BEFORE ALLAN L. MCVEY, INSURANCE COMMISSIONER
OF THE STATE OF WEST VIRGINIA

In the Matter of:

CARESOURCE WEST VIRGINIA CO.

Administrative Proceeding No. 21-IC-02123

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER ADOPTING REPORT OF MARKET CONDUCT COMPLIANCE EXAMINATION, ASSESSING PENALTY AND DIRECTING CORRECTIVE ACTION

NOW COMES, Allan L. McVey, Insurance Commissioner of the State of West Virginia (hereinafter, "Commissioner"), who, after consideration of the *Report of Market Conduct Examination* (hereinafter, the "*Examination Report*") of CareSource West Virginia Co. (hereinafter, "CareSource") for the examination period ending March 31, 2021, made the following findings of fact and conclusions of law and order.

FINDINGS OF FACT

1. The market conduct examination focused on selected standards contained in the *Market Regulation Handbook.* The examination was conducted in accordance with *W. Va. Code* §33-2-9(c) by examiners duly appointed by the Commissioner and covered the period ending March 31, 2021.

2. On or about October 18, 2022, the examiner filed with the Commissioner, pursuant to W. Va. Code §33-2-9, the *Examination Report*.

3. A true copy of the *Examination Report* was provided to CareSource and CareSource was notified, pursuant to *W.Va. Code* §33-2-9(j)(2), that it had ten (10) days after receipt of the *Examination Report* to file a submission or rebuttal with the Commissioner.

4. As set forth in the *Examination Report*, the examination focused on the methods used by CareSource to manage its operations for each of the areas examined, including whether and how CareSource complies with West Virginia's statutory and regulatory law.

5. The exam discovered instances where CareSource was non-compliant with West Virginia law.

6. The Commissioner reviewed the *Examination Report* and considered CareSource submissions prior to issuing these findings of fact, conclusions of law and order.

CONCLUSIONS OF LAW

1. The Commissioner has jurisdiction over the subject matter and the parties to this proceeding.

2. This proceeding is conducted pursuant to and in accordance with *W. Va. Code* §33-2-9.

3. The Commissioner is charged with the responsibility of verifying CareSource's continued compliance with West Virginia law.

4. As detailed in the *Examination Report*, CareSource was non-compliant with provisions of West Virginia law as follows:

- Standard B4: CareSource did not timely respond to two (2) complaints received from the Commissioner.

- Standard D1: CareSource's records of appointed insurance producers did not match the Commissioner's records.
- Standard D2: CareSource failed to send notifications to six (6) terminated producers as required by W.Va. Code § 33-12-25(d).
- Standard E3: CareSource sent cancellation notices to three members prior to the grace period established in internal standards and one invoice had a due date set earlier than internal standards.
- Standard H3: CareSource did not issue acknowledgement letters in fifty-seven (57) first level reviews in grievances and four (4) letters could not be located for grievances submitted by members. Additionally, thirty-seven (37) decision letters could not be located for grievances resulting in upheld reviews.
- Standard H4: The decision letters did not provide notice of the covered person's right to contact the Commissioner pursuant to W.Va. Code R. § 114-96-6.5.e.
- Standard I5: Newly credentialed providers were not consistently added to the provider directory pursuant to W.Va. Code § 33-55-4(a)(2)(A).

5. The Commissioner has determined that CareSource should be assessed a penalty and should file a corrective action plan to address the aforementioned violations.

ORDER

Pursuant to W.Va. Code §33-2-9(j)(3)(A), following the review of the *Examination Report*, the examination work papers, and CareSource's response thereto, it is **ORDERED** as follows:

1. The referenced and attached *Examination Report* is hereby **ADOPTED** and **APPROVED** and by this reference, incorporated herein and made a part hereof;

2. CareSource shall endeavor to comply with the recommendations contained in the *Examination Report*;

3. CareSource shall continue to monitor its compliance with applicable West Virginia law;

4. CareSource shall specifically cure the violations and deficiencies identified in the *Examination Report* so as to bring itself into compliance and conformity with West Virginia law, as set forth hereinabove, to the extent such has not already been completed and/or accomplished;

5. CareSource shall file a Corrective Action Plan (CAP), subject to the approval of the Commissioner, which said CAP shall detail CareSource's changes to its procedures and/or internal policies to ensure compliance with West Virginia law and shall further incorporate all recommendations of the Commissioner's examiners and address all violations specifically cited in the *Examination Report*;

6. The CAP shall be submitted to the Commissioner for his approval within 30 days of the date this order is entered;

7. CareSource shall make reasonable changes to the CAP if and as directed by the Commissioner within 30 days of its receipt of the Commissioner's changes to, or disapproval of, the CAP;

8. CareSource shall, within 90 days of its receipt of notice from the Commissioner of his final approval thereof, implement the CAP; and

9. CareSource shall pay an administrative penalty in the amount of Thirty-Eight Thousand Five Hundred Dollars ($38,500.00) for its non-compliance with West Virginia law as

set forth hereinabove. The assessment of said penalty is in lieu of any other regulatory penalty and it shall be remitted within 30 calendar days of the date this order is entered.

Entered this 19th day of December, 2022.

Allan L. McVey
CPCU, ARM, AAI, AAM, AIS
Insurance Commissioner

Report of Market Conduct Examination

As of March 31, 2021

CareSource West Virginia Co.

230 North Main Street
Dayton, OH 45402

NAIC COMPANY CODE 15728
Examination Number 21-IC-02123

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October 18, 2022

The Honorable Allan L. McVey, CPCU, ARM, AAI, AAM, AIS
West Virginia Insurance Commissioner
900 Pennsylvania Avenue
Charleston, West Virginia 25302

Dear Commissioner McVey:

Pursuant to your instructions and in accordance with *W.Va. Code §33-2-9*, an examination has been made as of March 31, 2021 of the business affairs of:

CareSource West Virginia Co.
230 North Main Street
Dayton, OH 45402

Hereinafter referred to as the "Company." The following report of the findings of this examination is herewith respectfully submitted.

COMPLIANCE WITH PREVIOUS EXAMINATION FINDINGS

The West Virginia Office of the Insurance Commissioner ("WVOIC") previously conducted a comprehensive market conduct examination of the Company as of June 30, 2017.

The June 30, 2017 examination major areas of concern included:

- Member responsibility overstated on certain out of network claims (Standard G3).
  - *2021 Update: No issues of overstated cost shares observed for out of network claims.*
- Awkward (if not inaccurate) language on Explanations of Benefits (EOBs) (Standard G3).
  - *2021 Update: Language was corrected as recommended*
- Timeliness of processing in and out of network claims (Standard G1).
  - *2021 Update: No late processing times observed during testing.*
- Failure to pay interest on late payments of in network claims (Standard G1).
  - *2021 Update: No late payments were observed during testing.*
- Improper application of member cost sharing to certain preventative service claims (Standard G1).
  - *2021 Update: One instance was noted of improper application of member cost sharing.*
- Certain disclosures not included when acknowledging receipt of internal grievances involving adverse determination (appeals) and untimely resolution (Standard H3).
  - *2021 Update: Instances observed of acknowledgement letters and decision letters not sent within required timeframes and/or in a format with all required content.*
- Improperly denied claims due to delays in incorporating credentialed and/or contracted providers into Company systems (Standard J2).
  - *2021 Update: Delays identified in incorporating providers, but improvements were observed and did not observe any improper denial of claims as a result of delays.*
- Inaccurate and/or outdated information in the online provider directory (Standard I5).
  - *2021 Update: Delays identified in updating the provider directory with new providers*
- Untimely responses to prospective (preauthorization) and retrospective utilization review requests (Standard L4).
  - *2021 Update: One instance of non-compliance noted but significant improvements with 99% compliance.*
- Failure to include all required information in adverse determination notices resulting from utilization review requests (Standard L5).
  - *2021 Update: All required information has been incorporated into notices.*

PURPOSE AND SCOPE OF THE EXAMINATION

Market Conduct Examiners with the WVOIC reviewed certain business practices of CareSource West Virginia Co. W. Va. Code §33-2-9 empowers the Commissioner to examine any entity engaged in the business of insurance. The findings in this report, including all work products developed in producing it, are the sole property of the WVOIC.

The purpose of this market conduct examination was to determine the Company's compliance with West Virginia laws and regulations and is part of a combined examination being performed in conjunction with our Financial Conditions Division. Separate reports will be issued accordingly. This examination is not

intended to duplicate a review of the Company's Operations and Management but rather establish an understanding of the examinee and, except for the standards specifically mentioned in this report, will rely on the results obtained by our Financial Conditions Division (Reference Numbers: 15728-WV-2020-2). The conclusions and findings of this market conduct examination are public record.

The examiners may not have discovered every unacceptable or non-compliant activity in which the Company is engaged. The failure to identify, comment on, or criticize specific company practices does not constitute an acceptance of the practices by the WVOIC or its' designee.

The basic business areas that were reviewed and tested under this examination were:

- Operations and Management
- Complaints
- Marketing and Sales
- Producer Licensing
- Policyholder Services
- Underwriting and Rating
- Claims
- Grievances Procedures
- Network Adequacy
- Provider Credentialing
- Quality Assessment and Improvement
- Utilization Review
- External Review

"W.Va. Code R." as used herein refers to the West Virginia Code of State Rules. "W.Va. Code" as used herein refers to the West Virginia Code Annotated.

EXECUTIVE SUMMARY

The examination fieldwork began June 9, 2021, and concluded on September 16, 2022. The entirety of the examination was performed remotely, with the Company providing examiners access to all requested files. A total of fifty-nine (59) standards were reviewed during this examination. Of these fifty-nine (59) standards; five (5) standards was N/A, thirty-nine (39) standards were compliant, eight (8) were predominantly compliant, and the Company failed seven (7) standards.

The areas of concern are listed below:

- Standard A3: The Company was found to be predominantly compliant with recordkeeping. There were instances noted during testing where certain documentation could not be located in the policy files or grievance files and grievances were stored in multiple locations. W. Va. Code R. §114-15-4
- Standard B4: Two (2) complaints were not responded to within the fifteen (15) working days as set by WVOIC Consumer Services Division.

- Standard D1: The Company's records of appointed producers did not agree to WVOIC's records.
- Standard D2: Notifications were not sent to six (6) terminated producers. W. Va. Code §33-12-25(d)
- Standard E2: One (1) member was not timely cancelled.
- Standard E3: Three (3) members had cancellation notices triggered prior to the grace period established in internal standards and one (1) invoice had a due date set earlier than internal standards.
- Standard F5: Two (2) policies cancellation dates did not agree with Marketplace instruction. W. Va. Code R. §114-15-4 *(this issue was also considered in A3 above for lack of support for these files)*
- Standard G1: One (1) claim was retroactively denied for a period that exceeded the allowable statutory time periods. W. Va. Code §33-45-2(a)(7(C)
- Standard G3: One (1) claim for preventative health services was inappropriately applied a cost share and another claim was inappropriately denied.
- Standard G4: See denied claims noted in Standards G1 and G3 above.
- Standard H3: Acknowledgement letters were not issued for the fifty-seven (57) first level reviews submitted by providers and four (4) letters could not be located for grievances submitted by members. Additionally, thirty-seven (37) decision letters could not be located for grievances resulting in upheld reviews. The EOP and EOB is utilized as the decision letter for overturned reviews but does not include all required provisions. This was used as the decision letter for forty-six (46) samples. W. Va. Code R. §§114-96.5.6.a and 5.6.d. *(this issue was also considered in A3 above for missing files)*
- Standard H4: The decision letters did not contain the person's right to contact WVOIC and the contact information for WVOIC. W. Va. Code R. §114-96-6.5.e
- Standard I5: Newly credentialed providers were not consistently added to the provider directory within thirty (30) days. W. Va. Code §33-55-4(a)(2)(A)
- Standard J2: One (1) provider was added to the provider directory before the credentialing was complete and approved. W. Va. Code §33-45-2(a)(11)
- Standard L4: One (1) letter for a prospective review was not sent within required timeframes. W. Va. Code R. §114-95-7.1.c

The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business according to the West Virginia insurance laws and regulations.

HISTORY AND PROFILE

The Company was organized as a non-profit corporation domiciled in the State of West Virginia on January 30, 2015. The Sole Member of the Company is CareSource Management Group Co. ("CSMG"), which changed its name to CareSource ("CS") effective September 14, 2020, in West Virginia. The Company received a Certificate of Authority ("COA") on April 15, 2015, to transact business as a Health Maintenance Organization ("HMO") in the State of West Virginia in accordance with W. Va. Code §33-25A. Several amendments were made to the COA to expand the Company's service area. The Company is permitted to write in all 55 counties of West Virginia for which it can begin offering products effective January 1, 2021. The Company's only market line is offering Qualified Health Plans on the Federal Exchange ("Marketplace") in West Virginia under the Affordable Care Act.

METHODOLOGY

The examination was conducted in accordance with the standards and procedures established by the NAIC and West Virginia's applicable statutes and regulations. This is a report by test of company compliance with selected Standards contained in the *NAIC's Market Regulation Handbook* ("Handbook") and Standards approved by the WVOIC which are based on applicable West Virginia statutes and administrative rules, as referenced herein. Testing is based on guidelines contained in the Handbook. All tests applied are included in this report.

Tests designed to measure the level of compliance with West Virginia's statutes, rules and regulations were applied to the files. Each area of the examination has specific elements that were tested and are listed below.

The examiners used the NAIC standards of 7% error ratio on claims tests (93% compliance rate) and 10% error ratio on all other tests (90% compliance rate) to determine whether an apparent pattern or practice of being compliant or non-compliant existed for any given test. The examination results were categorized as follows: 100% compliant rate is "Compliant", 90% (or 93% for claims) to 99% is "Predominately Compliant", and less than 90% (or 93% for claims) is "Non-Compliant". Certain standards consisted of testing elements that were qualitative in nature. The examination results on these standards were based on the examiner's discretion as various elements may have been put into consideration. Except as otherwise noted, tests were conducted via random sample taken from a given population where applicable.

STANDARD & REVIEW ELEMENTS

A. Operations and Management

The operations and management portion of the examination is designed to provide a view of the Company and how it operates. As mentioned previously, this review is not intended to duplicate a review of the Company's Operations and Management being conducted by our Financial Conditions Division but rather establish an understanding of the examinee.

Standard A1: The regulated entity has antifraud initiatives in place that are reasonably calculated to detect, prosecute and prevent fraudulent insurance acts. (2021 NAIC Market Regulation Handbook Chapter 20, § A Standard 3)

- Does the Company have an adequate, up-to-date fraud plan in compliance with statutes, rules and regulations? [W. Va. Code §33-41-11a]
- Does the Company's antifraud plan include procedures for the mandatory reporting of possible fraudulent insurance acts to the insurance commissioner or applicable state regulatory agency pursuant to applicable state statutes, rules and regulations? [W. Va. Code §33-41-5]

Standard A2: The regulated entity is adequately monitoring the activities of any entity the contractually assumes a business function or is acting on behalf of the regulated entity. (2021 NAIC Market Regulation Handbook Chapter 20, § A Standard 6)

- Do the Company contracts with third-party entities specify the responsibilities of the MGA, GA, and TPA concerning recordkeeping and responsibilities of the regulated entity for conducting audits? [W Va. Code §33-27-2 and W. Va. Code R. §114-53]
- Does the Company audit the activities of the contracted entities? [W. Va. Code §33-37-4]
- Does the vendor provide performance reports to the Issuer to determine instances of noncompliance being documented and addressed?

Standard A3: Records are adequate, accessible, consistent and orderly and comply with state record retention requirements. (2021 NAIC Market Regulation Handbook Chapter 20, § A Standard 7)

- Are the records adequate and accessible? [W. Va. Code §33-2-9 and W. Va. Code R. §114-15-4]

Standard A4: The regulated entity cooperates on a timely basis with examiners performing the examinations. (2021 NAIC Market Regulation Handbook Chapter 20, § A Standard 9)

- Did the Company provide records and cooperate with examiners on a timely basis? [W. Va. Code §33-2-9 and W. Va. Code R. §114-15-4.9(a)]

Standard A5: The regulated has policies and procedures to protect the privacy of nonpublic personal information relating to its customers, former customers and consumers that are not customers. (2021 NAIC Market Regulation Handbook Chapter 20, § A Standard 12)

- Do the Companies policies, practices and procedures regarding protection and disclosure of nonpublic personal information of customers, former customers and consumers who are not customers comply with applicable state laws regarding privacy? [W. Va. Code R. §§114-57-11 and 114-62-5]

Standard A6: The regulated entity provides privacy notices to its customers and, if applicable, to its consumers who are not customers regarding treatment of nonpublic personal financial information. (2021 NAIC Market Regulation Handbook Chapter 20, § A Standard 13)

- Do the Company's privacy notices comply with applicable state laws? [W. Va. Code R. §§114-57-2 and 114-57-5]
- Does the Company provide privacy notices timely as required by applicable state laws? [W. Va. Code R. §§114-57-4 and 114-57-8]

Standard A7: If the regulated entity discloses information subject to an opt-out right, the regulated entity has policies and procedures in place so that nonpublic personal financial information will not be disclosed when a consumer who is not a customer has opted out, and the regulated entity provides opt-out notices to its customers and other affected consumers. (2021 NAIC Market Regulation Handbook Chapter 20, § A Standard 14)

- Does the Company provide consumers the opportunity to opt out before nonpublic personal information is disclosed? [W. Va. Code R. §§114-57-6]

- Does the Company have the capability to keep nonpublic personal financial information from being unlawfully disclosed to nonaffiliated third parties when a consumer has opted out? [W. Va. Code R. §114-57-9]

Standard A8: The regulated entity's collection, use and disclosure of nonpublic personal financial information are in compliance with applicable statutes, rules and regulations. (2021 NAIC Market Regulation Handbook Chapter 20, § A Standard 15)

- Does the Company comply with regulations regarding disclosing nonpublic personal financial information of its customers or consumers who are not customers to nonaffiliated third parties for joint marketing purposes? [W. Va. Code R. §114-57-11]

Standard A9: In states promulgating the health information provisions of the *Privacy of Consumer Financial and Health Information Model Regulation* (#672), or providing equivalent protection through other substantially similar laws under the jurisdiction of the insurance department, the regulated entity has policies and procedures in place so that nonpublic personal health information will not be disclosed, except as permitted by law, unless a customer or a consumer who is not a customer has authorized the disclosure. (2021 NAIC Market Regulation Handbook Chapter 20, § A Standard 16)

- Does the Company obtain valid authorizations from customers and consumers who are not customers before disclosing its nonpublic personal health information, except to the extent such disclosures are permitted? [W. Va. Code R. §114-57-15]

B. Complaint Handling

The NAIC definition of a complaint is "any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws. An oral communication, which is subsequently converted to a written form, would meet the definition of a complaint for this purpose." The complaint handling portion of the exam is designed to allow the examiner to assess the regulated entity's procedures for processing consumer or other related complaints.

Standard B1: All complaints are recorded in the required format on the regulated entity's complaint register. (2021 NAIC Market Regulation Handbook Chapter 20, § B Standard 1)

- Is the Company recording all complaints, both directly from the consumer as well as the Commissioner's office, in a regulated complaint register? [W. Va. Code R. §§ 114-15-4.6 & 114-96-3.1a]

Standard B2: The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders. (2021 NAIC Market Regulation Handbook Chapter 20, § B Standard 2)

- Does the Company have adequate complaint handling procedures in place?

Standard B3: The regulated entity takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations and contract language. (2021 NAIC Market Regulation Handbook Chapter 20, § B Standard 3)

- Does the Company respond fully to the issues raised in all complaints? [W. Va. Code §33-25A-12 and W. Va. Code R. §§114-53 & 96]
- Does the Company adequately document all complaint files? [W. Va. Code §33-25A-12 and W. Va. Code R. §§114-53 & 96 & 15-4.6]

Standard B4: The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations. (2021 NAIC Market Regulation Handbook Chapter 20, § B Standard 4)

- Does the Company respond timely, within 15 working days, to the issues raised in all complaints received by the WVOIC? [HMO's are not subject to W. Va. Code §33-11-4 (Unfair Trade Practices Act) and therefore there are no specific regulatory or statutory timeframes for complaints received from WVOIC; however, WVOIC Consumer Services Division has adopted a fifteen (15) working day timeframe for responses to its office]

C. Marketing and Sales

The marketing and sales portion of the examination is designed to evaluate the representations made by the Company about its product(s). The areas to be considered in this kind of review include all media, written and verbal advertising and sales materials.

Standard C1: All advertising and sales materials are in compliance with applicable statutes, rules, and regulations. (2021 NAIC Market Regulation Handbook Chapter 20, § C Standard 1)

- Are advertising materials free from misrepresentation of policy benefits or false, deceptive or misleading statements? [W. Va. Code §33-25A-14 & W. Va. Code R. §114-10-1 et seq.]
- Do all advertising materials disclose the name of the Company, comply with applicable statutes, rules and regulations and cite the source of statistics used? [W. Va. Code R. §114-10-1 et seq.]

Standard C2: Regulated entity internal producer training materials are in compliance with applicable statutes, rules and regulations. (2021 NAIC Market Regulation Handbook Chapter 20, § C Standard 2)

- Do producer training materials make references to employing unfair discrimination tactics or avoiding statutory compliance?

D. Producer Licensing

The producer licensing portion of the examination is designed to test the Company's compliance with state producer licensing laws and rules.

Standard D1: Regulated entity records of licensed and appointed (if applicable) producers and in jurisdictions where applicable, licensed company or contracted independent adjusters agree with department of insurance records. (2021 NAIC Market Regulation Handbook Chapter 20, § D Standard 1)

- Are the Company's producer licensing/ appointment records maintained according to W.Va. Code R. §114-15-4.5?
- Do the Company's producer appointment records agree with the WVOIC records?

Standard D2: Termination of producers complies with applicable standards, rules and regulations regarding notification to the producer and notification to the state, if applicable. (2021 NAIC Market Regulation Handbook Chapter 20, § D Standard 3)

- Does the Company notify the Commissioner's Office (on a form prescribed by the WVOIC) within thirty (30) days of terminating the producer's authority? [W. Va. Code §33-12-25]
- Is the producer notified simultaneously? [W. Va. Code §33-12-25(d)]

Standard D3: Records of terminated producers adequately document reasons for termination. (2021 NAIC Market Regulation Handbook Chapter 20, § D Standard 5)

- Do company records document reason for producer termination? [W. Va. Code §33-12-25(a) & (b)]

E. Policyholder Service

The policyholder service portion of the examination is designed to test if the Company is compliant with statues regarding notice/billing, delays/no response, premium refund, and coverage questions.

Standard E1: Reinstatement is applied consistently and in accordance with policy provisions. (2021 NAIC Market Regulation Handbook Chapter 24, § E Standard 1)

- Does the Company consistently and in a nondiscriminatory manner comply with the reinstatement provisions of the policy? [W. Va. Code §33-15-4]

Standard E2: Policy issuance and insured requested cancellations are timely. (2021 NAIC Market Regulation Handbook Chapter 20, § E Standard 2) *Policy issuance reviewed under Standard F3.*

- Were insured requested cancellations processed timely and without excessive paperwork required? [W. Va. Code §33-25A-1 et seq.]

Standard E3: Premium notices and billing notices are sent out with an adequate amount of advance notice. (2021 NAIC Market Regulation Handbook Chapter 20, § E Standard 1)

- Were premium and billing notices sent in accordance with Company's guidelines and with adequate amount of advance notice?

F. Underwriting and Rating

The underwriting and rating portion of the examination is designed to provide a view of how the Company treats the public and whether that treatment is in compliance with applicable statues, rules and regulations.

Standard F1: The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the regulated entity's rating plan. (2021 NAIC Market Regulation Handbook Chapter 20, § F Standard 1)

- Do the premium rates charged match the premium rates that were filed and approved? [W. Va. Code §§33-25A-3 and 33-25A-8(2)]

Standard F2: All forms, including policies, contracts, riders, amendments, endorsement forms and certificates are filed with the insurance department, if applicable. (2021 NAIC Market Regulation Handbook Chapter 20, § F Standard 5)

- Have all the forms and endorsements been filed and approved with the Commissioner? [W. Va. Code §§33-6-8, 33-25A-3 and 33-25A-8]

Standard F3 - Policies, contracts, riders, amendments and endorsements are issued or renewed accurately, timely and completely. (2021 NAIC Market Regulation Handbook Chapter 20, § F Standard 6)

- Are policies issued timely?
- Are renewals and endorsements issued in the appropriate time frame, following the Company's procedures?

Standard F4: Cancellation/nonrenewal, discontinuance and declination notices comply with policy and contract provisions, state laws and the regulated entity's guidelines. (2021 NAIC Market Regulation Handbook Chapter 20, § F Standard 8)

- Were company-initiated cancellations and non-renewals within applicable statutes and policy provisions? [W.Va. Code §33-25A-8(1)(b) and W. Va. Code R. §114-54-6.2]
- Was written cancellation notice given to the policyholder?

Standard F5: Cancellation practices comply with policy provisions, HIPAA and state laws. (2021 NAIC Market Regulation Handbook Chapter 24, § F Standard 1)

- Does the Company cancel policies for other than non-payment of premium?
- Does the Company provide a three (3) month grace period if at least one (1) full month's premium was paid during the benefit year for subsidized plans?
- Does the Company comply with its filed and approved policy provisions with respect to cancellations, terminations and refunds? [W. Va. Code §33-25A-8(1)(b)]

Standard F6: The regulated entity does not improperly deny coverage or discriminate based on health status in the group market or against eligible individuals in the individual market in conflict with the requirements of HIPAA or state law. (2021 NAIC Market Regulation Handbook Chapter 24, § F Standard 7)

- Do Company enrollment practices related to guaranteed renewability provide adequate and appropriate processes to ensure the health carrier renews, or continues in force, at the option of the policyholder, individual market health insurance coverage, in compliance with regulations? [W. Va. Code §33-15-2(b) and W. Va. Code R. §114-54-6]
- Do Company enrollment practices ensure that nonrenewal or discontinuance of coverage of a health benefit plan is performed only as defined by applicable statutes and rules? [W. Va. Code R. §114-54-6]

G. Claims

This portion of the examination is designed to provide a view of how the Company treats claimants and whether that treatment is compliant with applicable statutes and rules.

Standard G1: Claims are resolved in a timely manner. (2021 NAIC Market Regulation Handbook Chapter 20, § G Standard 3)

- Does the Company resolve claims in accordance with stat requirements? [W. Va. Code §33-45-2(a)(1) & (a)(3)]

Standard G2: Claim files are adequately documented. (2021 NAIC Market Regulation Handbook Chapter 20, § G Standard 5)

- Do the files contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed? [W. Va. Code R. § 114-15-4.4]

Standard G3: Claims are handled in accordance with policy provisions, HIPAA and state law. (2021 NAIC Market Regulation Handbook Chapter 20, § G Standard 6 and Chapter 24, § G Standard 1)

- Does the Company handle claims in accordance with policy provisions? [W. Va. Code §33-45-2]
- Did the Company pay benefits in accordance with its Evidence of Coverage (EOC)?
- Does the Company properly apply deductible deductibles, co-payments, coinsurance and other methods of cost-sharing on preventative items and services, in accordance with final regulations?
- Did the Company apply cost sharing as indicated by the members plan?
- Were claims denied for appropriate reasons?

Standard G4: Denied and closed without payment claims are handled in accordance with policy provisions and state law. (2021 NAIC Market Regulation Handbook Chapter 20, § G Standard 9)

- Were claims denied for appropriate reasons?
- Did the Company include proper language in its adverse determination notices?

Standard G5: The Company complies with the requirements of the federal Newborns' and Mothers' Health Protection Act of 1996. (2021 NAIC Market Regulation Handbook Chapter 24, § G Standard 2)

- Does the Company comply with the standards of the NMHPA with regard to 48/96-hour minimums?

Standard G6: The health plan complies with the requirements of the federal Mental Health Parity Act of 1996 (MHPA) and the revisions made in the Mental Health Parity and Addiction Equity Act of 2008. (2021 NAIC Market Regulation Handbook Chapter 24, § G Standard 3)

- Does the Company comply with the requirements of the MHPA and the revisions made in the Mental Health Parity and Addiction Equity Act of 2008?
- Does the Company apply quantitative or non-quantitative treatment limitations consistent with those that are applied to non-mental health services?
- Does the Company apply cost sharing to mental health services in parity with medical/surgical treatment services?

Standard G7: The health plan complies with the requirements of the federal Women's Health and Cancer Rights Act of 1998. (2021 NAIC Market Regulation Handbook Chapter 24, § G Standard 4)

- Does the Company comply with the standards of the federal Women's Health and Cancer Rights Act of 1998 with regard to providing for breast reconstruction resulting from a mastectomy?

H. Grievance Procedures

The NAIC definition of a grievance is "a written complaint, or an oral complaint that involves an urgent care request, submitted by or on behalf of a covered person regarding the: (a) availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (b) claims payment, handling, or reimbursement for health care services; or (c) matters pertaining to the contractual relationship between a covered person and a health carrier. This portion of the examination is designed to evaluate how well the company handles grievances. provide a view of how the Company treats claimants and whether that treatment is compliant with applicable statutes and rules.

Standard H1: The health carrier documents, maintains and reports grievances and establishes and maintains grievance procedures in compliance with applicable statutes, rules and regulations. (2021 NAIC Market Regulation Handbook Chapter 24, § H Standard 2)

- Does the Company define "Grievance" as a written compliant or, if the complaint involves an urgent care request submitted by or on behalf of a covered person, an oral complaint? [W. Va. Code R. §114-96-2.17]
- Does the Company maintain a grievance register consisting of written records to document all grievances received? [W. Va. Code R. §114-96-3.1]
- Did the examiners observe any instances of member communications that could be construed as a grievance that were not treated as such?

Standard H2: A health carrier has implemented grievance procedures, disclosed the procedures to covered persons, in compliance with applicable statutes, rules and regulations, and files with the commissioner a copy of its grievance procedures, including all forms used to process a grievance. (2021 NAIC Market Regulation Handbook Chapter 24, § H Standard 3)

- Has the Company filed with the insurance commissioner a copy of its grievance procedures required by applicable state statutes, rules and regulations regarding first level review of grievances involving an adverse determination, standard review of grievances not involving an adverse determination, and voluntary review of grievances from covered persons, or if applicable,

the covered person's authorized representative, including all forms used to process grievance requests? [W. Va. Code §§114-96-4.2 and 4.3]

- Does the Company file annually with the insurance commissioner, as part of its annual grievance report required by applicable state statutes, rules and regulations, a certificate of compliance stating that the health carrier has established and maintains, for each of its health benefits plans, grievance procedures that fully comply with applicable state statutes, rules and regulations? [W. Va. Code R. §114-96-4.3]
- Does the Company include a description of its grievance procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other EOC provided to covered person? [W. Va. Code R. §114-96-4.4]
- Do the Company's grievance procedure documents include a statement of a covered person's right to contact the commissioner's office for assistance at any time, and include the telephone number and address of the insurance commissioner's office? [W. Va. Code R. §114-96-4.5]
- Does the Company submit to the insurance commissioner, at least annually, a report of grievances filed in the format specified by the insurance commissioner? [W. Va. Code §33-25A-12(e) and W. Va. Code R. §114-96-3.2]

Standard H3: The health carrier has procedures for and conducts first level reviews of grievances involving an adverse determination in compliance with applicable statutes, rules and regulations. (2021 NAIC Market Regulation Handbook Chapter 24, § H Standard 4)

- Does the Company ensure that the first level review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the review decision? [W. Va. Code R. §§114-96-5.2b and c and 5.3]
- Does the Company provide the notice in a culturally and linguistically appropriate manner in accordance with regulation? [W. Va. Code R. §114-96-5.9]
- Does the Company provide acknowledgement letters within three (3) working days after receipt of the grievance, to include provisions of subsection 5.4? [W. Va. Code R. §114-96-5.6.d]
- Did the Company resolve grievances with respect to prospective determinations within thirty (30) days? [W. Va. Code R. §114-96-5.6.b]
- Did the Company resolve grievances with respect to retrospective determinations within the time period outlined within sixty (60) days? [W. Va. Code R. §114-96-5.6.c]

Standard H4: The health carrier has procedures for and conducts standard reviews of grievances not involving an adverse determination in compliance with applicable statutes, rules and regulations. (2021 NAIC Market Regulation Handbook Chapter 24, § H Standard 5)

- Does the Company have established written policies and procedures regarding review of grievances that do not involve an adverse determination, which permit the covered person to file a grievance with the health carrier, and which comply with applicable statutes and rules? [W. Va. Code R. §114-96-6.1]
- Does the Company within three (3) working days from the date the grievance is received, inform the covered person of his or her right to submit written material for the person or persons designated by the health carrier to consider when conducting the review? [W. Va. Code R. §114-96-6.2.b]

- Does the Company notify the person in writing of the decision within twenty (20) working days after the date of receipt of the request, for a standard review of a grievance? [W. Va. Code R. §114-96-6.4]
- Does the Company's written decision issued to pursuant to a standard review of a grievance not involving an adverse determination contain all the required information pursuant to applicable statutes and rules? [W. Va. Code R. §114-96-6.5]

Standard H5: The health carrier has procedures for voluntary reviews of grievances and conducts voluntary reviews of grievances in compliance with applicable statutes, rules and regulations. (2021 NAIC Market Regulation Handbook Chapter 24, § G Standard 6)

- Does the Company have established written policies and procedures regarding review of voluntary review of grievances?

Standard H6: The health carrier has procedures for and conducts expedited reviews of urgent care requests of grievances involving an adverse determination in compliance with applicable statutes, rules and regulations. (2021 NAIC Market Regulation Handbook Chapter 24, § H Standard 7)

- Does the Company have established written policies and procedures regarding receiving and resolving expedited review of urgent care requests of grievances involving an adverse determination in accordance with final regulations? [W. Va. Code R. §114-96-7.1]
- Does the Company notify the person of the decision within seventy-two (72) hours working days after the date of receipt of the request, for a standard review of a grievance? [W. Va. Code R. §114-96-7.6]
- Did decision notifications include all required information? [W. Va. Code R. §114-96-7.8.a]

I. Network Adequacy

This portion of the examination is designed to ensure that companies offering network plans maintain service networks that are sufficient to ensure that all services are accessible without reasonable delay. It is noted that during the 2020 Legislative Session, House Bill 4061 was passed enacting the Health Benefit Network Access and Adequacy Act. The legislation requires a health insurer that maintains a network of health care providers for its insureds to ensure that the network is sufficient in numbers and has appropriate types of providers in order for all covered services to be accessible without unreasonable travel or delay. The rule became effective April 1, 2021. In response to the new requirements, WVOIC had scheduled a targeted review of the state's carriers for compliance with the new requirements. Based on the planned review, the standards were reviewed at a high-level.

Standard I1: The health carrier demonstrates, using reasonable criteria, that it maintains a network that is sufficient in number and types of providers to ensure that all services to covered persons will be accessible without unreasonable delay. (2021 NAIC Market Regulation Handbook Chapter 24, § I Standard 1)

- Has the Company established and maintained adequate arrangements to ensure reasonable proximity of participating providers to the business or personal address of enrollees? [W. Va. Code R. §114-53-6]

Standard I2: The health carrier files an access plan with the insurance commissioner for each network plan that the carrier offers in the state, and files updates whenever it makes a material change to an existing network plan. The carrier makes the access plans available: 1) on its business premises; 2) to regulators; and 3) to interested parties, absent proprietary information, upon request. (2021 NAIC Market Regulation Handbook Chapter 24, § I Standard 2)

- Did the Company file a written access plan with the commissioner?

Standard I3: The health carrier ensures covered persons have access to emergency services 24 hours per day, 7 days per week within its network and provides coverage for emergency services outside of its network, pursuant to the appropriate section of state law that corresponds to the Utilization Review and Benefit Determination Model Act (#73) and/or the Health Benefit Plan Network Access and Adequacy Model Act (#74). (2021 NAIC Market Regulation Handbook Chapter 24, § I Standard 4)

- Did the Company contract with facilities to provide covered persons with access to emergency services?
- Did the Company provide emergency services necessary to screen a stabilize a covered person without a required prior authorization?
- Are emergency services obtained from a non-contracting provider covered without the need of a prior authorization when such services would have been delayed if using a contracted provider and potentially worsen the emergency?

Standard I4: The health carrier's arrangements with participating providers comply with applicable statutes, rules and regulations. (2021 NAIC Market Regulation Handbook Chapter 24, § I Standard 7)

- Did the Company notify contracted providers of the specific covered health services the provider will be responsible for, including any limitations of conditions or services?
- Did the Company notify contracted providers of the provider's responsibilities with respect to the carrier's applicable administrative policies and procedures such as payment terms, utilization review, quality assessment and improvement program, credentialing, grievance procedures, data reporting requirement, and confidentiality requirements and any applicable federal or state programs?
- Did the Company offer an inducement under the network plan to a provider to provide less than medically necessary services to a covered person?

Standard I5: The health carrier provides at enrollment a provider directory that lists all providers who participate in its network. It also makes available, on a timely and reasonable basis, updates to its directory. (2021 NAIC Market Regulation Handbook Chapter 24, § I Standard 8)

- Does the Company provide directory updates to enrollees?
- Does the Company post a current and accurate version of the provider directory for each of its network plans? [W. Va. Code §33-55-4(a)(1)(A)]
- Are monthly updates made to the provider directory? [W. Va. Code §33-55-4(a)(2)(A)]
- Does the electronic version of the provider directory allow for certain information to be searchable? [W. Va. Code §33-55-4(b)]

J. Provider Credentialing

This portion of the examination is designed to provide a view of how the Company verifies that participating health care professionals meet minimum specific standards of professional qualification.

Standard J1: the health carrier establishes and maintains a program for credentialing and re-credentialing in compliance with applicable statutes, rules and regulation. (2021 NAIC Market Regulation Handbook Chapter 24, § J Standard 1)

- Did the Company have policies and procedures for credentialing and re-credentialing verification of all health care professionals? [W.Va. Code R. §114-53-6.2]
- Did the Company establish a credentialing verification committee consisting of licensed physicians and other health care professionals to review credentialing verification information? [W. Va. Code R. §114-53-6.2(b)]

Standard J2: The health carrier verifies the credentials of a health care professional before entering into a contract with the health care professional. (2021 NAIC Market Regulation Handbook Chapter 24, § J Standard 2)

- Are providers properly credentialled before being added to the provider directory? [W. Va. Code §33-45-2(a)(11)]

Standard J3: The health carrier monitors the actives of the entity with which it contracts to perform credentialing functions and ensures the requirements of applicable state provisions equivalent to the Health Care Professional Credentialing Verification Model Act (#70) and accompanying regulations are met. (2021 NAIC Market Regulation Handbook Chapter 24, § J Standard 8)

- Did the Company have procedures in place to monitor the activities of the entities of the delegated entities? [W. Va. Code R. §114-53-6]

K. Quality Assessment and Improvement

This portion of the examination is designed to ensure that companies offering managed care plans have quality assessment programs in place that enable the company to evaluate, maintain, and when required by state law, improve the quality of health care services provided to covered person.

Standard K1: The health carrier develops and maintains a quality assessment program in compliance with applicable statutes, rules and regulations. (2021 NAIC Market Regulation Handbook Chapter 24, § K Standard 1)

- Does the Company have an established system designed to assess the quality of health care provided to covered persons, which includes a system for systematic collection, analysis and reporting or relevant data in accordance with statutory and regulatory requirements?

Standard K2: The health carrier monitors the activities of the entity with which it contracts to perform quality assessment or quality improvement functions and ensures that the requirements of applicable state provisions equivalent to the Quality Assessment and Improvement Model Act (#71) and accompanying regulations are met. (2021 NAIC Market Regulation Handbook Chapter 24, § K Standard 7)

- Does the Company have a policy to address effective methods of accomplishing oversight of each delegated entity?

L. Utilization Review

This portion of the examination is designed to verify that the Company and their designees that provide or perform utilization review services comply with standards and criteria for the structure and operation of utilization review processes. NAIC defines utilization review as a set of formal techniques designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings. a view of how the Company treats claimants and whether that treatment is compliant with applicable statutes and rules.

Standard L1: The health carrier establishes and maintains a utilization review program in compliance with applicable statutes, rules and regulations. (2021 NAIC Market Regulation Handbook Chapter 24, § L Standard 1)

- Does the Company have a utilization review program that describes all review activities, both delegated and nondelegated, for the filing of benefit requests, notification of utilization review and benefit determinations, and review of adverse determinations in accordance with statutes, rules and regulations? [W. Va. Code R. §114-95-5]

Standard L2: The health carrier operates its utilization review program in accordance with applicable state statutes, rules and regulations. (2021 NAIC Market Regulation Handbook Chapter 24, § L Standard 2)

- Does the Company have established and implemented written policies and procedures regarding the operation of its utilization review program, in accordance with final regulations? [W. Va. Code R. §114-95-5]
- Does the Company ensure the review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the utilization review or benefit determination?

- Does the Company have procedures to ensure effective corporate oversight of its utilization review program? [W. Va. Code R. §114-95-3]
- Does the Company use documented clinical review criteria and ensure that qualified health care professionals administer the utilization review program and oversee review decisions, and that it appoints clinical peers to evaluate the clinical appropriateness of adverse determinations? [W. Va. Code R. §114-95-5]

Standard L3: The health carrier discloses information about its utilization review and benefit determination procedures to covered persons, or, if applicable, the covered person's authorized representative, in compliance with applicable statutes, rules and regulations. (2021 NAIC Market Regulation Handbook Chapter 24, § L Standard 3)

- Does the Company provide a clear and accurate summary of its utilization review and benefit determination procedures to covered person, or, if applicable, to the covered person's authorized representative? [W. Va. Code §114-95-11]
- Does the Company provide a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining adverse review determinations, and a statement of rights and responsibilities of covered persons, or if applicable, the covered person's authorized representative, with respect to those procedures, in the certificate of coverage or member handbook provided to covered persons? [W. Va. Code §114-95-11]

Standard L4: The health carrier makes standard utilization review and benefit determinations in a timely manner and as required by applicable state statutes, rules and regulations, as well as the provisions of HIPAA. (2021 NAIC Market Regulation Handbook Chapter 24, § L Standard 4)

- Did the Company notify the covered person of a concurrent review determination with time sufficiently in advance of the reduction or termination to allow the covered person to file a grievance to request a review of the adverse determination? [W. Va. Code R. §§114-95-7.1.e and 7.3]
- Did the Company notify the covered person of a prospective review determination within fifteen (15) days after receiving the request? [W. Va. Code R. §114-95-7.1.c]
- Did the Company notify the covered person of a retrospective review determination within thirty (30) days after receiving the request? [W. Va. Code R. §114-95-7.1.d]

Standard L5: The health carrier provides written notice of an adverse determination of standard utilization review and benefit determinations in compliance with applicable statutes, rules and regulations. (2021 NAIC Market Regulation Handbook Chapter 24, § L Standard 5)

- Does the Company provide the notice in a culturally and linguistically appropriate manner? [W. Va. Code §114-95-7.3.b]
- Does the Company issue notification in writing or electronically of an adverse determination in a manner calculated to be understood by the covered person and include the provisions required per statutes? [W. Va. Code R. §114-95.7]

Standard L6: The health carrier conducts expedited utilization review and benefit determinations in a timely manner and in compliance with applicable statutes, rules and regulations. (2021 NAIC Market Regulation Handbook Chapter 24, § L Standard 6)

- Does the Company provide the notice in a culturally and linguistically appropriate manner? [W. Va. Code §114-95-8.2.b]
- Does the Company have established written procedures pursuant to applicable state statutes, rules and regulations for receiving benefit requests from covered persons of expedited utilization review and benefit determinations with respect to urgent care requests and concurrent review urgent care requests? [W. Va. Code §114-95-8]
- Does the Company, for an urgent care request, provide notice of the adverse determination, no later than seventy-two (72) hours after the receipt of the request by the health carrier, in accordance with applicable state statutes, rules and regulations regarding procedures for expedited utilization review and benefit determination? [W. Va. Code §114-95-8.1.b]

Standard L7: The health carrier monitors the activities of the utilization review organization or entity with which the carrier contracts and ensures that the contracting organization complies with applicable state provisions equivalent to the Utilization Review and Benefit Determination Model Act (#73) and accompanying regulations. (2021 NAIC Market Regulation Handbook Chapter 24, § L Standard 7)

- Does the Company adequate oversight of any delegated entities? [W. Va. Code §114-95-4]
- Does the Company have policies and procedures in place that ensure the utilization review programs of designees comply with all applicable state laws establishing confidentiality and reporting requirements? [W. Va. Code §114-95-4]

M. External Review

This portion of the examination is designed to review the Company's compliance with external review procedures that assure covered persons have the opportunity for an intendent review of an adverse determination or final adverse determination.

Standard M1: Companies covered under the Health Carrier External Review Model Act (#75) will be in compliance with the applicable statutes, rules and regulations. (2021 NAIC Market Regulation Handbook Chapter 24, § M Standard 1)

- Does the Company notify covered persons in writing of their right to request an external review and include notice of the Company's responsibilities? [W. Va. Code R. §§114-96-1 et seq. and 114-97-3]
- Does the Company provide the review procedures in or attached to the policy, certificate, membership booklet, or EOC? [W. Va. Code R. §114-97-14]
- Does the Company maintain written records in the aggregate and for each type of health benefit plan offered by the health carrier on all requests for external review? [W. Va. Code §114-96-3]

Standard M2: In jurisdictions that choose Option 1 or Option 2 under the Health Carrier External Review Model Act (#75) for providing an external review process, companies will be in compliance with the requirements for a review of a standard, expedited or

experimental/investigational review. (2021 NAIC Market Regulation Handbook Chapter 24, § M Standard 2)

- Does the Company comply with the external review process requirements for a standard, expedited, or experimental/investigational review? [W. Va. Code §§114-97-3, 114-97-6, 7, and 8]

COMPLIANCE TABLE

Review Section	***# Pass***	***# Fail***	***Minimum Standard Compliance %***	***Compliance Result %***	***Examination Result***		
					Compliant	**Predominantly Compliant**	**Non-Compliant**
A1	Pass	-	-	-	X		
A2	Pass	-	-	-	X		
A3	Pass	-	-	-		X	
A4	Pass	-	-	-	X		
A5	Pass	-	-	-	X		
A6	Pass	-	-	-	X		
A7	N/A	N/A	N/A	N/A	N/A		
A8	Pass	-	-	-	X		
A9	Pass	-	-	-	X		
B1	33	0	90%	100%	X		
B2	Pass	-	-	-	X		
B3	8	0	90%	100%	X		
B4	11	2	90%	84%			X
C1	8	0	90%	100%	X		
C2	Pass	-	-	-	X		
D1	-	Fail	-	-			X
D2	0	6	90%	0%			X
D3	Pass	-	-	-	X		
E1	Pass	-	-	-	X		
E2	9	1	90%	90%		X	
E3	21	4	90%	84%			X
F1	60	0	90%	100%	X		
F2	60	0	90%	100%	X		
F3	60	0	90%	100%	X		
F4	25	0	90%	100%	X		
F5	23	2	90%	92%		X	
F6	Pass	-	-	-	X		
G1	149	1	93%	99%		X	
G2	150	0	93%	100%	X		
G3	133	2	93%	99%		X	
G4	48	2	93%	96%		X	
G5	Pass	-	-	-	X		
G6	6	0	93%	100%	X		
G7	Pass	-	-	-	X		

H1	Pass	-	-	-	X		
H2	Pass	-	-	-	X		
H3	27	68	90%	28%			X
H4	0	6	90%	0%			X
H5	N/A	N/A	N/A	N/A	N/A		
H6	3	0	90%	100%	X		
I1	Pass	-	-	-	X		
I2	N/A	N/A	N/A	N/A	N/A		
I3	Pass	-	-	-	X		
I4	Pass	-	-	-	X		
I5	-	Fail	-	-			X
J1	Pass	-	-	-	X		
J2	19	1	90%	95%		X	
J3	Pass	-	-	-	X		
K1	Pass	-	-	-	X		
K2	N/A	N/A	N/A	N/A	N/A		
L1	Pass	-	-	-	X		
L2	Pass	-	-	-	X		
L3	Pass	-	-	-	X		
L4	99	1	90%	99%		X	
L5	29	0	90%	100%	X		
L6	13	0	90%	100%	X		
L7	N/A	N/A	N/A	N/A	N/A		
M1	Pass	-	-	-	X		
M2	Pass	-	-	-	X		

Some Elements of Review are qualitative instead of quantitative resulting in a pass or fail

OBSERVATIONS

A1 – The Company had antifraud initiatives in place that appear to be reasonably calculated to detect, prosecute, and prevent fraudulent insurance acts as required per W. Va. Code §33-41-11a. The plan is applicable to the group and requires for potential fraud, waste, and abuse to be promptly reported to the appropriate state and federal agencies which includes the state's Department of Insurance.

A2 – The Company outsourced various activities including certain claim payments and claims adjustment. The contracts specified the responsibilities of each party including the Company's performance of audits on the delegated entity. Performance reports were submitted by the vendors depending on the frequency set forth in the contract. The data contained in the reports align with the contract responsibilities and service levels. Annual audits were performed by the Company for each TPA during the exam period. Policies and procedures are in place for how any issues of non-compliance are to be handled.

A3 – The Company was predominantly compliant with its recordkeeping. There were instances noted during testing where certain files supporting cancellations could not be provided (see Standard F5) as well as the decision letters sent in response to grievances (see Standard H3). There was also difficulty understanding the completeness of the grievances as some records were stored in multiple locations with different identifiers. Overall, there was not a significant concern with the Company's records, but slight issues were observed during testing.

A4 – Director, KY/WV Plan Compliance Officer, answered all questions and arranged for meetings with management as needed for the examiner to perform the review. All company representatives were cooperative and responded to the examiner's requests timely and accurately.

A5 – Policies and procedures were in place to protect nonpublic personal health information for its customers. The Company's policies require annual training for all workforce members and an annual attestation that all corporate policies were read and understood. If any material changes are made during the interim, additional training is provided for those employees whose functions were affected by the change. The Company appears to have adequate policies in place to address protected health information, but the policies were silent on the protection of the consumers nonpublic personal financial information. Recommend amending policies to address the privacy of nonpublic personal financial information.

A6 – Privacy notices are provided to customers as part of their "Welcome Kit" for all new and renewed policies. The notice is available in the Member Handbook and a current copy is available on the Company's website. The notice was found to be limited to the privacy of health information and did not make any reference to the use and disclosure of nonpublic personal financial information. The Company also discloses personal health and financial information to an affiliate for purposes of providing administrative services to the Company. The Company did not address the disclosure to its affiliate within the privacy notice as required. Additionally, the notice did not address the following required sections: (a) categories of nonpublic personal financial information that the licensee collects or (b) the licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.

A7 – The Company did not disclose nonpublic personal financial information to nonaffiliated third parties. As such, no opt-out notice was required to be provided to the member.

A8 – The Company's collection, use and disclosure of nonpublic personal financial information was compliant with applicable laws. The only disclosure of such information is made to its affiliate, CareSource Management Services LLC, for purposes of providing administrative services.

A9 – The Company requires authorization for disclosure of nonpublic personal health information to non-affiliated third parties.

B1- The Company recorded all complaints received from WVOIC in the required format.

B2 - The Company has adequate complaint handling procedures in place to handle the complaints received from regulators and directly from the policyholder. The Company's policy related to handling complaints fell under the Member Grievance Policy. The Company did not differentiate between a complaint versus a grievance. Policyholders may submit complaints/grievances in writing, by phone, or in person and such instructions are communicated to the member in the Member Handbook.

B3 – The complaints reviewed were found to be adequately documented and fully addressed by the Company. No exceptions noted.

B4 – Two (2) complaints were responded to in excess of the fifteen (15) day requirement set forth by the WVOIC Consumer Services Division. The Company was using the day the complaint was received from WVOIC as the first day of the fifteen (15) day response period. The Company had recorded the notice received four (4) days after the date of the letter. In response to the findings, the Company explained that during the audit period, improvements were made, and a dedicated team was put in place to address WV complaints and keep a log of all pending complaints. The Company also explained that a team meets on a weekly basis to discuss all complaints and determine any barriers or additional information needed.

C1 – Advertising materials are submitted to the WVOIC Rates and Forms Division prior to use. No false or misleading statements were identified during the review of the sampled advertising materials.

C2 – The Company began utilizing independent agents in September 2019 along with the continued use of its licensed employees. The Company contracts with Field Marketing Organizations (FMOs) who specialize in working as an intermediary between individual agents and CareSource. Agent training is conducted by CareSource and the FMOs. Training is conducted at least annually with additional training held for changes. The training materials were reviewed and did not encourage the use of any discriminatory tactics or non-compliance of regulations.

D1 – There were a significant number of discrepancies between the Company's records of appointed producers compared to WVOIC's records (maintained on NAIC's State Based Systems [SBS]).

D2 – Twenty (20) terminated producers were randomly sampled to verify proper notification to WVOIC and the producer. Thirteen (13) of the terminated producers did not require any notification as these producers had the appointment terminated by WVOIC for reasons other than initiated by the Company (e.g. license expired, producer requested) and one (1) producer was still active. For the remaining samples, the Company had timely notified WVOIC. However, notification letters were not sent to the terminated producers. The Company was not sending termination notifications for the producers that were also a

CareSource employees and the remaining were due to human error. A corrective action plan was provided by the Company to remediate the issue.

It was observed during testing that notifications had been sent to certain producers whose termination was not initiated by the Company and were therefore not required to be sent notifications. These letters did not include a date. Examiners pointed out that a date would be necessary when sending letters to comply with W. Va. Code §33-12-25(d).

D3 – The spreadsheet provided by the Company did not include a reason for termination for each producer. It is noted that the reasons were adequately documented in the supporting documentation obtained during testing. No exceptions noted.

E1 – The Company's policy only allows for reinstatement based on the effective date on the eligibility records (834) received from CMS or the effective date submitted through the Center's For Medicare & Medicaid Services ("CMS") Health Insurance Casework System ("HICS") process. The following factors are not considered in the special reinstatement/effectuation decision process: APTC Value, Premium Value, Submitted Claims Value, and Member Health or Diagnosis Information. No concerns were noted.

E2 – All policies are offered through the Marketplace. All insured-requested notifications are submitted through Marketplace and then communicated to the Company through an 834 file. It is noted that the reason for the cancellation was not specified in the 834 file. As such, the samples included in testing may have been for reasons other than insured-requested cancellations. The notification date to the Company was compared to the date the notification was sent to the policyholder from the Company and the member's effective termination date in the system. All samples were timely and accurately processed with the exception of one sample. For this sample, the Company received two (2) 834 transactions on 12/14/2020 – one to cancel enrollment for the 2021 policy period and another for a financial change to the member. The Company explained that the financial change to the member profile allowed the account to remain active. On 6/4/2021, the Company found the member's term date did not agree with CMS's System of Exchange Enrollment Data and updated the record to reflect a cancellation date as of 1/1/2021. Notification of termination was sent to the member on the same day.

E3 – Twenty-five (25) cancelled policies were sampled with Standard F4 to verify cancellation notice was provided timely to the policyholder per the Company's procedures. Per the Company's guidelines, initial invoices are sent to members upon enrollment with due dates set thirty (30) days after the invoice date or the first day of coverage on the new policy, whichever is later. Following the initial invoice, a cancellation notice is triggered fifteen (15) days later after the due date if payment is not received. The majority of samples were found to not be effectuated and the others were cancelled for various reasons. The following billing issues were noted during review:

- Three (3) samples had cancellation notices sent before the fifteen (15) day grace period (4, 4, and 5 days after due date).
- One (1) sample had the cancellation notice sent fifty-one (51) days after the due date.
- The initial invoice for one (1) sample had the due date set twelve (12) days after the invoice date which is less than the thirty (30) day timeframe.

During testing, it was observed that some invoices are being sent on the same day as a Notice of Cancellation. The invoices include a due date for the amount outstanding. Based on the new due date provided, the member could reasonably assume that additional time has been granted to make the premium payment.

It was also observed that invoices are sent for six (6) months following termination. The template used is the same invoice used for an active policy invoice which states "Your invoice reflects the amount due to maintain your coverage with CareSource." An additional note was added to the past due accounts that stated "You currently have an outstanding balance from a previous eligibility period. The contradicting statements could lead to confusion on whether the policy is active or not.

F1 – Premium rates were recalculated for 60 policies and agreed to the rates filed and approved with WVOIC without exception.

F2 – Policy forms were filed with WVOIC for all years during the examination. The policies and forms found in the 60 samples reviewed with Standard F1 were found to be filed and approved prior to use.

F3 – All applicants must enroll in the plan through Marketplace. Application and policy data (including the issue dates) are provided to the Company through the transmission of the 834 file. As Marketplace is responsible for the policy's issue date, testing compared the date the new member data was provided to the date the acknowledgement letter was sent to the policyholder. The majority of acknowledgement letters were sent 2-3 days after receipt of the 834 file. Letters are not sent during open enrollment until the last week of November/first week of December. No issues were noted during review.

F4 – Twenty-five (25) cancelled policies were sampled to verify proper notice was sent to the policyholder. The Company provided proper notice for each sample.

F5 – All cancellations that were initiated by the Company were due to non-payment. The majority of the samples were policies that were not effectuated. There were no instances noted of the Company cancelling policies for reasons that violated statutes, rules, or its EOC. The following issues were noted during review:

- One (1) member had two policies active in the system with overlapping time periods, one beginning 1/1/2021 and the other 2/1/2021. CMS notified the Company via an 834 on 10/31/2020 to cancel the 1/1/2021 policy. On 1/4/2021, an 834 was received for a financial change for a policy effective 2/1/2021. On 1/7/2021, an additional cancellation was received via 834. The policy effective 1/1/2021 was ultimately canceled for non-payment on 5/4/2021. The policy effective 2/1/2021 was cancelled for non-payment on 2/24/2021. The policies should have been cancelled per the CMS instruction rather than non-payment.
- One (1) member was provided a notice of cancellation on 11/8/2019 to cancel the application for coverage effective 1/1/2020 noting the cause to be "Per Marketplace Instruction". This member had been enrolled from February 2017 to December 2017. The Company could not provide an explanation for why the member was enrolled for the 2020 policy year.

It is noted that additional issues were identified related to billing – see issues at Standard E3 above.

F6 – No applications were denied or rescinded during the exam period. Applicants are submitted directly to Marketplace, and Marketplace determines eligibility. The Company's EOC states that policies may only be rescinded for acts of fraud or material representation of a material fact. No instances were observed of policies being rescinded during the exam period.

G1 – All claim files reviewed were paid or denied within thirty (30) days of receipt. It is noted that while there are no statutory timeframes set for non-contracted providers, the Company's policies provide for the same time periods for both contracted and non-contracted providers.

During review, twenty-one (21) claims were reprocessed months after the original processing date for various reasons including updating rates due to CMS publications, retroactive updates to provider contracts, or as a result of internal corrections (configuration updates, etc.). There were certain updates published by CMS that were found to not be timely implemented into the Company's system. Some updates were found to be implemented as much as 495 days after CMS had published the changes. Overall, the rate changes had a minimal impact to the total allowable amounts and increases/decreases were typically below $10.

One (1) paid claim was found to be retroactively adjusted to partially recoup funds 414 days after the payment date and funds were recouped from the provider following an internal control reconciliation that found rates did not align with the PBM contract. The claim was submitted by a provider out of network and was not subject to the requirements set forth in W. Va. Code §33-45-2(a)(7)(C). It is noted that this claim was later adjusted and payment was made to the provider. While the adjustment did not violate any regulations, it is recommended for the Company to establish limits for these adjustments that are similar to those required for contracted providers.

One (1) denied claim was retroactively denied more than one year after the claim was originally paid which exceeds the time period set forth in W. Va. Code §33-45-2(a)(7)(C). The criteria to identify retroactive eligibility changes did not include dental claims during 2018. This was discovered in 2019 by the Company and corrected at which time applicable claims were reprocessed.

G2 – All claim files reviewed had adequate documentation maintained.

G3 – The Company was predominately compliant in handling claim files in accordance with policy provisions and state law. One (1) claim filed for preventative health services had a deductible inappropriately applied to one of the line items. The Company explained that the error was previously identified, and this claim had been erroneously excluded from the previous adjustments made to correct this issue. One (1) denied claim was denied during auto-adjudication for the service not being appropriate for the age of the patient. This particular claim was processed using the mother's date of birth versus the newborn. The claim was not pended during auto-adjudication for manual review.

G4 – The Company was predominately compliant in handling the claims denied and closed without payment in accordance with policy provisions and state law. As noted in Standard G3 above, one (1) claim had been incorrectly denied due to using the wrong demographic. As noted in Standard G1 above, one (1) claim was retroactively denied in excess of one year from when the claim was originally paid.

One (1) denied claim did not have an Explanation of Payment (EOP) sent to the provider due to the assignment of payments to the subscriber. W. Va. Code §33-45-2(a)(3) requires timely notification to the person submitting the claim for a covered benefit. The sampled claim was submitted by a non-contracted provider which is precluded from W. Va. Code §33-45. As a best practice, and EOP should be sent to the person submitting the claim regardless of assignment to ensure compliance with the Code.

During review of the denied claims, it was found that the timeframes listed in the 2021 provider manual for claims submission did not agree to the provider contracts. Effective November 1, 2019, the Company amended its timeframes for submitting claims and appeals from 365 calendar days to 180 calendar days from the date of service or discharge. Notification was sent to the current providers and new contracts were written with the new timeframes. This issue was self-corrected as the discrepancies had been corrected as of the 2022 Provider Manual.

The Explanation of Benefits (EOB) for denied claims was found to have unclear language that gave the impression that the member is not responsible for the claims that were retroactively denied due to coverage issues. The denied claims had $0.00 listed under "Your Responsibility" and the full claim amount was included under "Savings/Discount". The issue appeared to be self-corrected as the EOB layout was adjusted in 2020 and the claim amount was listed under the category of "Exclusion/Not Covered" and the full claim amount was listed under "Your Responsibility".

G5 – The EOC was found to comply with the minimum length of stay of 48/96 hours and with the time beginning at the time of delivery or time admitted to the hospital. Shorter time periods are permitted with certain conditions being met. Of the claims sampled, there were no paid claims applicable to this Act and no claims were found to be denied for reasons that would violate this Act.

G6 – Of the paid claims sampled, six (6) had procedure codes and/or diagnosis codes related to mental health services (no substance use observed). There did not appear to be any QTLs or cost sharing in place that was more stringent than other medical and surgical benefits offered. A high-level review of the 2021 Summary of Benefits and Coverage (SBC) did not identify any limits or caps placed on mental health and substance use services. It was observed that the SBC lists Autism Spectrum Disorder Services as a Covered Service category which placed limits on Physical, Occupational, and Speech Therapy. These services are combined with all Habilitative Services which include other medical benefits. No issues were noted with these limits placed. During the review of testing denied claims, no services were found to be denied related to mental health services (noted that diagnosis of claims was not reviewed for claims denied for lack of eligibility).

The report filed with the Commissioner in April 2021 as required by W. Va. Code R. §114-64-Mental Health Parity was reviewed. No initial concerns were identified. As the Act became effective May 1, 2021, after the exam period, no further procedures were performed to verify compliance with the rule.

G7 – The EOC provides for breast reconstruction resulting from a mastectomy. The EOC also includes a "Women's Health and Cancer Rights Act Notice" which outlines the additional medical care that is required to be covered along with this coverage. Of the claims sampled, there were no paid claims applicable to this Act and no claims were found to be denied for reasons that would violate this Act.

H1 – The Company maintains grievance and appeal procedures. The procedures were filed with the commissioner for all years during the exam period. The Company maintained a register of all grievances filed. It was discovered during the testing of External Review standards that certain grievances were submitted as an external review and also recorded as a grievance after discovering that the internal grievances processes were not exhausted. There were no instances observed in which a member communication could have been construed as a grievance and not recorded as such.

H2 – The Company maintains grievance and appeal procedures. The grievance procedures were filed with the commissioner for all years during the exam period. The Company had filed the Certificate of Compliance for plan years 2018 and 2020 but failed to file for plan year 2019. The grievances report was not provided for all years during the examination. It is noted that the report was not yet due for 2021 at the time of testing. The description of grievance procedures is provided to covered persons in the EOC. Additionally, the procedures are provided in adverse determination letters. The grievance procedures included a statement informing the member of their right to contact the WVOIC and its contact information.

H3 – Examiner tested ninety-five (95) first level review selections. It was observed that the Company does not send acknowledgement letters for any grievances submitted by providers. Acknowledgement letters are to be sent to the covered person(s) which includes its authorized representative per W. Va. Code R. §114-96-5.6.d. The sample included fifty-seven (57) grievances submitted by providers. For the samples not received by providers, four (4) did not have acknowledgement letters sent timely (within three [3] working days).

For the reviews that resulted in overturned decisions, the Company provides only the EOB or EOP to notify the covered person(s) of the final decision. The EOB and EOP does not include all required provisions. Forty-six (46) samples had overturned decisions and only the EOB and EOP had been provided to communicate the decision.

The Company was unable to locate the decision letters for thirty-seven (37) samples. Note that for purposes of calculating this total, the EOP/EOB was considered a decision letter despite the lack of required provisions.

H4 – Six (6) grievances were randomly selected by complaint type. Acknowledgement letters were sent timely to each covered person (same day or up to two (2) days). Resolution letters were also sent timely and sent between one (1) and ten (10) days. The decision letters did not contain the reviewer's name and credentials (if applicable). Based on the nature of this type of grievance, it is recommended as a best practice to add the reviewer's name and credentials to the template but not found as critical. The notification did not contain the covered person's right to contact the Commissioner's office or its telephone number and address. The letters should be updated to include covered person's right to contact the commissioner.

H5 – WVOIC did not adopt Section 9 of the Health Carrier Grievance Procedure Model Act which refers to the voluntary review of grievances. As such, no additional procedures were performed related to voluntary review of grievances.

H6 – Of the ninety-eight (98) first level review grievances, three (3) selections were expedited. One (1) of the three (3) expedited reviews involved a final adverse determination. Decisions were made in twenty-four (24) to forty-eight (48) hours. A decision letter was provided to each covered person with all required provisions.

I1 – The Company had established a written access plan as of April 1, 2021, in response to the legislation recently passed creating W. Va. Code R. §114-100-Health Benefit Plan Network Access and Adequacy. No written plan had been established prior to this time as required with W. Va. Code R. §114-53-6.1 but the Company explained that the aspects of the plan have been in place prior to the creation of the written plan. The Company was found to have appropriate mechanisms in place during the exam period to assure the availability of primary care and specialty care practitioners and other facilities as described in W. Va. Code R. §114-53-6.1. Monthly reports are reviewed with Provider Engagement to identify any gaps in coverage for the network. Provider Engagement is responsible to recruit providers as needed. In addition, the number of providers available throughout the state is a concern as there may not be specific provider types available within the time and distance standards.

As noted above, W. Va. Code R. §114-100 was passed after the exam period. Examiners performed a high-level review to determine the initiatives put in place to comply with the requirements. No significant concerns were identified with the processes implemented.

I2 – The Company was not required to file an access plan with the commissioner during the exam period. W. Va. Code R. §114-100 became effective after the exam period on April 1, 2021, which required the filing of a written access plan to the commissioner. As noted In Standard I1 above, the Company had created this plan following the passing of the new regulation. This plan was confirmed to be timely filed with the commissioner. Based on the timing of the new legislation, no further procedures were performed.

I3 – The Company actively monitored the coverage provided for hospitals and critical care services within the network. The Company offers a CareSource24 Nurse Advice Line that is available to members 24 hours a day, 365 days a year. A Registered Nurse is available to answer questions and advise members on whether care is needed, what kind of care, when it is needed, and who should provide it. It is noted that the Company does advise the member to dial 911 first in the event of a true medical emergency. The EOC allows for the coverage of emergency health care services by contracted and non-contracted providers without the need of a prior authorization for conditions that reasonably appear to constitute an emergency medical condition based on symptoms and conditions in the emergency room. No concerns were noted during review.

I4 – Examiner reviewed the agreement with contracted providers, the provider manual, and the website to gain an understanding of how duties and responsibilities are communicated to the provider as well as the communication of any changes to these responsibilities. The provider manual included, but was not limited to, the following topics: (1) Credentialing and Recredentialing, (2) Claims Submissions, (3) Referral and Prior Authorizations, (4) Utilization Management, (5) Pharmacy, (6) Member Enrollment and Eligibility, (7) Covered Services and Exclusions, (8) Member Grievances and Member/Provider Appeals,

and (9) Covered Services and Exclusions. The Manual also has a section dedicated to primary care providers that outlines various items including, but not limited to, the roles and responsibilities, prenatal and postpartum care, immunization schedules, clinical practice registry and telephone arrangements/24-hour access.

The provider portal houses the most up-to-date list of services that require a prior authorization and all policies (Administrative, Medical, Reimbursements, and Pharmacy). Changes that participating providers need to be aware of (e.g. network notifications, policy updates) are posted on the website, communicated through a fax blast, or regular provider meeting updates. Updates and Announcements can be searched on the website by state and health plan. No concerns were noted through review.

I5 – The Company provides the location of the online search tool for the provider directory in the new member kit sent out for all new policies. The Company also offers for a printed copy to be provided upon request. In conjunction with the testing of provider credentialing standards, the new credentialed providers were reviewed to ensure they were timely added to the provider directory. The average timeframe for adding the providers was twenty-three (23) days and ranged from eight (8) to fifty-seven (57) days following the approval of the application. Of the twenty (20) samples taken, six (6) samples were added to the directory in excess of thirty (30) days. As such, the provider directory was not being completely updated during the monthly update as these new providers were not added.

The electronic version of the provider directory was reviewed to ensure all search functions were in place. All functions were found to be included; however, the search toll for facility or health care professional by name was not as easily located.

J1 – The Company had established written policies and procedures governing the credentialing and recredentialing of all providers. The Company designated a Credentialing Committee to make recommendations regarding the credentialing decisions. Annually, the Committee reviews the policies, procedures, and reports required as part of the delegation agreements. The Company had delegated the functions for primary source verification and decision making but the Committee retains the authority to make the final credentialing determination regarding any provider. The Committee is composed of at least two (2) primary care practitioners, two (2) specialists, and at least one (1) community provider. The Committee is chaired by the VP, Senior Medical Director, or designated Medical Director.

J2 – In conjunction with testing for Network Adequacy standards, Examiners verified that new credentialed providers had their applications completed and approved prior to being added to the provider directory. All providers were properly approved prior to being added with the exception of one provider. The provider was added to the directory sixteen (16) days before being approved.

J3 – Approximately 98% of the applications are outsourced to various entities that the Company had delegated credentialing functions to, and the other 2% are performed internally (mostly expedites/priority request). The delegated vendors report their performance monthly and is reviewed by the Company. A quarterly review is completed by a credentialing specialist and an annual evaluation is performed on all delegated entities to validate the information provided. The Company will work with the

vendors to identify the cause of any deficiencies and ensure a mitigation plan is implemented to correct the deficiency. Deficiencies are reported to various Committees for oversight. No concerns noted through review.

K1 – The Company appears to maintain a quality assessment program in compliance with applicable statutes, rules and regulations. Examiner obtained and reviewed the Company's KY/WV Marketplace Quality Improvement policies and procedures and program description and reviewed the meeting minutes for the CareSource Quality Improvement for KY/WV Marketplace Committee. The Committee provides the direction and oversight of clinical, non-clinical, and quality operations for the WV Marketplace product.

K2 – The Company does not contract with a third-party to perform quality assessment or quality improvement functions as these are performed within the CareSource organization. The Company's program undergoes an annual evaluation by the WV Marketplace Quality Improvement Committee.

L1 – As part of understanding the Company's utilization review program, Examiners obtained and reviewed the Company's utilization management (UM) policies and procedures, UM Program Descriptions, UM program evaluations and work-plans, UM job descriptions, medical policy statements, and meeting minutes for the Utilization Management/Care Management (UM/CM) Committee. CareSource has a UM program in place that encompasses activities associated with the review and authorization of medical, dental and behavioral health care services, appropriate resource utilization, and oversight of delegated activities, and includes prior approval, pre-certification, prospective, concurrent and retrospective review, discharge planning, case management, and utilization review activities. Annually, the program's processes are reviewed by the Quality Enterprise Committee and the Quality Assurance Committee. It is the policy of CareSource that all UM activities occur in accordance with applicable federal and state laws, rules, regulations, and accreditation standards.

L2 – As noted above in Standard L1, the Company had established a UM program in compliance with regulations. The Company's utilization reviews are conducted to ensure independence and impartiality of the individuals making the review. The utilization review and clinical appeal activities are supported by explicit, written clinical review criteria and review procedures. Based on review, the Company operates its UM Program in accordance with W. Va. Code R. §114-95.

W. Va. Code §33-25A-8s was recently passed related to episode of care. W Va. Code §33-25A-8s(b) requires an HMO to develop prior authorization forms and portals to accept prior authorization for an episode of care. The Company's forms shall also contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment and all other items that shall be bundled together as part of the episode of care. This list shall be prepared with science-based standards. The Company only issues prior authorizations for specific services. As such, no listing has been prepared for which items may be bundled together for approval.

Included within W. Va. Code §33-25A-8s(k) is a limited "gold card" exemption. Inquiry was made to the Company regarding any providers that have been qualified for this exemption. The Company explained that no providers have qualified to date. A report is used by the Company to track all prior authorization

activities. Based on the review of the 2020 and 2021 data, the Company appears to be in compliance with the requirements.

L3 – The Company provides a clear and accurate summary of its utilization review and benefit determination procedures, including the procedures for obtaining adverse review determinations and a statement of rights and responsibilities of covered persons, through the member handbook, EOC, and the Company website. The Company's website provides a current list of benefits requiring prior authorization.

L4 – A sample of concurrent, prospective, and retrospective utilizations reviews were tested to ensure the Company's compliance with timeliness requirements. Twenty-five (25) concurrent reviews (approved and denied) were found to be compliant with regulatory requirements with no failures. For prospective reviews, sixty (60) samples were reviewed - thirty-two (32) approved, thirteen (13) expedited, and fifteen (15) denied. All were sent timely with the exception of one (1) approved sample. Fifteen (15) retrospective reviews (approved and denied) were determined to be sent timely.

During review, it was found that the Company had established internal timeliness standards that were stricter than regulatory requirements for its concurrent and prospective reviews. Notifications for concurrent reviews are to be sent within twenty-four (24) hours and prospective reviews in five (5) days. Based on these standards, the Company had more instances of failure – four (4) for concurrent, twelve (12) for approved prospective, and two (2) for denied prospective. Examiner did not consider these to be a non-compliance for purposes of the standard.

L5 – In conjunction with testing Standard L4, notices of adverse determination for standard utilization reviews and benefit determinations were reviewed and found to be compliant with W. Va. Code R. §114-95-7. Notices were issued in a manner that is clearly understood by the covered person and each notice provided a reason for the denial. The notices were provided in an appropriate cultural and linguistic manner, and each included the contact information for WVOIC.

L6 – The Company has procedures in place for receiving benefit requests from covered persons of expedited utilization review and benefit determination with respect to urgent care requests and concurrent review of urgent care requests. As noted above in Standard L4, thirteen (13) of the prospective reviews sampled were expedited. All notifications were sent within the seventy-two (72) hour time requirement. Notifications were sent in a culturally and linguistically appropriate manner.

L7 – The Company does not contract with a third-party to perform the functions and/or activities of the utilization review. As such, the standard was not applicable, and no procedures were performed.

M1 – Two (2) external reviews were conducted during the exam period. It was verified that proper notice of the external review process was in place. In conjunction with the testing of utilization review, members were found to be properly provided notice of the external review process through the Members Handbook, EOC, and Notice of Adverse Determination letters. The Notice of Adverse Determination letters specifically lists the member's right to request the external review.

M2 –Two (2) external reviews were conducted during the exam period. The listing of external reviews submitted by the Company were compared to WVOIC's records. The Company's listing had additional records that were found to not be true external reviews. Certain requests were submitted to the Company as external reviews, but the member had not exhausted all other internal grievance processes. The Company explained that the grievance was submitted and recorded as an external review. Upon further review, the grievance was added to the grievance register but the record remained on both registers. The external reviews were reviewed with no issues noted.

Subsequent Event - Insulin Cap – On January 21, 2022, CareSource disclosed to the WVOIC that it failed to implement W.Va. Code §33-59-1, Cost Sharing in Prescription Insulin Drugs, effective July 1, 2021. This failure was discovered during its annual auditing and monitoring plan for 2022. Although the time frame involved extended beyond the scope of the exam period, the examiner incorporated procedures to determine if all eligible claims had been reevaluated and reviewed the accuracy of the calculations made to the impacted members. Per the request of the Insurance Commissioner, the Company has agreed to reevaluate all claims that fall under the aforementioned Code and ensure proper payments have been made to affected members.

Subsequent Events – Guiding Care Letter Failure – On November 19, 2021, CareSource disclosed to the WVOIC that beginning July 1, 2021, there were a large volume of letters processed through its vendor where the address on the PDF printed letter did not match the manifest file sent to the print vendor due to poor mapping and incorrect logic pulls that are intended to match the letter to the manifest. As a result, certain member and provider letters were sent outside of compliant timeframes that impacted Care Management, Grievances and Appeals, and Utilization Management. The affected letters were identified and re-sent on August 20, 2021. This failure impacted 48 providers and 47 members.

RECOMMENDATIONS

A3 - The Company should ensure that all records are consistently maintained and done so in an orderly fashion to comply with state record retention requirements as well as provide adequate support for the Company's compliance with statutes, rules, internal guidelines, and other regulatory agencies. As a best practice, the Company should also execute periodic reviews of company practices and procedures pertaining to record retention to further the achievement of future compliance with W. Va. Code §33-2-9 and W. Va. Code R. §114-15-4.

A5 - The Company should establish policies and procedures to protect the privacy of nonpublic personal financial information or amend its current policies in place related to the protection of protected health information to include financial information.

A6 – The Company should amend its privacy notice to disclose all information required as set forth in W. Va. Code R. §114-57-5. The notice should include the use and disclosure of nonpublic personal financial information as well as state the disclosure of nonpublic personal information to an affiliated party. Additionally, the notice should include the categories of nonpublic personal financial information that the license collects and the Company's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.

B4 – The Company should ensure that all complaints are responded to within fifteen (15) working days of the date of the letter.

D1 – The Company should routinely perform an internal reconciliation of its appointed producers to identify any discrepancies in its records.

D2 – The Company should send a notification of termination to each producer terminated as specified in W. Va. Code §33-12-25(d). As noted above, a corrective action plan was drafted by the Company to remediate this issue.

E2 – A reconciliation should be performed monthly to ensure that all member policy data agrees to the Marketplace enrollment records. Additionally, notification of cancellation should be sent timely to the policyholder following receipt of such notifications from Marketplace.

We also recommend the Company establish a means to flag those members that receive more than one (1) 834 transaction in a single day to identify those transactions from CMS that are providing conflicting instruction and may lead to inaccurate member information.

E3 - The Company should follow its internal guidelines regarding timeframes for invoice due dates and the grace period in place prior to triggering a cancellation notice (initial invoice due date set 30 days after the invoice date or the first day of coverage, whichever is later, and cancellation notices initiated 15 days after the due date of the initial invoice).

To avoid any confusion to the member, billing procedures should be updated to ensure that invoices are not being sent on the same day as a Notice of Cancellation. Additionally, the Company should adhere to the due dates communicated within notifications. Furthermore, a different template should be utilized

for invoicing inactive or past due accounts to be clear that the amount due is outstanding and the policy is no longer active.

F5 – As noted above in Standard E2, the Company should perform monthly reconciliations to ensure that all member policy data and member count agrees to the Marketplace enrollment records.

As noted in Standard A3, the Company should retain all supporting documentation for the policy files including the communications provided by CMS related to enrollment and termination of members.

G1 – The Company should enhance its internal processes to ensure that updates to rates or other billing related items as published by CMS or a result of other agencies and/or regulatory changes are implemented timely.

The Company should also establish timeframes for retroactive adjustment of claims from out of network providers that are consistent with timeframes set for in-network providers and the parameters established in W. Va. Code §33-45-2(a)(7)(C).

Additionally, the Company should identify all dental claims that were included in the retroactive adjustment and return all payments for those that were recouped more than one year from the date of the original payment. The Company should limit any retroactive adjustments to the timeframes set forth in W. Va. Code §33-45-2(a)(7)(C).

G3 – The Company should reprocess the claims for the impacted member to determine what, if any, amounts are due to the member/provider due to inappropriate denial of the newborn's claims. Additionally, we recommend the Company internally reviews its rules for auto-adjudicating claims that may be submitted for newborns that have not been enrolled in the Marketplace to see that the claims are pended for further review.

The Company should perform a review to identify all the preventative health service claims that may have been excluded from the prior adjustment in error and reprocess as needed.

G4 – In addition to the recommendations already discussed in G1 and G3, we also recommend the Company send an EOP for each claim to the person/entity submitting a claim regardless of the assignment to ensure compliance with W. Va. Code §33-45-2(a)(3).

H2 – The Company should annually file the Certificate of Compliance and Grievances Report to WVOIC to comply with W. Va. Code R. §§114-96 4.3 and 3.2.

H3 – The Company should issue acknowledge letters for all grievances regardless of whether the grievance was submitted by the covered person or the covered person's authorized representative. The letters should be issued within the timeframes set forth in W. Va. Code R. §114-96-5.6.d.

The Company's process should also be updated to provide a decision letter for all reviews resulting in an overturned decision that contains the required content and is sent within the required timeframes.

H4 – Decision letters should be updated to include the covered person's right to contact the commissioner. Based on the nature of the grievances for standard reviews not involving an adverse determination, it is recommended as a best practice to add the reviewer's name and credentials to the template.

I5 – The Company should implement processes to ensure that new credentialed providers are incorporated into the monthly update of its provider directory in order to comply with W. Va. Code §33-55-4. The Company should also review the layout of its electronic provider directory and consider adjustments to make the search function by health care professional name and facility name included in the same area as the search criteria.

J2 – Evaluate internal processes and implement controls, as needed, to ensure providers may not be added to the provider directory until the application has obtained all necessary approvals to ensure the directory presents accurate information to members.

L2 – The Company should allow for the submission of one prior authorization for an episode of care. The Company should also establish a comprehensive listing of what procedures, services, etc. may be bundled together for an episode of care and make this listing available to its providers and members. The listing should be established and updated following the guidance within W. Va. Code §33-25A-8s.

L4 – The Company should continue to strive to meet all response time requirements in accordance with W. Va. Code R. §114-95-7. The Company should also review its internal response times established for concurrent and prospective reviews to determine whether these times are still appropriate. If the Company chooses to make no changes, it should consider enhancing its process to see that internal timeframes are achieved.

M2 – The Company should properly log only valid WV external review submissions to properly segregate these from other types of grievances and appeal type submissions. Requests should be reviewed upon submission and recorded in the proper register to ensure the request is properly handled in accordance with applicable statutes, rules, and internal guidelines.

EXAMINER'S SIGNATURE AND ACKNOWLEDGEMENT

The examiner would like to acknowledge the cooperation and assistance extended by the Company during the examination.

This is to certify that the undersigned is a duly qualified Examiner appointed by the West Virginia Offices of the Insurance Commissioner. In addition to the undersigned, Mel Heaps, CFE, with Lewis & Ellis, Inc. also participated in this examination.

Jessica Lynch, CFE, MCM
Examiner-in-Charge

Tom Whitener, CPCU, SPIR, CIE, FLMI, CCP, AFSB, AMCM
Market Conduct Director
West Virginia Offices of the Insurance Commissioner

EXAMINER'S AFFIDAVIT

State of West Virginia

County of Kanawha

EXAMINER'S AFFIDAVIT AS TO STANDARDS AND PROCEDURES USED IN AN EXAMINATION

I, Jessica Lynch, being duly sworn, states as follows:

1. I have the authority to represent West Virginia in the examination of CareSource West Virginia Co.

2. I have reviewed the examination work papers and examination report, and the examination of CareSource West Virginia Co. was performed in a manner consistent with the standards and procedures required by West Virginia.

The affiant says nothing further.

Jessica Lynch, CFE, MCM
Examiner-in-Charge

Subscribed and sworn before me by Jessica Lynch on this 18th day of October, 2022.

Katrina Richardson
Notary Public

My commission expires: 10/22/26 (date).

KATRINA RICHARDSON
Notary Public - State of Florida
Commission # HH 317043
My Comm. Expires Oct 22, 2026
Bonded through National Notary Assn.