

Blue Cross Blue Shield
of Vermont
Market Conduct Examination

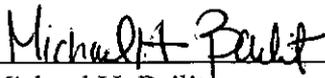
Submitted to:

The Vermont Department of Banking, Insurance,
Securities, and Health Care Administration

Submitted by: Bailit Health Purchasing, LLC

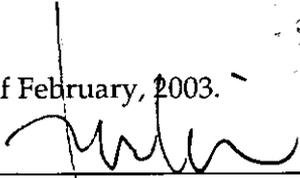
AFFIDAVIT OF MARKET CONDUCT EXAMINER

I, Michael H. Bailit, being first duly sworn, state that I and my firm, Bailit Health Purchasing, LLC, have been duly appointed as Market Conduct Examiner for the Vermont Department of Banking, Insurance, Securities, and Health Care Administration. A Market Conduct Examination of Blue Cross Blue Shield of Vermont was performed by Bailit Health Purchasing, LLC. The Information contained in this report, consisting of the following pages, is true and accurate to the best of my knowledge and belief. Any conclusions and recommendations contained in and made a part of this report are such as may be reasonably warranted from the facts disclosed in the Examination Report.



Michael H. Bailit
President
Bailit Health Purchasing, LLC

Subscribed and sworn to before me on this 10th day of February, 2003.



Notary Public

My commission expires:

Touko M. Liu
NOTARY PUBLIC
My commission expires Jan. 28, 2005

Blue Cross Blue Shield of Vermont Market Conduct Examination

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Introduction

A market conduct examination is an evaluation to determine whether a regulated entity is operating in a manner that conforms to regulatory requirements. The purpose of this examination was to test Blue Cross Blue Shield of Vermont's (BCBSVT or the company) compliance with applicable Vermont statutes and regulations, including 18 V.S.A. Section 9418, which spells out requirements for timely processing of health care claims along with penalties for non-compliance, and Department Regulation 79-2, Section 5 (Fair Claims Practices Regulation), which requires that "an insurer who receives an inquiry or complaint from the Department of Banking and Insurance shall furnish a response within fifteen (15) working days addressing itself to the specifics of the inquiry or complaint."

To determine BCBSVT's compliance with these statutes, a multi-faceted examination was conducted of BCBSVT's policies, practices, claims processing systems (including the company's Systems Unification Project) and management systems.

Bailit Health Purchasing, LLC (BHP) acted as the agent of the Vermont Department of Banking, Insurance, Securities, and Health Care Administration, under the Commissioner's examination authority as set forth in Chapters 1, 101, 123 and 125 of Title 8 V.S.A. and Chapter 221 of Title 18 V.S.A. BHP conducted an examination of the practices of Blue Cross Blue Shield of Vermont (BCBSVT) that commenced in late 2001 and extended into 2002.

BHP engaged a sub-contractor, Mercer Human Resource Consulting, to assist with a component examination, the review of BCBSVT's Systems Unification Project. This report describes the conduct of the examination, and the findings that resulted from it. A separate report on the Systems Unification Project evaluation will be presented to BCBSVT. That report is confidential as a result of the proprietary nature of its contents.

The examination was prompted by concerns expressed to the Department by several physicians, hospitals, and other health care providers that BCBSVT was failing to pay claims in a timely fashion. These concerns were corroborated by significant declines in consumer satisfaction data related to customer service and claims handling for BCBSVT's managed care product (Vermont Health Partnership). The consumer satisfaction data for 2000 and 2001 is presented in **Appendix H**. In addition, the Department observed that BCBSVT was not responding to its inquiries regarding specific consumer complaints in a manner consistent with regulatory requirements.

II. Examination Methods and Findings

The Department engaged BHP in December 2001 to conduct the examination of BCBSVT's market conduct. In mid-January 2002, BHP sent an initial letter requesting a series of documents and reports relevant to the questions at hand. Over the next several weeks BCBSVT provided a variety of requested reports, planning documents, policy and

procedure manuals, organizational charts and job descriptions. During this time BHP formulated, and BCBSVT responded to, additional written and verbal inquiries.

Also during this period, BHP conducted both mail and telephone surveys of providers focusing on their experience with BCBSVT's claims payment and customer service/provider support functions. In addition, BHP reviewed all complaints logged with the Consumer Services Section of the Division of Health Care Administration during calendar years 2000 and 2001. In early April 2002, BHP conducted on-site interviews with a wide cross section of BCBSVT managers and staff and also reviewed BCBSVT claim payment records.

After analyzing the initial data submissions the Department and BHP found that there were gaps in the data and several remaining questions. In order to conduct a thorough analysis, the Department and BHP made additional information requests and subsequently convened an on-site meeting with BCBSVT managers on September 3.

The examination sought to address three specific issues:

1. Determine whether BCBSVT processed claims in a timely fashion;
2. Determine whether BCBSVT paid interest on claims not processed in a timely fashion; and,
3. Determine whether BCBSVT was responsive to the Department regarding consumer complaints.

1. Determine whether BCBSVT processed claims in a timely fashion, in compliance with 18 V.S.A. Section 9418.

Methodology

The provisions of 18 V.S.A. Section 9418 state that within 45 days of receipt, health plans must either pay a claim, or they must notify the claimant in writing that the claim is denied or contested. In the latter case, the health plan is required to provide "specific reasons" as to why the claim is being denied or contested and a description of any additional information required in order to determine the health plan's liability for the claim. BHP took a multi-faceted approach to investigating whether BCBSVT was in compliance with this statutory mandate. The examination included:

- policy and procedure manuals review;
- provider surveys and interviews;
- interviews with current BCBSVT staff
- review of past performance, including
 - randomly sampled claims;
 - specific cases identified by providers;
- review of BCBSVT claim processing systems and management systems, including
 - systems upgrade activities; and
 - management structure and processes.

Findings

During CY 2001, BCBSVT processed just over 1.5 million claims, or an average of roughly 125,000 per month. The company paid 86% of the claims, denying 14%.

Timeliness of claim processing

BHP requested and received a detailed report on claims received on 17 selected days in CY 2001 and 2002 (one date per month for 17 months). The reasoning was that this claims data set would provide a representative picture of BCBSVT's claims processing operations during the time period in question. The data included paid, denied, adjusted and suspended claims for BCBSVT's indemnity and managed care products. BCBSVT could not identify any contested claims.

Table 1 below summarizes the findings regarding claims payment timeliness for the 17 selected dates.

Table 1: Statistics for processed claims received during 2001 and 2002¹

Date	Indemnity			Managed Care			Total		
	Claims	% Compliant	% Non-Compl	Claims	% Compliant	% Non-Compl	Claims	% Compliant	% Non-Compl
10-Jan-01	8457	97%	3%	5044	87%	13%	13501	93%	7%
7-Feb-01	8966	99%	1%	3892	57%	43%	12858	86%	14%
14-Mar-01	6995	98%	2%	3795	90%	10%	10790	95%	5%
11-Apr-01	8990	98%	2%	6132	88%	12%	15122	94%	6%
9-May-01	7389	98%	2%	4667	83%	17%	12056	92%	8%
13-Jun-01	8984	98%	2%	6482	88%	12%	15466	94%	6%
11-Jul-01	8291	99%	1%	6457	92%	8%	14748	96%	4%
15-Aug-01	7065	99%	1%	4903	96%	4%	11968	98%	2%
12-Sep-01	7344	100%	0%	5722	94%	6%	13066	97%	3%
10-Oct-01	9559	100%	0%	7054	89%	11%	16613	95%	5%
28-Nov-01	7916	98%	2%	6693	87%	13%	14609	93%	7%
12-Dec-01	9710	99%	1%	7823	79%	21%	17533	90%	10%
9-Jan-02	7686	98%	2%	7737	69%	31%	15423	83%	17%
13-Feb-02	8078	98%	2%	6316	74%	26%	14394	87%	13%
13-Mar-02	7967	99%	1%	7582	79%	21%	15549	89%	11%
10-Apr-02	7101	98%	2%	5193	84%	16%	12294	92%	8%
15-May-02	7160	98%	2%	3991	87%	13%	11151	94%	6%
Total/Avg.	137658	98%	2%	99483	84%	16%	237141	92%	8%

¹BCBSVT provided Medicomp claims data, but the Department decided not to analyze them due to their low claim volume when compared to the indemnity and managed care products. The decision was made not to request or analyze Interplan Transfer System (ITS) or Federal Employee Program (FEP) claims data due to the separate operating systems for these programs.

The data revealed that BCBSVT was non-compliant with the 45-day standard for 16% of the sampled managed care claims. Managed care claim compliance exceeded 90% for only three of the 17 sampled dates. Compliance for the indemnity line of business was much higher, with only 2% of indemnity claims non-compliant over the 17 sampled

dates. When combining indemnity and managed care claims, 8% of all claims were non-compliant, with significant variation by month over the 17 months.

Other Findings

The findings from the review of BCBSVT claim processing policy and procedure manuals regarding timely payment can be found in **Appendix A**. The findings regarding timely payment from the provider survey and provider interviews can be found in **Appendix B**. The findings regarding timely payment from interviews with current BCBSVT staff can be found in **Appendix C**. The results of the review of denied claims and of problem claims identified by surveyed providers can be found in **Appendix D**.

Conclusion

BCBSVT did not consistently comply with the requirements of 18 V.S.A. Section 9418 regarding timely processing of health care claims from January 2001 through May 2002.

- 16% of managed care claims were not processed within 45 days across 17 dates sampled between January 2001 and May 2002. For two sampled payment dates, 31% and 43% of managed care claim payments were untimely.
- 8% of all (i.e., managed care and indemnity) claims were not processed within 45 days for the aforementioned period. Across the sample of 17 dates, there were five months in which the percentage of total non-compliant claim processing ranged between 10% and 17%.
- As set forth in **Appendix A**, at the time of the site visit, the 45-day timely processing requirement was not identified in BCBSVT policy or procedure, and BCBSVT had no internal reporting system in place to assess compliance with the timely processing requirement.

2. Determine whether BCBSVT paid interest on claims not processed in a timely fashion, in compliance with 18 V.S.A. Section 9418 (e).

Methodology

The provisions of 18 V.S.A. Section 9418 (e) state that interest shall accrue for claims that are not paid within 45 days following receipt of the information required by a health plan to determine liability for the claim. This section of the statute anticipates four conditions, where the “45-day clock” begins:

1. with the date of receipt, when all the necessary information is included with the original submission, i.e., a claim is uncontested;
2. with the date of receipt from the provider of the required information, when some information is missing or problematic, and thus the claim is contested and the health plan notifies the provider;

3. with the date of original receipt, when some information is missing or problematic, and thus the claim is contested, but the health plan fails to notify the provider. In these instances the clock reverts back to the original submission date, and
4. with the date of original receipt, when a claim is denied, but a later ruling determines that the health plan was liable for payment.

BHP reasoned that for a health plan to comply with this section of the statute, it would first have to have systems in place to track when information was received and when payments were made. It would also need to formulate operational policies that assured compliance, and clearly communicate said policies to all levels of the organization. BHP again took a multi-faceted approach to test whether BCBSVT was in compliance with these requirements. The review included:

- review of policy and procedure manuals;
- provider surveys;
- interviews with current BCBSVT staff, and
- review of reports.

Findings

Interviews with staff

During the site visit BHP interviewed operations management staff regarding BCBSVT's practice of paying interest to providers for those claims that were not processed within 45 days. BHP was told that in the past, BCBSVT had only paid interest at the explicit request of a provider that they do so, and that the organization had been under the false impression until late in 2001 that it was only obligated to pay interest in those circumstances. The BCBSVT manager did not identify the basis for this understanding, and there does not appear to be any such basis in the statute.

Staff was quite direct in acknowledging that BCBSVT had no controls in place for tracking these claims and that as a result the process was administratively burdensome. Plans were underway to first develop a tracking system, and then use PowerSTEPP to automate payment. Subsequent to the site visit, BCBSVT reported that it implemented a system to automate payment of interest.

Review of reports

BHP requested that BCBSVT provide monthly reports covering calendar year 2000 to date detailing interest payments made in compliance with 18 V.S.A. Section 9418 (e). In response BCBSVT supplied an ad hoc report detailing interest payments made to a single provider. BCBSVT did not have the systems in place to readily identify interest payments made during calendar years 2000 and 2001, but was in the process of developing the system support required to identify, capture and track this information beginning in 2002.

The findings regarding interest payment from the provider survey can be found in **Appendix E**. The findings regarding interest payment from the review of BCBSVT claim adjudication policy and procedure manuals can be found in **Appendix F**.

Conclusion

Prior to the April 2002 site visit, it was neither policy nor practice for BCBSVT to comply with 18 V.S.A. Section 9418 (e) and routinely pay interest penalties to providers when it had taken more than 45 days to pay claims, even if a claim was originally denied and later determined to be liable for payment. BCBSVT has since reported that it has developed a system to identify those instances where interest penalties accrue and make corresponding interest payments.

3. Determine whether BCBSVT was responsive to the Department regarding consumer complaints in a manner consistent with Regulation 79-2, Section 5.

Methodology

The Department, through the Consumer Services Section of the Division of Health Care Administration, receives hundreds of consumer health insurance complaints every year. The Department has established a system to forward these complaints directly to the health insurers to facilitate resolution. Regulation 79-2, Section 5.C. requires that an insurer receiving an inquiry or complaint from the Department must “furnish a response within fifteen (15) working days addressing itself to the specifics of the inquiry or complaint.” The timeliness and quality of insurer responses has a direct impact on consumers, who may be facing expensive health care bills or awaiting eligibility or coverage decisions. To investigate this issue, BHP conducted:

- interviews with BISHCA staff;
- interviews with BCBSVT staff, and
- reviews of BISHCA consumer complaint files.

Findings

Review of BISHCA consumer complaint files

In examining the consumer complaint files, BHP tracked the time between the date the original complaint was mailed from BISHCA to BCBSVT, and the date that BISHCA received a response. For complaint correspondence through May 2000, two days were allowed for mail delivery so that responses received by BISHCA within 17 working days from the date upon which they were mailed by BISHCA were considered to be compliant with the regulation. Those received after 17 working days were non-compliant. Beginning in May 2000, compliance was defined as 15 working days, as BCBSVT began using same-day courier delivery at this time.

During calendar year 2000, BCBSVT requested a number of extensions for filing complaint responses, a practice that was not used in 2001. For several of the calendar year 2000 cases, multiple extensions were requested. In calculating compliance with the regulation, a response was considered to be compliant if an extension was requested within 15 working days, and the response was then filed within the requested amount of time. A response was determined to be out of compliance when an extension was requested but the response was filed after the extended date. In most of the cases where one or more extensions were requested, the responses were still received past the requested extension date, and so were categorized as non-compliant.

As can be seen in Table 2 below, BCBSVT was not compliant with the timeliness requirement during the review period. There was a dramatic drop in compliance with the regulation in the fall/winter of 2000-2001. By the spring of 2001, performance was better, but the rate of compliance still left much room for improvement.

Table 2: Timeliness of BCBSVT responses to consumer complaints

	Compliant	Non- Compliant	% Compliant	Extensions Requested
Jan 2000 - Oct 2000	38	10	79%	11
Nov 2000 - Feb 2001	4	19	17%	4
Mar 2001 - Feb 2002	37	23	62%	0
Total	79	52	60%	15

In reviewing the consumer complaint files, BHP reviewers also asked the question as to whether the written response from BCBSVT adequately addressed the issues raised in the original complaint. BHP reviewers tried to act as prudent laypersons and determine if the health plan's response was complete and made sense. It was generally found that written responses from BCBSVT directly addressed the issues raised by the complainants.

At the same time, written responses developed during the first year of our review tended to be more comprehensive, and included fuller explanations of actions taken by BCBSVT. Responses developed in 2001, while directly addressing the issues at hand, were much briefer, and tended not to provide detail about BCBSVT's actions. For example, there were cases where a response might refer to a specific clause in the member's contract without either attaching the relevant page of the contract or including the critical text in the body of the letter.

Conclusion

BCBSVT failed to respond in a timely fashion to Department-forwarded member complaints, with particularly poor performance in the late fall of 2000 through the winter of 2001. The dramatic drop in performance observed at this time corresponded with a period of change in personnel responsible for coordinating BCBSVT's responses.

With respect to the quality of BCBSVT responses, responses generally met a minimum acceptable threshold in terms of clarity and completeness. Responses, while not always as expansive as BISHCA staff ideally desired, did generally adequately respond to the

complaint. There were opportunities for improvement. It appeared to us that the newest BCBSVT staff member responsible for coordinating and formulating responses possessed a more terse writing style than that of her predecessors, and as a result, conveyed less information to BISHCA than her predecessors.

III. Conclusion and Recommendations

This market conduct exam focused upon BCBSVT's compliance with three regulatory requirements:

1. timely adjudication of provider claims;
2. payment of interest resulting from untimely adjudication of provider claims, and
3. timely response to consumer complaints transmitted by BISHCA.

Based on the data that BCBSVT provided and information collected during on-site visits, BCBSVT failed to fully comply with any of the three areas of inquiry during the review period.

BCBSVT reported that the company was taking several actions to address performance in these areas, including the introduction of new timeliness tracking and interest payments procedures, organizational and personnel changes, benefit plan changes, and systems upgrade and integration activities. BHP was not able to fully assess whether the changes that were in development or being implemented during the exam period were fully addressing the identified areas of non-compliance.

Recommendations

BHP consulted with the Division of Health Care Administration to develop the following recommendations, based on the results of the market conduct examination.

BCBSVT should submit a specific written response to BISHCA for each of the following recommendations:

Timely Claims Adjudication and Interest Payment

- **Recommendation #1:** The company should provide BISHCA with documentation showing it has identified and remedied the problems that caused it to fail to comply with the 45-day timely processing requirement.
- **Recommendation #2:** The company should provide evidence to BISHCA that its claim processing systems have been modified to accurately identify those circumstances regarding timely claim processing where interest penalties accrue and make corresponding interest payments.

- **Recommendation #3:** The company should provide to BISHCA a report detailing its payment of interest on all claims that did not meet the 45-day timely processing requirement.
- **Recommendation #4:** For any interest due on claims but not paid to date, the company should calculate interest, make payment accordingly and confirm to BISHCA.
- **Recommendation #5:** Beginning in 2003, the company should provide to BISHCA a quarterly report, not later than 20 days from the end of the each quarter, showing all claim payments that exceed the 45-day timely processing parameters. In addition, the report should show the payment of interest for each claim specified above that has exceeded the 45-day timely processing requirement.

Consumer Complaints

- **Recommendation #6:** BCBSVT should provide BISHCA with a written description of how it intends to maintain compliance with the 15-day response requirement for complaints.

Appendix A:

Review of Claim Processing Policy and Procedure Manuals Regarding Timely Processing

BHP reasoned that compliance with the provisions of the statute was more likely if BCBSVT clearly acknowledged statutory requirements in its standard contract language and policy and procedure manuals. In response to the Department's request, BCBSVT sent the following documents:

- Provider documents, including
 - Provider Manual
 - Provider Participation Agreement – FFS
 - Hospital Services Agreement
- Customer Service Training Manual
- Instructions for claims processing, including
 - Blue Shield Coding Reference
 - Indemnity Claim Procedures
 - Managed Care Claim Processing Guideline
 - OPL Claims Processing

In reviewing each of these documents, BHP assessed whether instructions contained in the document were consistent with 18 V.S.A. Section 9418. There was particular focus on any timeframes referenced, and whether they were consistent with the statute.

After careful review, BHP found that none of these documents directly referenced any of the requirements of 18 V.S.A. Section 9418. There was no language in any of the manuals stating that claims had to be paid or processed within 45 days; indeed there were no explicit mentions of any timeframes. While both provider contracts contained language stating that BCBSVT shall pay “complete claims” within timeframes mandated by the statute, neither fully addressed the statutory requirement. For example, neither contract made mention of the fact that all claims must be processed within 45 days, or that the health plan is obligated to provide specific reasons for denying or contesting a claim within that timeframe.

In The Provider Manual, Section 8 is devoted to Claim Submission Guidelines, Section 9 covers Policy and Coding Guidelines, and Section 10 covers Claim Adjustments, Payment Inquiries, and Supplies. The Manual contains no specific references to the statute. There is no mention of timeframes for claims payment, other than that the provider must submit the claim within one year of the service date. Both the BCBSVT Provider Participation Agreement – Fee for Service and the Hospital Services Agreement require that the contracted provider abide by BCBSVT's rules, as published in the Provider Manual. Neither boilerplate contract had any specific references to the statute, although both included a general requirement that the Agreement be governed in

accordance with the laws of the State of Vermont. The BCBSVT Provider Participation Agreement - Fee for Service (Section VI – Payment Agreement) states that “payment by the Plan shall be within 45 days of the Plan’s receipt from Provider of a complete claim, unless Plan requests additional information within the 45 day period, or the claim involves other party liability, coordination of benefits, or otherwise requires investigation.” There did not appear to be a definition of complete claim in this agreement. Also, in Section V – Claims Submission, in addition to specifying that the provider must submit claims within one year from the date of service or discharge (inpatient), there is language that BCBSVT shall notify the provider and member “on a timely basis” of benefits paid and/or reasons for not paying. The hospital contract, Section 7.04 states that the Plan shall process and pay “complete claims” within 30 days of receipt. A complete claim is defined in Exhibit A as a request for payment “which is accurate and provides that information necessary for proper processing..., which does not unduly require medical records or other information, and to which there is no substantial issue ... regarding the payer’s responsibility for payment.” There is no language about gathering information regarding incomplete claims, nor discussion of timelines for gathering such information.

The Customer Service Training Manual contains separate sections for helping the customer service representative to navigate different software systems: the AS-400 (“the FRED”), the MHS (PowerSTEPP) system, RESTAT, and Lotus Notes. It gives procedural direction for tasks such as verifying eligibility or benefits, or investigating the status of a claim. The focus is not on policies about when to pay or deny a claim, but rather how to help a plan member or provider to understand the status of a claim. The manual contains no references to the statute. Timeframes for paying or adjudicating claims are not addressed directly. The document does not shed much light on BCBSVT policy (or its implementation) regarding timely payment of claims.

A thick package entitled Indemnity Claim Procedures appears targeted to suspense analyst staff and contains detailed instructions about how to work suspended claims. The package contains no specific reference to the statute. There are hundreds of suspense conditions, and while there are usually instructions about printing reasons for suspending the claim and mailing that information to the provider, we could find no specific reference to 45-day timelines, or any instructions for dealing with suspended claims within 45 days once the required information had been submitted by a provider.

The Blue Shield Coding Reference appears to be a reference tool for claims entry staff. It has no introduction or overview. While this volume contains detailed instructions about how to enter claims, there are no specific references to the statute, to a 45-day timeline for paying or notifying the provider of the reasons for contesting or denying the claim, or for dealing with denied claims within 45 days once the required information is submitted.

The Managed Care Claim Processing Guideline contains instructions for claims processing staff, covering a series of suspended claims codes. As with the other claims processing packages submitted, it contains no reference to the statute and is silent on the issue of the 45-day turnaround time.

The OPL Claims Processing package contains a series of guidelines mainly related to coordination of benefits (COB) procedures. It is written for the claims staff, with specific keying instructions. As with the Indemnity Claims package, there is no specific reference to the statute, and timeframes are not addressed.

Appendix B: **Provider Survey and Interviews** **Regarding BCBSVT Timely Claim Processing**

Provider survey results

Prior to going on site at BCBSVT, BHP conducted mail surveys with a random sample of providers and telephone surveys with the top billing hospital and clinic/group practice providers. The same survey instrument was used for the telephone survey as was used in the mail survey. The purpose of these surveys was to obtain information from providers regarding their experience with BCBSVT's claims processing and related provider support functions. In addition, BHP conducted telephone interviews with two practitioners that had registered complaints with BISHCA.

For the **mail survey**, BHP selected 28 providers from the BCBSVT Directory of Primary Care Physicians, Spring-Summer 2001 and 37 providers from the Directory of Specialists, Winter 2000-2001. Providers were selected at random within each directory. This sampling methodology led to a cross section of disciplines among the specialists, and a geographic cross section among both types of practitioners. Surveys were mailed out by BISHCA in mid-February. In mid-March, BHP made a single outreach telephone call to a sub-set of the providers that had not responded. Nine of the original 65 providers were eliminated from the sample because the survey was returned without a forwarding address or the telephone number listed in the provider directory was no longer in service. Twelve providers faxed back responses, and an additional 7 responded to outreach telephone calls. Thus, the response rate was 34% (19/56).

These respondents were all delivering outpatient services. They estimated submitting on average over 200 claims worth \$25,000 per month to BCBSVT. Eleven estimated that on average they received payment within 45 days for at least 75% of their claims. Four said that on average they received payment within 45 days on less than 10% of their claims. When asked to rate BCBSVT's provider support function in helping to resolve claim payment issues on a scale of 1 to 5¹, this group's average rating was 2.8, and included four 'Poor' and two 'Excellent' ratings. Comments tended to express frustration with the process. For example, several respondents indicated displeasure with long telephone wait times, and others said that while customer service representatives were friendly, they were ineffective in resolving problems. Several respondents cited problems resolving claims involving out-of-state members.

For the **telephone survey**, BHP asked BCBSVT to supply contact names for the top billing hospital and clinic/group practices. During the first three weeks of March 2002, BHP interviewed managers responsible for billing at 9 hospitals and 4 clinics or group practices. The hospitals estimated submitting several thousand claims per month to BCBSVT. The value of these claims was said to range from \$.5M to \$5M. The clinics

¹ Scale: Excellent = 5, Very Good = 4, Average = 3, Not Very Good = 2, Poor = 1

said they submitted several hundred claims worth roughly \$100-150K per month. Only one of the hospital billing managers estimated that on average she received payment on 80% of her claims within 45 days. The rest of those interviewed estimated between 50-70% of their claims were generally paid within 45 days.

This group was quite critical of BCBSVT: the average rating of BCBSVT's provider support function was 1.8. Five respondents gave 'Poor' ratings; the highest rating that BCBSVT received from this group was 'Average'. A common theme was BCBSVT's lack of responsiveness to provider inquiries, particularly on the part of provider representatives. Other comments clustered around issues such as diagnostic coding that hindered payment of emergency room claims, problems with ITS claims involving out-of-state members² and problems with Claim Check software³.

Table 1: BCBSVT strengths and weaknesses described in provider survey responses.

<p>BCBSVT strengths:</p> <ul style="list-style-type: none"> • Web access for status checks works well. • BCBSVT does a good with initial notifications, both verbally and in writing. • BCBSVT does a good job with HIPAA. • Customer service reps, when you get through, are friendly; they try to help.
<p>BCBSVT weaknesses:</p> <ul style="list-style-type: none"> • It is difficult to get through, and calls are not always returned. • The customer service reps need training; callers are frequently transferred from one rep to another. Phone reps do not have the ability to resolve issues; they are just intermediaries. • The ITS/BlueCard program is very problematic. • High dollar claims get "caught" by Claim Check software, have to go to medical review, and often get "lost" in suspense. • A major problem is that the BCBSVT system only looks at the first diagnosis, and thus rejects a lot of ER claims.

² ITS and BlueCard are both terms used to describe a program of the Blue Cross and Blue Shield Association that allows members from one state to receive health care services in another state. BCBSVT acts as the 'host plan' when members from other states receive services in Vermont, and as the 'home plan' when covered Vermonters receive care in other states. The home plan basically authorizes care according to benefit coverage, while the host plan processes a claim with its network provider.

³ Claim Check is a software package that reviews outpatient (HCFA 1500) claims for consistency around issues such as procedure codes and diagnosis. Claims outside certain parameters are suspended and flagged for further research.

Appendix C:

Current BCBSVT Staff Interviews Regarding BCBSVT Claim Processing

During the site visit component of the market conduct examination, BHP staff interviewed a mix of BCBSVT personnel from multiple operational units and at varying levels of seniority. Staff members from the following areas of the organization were interviewed:

Operations: BCBSVT had organized its operational staff such that there was one mid-level manager responsible for resolution of suspended claims, adjustments to previously processed claims, and member customer service for the indemnity line of business. Another mid-level manager had responsibility for parallel activities for the managed care line of business, and a third for the Medicomp line of business. A fourth mid-level manager was responsible for a dedicated Provider Service Unit (PSU) that was responsible for handling all incoming provider calls. These four managers reported to a senior manager, who in turn reported to the Vice President of Operations. This organizational structure was relatively new – the dedicated PSU was created in 2001. Staff members were interviewed at multiple levels within Operations.

Operations (Interplan Transfer System – (ITS)): Responsibility for operational and system issues pertaining to claims administered through the national Blue Cross Blue Shield Association (i.e., “ITS” or “BlueCard” claims) was contained in an independent unit reporting to the Vice President, Internal Audit and Reengineering. The BlueCard Administrator and the BlueCard Claims Project Leader were interviewed.

Provider Relations: BCBSVT maintained a separate Provider Relations unit that was primarily responsible for outreach to and education of providers. While these employees received some calls from providers, their role was primarily field-oriented. This unit reported up through the Vice President, Managed Health Systems. The Acting Director from this unit was interviewed.

Management Information Systems: Staff responsible for management information systems worked for the Vice President, Information Services and Technology. Interviews were conducted with those senior managers within this division of the organization who maintained responsibility for the BCBSVT Systems Unification Project.

Interviews with current BCBSVT staff: Operations and Provider Relations

Operations staff members were asked if BCBSVT paid claims on a timely basis during 2001. According to staff, the organization had outsourced claims entry to a Kentucky firm in 2000 with poor results. This hurt the ability of BCBSVT to pay claims in a timely manner during early 2001. The quantitative analysis of BCBSVT data, discussed in the main body of this report, bears this out.

Management staff stated that they were aware of 18 V.S.A. Section 9418, and particularly the 45-day standard, but indicated that policy had not been written to reflect the statutory requirement. Different managers provided conflicting information as to whether or not front line operations staff had received training on the requirement.

One senior manager said that she was not aware of any problems that BCBSVT had experienced regarding the timely payment of claims over the past two years. Another senior manager said that the biggest challenges to timely claim payment were as follows:

1. late employer premium payment (referred to as “paid to date” within BCBSVT);
2. managed care facility claims with a second claims modifier, and
3. managed care claims lacking a primary care provider referral.

A large percentage of the claims that BCBSVT suspended for payment were reportedly due to the lack of timely employer premium payment for the period in which the service has been incurred. Staff indicated that approximately 70% of the indemnity suspended claims were suspended for this reason.

The referral issue pertains to the managed care line of business. BCBSVT customarily suspended a claim for 14 days if there was no referral in the system. This would give the primary care provider time to make a retroactive referral. (As of late summer 2002, BCBSVT no longer required primary care physician referrals for its managed care product.)

When claims had been suspended for 30 days, they were flagged for special attention by the suspense claim analysts to ensure timely payment.

Management staff indicated that they historically had not tracked compliance with the 45-day standard. At the time of the site visit BCBSVT managers said that the company was currently developing a tracking system that would enable it to assess its compliance with the requirement. (BCBSVT indicated subsequent to the site visit that such a report had been completed.)

Management staff was asked how they handled fluctuations in volume of claims and telephone calls. They said that BCBSVT had tried using Kelly temporary employees in the past, but that had not worked well. They also said that the four telephone units (i.e., Managed Care, Indemnity, PSU, and Medicomp) would redistribute volume at times to help one another shoulder fluctuations.

It was indicated that going forward, BCBSVT intended to anticipate future turnover by regularly hiring and training new employees. Management hoped that this would prevent problems of understaffing in the future.

Front-line operations staff members were interviewed separately and individually. BCBSVT selected the front-line staff to be interviewed. Most of them had been working

within BCBSVT for between one and three years, and had been within their current position for less time. They were asked whether there were major challenges in attempting to pay claims on a timely basis. They identified the following issues:

1. the amount of information that they needed to know;
2. communication and coordination with other units;
3. work volume requirements, and
4. Provider Relations responsiveness.

With regard to information requirements, a relatively new employee said that while there was a six-week training course, there were still information needs following training. While BCBSVT did offer ongoing training, it was difficult to take advantage of the training due to telephone coverage responsibilities.

With regard to communication and coordination, staff members reported that when claims got “stuck” it was usually because of the need to coordinate with another unit. High levels of staff turnover had made this type of coordination particularly difficult at times. Turnover was reportedly often due to lateral transfers to other units.

With regard to work volume requirements, staff spoke of the quotas that they had to meet in terms of answering telephone calls and researching claims. They said that the quotas were hard to meet if the telephones were busy, and that the research activities usually didn’t get addressed under such circumstances. This, in turn, upset providers. One employee suggested the creation of a dedicated research time to address this problem.

Work volume pressure appeared to be particularly notable for the PSU employees who were interviewed. An employee in another unit said that the PSU telephone lines got tied up much more than did the indemnity and managed care telephone lines for members. A mid-level operations manager indicated that providers had high expectations and that those expectations were increasing. It was suggested that providers often demanded unnecessary “hand holding” and could be “not nice” at times.

With regard to Provider Relations responsiveness, it was reported that providers would call a representative within Provider Relations five or six times without getting a response. As a result, the providers would instead call the PSU. (Senior managers in Operations said that this problem was abating as more providers learned that they should call the PSU and not Provider Relations, in most instances.)

Finally, several staff mentioned recent systems problems that had resulted from the systems unification process.

Appendix D: **Review of Denied Claims and of Problem Claims Identified by Surveyed Providers**

While on site, BHP closely reviewed a subset of the claims that were paid after 45 days. This subset included different types of claims, e.g., inpatient, outpatient, professional, etc., and different types of services, e.g., lab, x-ray, surgeon fees, etc., with some submitted electronically and some on paper. Other than the fact that all of these claims had been suspended, there were no discernible patterns. Some were “caught” by Claim Check software, while others were not. Some needed to be worked manually, while others did not. In a number of cases it appeared that proper referrals were initially lacking. BHP’s ability to investigate the history of these claims was limited by the fact that BCBSVT does not preserve information about why a claim is suspended once the situation is resolved. Suspended claims are identified and “worked,” but once they are resolved and processed, the electronic record indicates only the actions taken.

BHP also explored a small sample of cases gathered from specific provider complaints. One provider cited difficulties with provider support in trying to get reimbursed for oral surgery procedures. This provider stated that they devote a half time position in the billing office to deal with BCBSVT issues. The following cases represent two examples outlined by this provider:

- Case 1 – Impacted wisdom teeth were removed in January 2000. The claim was originally rejected in February 2000 because of problems with the member’s coverage; BCBSVT required proof of a denial by the member’s dental insurer. This was duly submitted by the provider in March but (according to the provider) was lost by BCBSVT and was rejected for the same reason in June. The provider got another denial from the dental carrier and re-submitted in October. Over the next 6 months, the claim was not processed while the provider noted several follow-up telephone calls. According to BCBSVT records, the coverage issue was resolved in April 2001, but then the claim rejected for lack of referral, and as of April 2002 had not been paid. The provider documented 5 additional phone calls between April 2001 and March 2002.
- Case 2 – Impacted wisdom teeth were removed in June 2001. The claim was rejected in late June for the same reason as in the previous case, and re-billed with the accompanying denial from the dental carrier in September. Four telephone calls and almost seven months later, the claim was “pushed through manually” and paid in late March 2002.

In each of these cases, BCBSVT processed the initial claim within 45 days, in each case issuing a denial. For both claims, the provider subsequently appealed the denial .

The provider submissions raised three additional issues. First, providers argued that after they resubmitted the claims with all necessary documentation attached, it took months for

processing. A review of this small sample of claims confirmed that, in fact, very long, unexplained delays occurred in the processing of claim resubmissions.

Second, the providers argued that their original claims, or re-submissions with attached EOBs, included all the information that BCBSVT needed to determine its liability. BHP did not try to determine whether or not BCBSVT was denying claims that should have been paid; the scope of the examination focused more narrowly on the issue of timeliness of processing. Having reviewed only a few examples, BHP cannot draw any major conclusions about the frequency with which BCBSVT erroneously denies legitimate claims.

Appendix E:

Provider Survey Results Regarding BCBSVT Interest Payment Practice

In conducting the telephone surveys with top billing providers and the follow-up calls to non-respondents from the mail survey, BHP raised the issue of interest payment in those instances where providers reported a problem with timely payment. In these cases providers were asked if they were aware of the statute, and if they had received any interest payment from BCBSVT. Many providers were unaware of the statute. A few said they were aware of the statute, but had never pursued getting interest payments for late payment of claims. One provider said they had asked BCBSVT for interest payment on batches of claims that were not paid in a timely fashion, but they decided not to pursue the matter when BCBSVT told them that they would have to separately document their case for each claim. Only one provider reported receiving interest after “a long struggle.”

Appendix F: **Review of Claim Adjudication Policy and Procedure Manuals Regarding Interest Payment**

Prior to going on-site, BHP looked to verify if BCBSVT had formulated any formal policies that would assure compliance with the statute. As previously noted, we reviewed several documents submitted by BCBSVT including:

- Provider documents, including
 - Provider Manual
 - Provider Participation Agreement – FFS
 - Hospital Service Agreement
- Customer Service Training Manual
- Instructions for claims processing, including
 - Blue Shield Coding Reference
 - Indemnity Claim Procedures
 - Managed Care Claim Processing Guideline
 - OPL Claims Processing

There appeared to be no direct reference to 18 V.S.A. Section 9418 in any of these documents. There also appeared to be no language in any of these documents regarding accrual or payment of interest. While the two provider contract boilerplates included language about BCBSVT's obligation to pay "complete claims" within timeframes consistent with the statute, neither included any mention of interest payment.

Appendix G: **Interviews Regarding** **BCBSVT Responsiveness to Consumer Complaints**

Interview with current BCBSVT staff

Responsibility for BISHCA member complaints was located within the BCBSVT Operations Managed Care Unit at the time of the site visit. BHP interviewed the individual responsible for day-to-day handling of member complaints forwarded by BISHCA to BCBSVT. This employee had been responsible for managing the function since January 15, 2001, after spending a year as a customer service representative within BCBSVT. Prior to her assuming the position, it had been vacant since October 2000.

BISHCA staff within the Consumer Services Section of the Division of Health Care Administration reported that they used both informal and formal processes with BCBSVT for resolving member complaints. The informal process entailed the transmission of a facsimile from BISHCA to BCBSVT that included the member's authorization for release of information. The informal method was generally used for relatively simple concerns, when BISHCA staff believed that it would lead to a more rapid resolution for the consumer.

The formal complaint process, on the other hand, was initiated through the transmission of the complaint with an official form developed by BISHCA. It is this system for formal complaints that was the focus of the examination. A courier system was devised in May 2000 to address problems with timely correspondence transfer between BCBSVT and BISHCA. A BCBSVT courier delivered the formal complaint from BISHCA to BCBSVT, and delivered related documents daily between the two organizations whenever there were complaints in process.

Once a complaint was received at BCBSVT, it was entered into BCBSVT's customer service call tracking system ("the FRED") and also into a Microsoft Access database. Complaints were then frequently routed to an appropriate department within BCBSVT, including Marketing, Legal Services, and Medical Services. Staff reported that these departments were usually very responsive, typically responding within 24 hours. BHP was told that when staff had to be reminded on occasion that the complaint response needed to be sent to BISHCA, there was a rapid response.

Once information was provided from the internal department(s), the employee responsible for handling BISHCA-transmitted complaints wrote a response letter. She typically wrote the letter and transmitted it without any internal review, although internal review occurred occasionally when the content was particularly technical.

BHP was told that on rare occasions BCBSVT would request a five or 10-day extension in order to respond to a complaint.

Since the site visit, BCBSVT has transferred responsibility for this function to the Legal Services department.

Appendix H

2000 and 2001 Consumer Satisfaction Data Regarding Customer Service and Claims Handling

BCBSVT consumer satisfaction with handling claims correctly and customer service was significantly below the national average for managed care plans in 2000 and 2001. Satisfaction with handling claims in a reasonable time declined from significantly above the national average in 1999 to significantly below the national average in 2001. The plan reported this data as part of the Consumer Assessment of Health Plans Survey (CAHPS[®]), a nationally validated and standardized survey. The data from 2000 and 2001 is presented below:

	How much of a problem, if any, was it to get the help you needed when you called your health plan's customer service?	
	Percent that answered "not a problem"	
	2000	2001
BCBS/VHP	41%	43%
National Average	58%	60%
Regional Average	62%	63%

	How often did your health plan handle your claims in a reasonable time?		How often did your health plan handle your claims correctly?	
	Percent that answered "usually" or "always"		Percent that answered "usually" or "always"	
	2000	2001	2000	2001
BCBS/VHP	75%	74%	74%	78%
National Average	79%	82%	83%	85%
Regional Average	82%	84%	83%	86%

