**STATE OF MISSOURI**
**DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS**
**AND**
**PROFESSIONAL REGISTRATION**

# FINAL MARKET CONDUCT EXAMINATION REPORT

**Of the Life and Health Business of**

**Trisource Healthcare Inc d/b/a Blue Advantage**
**NAIC # 95916**

**MISSOURI EXAMINATION # 0903-12-TGT**

**NAIC EXAM TRACKING SYSTEM # MO268-M103**

**October 4, 2010**

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**VERIFICATION OF WRITTEN REPORT OF EXAMINATION**

# FOREWORD

This is a targeted market conduct examination report of Trisource Healthcare Inc dba Blue Advantage, (NAIC Code # 95916). This examination was conducted at the offices of the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP).

This examination report is generally a report by exception. However, failure to criticize specific practices, procedures, products or files does not constitute approval thereof by the DIFP. During this examination, the examiners cited errors made by the Company. Statutory citations were as of the examination period unless otherwise noted.

When used in this report:

- "Covansys" refers to Covansys (CSC - Computer Sciences Corporation), the claim designee for the Missouri Department of Elementary and Secondary Education (DESE) as described in 20 CSR 400-2.170(4) (C);
- "Company" refers to Trisource d/b/a Blue Advantage;
- "CSR" refers to the Missouri Code of State Regulation;
- "DESE" refers to the Missouri Department of Elementary and Secondary Education;
- "DIFP" refers to the Missouri Department of Insurance, Financial Institutions and Professional Registration;
- "Director" refers to the Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration;
- "First Steps" refers to Missouri's early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq and §376.1218 RSMo;
- "NAIC" refers to the National Association of Insurance Commissioners; and
- "RSMo" refers to the Revised Statutes of Missouri. All citations are to RSMo 2000, unless otherwise specified

## SCOPE OF EXAMINATION

The DIFP has authority to conduct this examination pursuant to, but not limited to, §§374.110, 374.190, 374.205, 375.445, 375.938, 375.1009, RSMo.

The purpose of this examination was to determine if the Company complied with Missouri statutes and DIFP regulations pursuant to Missouri's First Steps program. The primary period covered by this review is January 1, 2006, through December 31, 2008, unless otherwise noted. Errors outside of this time period discovered during the course of the examination, however, may also be included in the report.

The examination was a targeted examination involving the following business functions and lines of business: Equitable claim payments for Early Childhood Intervention Services, "First Steps."

The examination was conducted in accordance with the standards in the NAIC's *Market Regulation Handbook*. As such, the examiners utilized the benchmark error rate guidelines from the *Market Regulation Handbook* when conducting reviews that applied a general business practice standard. The NAIC benchmark error rate for claims practices is seven percent (7%), for electronically submitted health clams is five percent (5%), and ten percent (10%) for other trade practices. Error rates exceeding these benchmarks are presumed to indicate a general business practice contrary to the law. The benchmark error rates were not utilized, however, for reviews not applying the general business practice standard.

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

## COMPANY PROFILE

The Company is licensed by the DIFP under Chapter 354, RSMo, to write Health Maintenance Organization (HMO) business as set forth in its Certificate of Authority. The following information was obtained by the examiners from the Company's web site at:

**http://www.bluekc.com/About/About_Blue_KC.aspx**
**http://www.bluekc.com/About/Affiliates___Subsidiaries.aspx**

"Blue-Advantage Plus of Kansas City is a for-profit corporation formed in 2005 to offer Blue-Advantage Plus, a Medicaid replacement health maintenance organization, in a nine county region encompassing the Kansas City metropolitan area.

"Blue KC also owns several entities that are not licensed affiliates of the Blue Cross and Blue Shield Association and are not authorized by the Blue Cross and Blue Shield Association to use the Blue Cross and Blue Shield brand names and trademarks in providing their products and services.

"Blue KC is the largest health insurance provider in the Kansas City area, offering health empowerment and trusted support to more than one million members. For more than 70 years, our members have relied on our healthcare benefits and personalized services to help them achieve lifelong health and wellness.

"The Headquarters Address is One Pershing Square, 2301 Main, Kansas City, MO 64108 with a Service Area of 32 counties in greater Kansas City and northwest Missouri and Johnson and Wyandotte counties in Kansas."

# EXECUTIVE SUMMARY

The DIFP conducted a series of targeted market conduct examinations of 14 insurance companies providing First Steps benefits. For Trisource d/b/a Blue Advantage, the examiners found the following principal areas of concern:

- The Company improperly denied payments for First Steps benefits in 116 claim files.
- The Company improperly reduced payments for First Steps benefits in 930 claim files.
- The targeted examination revealed an overall error ratio of 73%.

The insurance coverage mandate for First Steps began as on January 1, 2006. This is the first examination targeting First Steps benefits and claim payments.

Examiners requested that the Company make refunds concerning claim underpayments found for amounts greater than $5.00 during the examination. Examiners criticized the Company for delaying claim payments by requesting information from the "provider" that had been satisfied by an established statute or regulation.

The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business according to the Missouri insurance laws and regulations. When applicable, corrective action for other jurisdictions should be addressed.

This market conduct examination was performed as a desk audit at the DIFP offices:

HST State Office Building
301 W. High Street
Jefferson City, MO 65101

# EXAMINATION FINDINGS

## I. UNDERWRITING AND RATING PRACTICES

The examiners reviewed the Company's forms filed by or on behalf of the Company with the DIFP.

An error can include, but is not limited to, any miscalculation of the premium based on the information in the file, an improper acceptance or rejection of an application, the misapplication of the Company's underwriting guidelines, incomplete file information preventing the examiners from readily ascertaining the Company's rating and underwriting practices, and any other activity indicating a failure to comply with Missouri statutes and regulations.

### A. Forms and Filings

The examiners reviewed the Company's policy and contract forms to determine its compliance with filing, approval, and content requirements to ensure that the contract language is not ambiguous or misleading and is adequate to protect those insured.

The examiners discovered no issues or concerns.

## II. CLAIMS PRACTICES

This section of the report is designed to provide a review of the Company's claims handling practices. Examiners reviewed how the Company handled claims to determine the timeliness of handling, accuracy of payment, adherence to contract provisions, and compliance with Missouri statutes and regulations.

To minimize the duration of the examination, while still achieving an accurate evaluation of claim practices, the examiners reviewed a statistical sampling of the claims processed. The examiners requested a listing of claims paid and claims closed without payment during the examination period for the line of business under review. The review consisted of claims from First Steps providers with a date of closing from January 1, 2006, through December 31, 2008.

### A. Unfair Settlement and General Handling Practices

Examiners reviewed the Company's claim handling processes to determine compliance with contract provisions, adherence to unfair claims statutes and regulations and compliance with First Steps statutes and regulations. Whenever a claim file reflected that the Company failed to meet these standards, the examiners cited the Company for noncompliance.

The examiners reviewed denied claims for adherence to Missouri's First Steps mandated benefits. For the following reviews, the examiners eliminated claims that were subsequently paid and those that did not involved the parameters specified. They reviewed records to determine that the Company's claims process is fair, reasonable, prompt and equitable according to the laws and regulations of Missouri.

The examiners asked for the computer processing specifications that control the requirements and payment levels for handling claims. The Company provided information and contracts related to claims clearinghouses and claim processing procedures.

| | |
|---|---|
| Field Size: | 251 total<br>25 files paid pre-8/28/2007<br>226 files paid post-8/28/2007 |
| Type of Sample: | Census |
| Number of Errors: | 184 total<br>27 files paid pre-8/28/2007<br>157 files paid post-8/28/2007 |
| Percent of Errors: | 73% total<br>15% of files paid pre-8/28/2007<br>84% of files paid post-8/28/2007 |
| Within Dept. Guidelines: | No |

1. Improperly Denied Claims

The examiners noted the following errors during their review:

A. Sixteen claims were wrongfully denied, in that they were a part of a system edit and improperly coded. These claims contained a denial code of N59 or N01 which stated "line items that denied as a subset of another service." Although these claims were re-adjudicated as a result of this examination, it should be noted that these claims were paid by the Company at a rate less than the amount billed.

Reference: §376.1218.5, RSMo, and 20 CSR 400-2.170(4)(C)3.C

The 16 claims applicable to this error are found in Appendix A.

B. Examiners discovered that payments for two claim files were wrongfully denied because the Company felt the charges exceeded the First Steps provider Medicaid rate published by DESE. To distinguish that a file was being paid at a reduced rate, these claim files contained Remittance Advice codes of PS and PSS, indicating that a "charge has been processed based upon the provider's participation status" with the

Company. The reasons for the reduced payment given to the examination staff were that the Company did not consider the Place of Service (POS) code as billed by DESE. As stated in the Company's response, dated October 18, 2009, to an examiner criticism, "The Company based its payment to DESE/Covansys on the Medicaid *published* fee schedule."

As advised by DESE and Mo HealthNet, the applicable Medicaid rate and applicable provider manuals are related to the HCY/EPSDT program and discussed in 13 CSR 70-70.010. Subsection (5) of this regulation states "Reimbursement. Payment will be made in accordance with the fee per unit of service as defined and determined by the MO HealthNet Division." The Mo HealthNet Therapy Manual indicates that POS codes may "have a higher…maximum allowable amount."

Reference: §§160.900, 208.144, 376.1218.4 and .5, RSMo, and 20 CSR 400-2.170(3)(B) and (4)(E)

| Claim Number | Claim Status | Reason Code |
|---|---|---|
| 08046F459600 | DENIED | PS |
| 08046F459A00 | DENIED | PS |

2. Improperly Reduced Claim Payments

The examiners noted the following errors during their review:

A. The aforementioned Appendix A claims were reprocessed as a course of this examination. The Company did not pay claims at the applicable Medicaid Rate. Although these claims were re-adjudicated as a result of this examination, it should be noted that these claims were paid by the Company at a rate less than the amount billed.

Reference: §376.1218.5, RSMo, and 20 CSR 400-2.170(4)(E)

The 16 claims applicable to this error may be found in Appendix B

B. Examiners discovered that payments for 162 claim files were wrongfully underpaid because the Company felt the charges exceeded the First Steps provider Medicaid rate published by DESE. To distinguish that a file was being paid at a reduced rate, these claim files contained remittance advice code of PSS indicating that a "charge has been processed based upon the provider's participation status" with the Company. The reasons for the reduced payment given to the examination staff were that the Company did not consider the Place of Service (POS) code as billed by DESE. As stated in the Company's response, dated October 18, 2009, to an examiner criticism, "The Company based its payment to DESE/Covansys on the Medicaid *published* fee schedule."

As advised by DESE and Mo HealthNet, the applicable Medicaid rate and applicable provider manuals are related to the HCY/EPSDT program and discussed in 13 CSR 70-70.010. Subsection (5) of this regulation states "Reimbursement. Payment will be made in accordance with the fee per unit of service as defined and determined by the MO HealthNet Division." The Mo HealthNet Therapy Manual indicates that POS codes may "have a higher…maximum allowable amount."

Reference: §§160.900, 208.144, 376.1218.4 and .5, RSMo, and 20 CSR 400-2.170(3)(B) and (4)(E)

The 162 claims applicable to this error may be found in Appendix C.

3. Unreasonable delay in the payment or denial of a claim

The Company issued letters which requested additional information about certain First Steps claims. Because §376.1218, RSMo and 20 CSR 400-2.170 set forth situations for the unconditional acceptance of diagnosis, provider status, and coordination of benefits, letters requesting additional related information delayed the payment of a First Steps claim.

Files indicate that the Company delayed payment to the provider by issuing a letter requesting additional information. The letter requested information about diagnoses and rendering provider name and address. Since the information requested duplicates the rules set forth in 20 CSR 400-2.170, the request does not pertain to the Company's "determination of liability" and is a "duplication of information and verification."

Additionally, the Company failed to supply the document criticized when originally requested.

Reference: §§ 374.205.2(2), 375.1007(11), 376.383.10, 376.1218 RSMo, 20 CSR 400-2.170(3) and (4)(C)3.C, and 20 CSR 100-8.040(6)(B).

| Claim Number | Letter Type | Letter Create Date |
|---|---|---|
| 07117F597700 | Provider/Group/Freeform | 5/3/2007 2:42:06 PM |
| 07117F599600 | Provider/Group/Freeform | 5/3/2007 2:40:16 PM |
| 07117F599700 | Provider/Group/Freeform | 5/3/2007 2:41:08 PM |
| 07117F599800 | Provider/Group/Freeform | 5/3/2007 2:38:35 PM |

The Company response to an Examiner inquiry revealed that there were similar letters sent in 2009. Examiners requested that the Company take corrective action so that such letters are not generated for future First Steps claims.

## III. CRITICISMS AND FORMAL REQUESTS TIME STUDY

This study is based upon the time required by the Company to provide the examiners with the requested material or to respond to criticisms. Missouri law requires companies to respond to criticisms and formal requests within 10 calendar days. Please note that in the event an extension was requested by the company and granted by the examiners, the response was deemed timely if it was received within the time frame granted by the examiners. If the response was not received within that time period, the response was not considered timely.

### A. Criticism Time Study

| Calendar Days | Number of Criticisms | Percentage |
|---|---|---|
| Received w/in time-limit, incl. any extensions | 3 | 100% |
| Received outside time-limit, incl. any extensions | 0 | 0 % |
| No Response | 0 | 0 % |
| Total | 3 | 100 % |

Reference: §374.205.2(2), RSMo, and 20 CSR 100-8.040

### B. Formal Request Time Study

| Calendar Days | Number of Requests | Percentage |
|---|---|---|
| Received w/in time-limit, incl. any extensions | 7 | 86% |
| Received outside time-limit, incl. any extensions | 1 | 14% |
| No Response | 0 | 0% . |
| Total | 8 | 100 % |

Reference: §374.205.2(2), RSMo, and 20 CSR 100-8.040

# EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Trisource Healthcare Inc. d/b/a Blue Advantage (NAIC #95916), Examination Number 0903-12-TGT. This examination was conducted by John S. Korte, E. Jack Baldwin, John T. Clubb, Mike Woolbright and David Pierce. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated May 27, 2010. Any changes from the text of the Market Conduct Examiner's Draft Report reflected in this Final Report were made by the Chief Market Conduct Examiner or with the Chief Market Conduct Examiner's approval. This Final Report has been reviewed and approved by the undersigned.

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Jim Mealer Date
Chief Market Conduct Examiner