Report to the
Massachusetts Division of Insurance

on the Targeted Market Conduct Examination of
the Readiness of

CeltiCare Health Plan of Massachusetts, Inc.

1380 Soldiers Field Road, Suite 300, Brighton, MA 02135

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

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

May 7, 2012

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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:

CeltiCare Health Plan of Massachusetts, Inc.
("The Company")

at their home office located at:

1380 Soldiers Field Road, Suite 300
Brighton, MA 02135

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 CeltiCare Health Plan of Massachusetts, 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

CeltiCare Health Plan of Massachusetts, Inc.™ is a Massachusetts Managed Care Organization. The Company offers a new form of local managed care that is tailored to meet the needs of Massachusetts' progressive healthcare system. The Company is a subsidiary of Celtic Insurance Company (Celtic); the parent company, Centene Corporation (Centene) is a national leader in the healthcare services field with over 28 years of experience providing programs and related services to individuals receiving benefits under Medicaid and other government funded programs.

The Company was designed to meet the specific needs of Commonwealth Care enrollees, the Commonwealth Care Health Insurance Authority (Authority), and other Massachusetts healthcare reform stakeholders. The Company is headquartered in Brighton, Massachusetts with nearly 65 local employees serving Commonwealth Care, Commonwealth Care Bridge and Commonwealth Choice members.

Celtic Insurance Company (Celtic) is also a Centene subsidiary. Celtic was founded in 1978. Celtic focuses exclusively on the individuals and families who turn to the individual health insurance market for affordable healthcare solutions.

Centene, The Company and Celtic's parent company, acquired Celtic in July 2008, which allowed Centene to offer states unique "exchange-based" and other cost-effective coverage solutions for low-income populations. Centene serves over 1.8 million members in full-risk managed care programs in 14 states: Arizona, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Ohio, South Carolina, Texas, Wisconsin, Massachusetts and Mississippi, with operations commencing in Louisiana in the second quarter and Washington in the third quarter of this year. Centene has more than 5,000 full-time employees nationwide.

Centene is a publicly-held company on the New York Stock Exchange (NYSE: CNC). Additional information on Centene's organizational structure and financial information can be obtained at the Company's website: www.centene.com.

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.

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 353 lines of claims with modifier 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 claims were reviewed to verify compliance with M.G.L.c. 176O § 5A.

No exceptions were noted.

The Company identified a universe of 18,777 lines of claims with a V diagnosis code reported during the Examination Period. A random sample of 109 claims was requested, received and reviewed. The claims were reviewed to verify compliance with M.G.L. c. 176O, § 5A.

No exceptions were noted.

The Company identified a universe of 8,423 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 92,818 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 indicated that:

> "The Company is committed to maintaining accurate up-to-date, 100% HIPAA compliant forms code sets within all company areas of use by purchasing and accessing only HIPAA compliant entities, services, books and data sets as valid sources in accordance with the health Insurance Portability And Accountability Act of 1996, §1173, Standards for information transactions and data elements."

The Company also indicated the percentage of compliance with each of the seven listed areas as follows:

1. The Company maintains 100% HIPAA compliance for the codes and forms.
2. The Company maintains 100% HIPAA compliance for the forms.
3. The paper claims received by the company follow the standardized claims format adopted by National Uniform Claim Committee (NUCC).
4. The paper claims received by the company follow the standardized claims format adopted by National Uniform Billing Committee (NUBC).
5. The Company maintains 100% HIPAA compliance for the ICD-9 code set.
6. The Company maintains 100% HIPAA compliance for the CPT code set.
7. The Company maintains 100% HIPAA compliance for HCPCS[1] code set.

During the on-site phase of the examination the Company demonstrated that they have implemented HIPAA compliant codes and forms, acceptance of standardized claim formats and utilization of standardized code sets. The Company indicated that if a claim is found to

[1] [1] HCPCS is Healthcare Common Procedure Coding System

contain a non-compliant code and/or form, it will be rejected and returned to the provider for correction and resubmission.

Recommendation(s):

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

Observation:

During the examination of the denied claims sample files an issue of denial code EXDW (Deny-inappropriate diagnosis billed, correct and resubmit) was identified. The Company indicated that vision claims billed with a medical DX condition code and a medical procedure code were denying EXDW in error. The Company was requested to:

- Indicate when the Company discovered the code errors;
- Provide the details of the plan in place to correct the error;
- Provide the total number of claims affected by this coding error.
- Provide the timeframe of when the errors will be corrected and claims processed and paid.

The Company indicated that the error was identified on December 1, 2011. Upon finding the error, CeltiCare entered a CR39070 to correct the error. The total number of errors was 1,762 service lines that denied EXDW. CR stands for Configuration Request. This means the Company put a request in to correct the configuration. After the CR was completed (12/27/2011), The Company pulled a report of claims to be set up as a project in order to adjust claims that were denied in error. The project is scheduled to be completed by 02/29/2012.

Recommendation(s):

The Company should provide proof of the project completion.

REPORT SUBMISSION

This report of examination is hereby respectfully submitted.

Examiners:
INS Regulatory Insurance Services, Inc.

Frank W. Kyazze, Examiner-In-Charge
Sean Connolly, Examiner
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	101,241
Total Number of Paper Claims (claims submitted in hard copy form)	44,016
Total Number of Electronic Claims	57,225

Top 5 Reasons for Denial:

1. The Time Limit for filing has expired	27.6%
2. Authorization Not on File – Do Not Bill Patient	19.27%
3. Please Submit Services to Behavioral Health Vendor	13.13%
4. Inappropriate Diagnosis billed, correct and resubmit	4.27%
5. Denied After Review of Patient's Claim History	3.85%

Percentage of Claims Paid	91.68%
Percentage of Claims Denied	8.32%

Time to Process Claims

1-15 Days	90.29%
15-30 Days	7.13%
30-45 Days	0.87%
Over 45 Days	1.71%