REPORT OF

THE

STATE AUDITOR

Children's Basic Health Plan
Department of Health Care Policy and Financing

Oversight of the State Managed Care Network

Performance Audit
October 2008

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This report contains the results of a performance audit of the Department of Health Care Policy and Financing's oversight of the State Managed Care Network within the Children's Basic Health Plan. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government. This report presents our findings, conclusions, and recommendations, and the responses of the Department of Health Care Policy and Financing.

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STATE OF COLORADO **REPORT SUMMARY**

SALLY SYMANSKI, CPA
State Auditor

Children's Basic Health Plan
Department of Health Care Policy and Financing
Oversight of the State Managed Care Network
Performance Audit
October 2008

Authority, Purpose, and Scope

This performance audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct performance audits of all departments, institutions, and agencies of state government. The audit work, performed from September 2007 to September 2008, was conducted in accordance with generally accepted government auditing standards. This is the second of two reports on the Children's Basic Health Plan (CBHP). The first report, the *Children's Basic Health Plan Performance Audit*, was released in June 2008 and included the results of our audit of the overall structure and operations of the program. This second audit focused on the administration of the CBHP State Managed Care Network (Network), which serves about 40 percent of the low-income children and pregnant women enrolled in CBHP, by the contracted Administrative Services Organization (ASO). At the time of our audit, the Department of Health Care Policy and Financing (Department) contracted with Anthem Blue Cross and Blue Shield (Anthem) as the ASO. Our audit assessed the Department's management of the Network through its oversight of Anthem, including (1) the effectiveness of Anthem's medical management practices for administering the Network for the CBHP program, and (2) the accuracy, allowability, and timeliness of claims processed by Anthem for the Network. The State Auditor contracted with Mercer Health & Benefits, LLC (Mercer) to conduct some of the audit work and provide expertise in the area of health care management. We acknowledge the assistance and cooperation provided by the Department of Health Care Policy and Financing.

Overview

The Children's Basic Health Plan Act [Section 25.5-8-101, et seq., C.R.S.] established CBHP as a private-public partnership to provide subsidized health insurance for low-income children and pregnant women. CBHP implements the provisions of federal Title XXI which created the State Children's Health Insurance Program (SCHIP). The Department is designated as the state agency authorized to receive federal SCHIP funds. CBHP is funded by approximately 35 percent state funds (including tobacco settlement, Amendment 35, and general fund monies) and 65 percent federal funds.

To be eligible for CBHP, an individual must be either a child under 19 years of age or a pregnant woman, have family income of less than 205 percent of the federal poverty level, and meet residency and citizenship requirements. Individuals are not eligible for CBHP if they are eligible for Medicaid or have other health insurance. CBHP offers a variety of medical services, including inpatient, outpatient, and emergency care; laboratory services; physician services; prescription drugs; and

limited vision, hearing, mental health, and dental services. The Department provides medical services to CBHP enrollees through five health plans—four contracted HMOs and the Network. At the time of our audit, the Network consisted of more than 4,800 individual providers managed by Anthem. In Fiscal Year 2008 the average monthly number of children enrolled in CBHP was about 57,700, with about 21,720 of them enrolled in the Network. In addition, the average monthly number of pregnant women enrolled in CBHP was about 1,570, all of whom were enrolled in the Network. Finally, for Fiscal Year 2008, total medical services costs were about $113 million, of which about $53 million was paid to Anthem for enrollees in the Network.

Key Findings

Management of Network Medical Care

Under its contract with the Department, Anthem was required to establish a medical case management program for CBHP enrollees in the Network to provide individualized services to patients with chronic, long-term, and high-risk medical conditions. Active and effective case management is critical to promoting patient health, ensuring the provision of high quality health care services, and controlling health care costs. Overall, we found the Department provided minimal oversight of Anthem’s case management program for CBHP. During the audit, we reviewed a sample of 19 CBHP enrollees identified by Anthem as being in the case management program during Calendar Year 2006. We identified exceptions with all of the 19 files we reviewed and provided the exceptions to Anthem and the Department on July 16, 2008. Anthem responded in writing on July 29, 2008 that it agreed with our exceptions and provided no additional information related to the exceptions. Three months later, in October 2008, as the audit report was being finalized, Anthem notified us that it disagreed with the case management exceptions and offered additional documents related to the sample of CBHP enrollees we had reviewed. Anthem’s disagreements focused on: (1) the number of CBHP members in the case management program, (2) the number of case management participants successfully contacted by Anthem, and (3) the thoroughness of case management assessments and care plans.

Because Anthem provided the additional data after the conclusion of our audit, we were unable to verify the accuracy or reliability of the supplemental data. Regardless of the additional information Anthem provided after our audit was completed, our concerns, as discussed in the following section, make it clear that a comprehensive case management program was not in place for the Network at the time of our audit. In particular, we are concerned that in Calendar Years 2006 and 2007, Anthem reported that it had only 54 and 24 CBHP enrollees, respectively, in its case management program. These figures represent less than one-half of 1 percent of the children and pregnant women in the Network in each of the two years.

- **Case Management Identification.** The Department’s contract with Anthem did not require Anthem to implement specific methods for early identification of CBHP enrollees who could benefit from case management. Early identification of case management candidates is important to maximize the value of the services and minimize the need for recurrent hospital admissions and other costly health care services. Anthem identified 14 of the 19 CBHP

enrollees with chronic or high-risk medical conditions in our sample for case management only after a hospitalization had occurred. Anthem identified another 2 CBHP enrollees for case management when requests for services were made that indicated the enrollees had been receiving care for chronic conditions for some time.

- **Case Management Engagement.** The files we reviewed during the audit indicated that Anthem successfully contacted only 7 of the 19 CBHP members in our sample to offer them case management services. We found that Anthem often did not have accurate contact information for CBHP enrollees and did not take advantage of the opportunity to contact CBHP enrollees just before they were discharged from the hospital. Anthem reports that its medical management protocols prevent personal contact with a patient while hospitalized. According to Mercer, it is industry practice for a health plan to make every effort to contact those needing case management before a hospital discharge.

- **Case Management Documentation.** According to documentation provided during our audit, only three of the seven CBHP members Anthem successfully contacted in our sample had case management assessments and care plans. We found that the three assessments that were provided to us were poorly documented and contained inconsistencies and inadequate data. Further, there was no evidence that reassessments were performed. Finally, we found no documentation during the audit that enrollees and providers had provided input into the care planning process or that the case management plans had been shared with the enrollees' primary care physicians.

- **Case Management Outcomes.** We found the Department and Anthem did not evaluate the overall effectiveness of case management services provided to CBHP enrollees. This was due, in part, to the Department's not requiring Anthem to report information that would be useful for this purpose. Additionally, we found that the Department and Anthem did not set any specific goals, outcomes, or performance standards related to case management services provided to CBHP enrollees. As a result, the Department does not have information to determine whether case management services improved health outcomes or provided other benefits to enrollees.

- **Cost and Utilization Data.** We found the Department failed to ensure that Anthem provided all required cost and utilization reports in the contract or that the submitted reports included complete, consistent, and comparable data specific to the CBHP population. As a result, the Department could not ensure that Network services were cost effective, as required by statute. Additionally, the Department could not evaluate or set goals for utilization management activities, network service delivery, or case management processes for CBHP enrollees.

Management of Network Payments

Under its contract with the Department, Anthem's responsibilities with respect to the Network included (1) administering all inpatient, outpatient, and pharmaceutical payment activities for

providers, and (2) establishing policies and procedures for all claims determinations, timely filing guidelines, claims reviews, and appeals. We identified deficiencies with Anthem's system for processing CBHP claims and the Department's oversight and enforcement of Anthem's compliance with contract requirements, as described below:

- **Claims Processing Accuracy.** A total of $234,000 in questioned costs was identified as a result of testing claims processing. We reviewed a judgmental sample of 52 CBHP claims representing about $852,400 paid to providers between April 2006 and March 2007 and found errors for 27 claims. Of these, 24 claims contained payment errors resulting in about $54,800 in overpayments and $20 in underpayments. We conducted further testing on a judgmental sample of 10 claims that were submitted late by providers and identified errors in 8 claims, resulting in overpayments of $19,900. Finally, we analyzed data on claims paid to non-participating providers which identified $159,300 in payment errors. The number and proportion of CBHP payment errors in our sample indicates that the Department needs to improve its oversight of the ASO contractor, including expanding efforts to evaluate the adequacy of the ASO's claims processing procedures.

- **Quality Assurance.** We also noted problems with the Department's contract requirements related to ensuring claims accuracy. For example, the contract allowed Anthem to audit less than one-half of 1 percent of the claims it processed, rather than requiring a sample size of 3 to 5 percent, which is consistent with industry standards. In addition, the Department did not have other mechanisms to identify claims processing errors, such as requiring Anthem to generate reports identifying claims anomalies.

- **Timeliness of Claims Payments.** Our testing found problems with timely claims processing. For the sample of 51 clean claims we reviewed, 35 were processed within 30 calendar days of receipt, and 16 were not. Further, 8 of the claims in our sample were processed between 100 and 525 days after receipt. Our findings confirmed information provided to the Department by Anthem, which indicated that Anthem often did not meet its contractual performance standards for timely claims processing.

- **Contract and Risk Management.** We identified significant concerns with the Department's lack of oversight of Anthem's administration of the Network throughout the audit. These concerns indicate that the Department needs to enhance accountability for services delivered to CBHP enrollees in the Network under its new ASO contract by: (1) strengthening contract requirements, (2) independently verifying services delivered by the contractor, (3) applying adequate sanctions for failure to meet contract standards and requirements, and (4) evaluating options for shifting the financial risk for the Network to the contractor.

Our recommendations and responses from the Department of Health Care Policy and Financing can be found in the Recommendation Locator and in the body of the report.

Recommendation Locator

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
1	20	Ensure that the Administrative Services Organization (ASO) contractor for the Network delivers a full range of case management services to Children's Basic Health Plan (CBHP) enrollees.	Agree	February 2009
2	23	Work with the ASO contractor to set specific goals, outcome measures, and performance standards for case management services provided to CBHP enrollees.	Agree	July 2009
3	27	Improve cost and utilization data and analysis for CBHP provided by the ASO contractor and use data reported by the contractor to make financial and programmatic decisions and to establish program goals.	Agree	November 2008
4	37	Improve the accuracy of claims payments for the CBHP Network by continuing to assess the extent of past payment errors and seeking recovery for such errors, implementing a comprehensive review process over the ASO's claims processing procedures, following up with the ASO on problems identified from such reviews, and including in the ASO contract liquidated damages for specified payment errors.	Agree	July 2010
5	41	Strengthen quality assurance mechanisms for CBHP related to the ASO's accuracy of claims processing by adding contract provisions and ensuring contractor compliance with the provisions.	Agree	July 2009
6	44	Ensure that CBHP claims for the Network are processed by the ASO contractor in a timely manner and assess liquidated damages when timeliness standards are not met.	Agree	Ongoing

Recommendation Locator

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
7	48	Enhance accountability for services delivered for CBHP by the ASO contractor by strengthening contract provisions, independently monitoring the ASO's compliance with the contract, applying liquidated damages appropriately, periodically reassessing liquidated damages amounts, and evaluating the costs and benefits of alternative delivery models for the Network.	Agree	July 2009
8	51	Collect and maintain sufficient documentation for disbursements of CBHP monies. Continue working with providers to resolve the outstanding dispute regarding capitation payments and work with the federal Centers for Medicare and Medicaid Services to determine any federal funds that should be repaid related to this issue.	Agree	April 2009

Overview of the Children's Basic Health Plan

The Children's Basic Health Plan Act created the Children's Basic Health Plan (CBHP) to provide subsidized health insurance for children in low-income families [Section 25.5-8-101, et seq., C.R.S.]. CBHP began operations in April 1998 when House Bill 98-1325 established the program to align with provisions of federal Title XXI, which was enacted by Congress in August 1997. Title XXI created the State Children's Health Insurance Program (SCHIP) to "initiate and expand the provision of child health assistance to uninsured, low-income children." Accordingly, CBHP serves as Colorado's SCHIP program and is marketed under the name "Child Health Plan Plus," or "CHP+." The Department of Health Care Policy and Financing (Department) is the state agency designated to receive federal SCHIP funds and is therefore responsible for administering the CBHP program in compliance with all applicable federal laws and regulations. In 2002 the Department began offering a prenatal program through CBHP for low-income pregnant women under a federal waiver.

CBHP is targeted primarily to individuals under 19 years of age in families between 100 and 205 percent of the federal poverty level, rather than to families who meet the more restrictive income requirements of Medicaid. Medicaid primarily serves families with incomes below 100 percent of the federal poverty level. In addition to meeting the income and age requirements, to be eligible for the CBHP program, a person must be a resident of Colorado and a U.S. citizen or a permanent U.S. resident who has had an Alien Registration Number for at least five years. In addition, eligible individuals may generally not have other insurance or have had such insurance within three months prior to the date they apply for CBHP coverage.

As the following table shows, the total number of enrollees in CBHP and the average monthly cost for medical services for enrollees increased between Fiscal Years 2003 and 2007. The rise in costs is due, in part, to increasing medical costs. According to the Federal Bureau of Labor Statistics, medical costs for people living along the Front Range rose about 21 percent between 2003 and 2007.

Department of Health Care Policy and Financing
Children's Basic Health Plan
Average Monthly Enrollment and Medical Services Cost per Enrollee
Fiscal Years 2003 through 2007

Average Monthly Figures	2003	2004[1]	2005	2006	2007	Percent Change 2003 - 2007[2]
Number of Enrolled Children	49,220	46,690	40,010	46,870	52,200	6%
Number of Enrolled Prenatal Women	400	120	560	1,140	1,340	235%
Total Number of Enrollees	**49,620**	**46,810**	**40,570**	**48,010**	**53,540**	**8%**
Medical Cost per Child[3]	NA[4]	$99	$97	$109	$121	22%
Medical Cost per Prenatal Woman	NA[4]	$796	$908	$874	$1,046	31%
Total Medical Cost per Enrollee	**$92**	**$101**	**$108**	**$128**	**$144**	**57%**

Source: Information from the Department of Health Care Policy and Financing and COFRS.
Notes:
[1] Due to budget constraints, CBHP enrollment was suspended for children and pregnant women during Fiscal Year 2004. The enrollment restrictions were lifted at the beginning of Fiscal Year 2005.
[2] For Average Monthly Medical Cost per Child and per Prenatal Woman, the percentage change is from 2004 and 2007.
[3] Includes dental costs for children. Prenatal enrollees do not have dental coverage.
[4] Medical cost data were not broken down between children and women in COFRS in Fiscal Year 2003. As a result, we could not determine the average monthly medical costs for each group.

In Fiscal Year 2008 an average of about 57,700 children and about 1,570 pregnant women were enrolled in CBHP each month. It is important to note that the Fiscal Year 2008 enrollment figures are not comparable to the enrollment figures in the table above. Beginning in Fiscal Year 2008, the Department no longer recognizes retroactive eligibility in the enrollment figures. In prior years, the Department had adjusted its enrollment figures retroactively. For example, the Department adjusted the enrollment figures for Fiscal Year 2007 to include individuals who applied in Fiscal Year 2007 but whose applications were not processed until Fiscal Year 2008. Retroactive adjustments were made because individuals who are found eligible for CBHP are enrolled effective on the date of application. The Department considers this new method of calculating enrollment figures to be consistent with the cash-based accounting required for budgetary purposes under Senate Bill 07-133 for CBHP expenditures beginning in Fiscal Year 2008.

Providing Health Care Services

The Children's Basic Health Plan Act states that the program was designed as a private-public partnership to take advantage of the "efficiency and creativity . . . [of the] private sector . . . while maintaining the highest level of accountability to the General Assembly . . . and the public. . . ." The Act also specifies that the Department may "allocate functions relating to the administration of [CBHP]" among private contractors, county departments of human/social services, and Department staff.

One of the primary functions the Department has allocated to private contractors is the provision of medical care services. The Department contracts with four

health maintenance organizations (HMOs) and more than 4,800 independent providers to offer health care to CBHP enrollees. The independent providers comprise the program's State Managed Care Network (Network) and are managed by an Administrative Services Organization (ASO) that contracts with the Department. During Fiscal Years 2004 through 2008, Anthem Blue Cross and Blue Shield (Anthem) was the Department's contracted ASO.

The Department pays the HMOs a monthly capitation payment to cover the medical services provided to CBHP enrollees by each HMO's providers. The HMOs are responsible for paying all provider claims from the amounts the HMOs receive from the Department. The Department pays the Network providers, through its ASO, on a fee-for-service basis. The table below shows the number of CBHP enrollees and the total payments made by the Department to the HMOs and the Network (collectively referred to as health plans) in Fiscal Year 2008.

Department of Health Care Policy and Financing
Children's Basic Health Plan
Average Monthly Enrollment and Total Annual Payments by Health Plan
Fiscal Year 2008

	Enrollment		**Annual Payments**	
Health Plan	**Average Monthly**	**Percent of Total**	**Amount**	**Percent of Total**
Managed Care Network – Women[1]	1,570	3%	$16,898,000	15%
Managed Care Network – Children	21,720	37%	$36,146,200	32%
Colorado Access	24,580	41%	$34,775,900	31%
Denver Health	3,900	7%	$5,508,500	5%
Rocky Mountain HMO	3,810	6%	$5,419,900	5%
Kaiser Permanente	3,690	6%	$5,238,900	4%
Delta Dental	N/A[2]	N/A[2]	$8,715,700	8%
Total	**59,270**	**100%**	**$112,703,100**	**100%**

Source: Information from the Department of Health Care Policy and Financing.
Notes:
[1] All pregnant women enrolled in CBHP are served through the State Managed Care Network.
[2] All children receive dental coverage through Delta Dental, so the enrollees in the dental plan are included in the enrollment counts for each of the medical health plans.

The State Managed Care Network

The State Managed Care Network provides health care services to all CBHP participants when they are initially enrolled in the program. While many enrollees move to an HMO within a few months, the Network continues to serve children in counties where there are no CBHP HMOs or where HMO provider coverage is limited. As shown in Appendix A, at the time of the audit the Network served children residing in 45 counties in the State. In addition, all pregnant women enrolled in CBHP receive services through the Network regardless of where they reside.

Administrative services provided by Anthem under its contract with the Department included (1) recruiting and managing providers in the Network, (2) processing claims, (3) handling customer service activities, (4) managing behavioral and pharmacy benefits, and (5) providing utilization review and case management services. In Fiscal Year 2008, the Department paid Anthem an administrative fee of $29 per enrollee per month, for a total of about $8.1 million, as well as about $44.9 million to cover claims payments for health care services delivered to CBHP enrollees in the Network.

Effective July 1, 2008, the Department began contracting with a new ASO to manage the Network – Colorado Access. This contract is effective through June 30, 2009, with the option for the Department to renew annually for up to four additional years. The Department has agreed to pay Colorado Access an administrative fee of $23.06 per enrollee per month and a lump sum payment of $103,195 for upgrading and updating the CBHP provider Web site. The Department's contract with Colorado Access includes the same types of services (e.g., processing claims) that were contained in the previous ASO contract with Anthem.

Program Revenue and Expenditures

Colorado receives federal matching funds for each state dollar spent on the CBHP program. Generally, CBHP expenditures are paid for with a 65 percent/35 percent split of federal and state dollars, respectively. Federal funding is authorized by Title XXI of the Social Security Act. Title XXI funds are allotted annually to states according to a formula based on each state's share of the total number of uninsured children at less than 200 percent of the federal poverty level, multiplied by a geographic cost factor.

In Colorado, funding for the State's share of CBHP expenditures comes primarily from tobacco settlement funds, Amendment 35 taxes on tobacco products, and state general fund monies. The following table shows the program's total revenue and expenditures for Fiscal Years 2004 through 2008.

Department of Health Care Policy and Financing
Children's Basic Health Plan
Revenue and Expenditures
Fiscal Years 2004 through 2008

Category	Fiscal Year					Percent Change 2004 to 2008
	2004 [1]	2005	2006	2007	2008	
Revenue						
Title XXI Federal Grant	$40,612,700	$40,591,100	$50,509,100	$65,666,000	$76,574,400	89%
Tobacco Settlement Funds [2]	$18,460,700	$20,629,500	$20,927,500	$19,214,800	$23,722,100	29%
Tobacco Tax [3]	$0	$0	$5,108,700	$9,597,700	$15,005,300	NA
General Fund	$1,143,500	$3,296,300	$2,000,000	$11,243,200	$5,564,400	387%
Annual Enrollment Fees [4]	$149,600	$122,600	$191,700	$232,100	$283,400	89%
Other [5]	$497,800	$744,800	$1,698,400	$378,500	$732,400	47%
Total Revenue	**$60,864,300**	**$65,384,300**	**$80,435,400**	**$106,332,300**	**$121,882,000**	**100%**
Expenditures						
Medical Services [6]	$56,742,800	$56,685,300	$70,774,200	$95,945,300	$112,752,500	99%
Contracted Personal Services [7]	$4,309,100	$4,217,200	$5,197,700	$5,516,400	$5,505,000	28%
Division Personal Services [8]	$629,100	$689,500	$800,200	$754,900	$1,014,700	61%
Operating Expenses [9]	$469,400	$412,100	$590,500	$626,600	$648,800	38%
Indirect Costs [10]	$136,100	$434,300	$386,500	$879,800	$1,106,600	713%
Transfers to Other Funds [11]	$0	$0	$8,100,000	$0	$377,800	NA
Total Expenditures	**$62,286,500**	**$62,438,400**	**$85,849,100**	**$103,723,000**	**$121,405,400**	**95%**

Source: Information from COFRS and the Department of Health Care Policy and Financing.

[1] Enrollment caps were in place in Fiscal Year 2004, which affected both the revenue and expenditures for CBHP. The enrollment caps were lifted at the beginning of Fiscal Year 2005.

[2] Statute allocates 24 percent of Colorado's Tobacco Litigation Settlement funding to the CBHP Trust Fund, stipulating a minimum of $17.5 million and a maximum of $30 million per fiscal year.

[3] Revenue from the Health Care Expansion Fund financed by increased tobacco taxes authorized by Amendment 35.

[4] CBHP requires families with incomes exceeding 150 percent of the federal poverty level to pay annual enrollment fees of $25 for one eligible child and $35 for two or more eligible children.

[5] Includes interest earned on the CBHP Trust Fund and other revenue, such as refunds of the prior year's reinsurance costs.

[6] Includes capitation payments to the HMOs as well as payments to the Administrative Services Organization for administration and payment of claims in the State Managed Care Network.

[7] Includes payments to administrative contractors for services such as eligibility determination and enrollment, customer service, marketing and outreach, rate setting, and quality review.

[8] Includes salaries, benefits, and employment taxes. CBHP Division staff are paid from the appropriation to the Department's Executive Director's Office instead of from the appropriation for the CBHP program.

[9] Includes general operating expenditures, such as printing, travel and reinsurance coverage for the State Managed Care Network to protect the State against catastrophic claims expenses.

[10] Includes transfers to other Department divisions to cover indirect costs, such as expenditures for CBMS and MMIS.

[11] For Fiscal Year 2006, reflects a transfer from the CBHP Trust Fund to the General Fund according to Senate Bill 05-211. For Fiscal Year 2008, reflects a transfer from the CBHP Trust Fund to the Department of Public Health and Environment for oversight of tobacco settlement programs and for the Short Term Innovative Health Program Grant Fund, in accordance with Senate Bill 07-97.

As the table shows, both revenue and expenditures for CBHP essentially doubled between Fiscal Years 2004 and 2008. The increase in revenue is due, in part, to the addition of tobacco tax monies beginning in Fiscal Year 2006 and growth in the amount of tobacco settlement monies received, both of which allow the Department to draw down more federal funding. The rise in expenditures is due primarily to the increase in medical services provided to eligible children and pregnant women.

Audit Scope and Methodology

This is the second of two reports on the Children's Basic Health Plan. The first report, the *Children's Basic Health Plan Performance Audit*, was released in June 2008 and included the results of our audit of the overall structure and operations of the program, including (1) the effectiveness and efficiency of the CBHP program in meeting its stated goals (as required by Section 2-3-113(2), C.R.S.); (2) compliance with state and federal laws and regulations; and (3) the Department's overall management and oversight of the program. This second report includes the results of our audit of the administration of the CBHP program's State Managed Care Network and focuses on the Department's management of the Network through its oversight of the Administrative Services Organization for the Network. As mentioned earlier, Anthem was the ASO at the time the audit was conducted. In particular, this audit assessed:

- The effectiveness of Anthem's medical management practices in administering the Network for the CBHP program, and

- The accuracy, allowability, and timeliness of claims processed by Anthem for the Network.

As part of this audit, we interviewed Department staff and collected and analyzed data from the Department. We also interviewed staff from Anthem and reviewed Anthem's policies and procedures. Effective July 1, 2008, the Department began contracting with a new ASO – Colorado Access. Therefore, we reviewed not only the contract in place with Anthem in Fiscal Years 2006 through 2008, but also the new contract. This audit did not include a review of services by and payments made to the four HMOs under contract with the Department for the CBHP program.

The State Auditor contracted with Mercer Health & Benefits, LLC (Mercer), to obtain Mercer's expertise in the area of health care management. Mercer conducted a review of a judgmental (non-random) sample of 52 claims from a total of 218,800 CBHP claims processed by Anthem between April 1, 2006 and March 31, 2007, to assess the accuracy, allowability, and timeliness of payments made to Network providers. Mercer also reviewed files maintained by Anthem for enrollees in the case management program to assess Anthem's medical management practices. Finally, Mercer provided industry standards to identify ways for the Department to improve its management of the Network.

Management of Network Medical Care

Chapter 1

The Department of Health Care Policy and Financing's (Department's) contract with the Administrative Services Organization (ASO) Anthem Blue Cross and Blue Shield (Anthem), required Anthem to establish a comprehensive medical case management program for CBHP enrollees in the State Managed Care Network (Network). Active and effective medical management is critical to promoting patient health, ensuring the provision of high-quality health care services, and controlling health care costs. Health plans typically establish case management programs to provide individualized services to patients with chronic, long-term, and high-risk medical conditions (e.g., diabetes, asthma, and high-risk pregnancies) that are intended to help the patients manage their health and minimize the necessity for recurrent hospital admissions and other costly health care services. Examples of services typically provided in case management programs include patient education on medical conditions; coordination of care with primary care physicians and other health care professionals; monitoring of medications and treatments; and referrals to community resources, support groups, and social services (e.g., transportation for medical appointments).

A variety of research indicates that case management services can positively impact clinical outcomes and process measures. These measures reflect the extent to which patients receive recommended care, such as the percentage of diabetic patients who undergo retinal eye exams. Case management can also result in reduced utilization of high-cost health care services. For example, the U.S. Department of Health & Human Services' March 2008 report, *Designing and Implementing Medicaid Disease and Care Management Programs*, contains information from a review of published literature which suggests that case management can help improve clinical outcomes and process measures for diabetes and asthma patients, as well as other chronic illnesses.

One reason an effective case management program is important for the Network is that all prenatal enrollees are served by the Network. A 2006 article published in *Professional Case Management*, a professional journal published by and for medical case managers, indicated that case management services can improve birth outcomes for women with high-risk pregnancies. According to claims data on all the pregnant women in CBHP who delivered babies in Fiscal Years 2006 and 2007, the CBHP program incurred significantly higher costs for pre-term, low-birth-weight deliveries (averaging about $11,000 each) than for full-term, normal-birth-weight deliveries (which averaged about $1,300 each). Case management alone is not expected to

prevent all pre-term births or the delivery of infants with low birth weights. However, case management is intended, in part, to educate pregnant women on healthy practices, with the goal of improving the health of both mother and infant and avoiding the need for high-cost medical care.

We conducted audit work to evaluate the adequacy of the Department's contract provisions related to case management and oversight of the contract to ensure that Anthem provided appropriate case management services to CBHP members. We identified concerns with case management for CBHP enrollees in the Network and improvements that could be made with the collection, analysis, and use of cost and utilization data for the program. We describe these issues in this chapter.

Case Management Program

At the beginning of our audit, we requested from Anthem a list of CBHP enrollees who were included in Anthem's case management membership for Calendar Years 2006 and 2007. In response to this request, Anthem provided a list of 54 and 24 CBHP enrollees in its case management membership for 2006 and 2007, respectively. We judgmentally selected a sample of 19 of the 54 CBHP enrollees in Anthem's case management membership in 2006. The sample included 10 pregnant women that Anthem had identified as having high-risk pregnancies (e.g., threatened premature labor) and 9 children that Anthem had identified as having severe or chronic medical conditions such as diabetes, epilepsy, asthma, or cancer. We reviewed the files for these 19 CBHP members for evidence that Anthem had complied with contract requirements related to case management and to identify ways in which the Department could improve the case management program for CBHP members in the Network.

We identified one or more exception with each of the 19 files we reviewed. We provided the detailed exceptions from our case management review to Anthem on July 16, 2008. Our exceptions showed that Anthem was unable to provide evidence that it had in place a comprehensive case management program that included: (1) early identification of and successful contact with case management candidates, or (2) adequate assessment of, care planning for, or provision of services to, case management participants. On July 29, 2008, Anthem responded in writing that it agreed with the case management exceptions. Anthem did not provide any additional documentation or information related to the exceptions at that time or during subsequent discussions about the audit results in August and September 2008. On October 16, 2008, three months after being provided the exceptions, and as the report was being finalized, Anthem notified us that it disagreed with the case management exceptions and offered additional case management documents related to the sample of 19 CBHP enrollees we had reviewed. Essentially, Anthem's disagreements related to the following three areas:

- **The number of CBHP members enrolled in the case management program.** Although Anthem had initially identified 54 CBHP members as being in the case management program in 2006, in October 2008 Anthem reported that, of the 19 CBHP members in our sample, only 3 were actually enrolled in case management and therefore had case management assessments and care plans, and would have received services.

- **The number of case management participants Anthem successfully contacted for the case management program.** Anthem reported in October 2008 that it had successfully contacted 11 of the 19 CBHP members in our sample. The results of our case file review indicated that Anthem had successfully contacted only 7 of the 19 CBHP members in our sample.

- **The thoroughness of the case management assessments and care plans.** Anthem reported in October 2008 that its case management assessments and care plans were comprehensive. The case management assessments and care plans we reviewed during the audit were not fully documented or complete.

Because Anthem provided these additional data after the conclusion of our audit, we were unable to verify the accuracy or reliability of the supplemental data. Regardless of Anthem's disagreements, we are concerned about the adequacy of the case management program available to CBHP members during the period of our audit and the Department's oversight of the program. In particular, we are concerned that in Calendar Years 2006 and 2007, Anthem reported that it had only 54 and 24 CBHP enrollees, respectively, in its case management program. These figures represent less than one-half of 1 percent of the children and pregnant women in the CBHP Network in each of the two years.

Overall, we determined that the Department did not provide appropriate oversight of Anthem to ensure that CBHP enrollees received adequate medical case management. Without such oversight, we are concerned that appropriate and effective case management practices were not in place for the CBHP enrollees in the Network. We identified three main areas in which the Department could improve ASO contract provisions and oversight to ensure the ASO maintains a comprehensive and effective case management system, as discussed in detail in the following sections.

Identification

The first area in which the Department could strengthen case management for CBHP enrollees in the Network is to require the ASO contractor to have mechanisms in place for early identification of case management candidates. The Department's contract with Anthem did not require Anthem to have specific mechanisms, such as

the health risk assessments discussed below, for early identification of CBHP enrollees with chronic or other high-risk conditions who could benefit from case management services. Instead, the contract specified that Anthem would use hospitalization as a trigger for identifying CBHP candidates for case management. In fact, Anthem identified 14 of the 19 CBHP enrollees in our sample (74 percent) for case management services after a hospitalization had occurred. Specifically:

- Anthem identified 11 enrollees with high-risk or chronic conditions after one or more hospitalizations. This included 4 pediatric enrollees who had conditions such as chronic asthma, cancer, or congenital hemiplegia (which can cause weakness or paralysis in one vertical half of the patient's body before, during, or soon after birth along with epilepsy, learning difficulties, and severe behavioral problems). It also included 7 prenatal enrollees who were hospitalized for threatened premature labor or other complications associated with their pregnancies.

- Anthem identified three high-risk prenatal enrollees after they delivered their babies.

Further, Anthem identified 2 of the 19 CBHP enrollees in our sample when requests for services were submitted that indicated the children had been receiving care for chronic conditions for some time. One child with quadriplegia and spinal meningitis was identified when Anthem received a request to continue home health services. The other child, with an autoimmune disorder, was identified when Anthem received a request for durable medical equipment.

According to Mercer, the following tools, which were not required in Anthem's contract, are industry standards that the Department could require the ASO to use for early identification of potential case management participants:

- **Use of health risk assessments,** which identify risk factors that negatively affect patients and assist health plans in determining which members would benefit from case management services. The use of health risk assessments is a common practice among both public and private sector health plans.

- **Development of a disease registry,** which compiles data on the occurrences of specific diseases (e.g., diabetes, asthma) within a health plan's member population. Health plans may use data from health risk assessments, referrals, and claims to identify members to be placed on the registry and enrolled in case management. For instance, a health plan may identify an asthma patient for placement on the registry based on emergency room, hospital, and pharmacy utilization patterns.

- **Analysis of pharmacy data,** which may reveal utilization patterns indicating the need for patient education or interventions. For example, according to data from Anthem for the period of January through September 2007, about 3,000 of the almost 8,000 pharmacy denials (38 percent) for CBHP enrollees were due to patients' trying to refill their medications too soon. The most frequently denied medications and supplies were asthma inhalers, insulin, and diabetes test strips. Overuse of medications and supplies could indicate escalating illness or noncompliance issues (e.g., more frequent use of medication than advised by the enrollee's physician).

Engagement

The second area in which the Department could strengthen case management for CBHP enrollees in the Network is to ensure that the ASO contractor has effective mechanisms for contacting case management candidates. Of the 19 CBHP members in our sample, the files we reviewed during the audit indicated that Anthem successfully contacted only 7 (4 prenatal and 3 pediatric) to offer them case management services during the period our audit covered. We noted two problems that limit the effectiveness of Anthem's efforts to contact potential case management participants. First, Anthem often did not have accurate contact information for CBHP enrollees. We found no evidence in the files we reviewed that case managers consistently verified or validated contact information during conversations with providers or CBHP enrollees. Second, Anthem did not take advantage of the opportunity to contact CBHP enrollees just before they were discharged from the hospital. Of the 11 enrollees who were identified as possible case management participants when they were hospitalized, Anthem's attempts to contact them after they were discharged were successful in only 2 cases.

Anthem reports that its medical management protocols prevent personal contact with a CBHP enrollee while the enrollee is hospitalized. According to Mercer, it is industry practice for a health plan to make every effort to coordinate care across transition periods, such as when a patient transitions from a hospital to an outpatient setting. Such efforts would normally include the health plan either directly contacting the patient regarding case management services before discharge or ensuring that current and accurate patient contact information is available to the health plan to reach the patient after discharge.

Documentation

The third area needing improvement relates to documentation of case management activities. The Department is responsible for ensuring that the ASO contractor has a comprehensive case management program for CBHP enrollees in the Network. For the Department to evaluate the adequacy of the case management program, the

ASO contractor must maintain complete and readily-accessible documentation of its case management activities for the Department's review. During the audit, we did not find that Anthem had complete and readily-accessible documentation of its case management program. Specifically, our review found a lack of evidence that Anthem had completed adequate case management assessments and care plans for all the CBHP members contacted for participation in the case management program, as discussed below.

Assessments. During our audit, we found case management assessments for three of the CBHP members that Anthem successfully contacted out of our sample of 19. However, the assessments we were provided were poorly documented, with inconsistencies and inadequate data. For example, the assessment for one enrollee contained a narrative of the most recent hospitalizations but did not contain other critical information normally found in assessments, such as the patient's co-morbidities (diseases or conditions that coexist with a primary disease); functional or developmental status; medication management; or preventive, health education, or social/economic needs. In addition, we found no evidence that reassessments were performed on enrollees. It is industry standard to conduct case management reassessments at least annually, or whenever a patient's condition changes, and use the reassessment to update the care plan.

Care Plans. We found that Anthem's files contained care plans for two of the CBHP members that Anthem successfully contacted out of our sample. However, we found no evidence in the files provided for the review that the case managers routinely reviewed or updated the plans, such as to reflect changes in short- or long-term goals, if enrollees' conditions changed. Further, we found no documentation of the enrollees' and providers' input into the care planning process or that the case management plans had been shared with the enrollees' primary care physicians.

As discussed previously, Anthem provided additional data at the time our report was being finalized. Regardless of these additional data, we are concerned that Anthem did not have complete and readily-available case management files for review during the audit. The lack of documentation available during the audit indicates that the Department would have faced similar difficulties if it had conducted a case file review as part of its contract monitoring efforts.

In spite of the additional information Anthem provided after our audit was completed, it is clear from the concerns we identified in the three areas discussed above that a comprehensive case management program was not in place for the CBHP Network at the time of our audit. The absence of effective methods to identify and contact case management participants in a timely manner results in an inability to provide case management services to all CBHP members who could have benefited from them.

Department Oversight

It is critical for the Department to ensure that its ASO contractor has mechanisms in place to expeditiously identify and engage enrollees who would benefit from case management services and maintains complete and readily-available case management files. We identified weaknesses in both the contractual requirements related to case management and the Department's oversight of the contract in these areas.

Contract Provisions. The Department's contract with Anthem did not direct Anthem to use specific techniques for early identification or effective contact of potential case management participants. The Department's new ASO contract, effective July 1, 2008, does include a requirement that the contractor "use claims and encounter data, pharmacy data, and other data collected from the utilization management process to identify" CBHP enrollees for case management. Claims, encounter, and pharmacy data can all be used in early identification systems, such as disease registries. However, the new contract does not contain specific direction regarding the ASO's processes for contacting CBHP enrollees for involvement in the case management program. At a minimum, the Department should ensure that the ASO contractor: (1) uses claims, encounter, and pharmacy data as part of a system for early identification of CBHP members who could benefit from case management, (2) requires contact with potential case management participants prior to or within a specified minimal period after the enrollee has been discharged from the hospital, and (3) requires ASO staff to update enrollee contact information on a regular basis.

In addition, the Department's contract with Anthem did not require Anthem to report data to the Department that could have been used to monitor compliance with contractual requirements or to measure the effectiveness of the case management program. The contract with Anthem required quarterly reporting of "all cases managed by the ASO" and the "triggers that shift a particular situation into case management." However, the contract did not specifically require reporting of: (1) the number of CBHP members identified for case management but never successfully enrolled in the program, and the reasons for non-participation; or (2) the types of case management services provided to participants and case management outcomes. The Department's new ASO contract requires the contractor to "propose and develop a case management/care management report to include mutually agreed upon qualitative and/or quantitative measures." The Department should ensure that the agreed-upon report contains data that are needed to measure compliance with the contract and the effectiveness of case management services.

Contract Monitoring. The Department did not adequately monitor compliance with the contract provisions that required Anthem to develop, implement, and administer an appropriate medical case management program. We reviewed the four quarterly

reports Anthem submitted in Fiscal Year 2007 and found that each of the reports contained case management information for only a single enrollee, which should have signaled either weaknesses in Anthem's case management program or reporting deficiencies, to the Department. The Department did not notice that Anthem was reporting such limited information on case management, nor did the Department question Anthem about the limited data.

In addition, the Department did not periodically review Anthem's case management files for CBHP enrollees to monitor the types of services provided. Conducting routine reviews of a sample of case management files would allow the Department to ensure that services are being delivered in accordance with the contract. The Department should implement a process to conduct routine reviews, provide the contractor with written findings from the reviews, require the contractor to provide written plans for correcting any deficiencies, and follow up to ensure that corrective actions are taken. To ensure that the review process is meaningful, the Department should direct the ASO contractor to maintain complete and readily-accessible case management files for the Department's review.

Further, we found no evidence that Anthem provided training to its case management staff specific to the CBHP program. In its contract with the Department, Anthem was required to "have procedures to ensure that all personnel who support clinical review activities have appropriate training, including training regarding the health care needs and unique characteristics of the enrolled population (e.g., pediatric, poor, rural, ethnic minorities)." Anthem acknowledged that it had not provided any CBHP-specific training to its case managers in recent years. The Department should monitor the new ASO contractor to ensure that the ASO's staff receive training specific to the CBHP program, as required by the contract.

One of the primary purposes of case management programs is to deliver services that help enrollees improve their health and reduce hospital admissions and other costly health care services. By failing to ensure that Anthem was properly identifying, contacting, and providing case management services to CBHP enrollees, the Department did not promote improvement in the health of enrollees or the containment of medical care costs.

Recommendation No. 1:

The Department of Health Care Policy and Financing should ensure that the Administrative Services Organization (ASO) contractor for the State Managed Care Network delivers a full range of case management services that specifically target the medical, financial, and social needs of CBHP enrollees. The Department should:

a. Establish policies for the ASO contractor and/or add requirements to the contract requiring the contractor to: (1) inform the Department of its procedures for contacting potential case management participants and maintaining current enrollee contact information, and (2) maintain complete and readily-accessible case management files that demonstrate the adequacy of the case management program.

b. Ensure that the agreed-upon case management/care management report required in the new contract contains the data needed to assess compliance with the contract and measure the effectiveness of case management services.

c. Review a sample of files maintained by the contractor for case management enrollees at least annually to assess the timely identification and contact procedures and the types and frequency of case management services provided to CBHP enrollees. The Department should provide a written report detailing the results of the review, including deficiencies, to the contractor.

d. Require the contractor to submit a plan to correct any deficiencies identified in the Department's review within a specified time frame and follow up to ensure that problems are addressed.

e. Enforce requirements for case management staff to receive appropriate training on the CBHP program.

Department of Health Care Policy and Financing Response:

Agree.

a. Implementation date: January 2009. The Department will incorporate into the case/care management policy and procedures requirements that the contractor inform the Department of the process by which potential case/care management participants are contacted. The policies and procedures are subject to approval by the Department. In the current contract with the new vendor there are specific guidelines regarding complete and accessible file maintenance.

b. Implementation date: January 2009. The Department will ensure and if needed, build upon, the established processes so that the agreed-upon case/care management report required in the new contract contains the data needed to assess compliance and measure the effectiveness of case/care management services.

c. Implementation date: January 2009. At least annually, the Department will review a sample of files maintained by the contractor for case/care management enrollees to assess the identification, contact procedures and the types and frequency of case management services provided to CBHP enrollees. The Department will also provide a written report to the contractor detailing the results of the review, including deficiencies.

d. Implementation date: February 2009. The Department will require the contractor to submit a plan to correct any deficiencies identified in the Department's review within a specified time frame and follow up to ensure that problems are addressed.

e. Implementation date: Implemented and ongoing. The Department will enforce requirements for case/care management staff to receive appropriate training on the CBHP program. This has already been done and will be ongoing.

Case Management Outcomes

The evaluation of a case management program's outcomes is important for assessing whether the program is meeting its mission and goals. According to a 2006 article published in *Professional Case Management*, the evaluation of outcomes for case management programs should include activities such as:

- Examining the effectiveness of case management interventions on patients' health outcomes.
- Evaluating actual patient outcomes in relation to expected outcomes.
- Performing cost-benefit analyses to demonstrate the value (return on investment) of case management services.
- Collecting and analyzing outcomes data (e.g., clinical, financial, variance, quality of life, patient satisfaction) systematically on an ongoing basis.

We reviewed quarterly reports submitted by Anthem to the Department for contract activities performed in Fiscal Year 2007 and other documents maintained by the Department related to the ASO contract. We found that the Department and Anthem did not evaluate the overall effectiveness of case management services provided to CBHP enrollees. The CBHP *Provider Policy and Procedure Manual* indicates that one of the primary purposes of case management services is to reduce the necessity for recurrent hospital admissions. However, we found no evidence that the Department or Anthem assessed whether case management services achieved this purpose. A primary problem that prevents the Department from evaluating Anthem's case management program is that the Department did not require Anthem

to report information that is useful for this purpose. According to the contract, Anthem was to provide quarterly reports that included all cases managed by Anthem and the triggers for placing enrollees into case management. The contract did not require any analysis or reporting of the outcomes of the case management services.

In addition, we found that the Department and Anthem did not set any specific goals, outcomes, or performance standards related to case management services provided to CBHP enrollees. As a result, the Department does not know whether case management services provided to enrollees were effective. The Department should develop goals for the case management program and establish outcomes and performance standards in its ASO contract that are targeted toward achieving the program's goals. Examples of performance standards and outcomes that could be established include:

- Clinical indicators, such as childhood and adolescent immunization status and proper treatment of children with upper respiratory infections.
- Enrollee satisfaction with case management services provided.
- Standards associated with specific case management activities, such as how soon after enrollment in the Network the ASO contractor completes health risk assessments on new CBHP enrollees.
- Estimated cost-benefit (e.g., a comparison of the cost of case management services with savings from the avoidance of more expensive medical care).

The new ASO contract requires the contractor to "propose and develop a case management/care management report to include mutually agreed upon qualitative and/or quantitative measures." The Department should ensure that the agreed-upon report contains data that is needed to measure the effectiveness of case management services and use the data reported to measure the contractor's compliance with contract requirements. Both the Department and the ASO contractor should analyze the data to identify ways to improve the case management program.

Recommendation No. 2:

The Department of Health Care Policy and Financing should work with its Administrative Services Organization (ASO) contractor for the State Managed Care Network to set specific goals, outcome measures, and performance standards for case management services provided to CBHP enrollees. This should include:

a. Ensuring that the agreed-upon reports on case management required in the contract include data to measure the effectiveness of case management services in achieving the specified goals, outcome measures, and performance measures.

b. Using the results to monitor the contractor's performance in delivering these services and to make decisions about future case management services provided to enrollees.

c. Developing specific performance standards related to case management services and including the standards in the ASO contract.

Department of Health Care Policy and Financing Response:

Agree.

a. Implementation date: November 2008. The Department will ensure that the agreed-upon reports on case management required in the contract include data to measure the effectiveness of case management services in achieving the specified goals, outcome measures, and performance measures. The first quarterly report from the new ASO vendor will be available in November 2008 at which point the Department will begin review.

b. Implementation date: November 2008. The Department will use the results to monitor the contractor's performance in delivering these services and to make decisions about future case management services provided to enrollees.

c. Implementation date: July 2009. The Department will develop additional performance standards related to case management services and include the new standards in the ASO contract. Review and analysis will be conducted throughout the year and standards confirmed in time to be incorporated into the current ASO contract extension.

Cost and Utilization Data

According to statute [Section 25.5-8-102(6)(b), C.R.S.], "health services that low-income children receive through the Children's Basic Health Plan should be cost-effective . . . ." To help ensure that the services provided through the Network were cost-effective, the contract between the Department and Anthem required Anthem to monitor utilization of the Network, in part by:

- Submitting quarterly and annual reports to the Department containing specific cost and utilization data, such as statistics for mental health and

substance abuse services, inpatient and outpatient hospital services, physician and provider services, transportation, durable medical equipment, and supplies.

- Identifying utilization variations that would affect the Department's ability to operate and manage the program within the fixed appropriation of the General Assembly.

We identified concerns related to the required annual and quarterly reports that indicate the Department is not fulfilling a fundamental responsibility to oversee the Network by obtaining and reviewing these reports to help manage the contractor and the CBHP Program.

First, we found the Department did not have the required annual reports from Anthem for either 2006 or 2007. The Department reported it was not aware of having received the 2006 report and had not received a 2007 report. Second, when we reviewed a copy of the 2006 report provided to us by Anthem, we found the report did not have information that would have been useful to the Department. Specifically, although the report included an overall assessment of Anthem's utilization management program, we found the information was for *all* of Anthem's product lines–both commercial and governmental–and did not break out the CBHP program. As a result of the Department's failure to hold Anthem accountable for reporting on CBHP in accordance with the contract, the Department could not evaluate or set goals for utilization management activities, network service delivery, or case management processes for CBHP enrollees.

Third, we reviewed the quarterly reports provided to the Department in 2006 to assess whether they complied with contract requirements and provided data that is useful for establishing program goals and outcomes and making financial and programmatic changes. We found problems with the reports, including:

- **Limited analysis**. For example, one quarterly report stated that the amount paid for medical and pharmacy claims had increased by nearly 13 percent from the prior quarter but did not include any explanation of this increase. According to the contract, Anthem was responsible "for designing and monitoring Network administrative budgets . . . and interpreting the data presented in member month, expenditure, and utilization reports and for making recommendations to the Department."

- **Lack of condition-specific cost and utilization data.** For instance, one quarterly report did not include cost and utilization data related to durable medical equipment. Reporting of condition-specific cost and utilization data was required by the contract.

- **Inconsistent formats.** For example, one quarterly report included cost and utilization statistics for different types of outpatient facility services, including emergency room, surgery, and radiology/pathology services. The report for the subsequent quarter did not include data for these specific types of outpatient services, so the Department could not compare and analyze the data from one quarter to the next. The Department could not provide any evidence showing that it had discussed with Anthem its expectations on the format of the quarterly reports.

Although Anthem adopted a more robust, standardized format for its quarterly reports in 2007, it still did not provide any analysis of the data. For example, one quarterly report indicated a 54 percent increase in hospital admissions per 1,000 enrollees from Fiscal Year 2006 to Fiscal Year 2007, but Anthem provided no analysis related to the potential causes of this increase. Another quarterly report listed a rate of emergency department/urgent care visits per 1,000 enrollees for the three month period, but Anthem did not provide any comparison data, trending, or analysis related to this measure.

We also found the Department did not require Anthem to monitor or report on statistics and trends that would be useful for managing the program, such as:

- Over- and under-utilization of certain services identified by the Department and the ASO contractor.
- Primary care, preventive ambulatory care, and specialty office visits per 1,000 enrollees.
- Inpatient admissions, including length of stay and days per 1,000 enrollees for medical, surgical, maternity, and neonatal intensive care unit areas.
- Percent of hospital readmissions within 30 days.
- Potentially preventable admissions.
- Low acuity, non-emergent admissions to the emergency department.

The Department has modified some of the requirements associated with utilization review in its new ASO contract. First, the new contract requires the contractor to (1) establish appropriate utilization review and management services for covered CBHP services and benefits; (2) use an effective mechanism to detect over- and under-utilization of services; and (3) monitor all enrollees 18 years and younger for prevention and wellness visits and all pregnant enrollees for prenatal care. Second, the new contract requires the contractor to "propose and develop a cost and utilization report for all provider types to include mutually agreed upon qualitative and/or quantitative measures." Third, the proposal from the new contractor lists a variety of detailed utilization reports it plans to provide for the CBHP program. The Department should ensure that the reports include analysis of cost and utilization statistics and trends. In addition, the Department should analyze and use the reported data to make financial and programmatic decisions related to the CBHP program.

Recommendation No. 3:

The Department of Health Care Policy and Financing should improve cost and utilization data and analysis provided by its Administrative Services Organization contractor for the State Managed Care Network by:

a. Ensuring that the cost and utilization reports submitted by the contractor comply with the agreed-upon design.

b. Regularly analyzing the reported cost and utilization data and using them to make financial and programmatic decisions and to establish program goals.

Department of Health Care Policy and Financing Response:

Agree.

a. Implementation date: Implemented and ongoing. The Department will continue to ensure that the reports submitted by the current contractor are in compliance with the agreed-upon design. This is currently being done with the new ASO contractor effective July 1, 2008 and will be an ongoing process.

b. Implementation date: November 2008. The Department will use the data and analyses provided by the ASO vendor to guide financial and programmatic decisions and assist with establishing program goals. The Department will begin regular analysis of cost and utilization with the first quarterly report submitted by the ASO in November 2008.

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Management of Network Payments

Chapter 2

According to its contract with the Department, Anthem's responsibilities with respect to the State Managed Care Network (Network) included: (1) administering all inpatient, outpatient, and pharmaceutical payment activities for providers; and (2) establishing policies and procedures for all claims determinations, timely filing guidelines, claims reviews, and appeals. The Department included performance standards in the contract related to claims processing and provisions that allowed liquidated damages to be assessed against Anthem for noncompliance with the standards.

We assessed the accuracy and timeliness of payments made by Anthem for claims submitted by CBHP providers as well as the Department's procedures for overseeing Anthem. We identified deficiencies with Anthem's system for processing CBHP claims and the Department's oversight and enforcement of Anthem's compliance with contract requirements. We also found that the Department has not always ensured that it has adequate evidence to support payments to health plans. We describe these issues in this chapter.

Claims Processing Accuracy

We assessed the Department's oversight of Anthem's claims processing to determine whether Anthem accurately processed and paid claims in accordance with contractual provisions and CBHP policies. Overall, we found errors in Anthem's claims processing that resulted in questioned costs totaling $234,000. We also noted improvements that the Department should make in its oversight of the ASO contractor's claims processing activities, as described in the following sections.

We judgmentally selected for review a sample of 52 CBHP claims representing about $852,400 from a total of 218,800 CBHP claims representing about $34.7 million paid to providers between April 2006 and March 2007. The sample was selected to include a variety of claims that (1) were approved and denied for payment; (2) represented a range of claim types (e.g., primary care provider, specialist, mental health, hospital, and emergency); and (3) covered a broad spectrum of dollar amounts (ranging from $13 to $562,000). We found errors in 27 of the 52 claims we reviewed (52 percent). Of these, 24 claims (46 percent) contained claims transaction errors, resulting in about $54,800 in overpayments to providers and $20

in underpayments. The overpayments are questioned costs and represent about 6 percent of the total dollars paid in our sample. The table below shows the claims error rates for our sample.

Children's Basic Health Plan Department of Health Care Policy and Financing CBHP Claims Paid by Anthem for the State Managed Care Network		
Results from Review of 52 Claims Paid Between April 2006 and March 2007		
Payment Errors[1]	**Claims with Errors**	**Error Rate**
Claims Transaction Errors[2]	24	46.2%
Financial Errors	$54,800	6.4 %
Procedural Errors [2, 3]	4	7.7%

Source: Mercer's review of a sample of 52 CBHP claims paid by Anthem between April 2006 and March 2007.
Notes:
[1] Two types of payment error rates are shown. The claims transaction error rate is the total number of claims with payment errors (24) divided by the total number of claims in the sample (52). The financial error rate is the total dollar amount of payment errors ($54,800) divided by the total dollars paid for the claims in the sample ($852,400).
[2] Three claims in our sample had multiple payment errors. These three claims and their associated payments have only been counted once to calculate the claims transaction and financial error rates. One claim in our sample had both a payment error and a procedural error. This claim was counted once within the payment errors and once within the procedural errors.
[3] The procedural errors identified did not result in payment errors. However, Anthem's failure to follow policies and procedures for processing these claims increased the risk that payment errors could have occurred.

We conducted further testing on a judgmental sample of 10 claims that were submitted late by providers and identified errors in 8 claims with an additional $19,900 in questioned costs. We also analyzed data on 28,200 claims paid to non-participating providers which identified further questioned costs of $159,300. Therefore, a total of about $234,000 in questioned costs was identified related to testing the accuracy of claims payments. We describe the payment and procedural errors we found in our sample of 52 claims and our additional testing in the following sections.

Payment Errors

We identified payment errors in two ways, which are described below.

Payment Errors from Sample Review. The claims payment errors we found fall into several categories, as described below. In total, we identified 27 payment errors on 24 of the claims in our sample of 52, with 3 claims having multiple payment errors. In addition, one of the 24 claims had both a payment error and a procedural error. The payments for the claims that had multiple errors have only been counted once as questioned costs.

- **Authorization Errors:** We identified seven claims with authorization errors resulting in $47,890 in questioned costs. For four of these claims, we found no evidence that the services had been prior authorized in accordance with requirements of the CBHP program. For the other three claims, more services were provided than authorized or allowed. These claims were for outpatient mental health services, which, at the time of the audit, were limited to 20 visits in a calendar year for CBHP enrollees. These three errors occurred either because Anthem had not established accumulators in its new claims processing system or because the accumulators in place were not working properly. Automated claims systems generally use accumulators to keep track of benefit maximums, copayments, authorizations, and other elements that must be tracked at the enrollee level.

- **Eligibility Errors:** We identified five claims for services provided to individuals not enrolled in CBHP on the dates the services were delivered, or paid for under another member's identification number, resulting in $3,410 in questioned costs. Four of the claims were paid for enrollees who were no longer eligible for the program (e.g., children who had reached 19 years of age or pregnant women who were at least 60 days postpartum) but had not been disenrolled. Anthem was not properly using the daily and monthly electronic enrollment files provided by the Department to remove enrollees from its records when individuals were no longer eligible. The remaining claim was submitted for an enrolled infant using the mother's member number. Although the infant was enrolled, paying any claim using another member's identification number is an inaccurate payment and creates a risk of duplicate payments.

- **Fee Schedule and Rates Errors:** We identified six claims for which the payments were not consistent with the fee schedules or types of rates (i.e., capitated or fee-for-service) established for the providers. In total, Anthem overpaid providers about $2,050 in questioned costs for these claims. For four of the claims, Anthem had not paid the correct fee from the fee-for-service schedule established for Network providers. For the other two claims, Anthem had paid both capitated and fee-for-service rates to providers who should have received only capitated payments for the period of these claims. These errors occurred because Anthem did not transfer historical capitated provider contract information to the new automated claims system when the new system was implemented in November 2006.

- **Program Benefit Errors:** We identified three claims with errors related to allowable CBHP benefits. Anthem overpaid two providers a combined total of about $330 in questioned costs and underpaid one provider $20. For one of these claims, Anthem paid for abortion services when the services were not allowable. Federal regulations [42 CFR 457.475] prohibit the use of

federal funds for abortion services unless an abortion is necessary to save the life of the mother or is performed to terminate a pregnancy resulting from an act of rape or incest. We found no documentation of review by clinical staff to support the need for abortion services to save the life of the mother or to terminate a pregnancy resulting from rape or incest. In addition, the Colorado Constitution generally prohibits the use of public funds for abortions unless specifically authorized in statute. Statutes do not authorize the use of CBHP monies to pay for abortions. For the second claim, Anthem paid more than the annual maximum allowed for eyeglasses or contacts. For the third claim, Anthem underpaid a provider $20 because a copayment was charged to the enrollee in error. Due to the enrollee's income level, the provider should not have charged her the $20 copayment.

- **Timely Filing Errors.** We found six claims that were not submitted by providers within required time frames, resulting in $1,150 in questioned costs. The CBHP *Provider Policy and Procedure Manual* states that claims submitted after the established deadlines of 120 days from the date of discharge for hospital claims and 180 days from the date of service for all other claims will be denied unless the provider can show proof of timely filing. The late claims we found were filed between seven months and almost three years after the date of discharge or service. To further analyze whether Anthem was paying claims that were submitted late, we judgmentally selected an additional sample of 10 claims totaling about $20,300 from claims paid by Anthem between April 2006 and March 2007. We selected our sample from a subset of the claims that had service dates between 3 and 15 months prior to the payment dates. We found that eight of the claims, totaling $19,900, were submitted by providers between one and three years after the date of discharge or service. These claims should have been denied by Anthem and are questioned costs. At the end of our audit, the Department investigated the eight claims that providers had submitted after the deadlines and reported that it could not explain why the claims had been paid. Specifically, the Department agreed that two of the claims were submitted late, four of the claims were for individuals who were not CBHP-eligible, and for the remaining two claims, the Department did not have sufficient information to determine why the claims were paid.

Payment Errors from Analysis of Non-Participating Provider Claims. We also tested claims paid to non-participating providers (providers that do not have contracts with the Department to serve CBHP enrollees) and found that Anthem had made errors in paying such claims. Anthem's policies, which were approved by the Department, required Anthem to negotiate claims submitted by non-participating providers, except for ambulance services. Negotiating claims to reduce payments below 100 percent of billed charges is intended as a cost-control mechanism and is a common practice in the health care industry.

We obtained data from Anthem on the 28,200 CBHP claims totaling almost $3.9 million paid to non-participating providers in Fiscal Year 2007 and found that 1,485 of the claims (about 5 percent) totaling about $430,700 (about 11 percent of the claims payments) were paid for non-ambulance services at 100 percent of billed charges. We provided our analysis to Anthem for review and Anthem reported that it had confirmed that 867 of the 1,485 claims (58 percent) totaling about $265,500 were incorrectly paid at 100 percent of billed charges. According to Anthem, if the claims had been paid based on the CBHP fee schedule, the claims payments would have totaled $106,200, or about $159,300 less than the actual amounts paid. Anthem reported that it was working to correct these errors. The $159,300 in payments that exceeded the fee schedule amounts are questioned costs, and the Department should seek recovery of these payments.

According to Anthem, the remaining 618 claims totaling about $165,130 were paid correctly for one of the following reasons: (1) the billed charges were lower than the CBHP fee schedule, so payment at 100 percent was allowable, (2) the claim was originally paid at 100 percent of billed charges in error and was subsequently adjusted (after the date on which we conducted our analysis), or (3) Anthem attempted to negotiate a payment lower than the billed charges but the provider was unwilling to accept a reduced payment.

Procedural Errors

Procedural errors are those where payments made by Anthem were allowed, but Anthem's failure to follow its policies and procedures increased the risk that claims could have been improperly paid. Procedural errors are important because they highlight weaknesses in internal controls that should be addressed. We identified procedural errors for four claims totaling $46,260 in our sample of 52, as follows:

- For three claims totaling $9,760, Anthem's claims system did not contain complete enrollment data for the enrollees because Anthem did not load historical enrollment data in its new claims system. According to data from the Medicaid Management Information System (MMIS), these three enrollees were eligible and enrolled in the program on the date of service. However, because the claims were paid absent the necessary information to confirm the enrollee's eligibility, there was a risk that payments could have been made for individuals not enrolled in the program at the time services were provided.

- For one claim for $36,500, there was no evidence of subrogation efforts by Anthem for a medical service provided to a child with a gunshot wound. Subrogation is a process used to recover the amount of a claim paid for services associated with injuries or death caused by a third party. The contract requires Anthem to "assume responsibility and administration

for . . . subrogation claims." In this case, Anthem should have pursued subrogation efforts with the individual who caused the gunshot wound.

Department Oversight

The large number and proportion of CBHP payment errors we identified in our sample relating to a variety of claims payment types is a significant concern. CBHP is a publicly-funded program involving an investment of over $100 million annually to improve the health of low-income children. In Fiscal Year 2008, the Department paid Anthem about $8.1 million to administer the Network and about $44.9 million to cover health care claims for CBHP enrollees. The combined total of about $53 million represented about 47 percent of the total amount the Department disbursed to health plans to provide health care coverage to CBHP enrollees. More oversight of the Network by the Department is needed to ensure the integrity and accuracy of the claims processing system. We identified three steps the Department should take to determine the extent of claims payment errors made by Anthem in the past and strengthen its ASO contract and enforcement of contract provisions going forward, as discussed below.

Identify and Recover Claims Payment Errors. The Department should work with Anthem to review and determine the extent of payment errors for all CBHP claims paid in Fiscal Years 2006 and 2007 and the causes of the errors. Specifically, this review should include identifying incorrect claims payments for:

- Individuals not eligible for the CBHP program at the time services were delivered, including children after they turned 19 years old and women in the prenatal program more than 60 days after they gave birth.
- Services not authorized prior to service delivery.
- Services that exceeded the number authorized and allowed.
- Services for which the fees paid did not match the Department's fee schedule for the CBHP program.
- Services that were covered by a capitation arrangement but paid as fee for service.
- Services not covered by the CBHP program.
- Late claims submissions.
- Non-participating provider claims paid at 100 percent of billed charges.

Using the results of our audit and this recommended review, the Department should seek recovery of any improperly paid claims and work with the federal Centers for Medicare and Medicaid Services to identify any federal funds that should be repaid to the federal government.

Perform Regular Claims Reviews. The Department has not historically conducted routine, on-site claims reviews to ensure the ASO is processing claims in an accurate and timely manner. The Department has established other mechanisms intended to help identify claims processing errors by the ASO. However, the mechanisms need to be strengthened to provide adequate oversight of the ASO, as described below.

First, the Department's contracts with Anthem and the new ASO require the ASOs to have quality assurance review processes for CBHP claims. As discussed later in this chapter, we identified weaknesses in Anthem's quality assurance process.

Second, in July 2007 the Department began requiring a contractor independent from the ASO to generate monthly "anomaly reports" that identify claims payments that may be erroneous. For example, the independent contractor identifies payments for individuals who do not have eligibility information in the ASO's system (i.e., may not be eligible and enrolled in CBHP), duplicate payments, and payments in excess of the CBHP fee schedule. The Department's new ASO contract requires the ASO to "analyze and respond to reports which indicate claims payment or other data anomalies" and "provide feedback . . . and any corrective actions if needed, within 30 days," upon request by the Department. Although these types of reports can be a useful tool, they are not currently extensive enough to identify all of the different types of claims errors we found, such as payments for: (1) enrollees who should have been disenrolled, (2) more services than are authorized, (3) unallowed services, or (4) claims submitted late by providers. Furthermore, the Department's contract with the independent contractor does not contain specific direction on the anomaly reports, such as how often they must be run or what program criteria will be tested. Finally, this process does not provide for an independent verification (i.e., by the Department or other entity independent of the ASO) of the claims errors identified or the corrective actions that need to be taken

Third, in 2007, the Department contracted with a private health care actuarial consulting firm to perform a limited-scope review to determine the accuracy of claims paid by Anthem from July 2005 through February 2007. The actuarial firm reviewed about 176,000 claim lines totaling more than $27.8 million for services provided to CBHP enrollees in the Network. The firm identified potential errors for about 6,190 claim lines totaling about $950,000 due to payments for non-covered services, services not deemed medically necessary, and claims from non-participating providers at 100 percent of billed charges. The Department required Anthem to review all the potential errors and prepare and submit a plan to resolve the problems identified in the review. Additionally, the Department reduced payments made to Anthem by about $305,000 based on the results of the contractor's work.

The 2007 review is a good start on improving the Department's oversight of the ASO. However, the Department should ensure that future claims reviews are

sufficiently thorough to provide assurance that the ASO is processing claims in an accurate and timely fashion. The 2007 review by the actuarial contractor was not complete enough to provide an accurate assessment of Anthem's claims processing. For example, the Department did not verify the number of potential errors that were, in fact, incorrect payments, nor did it require the actuarial contractor to do so. In addition, the Department did not require the review to include all types of CBHP claims (e.g., pharmacy claims and denied claims were excluded). According to the Department, it limited the scope of the claims review due to budgetary constraints. The contractor also noted in its report that it found inaccuracies in the eligibility and enrollment data maintained by both the Department and Anthem.

The Department has extended the contract for the actuarial firm to conduct a claims review of CBHP claims processed by the new ASO in Fiscal Year 2009. However, the contract does not provide any specific direction on the number or dollar amount of claims to be reviewed, whether all claim types will be included, or how the results of the review will be used. In addition, it is not clear that the Department intends to continue such reviews in the future. The contract for the 2009 review states that the claims reviews are intended to "assist the Department in ensuring a successful transition in our Administrative Services Organization (ASO) vendor," which indicates that the reviews may not continue once the new ASO is well-established.

The Department has a fundamental responsibility to ensure that claims are paid properly. Although the efforts discussed above represent a good basis for overseeing the ASO, the Department should expand its methods to evaluate the adequacy of the ASO's claims procedures. Specifically, the Department should conduct annual on-site reviews of the ASO contractor's claims processing activities for CBHP to assess the accuracy and allowability of the claims payments made by the contractor. On site reviews could be targeted to address claims errors identified by the ASO's own quality assurance reviews and/or the anomaly reporting process. Conducting independent, on-site reviews of claims processing would allow the Department to verify the extent of claims processing problems, the underlying causes of the problems, and the adequacy of corrective actions taken to address the problems.

One way for the Department to offset a portion of the costs associated with annual on-site claims reviews is to share the costs with the ASO contractor. The contracts with Anthem and with the new ASO include a provision that allows the Department to perform a year-end audit of any of the performance measures reported by the contractor. The contracts stipulate that the Department may conduct the audit itself or use an outside firm and that up to $20,000 of the cost of the audit will be paid by the ASO contractor. The Department did not charge Anthem for any of the costs for the 2007 claims review.

Modify and Enforce the Contract. The Department should add provisions to the current ASO contract to specifically allow liquidated damages to be assessed for:

(1) incorrectly paying claims that should have been denied due to untimely filing, and (2) failing to undertake negotiations to reduce payments on claims submitted by non-participating providers. Although both the previous contract with Anthem and the current ASO contract stipulate that the Department may assess liquidated damages for claims transactions and financial errors, the contracts do not specify that payments for claims submitted late or paid to non-participating providers without attempted negotiations are considered to be erroneous payments. Once the provisions have been clarified, the Department should enforce the contract and assess liquidated damages whenever the contractor does not meet established standards.

In Fiscal Year 2008, about 40 percent of the average daily enrollment in CBHP was in the Network and about 47 percent of the total amount the Department disbursed to provide health care coverage for CBHP enrollees was for Network enrollees. Given the significant proportion of the CBHP program that is represented by the Network, it is critical for the Department to be accountable for how Network claims are administered by the ASO. The Department should strengthen its oversight of the ASO contractor to ensure that claims payments are accurate and consistent with program requirements.

Recommendation No. 4:

The Department of Health Care Policy and Financing should improve the accuracy of claims payments for the State Managed Care Network by:

a. Continuing to work with Anthem to assess the extent of payment errors, such as those identified in this audit and in the external contractor's review, in CBHP claims paid in Fiscal Years 2006 and 2007.

b. Using this audit and the review recommended in part "a" to determine the total dollar amount of claims paid in error and seeking recovery of such payments.

c. Implementing an on-site review process going forward to assess the Administrative Services Organization (ASO) contractor's: (1) controls to pay and deny claims in accordance with all applicable requirements, and (2) accuracy and timeliness in processing CBHP claims. The review should occur at least annually. If the Department continues to contract for claims reviews, it should ensure that the contracts provide adequate direction on the scope and purpose of the reviews.

d. Establishing a process to follow up with the ASO contractor on any problems identified from the on-site claims review process to ensure corrective action is taken.

e. Amending the ASO contract to include a liquidated damages provision for paying claims filed by providers after the established deadlines and paying claims without having negotiated with non-participating providers.

Department of Health Care Policy and Financing Response:

Agree.

a. Implementation date: Ongoing. The Department will continue to work with Anthem to assess claims payment errors paid in Fiscal Years 2006 and 2007.

b. Implementation date: January 2009. The Department has worked with Anthem to recover payments found to be made incorrectly in the limited scope claims audit. The Department will use findings from this audit and other reviews to determine a total dollar amount of claims paid by Anthem in error and will explore options for recovery.

c. Implementation date: July 2010. With the new ASO contract effective July 2008 the Department put into place a comprehensive review process to assess the ASO's compliance with claims processing requirements. This review process is performed by a third party vendor and is not conducted on-site; the review is conducted using claims data from the ASO vendor. The Department will ensure that the contractual language with the third-party vendor currently conducting claims reviews will provide adequate direction on the scope and purpose of the reviews. This revision would be made July 2009 when the next contract amendment is executed with the vendor. The Department will need additional resources to conduct an on-site claims review and would likely also use a third-party vendor for this process. The Department will request additional resources through the standard budgeting process. Should the Department receive additional resources in order to conduct an on-site claims review, the work will begin in July 2010.

d. Implementation date: Implemented and Ongoing. Any concerns noted through an on-site review will be followed up on by the Department to ensure that corrective action is taken. The Department will also continue with its current process in place to follow up with the ASO contractor on

all problems identified from the claims review process and ensuring that corrective action is taken. This process is ongoing. The current process became effective March 2007 when the Department requested a limited scope claims audit of Anthem. Following the audit, in July 2007, the Department established a third party review of claims to be conducted on a monthly basis via "anomaly reports." These reports list claims with errors and the ASO vendor is required to research these claims, provide a response, and correct any identified errors. This process is in place with the new ASO vendor.

e. Implementation date: January 2009. The Department will amend the current ASO contract to include a liquidated damages provision for paying claims filed by providers after the established deadlines and without having negotiated with non-participating providers.

Quality Assurance

The Department's contract with Anthem required Anthem to report on its compliance with performance standards on a quarterly basis, including standards relating to claims transaction and financial accuracy rates, which represent the percentage of claims or percentage of dollars paid correctly. Under the contract, Anthem audited at least 50 CBHP claims per month to evaluate and report on its compliance with the contact standards. We reviewed data in the quarterly reports submitted by Anthem for the one-year period of April 2006 through March 2007. The following table shows the data reported by Anthem for the one-year period, the applicable accuracy standards, and the liquidated damages assessed by the Department.

Department of Health Care Policy and Financing Children's Basic Health Plan Claims Accuracy Rates Reported by Anthem and Liquidated Damages April 2006 through March 2007				
	Reported Compliance Rates for Quarters Ending:			
Compliance Standard	**6/30/06**	**9/30/06**	**12/31/06**	**3/31/07**
Claims transaction accuracy of at least 96%[1]	100.0%	99.6%	89.7%	92.5%
Financial accuracy of at least 99%[2]	100.0%	99.9%	97.0%	99.3%[3]
Liquidated Damage Assessments				
Claims transaction accuracy[1]	$0	$0	$625	$625
Financial accuracy[2]	$0	$0	$625	$0[3]
Total assessments per quarter	**$0**	**$0**	**$1,250**	**$625**

Source: Anthem quarterly reports and information from the Department of Health Care Policy and Financing.
Notes:
[1] Claims transaction accuracy is the percent of claims processed without errors.
[2] Financial accuracy is the percentage of dollars correctly paid on claims.
[3] We identified a mathematical error in Anthem's financial accuracy calculation for the quarter ending March 31, 2007. Anthem reported a financial accuracy rate of 99.3%, but using the data in the report, we calculated a financial accuracy rate of 94.6%. Because Department staff did not identify the error, no liquidated damages were assessed for noncompliance for this quarter.

We evaluated the adequacy of the Department's contract terms and contract oversight related to Anthem's quality assurance procedures and identified a number of problems. First, the Department's contract did not require Anthem to audit a sample of claims to measure claims accuracy and timeliness that was consistent with industry standards. The contract required Anthem to audit a minimum of 50 claims each month and for the one-year period of April 2006 through March 2007, Anthem audited a total of 818 CBHP claims totaling about $644,000. This sample represented less than 1 percent of the 218,800 CBHP claims processed during the one-year period and about 2 percent of the $34.7 million in claims payments. According to industry standards, between 3 and 5 percent of claims processed should be audited each year. As a result of the concerns identified in our audit, the Department included in its new ASO contract (effective July 1, 2008) a requirement that the contractor audit 3 percent of all CBHP claims processed each year.

Second, the Department did not have other mechanisms in place to identify potential claims processing errors specific to the CBHP population. For example, the Department did not have a requirement for Anthem to generate periodic reports to identify potential claims processing errors, such as claims paid for enrollees 19 years and older who were not enrolled in the prenatal program or claims paid for noncovered services. Such reports could help the ASO identify some of the claims processing issues we found in our audit. Beginning in July 2007, the Department is requiring an independent contractor to generate anomaly reports for claims paid by the ASO. These reports can help to identify claims processing errors. However, the Department's contract with the independent contractor does not include specific provisions for the anomaly reports, such as how often they will be run or what

program criteria will be evaluated. If the Department continues using these reports as a mechanism to help identify claims processing problems, it should formalize specific requirements for the reports in the contract.

Finally, we found a mathematical error in Anthem's calculation of the accuracy rate for the January to March 2007 quarterly report. Using the raw data in the report, the correct financial accuracy rate was about 95 percent during this quarter, which is 4 percentage points lower than the 99 percent rate Anthem reported. The correct rate of 95 percent is not in compliance with the contractual performance standard and should have resulted in the Department's assessing $625 in liquidated damages against Anthem for the quarter. The Department did not notice the error in Anthem's report, which indicates a lack of sufficient review of the reports. To serve as an adequate contract monitoring tool, the required reports must be thoroughly reviewed by the Department's contract monitor.

It is important for the Department to ensure that its ASO contractor's quality assurance efforts are effective in identifying weaknesses in claims processing. The Department should use contract management procedures, including the annual review discussed in Recommendations No. 4 and 7 of this report, to measure the effectiveness of the contractor's quality assurance activities.

Recommendation No. 5:

The Department of Health Care Policy and Financing should strengthen quality assurance mechanisms related to the accuracy of claims processing for the Children's Basic Health Plan by the Administrative Services Organization (ASO). This should include:

a. Adding specific provisions to the contract with the independent contractor regarding the frequency and content of anomaly reports on claims processed by the ASO.

b. Measuring the ASO contractor's compliance with contract requirements associated with quality assurance activities for claims processing on a periodic basis and making recommendations to the contractor on areas of improvement, as necessary. This should include a thorough review of all ASO contractor reports and ensuring that the contractor's claims audits review the minimum percentage of claims specified in the contract.

Department of Health Care Policy and Financing Response:

Agree.

a. Implementation date: July 2009. The Department will add specific provisions to the third-party review contract regarding frequency and content of the State Managed Care Network claims anomaly reports. This revision will be made July 2009 when the next contract amendment is executed.

b. Implementation date: Implemented and ongoing. As begun in July 2007 with the first anomaly reports, the Department will continue to measure the current ASO contractor's compliance with contract requirements associated with quality assurance activities for claims processing on a periodic basis and make recommendations to the contractor on areas of improvement. With the new ASO contract that was effective July 2008, all contractor reports will be thoroughly reviewed and the Department will ensure that the minimum percentage of claims specified in the current contract are reviewed in accordance with the contract terms with the new ASO vendor. This is currently being done and will be ongoing.

Timeliness of Claims Payments

The Department's contract with Anthem included the following two performance measures related to timely processing of Network claims:

- At least 90 percent of clean claims must be processed within 14 calendar days of receipt. A clean claim is defined in state statute as "a claim for payment of health expenses that is submitted to a carrier on the uniform claim form . . . with correct and complete information, including all required documents."

- At least 99 percent of clean claims must be processed within 30 calendar days of receipt.

The contract contained no standard for processing *all* claims. However, processing all claims within 90 days of receipt is considered a best practice in the industry and is consistent with Colorado laws governing health care insurance carriers.

Data reported by Anthem in its quarterly reports to the Department between April 2006 and March 2007 showed that Anthem often did not meet the two performance standards in the contract related to timely processing of CBHP claims. In particular, Anthem reported that it exceeded the 14-day requirement for medical claims in two of the four quarters and the 30-day requirement in all four quarters during the one-year period. The Department assessed a total of $8,750 in liquidated damages for noncompliance with performance standards for three of these quarters but did not assess liquidated damages for one quarter. We estimate the Department should have assessed an additional $5,000 in liquidated damages against Anthem for exceeding the contractual timeliness standards in this quarter.

Our testing also identified problems with timely processing. For the judgmental sample of 52 claims we reviewed, 51 were clean. For these 51 claims, 35 were processed within 30 calendar days of receipt, and 16 were not. Further, 8 of the 52 claims in our sample were not processed within the industry standard of 90 days; these 8 claims were processed between 100 and 525 days after receipt.

To further analyze the timeliness of claims payments, we judgmentally selected an additional sample of five claims totaling $12,700 from claims paid by Anthem between April 2006 and March 2007. We selected our sample from a subset of the claims that had service dates between 3 and 15 months prior to the payment dates. We found that all five claims were paid late, ranging from 143 to 436 days after receipt.

We noted two problems that contributed to the delays in processing claims. First, the contract did not require Anthem to have a system in place to identify claims that aged past the standards established in the contract. Health plans often develop and use electronic reports to identify old claims and to prioritize adjudication of the claims. According to Department staff, the new ASO contractor has established mechanisms to identify claims that age past the standards established in the contract. Through its contract monitoring activities, the Department should ensure that the contractor appropriately uses these mechanisms to identify claims that age past acceptable limits and prioritizes finalization of these claims. Second, the contract between the Department and Anthem only addressed the time frames within which "clean claims" needed to be processed; it did not address the time allowed for processing claims requiring additional information. In most cases, Colorado insurance laws and industry standards require health care claims to be processed within 90 calendar days of receipt. The Department has included a provision in its new ASO contract that requires the contractor to adhere to time frames set forth in Section 10-16-106.5, C.R.S., which stipulates that health insurance carriers must finalize clean claims within 30 calendar days for electronically filed claims, 45 calendar days for paper claims, and 90 calendar days for claims requiring additional information from the provider.

Timely processing of CBHP claims by the ASO helps the Department maintain good working relationships with providers. Failure to process and pay claims in a timely manner can affect the Department's ability to retain and recruit providers for the State Managed Care Network. In addition, timely claims processing is essential for effective budgeting for the program.

Recommendation No. 6:

The Department of Health Care Policy and Financing should ensure that CBHP claims for the State Managed Care Network are processed by the Administrative Services Organization contractor in a timely manner. This should include monitoring the contractor's compliance with requirements in the contract related to the timely processing of claims and assessing liquidated damages when standards are not met.

Department of Health Care Policy and Financing Response:

Agree. Implementation date: Implemented and ongoing. The Department will continue to monitor the current ASO contractor's compliance with requirements in the contract related to the timely processing of claims and assess liquidated damages when standards are not met. Currently, the ASO self reports on claims processing timeliness; the Department is more diligently reviewing these reports to ensure compliance. This process began July 2008 and will be ongoing. If the Department is able to conduct an on-site claims review, timeliness of processing will be reviewed and corrective action required in cases where timeliness is identified as an issue.

Contract and Risk Management

As discussed in the Overview, CBHP enrollees receive services either through the Network or through one of the four HMOs under contract with the Department. In Fiscal Year 2008, the Network had an average monthly enrollment of about 23,290 members, or about 40 percent of the total average monthly enrollment in CBHP, while the HMOs had a combined average monthly enrollment of about 35,980. The Department uses one approach to pay for health care services delivered by the HMOs and another to pay for those delivered through the Network. Specifically, the Department pays the HMOs a monthly capitation payment for serving each CBHP enrollee. The HMOs are responsible for meeting the health care needs of their CBHP enrollees, and they do not receive additional payments for high-cost services or repay funds to the Department if the capitation payments exceed their costs. Thus,

the Department's contracts with the HMOs make the HMOs responsible for managing their costs within the capitated amounts the Department pays, and the HMOs bear the financial risk for managing care within the resources provided.

Conversely, for the Network, the Department pays for all of the health care services delivered to CBHP enrollees on a fee-for-service basis. The Department's ASO contract with Anthem and its new contract are similar to ASO contracts that managed care organizations sometimes have with employers who self-insure for their employees' medical benefits. Under this type of contract, the ASO is not "at risk" – that is, the ASO does not assume financial responsibility for the cost of providing care to the members covered by the insurance plan. Rather, the ASO contractor performs administrative services associated with enrolling members, maintaining member eligibility files, authorizing services in advance, and processing claims submitted by providers. In the case of CBHP, the ASO pays claims submitted by providers using the Department's money, not its own. Because the State, not the ASO, bears the financial risk, the ASO contractor may not aggressively manage the care and perform its duties as required by the contract. To mitigate the State's financial risk related to the Network, the Department included contract provisions that required Anthem to perform specific duties related to managing care and paying claims, including:

- *Utilization management*, which was to include (1) implementing a timely and accurate prior authorization process, (2) ensuring controls were in place to monitor and/or prevent unnecessary medical expenses for outpatient treatment, (3) ensuring that controls were in place for appropriate hospital admissions and lengths of stay, and (4) establishing programs that reduced pharmaceutical costs to the program and participants for maintenance drugs.

- *Case management*, which consists of providing individualized services to high-risk enrollees to manage their conditions and reduce the need for high-cost services.

- *Monitoring fiscal utilization of the Network*, which was to include identifying the costs of care and any monthly variations in medical cost trends, and preparing an annual financial report that provided specific cost and utilization data about the CBHP enrollee population receiving services through the Network.

- *Administration of claims payment activities for the Network*, which involved accurate and timely processing of claims submitted by providers, including proper application of the State's fee schedule and benefits package.

The contract also specified that the Department would impose liquidated damages if Anthem failed to meet performance standards included in the contract (e.g., timely processing of claims, accuracy of claims payments) or did not file required reports within the time frames prescribed in the contract. The duties listed above and the liquidated damages served as the Department's only mechanism for controlling costs in the Network.

As described throughout this report, we found a pervasive lack of management and oversight by the Department of Anthem's processes for managing health care for Network enrollees and paying CBHP claims. The Department paid Anthem about $53 million in Fiscal Year 2008 alone. We identified deficiencies with Anthem's administration of the Network that either resulted or could result in greater costs for CBHP. In particular, we identified:

- Weaknesses in Anthem's design and implementation of the case management program for CBHP enrollees, as discussed in Chapter 1. Case management programs are intended to improve enrollees' health status and to reduce hospital admissions and other high-cost services. However, evidence that Anthem had a comprehensive case management system was lacking. For example, documentation provided during the audit did not demonstrate that Anthem had provided case management services to CBHP enrollees in our sample or used effective mechanisms to contact enrollees who would benefit from case management services. In addition, neither the Department nor Anthem had established and analyzed outcomes for the case management program.

- A lack of analysis of cost and utilization trends to help control costs for the Network, as discussed in Chapter 1. Although Anthem provided some data on costs and utilization of Network services to the Department, neither the Department nor Anthem used these data to identify and implement program improvements.

- Inaccurate claims payments, procedural errors, and late claims processing, as discussed in this chapter. A total of about $234,000 in questioned costs was identified for the period of April 2006 through June 2007 due to weaknesses in the claims processing system. Further, we noted deficiencies in the Department's requirements related to Anthem's quality assurance process.

The Department has a responsibility to ensure that the ASO delivers high-quality services as required by the contract and controls Network costs. However, as we have discussed in this report, we noted concerns with Anthem's administration of the Network. It is essential for the Department to enhance accountability for services

delivered to CBHP enrollees in the Network under the new ASO contract. At a minimum, this should include the following:

Revising the contract to include additional requirements and performance standards. We found that the contract between the Department and Anthem lacked key requirements and performance standards that would have enabled the Department to effectively manage the contract. While we noted improvements with the Department's new ASO contract, we identified additional provisions that could be added or modified that would enhance accountability, including specifying performance standards related to the effectiveness of case management services delivered to enrollees and enhancing the types of cost and utilization data the contractor is required to report.

Implementing a process to independently verify services delivered by the contractor. The Department did not have any processes in place to independently verify any of the services Anthem was providing. Instead, the Department relied solely on self-reported data from Anthem to assess contract performance. As discussed throughout the report, the Department should, at a minimum, perform an annual on-site review of key activities conducted by the contractor that includes reviewing samples of case management files and claims and evaluating the ASO's procedures and controls for compliance with contractual requirements.

Improving contract monitoring documentation. We found that the Department maintained minimal documentation of its contract monitoring activities, its interaction with the contractor, and its decisions that the affected the contract. Specifically, the documentation of the Department's monitoring of the Anthem contract consisted of quarterly reports submitted by Anthem and several e-mails and memos regarding the contract, none of which were dated before January 2007. Department staff reported that they did not have a complete contract administration file for this contract.

Because the Department did not maintain adequate documentation to support its oversight of this contract, the Department had no evidence to support essential contract monitoring activities such as the frequency of meetings with the contractor and key information discussed during those meetings, concerns or contract compliance issues identified by the Department and its communication with the contractor on the issues, and any corrective action plans requested and received. Documentation of the contract oversight process is important to demonstrate accountability for the adequate performance of contractors and the appropriate use of public funds, and to support legal actions as necessary.

Applying adequate sanctions for failure to meet performance standards and other requirements in the contract. Although the Department has included contract provisions regarding liquidated damages since it first began contracting with

Anthem, it assessed no liquidated damages against Anthem between April 2003 and February 2007. Specifically, the Department did not assess any damages against Anthem until March 2007. The Department did assess a total of $12,845 in liquidated damages for Anthem's failure to meet contract requirements and standards between Marcy and June 2007, but assessed no liquidated damages in Fiscal Year 2008. The Department should ensure that it fully uses the liquidated damages provisions to promote high-quality and timely services. In addition, the Department included the same liquidated damage amounts in its new ASO contract as it had included in the contract with Anthem that had been executed in 2003. The Department should have a process to periodically reevaluate the liquidated damage amounts to ensure they adequately protect the State and serve as incentives for the ASO to meet compliance standards.

Evaluating options for shifting the financial risk for the Network to the contractor. The ASO contractor is currently not at risk for any of the health care services delivered to CBHP enrollees in the Network. One way for the Department to shift some of the financial risk to the ASO contractor is to capitate certain services provided by the ASO contractor, such as inpatient services or physician and outpatient services. This option transforms the arrangement from a simple ASO contract to a risk-based contract. We believe the Department should identify options for shifting the financial risk and evaluate the costs and benefits of the options. The Department should use the results of the evaluation to identify and adopt the appropriate delivery model to achieve the goals and objectives of the CBHP program.

Recommendation No. 7:

The Department of Health Care Policy and Financing should enhance accountability for services delivered by the Administrative Services Organization (ASO) contractor responsible for administering the CBHP State Managed Care Network by:

a. Adding to and strengthening provisions and performance standards in the contract to promote accountability.

b. Implementing a process to independently monitor the contractor's compliance with contract provisions, including on-site reviews of the contractor, ensuring that the contractor submits corrective action plans for substantial or recurring compliance issues identified from the monitoring process, and following up to ensure problems are addressed.

c. Maintaining a contract administration file containing all documentation of the Department's contract monitoring activities, its interaction with the contractor, and its decisions affecting the contract.

d. Applying liquidated damages when appropriate and periodically reassessing liquidated damage amounts to ensure they are adequate to protect the State and serve as incentives for contract compliance.

e. Evaluating the costs and benefits of alternative delivery models for the State Managed Care Network, including placing the ASO contractor at risk for a specified number of medical services.

Department of Health Care Policy and Financing Response:

Agree.

a. Implementation date: July 2009. The Department has already strengthened provisions in the current ASO contract that went into effect July 2008 and will continue to evaluate how to strengthen provisions and performance standards to promote accountability for the July 2009 contract amendment.

b. Implementation date: Implemented and ongoing. The Department will continue to independently monitor the current contractor's compliance with contract provisions. The Department agrees to ensure that the contractor submits corrective action plans for substantial or recurring compliance issues identified from the monitoring process, and follow up to ensure problems are addressed. As of July 2008, this is currently being done and will be an ongoing practice. Additionally, the Department will request resources through the standard budgeting process to conduct an on-site claims review that would include monitoring the contractor's compliance with contract provisions.

c. Implementation date: Implemented and ongoing. The Department will continue to maintain a contract administration file containing all documentation of the Department's contract monitoring activities, its interaction with the ASO contractor, and its decisions affecting the contract. As of July 2008 this is currently being done and will be an ongoing practice.

d. Implementation date: Implemented and ongoing. The Department will continue to apply liquidated damages when appropriate and periodically

reassess liquidated damage amounts to ensure they are adequate to protect the State and serve as incentives for contract compliance. A reassessment of liquidated damages was most recently done in May 2008 and will recur during each open procurement process.

e. Implementation date: July 2009. After a full year of operations with the new ASO vendor and more comprehensive reporting, the Department will evaluate the costs and benefits of alternative delivery models for the State Managed Care Network. This evaluation will include review of options to place the ASO vendor at risk for a specified number of medical services.

Reconciliation of CBHP Disbursements

Prior to May 2006, the Department paid all primary care providers in the Network on a capitated basis. The Department made monthly capitation payments to each provider for each enrollee assigned to the provider's practice. When the Department implemented the Colorado Benefits Management System (CBMS) in September 2004, it experienced problems with CBMS not maintaining data on all enrollees. As a result, some contracted primary care providers did not receive capitation payments for all the enrollees assigned to them. To address the underpayments, between July 2004 and April 2006 the Department made capitation payments to all CBHP primary care physicians based on the count of enrollees that had been assigned to the providers as of July 2004. In June 2006 the Department attempted to reconcile what it had paid the providers since July 2004 with the actual number of enrollees in each provider's practice each month. The Department used a combination of data from the automated eligibility system that preceded CBMS and from Anthem to identify any enrollees for whom a capitation payment had not been made. On the basis of this reconciliation effort, the Department paid more than 160 providers a combined lump sum amount of about $930,000.

In October 2006, one group of providers that had received a combined total of $4,800 from the reconciliation reported to the Department that it had been underpaid by an estimated $86,000. The Department has a number of requirements related to provider documentation. For example, the Department's CBHP provider contracts require providers to "maintain and provide, without charge, such medical, financial, and administrative records and information to the Department as may be necessary for compliance with state and federal law, as well as for administration of the Program." In addition, the Department's provider manual for CBHP requires that "all additional information reasonably required by [the Department] … to verify and confirm services and charges must be furnished upon request." The providers did not submit any records to support the $86,000 estimate.

The Department paid the providers the full $86,000 in January 2007 without obtaining any supporting documentation. Subsequently, the Department conducted further research and concluded that the amount owed to the providers due to problems with CBMS was only about $26,000. In December 2007, the Department requested that the providers either submit documentation to support the full $86,000 payment or refund to the Department the $60,000 difference by January 31, 2008. The Department used federal dollars to fund a portion of the $86,000 payment which is now in dispute. We estimate the amount of federal funds that were paid to these providers that is now in question is about $39,000. The CBHP provider contracts also address overpayments by the Department, stating: "In the event that the Contractor receives payment for medical services in an amount in excess of that authorized under the … [contract], whether as a result of the Contractor's error, the Department's (or its designee's) error, or otherwise, Contractor shall repay the amount of the overpayment to the Department upon discovering or being notified in writing by the Department of the overpayment within forty-five (45) days." As of September 2008, the Department reports that it has not received either additional documentation or any refund of monies from the providers.

Since the Department began paying all providers in the Network on a fee-for-service basis as of May 2006, this particular issue will not recur. However, the Department is responsible for effectively and efficiently managing the state and federal monies that fund the CBHP program. As such, it has an obligation to ensure that these monies are used only for eligible enrollees and legitimate claims. At the same time, the Department must work collaboratively with its contracted health plans and providers to maintain a robust health care system for CBHP participants. By making decisions to withhold or disburse CBHP funds without sufficient documented data to support the decision, the Department fails to prudently manage limited CBHP funds and risks damaging its relationship with health plans and providers.

Recommendation No. 8:

The Department of Health Care Policy and Financing should ensure that it collects and maintains appropriate and sufficient data to support disbursements of CBHP monies. Specifically, the Department should:

a. Continue to work with providers to resolve the outstanding dispute regarding capitation payments for Fiscal Years 2005 and 2006 and ensure that it has adequate supporting documentation for the amount it ultimately pays these providers.

b. Work with the federal Centers for Medicare and Medicaid Services to determine if any federal funds should be repaid related to this issue.

Department of Health Care Policy and Financing Response:

Agree.

a. Implementation date: Ongoing. The Department will continue to work with the group of providers regarding capitation payments for Fiscal Years 2005 and 2006. Once adequate supporting documentation is received from this provider group, a resolution on payment will be made.

b. Implementation date: April 2009. If the final resolution results in a refund to the Department, the Department will work with the federal Centers for Medicare and Medicaid Services to determine the amount of federal funds that should be repaid related to this issue.

Appendix A

The table below shows the counties covered by the HMOs and the State Managed Care Network for the Children's Basic Health Plan (CBHP) program during Fiscal Year 2007. The coverage areas represent services provided to children. All pregnant women enrolled in the program are served under the State Managed Care Network, and all enrolled children receive dental benefits through Delta Dental.

Department of Health Care Policy and Financing
Children's Basic Health Plan
HMO and State Managed Care Network[1] Coverage Areas[2]
Fiscal Year 2007

HMOs			Colorado Access or State Managed Care Network		State Managed Care Network Only	
Denver Health, Kaiser, or Colorado Access[3]	Colorado Access Only	Rocky Mountain Only				
Adams	Alamosa	Delta	Bent	Lincoln	Archuleta	La Plata
Arapahoe	Costilla	Mesa	Clear Creek	Mineral	Baca	Las Animas
Boulder	Gilpin	Montrose	Conejos	Morgan	Chaffee	Moffat
Broomfield	Kiowa		Crowley	Otero	Cheyenne	Montezuma
Denver	Logan		Custer	Park	Dolores	Ouray
Douglas	Phillips		Elbert	Pueblo	Eagle	Pitkin
Jefferson	Prowers		El Paso	Rio Grande	Garfield	Rio Blanco
	Saguache		Fremont	Teller	Grand	Routt
	Weld		Huerfano	Washington	Gunnison	San Juan
			Larimer	Yuma	Hinsdale	San Miguel
					Jackson	Sedgwick
					Kit Carson	Summit
					Lake	

Source: Department of Health Care Policy and Financing.
[1] As part of the State Managed Care Network, the Department contracts with about 4,800 providers to serve enrollees in these counties. At the time of the audit, Anthem managed the State Managed Care Network.
[2] The coverage areas in this table are for services provided to children in CBHP. All pregnant women enrolled in CBHP receive services through the State Managed Care Network.
[3] Enrollees in these counties can choose among Denver Health, Kaiser, and Colorado Access, except for Adams, Boulder, Broomfield, and Douglas, which do not have access to the Denver Health plan.

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