

**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
Chlora Lindley-Myers
Director



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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.

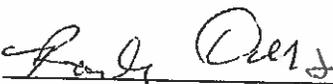
DATED: 3/18/2020


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

DATED: 3/13/2020


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

DATED: 3/13/2020


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

Good Health HMO, Inc. dba Blue Care, Inc.
NAIC # 95315

MISSOURI EXAMINATION #1603-23- TGT

NAIC EXAM TRACKING SYSTEM #MO-HICKSS1-23

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 Good Health HMO, Inc. dba Blue Care, Inc. (NAIC #95315). This examination was conducted in conjunction with the examination of Blue Cross Blue Shield of Kansas City 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, 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 “Good Health,” refers to Good Health HMO, Inc. dba Blue Care Inc.;
- “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;
- “HMO” refers to Health Maintenance Organization as defined and described in Chapter 354, RSMo;
- “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, §§354.465.1, 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 uncovered 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 submitted to the Department and to test for compliance with the handling 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 it 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 W. High Street, Room 530
Jefferson City, MO 65101

COMPANY PROFILE

Good Health HMO, Inc. is a wholly-owned subsidiary of Blue Cross and Blue Shield of Kansas City. According to the records of the Missouri Secretary of State, Good Health HMO, Inc. was incorporated as a “General Business Corporation” on October 12, 1988, and was subsequently granted a certificate of authority to operate as a Health Maintenance Organization (HMO) under the provisions of Chapter 354, RSMo. The Company operates as an individual practice association model HMO, providing comprehensive health care services to its members on a prepaid basis. The Company does business under the fictitious name of “Blue-Care,” but the records of the Missouri Secretary of State indicate the Company’s fictitious name registration expired effective June 24, 2019.

The Company is part of an “Insurance Holding Company System,” within the meaning of §382.010, RSMo, along with several other subsidiaries of Blue Cross and Blue Shield of Kansas City. The Company holds a 1% interest in one of these subsidiaries, New Directions Behavioral Health, LLC (“New Directions”). New Directions manages behavioral health benefits and operates an employee assistance program.

The Company is licensed as a HMO in the states of Missouri and Kansas, and conducts business in an 11 county service area consisting of the Missouri counties of Andrew, Buchanan, Cass, Clay, Jackson, Johnson, Lafayette, Platte, and Ray, and the Kansas counties of Johnson and Wyandotte. At the beginning of the exam period, the Company offered its individual practice association HMO product in the individual market, the small employer market and the large employer market in Missouri, but the Company withdrew from the individual and small employer markets in 2013 and terminated all coverage in these markets in 2014.

EXECUTIVE SUMMARY

The Department conducted a targeted market conduct examination of Good Health HMO, Inc. The examiners found the following principal 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 submitted to the Department.
- The Company did not appear to be properly monitoring the actions of its utilization review agent as required by the utilization review statutes 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 because information regarding other insurance had not been supplied for coordination of benefits purposes, but the Company failed to readjudicate and pay the claims after the information was received.
- The Company denied six claims for ABA services for the reason that they had not received prior authorization 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 is 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 list of all complaints relating to autism claims, services or benefits processed by the Company during the examination period. The list provided by the Company contained five autism related complaints filed directly with the Company. The examiners requested all five of these complaint files for review.

A. Handling of Direct Complaints

The examiners reviewed the five complaints filed directly with the Company 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.

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 the provisions of §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 to the Department for this examination.

The examiners sought further clarification regarding the Company's 2013, 2014, and 2015 autism data. Because this examination was conducted in conjunction with the examination of the Company's parent, Blue Cross Blue Shield of Kansas City, that Company responded on behalf of Good Health 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 to the Department.

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, the claim would be reviewed to determine if the services 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, "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 indicated 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 Blue Cross Blue Shield of Kansas City, 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 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, `23, 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 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 mandated offers of coverage, the examiners requested information and documentation on compliance with the requirement in Formal Request 5. The Company responded that it did not offer any individually underwritten health benefit plans during the time period covered by the examination.

The examiners found no errors in this review.

IV. CLAIMS

This section of the report is 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 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 first 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 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:	1836
Number of Errors:	7
Error Ratio:	0.38%

The examiners found the following errors.

1. Criticism 9: Authorization for six months of ABA services was granted by New Directions. Notice of the authorization was sent to the provider, but the examiners did not see any documentation in the claim file indicating notice had been sent to the member. When New Directions entered the authorization in the claim system, they neglected to enter one of the procedure codes that had been authorized. As a result, two claim lines filed under a single claim number were denied for lack of prior authorization. The provider subsequently contacted the Company about the denial, and the Company investigated and paid the claim lines. The examiners believed the Company's actions in (1) denying claim lines for services that had been authorized, (2) failing to investigate its own records for the authorization when the claim was filed, (3) failing to send the member notice of the authorization, and (4) not investigating and paying the claim lines until contacted by the provider were contrary to §§375.1007(3), (4) and (11), and 376.1361.12.

Reference: §§375.1007(3), (4), & (11), 376.1361.12, RSMo

In response to Criticism 9, the Company disagreed that its actions constituted statutory violations. The Company argued that its (1) establishment of an automated claim processing system, (2) mechanism for providers and members to inquire about denied claims, (3) establishment of standard operational procedures for investigating and resolving member and/or provider claim inquiries, and (4) standard procedure for sending authorization notices to members fully complied with the statutory requirements.

2. Criticism 11: New Directions issued an authorization for three months of ABA services. This authorization was divided into three, one month authorizations for entry into the Company's claim system, however, the provider and member were only given the three month authorization number and not the authorization numbers for the one month authorizations. The examiners did not note any issues with the entry of the first two monthly authorizations, but the third monthly authorization was not entered into the claims system until after the authorization period had expired. This resulted in eight claim lines filed under a single claim number being denied for lack of prior authorization. The eight claim lines remained unpaid until the provider contacted the Company and requested that the claim be reopened and paid. The examiners believed the Company's actions in (1) representing to the provider and the member that the services had not been authorized, (2) denying claim lines for services that had been authorized, (3) failing to investigate its own records for the authorization when the claim was filed, (4) failing to send the provider and the member notice of the one month authorization numbers, and (5) not investigating and paying the claim lines until contacted by the provider were contrary to §§375.1007(1), (3), (4) and (11), and 376.1361.12.

Reference: §§375.1007(1), (3), (4), and (11), and 376.1361.12, RSMo

In response to Criticism 11, the Company agreed in part and disagreed in part. The Company acknowledged that "clerical errors" delayed entry of the authorization in the claims system, but disagreed that its actions constituted a statutory violation. The Company argued that (1) its statements to the provider and member were not intentional representations, (2) it had established appropriate standard operational procedures for

processing claims with authorizations, (3) it had fully investigated and paid the claim when the provider inquired in accordance with its procedures, and (4) the furnishing of the three month authorization number to the provider and member was sufficient for purposes of the law.

3. Criticism 12: Six months of ABA services were authorized by New Directions. New Directions divided the six month authorization into six, one month authorizations, but did not apprise the provider or the member of these authorization numbers. There was a delay in New Directions entering one of the one month authorizations into the claim system, so six lines under a single claim number were denied as not having prior authorization. The claim lines remained unpaid until the provider inquired further. As with the claim in Criticism 11 above, the examiners believed the Company's actions in (1) representing to the provider and the member that the services had not been authorized, (2) denying claim lines for services that had been authorized, (3) failing to investigate its own records for the authorization when the claim was filed, (4) failing to send the provider and the member notice of the one month authorization numbers, and (5) not investigating and paying the claim lines until contacted by the provider were contrary to §§375.1007(1), (3), (4) and (11), and 376.1361.12.

Reference: §§375.1007(1), (3), (4), and (11), and 376.1361.12, RSMo

In response to Criticism 12, the Company agreed in part and disagreed in part giving similar reasons for their disagreement to those given in Criticism 11 above.

4. Criticism 13: The Company denied six lines of ABA services under a single claim number for failure to provide information about the existence of other insurance covering the member for coordination of benefits ("COB") purposes. The member's parent subsequently contacted the Company to provide the COB information, but the Company failed to readjudicate the claim until the provider contacted the Company to inquire about several unpaid claims. The examiners believed that the Company's actions in failing to investigate and pay the unpaid claim lines when it received the COB information until the provider inquired were contrary to §375.1007(3), (4), and (11).

Reference: §375.1007(3), (4), and (11), RSMo

In response to Criticism 13, the Company disagreed that its actions constituted statutory violations and explained that it had standard procedures in place to readjudicate claims when COB information was received, but the customer service representative who received the COB information apparently overlooked this claim.

5. Criticism 14: Authorization for six months of ABA services was provided to the member and the provider, but there was a delay in entering the authorization into the claim system. As a result, the Company denied nine lines under a single claim number for not obtaining prior authorization. The claim lines remained unpaid until the provider inquired about the denials. The examiners believed the Company's actions in (1) denying claim lines for services that had been authorized, (2) failing to investigate its own records for the

authorization when the claim was filed, and (3) not investigating and paying the claim lines until contacted by the provider were contrary to §375.1007(3), (4) and (11).

Reference: §375.1007(3), (4), and (11), RSMo

In response to Criticism 14, the Company disagreed that its actions constituted statutory violations and argued that its (1) establishment of an automated claim processing system, (2) mechanism for providers and members to inquire about denied claims, and (3) establishment of standard operational procedures for investigating and resolving member and/or provider claim inquiries fully complied with the statutory requirements.

6. Criticism 15: Authorization for ABA services was given and entered into the claim system. When claims were subsequently submitted, however, seven claim lines under a single claim number were denied for lack of prior authorization. The claim lines remained unpaid until the provider called to inquire about the denials. The examiners believed the Company's actions in (1) denying claim lines for services that had been authorized, (2) failing to investigate its own records for the authorization when the claim was filed, and (3) not investigating and paying the claim lines until contacted by the provider were contrary to §375.1007(3), (4) and (11).

Reference: §375.1007(3), (4), and (11), RSMo

In response to Criticism 15, the Company disagreed that its actions constituted statutory violations. The Company explained that the denials appeared to be due to an oversight on the part of a claims examiner conducting a manual review, and argued that its (1) establishment of an automated claim processing system, (2) mechanism for providers and members to inquire about denied claims, and (3) establishment of standard operational procedures for investigating and resolving member and/or provider claim inquiries fully complied with the statutory requirements.

7. Criticism 16: A six month authorization for ABA services was given and entered into the claim system. When claims were subsequently submitted, however, three claim lines under a single claim number were denied for the services exceeding the number authorized. The claim lines remained unpaid until the provider called to inquire about the denials. The examiners believed the Company's actions in (1) denying claim lines for services that had been authorized, (2) failing to investigate its own records for the authorization when the claim was filed, and (3) not investigating and paying the claim lines until contacted by the provider were contrary to §375.1007(3), (4) and (11).

Reference: §375.1007(3), (4), and (11), RSMo

In response to Criticism 16, the Company disagreed that its actions constituted statutory violations. The Company explained that the claim was incorrectly matched to the wrong authorization by the claim system, which caused the denial, and argued that its (1) establishment of an automated claim processing system, (2) mechanism for providers and members to inquire about denied claims, and (3) establishment of standard operational

procedures for investigating and resolving member and/or provider claim inquiries fully complied with the statutory requirements.

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 parent, Blue Cross Blue Shield of Kansas City, the examiners noted many instances of claims denied due to delays in the Company 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 with the examiners’ assertion that its actions were inconsistent with §376.1224.7. The Company argued 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 stated that:

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	0	0%
Over 10 days with extension	11	100%
Over 10 days without extension or after extension due date	0	0%
Totals	11	100%

B. Formal Request Time Study

Number of Calendar Days to Respond	Number of Requests	Percentage of Total
0 to 10 days	10	39%
Over 10 days with extension	16	61%
Over 10 days without extension or after extension due date	0	0%
Totals	26	100%

EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Good Health HMO, Inc. d/b/a Blue Care, Inc. (NAIC #95315), Examination Number 1603-23-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 25, 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