

**DELAWARE DEPARTMENT OF INSURANCE**  
**MARKET CONDUCT EXAMINATION REPORT**  
**ON**

**COVENTRY HEALTHCARE of DE, INC**

NAIC Code 96460  
2751 Centerville Road, Suite 400  
Wilmington, DE 19808-1641

January 12, 2010



Karen Weldin Stewart, CIR-ML  
Commissioner



Delaware Department of Insurance

REPORT ON EXAMINATION  
OF THE  
**Coventry Healthcare of Delaware, Inc.**  
AS OF  
January 12, 2010

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 27th day of September 2010

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## SALUTATION

January 12, 2010

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 08-722 and pursuant to statutory provisions including 18 Del. CODE §§318-322, a Market Conduct Examination has been conducted of the affairs and practices of:

Coventry Healthcare of DE, Inc.

Coventry Healthcare of DE, Inc., hereinafter referred to as the “Company,” “CHC,” or as “Coventry,” is incorporated under the laws of the State of Delaware. 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:

2751 Centerville Road, Suite 400  
Wilmington, DE 19808-1641  
and  
211 Lake Drive  
Newark, DE 19712-0001

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 Coventry Healthcare of DE, 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,” “Coventry” or “CHC” refers to Coventry Healthcare of DE, Inc.

“Del. CODE” 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. CODE §§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 December 31, 2007.

The purpose of this targeted examination is to determine the Company's compliance with 18 Del. CODE §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 only 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. CODE §64 and Del. Admin. Code 1403.

Coventry provides group health insurance coverage. The Company issues policies through independent agents, agencies and general agencies. Occasionally, at the group's request, the Company may issue policies directly to the group.

A limited review of denied claims was made to verify compliance with 18 Del. CODE §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, the appeal letters could not 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 if there are any patterns of mistreatment, the accuracy of handling, the resolution of the complaint and 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 Coventry Healthcare of Delaware, Inc. (CHCDE) are located at 2751 Centerville Road, Suite 400, Wilmington, DE 19808-1641. CHCDE is a Managed Care Organization that is incorporated in the State of Delaware and was granted a Certificate of Authority as a Health Maintenance Organization on October 6, 1986, as Principal Health Care of Delaware, Inc. CHCDE is a wholly-owned subsidiary of Coventry Healthcare, Inc.

CHCDE was formerly known as Physicians Health Plan of Delaware, Ltd. from May 29, 1985 until October 14, 1986, and Principal Health Care of Delaware, Inc. from October 14, 1986 until October 4, 1999. It was acquired by Coventry Healthcare, Inc. on April 1, 1998, and the name was changed to Coventry Healthcare of Delaware, Inc. on October 4, 1999. Physicians Health Plan of Delaware, Ltd., a Delaware corporation, was incorporated on May 29, 1985, by Delaware physicians in order to establish and operate an IPA-Model HMO. On October 14, 1986, the Company changed its name to Health Plan of Delaware, Ltd. The Company's Certificate of Authority was granted by the State of Delaware on November 17, 1986.

In 1988, Principal Health Care, Inc. acquired Health Plan of Delaware, Ltd. and on December 15, 1988, changed Health Plan of Delaware, Ltd's name to Principal Health Care of Delaware, Inc. Principal Health Care of Delaware, Inc. was acquired by Coventry Healthcare, Inc. on April 1, 1988 and became a wholly-owned subsidiary of Coventry Healthcare, Inc. when Principal Health Care, Inc. merged with Coventry Cooperation to form Coventry Healthcare, Inc. The name was changed to Coventry Healthcare of Delaware, Inc. on October 4, 1999.

#### B. Profile

Coventry has a provider network of over 19,000 participating physicians and 120 hospitals throughout Delaware, Maryland, southern Pennsylvania and southern New Jersey.

As stated above, Coventry Healthcare of Delaware, Inc. is a subsidiary of Coventry Healthcare, Inc., which is based in Bethesda, Maryland and operates health plans throughout the mid-Atlantic, southeast and Midwest United States. Open Access HMO, Point of Service and Consumer Driven products are underwritten through Coventry Healthcare of Delaware, Inc., which is licensed in Delaware and Maryland. PPO products are underwritten through Coventry Health and Life Insurance Company, a subsidiary of Coventry Healthcare, Inc.

### C. MGA/Vendor Oversight

During the period under examination, the Company used the services of United Behavioral Health (UBH) and MedSolutions (MSI). These services include complaint handling, claims processing and utilization review. However, on July 31, 2008, the Company terminated its contract with UBH. Effective August 1, 2008, the Company began to utilize the services of MHNNet, which is a subsidiary of Coventry.

Audits conducted by Coventry of its vendors were made to satisfy the requirements under Delaware law to perform a minimum of one annual onsite audit of its downstream risk providers and/or delegated entities.

The Company provided the following audits or other documentation regarding its vendors and/or third parties: MedSolutions Executive Summary Audit Memo, UBH Commercial Executive Summary Audit, 2007 Delegated Claims Audit MedSolutions, 2007 Delegated Claims Audit UBH, Delegated Claims Audit UBH Commercial (Delegated Vendor Audit – Claim Criteria UBH), 2007 Delegated Vendor Claims Audit Grid, CovDE CHL MCE ORS CAP F, Delegated Vendor Audit Claims Criteria – MedSolutions, Delegated Vendor State of Delaware 1310 Audit Responses, UBH Claims Audit Report and UBH Correct Response.

The examiners found no errors in this review. There were no areas of concern related to Quality of Care noted in these audit reports.

### 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.

These documents included the Broker License Audit, EQRO Cap, CHCDE Audit Result, Mock DE URAC Audit, URAC, QI Program Evaluation for CSO, CSO Response, URA Complaint Updates, URAC 2008 Audit Announcements, Compliance Program and URAC 2008 Audit Findings.

The Company was audited by the Utilization Review Accreditation Commission (URAC) in January and March of 2008. URAC provides health care accreditation and certification. The results from this Audit revealed findings related to “Appeals.” See the caption “Appeals” below for additional details.

## **COMPANY OPERATIONS AND MANAGEMENT**

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

- The Company provided a written description of the media used for record retention, types of records placed on various media and purge schedules. The procedures meet the requirements contained in 18 Del. Admin. Code 1403 §12.

FINDING: Minutes of Committee Meetings - 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. No findings related to the minutes were noted.

FINDING: The Company has policies and procedures in place to ensure that it maintains all records for the minimum period required by applicable law, regulation and contract or operating requirement. These policy and procedures are written to comply with the Coventry Corporate Policy and Procedure on Document Retention and Destruction Policy that were approved by the Board of Directors. The Company indicates that in all cases Coventry will comply with the most stringent requirement required by either: CHC, Inc., the Company's own policy, applicable state requirement or contractual requirements. The Company's policies and procedures cover all documents received, generated or distributed by Coventry. Any third party contractor with whom CHC has contractually delegated responsibility for record retention or destruction is required to comply with these policies and procedures. The Coventry Compliance Officer is responsible for monitoring compliance with these policies and procedures.

A critical component of CHC's records management system is its record retention and destruction procedures. The Company's general retention requirements under Delaware Law are reviewed by the Company's Policy and Procedure Workgroup. Areas reviewed include medical records and the maintenance of medical records, MCO Quality Assurance, Annual Records, Examinations, Health Care Professional Credentialing, department reviews, fiscal examinations, written grievance procedure. Retention requirements for third party administrators, reinsurers, labor and human resource requirements, financial/tax requirements, statute of limitations requirements are also reviewed.

- 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.

FINDING: There have been six (6) Market Conduct examinations {DE (3) and MD (3)} completed during the years 2002 until present.

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 noted 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. This coverage 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 descriptive chart that summarizes its Reinsurance Program. This chart reflects the contract periods, run-out through date, product, deductible based upon eligible charges and the reinsurer's share of expenses in excess of the deductible. This chart also reflects the maximum reinsurance coverage payables per member. The products included are HMO, POS and Medicaid.

- The Company provided a copy of Coventry Healthcare, Inc's, the parent of Coventry Healthcare of DE, Inc., Annual Report to its shareholders. This is a twenty (20) page document detailing its operations. The examiners noted no areas of concern mentioned in this report.

## **COMPLAINT HANDLING**

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

FINDING: Based upon a review of complaint records, the Company has complied with 18 Del. CODE §2304(17) which requires the Company to "... maintain a complete record of all complaints received." The guidelines for complaint handling were reviewed and there were no areas of concern noted. Based upon the complaint review, the examiners found no errors. There were findings related to Appeals. See the caption "Appeals" below for additional details.

The Company has a written procedure for Complaint Handling. Coventry records all complaints received, along with a brief explanation of any resolution. The complaint process is explained in the Company's Notice of Privacy Practices and complaints are received via telephone, in person or in writing. When Coventry receives a complaint, the Company evaluates it and reviews it through the Business Unit's currently established Complaint process. If the complaint also pertains to an individual who feels that Coventry has violated their privacy rights, a copy of the complaint will be forwarded to, and reviewed by, the Privacy Office. The complaint will be logged into the Customer/Member Service Documentation System and investigated. According to the Company, they do not distinguish between "grievances" and "complaints."

No Issues were found regarding the Company's complaint procedures.

## **APPEALS**

A limited review of denied claims was made to verify compliance with 18 Del. CODE § 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, not all of the appeal letters could be linked to the specific policyholder.

It was determined that the Company changed their procedures and systems to include an identifier on the appeals backer in July of 2007. Any appeal notices sent before that time would not have this identifier and any appeal backers after this date would include an identifier linking the backer to that specific policyholder.

An audit of the Company entitled “Corporate QI Mock URAC Audit” was performed by (URAC) in January and March 2008. This audit was performed to evaluate compliance with URAC’s Health Plan Standards v5.0. Documents reviewed during this audit included Quality Improvement Committee meeting minutes, appeal files, complaint logs and files, personnel files and credentialing/recredentialing files.

The findings of this audit showed appeal files were not completed timely and that there was a backlog of appeals to be entered into the Company’s Complaint Tracking System and subsequently investigated. This backlog of appeals was not reported to the Quality Improvement Committee of the Company.

The Mock Audit also randomly selected eleven (11) personnel files for review. Documentation of ongoing training was not consistent, one employee had no evidence of performance evaluations between 1992 and 2000 and primary source license verification was not completed on two of the four applicable files.

Complaint logs were also reviewed. Thirteen (13) complaint files were reviewed with three (3) being QOC complaints. Overall issues included the following: (1) timeliness - it took an inordinate amount of time for the Company to resolve complaints; (2) the CSO did not take the opportunity to give the member their appeal rights when they complained about a denial of services; and (3) incomplete investigations.

Some complaints also needed to be reviewed by the Health Plan’s staff for potential further action. These cases included the following issues: the MedSolutions (MSI) directing care; a complaint received in 2007 but not yet reviewed by the Medical Director or resolved; personal health information was provided to an employer; and balance billing and improper handling of appeal requests.

The findings of the mock audit were shared with the Company. The specific actions taken by the Company to correct each of the issues noted in the audit were shared with the DDOI. The examiners reviewed these proposed corrective measures and noted no QOC areas of concern.

## **POLICY FORMS AND FILINGS**

The Company provided a binder containing all 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. This information was reviewed while the examiners were onsite and 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. CODE §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 indicates that Coventry is a stock insurer authorized to transact the business of 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. CODE §6405 - Suspension or revocation of certificate of authority

FINDING: This statute is not applicable at this time.

- 18 Del. CODE §6406 - Annual Report - Every MCO is required to annually file its Annual Report with the Department, a report covering the preceding fiscal year; 18 Del. Admin. Code 1403 §12.2 Reporting Requirements and Statistics

FINDING: The 2007 Annual Report was not submitted to the Department by the filing deadline of June 1<sup>st</sup>. The Company incorrectly believed that it was not required to submit its Annual Report to the Department since it thought an Annual Report was only required of those entities that provided coverage for Medicaid. The Company acknowledges that this Report is to be filed annually with the Department of Insurance and has updated its records to reflect this on-going responsibility.

During the course of this examination the Company was able to provide the examiners with all of the documentation normally provided in an Annual Report and the examiners were able to review these materials in a timely manner. Because of the proximity to the due date for the 2008 report the Company was not required to submit the information for the 2007 annual report in a report format. The Company did provide the DDOI with a 2008 annual report which is on file at the DDOI.

The Company provided reports required to be submitted pursuant to 18 Del. CODE §6406. The Company's network adequacy and accessibility procedures are found in the following documents: Announcement to MIA & DOI, 2007 CHC-DE Officer Director Notice, Access and Availability Survey Policy, DOI list of OD, Access & Availability Executive Summary, Access Standards, Announcement to MIA and DOI, GeoAccess Req. Policy and Available Standards Policy.

The Company also provided copies of reports that are submitted on an annual basis pertaining to: (1) network adequacy; (2) grievances, arbitration and appeals; and (3) capital funds. The Company also provided information pertaining to changes in/to: (1) organization, bylaws, and the board; (2) CEO; (3) Medical Director; (4) marketing materials, grievance procedures, Utilization Review (UR); and (5) provider contracts – approved by DDOI prior to execution.

Based upon a review of the documents provided, the Company has complied with the requirements of this statute and regulation.

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

FINDING: The Company's Physician Incentive Plan Policy was included in the review of Prohibited Practices. 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 (*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. CODE §6409 – Fees and 18 Del. Admin. Code 1403 §4.0 - Capital Funds Required

FINDING: The examiners noted no exceptions in this review.

- 18 Del. CODE §6410 - Provision of professional services; 18 Del. Admin. Code 1403 §11.1 - Medical Director's Duties; 18 Del. Admin. Code 1403 §11.2 - Health Care Professional Credentialing

FINDING: The examiners reviewed the Medical Director's license, their job description and job responsibilities/duties. A review of all health care professional employment contracts (one contract for each type of healthcare professional – *i.e.*, physician, surgeon, nurse, physical therapist and review of contracts addressing extenuating circumstances) was also completed.

The Company provided a copy of the following documents for review: Provider Agreement Redline Policy; the Ancillary Application; Contract Policy and Procedure; Employee Training; Medical Director Job Profile; and the Utilization Management Program Structure and Authority. These documents show that the Medical Director's responsibilities encompass all the duties required under this regulation.

The Utilization Management (UM) Plan's Medical Director, a Board Certified Physician, has the overall responsibility for the UM Program, including the annual UM Plan and any medical decision making in the area of utilization management.

- Section 11.2 - Health Care Professional Credentialing

FINDING: The Company has standards that address its credentialing selection, verification and retention standards and criteria. Coventry's policies also establish standards for the participation of network providers. The policy provides a sufficient number of participating providers, by specialty, to service their members. The providers are required to notify the MCO of any status changes to the criteria within the credentialing process. A review of credentialing standards is conducted every two or three years to ensure the standards are maintained.

The Company's Credentialing Policy provides a clearly defined, systematic, on-going process for evaluating potential delegated credentialing entities to ensure they meet applicable credentialing and re-credentialing standards. In order to carry out its credentialing policy, the Company utilizes a Credentialing Committee, a Contract Implementation Department and a Credentials Verification Center. The Company's verification procedures comply with the responsibilities outlined in this regulation.

- 18 Del. CODE §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 documents provided by the Company, and a review of the Company's policies, practices and procedures regarding protection and disclosure of nonpublic personal information of a Member or its policyholders (customers, former customers and consumers who are not customers), the Company complies with applicable laws regarding privacy. Based upon a review of these documents, which also included the Member Services and the Privacy Office procedures, the treatment of nonpublic personal information complies with the Company's privacy policies, practices and procedures and with applicable privacy laws. The examiners found no errors in this review.

The Company provided a "notice of information practices" which contains the required information in accordance with 18 Del. Admin. Code §904 - Privacy of Consumer Financial and Health Information. The Company indicated that it acts in accordance with this Notice. The Notice includes a description of the Uses and Disclosures of Protected Health Information (PHI) by the Company, along with the Member's rights with respect to their PHI. The Company stated that it will use and disclose PHI only in conformance with the contents of the Notice and will promptly revise it whenever there is a material change to the uses and disclosures, legal duties, the Member's rights or other privacy practices that render the statements no longer accurate.

No issues were found with regard to the Company's confidentiality of health information procedure.

- 18 Del. CODE §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 properly address the requirements of the statute.

- 18 Del. CODE §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 member handbooks and found no evidence of such a provision or nondisclosure clause.

- 18 Del. CODE §6415 - Refusal to contract

FINDING: Pursuant to 18 Del. CODE §6415, “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 one 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 noted no errors in this review.

- 18 Del. CODE §§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 are 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, §11 – Medical Director Duties 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

FINDING: Because underwriting was not reviewed as a part of this examination a sample contract was provided by the Company for the examiners review. All required contractual provisions were contained within this sample contract.

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

FINDING: A copy of the Company's Member Rights and Responsibilities was obtained from the Company's website. A review conducted by the examiners found that all required enrollee rights and responsibilities were listed in this document.

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

FINDING: The Company provided five documents that contain the policies and procedures related to Provider Relations. The first document titled "Primary Care Physician Voluntary Termination Policy" states, "The purpose of this policy and procedure is to outline a mechanism to ensure Coventry Healthcare of Delaware (CHCDE) participating providers receive communications, in accordance with state and federal regulations, of changes in policies, procedures, and processes, including fee schedule changes that may affect them."

The second document titled "Retroactive Fee Adjustment Policy" states, "This policy and procedure ensures all retroactive fee adjustments are implemented and addressed appropriately, maintaining the integral relationship between the fee schedule and claim payments."

A "Provider Communication Policy" was also included in the documents. This document also provides "... a mechanism to ensure Coventry Healthcare of Delaware (CHCDE) participating providers receive communications, in accordance with state and federal regulations, of changes in policies, procedures, and processes, including fee schedule changes, that may affect them."

The Company provided a procedure titled "Provider Non-Compliance Policy and Procedure." This procedure addresses incidents of non-compliance in an effort to identify potential performance concerns.

The last document titled "Provider Participating Status Dispute Resolution Policy" states that the purpose of the procedure is "[T]o provide a mechanism for participating providers with Coventry Healthcare of Delaware, Inc., (CHCDE) to dispute issues between the provider and the plan that may result in a change in network status of the provider."

The examiners found no errors in the review of these documents. All required documentation and procedures relating to provider relations were provided and reviewed by the examiners.

- Section 11.3 - Provider Network Adequacy

FINDING: The examiners reviewed the Company's Provider Network Adequacy, both Primary, Specialty and Ancillary Providers & Facility and Ancillary Health Care Services to determine compliance with the requirements of this regulation. The Company also provided the GeoAccess Request Policy, Availability Standards Policy, Access Standards, Access and Availability Survey Policy and as well as their Out of Network Letter. The examiners also reviewed the Company's related procedures and complaints. 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.

The Company's Network Management Department is responsible for obtaining a listing of participating providers and for identifying any high-volume specialty providers. Coventry

utilizes a survey of provider Access and Availability that is performed on an annual basis. Coventry's Provider Relations secures a current listing of participating providers from the Credentialing Department. The Company maintains contracts or other arrangements acceptable to the Department, with providers who have the capability to provide covered health services to enrollees and are geographically accessible. During the process of this examination the examiners reviewed copies of the Participating Ancillary Agreement, Participating Hospital Agreement and Participating Physician Agreement.

The examiners noted no errors in this review.

The Access and Availability Survey Policy and Procedure applies to all providers who make available Primary Care services. This policy and procedure also applies to all other participating providers in the Coventry network on an as-needed basis to ensure their compliance with both the Access and Availability Standard Policies.

Coventry maintains a system to measure the access and availability of Primary Care Providers and high volume specialty providers.

Coventry maintains policies and procedures to ensure that its membership has access to physician care on a 24 hours/7 days a week basis. Monitoring of performance results are compared against the availability standards at least annually. The Director of Provider Relations ensures that the *Access and Availability Survey* Policy and Procedure is reviewed along with the Network Management Department. The senior management in the Network Management Department also reviews the network's need for primary care and specialty providers and verifies any changes to availability standards.

Results of performance monitoring are presented to the Physician Utilization Management/Quality Management and Quality Improvement Committees for review, discussion and action, as appropriate. Complaints are also reviewed and investigated by the Committees during this review. Coventry's Network Management Department performs GeoAccess reporting on an annual basis, or more frequently if needed. These reports are reviewed to determine if there are any areas for improvement as it relates to the availability of health care services.

- Section 11.3.3 - Emergency and Urgent Care Services

**FINDING:** The Company provided the following documents for review: Timeliness of Utilization Management, Out of Area Utilization Management, GMA Excerpt (Group Membership Agreement) and the Utilization Improvement Manual.

The Company's policies and procedures governing the provision of emergency and urgent care meet the guidelines outlined in this regulation. Coventry's policies and procedures ensure that its membership and enrollees have access to physician care (including available and accessible services for urgent or emergency services) on a 24 hours/7 days a week basis.

The HMO Open Access Group Membership Agreement outlines the Member Rights and Responsibilities Statement, Coverage for Services, and Emergency and Urgent Care Benefits. The Company's Membership Handbook and Agreement has established written policies and procedures that address Emergency and Urgent Care Services. According to Section 2.9 of the

Agreement medical emergencies and urgent care services are covered within, or outside of, the Service area. Section 2.11 of the Agreement states that a member is responsible for services not provided or referred in advance by the Primary Care Physician and not authorized by the MCO. An exception to this provision is in a Medical Emergency or Urgent Care situation.

In addition to the above provisions the Company also meets the following standards that are required by this Regulation: its guidelines are distributed to each enrollee at the time of initial enrollment and after any revisions are made; balance billing is prohibited; arbitration is recognized for instances where agreement cannot be reached; and enrollees have access to emergency care 24 hours per day, seven days per week.

- Section 11.4 - Utilization Management

FINDING: The Company provided the following documents for review: Timeliness of Utilization Management, Out of Area Utilization Management, GMA (Group Membership Agreement) Excerpt and Utilization Improvement Manual, Utilization Management Criteria, Compensation Plans for Medical Management Staff and New Medical Technologies/New Applications of Existing Technologies.

The Company's written Utilization Management Plan provides a clearly defined, systematic and on-going process for evaluating potential or actual delegation of Utilization Management services. This Plan is reviewed and updated at least annually.

Coventry does not allow reimbursement, bonuses or incentives for physicians/providers based on consumer utilization of health care services. This policy and procedure pertains to all participating CHCDE physicians/providers.

Coventry's procedures state 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.

- Section 11.4.5 - Utilization Management Staff Availability

FINDING: The Company provided the following documents for review: Prior Authorization Policy, Expedited Authorization, After Hours Authorization and the Provider Manual Excerpt. These procedures serve as the primary document to monitor provider access and availability for all membership.

Coventry's "HMO Open Access Group Membership Agreement" lists a local and a toll-free number for members to call the Customer Service area Monday through Friday, 8:00 a.m. to 5:00 p.m. Coventry provides coverage for out-of-area care for Commercial and Diamond Plan members when the member's condition requires emergency or urgent care. An authorization is not required for emergency services in or out of the service area. Utilization management will continue while the member is out of the service area. Utilization Management Coordinators (UMC) assist in facilitating the transfer once the member's condition has stabilized to the extent that s/he can safely be transported to an in-area provider.

- 11.4.6 - Utilization Management Determinations

FINDING: The Company provided the following documents for review: Timeliness Document, Adverse Decision Notification Letters, Reversal Certificate Decisions Policy, UM Program Structure & Authority, Denial Policy and Timeliness.

The examiners review of the Company's documentation showed proper utilization management determinations and showed that determinations to authorize services are rendered by appropriately qualified staff.

- 11.5 Quality Assessment and Improvement

FINDING: Under the direction of the Medical Director, or his designated physician, the MCO is required to have a system-wide continuous quality improvement program to monitor the quality and appropriateness of care and services provided to enrollees. This program should be based on a written plan which is reviewed at least semi-annually and revised as necessary.

The Company provided the following documents for review: Utilization Management (UM) Program Structure and Authority, Employee Training, Medical Director Information (Medical Management-Medical Review), Provider Agreement Redline Policy, Ancillary Application and Contract Policy, UM/QM Committee Meetings Minutes, Survey Fall Living Well, URAC Audit Findings, Broker License Audit, QI Program Evaluation for CSO, Audit Results, Responses URA Complaints Updates and URAC 2008 Audit Announcement.

No errors were found regarding these documents or the Company's Quality Assessment Program during the course of this review.

FINDING: The Company provided a Report of Independent Auditors (Statutory Basis Financial Statements) and Other Financial Information for the years ended December 31, 2007 and December 31, 2006.

No issues or concerns were found during the course of this review

- 11.5.3 - Reporting and Disclosure Requirements

The requirements of this regulation are discussed in various sections of this report. The examiners noted no errors.

- 13.0 Compliance with Regulation

FINDING: The Company provided copies of any policies and procedures provided to any outside entity that assists the MCO in meeting the requirements of this regulation, focusing on third party providers of services related to the requirements of Complaint Handling, Marketing and Sales, Provider Credentialing, Network Adequacy, Policyholder Service, Underwriting and Rating, Utilization Review and Claims. The Company provided the documents entitled Delegated Claims, Delegated Utilization Management and Delegation Oversight.

Coventry maintains a system to ensure compliance with regulatory requirements for Delegation Oversight. According to the Company, it follows the procedures outlined in its policies to “ensure the appropriate pre-assessment and appropriate oversight of all delegated entities.”

Coventry ensures that appropriate structure and mechanisms are in place to oversee delegated and sub-delegated activities. Prior to delegating functions to another entity, the organization conducts a review of the potential contractor’s policies and procedures and the capacity to perform the delegated functions. Coventry outlines and follows criteria and processes for approving contractors. Site visits are not required for those entities that are accredited by an organization whose standards meet the CHCDE standards. Compliance with regulations is made by the Company’s Compliance Department and the Legal Department. The Oversight of Delegated Utilization Management (UM) Activities Policy provides a clearly defined, systematic and on-going process for evaluating potential or actual delegation of UM services.


The delegate’s policies and procedures must be consistent with CHCDE standards. On an annual basis Coventry reviews the delegates Policy and Procedure Manual and all related materials to ensure compliance with Coventry, URAC, NCQA, State Departments of Insurance and other applicable government agency standards.

## CONCLUSION

The examination was conducted by Brian Tinsley, Gloria Dunn and Cynthia Amann and is respectfully submitted.



Brian Tinsley  
Market Conduct Examiner-in-Charge  
Insurance Department  
State of Delaware



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Cynthia M Amann  
Market Conduct Supervising Examiner