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Department of Insurance and Financial Institutions
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Department of Insurance and Financial Institutions

State of Arizona

Market Regulation and Consumer Services Division - Market Conduct Examinations

REPORT OF TARGET MARKET CONDUCT EXAMINATION

OF

Health Net of Arizona Inc., CoCode 95206

AS OF

AUGUST 31, 2021

NAIC MATS # AZ-AILORM-7

AZ Exam # 33356

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Douglas A. Ducey, Governor
Evan G. Daniels, Director

Honorable Evan G. Daniels
Director of Insurance
State of Arizona
100 N. 15th Ave, Suite 261
Phoenix, Arizona 85007-2630

Dear Director Daniels:

Pursuant to your instructions and in conformity with the provisions of the Insurance Laws and Rules of the State of Arizona, an examination has been made of the market conduct affairs of the:

Health Net of Arizona Inc., CoCode 95206

The examination was conducted by Department of Insurance and Financial Institutions staff.

The examination covered the period of January 1, 2018 through December 31, 2019.

As a result of that examination, the following Report of Examination is respectfully submitted.

Sincerely yours,

Maria G. Ailor, AIE, AMCM
Assistant Director
Market Regulation and Consumer Services Division

FOREWORD

This targeted market conduct examination report of Health Net of Arizona Inc. (herein referred to as the "Company"), was prepared by employees of the Arizona Department of Insurance and Financial Institutions (Department). The purpose of a targeted market conduct examination is to review business practices of insurers licensed to conduct the business of insurance in the state of Arizona to determine compliance with State and Federal insurance laws. The Department conducted the examination of the Company in accordance with Arizona Revised Statutes (A.R.S.) §§ 20-142, 20-156, 20-157, 20-158 and 20-159. The findings in this report, including all work product developed in the production of this report, are the sole property of the Department.

The examination of the Company consisted of a review of the following business operations for the Company's accident and health insurance lines of business:

1. Health Care Appeals
2. Ambulance Claims
3. Provider Network Adequacy
4. Balance Billing
5. Benefit Representation
6. Newborn Screening and Coverage
7. Timely Payment of Claims
8. Provider Grievances
9. Deductible Accumulator
10. Consumer Complaints
11. Monitoring and Oversight

Certain unacceptable or non-compliant practices may not have been discovered if they were outside the scope of the examination and/or were not preliminarily identified as an area of concern. However, failure to identify or criticize specific Company practices does not constitute acceptance of those practices by the Department. If findings outside the scope of these areas were discovered in the course of the examination, they are included in the report.

SCOPE AND METHODOLOGY

The Department conducted a Targeted Market Conduct Examination of the Company's accident and health insurance operations for the review period January 1, 2018 through December 31, 2019. The focus of the examination was to ensure compliance with the Corrective Action Plan (CAP) the Company submitted to the Department on August 2, 2019 to address violations relative to Health Care Appeals, Ambulance Claims, Provider Network Adequacy, Balance Billing, Benefit Representation, Newborn Screening and Coverage, Timely Payment

of Claims, Provider Grievances, Deductible Accumulator, Consumer Complaints, and Monitoring and Oversight.

The examination did not involve any testing as outlined in the NAIC Market Regulation Handbook, because the Company agreed to engage in a CAP in lieu of a test of standards. In order to ensure the completion of the CAP, the Company was required to submit a monthly report demonstrating its progress in completing the action steps, objectives, and milestones articulated in the plan along with supporting documentation and metrics.

Administration of accident and health insurance is generally regulated by the insurance laws of each applicable state as overseen by the state's insurance department. However, the body of federal laws and regulations related to the Patient Protection and Affordable Care Act (PPACA or ACA) also apply to many health insurance products, particularly major medical health insurance plans.

HISTORY OF THE COMPANY

The Company is a wholly owned subsidiary of Health Net Inc. (HNI), which is a wholly owned subsidiary of Centene Corporation (Centene), a Delaware stock corporation. Centene acquired HNI effective March 24, 2016.

The Company was formed as a Health Maintenance Organization (HMO) for the purpose of providing comprehensive managed healthcare services to residents of Arizona. The Company is licensed to provide such services to residents throughout the State of Arizona. Membership operations commenced on November 1, 1982. The Company contracts directly with healthcare providers on fee for service, diagnostic rate grouping, per diem, and capitated[1] bases.

The Company provides healthcare services to individuals through government subsidized programs, including Medicare through its contract with the Centers for Medicare and Medicare Services (CMS). The Company also offers health plans through federally facilitated exchanges where individuals may purchase health coverage under regulations established by the U.S. Department of Health and Human Services (HSS). In 2019, the Company ended its small group, large group, and Federal Employee Health Benefits Program (FEHBP) Business.

EXAMINATION OVERVIEW

Examination Background

The Department sent a letter to the Company on July 11, 2019 to advise that the Department had identified several areas of noncompliance with Arizona statute in the areas of Health Care Appeals, Ambulance Claims, Provider Network Adequacy, Balance Billing, Benefit Representation, Newborn Screening and Coverage, Timely Payment of Claims, Provider Grievances, Deductible Accumulator, Consumer Complaints, and Monitoring and Oversight. The letter instructed the Company to submit the following in response to the Department's concerns:

- A CAP with a list of action steps, objectives, and milestones addressing each of the areas of

[1] Capitated payments refers to a contractual relationship whereby the plan pays a fixed amount per member for a specified time period for services.

noncompliance;

- A template for a monthly report that would show the Company's progress in completing the action steps, objectives, and milestones articulated in the CAP; and
- Samples of supporting documentation and metrics that the Company would provide with the monthly report.

In response to the letter dated July 11, 2019, the Company submitted a CAP to the Department on August 2, 2019 detailing how it planned to address each of the areas of noncompliance.

The Department sent a Call Letter to the Company on October 31, 2019 advising that the Department was conducting a Targeted Market Conduct Examination of the Company's accident and health insurance operations for the review period January 1, 2018 through December 31, 2019. The focus of the examination was to ensure compliance with the Corrective Action Plan (CAP) the Company submitted to the Department on August 2, 2019 to address violations relative to Health Care Appeals, Ambulance Claims, Provider Network Adequacy, Balance Billing, Benefit Representation, Newborn Screening and Coverage, Timely Payment of Claims, Provider Grievances, Deductible Accumulator, Consumer Complaints, and Monitoring and Oversight.

Examination Objectives

The objective of the examination was to ensure completion of the action steps, objectives, and milestones detailed in the CAP the Company submitted to the Department on August 2, 2019. This included reviewing the monthly reports submitted by the Company including all supporting documentation and metrics and meeting with the Company monthly to discuss the CAP.

Executive Summary

The Department sent a letter to the Company on July 11, 2019 to advise that the Department had identified several areas of noncompliance with Arizona statute in the areas of Health Care Appeals, Ambulance Claims, Provider Network Adequacy, Balance Billing, Benefit Representation, Newborn Screening and Coverage, Timely Payment of Claims, Provider Grievances, Deductible Accumulator, Consumer Complaints, and Monitoring and Oversight.

In response to the letter dated July 11, 2019, the Company submitted a CAP to the Department on August 2, 2019 detailing how it planned to address each of the areas of noncompliance. For each area of noncompliance the Department had identified, the Company identified the underlying components contributing to the issue and developed a set of action steps it would take to resolve each of the components. The Department held monthly meetings with the Company as it implemented the action steps laid out in the CAP to offer guidance and input.

On December 1, 2020, the Company reported to the Department that they had completed all of the action steps laid out in the CAP and requested that the examination be formally closed. However, the Department noted that it continued to receive consumer complaints related to Health Care Appeals, Provider Network Adequacy, Newborn Screening and Coverage, Timely Payment of Claims, and Oversight and Monitoring. All other issues

addressed by the CAP including Ambulance Claims, Balance Billing, Benefit Representation, Provider Grievances, Deductible Accumulator, and Consumer Complaints appear to have been resolved.

On August 20, 2021 the Company submitted additional information related to the remaining outstanding items including Health Care Appeals, Provider Network Adequacy, Newborn Screening and Coverage, Timely Payment of Claims, and Oversight and Monitoring. The information provided substantiated that the Company had taken the steps necessary to fully remediate these issues and had adequate processes in place to ensure ongoing compliance.

ISSUES AND CORRECTIVE ACTION PLAN

Issue 1: Health Care Appeals (A.R.S. §§ 20-2530 through 20-2538)

1. The Company failed to send timely Acknowledgement Letters for Level 3 Standard and Expedited Appeals.

   CORRECTIVE ACTION

   The Company will develop policies and procedures for standard and expedited health care appeals, conduct training on the policies and procedures, and create workflows to support these processes.

   The Company will review the Acknowledgment and Decision Letter Templates and packet checklist for compliance with statutes for standard and expedited Health Care Appeals.

   The Company will develop a backup process to submit responses to the Department for both appeals and complaints if the Department system is down.

   The Company will create a coding system for its grievances and appeals to allow for better data tracking and analysis, and conduct staff training on the coding system.

   The Company will develop metrics for appeal and grievance data for better monitoring and oversight.

   Finally, the Company will develop performance metrics associated with the policies and procedures, specifically for Level 3 appeals, and establish a process to monitor the performance metrics.

   SUBSEQUENT EVENT

   Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

2. The Company failed to submit complete records for Level 3 Standard and Expedited Appeals.

   CORRECTIVE ACTION

   The Company will develop policies and procedures for standard and expedited health care appeals, , conduct training on the policies and procedures, and create workflows to support these processes.

   The Company will review the Acknowledgment and Decision Letter Templates and packet checklist for compliance with statutes for standard and expedited Health Care Appeals.

   The Company will develop a backup process to submit responses to the Department for both appeals and complaints if the Department system is down.

   The Company will create a coding system for its grievances and appeals to allow for better data tracking and analysis, and conduct staff training on the coding system.

   The Company will develop metrics for appeals and grievances data for better monitoring and oversight.

   Finally, the Company will develop performance metrics associated with the policies and procedures, specifically for Level 3 appeals, and establish a process to monitor the performance metrics.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

3. The Company failed to submit medical records for Level 3 Standard and Expedited Appeals and consumer complaints from the Department.

CORRECTIVE ACTION

The Company will develop policies and procedures for standard and expedited health care appeals, conduct training on the policies and procedures, and create workflows to support these processes.

The Company will review the Acknowledgment and Decision Letter Templates and packet checklist for compliance with statutes for standard and expedited Health Care Appeals.

The Company will develop a backup process to submit responses to the Department for both appeals and complaints if the Department system is down.

The Company will create a coding system for its grievances and appeals to allow for better data tracking and analysis, and conduct staff training on the coding system.

The Company will develop metrics for appeals and grievances data for better monitoring and oversight.

Finally, the Company will develop performance metrics associated with the policies and procedures, specifically for Level 3 appeals, and establish a process to monitor the performance metrics.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

4. The Company's process for Level 1 Standard and Expedited Appeals was not complaint with Arizona statutes and rules.

The Company will revise its current policies and procedures for Level 1 standard and expedited health care appeals, conduct training on the policies and procedures, and create workflows to support these processes.

The Company will review the Acknowledgment and Decision Letter Templates and packet checklist for compliance with statutes for standard and expedited Health Care Appeals.

5. The Company failed to process Level 2 Standard and Expedited Appeals in a timely manner.

CORRECTIVE ACTION

The Company will develop policies and procedures for Level 2 standard and expedited health care appeals, conduct training on the policies and procedures, and create workflows to support these processes.

The Company will review the Acknowledgment and Decision Letter Templates and packet checklist for

compliance with statutes for standard and expedited Health Care Appeals.

The Company will develop a backup process to submit responses to the Department for both appeals and complaints if the Department system is down.

The Company will create a coding system for its grievances and appeals to allow for better data tracking and analysis, and conduct staff training on the coding system.

The Company will develop metrics for appeals and grievances data for better monitoring and oversight.

Finally, the Company will develop performance metrics associated with the policies and procedures, specifically for Level 3 appeals, and establish a process to monitor the performance metrics.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

6. The Company incorrectly categorized its appeals and complaint cases.

CORRECTIVE ACTION

The Company will develop policies and procedures for standard and expedited health care appeals, conduct training on the policies and procedures, and create workflows to support these processes.

The Company will review the Acknowledgment and Decision Letter Templates and packet checklist for compliance with statutes for Health Care Appeal, standard and expedited.

The Company will develop a backup process to submit responses to the Department for both appeals and complaints if the Department system is down.

The Company will create a coding system for its grievances and appeals to allow for better data tracking and analysis, and conduct staff training on the coding system.

The Company will develop metrics for appeals and grievances data for better monitoring and oversight.

Finally, the Company will develop performance metrics associated with the policies and procedures, specifically for Level 3 appeals, and establish a process to monitor the performance metrics.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

7. The Company failed to process appeals and complaint cases in a timely manner.

CORRECTIVE ACTION

The Company will develop policies and procedures for standard and expedited health care appeals, conduct training on the policies and procedures, and create workflows to support these processes.

The Company will review the Acknowledgment and Decision Letter Templates and packet checklist for

compliance with statutes for standard and expedited Health Care Appeal.

The Company will develop a backup process to submit responses to the Department for both appeals and complaints if the Department system is down.

The Company will create a coding system for its grievances and appeals to allow for better data tracking and analysis, and conducted staff training on the coding system.

The Company will develop metrics for appeals and grievances data for better monitoring and oversight.

Finally, the Company will develop performance metrics associated with the policy and procedure, specifically for Level 3 appeals, and established a process to monitor the performance metrics.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

Issue 2: Ambulance Claims (A.R.S. §§ 20-461(A)(6), 20-462, 20-3102(A), 36-2239(D))

1. The Company incorrectly calculated interest on ambulance claims.

   CORRECTIVE ACTION

   The Company will ensure that its claim system is correctly configured to pay interest in accordance with Arizona law and implement a monitoring process to track issues related to ambulance claims.

   The Company will reprocess ambulance claims from 2018 through 2019 to pay the 10% interest per annum required by law.

   SUBSEQUENT EVENT

   Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

   The Company reprocessed ambulance claims for 132 members and paid an additional $1,933.40 in interest for their ambulance claims.

2. The Company inappropriately denied ambulance claims due to taxonomy codes. Specifically, claims from non-contracted providers were denied for incorrect/lack of taxonomy codes.

   CORRECTIVE ACTION

   The Company will establish a process to contact providers who submit claims without the required taxonomy code to advise them of the process for resubmitting the claim with the correct code. This communication will include specific instructions for those providers who submit paper claims when necessary.

   SUBSEQUENT EVENT

   Throughout the examination the Company submitted documentation to support each action step they

took to complete these CAP items.

Issue 3: Provider Network Adequacy (A.R.S. § 20-3102, AAC R20-6-1911, and R20-6-1912)

1. The Company failed to have an effective process for communicating changes in provider network availability to its contracted providers.

CORRECTIVE ACTION

The Company will develop a Provider Communication Policy and Procedure that includes processes for sending Member Communications that includes:

- Establishing a threshold for member notification when a provider terminates from the network (≤ 5% of the network or membership are impacted by a change to Provider Network Availability);
- Notification of material change submission to the Department of Insurance; and
- Review and approval of the notification both cross functionally and by the executive management team.

The Company will develop a tracking mechanism for member and provider communications related to operational or claims payment system changes.

The Company will create an employee training program with information on how and when to submit requests for provider communications, and a training program for employees with direct responsibility for creating and distributing provider communications.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

2. The Company failed to have an effective process for communicating procedures for handling claims to contracted providers.

CORRECTIVE ACTION

The Company will develop a Provider Communication Policy and Procedure that includes processes for sending Member Communications including:

- Establishing a threshold for member notification when a provider terminates from the network (≤ 5% of the network or membership are impacted by a change to Provider Network Availability);
- Notification of material change submission to the Department of Insurance; and
- Review and approval of the notification both cross functionally and by the executive management team.

The Company will develop a tracking mechanism for member and provider communications related to operational or claims payment system changes.

The Company will create an employee training program with information on how and when to submit requests for provider communications, and a training program for employees with direct responsibility for creating and distributing provider communications.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

3. The Company sent members inaccurate Explanation of Benefits (EOB) forms due to claims processing errors resulting from provider pay class codes not being configured correctly.

CORRECTIVE ACTION

The Company will establish internal claim audits to identify errors and correct claims that includes a timeline for investigation, escalation, and resolution.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

4. The Company failed to have an effective process for communicating grievance procedures to contracted providers.

CORRECTIVE ACTION

The Company will revise its provider grievance policies and procedures to include effectuation processes and timeframes.

The Company will develop a comprehensive provider grievance process beyond the policies and procedures that includes adding instructions for filing a grievance to the Provider Manual, website, and new provider orientation checklist. The Company will also send a communication to all providers to inform them of the availability of the new information and forms.

The Company will develop training for staff regarding the provider grievance process.

The Company will develop a management oversight tool to track timely processing of provider grievances.

Finally, the Company will establish an auditing process to ensure compliance with the provider grievance policies and procedures.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they

took to complete these CAP items.

5. The Company failed to maintain accurate provider directories, including the provider contract status.

CORRECTIVE ACTION

The Company will establish a dedicated team responsible for maintaining the accuracy of the provider directories and hire a manager to oversee this team.

The Company will develop policies and procedures for complying with Arizona specific regulations regarding provider roster loading, develop staff training regarding the policies and procedures, revise the performance metrics associated with the policies and procedures, and establish a process to monitor the performance metrics and escalate any issues.

The Company will establish cross functional management meetings dedicated to discussing provider directory needs and issues.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

6. The Company denied claims because the claim system contained inaccurate information on the provider type and specialty.

CORRECTIVE ACTION

The Company will establish a dedicated team responsible for maintaining the accuracy of the provider directories and hire a manager to oversee this team.

The Company will develop policies and procedures for complying with Arizona specific regulations regarding provider roster loading, develop staff training regarding the policies and procedures, revise the performance metrics associated with the policies and procedures, and establish a process to monitor the performance metrics and escalate any issues.

The Company will establish cross functional management meetings dedicated to discussing provider directory needs and issues.

The Company determined that it incorrectly applied emergency room cost sharing to urgent care services due to a benefit configuration error. This impacted 840 claims in 2018 and 321 claims in 2019. The Company will resolve the configuration error and correct all of the impacted claims. The Company will also identify the issues that lead to this error and create policies and procedures to resolve them.

SUBSEQUENT EVENT:

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

The Company reprocessed urgent care claims to which emergency room cost sharing was incorrectly

applied during the period 2018 through 2019. There were 1,161 claims reprocessed resulting in additional payments of $66,191.00.

Issue 4: Balance Billing (A.R.S. §§ 20-461(A)(6), 20-142(A), 20-1051(5) and AAC R20-6-1904 and R20-6-1910)

1. The Company failed to pay claims for care rendered by out-of-network providers at in-network facilities and for emergency care provided by out-of network providers in a manner that would ensure members were not held liable for any costs that should be the responsibility the Company per Arizona law.

   CORRECTIVE ACTION
   The Company will conduct a survey to proactively identify members who were enrolled during 2018 or 2019 to resolve balance billing issues. Once the surveys are returned the Company will review the responses and reimburse any member who paid a provider for services that were balance billed with the applicable 10% per annum interest.

   The Company will implement a process to execute negotiated single case agreements (SCA) with out-of-network providers, if necessary, to prevent members from being balanced billed.

   The Company will develop policies and procedures to clarify how claims should be adjudicated to prevent balance billing.

   Finally, the Company will revise its EOB form for members and Explanation of Payment (EOP) form for providers to more clearly explain balance billing requirements.

   SUBSEQUENT EVENT
   Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

   As a result of the survey the Company conducted there were 696 providers and 9 members whose claims were reprocessed resulting in payments of $2,065,357.00.

2. The Company's staff made incorrect statements to members that the Company was only responsible for paying the Medicare rate for out-of-network providers, and that the member would be subject to balance billing.

   CORRECTIVE ACTION
   The Company will train its appeals and grievances staff on balance billing requirements and develop an appeals and grievances team dedicated to handling balance billing issues.

   SUBSEQUENT EVENT
   Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

3. The Company's staff made incorrect statements to out-of-network providers that the Company was only responsible for paying the "median" rate and took no additional steps to ensure the member would not be balanced billed.

   CORRECTIVE ACTION
   The Company will correct the language on its EOB form to ensure it is compliant with Arizona law, create complaint response letters specific to balance billing, and create processes to ensure that Arizona materials contained accurate information related to balance billing.

   SUBSEQUENT EVENT
   Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

4. The Company's staff made incorrect statements/claims to members that the Company cannot communicate directly with the member to resolve balance billing issues, and that the provider must contact the Company to resolve these issues.

   CORRECTIVE ACTION
   The Company will develop training on balance billing for both grievance and appeals staff and the call center representatives and require annual training on balance billing for these staff.

   SUBSEQUENT EVENT
   Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

5. The Company does not have an effective process for handling network exceptions to ensure that a beneficiary is reimbursed directly for out-of-network costs.

   CORRECTIVE ACTION
   The Company will revise its member complaint policies and procedures to ensure that when a complaint related to balance billing is received it is processed in accordance with Arizona law.

   SUBSEQUENT EVENT
   Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

6. The Company violated the terms of a Consent Order filed by the Department on May 6, 2011 related to claims for emergency care received from out-of-network providers and for services performed at in-network facilities by out-of-network providers.

CORRECTIVE ACTION

The Company will implement a process to execute negotiated single case agreements (SCA) with out-of-network providers or to pay billed charges if an agreement cannot be reached within 14 days to prevent members from being balanced billed.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

Issue 5: Benefit Representation (A.R.S. §§ 20-443 and 20-461)

1. The Company misrepresented the plan benefit design for the years 2017, 2018 and 2019 in documents delivered to members.

CORRECTIVE ACTION

The Company will develop policies and procedures to review documents containing benefit and cost sharing information to ensure they are consistent and accurate in their representation of the plan benefits.

The Company will implement quality assurance reviews of documents containing benefit and cost sharing information to mitigate manual input errors.

The Company will utilize an external consultant to conduct an audit of documents for the 2020 benefit year including a review of all summary of benefit and coverage and schedule of benefits documents.

The Company will create a "Filing Manual" to train new staff and ensure existing staff follow the policies and procedures related to document generation.

The Company's parent corporation, Centene, will create a tool to automate document generation that will pull plan benefit information from a single source of truth.

The Company will conduct a coordinated review of the benefit configuration for its Arizona products.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

Issue 6: Newborn Screening and Coverage (A.R.S. §§ 20-461, 20-1051 and 20-1057, AAC R20-6-1902, R20-6-1904, R9-13-203, and R9-13-208)

1. The Company failed to provide coverage in accordance with the plan of benefits which stated that the Company would reimburse required health care services including but not limited to preventive newborn screening laboratory testing.

CORRECTIVE ACTION

The Company will correct the claim system configuration retrospectively back to 01/01/2018 to pay newborn screening laboratory testing claims in accordance with the plan of benefits.

The Company will develop processes to review and reprocess newborn claims received from 01/01/2018 through 12/31/2019 in accordance with the plan of benefits including 10% per annum interest.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete the CAP items were complete.

The Company corrected its system configuration retrospectively to pay for newborn screening laboratory testing resulting in claims being reprocessed for 62 members with payments totaling $102,509.65.

The Company reviewed and manually reprocessed newborn claims, other than those for newborn screening, for the period 01/01/2018 through 10/31/2019 because they could not be corrected through system configuration. This resulted in claims being reprocessed for a total of 582 members and payments totaling $1,656,584.00.

2. The Company inconsistently responded to appeals and grievances related to newborn claims. Some were overturned while others were denied.

CORRECTIVE ACTION:

The Company will train its appeals and grievances staff on newborn coverage requirements.

SUBSEQUENT EVENT:

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

3. The Company failed to identify trends in its claims data related to newborn claim handling issues.

CORRECTIVE ACTION

The Company will develop a coding system for its appeals and grievances that will allow for enhanced tracking of data, including newborn claim handling issues, train appeals and grievances staff on the coding system, and develop a reference document for staff to utilize to supplement the training.

The Company will develop a monthly data analysis process to identify trends related to appeals and grievances using the coding system.

SUBSEQUENT EVENT:

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

Issue 7: Timely Payment of Claims (A.R.S. § 20-3102 and AAC R20-6-1911(3))

1. The Company failed to timely pay clean claims to both contracted and non-contracted providers.

   CORRECTIVE ACTION
   The Company will establish a process to monitor pending claims to ensure they are processed in a timely manner.

   The Company will also develop a process to identify and correct provider data issues.

   SUBSEQUENT EVENT
   Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

2. The Company failed to pay the contracted rate to in network providers.

   CORRECTIVE ACTION
   The Company will establish internal claim audits to identify errors and correct claims that includes a timeline for investigation, escalation, and action.

   SUBSEQUENT EVENT
   Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

3. The Company failed to communicate taxonomy code changes in a timely manner resulting in incorrect claim payments.

   CORRECTIVE ACTION
   The Company will establish a standing agenda item as part of its product team meeting to discuss operational changes that may impact the provider network.

   SUBSEQUENT EVENT
   Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

4. The Company failed to correct provider load errors related to contracting status in a timely manner resulting in incorrect claim payments.

   CORRECTIVE ACTION
   The Company will develop policies and procedures for complying with Arizona's specific regulations regarding provider roster loading, develop staff training regarding the policies and procedures, revise the performance metrics associated with the policies and procedures, and establish a process to monitor the performance metrics and escalate any issues.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

5. The Company identified a data synchronization error between the member eligibility system and the claims system that resulted in erroneous claim denials.

   CORRECTIVE ACTION

   The Company will resolve the synchronization issue then identify and reprocess all impacted claims.

   SUBSEQUENT EVENT

   Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

   The Company resolved the synchronization issue then identified and reprocessed the impacted claims for 150 members resulting in payments of $45,031.94.

6. The Company did not have policies and procedures in place to retroactively review and reprocess claims en masse.

   CORRECTIVE ACTION

   The Company will develop policies and procedures for retroactively reviewing and reprocessing claims en masse that includes timelines and processes for member communications.

   SUBSEQUENT EVENT

   Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

Issue 8: Provider Grievances (A.R.S. § 20-3101 and 20-3102 and Regulatory Bulletin 2006-02)

1. The Company failed to establish an effective internal system for resolving provider payment disputes and contractual grievances.

   CORRECTIVE ACTION

   The Company will develop policies and procedures for complying with provider grievance requirements, develop staff training regarding the policies and procedures, revise the performance metrics associated with the policies and procedures, and establish a process to monitor the performance metrics and escalate any issues.

   The Company will also develop a comprehensive provider grievance process beyond the policies and procedures including adding/revising the instructions for filing a grievance in the Provider Manual, on its website, and on its new provider orientation checklist. Then, the Company will send a communication to

all its providers to inform them of the new information and forms available in the Provider Manual and on the website.

The Company will develop a training program for staff regarding the provider grievance process.

The Company will develop a management oversight tool to track timely processing of provider grievance cases.

Finally, the Company will establish an auditing process to ensure compliance with the provider grievance policies and procedures.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

2. The Company failed to resolve provider grievances timely and accurately.

CORRECTIVE ACTION

The Company will develop policies and procedures for complying with provider grievance requirements, develop staff training regarding the policies and procedures, revise the performance metrics associated with the policies and procedures, and establish a process to monitor the performance metrics and escalate any issues.

The Company will also developed a comprehensive provider grievance process beyond the policies and procedures including adding/revising the instructions for filing a grievance in the Provider Manual, on its website, and in its new provider orientation checklist. Then, the Company will send a communication to all its providers to inform them of the new information and forms available in the Provider Manual and on the website.

The Company will develop a training program for staff regarding the provider grievance process.

The Company will develop a management oversight tool to track timely processing of provider grievance cases.

Finally, the Company will establish an auditing process to ensure compliance with the provider grievance policies and procedures.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

3. The Company identified ongoing trends with providers expressing dissatisfaction with the Company's provider grievance processes.

CORRECTIVE ACTION

The Company will develop a process to escalate provider grievances to a Provider Engagement Specialist.

The Company will also develop a management oversight tool to track timely processing of provider grievance cases.

The Company will formalize the provider grievance escalation processes as part of the provider grievance policies and procedures.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

4. The Company is not reprocessing claims associated with provider grievances timely or accurately.

CORRECTIVE ACTION

The Company will revise its policies and procedures for provider grievances to include the specific requirements for timely handling of the grievance and reprocessing of claims, develop staff training programs regarding the policies and procedures, revise the performance metrics associated with the policies and procedures, and establish a process to monitor the performance metrics and escalate any issues.

The Company will develop a training program for staff regarding the provider grievance process.

The Company will develop a management oversight tool to track timely processing of provider grievance cases.

Finally, the Company will establish an auditing process to ensure compliance with the provider grievance policies and procedures.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

5. The Company is not correcting provider directory errors in a timely manner which results in incorrect claim payments.

CORRECTIVE ACTION

The Company will establish a dedicated team responsible for maintaining the accuracy of the provider directories and hire a manager to oversee this team.

The Company will develop policies and procedures for complying with Arizona's specific regulation regarding provider roster loading, develop staff training regarding the policies and procedures, revise the performance metrics associated with the policies and procedures, and establish a process to monitor the performance metrics and escalate any issues.

The Company will establish cross functional management meetings dedicated to discussing provider directory needs and issues.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

Issue 9: Deductible Accumulator (A.R.S. § 20-461(A)(6) and AAC R20-6-802(E)(2))

1. The Company failed to correctly calculate deductible accumulator totals for its members.

   CORRECTIVE ACTION:

   The Company will develop an Accumulator Governance Committee to identify and prioritize accumulator issues.

   The Company will also enhance its Member Portal to show detailed accumulator data and revise its EOB form to show detailed accumulator information. While the portal updates are underway, the Company will develop a work around to remediate accumulator issues to send members a letter with the correct claim and accumulator totals.

   The Company will develop training for providers regarding the grievance process.

   The Company will refine the call center escalation policies and procedures, create workflows, and train call center staff on the process.

   The Company will identify all members impacted by the incorrect accumulator totals, systematically reprocess claims for those members, and issue refunds to providers who in turn will be required to reimburse members.

   The Company will establish a validation process for mass production updates to ensure there are no errors.

   The Company will modify its data loading process to ensure sufficient auditing and testing is conducted before roll out.

   SUBSEQUENT EVENT:

   Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

   The Company identified all members impacted by the incorrect accumulator totals and reprocessed their claims. This resulted in payments of $823,228.83 to 4,799 members in December 2019 and an additional $2,973.29 to 3 members in November 2020.

2. The Company provided incorrect information to its members and providers about deductible accumulator totals.

CORRECTIVE ACTION

The Company will provide training to its call center and appeals and grievances staff on answering member and provider questions regarding deducible accumulator totals.

The Company will automate the data loading processes for the deductible accumulator information on the member and provider portals if one of the files fails to load.

The Company will develop policies and procedures for displaying disclaimer language on the member and provider portals if/when an error is identified with the deductible accumulator information.

The Company will develop a process to review EOB form mailing jobs including validating the data produced by the vendor.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

Issue 10: Consumer Complaints (A.R.S. § 20-461 and AAC R20-6-801(E)(2))

1. The Company failed to respond in a timely and adequate manner to consumer complaints from the Department.

CORRECTIVE ACTION

The Company will develop policies and procedures to respond to consumer complaints from the Department that includes process for checking if there is already a complaint on file from the member, a checklist of required documents, and a process for reviewing the response before it is submitted to the Department.

The Company will also conduct training for its appeals and grievances and call center staff on the policies and procedures and develop work flows to support the process.

The Company will create annual performance goals for the timely processing of consumer complaints.

The Company will develop a management oversight tool to track timely processing of member grievances.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

2. The Company failed to identify the systemic errors in its consumer complaint handling processes.

CORRECTIVE ACTION

The Company will develop policies and procedures to respond to consumer complaints from the Department that will include a process for checking if there is already a complaint on file from the

member, a checklist of required documents, and a process for reviewing the response before it is submitted to the Department.

The Company will also conduct training for its appeals and grievances and call center staff on the policies and procedures and develop work flows to support the process.

The Company will create annual performance goals for the timely processing of consumer complaints.

The Company will develop a management oversight tool to track timely processing of member grievances.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

3. The Company has a much higher volume of consumer complaints than other similarly situated companies in Arizona.

CORRECTIVE ACTION

The Company will develop an Accumulator Governance Committee to identify and prioritize accumulator issues.

The Company will develop training for providers regarding the grievance process.

The Company will refine the call center escalation policies and procedures, create workflows, and train call center staff on the process.

The Company will develop a weekly report to evaluate trends in consumer call data and develop a process to escalate the issues to ensure a more rapid response.

The Company will develop a report to identify trends in claim overturns to evaluate gaps in provider knowledge or resource materials regarding claim and prior authorization submissions.

The Company will create a Quality Improvement Committee responsible for reviewing trends in appeals and grievances data and identifying areas for process improvement.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

ISSUE 11 - Monitoring and Oversight (A.R.S. §§ 20-2530 to20-2538, 20-3101 and 20-3102, ADOI Circular Letter 2000-13 Health Care Appeals Laws Revisions from HB 2600 and SB 1330, and ADOI Regulatory Bulletin 2006-02 Health Care Provider Timely Payment and Grievance Law)

1. The Company failed to review the substance of inquiries and complaints from members and providers to identify systemic issues with it operational processes including network adequacy, claims, grievances and appeals, policyholder services, and complaint handling.

CORRECTIVE ACTION

The Company will develop policies and procedures for operational areas including health care appeals, provider grievances, and consumer complaints, conduct training on the policies and procedures, and create workflows to support these processes.

The Company will create a coding system for its grievances and appeals to allow for better data tracking and analysis, and conduct staff training on the coding system.

The Company will develop metrics for appeals and grievances data and create a process to escalate the results to compliance and executive management when necessary.

The Company will form a quality improvement committee to monitor performance metrics for each operational area to identify issues and oversee issue resolution.

The Company will refine the call center escalation policies and procedures, create workflows, and train call center staff on the process. This escalation process will include instructions to refer issues related to benefit misrepresentation to compliance for resolution.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

2. The Company failed to analyze claim denial and other available data to identify systemic issues with operational areas including network adequacy, claims, grievance and appeals, policyholder services, and complaint handling.

CORRECTIVE ACTION

The Company will establish internal claim audits to identify errors and correct claims including establishing a timeline for investigation, escalation, and resolution.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

3. The Company failed to appropriately classify complaint reasons and resolutions which would have allowed for better issue tracking.

CORRECTIVE ACTION

The Company will create standardized codes for its grievances and appeals to allow for better data tracking and analysis, and conduct training on the coding.

The Company will develop metrics for appeals and grievances data and create a process to escalate the results to compliance and executive management when necessary.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.

4. The Company failed to consider the outcomes of operational decisions, such as policy and procedure changes or system updates, to identify possible issues including negative impacts to members and providers and/or violations of Arizona law.

CORRECTIVE ACTION

The Company will establish a panel of members who meet quarterly to review system changes and policies and procedures to provide feedback.

The Company will also establish a bi-annual provider meeting to review system changes and policies and procedures for feedback.

The Company will form a quality improvement committee to monitor performance metrics for each operational area to identify issues and oversee issue resolution.

SUBSEQUENT EVENT

Throughout the examination the Company submitted documentation to support each action step they took to complete these CAP items.