

**STATE OF MONTANA and
MONTANA UNIVERSITY SYSTEM**

**ANALYSIS AND EVALUATION OF
CLAIMS PROCESSING
FOR THE PERIOD
JANUARY 1, 2008 THROUGH DECEMBER 31, 2010 (STATE)
JULY 1, 2008 THROUGH JUNE 30, 2010 (MUS)**



**Prepared Under Contract With:
MONTANA LEGISLATIVE BRANCH, AUDIT DIVISION
PO Box 201705, Helena MT 59620-1705**

LEGISLATIVE AUDIT DIVISION

Tori Hunthausen, Legislative Auditor
Deborah F. Butler, Legal Counsel



Deputy Legislative Auditors:
Cindy Jorgenson
Angie Grove

August 2012

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the audit of the medical and pharmacy claims for the employee benefits plans at the State of Montana for the three years ended December 31, 2010 and the Montana University System for the two years ended June 30, 2009.

The audit was conducted by Wolcott & Associates under a contract between the firm and our office. The comments and recommendations contained in this report represent the views of the firm and not necessarily the Legislative Auditor.

The agencies' written responses to the report recommendations are included in the back of the audit report.

Respectfully submitted,

A handwritten signature in cursive script, appearing to read "Tori Hunthausen".

Tori Hunthausen, CPA
Legislative Auditor

10C-09

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FOR THE PERIOD
JANUARY 1, 2008 THROUGH DECEMBER 31, 2010 (STATE)
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TRADITIONAL PLANS

ADMINISTERED BY

**BLUE CROSS BLUE SHIELD OF MONTANA,
ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC. and
DELTA DENTAL PLAN**

FINAL REPORT

AUGUST, 2012

PRESENTED BY

**WOLCOTT & ASSOCIATES, INC.
12120 STATE LINE ROAD, SUITE 297
LEAWOOD, KANSAS 66209**

**STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
 TRADITIONAL HEALTH CARE PLAN AUDIT
 OF BLUE CROSS BLUE SHIELD OF MONTANA,
 ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC. and
 DELTA DENTAL PLAN
 JANUARY 1, 2008 - DECEMBER 31, 2010 (STATE)
 JULY 1, 2008 THROUGH JUNE 30, 2010 (MUS)**

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I - INTRODUCTION

The State of Montana (State) provides self-funded medical care and dental care benefits as part of an overall employee benefit and compensation program. The plan covers approximately 15,000 employees and retirees, plus their dependents for a total of 32,000 covered lives.

The State has negotiated a contract with Blue Cross Blue Shield of Montana (BCBSMT) to provide administration services to its indemnity medical and dental plans.

The Montana University System (MUS) is a member of the Montana Association of Health Care Purchasers, and had also contracted to have their medical and dental care benefits administered by BCBSMT until June 30, 2005. However, as of July 1, 2005 MUS contracted with Allegiance Benefit Plan Management, Inc. (Allegiance) to administer their medical and dental care benefits. MUS contracted with Delta Dental as of July 1, 2007 to administer their dental care benefits. The plan covers approximately 8,000 employees and retirees, plus their dependents.

PURPOSE OF SERVICE

Section 2.18.816, MCA requires the State Employee Benefits Plan to be audited every two years by or at the direction of the Legislative Audit Division. Wolcott & Associates, Inc. was awarded the audit contract for the 2002-2003 Plan Years and subsequently renewed that contract for the 2004-2005 Plan Years, the 2006-2007 Plan Years and the 2008-2010 Plan Years.

The purpose of the service is to comply with Section 2.18.816, MCA.

The State and MUS recognize that they have a fiduciary responsibility to administer this plan (and other employee benefit plans) for the benefit of plan participants and their dependents and in accordance with the plan provisions. Both plan sponsors believe it is prudent to perform periodic audit and review services to determine if the benefit plans they sponsor are meeting these objectives.

AUDIT TIMING AND STAFF

The Legislative Audit Division advised Wolcott & Associates, Inc. that the contract would be renewed June 30, 2011. All preliminary work was completed and on-site services were performed in September, October and November, 2011.

On-site audit services were performed at:

Blue Cross & Blue Shield of Montana
560 North Park Avenue
Helena, Montana 59601

Allegiance Benefit Plan Management, Inc.
2806 South Garfield Street
Missoula, Montana 59801

Delta Dental Plan
1000 Mansell Exchange West, Bldg. 100, Suite 100
Alpharetta, Georgia 30022

Wolcott & Associates, Inc. staff involved in the audit are listed below:

<u>Name</u>	<u>Title</u>	<u>On-site</u>
Brian Wyman	Manager	Yes
Marie Pollock	President, Project Director	Yes
Richard Reese	Actuary	No
Jenny Hill	Statistician	No

SCOPE OF AUDIT

The scope of audit services covered medical care benefit claims paid by BCBSMT, PHP/AMC, and DDP during the period from January 1, 2008 through December 31, 2010 for The State and July 1, 2008 through June 30, 2010 for MUS. Test work was performed on 511 previously processed claims (211 medical claims per plan per administrator and 100 dental claims for DDP), all of which were selected on a stratified, random (statistical) basis.

Claims Adjudication Audit

Elements of claims adjudication which were evaluated include:

- Turnaround time required to process each claim.
- Eligibility of claimants to receive payment.
- Administration of coordination of benefits, including Medicare.
- Administration of subrogation provisions.
- Calculation accuracy, including Usual, Customary and Reasonable (UCR) limits and computation of deductible and co-payment limits.
- Completeness of necessary information.
- Payee accuracy, including benefit assignments to service providers.

- **Consistency of payments to BCBSMT and Allegiance member physicians and other physicians.**
- **Compliance with benefit plan structure.**
- **Identification of duplicate claim submissions.**

II - STATISTICAL CLAIM AUDIT RESULTS - BCBSMT

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 211 claims processed at BCBSMT.

The State claims were selected from the population of claims paid by BCBSMT between January 1, 2008 and December 31, 2010. Prior to selection, the population of claims was stratified.

AUDIT PROCEDURE

Information presented below describes our test work on the 211 previously processed claims (medical and dental) in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on BCBSMT's records to the coverage indicated on the plan's records.
- Verification that members are employees/retirees of the plan and covered under the plan at the time the claim was incurred.
- Review to determine that BCBSMT is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).
- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.

- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.
- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 211 claims, processed by BCBSMT, in our statistical sample, none were judged to contain a payment error. This represents a frequency of payment error of 0.00%.

Our sample contained a total payment of \$917,027.59 for the 211 claims. The overpayments totaled \$0.00 or 0.00% of the total. The underpayment totaled \$0.00 or 0.00% of the total. This financial error rate is superior to the range of .5 to 1 percent error rate normally observed during our audits of similar plans. It is also more favorable than the BCBSMT standard of 1%. In addition, it is more favorable than the 0.96% reported in the prior audit report.

The frequency of payment error in our sample is superior to the range of three to five percent error rate normally observed during our audits of similar plans. In addition, it is more favorable than the BCBSMT standard of 3% and the 3.32% error rate reported in the prior audit report.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 2.5%, that the true frequency of error in the population does not exceed 2.5%.

Based on this extension, we believe that the true magnitude of payment error in the population is \$0.00 or (0.00% of payments in the population). The magnitude of payment error is the sum of

\$0.00 in projected overpayments plus \$0.00 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in Exhibit A. A discussion of error types is presented below.

A summary of error by type for BCBSMT is presented below:

BCBSMT HEALTH CARE CLAIMS
JANUARY 1, 2008 THROUGH DECEMBER 31, 2010
SUMMARY OF ERRORS BY TYPE

<u>ERROR TYPE</u>	<u>NUMBER</u>	<u>NET PAYMENT ERROR</u>
--------------------------	----------------------	-------------------------------------

No errors were identified

BCBSMT has included their response as Exhibit C.

III - STATISTICAL CLAIM AUDIT RESULTS - ALLEGIANCE

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 211 claims for MUS.

The MUS claims were selected from the population of claims paid by Allegiance between July 1, 2008 and June 30, 2010. Prior to selection, the population of claims was stratified.

AUDIT PROCEDURE

Information presented below describes our test work on the 211 previously processed claims (medical and dental) in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on Allegiance's records to the coverage indicated on the plan's records.
- Verification that members are employees/retirees of the plan and covered under the plan at the time the claim was incurred.
- Review to determine that Allegiance is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).
- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.

- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.
- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 211 MUS claims in our statistical sample, 3 were judged to contain a payment error. This represents a frequency of payment error of 1.42%.

Our sample contained a total payment of \$1,515,593.21 for the 211 claims. The overpayment totaled \$2,060.34 or 0.14% of the total. The underpayments totaled \$107.09 or 0.01% of the total.

This financial error rate is more favorable than the .5 to 1 percent error rate normally observed during our audits of similar plans. It is also more favorable than the Allegiance standard of 1%.

The frequency of payment error in our sample is more favorable than the three to five percent error rate normally observed during our audits of similar plans. It is also more favorable than the Allegiance standard of 3%.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 0.6%, that the true frequency of error in the population is between .82% and 2.02%.

Based on this extension, we believe that the true magnitude of payment error in the population is \$21,558 or (0.001% of payments in the population). The magnitude of payment error is the sum of \$0 in projected overpayments plus \$21,558 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit B**. A discussion of error types is presented below.

A summary of error by type for Allegiance is presented below:

ALLEGIANCE HEALTH CARE CLAIMS
JULY 1, 2008 THROUGH JUNE 30, 2010
SUMMARY OF ERRORS BY TYPE

<u>ERROR TYPE</u>	<u>NUMBER</u>	<u>NET PAYMENT ERROR</u>
Duplicate payment	1	2,060.34
Incorrect application of ER copay	<u>2</u>	<u>(107.09)</u>
Total	<u>3</u>	<u>\$1,953.25</u>

Allegiance has included their response as **Exhibit D**.

RECOMMENDATION

Our recommendations are as follows:

- We identified 2 errors involving the misapplication of the emergency room copay. This issue was identified in the last audit that was performed at Allegiance for MUS.

We believe Allegiance should perform enhanced training for the processors responsible for the administration of the MUS traditional plan.

IV - ELIGIBILITY

The plan sponsors use various methods to report new entrants, changes and termination of coverage to BCBSMT and Allegiance. This section describes the methods employed and presents the results of the verification of eligibility for the 422 (211 for the 2 plan sponsors) in our sample where a payment was made by BCBSMT or Allegiance.

STATE OF MONTANA

The State prepares and sends to BCBSMT a biweekly eligibility tape showing each individual to be covered for the coming month. BCBSMT runs this tape and compares it to the data for the prior month.

Eligibility Verification

Each of the State participants in our sample was researched on the State eligibility system to verify that the State's records indicated that coverage was in force on the date the services were rendered.

No exceptions were noted.

MONTANA UNIVERSITY SYSTEM - ALLEGIANCE

Allegiance receives the enrollment data from each campus on a daily basis. The enrollment information is then updated in Allegiance's system.

Eligibility Verification

Each of the MUS participants in our sample was researched at the applicable campus to verify that the Allegiance's records indicated that coverage was in force on the date the services were rendered. MUS records confirmed that all participants in the sample were covered as of the date the services were rendered.

No exceptions were noted.

V - CLAIM PAYMENT TURNAROUND TIME

The purpose of this section is to present our analysis of the claim turnaround time information for each of the 422 claims in our sample.

Claim Processing Time

Claim processing time or turnaround time for this audit was measured from the "received date" as entered on the claim document to the date the claim was processed.

Results, by plan sponsor, are presented below.

STATE of Montana - BCBSMT

Of the 211 claims in our sample, 193 or 91.5% were processed within 7 calendar days, 18 or 8.5% were processed between 8 and 14 calendar days, 1 or 0.5% were processed between 15 and 30 calendar days and 0 or 0.0% were processed after 30 calendar days.

BCBSMT informed us that company policy for turnaround time is 97% claims are to be processed within 30 days.

MUS - ALLEGIANCE

Of the 211 claims in our sample, 103 or 48.8% were processed within 7 calendar days, 65 or 30.8% were processed between 8 and 14 calendar days, 28 or 13.3% were processed between 15 and 30 calendar days and 15 or 7.1% were processed after 30 calendar days.

Allegiance informed us that company policy for turnaround time is 7 day average for non-investigated claims and 21 day average for claims requiring investigation.

VI - COST CONTAINMENT

Discussion regarding cost containment procedures utilized at BCBSMT and Allegiance is presented below.

CASE MANAGEMENT

BCBSMT

A mandatory pre-admission notification provision is part of each plan sponsor's Plan provisions. The notification procedure is used to alert APS Healthcare Northwest, Inc. (the case management firm utilized by the plans) of potentially large claims which could be eligible for individual case management to reduce the magnitude of the claim.

Typically, participants are referred to case management based on diagnosis. However, APS has indicated that they receive these referrals from BCBSMT and in some cases from the hospital.

This procedure is can be initiated by either the individual or the provider of services.

BCBSMT indicated that there were 34 denials in 2006 and 26 denials in 2007 for the State Plan.

It should be noted that the plan document indicates that all DME in excess of \$1,000 should be pre-authorized. However, BCBSMT does not require this process for any of its book of business. Therefore, they have indicated that the State and MUS have agreed to the BCBSMT's policies and procedures regarding DMEs in excess of \$1,000.

Allegiance

A mandatory pre-admission notification provision is part of each plan sponsor's Plan provisions. Allegiance utilizes the services of StarPoint for the preauthorization process. The notification procedure is used to alert StarPoint of potentially large claims which could be eligible for individual case management to reduce the magnitude of the claim.

Typically, participants are referred to case management based on diagnosis. However, StarPoint has indicated that they receive these referrals from Allegiance and in some cases from the hospital.

This procedure can be initiated by either the individual or the provider of services.

Allegiance indicated that there were 6 denials for the 2008-2010 for the MUS Plan.

FACILITY DISCOUNTS

BCBSMT

Each sample facility claim was reviewed for the appropriate facility discount. In addition, we reviewed the congruency (multiple claims for same facility) of application of the facility discount.

We did not identify any errors as it pertains to the application of facility discounts.

We did not identify any claims where the billed amount equaled the allowed amount.

Allegiance

Each sample facility claim was reviewed for the appropriate facility discount. In addition, we reviewed the congruency (multiple claims for same facility) of application of the facility discount.

We did not identify any errors as it pertains to the application of facility discounts.

We did not identify any facility claims where the billed amount equaled the allowed amount.

DISCOUNTS

Blue Card Program - BCBSMT

BCBSMT participates in a program called "Blue Card". This program allows members to receive treatment outside of Montana and still receive discounts through the Blue Cross Blue Shield organization. The claims are submitted to the "host plan" (the Blue Cross Blue Shield organization in the State in which services were rendered). The claim processes through the ITS system and is relayed to the BCBSMT system for payment.

During our audit of claims, we reviewed several claims in which services were rendered outside the State of Montana and claims were processed through the Blue Card (ITS) system.

We did not identify any issues with a claim processed through this system.

Cascading Network Arrangements - Allegiance

The MUS plan participates in a cascading network arrangement offered through Allegiance. This arrangement allows for services that may not be discounted through the Allegiance PPO network to be discounted through another network (MultiPlan, Beechstreet, etc.).

During our audit of claims, we identified several claims in which the cascading network arrangement applied. We did not identify any issue with these claims. Therefore, we conclude that the cascading network arrangement is being applied appropriately.

ACCESS FEES

BCBSMT

During our review of Blue Card claims, we reviewed the application of the access fees that were charged to the State Plan for the use of the Blue Card system.

The fees that were charged to the Plan were in accordance to the contract between BCBSMT and the State of Montana.

Allegiance

During our review of the claims processed, we noted that the only access fees that were applied and charged to the MUS plan were those from MultiPlan. MultiPlan is service that charges based on a percentage of savings. MultiPlan is utilized for non-network claims.

We believe that is in agreement with the contract between Allegiance and MUS.

AGENT COMMISSIONS

We discussed the issue of agent commissions with both BCBSMT and Allegiance. Both vendors indicated that no agent commissions were being charged to either Plan.

We believe that is in agreement with the contract between the State, MUS and both vendors.

HIGH DOLLAR CLAIM REVIEW

BCBSMT

We reviewed the high dollar claim review process with BCBSMT. They indicated that all claims above \$50,000 are subjected to audit by a senior manager. In addition, all line items in excess of \$5,000 are subjected to audit by a senior manager.

We did not identify any issues regarding high dollar claims. Therefore, we believe the process is working appropriately.

Allegiance

We reviewed the high dollar claim review process with Allegiance. They indicated that all claims processed with payment amounts between \$10,000 and \$25,000 are subjected to audit by an intermediate claims examiner. Claims that are processed with payment amounts between \$25,000 and \$100,000 are subjected to audit by the claims manager. Claims that are processed with payment exceeding \$100,000 are subjected to audit by the director of claims.

We did not identify any issues regarding high dollar claims. Therefore, we believe the process is working appropriately.

VII - OTHER REVIEW AREAS

The results of our review in areas requested by the two plan sponsors is as follows.

HIPAA POLICIES

BCBSMT

We reviewed the BCBSMT HIPAA policy (10 parts).

We believe the policy is extensive and thorough. Further, we believe that BCBSMT has taken the appropriate measures to ensure that the policies are applied and followed by the personnel at BCBSMT.

Allegiance

We reviewed the Allegiance HIPAA policy.

We believe the policy is extensive and thorough. Further, we believe that Allegiance has taken the appropriate measures to ensure that the policies are applied and followed by the personnel at Allegiance.

PERFORMANCE GUARANTEE RESULTS

BCBSMT

Category	Measure	Target	Definition	Audit Finding	Vendor Result
CLAIM QUALITY					
Financial Payment	Accuracy of paid benefit \$	98.0%	Calculated as the total audited "paid" dollars minus the absolute value of over and under payments, divided by total audited paid dollars.	100.0%	99.56% in 2008 99.46% in 2009 99.50% in 2010
Payment Incidence Accuracy	Incidence of claims processed without payment error	97.0%	Calculated as the total number of audited claims (pays and no pays) minus the number of claims processed with payment error, divided by the total number of audited claims	100.0%	97.10% in 2008 98.3% in 2009 98.1% in 2010

Category	Measure	Target	Definition	Audit Finding	Vendor Result
CLAIM TIMELINESS					
Turnaround Time in 14 Calendar Days	Timeliness of claims processing	95%	Plan will pay 95% of clean claims within 30 calendar days and 95% of all claims (paid or denied within 60 Calendar Days.	100%	96.0% in 2008 97.5% in 2009 & 95.6% in 2010 (within 14 days)
CUSTOMER SERVICE					
Telephone Response Time	Timeliness of customer service call answer	90% answered in 60 seconds or less	The amount of time that elapses between the time a call is received into a customer service queue to the time the phone is answered by a CSR.	N/A	88.48% in 2008 67.1% in 2009 86.0% in 2010
Call Abandonment Rate	The percentage of calls that are abandoned before answer	5% or less	Percentage of calls that reach the vendor and are placed in member service queue, but are not answered because caller hangs up before CSR is available.	N/A	.88% in 2008 3.5% in 2009 1.8% in 2010

Category	Measure	Target	Definition	Audit Finding	Vendor Result
First Call Resolution	Percentage of calls that are handled to conclusion on first call	80%	A call that is resolved during or after the call is received, and does not result in a follow-up call from the member regarding the same issue within 30 calendar days.	N/A	92.4% in 2008 81.5% in 2009 84.1% in 2010
Call Quality	Average percentage of customer service quality points earned per monitored call	90%	Call quality is measured by monitoring a random sample of calls answered by the Member Services Call Center. The sample is reviewed to determine the percentage of customer service quality points earned.	N/A	91.84% in 2008 97.3% in 2009 N/A in 2010
ADMIN.					
ID Cards	Percentage of ID cards sent with correct info. within 5 business days of receipt of eligibility file	99%	Requires the plan to send at least 99% of ID cards with correct information within 5 business days of receipt of clean eligibility data.	N/A	N/A in 2008 99.4% in 2009 100% in 2010

Allegiance

Category	Measure	Target	Definition	Audit Finding	Vendor Result
CLAIM QUALITY					
Financial Payment	Accuracy of paid benefit \$	99.0%	Calculated as the total audited "paid" dollars minus the absolute value of over and under payments, divided by total audited paid dollars.	99.85%	99.8% in 2008-2009 99.9% in 2009-2010
Payment Incidence Accuracy	Incidence of claims processed without payment error	97.0%	Calculated as the total number of audited claims (pays and no pays) minus the number of claims processed with payment error, divided by the total number of audited claims	98.58%	99.8% in 2008-2009 99.7% in 2009-2010
CLAIM TIMELINESS					
Turnaround Time in 30 Calendar Days	Timeliness of claims processing	95%	Plan will pay 95% of clean claims within 30 calendar days and 95% of all claims (paid or denied within 60 Calendar Days.	92.9%	98.8% in 2008-2009 98.9% in 2009-2010

Category	Measure	Target	Definition	Audit Finding	Vendor Result
CUSTOMER SERVICE					
Telephone Response Time	Timeliness of customer service call answer	90% answered in 30 seconds or less	The amount of time that elapses between the time a call is received into a customer service queue to the time the phone is answered by a CSR.	N/A	90.9% in 2008-2009 96.0% in 2009-2010
Call Abandonment Rate	The percentage of calls that are abandoned before answer	3% or less	Percentage of calls that reach the vendor and are placed in member service queue, but are not answered because caller hangs up before CSR is available.	N/A	2.2% in 2008-2009 .8% in 2009-2010
First Call Resolution	Percentage of calls that are handled to conclusion on first call	85%	A call that is resolved during or after the call is received, and does not result in a follow-up call from the member regarding the same issue within 30 calendar days.	N/A	91.5% in 2008-2009 93.6% in 2009-2010
Call Quality	Average percentage of customer service quality points earned per monitored call	85%	Call quality is measured by monitoring a random sample of calls answered by the Member Services Call Center. The sample is reviewed to determine the percentage of customer service quality points earned.	N/A	98.2% in 2008-2009 99.92% in 2009-2010

Category	Measure	Target	Definition	Audit Finding	Vendor Result
ADMIN.					
ID Cards	Percentage of ID cards sent with correct info. within 5 business days of receipt of eligibility file	99%	Requires the plan to send at least 99% of ID cards with correct information within 5 business days of receipt of clean eligibility data.	N/A	100% in 2008-2009 100% in 2009-2010

VIII - DELTA DENTAL REVIEW

The results of our audit of claims processed at Delta Dental Plan are presented in this section.

SAMPLE SIZE AND METHODOLOGY

MUS contracted with Delta Dental Plan (DDP) beginning July 1, 2007 for the administration of dental claims. We chose a random sample of 100 claims for the period July 1, 2008 through June 30, 2010.

AUDIT PROCEDURE

Information presented below describes our test work on the 100 previously processed claims (medical and dental) in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on DDP's records to the coverage indicated on the plan's records.
- Verification that members are employees/retirees of the plan and covered under the plan at the time the claim was incurred.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).
- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.
- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.

- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.
- Review provider contracts and claim system, in order to verify that balance billing is not allowed for network provider services.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 100 MUS dental claims in our, none were judged to contain a payment error. This represents an accuracy rate of 100%.

However, we did identify 3 CDT codes for which the DDP allowable and MUS allowable were different. The 3 codes were D2391, D2392 and D2393. DDP indicated that the allowables in their system were the agreed upon amounts.

We recommend that MUS and DDP discuss this issue, in order to address any differences between the MUS schedule of benefits (including the allowance table) and DDP's allowance amounts in their system.

DDP PERFORMANCE GUARANTEE

Category	Measure	Target	Definition	Audit Finding	Vendor Result
CLAIM QUALITY					

Category	Measure	Target	Definition	Audit Finding	Vendor Result
Financial Payment	Accuracy of paid benefit \$	>99.0%	Calculated as the total audited "paid" dollars minus the absolute value of over and under payments, divided by total audited paid dollars.	100%	99.3% in 2008 99.37% in 2009 99% in 2010
Payment Incidence Accuracy	Incidence of claims processed without payment error	>98.0%	Calculated as the total number of audited claims (pays and no pays) minus the number of claims processed with payment error, divided by the total number of audited claims	100%	99.3% in 2008 99.52% in 2009 99% in 2010
Claims Processing Accuracy	Incidence of claims processed without any error	>97%	Calculated as the total number of audited claims minus the number of claims processed with error, divided by the total number of audited claims	100%	99.5% in 2008 99.37% in 2009 99% in 2010
CLAIM TIMELINESS					

Category	Measure	Target	Definition	Audit Finding	Vendor Result
Turnaround Time in 14 Calendar Days	Timeliness of claims processing	90%	TAT is measured from the date a claim is received by DDP to the date it is processed for payment, denial, or pending for other information.	94%	94.18% in 2008 94.90% in 2009 93% in 2010
CUSTOMER SERVICE					
Telephone Response Time	Timeliness of customer service call answer	90% answered in 30 seconds or less	The amount of time that elapses between the time a call is received into a customer service queue to the time the phone is answered by a CSR.	N/A	93.7% in 2008 90% in 2009 64% in 2010
Call Abandonment Rate	The percentage of calls that are abandoned before answer	3% or less	Percentage of calls that reach the vendor and are placed in member service queue, but are not answered because caller hangs up before CSR is available.	N/A	0.20% in 2008 0.69% in 2009 13% in 2010

Category	Measure	Target	Definition	Audit Finding	Vendor Result
First Call Resolution	Percentage of calls that are handled to conclusion on first call	90%	A call that is resolved during or after the call is received, and does not result in a follow-up call from the member regarding the same issue within 30 calendar days.	N/A	99% in 2008 99% in 2009 98% in 2010
Grievance Reporting	Tracking, monitoring of grievance activity; resolution; provision of summary reports	Non-complex be resolved within 2 working days. Complex grievance involving clinical care issues will be resolved within 30 working days.	Grievances will be tracked by type of grievance and MUS will receive quarterly reports summarizing grievance activity by type of grievance. Information regarding type of grievance will also be included.	N/A	Vendor only indicates that is was met for the 3 year period
Reporting	On-time delivery of quarterly and annual reports	100%	Quarterly reports will be delivered by no later than 30 days following the close of the quarter; annual reports will be delivered by no later than 45 days following the close of the plan year.	100% 100%	Vendor only indicates that is was met for the 3 year period

IX - PRIOR AUDIT RECOMMENDATIONS

The most recently completed audit for the State of Montana and Montana University System, was performed for the period January 1, 2006 through December 31, 2007.

The report for that audit, issued in December, 2008, contained the following recommendations:

BCBSMT

- We identified 2 claims that the coinsurance and/or deductible was not correctly applied. BCBSMT has indicated that this is a system issue and is currently being reviewed.

We recommend BCBSMT perform an analysis, in order to understand the extent of this issue in the system and the amount of overpayments it has produced.

BCBSMT response: This has been completed and discussed with the State.

- We identified 2 claims that had adjustments made to them after the original processing of the claim. The adjustments were warranted and were for late charges and correction of pricing. Upon the performance of the adjustments, the processor failed to apply the coinsurance provisions to the claims.

We recommend that BCBSMT perform enhanced training in this area and conduct an analysis of all adjustments, in order to determine if other overpayments exist.

BCBSMT response: This has been completed and discussed with the State.

- We identified an issue unique to the Blue Card program. If the allowance of a charge submitted through the Blue Card program is greater than the billed amount, BCBSMT will pay 100% of the charge, instead of applying deductible and/or coinsurance.

We recommend BCBSMT discontinue this practice and conduct an analysis, in order to identify overpayments caused by this procedure.

BCBSMT response: This has been completed and discussed with the State.

Allegiance

- We identified 2 errors involving the misapplication of the emergency room copay. This issue was identified in the last audit that was performed at Allegiance for MUS.

We believe Allegiance should perform enhanced training for the processors responsible for the administration of the MUS traditional plan.

Due to the fact that we found these same type of errors this audit period, too. We believe Allegiance has not made the appropriate changes to the system.

EXHIBIT A

**STATE OF MONTANA
TRADITIONAL PLAN CLAIM AUDIT - BCBSMT
SUMMARY OF FINDINGS
AUDIT PERIOD JANUARY 1, 2008 THROUGH DECEMBER 31, 2010**

CLAIM #	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
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No errors identified

EXHIBIT B

**MONTANA UNIVERSITY SYSTEM
TRADITIONAL PLAN CLAIM AUDIT - ALLEGIANCE
SUMMARY OF FINDINGS
AUDIT PERIOD JULY 1, 2008 THROUGH JUNE 30, 2010**

CLAIM #	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
200903233073	1,884.58	1,899.23	(14.65)	Should have applied \$75 copay for ER and paid ER charge at 100%
200812010946	2,060.34	-	2,060.34	Data entry. Incorrect date was entered, which caused the duplicate payment. Claim was adjusted prior to audit
200812108517	892.95	985.39	(92.44)	Should have applied \$75 copay for ER and paid ER charge at 100%
Totals	<u>3,944.92</u>	<u>1,899.23</u>	<u>2,045.69</u>	



560 N. Park Avenue
PO Box 4309
Helena, Montana 59604
Customer Information Line: 800.447.7828

www.bcbsmt.com

March 9, 2012

MARIE POLLOCK
WOLCOTT & ASSOCIATES, INC
12120 STATE LINE ROAD, Suite 297
LEAWOOD KS 66209

RE: State of Montana Traditional Claim Audit

Dear Marie:

This letter is in acknowledgement of the draft report for the State of Montana Traditional claim audit recently completed for the audit period January 1, 2008 through December 31, 2010.

This letter includes Blue Cross Blue Shield of Montana's (BCBSMT) responses to the Prior Audit Recommendations.

IX – PRIOR AUDIT RECOMMENDATIONS

We identified 2 claims that the coinsurance and/or deductible was not correctly applied. BCBSMT has indicated that this is a system issue and is currently being reviewed.

We recommend BCBSMT perform an analysis, in order to understand the extent of this issue in the system and the amount of overpayments it has produced.

BCBSMT Response: The system coding was corrected and this issue has not occurred since. A report was run to identify all claims affected by this issue. All claims identified were adjusted in March of 2007.

We identified 2 claims that had adjustments made to them after the original processing of the claim. The adjustments were warranted and were for late charges and correction of pricing. Upon the performance of the adjustments, the processor failed to apply the coinsurance provisions to the claims.

We recommend that BCBSMT perform enhanced training in this area and conduct an analysis of all adjustments, in order to determine if other overpayments exist.

BCBSMT Response: As issues are identified, BCBSMT updates desk level procedures and training. Employees are educated on any updated processes and procedures. BCBSMT has not identified additional occurrences of this issue.

We identified an issue unique to the Blue Card program. If the allowance of a charge submitted through the Blue Card program is greater than the billed amount, BCBSMT will pay 100% of the charge, instead of applying deductible and/or coinsurance.

We recommend BCBSMT discontinue this practice and conduct an analysis, in order to identify overpayments caused by this procedure. BCBSMT has not identified additional occurrences of this issue.

BCBSMT response: This system issue has been resolved. BCBSMT has not identified additional occurrences of this issue.

Thank you for the opportunity to comment on this audit report. If you have any questions or comments, please contact me at (406) 437-5211.

Sincerely,



**Arlene Troy
Internal Audit
Blue Cross and Blue Shield of Montana**

**FORMAL RESPONSE OF ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC.
TO
WOLCOTT & ASSOCIATES AUDIT
OF
THE MONTANA UNIVERSITY SYSTEM TRADITIONAL PLAN
AND
THE STATE OF MONTANA and THE MONTANA UNIVERSITY SYSTEM MANAGED CARE PLANS**

Allegiance Benefit Plan Management submits this formal response to the above referenced audit.

Because these audits are for three distinctly separate and individual plans, Allegiance addresses the audit results for each plan separately. The audit results for these plans should not and cannot be combined for any purpose because they are separate and distinct plans. Allegiance will address each plan separately below.

Montana University System Traditional Plan

The auditors identified three (3) claims errors as stated on page III-3.

The first of those errors is indicated as a \$2,060.34 duplicate overpayment. Allegiance objects to this claim being classified as an error. The claim was in fact a duplicate payment of a previous claim. However, that claim was a claim incurred in 2008 and which was discovered by Allegiance through its own internal audit process, corrected, and refunds received in January and February of 2009, long before Allegiance had received any claims request regarding this audit. The correction and adjustment of the claim was through Allegiance's own efforts, far before this claim was identified as a potential claim for the Wolcott audit. It is not an error.

The remaining two (2) claims that were assigned error are alleged underpayments of emergency copayments in the aggregate amount of \$107.09.

Although Allegiance does agree that two small underpayment errors were found, the auditor also states that the same errors were identified in the prior audit performed at Allegiance. Allegiance disagrees with that statement. We do agree that an error was found regarding emergency room payments in the prior audit, but this was not the same error as the error found in the prior audit. The error from the prior audit was in fact addressed and fixed immediately after the audit.

State of Montana Managed Care Plan

In the State of Montana Managed Care claim audit, the auditor identified nine (9) claim errors with regard to the State of Montana Managed Care Plan as differentiated from the Montana University System Managed Care Plan which is a separate plan.

Of those four (4) were errors associated with emergency room payment, and one (1) was an alleged error regarding coordination with Medicare. Allegiance does not agree with the assignment of error for these claims.

With regard to the coordination with Medicare claim which indicates an overpayment of \$21.13, this coordination of benefits issue was identified by Allegiance through its internal audit processes prior to any selection of this claim by the auditor, or any identification by the auditor of this claim as being an issue.

The correction of the error was made long before the audit process was started. The correction occurred on August 29, 2010.

In addition, there are four (4) claims listed as errors regarding the payment of the emergency room visit. Those errors indicate overpayment in the amount of \$144.94, \$268.34, \$172.08 and \$209.62, respectively. The auditor alleges that only the emergency room facility charge should be paid at 100% and that all other charges should be subject to deductible and co-insurance requirements of the Plan. The claims in question were paid based upon the written direction from Mike Young, a principal in PEAK Health Care that assists the State in operating this particular managed care plan, and from direction from Connie Welsh, the Plan Administrator, regarding how this benefit should pay. The benefit paid as directed and as confirmed by Mr. Young from PEAK and by Connie Welsh as the Plan Administrator of the Plan. There was no error. A copy of that written direction is attached.

Montana University System Managed Care Plan

The auditor identified nine (9) claims for which error was assigned under the audit of the Montana University System Managed Care Plan.

For one of those, the auditor claims an error based on an overpayment on an out-of-network benefit level. However, the error was in fact detected by Allegiance's internal audit system long before this claim was identified for this audit and was corrected at that time. The correction of the claim occurred through Allegiance's own efforts and without any notice from the auditor or selection by the auditor of this claim.

In addition, the auditor has identified three (3) "urgent care" claims for which the auditor claims a \$10.00 overpayment occurred on each claim. The auditor assigns error stating that the \$25.00 urgent care copayment should have been assigned to these claims rather than the \$15.00 office visit copayment. The auditor assigns this error based on the place of service being an urgent care facility. However, the benefit contained in the Plan Document does not identify this by facility, but rather identifies urgent care by the type of care received which is defined as "acute illness or injury that requires immediate treatment". The claims in question were not such claims, but were in fact office visits for non-urgent purposes. Therefore, Allegiance applied the copayment for an office visit based upon the type of service provided rather than the urgent care \$25.00 copay, because the service provided as not an urgent care service.

**STATE OF MONTANA,
MONTANA UNIVERSITY SYSTEM**

**ANALYSIS AND EVALUATION OF MANAGED CARE PLAN
CLAIMS PROCESSING
FOR THE PERIOD
JANUARY 1, 2008 THROUGH DECEMBER 31, 2010 (STATE)
JULY 1, 2008 THROUGH JUNE 30, 2010 (MUS)**

ADMINISTERED BY

**NEW WEST HEALTH PLAN
BLUE CROSS BLUE SHIELD OF MONTANA
PEAK HEALTH PLAN/ALLEGIANCE MANAGED CARE**

FINAL REPORT

AUGUST, 2012

PRESENTED BY

**WOLCOTT & ASSOCIATES, INC.
12120 STATE LINE ROAD, SUITE 297
LEAWOOD, KANSAS 66209**

**STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
MANAGED CARE PLAN CLAIMS AUDIT
OF NEW WEST HEALTH PLAN, BLUE CROSS BLUE SHIELD OF MONTANA &
PEAK/ALLEGIANCE MANAGED CARE HEALTH PLAN
JANUARY 1, 2008 - DECEMBER 31, 2010 (STATE)
JULY 1, 2008 - JUNE 30, 2010 (MUS)**

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I - INTRODUCTION

The State of Montana (State) provides self-funded Managed Care Plan as part of an overall employee benefit and compensation program. The plan covers approximately 3,000 employees and retirees, plus their dependents.

The State has negotiated a contract with New West Health Plan (NWHP), Blue Cross Blue Shield of Montana (BCBSMT) and Peak Health Plan/Allegiance Managed Care (PHP/AMC) to provide administration services to its plans.

The Montana University System (MUS) is a member of the Montana Association of Health Care Purchasers, and has also contracted to have their medical benefits administered by BCBSMT, PHP/AMC and NWHP. The plan covers approximately 1,000 employees and retirees, plus their dependents.

The State invited MUS to participate in an audit of NWHP, BCBSMT and PHP/AMC's processing of medical care claims.

PURPOSE OF SERVICE

Section 2.18.816, MCA requires the State Employee Benefits Plan to be audited every two years by or at the direction of the Legislative Audit Division. Wolcott & Associates, Inc. was awarded the audit contract for the 2002-2003 Plan Years. Subsequently, our contract was renewed for the 2004-2005, 2006-2007 and 2008-2010 Plan Years.

The purpose of the service is to comply with Section 2.18.816, MCA.

The State and MUS recognize that they have a fiduciary responsibility to administer this plan (and other employee benefit plans) for the benefit of plan participants and their dependents and in accordance with the plan provisions. Both plan sponsors believe it is prudent to perform periodic audit and review services to determine if the benefit plans they sponsor are meeting these objectives.

AUDIT TIMING AND STAFF

The Legislative Audit Division advised Wolcott & Associates, Inc. that the contract would be renewed June 30, 2011. All preliminary work was completed and on-site services were performed in September, October and November, 2011.

On-site audit services were performed at:

New West Health Plan
130 Neill Avenue

Helena, Montana 59601

Blue Cross & Blue Shield of Montana
560 North Park Avenue
Helena, Montana 59601

Peak Health Plan/Allegiance Managed Care
2806 South Garfield Street
Missoula, Montana 59806

Wolcott & Associates, Inc. staff involved in the audit are listed below:

<u>Name</u>	<u>Title</u>	<u>On-site</u>
Brian Wyman	Vice President	Yes
Marie Pollock	President, Project Director	Yes
Richard Reese	Actuary	No
Jenny Hill	Statistician	No

SCOPE OF AUDIT

The scope of audit services covered medical care benefit claims paid by NWHP, BCBSMT and PHP/AMC during the period from January 1, 2008 through December 31, 2010 for The State and July 1, 2008 through June 30, 2010 for MUS. Test work was performed on 1,266 previously processed claims (211 claims per plan per administrator), all of which were selected on a stratified, random (statistical) basis.

Claims Adjudication Audit

Elements of claims adjudication which were evaluated include:

- Turnaround time required to process each claim.
- Eligibility of claimants to receive payment.
- Administration of coordination of benefits, including Medicare.
- Administration of subrogation provisions.
- Calculation accuracy, including Usual, Customary and Reasonable (UCR) limits and computation of deductible and co-payment limits.
- Completeness of necessary information.

- **Payee accuracy, including benefit assignments to service providers.**
- **Consistency of payments to member physicians and other physicians.**
- **Compliance with benefit plan structure.**
- **Identification of duplicate claim submissions.**

II - STATISTICAL CLAIM AUDIT RESULTS - NEW WEST HEALTH PLAN

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 422 claims (211 per plan).

The claims were selected from the population of claims paid by NWHP between January 1, 2008 and December 31, 2010 for The State Plan. The claims were selected from the population of claims paid by NWHP between July 1, 2008 and June 30, 2010 for The MUS Plan. Prior to selection, the population of claims was stratified.

AUDIT PROCEDURE

Information presented below describes our test work on the 422 previously processed claims in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on NWHP's records to the coverage indicated on the plan's records.
- Verification that members are employees/retirees of the plan and covered under the plan at the time the claim was incurred.
- Review to determine that NWHP is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).
- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.

- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.
- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 422 claims in our statistical sample, 9 were judged to contain a payment error. This represents a frequency of payment error of 2.1%. This is less favorable than the 1.3% error reported in the prior audit.

Our sample contained a total payment of \$2,335,356.85 for the 422 claims. The overpayment totaled \$27,294.95 or 1.17% of the total. The underpayment totaled \$2,461.92 or 0.10% of the total. This financial error rate is less favorable than the .5 to 1 percent error rate normally observed during our audits of similar plans. It is also less favorable than the NWHP standard of 1%. In addition, it is less favorable than the 0.014% error rate reported in the prior audit.

The frequency of payment error in our sample is more favorable than the range of three to five percent error rate normally observed during our audits of similar plans. In addition, it is more favorable than the NWHP standard of 3%.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 1.3%, that the true frequency of error in the population is within the range of 0.8% to 3.4%.

Based on this extension, we believe that the true magnitude of payment error in the population is \$438,043 or (0.61% of payments in the population). The magnitude of payment error

is the sum of \$304,690 in projected overpayments plus \$133,353 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit A**. A discussion of error types is presented below.

A summary of error by type is presented below:

**NWHP HEALTH CARE CLAIMS
JANUARY 1, 2008 THROUGH DECEMBER 31, 2010 (State)
JULY 1, 2008 THROUGH JUNE 30, 2010 (MUS)
SUMMARY OF ERRORS BY TYPE**

<u>ERROR TYPE</u>	<u>NUMBER</u>	<u>NET PAYMENT ERROR</u>
COB	3	\$26,465.22
Incorrect application of copay provision	1	15.00
Incorrect application of routine newborn benefit	1	(151.65)
Incorrect application of coinsurance/deductible provisions.	<u>4</u>	<u>1,495.54net</u>
Total	<u>9</u>	<u>\$22,824.11</u>

NWHP has included their response as **Exhibit D**.

RECOMMENDATIONS

Our recommendations are as follows:

- We identified one claim where the participant was a retiree with both Medicare A and B. Services were rendered in a VA facility. Medicare benefits should have been assumed due to the fact that Medicare and VA facilities cannot coordinate with each other. The member is held harmless and the VA facility is supposed to submit a Medicare remittance advice, which would indicate what Medicare would pay if they could coordinate. This

is standard practice in the industry.

NWHP responded that they did not assume benefits because the plan document does not include that type of clause. The plan document does not need to include an assumption clause in the case of a VA facility and Medicare. This participant did have Medicare.

We recommend NWHP review their procedures for this type of situation and make the appropriate modifications, in order to process the claims accordingly. Furthermore, we recommend NWHP identify all claims that are affected by this incorrect procedure and reimburse The State and MUS for all overpayments.

- We identified issues with the system configuration for The State Plan. This affected coinsurance and deductible accumulators. NWHP had identified this issue in 2008 and has made the appropriate changes to correct the situation.

III - STATISTICAL CLAIM AUDIT RESULTS - BCBSMT

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 422 claims (211 per plan).

The claims were selected from the population of claims paid by BCBSMT between January 1, 2008 and December 31, 2010 for The State Plan. The claims were selected from the population of claims paid by BCBSMT between July 1, 2008 and June 30, 2010 for The MUS Plan. Prior to selection, the population of claims was stratified.

AUDIT PROCEDURE

Information presented below describes our test work on the 422 previously processed claims in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on BCBSMT's records to the coverage indicated on the plan's records.
- Verification that members are eligible participants of the plan and covered under the plan at the time the claim was incurred.
- Review to determine that BCBSMT is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).

- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.
- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.
- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 422 claims in our statistical sample, 6 were judged to contain a payment error. This represents a frequency of payment error of 1.42%. The results were more favorable than the 6.67% reported in the prior audit report.

Our sample contained a total payment of \$2,238,633.95 for the 422 claims. The overpayments totaled \$543.36 or 0.02% of the total. The underpayments totaled \$1,663.30 or 0.07% of the total. This error rate is more favorable than the .5 to 1 percent error rate normally observed during our audits of similar plans. It is also more favorable than the BCBSMT standard of 1%. In addition, the results are more favorable than the 0.18% reported in the prior audit report.

The frequency of payment error in our sample is more favorable than the three to five percent error rate normally observed during our audits of similar plans. It is also more favorable than the BCBSMT standard of 3%.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 1.5%, that the true frequency of error in the population does not exceed 2.92%.

Based on this extension, we believe that the true magnitude of payment error in the population is \$85,668 or (0.19% of payments in the population). The magnitude of payment error is the sum of \$72,797 in projected overpayments plus \$12,871 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit B**. A discussion of error types is presented below.

A summary of error by type is presented below:

BCBSMT HEALTH CARE CLAIMS
 JANUARY 1, 2008 THROUGH DECEMBER 31, 2010 (State)
 JULY 1, 2008 THROUGH JUNE 30, 2010 (MUS)
 SUMMARY OF ERRORS BY TYPE

<u>ERROR TYPE</u>	<u>NUMBER</u>	<u>NET PAYMENT ERROR</u>
Incorrect application of injection benefit without an office visit.	2	\$ 57.21
Incorrect application of deductible.	1	400.00
Incorrect payment services for gender related issue.	1	0.00*
Incorrect denial for pre-certified inpatient stay	1	(1,663.30)
COB	<u>1</u>	<u>86.15</u>
Total	<u>6</u>	<u>(\$1,119.94)</u>

*Charges were applied to the deductible.

BCBSMT has included their response as Exhibit E.

RECOMMENDATIONS

Our recommendations are as follows:

- We identified 2 errors caused by a system issue. BCBSMT has indicated that these issues were identified prior to our audit.

The two errors involved injection related services. These claims are being paid at 100%. They should be subject to the coinsurance provisions with a maximum of \$10.

We recommend that BCBSMT review all the above mentioned system issue and determine, through analysis, the magnitude of overpayments/underpayments that exist. Further, we recommend that BCBSMT make the corrections to the system, in order to prevent these types of errors from occurring in the future.

- We identified an error regarding services rendered that were inconsistent with the gender of the patient.

We recommend that BCBSMT review this issue and make adjustments to the system, in order for this type of claim to be identified prior to processing for payment.

DISCUSSION

We identified 3 claims that warrant further discussion.

- We identified 2 claims for chemotherapy related services. We inquired whether or not they were reviewed for possible experimental therapy. BCBSMT indicated to us that they do not review these types of claims for experimental related services.

We recommend that BCBSMT formulate a process, in order to review claims for the possibility of services related to experimental therapy. This would be consistent with other major administrators for which we have performed audits.

- We identified a claim that, when reviewing history, we noticed that the accumulators had exceeded the annual limits. BCBSMT indicated that the sample claim, which paid first, was correct. However, subsequent claims had applied coinsurance in excess of the annual limit.

We recommend BCBSMT review this issue and determine whether this was an isolated issue or a system issue.

IV - STATISTICAL CLAIM AUDIT RESULTS - PEAK/ALLEGIANCE MC

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 422 claims (211 claims per Plan).

The claims were selected from the population of claims paid by PHP/AMC between January 1, 2008 and December 31, 2010 for The State. The claims were selected from the population of claims paid by PHP/AMC between July 1, 2008 and June 30, 2010 for MUS. Prior to selection, the population of claims was stratified.

AUDIT PROCEDURE

Information presented below describes our test work on the 422 previously processed claims in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on PHP/AMC's records to the coverage indicated on the plan's records.
- Verification that members are eligible participants of the plan and covered under the plan at the time the claim was incurred.
- Review to determine that PHP/AMC is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).

- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.
- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.
- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 422 claims in our statistical sample, 18 were judged to contain a payment error. This represents a frequency of payment error of 4.27%. The results are less favorable than the 0.0% reported in the prior audit report.

Our sample contained a total payment of \$1,651,630.60 for the 422 claims. The overpayments totaled \$3,865.66 or 0.23% of the total. The underpayments totaled \$943.64 or 0.06% of the total. This error rate is more favorable than the .5 to 1 percent error rate normally observed during our audits of similar plans. It is also more favorable than the PHP/AMC standard of 1%. However, the results are less favorable than the 0.00% reported in the prior audit report.

The frequency of payment error in our sample is within the range of the three to five percent error rate normally observed during our audits of similar plans. However, it is less favorable than the PHP/AMC standard of 3%.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 2.5%, that the true frequency of error in the population is within the range of 1.77% to 6.77%.

Based on this extension, we believe that the true magnitude of payment error in the population is \$222,458 or (1.12% of payments in the population). The magnitude of payment error is the sum of \$135,157 in projected overpayments plus \$87,301 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit C**. A discussion of error types is presented below.

A summary of error by type is presented below:

**PHP/AMC HEALTH CARE CLAIMS
JANUARY 1, 2008 THROUGH DECEMBER 31, 2010 (STATE)
JULY 1, 2008 THROUGH JUNE 30, 2010 (MUS)
SUMMARY OF ERRORS BY TYPE**

<u>ERROR TYPE</u>	<u>NUMBER</u>	<u>NET PAYMENT ERROR</u>
Incorrect application of orthotic benefit	1	\$(82.75)
Incorrect application of out-of-network benefits	1	(601.40)
Incorrect application of mammogram benefit	1	(19.29)
Incorrect application of injection benefit	1	8.50
Incorrect application of routine services copay	1	15.00
Incorrect application of routine newborn services	1	(240.20)
COB	2	2,519.75

Incorrect application of lab services benefit	1	0.65
Incorrect application of maternity benefit	1	496.78
ER issue	5	794.98
Urgent care copay issue	<u>3</u>	<u>30.00</u>
Total	<u>18</u>	<u>\$2,922.02</u>

PHP/AMC has included their response as **Exhibit F**.

RECOMMENDATIONS

Our recommendations are listed below.

- We identified 5 claims where the ER benefit was not being calculated correctly. PHP/AMC is applying the copay, but paying the remaining charges at 100% even when the participant has not met their out-of-pocket maximum.

This situation has been discussed with The State and MUS and they are in agreement that the copay provision is only applicable to the ER (revenue code 450) charge. The remaining services should be subject to the deductible and coinsurance.

We recommend that PHP/AMC make the appropriate changes to their system, in order to process the claims in accordance with the plan document. Furthermore, we believe PHP/AMC should identify the magnitude of overpayment this issue has caused for MUS and The State and reimburse those funds to the appropriate group.

- We identified 3 MUS claims where the participant had received services in an urgent care setting (place of service 20). However, PHP/AMC has only applied the office visit copay. The plan document clearly states that services rendered in an urgent care setting are subject to a higher copay rate.

This situation has been discussed with MUS and they are in agreement that the copay provision for services rendered in an urgent care setting should be applied.

We recommend that PHP/AMC make the appropriate changes to their system, in order to process the claims in accordance with the plan document. Furthermore, we believe

PHP/AMC should identify the magnitude of overpayment this issue has caused for MUS and reimburse those funds to the appropriate group.

DISCUSSION ITEM

We identified a claim that warrants further discussion.

- We identified 1 claim for services rendered due to an accidental laceration during a surgical procedure. We inquired whether or not this had been investigated for possible subrogation (medical malpractice) against the hospital/provider. PHP had indicated that this was not investigated and/or the investigation was incomplete.

We recommend that PHP improve their subrogation review procedures, in order to thoroughly review possible third party liability claims. This would be consistent with other major administrators for which we have performed audits.

V - ELIGIBILITY

The plan sponsors use various methods to report new entrants, changes and termination of coverage to BCBSMT, NWHP and PHP/AMC. This section describes the methods employed and presents the results of the verification of eligibility for the 1,266 (211 claims per group per administrator) in our sample where a payment was made by each administrator.

STATE OF MONTANA

The State prepares and sends to the vendors a biweekly eligibility tape showing each individual to be covered for the coming month. The administrators run this tape and compares it to the data for the prior month.

Eligibility Verification

Each of the State participants in our sample was researched on the State eligibility system to verify that the State's records indicated that coverage was in force on the date the services were rendered.

No exceptions were noted.

MONTANA UNIVERSITY SYSTEM

The administrator's receive the enrollment data from each campus on a daily basis. NWHP, BCBSMT and PHP/AMC then follow the same process as the State.

Eligibility Verification

Each of the MUS participants in our sample was researched at the applicable campus to verify that the administrator's records indicated that coverage was in force on the date the services were rendered. MUS records confirmed that all participants in the sample were covered as of the date the services were rendered.

No exceptions were noted.

VI - CLAIM PAYMENT TURNAROUND TIME

The purpose of this section is to present our analysis of the claim turnaround time information for each of the 1,266 claims in our sample.

Claim Processing Time

Claim processing time or turnaround time for this audit was measured from the "received date" as entered on the claim document to the date the claim was processed.

Results, by plan sponsor, are presented below.

NWHP

Of the 422 claims in our sample, 379 or 63% were processed within 7 calendar days, 159 or 27% were processed between 8 and 14 calendar days, 55 or 9% were processed between 15 and 30 calendar days and 7 or 1% were processed after 30 calendar days.

NWHP informed us that company policy for turnaround time is 14 days.

BCBSMT

Of the 422 claims in our sample, 361 or 85.6% were processed within 7 calendar days, 37 or 8.9% were processed between 8 and 14 calendar days, 20 or 4.8% were processed between 15 and 30 calendar days and 3 or 0.7% were processed after 30 calendar days.

BCBSMT informed us that company policy for turnaround time is 97% claims are to be processed within 30 days.

PHP/AMC

Of the 422 claims in our sample, 179 or 42.4% were processed within 7 calendar days, 139 or 32.9% were processed between 8 and 14 calendar days, 91 or 21.6% were processed between 15 and 30 calendar days and 13 or 3.1% were processed after 30 calendar days.

PHP/AMC informed us that company policy for turnaround time is 14 days.

COMMENT

The turnaround time results for BCBSMT do meet their own turnaround time standard and industry standards. However, the results for PHP/AMC and NWHP indicate that they have not met their turnaround time standard, nor the industry standard.

VII - HIGH DOLLAR CLAIM REVIEW

The results of our review in regarding each vendor's high dollar claim review is discussed below.

HIGH DOLLAR CLAIM REVIEW

BCBSMT

We reviewed the high dollar claim review process with BCBSMT. They indicated that all claims above \$50,000 are subjected to audit by a senior manager. In addition, all line items in excess of \$5,000 are subjected to audit by a senior manager.

We did not identify any issues regarding high dollar claims. Therefore, we believe the process is working appropriately.

PHP/AMC

We reviewed the high dollar claim review process with Allegiance. They indicated that all claims processed with payment amounts between \$10,000 and \$25,000 are subjected to audit by an intermediate claims examiner. Claims that are processed with payment amounts between \$25,000 and \$100,000 are subjected to audit by the claims manager. Claims that are processed with payment exceeding \$100,000 are subjected to audit by the director of claims.

We did not identify any issues regarding high dollar claims. Therefore, we believe the process is working appropriately.

NWHP

We reviewed the high dollar claim review process with NWHP. They indicated that all claims processed with payment amounts greater than \$10,000 and all institutional claims with payment amounts greater than \$25,000 are held for quality review prior to releasing the payment. Once the payment has been reviewed by the internal quality auditor, the Claims Manager reviews and releases the payments.

We did identify 3 errors for high dollar claims. Therefore, we believe further training should be conducted with the managers that review these claims.

EXHIBIT A

STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM MANAGED CARE CLAIM AUDIT SUMMARY OF FINDINGS - NEW WEST HEALTH PLAN MANAGED CARE AUDIT PERIOD JANUARY 1, 2008 THROUGH DECEMBER 31, 2010 (STATE) AUDIT PERIOD JULY 1, 2008 THROUGH JUNE 30, 2010 (MUS)							
Claim No.	Claim Type	Group	Amount Paid	Audited Amount	Dollar Value of Error	Type	NWHP Response
EU091760000037	i	State	75,528.73	77,073.63	(1,544.90)	Coinsurance was already satisfied. Should have paid 100% of charges.	Agree
0907501302	i	State	26,397.66	-	26,397.66	Should have assumed Medicare A. Participant is retiree and has Medicare. VA should provide Medicare remittance, which shows what Medicare would have paid. This is standard in all insurance companies/TPAs. No assumption clause is necessary in plan document.	Disagree, SOM does not have an "estimate Medicare payment" in their SPD. See S.3 paragraph 2 bullet b on page 76.
0816800507	i	State	16,175.77	15,426.55	749.22	Should have applied entire OOP. Only \$1750.78 was met.	Agree
eu091320000014	i	State	1,384.25	2,149.62	(765.37)	Coinsurance and deductible were already satisfied. Should have paid 100% of charges.	Agree
eu0823500105	i	State	755.58	907.23	(151.65)	Routine newborn hospital charges are not subject to deductible.	Agree
eu0800800285	i	State	564.63	499.12	65.51	Should have applied remaining deductible. Only \$334.48 was met.	Agree
0835000302	i	MUS	1,345.72	1,285.72	60.00	COB error. Should not have paid more than \$1285.72. \$60 reflects the difference between ASP and private room rate reduction, which is non-covered.	Agree
eh090650001529	p	MUS	102.40	87.40	15.00	Should apply \$15 copay.	Agree.
0818500051	p	MUS	37.22	29.68	7.56	COB error. Should only pay \$29.66, which is patient responsibility after primary payment.	Disagree, other carrier allowed \$148.69 and paid \$111.67, patient balance = \$37.22 which is what New West paid as secondary carrier.

EXHIBIT B

**STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
MANAGED CARE CLAIM AUDIT
SUMMARY OF FINDINGS - BCBSMT
AUDIT PERIOD JANUARY 1, 2008 THROUGH DECEMBER 31, 2010**

GROUP	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
MT	-	-	-	Claim for services related to recurring pregnancy loss for a male participant. Claim should have been denied. Overstatement to the deductible.
MT	86.15	-	86.15	Claim should have been coordinated with other insurance. Claim was adjusted prior to audit.
MT	1,434.56	1,034.56	400.00	When claim originally processed participant had meet the deductible and out-of-pocket. However, due to adjustments, the deductible was never met.
MT	773.62	771.97	1.65	Coinsurance should have been applied to the last 2 lines of injectibles. This is a system issue.
MUS	43,413.63	45,076.93	(1,663.30)	Should have paid full length of inpatient stay. All days were pre-certified.
MUS	340.81	285.25	55.56	Routine injections without an office visit should be paid at 75% with a maximum of \$10. System issue was corrected 9/12/11
	<u>46,048.77</u>	<u>47,168.71</u>	<u>(1,119.94)</u>	

EXHIBIT C

**STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
MANAGED CARE CLAIM AUDIT
SUMMARY OF FINDINGS - PEAK HEALTH PLAN/ALLEGIANCE MANAGED CARE
AUDIT PERIOD JANUARY 1, 2008 THROUGH DECEMBER 31, 2010 (STATE)
AUDIT PERIOD JULY 1, 2008 THROUGH JUNE 30, 2010 (MUS)**

CLAIM #	GROUP	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
200811072431	MUS	100.00	182.75	(82.75)	Orthotic benefit is not allowing \$100 per foot, rather it is allowing a maximum of \$100.
200910266871	MUS	256.58	857.98	(601.40)	Claim was paid to the member at out-of-network benefit level incorrectly. Refund was never received from the member. Claim was adjusted prior to audit.
200908255343	MUS	813.76	833.05	(19.29)	Mammogram should have been paid at 100%.
200901194204	MUS	34.00	25.50	8.50	Injection paid at 100%. Should have been paid at 75%.
200901274596	STATE	112.80	97.80	15.00	Should have applied \$15 copay. Routine services (including lab) are subject to the copay provision.
200812242004	STATE	274.03	514.23	(240.20)	Routine newborn charges should not be subject to the deductible.
200712065924	STATE	2,498.62	-	2,498.62	Claim should have been coordinated with other insurance.
200809034549	MUS	47.60	46.95	0.65	Charges for lab services should be subject to the deductible and coinsurance. No copay should apply.
200910142189	STATE	6,605.46	6,108.68	496.78	Maternity related services should be subject to deductible and coinsurance. No copay should be applied.
200901136163	MUS	3,204.85	3,204.85	-	ER charge should not be paid at 100% for an inpatient claim. Out-of-pocket has been met. Therefore, no financial error.

200911125079 STATE	33.91	12.78	21.13	Incorrect coordination with Medicare. Claim was adjusted prior to audit.
201006105070 MUS	147.44	137.44	10.00	Urgent care should have applied \$25 copay, not \$15.
200912164388 MUS	130.40	120.40	10.00	Urgent care should have applied \$25 copay, not \$15.
200810294918 MUS	83.87	73.87	10.00	Urgent care should have applied \$25 copay, not \$15.
200803144762 STATE	598.77	453.83	144.94	ER issue. Should only pay ER charge at 100%. All other charges should be subject to deductible and coinsurance.
200809230580 STATE	1,207.18	938.84	268.34	ER issue. Should only pay ER charge at 100%. All other charges should be subject to deductible and coinsurance.
200901072564 STATE	973.84	801.76	172.08	ER issue. Should only pay ER charge at 100%. All other charges should be subject to deductible and coinsurance.
200902102756 STATE	1,034.61	824.99	209.62	ER issue. Should only pay ER charge at 100%. All other charges should be subject to deductible and coinsurance.



**NEW WEST
HEALTH SERVICES**

March 2, 2012

Wolcott & Associates, Inc.
Marie Pollock, President, Project Director
12120 State Line Road, Suite 297
Leawood, KS 66209

Dear Ms. Pollock:

Thank you for the opportunity to respond to the State of Montana, Montana University System Analysis and Evaluation of Managed Care Plan Claims Processing Report.

First, there are a couple of housekeeping items with respect to the report. On page I-2, in the Scope of the Audit section, please change the period to January 1, 2008 through December 31, 2010. On page II-1, please remove the reference of BCBSMT, to NWHP in the Sample Size and Methodology section.

The following is New West's response to the findings:

NEW WEST HEALTH PLAN RESPONSE EXHIBIT D

II - STATISTICAL CLAIM AUDIT RESULTS – NWHP

One of the discrepancies included in the statistical data has not been agreed to by New West. Removing this discrepancy from the sample as an error would produce satisfactory results. However, New West will accept the recommendation of Wolcott and review policies regarding Coordination of Benefits with Veterans Affairs with involvement of Medicare.

Errors identified as being processor driven have led to additional education provided to individuals responsible in addition to training on related topics provided to the entire Claims Department staff.

Wolcott and Associates
March 2, 2012
Page 2

VI - CLAIM PAYMENT TURNAROUND TIME

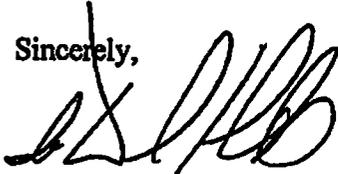
The comment made by Wolcott reveals the claims payment turnaround results are less than NWHP and industry standard. This statement appears to exclude whether claims were clean or unclean. With additional information regarding whether there was additional information necessary to process the claim, it is New West's opinion that clean claims are paid within the statutory requirement of 30 days.

VII - HIGH DOLLAR CLAIM REVIEW

New West previous to these audit results took internal steps to increase and ensure the accuracy of High Dollar Claims in addition to review being performed by State of Montana and Montana University System prior to the claim being released.

Please let me know if you have any questions regarding this response. I can be reached at 406-457-2200.

Sincerely,



I. David Kibbe
President and CEO



580 N. Park Avenue
PO Box 4309
Helena, Montana 59604
Customer Information Line: 800.447.7828

www.bcbsmt.com

January 31, 2012

MARIE POLLOCK
WOLCOTT & ASSOCIATES, INC
12120 STATE LINE ROAD, Suite 297
LEAWOOD KS 66209

RE: Montana University System and State of Montana Managed Care Claim Audit

Dear Marie:

This letter is in acknowledgement of the draft report for the Montana University System and State of Montana Managed Care claim audit recently completed for the audit period January 1, 2008 through December 31, 2009.

This letter includes Blue Cross Blue Shield of Montana's (BCBSMT) response to the Summary of Findings, Recommendations and Discussion points.

Exhibit B

Group
State

Claim for services related to recurring pregnancy loss for a male participant. Claim should have been denied. Overstatement to the deductible. (No dollar error value assigned)

Comment: BCBSMT agrees with this finding. The audit claim processed in 2009.

State

Claim should have been coordinated with other insurance. Claim was adjusted prior to audit. (Overpaid \$86.15)

Comment: BCBSMT agrees with this finding. The COB information was updated and the claim was adjusted to reverse the payment prior to the audit.

State

When the claim originally processed the participant had met the deductible and out-of-pocket. However, due to adjustments, the deductible was never met. (Overpaid \$400)

Comment: BCBSMT agrees that the member's individual deductible for 2008 is currently not met due to adjustment of one claim in April 2009, after the audit claim processed. However, BCBSMT disagrees with any payment error assessed on the audit claim. The audit claim processed correctly with the information that was in the claims processing system at that time.

State

Coinsurance should have been applied to the last 2 lines of injectibles. This is a system issue. (Overpaid \$1.65)

Comment: BCBSMT agrees with this finding. The audit claim processed in 2009.

MUS

Should have paid full length of inpatient stay. All days were pre-certified. (Underpaid \$1,663.30)

Comment: BCBSMT agrees with this finding. The claim has been adjusted, and all 4 days of room charges that were approved have been paid.

MUS

Routine injections without an office visit should be paid at 75% with a maximum of \$10. System issue was corrected 9/12/11. (Overpaid \$55.56)

Comment: BCBSMT agrees with this finding. The audit claim was processed in 2009.

III-3 RECOMMENDATIONS

- We identified 2 errors caused by a system issue. BCBSMT has indicated that these issues were identified prior to our audit. The two errors involved injection related services. These claims are being paid at 100%. They should be subject to the coinsurance provisions with a maximum of \$10.

Recommendation: We recommend that BCBSMT review all the above mentioned system issue and determine, through analysis, the magnitude of overpayments/underpayments that exist. Further, we recommend that BCBSMT make the corrections to the system, in order to prevent these types of errors from occurring in the future.

Comment: The first error identified was for a State member with infusion therapy services where 2 different injected drugs were paid at 100% but should have applied 25% coinsurance. BCBSMT met with the State Benefits Division on this issue prior to the audit. Effective 01/01/10, the State agreed that injectable, infusion and drug codes for in network providers would waive the deductible but coinsurance would apply to all. BCBSMT ran an impact report and provided it to the State.

The second error identified was for an MUS member with immunization services. All vaccine and vaccine administration services were paid at 100% in absence of an office visit but should have applied 25% coinsurance. The system coding was corrected 09/12/11. An impact report was run. This was discussed with MUS and they elected to have the claims adjusted on a complaint basis only.

- We identified an error regarding services rendered that were inconsistent with the gender of the patient.

Recommendation: We recommend that BCBSMT review this issue and make adjustments to the system, in order for this type of claim to be identified prior to processing for payment.

Comment: This issue was resolved when BCBSMT replaced the current claims editing system, Claims Accuracy Initiative (CAI), with the Ingenix KnowledgeBase product for claims review effective November 15, 2010. The Ingenix KnowledgeBase evaluates the accuracy and adherence of reported services to accepted national reporting standards and BCBSMT coding policies.

DISCUSSION

We identified 3 claims that warrant further discussion.

Discussion Point: We identified 2 claims for chemotherapy related services. We inquired whether or not they were reviewed for possible experimental therapy. BCBSMT indicated to us that they do not review these types of claims for experimental related services.

We recommend that BCBSMT formulate a process, in order to review claims for the possibility of services related to experimental therapy. This would be consistent with other major administrators for which we have performed audits.

BCBSMT Comments: The initial response provided was incorrect. BCBSMT's Integrated Health Management department does a thorough review of all new

procedure codes on an annual basis. Chemotherapeutic drugs are set to pend to determine medical necessity criteria, and a determination is made to allow or deny as investigational/experimental. The decision to edit these drugs is reviewed based on information obtained from the annual CPT Symposium in Chicago, input from the BCBS Association, BCBS Association policies, and internally through the Compensation team, Medical Review, our Medical Director, and our Pharmacy Program Coordinator. For those drugs that are not identified through this process and are billed with generic HCPCS codes, we manually pend for analysis of pricing and medical criteria. In the absence of a medical policy specific to the drug, we complete on-line research and work with the Medical Director and Compensation team for coverage and payment. Additionally, all out of country services are reviewed to ensure experimental services are not being allowed.

Discussion Point: We identified a claim that, when reviewing history, we noticed that the accumulators had exceeded the annual limits. BCBSMT indicated that the sample claim, which paid first, was correct. However, subsequent claims had applied coinsurance in excess of the annual limit.

We recommend BCBSMT review this issue and determine whether this was an isolated issue or a system issue.

BCBSMT Comments: BCBSMT is reviewing the necessary steps to identify members that have over accumulated on the deductible and out of pocket maximums.

Thank you for the opportunity to comment on this audit report. If you have any questions or comments, please contact me at (406) 437-5211.

Sincerely,



Arlene Troy
Internal Audit
Blue Cross and Blue Shield of Montana

**FORMAL RESPONSE OF ALLEGIANCE BENEFIT PLAN MANAGEMENT, INC.
TO
WOLCOTT & ASSOCIATES AUDIT
OF
THE MONTANA UNIVERSITY SYSTEM TRADITIONAL PLAN
AND
THE STATE OF MONTANA and THE MONTANA UNIVERSITY SYSTEM MANAGED CARE PLANS**

Allegiance Benefit Plan Management submits this formal response to the above referenced audit.

Because these audits are for three distinctly separate and individual plans, Allegiance addresses the audit results for each plan separately. The audit results for these plans should not and cannot be combined for any purpose because they are separate and distinct plans. Allegiance will address each plan separately below.

Montana University System Traditional Plan

The auditors identified three (3) claims errors as stated on page III-3.

The first of those errors is indicated as a \$2,060.34 duplicate overpayment. Allegiance objects to this claim being classified as an error. The claim was in fact a duplicate payment of a previous claim. However, that claim was a claim incurred in 2008 and which was discovered by Allegiance through its own internal audit process, corrected, and refunds received in January and February of 2009, long before Allegiance had received any claims request regarding this audit. The correction and adjustment of the claim was through Allegiance's own efforts, far before this claim was identified as a potential claim for the Wolcott audit. It is not an error.

The remaining two (2) claims that were assigned error are alleged underpayments of emergency copayments in the aggregate amount of \$107.09.

Although Allegiance does agree that two small underpayment errors were found, the auditor also states that the same errors were identified in the prior audit performed at Allegiance. Allegiance disagrees with that statement. We do agree that an error was found regarding emergency room payments in the prior audit, but this was not the same error as the error found in the prior audit. The error from the prior audit was in fact addressed and fixed immediately after the audit.

State of Montana Managed Care Plan

In the State of Montana Managed Care claim audit, the auditor identified nine (9) claim errors with regard to the State of Montana Managed Care Plan as differentiated from the Montana University System Managed Care Plan which is a separate plan.

Of those four (4) were errors associated with emergency room payment, and one (1) was an alleged error regarding coordination with Medicare. Allegiance does not agree with the assignment of error for these claims.

With regard to the coordination with Medicare claim which indicates an overpayment of \$21.13, this coordination of benefits issue was identified by Allegiance through its internal audit processes prior to any selection of this claim by the auditor, or any identification by the auditor of this claim as being an issue.

The correction of the error was made long before the audit process was started. The correction occurred on August 29, 2010.

In addition, there are four (4) claims listed as errors regarding the payment of the emergency room visit. Those errors indicate overpayment in the amount of \$144.94, \$268.34, \$172.08 and \$209.62, respectively. The auditor alleges that only the emergency room facility charge should be paid at 100% and that all other charges should be subject to deductible and co-insurance requirements of the Plan. The claims in question were paid based upon the written direction from Mike Young, a principal in PEAK Health Care that assists the State in operating this particular managed care plan, and from direction from Connie Welsh, the Plan Administrator, regarding how this benefit should pay. The benefit paid as directed and as confirmed by Mr. Young from PEAK and by Connie Welsh as the Plan Administrator of the Plan. There was no error. A copy of that written direction is attached.

Montana University System Managed Care Plan

The auditor identified nine (9) claims for which error was assigned under the audit of the Montana University System Managed Care Plan.

For one of those, the auditor claims an error based on an overpayment on an out-of-network benefit level. However, the error was in fact detected by Allegiance's internal audit system long before this claim was identified for this audit and was corrected at that time. The correction of the claim occurred through Allegiance's own efforts and without any notice from the auditor or selection by the auditor of this claim.

In addition, the auditor has identified three (3) "urgent care" claims for which the auditor claims a \$10.00 overpayment occurred on each claim. The auditor assigns error stating that the \$25.00 urgent care copayment should have been assigned to these claims rather than the \$15.00 office visit copayment. The auditor assigns this error based on the place of service being an urgent care facility. However, the benefit contained in the Plan Document does not identify this by facility, but rather identifies urgent care by the type of care received which is defined as "acute illness or injury that requires immediate treatment". The claims in question were not such claims, but were in fact office visits for non-urgent purposes. Therefore, Allegiance applied the copayment for an office visit based upon the type of service provided rather than the urgent care \$25.00 copay, because the service provided as not an urgent care service.

**STATE OF MONTANA AND
MONTANA UNIVERSITY SYSTEM,
PRESCRIPTION DRUG CLAIM AUDIT**

FOR THE PERIOD

JANUARY 1, 2008 THROUGH DECEMBER 31, 2010 (STATE)

JULY 1, 2008 THROUGH JUNE 30, 2010 (MUS)

**ADMINISTERED BY
CAREMARK**

FINAL REPORT

AUGUST, 2012

PRESENTED BY

**WOLCOTT & ASSOCIATES, INC.
12120 STATE LINE ROAD, SUITE 297
LEAWOOD, KANSAS 66209**

**STATE OF MONTANA
AND MONTANA UNIVERSITY SYSTEM
PRESCRIPTION DRUG PLAN AUDIT
OF CAREMARK**

**JANUARY 1, 2008 THROUGH DECEMBER 31, 2009 (STATE)
JULY 1, 2008 THROUGH JUNE 30, 2010 (MUS)**

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<u>EXHIBITS</u>	
DESCRIPTION OF ERRORS	EXHIBIT A

I - INTRODUCTION

The State of Montana (State) provides a prescription drug benefit as part of an overall employee benefit and compensation program. The plan covers approximately 15,000 employees and retirees, plus their dependents for a total of 32,000 covered.

The State is a member of the Montana Association of Health Care Purchasers. The Association has negotiated a contract with Caremark to provide prescription drug benefits to employees and Association members that elect such benefits. The State has elected to have its prescription drug benefits provided by Caremark.

The Montana University System (MUS), has also contracted with Caremark for the provision of prescription drug benefits. The plan covers approximately 8,000 employees and retirees, plus their dependents.

PURPOSE OF SERVICE

Section 2.18.816, MCA requires the State Employee Benefits Plan to be audited every two years by or at the direction of the Legislative Audit Division. Wolcott & Associates, Inc. was awarded the audit contract for the 2002-2003 Plan Years and subsequently renewed that contract for the 2004-2005 Plan Years, the 2006-2007 Plan Years and the 2008-2010 Plan Years.

The purpose of the service is to comply with Section 2.18.816, MCA.

The State and MUS recognize that they have a fiduciary responsibility to administer this plan (and other employee benefit plans) for the benefit of plan participants and their dependents and in accordance with the plan provisions. Both sponsors believe it is prudent to perform periodic audit and review services to determine if the benefit plans they sponsor are meeting these objectives.

AUDIT TIMING AND STAFF

The Division advised Wolcott & Associates, Inc. that we had been awarded the audit contract. All preliminary work was completed and the audit process began December 15, 2011.

Wolcott & Associates, Inc. staff involved in the audit are listed below:

<u>Name</u>	<u>Title</u>	<u>On-site</u>
Marie Pollock	Vice President	No
Brian Wyman	Manager	No
Richard Reese	Actuary	No

SCOPE OF AUDIT

The scope of audit services covered prescription drug benefit claims paid by Caremark during the period from January 1, 2008 through December 31, 2009 for the State and July 1, 2008 through June 30, 2010 for MUS. Test work was performed on 220 previously processed claims, 200 of which were selected on a stratified, random (statistical) basis and the remaining 20 were the top paid claims.

Scope elements included:

- **Eligibility of claimants to receive payment.**
- **Calculation accuracy.**
- **Completeness of necessary information.**
- **Compliance with benefit plan structure.**
- **Identification of duplicate claim submissions.**

II - STATISTICAL CLAIM AUDIT RESULTS

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 220 claims.

The claims were selected from the population of claims paid by Caremark between January 1, 2008 through December 31, 2009 for The State and July1, 2008 through June 30, 2010. Prior to selection, the population of claims was stratified.

The strata types were as follows: (1) Top 20 highest dollar amount and, (2) Electronic, paper or Mail Order (combined).

AUDIT PROCEDURE

Each sample claim was manually reprocessed based on the plan's provisions in force as of the date the prescription was dispensed. Ingredient costs for electronic and paper (including out-of-network) claims were calculated based on Average Wholesale Prices (AWP) on the package size submitted or other applicable prices in effect on the date the prescription was dispensed. Ingredient costs for mail order claims were calculated based on AWP on package size submitted or other applicable prices in effect on the date the prescription was dispensed.

The percentage discounts, dispensing fees, and copayment amounts were compared to the plan's agreed upon provisions as of the date the prescription was dispensed.

Each sample claim's medication was identified and compared to the plan's requirements for:

- Exclusions,
- Pricing used at the time the prescription was dispensed,
- Recalculating payment amount,
- Appropriate copayment (generic, branded, etc.)
- Compliance with pre-approval requirements,
- Maximum number of days supply,
- Refill timing,
- Formulary limitations and,
- Eligibility of participant.
- Review of non-Caremark mail order claim processing

DEFINITION OF ERROR

All network pharmacy claim (electronic claims) payments were paid to the retail pharmacy. All mail order initial and refilled claim payments were paid to Caremark mail order pharmacy.

We defined an error to be any claim where the payment to the participant or the pharmacy did not agree with the plan document provisions.

AUDIT RESULTS

Of the 220 claims in our statistical sample, 12 were judged to contain a payment error. This represents a frequency of payment error of 5.4%. Of these 12 claims, 10 were underpayments by the members and 2 were overpayments for incorrect copayment.

Our sample contained a total payment of \$801,316.14 for the 220 claims. The net overpayment totaled \$44.57 or 0.006% of the total.

The sample's error magnitude, extended to the population, produces a projected overpayment of \$316,528 (0.40% of \$78,325,828). The error magnitude rate in the sample differs from the error magnitude rate when extended to the population due to the weighting of the sample strata.

As a result, we are 95 percent confident that the true value of the prescription paid claims during the period ranges from \$80,594,052 (the \$78,325,828 recorded claims, minus the \$316,528 projected net error, plus the \$2,584,752 value of the 3.3 percent precision) and \$75,424,548 (the \$78,325,828 recorded claims, minus the \$316,528 projected net error, less the \$2,584,752 value of the 3.3 percent precision).

The Caremark standard accuracy rate is 99 percent or more of the gross dollar payments should be paid accurately. We understand the measurement is made by summing the overpayments and underpayments, and dividing the result by the total dollars and subtracting from 100%.

The overpayments/underpayments percentage from our results (extended to the population) total 0.006 percent. This equals a payment accuracy rate of 99.99 percent. These results are superior to the Caremark standard accuracy rate. They are also superior to the 99% accuracy standard established by other claim processors with which we are familiar.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in Exhibit A. A discussion of error types is presented below.

**CAREMARK PHARMACY CLAIMS
JANUARY 1, 2008 THROUGH DECEMBER 31, 2009 (STATE)
JULY 1, 2008 THROUGH JUNE 30, 2010 (MUS)**

SUMMARY OF ERRORS BY TYPE

<u>ERROR TYPE</u>	<u>NUMBER</u>	<u>NET PAYMENT ERROR</u>
Incorrect payment amount by member.	10	\$0.00
Incorrect copayment	<u>2</u>	<u>44.57</u>
Total	<u>12</u>	<u>\$44.57</u>

Corrective Action

Caremark's response to our findings will be added to our final report as Exhibit B. For those errors with which we agree, they have assured us that corrective action either has been or will be taken for each identified error and that steps will be taken to reduce the frequency of the types of errors observed.

Eleven claims in our sample (MUS) were retail claims that were calculated by the ingredient cost minus the discount. The member was charged this calculated cost, which was less than the copayment amount. According to the MUS plan, it specifically states that for retail pharmacy, the member pays the greater of the applicable copayment or a percentage, whichever is higher.

We believe Caremark's processing of these types of claims is contradictory to the MUS contract and intention of how the plan should be administered.

CONCLUSION

Based on our audit of 220 claims, we conclude that Caremark is not processing the State and MUS claims in agreement with the plan provisions. We recommend Caremark discuss these issues with the State and MUS and develop a plan of action to alleviate these types of errors in the future.

III - ELIGIBILITY

The State and MUS use various methods to report new entrants, changes and termination of coverage to Caremark. This section describes the methods employed and presents the results of the verification of eligibility for 20 of the claims in our sample.

STATE OF MONTANA

The State prepares and sends to Caremark a biweekly eligibility tape showing each individual to be covered for the coming month. Caremark runs this tape and compares it to the data for the prior month. An exception report is generated showing all errors in the file. The exception report is sent back to the State for correction or approval to load the file. If no exceptions were found, the file is loaded into the claim system.

MONTANA UNIVERSITY SYSTEM

Allegiance Benefit Plan Management, Inc. (Allegiance) processes claims for the MUS health care plan. Allegiance has also contracted to provide eligibility data to Caremark on behalf of MUS. Allegiance receives the enrollment data from each campus on a daily basis and transmits new entrant, change and termination data to Caremark electronically each day. An exception report is generated showing all errors in the file. The exception report is sent back to Allegiance for correction or approval to go ahead and load the file. If no exceptions were found, the file is loaded into the claim system.

ELIGIBILITY VERIFICATION

Each of the 20 participants in our sample was researched on Caremark's eligibility system to verify that coverage was in force on the date the prescription was dispensed.

No exceptions were noted.

CONCLUSION

We conclude that the policies and procedures relating to the eligibility system are adequate and in compliance with the State's and MUS plan provisions.

Eligibility File Processing

Below are the eligibility file processing accuracy percentages.

<u>State</u>	<u>Accuracy Percentage</u>
---------------------	-----------------------------------

For the period ending 12/31/2009	100%
----------------------------------	------

For the period ending 12/31/2008	100%
----------------------------------	------

MUS

For the period ending 12/31/2010	No information was provided.
----------------------------------	------------------------------

For the period ending 12/31/2009	100%
----------------------------------	------

For the period ending 12/31/2008	100%
----------------------------------	------

Eligibility File Updates Timeliness

Below are the eligibility file update timeliness percentages.

<u>State</u>	<u>Less than or equal to 24 hours</u>
---------------------	--

For the period ending 12/31/2009	100%
----------------------------------	------

For the period ending 12/31/2008	100%
----------------------------------	------

MUS

For the period ending 12/31/2010	No information was provided.
----------------------------------	------------------------------

For the period ending 12/31/2009	100%
----------------------------------	------

For the period ending 12/31/2008	100%
----------------------------------	------

Identification Cards Timeliness on Reporting

Below are the identification card timeliness on reporting percentages.

<u>State</u>	<u>Less than or equal to 30 days</u>
---------------------	---

For the period ending 12/31/2009	100%
----------------------------------	------

For the period ending 12/31/2008	Did not meet performance guarantee.
----------------------------------	-------------------------------------

MUS

For the period ending 12/31/2010	100%
For the period ending 12/31/2009	100%
For the period ending 12/31/2008	Did not meet performance guarantee.

Identification Cards Timeliness on Initial Cards

Below are the identification card timeliness on Initial ID cards percentages.

<u>State</u>	<u>98% in less than 5 business days</u>
For the period ending 12/31/2009	100%
For the period ending 12/31/2008	97% Did not meet performance guarantee.

MUS

For the period ending 12/31/2010	100%
For the period ending 12/31/2009	100%
For the period ending 12/31/2008	73% Did not meet performance guarantee.

Identification Cards Timeliness on Ongoing Cards

Below are the identification card timeliness on ongoing ID cards percentages.

<u>State</u>	<u>98% in less than 5 business days</u>
For the period ending 12/31/2009	100%
For the period ending 12/31/2008	100%

MUS

For the period ending 12/31/2010	100%
For the period ending 12/31/2009	100%
For the period ending 12/31/2008	100%

IV - LOGIC AND CLAIM TEST RESULTS

This section presents the results of test claims submitted to the Caremark claim system as a method of assessing the system's ability to identify inappropriate transactions.

LOGIC CLAIMS

The follow claim types were entered into the Caremark claim processing system.

- Duplicate claim
- Claim on a termed member
- Clam for a non-covered drug
- Clam for refill to soon and
- Claim with to many days supply.

Each claim that was entered had the appropriate edits to stop the claim from adjudicating. However, Caremark could not entered these test claims into the State or MUS system edits since they were already terminated as a client.

CONCLUSION

We conclude that the system edits are in place and working on Caremark general system. However, we can't not conclude that the edits were in place during the audit period for the State or MUS.

V - OTHER REVIEW ITEMS

Discussion regarding other claim review items are presented below.

PHARMACY NETWORK ACCESS

Caremark agreed, based upon census, that 100% of covered participants living in suburban areas will have access to at least one network pharmacy within five miles of the participant and 96.4% of covered participants living in rural areas will have access to one network pharmacy within fifteen miles of the participant.

Caremark was noncompliant with our request regarding this subject.

PHARMACY AUDITING

Caremark has two types of retail pharmacy audits: (1) Internal desk audits and (2) On-site field audits. After the claims go through a series of system edits, claims are the selected for a desk audit. Caremark agreed to field audit 5% of active network pharmacies each year of the contract. An active network pharmacy is defined as any pharmacy processing at least 400 prescriptions per year.

On-site pharmacy audit percentages

Below are the on-site pharmacy audit percentages.

<u>State</u>	<u>Greater than or equal to 5%</u>
For the period ending 12/31/2009	8%
For the period ending 12/31/2008	5%
<u>MUS</u>	
For the period ending 12/31/2010	5%
For the period ending 12/31/2009	8%
For the period ending 12/31/2008	5%

PHARMACY PARTICIPATION

Caremark guaranteed that no more than 25% of the network pharmacies will voluntarily terminate their contracts with Caremark during any calendar year.

Caremark was noncompliant with our request regarding this subject.

CUSTOMER SERVICE RESPONSE TIME

Caremark guaranteed that a maximum telephone answering time averages less than 30 seconds for all customer service calls received. Caremark also guaranteed an abandonment rate of less than 3% for all customer service calls.

Average speed to answer

Below are the average speed to answer times.

<u>State</u>	<u>Average speed to answer in seconds</u>
For the period ending 12/31/2009	35 Did not meet the performance guarantee.
For the period ending 12/31/2008	111 Did not meet the performance guarantee.

MUS

For the period ending 12/31/2010	37 Did not meet the performance guarantee.
For the period ending 12/31/2009	35 Did not meet the performance guarantee.
For the period ending 12/31/2008	117 Did not meet the performance guarantee.

Telephone abandonment rates

Below are the telephone abandonment rate percentages.

<u>State</u>	<u>Abandonment rate less than or equal to 3%</u>
For the period ending 12/31/2009	1%
For the period ending 12/31/2008	16% Did not meet performance guarantee.

MUS

For the period ending 12/31/2010	2%
For the period ending 12/31/2009	1%
For the period ending 12/31/2008	32% Did not meet performance guarantee.

REBATES

Caremark guaranteed rebates for two tier medication is \$23.32 for mailorder and \$6.70 for retail. For three tier medication the rebate is \$24.26 for mailorder and \$7.20 for retail.

For 2008 retail rebates were a total of \$629,344.80

For 2008 mail order rebates were a total of \$559,818.32

For 2009 retail rebates were a total of \$771,777.60

For 2009 mail order rebates were a total of \$655,723.54

Conclusion

We conclude that Caremark rebates procedures are working as describe.

PRIOR AUTHORIZATION/DRUG UTILIZATION PROCESS

We were requested to review several items as it relates to the prior authorization and drug utilization process.

We noted is our sample of claims, that prior authorization was received for those medication that required the prior authorization.

DENIED CLAIMS

We were requested to review the reason behind denials, provider type and whether or not there were multiple claims denied for one provider.

Caremark was noncompliant with our request regarding this subject.

For the period ending 12/31/2009 100%

For the period ending 12/31/2008 100%

Mailorder turnaround time for claims that require intervention

Below are the time mailorder turnaround time percentage for those claims that require intervention.

State **100% turnaround within 5 business days**

For the period ending 12/31/2009 100%

For the period ending 12/31/2008 100%

MUS

For the period ending 12/31/2010 No information was provided.

For the period ending 12/31/2009 100%

For the period ending 12/31/2008 100%

Caremark was noncompliant with our request regarding rebate calculation and plan reporting subject.

SYSTEM CONTROLS AND ACCESS

We were requested to review the availability of the on-line claim processing system, including response times, and review Caremark's system of controls.

Below are the system availability percentages.

State **Percentage of system availability**

For the period ending 12/31/2009 99.9%

For the period ending 12/31/2008 100%

MUS

For the period ending 12/31/2010 No information was provided.

For the period ending 12/31/2009	99.9%
For the period ending 12/31/2008	100%

PAPER CLAIM TURNAROUND TIME

Caremark guaranteed that the turnaround time on paper pharmacy claims be all processed with 10 business days.

Below are the turnaround time on paper claims in average days processes.

<u>State</u>	<u>Number of days for paper claims to be processed.</u>
For the period ending 12/31/2009	1
For the period ending 12/31/2008	3

MUS

For the period ending 12/31/2010	No information was provided.
For the period ending 12/31/2009	1
For the period ending 12/31/2008	3

WRITTEN INQUIRIES

Caremark guaranteed that 95% of written inquiries they received will be responded to within 5 business days and 100% will be responded to within 10 business days.

Below are the percentage of written inquiries within 5 business days.

<u>State</u>	<u>Percentage within 5 business days</u>
For the period ending 12/31/2009	99%
For the period ending 12/31/2008	98%

MUS

For the period ending 12/31/2010	No information was provided.
For the period ending 12/31/2009	89% Did not meet performance guarantee.
For the period ending 12/31/2008	100%

Below are the percentage of written inquiries within 10 business days.

<u>State</u>	<u>Percentage within 10 business days.</u>
For the period ending 12/31/2009	99% Did not meet performance guarantee.
For the period ending 12/31/2008	100%

MUS

For the period ending 12/31/2010	No information was provided.
For the period ending 12/31/2009	89% Did not meet performance guarantee.
For the period ending 12/31/2008	100%

REPORTING

Caremark guaranteed that quarterly reviews of utilization and plan performance be generated within 45 days and rebate reports be generated within 60 days.

Below are the percentages of quarterly reviews.

<u>State</u>	<u>Percentage of reports within 45 days</u>
For the period ending 12/31/2009	100%
For the period ending 12/31/2008	100%

MUS

For the period ending 12/31/2010	No information was provided.
For the period ending 12/31/2009	Did not meet performance guarantee.
For the period ending 12/31/2008	100%

Below are the percentages for rebate reporting.

<u>State</u>	<u>Percentage of reports within 60 days</u>
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For the period ending 12/31/2009	100%
For the period ending 12/31/2008	100%

MUS

For the period ending 12/31/2010	No information was provided.
For the period ending 12/31/2009	100%
For the period ending 12/31/2008	100%

FORMULARY UPDATES

Caremark guarantees that members will received written notification of changes to formulary status of a drug within 60 days.

Below are the percentage of written notification of formulary status.

<u>State</u>	<u>Percentage of written formulary updates with 60 days</u>
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For the period ending 12/31/2009	100%
For the period ending 12/31/2008	100%

MUS

For the period ending 12/31/2010	100%
For the period ending 12/31/2009	100%

For the period ending 12/31/2008

100%

STATE OF MONTANA
AND
MONTANA UNIVERSITY SYSTEM
PRESCRIPTION DRUG CLAIM AUDIT
SUMMARY OF FINDINGS

CLAIM #	STRATA	PLAN	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
142	2	MUS	\$ -	\$ -	\$ -	Prescription total cost is \$11.24. However MUS states that the copay is \$20.00.
147	2	MUS	\$ -	\$ -	\$ -	Prescription total cost is \$7.70. However MUS states that Mailorder copay is \$20.00.
48	2	State	\$ 113.58	\$ 73.58	\$ 40.00	Did not apply to copayment.
148	2	MUS	\$ -	\$ -	\$ -	Prescription total cost is \$4.92. However MUS states that the copay is \$10.00.
15	1	MUS	\$ 17,158.50	\$ 21,033.00	\$ (3,874.50)	Incorrect discount applied.
179	2	MUS	\$ -	\$ -	\$ -	Prescription total cost is \$6.78. However MUS states that the copay is \$10.00.
139	2	MUS	\$ -	\$ -	\$ -	Prescription total cost is \$9.58. However MUS states that the copay is \$10.00.
140	2	MUS	\$ -	\$ -	\$ -	Prescription total cost is \$6.64. However MUS states that the copay is \$10.00.
144	2	MUS	\$ -	\$ -	\$ -	Prescription total cost is \$3.03. However MUS states that the copay is \$10.00.
145	2	MUS	\$ -	\$ -	\$ -	Prescription total cost is \$3.24. However MUS states that the copay is \$10.00.
146	2	MUS	\$ -	\$ -	\$ -	Prescription total cost is \$4.92. However MUS states that the copay is \$10.00.
148	2	MUS	\$ -	\$ -	\$ -	Prescription total cost is \$2.48. However MUS states that the copay is \$10.00.
127	2	MUS	\$ -	\$ -	\$ -	Prescription total cost is \$2.06. However MUS states that the copay is \$10.00.
105	2	State	\$ 4.57	\$ -	\$ 4.57	Incorrect copayment applied and incorrect day supply.
			\$ 17,276.85	\$ 21,106.58	\$ (3,829.93)	

The State of Montana and
The Montana University System
Claims & PG Audit Response
Dated September 2011

Regarding:
Wolcott & Associates, Inc.
Audit Report

Dated May 2012

INTRODUCTION

Wolcott & Associates, Inc. ("Wolcott") performed an audit on behalf of The State of Montana ("State MT") and the Montana University System ("MUS"), both CVS Caremark ("CM") clients. Wolcott was retained to conduct a performance assessment of State MT and MUS' pharmacy programs provided to its employees and administered by CM. The purpose of the audit was to perform an assessment of compliance with Section 2.18.816, MCA, CM's performance guarantees and an assessment of adherence with the contractual and administrative practices and provisions by which CM administers the pharmacy program. The audit period was 1/1/2008 – 12/31/2009 for State MT and 7/1/2008 – 6/30/2010 for MUS. CM has reviewed and researched the materially significant findings enclosed in this report to evaluate whether they are, in our view, outstanding financial liabilities owed to our client and/or opportunities for process improvement. Below is our response to the findings reported by Wolcott.

FINDINGS

Wolcott Finding 1: The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 220 claims. The claims were selected from the population of claims paid by Caremark between January 1, 2008 through December 31, 2009 for The State and July 1, 2008 through June 30, 2010. The strata types were as follows: (1) Top 20 highest dollar amount and, (2) Electronic, paper or Mail Order (combined). The percentage discounts, dispensing fees, and copayment amounts were compared to the plan's agreed upon provisions as of the date the prescription was dispensed.

Of the 220 claims in our statistical sample, 12 were judged to contain a payment error. This represents a frequency of payment error of 5.4%. Of these 12 claims, 10 were underpayments by the members and 2 were overpayments for incorrect copayment. Eleven claims in our sample (MUS) were retail claims that were calculated by the ingredient cost minus the discount. The member was charged this calculated cost, which was less than the copayment amount. According to the MUS plan, it specifically states that for retail pharmacy, the member pays the greater of the applicable copayment or a percentage, whichever is higher.

We believe Caremark's processing of these types of claims is contradictory to the MUS contract and intention of how the plan should be administered. We believe Caremark's processing of these types of claims is contradictory to the MUS contract and intention of how the plan should be administered.

CVS Caremark Response: Caremark maintains that Claim #'s 142, 147, 146, 179, 139, 140, 144, 145, 146, 148 and 127 adjudicated correctly and charged the appropriate copay. Per the Montana University System contract dated 07/01/2008, page 25, "Sponsor acknowledges that the Participating Pharmacy will collect from the Plan Participant the lowest of the discounted cost, applicable co-pay, or the Participating Pharmacy's usual and customary price." For the claims above the member, or Plan Participant, was correctly charged the discounted cost of the drug.

This amount was lower than both the co-pay and the usual and customary price. These claims charged the member the correct amount and in accordance with the contract language. Caremark considers this issue closed.

Regarding claim # 46: The member was hard-coded with a \$0 copay. Please see the attachment below. Caremark maintains that the member correctly paid a \$0 copay and considers this issue closed.

Claim 46 Supporting
Info..pdf

Regarding claim # 105: Please see the attachment below for information related to 90-day fills of medication at VA facilities. This claim processed for a 90-day supply and was filled at a Veterans Administration Medical Center pharmacy. Per this document, if a member fills a prescription for a 90-day supply, he/she would be charged a copay for *each 30-day supply*.

VA 90 Days - Claim 105.pdf
PharmaCare.pdf

In this instance, the total cost of the drug was \$23.16. A dispensing fee of \$1.50 applied. The member was correctly charged two retail copays of \$10 each to arrive at \$20. If the member had been charged three copays (\$30) for the 90-day supply, he would have paid more than the total cost of the drug. Again, per the State of Montana contract dated 07/01/2008, page 25, "Sponsor acknowledges that the Participating Pharmacy will collect from the Plan Participant the lowest of the discounted cost, applicable co-pay, or the Participating Pharmacy's usual and customary price." For this claim the member was correctly charged the applicable co-pay (two copays), as it was the lowest of the three. This claim charged the member the correct amount and in accordance with the contract language. Caremark considers this issue closed.

Wolcott Finding 2: Wolcott noted that no information was provided for the PG item "Eligibility File Processing" for MUS for the period ending 12/31/2010.

CVS Caremark Response: Caremark has been unable to locate the information related to this PG item for the period ended 12/31/10. It should be noted that MUS terminated its contract with Caremark on 6/30/10.

Wolcott Finding 3: Wolcott noted that no information was provided for the PG item "Eligibility File updates Timeliness" for MUS for the period ending 12/31/2010.

CVS Caremark Response: Caremark has been unable to locate the information related to this PG item for the period ended 12/31/10. It should be noted that MUS terminated its contract with Caremark on 6/30/10.

Wolcott Finding 4: Wolcott noted that no information was provided for the PG item "Identification Cards Timeliness on Ongoing Cards" for MUS for the period ending 12/31/2009.

CVS Caremark Response: This PG item was met. Please see the updated PG report for MUS 2009 below.

MT Univ System
2009.pdf

Wolcott Finding 5: Wolcott noted that no information was provided for the PG item "Identification Cards Timeliness on Ongoing Cards" for MUS for the period ending 12/31/2008.

CVS Caremark Response: This PG item was met. Please see the updated PG report for MUS 2008 below.

MT Univ System
2008.pdf

Wolcott Finding 6: Wolcott asked that Caremark confirm that 100% of covered participants living in suburban areas will have access to at least one network pharmacy within five miles of the participant and 96.4% of covered participants living in rural areas will have access to one network pharmacy within fifteen miles of the participant.

CVS Caremark Response: Caremark has been unable to locate the information requested above but maintains that this provision was met during the audit period.

Wolcott Finding 7: Wolcott asked that Caremark confirm that no more than 25% of the network pharmacies voluntarily terminated their contracts with Caremark during any calendar year.

CVS Caremark Response: Caremark confirms that we have met this performance guarantee for our commercial national networks for both State MT and MUS for the audit period.

Wolcott Finding 8: Wolcott noted that no information was provided for the PG item "Telephone Abandonment Rates" for State MT for the period ending 12/31/2010.

CVS Caremark Response: Caremark maintains that there is no reporting for the calendar year 2010 for State MT, as their contract termed 12/31/2009. State MT was not an active client for any portion of 2010. Caremark considers this issue closed.

Wolcott Finding 9: Wolcott asked that Caremark confirm that the guaranteed rebates for two tier and three tier medications were met. Rebates for two tier medication were \$23.32 for mailorder and \$6.70 for retail. For three tier medication the rebate was \$24.26 for mailorder and \$7.20 for retail.

CVS Caremark Response: Caremark confirms that the rebate guarantees were met. Please see the below document, which shows that all rebates were for tier three meds. There were no tier two rebates.

Rebate Supporting
Info..xls

Wolcott Finding 10: Caremark was asked to provide a sample of denied claims, along with the reason behind the denials, provider type and whether or not there were multiple claims denied for one provider. Wolcott was asked to review these denied claims as part of the audit.

CVS Caremark Response: Caremark has been unable to locate the information requested above.

Wolcott Finding 11: Wolcott noted that no information was provided for the PG item "Mailorder Accuracy Percentage" for MUS for the period ending 12/31/2010.

CVS Caremark Response: This PG item was met. Please see the updated PG report for MUS 2010 below.

Montana University
System 2010.pdf

Wolcott Finding 12: Wolcott noted that no information was provided for the PG item "Mailorder Turnaround Time for Claims That Did Not Require Intervention" for MUS for the period ending 12/31/2010.

CVS Caremark Response: This PG item was met. Turnaround time for the period was 1 day. Please see the updated PG report for MUS 2010 below.

Montana University
System 2010.pdf

Wolcott Finding 13: Wolcott noted that no information was provided for the PG item "Mailorder Turnaround Time for Claims That Require Intervention" for MUS for the period ending 12/31/2010.

CVS Caremark Response: This PG item was met. Turnaround time for the period was 1 day. Please see the updated PG report for MUS 2010 below.

Montana University
System 2010.pdf

Wolcott Finding 14: Wolcott noted that no information was provided for the PG item "System Controls and Access" for MUS for the period ending 12/31/2010.

CVS Caremark Response: This PG item was met. Please see the updated PG report for MUS 2010 below.

MT Univ System
2010.pdf

Wolcott Finding 15: Wolcott noted that no information was provided for the PG item "Paper Claim Turnaround Time" for MUS for the period ending 12/31/2010.

CVS Caremark Response: This PG item was met. Turnaround time for the period was 2 days. Please see the updated PG report for MUS 2010 below.

MT Univ System
2010.pdf

Wolcott Finding 16: Wolcott noted that no information was provided for the PG item "Written Inquiries/5 Business Days" for MUS for the period ending 12/31/2010.

CVS Caremark Response: Caremark has been unable to locate the information related to this PG item for the period ended 12/31/10. It should be noted that MUS terminated its contract with Caremark on 6/30/10.

Wolcott Finding 17: Wolcott noted that no information was provided for the PG item "Written Inquiries/10 Business Days" for MUS for the period ending 12/31/2010.

CVS Caremark Response: Caremark has been unable to locate the information related to this PG item for the period ended 12/31/10. It should be noted that MUS terminated its contract with Caremark on 6/30/10.

Wolcott Finding 18: Wolcott noted that no information was provided for the PG item “Reporting/45 days” for MUS for the period ending 12/31/2010.

CVS Caremark Response: Caremark has been unable to locate the information related to this PG item for the period ended 12/31/10. It should be noted that MUS terminated its contract with Caremark on 6/30/10.

Wolcott Finding 19: Wolcott noted that no information was provided for the PG item “Reporting/60 days” for MUS for the period ending 12/31/2010.

CVS Caremark Response: This PG item was met. Please see the updated PG report for MUS 2010 below.

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2010.pdf

SUMMARY

It is Caremark’s view that we were in compliance with the contract and plan design for both State MT and MUS for the audit period of 1/1/2008 – 12/31/2009 for State MT and 7/1/2008 – 6/30/2010 for MUS.