

**Report to the  
Massachusetts Division of Insurance**

*on the Targeted Market Conduct Examination of  
the Readiness of*

**Boston Medical Center Health Plan, Inc.**

Two Copley Place, Suite 600, Boston, MA 02116

*for Compliance with M.G.L. c. 176O, §5A*

*For the Period September 1, 2011 through December 31, 2011*

**May 7, 2012**

## Table of Contents

FOREWORD .....	4
PROFILE .....	5
SCOPEOF EXAMINATION.....	6
EXAMINATION RESULTS .....	7
REPORT SUBMISSION .....	10
APPENDIX.....	11

The Honorable Joseph G. Murphy  
Commissioner of Insurance  
Massachusetts Division of Insurance  
1000 Washington Street, Suite 810  
Boston, Massachusetts 02118-6200

Dear Commissioner Murphy:

Pursuant to your instructions and in accordance with Massachusetts General Laws, Chapter 175, Section 4, a targeted examination has been made of the market conduct affairs of:

**Boston Medical Center Health Plan, Inc.**  
("The Company")

at their home office located at:

**Two Copley Place, Suite 600**  
**Boston, MA02116**

The following report thereon is respectfully submitted.

## FOREWORD

This report on the market conduct examination of the Company is provided pursuant to the *NAIC Market Regulation Handbook*. Some practices, procedures and files subject to review during the examination were omitted from the report if no improprieties were noted.

The Commonwealth of Massachusetts conducted a series of targeted examinations to determine insurance company compliance with Massachusetts General Law (M.G.L.) Chapter (c.) 176O, § 5A. In accordance with that section, insurers are required to meet the following criteria no later than July 1, 2012:

1. Implementation of HIPAA compliant codes and forms;
2. Acceptance of standardized claim formats; and
3. Utilization of standardized code sets.

These examinations measured the companies' readiness to achieve 100 percent compliance with these requirements by July 1, 2012.

INS Regulatory Insurance Services, Inc. (INS) was engaged by the Division of Insurance ("Division") to conduct this series of targeted examinations, including the examination of Boston Medical Center Health Plan, Inc. In order to measure the Company's compliance with these impending requirements, INS engaged in the following:

- INS sent interrogatories to the Company which posed a series of questions regarding reports and information that demonstrate the Company's current level of compliance with M.G.L. 176O, § 5A.
- The Company provided responses to the interrogatories that included policies, procedures and reports illustrating their current level of compliance with the law.
- INS collected data samples from the Company, which were analyzed using ACL ® software.
- INS selected representative samples of claim data submissions and reviewed the same in an on-site visit to the Company.

## **PROFILE**

Boston Medical Center Health Plan, Inc. is a not for profit, 501(c)(3) organization licensed as a Health Maintenance Organization (“HMO”) in Massachusetts in 2008. Founded in 1997 by Boston Medical Center (BMC), the largest “safety net” hospital in New England, the Company operates as an affiliate of BMC, which is the sole corporate member of the HMO. The Company’s mission, as set forth in its bylaws, is to “assist and support BMC in providing and enhancing access to efficient, effective medical care among low income, underserved, disabled, elderly and other vulnerable residents.”

The Company maintains offices in Boston (its headquarters), New Bedford and Springfield, Massachusetts, and it employs approximately 400 individuals across these three offices. The Company has nearly 15 years of experience in managing care for people who qualify for government-subsidized insurance. The Company’s primary line of business is Medicaid, and it serves nearly 240,000 members in Massachusetts (as of fiscal year ending October 31, 2011), 83% of whom are on MassHealth (Medicaid managed care in Massachusetts). The Company also provides coverage through the Massachusetts Commonwealth Health Insurance Connector Authority (“Connector”), which oversees two key state government programs in which the Company participates, Commonwealth Care and Commonwealth Choice. Commonwealth Care provides partially or fully subsidized insurance for adults who meet certain income and other eligibility requirements and the Company serves nearly 40,000 members of that program across Massachusetts. Commonwealth Choice is insurance purchased by individuals and small businesses through the Connector’s shopping exchange; the Company serves approximately XXX members within that program. The Company also sells insurance directly to small groups through its Employer Choice Plan. The Company began offering coverage through the Connector’s Commonwealth Choice program and its own Employer Choice Program beginning January 1, 2012.

## **SCOPE OF EXAMINATION**

The Division conducted an examination of the Company's status to be fully compliant with M.G.L. c. 176O § 5A as of July 1, 2012. Data was collected from the Company from the period of October 1, 2011 through December 31, 2011 (the "Examination Period"). Based on the submitted data, information was analyzed and sample files selected for review. The files were reviewed during an onsite visit, and the review included group and individual health insurance, but did not include disability income, long-term care, short-term travel, accident only, limited policies (including dental, vision, pharmaceutical policies, or specified disease policies) or policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act (Medicare). Only data for fully insured plans were included; self-insured or Administrative Services Only contracts were not included in the review.

The Company initially indicated that it did not offer group or individual health insurance in the commercial market during the Examination Period. The Division subsequently inquired about whether any product lines data was available to demonstrate compliance with M.G.L. c. 176O, § 5A. The Company indicated that the Commonwealth Care product line would serve as a valid representation of readiness and compliance with that law.

## **EXAMINATION RESULTS**

The following is a summary of examiner findings, along with related recommendations and required actions and, if applicable, subsequent Company actions as part of the targeted market conduct examination of the Company.

The Company identified a universe of 8,643 lines of claims with modifier codes 50, 51, 52, 59 and 91 that were reported during the Examination Period. A random sample of 109 claims was requested, received and reviewed. The files were reviewed to verify compliance with M.G.L. c. 176O, § 5A.

No exceptions were noted.

The Company identified a universe of 100,363 denied claims reported during the Examination Period. A random sample of 109 claims was requested, received and reviewed. The files were reviewed to verify compliance with M.G.L. c. 176O, § 5A.

No exceptions were noted.

The Company identified a universe of 378,912 paid claims reported during the Examination Period. A random sample of 109 claims was requested, received and reviewed. The files were reviewed to verify compliance with M.G.L. c. 176O, § 5A.

No exceptions were noted.

**Finding(s):**

In response to the interrogatory, the Company stated that “[t]he following describes [the Company’s] procedures for ensuring compliance for each of the code sets listed.”

- a) HIPAA compliant codes and forms: Please see the attached policies: “Policy 4.31: Reimbursement Guidelines: General Billing and Coding Guidelines” and “Policy 4.32.”
- b) Reimbursement Guidelines: General Clinical Editing Guidelines.” Policies 4.31 and 4.32 describe [the Company’s] policies and procedures regarding HIPAA compliant code sets. In addition to the above referenced policies, [the Company] ensures compliance with HIPAA standard code sets by mandating through internal procedures that only valid CPT/HCPCS<sup>1</sup> codes, Revenue codes, ICD-9 codes, and other transaction processing codes are added to our code repository which is the sole source of valid coding used during claim adjudication. These codes are loaded based on source files obtained from CMS, AMA, and WHO<sup>2</sup> at regular intervals dictated by these agencies. Additionally, when either a professional or [an] institutional claim is submitted with a transaction code that is not valid (either invalid, or expired) and therefore not present within our code repository, the claim denies with an explanation to the provider that the code is invalid and must be resubmitted with a valid code. [Company] systems do not allow any overrides for these denials to ensure compliance with HIPAA coding requirements.
- c) HIPAA compliant forms: As referenced in the above policies (General Billing and Coding Guidelines and Clinical Editing Guidelines), [the Company] does not accept or process claims unless HIPAA compliant forms are submitted. This includes both paper-based claim forms as well as their electronic equivalents.
- d) NUCC<sup>3</sup> Claim Forms: [The Company’s] procedure for ensuring compliance with NUCC claim forms is similar to our procedure in b. above.

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<sup>1</sup> HCPCS is Healthcare Common Procedure Coding System

<sup>2</sup> WHO is World Health Organization

<sup>3</sup> NUCC is National Uniform Claim Committee



- e) NUBC<sup>4</sup> Claim Forms: [The Company's] procedure for ensuring compliance with NUBC claim forms is similar to our procedure in b. above.
- f) ICD Code Compliance: [The Company's] procedure for ensuring compliance with ICD code sets is similar to our procedure in a. above.
- g) CPT Code Compliance: [The Company's] procedure for ensuring compliance with CPT code sets is similar to our procedure in a. above.
- h) HCPCS<sup>5</sup> Code Compliance: [The Company's] procedure for ensuring compliance with HCPCS code sets is similar to our procedure in a. above.

As a result of the above controls, the [Company's] compliance rate with the above seven listed areas is 100%.” Furthermore, “BMCHP requires that both electronic and paper claims be submitted in compliant format. See Policy 4.31. As noted above, BMCHP continuously updates new code sets and standardized claim forms as the primary means to ensure compliance with the above seven areas. As previously stated, any claims submitted using incorrect forms or coding are denied, and the provider is instructed to resubmit using compliant codes and/or forms.”

“After conducting its internal analysis, BMCHP's believes that it is compliant with the required codes. Since our commercial product will follow the same policies and procedures as our existing Commonwealth Care product, it is our position that we are compliant for the July 1, 2012 deadline.”

**Recommendation(s):**

Based on a review of Boston Medical Center Health Plan, Inc.'s responses, it appears that the Company is in compliance with M.G.L. c. 176O, § 5A. Consequently, no recommendations are warranted at this time to address any identified compliance issues.

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<sup>4</sup> NUBC is National Uniform Billing Committee

<sup>5</sup> HCPCS is Healthcare Common Procedure Coding System

## **REPORT SUBMISSION**

This report of examination is hereby respectfully submitted.

Examiners:

INS Regulatory Insurance Services, Inc.

Sean Connolly, MCM, Examiner

Frank Kyazze, CIE, Examiner in Charge

Shelly G. Schuman, Supervising Insurance Examiner

## APPENDIX

The following summarizes the data analysis conducted during the examination. All analyses were conducted utilizing ACL ® software. Duplicate claims were removed.

Total Number of Claims	481,293
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Total Number of Paper Claims (claims submitted in hard copy form)	44,774
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Total Number of Electronic Claims	436,519
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### Top 5 Reasons for Denial:

1. Included in Per Diem/Global payment	20.33%
2. Included in PAPE Primary Payment	17.78%
3. Termination-Member Ineligible	11.65%
4. Submitted after plan filing limit	6.43%
5. Retraction: Other insurance is primary	5.01%

Percentage of Claims Paid	78.73%
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Percentage of Claims Denied	20.85%
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### Time to Process Claims:

1-15 Days	76.32%
15-30 Days	8.84%
30-45 Days	1.66%
Over 45 Days	13.18%