MARKET CONDUCT
EXAMINATION REPORT

ON

OPTIMUM CHOICE, INC

AS OF

JUNE 30, 2008

Karen Weldin Stewart, CIR-ML
Commissioner

Delaware Department of Insurance

I, Karen Weldin Stewart, Insurance Commissioner of the State of Delaware, do hereby certify that the attached REPORT ON EXAMINATION, made as of December 28, 2009 on

OPTIMUM CHOICE, INC.

is a true and correct copy of the document filed with this Department.

Attest By: Madelyn Wright

Date: 28 December 2009

In Witness Whereof, I have hereunto set my hand and affixed the official seal of this Department at the City of Dover, this 28th day of December 2009.

Karen Weldin Stewart, CIR-ML
Insurance Commissioner

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Karen Weldin Stewart, CIR-ML
Commissioner

Delaware Department of Insurance

REPORT ON EXAMINATION

OF THE

OPTIMUM CHOICE, INC.

AS OF

JUNE 30, 2008

The above-captioned Report was completed by examiners of the Delaware Department of Insurance.

Consideration has been duly given to the comments, conclusions and recommendations of the examiners regarding the status of the Company as reflected in the Report.

This Report is hereby accepted, adopted and filed as an official record of this Department.

Karen Weldin Stewart, CIR-ML
Insurance Commissioner

Dated this 28th day of December 2009

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SALUTATION

March 24, 2009

Honorable Karen Weldin Stewart, CIR-ML
Insurance Commissioner
State of Delaware
841 Silver Lake Boulevard
Dover, Delaware 19904

Dear Commissioner Stewart:

In compliance with the instructions contained in the Certificate of Examination Authority Number 08-721 and pursuant to statutory provisions including 18 Del. C. §318-322, a Market Conduct Examination has been conducted of the affairs and practices of:

Optimum Choice, Inc.

hereinafter referred to as the "Company," "Optimum," or as "OCI," incorporated under the laws of the State of Maryland. This examination consists of two phases, an on-site phase and an off-site phase. The on-site phase of the examination was conducted at the following Company location:

4 Taft Court
Rockville, Maryland 20850

The off-site examination phase was performed at the offices of the Delaware Department of Insurance, hereinafter referred to as the "Department" or "DDOI," and other appropriate locations.

The report of examination thereon is respectfully submitted.

FOREWORD

This Market Conduct Examination Report reflects the insurance activities of Optimum Choice, Inc. in the State of Delaware. This report is, in general, a report by exception. As such, some of the information reviewed by the examiners will not be referenced in this written report, since reference to or comments about any practices, procedures, or files that did not result in any errors or irregularities is generally not made. However, since the examiners also reviewed the Company's general business practices as they pertain to Quality of Care, the examiners' observations about those portions of the Company's operations have been provided.

This report does not reflect a comprehensive review of all of the practices and activities of the Company.

Where used in the report:

"Company," "Optimum" or "OCI" refers to Optimum Choice, Inc.
"Del. C." refers to Delaware's Statutes
"Del. Admin. Code" refers to Delaware's Regulations
"DDOI" refers to the Delaware Department of Insurance
"MCO" refers to a Managed Care Organization
"NAIC" refers to the National Association of Insurance Commissioners
"NAIC MRH" refers to the NAIC's *Market Regulation Handbook*

SCOPE OF EXAMINATION

The Delaware Department of Insurance has authority to perform this examination pursuant to, but not limited to, 18 Del.C. §318-322. This examination began November 10, 2008. The examination period is generally the two (2) full calendar years preceding the commencement date of the examination, and the current year to date, unless otherwise stated. The examination period for this examination is January 1, 2006 through June 30, 2008.

The purpose of this examination is to determine the Company's compliance with 18 Del.C. §64, as amended effective July 6, 2006, which transferred regulatory authority over Managed Care Organizations from the Department of Health and Social Services to the Department of Insurance. This examination focused on a review of the Company's Managed Care coverages, with a concentration on Quality of Care issues. The relevant statutes and/or regulations are Chapter 64 - the "Delaware Managed Care Organization Act" or the "Delaware MCO Act" and Del. Admin. Code 1403 - Health Maintenance Organizations.

This examination was performed in accordance with Market Regulation standards established by the Department and examination procedures established by the NAIC. While the examiners generally report on the errors found in individual files, this examination also reviewed general business practices of the Company and comments are provided thereon.

EXECUTIVE SUMMARY

This examination focused on a review of the Company's Managed Care coverages, with a concentration on Quality of Care issues, pursuant to 18 Del. C. §64 and 18 Del. Admin. Code 1403.

Optimum Choice, Inc. is a non-staff model HMO. OCI has no individual policies in Delaware and serves the people of Delaware most often as an employer based carrier.

A limited review of denied claims was made to verify compliance with 18 Del.C. §332(c)(7), Notice of Policyholder Right to Pursue External Review. The examiners found that the Appeal Notice was included with all of the claim files; however, none of the appeal letters could be linked to the specific policyholder.

For any cited exceptions in the report, recommendations have been made to address the issues and concerns noted by the examiners.

EXPLANATION OF THE EXAMINATION PROCESS

FORMS and FILINGS

The examiners review the Company's policy forms, contracts and underwriting guidelines to determine compliance with filing approval and content requirements, to ensure that the contract language is not ambiguous, and that the provisions of the policies adequately protect the consumer. For this examination, the examiners focused on the business areas of the Company that have an impact upon the Quality of Care provided to consumers.

AUTHORITY

Delaware law limits which companies may sell insurance, as well as the type of insurance that a company is allowed to market. The Department issues a Certificate of Authority to an insurer only after the insurer has completed an application process. The examiners review the Company's operations to ensure they are in compliance with their Certificate of Authority and the licensing requirements of Delaware.

COMPLAINTS

The examiners review the complaints the Company received directly from consumers and the complaints received by the Department. The purpose of the review is to determine the accuracy of handling and the resolution of the complaint along with the timeliness of the response.

COMPANY PROCEDURES

The examiners review the Company's procedures to determine if they are in compliance with the statutes and regulations. The purpose of the review is to determine if the procedures assist the Company in meeting its compliance obligations, its contractual obligations and business effectiveness. The examiners also look at the oversight utilized by the Company to ensure that the procedure is being followed and is performing as intended.

EXAMINATION FINDINGS

I. Company Overview

A. History

The principal executive offices for Optimum Choice, Inc. (OCI) are located at 4 Taft Court, Rockville, Maryland 20850. OCI is incorporated and domiciled in Maryland and is licensed as an HMO in Delaware, the District of Columbia, Maryland, Virginia and West Virginia.

OCI is a non-staff model HMO. OCI has no individual policies in Delaware and serves the people of Delaware most often as an employer based carrier. All of the outstanding shares of the capital stock of OCI are owned by Mid-Atlantic Medical Services, LLC (MAMSI).

On February 10, 2004, pursuant to a transaction described in the Form A filing dated November 3, 2003, and filed with the Maryland Insurance Administration, UnitedHealth Group Incorporated's wholly owned subsidiary Mid-Atlantic Medical Services, LLC merged into Mid-Atlantic Medical Services, Inc., resulting in subsidiaries which include OCI and MD-Individual Practice Association, Inc. becoming part of the United Insurance Holding Company Group. MAMSI is a wholly owned subsidiary of UnitedHealth.

B. Profile

Optimum Choice, Inc. is a wholly owned subsidiary of Mid Atlantic Medical Services, LLC (MAMSI). The Company provides a prescribed range of health care services including physician, hospital, and prescription drug services. These health plans offer products for commercial HMO, POS, EPO and PPO customers.

The Company operates in the Mid-Atlantic Region of UnitedHealthcare, which is comprised of the 5-state region of Delaware, District of Columbia, Maryland, Virginia and West Virginia. Other affiliated health plans operating in Delaware include UnitedHealthcare Insurance Company and MAMSI Life and Health Insurance Company. The Company also has an agreement with OneNet PPO, LLC to provide professional services.

C. Vendor Oversight

Routine monitoring activity of vendors is performed by Vendor Relationship Managers and by UHC's Quality Assurance staff. All vendors reviewed have effective Master Service Agreements which contain standard contractual provisions including: Confidentiality, Term & Termination, Payment and Performance. Vendor employees are required to attend HIPPAA training at the time they are hired and receive the same training curriculum as UHC employees.

The MCO reported contracting with only one vendor in Delaware and that is MEDCO, a Pharmacy Benefit Manager. According to the MCO, all other vendors and Third Party Administrators are wholly owned subsidiaries of the MCO.

The Company provided audit reports performed on these vendors. The examiners reviewed these audit reports and noted the following:

- OCI performs routine internal audits of its affiliated health plans, third party administrators and vendors through the National Monitoring and Assessments Department.
- The audit program was created to follow NAIC guidelines for self-audit and risk assessment.
- The Company did not complete an internal audit of any of the vendors who provide benefits to members covered by plans reviewed by this examination under its internal audit program during the requested time period.

D. Internal Audits

• The Company was asked to provide all internal audit schedules and internal audit reports conducted by the Company or any entity within the last three (3) years as well as a copy of the Company's Internal Audit Procedures.

OCI's Department of Regulatory Affairs' rules and procedures require the following seven (7) steps to be completed within their Regulatory Audit procedure: planning, data gathering, review and validation, report preparation, assessment finalization, completion of assessment file/working papers, compliance and procedure follow up. The Managers and Compliance Analysts in the Regulatory Affairs and Regulatory Audit Section of OCI are responsible for completing this Internal Review.

• The Company was asked to provide a copy of each report provided to management by the Audit Staff. OCI provided ten (10) reports prepared for and used by Management for Internal Audit procedures. The reports covered a variety of topics including, but not limited to, personnel work-flow and claims processing. The examiners reviewed these reports and no exceptions or problems were noted.

• The Company was asked to provide its Privacy and HIPAA Procedures.

OCI has a written Disclosure Policy that is sent to their customers that outlines the Company's Privacy policy, states who the Company can and cannot disclose information to and presents the customer's rights regarding disclosure of their own information.

The policy states that the Company is required by law to protect the privacy of the customer's health information. The notice explains how the Company uses the customer's information, when they disclose information to others and the customer's rights regarding their health information that is disclosed in the notice. The examiners found no errors in this review.

Refer also to the section of this report pertaining to 18 Del. C. §6412 - Confidentiality of Health Information for related information.

COMPANY OPERATIONS AND MANAGEMENT

• OCI provided a current organizational chart outlining the relationships of subsidiaries, branch offices and divisions/departments to the overall corporate management structure. The Company also provided a current organizational chart outlining the structure of Delaware operations with respect to management, marketing, customer service, complaints, underwriting and claims.

The information provided by OCI contained a description of its Management Structure, the name, title, start date, date last elected and the termination date of these individuals.

• OCI provided its record retention guidelines and a written description of the media used for record retention, types of records placed on various media and purge schedules. The Company provided the following response to the examiners request for information pertaining to the Company's record retention process:

> The Medical Affairs (MA) Central File Room retains denial files for all MA Departments that send files to the Central File Room for one rolling calendar year, at a minimum. All approval and other closed/completed cases are held according to the time schedule noted in the guidelines.
>
> Off-site Storage: Once the retention period for records in the Central File Room has been reached, the files are purged based on authorization type, labeled and boxed in terminal digit order, bar-coded and then forwarded off-site to the Company's contracted records management vendor, *e.g.*, Iron Mountain, for long term storage for a minimum of seven years; longer for protected health information of minors.

The examiners reviewed the procedures provided as well as confirmed adherence thereto during the course of the examination. The procedures meet the requirements of 18 Del. Admin. Code 1403 §12 - Recordkeeping and Reporting Requirements. The examiners found no errors in this review.

• The Company provided copies of all Financial and Market Conduct Examination reports conducted during the last five (5) years. The Company also provided a description of all fines, penalties and recommendations from any state for the last five (5) years.

There have been five (5) market conduct examinations {VA, MD, VA, DE, VA} completed during the years 2002 until present. Maryland is currently conducting an examination therefore a final report is not available.

The examiners reviewed these reports focusing on any repeat errors, errors that pertain to Quality of Care issues and/or directives from other states for the Company to implement any corrective actions. The examiners found no errors in this review.

• The Company is in compliance with 18 Del. Admin. Code 1403 §5.0 which requires each MCO to have reinsurance protection in the event of catastrophic or unusual losses which would be in excess of the levels of loss which the MCO assumes in the basis of its calculation of premium charges.

• The Company provided a copy of its Annual Report to Shareholders, a 204 page document providing Company corporate information, such as a state-of-the-company report, an opening letter from the Chief Executive Officer, financial data, results of continuing operations, market segment information, new product plans, subsidiary activities and research & development activities on future programs.

The examiners noted that on an annual basis, the MCO gathers information regarding the current status of its network as it relates to primary care physician/member ratios and geographical distribution of primary care physicians and high volume specialists services for suburban, urban and rural areas of the state.

The MCO has procedures in place to ensure they have enough providers/specialists in all areas and that they are accessible to their members.

• The Company provided the minutes from all committee meetings that occurred within the Company during the scope of this examination concerning the following areas: a. Quality of Care, b. Credentialing or Accreditation of Providers, c. Claims, d. Peer Review and e. Grievances/Appeals.

The Review Committees for the above areas are comprised of medical professionals in various fields of specialty and expertise. The minutes of these meetings were recorded in accordance with the requirements of 18 Del. Admin. Code 1403 §12 - Recordkeeping and Reporting Requirements.

The minutes are maintained in a confidential manner. The chairperson of the committee reviews the minutes for accuracy and completeness. The minutes use a standard format that includes a topic, discussion, recommendations and follow-up format. Follow-up items become topics for the next committee meeting. The examiners reviewed the above minutes and found no areas of concern.

COMPLAINT HANDLING

NOTE: As used in this report, the term complaint includes all DDOI Complaints and Grievances, all Complaints or Grievances submitted directly to the Company and all Quality Assurance issues.

• OCI provided a copy of its Grievance Policy and related information. OCI also provided information detailing its Delaware quarterly reporting of complaints, grievances and the various levels of appeals. These reports are prepared by a Senior Analyst in the Operations Division of the Company and are reviewed by a Supervisor in the Customer Support Group.

The Medical Affairs/Appeal Division of OCI has guidelines and definitions of terms used in the complaint procedure. The Company separates a complaint or grievance into one of two categories, either "clinical" or "coverage" grievance. Each type of grievance has various levels of appeals offered to the consumer.

The Medical Affairs Department has established procedures for registering and responding to grievance and appeal requests from Delaware enrollees that are in accordance with Delaware law, Department of Labor Claims Regulations, and accrediting agency standards, by which grievances made by enrollees, their representatives, or physicians/ health care providers on their behalf are investigated and resolved in a timely and appropriate manner.

The examiners reviewed the complaint files for the current year and the two calendar years preceding. According to the documentation reviewed by the examiners the Company responded to all complaints within the twenty-one (21) day time period required by statute. The responses were complete and responsive to all of the issues in the complaints. The responses contained adequate documentation to support the Company's position. The Company's actions appear to comply with all applicable statutes, rules, policies and contract provisions.

• OCI's Complaint Register contains a breakdown of the number of complaints and the level of their status by state. The registers are divided into the following categories: HIPPA; Level 0 Inquiries; Expedite, First Level 2 and Second Level 3; Level 1 Complaints; Level 2 First Level of Appeal and Level 3 Second Level/Panel Review Level Review. The Company's definition of a complaint is "an expression of dissatisfaction" and receipt of a complaint is considered the first step in the appeal process.

Based upon a review of complaint records the Company complies with 18 Del. C. §2304(17), which requires the Company to "… maintain a complete record of all complaints received." The Company's guidelines for complaint handling were also reviewed and there were no areas of concern noted.

• The examiners reviewed a sample of Denied Claims from a list provided by OCI. All of the files contained a "Right to Appeal" letter; however, the letters are a generic form letter. There was no identifying information on the letter to associate it with the consumer. This is in violation of 18 Del Admin. Code 1301 §4 – Mediation Services, which requires the following: "At the time a carrier provides to a covered person written notice of a carrier's final coverage decision, if

the decision does not authorize payment of the claim in its entirety, the carrier shall provide the covered person with a written notice of mediation services offered by the Department. Such notice may be separate from or a part of the written notice of the carrier's decision…." The examiners were shown the procedures being used by the Company to link the letter with the consumer, however the Company was unable to document specific appeal letters sent to specific consumers.

Recommendation: OCI is advised to develop a more direct means of connecting the specific appeal notice letter to the specific consumer, thereby complying with 18 Del Admin. Code 1301 §4.

POLICY FORMS AND FILINGS

• OCI provided an Excel spreadsheet summarizing the Policy forms {including policies, applications, riders, endorsements and amendments} filed with the DDOI, approved by the DDOI and/or filed with the DDOI but disapproved, or the Company amended, withdrew, or otherwise discontinued their use during the examination period. The forms appear to be compliant with all relevant statutes and regulations.

QUALITY OF CARE REVIEW - Statutory Requirements
Chapter 64 - Regulation of Managed Care Organizations

• 18 Del. C. §6404 - Certificate of authority; when required; application and issuance; 18 Del Admin. Code 1403 §3.0 Certificate of Authority.

FINDING: The Company provided its Delaware Certificate of Authority for the period under examination. The Certificate of Authority shows that OCI is authorized to transact business as a Health Maintenance Organization within the State of Delaware. A review of the premium schedules was made to ensure the Company is licensed for the lines of business being written. The Company is operating in accordance with the requirements of its Certificate of Authority and the laws of Delaware.

• 18 Del. C. §6405 - Suspension or revocation of certificate of authority

FINDING: This statute is not applicable at this time.

• 18 Del. C. §6406 - Annual Report - Every MCO is required to annually file a report covering the preceding fiscal year with the Department.

FINDING: OCI provided a copy of its Annual Report dated June 23, 2008 which covered the preceding year of 2007. The report contained the Company's policies and procedures measuring the adequacy of their provider network; statistical information regarding enrollees' access to provider population; grievance appeal information; a provider directory and the current organizational chart. The examiners found the Company to be in compliance with this statute.

• 18 Del. C. §6407 - Prohibited practices; 18 Del. Admin. Code 1403 §10.0 Prohibited Practices, 18 Del. C. §2303 and 2304 – Unfair Trade Practices and Insurance Fraud

FINDING: Based upon a review of various Company documents, including procedures and complaint files, the examiners did not find evidence pertaining to any of the practices prohibited by these statutes and regulation (*e.g.*, questionable reimbursements, bonuses or incentives for physicians/providers based on a consumer's utilization of health care services, retribution or penalties for a provider reporting a questionable practice, advertising or solicitations which were untrue or misleading, cancellation or failure to renew the enrollment of an enrollee solely on the basis of the enrollee's health nor evidence of improper cancellations or nonrenewals). No advertising complaints were found during the examiners' review.

• 18 Del. C. §6409 – Fees and 18 Del. Admin. Code 1403 §4.0 Capital Funds Required

FINDING: The examiners found no exceptions in this review.

• 18 Del. C. §6410 - Provision of professional services

To measure compliance with this statute the examiners reviewed a copy of the following items:
a. the Medical Director's license, their job description and job responsibilities/duties
b. a representative copy of all health care professional employment contracts
c. one contract for each type of healthcare professional – *i.e.*, physician, surgeon, nurse, physical therapist, etc.
d. any contracts that address extenuating circumstances.

FINDING: These items were reviewed and the examiners found no areas of concern.

Refer to the sections addressing 18 Del. Admin. Code 1403 §7.0 Required Contractual Provisions and 18 Del. Admin. Code 1403 §9.0 Provider Relations for additional information related to this review.

• 18 Del. C. §6412 - Confidentiality of health information
FINDING: The examiners reviewed the Company's written procedures as well as determined the Company's actual practices for maintaining confidential information. The statute contains specific instructions for the protection of any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant. The examiners reviewed how the Company develops and enforces its procedures, how employees are initially made aware of the procedures and subsequently updated about changes, and how employees are kept informed about HIPAA and DE's Privacy Regulation. [Reference 18 Del. Admin. Code §904 and 905].

Based upon a review of the procedures used by OCI, the treatment of nonpublic personal information complies with the Company's Privacy policies and practices and with the applicable state laws regarding privacy. These procedures are enforced by employees who are frequently made aware of HIPAA and the Privacy Requirements of DE.

The Company has formal written procedures for Customer and Consumer Privacy Protection that are in compliance with this statute.

• 18 Del. C. §6413 - Freedom of choice

FINDING: The examiners did not conduct an underwriting review during this examination. This type of review would confirm compliance with this statute by reviewing declinations and the reason(s) for the Company's actions. The examiners did not find any complaints pertaining to this issue and the procedures provided by the Company appear to properly address the requirements of the statute.

• 18 Del. C. §6414 - Nondisclosure clause

FINDING: An MCO contract cannot contain a provision or nondisclosure clause prohibiting physicians or other health care providers from giving patients information regarding diagnoses, prognoses and treatment options. The examiners reviewed the provider complaints and member handbooks and found no evidence of such a provision or nondisclosure clause. Also, the MCO's Provider Agreement states that "Nothing in the agreement is intended to interfere with Providers relationship with Members as Provider's patients."

• 18 Del. C. §6415 - Refusal to contract

FINDING: An MCO cannot refuse to contract with or compensate for covered services with an otherwise eligible healthcare provider solely because that provider has in good faith communicated with 1 or more of the provider's current, former or prospective patients regarding the provisions, terms or requirements of the health maintenance organization's products or services as they relate to the needs of that provider's patients.

The examiners reviewed provider complaints and consumer complaints being mindful of allegations of restricted information or restricted treatment options. The examiners found no errors in this review.

• 18 Del. C. §6416 and 6417 - Independent health care appeals program and Appeal reviews; independent utilization review organizations

FINDING: The DDOI has jurisdiction over the Independent Utilization Review Organization (IURO). The procedures provided by the Company appear to be compliant with the requirements of these statutes. However, since the DDOI was only recently given jurisdiction over MCOs these procedures were not tested during this examination.

QUALITY OF CARE REVIEW - Regulatory Requirements
1403 - Health Maintenance Organizations

• 18 Del. Admin. Code 1403 §1 and §2 are definitions; §3 – Certificate of Authority, §4 – Capital Funds Required, §5 – Reinsurance Requirement, §10 – Prohibited Practices and §12.0 Recordkeeping and Reporting Requirements are addressed above in the Statutory Review.

• 18 Del.Admin.Code 1403 §6.0 Special Requirement in the Event of Financial Impairment/Insolvency

FINDING: This requirement is not applicable during the time period of this examination.

• 18 Del.Admin. Code 1403 §7.0 Required Contractual Provisions

OCI provided copies of its Provider Contracts which include the Provider Agreement, the duties of the Provider, Provider participation in the Network, Payment Provisions, Liabilities of Parties, Confidentiality of Records, Resolution of Disputes and Terms & Termination. These contracts are in compliance with the requirements of this regulation.

OCI has a Provider Contract that mandates that the Provider shall maintain in good standing all federal, state and local licenses; certifications and permits, without sanction, censure, probation or material restriction, which are required to provide health care services according to the laws of the jurisdiction in which Covered Services are provided; and shall comply with all applicable statutes and regulations. The Provider is also required to ensure that all healthcare professionals employed by or under contract with the Provider to render Covered Services to Members, including covering Providers, comply with this provision. The MCO and its Providers are required to comply with all applicable federal and state laws and regulations.

The examiners also confirmed that the contracts used by OCI do not contain any language allowing for balance billing to the consumer and that the contract addresses coverage continuation in the case of an insolvency. Refer to 18 Del. Admin. Code 1403 §7.1.1 and 7.1.2.

The examiners found no errors in this review.

• 18 Del. Admin. Code 1403 §8.0 Enrollee Rights and Responsibilities

FINDING: OCI provided copies of all information pertaining to an Enrollee's Rights and Responsibilities as detailed in this regulation. There are currently twenty (20) specific criteria that the MCO must address. In addition to providing information to show its compliance with these requirements, the Company has also established a Notice of Privacy Practices which outlines the member's rights as they pertain to restricting the disclosure of and the use of their personal health information. This notice also complies with the requirements of this regulation.

The examiners reviewed the Enrollee Information provided to all new enrollees and the information provided to the members at the time of renewal. The examiners found no errors in this review.

• 18 Del. Admin. Code 1403 §9.0 Provider Relations

The MCO established Plan Summaries for each releveant Plan. The Provider is supplied with the applicable Plan Summary that relates to his/her program. The Plan Summary outlines the terms and conditions of the member's coverage, including copays and deductibles. The Plan requires the Provider to determine if an individual is a member.

The Provider can only provide covered services at credentialed locations and shall accept new patients without regard to race, religion, gender, national origin, age or physical or mental status. The Provider must also comply with all laws and requirements of all regulatory authorities.

The Plan Summary provides that the MCO and the Provider work together to resolve any disputes with their business relationship. If the dispute cannot be resolved and either party wishes to pursue the dispute, it is submitted for arbitration.

The Provider contract addresses the termination of Providers. The agreement requires that the Provider cooperate with the MCO in notifying members of their pending termination and they must continue to provide services to the member until a new Provider can be established.

If the MCO determines that the health, safety or welfare of its members is in jeopardy, the Provider's termination will be immediate. If those factors do not apply then the agreement may be terminated by either party upon ninety (90) days prior written notice.

The examiners found no errors in this review.

• 18 Del. Admin. Code 1403 §11.0 Quality Assurance and Operations

OCI has a written procedure designed to integrate the goals and objectives of its Quality Improvement Program (QIP) into all of its health plan activities. The plan requires measuring performance against key monitors; reviewing the quality and utilization of clinical care and service; and analyzing, identifying and addressing continuity and coordination of care, improvements to patient safety, customer and practitioner satisfaction and access and availability of care.

The Company provided copies of all information pertaining to its Quality Assurance and Operations, in particular, information detailing how the MCO met each of the requirements of this section of the Regulation. The examiners found no errors in this review.

The Company has a Chief Medical Officer in place to take care of the primary responsibility for the Quality Assessment activities.

The MCOs Regional Chief Medical Director is the designated senior physician who is responsible for the implementation of the Quality Improvement Program. The Director is responsible for providing management with information for strategic decision making and planning. This individual is also responsible for the oversight and maintenance of quality health care delivery programs, policies, procedures and measurements. In addition to other duties it is

the Medical Director's responsibility to ensure compliance with state and federal requirements, accreditation standards and Company policies.

• Section 11.2 - Health Care Professional Credentialing

The Company has established written policies and procedures for credentialing that are in compliance with this regulation. The Credentialing Entity will consider applications from licensed Practitioners based on geographical or specialty needs.

The National Credentialing Committees have the responsibility and authority to implement the Credentialing Plan. They also have the authority to make necessary professional judgments about medical practices and clinical issues.

OCI's Peer Review Committee reviews background and performance information and provides that information to the Credentialing Entity so that they can make a decision to contract with physicians and other health care professionals. The policy requires that all licensed Practitioners who provide coverage to members be hospital or component-based practitioners.

Applicants have the right to review certain information submitted with their credentialing or re-credentialing application and may submit information to correct erroneous information that has been gathered by the Credentialing Entity. The applicant also has the right to obtain information about the status of their application unless it is peer review protected.

Information gathered in the credentialing process is protected by the peer review privilege. OCI's policy also mandates that delegated entities maintain the confidentiality of credentialing information.

The MCO requires twelve (12) criteria such as proof of licensure, liability coverage limits, DEA registration, status of hospital privileges, specialty board certification status, if applicable. All participating providers must notify OCI of any change to the status of any of these twelve (12) items.

• Section 11.3 - Provider Network Adequacy

The examiners reviewed the Company's Provider Network Adequacy, both (1) Primary, Specialty and Ancillary Providers & Facility and (2) Ancillary Health Care Services to determine compliance with the requirements of this regulation. The examiners also reviewed the Company's related procedures and complaints to see if any raised concerns related to this issue. The regulation states that Providers must be geographically accessible and available within a reasonable period of time; if not, the MCO must cover non-network providers and shall prohibit balance billing.

In their Annual Report OCI provides a breakdown of primary care providers for all of the subsidiary companies and shows geographic availability and the number of providers based on specialty. The report also reflects the numbers of complaints regarding access and availability, cultural availability, etc. The Annual Report shows compliance with this regulation.

OCI states in its Annual Report that it meets or exceeds the goal of availability of primary care practitioners, practitioner specialists and hospitals. Goals are also met in the number of practitioners available geographically. The Company is increasing efforts to address diversity of specialty, language and ethnicity. Recruitment in Kent and Sussex Counties is underway in order to address concerns pertaining to access to a practitioner and long waiting periods.

The Company stated that when emergency care services are performed by a non-network provider, the Claims Department attempts to negotiate with the provider for the services rendered. If the provider refuses to negotiate payment, the claim is processed as “in plan” for the member. This means the service is covered at 100%, subject to any co-payment or deductible for the member. This prevents the issue of balance billing the member.

• Section 11.3.3 - Emergency and Urgent Care Services

FINDING: The MCO Open Emergency/Direct/Urgent Admission Process outlines the Member’s Rights and Responsibilities Statement, Coverage for Services and Emergency & Urgent Care Benefits. The Company has established written policies and procedures governing the provision of emergency and urgent care which meet the guidelines outlined in this regulation.

OCI does not require preauthorization of emergency or urgent care services. Through the enrollee’s Evidence of Coverage (EOC) or Certificate of Coverage (COC), OCI provides an explanation of how to access emergency care and what the Company’s responsibilities are as well as the enrollee’s responsibilities. Enrollees are advised to call 911 for assistance or proceed to the nearest hospital emergency room in the case of an emergency, as defined in the EOC or COC. This directive is supported in the UM Program Descriptions, Section X, Part D, and within the “Emergency/Direct/Urgent Admission Process” policy.

The following standards are also required by this Regulation: OCI’s guidelines are distributed to each enrollee at the time of initial enrollment and after any revisions are made; the policies are easily understood; when emergency care services are performed by non-network providers, OCI attempts to make acceptable service arrangements with the provider and enrollee, and they do not allow balance billing; arbitration is recognized for instances where agreement cannot be reached; enrollees have access to emergency care 24 hours per day, seven days per week; and OCI relies upon the prudent lay person standard for whether or not a condition merited emergency treatment.

All participating hospitals are required to notify the Company of an emergency admission within 24 hours, or the next business day, whichever comes first. For out-of-plan and out-of-area (within the United States) emergency admissions, the enrollee must notify the health plan of emergency admissions within 48 hours of the admission, if the enrollee is physically capable of so doing. Once notified, the Clinical Care Coordinator staff will ascertain whether the clinical circumstances warrant additional hospitalization and at what point the enrollee’s condition is such that the enrollee can be transferred to a participating facility.

• Section 11.4 - Utilization Management

FINDING: The Utilization Management (UM) Program is under the direction and oversight of the Regional Chief Medical Officer. The written UM Program Description is provided annually for review and approval to the Medical Advisory Committee which is a peer review committee. The 2006 version was reviewed and approved by the Medicine, Surgery and UM Peer Review Committee, which in 2007 became the Medical Advisory Committee.

The Company provides access to the Utilization Management staff for enrollees, physicians and practitioners via telephone, fax and e-mail. The Company states that their response time to inquiries is within one business day.

OCI uses nationally published written criteria whenever possible. A listing was provided to the examiners along with a listing of practitioners used in the review and approval of these criteria. When internal criteria are developed and subsequently revised, OCI relies upon its practitioners input. Criteria are made readily available, upon request, to affected providers and enrollees as supported by the “Provision of Criteria, Physician Listing and UM Plan Components.

OCI currently prohibits reimbursement, bonuses or incentives for physicians/providers based on consumer utilization of health care services, as per the requirements of this regulation. OCI has a written policy and procedure stating that all clinical and non-clinical employees of the MCO that are involved in the decision making process do not receive additional compensation. The staff is not compensated based on the outcome of individual certification decisions or the number or type of non-certification decisions. This policy and procedure pertains to all participating OCI physicians/providers.

• Section 11.4.5 - Utilization Management Staff Availability - this regulation requires that appropriately qualified staff be immediately available by telephone, during routine provider work hours, to render Utilization Management (UM) determinations.

FINDING: OCI provides access to UM staff for enrollees/participants, physicians, health care practitioners and providers seeking information about the UM process and authorization of care via telephone, fax and e-mail. The UM Program Descriptions addresses the hours of operation in Section VIII, Part A. The Medical Affairs Department is available both during work hours and after hours via telephone. Both local and toll-free telephone numbers are provided to enrollees/participants on their membership cards; Members Services staff provide general information about the UM process and confirmation of approval or denial of coverage for a requested service. Member Services staff triages calls upon request to appropriate UM staff. When adverse decisions are rendered, a toll-free telephone number is provided to the enrollees/participants within the notification letter that informs them to contact the Medical Director who rendered the decision or the Member Services Department to discuss any issues.

• Section 11.4.6 - Utilization Management Determinations

OCI’s procedures require qualified health professionals to make preauthorization, precertification, concurrent and retrospective review decisions.

The Provider must request authorization for health services from the MCO by telephone prior to providing any services to a member, regardless of the time of day or day of the week, and they may not bill the member if this requirement is not followed.

A determination to deny or limit service must be rendered by qualified staff, must be made timely, may not retroactively deny reimbursement for a covered service provided to the enrollee by a provider who relied on written or verbal authorization from the MCO prior to performing the service, and the enrollee must receive written notice of all determinations to deny coverage.

The examiners found no errors in this review.

• 11.5 Quality Assessment and Improvement

OCI's Quality Improvement Program (QIP) policy and procedure manual provides the following processes: Promote and incorporate quality into the health plan's organizational structure and processes; Provide effective monitoring and evaluation of member care and services provided by contracted providers compared to the requirements of evidence based medicine to ensure the MCO is perceived by customers and professionals; Ensure prompt identification and analysis of opportunities for improvement with implementation of actions and follow-up; Coordinate quality improvement, risk management and patient safety activities, and Maintain compliance with local, state and federal regulatory requirements and accreditation standards.

In addition to the above materials the examiners also reviewed provider complaints. The examiners found no errors in this review.

One of the standards that OCI established in its QIP is to facilitate a partnership between customer's practitioners, providers and health plan staff for the continuous improvement of quality health care delivery. This procedure also establishes continuous improvement of communication and education in support of these efforts, and "… considers and facilitates achievement of public health goals in the areas of health promotion and early detection and treatment."

The examiners reviewed OCI's QIP to ensure that participating providers have the opportunity to participate in developing, implementing and evaluating the Quality Improvement system. OCI's written policy states that practitioner surveys are to be conducted annually. The surveys are designed to assess which services are important to practitioners and providers and to determine practitioner satisfaction with OCI's processes. The survey results are summarized and reviewed by the National Service/Operations Committee to identify areas for improvement and develop action plans. The examiners found no errors in this review.

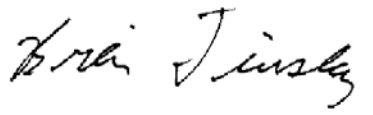
The MCO has a written procedure to establish communication of their QIP through the following: Board of Directors and Regional QI reports, Customer/Provider newsletters and internet portals, Customer/Provider handbooks, Regulatory body reports, surveys, staff meetings and employee communication material and internet portals.

The MCOs QIP is integrated into all health plan activities. The information regarding the QIP is part of the Annual Report that is provided to the DDOI.

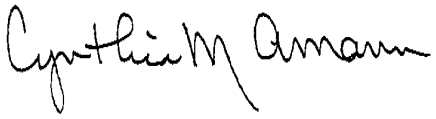
Last, this Regulation requires an MCO to document and communicate information about its Quality Assessment program and its QIP in its marketing materials; that it include a statement of enrollee rights and responsibilities; and make available annually to participating providers and enrollees findings from its quality assessment and quality improvement programs and information about its progress in meeting internal goals and external standards, where available. This information was provided to the examiners and they found no errors in this review.

CONCLUSION

The examination was conducted by Brian Tinsley and Ron Poplos, supervised by Cynthia M. Amann and is respectfully submitted.



Brian Tinsley, MCM, AFE
Examiner in Charge



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Market Conduct Examination Supervisor