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HEARINGS UNIT
OFFICE OF
INSURANCE COMMISSIONER

STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

In the Matter of

COORDINATED CARE CORPORATION,

Authorized Health Maintenance Organization.

Order No. 17-0477

WAOIC No. 500635
NAIC No. 95831

CONSENT ORDER LEVYING A FINE AND RESCINDING NOTICE OF SUSPENSION ORDER NO. 17-0475 AND CEASE AND DESIST ORDER NO. 17-0474

This Consent Order Levying a Fine ("Order") is entered into by the Insurance Commissioner of the state of Washington ("Insurance Commissioner"), acting pursuant to the authority set forth in Chapter 48.46 RCW, and Coordinated Care Corporation. This Order is a public record and will be disseminated pursuant to Title 48 RCW and the Insurance Commissioner's policies and procedures.

BASIS:

1. Coordinated Care Corporation ("the Company") is an authorized Health Maintenance Organization (HMO) domiciled in Indiana and duly authorized to engage in the business of insurance in the state of Washington to act as a Health Maintenance Organization (HMO).

2. From mid-May 2017 to the present, the Insurance Commissioner received approximately one hundred (100) complaints related to Coordinated Care's inadequate network, such as insufficient anesthesiologists and out-of-network charges.

3. Based upon the number of consumer complaints and information gathered by the Insurance Commissioner's staff in investigating the consumer complaints, there was sufficient evidence to indicate that the Company failed to monitor its network of providers, failed to report its inadequate network to the Insurance Commissioner, and failed to file a timely alternative access delivery request ("AADR") to ensure that consumers receive access to healthcare providers. Therefore, to review the Company's network for sufficiency, the Insurance Commissioner's Network Access Section of the Rates and Forms Division ("Network Access") notified the Company on September 18, 2017, that, per WAC 284-170-480(4), that it must provide copies of all executed and active (signed) provider and facility contracts for:

a. Anesthesiologist and Hospital Access;
b. All other contracted anesthesiologists; and
c. Hospitals.

4. On September 22, 2017, Network Access also requested updated/corrected geonetwork reports and submission of Provider Network Form A reports for July, August, and September 2017, which would demonstrate if the Company was adequately monitoring its network and if the Company had knowledge of any deficiencies in its network.

5. Upon reviewing all of the materials submitted by the Company, the Insurance Commissioner determined that the Company had an insufficient network of providers in a number of its service areas, including its largest service areas, such as King, Pierce, and Spokane Counties. On October 31, 2017, the Insurance Commissioner communicated these findings to the Company: that its network was insufficient and that it must submit its AADR to ensure that consumers would have access to necessary healthcare services as required by the Insurance Code.

6. On November 3, 2017, the Company responded with an AADR for the Insurance Commissioner's consideration. The AADR was disapproved on November 16,

2017. The notice of disapproval provided the Company with guidance for resubmission and instructed the Company to refile an AADR within one (1) business day. The Company was also notified that it had sixty (60) days to submit a detailed action plan to change its organizational insufficiencies and come into compliance with the law.

7. On November 16, 2017, the Company then submitted a second AADR, which was disapproved on December 6, 2017. The Company did not follow the provided guidance and was instructed to refile another AADR within one (1) business day.

8. On December 6, 2017, the Company submitted a third AADR. This request was denied on December 12, 2017. The Company's AADR was incomplete, and again, did not follow the Insurance Commissioner's advice so that the request would comply with the Insurance Code.

9. In its ongoing responses to the Insurance Commissioner, the Company admitted that it failed to provide an adequate network of providers, failed to monitor its network of providers, failed to report its inadequate network to the Insurance Commissioner, and failed to timely file an AADR to ensure that consumers received access to healthcare providers.

10. The Company also did not renew its producer appointments timely. The Company was required to renew its producer appointments online by March 8, 2017. A total of four-hundred twenty-six (426) producer appointments were allowed to lapse. In addition, the Company did not complete the online renewal process, but rather sent a check by mail. The renewal was finally processed online on April 24, 2017, after a lapse of forty-seven (47) days. During the lapse, between March 8, 2017 and April 24, 2017, thirty-two (32) transactions were processed by twenty-nine (29) producers, through six (6) agencies.

11. The Company failed to provide an adequate network of providers, failed to monitor its network of providers, failed to report its inadequate network to the Insurance Commissioner, failed to timely file an alternative access delivery request to ensure that consumers received access to healthcare providers, and failed to timely renew its producer appointments, which allowed unappointed producers to conduct transactions.

12. The Company's actions described herein violate Insurance Code provisions that include RCW 48.46.130(1)(b), RCW 48.46.130(1)(c), WAC 284-170-200, WAC 284-170-210, WAC 284-170-230(3), RCW 48.17.160, and WAC 284-17-443.

13. RCW 48.46.130(1) states that the Insurance Commissioner may, consistent with the provisions of the administrative procedure act, chapter 34.05 RCW, initiate proceedings to determine whether a health maintenance organization has:

(b) Materially breached its obligation to furnish the health care services specified in its contracts with enrolled participants.

14. RCW 48.46.130(1) states that the Insurance Commissioner may, consistent with the provisions of the administrative procedure act, chapter 34.05 RCW, initiate proceedings to determine whether a health maintenance organization has:

(c) Violated any provision of this chapter, or any rules and regulations promulgated thereunder.

15. WAC 284-170-200(1) provides that an issuer must maintain each provider network for each health plan in a manner that is sufficient in numbers and types of providers and facilities to assure that, to the extent feasible based on the number and type of providers and facilities in the service area, all health plan services provided to enrollees will be accessible in a timely manner appropriate for the enrollee's condition. An issuer must demonstrate that for each health plan's defined service area, a comprehensive range of primary, specialty, institutional, and ancillary services are readily available without unreasonable delay to all enrollees and that emergency services are accessible twenty-four hours per day, seven days per week without unreasonable delay.

16. WAC 284-170-200(1)(2) states that each enrollee must have adequate choice among health care providers, including those providers which must be included in the network under WAC 284-170-270, and for qualified health plans and qualified stand-alone dental plans, under WAC 284-170-310.

17. WAC 284-170-200(1)(4) provides that an issuer must establish sufficiency and adequacy of choice of providers based on the number and type of providers and facilities necessary within the service area for the plan to meet the access requirements set forth in this

subchapter. Where an issuer establishes medical necessity or other prior authorization procedures, the issuer must ensure sufficient qualified staff is available to provide timely prior authorization decisions on an appropriate basis, without delays detrimental to the health of enrollees.

18. WAC 284-170-210(1) states that where an issuer's network meets one or more of the criteria in WAC 284-170-200 (15)(a) through (d), the issuer may submit an alternate access delivery request for the Insurance Commissioner's review and approval. The alternate access delivery request must be made using the Alternate Access Delivery Request Form C, as provided in WAC 284-170-280 (3)(d).

a) An alternate access delivery system must provide enrollees with access to medically necessary care on a reasonable basis without detriment to their health.

(b) The issuer must ensure that the enrollee obtains all covered services in the alternate access delivery system at no greater cost to the enrollee than if the service was obtained from network providers or facilities or must make other arrangements acceptable to the Insurance Commissioner.

(i) Copayments and deductible requirements must apply to alternate access delivery systems at the same level they are applied to in-network services.

(ii) The alternate access delivery system may result in issuer payment of billed charges to ensure network access.

(c) An issuer must demonstrate in its alternate access delivery request a reasonable basis for not meeting a standard as part of its filing for approval of an alternate access delivery system, and include an explanation of why the alternate access delivery system provides a sufficient number or type of the provider or facility to which the standard applies to enrollees.

(d) An issuer must demonstrate a plan and practice to assist enrollees to locate providers and facilities in neighboring service areas in a manner that assures both availability and accessibility. Enrollees must be able to obtain health care services from a provider or facility within the closest reasonable proximity of the enrollee in a timely manner appropriate for the enrollee's health needs.

Alternate access delivery systems include, but are not limited to, such provider network strategies as use of out-of-state and out of county or service area providers, and exceptions to network standards based on rural locations in the service area.

19. WAC 284-170-230(3) states an issuer of a health plan must maintain and monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish covered health plan services to enrollees. An issuer must notify the Insurance Commissioner in writing within fifteen days of a change in its network as described below:

(a) A reduction, by termination or otherwise, of ten percent or more in the number of either specialty providers, mental health providers, or facilities participating in the network;

(b) Termination or reduction of a specific type of specialty provider on the American Board of Medical Specialties list of specialty and subspecialty certificates, where there are fewer than two of the specialists in a service area;

20. RCW 48.17.160(1) states an insurance producer or title insurance agent shall not act as an agent of an insurer unless the insurance producer or title insurance agent becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.

21. RCW 48.17.160(2) states that to appoint an insurance producer or title insurance agent as its agent, the appointing insurer shall file, in a format approved by the Insurance Commissioner, a notice of appointment within fifteen days from the date the agency contract is executed or the first insurance application is submitted, whichever is earlier.

22. WAC 284-17-443(2) states that the insurer or business entity may review the list online, make any changes, and must remit the correct fees via electronic submission to the Insurance Commissioner.

23. WAC 284-17-443(3) requires that the online appointment or affiliation renewal and payment of fees must be completed no later than the renewal date.

24. RCW 48.46.135 provides that after hearing or upon stipulation by the registrant and in addition to or in lieu of the suspension, revocation, or refusal to renew any

registration of a health maintenance organization, the Insurance Commissioner may levy a fine against the party involved for each offense in an amount not less than fifty dollars and not more than ten thousand dollars.

25. By failing to provide an adequate network of providers, failing to monitor its network of providers, failing to timely file an alternative access delivery request to ensure that consumers received access to healthcare providers, and by allowing producer appointments to lapse and permitting sales by unappointed producers, the Company violated RCW 48.46.130(1)(b), RCW 48.46.130(1)(c), WAC 284-170-200, WAC 284-170-210, WAC 284-170-230(3), RCW 48.17.160, and WAC 284-17-443, justifying the imposition of a fine.

26. The Company is willing to settle this case, agreeing to follow a Compliance Plan, and paying a fine. The Insurance Commissioner is also willing to settle this case in light of the Company's agreement to enter into a Compliance Plan, and in return for execution of this Consent Order, and payment of a fine.

CONSENT TO ORDER:

The Insurance Commissioner of the state of Washington and the Company agree that the best interest of the public will be served by entering into this Order. NOW, THEREFORE, the Company consents to the following in consideration of its desire to resolve this matter without further administrative or judicial proceedings. The Insurance Commissioner consents to settle this matter in consideration of the Company's payment of a fine, upon the Company fully carrying out its obligations under the Compliance Plan attached hereto as Exhibit A, and upon such terms and conditions as are set forth below:

1. The Company acknowledges its duty to comply fully with the applicable laws of the state of Washington.

2. The Company consents to the entry of this Order, waives any and all hearing or other procedural rights, and further administrative or judicial challenges to this Order.

3. By agreement of the parties, the Insurance Commissioner will impose a fine of One and a Half Million Dollars ($1.5 Million) and suspend One Million Dollars ($1,000,000.00) of that, on the conditions that:

a. The Company pays Five Hundred Thousand Dollars ($500,000.00) by **January 15, 2018**; and

b. The Company commits no further violations of the statutes and/or regulations that are the subject of this Order for a period of two years from the date this Order is entered;

c. The Company complies with and carries out the Compliance Plan set forth in Exhibit A hereto, which Compliance Plan is hereby incorporated into this Order by reference as though fully set forth herein.

4. The suspended portion of this fine will be imposed at the sole discretion of the Insurance Commissioner according to the conditions as set forth above, without any right to hearing, appeal or advance notice. The suspended portion of the fine will be paid within thirty (30) days of the entry of an Order imposing it. Failure to pay the suspended portion of the fine when imposed shall constitute grounds for revocation of the Company's certificate of registration.

5. By agreement of the parties, the Insurance Commissioner hereby rescinds Order to Cease and Desist (Order No. 17-0474), and Notice of Suspension of Certificate of Registration (Order No. 17-0475), so that only this Consent Order, No. 17-0477, shall remain in effect.

6. The Company understands and agrees that any failure to comply with any insurance statutes and/or regulations constitutes grounds for further penalties.

7. This Order and the violations set forth herein constitute admissible evidence that may be considered in any future action by the Insurance Commissioner involving the Company. However, the facts of this Order, and any provision, finding, or conclusion contained herein does not, and is not intended to, determine any factual or legal issue or have any preclusive or collateral estoppel effects in any lawsuit by any party other than the Insurance Commissioner.

8. The parties respectfully request that the Presiding Officer terminate the proceedings in the Notice of Suspension of Certificate of Registration, Order No. 17-0475, which is resolved by this Consent Order.

EXECUTED this 15 day of December, 2017.

COORDINATED CARE CORPORATION

By:

Printed Name: J. Fathi MD

Printed Corporate Title: President/CEO

AGREED ORDER:

Pursuant to the foregoing factual Basis and Consent to Order, the Insurance Commissioner of the state of Washington hereby Orders as follows:

1. The Company shall pay a fine in the amount of One and a Half Million Dollars ($1.5 Million) by **January 15, 2018**, of which amount the sum of One Million Dollars ($1,000,000.00) is suspended on the condition that the Company fully complies with the statutes and/or regulations of the state of Washington which are the subject of this Order for the next two (2) years, and upon the further condition that the Company fully carry out its obligations under the Compliance Plan attached hereto as Exhibit A.

2. This Order and the violations set forth herein constitute admissible evidence that may be considered in any future action by the Insurance Commissioner involving the Company. However, the facts of this Order, and any provision, finding, or conclusion contained herein does not, and is not intended to, determine any factual or legal issue or have any preclusive or collateral estoppel effects in any lawsuit by any party other than the Insurance Commissioner.

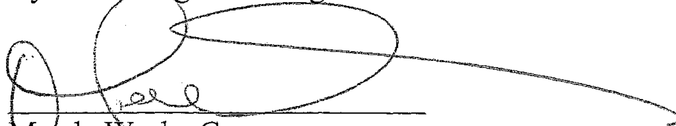
3. Order to Cease and Desist (Order No. 17-0474), and Notice of Suspension of Certificate of Registration (Order No. 17-0475), are hereby rescinded and only this Consent Order, No. 17-0477, shall remain in effect.

4. The parties respectfully request that the Presiding Officer terminate the proceedings in this matter in accordance with this Consent Order.

ENTERED at Tumwater, Washington, this 15th day of December 2017.

MIKE KREIDLER
Insurance Commissioner

By and through his designee



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