'n of Psychology Providers v. Rank* (1990) 51 Cal.3d 1, 11-12.) The Regulation is both reasonable and logical, foreclosing judicial intervention. It was promulgated at the Legislature's explicit directive, which alone should eliminate all argument as to its necessity, and render any challenge an impermissible attack on the wisdom of the execution of that directive. (Health & Saf. Code, § 1371.39(a)(1); *Morris v. Williams, supra,* 67 Cal.2d 733, 737, *Moore v. Bd. of Accountancy, supra,* 2 Cal.4th 999, 1014 [court only inquires into legality not wisdom].) Even absent that fact, the Regulation is necessary to implement the Act's consumer protection intent and the legislative mandates that plans assume full financial risk and make direct payments to providers for all recoverable costs associated with out-of-network emergency medical care. (See, Health & Saf. Code, §§ 1342, 1342(d), 1345(b)(6), 1367(i), 1371.4(a)-(c), 1375.1(a)(2).) Balance billing is inherently irreconcilable with those authorities. Indeed, billing the enrollee is inconsistent with the entire concept of a prepaid health plan. (Health & Saf. Code, § 1345(f)(1).) A court is obligated to harmonize statutes in the same Act. (e.g., *People v. Gonzalez* (2008) 43 Cal.4th 1118, 1126.) It would be impossible to honor that obligation while also permitting balance billing much less characterizing it as a "fair" practice.

The Regulation is likewise consistent with more general law outside the Act. Courts have found unfair billing, contracting, and collection practices in the field of health care to violate the Business and Professions Code section 17200 prohibition on unfair business practices. (*Bondanza v. Peninsula Hospital and Medical Center* (1979) 23 Cal.3d 260; *Podolsky v. First Healthcare*

Corp. (1996) 50 Cal.App.4th 632, 647.) The Legislature delegated to the Department the discretion to define further unjust billing patterns. There is nothing unreasonable about including an unjust practice, the double billing of enrollees for services they have already prepaid, as an instance of an unjust billing pattern. Moreover, this Court's inquiry encompasses only the Regulation's legality, not its wisdom. (*Moore v. Bd. of Accountancy, supra,* 2 Cal.4th 999, 1014; *Faulkner v. Cal. Toll Bridge Authority* (1953) 40 Cal.2d 317, 329.)

Balance billing might also be likened to a fraudulent business practice. An emergency provider's attempt to collect a bill from an enrollee is a representation that the enrollee is liable for that balance, despite the fact that the plan is solely responsible and has already in fact made a customary and reasonable payment. (cf. Health & Saf. Code, §§ 1367(i), 1371.4(b).) Thus, such a practice is an attempt to defraud the enrollee because the enrollee is not liable for the bill.

Where providers use aggressive collection tactics in the furtherance of balance billing, their conduct could be more closely described as extortion. Unfortunately, some providers employ intimidating tactics including the use of collection agencies making threats of ruined credit. (RRFJN at Exh. A, Initial Statement of Reasons RMF 17-18, Final Statement of Reasons RMF at 4535, Public Testimony RMF at 3316-3317, McClelland Decl. at Exh. A.) In this modern age, the importance of a credit rating to an individual's financial health cannot be overestimated. It should strike no one as unusual that a person in medical dire straits may need more access to credit to pay bills, thus making threats to an enrollee's credit rating particularly predatory. By threatening an enrollee, often sick or debilitated, with the destruction of his credit unless he pays a bill he does not owe, for services which he prepaid, the balance biller uses fear to extract unjustified monetary gain. (RRFJN at Exh. A; Pen. Code, § 518; See, *Flatley v. Mauro* (2006) 39 Cal.4th 299, 326-327 [attempt to collect a sum not owed, even through the legal processes, is extortion].) Petitioners will find no law authorizing such conduct. The Supreme Court has explained that a strong public policy militates against self-help by force or fear, such that the courts will not recognize a good faith defense to the satisfaction of a debt when accomplished by the use of those tactics. (*People v. Beggs* (1918) 178 Cal. 79, 84.) Notably, it was these aggressive tactics which formed a foundation for, and the necessity of the Regulation. (Initial Statement of Reason, RMF 17-18.). The Department was well within its discretion to consider these predatory practices when promulgating its definition.

Further, the court should not overlook the intrinsic damage to the physician-patient relationship caused by balance billing. “The doctor-patient relationship is a fiduciary one ... [t]he same is true of the hospital-patient relationship.” (*Wohlgemuth v. Meyer* (1956) 139 Cal.App.2d 326, 331.) “It undoubtedly is the established rule that the relation of physician and patient is confidential, and the law demands the strictest good faith and fair dealing in all transactions arising from that relationship. Once this relation is shown to exist, all dealings between the parties will be closely scrutinized, to ascertain if the confidence of the testing party has been betrayed, or his mind unduly influenced to his prejudice.” (*Cole v. Wolfskill* (1920) 49 Cal.App. 52, 54 [emphasis added].) In the professional context, the fiduciary relationship extends beyond the provision of services and applies also to the billing for those services. (See *Bird. Marella, Boxer & Wolpert v. Superior Court* (2003) 106 Cal.App.4th 419, 430-31; *Charnay v. Cobert* (2006) 145 Cal.App.4th 170, 182.) The law regards the fiduciary duty with significant gravity. “A person standing in a fiduciary relation with another is liable to the other for harm resulting from a breach of duty imposed by such relation.” (e.g., Restatement First of Torts § 874.)

Balance billing is the exploitation of both the vast disparity in knowledge between patient and .provider, and the vulnerability of the patient who knows he may, once again have to turn to that provider for life-saving medical care. At best, it turns the patient into a pawn in an effort to obtain inexpensive leverage over the health plan. At worst, it is the extortion of a balance from the patient he does not owe. Either way, the provider is using its superior position over the patient in a manner which discourages the patient from seeking necessary medical care in the future. (Initial Statement Reasons, at RMF 18.) Such a practice certainly does not meet the applicable standard of the highest good faith and fair dealing required of a fiduciary. Thus, there is nothing unreasonable about enacting a regulation which respects and bolsters the physician-patient relationship. Moreover, preserving the fairness of the provider-patient relationship is consistent with the codified intent of the Act. (Health & Saf. Code, 1342(a)&(g).)[9]

Finally, preserving the rights of the enrollee with a prepaid health plan from incurring unjustified charges is consistent with established maxims of jurisprudence. A provider who takes the benefit of a plan's payment for the services provided to an enrollee must bear the burden of disputing the reimbursement amount with the plan. (Civ. Code, § 3521 [He who takes the benefit must bear the burden].) The transitory nature of medical emergencies serves to reinforce this result. An enrollee with an emergency must seek treatment at the nearest emergency facility in order to protect life and limb, regardless of the boundaries of their provider network. This is particularly true in the case of ambulance-transported emergencies, where enrollees have absolutely no choice in the ambulance's destination. No man is responsible for that which no man can control. (Civ. Code, § 3526.) The Legislature's approach to coverage for non-network emergency medical care under the Act reveals the-influence of that maxim. (See, Health & Saf. Code, §§ 1342, 1342, 1345(b)(6), 1367(i), 1371.4(a)-(c), 1375.1(a)(2).) When a suggested construction of a statute in any given case necessarily involves a decided departure from what may be fairly said to be the plain purpose of the enactment, such construction will not be adopted to the exclusion of a possible, plausible interpretation which will promote and put in operation the legislative intent. (*People v. Merrill* (1914) 24 Cal.App. 206, 210; see also, *County of Los Angeles v. Frisbie* (1942) 19 Cal. 2d 634, 644.)

Contrary to Petitioners' challenge, there is more than enough evidence in the record to meet the deferential *substantial evidence* standard.[10] Defining balance billing as an unfair billing pattern is necessary to ensure consistency with the Department's enrollee protection obligation. (Health & Saf. Code, § 1341(a), Initial Statement Reasons RMF at 17.) On this ground alone, the Regulation is compatible with the Act's provisions and intent. (Health & Saf. Code, §§ 1341(a), 1342; Initial Statement Reasons RMF at 16-17; Public testimony RMF at 3316-3331, 3708-3710, Responses to Comments RMF at 4283-4287, 4293, 4297-4301, 4308, 4312, 4316, 4320-4323, 4325-4328, 4332, 4336 4337, 4340, 4341, 4343-4345, 4347,4348, 4352, 4357, 4360-4362, 4368, 4370, 4376, 4381, 4382, 4393, 4394, 4397-4402, 4409-4415, 4417-4421, 4425-4430, 4433, 4442, 4443, 4444, 4450-4456, 4458, 4469, 4488, 4492.)

Lastly, while Petitioners pejoratively assert the Department acted “rashly” in promulgating the Regulation, Petitioners concede the Department went through the rulemaking process on two prior. occasions relative to this topic. In each case, the Department promulgated a proposed regulation, considered thoughtful public commentary, and in each of those cases elected not to proceed with publication, but instead to deliberate further before finally arriving at the version of the Regulation currently before this Court. Far from rash, the Department's conduct evidences a very deliberate process which considered alternatives and carefully weighed all of the interests at stake, finding no alternative which permitted balance billing to be consistent with the Act's objectives.

3. The Regulation was Promulgated in Compliance With the APA.

An agency must give the public notice of its proposed regulatory action (Gov. Code, §§ 11346.4, 11346.5); issue a complete text of the proposed regulation with a statement of the reasons for it (Gov. Code, § 11346.2, subds. (a), (b)); give interested parties an opportunity to comment on the proposed regulation (Gov. Code, § 11346.8); respond in writing to public comments (Gov. Code, § 11346.8, subd. (a), 11346.9); and forward a file of all materials on which the agency relied in the regulatory process to the Office of Administrative Law (OAL) (Gov. Code, § 11347.3, subd. (b).), which reviews the regulation for consistency with the law, clarity, and necessity (Gov. Code, §§ 11349.1, 11349.3).(*Tidewater Marine W. v. Bradshaw, supra,* 14 Cal.4th 557, 568.) The Regulation was promulgated lawfully pursuant to the APA. The Department published the Regulation and complied with all requirements for public participation. (SRMF at 1-4535. Responses to Comments RMF at 4372.) The Regulation was duly submitted to the OAL *and approved* by that agency.

The Legislature established the OAL in 1979, and charged it with review of adopted regulations for the purpose of reducing the number of administrative regulations and improving the quality of thos regulations which are adopted. The Legislature also stated that no regulation is valid or effective “unless consistent and not in conflict with the statute and reasonably necessary to effectuate the purpos of the statute.” Since the Legislature expressly conferred upon administrative agencies the discretion to determine necessity, subject to review by the OAL, it follows that the scope of judicial authority to require rulemaking is necessarily deferential and narrow. (*Alfaro v. Terhune, supra,* 98 Cal.App.4th 492, 503 [citations omitted].)

Further, the filing of a certified copy of a regulation with the Secretary of State raises the rebuttable presumption that all requirements of the APA relative to such regulation have been complied with. (Gov. Code, § 11343.6(c).) Petitioners concede the Regulation was forwarded to the Secretary of State and have offered no evidence to rebut the presumption of validity. (POB at p. 7.) Accordingly, the Regulation was properly enacted and Petitioners' claims must fail.

Petitioners boldly contradict the evidence and allege the Department did not consider the fiscal impact of the Regulation. Petitioners are incorrect; the Department did in fact consider the fiscal impact of Rule 1300.71.39. (Form 399 at RMF 92, Final Statement of Reasons at RMF 4535.) Again, Petitioners inappropriately focus on the wisdom of the regulation and not the process under which it was promulgated. (*Moore v. Bd. of Accountancy, supra,* 2 Cal.4th 999, 1014.) Here they mistakenly focus upon the Department's conclusion, when the issue is whether the fiscal impact *was considered.* Substantial evidence supports that the Department's rulemaking process considered the fiscal impact of the Regulation, but concluded that there was no appreciable impact. (*Ibid.*) Where the Department conducted the required analysis, the courts must defer to the Department's conclusion. (*Western States Petroleum Assn. v. Superior Court, supra,* 9 Cal.4th 559, 573-574; *Moore v. Bd. of Accountancy, supra,* 2 Cal.4th 999, 1014.) The APA requires only consideration of the regulation's economic impact, not a conclusion the Petitioners prefer.

First, Petitioners ignored abundant evidence in the record that the Department did consider the economic impact of the Regulation. (Form 399 at RF92, Final Statement of Reasons at RMF 4535, Responses to Public Comments at RMF 4283, 4285, 4288, 4289, 4292, 4293, 4296, 4297, 4299, 4311, 4312, 4316, 4317, 4320, 4345, 4346, 4349, 4368, 4369, 4370, 4371, 4372, 4377, 4378, 4394, 4396, 4397, 4398, 4400, 4402-4405, 4413, 4416, 4418, 4422, 4425-4430, 4442, 4446, 4449, 4450,4452-4457, 4469, 4487, 4488, 4492.)

Moreover, the Department's.conclusion that the Regulation did not have a significant economic impact was correct. The Regulation does not affect any emergency service provider's right to reimbursement, but merely classifies balance billing as an unfair billing pattern. In other words, non-network emergency provideis are still entitled to the exact same reimbursement amount for their services - i.e., the reasonable and customary amount of the service; and likewise still retain all of their rights to seek reimbursement directly from the plans through the proper channels. (Health & Saf. Code, § 1371.4(b); Cal. Code Regs., tit. 28, §§ 1300.71(a)(3)(B), 1300.71.38, *Bell v. Blue Cross, supra,* 131 Cal.App.4th 211, 220.) Disallowing balance billing merely prevents some providers from using their patients as inexpensive leverage against the plans to avoid the costs associated with the legal system and/or to obtain unreasonable compensation. In any event, this Court has no jurisdiction to judge the wisdom of this analysis, but instead should defer to the Department's expertise. (*Moore v. Bd. of Accountancy, supra,* 2 Cal.4th 999, 1014, *Morris v. Williams, supra,* 67 Cal.2d 733, 737.)

Petitioners also incorrectly state the Department did not file a declaration attesting to its consideration of economic impact. The record shows otherwise. The Department complied with all of the filing requirements of the OAL, which approved the Regulation. These requirements included the completion of OAL's Fiscal Impact Statement which is a standardized form with an attestation/declaration signed by the Department's Chief Deputy Director, Edward Heidig, and Undersecretary Marjorie M. Berte of the Business, Transportation and Housing Agency. (Fiscal Impact Statement at RMF 92-95.) Additionally the Notice of Publication sent to OAL contains a similar attestation to the veracity of the contents of the Regulation. (Notice of Publication at RMF 4.) Further, the Department appropriately completed all of the required filings for the OAL which then approved the Regulation. (RMF generally.) The Regulation was then filed by certified copy with the Secretary of State on September 15, 2008, invoking the rebuttable presumption in favor of compliance. (Gov. Code, § 11343.6(c).) Petitioners quibbling must be disregarded as trifling and indicative of the overall insufficiency of their argument. (Civ. Code, § 3533 [The law disregards trifles].)

The Department considered the fiscal impact of the Regulation and concluded there was none. (e.g., Fiscal Impact Statement, Final Statement of Reasons at RMF 92-95, Final Statement of Reasons at RMF 4535.) OAL approved the Regulation. Nowhere in Petitioners' argument is there any evidence to overcome the presumption in favor of compliance. The APA does not require

the Department to reach a conclusion the Petitioners like. Moreover, the courts are not empowered to second guess an agency's determinations, and should defer to the Department. (See, *Western States Petroleum v. Sup. Court, supra,* 9 Cal.4th 559, 572-573, *Moore v. Bd. of Accountancy, supra,* 2 Cal.4th 999).

IV. PETITIONERS' CHALLENGE MUST FAIL.

A. The Law to be Applied: The Knox-Keene Act Preempts Common Law.

Petitioners' contentions primarily fail because they are based on common law which is in direct contradiction to the Knox-Keene Act. General rules of common or statutory law are preempted by the specific language of the Act. (e.g., *Bank of Am. v. Lallana* (1998) 19 Cal.4th 203, 209-210.) Any reliance upon general insurance law is irrelevant because, as explained above, Petitioners analogy to a traditional indemnity plan is fatally flawed. Further, in addition to preemption, Petitioners cannot rely on contract law, because a contract extracted by a hospital provider from an enrollee in an emergency is inherently coerced.[11] (*City of Santa Barbara v. Superior Court* (2007) 41 Cal.4th 747, 789 [the admission room of a hospital contains no bargaining table].)

The general rule as stated by the Supreme Court is that "statutes do not supplant the common law unless it appears that the Legislature intended to cover the entire subject or, in other words, to 'occupy the field.' [Citations.] '[G]eneral and comprehensive legislation, where course of conduct, parties, things affected, limitations and exceptions are minutely described, indicates a legislative intent that the statute should totally supersede and replace the common law dealing with the subject matter."' (*Van De Kamp v. Gumbiner, supra,* 221 Cal.App.3d 1260, 1283 [citing, *I. E. Associates v. Safeco Title Ins. Co.* (1985) 39 Cal.3d 281, 285].) The Second District found that the Knox-Keene Act's regulatory scheme was so pervasive it did preempt common law. (*Van De Kamp v. Gumbiner, supra,* 221 Cal.App.3d 1260, 1284)[12] Thus, the Knox-Keene Act's comprehensive regulation of the financial responsibility associated with enrollees' emergency services, precludes the application: of general common law to the subject. providers therefore have no claim against the enrollee. Therefore, any attempt to collect from the enrollee a balance for which he is not responsible approaches, and perhaps even reaches, the level of extortion, conversion or fraud, making such a practice unquestionably an "unfair billing pattern."

B. Consideration of Significant Public Policy Interests Merit Denying Petitioners Relief.

Where, as here, the defendants are public agencies and the Petitioners seeks to restrain them in the performance of their duties, public policy considerations also come into play. The law will hold rulemakers to the standards set forth in the APA, but the law offers no assistance to a special interest group trying to avoid the impact of a proper regulation. Toward that end, there is a general prohibition against enjoining public officers or agencies from performing their duties. (*Tahoe Keys Prop. Owners Ass'n v. State Water Res. Bd.* (3d Dist. 1994) 23 Cal.App.4th 1459, 1471 [citing, *Agricultural Labor Relations Bd. v. Superior Court, supra,* 16 Cal.3d 392, 401; *Golden Gate S. T., Inc. v. San Francisco* (1937) 21 Cal.App.2d 582, 584-585.) Indeed, our Supreme Court concluded courts have no jurisdiction to enjoin a regulation absent a finding it is unconstitutional or otherwise invalid. (*Agricultural Labor Relations Bd. v. Superior Court, supra,* 16 Cal.3d 392, 401.)

The Regulation is neither. In fact, the proper approach to the public policy concerns at issue in this case are manifest and expressly set forth in the Act. Rule 1300.71.39 limits its reach to emergency services. (Cal. Code Regs., tit. 28, § 1300.71.39(a).) Emergency services are clearly among those basic health care services required to be paid by the plan. (Health & Saf. Code, §§ 1345(b)(6), 1367(i), 1371.4(b), 1375.1.) Stated differently, the enrollee bears no financial risk for emergency care beyond co-pays and deductibles. *(Ibid.)* The Legislature unequivocally affirmed this result in stating the Act's intent: "Helping to ensure the best possible health care for the public at the lowest possible cost by *transferring the financial risk of health care from patients to providers.*" (Health & Saf. Code, § 1342(d) [emphasis added].) Rule 1300.71.39 effectuates this intent.

Centrally, balance billing presents the question of where the risk should lie if the plan's payment is less than the provider's billed charge.[13] A provider who engages in balance billing pushes the risk to the enrollee, demanding the enrollee indemnify

the provider's risk even where the provider is charging an exorbitant or unreasonable fee, ignoring the fact that the enrollee has already prepaid for emergency services, and ignoring the available legal and dispute resolution options open to the provider. There is nothing in the Act to suggest the Legislature would ever tolerate, much less allow such a result. Quite the contrary, the Legislature's policy is to shift the risk from enrollee to provider. (Health & Saf. Code, § 1342(d).) The Regulation merely gave voice to the public policy codified in the Act.

Petitioners' contentions have long been rejected by the Third District Court of Appeal. Petitioner California Medical Association (CMA) brought a substantially similar challenge to a regulation promulgated by the former Department of Health Services, which the Third District Court Appeal rejected. (*Cal. Med. Ass'n v. Lackner* (1981) 124 Cal.App.3d 28.) The *Lackner* Court's reasoning is exactly on point.

In *Lackner,* CMA challenged a Department of Health Services' regulation. The Court premised its analysis on the broad and general regulatory power delegated to the agency by the Legislature and acknowledged that the use of rulemaking authority to define generalized subjects of discipline is superior to a piecemeal case-by-case approach (*Cal. Med. Ass'n v. Lackner, supra,* 124 Cal.App.3d 28, 38.) There, the Department of Health Services had been granted general regulatory and rulemaking authority similar to that granted to the Department in sections 1341, 1344, 1346. Moreover, that agency used such authority to add further specificity to its regulatory scheme. (*Id.* at pp. 38, 39.) Notably, the Court recognized the regulation at issue as reasonable precisely because it implemented the legislative concerns. (*Id.* at p. 39.) Here, the Legislature likewise specifically intended that the Department further define unfair billing patterns. (Health & Saf. Code, § 1371.39(b)(1).) The Legislature also expressed its policy directive that risk not be shifted to the patient. (Health & Saf. Code, § 1342(d).) The Regulation gives effect to the Legislature's policies and the Governor's Executive Order S-13-06 that the Department end balance billing. (RFJN at Exh. B.) As such, the legislative and executive branches have unmistakably expressed a public policy which will not tolerate balance billing.

C. Petitioners' Claims Give Rise to Substantial Questions of Separation of Powers Doctrine.

Petitioners' arguments amount to an attempt to usurp the State's Constitutional system and usher in a weak regulatory regime. Under the California Constitution, the Legislature is the policymaker. (Cal. Const., Art. IV, § 1.) Courts are careful not to intrude on the powers of the legislative and executive branches of government. (Cal. Const. Art. III, § 3.) The highest courts have long counseled the judiciary to respect the constitutional balance and separation of powers. (e.*g.*, *Obrien v. Jones* (2000) 23 Cal. 4th 40, 76; *In re Marriage Cases* (2008) 43 Cal.4th 757, 873; *Cleburne v. Cleburne Living Center. Inc.* (1985) 473 U.S. 432, 441.)

The separation of powers doctrine employs a careful balance between those who make law and those interpreting it. Courts have no jurisdiction to enjoin a regulation absent a finding it is unconstitutional or otherwise invalid. (*Agricultural Labor Relations Bd. v. Superior Court, supra,* 16 Cal.3d 392, 401.) The reasoning or wisdom underlying the agency's action is beyond the scope of judicial inquiry. (*Moore v. Bd. of Accountancy, supra,* 2 Cal.4th 999, 1014, *Faulkner v. Cal. Toll Bridge Authority, supra,* 40 Cal.2d 317, 329.) In reviewing the request for an injunction in this case, a court must also bear in mind the extent to which separation of powers principles may affect the propriety of injunctive relief against state officials. (*O'Connell v. Sup. Ct.,* (2006) 141 Cal.App.4th 1452, 1464.) The First District Court of Appeal explained:

In that context, our Supreme Court has emphasized that "principles of comity and separation of powers place significant restraints on courts' authority to order or ratify acts normally committed to the discretion of other branches or officials. [Citations.] In particular, the separation of powers doctrine (Cal. Const., art. III, § 3) obligates the judiciary to respect the separate constitutional roles of the Executive and the Legislature." (citations) In the same context, the Supreme Court has stressed that "a judicial remedy must be tailored to the harm at issue [citations]," and that "[a] court should always strive for the least disruptive remedy adequate to its legitimate task." (citations, *O'Connell v. Sup. Ct.,* (2006) 141 Cal.App.4th 1452, 1464.)

Thus, in assessing any request to enjoin the regulation a court is constrained by principles of comity and separation of powers. (*O'Connell v. Sup. Ct., supra* 141 Cal.App.4th 1452, 1476.) The O'Connell court noted that in the context of educational policy

and finance, the Legislature was the constitutional policymaker not the courts. (*Id.* at p. 1474.) The Court's reasoning is on point as healthcare policy is no less important than educational policy and it too was committed to the Legislature.

As the policymaker on the subject of managed health care, the Legislature expressed its policy intent directly within the Act, stating in pertinent part its intent to:
"... promote the delivery and the quality of health and medical care to the people of the State of California who enroll in, or subscribe for the services rendered by, a health care service plan or specialized health care service plan by accomplishing all of the following:

(d) Helping to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers.

(e) Promoting effective representation of the interests of subscribers and enrollees.

(f) Ensuring the financial stability thereof by means of proper regulatory procedures.

(g) Ensuring that subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing continuity of care. (Health & Saf. Code, § 1342.)

The Legislature then created the Department, charging it with "... the execution of the laws of this state relating to health care service plans and the health care service plan business including, but not limited to, those laws directing the department to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interests of enrollees." (Health & Saf. Code, § 1341(a); *Viola v. Dept. Managed Health Care, supra,* 133 Cal.App.4th 299, 307; *Van de Kamp v. Gumbiner, supra.* 221 Cal.App.3d 1260, 1284.) Consistent with its constitutional prerogative, the Legislature delegated enforcement and rulemaking authority to the Department, including the explicit authority to define terms. (Health & Saf. Code, §§ 1341, 1344, 1386, 1371.39; *Cal. Med. Ass'n. Inc., v. Aetna, supra,* 94 Cal.App.4th 151, 157.) There is nothing inconsistent or unusual with this delegation and it was well within the Legislature's constitutional authority. Our Supreme Court recently held that where the Legislature chooses to delegate to an executive agency, it is not for the court to second guess the Legislature's choice. (*In re Qawi* (2004) 32 Cal.4th 1, 26.)

The Department determined that balance billing is a pernicious practice. The Legislature delegated to the Department the discretion to further define other instances of unfair billing patterns. (Health & Saf. Code, § 1371.39(b)(1).)

The Department weighed all of the evidence, including Petitioners' arguments and public comments, but decided that the harmful effects of balance billing on the consumer could not be tolerated or justified under the legislative framework of the Act. "In considering a regulation's reasonableness, the court will defer to the agency's expertise and will not superimpose its own policy judgment upon the agency in the absence of an arbitrary and capricious decision." (*Cal. Med. Assn v Lackner, supra,* 124 Cal.App.3d, 28, 41 [citations omitted]; *California Hotel & Motel Assn. v. Industrial Welfare Com.* (1979) 25 Cal.3d 200. 211-212; *Industrial Welfare Com. v. Superior Court* (1980) 27 Cal.3d 690, 702.) This Court is duty bound to respect the Department's determinations.

Petitioners' instant challenge, however, ignores the general delegation of rulemaking authority in section 1344 and parses section 1371.39. Petitioners cite at length a host of unrelated sections of the Act, but mention section 1344 only once. (POB at p. 3.) Petitioners' myopic reading of the statutes fails to harmonize the Act and denies the Department the authority expressly delegated to it. This is a dangerous argument with troubling implications.

If Petitioners' incredibly narrow construction of section 1371.39 can invalidate the express delegation made in an unambiguous statute, then no agency's regulation is safe. The courts would become de facto regulatory agencies, acting without special

expertise and regulating ad hoc. Petitioner CMA previously made a substantially similar argument, including identical jurisdictional and delegated authority arguments, in Lackner. (*Cal. Med. Ass'n v Lackner, supra.* 124 Cal.App.3d 28, 41.) The Lackner court expressly rejected those arguments, describing them as an unwarranted recipe for regulatory anemia, and instead upheld the agency regulation concerning a narrow definitional issue based on the broad grant of regulatory authority by the Legislature. *(Ibid.)*

Lackner is directly on-point. Petitioners' narrow approach to the regulatory process, if adopted, would render the Department, and any other agency with a similar broad delegation, anemic if not impotent. Likewise, the Supreme Court's leading cases on the issue of regulatory authority, including *Agricultural Labor Relations Board v. Superior Court, supra, Western States Pet. Ass'n, supra, Moore v. Bd. of Accountancy, supra;* and *Cal. Ass'n of Psychology Providers v. Rank, supra,* lend no support to Petitioners' argument. Rather, the Supreme Court in those cases was appropriately deferential based upon the separation of powers and agency expertise. Consequently, the Department urges this court to show. the same wise restraint and deny Petitioners' request for writ relief.

D. Petitioner's Contentions are Flawed and Unsupported by the Law.

Petitioners' substantive contentions are off-point and unpersuasive. Further, Petitioners' arguments contradict established case law. If adopted, Petitioners' contentions would result in the sort of terminal regulatory anemia expressly rejected by the Third District Court of Appeal. (*Cal. Med. Ass'n v Lackner, supra,* 124 Cal.App.3d 28, 38.)

1. The Department's Jurisdiction Reaches Providers.

The Regulation is valid as applied to the providers identified therein - hospitals and hospital- physicians. Petitioners' jurisdictional argument fails for a multitude of reasons. In short, Petitioners' argument misses the fact that the Department acts in dual roles: a) as a licensor and regulator of health plans; and b) as a public prosecutor enforcing violations of the Knox-Keene Act against any person. (See, Health & Saf. Code, §§ 1386 [discipline of licensees], 1387 [may prosecute any person for civil penalties], 1390 [criminal penalties against any person, 1391 [cease and desist order against any person, 1392 [injunctive and equitable relief against any person].)

Petitioners' jurisdictional argument is far too broad. Concededly, the Medical Board of California has the exclusive authority to regulate physicians for compliance with the Medical Practice Act. (Bus. & Prof. Code, § 2220.5(b).) However, that exclusive jurisdiction is not without boundaries. “[G]eneral and comprehensive legislation, where course of conduct, parties, things affected, limitations and exceptions are minutely described, indicates a legislative intent that the statute should totally supersede and replace the common law dealing with the subject matter.” (*Van de Kamp v. Gumbiner, supra,* 221 Cal.App.3d 1260, 1283.) The Medical Practice Act, therefore, preempts other legislation only to the extent the Act has occupied the field, leaving all uncovered areas appropriately subject to other regulation.

Here, the Medical Practice Act occupies the field relative to the practice of medicine, but that is substantially short of regulation of the entire field of non-medical business practices of physicians. In other words, a physician's non-medical business practices are not minutely described by the Medical Practice Act and thus the provisions of the Knox-Keene Act which implicate, proscribe or include providers are not preempted.[14] It is thus apparent Petitioners took their argument further than the law would support them. Their contention would have the absurd result of depiving the Attorney General or any District Attorney of the ability to prosecute a physician civilly or criminally for violation of any law including, e.g., fraud or false advertising merely because the offender was a physician. A medical license is not sovereign immunity for the holder from all statutes other than the Medical Practice Act. Instead, where an applicable statute is not at odds with the Medical Practices Act, the physician is bound to follow it.

Support for the concurrent enforceability of the Knox-Keene Act and the Medical Practice Act comes not only from an absence of inconsistency, but also affirmative statements from the Legislature. The Legislature's directive in section 1371.39(b)(2) that the Department disclose its "actions against providers" reflects an intent that the Medical Practice Act does not occupy the entire field of physician-related conduct. Again, Petitioners fail to acknowledge the difference between discipline and prosecution. The Department does not and would not claim it has jurisdiction over the license of any physician (or hospital). However, where the Legislature enacted specific prohibitions or rules proscribing certain conduct by providers, those statutes are applicable and enforceable against providers. The Knox-Keene Act gives the Department the express authority to prosecute "any person"[15] for violations of the Act. (Health & Saf. Code, §§ 1387, 1391, 1392.) There is no support in the law to exempt physicians from that broad reach.

Petitioners also incorrectly limit the Department's jurisdiction. The Department is the exclusive enforcement agency for violations of the Knox-Keene Act. (Health & Saf. Code, § 1341, *Van de Kamp v. Gumbiner, supra; Cal. Med. Ass'n v. Aetna, supra.*) Pursuant to that authority, the Department regulates every facet of licensed health plans, but its jurisdiction is limited only by the Act, which regulates non-plan conduct where it relates to managed care. As already noted, Section 1371.4 extended the Act's reach to all providers in order to make the Act consistent with its prepaid plan objective. (Health & Saf. Code § 1371.4(b) [plan must reimburse all emergency providers directly].) Further,, the Act explicitly proscribes the conduct of providers in several instances.

The Act prohibits a contracting provider from collecting or attempting to collect from an enrollee sums owed by the plan. (Health & Saf. Code, § 1379 ["provider shall not collect..."].) Likewise, the Act states providers are each responsible for their own acts or omissions. (Health & Saf. Code, § 1371.25.) As well, any provider providing healthcare or other services to a plan must make its book and records open to Department inspection. (Health & Saf. Code §1381(a).) Further, providers must reimburse plans when the plan notifies them of an overpayment, including interest if provider fails to do so in a timely manner. (Health & Saf. Code, § 1371.1 ["provider shall reimburse the health care service plan..."].) Importantly, these sections place affirmative obligations on the provider. Petitioners are, therefore, fundamentally incorrect in their assertion that the Act does not apply to providers or govern their conduct.

Here, the Legislature extended to the Department the Act's authority over providers' unfair billing patterns. (Health & Saf. Code, § 1371.39.) Though there is an argument such authority could have been granted to either the Medical Board or the Department, this overlap is not a bar to rulemaking In fact, petitioner CMA made that argument unsuccessfully in *Lackner.* There, the Third District recognized that the licensees of the various licensing bodies necessarily interact in the real world and thus the Medical Board and another agency can share an issue of common concern without implicating a jurisdictional dilemma. (*Cal. Med. Ass'n v. Lackner, supra,* 124 Cal.App.3d 28, 40.). The Third District Court of Appeal further noted that a court should not hypothesize a jurisdictional conflict where none appears. *(Ibid.)* The Court specifically rejected CMA's attempt to erect a wall of separation between the jurisdictions of two agencies sharing an issue of common concern. *(Ibid.)*

The present case is indistinguishable. By directing the Department to define further unfair billing patterns by providers, and to report on actions taken against providers, the Legislature necessarily created issues of common concern between the Department and various licensing agencies including, but not limited to, Department of Public Health [regulating hospitals], Medical Board of California [physicians], and conceiyably the licensing bodies for psychologist, dentists, and possibly others. This overlap is not a bar to the Regulation. (*Cal. Med. Ass'n v. Lackner, supra,* 124 Cal.App.3d at p. 40.) -
Finally, Petitioners also ignore the express directive from the Legislature to the Department: The department shall convene appropriate state agencies to make recommendations by July 1, 2001, to the Legislature and the Governor for the purpose of developing a system for responding to unfair billing patterns as defined in this section. *This section shall include a process by which information is made available to the public regarding* ***actions taken against providers for unfair billing patterns*** *and the activities that were the basis for the action.* (Health & Saf. Code, § 1371.39(b)(2) [emphasis added].)

Were Petitioners correct that the Department had no authority over providers, section 1371.39(b)(2) would have no purpose; the Department could not make recommendations to the Governor and Legislature about a system of publicizing *actions taken against providers* if the Department had no authority to take such actions against providers. Petitioners' argument renders subdivision (b)(2) meaningless surplusage. Courts must avoid a construction that makes any provision surplusage. (e.g., *Cooley v. Superior Court* (2002) 29 Cal.4th 228, 249; *Navellier v. Sletten* (2002) 29 Cal.4th 82, 95.)[16]

In summary, Petitioners' arguments on the issues of preemption and jurisdiction are simply without merit. The Medical Practice Act does not occupy the field of billing for emergency medical services provided to health plan enrollees and thus it does not preempt the Knox-Keene Act on that subject. Likewise, the law lends no support to their arguments ignoring the Department's jurisdiction as a public prosecutor. Instead, the Act includes numerous statutes supporting a specific intent to include any person, including providers, within the jurisdiction of the Act. Clearly the Legislature did not intend those references to be impotent. The clear import of the Act's broad language was to implicate those who had some connection to the managed care arena, be they enrollees receiving care, providers providing care, and plans reimbursing providers for care. “Well-established canons of statutory construction preclude a construction [that] renders a part of a statute meaningless or inoperative.” (*Copley Press, Inc. v. Sup.Court* (2006) 39 Cal. 4th 1272, 1285 [citations omitted].) Petitioners' contentions do just that and are thereby proven to be erroneous.

2. Balance Billing Can Be a Pattern.

Petitioners' argument that balance billing is not a pattern can be answered with simple logic. A pattern is a mode of behavior or series of acts that are recognizably consistent. (“pattern” Black's Law Dictionary 1149 (7th ed. 1999).) Many of the providers who balance bill do so in a prolific and systematic manner evincing a recognizably consistent series of acts. For example, one Southern California hospital chain balance billed as many as 6,000 Kaiser Foundation Health Plan enrollees in July 2008. (RRFJN at Exh. A.) That provider's actions included the systematic threatening of each enrollee's credit rating through the use of a collection agency. (Ibid.) Such conduct would clearly be a pattern. Whether a single, isolated act of balance billing might likewise be included within the Regulation is a different question more suitable for an as-applied challenge than Petitioners' present facial challenge.

3. Failures of the Legislative Process Do Not Impair the Department's Rulemaking Authority.

Petitioners incorrectly point to legislative failures in an attempt to obfuscate the successful enactment of sections 1344 and 1371.39. The failure of any Assembly Bill or Senate Bill has no impact on the interpretation of section 1371.39(b)(1). That section needs no construction because it is unambiguous. (*Catholic Mutual Relief Society v. Superior Court, supra,* 42 Cal.4th at p. 369.) Further, the interpretive value of unenacted legislation is vanishingly small. (*Cal. Med. Ass'n v. Lackner, supra.* 124 Cal.App.3d 28, 39.) “The [bills] may have failed because the legislature felt [them] unnecessary to accomplish the result intended. [They] may have died for any of the multitude of reasons other than consideration on the merits that exist for the failure of measures to pass.” (*Ibid.* [citations omitted].)[17]

The Third District Court of Appeal's reasoning is on-point and compelling. There are multitude of reasons why legislation may fail passage, may be vetoed or otherwise fail to become law, none of which are relevant to the review of Rule 1300.31.79. Furthermore, by concentrating on the vanishingly small relevance of non-law, Petitioners ignore the most important legislative successes - the codification of sections 1342, 1344 and particularly section 1371.39. Section 1344, expressly granted the Department the authority to engage in rulemaking to define any terms. (Health & Saf. Code, § 1344(a).) Section 1371.39 further and more explicitly delegated to the Department the authority to define unfair billing patterns. Neither is ambiguous.

Petitioners' patchwork of failed legislative bills belies the weakness of their argument. Their mountains of irrelevant extrinsic material offers no evidence of the proper interpretations of sections 1344 and 1371.39, but instead underscores their inability to escape the clear text and plain meaning of those two statutes. The Department, on the other hand, urges this court to enforce

the unambiguous text of section 1371.39(b)(1) to reach a result which is at harmony with the Act. According to the Supreme Court, the principle of Occam's razor is as valid judicially as it is scientifically, and it says: the simplest of competing theories should be preferred over more complex ones. (*Brodie v. Workers' Comp. Appeals Bd.* (2007) 40 Cal.4th 1313, 1328 [citations omitted];) Unquestionably, that principle weighs against the Petitioners in this case.

4. The Department Was Not Required to Submit a Report to the Legislature As a Condition Precedent to Rulemaking.

Petitioners again seek to eviscerate the plain meaning of section 1371.39. That statute imposed three separate and distinct requirements on the Department. First, the Department was instructed to define other demonstrable and unjustified billing patterns. (Health & Saf. Code, § 1344(b)(1) ["as defined by the department"].) Second, the Department was to convene appropriate state agencies to make recommendations to the Legislature and the Governor for the purpose of developing a system for responding to unfair billing patterns as defined in this section, and was to report on actions taken against providers. (Health & Saf. Code, § 1371.39(b)(2).) Third, the Department was to report to the Legislature and the Governor information regarding the development of the definition of "unfair billing pattern" by December 31, 2001. (Health & Saf. Code, § 1344(c).) Even when examined together, these separate requirements offer no support to the Petitioners' case.

The obligation to report to the Legislature is set forth in subdivision (c). That ministerial obligation is not, structurally within the statute or by its plain text, a condition precedent to the delegation of authority to define other unfair billing patterns in subdivision (b)(1). Indeed, subdivision (b)(1) *precedes* subdivision (c) thus disproving Petitioners' argument. Second, the duty to prepare a report to the Legislature is a ministerial act. Petitioners' remedy is limited to a writ of mandate requiring the Department to perform that ministerial act, nothing more. (e.g., Code Civ. Proc., § 1085; *Santa Clara County Counsel Attys. Assn. v. Woodside* (1994) 7 Cal.4th 525, 539-540.)

There is nothing in the text of the statute which links the Department's express authority to define unfair billing patterns to the provision of the report described in subdivision (c). The Civil Code defines a condition precedent: "A condition precedent is one which is to be performed before some right dependent thereon accrues, or some act dependent thereon is performed." (Civ. Code, § 1436.) Section 1371.39(b)(1) is in no way conditioned upon the performance of any act by the Department. The statute lacks any of the characteristic language indicating a condition to performance such as "subject to." In Civil Code parlance, the Department's authority to define further unfair billing patterns is not conditioned upon any act, to file a report or otherwise, before the Department's authority to define further unfair billing patterns accrues.[18]

5. Petitioners Contort Section 1371.39, Ignoring its Intent and Text: The Legislature did not merely intend the Department to just report.

Petitioners' arguments regarding the enactment of section 1371.39 are nonsensical, ignoring both the statute's text and intent. The enactment of section 1371.39 stated the Legislature's intent:

SECTION 1. The Legislature finds and declares the following:

(a) Health care services must be available to citizens without unnecessary administrative procedures, interruptions, or delays.

(b) The billing by providers and the handling of claims by health care service plans are ... essential components the health care delivery process.-and can be made more effective and efficient.

(c) The present system of claims submission by providers and the processing an payment of those claims by health care service plans are complex and are in need of reform in order to facilitate the prompt and efficient submission, processing, and payment of claims. Providers and health care service plans both recognize the problems in the current system and that there is an urgent need to resolve these matters.

(d) To ensure that health care service plans and providers do not engage in patterns of unacceptable practices, the Department of Managed Health Care should be authorized to assist in the development of a new and more efficient system of claims submission, processing, and payment. (Health & Saf. Code §1371.39, Note; Stats 2000, ch. 825 § 6, Section 1 (SB 1177) [emphasis, supplied].)

The Legislature thus contemplated payment *and* billing procedures, and found their current state wanting. (Health & Saf. Code, §§ 1371.37, 1371.39; Note; Stats 2000 c. 825 § 6, Section 1 (c); SB 1177.) Petitioners' contention that the legislation only sought to proscribe plan payment practices is, thus, incorrect. Further, if the legislation only sought to curtail plans' unfair payment practices, of what use was the Legislature's specifically defined unfair billing patterns (unbundling and upcoding of claims)? (Health & Saf. Code, § 1371.39(b)(1).) Petitioners' contentions thus also render the Legislature's two specified unfair billing patterns meaningless surplusage.

The legislative intent makes clear that the Legislature focused on two things: 1) the effective provision of health care services as the penultimate goal; and 2) that the myriad of billing and payment practices used in California were negatively affecting health care services. If one examines sections 1371.37-1371.39 in this context, the statutes are compatible. The Legislature saw an indivisible problem: payment and billing practices, the combination of which was adversely affecting health care services. It is thus perfectly reasonable that the Legislature acted as it did in first defining and prohibiting unfair payment patterns and then defining unfair billing patterns to include up-coding, unbundling, and other unjust billing practices as defined by the Department. The Legislature defined the two unfair billing practices it identified in subdivision (b)(1), but left it to the Department to define others in the future:: The Legislature is not obligated to eradicate all evils of the same genus or none at all. (*Warden v. State Bar of Cal.* (1999) 21 Cal.4th 628, 649; *State Board of Dry Cleaners v. Thrift-D-Lux Cleaners, Inc.* (1953) 40 Cal.2d 436, 458 [citing, *Hampton & Co. v. United States* (1928) 276 U.S. 394, 407-408 [Legislature cannot and need not anticipate every situation that might arise and supply a rule for each situation].).) It is not this court's question to second guess the wisdom of the Legislature's delegation. (*e.g., Moore v. Bd. of Accountancy, supra,* 2 Cal.4th 999, 1014; *Western States Petroleum v. Sup. Court, supra,* 9 Cal.4th 559, 572-573.)

Though omitted by Petitioners, the Department addressed the problem in an identical manner, first targeting plans' payment practices, and now addressing unfair billing patterns. Prior to adopting Rule 1300.31.79, the Department promulgated regulations addressing plans' claims payment practices. (Cal. Code Regs., tit. 28, §§ 1300.71, 1300.71.38.) The present Regulation now addresses unfair billing patterns by providers just as the Legislature did in enacting sections 1371.37 and 1371.39.

Petitioners wrongly contend that the Legislature only conferred upon the Department the authority to develop a definition of unfair billing patterns and report that definition to the Legislature for its action. Petitioners' construction is unavailing for several reasons. First, the Legislature delegated to the Department three *separate* obligations and authority: i) to define unfair billing patterns pursuant to subdivision (b)(1); ii) Department shall convene appropriate state agencies to make recommendations pursuant to subdivision (b)(2); and iii) the Department report to the Legislature and the Governor information regarding the development of the definition of "unfair billing pattern" pursuant to subdivision (c).

Second, the Legislature delegated to the Department the authority to define other demonstrable and unjustified billing patterns. (Health & Saf. Code, § 1371.39(b)(1).) The ability of an agency to define terms, definitions, or rules of general application is solely limited to a regulation promulgated in accordance with the APA and published by the Secretary of State. (*Tidewater Marine Western Inc. v. Bradshaw, supra.* 14 Cal.4th 557, 568-569.) Moreover, an informal definition, one not promulgated through the APA, is void and unenforceable. (Ibid.) Thus, the Legislature must have been aware of its own laws (the APA) when it directed the Department to define other demonstrable and unjustified billing patterns and intended the Department to define unfair billing patterns lawfully through the APA process. (*Viking Pools, Inc. v. Maloney,* (1989) 48 Cal.3d 602, 609 [Legislature presumed aware of its laws].) The Legislature would hardly direct an agency to take an unlawful act.[19]

Third, under Petitioners' argument, subdivision (c) takes away what subdivision (b)(1) grants. In other words, subdivision (b)(1) grants the Department the authority to define other demonstrable and unjust billing patterns. Yet Petitioners contend the statute then takes away that authority in subdivision (c) and relegates the Department to a paper delivery service, shuttling definitions to the Legislature for statutory adoption. A construction which finds that the same statute takes away what it also grants yields unfavored, absurd results. (See, e.g., *Simmons v. Ghaderi* (2008) 44 Cal.4th 570, 583; 2A Sutherland, Statutory Construction (4th ed. 1984) § 45.12.)[20]

Notably, if all the Department was authorized to do was to report on definitions to the Legislature, then subdivision (c) would have been the only language necessary to effectuate that intent. Under Petitioners' view, therefore, the definitional delegation in subdivision (b)(1) is meaningless surplusage. Courts are to avoid an interpretation that makes any portion of a statute meaningless surplusage. (e.g., *People v. Hovarter* (2008) 44 Cal.4th 983, 1025; *Navellier v. Sletten* (2002) 29 Cal.4th 82, 95.) It is far more probable that the Legislature merely intended to monitor the Department's rulemaking in enacting subdivision (c).

6. The Regulation is Not Unconstitutionally Vague.

While the exclusion against vagueness can extend to administrative regulations, the standard of constitutional vagueness is less strict than when a criminal law is challenged. (*Teichert Construction v. California Occupational Safety and Health Appeals Board* (3d Dist. 2006) 140 Cal.App.4th 883, 890 [*citing, Cranston v. City of Richmond* (1985) 40 Cal.3d 755, 763; and *Ford Dealers Assn. V. DMV, supra,* 32 Cal.3d 347, 366.].) Administrative regulations are not unconstitutionally vague, even if portions of them must be refined and developed on a case-by-case basis. (*Wallace Berrie & Co. v. State Bd. of Equalization* (1985) 40 Cal.3d 60, 65; *Ford Dealers Ass'n v. DMV, supra,* 32 Cal.3d 347, 365-369.)

In this facial challenge it is Petitioners' responsibility to demonstrate that the provisions of a regulation "present a total and fatal conflict with applicable constitutional prohibitions." (*Action Apartment Association v. City of Santa Monica* (2008) 166 CaI.App.4th 456, 468 [quoting *Tobe v. City of Santa Ana* (1995) 9 Cal.4th 1069].)

The phrase "sums owed by the plan" is abundantly clear and has specific meaning. Section 1367(i) sets forth the requirement that a plan pay for all basic healthcare services. Section 1345(b) then defines those basic healthcare services to include emergency services. (Health & Saf. Code, § 1345(b)(6).) Services for which the enrollee has prepaid with his/her premiums, i.e., all basic healthcare services, are sums owed by the plan. (Health & Saf. Code, §§ 1367(i), 1375.1) Further, the Act is replete with mandated services and, hence, further sums owed by the plan.[21] In that health plans are prepaid, each mandate is a sum owed by the plan. In fact, the Act is even clearer in specifying that co-pays, deductibles, and coinsurance are not sums owed by the plan. (Health & Saf. Code, § 1367(i).) Far from vague, the Regulation even restated the statutory clarification that co-pays, deductible, and coinsurance are not sums owed by the plan. (Cal. Code Regs., tit. 28, § 1300.71.39(b)(2).)

The Regulation is further not vague in what balance billing concerns. Petitioners posit that if a plan has paid what the plan contends is reasonable and customary value, then the balance owing is not a sum owed by the plan. Petitioners are correct in a limited context, but their argument fails. Petitioners are only entitled to the reasonable and customary amount, no more. (*Bell v. Blue Cross, supra,* 131 Cal.App.4th 211, 220; Cal. Code Regs. tit. 28, § 1300.71(a)(3)(B).)[22] Thus, while Rule 1300.71.39 would not apply where the plan has paid the reasonable and customary amount, the provider still may not collect the balance of an unreasonable and uncustomary bill. (*Ibid.*) Petitioners cannot articulate any statutory or common law claim which would support recovering an unreasonable or uncustomary amount. Therefore, Petitioners' contention lacks merit & should be rejected.

Petitioners cannot create vagueness from what is in actuality an alleged breach of an implied contract. Balance billing by definition occurs after the plan has made its reasonable and customary payment. Balance billing providers do not claim that that the balance owing is unreasonable yet collectable, they instead contend the balance is a reasonable and customary charge which the plan should have paid. Providers are thus contending that the plan breached its duty to pay reasonable and customary value, but that the enrollee should nevertheless pay for the plan's obligation. This argument necessarily completes its circular

trajectory back to the simple proposition that the provider billed the enrollee for a reasonable and customary amount *owed by the plan*. Thus, Petitioners cannot escape the Regulation's clarity. Billing an enrollee for emergency sums owed by the plan is balance billing and, consequently, an unfair billing pattern.

Petitioners incorrectly contend the Regulation is invalid because providers cannot determine which patients have an HMO, PPO, or ERISA plan, an argument which fails for one glaring factual miscalculation. Balance billing by definition occurs only *after* the provider has billed the enrollee's plan and received some payment. Thus, the provider has already received both an Explanation of Benefits and a payment from the plan. The provider thus has ample notice and clarity of whether his or her patient is a health plan enrollee, whether the service was for a sum owed by the plan,[23] and the effect of those two antecedent questions.

Petitioners contend they have no way of knowing what the amount owed by the plan is. However, Petitioners omit that every emergency provider has a direct claim for breach of implied contract and unfair business practices against the plan in the event the plan has not paid the reasonable and customary amount required by law. (*Bell v. Blue Cross, supra,* 131 Cal.App.4th 211, 220.) The Legislature's enactment of section 1371.4(b) made clear that the plan's duty to reimburse an emergency provider runs straight to the provider and not through the enrollee. (Health & Saf. Code, § 1371.4(b).) Indeed the Bell Court noted that the chief purpose in giving providers a direct claim against the plan was to take the enrollee out of the middle. (*Bell, supra,* at pp. 218-219.) Petitioners' argument thus lays bare the nexus of balance billing - some providers' preference to use the enrollee as cheap leverage to extract higher payments from either plan or enrollee.[24]

This is an important point. The Department strongly supported the rights of providers [to direct reimbursement] in *Bel1*.[25] The Department continues to support the wisdom of Bell, to take the enrollee out of the middle of any billing dispute between plan and provider. Petitioners are exactly correct that the Regulation does not address what is the reasonable and customary value of the service. But this is makeweight. The Regulation does not address the subject because it has already been addressed both by the courts e.g. in *Bell v. Blue Cross and Cal. Physician Serv v. Aoki, supra,* and by regulation. (See, Cal. Code Regs., tit. 28, § 1300.71 [defining reimbursement of a claim].) Additionally, the Department provides both a Provider Complaint Unit and an Independent Dispute Resolution Process for fast, efficient resolution of billing disputes, and has required by regulation, all plans to provide fast, fair dispute resolution systems for providers. (See, Health & Saf. Code, § 1371.38; Cal. Code Regs., tit. 28, § 1300.71.38.) Hence, other regulatory and case law addresses the issues raised by Petitioners and, consequently, the Regulation did not.

V. CONCLUSION

Ultimately, this case presents the question of whether a trade group(s) dissatisfied with an agency's regulatory conclusions and choices may obtain relief through the judiciary? The Answer is clearly No. The courts have emphatically held that this court's inquiry is into the legality of a regulation and not its wisdom, which is soundly entrusted to the expertise of the agency. The Department properly promulgated Rule 1300.71.39 through the Administrative Procedures Act's process and a certified copy was duly served on the Secretary of State after approval by the Office of Administrative Law. Petitioners have offered no evidence to overcome the presumption of validity afforded by the Government Code. The Regulation defines a particularly pernicious and consumer-hostile billing practice as an unfair billing pattern pursuant to an express Legislative delegation to the Department that it may define such patterns. The Department also delegated broad and general rulemaking authority to define terms.

Finally, the Regulation is reasonable and necessary. The Act protects enrollees who have purchased a prepaid health plan; all emergency services have already been pre-purchased through premiums. The Legislature intended the enrollee suffer no further risk for services including emergency services and expressed its intent to shift the risk to the provider. The Regulation is manifestly consistent with this intent and the very nature of a prepaid health plan. Permitting balance billing vitiates the concept of a health plan which the Legislature legitimized in the Act. No other alternative would give effect to this intent. Consequently, the Regulation is necessary, appropriate, and should be upheld.

Dated: November 7, 2008

Footnotes

1 All section references are to the Health and Safety Code, unless otherwise indicated.

2 While many of the health plans in California are affiliated with well-known national brands that sell a myriad of health insurance products across the country, the Department regulates only those products which fall within the definition of managed care, thus defining the reach of the regulation and thereby the boundaries of this inquiry. For example, the Department regulates the managed care products offered in California under the Anthem Blue Cross or Kaiser Permanente brands, but those brands also offer other products in California that lie outside of the Department's jurisdiction.

3 These organizations may either be integrated medical groups (i.e., groups of physicians who provide medical services solely through the group) or independent practice associations. The term independent practice association (IPA) refers to physicians who otherwise practice individually, or in small groups, to combine for purposes of managed care contracting. (See, e.g., Health & Saf. Code, § 1373(h)(6); *Cal. Med. Ass'n, Inc. v. Aetna, supra,* 94 Cal.App.4th 151, 157.)

4 The provider clearly has the right to dispute the plan's payment directly with the plan under both an implied contract cause of action and as an unfair business practice. (*Bell v. Blue Cross, supra,* 131 Cal.App.4th 211, 220; *California Physicians' Service v. Aoki Diabetes Res. Institute* (2008) 163 Cal.App.4th 1506, 1507.)

5 A provider is any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services. (Health & Saf. Code, § 1345(i).)

6 Section 1371.39(b)(1), reads, "Unfair billing pattern" means engaging in a demonstrable and unjust pattern of unbundling of claims, up-coding of claims, or other demonstrable and unjustified billing patterns, "as defined by the department."

7 Hereinafter, California Code of Regulations, title 28, section 1300.71.39 will be described as "Rule 1300.71.39" or "the Regulation."

8 Petitioners' opening Brief omits or ignores the applicable standards of review and instead asks this court to address the issue without respect to the deference owed to the Department, nor of the presumptions afforded by statute and the Supreme Court's precedents. Such an argument is wholly unsupported.

9 Section 1342 states in pertinent part:

It is the intent and purpose of the Legislature to promote the delivery and the quality of health and medical care to the people of the State of California who enroll in, or subscribe for the services rendered by, a health care service plan or specialized health care service plan by accomplishing all of the following:

(a) Ensuring the continued role of the professional as the determiner of the patient's health needs which fosters the traditional relationship of trust and confidence between the patient and the professional.

(g) Ensuring that subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing continuity of care.

10 Several of California's sister states also prohibit the practice including Connecticut, Pennsylvania, Alabama, and the federal courts with respect to the Medicaid system. (See, Gianetti v. Blue Cross 2008 U.S. Dist. LEXIS 36749; Nickel v. Workers' Comp. Appeal Bd. (Agway Agronomy), 2008 Pa. Commw. LEXIS 515; Roberts v. Univ. of Ala. Hosp., 2008 Ala. Civ. App. LEXIS 216 (April 18, 2008 Sup. Ct Alabama); Gianetti v. Siglinger, 2004 Conn. Super. LEXIS 1086.)

11 Except in rare cases of physical compulsion, duress renders a contract voidable and subject to rescission. (Civ. Code, §§ 1566, 1567; 1 Witkin, Summary of Cal. Law (10th ed. 2005) Contracts, § 310, p. 336.)

12 The courts have universally concurred with the Gumbiner court. (See, *Viola v. Dept. Managed Health Care, supra,* 133 Cal.App.4th 299, 307; *California Medical Assn. v. Aetna U.S. Healthcare of California, Inc., supra,* 94 Cal.App.4th 151, 155; fn. 3.)

13 Again, the Department notes that there may be a balance even where the pan meets its obligation to pay the customary and reasonable amount. A balance is not indicative of a payment l than the reasonable and customary amount.

14 The Medical Practice Act demonstrates no real regulation of physician billing with two exceptions: 1) Business and Professions Code section 125.9 provides for fines for fraudulent billing; and 2) Business and Professions Code section 732 which requires a physician to refund a patient's direct payment if an insurer or third-party payer subsequently pays the bill. Neither law may be characterized as governing physician billing in a way that should merit a finding of complete preemption.

15 The Act defines person broadly and without limitation. Its expansive definition would include a hospital and hospital-based physician. (Health & Saf. Code, § 1345(j) ["Person" means any person, individual, firm, association, organization, partnership, business trust, foundation, labor organization, corporation, limited liability company, public agency, or political subdivision of the state.)

16 Even assuming arguendo some preemption existed over hospitals and physicians, the Legislature clearly abrogated such exclusive authority in section 1371.39 by authorizing the Department to define unfair billing patterns by providers and to publicize the Department's actions taken against providers.

17 See also, *State Compensation Ins. Fund v. Workers' Comp. Appeals Bd.* (1979), 88 Cal.App.3d 43, 62-63. ["We agree with the view that "'[as] evidences of legislative intent [unpassed bills] have little value."'].)

18 By analogy, a contract provision will not be construed as conditions precedent in the absence of language plainly requiring such construction. *Berry v. Kettle* (1967) 256 Cal App.2d 252,

19 The law never requires impossibilities." (Civ. Code, § 3531) Moreover, "[i]t is primarily the prerogative of the Legislature to declare what is against public policy," (*Tunstall v. Wells* (2006) 144 Cal.App.4th 554, 564), and the Court will always attempt to avoid interpretation any statute "that would lead to absurd consequences." (*Wilcox v. Birthwhistle* (1999) 21 Cal.4th 973, 977.)

20 No section of a statute will be read to cancel out another, unless expressly noted by the Legislative body. (*Metropolitan Life Insurance Co. v. Supreme Court* (1985) 471 U.S. 724, 740 ["While congress occasionally decides to return to the States what it has previously taken away, it does not normally do both at the same time"].) In regards to contracts, "each word and clause is to be given effect wherever possible unless clearly contrary to the nature of the contract or the parties' intent." (Civ. Code, § 1653; *Link v. National Association of Stock Car Racing* (1984) 158 Cal.App.3d 138, 143 citing Jarrett v. Allstate Ins. Co. (1962) 209 Cal.App.2d 804, 809.)

21 (See e.g., Health & Saf. Code, §§ 1367(i) [basic healthcare services], 1367.06 [pediatric asthma drugs], 1367.2 [alcoholism], 1367.36 [immunization], 1367.45 [AIDS vaccine], 1367.54 [alpha feto protein], 1367.6 [breast cancer screening], 1367.635 [mastectomies], 1367.71 [anesthesia for dental services], 1371.4(b) [emergency services].)

22 Cal. Code Regs., tit. 28, § 1300.71(a)(3)(B) states in pertinent part that the reimbursement amount for a non-network provider is:

"...the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration: (1) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case... "

23 Emergency services will always be sums owed by the plan, whether rendered in-network or out of network. (Health & Saf. Code, §§ 1367(i), 1345(b)(6), 1371.4(b).)

24 The Department of course recognizes that not all providers balance bill, and remains strongly supportive of the rights of those providers to seek reimbursement directly from plans.

25 Both the Department and Petitioner California Medical Association were amicus curiae parties in support of the provider-Petitioners.

End of Document

EXHIBIT H

Edmund G. Brown Jr., Governor
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Department of Managed Health Care
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Sacramento, CA 95814-2725
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DATE: March 11, 2015

ACTION: Notice of Decision on Petition for Rulemaking Action

SUBJECT: Petition by the California Association of Physician Groups requesting amendment or repeal of subdivision (a)(3)(B) of Title 28, section 1300.71.

PETITIONER

The California Association of Physician Groups' (CAPG or Petitioner) petition for rulemaking action (Petition) was received by the Department of Managed Health Care (Department) on August 12, 2014. On September 3, 2014, CAPG provided the Department with an extension of time until March 11, 2015, to respond to the Petition. Pursuant to the requirements of Government Code section 11340.7, the Department issues this Decision on the CAPG Petition.

CONTACT PERSON

Inquiries concerning this decision may be directed to Emilie Alvarez, Regulations Coordinator, Department of Managed Health Care, Office of Legal Services, by mail at: 980 9th Street, Suite 500, Sacramento, CA 95814, by telephone at: (916) 322-6727, or by e-mail at: ealvarez@dmhc.ca.gov or regulations@dmhc.ca.gov.

AVAILABILITY OF PETITION

The Petition for rulemaking action is available upon request directed to the Department's Contact Person listed above.

AUTHORITY

Under authority established in the Knox-Keene Health Care Service Plan Act of 1975 (the Act)[1], including but not limited to Health and Safety Code sections 1343, 1344 and 1346, the Department may adopt, amend and rescind regulations as necessary to carry out the provisions of the Act.

[1] Health and Safety Code section 1340 *et seq*. and California Code of Regulations, title 28.

SUMMARY OF THE PETITION

The action requested by the Petitioner specifically concerns the considerations relevant to the reasonable and customary value of services performed by non-contracted providers, which are detailed in title 28, section 1300.71, subdivision (a)(3)(B), and are known as the "*Gould* factors."[2] The Petitioner requests that the Department amend or repeal section 1300.71, subdivision (a)(3)(B) for the following reasons:

1. Recent court decisions demonstrating that the "reasonable value" of health care services is the only legal issue to be resolved between payors and non-contracted providers; and,
2. The regulation violates the consistency standard under the Administrative Procedure Act (APA) based on recent court decisions.

The Petition requests two alternative rulemaking actions:

1. Repeal subdivision (a)(3)(B) of section 1300.71; or,
2. Amend subdivision (a)(3)(B) of section 1300.71 to include the following two new factors:
    a. The average contract rates for the service of payors and providers in the general geographic area in which the service was provided; and,
    b. The average amount for the service paid to and accepted by non-contracted providers in the general geographic area in which the service was provided, including payments made by both commercial and government payors (e.g., Medicare and Medi-Cal Programs.

In justification of its request, the Petition states that adding the above-stated factors to the six *Gould* factors currently in the regulation "will make the Regulation consistent with prevailing law, and will provide appropriate guidance to payors, providers, and dispute resolvers in this area."

The Petition also cites recent legal developments as a reason for amending the current version of the regulation:

> "[A]s a result of legal developments since the Regulation was adopted, its importance in California's delegated model has grown significantly, while its intrinsic limitations have become more manifest. Since the Regulation was adopted, the courts decided the *Bell*, *Prospect* and *Children's Hospital Central California*[3] cases and the Workers Compensation Appeals Board has had the opportunity to apply the *Gould* case itself.
>
> . . .

[2] *Gould v. Workers' Compensation Appeals Board, City of Los Angeles* (*Gould*) (1992) 4 Cal.App.4th 1059, 1071.
[3] *Bell* v. *Blue Cross of California* (2005), 131 Cal.App.4th 211, hereafter "*Bell*"; *Prospect Medical Group* v. *Northridge Emergency Medical Group* (2009), 45 Cal.4th 497, hereafter "Prospect"; and *Children's Hospital of Central California* v. *Anthem Blue Cross* (2014), 226 Cal.App.4th 1260, hereafter "*Children's Hospital*".

> Unfortunately, the plain meaning of the language employed in *Gould* does not clearly signal the way the factors are to be employed in a non-fee schedule environment. As the application in the *Kunz*[4] case shows, and as the court explicitly held in *Children's Hospital*, the factors, although facially limited to charges, should include customary payment data when the services at issue have no applicable fee schedule amount. Because the regulation itself does not indicate its context, the *Gould* language should be revised so that it will be applied in a manner consistent with common law *quantum meruit* principles, i.e., include within its scope factors relating to prevailing payments as well as billed charges."

Finally, the Petition states that the regulation fails to meet the consistency requirement under the APA. The Petition states:

> "The APA requires that regulations adopted by state agencies must be consistent with law. See Gov. Code § 11349.1. 'Consistency' means being 'in harmony with, and not in conflict with or contradictory to existing statutes, court decisions, or other provisions of law.' Gov. Code § 11349(d). For the reasons set forth above, the Regulation conflicts with existing court decisions governing the measure of quantum meruit claims. Accordingly, the Regulation violates the consistency standard for regulations under the APA and should be amended to conform to applicable law."

DEPARTMENT DETERMINATION

Section 1300.71,[5] subdivision (a)(3)(B), which defines "reimbursement of claim,"[6] was adopted by the Department pursuant to the APA and approved by the Office of Administrative Law (OAL) on July 24, 2003.

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[4] *Kunz* v. *Patterson Floor Coverings, Inc*., et al., 67 Cal.Comp.Cas. 1588 (en banc 2002).
[5] California Code of Regulations (CCR), title 28, section 1300.71, detailing claims settlement practices and rules between payors and contracted and non-contracted providers.
[6] See 28 CCR, section 1300.71(a)(3), which reads in part:

(3) Reimbursement of a Claim means:
(A) For contracted providers with a written contract, including in-network point-of-service (POS) and preferred provider organizations (PPO): the agreed upon contract rate;
(B) For contracted providers without a written contract and non-contracted providers, except those providing services described in paragraph (C) below: the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration:
(i) the provider's training, qualifications, and length of time in practice;
(ii) the nature of the services provided;
(iii) the fees usually charged by the provider;
(iv) prevailing provider rates charged in the general geographic area in which the services were rendered;
(v) other aspects of the economics of the medical provider's practice that are relevant; and
(vi) any unusual circumstances in the case; and
(C) For non-emergency services provided by non-contracted providers to PPO and POS enrollees: the amount set forth in the enrollee's Evidence of Coverage.

The "legal developments" cited by the Petitioner do not require the Department to initiate rulemaking to amend or repeal subdivision (a)(3)(B). The holdings in *Bell* (2005) and *Prospect* (2009) do not address the validity of factors used in determining reasonable payments for non-contracted providers, the subject matter of subdivision (a)(3)(B). The *Children's Hospital* case held that in determining *quantum meruit* cases the courts should consider a wide variety of evidence, including evidence of "agreements to pay and accept a particular price."[7]

However, the *Children's Hospital* decision does not in and of itself invalidate the Department's current regulation or require that the regulation be amended. To the contrary, the Department's current regulation contains a non-exhaustive list of factors that should be "take[n] into consideration." This is not an exclusive list. If applicable, other factors, such as those considered under the common law theory of *quantum meruit*, may be appropriately applied when determining the reasonable and customary rate. The *Children's Hospital* court clearly acknowledges this when it states that "while the *Gould* court set forth a comprehensive set of factors, for the situation presented there, those factors are not exclusive or necessarily appropriate in all cases."[8] The *Children's Hospital* court decision even notes that the Department acknowledged this fact in response to public comments during the rulemaking process for Section 1300.71: "[t]he [Department] . . . noted that 'the regulations are intended to set forth *the minimum* payment criteria to ensure compliance with the Act's claims payment and dispute resolution standards' (italics added), and that, to the extent providers wish to pursue other common law or statutory remedies, they may seek redress in the courts."[9]

For the reasons stated above, the Department declines to initiate rulemaking to amend or repeal section 1300.71, subdivision (a)(3)(B) based on legal developments since the regulation was promulgated.

The Department further declines to amend or repeal section 1300.71, subdivision (a)(3)(B) on the grounds that does not meet the consistency standard under the APA. As shown, the regulation is consistent with current law. The OAL conducted a review of the regulation and made a determination concerning the consistency of section 1300.71 with existing statutes, court decisions and other provisions of law when it reviewed the rulemaking file and issued and approval in 2003. As discussed above, the existing regulation is not inconsistent with current law, including recent case law.

CONCLUSION

For the reasons set forth above, the Department has determined that it will not initiate a rulemaking action to amend or repeal section 1300.71(a)(3)(B).

The Petitioner should note that the Department is currently in the process of obtaining information from its stakeholders regarding reasonable and customary values of payment for

[7] *Children's Hospital* at p. 1274.
[8] *Id.*
[9] *Id.* at p. 1273.

services received by providers. The request for information was sent out on February 13, 2015, and responses are due by March 16, 2015.

The Department appreciates the Petitioner's interest in the Department's rulemaking process.

EXHIBIT I

SUMMARY INDIVIDUAL DISCLOSURE REPORT(SIDR)

Facility No.: 106500852
RPE Date: 12/31/2016

01/01/2016 thru 12/31/2016
(Using Data AUDITED by OSHPD on 12/14/2017)

Print Date: 12/9/2019
Days in Report: 366

DOCTORS MEDICAL CENTER - MODESTO
1441 FLORIDA AVENUE

MODESTO, CA 95350

Phone: (209) 578-1211
Owner: TENET HEALTHCARE CORPORATION
County: Stanislaus

Related to Other Facilities:
Parent Organization:

Type of Care: General
Type of Control: Investor - Corp

HSA: 06 - North San Joaquin
HFPA: 0511

LICENSED BEDS*	
Intensive	89
Acute	372
Long-Term	
Other	
Total	461
Occupancy Rate	76.39%
* Excluding beds in suspense	

AVAILABLE BEDS	
Intensive	89
Acute	372
Long-Term	
Other	
Total	461
Occupancy Rate	76.4%
No. Bassinets	24

EMERGENCY SERVICES	
Emergency Room	X
Trauma Center Designation	2
Observation	X
Orthopedic	X
Psychiatric	X
Helicopter	X

FINANCIAL AND UTILIZATION DATA BY PAYER	TOTAL	MEDICARE TRADITIONAL	MEDICARE MANAGED CARE	MEDI-CAL TRADITIONAL
Patient (Census) Days	128,886	34,843	13,047	27,105
Hospital Discharges (Excluding Nursery)	25,752	5,706	3,023	4,399
Average Length of Stay (Incl. L-T Care)	5.0	6.1	4.3	6.2
Average Length of Stay (Excl. L-T Care)	5.0	6.1	4.3	6.2
Outpatient Visits (Incl. ER Visits)	156,761	30,283	10,406	11,436
Outpatient Emergency Services Visits	91,025	7,305	4,866	9,644
Gross Inpatient Revenue	$3,414,462,853	$923,852,624	$429,867,168	$480,753,255
Gross Outpatient Revenue	$1,374,560,896	$237,102,046	$185,789,164	$86,001,724
Deductions from Revenue	$4,179,059,679	$1,054,516,799	$573,636,771	$456,083,579
Net Inpatient Revenue	$451,899,403	$86,773,069	$35,779,352	$93,877,668
Net Outpatient Revenue	$182,209,835	$19,664,802	$15,463,883	$16,793,732
Net Inpatient Revenue per Day	$3,506	$2,490	$2,742	$3,463
Net Inpatient Revenue per Discharge	$17,548	$15,207	$11,836	$21,341
Net Outpatient Revenue per Visit	$1,162	$649	$1,486	$1,468
Adjusted Patient Days	180,772			
Net Revenue per Adj Patient Day	$3,508			
Purchased Inpatient Days				

FINANCIAL AND UTILIZATION DATA BY PAYER	MEDI-CAL MANAGED CARE	COUNTY INDIGENT TRADITIONAL	COUNTY INDIGENT MANAGED CARE	THIRD PARTY TRADITIONAL
Patient (Census) Days	34,946	24	37	2,954
Hospital Discharges (Excluding Nursery)	8,398	5	7	478
Average Length of Stay (Incl. L-T Care)	4.2	4.8	5.3	6.2
Average Length of Stay (Excl. L-T Care)	4.2	4.8	5.3	6.2
Outpatient Visits (Incl. ER Visits)	68,444		57	3,430
Outpatient Emergency Services Visits	52,821		52	1,303
Gross Inpatient Revenue	$1,000,674,928	$144,916	$2,222,729	$56,210,613
Gross Outpatient Revenue	$528,711,656		$380,499	$24,812,386
Deductions from Revenue	$1,387,745,473	$108,281	$2,335,115	$74,050,876
Net Inpatient Revenue	$92,675,528	$36,635	$228,924	$3,855,878
Net Outpatient Revenue	$48,965,583		$39,189	$3,116,245
Net Inpatient Revenue per Day	$2,652	$1,526	$6,187	$1,305
Net Inpatient Revenue per Discharge	$11,035	$7,327	$32,703	$8,067
Net Outpatient Revenue per Visit	$715		$688	$909
Adjusted Patient Days				
Net Revenue per Adj Patient Day				
Purchased Inpatient Days				

FINANCIAL AND UTILIZATION DATA BY PAYER	THIRD PARTY MANAGED CARE	OTHER INDIGENT	OTHER PAYERS
Patient (Census) Days	14,784	470	676
Hospital Discharges (Excluding Nursery)	3,456	115	165
Average Length of Stay (Incl. L-T Care)	4.3	4.1	4.1
Average Length of Stay (Excl. L-T Care)	4.3	4.1	4.1
Outpatient Visits (Incl. ER Visits)	26,886	746	5,073
Outpatient Emergency Services Visits	9,663	663	4,708
Gross Inpatient Revenue	$481,305,658	$20,504,560	$18,926,402
Gross Outpatient Revenue	$271,092,169	$6,697,805	$33,973,447
Deductions from Revenue	$550,826,010	$27,202,365	$52,554,410
Net Inpatient Revenue	$138,489,841		$182,508
Net Outpatient Revenue	$78,003,470		$162,931
Net Inpatient Revenue per Day	$9,368		$270
Net Inpatient Revenue per Discharge	$40,072		$1,106
Net Outpatient Revenue per Visit	$2,901		$32
Adjusted Patient Days			
Net Revenue per Adj Patient Day			
Purchased Inpatient Days			

LIVE BIRTH SUMMARY	
Natural Births	2,587
Cesarean Sections	1,241
Total Live Births	3,828

GROSS PATIENT REVENUE BY REVENUE CENTER	TOTAL	PERCENT OF TOTAL
Daily Hospital Services	$1,144,853,909	23.9%
Ambulatory Services	$344,278,594	7.2%
Ancillary Services	$3,299,891,246	68.9%
Total Gross Patient Revenue	$4,789,023,749	100.0%

SUMMARY STATEMENT OF INCOME	
Gross Patient Revenue	$4,789,023,749
Provision for Bad Debt	$23,463,073
Medicare Trad. Contractual Adj	$1,054,516,799
Medicare Managed Contractual Adj	$573,636,771
Medi-Cal Trad. Contractual Adj	$429,746,349
Medi-Cal Managed Contractual Adj	$1,337,992,949
Disproportionate Share Funds Recd	($12,794,118)
Co. Indigent Trad. Contractual Adj	$108,281
Co. Indigent Managed Contractual Adj	$2,335,115
Third Party Trad. Contractual Adj	$74,050,876
Third Party Managed Contractual Adj	$550,826,010
Charity-Other	$116,086,237
All Other Deductions	$29,091,337
Total Deductions from Revenue	$4,179,059,679
Capitation Premium Revenue	$24,145,168
Net Patient Revenue	$634,109,238
Other Operating Revenue	$3,178,451
Total Operating Expenses	$566,673,555
Net from Operations	$70,614,134
Non-Operating Revenue (+)	$557,438
Non-Operating Expenses (-)	$373,619
Provision for Income Taxes (-)	
Extraordinary Items (-)	
Net Income	$70,797,953

OPERATING EXPENSES BY CLASSIFICATION	
Salaries and Wages	$191,600,719
Employee Benefits	$76,625,668
Physician's Professional Fees	$35,060,342
Other Professional Fees	$18,666,852
Supplies	$80,890,655
Purchased Services	$87,426,741
Depreciation	$11,010,263
Leases and Rentals	$3,724,526
Interest	$197,133
All Other Expenses	$61,470,656
Total Operating Expenses	$566,673,555

ADJUSTED PATIENT REVENUE	
Adjusted Inpatient Revenue	$431,390,411
Revenue Per Day	$3,347
Revenue Per Discharge	$16,752
Adjusted Outpatient Revenue	$168,231,368
Revenue Per Visit	$1,073

OPERATING EXPENSES BY COST CENTER GROUP	
Daily Hospital Services	$130,931,483
Ambulatory Services	$30,908,559
Ancillary Services	$170,847,807
Purchased Inpatient Services	
Purchased Outpatient Services	
Research	
Education	$4,989,510
General Services	$61,739,787
Fiscal Services	$34,585,684
Administrative Services	$122,833,313
Unassigned Costs	$9,837,412
Total Operating Expenses	$566,673,555

ADJUSTED PATIENT EXPENSES	
Adjusted Inpatient Expense	$398,859,076
Expenses Per Day	$3,095
Expenses Per Discharge	$15,488
Adjusted Outpatient Expenses	$125,413,742
Expenses Per Visit	$800

BALANCE SHEET SUMMARY	
Total Current Assets	$249,514,148
Limited Use Assets	
Net Property, Plant, and Equipment	$68,904,805
Construction-in-Progress	$2,438,735
Other Assets	$118,851,387
Intangible Assets	$10,927,715
Total Assets	$450,636,790

BALANCE SHEET SUMMARY	
Total Current Liabilities	$86,703,646
Deferred Income	$241,639
Net Long-Term Debt	$2,830,673
Total Liabilities	$89,775,958
Equity	$360,860,832
Total Liabilities and Equity	$450,636,790

FINANCIAL RATIO FORMULAS

Liquidity Ratios	Ratio	Formulas
Current Ratio	2.88	(Total Current Assets + Board Designated Cash + Board Designated Investments) / Total Current Liabilities
Acid Test Ratio	0.01	(Cash + Marketable Securities + Board Designated Cash + Board Designated Investments) / Total Current Liabilities
Days in Accounts Receivable	61.89	Net Accounts Receivable / (Net Patient Revenue / Days in Report Period)
Bad Debt Rate	0.49%	(Provision for Bad Debts / Total Gross Patient Revenue) x 100
Debt, Risk, and Leverage Ratios		
Long-Term Debt to Assets Rate	0.63%	(Net Long-Term Debt / Total Assets) x 100
Debt Service Coverage Ratio	415.99	(Net Income + Interest-Working Capital + Interest-Other + Depreciation Expense) / (Principal Payments on Short-Term and Long-Term Debt, Notes, and Loans + Interest-Working Capital + Interest-Other)
Interest Expense as a Percentage of Operating Expense	0.03%	((Interest-Working Capital + Interest-Other) / Total Operating Expense) x 100
Profitability Ratios		
Net Return on Operating Assets	22.24%	((Net from Operations + Interest-Working Capital + Interest Other) / (Total Current Assets + Net Property, Plant, and Equipment)) x 100
Net Return on Equity	19.62%	(Net Income / Equity) x 100
Operating Margin	11.08%	(Net from Operations / Total Operating Revenue) x 100
Turnover on Operating Assets	2.00	Total Operating Revenue / (Total Current Assets + Net Property, Plant, and Equipment)
Fixed Asset Ratios		
Fixed Asset Growth Rate	16.67%	((Current Year Gross Property, Plant, and Equipment + Construction-in-Progress) - (Prior Year Gross Property, Plant, and Equipment + Construction-in-Progress)) / (Prior Year Net Property, Plant, and Equipment + Construction-in-Progress) x 100
Average Age of Plant	16.88	Accumulated Depreciation / Depreciation Expense
Net PPE Assets Per Bed	154,758	(Net Property, Plant, and Equipment + Construction-in-Progress) / Licensed Beds (End of Period)
Other Ratio		
Cost-to-Charge Ratio	11.77%	((Total Operating Expenses - Other Operating Revenue) / Gross Patient Revenue) x 100

SUMMARY OF FINANCIAL AND UTILIZATION DATA FOR SELECTED COST CENTERS	UNITS OF SERVICE	GROSS REV PER UNIT	ADJ REV PER UNIT	ADJ DIRECT EXP PER UNIT	ADJ TOTAL EXP PER UNIT	PROFIT/LOSS PER UNIT
REVENUE-PRODUCING COST CENTERS						
Daily Hospital Services (Unit of Service)						
Medical/Surgical Intensive Care (Patient Days)	6,483	$15,536.24	$894.02	$1,993.96	$3,098.84	($2,204.81)
Coronary Care (Patient Days)	3,906	$14,560.04	$1,927.88	$1,811.45	$2,792.14	($864.27)
Burn Care (Patient Days)						
Definitive Observation (Patient Days)	12,018	$11,741.18	$1,554.64	$946.22	$1,589.40	($34.76)
Medical/Surgical Acute (Patient Days)	60,657	$7,301.37	$966.77	$779.96	$1,414.07	($447.30)
Pediatric Acute (Patient Days)	3,068	$5,682.20	$686.76	$1,069.26	$1,722.69	($1,035.93)
Psychiatric Acute - Adult (Patient Days)	20,737	$5,516.67	$578.71	$575.01	$1,113.59	($534.88)
Obstetrics Acute (Patient Days)	11,398	$6,500.71	$860.75	$771.51	$1,271.92	($411.17)
Alternate Birthing Center (Patient Days)						
Chemical Dependency Services (Patient Days)						
Skilled Nursing Care (Patient Days)						
Total Daily Hospital Services (Patient Days - Excl. Newborn)	128,886	$8,705.85	$1,068.25	$920.16	$1,579.62	($511.37)
Nursery Acute (Newborn Days)	7,610	$2,995.01	$396.57	$190.14	$302.98	$93.59
Ambulatory Services (Unit of Service)						
Emergency Services (Visits)	106,220	$3,116.02	$296.73	$161.25	$274.60	$22.12
Clinics (Visits)	266	$300.57	($242.16)	$518.01	$2,331.27	($2,573.43)
Observation Care (Observation Hours)	64,384	$205.25	$27.18	$19.59	$28.32	($1.14)
Home Health Care Services (Home Health Care Visits)						

SUMMARY OF FINANCIAL AND UTILIZATION DATA FOR SELECTED COST CENTERS	UNITS OF SERVICE	GROSS REV PER UNIT	ADJ REV PER UNIT	ADJ DIRECT EXP PER UNIT	ADJ TOTAL EXP PER UNIT	PROFIT/LOSS PER UNIT
REVENUE-PRODUCING COST CENTERS						
Ancillary Services (Unit of Service)						
Labor and Delivery Services (Deliveries)	3,754	$15,262.11	$1,825.85	$2,298.23	$3,598.47	($1,772.62)
Surgery and Recovery Services (Operating Mins)	1,323,990	$339.96	$44.41	$26.18	$42.97	$1.43
Medical Supplies Sold to Patients (CS&S Adjusted Inpatient Days)	218,210	$1,163.85	$154.10	$169.00	$260.75	($106.65)
Clinical Laboratory Services (Tests)	1,323,187	$519.53	$68.79	$7.37	$18.30	$50.49
Cardiac Catheterization Services (Procedures)	5,148	$29,395.37	$3,892.21	$1,127.60	$2,195.34	$1,696.86
Radiology - Diagnostic (Procedures)	74,236	$1,692.48	$219.91	$54.55	$107.24	$112.67
Magnetic Resonance Imaging (Procedures)	3,424	$9,153.06	$1,211.95	$156.79	$364.46	$847.48
Computed Tomographic Scanner (Procedures)	28,492	$12,090.43	$1,600.88	$59.49	$271.98	$1,328.90
Drugs Sold to Patients (Pharmacy Adj. Inpatient Days)	153,611	$4,496.78	$595.41	$118.78	$287.11	$308.31
Respiratory Therapy (Respiratory Therapy Adj. Inpatient Days)	137,032	$799.74	$105.89	$39.83	$66.54	$39.36
Lithotripsy Services (Procedures)	203	$25,656.56	$3,397.16	$1,380.01	$2,174.06	$1,223.10
Physical Therapy (Sessions)	86,887	$426.08	$56.42	$26.36	$41.04	$15.38

NON-REVENUE PRODUCING COST CENTERS	UNITS OF SERVICE	ADJ DIRECT EXP PER UNIT
Cost Center (Unit of Service)		
Dietary (Patient Meals)	368,071	$7.28
Laundry and Linen (Dry & Clean lbs Processed)	2,351,239	$0.71
Social Work Services (Personal Contacts)	79,455	$19.74
Housekeeping (Square Feet Serviced)	561,262	$8.75
Plant Operations (Gross Square Feet)	561,262	$6.23
Plant Maintenance (Gross Square Feet)	561,262	$14.74
Patient Accounting ($ 1,000 of Gross Patient Rev.)	4,789,024	$3.29
Admitting (Admissions)	25,753	$178.63
Hospital Administration (Hospital FTE Employees)	2,007	$47,157.46
Medical Records (Adj. Inpatient Days)	180,772	$34.92
Nursing Administration (Nursing Service FTE Personnal)	940	$3,845.56
Utilization Management (Admissions)	25,753	$332.78
Community Health Education (Participants)	1,277	$303.16
Insurance - Malpractice ($ 1,000 of Gross Patient Rev.)	4,789,024	$0.90
Interest Other (Gross Square Feet)	561,262	$0.35

PERCENTAGE OF HOURS AND AVERAGE HOURLY RATE BY EMPLOYEE CLASSIFICATION	MANAGEMENT AND SUPERVISION	TECHNICAL AND SPECIALIST	REGISTERED NURSES	LICENSED VOCATIONAL NURSES	AIDES AND ORDERLIES
Cost Center Group					
Daily Hospital Services	6.58%	5.86%	66.21%	0.93%	8.24%
Ambulatory Services (Unit of Service)	4.88%	19.48%	58.78%	0.76%	0.24%
Ancillary Services	5.89%	36.59%	27.79%	0.35%	19.99%
Total Patient Care Services	6.16%	19.26%	50.26%	0.68%	12.26%
Research					
Education		100.00%			
General Services	10.52%	45.76%			
Fiscal Services	13.37%	2.29%			
Administrative Services	16.10%	6.74%			
Total Operating Cost Centers	7.75%	19.54%	39.33%	0.53%	9.60%
Non-Operating Cost Centers					
Average Hourly Rate	$65.81	$37.63	$61.70	$36.63	$19.61

	ENVIRONMENTAL AND FOOD SERVICE	CLERICAL AND OTHER EMPLOYEES	REGISTRY AND TEMP HELP	TOTAL PRODUCTIVE HOURS	TOTAL PAID HOURS
Cost Center Group					
Daily Hospital Services		4.57%	7.61%	1,475,672	1,792,940
Ambulatory Services (Unit of Service)		12.11%	3.76%	238,622	276,726
Ancillary Services		6.68%	2.69%	1,138,200	1,347,389
Total Patient Care Services		6.04%	5.33%	2,852,494	3,417,055
Research					
Education				240	328
General Services	11.42%	29.59%	2.71%	297,198	343,840
Fiscal Services		84.34%		154,966	183,442
Administrative Services	0.04%	75.62%	1.50%	339,666	394,818
Total Operating Cost Centers	0.93%	17.78%	4.53%	3,644,564	4,339,483
Non-Operating Cost Centers					
Average Hourly Rate	$30.96	$32.72	$102.58		

HOSPITAL PERSONNEL PROFILE	
Total Number of Productive Hospital FTE's*	1,673
No. of Nursing Registry & Temp Help FTE's	79
Total Number of Nursing FTE's**	940
Number of Nursing Registry FTE's	73

* Excludes Registry Nurses & Temp Help
** Includes Nursing Registry

EXHIBIT J

SUMMARY INDIVIDUAL DISCLOSURE REPORT(SIDR)

Facility No.: 106500852
RPE Date: 12/31/2017

01/01/2017 thru 12/31/2017
(Using Data AUDITED by OSHPD on 9/26/2018)

Print Date: 12/9/2019
Days in Report: 365

DOCTORS MEDICAL CENTER - MODESTO
1441 FLORIDA AVENUE

MODESTO, CA 95350

Phone: (209) 578-1211
Owner: TENET HEALTHCARE CORPORATION
County: Stanislaus

Related to Other Facilities:
Parent Organization:

Type of Care: General
Type of Control: Investor - Corp

HSA: 06 - North San Joaquin
HFPA: 0511

LICENSED BEDS*	
Intensive	89
Acute	372
Long-Term	
Other	
Total	461
Occupancy Rate	77.62%
* Excluding beds in suspense	

AVAILABLE BEDS	
Intensive	89
Acute	372
Long-Term	
Other	
Total	461
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No. Bassinets	24

EMERGENCY SERVICES	
Emergency Room	X
Trauma Center Designation	2
Observation	X
Orthopedic	X
Psychiatric	X
Helicopter	X

FINANCIAL AND UTILIZATION DATA BY PAYER	TOTAL	MEDICARE TRADITIONAL	MEDICARE MANAGED CARE	MEDI-CAL TRADITIONAL
Patient (Census) Days	130,605	35,150	12,291	27,658
Hospital Discharges (Excluding Nursery)	26,367	6,161	2,887	4,091
Average Length of Stay (Incl. L-T Care)	5.0	5.7	4.3	6.8
Average Length of Stay (Excl. L-T Care)	5.0	5.7	4.3	6.8
Outpatient Visits (Incl. ER Visits)	160,330	30,162	12,007	12,888
Outpatient Emergency Services Visits	92,842	7,479	5,441	9,181
Gross Inpatient Revenue	$3,734,482,240	$1,039,459,938	$440,061,796	$536,919,073
Gross Outpatient Revenue	$1,500,141,277	$249,185,684	$219,853,707	$92,161,747
Deductions from Revenue	$4,626,009,752	$1,169,185,378	$622,370,379	$581,038,713
Net Inpatient Revenue	$442,969,019	$99,263,414	$31,882,923	$41,003,831
Net Outpatient Revenue	$189,853,099	$20,196,830	$15,928,624	$7,038,276
Net Inpatient Revenue per Day	$3,392	$2,824	$2,594	$1,483
Net Inpatient Revenue per Discharge	$16,800	$16,112	$11,044	$10,023
Net Outpatient Revenue per Visit	$1,184	$670	$1,327	$546
Adjusted Patient Days	183,069			
Net Revenue per Adj Patient Day	$3,457			
Purchased Inpatient Days				

FINANCIAL AND UTILIZATION DATA BY PAYER	MEDI-CAL MANAGED CARE	COUNTY INDIGENT TRADITIONAL	COUNTY INDIGENT MANAGED CARE	THIRD PARTY TRADITIONAL
Patient (Census) Days	36,068		94	3,100
Hospital Discharges (Excluding Nursery)	8,865		11	525
Average Length of Stay (Incl. L-T Care)	4.1		8.5	5.9
Average Length of Stay (Excl. L-T Care)	4.1		8.5	5.9
Outpatient Visits (Incl. ER Visits)	69,437		12	3,188
Outpatient Emergency Services Visits	53,971		10	1,698
Gross Inpatient Revenue	$1,091,698,642		$3,660,862	$66,438,804
Gross Outpatient Revenue	$581,835,240		$82,742	$33,207,944
Deductions from Revenue	$1,487,483,709		$3,400,662	$86,621,299
Net Inpatient Revenue	$121,366,363		$335,362	$8,743,764
Net Outpatient Revenue	$64,683,810		$7,580	$4,281,685
Net Inpatient Revenue per Day	$3,365		$3,568	$2,821
Net Inpatient Revenue per Discharge	$13,691		$30,487	$16,655
Net Outpatient Revenue per Visit	$932		$632	$1,343
Adjusted Patient Days				
Net Revenue per Adj Patient Day				
Purchased Inpatient Days				

FINANCIAL AND UTILIZATION DATA BY PAYER	THIRD PARTY MANAGED CARE	OTHER INDIGENT	OTHER PAYERS
Patient (Census) Days	14,867	286	1,091
Hospital Discharges (Excluding Nursery)	3,507	79	241
Average Length of Stay (Incl. L-T Care)	4.2	3.6	4.5
Average Length of Stay (Excl. L-T Care)	4.2	3.6	4.5
Outpatient Visits (Incl. ER Visits)	27,079	486	5,071
Outpatient Emergency Services Visits	9,983	461	4,618
Gross Inpatient Revenue	$509,389,600	$12,073,171	$34,780,354
Gross Outpatient Revenue	$281,135,013	$4,636,577	$38,042,623
Deductions from Revenue	$586,819,614	$16,709,748	$72,380,250
Net Inpatient Revenue	$140,244,947		$128,415
Net Outpatient Revenue	$77,401,982		$314,312
Net Inpatient Revenue per Day	$9,433		$118
Net Inpatient Revenue per Discharge	$39,990		$533
Net Outpatient Revenue per Visit	$2,858		$62
Adjusted Patient Days			
Net Revenue per Adj Patient Day			
Purchased Inpatient Days			

LIVE BIRTH SUMMARY	
Natural Births	2,593
Cesarean Sections	1,245
Total Live Births	3,838

GROSS PATIENT REVENUE BY REVENUE CENTER	TOTAL	PERCENT OF TOTAL
Daily Hospital Services	$1,223,197,452	23.4%
Ambulatory Services	$420,414,347	8.0%
Ancillary Services	$3,591,011,718	68.6%
Total Gross Patient Revenue	$5,234,623,517	100.0%

SUMMARY STATEMENT OF INCOME	
Gross Patient Revenue	$5,234,623,517
Provision for Bad Debt	$31,811,165
Medicare Trad. Contractual Adj	$1,169,185,378
Medicare Managed Contractual Adj	$622,370,379
Medi-Cal Trad. Contractual Adj	$543,971,656
Medi-Cal Managed Contractual Adj	$1,429,665,169
Disproportionate Share Funds Recd	($7,240,934)
Co. Indigent Trad. Contractual Adj	
Co. Indigent Managed Contractual Adj	$3,400,662
Third Party Trad. Contractual Adj	$86,621,299
Third Party Managed Contractual Adj	$586,819,614
Charity-Other	$118,836,279
All Other Deductions	$40,569,085
Total Deductions from Revenue	$4,626,009,752
Capitation Premium Revenue	$24,208,353
Net Patient Revenue	$632,822,118
Other Operating Revenue	$3,078,732
Total Operating Expenses	$551,968,459
Net from Operations	$83,932,391
Non-Operating Revenue (+)	$565,168
Non-Operating Expenses (-)	$327,328
Provision for Income Taxes (-)	
Extraordinary Items (-)	
Net Income	$84,170,231

OPERATING EXPENSES BY CLASSIFICATION	
Salaries and Wages	$198,840,839
Employee Benefits	$80,547,706
Physician's Professional Fees	$40,839,548
Other Professional Fees	$14,807,049
Supplies	$85,913,657
Purchased Services	$90,587,123
Depreciation	$12,301,912
Leases and Rentals	$3,417,675
Interest	$242,807
All Other Expenses	$24,470,143
Total Operating Expenses	$551,968,459

ADJUSTED PATIENT REVENUE	
Adjusted Inpatient Revenue	$427,000,753
Revenue Per Day	$3,269
Revenue Per Discharge	$16,195
Adjusted Outpatient Revenue	$165,871,960
Revenue Per Visit	$1,035

OPERATING EXPENSES BY COST CENTER GROUP	
Daily Hospital Services	$133,811,224
Ambulatory Services	$31,943,430
Ancillary Services	$173,287,651
Purchased Inpatient Services	
Purchased Outpatient Services	
Research	
Education	$5,552,698
General Services	$68,043,164
Fiscal Services	$35,528,859
Administrative Services	$93,099,795
Unassigned Costs	$10,701,638
Total Operating Expenses	$551,968,459

ADJUSTED PATIENT EXPENSES	
Adjusted Inpatient Expense	$389,892,012
Expenses Per Day	$2,985
Expenses Per Discharge	$14,787
Adjusted Outpatient Expenses	$114,240,513
Expenses Per Visit	$713

BALANCE SHEET SUMMARY	
Total Current Assets	$323,083,558
Limited Use Assets	
Net Property, Plant, and Equipment	$74,080,724
Construction-in-Progress	$2,006,291
Other Assets	$148,813,371
Intangible Assets	$11,824,485
Total Assets	$559,808,429

BALANCE SHEET SUMMARY	
Total Current Liabilities	$124,622,124
Deferred Income	$249,868
Net Long-Term Debt	$3,850,724
Total Liabilities	$128,722,716
Equity	$431,085,713
Total Liabilities and Equity	$559,808,429

FINANCIAL RATIO FORMULAS

Liquidity Ratios	Ratio	Formulas
Current Ratio	2.59	(Total Current Assets + Board Designated Cash + Board Designated Investments) / Total Current Liabilities
Acid Test Ratio	0.00	(Cash + Marketable Securities + Board Designated Cash + Board Designated Investments) / Total Current Liabilities
Days in Accounts Receivable	67.46	Net Accounts Receivable / (Net Patient Revenue / Days in Report Period)
Bad Debt Rate	0.61%	(Provision for Bad Debts / Total Gross Patient Revenue) x 100
Debt, Risk, and Leverage Ratios		
Long-Term Debt to Assets Rate	0.69%	(Net Long-Term Debt / Total Assets) x 100
Debt Service Coverage Ratio	398.32	(Net Income + Interest-Working Capital + Interest-Other + Depreciation Expense) / (Principal Payments on Short-Term and Long-Term Debt, Notes, and Loans + Interest-Working Capital + Interest-Other)
Interest Expense as a Percentage of Operating Expense	0.04%	((Interest-Working Capital + Interest-Other) / Total Operating Expense) x 100
Profitability Ratios		
Net Return on Operating Assets	21.19%	((Net from Operations + Interest-Working Capital + Interest Other) / (Total Current Assets + Net Property, Plant, and Equipment)) x 100
Net Return on Equity	19.53%	(Net Income / Equity) x 100
Operating Margin	13.20%	(Net from Operations / Total Operating Revenue) x 100
Turnover on Operating Assets	1.60	Total Operating Revenue / (Total Current Assets + Net Property, Plant, and Equipment)
Fixed Asset Ratios		
Fixed Asset Growth Rate	12.62%	((Current Year Gross Property, Plant, and Equipment + Construction-in-Progress) - (Prior Year Gross Property, Plant, and Equipment + Construction-in-Progress)) / (Prior Year Net Property, Plant, and Equipment + Construction-in-Progress) x 100
Average Age of Plant	15.45	Accumulated Depreciation / Depreciation Expense
Net PPE Assets Per Bed	165,048	(Net Property, Plant, and Equipment + Construction-in-Progress) / Licensed Beds (End of Period)
Other Ratio		
Cost-to-Charge Ratio	10.49%	((Total Operating Expenses - Other Operating Revenue) / Gross Patient Revenue) x 100

SUMMARY OF FINANCIAL AND UTILIZATION DATA FOR SELECTED COST CENTERS	UNITS OF SERVICE	GROSS REV PER UNIT	ADJ REV PER UNIT	ADJ DIRECT EXP PER UNIT	ADJ TOTAL EXP PER UNIT	PROFIT/LOSS PER UNIT
REVENUE-PRODUCING COST CENTERS						
Daily Hospital Services (Unit of Service)						
Medical/Surgical Intensive Care (Patient Days)	6,596	$16,579.85	$599.36	$1,974.00	$2,881.02	($2,281.66)
Coronary Care (Patient Days)	3,908	$15,980.09	$1,931.86	$1,899.53	$2,720.55	($788.69)
Burn Care (Patient Days)						
Definitive Observation (Patient Days)	13,766	$11,526.04	$1,393.40	$926.25	$1,431.06	($37.66)
Medical/Surgical Acute (Patient Days)	60,330	$7,705.77	$931.56	$779.65	$1,343.34	($411.77)
Pediatric Acute (Patient Days)	3,569	$6,001.38	$669.27	$1,102.10	$1,648.71	($979.44)
Psychiatric Acute - Adult (Patient Days)	20,768	$5,799.16	$571.11	$583.82	$1,081.97	($510.86)
Obstetrics Acute (Patient Days)	10,959	$6,823.62	$824.92	$760.75	$1,190.26	($365.34)
Alternate Birthing Center (Patient Days)						
Chemical Dependency Services (Patient Days)						
Skilled Nursing Care (Patient Days)						
Total Daily Hospital Services (Patient Days - Excl. Newborn)	130,605	$9,188.81	$1,017.69	$919.78	$1,491.49	($473.80)
Nursery Acute (Newborn Days)	7,246	$3,187.02	$385.28	$209.19	$330.99	$54.30
Ambulatory Services (Unit of Service)						
Emergency Services (Visits)	108,970	$3,715.83	$333.97	$162.98	$265.88	$68.09
Clinics (Visits)	200	$386.28	($328.30)	$714.15	$3,150.36	($3,478.66)
Observation Care (Observation Hours)	73,355	$210.25	$25.42	$19.19	$25.95	($0.53)
Home Health Care Services (Home Health Care Visits)						

SUMMARY OF FINANCIAL AND UTILIZATION DATA FOR SELECTED COST CENTERS	UNITS OF SERVICE	GROSS REV PER UNIT	ADJ REV PER UNIT	ADJ DIRECT EXP PER UNIT	ADJ TOTAL EXP PER UNIT	PROFIT/LOSS PER UNIT
REVENUE-PRODUCING COST CENTERS						
Ancillary Services (Unit of Service)						
Labor and Delivery Services (Deliveries)	3,838	$14,691.53	$1,585.88	$2,423.15	$3,519.94	($1,934.06)
Surgery and Recovery Services (Operating Mins)	1,401,810	$346.62	$41.33	$24.50	$38.34	$2.99
Medical Supplies Sold to Patients (CS&S Adjusted Inpatient Days)	211,527	$1,338.77	$161.85	$196.64	$279.02	($117.18)
Clinical Laboratory Services (Tests)	1,369,932	$555.16	$67.11	$7.70	$17.71	$49.40
Cardiac Catheterization Services (Procedures)	5,388	$31,405.82	$3,796.70	$1,033.78	$1,956.81	$1,839.89
Radiology - Diagnostic (Procedures)	74,569	$1,777.98	$203.71	$54.16	$99.00	$104.71
Magnetic Resonance Imaging (Procedures)	3,941	$9,040.34	$1,092.90	$243.77	$436.59	$656.31
Computed Tomographic Scanner (Procedures)	30,647	$12,726.60	$1,538.54	$70.83	$267.29	$1,271.25
Drugs Sold to Patients (Pharmacy Adj. Inpatient Days)	153,023	$4,762.50	$575.75	$90.41	$273.70	$302.04
Respiratory Therapy (Respiratory Therapy Adj. Inpatient Days)	137,657	$894.86	$108.18	$39.33	$62.44	$45.74
Lithotripsy Services (Procedures)	152	$25,653.70	$3,101.32	$1,482.59	$2,137.82	$963.50
Physical Therapy (Sessions)	88,426	$418.62	$50.61	$26.76	$38.54	$12.07

NON-REVENUE PRODUCING COST CENTERS	UNITS OF SERVICE	ADJ DIRECT EXP PER UNIT
Cost Center (Unit of Service)		
Dietary (Patient Meals)	358,121	$6.97
Laundry and Linen (Dry & Clean lbs Processed)	2,556,602	$0.61
Social Work Services (Personal Contacts)	80,482	$20.52
Housekeeping (Square Feet Serviced)	574,342	$8.75
Plant Operations (Gross Square Feet)	605,435	$6.13
Plant Maintenance (Gross Square Feet)	574,342	$16.37
Patient Accounting ($ 1,000 of Gross Patient Rev.)	5,234,624	$3.27
Admitting (Admissions)	26,416	$175.97
Hospital Administration (Hospital FTE Employees)	2,088	$30,506.37
Medical Records (Adj. Inpatient Days)	183,069	$32.73
Nursing Administration (Nursing Service FTE Personnal)	977	$4,821.72
Utilization Management (Admissions)	26,416	$331.92
Community Health Education (Participants)	3,175	$135.29
Insurance - Malpractice ($ 1,000 of Gross Patient Rev.)	5,234,624	$0.82
Interest Other (Gross Square Feet)	587,215	$0.41

PERCENTAGE OF HOURS AND AVERAGE HOURLY RATE BY EMPLOYEE CLASSIFICATION	MANAGEMENT AND SUPERVISION	TECHNICAL AND SPECIALIST	REGISTERED NURSES	LICENSED VOCATIONAL NURSES	AIDES AND ORDERLIES
Cost Center Group					
Daily Hospital Services	6.21%	4.91%	69.47%	0.60%	8.70%
Ambulatory Services (Unit of Service)	5.10%	19.26%	58.94%	0.67%	0.43%
Ancillary Services	6.26%	35.26%	27.72%	0.29%	18.39%
Total Patient Care Services	6.13%	17.54%	52.89%	0.49%	11.62%
Research					
Education		100.00%			
General Services	8.48%	49.69%			
Fiscal Services	12.13%	3.20%			
Administrative Services	17.84%	4.72%			
Total Operating Cost Centers	7.69%	18.40%	41.30%	0.38%	9.08%
Non-Operating Cost Centers					
Average Hourly Rate	$67.38	$38.51	$59.75	$38.78	$21.10

	ENVIRONMENTAL AND FOOD SERVICE	CLERICAL AND OTHER EMPLOYEES	REGISTRY AND TEMP HELP	TOTAL PRODUCTIVE HOURS	TOTAL PAID HOURS
Cost Center Group					
Daily Hospital Services		4.42%	5.69%	1,576,837	1,909,909
Ambulatory Services (Unit of Service)		13.25%	2.35%	253,739	296,311
Ancillary Services		9.26%	2.82%	1,099,842	1,315,276
Total Patient Care Services		7.00%	4.33%	2,930,418	3,521,496
Research					
Education				2,397	2,629
General Services	11.82%	29.89%	0.12%	306,000	352,160
Fiscal Services		84.67%		150,862	178,999
Administrative Services		75.78%	1.67%	362,591	421,572
Total Operating Cost Centers	0.96%	18.63%	3.55%	3,752,268	4,476,856
Non-Operating Cost Centers					
Average Hourly Rate	$31.08	$32.76	$98.51		

HOSPITAL PERSONNEL PROFILE	
Total Number of Productive Hospital FTE's*	1,740
No. of Nursing Registry & Temp Help FTE's	64
Total Number of Nursing FTE's**	977
Number of Nursing Registry FTE's	61

* Excludes Registry Nurses & Temp Help
** Includes Nursing Registry

EXHIBIT K

SUMMARY INDIVIDUAL DISCLOSURE REPORT(SIDR)

Facility No.: 106392287
RPE Date: 12/31/2016

01/01/2016 thru 12/31/2016
(Using Data AUDITED by OSHPD on 3/19/2018)

Print Date: 12/9/2019
Days in Report: 366

DOCTORS HOSPITAL OF MANTECA
1205 EAST NORTH STREET
MANTECA, CA 95336

Phone: (209) 823-3111
Owner: TENET HEALTHCARE CORP
County: San Joaquin

Related to Other Facilities:
Parent Organization:

Type of Care: General
Type of Control: Investor - Corp

HSA: 06 - North San Joaquin
HFPA: 0507

LICENSED BEDS*	
Intensive	8
Acute	65
Long-Term	
Other	
Total	73
Occupancy Rate	54.46%
* Excluding beds in suspense	

AVAILABLE BEDS	
Intensive	8
Acute	65
Long-Term	
Other	
Total	73
Occupancy Rate	54.5%
No. Bassinets	5

EMERGENCY SERVICES	
Emergency Room	X
Trauma Center Designation	
Observation	X
Orthopedic	X
Psychiatric	X
Helicopter	X

FINANCIAL AND UTILIZATION DATA BY PAYER	TOTAL	MEDICARE TRADITIONAL	MEDICARE MANAGED CARE	MEDI-CAL TRADITIONAL
Patient (Census) Days	14,550	6,552	2,137	739
Hospital Discharges (Excluding Nursery)	3,851	1,376	470	224
Average Length of Stay (Incl. L-T Care)	3.8	4.8	4.5	3.3
Average Length of Stay (Excl. L-T Care)	3.8	4.8	4.5	3.3
Outpatient Visits (Incl. ER Visits)	69,283	14,737	5,182	2,226
Outpatient Emergency Services Visits	29,698	3,367	1,206	1,795
Gross Inpatient Revenue	$383,022,764	$156,804,745	$53,449,919	$18,897,917
Gross Outpatient Revenue	$459,044,057	$105,837,342	$45,571,872	$12,941,583
Deductions from Revenue	$735,581,099	$240,648,942	$90,693,571	$27,897,312
Net Inpatient Revenue	$44,003,122	$13,846,806	$4,495,401	$2,339,834
Net Outpatient Revenue	$62,482,600	$8,146,339	$3,832,819	$1,602,354
Net Inpatient Revenue per Day	$3,024	$2,113	$2,104	$3,166
Net Inpatient Revenue per Discharge	$11,426	$10,063	$9,565	$10,446
Net Outpatient Revenue per Visit	$902	$553	$740	$720
Adjusted Patient Days	31,988			
Net Revenue per Adj Patient Day	$3,329			
Purchased Inpatient Days				

FINANCIAL AND UTILIZATION DATA BY PAYER	MEDI-CAL MANAGED CARE	COUNTY INDIGENT TRADITIONAL	COUNTY INDIGENT MANAGED CARE	THIRD PARTY TRADITIONAL
Patient (Census) Days	2,809			139
Hospital Discharges (Excluding Nursery)	978			45
Average Length of Stay (Incl. L-T Care)	2.9			3.1
Average Length of Stay (Excl. L-T Care)	2.9			3.1
Outpatient Visits (Incl. ER Visits)	23,088			1,790
Outpatient Emergency Services Visits	15,576			846
Gross Inpatient Revenue	$86,513,078			$3,677,348
Gross Outpatient Revenue	$135,443,896			$8,974,025
Deductions from Revenue	$205,129,280			$10,188,874
Net Inpatient Revenue	$6,558,999			$824,415
Net Outpatient Revenue	$10,268,695			$1,638,084
Net Inpatient Revenue per Day	$2,335			$5,931
Net Inpatient Revenue per Discharge	$6,707			$18,320
Net Outpatient Revenue per Visit	$445			$915
Adjusted Patient Days				
Net Revenue per Adj Patient Day				
Purchased Inpatient Days				

FINANCIAL AND UTILIZATION DATA BY PAYER	THIRD PARTY MANAGED CARE	OTHER INDIGENT	OTHER PAYERS
Patient (Census) Days	2,024		150
Hospital Discharges (Excluding Nursery)	724		34
Average Length of Stay (Incl. L-T Care)	2.8		4.4
Average Length of Stay (Excl. L-T Care)	2.8		4.4
Outpatient Visits (Incl. ER Visits)	19,872	16	2,372
Outpatient Emergency Services Visits	4,995	9	1,904
Gross Inpatient Revenue	$59,212,285		$4,467,472
Gross Outpatient Revenue	$137,754,544	$115,573	$12,405,222
Deductions from Revenue	$144,764,542	$115,573	$16,143,005
Net Inpatient Revenue	$15,693,082		$244,584
Net Outpatient Revenue	$36,509,205		$485,105
Net Inpatient Revenue per Day	$7,753		$1,631
Net Inpatient Revenue per Discharge	$21,676		$7,194
Net Outpatient Revenue per Visit	$1,837		$205
Adjusted Patient Days			
Net Revenue per Adj Patient Day			
Purchased Inpatient Days			

LIVE BIRTH SUMMARY	
Natural Births	431
Cesarean Sections	221
Total Live Births	652

GROSS PATIENT REVENUE BY REVENUE CENTER	TOTAL	PERCENT OF TOTAL
Daily Hospital Services	$88,867,664	10.6%
Ambulatory Services	$94,927,697	11.3%
Ancillary Services	$658,271,460	78.2%
Total Gross Patient Revenue	$842,066,821	100.0%

SUMMARY STATEMENT OF INCOME	
Gross Patient Revenue	$842,066,821
Provision for Bad Debt	$5,788,256
Medicare Trad. Contractual Adj	$240,648,942
Medicare Managed Contractual Adj	$90,693,571
Medi-Cal Trad. Contractual Adj	$27,692,118
Medi-Cal Managed Contractual Adj	$205,129,280
Disproportionate Share Funds Recd	
Co. Indigent Trad. Contractual Adj	
Co. Indigent Managed Contractual Adj	
Third Party Trad. Contractual Adj	$10,007,915
Third Party Managed Contractual Adj	$141,947,218
Charity-Other	$320,767
All Other Deductions	$13,353,032
Total Deductions from Revenue	$735,581,099
Capitation Premium Revenue	
Net Patient Revenue	$106,485,722
Other Operating Revenue	$199,158
Total Operating Expenses	$99,504,722
Net from Operations	$7,180,158
Non-Operating Revenue (+)	$302,843
Non-Operating Expenses (-)	$162,831
Provision for Income Taxes (-)	
Extraordinary Items (-)	
Net Income	$7,320,170

OPERATING EXPENSES BY CLASSIFICATION	
Salaries and Wages	$33,338,971
Employee Benefits	$11,476,185
Physician's Professional Fees	$2,865,934
Other Professional Fees	$5,036,250
Supplies	$14,815,139
Purchased Services	$14,695,854
Depreciation	$6,302,716
Leases and Rentals	$912,676
Interest	$45,666
All Other Expenses	$10,015,331
Total Operating Expenses	$99,504,722

ADJUSTED PATIENT REVENUE	
Adjusted Inpatient Revenue	$47,895,750
Revenue Per Day	$3,292
Revenue Per Discharge	$12,437
Adjusted Outpatient Revenue	$55,763,134
Revenue Per Visit	$805

OPERATING EXPENSES BY COST CENTER GROUP	
Daily Hospital Services	$12,564,934
Ambulatory Services	$7,426,651
Ancillary Services	$35,104,202
Purchased Inpatient Services	
Purchased Outpatient Services	
Research	
Education	
General Services	$13,755,937
Fiscal Services	$7,142,064
Administrative Services	$22,026,552
Unassigned Costs	$1,484,382
Total Operating Expenses	$99,504,722

ADJUSTED PATIENT EXPENSES	
Adjusted Inpatient Expense	$51,449,271
Expenses Per Day	$3,536
Expenses Per Discharge	$13,360
Adjusted Outpatient Expenses	$44,876,583
Expenses Per Visit	$648

BALANCE SHEET SUMMARY	
Total Current Assets	$36,584,445
Limited Use Assets	
Net Property, Plant, and Equipment	$28,385,660
Construction-in-Progress	$176,594
Other Assets	$42,647,502
Intangible Assets	$10,312,356
Total Assets	$118,106,557

BALANCE SHEET SUMMARY	
Total Current Liabilities	$11,728,088
Deferred Income	$691,586
Net Long-Term Debt	$589,871
Total Liabilities	$13,009,545
Equity	$105,097,012
Total Liabilities and Equity	$118,106,557

FINANCIAL RATIO FORMULAS

Liquidity Ratios	Ratio	Formulas
Current Ratio	3.12	(Total Current Assets + Board Designated Cash + Board Designated Investments) / Total Current Liabilities
Acid Test Ratio	0.00	(Cash + Marketable Securities + Board Designated Cash + Board Designated Investments) / Total Current Liabilities
Days in Accounts Receivable	61.25	Net Accounts Receivable / (Net Patient Revenue / Days in Report Period)
Bad Debt Rate	0.69%	(Provision for Bad Debts / Total Gross Patient Revenue) x 100
Debt, Risk, and Leverage Ratios		
Long-Term Debt to Assets Rate	0.50%	(Net Long-Term Debt / Total Assets) x 100
Debt Service Coverage Ratio	123.95	(Net Income + Interest-Working Capital + Interest-Other + Depreciation Expense) / (Principal Payments on Short-Term and Long-Term Debt, Notes, and Loans + Interest-Working Capital + Interest-Other)
Interest Expense as a Percentage of Operating Expense	0.05%	((Interest-Working Capital + Interest-Other) / Total Operating Expense) x 100
Profitability Ratios		
Net Return on Operating Assets	11.12%	((Net from Operations + Interest-Working Capital + Interest Other) / (Total Current Assets + Net Property, Plant, and Equipment)) x 100
Net Return on Equity	6.97%	(Net Income / Equity) x 100
Operating Margin	6.73%	(Net from Operations / Total Operating Revenue) x 100
Turnover on Operating Assets	1.64	Total Operating Revenue / (Total Current Assets + Net Property, Plant, and Equipment)
Fixed Asset Ratios		
Fixed Asset Growth Rate	14.44%	((Current Year Gross Property, Plant, and Equipment + Construction-in-Progress) - (Prior Year Gross Property, Plant, and Equipment + Construction-in-Progress)) / (Prior Year Net Property, Plant, and Equipment + Construction-in-Progress) x 100
Average Age of Plant	8.03	Accumulated Depreciation / Depreciation Expense
Net PPE Assets Per Bed	391,264	(Net Property, Plant, and Equipment + Construction-in-Progress) / Licensed Beds (End of Period)
Other Ratio		
Cost-to-Charge Ratio	11.79%	((Total Operating Expenses - Other Operating Revenue) / Gross Patient Revenue) x 100

SUMMARY OF FINANCIAL AND UTILIZATION DATA FOR SELECTED COST CENTERS	UNITS OF SERVICE	GROSS REV PER UNIT	ADJ REV PER UNIT	ADJ DIRECT EXP PER UNIT	ADJ TOTAL EXP PER UNIT	PROFIT/LOSS PER UNIT
REVENUE-PRODUCING COST CENTERS						
Daily Hospital Services (Unit of Service)						
Medical/Surgical Intensive Care (Patient Days)	1,935	$8,922.03	$1,128.26	$1,418.89	$2,342.55	($1,214.29)
Coronary Care (Patient Days)						
Burn Care (Patient Days)						
Definitive Observation (Patient Days)						
Medical/Surgical Acute (Patient Days)	11,068	$5,494.14	$694.78	$706.51	$1,321.47	($626.70)
Pediatric Acute (Patient Days)						
Psychiatric Acute - Adult (Patient Days)						
Obstetrics Acute (Patient Days)	1,547	$4,428.08	$559.96	$946.05	$1,573.41	($1,013.45)
Alternate Birthing Center (Patient Days)						
Chemical Dependency Services (Patient Days)						
Skilled Nursing Care (Patient Days)						
Total Daily Hospital Services (Patient Days - Excl. Newborn)	14,550	$5,836.67	$738.09	$826.72	$1,484.05	($745.96)
Nursery Acute (Newborn Days)	1,242	$3,175.66	$401.59	$431.71	$687.34	($285.75)
Ambulatory Services (Unit of Service)						
Emergency Services (Visits)	32,233	$2,851.70	$288.24	$141.55	$261.45	$26.79
Clinics (Visits)	637	$286.12	$36.18	$206.21	$517.00	($480.82)
Observation Care (Observation Hours)	13,910	$203.20	$25.70	$28.75	$42.37	($16.68)
Home Health Care Services (Home Health Care Visits)						

SUMMARY OF FINANCIAL AND UTILIZATION DATA FOR SELECTED COST CENTERS	UNITS OF SERVICE	GROSS REV PER UNIT	ADJ REV PER UNIT	ADJ DIRECT EXP PER UNIT	ADJ TOTAL EXP PER UNIT	PROFIT/LOSS PER UNIT
REVENUE-PRODUCING COST CENTERS						
Ancillary Services (Unit of Service)						
Labor and Delivery Services (Deliveries)	652	$18,865.04	$2,385.63	$1,066.99	$2,215.53	$170.09
Surgery and Recovery Services (Operating Mins)	348,660	$261.03	$33.01	$21.18	$37.15	($4.14)
Medical Supplies Sold to Patients (CS&S Adjusted Inpatient Days)	32,586	$2,450.29	$309.86	$229.18	$356.36	($46.51)
Clinical Laboratory Services (Tests)	284,821	$289.66	$36.63	$11.05	$20.58	$16.05
Cardiac Catheterization Services (Procedures)						
Radiology - Diagnostic (Procedures)	33,375	$1,686.70	$210.79	$106.62	$200.13	$10.65
Magnetic Resonance Imaging (Procedures)	1,528	$8,396.12	$1,061.75	$253.89	$526.03	$535.73
Computed Tomographic Scanner (Procedures)	8,671	$9,027.08	$1,141.54	$49.39	$248.10	$893.44
Drugs Sold to Patients (Pharmacy Adj. Inpatient Days)	24,289	$5,426.91	$686.28	$183.19	$456.15	$230.13
Respiratory Therapy (Respiratory Therapy Adj. Inpatient Days)	15,938	$1,509.19	$190.85	$74.80	$131.43	$59.42
Lithotripsy Services (Procedures)	26	$12,674.96	$1,602.84	$1,274.12	$1,871.12	($268.27)
Physical Therapy (Sessions)	19,857	$118.98	$15.05	$25.96	$35.46	($20.42)

NON-REVENUE PRODUCING COST CENTERS	UNITS OF SERVICE	ADJ DIRECT EXP PER UNIT
Cost Center (Unit of Service)		
Dietary (Patient Meals)	43,968	$10.97
Laundry and Linen (Dry & Clean lbs Processed)	529,790	$0.62
Social Work Services (Personal Contacts)		
Housekeeping (Square Feet Serviced)	101,366	$8.17
Plant Operations (Gross Square Feet)	122,352	$6.90
Plant Maintenance (Gross Square Feet)	122,352	$20.59
Patient Accounting ($ 1,000 of Gross Patient Rev.)	842,067	$3.26
Admitting (Admissions)	3,873	$485.32
Hospital Administration (Hospital FTE Employees)	377	$41,982.82
Medical Records (Adj. Inpatient Days)	31,988	$52.97
Nursing Administration (Nursing Service FTE Personnal)	127	$10,232.12
Utilization Management (Admissions)	3,873	$332.28
Community Health Education (Participants)		
Insurance - Malpractice ($ 1,000 of Gross Patient Rev.)	842,067	$0.84
Interest Other (Gross Square Feet)	122,352	$0.37

PERCENTAGE OF HOURS AND AVERAGE HOURLY RATE BY EMPLOYEE CLASSIFICATION	MANAGEMENT AND SUPERVISION	TECHNICAL AND SPECIALIST	REGISTERED NURSES	LICENSED VOCATIONAL NURSES	AIDES AND ORDERLIES
Cost Center Group					
Daily Hospital Services	13.02%	1.74%	61.40%		14.57%
Ambulatory Services (Unit of Service)	14.29%	11.69%	47.60%		6.61%
Ancillary Services	8.82%	52.12%	21.87%		2.79%
Total Patient Care Services	10.97%	29.44%	38.92%		7.39%
Research					
Education					
General Services	15.86%	42.53%			
Fiscal Services	16.16%	0.29%			
Administrative Services	24.60%	5.08%			
Total Operating Cost Centers	13.44%	25.09%	26.81%		5.09%
Non-Operating Cost Centers					
Average Hourly Rate	$59.87	$40.69	$56.50		$23.15

	ENVIRONMENTAL AND FOOD SERVICE	CLERICAL AND OTHER EMPLOYEES	REGISTRY AND TEMP HELP	TOTAL PRODUCTIVE HOURS	TOTAL PAID HOURS
Cost Center Group					
Daily Hospital Services			9.28%	171,924	202,517
Ambulatory Services (Unit of Service)			19.81%	61,520	70,482
Ancillary Services		10.87%	3.54%	258,031	294,302
Total Patient Care Services		5.71%	7.58%	491,475	567,301
Research					
Education					
General Services	19.29%	22.32%		71,200	82,141
Fiscal Services		83.27%	0.28%	76,283	86,036
Administrative Services		69.07%	1.25%	74,447	87,048
Total Operating Cost Centers	1.93%	22.27%	5.38%	713,405	822,526
Non-Operating Cost Centers					
Average Hourly Rate	$20.40	$27.07	$91.75		

HOSPITAL PERSONNEL PROFILE	
Total Number of Productive Hospital FTE's*	325
No. of Nursing Registry & Temp Help FTE's	18
Total Number of Nursing FTE's**	127
Number of Nursing Registry FTE's	18

* Excludes Registry Nurses & Temp Help
** Includes Nursing Registry

EXHIBIT L

SUMMARY INDIVIDUAL DISCLOSURE REPORT(SIDR)

Facility No.: 106392287
RPE Date: 12/31/2017

01/01/2017 thru 12/31/2017
(Using Data AUDITED by OSHPD on 10/11/2018)

Print Date: 12/9/2019
Days in Report: 365

DOCTORS HOSPITAL OF MANTECA
1205 EAST NORTH STREET

MANTECA, CA 95336

Phone: (209) 823-3111
Owner: TENET HEALTHCARE CORPORATION
County: San Joaquin

Related to Other Facilities:
Parent Organization:

Type of Care: General
Type of Control: Investor - Corp

HSA: 06 - North San Joaquin
HFPA: 0507

LICENSED BEDS*	
Intensive	8
Acute	65
Long-Term	
Other	
Total	73
Occupancy Rate	52.05%
* Excluding beds in suspense	

AVAILABLE BEDS	
Intensive	8
Acute	65
Long-Term	
Other	
Total	73
Occupancy Rate	52.0%
No. Bassinets	5

EMERGENCY SERVICES	
Emergency Room	X
Trauma Center Designation	
Observation	X
Orthopedic	X
Psychiatric	X
Helicopter	X

FINANCIAL AND UTILIZATION DATA BY PAYER	TOTAL	MEDICARE TRADITIONAL	MEDICARE MANAGED CARE	MEDI-CAL TRADITIONAL
Patient (Census) Days	13,868	6,303	1,711	779
Hospital Discharges (Excluding Nursery)	3,869	1,408	418	239
Average Length of Stay (Incl. L-T Care)	3.6	4.5	4.1	3.3
Average Length of Stay (Excl. L-T Care)	3.6	4.5	4.1	3.3
Outpatient Visits (Incl. ER Visits)	70,052	15,598	4,377	2,566
Outpatient Emergency Services Visits	32,284	3,747	1,298	2,106
Gross Inpatient Revenue	$388,965,869	$161,577,025	$46,738,381	$20,422,401
Gross Outpatient Revenue	$501,079,584	$117,987,271	$43,575,056	$16,791,285
Deductions from Revenue	$789,764,036	$256,044,201	$91,628,792	$36,015,078
Net Inpatient Revenue	$43,701,842	$15,326,025	$3,369,575	$657,781
Net Outpatient Revenue	$64,406,022	$8,194,070	$3,141,517	$540,827
Net Inpatient Revenue per Day	$3,151	$2,432	$1,969	$844
Net Inpatient Revenue per Discharge	$11,295	$10,885	$8,061	$2,752
Net Outpatient Revenue per Visit	$919	$525	$718	$211
Adjusted Patient Days	31,733			
Net Revenue per Adj Patient Day	$3,407			
Purchased Inpatient Days				

FINANCIAL AND UTILIZATION DATA BY PAYER	MEDI-CAL MANAGED CARE	COUNTY INDIGENT TRADITIONAL	COUNTY INDIGENT MANAGED CARE	THIRD PARTY TRADITIONAL
Patient (Census) Days	2,882			131
Hospital Discharges (Excluding Nursery)	1,054			39
Average Length of Stay (Incl. L-T Care)	2.7			3.4
Average Length of Stay (Excl. L-T Care)	2.7			3.4
Outpatient Visits (Incl. ER Visits)	24,032			1,723
Outpatient Emergency Services Visits	17,071			908
Gross Inpatient Revenue	$92,202,177			$3,784,775
Gross Outpatient Revenue	$160,476,264			$9,466,841
Deductions from Revenue	$230,317,023			$10,906,918
Net Inpatient Revenue	$8,159,665			$400,963
Net Outpatient Revenue	$14,201,753			$1,943,735
Net Inpatient Revenue per Day	$2,831			$3,061
Net Inpatient Revenue per Discharge	$7,742			$10,281
Net Outpatient Revenue per Visit	$591			$1,128
Adjusted Patient Days				
Net Revenue per Adj Patient Day				
Purchased Inpatient Days				

FINANCIAL AND UTILIZATION DATA BY PAYER	THIRD PARTY MANAGED CARE	OTHER INDIGENT	OTHER PAYERS
Patient (Census) Days	1,946	3	113
Hospital Discharges (Excluding Nursery)	663	1	47
Average Length of Stay (Incl. L-T Care)	2.9	3.0	2.4
Average Length of Stay (Excl. L-T Care)	2.9	3.0	2.4
Outpatient Visits (Incl. ER Visits)	19,427	19	2,310
Outpatient Emergency Services Visits	5,364	19	1,771
Gross Inpatient Revenue	$60,500,014	$92,168	$3,648,928
Gross Outpatient Revenue	$138,683,263	$268,824	$13,830,780
Deductions from Revenue	$147,932,716	$360,992	$16,558,316
Net Inpatient Revenue	$15,566,867		$220,966
Net Outpatient Revenue	$35,683,694		$700,426
Net Inpatient Revenue per Day	$7,999		$1,955
Net Inpatient Revenue per Discharge	$23,479		$4,701
Net Outpatient Revenue per Visit	$1,837		$303
Adjusted Patient Days			
Net Revenue per Adj Patient Day			
Purchased Inpatient Days			

LIVE BIRTH SUMMARY	
Natural Births	438
Cesarean Sections	190
Total Live Births	628

GROSS PATIENT REVENUE BY REVENUE CENTER	TOTAL	PERCENT OF TOTAL
Daily Hospital Services	$91,900,678	10.3%
Ambulatory Services	$132,521,687	14.9%
Ancillary Services	$665,623,088	74.8%
Total Gross Patient Revenue	$890,045,453	100.0%

SUMMARY STATEMENT OF INCOME	
Gross Patient Revenue	$890,045,453
Provision for Bad Debt	$5,968,650
Medicare Trad. Contractual Adj	$256,044,201
Medicare Managed Contractual Adj	$91,628,792
Medi-Cal Trad. Contractual Adj	$35,832,690
Medi-Cal Managed Contractual Adj	$230,317,023
Disproportionate Share Funds Recd	
Co. Indigent Trad. Contractual Adj	
Co. Indigent Managed Contractual Adj	
Third Party Trad. Contractual Adj	$10,700,600
Third Party Managed Contractual Adj	$144,831,579
Charity-Other	$543,380
All Other Deductions	$13,897,121
Total Deductions from Revenue	$789,764,036
Capitation Premium Revenue	$7,826,447
Net Patient Revenue	$108,107,864
Other Operating Revenue	$722,997
Total Operating Expenses	$95,857,519
Net from Operations	$12,973,342
Non-Operating Revenue (+)	$330,755
Non-Operating Expenses (-)	$141,541
Provision for Income Taxes (-)	
Extraordinary Items (-)	
Net Income	$13,162,556

OPERATING EXPENSES BY CLASSIFICATION	
Salaries and Wages	$34,372,416
Employee Benefits	$12,575,418
Physician's Professional Fees	$3,029,700
Other Professional Fees	$4,568,165
Supplies	$13,896,673
Purchased Services	$14,148,319
Depreciation	$6,715,199
Leases and Rentals	$1,259,132
Interest	$37,934
All Other Expenses	$5,254,563
Total Operating Expenses	$95,857,519

ADJUSTED PATIENT REVENUE	
Adjusted Inpatient Revenue	$46,721,090
Revenue Per Day	$3,369
Revenue Per Discharge	$12,076
Adjusted Outpatient Revenue	$58,405,699
Revenue Per Visit	$834

OPERATING EXPENSES BY COST CENTER GROUP	
Daily Hospital Services	$12,851,684
Ambulatory Services	$8,128,559
Ancillary Services	$33,518,920
Purchased Inpatient Services	
Purchased Outpatient Services	
Research	
Education	
General Services	$14,167,351
Fiscal Services	$7,034,921
Administrative Services	$17,227,354
Unassigned Costs	$2,928,730
Total Operating Expenses	$95,857,519

ADJUSTED PATIENT EXPENSES	
Adjusted Inpatient Expense	$48,042,344
Expenses Per Day	$3,464
Expenses Per Discharge	$12,417
Adjusted Outpatient Expenses	$43,050,778
Expenses Per Visit	$615

BALANCE SHEET SUMMARY	
Total Current Assets	$33,457,003
Limited Use Assets	
Net Property, Plant, and Equipment	$25,986,560
Construction-in-Progress	$409,357
Other Assets	$51,704,218
Intangible Assets	$11,413,081
Total Assets	$122,970,219

BALANCE SHEET SUMMARY	
Total Current Liabilities	$15,775,900
Deferred Income	$574,962
Net Long-Term Debt	$584,939
Total Liabilities	$16,935,801
Equity	$106,034,418
Total Liabilities and Equity	$122,970,219

FINANCIAL RATIO FORMULAS

	Ratio	Formulas
Liquidity Ratios		
Current Ratio	2.12	(Total Current Assets + Board Designated Cash + Board Designated Investments) / Total Current Liabilities
Acid Test Ratio	0.00	(Cash + Marketable Securities + Board Designated Cash + Board Designated Investments) / Total Current Liabilities
Days in Accounts Receivable	59.70	Net Accounts Receivable / (Net Patient Revenue / Days in Report Period)
Bad Debt Rate	0.67%	(Provision for Bad Debts / Total Gross Patient Revenue) x 100
Debt, Risk, and Leverage Ratios		
Long-Term Debt to Assets Rate	0.48%	(Net Long-Term Debt / Total Assets) x 100
Debt Service Coverage Ratio	525.01	(Net Income + Interest-Working Capital + Interest-Other + Depreciation Expense) / (Principal Payments on Short-Term and Long-Term Debt, Notes, and Loans + Interest-Working Capital + Interest-Other)
Interest Expense as a Percentage of Operating Expense	0.04%	((Interest-Working Capital + Interest-Other) / Total Operating Expense) x 100
Profitability Ratios		
Net Return on Operating Assets	21.89%	((Net from Operations + Interest-Working Capital + Interest Other) / (Total Current Assets + Net Property, Plant, and Equipment)) x 100
Net Return on Equity	12.41%	(Net Income / Equity) x 100
Operating Margin	11.92%	(Net from Operations / Total Operating Revenue) x 100
Turnover on Operating Assets	1.83	Total Operating Revenue / (Total Current Assets + Net Property, Plant, and Equipment)
Fixed Asset Ratios		
Fixed Asset Growth Rate	8.45%	((Current Year Gross Property, Plant, and Equipment + Construction-in-Progress) - (Prior Year Gross Property, Plant, and Equipment + Construction-in-Progress)) / (Prior Year Net Property, Plant, and Equipment + Construction-in-Progress) x 100
Average Age of Plant	8.21	Accumulated Depreciation / Depreciation Expense
Net PPE Assets Per Bed	361,588	(Net Property, Plant, and Equipment + Construction-in-Progress) / Licensed Beds (End of Period)
Other Ratio		
Cost-to-Charge Ratio	10.69%	((Total Operating Expenses - Other Operating Revenue) / Gross Patient Revenue) x 100

SUMMARY OF FINANCIAL AND UTILIZATION DATA FOR SELECTED COST CENTERS	UNITS OF SERVICE	GROSS REV PER UNIT	ADJ REV PER UNIT	ADJ DIRECT EXP PER UNIT	ADJ TOTAL EXP PER UNIT	PROFIT/LOSS PER UNIT
REVENUE-PRODUCING COST CENTERS						
Daily Hospital Services (Unit of Service)						
Medical/Surgical Intensive Care (Patient Days)	1,809	$9,692.41	$1,177.27	$1,534.73	$2,371.67	($1,194.40)
Coronary Care (Patient Days)						
Burn Care (Patient Days)						
Definitive Observation (Patient Days)						
Medical/Surgical Acute (Patient Days)	10,571	$5,981.31	$726.51	$755.46	$1,322.46	($595.95)
Pediatric Acute (Patient Days)						
Psychiatric Acute - Adult (Patient Days)						
Obstetrics Acute (Patient Days)	1,488	$4,814.99	$584.84	$948.25	$1,502.23	($917.38)
Alternate Birthing Center (Patient Days)						
Chemical Dependency Services (Patient Days)						
Skilled Nursing Care (Patient Days)						
Total Daily Hospital Services (Patient Days - Excl. Newborn)	13,868	$6,340.26	$770.11	$877.80	$1,478.61	($708.50)
Nursery Acute (Newborn Days)	1,150	$3,455.65	$419.73	$589.88	$849.94	($430.20)
Ambulatory Services (Unit of Service)						
Emergency Services (Visits)	34,934	$3,656.58	$373.28	$139.71	$254.34	$118.94
Clinics (Visits)	581	$291.35	$35.39	$224.15	$531.20	($495.82)
Observation Care (Observation Hours)	21,813	$211.50	$25.69	$29.45	$40.69	($15.00)
Home Health Care Services (Home Health Care Visits)						

SUMMARY OF FINANCIAL AND UTILIZATION DATA FOR SELECTED COST CENTERS	UNITS OF SERVICE	GROSS REV PER UNIT	ADJ REV PER UNIT	ADJ DIRECT EXP PER UNIT	ADJ TOTAL EXP PER UNIT	PROFIT/LOSS PER UNIT
REVENUE-PRODUCING COST CENTERS						
Ancillary Services (Unit of Service)						
Labor and Delivery Services (Deliveries)	627	$20,760.94	$2,521.69	$1,284.46	$2,400.74	$120.95
Surgery and Recovery Services (Operating Mins)	327,285	$278.33	$33.81	$21.93	$35.96	($2.15)
Medical Supplies Sold to Patients (CS&S Adjusted Inpatient Days)	32,505	$2,373.62	$288.31	$223.00	$326.94	($38.63)
Clinical Laboratory Services (Tests)	284,576	$329.99	$40.08	$11.65	$20.77	$19.31
Cardiac Catheterization Services (Procedures)						
Radiology - Diagnostic (Procedures)	33,121	$1,796.22	$215.80	$99.71	$181.95	$33.85
Magnetic Resonance Imaging (Procedures)	1,357	$8,686.12	$1,055.05	$362.31	$627.98	$427.07
Computed Tomographic Scanner (Procedures)	8,890	$9,028.01	$1,096.57	$57.21	$233.14	$863.44
Drugs Sold to Patients (Pharmacy Adj. Inpatient Days)	21,731	$5,285.78	$642.03	$131.96	$418.23	$223.80
Respiratory Therapy (Respiratory Therapy Adj. Inpatient Days)	15,754	$1,572.19	$190.96	$74.71	$123.87	$67.09
Lithotripsy Services (Procedures)	63	$12,912.21	$1,568.36	$2,468.59	$3,184.03	($1,615.67)
Physical Therapy (Sessions)	18,991	$121.02	$14.70	$26.08	$33.66	($18.96)

NON-REVENUE PRODUCING COST CENTERS	UNITS OF SERVICE	ADJ DIRECT EXP PER UNIT
Cost Center (Unit of Service)		
Dietary (Patient Meals)	43,408	$10.99
Laundry and Linen (Dry & Clean lbs Processed)	498,764	$0.63
Social Work Services (Personal Contacts)		
Housekeeping (Square Feet Serviced)	122,448	$6.54
Plant Operations (Gross Square Feet)	122,448	$7.48
Plant Maintenance (Gross Square Feet)	122,448	$17.80
Patient Accounting ($ 1,000 of Gross Patient Rev.)	890,045	$3.13
Admitting (Admissions)	3,858	$506.07
Hospital Administration (Hospital FTE Employees)	393	$28,597.06
Medical Records (Adj. Inpatient Days)	31,733	$54.31
Nursing Administration (Nursing Service FTE Personnal)	128	$9,330.38
Utilization Management (Admissions)	3,858	$317.85
Community Health Education (Participants)		
Insurance - Malpractice ($ 1,000 of Gross Patient Rev.)	890,045	$0.92
Interest Other (Gross Square Feet)	122,448	$0.31

PERCENTAGE OF HOURS AND AVERAGE HOURLY RATE BY EMPLOYEE CLASSIFICATION	MANAGEMENT AND SUPERVISION	TECHNICAL AND SPECIALIST	REGISTERED NURSES	LICENSED VOCATIONAL NURSES	AIDES AND ORDERLIES
Cost Center Group					
Daily Hospital Services	13.66%	0.84%	60.44%		14.92%
Ambulatory Services (Unit of Service)	15.64%	10.16%	51.80%		6.12%
Ancillary Services	9.83%	48.95%	22.31%		7.58%
Total Patient Care Services	11.98%	26.68%	39.78%		9.94%
Research					
Education					
General Services	12.07%	30.86%			
Fiscal Services	17.33%	4.13%			
Administrative Services	25.05%	3.86%			
Total Operating Cost Centers	13.89%	22.61%	26.00%		6.50%
Non-Operating Cost Centers					
Average Hourly Rate	$61.21	$42.83	$58.59		$23.72

	ENVIRONMENTAL AND FOOD SERVICE	CLERICAL AND OTHER EMPLOYEES	REGISTRY AND TEMP HELP	TOTAL PRODUCTIVE HOURS	TOTAL PAID HOURS
Cost Center Group					
Daily Hospital Services			10.14%	166,863	199,736
Ambulatory Services (Unit of Service)		1.90%	14.37%	67,187	78,718
Ancillary Services		10.48%	0.86%	243,537	283,140
Total Patient Care Services		5.61%	6.00%	477,587	561,594
Research					
Education					
General Services	42.31%	14.76%		102,995	114,585
Fiscal Services		78.54%		74,608	84,340
Administrative Services		70.13%	0.95%	75,536	85,718
Total Operating Cost Centers	5.96%	21.02%	4.02%	730,726	846,237
Non-Operating Cost Centers					
Average Hourly Rate	$15.51	$27.98	$98.31		

HOSPITAL PERSONNEL PROFILE	
Total Number of Productive Hospital FTE's*	337
No. of Nursing Registry & Temp Help FTE's	14
Total Number of Nursing FTE's**	128
Number of Nursing Registry FTE's	14

* Excludes Registry Nurses & Temp Help
** Includes Nursing Registry

HR013

No. S274927

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

COUNTY OF SANTA CLARA,

Petitioner,

v.

THE SUPERIOR COURT OF SANTA CLARA,

Respondent,

DOCTORS MEDICAL CENTER OF MODESTO, et al.

Real Parties in Interest.

After a Decision by the Court of Appeal,
Sixth Appellate District
Case No. H048486

[PROPOSED] ORDER

Pursuant to Rule 8.54 of the California Rules of Court and California Evidence Code Section 452 and 459, the Motion Requesting Judicial Notice filed by Petitioner the County of Santa in support of the Answer Brief on the Merits is GRANTED.

The Court therefore takes judicial notice of the following documents:

Exhibit A – Governor's Executive Order No. S-13-06 (July 25, 2006) (App. 19-20) (included in the record, Appendix of Exhibits in Support of Petition for Writ of Mandate (App.) 19-20)

Exhibit B – Consent Agreement, In the Matter of Health Net of California, Inc., Department of Managed Health Care (DMHC), No. 04-300 (App. 693-700)

Exhibit C – California Department of Managed Health Care, Health Care Service Plans' Provider Dispute Resolution Mechanisms, 2017 Annual Report (App. 675-691)

Exhibit D – California Department of Managed Health Care 2020 Annual Report

Exhibit E – California Department of Managed Health Care 2021 Annual Report

Exhibit F – Letter Brief, *Bell v. Blue Cross of California*, 2005 WL 2236533 (Cal.App. 2 Dist. Jul. 8, 2005)

Exhibit G – Respondents' Hearing Brief in Opposition to Petitioners' Writ of Mandate, *California Medical Assn. v. DMHC*, 2008 WL 5818770 (Cal. Superior Nov. 7, 2008)

Exhibit H – California Department of Managed Health Care Notice of Rulemaking Action (Mar. 11, 2015)

Exhibit I –Summary Individual Disclosure Report for Doctors Medical Center of Modesto for the period of January 1 through December 31, 2016

Exhibit J – Summary Individual Disclosure Report for Doctors Medical Center of Modesto for the period of January 1 through December 31, 2017

Exhibit K – Summary Individual Disclosure Report for Doctors Hospital of Manteca Modesto for the period of January 1 through December 31, 2016

Exhibit L – Summary Individual Disclosure Report for Doctors Hospital of Manteca Modesto for the period of January 1 through December 31, 2017

IT IS SO ORDERED

DATED: _____ By: _____
Justice of the Supreme Court

CERTIFICATE OF SERVICE

I, Susan Greenberg, declare:

I am now and at all times herein mentioned have been over the age of eighteen years, employed in Santa Clara County, California, and not a party to the within action or cause; that my business address is 70 West Hedding Street, 9th Floor, San Jose, California 95110-1770. My electronic service address is: susan.greenberg@cco.sccgov.org. Participants who are registered with TrueFiling will be served electronically. Participants who are not registered with TrueFiling will receive hard copies via United States Postal Service. On **December 12, 2022**, I caused to be served, copies of the following:

REQUEST FOR JUDICIAL NOTICE; DECLARATION OF SUSAN P. GREENBERG; [PROPOSED] ORDER

to the people listed below at the following:

PLEASE SEE ATTACHED SERVICE LIST

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on **December 12, 2022.**

DocuSigned by:
Susan Greenberg
F6B0E7284644468...

Susan Greenberg

SERVICE LIST

County of Santa Clara v. The Superior Court of Santa Clara
Case No. S274927

Mitchell C. Tilner Peder K. Batalden Horvitz & Levy, LLP 3601 West Olive Avenue, 8th Floor Burbank, CA 91505 mtilner@horvitzlevy.com pbatalden@horvitzlevy.com	***Via TrueFiling***
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Edward Stumpp Michaela Cox Case E. Mitchnick Faatima Seedat Helton Law Group 1590 Corporate Drive Costa Mesa, CA 92626 estumpp@helton.law mcox@helton.law cmitchnick@helton.law Fseedat@helton.law	***Via TrueFiling***
Clerk of the Court California Court of Appeal Sixth Appellate District 333 West Santa Clara Street Suite 1060 San José, CA 95113	Case H048486 ***Via TrueFiling***
Honorable Maureen A. Folan Santa Clara County Superior Court 191 North First Street San Jose, CA 95113	Case No 19CV349757 ***Via U.S. Mail***
Paul R. Johnson King & Spalding 633 West 5th Street, Suite 1600 Los Angeles, CA 90071 pjohnson@kslaw.com	California Hospital Association ***Via TrueFiling***

STATE OF CALIFORNIA
Supreme Court of California

PROOF OF SERVICE

STATE OF CALIFORNIA
Supreme Court of California

Case Name: **SANTA CLARA, COUNTY OF v. S.C. (DOCTORS MEDICAL CENTER OF MODESTO)**
Case Number: **S274927**
Lower Court Case Number: **H048486**

1. At the time of service I was at least 18 years of age and not a party to this legal action.

2. My email address used to e-serve: **susan.greenberg@cco.sccgov.org**

3. I served by email a copy of the following document(s) indicated below:

Title(s) of papers e-served:

Filing Type	Document Title
REQUEST FOR JUDICIAL NOTICE	County of Santa Clara's Request for Judicial Notice

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Santa Clara County Counsel		Serve	PM
Susan Sarff King & Spalding LLP	ssarff@kslaw.com	e-Serve	12/12/2022 5:44:56 PM

This proof of service was automatically created, submitted and signed on my behalf through my agreements with TrueFiling and its contents are true to the best of my information, knowledge, and belief.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

12/12/2022

Date

/s/Susan Greenberg

Signature

Greenberg, Susan (318055)

Last Name, First Name (PNum)

Office of the County Counsel

Law Firm