

**IN THE DEPARTMENT OF COMMERCE AND INSURANCE
STATE OF MISSOURI**

<i>In Re:</i>)	
)	
BLUE CROSS BLUE SHIELD OF KANSAS CITY (NAIC #47171))	Market Conduct Examination No. 1603-22-TGT NAIC MATS NO. MO-HICKSS1-22
)	
GOOD HEALTH HMO, INC. D/B/A BLUE CARE, INC. (NAIC #95315))	Market Conduct Examination No. 1603-23-TGT NAIC MATS NO. MO-HICKSS1-23

ORDER OF THE DIRECTOR

NOW, on this 8th day of April, 2020, Director, Chlora Lindley-Myers, after consideration and review of the market conduct examination report of Blue Cross and Blue Shield of Kansas City (NAIC #47171) (hereinafter “BCBSKC”), examination report number 1603-22-TGT and the market conduct examination report of Good Health HMO, Inc. d/b/a Blue Care, Inc. (NAIC #95315) (hereinafter “Good Health”), examination report number 1603-23-TGT, prepared and submitted by the Division of Insurance Market Regulation (hereinafter “Division”) pursuant to §374.205.3(3)(a)¹, does hereby adopt such reports as filed. After consideration and review of the Stipulation of Settlement (“Stipulation”), the examination reports, relevant work papers, and any written submissions or rebuttals, the findings and conclusions of such reports are deemed to be the Director’s findings and conclusions accompanying this order pursuant to §374.205.3(4). Director does hereby issue the following orders:

This order, issued pursuant to §374.205.3(4), §374.280 RSMo, and §374.046.15. RSMo, is in the public interest.

IT IS THEREFORE ORDERED that BCBSKC, Good Health, and the Division having agreed to the Stipulation, the Director does hereby approve and agree to the Stipulation.

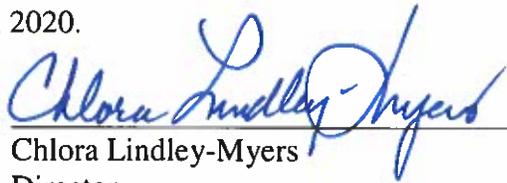
IT IS FURTHER ORDERED that BCBSKC and Good Health shall not engage in any of the violations of law and regulations set forth in the Stipulation, shall implement procedures to place each in full compliance with the requirements in the Stipulation and the statutes and regulations of the State of Missouri, and to maintain those corrective actions at all times, and shall

¹ All references, unless otherwise noted, are to Missouri Revised Statutes 2016 as amended.

fully comply with all terms of the Stipulation.

IT IS SO ORDERED.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of my office in Jefferson City, Missouri, this 08th day of April, 2020.



Chlora Lindley-Myers
Director



**IN THE DEPARTMENT OF COMMERCE AND INSURANCE
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STIPULATION OF SETTLEMENT

It is hereby stipulated and agreed by the Division of Insurance Market Regulation (hereinafter "the Division"), Blue Cross Blue Shield of Kansas City (NAIC #47171) (hereinafter "Blue Cross KC"), and Good Health HMO, Inc. d/b/a Blue Care, Inc. (NAIC #95315) (hereinafter "Good Health") as follows:

WHEREAS, the Division is a unit of the Missouri Department of Commerce and Insurance (hereinafter "the Department"), an agency of the State of Missouri, created and established for administering and enforcing all laws in relation to insurance companies doing business in the State of Missouri;

WHEREAS, Blue Cross KC and Good Health have been granted certificates of authority to transact the business of insurance in the State of Missouri;

WHEREAS, the Division conducted a Market Conduct Examination of Blue Cross KC, examination #1603-22-TGT and Good Health, examination #1603-23-TGT;

WHEREAS, based on the Market Conduct Examination of Blue Cross KC, the Division alleges that:

1. The data provided by Blue Cross KC for the 2013, 2014 and 2015 autism annual reports was not consistent with the data provided during the examination for those same years.

2. Blue Cross KC did not adequately monitor its utilization review agent in that it failed to adequately monitor the utilization review agent's initiation of a monthly authorization loading process and daily automated reports in violation of §376.1359.1¹.

3. Blue Cross KC failed to maintain adequate documentation regarding the utilization review agent's authorization processes in violation of 20 CSR 100-8.040 (2).

4. Blue Cross KC improperly denied a claim for Applied Behavioral Analysis (ABA) services based on the annual maximum allowed for such services being met implicating the provisions of §375.1007 (1), (3) & (4).

5. Blue Cross KC improperly denied a claim for ABA services as not being covered under the plan implicating the provisions of §375.1007 (1), (3) & (4).

6. Blue Cross KC improperly denied eight claims for ABA services as not being authorized because the authorization for the services was not timely entered into the Company's claim system implicating the provisions of §375.1007 (1), (3) & (4).

7. Blue Cross KC's denial of claims for ABA services due to delays in entering prior authorizations into its claim system acts as an inappropriate limitation on the number of visits for ABA services in violation of §376.1224.7.

WHEREAS, based on the Market Conduct Examination of Good Health, the Division alleges:

1. The data provided by Good Health for the 2013, 2014 and 2015 autism annual reports was not consistent with the data provided during the examination for those same years.

2. Good Health improperly denied 16 claim lines under three separate claims for ABA services for lack of prior authorization implicating the provisions of §375.1007 (1), (3), (4) & (11)

¹ All references, unless otherwise noted, are to Missouri Revised Statutes 2016.

and Good Health did not provide notice of the authorizations to the providers and members in violation of §376.1361.12.

3. Good Health improperly denied 22 claim lines under three separate claims for ABA services for lack of prior authorization implicating the provisions of §375.1007 (3), (4) & (11).

4. Good Health improperly denied three claim lines under a single claim for ABA services for exceeding the number of authorized visits implicating the provisions of §375.1007 (3), (4) & (11).

5. Good Health's denial of claims for ABA services due to delays in entering prior authorizations into its claim system acts as an inappropriate limitation on the number of visits for ABA services in violation of §376.1224.7.

WHEREAS, the Division, Blue Cross KC and Good Health have agreed to resolve the issues raised in the Market Conduct Examinations as follows:

A. **Scope of Agreement.** This Stipulation of Settlement (hereinafter "Stipulation") embodies the entire agreement and understanding of the signatories with respect to the subject matter contained herein. The signatories hereby declare and represent that no promise, inducement or agreement not herein expressed has been made, and acknowledge that the terms and conditions of this agreement are contractual and not a mere recital.

B. **Remedial Action.** Blue Cross KC and Good Health agree to take remedial action bringing the companies into compliance with the statutes and regulations of Missouri and agrees to maintain such remedial actions at all times, to reasonably ensure that the errors noted in the Market Conduct Examination Report do not recur. Such remedial actions shall consist of the following:

1. Blue Cross KC and Good Health agree to monitor all utilization review activities carried out by a utilization review organization on each companies' behalf involving ABA

services, including, but not limited to, any processes related to the issuance and entry of prior authorizations into the claim system.

2. Blue Cross KC and Good Health agree to maintain documentation regarding the prior authorization process for ABA services by a utilization review organization acting on the companies' behalf.

3. Blue Cross KC and Good Health agree to ensure that prior authorizations for ABA services are timely entered into the companies' claim system such that claims for ABA services are not denied for lack of prior authorization when such authorization was issued prior to the date of service.

4. Blue Cross KC and Good Health have represented to the Division that their utilization review organization is no longer dividing prior authorizations for ABA services into separate prior authorizations each covering a shorter period of time than the original authorization. Blue Cross KC and Good Health agree that they will maintain this remedial action.

5. Blue Cross KC agrees to reprocess and pay the claim referenced in Criticism 1 and Formal Request 16 and to reprocess and pay the eight claims referenced in Criticism 8 and Formal Request 22. A letter should be included with the payment indicating that as a result of a Missouri Market Conduct Examination, it was discovered that a claims payment is due to the member of provider, as appropriate.

6. Blue Cross KC and Good Health agree to review all claims for ABA services submitted by providers or members from January 1, 2015 through December 31, 2017 to determine if any claims were denied based on the failure to timely enter prior authorizations into the companies' claim system. If a claim was denied based upon the failure to timely enter prior authorizations into the companies' claim system, Blue Cross KC and Good Health will reprocess and pay the claim based upon the terms of the policy. A letter should be included with any payment

indicating that as a result of a Missouri Market Conduct Examination, it was discovered that a claims payment is due to the member or provider, as appropriate.

C. **Compliance.** Blue Cross KC and Good Health agree to file documentation with the Division, in a format acceptable to the Division, within 90 days of the entry of a final order of any remedial action taken pursuant to Paragraph B to implement compliance with the terms of this Stipulation and to document the payment of any restitution required by this Stipulation. Such documentation is provided pursuant to §374.205.

D. **Fees.** Blue Cross KC and Good Health agree to pay any reasonable examination fees expended by the Division in conducting its review of the documentation provided by Blue Cross KC and Good Health pursuant to Paragraphs B and C of this Stipulation.

E. **No Penalties.** The Division agrees that it will not seek penalties against Blue Cross KC or Good Health in connection with the above referenced Market Conduct Examinations.

F. **Non-Admission.** Nothing in this Stipulation shall be construed as an admission by Blue Cross KC or Good Health, this Stipulation being part of a compromise settlement to resolve disputed factual and legal allegations arising out of the above referenced Market Conduct Examinations.

G. **Waivers.** Blue Cross KC and Good Health, after being advised by legal counsel, do hereby voluntarily and knowingly waive any and all rights for procedural requirements, including notice and an opportunity for a hearing, and review or appeal by any trial or appellate court, which may have otherwise applied to the above referenced Market Conduct Examinations.

H. **Changes.** No changes to this Stipulation shall be effective unless made in writing and agreed to by representatives of the Division, Blue Cross KC and Good Health.

I. **Governing Law.** This Stipulation shall be governed and construed in accordance with the laws of the State of Missouri.

J. **Authority.** The signatories below represent, acknowledge and warrant that they are authorized to sign this Stipulation, on behalf of the Division, Blue Cross KC and Good Health respectively.

K. **Counterparts.** This Stipulation may be executed in multiple counterparts, each of which shall be deemed an original and all of which taken together shall constitute a single document. Execution and delivery of this Stipulation by facsimile or by an electronically transmitted signature shall be fully and legally effective and binding.

L. **Effect of Stipulation.** This Stipulation shall become effective only upon entry of a Final Order by the Director approving this Stipulation.

M. **Request for an Order.** The signatories below request that the Director issue an Order approving this Stipulation, adopting the Report, and ordering the relief agreed to in the Stipulation, and consent to the issuance of such Order.

DATED: 3/18/2020

Stewart Freilich
Stewart Freilich
Chief Market Conduct Examiner and
Senior Counsel
Division of Insurance Market Regulation

DATED: 3/13/2020

Scott McAdams
Scott McAdams
Senior Vice President
Blue Cross Blue Shield of Kansas City

DATED: 3/13/2020

Randy Ousler
Randy Ousler,
Officer
Good Health HMO, Inc. d/b/a Blue Care, Inc.

STATE OF MISSOURI
DEPARTMENT OF COMMERCE AND INSURANCE



FINAL MARKET CONDUCT EXAMINATION REPORT
Health Business of

Blue Cross Blue Shield of Kansas City
NAIC # 47171

MISSOURI EXAMINATION #1603-22- TGT

NAIC EXAM TRACKING SYSTEM #MO-HICKSS1-22

March 17, 2020

Home Office
2301 Main Street
Kansas City, MO 64108

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FOREWORD

This is a targeted market conduct examination report of Blue Cross Blue Shield of Kansas City (NAIC #47171). This examination was conducted in conjunction with the examination of Good Health HMO, Inc., at the offices of the Missouri Department of Commerce and Insurance. This examination report is generally a report by exception. However, failure to criticize specific practices, procedures, products or files does not constitute approval thereof by the Department. During this examination, the examiners cited errors made by the Company. Statutory citations were as of the examination period unless otherwise noted.

When used in this report:

- “ABA” refers to Applied Behavior Analysis;
- “Autism spectrum disorders” refers to a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger’s Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett’s Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association;
- “CPT” refers to Current Procedural Terminology, a medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations;
- “Company,” or “BCBSKC,” refers to Blue Cross Blue Shield of Kansas City;
- “Criticism” refers to a written form requesting an explanation of an error or a written acknowledgement of an error and requesting that the Company agree or disagree with an explanation of its position;
- “CSR” refers to the Missouri Code of State Regulations;
- “DCI” or “Department” refers to the Missouri Department of Commerce and Insurance;
- “Director” refers to the Director of the Missouri Department of Commerce and Insurance;
- “EOB” refers to Explanation of Benefits, a document submitted to an insured or member explaining the amount of payment and/or how a claim was processed;
- “Formal Request” or “FR” refers to a document for formalized questions and/or informational requests submitted to the Company by market conduct examiners;
- “NAIC” refers to the National Association of Insurance Commissioners;
- “Provider” refers to any person, entity, or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri; or licensed as an assistant board-certified behavior analyst;
- “RSMo” refers to the Revised Statutes of Missouri. All citations are to RSMo 2000, unless otherwise specified.

SCOPE OF EXAMINATION

The Department has authority to conduct this examination pursuant to, but not limited to, §§374.110, 374.190, 374.205, 375.938, and 375.1009, RSMo 2000.

The purpose of this examination is to determine if the Company complied with Missouri statutes and regulations and to consider whether the Company's operations are consistent with the public interest. Unless otherwise noted, the primary period covered by this review was January 1, 2013, through December 31, 2015. Errors found outside the examination time period may also be included in the report. The examination was a targeted examination to validate the Company's annual autism reports to the Department and to test for compliance with claims handling practices of autism claims.

The examination was conducted in accordance with the standards in the NAIC's *Market Regulation Handbook*. As such, the examiners utilized the benchmark error rate guidelines from the *Market Regulation Handbook* when conducting reviews applying a general business practice standard. The NAIC benchmark error rate for claims practices is seven percent (7%) and for other trade practices is ten percent (10%). Error rates exceeding these benchmarks are presumed to indicate a general business practice. The benchmark error rates were not utilized, however, for reviews not applying the general business practice standard.

In performing this examination, the examiners only reviewed specific segments of the Company's practices, procedures, products and files. Therefore, some noncompliant practices, procedures, products and files may not have been discovered. As such, this report may not fully reflect all of the practices and procedures of the Company. As indicated previously, failure to identify or criticize improper or noncompliant business practices in this state or other jurisdictions does not constitute acceptance of such practices.

This market conduct examination was performed as a desk audit at the following Department office:

Harry S Truman State Office Building
301 West High Street, Room 530
Jefferson City, MO 65101

COMPANY PROFILE

Blue Cross Blue Shield of Kansas City (“BCBSKC”) was incorporated under the laws of the State of Missouri on May 17, 1982, through the merger of Blue Cross of Kansas City with Blue Shield of Kansas City. The Company commenced business on that same date as a consolidated, not-for-profit health services corporation. The Company also obtained a certificate of authority on May 17, 1982, to be a licensed insurer in the State of Kansas.

On February 10, 1995, the Missouri Department of Insurance granted BCBSKC a certificate of authority to operate as a Health Maintenance Organization (HMO) and on August 10, 1995, the Company was licensed as a Business Entity Producer. On February 23, 1998, the Missouri Department of Insurance granted BCBSKC a third party administrator license.

BCBSKC is a parent company that wholly owns Good Health, HMO, Inc., Blue Advantage Plus of Kansas City, Inc., and Missouri Valley Life and Health Insurance Company. BCBSKC also controls several non-insurance subsidiaries. Among them is New Directions Behavioral Health, LLC, which manages behavioral health benefits and operates an employee assistance program.

EXECUTIVE SUMMARY

The Department conducted a targeted market conduct examination of Blue Cross Blue Shield of Kansas City. The examiners found the following areas of concern:

- The Company was unable to provide the examiners with sufficient data to enable the examiners to compare and validate the accuracy of the Company's annual autism reports to the Department.
- The Company did not appear to be properly monitoring the actions of its utilization review agent when the utilization review agent (1) implemented a process to split six month authorizations into monthly units, and (2) delayed entering the authorizations into the Company's claim system resulting in claim denials for lack of prior authorization.
- The Company failed to maintain documentation of the utilization review agent's implementation of the practice of splitting six month authorizations into monthly units and the claims adjudication process for this issue.
- The Company denied a claim for ABA services for the reason that the annual maximum had been met even though both the Company's claim system and documentation in an earlier complaint file showed that the Company had previously authorized ABA services for the dates provided in the claim.
- The Company denied a claim for ABA services as not being covered despite having given prior authorization for the services, and the Company did not resolve the issue until the provider called to ask why the dates of service were denied as non-covered services when similar services had been allowed.
- Due to a delay in entering a prior authorization into the claim system, the Company denied eight claims for ABA services for the reason that they had not been prior authorized even though the claims had received prior authorization.
- The Company, through the actions of its utilization review agent, limited the number of visits an individual may make to an autism service provider by dividing six month authorizations into one month authorizations, delaying the entry of authorizations into the claim system, and denying claims for authorized ABA services as not being authorized.

EXAMINATION FINDINGS

I. COMPLAINTS

This section of the report provides a review of the Company's complaint handling practices. Included within this review are complaints termed "grievances" or "appeals" under Missouri's utilization review statutes in §§376.1350 to 376.1389, RSMo. The examiners reviewed how the Company handled complaints related to mandated autism coverages to ensure it was performing according to its own guidelines and Missouri statutes and regulations.

To conduct this review, the examiners first requested a listing of all complaints relating to autism claims, services or benefits processed by the Company during the examination scope. The listing provided by the Company contained 39 autism related complaints consisting of 11 complaints filed with the Department and 28 complaints filed directly with the Company. The examiners requested all 39 of these complaint files for review.

A. Handling of Department Complaints

The examiners reviewed 11 complaints filed with the Department to assess the Company's handling of these complaints. This included a review of the nature, disposition, and the time taken to process the complaint.

The examiners found no errors during this review.

B. Handling of Direct Complaints

The examiners reviewed 28 complaints filed directly with the Company to assess the Company's handling of these complaints. While the examiners found no errors in this review, they noted one complaint where authorization was granted for ABA therapy, but a claim subsequently submitted during the period authorized was denied by the Company. This denied claim is discussed under "Criticism 1" in the "Claims" section of this report.

II. OPERATIONS/MANAGEMENT

The Operations/Management portion of the examination provides a view of what the regulated entity is and how it operates. For the purposes of this examination, the examiners' review focused on the Company's filing of statutorily required autism reports and the Company's oversight of an affiliated entity, New Directions Behavioral Health, LLC ("New Directions") in its conduct of utilization review activities.

A. Data Reporting for Annual Autism Reports

Pursuant to §376.1224.19(2), RSMo, all health carriers and health benefit plans subject to §376.1224 are required to provide the Department with the data requested by the Department for inclusion in the autism annual report. In order to test the accuracy of the autism data reported, the Company was requested to provide data for policies and certificates in effect, medical claims and pharmacy claims for calendar years 2013, 2014, and 2015. The examiners compared the examination data received to previous autism data reported and determined that the Company data provided to the Department for the 2013, 2014, 2015 annual reports was not consistent with the Company data for the same time period provided during this examination.

The examiners sought further clarification regarding the Company's 2013, 2014 and 2015 autism data in Formal Request 2. In response, the Company stated that:

Blue Cross Blue Shield of Kansas City (Company) acknowledges that a list of members and applicable claims for the 2013, 2014 and 2015 Annual Autism Reports cannot be recreated in the format requested by the Department. While the underlying data supporting the reports previously provided is maintained by the Company, the passage of time since its original run date would yield different results than were originally reported.

As a consequence, the examiners were unable to compare and validate the accuracy of the Company's annual autism reports provided to the Department.

B. Oversight of the Company's Utilization Review Agent

The Company utilizes the services of an affiliated entity, New Directions Behavioral Health, LLC ("New Directions"), for utilization review of its behavioral health benefits, including the provision of ABA therapy for autism spectrum disorders. Prior to January 1, 2014, the Company and New Directions did not require prior authorization for ABA services. During this period, the Company and New Directions would perform a retrospective review by requesting a treatment plan at the time a claim was filed. Upon receipt of the treatment plan, services would be reviewed to determine if they were medically necessary. If so, the claim would be paid.

Beginning January 1, 2014, the Company and New Directions began requiring prior authorization for ABA services upon renewal of plans. In response to Formal Request 15, the Company stated that, "The Company provided notice directly to members regarding the prior authorization requirement for ABA services via their next applicable Certificate of Coverage after the requirement became effective."

Beginning in the first quarter of 2015, New Directions implemented a process to split six month authorizations into monthly units. In response to Formal Request 38 the Company stated:

ABA authorizations are based on the projected weekly intensity of services proposed by the ABA provider. Authorizations are given for six months of projected services. New Directions originally loaded authorizations to the claims system monthly as an attempt to ensure providers would not over-utilize ABA sessions early in the six month authorization period. Six month authorizations were split into monthly segments and entered into Facets [i.e., the Company's claim system].

In conjunction with this process, New Directions created a daily automated report in the first quarter of 2015 to help track and enter the monthly approvals into the Facets claim system. In response to Formal Request 40, the Company stated: "The report is typically viewed daily by the Customer Service Center to verify each member included on the report has their corresponding authorization(s) loaded into Facets."

Although New Directions initiated both the monthly authorization loading process and the daily automated report in the first quarter of 2015, the Company stated it first became aware of New Directions monthly authorization loading process in October 2015 and first became aware of the daily automated report in early 2016. The Company stated that the practice of splitting six month authorizations into monthly authorizations for loading into the claim system had ceased in November 2017. Currently, authorizations are loaded into the Facets claim system for the full six months.

In reviewing claims for both the Company and Good Health HMO, Inc., the examiners noted instances of claim denials for lack of preauthorization even though New Directions had issued an authorization for the ABA services. The examiners were concerned that the New Directions change in process had resulted in delays in entering authorizations in the claim system, and the Company was not aware of the issue until many months after it began. Accordingly, the examiners requested documentation regarding: (1) the process and training for entering authorizations for autism services into the claim system; and (2) the initiation, implementation and training for the one month authorization loading process and the daily automated report. The Company responded that neither New Directions nor the Company had maintained such documentation. As a consequence, the examiners sent the Company Criticism 10 indicating their belief that: (1) the Company did not appear to be properly monitoring the actions of its utilization review agent, New Directions, as required by the utilization review statutes; and (2) the Company's failure to maintain documentation

of the processes was contrary to the utilization review statutes and the records maintenance regulation.

Reference: §§376.1353, 376.1356, and 376.1359.1, RSMo, and 20 CSR 100-8.040(2) and (3)(B)1

In response to Criticism 10, the Company disagreed that it had not monitored the activities of New Directions, and described the dedicated staff member and joint committees it had created to interact and monitor New Directions. The Company also disagreed with the examiners' citation of documentation errors given that: (1) "Both the Company and New Directions implemented written utilization review programs throughout the audit period and filed the annual report of its utilization review activities with the director"; and (2) "appropriate books and records are maintained as evidenced by the information provided in response throughout the examination."

III. UNDERWRITING AND RATING

This section of the report provides a review of the Company's underwriting and rating practices. These practices may include the use of policy forms, adherence to underwriting guidelines, assessment of premium, procedures to decline or terminate coverage, and the handling of mandatory optional coverages. For the purposes of this examination, the examiners confined their review to the Company's administration of the mandatory offer of autism coverage in the individual market.

During the time period covered by this examination, §376.1224, RSMo, only required insurers to automatically provide coverage for autism benefits, including ABA therapy, for employer group health benefit plans. Insurers were not required to automatically provide autism coverage in their individually underwritten health benefit plans. Instead, §376.1224.13, RSMo, required insurers to offer autism coverage as an optional benefit to be accepted or declined by the applicant.

To determine how the Company was handling this mandated offer of coverage, the examiners requested information and documentation on compliance with this requirement in Formal Request 5. The Company responded that it had provided a line item allowing an applicant to choose the coverage in its applications for individually underwritten health benefit plans prior to January 1, 2014. After that date, the Company automatically included autism services as a standard benefit rather than offering it as an option in all individually underwritten health benefit plans.

The examiners found no errors in this review.

IV. CLAIMS

This section of the report provides a review of the Company's claims handling practices. For the purposes of this examination, the examiners restricted their review to claims dealing with benefits for autism services as required by §376.1224, RSMo. The examiners reviewed the Company's handling of autism claims to determine the timeliness, accuracy of payment, adherence to contract provisions, and compliance with Missouri statutes and regulations.

A. Unfair Claims Settlement Practices

To conduct this review, the examiners extracted from the claims data provided by the Company claim lines with specific claim characteristics, such as CPT codes, diagnostic codes or provider types, indicating that the claim was for autism related services. From this set of autism claims, any claim lines that were denied or paid at zero were deleted. Paid claim lines for any member who had a denied claim were also extracted for comparison purposes. Claim lines for claims that were readjusted were treated as part of the original claim.

The examiners reviewed the resulting claims data and targeted for review any claims for members who had repeated claim denial codes with the following descriptions:

- "The annual maximum allowed for these services has been met for this member."
- "Services are not payable per Medical Review Guidelines."
- "Member not eligible for benefits".
- "This service is not covered under the plan."
- "This claim cannot be processed without additional information. A separate request is being sent."
- "Final benefit determination cannot be made until we receive complete medical records,"
- "Please submit the diagnosis, specific illness, injury or condition that required treatment. Once received, we will reprocess the claim."
- "Prior authorization was not obtained for these services, therefore the services are not covered under the member's plan."
- "Services exceed the number authorized by Utilization Management"
- "This is not a contracted service under the provider's New Directions contract."

The examiners requested copies of the claim files for review. The examiners also reviewed claims related to complaint files involving claim denials. In addition, the examiners requested and reviewed the Company's and New Direction's operating procedures and claim processing manuals. The results of the review are as follows:

Field Size:	4420
Number of Errors:	10
Error Ratio:	0.23%

The examiners found the following errors.

1. Criticism 1 and Formal Request 16: The member in this case was covered by an individual policy that provided autism benefits. The Company denied a claim for ABA services giving as its reason for the denial to both the member and the provider that “the annual maximum allowed for these services has been met for this member.” The examiners noted, however, that both the Company’s claims system and an earlier complaint file indicated that the Company had previously authorized ABA services for the dates provided in the claim. In response to the examiner’s request for an explanation in Formal Request 16, the Company stated the following:

At the time [the claim] was processed, the annual max benefit for 2013 of \$42,117, had been exceeded by the member. Per claim notes during the review to evaluate whether the annual benefit limit should be overridden, reviewers inadvertently concluded that there was not an active treatment plan in place for the date of service, when in fact there was an active treatment plan on file. [The authorization] was applicable to the date of service and procedure code billed on the claim. The root cause appears to be the result of human error associated with the manual review process. To date the claim has not been subsequently adjusted.

The examiners felt that the Company’s failure to investigate its own records, its denial of a claim that was payable, and its statements with regard to its reason for denial are contrary to the provisions of §375.1007(1), (3), and (4).

Reference: §§375.1007(1), (3), and (4), RSMo

In response to Criticism 1, the Company stated that it “has established policies and procedures to ensure that manually processed claims [for ABA services] are adjudicated accurately” and disagreed “that the error outlined in this Criticism represented a violation of the unfair claim practice standards defined in §375.1007.”

2. Criticism 3, Formal Request 18 and Formal Request 36: The provider in this criticism had received authorization for ABA services delivered from December 1, 2013, to January 28, 2014. The Company subsequently received a claim for ABA services on December 12, 2013, that was pended by the system on December 16, 2013, for the reason “FSG; service payment prefix not found.” The claim file indicates the claim received manual processing on December 24, 2013, and January 7, 2014, resulting in the claim being denied for “service not covered under the plan.” The claim remained denied until the provider called on July 10, 2014, to ask why the dates of service between December 2nd and 6th were denied as non-covered services when similar services had been allowed. In response to a request for an explanation in Formal Request 18, the Company replied:

It appears there was an isolated service prefix loading issue that required the original claim to be routed to technical experts who attempted to address the issue. Once they believed it was addressed it was returned for adjudication, that was ultimately a denial as not covered under the plan.

The Company subsequently received a provider inquiry about the denial prompting a re-evaluation of the claim, and further correction to the set-up issue which resulted in payment based on the member's authorization. The Company's processes for providers and/or members to inquire about claims processing and benefits facilitated the appropriate resolution and claim payment.

Despite the ultimate resolution of this claim, the examiners felt that the Company's failure to investigate its own records until prompted by the provider's inquiry, its denial of a claim that was payable, and its statements with regard to its reason for denial are contrary to the provisions of §375.1007(1), (3), and (4).

Reference: §§375.1007(1), (3) and (4), RSMo

In response to Criticism 3, the Company disagreed that its actions constituted violations of law and reiterated its belief that its standards and procedures for adjudicating and readjudicating claims are in accordance with the law.

3. Criticism 8 and Formal Request 22: The provider in this criticism had received authorization for ABA services delivered from March 24, 2014, to June 30, 2014. When the provider subsequently submitted eight claims for services delivered during this period, the claims were denied for the reason that "Prior authorization was not obtained for these services, therefore the services are not covered under the member's plan." The documents provided in response to Formal Request 22 reflect that the authorization for ABA services was not entered into the Company's claim system until July 1, 2014, which caused the eight claims submitted prior to that date to be denied.

The examiners felt that the Company's denial of claims it had previously authorized due to its late entry of the authorization in its claim system and its failure to readjudicate and pay those claims once the authorization had been entered are contrary to the provisions of §376.1007(3) and (4), RSMo.

Reference: §§375.1007(3) and (4), RSMo

In response to Criticism 8, the Company disagreed that its actions constituted a violation of law and explained that it had taken proactive measures to eliminate the late entry of authorizations through the initiation in the first quarter of 2015 of an automated daily report of prior authorizations for review by New Directions' Clinical Support Coordinators.

B. Limitation on ABA Benefits

Section 376.1224.4(3) states

(3) Except for inpatient services, if an individual is receiving treatment for an autism spectrum disorder, a health carrier shall have the right to review the treatment plan not more than once every six months unless the

health carrier and the individual's treating physician or psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall only apply to a particular individual being treated for an autism spectrum disorder and shall not apply to all individuals being treated for autism spectrum disorders by a physician or psychologist. The cost of obtaining any review or treatment plan shall be borne by the health benefit plan or health carrier, as applicable.

Section 376.1224.7 states:

7. Subject to the provisions set forth in subdivision (3) of subsection 4 of this section, coverage provided under this section shall not be subject to any limits on the number of visits an individual may make to an autism service provider, except that the maximum total benefit for applied behavior analysis set forth in subsection 5 of this section shall apply to this subsection.

In reviewing claims for ABA services for the joint examinations of the Company and its subsidiary, Good Health HMO, Inc., the examiners noted many instances of claims being denied due to delays in entering prior authorizations into the Facets claim system. The practice of New Directions dividing six month authorizations into six, one month authorizations appeared to the examiners to exacerbate the problem given that it resulted in claims being denied in the middle of the six month authorization period that New Directions had communicated to the providers. To the examiners, this extra-contractual limitation on visits seemed inconsistent with the prohibition in §376.1224.7 against limiting “the number of visits an individual may make to an autism service provider.” Accordingly, the examiners sent the Company Criticism 18 citing it for this issue.

Reference: §376.1224.7, RSMo.

The Company disagreed maintaining that the division of the six month authorizations into one month increments did not serve to limit treatment since it was consistent with the way the treatment plans were structured. The Company further stated:

In the cases cited by the examiners in criticisms 8, 9, 11, 12 and 14, the treating clinicians submitted the treatment plans in weekly increments for each 6-six month period, which was the basis for New Directions' authorizations. Given that the authorizations were loaded on a less restrictive basis than what was requested in the treatment plans (i.e., monthly), there is no evidence to support that the Company (inclusive of New Directions) violated §376.1224.7.

V. CRITICISMS AND FORMAL REQUESTS TIME STUDY

This study is based upon the time required by the Company to provide the examiners with the requested material or to respond to criticisms. Missouri statutes and regulations require companies to respond to criticisms and formal requests within 10 calendar days. In the event an extension of time was requested by the Company and granted by the examiners, the response was deemed timely if it was received within the time frame granted by the examiners. If the response was not received within the allotted time, the response was not considered timely.

A. Criticism Time Study

Number of Calendar Days to Respond	Number of Findings	Percentage of Total
0 to 10 days	7	78%
Over 10 days with extension	2	22%
Over 10 days without extension or after extension due date	0	0%
Totals	9	100%

B. Formal Request Time Study

Number of Calendar Days to Respond	Number of Requests	Percentage of Total
0 to 10 days	14	37%
Over 10 days with extension	24	63%
Over 10 days without extension or after extension due date	0	0%
Totals	38	100%

EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Blue Cross Blue Shield of Kansas City (NAIC #47171), Examination Number 1603-22-TGT. This examination was conducted by John Korte, CIE, Kembra Springs, and Mike Woolbright, CIE. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated November 19, 2019. Any changes from the text of the Market Conduct Examiner's Draft Report reflected in this Final Report were made by the Chief Market Conduct Examiner or with the Chief Market Conduct Examiner's approval. This Final Report has been reviewed and approved by the undersigned.

3/17/2020
Date

Stewart Freilich
Stewart Freilich
Chief Market Conduct Examiner