The North Carolina State Health Plan for Teachers and State Employees

Performance/Efficiency Audit
Comprehensive Report

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Appreciations

Navigant Consulting, Inc. and its two subcontractors, MGT of America, Inc. and Intellogy Advisors, could not have completed this analysis without the assistance of the dedicated staff at the North Carolina State Health Plan (SHP). We wish to thank Jack W. Walker, Ph.D., Executive Administrator and Lacey Barnes, Deputy Executive Administrator, for their leadership and guidance throughout the project. We also appreciate the assistance of Linda Forsberg, Director, Health Plan Operations; Mona Moon, Chief Financial Officer; Tracy Stephenson, Director, Pharmacy Services and Wendy Greene, Legal Counsel for the SHP.

We also wish to thank the staff at Blue Cross Blue Shield of North Carolina (BCBSNC) and Medco Health Solutions, Inc. for their assistance in providing us with documents and for participating in interviews.

Executive Summary

The North Carolina Health Plan for Teachers and State Employees (SHP) provides health care coverage to more than 661,000 teachers, state employees, retirees, current and former lawmakers, university and community college personnel and their dependents. To administer this benefit for its members, the SHP contracts with two vendors: Blue Cross Blue Shield of North Carolina (BCBSNC), the medical benefits administration contractor and Medco Health Solutions (Medco), the pharmacy benefit manager.

The SHP contracted with Navigant Consulting, Inc. to conduct a review of the operations of these two vendors following concerns raised by various State agencies and oversight bodies regarding the performance and operation of the SHP. In particular, a State Auditor's report pointed to the loss of $80 million to the State for fiscal year 2008.

In addition to a performance and efficiency review of nine functions performed by BCBSNC: appeals, claims administration, customer services, finance, information technology and data reporting, membership accounting, provider relations and delivery systems and utilization and other medical management, Navigant Consulting, Inc. and its two subcontractors, MGT of America and Intellogy Advisors, reviewed Medco's performance and the pharmacy benefit program, and the governance structure of the SHP and the administrative services agreement that governs SHP's relationship with BCBSNC. The performance and efficiency review covered fiscal years 2006 through 2008. The following pages provide a summary of the in-depth reviews of each of the areas named above.

Findings and Recommendations

For each of the areas reviewed, we summarized key findings and made recommendations to respond to the detailed scope of work set out by the SHP in its Request for Proposals. The work was extensive and required the cooperation of BCBSNC and Medco as well as the executive team and staff from the SHP. Major findings and recommendations are highlighted here, with additional findings and recommendations and more discussion in the report which follows.

The first of the findings and recommendations for improvement presented in this summary focus on the governance of the SHP. For BCBSNC performance and the administrative service agreement between SHP and BCBSNC, we have grouped our key findings and recommendations into major themes. Finally, we discuss key findings and recommendations from the review of Medco's performance and the SHP's pharmacy program.

Governance

The SHP's governance structure is unique. In contrast to the SHP, many states operate their health plans through an executive branch agency and several of these organizations are overseen by a governing board. The SHP reports to the legislative oversight committee. The

legislative oversight committee lacks the capacity and resources to govern the SHP effectively and has limited availability to devote proper attention to monitoring. In addition, the Board of Trustees lacks the authority to govern the SHP because North Carolina Statutes have not granted the board any type of decision-making responsibility. Finally, there has been very little oversight of the SHP performed by any other body within state government.

Recommendations:

- **The State should make the SHP an independent agency accountable to both the Governor's Office and a governing board. Under this approach, the SHP can be in direct communication with the Governor's Office and control agencies on all issues pertaining to state government matters, including budgeting, accounting and administrative activities affecting executive branch agencies.**[1]

- **The State should discontinue the operations of the current Board of Trustees and establish a new governing board, tasked with the direct authority to manage its operations. The State should establish a formal charter for the governing board, and a set of guiding principles, and allow for an appropriate balance of representation on the governing board. The General Assembly should seek to discontinue the existence of the State Health Plan Administrative Commission, since the primary functions of that commission could be absorbed within the new governing board.**

Overall Summary Findings and Recommendation Regarding BCBSNC Performance

Major findings related to BCBSNC's performance in administering the SHP's medical benefits are:

BCBSNC's cost allocation methodology, policies and procedures complied with the Administrative Services Agreement terms, but the Agreement provides wide latitude in the types of costs that BCBSNC can charge to the SHP.

One of the key provisions of the administrative services agreement between the SHP and BCBSNC is the cost-plus arrangement. This means that the SHP reimburses BCBSNC for all direct and indirect costs related to providing services for the SHP, as well as a share of overhead costs, as long as these are allocated in accordance with the same methodology used to allocate costs to other BCBSNC lines of business. The "plus" refers to a profit allowance of 0.625 percent. Under this "cost-plus" arrangement, SHP is bearing 100 percent of the business risk. With the cost-plus methodology, BCBSNC will always make a profit and has no risk of incurring a loss if its costs increase. Thus, BCBSNC has no incentive to control or reduce its

[1] Control agencies are those state agencies that oversee the operational or administrative functions of all state agencies. Examples include the State Controller's Office (financial reporting), the Office of State Personnel (statewide hiring practices), and the Office of State Budget and Management.

costs. **BCBSNC's cost allocation methodology, policies and procedures for charging direct, indirect and overhead costs, resulted in a consistent and equitable approach for distributing costs to various lines of business, including the SHP, and complied with Administrative Services Agreement terms.** However, **the Administrative Services Agreement does not provide definitions of allowable versus unallowable costs; nor does it prohibit or limit cost centers or cost types (such as lobbying, contributions, donations and gifts, public relations and advertising and entertainment expenses) that can be charged to the SHP**. Further, **the Administrative Services Agreement places no cap on the amount of overhead or indirect costs that BCBSNC can charge to the State**. As a result, the SHP can and does, receive allocated portions of all cost centers that can be justifiably deemed by BCBSNC to benefit the SHP.

To strengthen a cost-plus contract so that it contains the proper controls on the types of costs that can be charged would require including definitions of unallowable costs and specifying caps on indirect or overhead costs and total costs expressed as a per member per month (PMPM) amount. In addition, a cost-plus contract requires continuous cost reporting by the contractor and monitoring by the SHP, thus creating administrative burdens for all parties involved. A more direct and efficient method is to contract for administrative services on a flat per member per month fee basis. Such methods are more commonly used today between administrative services organizations and health benefit plans than cost-plus arrangements.

Recommendation:

- **The SHP should discontinue the use of cost-plus arrangement in favor of a flat fee arrangement in future agreements for administration of its medical benefits.**

The Administrative Services Agreement is non-prescriptive in terms of performance and provides limited operational and management guidance in key areas.

The audit team found that BCBSNC's service performance in many functional areas was generally consistent with industry standards and met requirements of the Administrative Service Agreement and North Carolina regulatory requirements**.** For example, information technology applications and systems used to process SHP membership information and claims were stable and there were minimal instances of system downtime. The Membership Accounting area maintained a consistent level of service, timeliness and accuracy in processing SHP member applications and files and issuing member identification cards. The Claims Administration area generally maintained high levels of member and provider satisfaction with claims processing timeliness. The Customer Service area met the performance guarantee levels for measures specified in the Administrative Service Agreement such as time required to resolve SHP members' inquiries and its staffing levels adjusted appropriately with call volume. BCBSNC also maintained a broad provider network that provided SHP members with appropriate levels of access to a variety of providers and services. In addition, the audit team determined that, with a few exceptions, the utilization management call centers for the SHP's

Preferred Provider Organization (PPO) and Comprehensive Major Medical (CMM) products performed at or better than industry standards. The audit team found that BCBSNC complied with North Carolina statutory and regulatory requirements for credentialing and recredentialing providers, processing SHP member appeals and grievances and notifying SHP members and their providers about utilization management decisions on service authorization requests. The audit team also found that all licenses were current for the sample of utilization management clinical staff dedicated to the SHP reviewed.

Although BCBSNC's performance met the requirements of the Administrative Services Agreement, the Agreement does not identify and require performance metrics for the full-range of operational functions that BCBSNC provides. Additionally, the Agreement includes metrics that may not be the best measures of performance. Finally, **throughout the audit period, and currently to some extent, the Administrative Services Agreement has restricted periodic and ongoing access to information, such as key performance measures and cost data that the SHP needs to effectively and efficiently oversee BCBSNC activities and report to the legislature**.

Recommendations:

- **The SHP should start now to work with BCBSNC to identify the information it needs to effectively manage and monitor the contract and to periodically update the exhibits to the Administrative Agreement which specify the types of data it needs and timelines for reporting.**

- **The SHP should also develop and implement a plan for monitoring and management that includes policies and procedures that delineate roles and responsibilities, identify key decision-makers and provides escalation paths for both the SHP and BCBSNC.**

There is information and analysis that would be useful to the SHP in managing its medical benefits, but the Administrative Services Agreement does not require BCBSNC to provide such information or conduct such analysis.

BCBSNC did not provide the SHP with sufficient detail regarding BCBSNC's return on investment analyses of its medical policies and authorization requirements for its utilization management program. The audit team could not determine if the activities that the utilization management staff are performing are achieving any medical expense savings for the SHP. In the appeals area, the lack of information related to the underlying causes of appeals and grievances makes it difficult to understand the significant increases in the number of medical benefit appeals and grievances per member during the audit period. Analysis of trends in appeals and grievances could reveal benefit coverage issues that the SHP needs to address, for example if there are consistent denials of services that the SHP believes should be covered, or if members need to be advised of prior authorization or other requirements to obtain coverage.

BCBSNC did not conduct adequate planning for the implementation of the PPO product on the PowerMHS system.

In October 2006, the SHP began offering BCBSNC's PPO product to members and BCBSNC began supporting SHP members who selected the PPO product on PowerMHS, the administrative system that BCBSNC was using for the rest of its commercial lines of business. The transition of the SHP members from the CMM product supported on the Long Range System Planning (LRSP) system to the PPO product supported on PowerMHS had, and continues to have, significant impacts on several functional areas: Information Technology and Data Reporting, Claims Administration and Membership Accounting. **The BCBSNC information technology department underestimated the complexity associated with transitioning SHP members to the PPO product on the PowerMHS system and did not conduct adequate planning for the transition. This lack of adequate planning was evident in greater than anticipated costs to the SHP in the Information Technology area, but was also evident in the loss of efficiency and productivity in the Claims Administration and Membership Accounting functional areas. The loss in productivity resulted from the way BCBSNC configured the PowerMHS system for the SHP business.** Within BCBSNC, the information technology department is responsible for making system changes and developments to the core PowerMHS system. However, the operational business areas, notably claims administration and membership accounting, are responsible for setting up PowerMHS from a product and business structure standpoint to support various lines of business. If the information technology department had adequately planned for the transition of SHP members to PowerMHS there would have been significant involvement by the claims administration and membership accounting areas in the system configuration. **However, the audit team found no evidence of integrated work performed by the Information Technology and operations areas for system configuration to support effective and efficient, end-to-end processing of SHP business.** There was a lack of integration among various business units at BCBSNC and the organizational silos may have hampered the cross-functional planning necessary to implement the PowerMHS system for the PPO.

Recommendations:

- **BCBSNC's information technology department should increase the rigor with which it plans for activities such as the transition of members from the CMM to the PPO product.**

- **BCBSNC should make configuration, workflow and productivity enhancements to PowerMHS and establish a formal continuous improvement process for the claims administration and membership accounting areas.**

BCBSNC did not provide information about potential cost increases associated with the implementation of the PPO plan on the PowerMHS system that affected the SHP.

It appears that BCBSNC did not effectively communicate with the SHP about cost and implications of transition to the PowerMHS system. BCBSNC communicated with the SHP about the $16 million needed for extra internal and external staffing during the transition, equipment and software and facility costs related to implementing the PPO product, which are now being amortized each month to the SHP as part of the administrative costs. However, BCBSNC did not communicate with the SHP about the increase in costs in the claims administration and membership accounting areas from the loss in productivity and efficiency due to PowerMHS system configuration issues. Another action related to the transition to the PowerMHS system that had cost implications for the SHP that BCBSNC did not communicate was discontinuation of *Blue e*, a tool which provided state agencies self-service capability to perform membership information maintenance for their employees covered by the SHP. BCBSNC's failure to communicate these cost implications to the SHP may be because it did not fully understand the implications itself, which points again to the inadequate cross-functional planning necessary to implement the PowerMHS system for the PPO.

Recommendation:

- **BCBSNC should establish a process to thoroughly evaluate the cost and service implications of proposed changes to functional areas such as claims administration and membership accounting and communicate the results of the evaluation to the SHP prior to implementing changes. SHP should be included in decisions that cause major increases in the cost of providing services.**

BCBSNC is not monitoring the quality and efficiency of performance of its recovery functions, including recoveries for fraud and abuse. Nor does BCBSNC clearly establish organizational goals for recoveries. In addition, management reporting – including dashboards – about recoveries is not comprehensive or measured against external benchmarks.

Without proper information about recoveries, BCBSNC management cannot take corrective action.

The retroactivity process can be improved to reduce inappropriate and incorrect claim payments to providers.

The retroactivity processes at BCBSNC support "pay and pursue" or "retrospective analysis", that is, BCBSNC pays the provider and then attempts to collect any overpayments that have occurred based on its review of the service. A defined process to develop and continuously improve prepayment edits in the claim processing system that assure that claims are paid correctly does not exist. Additionally, processes do not support full transparency to the SHP regarding identification and recovery of claim dollars. Furthermore, the overall structure of the retroactivity process does not support direct accountability to the SHP. BCBSNC contracted with a variety of recovery vendors during the audit period, but its contractual relationships

with the various vendors were unclear and BCBSNC did not track or measured the vendors' performance against industry benchmarks.

Operations within the Special Investigations Unit lack appropriate controls and do not meet industry standards.

The Special Investigations Unit is the department within BCBSNC that is responsible for detecting, investigating, reporting and preventing fraudulent, wasteful or abusive activity. Annual recovery goals for the Special Investigations Unit were not well-defined or documented. Further, anti-fraud software, used to identify aberrant billing practices, was not in use during the entire audit period. BCBSNC did implement an anti-fraud software application, called EDI Watch, in 2007. BCBSNC's level of fraud recoveries for the SHP is well below the industry average. For every $1 the SHP spent on fraud and abuse detection, the SHP received only 10 cents in actual fraud recoveries.

Overall, the BCBSNC recovery dollars are equal to a little more than 1 percent of the SHP's total medical expenses, which is significantly below the industry average of 3 to 5 percent. In response to this finding in the draft report, BCBSNC stated that it achieved $2,006,469 in fraud and abuse recoveries and $822,472 in savings due to prepayment interventions. **However, BCBSNC did not provide any supporting documentation to substantiate these amounts or indicate the time period to which these amounts pertained.** Thus, the audit team did not include these amounts in its analyses of recoveries. A recovery improvement of two percent of the SHP's medical claims expense, which totaled $2.2 billion in fiscal year 2008, would yield significant savings for the SHP.

Recommendations:

- **BCBSNC should implement a formal recovery function improvement program with full transparency to the SHP that includes the ability to establish State prioritization over other initiatives.**

- **BCBSNC should develop an action plan to improve recoveries through engagement of vendors and tools that increase recoveries related to other carrier liability, subrogation and fraud and abuse**.

- **The SHP should weigh the cost and benefits of outsourcing all recovery functions to outside vendors and consultants.**

<u>Pharmacy Benefits Management and the SHP's Pharmacy Program</u>

Unlike the SHP's Administrative Services Agreement with BCBSNC, its contract with Medco is not a cost-plus arrangement. Rather, the contract between Medco and the SHP has two major cost components – fees and drug pricing. Medco charges an administrative fee and a utilization management fee to the SHP. In general, **Medco met its contractual obligations to the SHP; the**

administrative and utilization management fees and the discounts offered the SHP for brand and generic drugs during the audit period were consistent and competitive with industry standards. In addition**, Medco's operational processes and core functions and systems are efficient, standardized and highly automated.** There are some areas where the contract between the SHP and Medco could be improved, however**.** In future pharmacy benefit management (PBM) contracting, the SHP should require access to and transparency of information that is important to its management of the pharmacy program. Requiring the PBM to disclose certain pricing information would enable the SHP to audit the competitiveness of pricing.

There is a gap in alignment between the Medco contract and the SHP's current benefits and therefore, the SHP cannot take full advantage of several incentives in the contract. The SHP was not able to implement programs and initiatives recommended by Medco that would have improved drug cost savings for the SHP and its members, because North Carolina statute and regulations preclude the implementation of some of these recommendations. **North Carolina General Statue 135-45.6 does not support the SHP in providing its members with a pharmacy benefit offering that is consistent with industry standards and that delivers significant savings.**

Recommendations:

- **The SHP should increase mail order utilization to achieve greater cost savings for it and its members.**

- **The SHP should implement a more comprehensive specialty pharmacy program. The audit team notes that in 2009, beyond the audit period, the SHP implemented a specialty pharmacy program.**

- **The SHP should continue to encourage generics utilization to achieve cost savings for the SHP and its members. The audit team notes that in 2009, beyond the audit period, the SHP implemented a benefit change to encourage generic utilization.**

- **One area where the SHP can implement changes without legislation is in the specialty pharmacy area. The SHP could improve coordination of specialty pharmacy drugs between those billed under the medical benefit and those billed under the pharmacy benefit to decrease the potential for double billing.**

- **The SHP should establish a single set of prior authorization criteria for drugs covered under both the medical and pharmacy benefits.**

- **The SHP should implement a process to routinely audit for duplicate billing of specialty pharmacy claims.**

Potential Cost Savings From Implementation of Recommendations Related to BCBSNC Performance

In many of the BCBSNC functional areas, the audit team identified savings opportunities and quantified the savings to the SHP that would be achieved from implementation of its recommendations. These savings estimates total approximately $5.8 million over the four fiscal year period of 2011 – 2014. The savings estimate for fiscal year 2011 of approximately $2.7 million represents a 2.4 percent reduction from BCBSNC's total administrative costs of $110.5 million billed to the SHP in fiscal year 2009.[2] These estimates of potential savings apply to the SHP's entire membership.

In addition, our recommendation that BCBSNC take immediate steps to improve its retroactivity and recovery processes, including improvement of the fraud and abuse recovery initiatives represents a significant savings opportunity for the SHP. The audit team found that BCBSNC's recovery dollars were approximately one percent of the SHP's total medical claims expenses, which is significantly below the industry average of three to five percent. A recovery improvement of two percent of the SHP's medical claims expense, which totaled approximately $2.2 billion in fiscal year 2008, would yield significant savings for the SHP.

Potential Cost Savings From Implementation of Recommendations Related to the SHP's Pharmacy Program

The audit team quantified potential savings for its recommendations that relate to the SHP's pharmacy benefit program. These estimated potential savings to the SHP total $53.75 million over the four fiscal year period of 2011 – 2014.

These savings would be realized through the following pharmacy program changes:

- Establish mail order copayment incentives to increase SHP member mail order utilization. Increased mail order utilization would achieve drug cost and administrative cost savings for the SHP.
- Maximize generic utilization with mandatory generic substitution with SHP members paying the difference between the costs of brand and generic drugs.
- Implement a more comprehensive specialty pharmacy program and a process to audit for duplicate billing of specialty pharmacy claims under the pharmacy and medical benefits.

These estimates of potential savings apply to the SHP's entire membership. Legislation would be required for the SHP to implement the first recommendation above.

[2] The $110.5 million in administrative costs excludes profit, amortization of costs for converting from the CMM plan to the PPO plan and access fees.

Blue Cross Blue Shield of North Carolina Comments on Comprehensive Report Executive Summary

This is an Executive Summary response to Navigant's Comprehensive Report. These points, and more, are explained in BCBSNC's responses in the second half of the Comprehensive Report and in each of Navigant's individualized reports.

Blue Cross and Blue Shield of North Carolina (BCBSNC) is pleased that the Navigant audit confirmed that BCBSNC is living up to its contract with the State Health Plan (SHP) and providing quality service at a fair cost. Navigant is the third auditor in a year to verify this fact. Navigant has also found that BCBSNC's administration of the SHP's benefits has been consistent and at a reasonable cost. In fact, Navigant found that BCBSNC's administrative costs are substantially lower than benchmarked companies. According to Navigant, if the SHP and BCBSNC implemented all of the recommended changes, BCBSNC's total administrative cost, not including implementation cost, could potentially be reduced by approximately 1 percent per year over the next four years.

BCBSNC believes that Navigant has reported accurately from an overall perspective, but many aspects of the in-depth analysis are inaccurate or misleading. Below BCBSNC points out, at a high level, some of the items of agreement and disagreement with the audit report. BCBSNC's detailed responses are included in each of the functional area audit reports.

It is important to note that the audit timeframe was July 2005 through June 2008. Many of the concerns raised by Navigant are at least two years old and have already been addressed by BCBSNC as part of its normal business practices.

BCBSNC agrees that there are opportunities for continued improvement:

- Presenting the SHP with **more detailed recovery information** and jointly establishing recovery goals.
- **Boosting overpayment recoveries**. BCBSNC has already contracted with multiple recovery vendors and anticipates that financial recoveries will increase with these new vendors.
- **Increasing coordination** efforts between IS and operations areas which may result in higher quality and greater efficiencies.
- **Continuing to look for gains in efficiencies** in all aspects of the services and systems related to the administration of the SHP.

There is also a need to clarify some of the items contained in Navigant's audit report as noted below.

- **Actual costs for implementing/operating the PPO plans have either aligned with or have been better than estimates, resulting in overall savings to the SHP.** BCBSNC and the SHP worked collaboratively to introduce and administer a set of PPO plans to the SHP members. During initial discussions, the SHP expected that a set of PPO plans would have slightly higher administrative costs (which would be offset by medical savings) as compared to the CMM plans. The SHP was more interested in the potential

medical cost savings associated with the new PPO offering. BCBSNC provided the SHP with several cost estimates, including an estimated cost range of creating the PPO plan. BCBSNC's performance was better than the estimates.

- **The creation and transition to the PPO plans was incredibly complex.**, BCBSNC was challenged to implement the plans within an aggressive seven-month timeframe. The SHP requested that the three PPO plans be introduced in the middle of a benefit year. Prior accumulators (e.g., deductibles and coinsurance) had to be transferred. New benefit booklets had to be written and mailed. Customer Service maintained member satisfaction while fielding a variety of questions related to the new plans. All of these complexities were explained to the SHP and taken into consideration during the transition to the PPO plans. **BCBSNC created, established and serviced three PPO products at a cost within the estimated range provided to the SHP.**

Navigant found that the SHP obtained a quality product at an administrative rate competitive at the best benchmarked tier. Member satisfaction has remained high. The North Carolina State Auditor's report found that health care is more affordable under the PPO plans. BCBSNC will continue to work with the SHP to find additional efficiencies as it provides SHP members reliable health coverage at a reasonable cost.

With respect to cost, Navigant proposes some changes that it believes would result in savings to the SHP. However, in its proposals, **Navigant makes several unsubstantiated assumptions, resulting in inaccurate figures related to the potential savings calculation under Table 4 of this Comprehensive report:**

- Membership Accounting potential savings assumes that the department could function with a 75 percent reduction in staff. It cannot function effectively at that level.
- Navigant's "ideal" cost for Claims Administration is based on the cost to administer the CMM product and is, therefore, not an appropriate standard to apply to PPO products. It would be more appropriate to base the comparison on industry benchmark. When Navigant did so, **it found that BCBSNC's cost to administer the PPO products is significantly better than industry standard.**
- In reference to the projected IT and Data Reporting savings, Navigant assumes that big systems changes are coming in 2011. BCBSNC is not aware of any such changes. If there are, this calculation would need to take into account the implementation expense of achieving such savings.
- Utilization Management potential savings assumes the SHP has an average population; it does not. **SHP members use anywhere from 15 percent to 40 percent more services than a typical PPO plan population.**

It is also important to recognize there will be costs associated with implementing Navigant's recommendations. For example, Navigant's recommendation to require SHP approval for systems changes actually would require BCBSNC to establish a separate system for the SHP. The SHP would lose the benefit of a shared-savings platform, resulting in substantial increases in cost. Furthermore, this could result in inconsistent administration of provider contracts.

BCBSNC has been responsive to all inquiries from Navigant during the audit. Sometimes the responses contain proprietary and confidential information. In order to keep costs low, BCBSNC must require that its proprietary and confidential information stay out of third-parties' hands. BCBSNC will continue to protect such information.

Pharmacy Pages E-14 and E-15

Recommendation 5: Medco should extend access to its Therapeutic Resource Centers programs to SHP members with chronic and complex conditions who receive their medications at retail pharmacies.

Medco Response: Medco notes that the Therapeutic Resource Centers (TRC) are not limited to members using Mail Order. Please note that any members calling the Medco Customer Service are automatically stratified to the appropriate TRC depending on their disease state and are provided the opportunity to speak to a Medco specialist pharmacist. Additionally, the Health Action Plan identifies financial and clinical gaps in care regardless of the patient being at retail or mail. Medco does not agree with the "gap in clinical services" as mentioned. Medco notes no issue.

Recommendation 8: Medco should improve its prior authorization form and process to minimize the administrative errors that result in denials and courtesy appeals.

Medco Response: Please note that Medco is not able to determine whether a case is an "administrative error" or an appeal. Medco must take the provider at their word when the sign the fax form and send it in to us. Hence, Medco handles all "corrections" as appeals. This is for audit purposes. Additionally, Medco has not received any significant feedback that this has been an issue. Medco notes no issue.

I. Introduction

Overview of the Performance Review

Navigant Consulting, Inc. and its two subcontractors, MGT of America and Intellogy Advisors, conducted the performance and efficiency review of the North Carolina Health Plan for Teachers and State Employees (SHP). The SHP requested this review following concerns raised by various State agencies and oversight bodies regarding the performance and operation of the SHP. In April 2009, the North Carolina State Auditor's Office issued a report of its findings and recommendations following a performance audit of the SHP. The State Auditor noted significant deficiencies, finding that the SHP had come in close to $138 million off of its budget for fiscal year 2008, resulting in an almost $80 million loss to the state. The audit report found that the SHP underestimated total claims expenses by $163.8 million and that costs under both the Comprehensive Major Medical (CMM) and Preferred Provider Organization (PPO) plans failed to meet expectations. The auditor's report of the losses by the SHP came at the same time that the North Carolina General Assembly was working to close budget gaps in a time of diminishing revenues and increasing expenses.

The SHP requested reviews of the governance structure, administrative services agreement and 10 functional areas:

- Provider Relations and Delivery Systems
- Membership Accounting
- Utilization Management
- Other Medical Management
- Appeals
- Customer Services
- Claims Administration
- Information Technology and Data Reporting
- Finance
- Pharmacy Management

This report provides a comprehensive overview of the audit team's findings related to the performance and efficiency review. In addition, Navigant Consulting prepared an individual report for each of the areas included in this review. Each individual report contains detailed descriptions of processes, procedures, findings and recommendations.

Appendix A describes the approach to the performance review. Appendix B lists individuals interviewed and Appendix C lists materials reviewed as part of the performance review.

Governance of the SHP

The SHP operates as an agency within state government, but reports to a legislative oversight committee, which has the primary responsibility for overseeing the SHP. Within the North Carolina General Assembly, the Committee on Employee Hospital and Medical Benefits (Oversight Committee) has the primary responsibility for overseeing the SHP. The responsibility for day-to-day management of the SHP is assigned to the executive administrator of the SHP, who is responsible for all of its key operations, including membership functions, provider and participant relations, communications and negotiation and execution of contracts with third-parties to carry out plan activities. State law also established the creation of the Board of Trustees of the SHP. The Board is responsible for reviewing claim appeals and providing guidance to the executive administrator in developing policies. A discussion of the responsibilities and authority of the entities that are involved in the administration and governance of the SHP is provided in Appendix D of this report.

SHP Organization and Operations

The SHP provides health care coverage to more than 661,000 teachers, state employees, retirees, current and former lawmakers, university and community college personnel and their dependents. To administer this benefit for its members, the SHP contracts with outside vendors: Blue Cross Blue Shield of North Carolina (BCBSNC), the medical claims processing contractor and Medco Health Solutions (Medco), the pharmacy benefit manager (PBM). These contactors are referred to by name and as the Administrative Service Organizations (ASOs) throughout this report.

The SHP has seen many changes to its organizational and oversight structure and the types of plans offered. At the beginning of the audit period, June 2005, the SHP offered only an indemnity, CMM plan. In February 2006, the SHP signed an administrative services agreement with BCBSNC so that effective October 2006, the SHP could begin transitioning to a new benefits plan, offering three PPO plans, with a high, medium and low option in addition to the indemnity plan. The SHP gradually transitioned all members to the PPO, with the indemnity plan being eliminated as of July 2008. Recent legislation eliminated the high or PPO plus option effective July 1, 2009, leaving two PPO options for its members. The administrative services agreement expires in June 2013, with optional renewal periods until June 2016.

In signing the administrative services agreement, however, the then-executive administrator exercised an option to sign a sole-source agreement with BCBSNC and did not seek competitive bids. Additionally, the executive administrator did not seek a review of the administrative services agreement terms with legal counsel or the North Carolina State Attorney General's office.

Appendix D provides an overview of the history of the SHP and of the need for this audit.

BCBSNC Services Provided to the SHP

An understanding of the separate processes carried out by functional area staff is helpful to better understand the significance of the findings and recommendations. Table 1 below provides an overview of the functions that BCBSNC provided to the SHP during the audit period for the SHP. Each functional area report provides more detailed description of processes and procedures.

Table 1: Overview of BCBSNC Functional Areas and Services Provided for SHP

Functional Area	Services
Provider Relations and Delivery System	• Credential and recredential network providers • Negotiate provider reimbursement • Monitor network access and availability • Maintain the provider directory
Membership Accounting	• Process enrollment information from groups, employees and retirees • Make changes to eligibility information files such as adding dependents and changing choice of plan • Generate member identification cards and welcome kits • Bill state and local agencies for their employees' premiums • Post and reconcile state and local agencies' premium payments • Administers Consolidated Omnibus Budget Reconciliation Act (COBRA) health care continuation[3]
Utilization Management	• Manage members' use of health care resources • Interface with case management, disease management and behavioral health services utilization management vendors • Develop and analyze the medical policies and review criteria used by utilization management staff
Other Medical Management	• Serve as point of contact for members in select general acute care hospitals • Assist with initial reviews for inpatient care • Facilitate the discharge planning process • Approve discharge services
Appeals	• Provide escalating levels of review to address members' requests for a review of a formal decision related to medical necessity, benefits, contractual issues or quality of care • Process pharmacy benefit-related appeals and grievances
Customer Service	• Respond to member and provider telephone inquires • Respond to member and provider written inquiries

[3] The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events.

Functional Area	Services
Claims Administration	• Determine benefits • Administer medical policy • Receive, adjudicate and pay claims • Identify and adjust claims related to overpayment and fraud
Information Technology and Data Reporting	• Manage information systems hardware and business and application management of services such as claims processing, enrollment processing, adjudication services, internal and external interfaces • Manage services such as analytical data warehouse capture and support reporting, including service level reporting in managing contractual obligations
Finance	• Maintain the corporate accounting structure and cost accounting system • Monitor trends in administrative costs

Medco Organization and Operations

The specialized nature of pharmacy management often has the pharmacy benefit administered separately from health plan medical benefits. While some health plans choose to administer pharmacy benefits in-house, the SHP has contracted the management of its pharmacy program to a PBM – Medco. Medco is one of the country's largest pharmacy benefits management companies and assists health plans in managing drug costs by designing drug formularies, negotiating discounts with pharmaceutical companies and processing claims. Medco provides the following services to the SHP:

- Pharmacy customer service
- Pharmacy claims processing
- Pharmacy network pricing
- Manufacturer contracting
- Pharmacy program management and support
- Clinical pharmacy management

Regulations that Govern the SHP and its Administration

The SHP is governed by North Carolina statute and overseen by the legislature. North Carolina General Statute (N.C.G.S.) Chapter 135 authorized the creation of the SHP and prescribed the organizational structure of the entity within the context of state government. The statute establishes the roles of the legislative oversight committee, the executive administrator of the SHP and the Board of Trustees of the SHP. N.C.G.S. Section 135-44.3 states that any references in Chapter 135 to the "Executive Administrator and Board of Trustees" means that the executive

administrator shall have the power, duty, right, responsibility, privilege, or other function mentioned, after consulting with the Board of Trustees.

The benefit options offered by the SHP are authorized under Article 3A of N.C.G.S Chapter 135, various Session Laws enacted by the North Carolina General Assembly, and select provisions of Chapter 58 of the North Carolina General Statutes regarding insurance laws. The SHP pharmacy program is specifically governed by N.C.G.S. 135-45.6.

Additionally, there are North Carolina statutes and administrative code related to the operations of all health plans in the state. These regulations, which affect the operations of the BCBSNC functional areas, are detailed in each functional area report.

II. Findings and Recommendations

Each of the sections that follow provides the audit team's findings and recommendations regarding the functional areas reviewed. The findings and recommendations are organized according to the area to which they relate:

- Governance of the SHP
- Contracts with Administrative Services Organizations
  - SHP's Administrative Services Agreement with BCBSNC
  - SHP's Contract with Medco
- BCBSNC Performance
- Medco Performance and the SHP's Pharmacy Program

In addition, we have identified where legislation is required to implement specific recommendations. Following the discussion of the major findings and recommendations are estimates of the potential savings from implementing our recommendations.

Governance of the SHP

The audit team determined that the **SHP's governance structure is unique.** In contrast to the SHP, many states operate their health plans through an executive branch agency and several of these organizations are overseen by a governing board.[4] The involvement of a legislative committee as an oversight entity and the lack of an authoritative board to govern operations create a number of challenges to the SHP as it works to maintain effective leadership over the organization.

First, the Oversight Committee lacks the capacity and resources to govern the SHP effectively. In particular, an ongoing challenge of having a legislative body in an oversight role is the limited availability to devote proper attention to monitoring responsibilities. Legislators have numerous responsibilities while serving in their elected offices and likely find it difficult to dedicate sufficient time and resources towards managing a multibillion dollar benefits plan. Moreover, the General Assembly convenes for only a portion of the year, thereby limiting the availability of the legislators to stay involved with the SHP.

In addition, **the Board of Trustees lacks the authority to govern the SHP.** North Carolina Statutes have not granted the board any type of decision-making responsibility related to plan

[4] Appendices C and D in the Governance functional area report summarize the governance structure and other characteristics of those plans.

operations. Specifically, N.C.G.S. Section 135-44.3 states that any references in Chapter 135 to the "Executive Administrator and Board of Trustees" means that the executive administrator shall have the power, duty, right, responsibility, privilege, or other function mentioned, after consulting with the Board of Trustees. However, the statutes do not reference any power vested with the board to authorize or approve actions assigned to the executive administrator. Consequently, the executive administrator could carry out specific actions contrary to the Board's desires.

Previous governance reviews have identified similar issues with the governance of SHP. The Office of the State Auditor reported concerns about the inadequacy and ineffectiveness of the SHP's oversight in 2008 and in 1994.

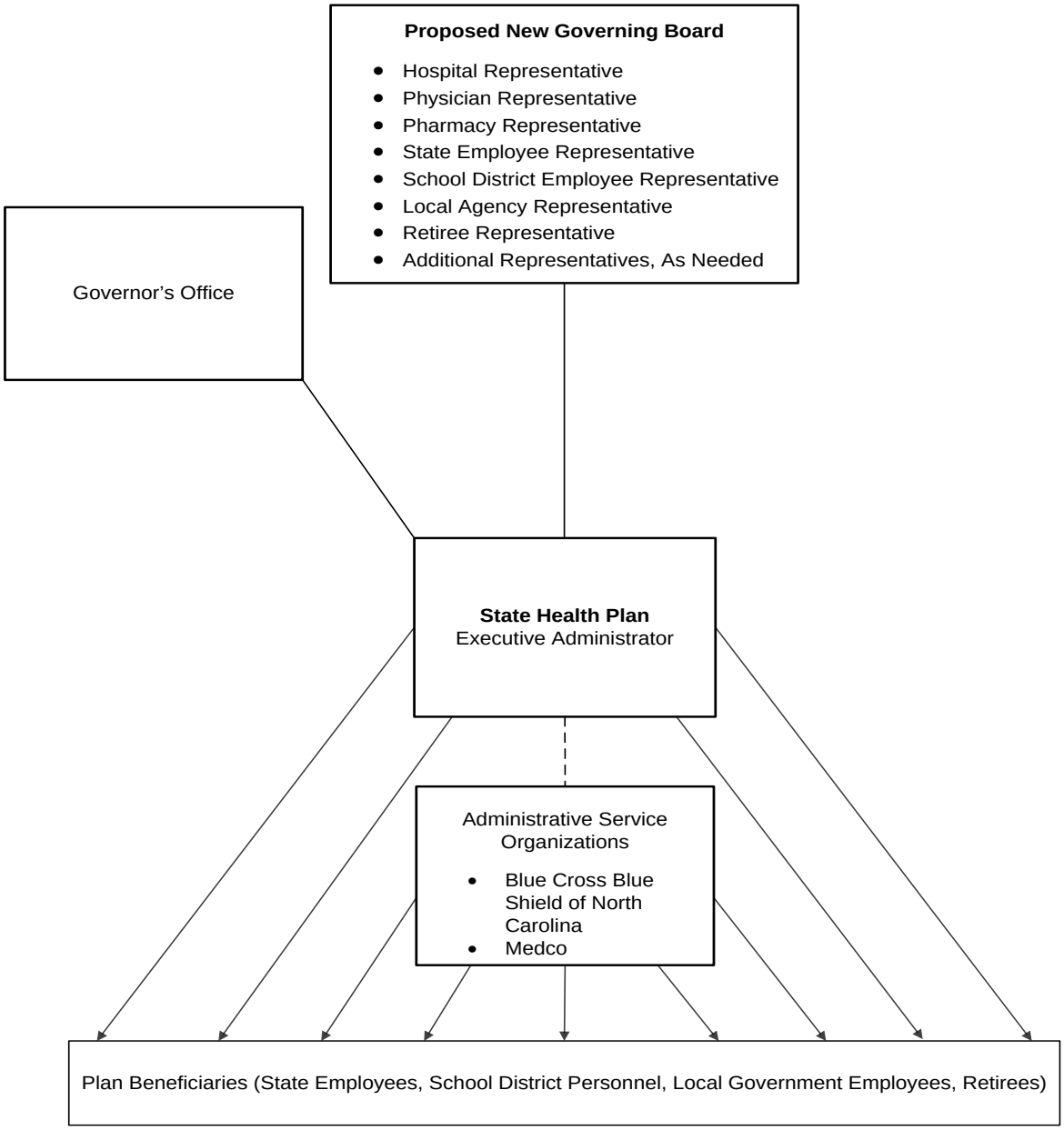
Finally, **there has been very little oversight of the SHP performed by any other body within state government.** The Governor's Office has had minimal direct involvement with the SHP; its interaction has been limited to dealing with budgeting issues through the Office of State Budget and Management. Other state agencies, such as the State Controller's Office, conduct routine services on behalf of the SHP, but do not perform any type of monitoring function.

Recommendations:

Recommendations regarding improved governance, for the most part, require changes to general statutes or creation of new policies and changes which cannot be accomplished solely by the SHP or its oversight committee.

- **The State should make the SHP an independent agency accountable to both the Governor's Office and a governing board.** This bifurcated structure will allow the SHP to be organized under the executive branch, with a governing body that assumes responsibility over operations and policy decisions. Under this approach, the SHP can be in direct communication with the Governor's Office and control agencies on all issues pertaining to state government matters, including budgeting, accounting and administrative activities affecting executive branch agencies. The General Assembly should seek to discontinue the existence of the State Health Plan Administrative Commission, since the primary functions of that commission could be absorbed within the new governing board. Figure 1 shows the recommended governance structure of the SHP.

Figure 1: Proposed Revisions to Governance Structure of the SHP



- **The State should discontinue the operations of the current Board of Trustees and establish a new governing board, tasked with the direct authority to manage its operations. The State should develop parameters to allow for an appropriate balance of representation on the governing board.** The State should also allocate at least three positions on the board for representatives with knowledge and experience in the medical and business field with pertinent experience. In addition, the prescribed mix of remaining members should represent the various participants of the SHP, while also factoring the desire for subject-matter knowledge and professional experience in administering health plans. At a minimum, the State

should consider requiring representation of at least one dedicated position on the governing board by each of the major groups of participants, including active state employees, school district personnel, local agency representatives and retirees. The State should designate additional positions if any of the groups are proportionally larger than the others. When selecting candidates to serve on the new governing board, the State should develop a methodology for ensuring a fair and equitable selection of competent board members. The State can apply best practices of other governments in developing its formal selection process.

- To provide the proper framework for exerting its oversight responsibilities effectively, **the State should establish a formal charter for the governing board, and a set of guiding principles.** The charter serves as the reference source to ensure consistency and continuity in the board's responsibilities as turnover among board members occurs over time. Key elements of a charter include a mission statement, goals and objectives and board responsibilities and protocols. The purpose of the guiding principles is to provide a high-level framework which the board can refer to whenever evaluating alternate courses of action and provide the criteria against which the SHP's policies and procedures will be evaluated. The principles can be revisited at any time and revised by the board as needed.

- **The State should develop a formal selection process to ensure an appropriate level of competence among governing board members**. Members of governing boards are entrusted to make decisions that are in the best interest of the public. Likewise, there is a common expectation that board representatives have the appropriate knowledge and background required to perform their duties. Consequently, it is incumbent upon the State to ensure that the process for evaluating potential board members focuses on the desired characteristics of such representatives.

- The governing board should work with the executive administrator to develop a formal communications and reporting relationship to allow for effective oversight and follow up. As the consolidated authoritative oversight entity, the governing board should have direct access to all key information and have the expectation that the SHP will provide meaningful and understandable reports. Elements of a communications and reporting structure that have proven to be effective in other organizations include:

- Timeline or schedule identifying frequency of written and verbal communications

- Identification of individuals tasked with communication responsibilities

- Preparation of agendas and information packets for board meetings

- Report templates identifying the data items, records, summaries, and financial data

- Protocol for following up on questions identified during the board's review of reports, including response time and format

- Protocol for addressing communication concerns

- **The governing board should interact frequently and closely with the executive administrator**, particularly during the board's initial formation when its members are being asked to take on more responsibility beyond the role of the Board of Trustees. To the extent that the governing board gains comfort with the SHP's methods of communication, it can modify the frequency, volume, and nature of the communications.

- Similar to the reporting structure with the proposed governing board, **the SHP should develop a formal communications strategy for periodically communicating its financial and operational status with the General Assembly and Governor's Office.** Although the earlier recommendations address the need for the governing board to exert control over plan management, the SHP should also communicate with the legislative and executive branch leadership to ensure that issues affecting the financial outlook of the SHP are communicated in a timely manner.

SHP Contracts with Administrative Services Organizations

The Administrative Services Agreement is the contract between the SHP and BCBSNC for administering the SHP's medical benefits. The SHP has a separate contract with Medco for administration of the SHP's pharmacy benefits. These contract documents list the obligations and rights of the SHP as well as BCBSNC and Medco, and provide guidance for the provision of services to members.

SHP's Administrative Service Agreement with BCBSNC

One of the key provisions of the Administrative Services Agreement between the SHP and BCBSNC is the cost-plus arrangement of that agreement. This means that the SHP reimburses BCBSNC for all direct and indirect costs related to providing services for the SHP, as well as a share of overhead costs, as long as these are allocated in accordance with the same methodology

used to allocate costs to other BCBSNC lines of business. The "plus" refers to a profit allowance of 0.625 percent.

Under this "cost-plus" arrangement, the SHP bears 100 percent of the business risk**.** With the cost-plus methodology, BCBSNC will always make a profit and has no risk of incurring a loss if its costs increase. Thus, BCBSNC has no incentive to control or reduce its costs. The assumption of risk by the customers is one of the main reasons that cost-plus arrangements are not in wide-spread use in contractual agreements between administrative services organizations and health benefit plans. The federal government, for example, discontinued using cost-plus contracts that lacked caps or strict performance guarantees in the 1940's.

The cost-plus arrangement is in contrast with other product lines where BCBSNC may have negotiated a flat per member per month (PMPM) rate for administrative costs, and thus bears the risk and reward associated with changes in its administrative costs. If BCBSNC's costs increase beyond the fixed contract amount, then BCBSNC incurs a loss for that product line; if costs decrease, then BCBSNC gains a larger profit. Because payment to BCBSNC is based on the costs that it incurs in administering the contract, the types of costs and the amounts of such costs that it reports to the SHP are important. The Administrative Services Agreement defines two types of costs – base administrative costs and overhead costs, as follows:

- Base administrative costs are comprised of "direct and indirect costs incurred by BCBSNC and/or its affiliates related to administering the operations of the Group Health Plan."

- Overhead costs are "general corporate expenses, incurred by BCBSNC and/or its affiliates in conducting business, including but not limited to, human resources, finance, legal and other functions not connected with administering the Group Health Plan." The Administrative Services Agreement specifies that BCBSNC must allocate overhead to the State using a methodology that is consistent with BCBSNC's standard business practices as applied to all BCBSNC lines of business. Under these definitions, a share of virtually all the costs that are not directly or indirectly charged to the State are allocable to the SHP as overhead so long as the allocation methodology is consistent with BCBSNC's standard business practices.

Although the Administrative Services Agreement defines base administrative costs and overhead costs, it does not provide definitions of allowable versus unallowable costs; nor does it prohibit or limit cost centers or cost types (such as lobbying, contributions, donations and gifts, public relations and advertising and entertainment expenses) that can be charged to the SHP. Further, the Administrative Services Agreement places no cap on the amount of overhead or indirect costs that BCBSNC can charge to the State. As a result, the SHP can and does receive allocated portions of all cost centers that can be justifiably deemed by BCBSNC to benefit the SHP. Other administrative services agreements and the federal government include restrictions and define allowable or unallowable activities to limit the charges they incur for selected types of costs or activities.

Recommendations:

There are a number of ways in which the SHP could strengthen future cost-plus agreements to ensure the contractor's cost allocation methodologies are consistent with the public's interest. Recommendations include establishing baselines and ceilings for specific administrative activity costs to motivate the contractor to control expenses and to add incentives so that the contractor can share in the benefit of any significant cost decreases and service level improvements; defining unallowable costs, such as lobbying, alcohol, contributions, donations and gifts, bad debts and public relations and advertising, among others; and placing caps on certain costs such as indirect or overhead costs and total costs expressed as a PMPM amount.

We recommend, however, a more direct and administratively less burdensome method of controlling the SHP's risk: contract for administrative services for medical benefits on a flat fee basis. Such an arrangement would obviate the need for implementing recommendations related to strengthening any future cost-plus agreement. For this reason, the recommendations that follow are those that only focus on discontinuing the cost-plus arrangement and determining ways to structure a flat fee arrangement.

- **The SHP should discontinue the use of cost-plus arrangement in favor of a flat fee arrangement in future agreements for administration of its medical benefits**.

- **In structuring a flat fee payment arrangement in the future, the SHP should carefully consider all cost components and (to the extent feasible) try to identify expected changes in costs for near and long term.**

- **The SHP should include provisions that allow for periodic market surveys at the discretion of the SHP to ensure that the SHP is paying reasonable amounts for administrative services in future years.**

In addition to specifying the payment arrangement, the Administrative Services Agreement has a strategic role in setting expectations for management relationships between SHP, BCBSNC and SHP members, and as such should specify broader aspects of strategic intent – not to replace or usurp the SHP strategic plan, but to help ensure compliance with it. However, with its focus primarily on legal rights and obligations of BCBSNC, the Administrative Services Agreement provides limited operational and management guidance in key areas. Where such guidance is provided, it is fragmented throughout the document. For example**:**

- **SHP and BCBSNC staff roles are not defined, and the lines of authority, communication and decision-making procedures between key stakeholders, including BCBSNC, SHP and oversight boards or governing bodies, are unclear and ill-defined.**

- **The original Administrative Services Agreement does not specify the type or frequency of financial reports. Even considering the amendments, the financial reporting requirements are either missing, or lack specificity about the type of information that BCBSNC will provide to the SHP.**

- **The Administrative Services Agreement does not identify and require performance metrics for the full-range of operational functions it provides. Additionally, it includes metrics that may not be representative of performance.**

These deficiencies do not appear to result from deliberate omission. Rather, it appears that the Administrative Services Agreement authors concentrated on writing a legal document. As a result, while the legal provisions of the relationship between the SHP and BCBSNC are defined, structured and understood, other factors such as communication, decision-making, the SHP's intent, operational boundaries and definitions of acceptable performance have evolved over time, but have not been formalized because of the Administrative Services Agreement's emphasis on legal structure.

Throughout the audit period, and currently to some extent, the Administrative Services Agreement has restricted periodic and ongoing access to information, such as key performance measures and cost data, that the SHP needs to effectively and efficiently oversee BCBSNC activities and report to the legislature.

In part, the issues with access to data or reports occurred because of a lack of definitions about what metrics the SHP needed, how frequently it needed the metrics and in what format these should be presented. Even with amendments to increase access by the SHP to data such as financial information, the level of detail and format of the reports cited in the amendments is vague. Typical administrative services agreements do not contain this level of detail; it is more common for exhibits or incorporating references to itemize required items and data in a level of detail that is updated periodically but not less than annually. Having a detailed itemization, including templates and example data, helps not only ensure that both parties understand the requirements and needs of each organization, but help maintains continuity through staffing changes.

The Administrative Services Agreement lacks sufficient guidance for functional areas, and fragments the guidance throughout the document. Guidance for functional area policies is not summarized in one place, but is instead found in several sections of the Administrative Services Agreement, which are not cross-referenced against each other. Therefore, readers must peruse the entire Administrative Services Agreement to fully understand all functional area requirements, rather than turning to a single location.

Recommendations:

The audit team made a number of recommendations that could improve the Administrative Services Agreement now and in the future. For the current Agreement, the SHP should:

- **Review the range of reports BCBSNC provides and identify areas where it needs additional information to effectively manage and monitor the contract**. In particular, the SHP should work to gain access to relevant BCBSNC service and cost information in the formats needed. The SHP should carefully identify and define all report and data needs, and provide BCBSNC with examples or templates, the format required, the reporting frequency and timing and responsible staff or groups who will produce and receive this report at each organization. The SHP should also ensure that the negotiated terms include processes for addressing mechanisms for SHP to follow-up on or investigate anomalies in the data or reports. The SHP and BCBSNC should periodically, but not less than annually, update the required data and reports exhibit or attachments to the Administrative Services Agreement.

- **Develop and implement a plan for monitoring and management that includes policies and procedures that delineate roles and responsibilities, identifies key decision makers and provides escalation paths for both the SHP and BCBSNC.**

Future Administrative Services Agreements should:

- **Incorporate the necessary level of detail and specificity in the Administrative Services Agreement to ensure that the SHP has access to the data and reports needed for effective oversight and monitoring.**

- **Provide legal, policy and procedural guidance for all major functional areas that identifies the business owner of each area, communication channels and frequency, escalation paths, required reporting requirements and formats and service level agreements to the extent applicable. Consolidate functional area guidance and separate out legal, policy and procedural requirements.**

  The SHP should also ensure that all functional areas that deal with members directly, such as claims, membership accounting and enrollment and customer services have service level agreements that clearly specify the services offered, communication channels used and that conform to the SHP customer engagement strategy.

- **Contain a more inclusive performance guarantee system that includes four to five industry standard representative measures for each functional area. These new performance measures should support the goals of the SHP and the State's fiscal interests in key functional areas.**

SHP's Contract with Medco

Throughout the audit period, June 2005 through June 2008, the SHP contracted with Medco to provide pharmacy benefit management services. Unlike the SHP's Administrative Services Agreement with BCBSNC, its contract with Medco is not a cost-plus arrangement. Rather, the contract between Medco and the SHP has two major cost components – fees and drug pricing.

Medco charges an administrative fee and a utilization management fee to the SHP. The administrative fee is for processing claims; it is an amount per retail paid claim processed. The utilization management fee is for providing coverage authorization services; it is an amount per paid claim and applies to both retail and mail order network claims. For the drug pricing component of the contract, Medco guarantees the SHP drug discounts for prescriptions filled within the retail network and mail order networks. If the drug discounts for prescriptions filled in the retail network, which are 98 percent of the SHP's pharmacy benefit utilization, surpass the guarantee, Medco passes the savings through to the SHP. The discount is a percentage off of the Average Wholesale Price (AWP) and varies depending on whether the drug is a brand or generic drug, whether the generic drug is on the Maximum Allowable Cost (MAC) price list – a list determined by Medco that sets the unit price for generic drugs regardless of manufacturer or distributor – and whether the drug is dispensed via the retail pharmacy network or the mail order pharmacy.[5]

The AWP discounts for generic drugs on the MAC list appear to be competitive with industry standards, but the more important issue is the actual unit price that is set as the maximum allowed cost for a specific generic. **The SHP's contract with Medco lacks provisions that would provide the SHP information that is important to its oversight of contractor performance.** The SHP could benefit from receiving additional information related to the MAC list. There can be several different manufacturers of a generic drugs and wide variation in the unit prices charged by each manufacturer. Therefore, it is the unit price guaranteed, not the discount percentage that is the true measure of competitiveness of pricing.

The contract does not require Medco to provide information about the unit cost of pharmaceuticals to the SHP. The Medco discount for generics dispensed at retail ranged from 57 to 62.5 percent during the audit period, a discount range that is within expectations for PBMs. However the current contract does not provide SHP with access to the MAC list used for the SHP which is the true measure of competitiveness. The SHP does have the ability to access the unit price through Medco's client reporting tool. In addition, the current contract with Medco does not allow the SHP to audit the MAC list to determine the competitiveness of Medco's pricing.

[5] The average wholesale price (AWP) is a term referring to the average price at which wholesalers sell drugs to physicians, pharmacies and other customers and in practice, is a figure reported by commercial publishers of drug pricing data.

Recommendation:

- **In future PBM contracting, the SHP should require access to and transparency of information that is important to its management of the pharmacy program.** One approach for more transparent information is to require the PBM in future contracts to disclose to the SHP the actual MAC list and for the SHP to audit the competitiveness of the pricing. (The audit team understands that the SHP has included this requirement in the PBM Request For Proposals it released recently.) Another option is for the SHP to create a specific SHP MAC list that is owned by the SHP and administered by the PBM. While this may require additional resources, possibly with additional contracted services, the pricing advantages gained should surpass the cost. In the area of mail order, future contract should specify the aggregate price differential between SHP's billed AWP price and the AWP price at which the PBM mail order or specialty pharmacy purchase those drugs.

BCBSNC's Performance

Cost Accounting, Allocation and Reporting

BCBSNC's cost accounting and allocation methodology, policies and procedures for charging direct, indirect and overhead costs generally appear to comply with industry standards and best practices. BCBSNC uses an Activity Based Costing (ABC) system to distribute costs to its product lines. ABC is a methodology that identifies resource costs during time periods that are "consumed" through activities and that can be traced to products, services, customer or any other object that creates a demand for the activity to be performed. The costs are determined to be consumed through cost drivers, which have a direct relationship between the work or activity being performed by a cost center and the product that is benefitting from this work.

BCBSNC appears to comply with Generally Accepted Accounting Principles (GAAP) in its accounting methodologies, including policies, procedures and work-flows. Overall, BCBSNC's activity based costing process for allocating administrative costs to SHP appears to be generally consistent with industry standards and best practices. BCBSNC conducts ongoing reviews of the allocation methods and makes adjustments when business needs, such as reorganization, dictate or a better set of measures becomes available.

BCBSNC's cost allocation methodology, policies and procedures for charging direct, indirect and overhead costs resulted in a consistent and equitable approach for distributing costs to various lines of business, including the SHP, and complied with Administrative Services Agreement terms. Additionally, the cost drivers assigned to the business activities occurring in the cost centers had a consistent and causal relationship to the activities performed.

In April 2009, the North Carolina State Auditor's Office issued a report with the results of its evaluation of factors that contributed to the SHP's fiscal year 2008 loss. **The SHP and BCBSNC**

have made some efforts to address the findings and recommendations identified by the State Auditor's Office in its report. However, the SHP has further opportunities to implement additional recommendations to improve its effectiveness in overseeing the Administrative Services Agreement.

To address the State Auditor's findings about access to data, reports and audit requirements, in June 2009, BCBSNC and the SHP amended the Administrative Services Agreement to provide for the SHP to conduct audits of the administrative costs and services provided to it. BCBSNC also agreed to provide the SHP with copies of its SAS 70 reports with the results of assessments of its internal controls.[6] Finally, BCBSNC and the SHP agreed that following an audit of BCBSNC administrative costs, they would work together to reach agreement related to any financial disputes related to the audit findings.

The audit team followed up on the State Auditor's Office finding that BCBSNC had no incentive to control costs by reviewing administrative charges, including shared savings collections, invoiced PMPM estimates and reconciliation statements from fiscal years 2005 – 2006 through 2007 – 2008. BCBSNC's actual PMPM costs for the PPO plan have decreased steadily since introduction of the plan in October 2006 and it appears that a flat rate would have resulted in higher costs to the SHP than those incurred through the cost-plus arrangement. Had the SHP elected to negotiate a flat rate and assuming it could have received a flat rate of $15 PMPM from the inception of the program, it still would have paid approximately $2 million more for administrative costs than it did under the cost-plus methodology.

Reports and data provided to the SHP by BCBSNC to monitor costs have historically lacked detail or were not in a format that the SHP could use to adequately monitor costs. BCBSNC has worked with the SHP to develop more useful reports, such as costs by "bucket" list, that is, the 12 major service categories that BCBSNC now uses for its reconciliation statements and invoices to the SHP. However, the audit team found that this report is not specific enough for the SHP to use in its oversight of BCBSNC activities.

Recommendation:

- **The SHP should request that BCBSNC provide more detailed activity cost reports on a periodic (quarterly) basis.** Such reports would be more relevant and useful than reports of costs by cost center or by the 12 major service categories that the SHP now receives from BCBSNC. The activity reports would allow the SHP to drill down, when necessary, to identify trends or rationale for changes in cost categories. The SHP could also use its own categories with the activities to separate out the reports internally by functional area. Because either BCBSNC or the SHP would have to format data to obtain these reports, the SHP would have to contract with BCBSNC to produce the reports in this format, or would need to arrange to receive

[6] The SAS 70 is an internationally recognized auditing standard developed by the American Institute of Certified Public Accountants (AICPA) to report on the processing of transactions by service organizations.

detailed activity reports periodically that its own staff could then format and analyze.

Cost Performance

Table 2 presents the change in costs billed to the SHP, expressed on a PMPM basis, for eight of the "bucket list" cost categories that BCBSNC uses on its invoices and reconciliation statements for the SHP.

Table 2: Change in BCBSNC PMPM Costs Billed to the SHP by Service Category for CMM and PPO Products Combined

Cost Category	Functional Area	Change in PMPM Cost from Prior Fiscal Year			Change in PMPM Cost between FY 2005-2006 and FY 2008-2009
		FY 2006-2007	FY 2007-2008	FY 2008-2009	
Provide Customer Services	Customer Service and Appeals	19%	-10%	-3%	4%
Enroll and Bill Customers	Membership Accounting	87%	46%	5%	188%
Manage Claims and Encounters	Claims Administration	83%	7%	-5%	85%
Network Management	Provider Relations and Delivery Systems	77%	0%	108%	266%
HealthCare and Health Partnerships	Utilization Management	52%	37%	10%	131%
Provide Information Management (including Underwriting and Experience Reporting)	Information Technology and Data Reporting	51%	20%	0%	80%
Other Services	N/A	49%	176%	-28%	195%
Overhead	N/A	2%	-1%	5%	5%
Total Administrative Costs		**34%**	**12%**	**2%**	**52%**

As Table 2 indicates, the largest increase in administrative costs occurred in fiscal year 2006 – 2007, the year the SHP's PPO product was implemented. In addition, prior to July 2007, the

CMM product agreement was not on a cost-plus basis and BCBSNC incurred a loss in fiscal years 2005 – 2006 and 2006 – 2007 since its costs incurred beyond the administrative flat rate fee were not reimbursed by the State. The cost categories and percentage changes in cost in Table 2 do not include costs related to transitioning from the CMM product to the PPO product that BCBSNC capitalized. These capitalized amounts included extra internal staffing and external staffing during the transition, equipment and software costs and facility costs. The transition costs of $16 million are now being amortized each month to the SHP as part of the administrative costs.

The audit team compared BCBSNC's costs with industry benchmarks for similar administrative services provided by other health plans and found that in general, they compared favorably. That is, in many instances, BCBSNC's costs fell below the 25th percentile for comparable organizations (for the benchmark results, a lower percentile means better performance and a higher percentile means poorer performance). In Table 3, categories shown in green indicate better cost performance relative to the benchmarks and areas in red indicate worse cost performance.

Table 3: BCBSNC's Cost Performance Compared Benchmarks

Cost Performance Relative to Benchmark by Period				
Benchmark Category	**Activities**	**January to December 2007**	**January to June 2008**	**Summary January 2007 to June 2008**
Claim and Encounter Capture and Adjudication (Claims Administration)	• Manage coordination of benefits and subrogation • BlueCard home and custom par fees • Access fees for BlueCard ASOs • Medicare crossover fees • Imaging (Note that this includes imaging for other functions than claims) • Claims and encounter adjudication • Claims and encounter capture • Collect health information • Conduct post-adjudication review • Provide reimbursements	Between 25th and 50th Percentiles	Between 25th and 50th Percentiles	Between 25th and 50th Percentiles
Customer Service and Appeals	• Respond to customer inquiries • Process grievances and appeals	Between 25th and 50th Percentiles	Between 25th and 50th Percentiles	Between 25th and 50th Percentiles

Cost Performance Relative to Benchmark by Period				
Benchmark Category	**Activities**	**January to December 2007**	**January to June 2008**	**Summary January 2007 to June 2008**
Enrollment, Membership and Billing (Membership Accounting)	• Enroll and bill groups • Enroll and bill members • Issue bills and allocate premiums	Below the 25th Percentile.	Between 25th and 50th Percentiles	Between 25th and 50th Percentiles
Provider Network Management Services (Provider Network and Delivery System)	• Manage provider relation services • Respond to provider inquiries • Perform provider credentialing • Manage provider contracting • Provider contract management support • Other provider network management and services	Between 25th and 50th Percentiles	Between 25th and 50th Percentiles	Between 25th and 50th Percentiles
Medical Management, Quality Assessment and Wellness (Utilization Management)	• Perform case management • Perform medical review • Perform pre-certification and concurrent care • Blue Points • Perform health management • Promote health and wellness • Bridges to Excellence • Develop and maintain health care management systems • Develop medical guidelines • Perform managed care quality management	Between 25th and 50th Percentiles	Above the 75th Percentile	Between 50th and 75th Percentiles

Cost Performance Relative to Benchmark by Period				
Benchmark Category	**Activities**	**January to December 2007**	**January to June 2008**	**Summary January 2007 to June 2008**
Information Systems Expenditures (Information Technology and Data Reporting)	• Provide information system operations • Provide information system network services • Provide information system decision support and technology • Deliver information system support services • Develop and maintain functional area systems (customer service, finance, claims, etc.) • Provide information systems applications and maintenance • Provide information technology security and enforcement • Provide information systems applications acquisition and development – Internet and eCommerce • Provide information systems applications acquisition and development – other	Below 25th Percentile	Below 25th Percentile	Below 25th Percentile
Advertising and Promotion	• Develop and manage community relations • Develop public relations program • Establish market presence	Below 25th Percentile	Below 25th Percentile	Below 25th Percentile
Corporate Executive and Governance	• Benchmark / track performance • Conduct quality assessments • Develop business plans • Develop strategies • Improve processes and systems • Interface with board of directors • Provide executive leadership	Above 75th Percentile	Above 75th Percentile	Above 75th Percentile

Cost Performance Relative to Benchmark by Period				
Benchmark Category	**Activities**	**January to December 2007**	**January to June 2008**	**Summary January 2007 to June 2008**
Finance and Accounting	• Conduct internal audits • Contract administration • Manage financial resources • Process finance and accounting transactions • Provide tax strategy and compliance	Between 25th and 50th Percentiles	Below 25th Percentile	Between 25th and 50th Percentiles
Corporate Services	• Sub-categories are shown below and rolled up to this category. • Note that some sub-categories were not "material" costs, but the category of corporate services, taken as a whole, was.	Below 25th Percentile	Below 25th Percentile	Below 25th Percentile
Actuarial	• Provide actuarial services • Provide financial planning and analysis	Below 25th Percentile	Below 25th Percentile	Below 25th Percentile
Association business dues and licenses and filing fees	• Association business dues and licenses and filing fees	Above 75th Percentile	Above 75th Percentile	Above 75th Percentile
Miscellaneous business taxes.	• Miscellaneous business taxes	Below 25th Percentile	Below 25th Percentile	Below 25th Percentile
Rating and Underwriting	• Provide account reporting and analysis • Perform underwriting and group rating	Below 25th Percentile	Below 25th Percentile	Below 25th Percentile
Product Development and Market Research	• Conduct future product analysis • Conduct market analysis • Conduct quantitative and qualitative analysis • Deploy products • Design products • Develop product market strategies • Maintain products • Perform competitor analysis	Below 25th Percentile	Below 25th Percentile	Below 25th Percentile

Cost Performance Relative to Benchmark by Period				
Benchmark Category	**Activities**	**January to December 2007**	**January to June 2008**	**Summary January 2007 to June 2008**
Sales and Marketing	• BlueCard marketing and sales support • Communicate to customer • Conduct sales and renewals • Develop and maintain marketing systems • Manage customer relationship • Manage distribution channels • Prospect customers	Below 25th Percentile	Below 25th Percentile	Below 25th Percentile
TOTAL All Activities	**All Activities**	Below 25th Percentile	Below 25th Percentile	Below 25th Percentile

Key:
<25th Percentile | 25th - 50th Percentile | 50th - 75th Percentile | >75th Percentile

Performance in Information Technology, Claims Administration and Membership Accounting

The transition of the SHP members from the CMM product supported on the Long Range System Planning (LRSP) system to the PPO product supported on PowerMHS, which occurred during the audit period, had significant impacts on several functional areas: Information Technology and Data Reporting, Claims Administration and Membership Accounting. At the beginning of the audit period, BCBSNC supported SHP indemnity CMM product members on the LRSP administrative processing system. In October 2006, the SHP began offering BCBSNC's PPO product to members and BCBSNC began supporting SHP members who selected the PPO product on PowerMHS, the administrative system that BCBSNC was using for the rest of its commercial lines of business. Thus, from October 2006 through the end of the audit period in June 2008, BCBSNC supported SHP members on two administrative systems – the LSRP system for the CMM product and the PowerMHS for the PPO product.

The BCBSNC Information Technology department underestimated the complexity associated with transitioning SHP members from the CMM product on the LRSP system to PPO product on the PowerMHS system and did not conduct adequate planning for the transition. This lack of adequate planning was evident in greater than anticipated costs to the SHP in the Information Technology area, but was also evident in the loss of efficiency and productivity in the Claims Administration and Membership Accounting functional areas. Our presentation of findings, therefore, first examines the issues associated with this transition and implementation period and then focuses on other aspects of performance in these areas.

Effect of Inadequate Information Technology Planning on Costs

Project documentation that BCBSNC provided to the audit team indicates that BCBSNC underestimated the work effort to implement the SHP's PPO on the PowerMHS system.[7] The initial project documentation that BCBSNC provided indicated that system development work for the transition would be primarily limited to synchronizing member benefit and claim balances between the LSRP and PowerMHS systems. However, additional discussions with the BCBSNC information technology staff indicated that there were 62 change requests submitted to the BCBSNC project teams for this effort, and that these change requests contributed to the significant additional hours. BCBSNC did not, however, provide the SHP with key information, such as target due dates, budget and return on investment, about these change orders so that the SHP could understand the implications of the change requests on the project's timelines and costs. **Three critical factors contributed to the higher than expected costs for the development work for the initiative to transition the SHP's business to the PPO plan on the PowerMHS system: high hourly costs for external contractors, additional or "bubble" internal staff resources and amounts added to existing external service vendor contracts.**

The split between internal and external resources used by BCBSNC for the development work for the PPO implementation was within industry standards, however. BCBSNC's mix of resources to support the SHP's information technology initiatives appear within anticipated averages of 60 to 70 percent internal and 30 to 40 percent external staff. BCBSNC leveraged internal resources at a rate of 66 to 74 percent for the transition of SHP business to the PPO plan on the PowerMHS system. Even though the ratio of internal to external resources was as expected, because of the high cost of external resources, costs were higher than expected.

As BCBSNC transitioned members to PowerMHS, its commercial platform, the SHP should have been able to share information technology resources with other commercial business lines. **Consequently, there should have been some reduction in staffing resources during the transition and in subsequent years of the audit period, thus providing savings to the SHP. To the contrary, however, there was a significant increase in PMPM costs during the transition period of SHP business to the PPO product and PowerMHS system, and PMPM costs continued to increase and leveled out only in the most recently completed fiscal year.**

The audit team saw no evidence that the SHP approves business and system changes that might affect its business. When BCBSNC makes changes to PowerMHS, for example, to increase support levels required, it does not provide the SHP a review or walkthrough of potential business impacts, including estimated costs. There was no sign-off or approval by the SHP for the 62 change requests forms that were completed as part of the transfer to the PPO product. As a result, the SHP was unaware of potential outstanding issues or problems that

[7] BCBSNC asserts that the documentation it provided to the audit team that indicates it planned for 21,000 hours is incorrect and provided subsequent documentation that indicates that BCBSNC incurred approximately 195,000 hours in completing the implementation to demonstrate that it planned for significantly more hours to implement the SHP's PPO on the PowerMHS system. However, it remains unclear to the audit team whether the subsequent documentation BCBSNC provided reflects hours that were planned and incurred or only incurred.

required additional operational support or manual workarounds – or the costs of this additional work – to support its business. It does not appear such a sign-off or approval process is currently in place, so the same problems could occur again in the future.

Recommendations:

- **BCBSNC should increase its rigor in planning large scale initiatives to implement them with more cost-effective resources.** In the future, this increased rigor would enable BCBSNC to better prepare and procure resources at reasonable, industry standard rates.

- **BCBSNC should investigate resource savings based on its shared services platform. There should be some decrease in staff and an accompanying decrease in costs when all lines of business (commercial, state and federal) are executed on one system.**

- **The SHP should work with BCBSNC to develop acceptance and sign-off criteria. An industry-based approval process should be put in place between SHP and BCBSNC.**

Impacts of Inadequate Information Technology Planning on Claims Administration and Membership Accounting Areas

PowerMHS provides a modern and robust architecture for the claims processing functions at BCBSNC. It was designed to support the specific needs of Blue Cross Blue Shield plans and it can be configured (that is, it is possible to move data fields and develop other shortcuts to aid efficient data entry and allow for the customization of workflow and user interfaces) to meet an individual plan's needs. The user experience is significantly different from that of legacy systems, such as LRSP. When compared to older claims systems, PowerMHS is easier for users to learn, and ultimately use for claims administration business functions. However, a **review of the transition to PowerMHS indicates that the PowerMHS system has not been configured for optimal use efficiency by BCBSNC.**

Within BCBSNC, the information technology department is responsible for making system changes and developments to the core PowerMHS system. However, the operational business areas, notably, Claims Administration and Membership Accounting, are responsible for setting up PowerMHS from a product and business structure standpoint to support various lines of business, for example, the SHP business setup. If the information technology department had adequately planned for the transition of SHP members to PowerMHS, there would have been significant involvement by the Claims Administration and Membership Accounting areas in the system configuration. **However, there was no evidence of integrated work performed by the Information Technology and operations areas for system configuration to support effective and efficient, end-to-end processing of SHP business.** There was a lack of integration among

various business units at BCBSNC and the organizational silos may have hampered the cross-functional planning necessary to implement the PowerMHS system for the PPO.

The impact of inadequate planning and involvement of the operations areas in configuring the PowerMHS system can be seen specifically in the Claims Administration area, where there was an increase in manual work for PPO claims because large numbers of claims submitted for the PPO product could not be processed automatically by the PowerMHS system. **PowerMHS did not have sufficiently robust business rules to allow for automatic processing of claims. As a result, there was a need for an increase in staffing in the Claims Administration area.** The audit team believes this was a preventable problem. Thorough testing and configuration should have predicted and prevented the large quantity of claims that were suspended for manual intervention. BCBSNC has taken some steps to enhance system functionality to reduce the manual intervention. However, these steps should have occurred prior to the transition to PowerMHS. Additional improvements are still needed.

In addition, since the SHP's PPO was implemented BCBSNC has not taken appropriate steps to improve the configuration of PowerMHS to make it more efficient. Because of the lack of configuration for optimal efficiency, claims administration staff must now take multiple steps to complete transactions in the new system. Some of these multiple steps, for example, re-keying fields or inputting coordination of benefits information in multiple places, could be eliminated. BCBSNC should have conducted workflow analyses to identify potential efficiencies that could be configured in the system. Furthermore, effective system configuration is a key component of an ongoing continuous improvement process which supports enhanced productivity. There was no evidence of a regularly scheduled process to identify and eliminate inefficiencies in how the system is configured to support the workflow of the user. A continuous process improvement initiative would improve workflow and enhance productivity.

The need for better systems configuration can also be seen in the **Membership Accounting functional area where there was a loss of efficiency and productivity with the implementation of the PPO product on the PowerMHS administration system.** BCBSNC staff reported that enrollment tasks on the PowerMHS system required more time than on the LRSP system. Similar to the issues associated with claims processing data entry, membership accounting staff must also input more information into more screens and key redundant information, such as effective dates, when entering enrollment information about an employee and spouse than was necessary in the old system. **The audit team found no evidence of a formal continuous process improvement program to regularly identify opportunities for improving the membership accounting function of the SHP.** Such continuous process improvement programs are commonly implemented in the industry to reduce waste and inefficiency on processes such as operational data entry and processing.

It appears that BCBSNC did not effectively communicate with the SHP about cost and services implications of transition to the PowerMHS system. Although BCBSNC assessed the cost implications of the migration on the SHP and presented and discussed the analysis with the SHP, it has not provided any documentation of this process. In addition, we could not confirm

that BCBSNC conducted an assessment of the service implications associated with the transition to PowerMHS.

Recommendations:

- **BCBSNC should create a more transparent and robust coordination of system development changes and business setup changes for PowerMHS.** During the audit period, there was a lack of transparency about how the information technology department coordinated with the business area setup. Industry experience indicates that a strongly coordinated, end-to-end approach to business setup and information technology work is necessary to minimize potential system-related issues related to processing inefficiencies and claims payment inaccuracies.

- **BCBSNC should establish a process to thoroughly evaluate the cost and service implications of proposed changes to functional areas such as Claims Administration and Membership Accounting systems and processes, and communicate the results of the evaluation to the SHP prior to implementing changes.** A process should be established that includes the SHP in decisions that cause major increases in the cost of providing services.

- **BCBSNC should make configuration, workflow and productivity enhancements to PowerMHS and establish a formal continuous improvement process for the claims administration and membership accounting areas.** BCBSNC should engage an independent consultant with expertise in healthcare payer claims processing systems in a productivity analysis and assessment of the current data entry screens. BCBSNC should take steps to:

    - **Improve the functionality to reduce the quantity of claims requiring manual intervention**. This would include a detailed analysis of claims edits to increase the percentage of claims that are processed without manual intervention. In addition, BCBSNC should use available software tools to identify the customized business rules and edits previously built into LRSP to ensure that logic is included in PowerMHS.

    - **Modify claims administration and membership accounting data entry screens where appropriate** to minimize redundant data entry and maximize keying efficiency by reducing screens, pre-populating redundant fields, and minimizing the use of the computer mouse when entering data. Review requirements to manually track and record information.

    - **Establish a formal recurring continuous improvement process for the Claims Administration and Membership Accounting areas.** Develop a more formalized program for identifying system and process changes. Establish cross functional teams that focus on improvements to the claims

process from beginning to end. The formal productivity and improvement processes should leverage a methodology, such as Lean/Six Sigma principles, to define, measure, analyze, design and verify process optimization opportunities. Lean/Six Sigma programs are cross-industry recognized methodologies to reduce process waste and improve cost performance. These methodologies also focus on maintaining high levels of service and quality.

- **Establish and implement productivity standards based on industry metrics versus internally driven metrics.**

Other Information Technology and Data Reporting Performance Results

Overall information technology application and system stability is evident and follows industry standards. The information technology applications and system monitoring are stable and no material issues related to major production problems and additional business requirements. System Performance Metrics and status reports for instances of system downtime appear to indicate significant system stability. Minimal instances (mostly less than one hour) of system downtime were reported following the move of the SHP business onto the PowerMHS. BCBSNC addressed system downtimes that did occur, which were not of material length, in a timely manner. Overall, during the audit period, BCBSNC maintained the stability of the system in terms of defects, system downtime and major outages.

Another function of the Information Technology area is data reporting. **The data reporting capabilities provided by BCBSNC are inefficient and do not address SHP needs.** BCBSNC is responsible for providing the SHP with standard operational reports, on-demand reporting and a web-based capability for utilization and payment reporting (eInfoNow) to support monitoring of the SHP business performance. However, eInfoNow is not meeting SHP's business needs:

- The system has drill-down capability, but due to very slow response time, the SHP must request ad-hoc data reporting from BCBSNC.

- The data accessed via eInfoNow is not as current as the data stored in the Corporate Data Warehouse. As a result, there are gaps that have led to the SHP's inability to rely on the information provided in the eInfoNow system.

- SHP requests for enhancement to eInfoNow are not efficiently addressed; BCBSNC serves as an intermediary with the HDMS vendor responsible for maintaining eInfoNow, creating the potential for SHP requests being conveyed incompletely or incorrectly.

BCBSNC is not in compliance with the PPO Administrative Services Agreement requirements for quarterly data reporting. The Administrative Services Agreement indicates that BCBSNC is required to provide quarterly reports to the SHP that provide the accessibility

performance targets for previous and current years, the number and types of providers participating in the health benefit plan's provider network and an evaluation of actual SHP performance against performance targets. The audit team found no documentation to support that these requirements were met during the audit period.

Recommendations:

- **BCBSNC should leverage current technologies and industry best practices in managing SHP data reporting needs internally.** As discussed with the SHP, the audit team agrees and recommends that the SHP continue developing reporting capabilities internally. To develop this capability requires the SHP to make an investment in the technology and staff resources to support the function. When the SHP has completed implementation of its own data reporting capabilities, it should discontinue eInfoNow and standard monthly, quarterly and yearly reports generated by BCBSNC.

- **BCBSNC should work with the SHP to define and develop reports that address provider network adequacy** and provide information to SHP that is required to monitor the network.

Other Membership Accounting Performance Results

During the audit period, BCBSNC's membership accounting area maintained a consistent level of service, timeliness and accuracy as evidenced through quality audit reports, service level metrics and Blue Cross Blue Shield Association required measures. BCBSNC performance exceeded target enrollment timeliness for all quarters except the fourth quarter of 2006 when the PPO product was launched. While not optimal, BCBSNC's timeliness performance of member identification cards issued within 30 days for this period is within industry norms for a product launch.

Additionally, BCBSNC generally maintained high performance in processing membership applications accurately. Performance dipped during the launch of the PPO product, as would be expected with a new product launch, but in the quarters after launch, performance trended up and returned to above target levels at the end of 2007.

BCBSNC discontinued *Blue e*, a tool which provided state agencies self-service capability to perform membership information maintenance for their employees covered by the SHP. When the PPO product on the PowerMHS system was implemented, BCBSNC discontinued an administration tool called *Blue e*, a system that interfaced with the LRSP system for the CMM product. State agencies used *Blue e* to perform member maintenance such as adding and deleting members, updating member information and requesting ID cards and member lists. The *Blue e* tool was not available for the PPO product and BCBSNC did not offer any alternative. Although *Blue e* continued to be available for the CMM product, as SHP

membership moved from the CMM to the PPO product, many state agencies stopped using it for the decreasing numbers of CMM members. As a result, the absence of *Blue e* shifted work from the state agencies to BCBSNC for enrollment transactions they were previously able to perform themselves.

At the end of the audit period, the State required BCBSNC to establish electronic enrollment data exchange between PowerMHS and the State's human resource system, BEACON, to automate approximately 15 percent of the SHP's member enrollment updates. During the second quarter of 2008, the BEACON electronic enrollment system was, on average, operating efficiently with high system processing rates and low manual intervention and errors.

After the audit period, BCBSNC introduced an on-line enrollment solution hosted by Benefitfocus, BCBSNC's electronic enrollment vendor, to support agencies that are not on the BEACON system.

Recommendations

- **The SHP and BCBSNC should develop and encourage use of self-service and automated enrollment capabilities.**

- **BCBSNC should continuously evaluate and improve electronic data exchange between BCBSNC systems and Benefitfocus, BCBSNC's electronic enrollment vendor, to attain a high level of system-to-system efficiency and reduce manual staff costs.**

- **Future administrative services agreements should protect the SHP from cost exposure from decisions to discontinue capabilities, such as *Blue e*, that are core to the administration of their product.**

Billing and payment policy and process variations cause an increase in billing and payment reconciliation work activity for BCBSNC and SHP Agencies. BCBSNC's Membership Accounting area mails approximately 475 discrete bills each month to approximately 325 state agencies and other governmental entities (state agencies). The Membership Accounting area also receives the payments from the state agencies in response to those bills and tracks which agencies are current with their payments. During the audit period and currently, state agencies paid the premiums for their employees covered by the SHP using varying and inconsistent processes. **There is not a standard process for billing, payment and reconciliation functions at the state agencies.** The variety of payment methodologies creates an additional administrative burden for both the BCBSNC Membership Accounting area and state agencies in the form of increased manual handling, extensive paper comparison and reconciliation and monitoring of outstanding balances. The administrative burden to BSBSNC translates into increased costs for the SHP.

Recommendations

- **The SHP should establish and enforce a policy that encourages standard billing, payment and reconciliation practices.** The SHP and BCBSNC should include representatives from various agencies to develop a uniform policy that will be effective and beneficial to both the state agencies and BCBSNC.

- **BCBSNC should discuss with the SHP whether an on-line billing and invoice retrieval tool is appropriate for the state agencies**. Such a tool would ease paper administration including printing, and could potentially help state agencies perform more automated reconciliations.

BCBSNC's Membership Accounting area maintained a consistent level of service, timeliness and accuracy that was in accordance with the Administrative Services Agreement service level requirements and industry standards. However, the service levels in the Administrative Service Agreement do not reflect current industry best practices.

Recommendation:

- **The SHP should work with BCBSNC to incorporate requirements in the Administrative Services Agreements that provide additional transparency into BCBSNC's performance regarding membership accounting; include service level requirements in the Administrative Services Agreements that cover changing business processes (for example, electronic enrollment processing).**

Other Claims Administration Performance Results

BCBSNC does not appear to clearly establish organizational goals for recoveries. In addition, management reporting – including dashboards – about recoveries is not comprehensive or measured against external benchmarks. Without proper information, BCBSNC management cannot take corrective action.

The retroactivity process can be improved to reduce inappropriate and incorrect claim payments to providers. The retroactivity processes at BCBSNC support "pay and pursue" or "retrospective analysis", that is, BCBSNC pays the provider and then attempts to collect any overpayments that have occurred based on its review of the service. A defined process to develop and continuously improve prepayment edits in the claim processing system that assure that claims are paid correctly does not exist. Additionally, processes do not support full transparency to the SHP regarding identification and recovery of claim dollars. Furthermore, the overall structure of the retroactivity process does not support direct accountability to the SHP. BCBSNC contracted with a variety of recovery vendors during the audit period, but its contractual relationships with the various vendors were unclear and BCBSNC did not track or

measured the vendors' performance against industry benchmarks. The SHP contracted directly with the firm that handles subrogation recoveries.[8]

Operations within the Special Investigations Unit lack appropriate controls and do not meet industry standards. The Special Investigations Unit is the department within BCBSNC that is responsible for detecting, investigating, reporting and preventing fraudulent, wasteful or abusive activity. Annual recovery goals for the Special Investigations Unit were also not well-defined or documented. Further, anti-fraud software, used to identify aberrant billing practices, was not in use during the entire audit period. BCBSNC did implement an anti-fraud software application, called EDI Watch, in 2007.

Although staffing levels grew 45 percent from 11 FTEs to 16 FTEs, fraud recoveries, measured as a percentage of medical costs (claim dollars), equaled 0.002 percent during the audit period. This level of fraud recoveries is well below the industry average. For every dollar the SHP spent on fraud and abuse detection, the SHP received only 10 cents in actual fraud recoveries. The audit team would have expected fraud and abuse recoveries to equal a bare minimum of .035 percent of medical costs (claims expense) during the audit period. Based on the audit team's knowledge of best practices in the industry, a recovery amount in this range would be substantially below the industry average. However, a recovery rate of .035 percent would have allowed the SHP to recover at least the amount it paid BCBSNC for the Special Investigations Unit's expenses; in other words, to realize at least a 1- to-1 return on investment.

Overall, the BCBSNC recovery dollars are equal to a little more than 1 percent of the SHP's total medical expenses, which is significantly below the industry average of 3 to 5 percent. In response to this finding in the draft report, BCBSNC stated that it achieved $2,006,469 in fraud and abuse recoveries and $822,472 in savings due to prepayment interventions. **However, BCBSNC did not provide any supporting documentation to substantiate these amounts or indicate the time period to which these amounts pertained. Thus, the audit team did not include these amounts in its analyses of recoveries.**

Recommendations:

- **BCBSNC should implement a formal recovery function improvement program with full transparency to the SHP that includes the ability to establish SHP prioritization over other initiatives.** BCBSNC should implement a productivity program to track, improve the speed, quality and efficiency of performance within all recovery departments. Training about recovery functions, especially fraud and abuse, should begin immediately. BCBSNC should develop detailed reports to track and measure performance across all recovery functions against industry benchmarks.

[8] Subrogation refers to an insurance company seeking reimbursement from the person or entity legally responsible for the medical expense, for instance, in the case of an accident, after the insurer has paid out money on behalf of its insured.

- **BCBSNC should develop an action plan to improve recoveries through engagement of vendors and tools that increase recoveries related to other carrier liability, subrogation and fraud and abuse**.

- **The SHP should weigh the cost and benefits of outsourcing all recovery functions to outside vendors and consultants.** The SHP should conduct a formal Request For Proposal (RFP) process to ensure that all outsourcing options are evaluated**.**

Appeals Area Performance Results

The BCBSNC appeals department maintains written operational policies and procedures specifying the handling of appeals and grievances. During the audit period, these policy and procedure documents were separately developed and maintained for the CMM plan and the PPO plan; however, as would be expected, there was significant overlap between the content of the materials. In addition, because statutory changes as well as internal policy changes may affect appeals policies and procedures, each of the policies and procedures documents have clearly identified effective dates.

BCBSNC's appeals policies and procedures generally accurately reflected statutory requirements. In addition, BCBSNC has an internal process for reviewing and updating the policies and procedures as needed.

BCBSNC generally processed SHP member Level I and Level II appeals and grievances in compliance with statutory requirements. A Level I appeal or grievance is a request for a review of a formal decision made by BCBSNC related to medical necessity, benefits, contractual issues or quality of care. Members who receive a Level I denial may request a Level II review. A review of a sample of cases found that BCBSNC resolved almost all in compliance with North Carolina statutes. Out of 60 cases, only one did not meet the time frame requirements, and all were compliant with statutory requirements for the content of the communications sent to members regarding their appeal or grievance.

The BCBSNC training materials for appeals are clear and well-organized and provide information that accurately and comprehensively reflects statutory requirements. These materials provide not only information regarding BCBSNC policy and procedures and statutory requirements, but also a number of sample documents which would be very useful to a new employee or as a reference for more seasoned staff members.

The BCBSNC Member Handbook and outreach materials are clear and well-organized and provide members with information that accurately and comprehensively reflects statutory requirements. The Member Handbook and outreach materials are key tools for communicating to the members their appeal rights and the process for filing appeals. Outreach materials are accurate and comprehensive in terms of the information conveyed to the member. The information contained information required by statute, such as the rationale for a decision, the individuals involved in the member's review and information regarding the member's rights to

further review if applicable. Furthermore, the information was communicated in a clear and easy to follow format allowing the member to understand the process and his or her rights moving forward.

BCBSNC appeals policies and procedures documents were generally compliant with state statutes. However, certain policies and procedures in effect during the audit period could have been strengthened. BCBSNC inter-departmental communications, for example, between the customer service and claims departments, were not documented in the written policy and procedures. For example, there is not a written process for the verification of claims payment for claims in question by the appeals department which would ensure the proper closure of the case file as well as proper payment of claims. In addition, there is no documentation of BCBSNC and Medco communications regarding pharmacy benefit appeals, including courtesy reviews, within the written policies and procedures. Finally, policies and procedures for tracking the underlying causes of appeals and grievances with the goal of identifying and resolving system issues, were not contained in policy and procedure documents.

Although BCBSNC staff were able to clearly explain how each of the above activities occurred in practice, the audit team could not fully assess the activities because of the absence of written policies and procedures addressing them.

The lack of information related to the underlying causes of appeals and grievances makes it difficult to understand the significant increases in the number of medical benefit appeals and grievances per member during the audit period. The number of medical benefit appeals and grievances per 1,000 members increased 60 percent. However, without reports that routinely analyze the volume and nature of appeals and grievances, it is not possible to draw conclusions about the increases. Analysis of trends in appeals and grievances could reveal benefit coverage issues that the SHP needs to address, for example if there are consistent denials of services that the SHP believes should be covered, or if members need to be advised of prior authorization or other requirements to obtain coverage. In addition, such analysis could also reveal changes that are necessary in BCBSNC's medical policies and utilization management procedures.

Recommendations:

- **BCBSNC should improve policies and procedures to support communication and collaboration among parties involved in the appeals process.**

- **BCBSNC should provide the SHP with an analysis of the number and nature of appeals and grievances on a routine basis and discuss the reasons for increases or decreases to the number of appeals with the SHP.**

Customer Services Area Performance Results

The Administrative Services Agreement requires BCBSNC to formally report to the SHP every quarter on two telephone accessibility measures, average speed of answer and abandon rate; and on two customer service measures, telephone inquiry closure rates and correspondence inquiry closure rate. **BCBSNC met the performance guarantee levels for the measures specified in the Administrative Service Agreement regarding time required to resolve SHP members' inquiries.**

However, the Administrative Services Agreement lacks detail and policy guidance on a number of functions with the Customer Services area. For example, the Administrative Services Agreement lacked detail regarding the expected customer experience. The customer experience should include details about delivery, service and more importantly, the overall intent and vision of the SHP. An industry best practice in this area is to develop a service level agreement that stipulates all communication channels with the customer, communication channels preferences for each case type, hours of call center operation, after-hours service overseas and interstate service, languages supported, services for hearing impaired, etc. The service level policy should describe a clear aim for the customer service function, the services and timings he or she will be provided and how to deal with exceptions.

The Administrative Services Agreement also lacks appropriate performance measures related to the customer services function, resulting in a lack of detail about measures assessment and reporting and monitoring issues for the SHP. As a result, the SHP cannot adequately monitor BCBSNC accessibility or work performance, gain an insight into member behavior, or track particular cases or types of cases. **BCBSNC did not have, and could not generate, standard reports related to variance in call handle time by call or case type, frequency of call or case type and first contact resolution.** Another shortcoming related to the Administrative Services Agreement requirements relates to the fact that it requires quarterly reports on average figures on performance. These measures are reported as an average over a twelve-week sampling period. In a twelve-week period, there can be significant weekly reductions in member accessibility, although this can be balanced by other weeks of high member accessibility and not be shown in the quarterly report. A four-week sampling period would reveal these service fluctuations and increase transparency to BCBSNC and the SHP.

A comparison of BCBSNC performance measures to industry (sector) benchmarks indicates:

- The PPO average call handle time was high in comparison to sector benchmarks in 2007 and 2008, and increased toward the end of the audit period.

- The CMM plan had a higher speed of answer in comparison to sector benchmarks in 2006 and 2007.

- The CMM plan contact rates were higher in comparison to sector benchmarks from 2006 to 2008. Higher contact rates can increase workload, although the audit team did not find this generally to be the case.

The biggest issue identified relative to these metrics is the increase in call handle times for the PPO plans and the increased number of staff needed to support the PPO product in 2007 and 2008, although BCBSNC generally adjusted staffing levels in line with work that entered the call center. Staff salaries are the major cost component for a call center, and depending on the size and maturity of the call center, may account for between 60 and 70 percent of all costs according to the American Teleservices Association. Staff resources have to increase to cope with longer call handle times. While all customer contacts decreased by approximately 10 percent, call center workload increased by 14 percent over the course of the audit period.

The BCBSNC organizational structure, staff-to-supervisor ratios, member-to-staff ratios, staff attrition rates and tiered support structures were consistent with industry practice and BCBSNC adjusted its staffing levels in line with inbound workload**.**

BCBSNC customer service work flows were consistent with industry best practices, although the referral process to other BCBSNC departments can be problematic. BCBSNC does not adequately process some cases when transferring them outside of the BCBSNC call center to other departments. When members contact the SHP about frustration with their cases, it generates unnecessary additional work at the SHP and then for the BCBSNC call center.

BCBSNC did not have cost measures for industry standard measures, such as cost per call and cost per item of correspondence. It is an industry best practice to track cost per contact by communication channel so that alternative communication channels can be compared for cost-benefits analysis. **The telephone systems used by BCBSNC for both the CMM and PPO products to provide customer service were adequate; however, the PPO Interactive Voice Response system was more user-friendly and had greater functionality.** The audit team determined that the PPO interactive voice response system was superior to the CMM PBX system because of its speech recognition capability, which does not force the customer to make a manual selection. However, the audit team also found that the PPO Interactive Voice Response system has opportunities for improvement.

BCBSNC supporting technology for customer service was in line with industry best practices, and was not an impediment to efficient case handling. The audit team did not find any issues arising from supporting technology that would severely influence case processing times.

Overall, the existing BCBSNC customer service policies and procedures were sufficiently detailed and usable, and supported an effective work environment. The audit team found one area of concern, however, related to the "pay-and-educate" process. This process was available to customer service representatives to maintain customer satisfaction by forgiving amounts owed by members related to member misunderstandings regarding PPO coverage.

The process was designed to be a one-time waiver and includes educating the member about allowable coverage. The policy was also designed to reduce customer complaints and appeals, to reduce staff time spent in these activities and is consistent with the processes used in BCBSNC's other PPO lines of business. The customer service representatives have the authority to forgive a balance owed by a member of up to [redacted], and the BCBSNC team leaders have authority for amounts of up to [redacted]. **However, the pay-and-educate process appears out of compliance with state law and is not addressed in the Administrative Services Agreement. In addition, although the audit team was able to view a brief BCBSNC policy document while onsite, BCBSNC does not have a supporting procedural manual that provides a step-by-step process—including forgiveness limits—or decision-making guidance to staff.**

Recommendations:

- **The SHP should consider implementing a number of changes to the Administrative Services Agreement:**

  - Performance measures related to call handle times. The audit team determined that the high PPO average call handle time would have a high impact on workload and thus, cost of the PPO plan.

  - Requirements for the provision of monthly case latency reports that identify the number of cases 30 days or older, the case owner (the person responsible for the call resolution) and the steps taken to close the case. Tracking unresolved cases and the reasons why they are unresolved is an industry best practice that ensures that members have their inquiries resolved and needs met, and enables call centers to identify possible business process bottlenecks that cause delays.

  - Addition of a Service Level Agreement to the Administrative Services Agreement; the Service Level Agreement should include, for example, a requirement that BCBSNC contact members in writing when the case is open for more than 30 days, and update them every 30 days thereafter.

  - Greater detail about the type and levels of required performance measures. BCBSNC should gather a broader range of accessibility and performance measures for internal use, and if requested, supply them to the SHP.

- **BCBSNC should track the cost per contact for calls, e-mails, faxes and paper correspondence** as a way to measure efficiency and control and compare costs of different communication channels.

- **BCBSNC should provide accessibility measures in quarterly reports, even when they are not bound to meet performance guarantee targets, and when measures slip below targets, provide a narrative giving the SHP insight into why the target**

was not met. SHP did not have adequate insight into call center performance. The effect of this is that the SHP cannot adequately monitor BCBSNC accessibility or work performance, gain an insight into member behavior, or track particular cases or types of cases.

- **BCBSNC should identify the underlying cause for the high call handle times** for the PPO product in 2007 and 2008, specifically the long After Call Work time, and if the causes are present today, implement steps to reduce the call handle time. The SHP should consider implementing performance measures related to call handle times in the Administrative Services Agreement.

- **BCBSNC should develop a virtual queue system, and increase the number of self-service offerings in the Interactive Voice Response system to include claims status and unresolved claims.** Increasing self-service would reduce Customer Service Professional labor and cost to BCBSNC. The advantage of a virtual queue system is that members do not have to wait in the call-waiting queue, and can go about their normal business until they receive a call from the BCBSNC call center. The audit team understands that since the audit period, BCBSNC has added virtual hold to its customer service features however the audit team was unable to document this during its site visit.

- **BCBSNC should either discontinue its pay-and-educate program or seek approval from the SHP for the program, including not-to-exceed limits. BCBSNC should develop a complaint policy, pay-and-educate procedures, training and knowledge transfer policy and coaching and on-the-job training policies.** The audit team understands that since the audit period, BCBSNC has eliminated the pay-and-educate policy however the audit team was unable to document this during its site visit.

Provider Relations and Delivery Systems Area Performance Results

Provider Relations and Delivery Systems includes both credentialing and recredentialing as well as network management functions. Credentialing is the process of verifying provider qualifications prior to admitting a provider into a health plan's network. Network Management is the functional area of BCBSNC that oversees the development and maintenance of the provider network, including provider contracting, rate negotiation, education and servicing.

Credentialing

Credentialing is the process of verifying provider qualifications prior to admitting a provider into a health plan's network. **The BCBSNC credentialing and recredentialing workflows, policies, procedures and processes are consistent with industry standards and comply with contract terms and statutes.** Controls, procedures and staffing appear to be adequate. Credentialing and recredentialing procedures are regularly audited through external reviews

and internal processes. We reviewed the credentialing and recredentialing process for a sample of providers and found 100 percent compliance.

Network Management

Although there are requirements in the Administration Services Agreement for reporting about the provider network**, BCBSNC is not meeting its contract requirement to provide this data to the SHP**. During the audit period, BCBSNC provided a "GeoAccess" report to the SHP as part of monthly reporting that did not meet the contract requirements or provide adequate information to use for monitoring the network.[9] The GeoAccess report submitted to SHP during the audit period provided only the number of members by zip code.

Although BCBSNC is not meeting its contractual requirements for monitoring reports**, it appears to be doing a satisfactory job of monitoring access**. It establishes its own standards and is compliant with Department of Insurance reporting requirements. Member-to-Primary Care Physician ratios compare favorably to internal standards and external benchmarks.

Most network management policies, procedures, workflows and controls are adequate; however, few are documented in official standard operating procedure documents, workflows or other written sources. For example, data entry of enrollment and contracting information and validation of the database is a standardized and predictable process, which should have a standard operating procedure associated with it.

Members need access to accurate information about in-network providers so they may select a provider that meets their needs and avoid additional expenses for visiting an out-of-network provider. The provider directory is the main source of this information. **BCBSNC's process for updating the provider directory may result in inaccuracies** in the printed and electronic versions. The audit team identified a number of errors associated with the provider directory during the audit period. However, the information in the directories at this point in time is several years old and some providers have moved or retired since that time. Although the audit team uncovered some errors in the printed manual, the audit team saw no evidence that these errors contributed to member access problems.

While most of BCBSNC's payment methodologies are generally comparable to those used by the industry, for some provider types or services, BCBSNC could potentially save resources and costs [redacted] This approach can lead to higher than expected costs to the SHP, because [redacted]

[9] GeoAccess is a specific type of software that displays members' geographical access to providers in terms of travel times or distance.

[redacted] can better control payment by the health plan, and can reduce the amount that members pay for coinsurance. They may also require less intensive [redacted], revenue and volume than BCBSNC performs to maintain its current system.

BCBSNC does not contract with skilled nursing facilities, which may result in access problems or higher or unpredictable costs to the SHP. Historically, skilled nursing facilities were dissatisfied with BCBSNC's payment methodology because it did not adequately address variations in patient acuity. As a result, skilled nursing facilities began refusing in-network higher-acuity patients and BCBSNC decided to no longer contract with this provider type.

BCBSNC paid [redacted] in 2006, [redacted] in 2007 and [redacted] in 2008 for manually priced codes; the 2008 amount paid for manually priced codes equals half a percent of the SHP's total claims expenses for that year. BCBSNC pays for these manually priced services [redacted] While BCBSNC's methodologies for determining payment for manually priced claims are industry standard practices, there is potential for abuse of the system by providers [redacted]. BCBSNC was not able to provide the information requested about internal monitoring processes for manually priced codes.

Like health plans in other states, BCBSNC has had difficulty contracting with anesthesiologists and other hospital-based physicians, which may result in higher or unpredictable costs to the SHP for out-of-network services. Both BCBSNC and the SHP report that some anesthesiologists are reluctant to contract with BCBSNC. BCBSNC indicates the problem is that anesthesiologists expect to receive what BCBSNC considers to be unreasonable payment rates.

BCBSNC is already monitoring in-and out-of-network payments for anesthesiologists, but the SHP should be informed of the volume and dollar amount of anesthesia claims for in-network out-of-network providers. This information will help the SHP monitor the extent of the problem.

Recommendations:

- **The SHP should consider revising current Administrative Services Agreement requirements regarding network adequacy reporting.** Because of BCBSNC's extensive and well-established provider network, it appears that SHP members have access to a wide variety of providers and provider types; the access and availability of BCBSNC's network will likely not substantially change quarterly unless specific events, such as significant changes in reimbursement methodologies and payment levels occur.

- **BCBSNC's network management should have written standard operating procedures for at least some functions.** Many processes in the network management area should be documented in a more formal format. Some documentation is appropriate to assure internal procedures are consistent year-to-year.

- **BCBSNC should investigate which process might allow for mismatched phone or address information to appear in the provider directory. BCBSNC should also perform a validation or audit of the information in the current online directory by actually calling providers.** Based on the results and comments from providers' offices during the review of the directory during the audit period, it appears that there may be provider enrollment processes that result in incorrect information in the provider database (and therefore in the provider directory). We were not able to determine what might be causing these types of errors.

- **BCBSNC should work to adopt [redacted] methodologies for outpatient hospital payment.** Moving toward a [redacted] may result in better control of payment by the health plan, and can reduce the amount that members pay for coinsurance. It may also require [redacted], revenue and volume than BCBSNC performs to maintain its current system.

- **The SHP should monitor access and payments for skilled nursing facilities**. To accurately gauge the extent of the problem caused by lack of contracts with SNFs, **the SHP needs information about the number of member access-related inquiries, complaints and grievances associated with skilled nursing facilities services and the volume and dollar amount of claims for skilled nursing facilities.** This information will help the SHP determine if costs for these out-of-network services are excessive or rising, and if SNFs' out-of-network status has any impact on member access to services. Monitoring member access complaints will provide BCBSNC and SHP with the best indication if there are access problems.

- **BCBSNC should monitor payments for manually priced codes.** If BCBSNC does not have formal internal monitoring processes in place, BCBSNC should develop and implement a procedure. BCBSNC should document and share with SHP its internal monitoring processes for monitoring manually priced codes.

- **BCBSNC, SHP and other health plans in the state have little influence over the contracting behavior of, or the amounts charged by, hospital-based physicians. BCBSNC and SHP are not able to address this issue individually; legislation may be necessary.** Absent legislative action, BCBSNC and SHP should educate members about out-of-network services for anesthesiologists and emergency room physicians. BCBSNC should monitor out-of-network payments to anesthesiologists and emergency room physicians.

Utilization Management Area Performance Results

Part of the utilization management function is to perform analyses of the utilization of services for various populations, including high-cost providers, high-cost cases and high-cost members. **The BCBSNC utilization management department does not conduct specific analyses regarding over-utilization, under-utilization and abuse related to the SHP contract.** The audit team found no evidence that BCBSNC performed such analysis for the SHP during the audit period.

In addition, BCBSNC did not provide the SHP with sufficient detail regarding BCBSNC's return on investment analyses of medical policies and authorization requirements. BCBSNC provides general information and findings from its return on investment analyses – the net cost avoidance or savings the SHP realizes in medical expenses due to BCBSNC's utilization management activities – to the SHP. However, BCBSNC's reporting on its return on investment analyses, currently and during the audit period, for the SHP is sporadic. The audit team could not determine if the activities that the utilization management staff are performing are achieving any cost savings for the SHP. Accordingly, a thorough return on investment analysis would be necessary to determine how efficiently BCBSNC's SHP utilization management function was operating.

BCBSNC's utilization management department adequately fulfills timeliness and member and provider notification standards as set forth by the North Carolina General Statute. The audit team's review of a random sample of 48 prospective reviews, 42 concurrent reviews and 45 retrospective reviews performed by BCBSNC utilization management department during the audit period found that all the cases involving denials that the audit team reviewed included all the mandatory information as set forth by the North Carolina General Statutes. The audit team also reviewed all notification letters for the sample review cases and determined that all of them met statutory requirements for notification timeframes and included all required information to the member and provider. Furthermore, the audit team reviewed BCBSNC's utilization management standard operating procedures and confirmed written policies are consistent with North Carolina legislative mandates for notification time frames and additional informational inclusions.

The audit team also reviewed licenses for a sample of clinical staff employed in the utilization management areas for both the PPO and CMM products during the audit period and **found that licenses for all 13 sampled clinical staff were current**. In addition, the audit team **determined that, with a few exceptions, the utilization management call centers for the SHP's PPO and CMM products performed at or better than industry standards during the audit period.**

Onsite Utilization Management Functions

The onsite utilization management function provided by BCBSNC provides a low-cost way to manage inpatient utilization and enhance customer service to SHP members. Onsite utilization management nurses allow a health plan to obtain the most accurate and timely information about a patient, monitor for appropriate utilization, provide referrals to case management and identify information about a patient's condition that may affect the patient's discharge planning (for example, identifying and ordering the appropriate durable medical equipment). Using onsite utilization management nurses helps a health plan avoid costs related to unnecessary inpatient stays by directing patients to the appropriate level of care. Additionally, in cases where the health plan is reimbursing a hospital on a per diem basis, onsite utilization management nurses can help a health plan control risk related to length of stay overruns. The use of onsite utilization management nurses may also have added non-financial benefits, such as increased member satisfaction.

Onsite utilization management nurses do not have remote access to BCBSNC's utilization management system, MaxMC, while on location at the hospital. Instead, onsite utilization management nurses must access the system and enter data from their homes, after leaving the hospital. For the BCBSNC SHP population, MaxMC system monitors and tracks member authorization requests, participation in health and case management programs and appeals requests.

Recommendations:

- **BCBSNC should monitor and evaluate the appropriateness and cost-effectiveness of care and services provided to SHP members through additional utilization review activities that focus on identifying and correcting instances and patterns of over-utilization, under-utilization and mis-utilization.** BCBSNC should develop statistically valid methodologies for data collection regarding the utilization of services by provider and at least semi-annually, develop and distribute provider analyses comparing the average medical care utilization rates of the members of each primary care physician to the average utilization rates of all members. In addition to these analyses, BCBSNC should encourage appropriate communication and sharing of information related to areas where Special Investigations Unit has determined there is a greater potential for abuse.

- **The SHP and BCBSNC should work together to enhance the level of detail BCBSNC reports to the SHP regarding its return on investment analyses of medical policies and authorization requirements.** Such return on investment analyses should include not only the costs for the staff dedicated to performing UM reviews for SHP members but also the indirect costs that BCBSNC allocates to the UM function for the SHP. If such analysis determined that there was opportunity to improve the return on investment, there might be a potential savings through increased productivity, that is, having fewer BCBSNC staff perform the same

number of UM reviews or by reducing the number of reviews the UM department performs with a corresponding reduction in staffing. Alternately, the SHP could explore contracting with a vendor that specializes in providing UM services and is willing to do so on a risk-sharing basis.

- **BCBSNC should work with hospitals where it is providing onsite UM for SHP members to provide a way for BCBSNC's UM nurses to have access to the MaxMC system while on location at the hospital**. Providing onsite access to MaxMC will enhance onsite UM nurse efficiency by allowing UM nurses to access and enter patient information and requests in a timelier manner.

Pharmacy Benefits Management and the SHP's Pharmacy Program

The following findings relate to Medco's performance as the pharmacy benefit manager for the SHP and to the SHP's pharmacy benefit program. In general, we found that Medco met its contractual obligations to the SHP, although there are some areas where the contract between the SHP and Medco could be improved, as previously discussed in this report. The larger issue is that the SHP was not able to implement programs and initiatives recommended by Medco that would have improved drug cost savings for the SHP and its membership, because North Carolina statute and regulations preclude the implementation of some of these recommendations. The result is higher costs and a pharmacy program that is not consistent with industry standards.

Medco's Performance

Medco's operational processes and core functions and systems are efficient, standardized and highly automated and Medco is primarily performing according to the requirements of its contract:

- Medco's customer service centers use enabling technology and are integrated and connected to enterprise-wide data. Medco is able to quickly and accurately respond to member issues and the information needs of the SHP

- Medco maintains a fully automated and integrated mail order pharmacy program and specialty pharmacy programs with multiple distribution and dispensing pharmacies across the country.

- Medco manages its internal processes efficiently with the use of documented standard operating procedures across the organization within functional areas relevant to this audit such as eligibility, pharmacy network, etc.

- Medco's use of technology to capture, integrate and access enterprise-wide data is also one of its strongest assets. Medco leverages its enterprise-wide data in reporting, analytics, customer service and to identify clinical, service and savings

opportunities that may be of benefit to the SHP. For the SHP, Medco is easily able to identify members who can benefit from additional clinical programs and services and can quantify projected value.

The administrative and utilization management fees Medco charged to the SHP during the audit period were consistent with industry standards. These fees totaled less than two percent of the total expenditures for drugs paid by the SHP per year, and less than $2 PMPM. **In addition, the discounts Medco offered the SHP for brand and generic drugs were competitive with industry standards.** Medco guaranteed and continues to guarantee the SHP drug discounts for prescriptions filled within the retail network and mail order networks. The discount is a percentage off of the Average Wholesale Price (AWP) and varies depending on whether the drug is a brand or generic drug, whether the generic drug is on the Maximum Allowable Cost price list – a list determined by Medco that sets the unit price for generic drugs regardless of manufacturer or distributor – and whether the drug is dispensed via the retail pharmacy network or the mail order pharmacy.[10] During the audit period, the AWP drug discounts for the SHP were competitive with industry standards for brand and generic drugs on the Maximum Allowable Cost list.

Medco's Therapeutic Resource Centers clinical pharmacy programs that serve the needs of the population with chronic and complex medical conditions are primarily delivered to members who use the mail order pharmacy channel. However, a Medco customer service representative will refer any member to the Therapeutic Resource Centers, if a member calls into the call center and a Health Action Plan identifies them as a candidate for the Therapeutic Resource Centers. These Therapeutic Resource Centers programs address the complex medication issues and close gaps in care that affect individuals with chronic and complex medical conditions and contribute to unnecessary medical costs, suboptimal outcomes and overall quality of care. The SHP has a large number of members who are classified as having chronic and complex conditions and who fall into one of the targeted conditions for which Medco's Therapeutic Resource Centers clinical pharmacy program are designed. However, Medco limits their active engagement of members into these programs to only those SHP members who use the Medco mail order pharmacy or Accredo, its specialty pharmacy, and the use of mail order by SHP members is less than two percent.

Medco's prior authorization process generates a large number of denials due to administrative errors; appeals of these denials by Medco must then be processed by BCBSNC at the SHP's expense. Medco processes prior authorizations for pharmacy benefits, however, when a provider or member appeals a denial by Medco, BCBSNC, the contractor that administers the SHP's medical benefits, processes the appeal. Of the 72,000 prior authorizations Medco processed in calendar year 2008, 14 percent were denied and 11 percent of the denials were appealed. Nearly 80 percent of these appeals of Medco denials were considered "courtesy

[10] The average wholesale price (AWP) is a term referring to the average price at which wholesalers sell drugs to physicians, pharmacies and other customers and in practice, is a figure reported by commercial publishers of drug pricing data.

appeals" by BCBSNC, meaning the denial was due to an administrative error made by the provider in completing Medco's prior authorization form. Although BCBSNC has adjusted its appeals process to accommodate these administrative-related "courtesy appeals" of Medco denials, it nonetheless adds to BCBSNC's workload and costs, for which the SHP must pay. The audit team acknowledges that amount of time and effort to process a courtesy appeal is less than a traditional appeal, however, the volume of Medco courtesy appeals is significant and warrants a better solution.

Recommendations

- **Medco should extend access to its Therapeutic Resource Centers clinical pharmacy programs to SHP members with chronic and complex conditions who receive their medications at retail pharmacies.**

- **Medco should improve its prior authorization form and process to minimize the administrative errors that result in denials and courtesy appeals.**

The SHP's Pharmacy Program

There is a gap in alignment between the Medco contract and the SHP's current benefits and therefore, the SHP cannot take full advantage of several incentives in the contract. Specifically, in the area of mail order utilization, the contract stipulates that Medco will provide the SHP pricing concessions or incentives to encourage mail order utilization. Increasing mail order utilization is a key success driver for Medco since it owns its mail order operations and the majority of its revenue and gross margin comes from product revenue, which includes the mail order pharmacy operations. As the largest mail order pharmacy, Medco can leverage its size for volume concessions on drugs purchased, creating margins with which retail pharmacies have difficulty competing.

North Carolina General Statute 135-45.6 does not support the SHP in providing its members with a pharmacy benefit offering that is consistent with industry standards and that delivers significant savings. Although during the audit period many components of the SHP's pharmacy benefit were consistent with industry standards, there were three weaknesses associated with the SHP benefit design.

First, there was no mail order pharmacy incentive for members. The discounts Medco's contract offers the SHP for mail order prescriptions provide an opportunity for the SHP to realize lower drug ingredient and administrative costs which in turn would enable the SHP to offer its members lower copayment for mail order prescriptions. However, as discussed above, this is prohibited by Statute. The North Carolina SHP is among only 16 state health plans not offering a mail order pharmacy incentive benefit to its members. Compared to the overall industry, the level of mail order use within the SHP membership is significantly lower than average.

Second, there was an absence of competitive pricing for specialty drugs via an exclusive specialty pharmacy network and benefit. Specialty pharmacy drugs are different from traditional medications in that they typically require special handling and administration (for example, infused or injected), are considerably more expensive and are used to treat a small subset of patients with chronic high cost conditions, such as hemophilia, rheumatoid arthritis, cancer and HIV. Many of the specialty drugs are derived from biologic agents.

The growth in expenditures for traditional pharmacy agents is approximately one to three percent annually, while annual growth in expenditures for specialty drugs is in the teens. To serve the population taking specialty medications, specialty pharmacies have developed a service model that addresses the special handling, delivery and educational needs of the specialty segment. Specialty pharmacies are a form of home delivery or mail order in that the medications are mailed directly to the patient versus the patient picking up their medications at a retail pharmacy. However, specialty pharmacies are not as highly automated as traditional mail order pharmacies due to the unique handling requirements of these drugs. The average days supply is 30 days or less as opposed to 90 days in traditional mail order dispensing. Health plans and other payers have generally opted to structure specialty pharmacy networks with a subset of pharmacies that specialize in specialty drugs for cost and quality reasons. With their ability to concentrate on specialty drugs, specialty vendors can achieve better pricing concessions from specialty manufacturers. Health plans and payers benefit from the concentration of volume by being able to negotiate better drug discounts with a specialty pharmacy than can be realized with a traditional pharmacy. Specialty pharmacies are also beginning to negotiate rebates on some specialty drugs. [11]

During the audit period, the lack of a specialty pharmacy benefit and a specialty pharmacy to dispense specialty drugs adversely affected the SHP's costs. In July 2009, but outside of the audit period, the SHP was permitted to add Accredo as the exclusive specialty pharmacy vendor, thereby eliminating non-acute specialty drugs from being dispensed from the retail network. However, oncology/cancer drugs were excluded from the specialty network and left within the physician network under the medical pharmacy benefit. This decision could have significant impact on costs for the SHP if the costs of oncology drugs are not as aggressively managed on the medical side as they are on the pharmacy side of the SHP. Cancer is the area with the most specialty drugs in development in the pharmaceutical industry. Oncology/cancer drugs typically account for more than 50 percent of total specialty drug spending. Forecasts suggest that spending on cancer drugs could reach $80 billion nationally by 2012, due to the number of patients with cancer as well as the increasing cost of treatment.

The SHP also had higher drug costs within specialty pharmacy than it would have if it had an exclusive specialty pharmacy network and a specialty pharmacy benefit. With the absence of an exclusive pharmacy network, specialty drugs were dispensed primarily under a retail network contract and resulted in higher drug costs and additional administrative costs.

[11]IMS Health 2009 data: IMS Health is a company that provides data and analyses for the healthcare industry. IMS data is considered the gold standard in pharmaceutical and healthcare market intelligence information.

Third, there was a need for stronger incentives to increase the use of generic drugs, such as mandatory generic substitution or a "member pays the difference" program. During the audit period, the SHP had a lower generic utilization than industry standard and thus higher drug costs. At the end of 2008, the SHP's generic dispensing rate was about 62 percent; Medco's industry average was 66 percent for retail prescription claims during that period. The SHP implemented a benefit change in 2009 that requires members to pay the difference between the cost of a brand and generic drug if they choose a brand drug when a generic drug is available. As a result, the SHP's generic dispensing rate increased to 69 percent at the end of 2009.

The SHP could improve coordination of specialty pharmacy drugs between those billed under the medical benefit and those billed under the pharmacy benefit to decrease the potential for double billing. During the audit period, specialty medication billed under the pharmacy benefit accounted for 12 to 14 percent of the SHP's overall drug spending. However, specialty drugs billed under the pharmacy benefit, which Medco administers, are estimated to account only for approximately half of the SHP's total spending on specialty drugs; the other half were billed under the medical benefit which BCBSNC administers. While the SHP has made a number of specialty drugs available only through the pharmacy benefit, there are still a number of drugs that are available through both the pharmacy and medical benefits. This is a risk area for the SHP due to the potential for drugs to be double billed under both the pharmacy and medical benefits. Another potential risk area for the SHP associated with specialty drugs is if the prior authorization processes for the same drugs under the pharmacy benefit and medical benefit are not consistent. Both Medco and BCBSNC conduct prior authorization of specialty medications using criteria for determining the medical necessity and efficacy of the drugs for members' conditions. While the SHP attempts to coordinate the prior authorization criteria for medications between Medco and BCBSNC, having to maintain two sets of criteria and two different processes for the same drug is not optimal. The situation requires increased coordination between the two benefit programs and can cause confusion for members and providers.

Recommendations

- **The SHP should increase mail order utilization to achieve greater cost savings for it and its members.** Given the absence of administrative and dispensing fees at mail order as well as the more aggressive drug discounts, the SHP could realize significant savings by moving medications primarily used to treat chronic conditions to mail order. To accompany the mail order benefit, the SHP should create a maintenance medication list that specifically targets those medications applicable to mail order use. Without a benefit that provides an incentive to members, the SHP's options to increase use of mail order are limited to member communications and other marketing efforts. Given the savings opportunity, the SHP should consider targeted campaigns to educate members with chronic or complex conditions about the benefits of mail order. An alternative approach that offers an accommodation to community pharmacies and that has been implemented in many benefit plans is to allow dispensing of a 90-day supply by retail pharmacies for maintenance

medications. This offers a mail-like benefit at retail as long as the retail providers match the mail order discount rates.

- **The SHP should implement a more comprehensive specialty pharmacy program. The audit team notes that in 2009, beyond the audit period, the SHP implemented a specialty pharmacy program.** The audit team recommends one modification to the benefit to increase the maximum allowable member cost per prescription, which is currently set at $100. Given the cost of these medications, a $100 copayment is still significantly less than a 25 percent cost share. However, the SHP needs to assess the impact of increasing the member out-of-pocket expense for these expensive drugs with the impact it has on members' ability to afford and stay on therapy. Another strategy that the SHP could consider is creating a Brand Upper Limit list to control pricing on some specialty pharmaceuticals.

- **The SHP should continue to encourage generics utilization to achieve cost savings for the SHP and its members.** Since the end of the audit period, the SHP has implemented a benefit change that requires members to pay the difference between the cost of a brand and generic drug if they choose a brand drug when a generic drug is available. The savings to the SHP by maximizing the use of generic drugs when appropriate is significant and provides savings to the member as well as the SHP. The average price differential before the drug discount is applied between a brand and generic drug is $101. Based on 2008 SHP information, a one percentage point increase in generic utilization yields a one percent decrease in drug spending. For 2008, a one percentage point increase in generic utilization would have decreased the SHP's gross drug spending by $11 million. The growing number of generic drugs that are projected to come to market represents a growing area of savings opportunity for the SHP; establishing a pharmacy program and benefit that enables the SHP to realize these savings as early as possible is in its best interest as well as its members' best interests.

- **The SHP should implement a process to routinely audit for duplicate billing of specialty pharmacy claims.** Given the cost of specialty drugs and the number of new agents coming to market, the audit team recommends that the SHP implement a process for auditing all specialty pharmacy claims – those billed under the pharmacy and medical benefits – to identify potential duplicate billing. In instances where the audit identifies duplicate billing, SHP should recoup overpayments, educate providers and work with Medco and BCBSNC to improve processes and communications between each other. The SHP could conduct the audit itself (or contract the work), or contract with Medco or BCBSNC to conduct the audit.

  The SHP should begin by conducting such analysis monthly, and take quick corrective actions and institute provider education when duplicate billing is found.

The need for frequent analysis should decrease over time as providers become more aware of the requirements and the processes improve.

- **The SHP should establish a single set of prior authorization criteria for drugs covered under both the medical and pharmacy benefits.** While the SHP should also attempt to minimize the number of drugs covered under both the medical and pharmacy benefit, there will always be some drugs that need to be covered under both benefits. For those drugs, the SHP should attempt to implement a single set of prior authorization criteria that apply regardless of whether they are covered and processed under the medical or pharmacy benefit. A single set of criteria would make the prior authorization process clearer and simpler for providers and members and improve control for the SHP. The SHP has begun the process to synchronize the prior authorization criteria for drugs covered under both medical and pharmacy benefits.

Potential Cost Savings for BCBSNC Performance-Related Recommendations

In many of the BCBSNC functional areas, the audit team identified savings opportunities and quantified the savings to the SHP that would be achieved from implementation of its recommendations. Table 4 shows the incremental estimated potential savings for each year and the total over the four fiscal year period of 2011 – 2014. The savings estimate for fiscal year 2011 of approximately $2.7 million represents a 2.4 percent reduction from BCBSNC's total administrative costs of approximately $110.5 million billed to the SHP in fiscal year 2009.[12] These estimates of potential savings apply to the SHP's entire membership.

In addition, our recommendation that BCBSNC take immediate steps to improve its retroactivity and recovery processes, including improvement of the fraud and abuse recovery initiatives represents a significantly larger savings opportunity for the SHP than those presented in Table 4. The audit team found that BCBSNC's recovery dollars were approximately one percent of the SHP's total medical claims expenses, which is significantly below the industry average of three to five percent. A recovery improvement of two percent of the SHP's medical claims expense, which totaled approximately $2.2 billion in fiscal year 2008, would yield significant savings for the SHP.

[12] The $110.5 million in administrative costs excludes profit, amortization of costs for converting from the CMM plan to the PPO plan and access fees.

Table 4: Estimated Potential Savings for BCBSNC Performance-Related Recommendations

Functional Area	Short Term	Mid Term		Long Term
	FY 2011	FY 2012	FY 2013	FY 2014
Customer Service[13]	$210,000	$210,000	-	$630,000
Membership Accounting[14]	$600,000	$600,000	-	-
Claims Administration[15]	$552,900	$552,900	$552,900	$552,900
IT and Data Reporting[16]	$355,430	-	-	-
Utilization Management[17]	$956,000	-	-	-
Savings per Year	**$2,674,330**	**$1,362,900**	**$552,900**	**$1,182,900**
Total Savings FY 2011 - 2014	**$5,773,030**			

[13] BCBSNC could gradually reduce average call handle times for SHP members from the fiscal year 2008 level of 9 minutes 35 seconds to 8 minutes 45 seconds, 8 minutes, and 6 minutes 30 seconds, over fiscal years 2011 through 2014, thus reducing staffing levels by a total of [redacted] staff members; assumes [redacted] average annual salary and benefits.
[14] Savings calculations assume BCBSNC could make incremental improvements in its cost performance to achieve a PMPM cost in fiscal year 2012 that is 35 percent less than its fiscal year 2009 level and is consistent with industry best practices. Estimated savings are based on fiscal year 2009 SHP membership levels.
[15] Estimated savings that would be achieved if BCBSNC made functionality improvements to the PowerMHS claims system to reduce the quantity of claims requiring manual intervention. Savings calculations assume BCBSNC could make incremental improvements in its productivity each year through 2014 to reach a PMPM cost equal to its four-year average for fiscal years 2006 through 2009; a PMPM cost that is consistent with industry best practices. Estimated savings are based on fiscal year 2009 SHP membership levels.
[16] The total estimated savings is from two recommendations: that BCBSNC improve its planning for large Information Technology initiatives through more effective planning and thereby procure less expensive external contractor resources; and that the develop data reporting capabilities internally. Estimated savings from the first recommendation, $462,000, are based on the following assumptions: BCBSNC could achieve a [redacted] percent reduction in external resource rates, [redacted] percent of BCBSNC's current [redacted] in IT spending for support of the SHP is related to staffing/labor resource costs and that an average of [redacted] percent of staffing resources is external. Estimated savings from the second recommendation are a net negative savings of $106.570. The net negative savings estimate is calculated by subtracting a $500,000 estimated one-time investment by the SHP from $393,430 annual savings to the SHP from no longer paying for BCBSNC resources to support its data reporting. The $393,430 to the SHP from no longer paying for BCBSNC resources is the sum of the [redacted] annual amount that BCBSNC currently charges the SHP for eInfoNow and the estimated [redacted] cost for the [redacted] FTEs staff that BCBSNC charges the SHP for data reporting support assuming 1 FTE works 1,827 hours per year at a rate of [redacted] per hour inclusive of benefits and bonuses. Estimated savings assume the $500,000 investment by the SHP will be made in FY 2011 and that the SHP will not require BCBSNC data reporting support for the entire FY 2011. The audit team acknowledges that the SHP may spend considerably less than its estimate of $500,000 one-time investment.
[17] Assumes BCBSNC could make moderate improvements in its cost performance to reduce its PMPM costs to the 75th percentile of comparable health plans in the industry benchmarks.

Potential Cost Savings for Pharmacy Program-Related Recommendations

The audit team quantified potential savings for its recommendations that relate to the SHP's pharmacy benefit program. Table 5 shows the incremental estimated potential savings for each year and the total over the four fiscal year period of 2011 – 2014.

These savings would be realized through the following pharmacy program changes:

- Establish mail order copayment incentives to increase SHP member mail order utilization. Increased mail order utilization would achieve drug cost and administrative cost savings for the SHP.
- Maximize generic utilization with mandatory generic substitution with SHP members paying the difference between the costs of brand and generic drugs.
- Implement a more comprehensive specialty pharmacy program that includes oncology drugs and implement a process to audit for duplicate billing of specialty pharmacy claims under the pharmacy and medical benefits.

These estimates of potential savings apply to the SHP's entire membership. Legislation would be required for the SHP to implement the first recommendation above.

Table 5: Estimated Potential Savings for Pharmacy Program-Related Recommendations

Recommendation	Short Term	Mid Term		Long Term
	FY 2011	FY 2012	FY 2013	FY 2014
Establish mail order copayment incentive: Drug and Administrative cost savings[18]	$3,700,000	$2,900,000	$3,250,000	$3,700,000
Maximize generics utilization through mandatory generic substitution with SHP member paying difference between the costs of brand and generic drugs[19]	$6,875,000	$6,875,000	$6,875,000	$6,875,000
Implement a more comprehensive specialty pharmacy program and a process to audit for duplicate billing of specialty pharmacy claims[20]	$4,300,000	$4,300,000	$2,150,000	$2,150,000
Savings Per Year	$14,875,000	$14,075,000	$12,275,000	$12,525,000
Total Savings FY 2010 - 2014	**$53,750,000**			

[18] Drug cost savings based on current discount rates at mail and retail and constant Generic Drug Rate of 61.7 percent. Assumes mail order utilization would increase to 5 percent in 2011, 8 percent in 2012, 12 percent in year 2013 and 15 percent in 2014. Saving estimates do not include any savings or reduced expense from a benefit design that would require SHP members to pay the difference between the costs for drugs dispensed at retail vs. mail order for a maintenance medication dispensed at retail. Administrative savings are from avoiding per claim administrative and dispensing fee on retail prescriptions through increased utilization of mail order prescriptions. Administrative savings estimates assume the same mail order utilization rates for each year that are assumed for drug cost savings estimates and constant claims volume at the 2008 level.

[19] Saving estimates assume a 1 percentage point increase in generic drug utilization each year over the 2009 year end rate; the 1 percentage point increases are applied to the SHP's 2008 drug expenditures and average drug prices. The savings estimate assumes that the 1 percentage point increase in generic drug utilization is incrementally gained over the course of a year and assumes an average increase per quarter of 0.25 percentage points yielding an average increase of 0.625 percentage points over one year. The SHP implemented a benefit change that requires members to pay the difference between the cost of a brand and generic drug if they choose a brand drug when a generic drug is available. As a result, the generic dispensing rate increased to 69 percent at the end of 2009.

[20] Savings estimate for implementing a more comprehensive specialty pharmacy program assumes movement of some drugs to pharmacy benefit from medical benefit, implementing new provider drug pricing/reimbursement for drugs remaining under the medical benefit, audit functions and access to the medical pharmacy claims data and active oversight. The estimates also assume medical pharmacy is equal to specialty pharmacy spending (2008 base), and the following savings are achievable each year: 5 percent for FY 2011 and 2012 and 2.5 percent for FY 2013 and 2014. These assumptions do not account for growth of specialty pharmacy.

Blue Cross Blue Shield of North Carolina Comments on Comprehensive Report

In 2006, after seeing continued large increases in medical costs, the State Health Plan (SHP) requested BCBSNC's assistance in changing health insurance products for its members. In order to comply with North Carolina law and provide greater choice for SHP members, the SHP presented two different products at the same time: Comprehensive Major Medical (CMM) and Preferred Provider Organization (PPO). Administration of these two different products required claims processing on two different systems. The SHP and BCBSNC discussed the financial impact of operating two systems, and the SHP projected that the benefits of long-term medical savings would outweigh the short-term increase in administrative costs. As a result, BCBSNC created and provided a suite of PPO products for SHP members in late 2006.

General comments:

- BCBSNC provided Navigant with all available information requested.
- The audit was for the period of July 2005 through June 2008 and is not completely representative of BCBSNC's current business practices. Several improvements have been made since that time.
- BCBSNC has been compliant with the Administrative Services Agreement (ASA) and all applicable laws. In fact, BCBSNC has exceeded the requirements of the ASA in several areas.
- BCBSNC has established and implemented productivity standards based on its products, systems, and processes.
- BCBSNC acknowledges that its processes and systems can be improved. BCBSNC will continue to proactively seek and be engaged in conversations as to how such improvements can be achieved.
- BCBSNC provided cost estimates to the SHP regarding the PPO plans prior to their implementation. More detailed information was developed by functional area and BCBSNC was prepared to furnish it upon request.
- Some of Navigant's proposed administrative cost reductions cannot be achieved because of North Carolina state law or agency restrictions.
- Navigant found that, during the audit period, the cost-plus contract was better for the SHP than a flat fee arrangement.

BCBSNC's Performance

<u>Cost Accounting, Allocation, and Reporting / Cost Performance:</u>

BCBSNC has properly allocated costs and steadily reduced the administrative cost per member per month each year. Navigant determined that during the audit period the SHP actually saved millions from the cost-plus arrangement rather than a flat rate. In fact, **Navigant reported that BCBSNC's administrative cost is better than at least 75 percent of other benchmarked plans.**

Navigant's audit is the third audit in the past year to verify that BCBSNC's accounting and cost allocation methodology is consistent with the contract between the SHP and BCBSNC, other

lines of business, and industry standards. (The other two audits were conducted by the North Carolina State Auditor and Thomas & Gibbs.)

In addition to what is required by the contract, BCBSNC has provided activity cost reports to the SHP. BCBSNC will continue to work with the SHP to provide the information the Plan needs.

Generally, the cost to administer a CMM plan is lower than the cost to administer three PPO plans. Direct comparison between the administrative costs of the State CMM and PPO plans is inappropriate for two key reasons: (1) the CMM plan had the benefit of 20 years of experience and system refinements, whereas the PPO plans were new and were introduced in an atypical environment; (2) the introduction of PPO products in October 2006 began a period of significant transition that lasted until the last SHP member migrated away from the CMM plan on June 30, 2008. The SHP held four Annual Enrollment periods during this 21-month time frame, and BCBSNC handled additional inquiries from SHP members who were not familiar with the PPO products. Additional complexity was introduced because the PPO plans were implemented in the middle of a benefit year (requiring transfer of deductibles, coinsurance, etc.). **However, despite all this, since the introduction of the PPO plans, the administrative cost of the PPO plans has steadily declined.**

Navigant highlights the only functional area (Utilization Management) that was above industry standard in administrative cost. However, it is important to note that Utilization Management services are more frequently used (14 percent of non-SHP compared to 40 percent SHP) by SHP members. Normalizing the current Utilization Management costs for the increased usage, BCBSNC actually compares better than industry standard. As expected, the new plans required more performance tracking, quality assessments, and greater focus in improving processes and systems. **Despite all this, BCBSNC's administrative cost was still better than 75 percent of benchmarked plans.**

<u>Performance in Information Technology, Claims Administration, and Membership Accounting</u>

For Information Technology, there are two critical points that must be noted. First, BCBSNC provided estimates to the SHP of the cost prior to the implementation of the PPO plans. The actual cost of implementation fell within the estimated range. Second, the contract contemplated a shared systems model to minimize administrative costs to the SHP; to move away from that model (by allowing the SHP to unilaterally dictate systems changes) would result in substantial increases in administrative cost.

In 2006, at the request of the SHP, BCBSNC created a suite of three Preferred Provider Organization (PPO) products for the SHP in seven months – substantially faster than industry standard. To remain compliant with North Carolina law, BCBSNC has been required to maintain two separate claims processing systems since the suite of PPO products was first established for SHP members in 2006. This has resulted in higher staffing numbers and increased systems and administrative costs for the SHP. **However, despite this, Navigant found that "BCBSNC's overall IT costs trended below the 25th percentile in comparison to similar organizations."**

In other words, **BCBSNC's Information Technology costs were better than (less than) at least 75 percent of benchmarked plans.**

BCBSNC is able to keep costs low, in part, by coordinating system development and business changes for PowerMHS. There are several examples of coordination between IS and operations areas within BCBSNC: benefit configuration, change management requests, and system testing. However, BCBSNC recognizes that more coordination efforts may result in higher quality and greater efficiencies.

When the SHP asks BCBSNC for significant changes related to the SHP, BCBSNC estimates how much it will cost, and BCBSNC seeks SHP approval to proceed.

For Claims Administration, BCBSNC continuously fine tunes its configuration of PowerMHS to process SHP's PPO claims. Changing one aspect of claims processing affects multiple operational areas. For example, if BCBSNC increases First Pass Rates, there is a potential for more reprocessing of claims later. As another example, significant SHP-specific configuration changes may result in inconsistencies in claims processing between the SHP member claims and other BCBSNC member claims, which in turn could result in inconsistent provider contract administration.

BCBSNC disagrees with Navigant's position that configurations should simply align with the average benchmarked plan. **BCBSNC's position is that claims administration configuration should align with the cost, quality, and service targets of its customers not just with the average benchmarked plan.** BCBSNC will continue to look for opportunities to improve the functionality of the PowerMHS claims system, but with the broader goal of reducing overall costs and maintaining a high level of customer satisfaction.

For Membership Accounting, BCBSNC continues to reduce administrative costs. This is evidenced by staff reductions over the past 24 months and the fact that **Navigant found the Membership Accounting department performed better than (at lower cost than) 75 percent of benchmarked plans.** However, the continued reduction of staff, proposed by Navigant, would reduce BCBSNC's staff to levels so low that Membership Accounting would not be able to function properly.

BCBSNC endorses Navigant's recommendation that the SHP accept one common method of payment and reconciliation, but acknowledges that implementing this recommendation would create a burden for individual state agencies. BCBSNC cannot effectuate standardized billing, payment and reconciliation processes without actions by the State (agencies, legislators, etc.).

Currently, approximately 90 percent of SHP employees and retirees have access to self-service and automated enrollment capabilities through the use of BEACON or Benefitfocus. Additionally, BCBSNC continuously seeks ways to improve electronic data exchange with Benefitfocus to attain a high level of system to system efficiency.

BCBSNC recognizes the need to present the SHP with more detailed recovery information and to jointly establish recovery goals. BCBSNC has already contracted with multiple new recovery vendors to boost overpayment recoveries.

During the audit period, BCBSNC did not operate under a "pay and pursue" philosophy. BCBSNC utilized various means to ensure that claims were paid accurately. Examples include annual membership verification, high dollar claims review and system configurations to prevent possible overpayments. As long as other undisclosed coverage or incorrect provider filings occur, the potential for recoveries will exist.

BCBSNC disagrees with many of Navigant's statements related to the Special Investigations Unit (SIU) found in this Executive Summary. SIU handles the more complex and more litigious overpayment recovery efforts. By its very nature, the environment in which the SIU functions requires rigorous attention to various procedural, statutory and regulatory requirements. BCBSNC believes the SIU has in place the clearly defined processes and controls necessary to operate in this environment. By asserting that the SIU does not meet industry standards, Navigant rejects BCBSNC's information but does not supplement its own data as a response.

Since the start of the SHP PPO plans, SIU has made great strides towards improving its recovery efforts. For example, anti-fraud software was implemented in 2007. In 2009, SIU achieved an 8:1 return on investment for the SHP. In other words, the SHP recovered and prevented payment of eight times more dollars than it was charged for SIU's services. This compares favorably to an average of 4:1 for agencies within the federal government, an average of 5:1 for large Blue Cross and Blue Shield Plans, and an average of 7:1 for all health plans as calculated by the National Healthcare Anti-Fraud Association. SIU will continue to seek efficiencies and improvements to maximize the SHP's return on investment as it relates to complex overpayment recoveries.

Appeals Area Performance Results

BCBSNC is pleased that Navigant confirmed Appeals services provided for the State Health Plan (SHP) were compliant with North Carolina law and that member materials were clear and understandable. BCBSNC endorses Navigant's recommendations supporting communication and collaboration among parties involved in the Appeals process.

BCBSNC provides the SHP with an analysis of the number and nature of the appeals and grievances on a routine basis and engages in discussions with the SHP and the representative from the Attorney General's office who has responsibility for the SHP.

Customer Service Area Performance Results

BCBSNC is certainly willing to have discussion with the SHP regarding different measures to be included in the Administrative Services Agreement. However, several of Navigant's

recommendations could decrease member satisfaction or increase costs. For example, Navigant suggests contacting members when a case is open more than 30 days and every 30 days thereafter. COB and Appeals constitute the majority of the cases over 30 days old, and the members are aware of the status (usually BCBSNC is awaiting further information from an external source). Requiring additional written correspondence in such cases would be confusing to the member and decrease member satisfaction.

BCBSNC currently tracks the cost per call and cost per paper correspondence; however, due to the low volume of faxes and email those types of communications are not separately tracked.

BCBSNC's policy is to report standard call center performance metrics to the SHP on a daily, weekly and monthly basis. BCBSNC gathers a broader range of accessibility and performance measures for internal use and is willing to modify its contractual requirements and collect and report those performance measures the SHP would find helpful to manage their members' experience.

BCBSNC is keenly aware of the underlying causes for the high handle times in 2007 and 2008. The SHP had just introduced its first PPO plans, and many members were not familiar with the concept of a PPO product, even though the rest of the industry had been accustomed to it for years. Because of members' unfamiliarity with the PPO plans, BCBSNC placed an added emphasis on educating members. There were also multiple enrollment periods (three in the first twelve months). Additionally, the majority of retirees did not move to the PPO plans until the CMM plan was eliminated in 2008. Retirees call more often and have longer interactions than active employees.

For all these reasons, longer handle time was necessary to address member concerns. However, it is also important to note that members were increasingly being educated about the PPO product throughout the SHP's three-year migration process. The average handle time has since dropped by over two minutes and it now within industry standard.

BCBSNC has increased telephone system functionality. For example, in 2008, BCBSNC enabled ID card requests via the voice response system. BCBSNC has also developed a virtual queue system; it was available to providers in 2009 and activated for SHP members the first quarter of 2010. The pay and educate process, which was used during the audit period, was reviewed and approved by the previous SHP administration prior to its implementation. At the request of the current administration, BCBSNC stopped the program first quarter 2010.

<u>Provider Relations and Delivery Systems Area Performance Results</u>

BCBSNC is pleased that Navigant acknowledged the extensive and well-established provider network and that the quality of the credentialing workflows, policies and procedures are consistent with industry standards.

Navigant found no processes and procedures that were redundant or inefficient. Additionally, Navigant noted that BCBSNC's processes were considered industry standard. Based on SAS 70 audits and internal audits, BCBSNC believes that Network Management maintains a comprehensive set of written policies and procedures that meet or exceed industry standards.

BCBSNC uses internet-based provider directories because printed provider directories are often outdated as soon as they are printed. Navigant's findings support this decision. BCBSNC validates provider demographic data (used as a directory feed) as part of its regular provider contacts. Further, BCBSNC sends timely communications to providers soliciting updates and changes to such data. Any changes are modified on BCBSNC's website to ensure its members obtain the most current provider information. Additionally, since the audit period, BCBSNC has contracted with a leading national vendor to further validate provider demographic data.

BCBSNC continues to reimburse using a Medicare/prospective payment methodology for a majority of provider services, and is moving toward prospective payment for outpatient services.

BCBSNC will continue to monitor access and payments for skilled nursing facilities; however, BCBSNC deliberately chose against contracting with skilled nursing facilities (SNF) to make sure that BCBSNC and SHP members had access to SNFs. Prior efforts to contract with SNFs created access issues. Navigant verified that BCBSNC's current process for administering SNF claims does not impede SHP members from obtaining access to SNFs. For the past several months, BCBSNC and the SHP have been in detailed discussions regarding how to address this concern without adversely impacting members.

BCBSNC has recognized that manually priced codes based on charges create the potential opportunity for providers to "game the system" or bill unethically. As stated by Navigant, BCBSNC is monitoring this and BCBSNC's methodologies are industry standard.

BCBSNC shares the concerns and sentiments set forth by Navigant: BCBSNC has little influence in requiring anesthesiologists and other hospital-based physicians to contract with BCBSNC as in-network providers.

<u>Utilization Management and Onsite Utilization Management Area Performance Results</u>

BCBSNC does track utilization and medical expense trends. An insurer could not properly function without tracking utilization and medical expense trends.

The industry has had a difficult time defining "over- and under-utilization," which is why BCBSNC has moved away from this terminology. However, BCBSNC tracks utilization and medical expense trends through the following processes:

- Quality Management Process (QMP) – data-driven analytic model that evaluates the utilization determinations made in prior review service categories and post service categories;
- Utilization Management Process Monitoring – which includes inpatient reviews, concurrent reviews, discharge services planning, and prior review;
- Quality of Care (QOC) process – which tracks and trends adverse patient outcomes; and
- BCBSNC Special Investigation Unit (SIU) Referrals – improper patterns are referred for investigation.

Currently, BCBSNC shares its return on investment analyses of medical policies and authorization requirements with the SHP.

BCBSNC has worked to ensure that the SHP receives the information it needs. Key clinical staff members of the SHP and BCBSNC meet regularly to discuss the BCBSNC Utilization Management Program and other health care management matters. BCBSNC has developed and enhanced its reporting structure based on feedback from SHP staff involved in these meetings.

BCBSNC agrees with Navigant's recommendation to provide access to MaxMC (the system used to track the status of authorization requests) to enhance onsite nurse efficiency. Nurses in some hospitals already have access to MaxMC. However, for various reasons (internet connectivity, privacy concerns, etc.) BCBSNC is unable to fully implement the recommendation at this time.

Medco Health Solutions Comments on Comprehensive Report

Pharmacy Pages E-14 and E15

Recommendation 5: Medco should extend access to its Therapeutic Resource Centers programs to SHP members with chronic and complex conditions who receive their medications at retail pharmacies.

Medco Response: Medco notes that the Therapeutic Resource Centers (TRC) are not limited to members using Mail Order. Please note that any members calling the Medco Customer Service are automatically stratified to the appropriate TRC depending on their disease state and are provided the opportunity to speak to a Medco specialist pharmacist. Additionally, the Health Action Plan identifies financial and clinical gaps in care regardless of the patient being at retail or mail. Medco does not agree with the "gap in clinical services" as mentioned. Medco notes no issue.

Recommendation 8: Medco should improve its prior authorization form and process to minimize the administrative errors that result in denials and courtesy appeals.

Medco Response: Please note that Medco is not able to determine whether a case is an "administrative error" or an appeal. Medco must take the provider at their word when the sign the fax form and send it in to us. Hence, Medco handles all "corrections" as appeals. This is for audit purposes. Additionally, Medco has not received any significant feedback that this has been an issue. Medco notes no issue.

III. Appendices

Appendix A: Approach to the Audit

The audit team notes that the SHP clarified that although it used the term "performance and efficiency audit," it was not requesting an audit conducted in accordance with Generally Accepted Government Auditing Standards (GAGAS or Yellow Book). The primary reason for this was due to the increased time commitments that would be required for a Yellow Book audit—time commitments that would not result in a final comprehensive report by the deadline established by SHP in anticipation of the General Assembly's short session in May 2010. To the extent that the terms performance audit or efficiency audit are used in this report, they are not intended to mean a Yellow Book audit.

For this engagement, the audit team conducted performance review rather than a Yellow Book audit. The audit team notes that although it did not conduct a Yellow Book audit, it did employ some aspects of Yellow Book work in conducting this review. For example, the team performed risk-based quality review of key documents and data to assess the reliability, accuracy and completeness of the data.

The audit team divided the project into four stages: Initial Survey Stage, Detailed Fieldwork Stage, Functional Area Reporting Stage and Comprehensive Final Reporting Stage. During the initial survey, the audit team initiated the project with a kickoff meeting with the SHP to discuss and clarify the goals, objectives and the proposed work plan and timeline. After adjusting the work plan and timeline based on this first discussion, the audit team then held an entrance conference with the SHP and BCBSNC and Medco (the ASOs) to discuss the goals and objectives of the audit, the project timeline and the ASOs' responsibilities to provide requested documents and data and cooperate with the audit and the need for confidentiality agreement.

Following the execution of the confidentiality agreement with the ASOs, the audit teams began the initial survey phase in November 2009. During the initial survey stage, audit team members met with staff and managers at the SHP, representatives of user groups, state legislators and staff in several state agencies, including the Governor's Office, the Office of Budget and Management and the North Carolina General Assembly's Fiscal Research Division. The audit team also reviewed a number of documents, including state laws and regulations, SHP polices, the Administrative Services Agreement between the SHP and BCBSNC and prior audit reports. The interviews and information gathering were designed to assist the audit team in the preparation of its final audit work plan.

The audit team prepared an initial survey update document, which reported key issues or focus areas, as well as proposed a work plan with specific steps that the audit team recommended following in conducting fieldwork. The SHP management reviewed the draft work plans and provided comments and guidance that the audit team used to create the final work plans.

At the end of the initial survey, each functional area audit team prepared an initial survey update document, which reported key issues or focus areas and presented a proposed work plan with specific steps that the audit team recommended following in conducting fieldwork. The SHP management reviewed the draft work plans and provided comments and guidance that the audit team used to create the final work plans. In early January 2010, the audit team began carrying out the detailed fieldwork activities.

Appendix B: Individuals Interviews

In conducting the work for our analysis, the audit team interviewed and relied on data provided by several individuals within the SHP, BCBSNC and Medco. Table B-1 below lists the individuals that the audit team interviewed and relied on for data gathering and discussions.

Table B-1: Individuals Interviewed

Functional Area	Individuals Interviewed
Administrative Services Agreement	SHP: • Jack W. Walker, Ph.D., Executive Administrator • Mona Moon, Chief Financial Officer • Lacey Barnes, Deputy Executive Administrator • Wendy Greene, Legal Counsel • Becky Sandling, Contract Compliance Manager
Appeals	SHP: • Jane Shairer, Director of Customer Relations BCBSNC: • Taffy Jones, Manager, Claims, State Administrative Services • Kathy Hall, Senior Team Leader, State PPO Claims • Terri Carroll, Compliance Consultant, Appeals • Anne Kirby, Senior CGO Compliance & Audit Cons, State Administrative Services • Kathy Carter, Manager, Med Review Compliance, Appeals • Erin Lee, Manager, Quality and Support, Compliance Audit and Prob Mgt

Functional Area	Individuals Interviewed
Claims Administration	SHP: • Linda Forsberg , Director, Health Plan Operations BCBSNC: • Taffy Jones, Manager, Claims, State Administrative Services Department • Sandi Murray, Manager, Claims, State Administrative Services Department • Janet Jackson, Director, Operations Support , Electronic Solutions • Michelle Azzu, Manager, Data Entry, OCR Scanner • Becky Coffield, Senior Team Leader, Document Operations • Erin Lee, Manager, Quality and Support, Compliance Audit and Problem Management • Terry Baker, Operations Specialist, State PPO Claims • Penny Pyles, Associate Financial Recovery Specialist, State PPO Claims • Lynne Ross, Medical Policy Coordinator, Medical Policy • Faye Vaughan, Manager, SIU Analytics, Special Investigations • Betty Boylan, Senior Business App Administrator, SOS Management/COP • Jocelyn Pickett, Chief of Staff, Claims COS/Account Executive
Customer Service	SHP: • Jane Schairer, Director of Customer Relations, State Health Plan BCBSNC: • Kristen Zuco, Manager, Service Operations, State Administrative Services • Alex Chu, Legal Counsel • Carol Sutton, VP, State Operations, State Administrative Services • Wes Parker, Business Information & Financial Consultant, Analytics/Reporting • Roger Henkel, Dir, Financial Dec. Support, Cost and Budget NC Department of Administration: • Secretary Brett Cobb

Functional Area	Individuals Interviewed
Finance	SHP: • Jack W. Walker,Ph.D., Executive Administrator • Lacey Barnes, Deputy Executive Administrator • Mona Moon, Chief Financial Officer • Wendy Greene, Legal Counsel BCBSNC • Roger Henkel, Director, Financial Decision Support • Carol Sutton, Vice President of State Operations

Functional Area	Individuals Interviewed
Governance	SHP: • Jack W. Walker, Ph.D., Executive Administrator • Lacey Barnes, Deputy Executive Administrator • Wendy Greene, Legal Counsel Legislative Branch: • Senator Tony Rand, Oversight Committee Co-chair • Representative Hugh Holliman, Oversight Committee Co-chair • Mark Trogdon, Fiscal Research Division • Gann Watson, Bill Drafting Division Executive Branch • Andy Willis, Governor's Office • Mike Arnold, Governor's Office • Bill Stockard, Office of State Management and Budget • Ron Ottavio, Chief of Staff, State Treasurer's Office • Wayne Goodwin, Commissioner of Insurance • Louis Belo, Department of Insurance • Rose Vaughn Williams, Department of Insurance • Ted Hamby, Department of Insurance • Mark Edwards, Department of Insurance • Ronnie Condrey, Department of Insurance • Linda Coleman, State Personnel Director • David McCoy, State Controller • Tom Newsome, Chief Deputy Controller • John Baldwin, Chief of Staff, Department of Labor • Nancy Lipscomb, Department of Labor • Other Stakeholders • Pam Deardorff, North Carolina Retired School Personnel Association • Lacy Presnill, North Carolina Retired School Personnel Association • Marge Foreman, North Carolina Association of Educators • Steven Beam, Chair, SHP Board of Trustees • Dr. Dan Meyers, Member, SHP Board of Trustees • Dr. John Hammond, Member, SHP Board of Trustees

Functional Area	Individuals Interviewed
Information Technology and Data Reporting	SHP: • Lacey Barnes, Deputy Executive Administrator • Carol Durrell, Director of Production Development • Linda Forsberg, Director of Health Plan Operations • Beverly Harris, Director of Information Technology and Human Resources • Dr. Jack Walker, Executive Administrator BCBSNC: • Sarah Adams, Senior. Informatics Analyst, Clinical Informatics • Lenise Baxter, Senior Data Analyst, State Reporting • Elizabeth Egan, Manager, ASO Financial Operations, Membership Administration • Heidi Jurgens, Director, Information Systems Plan and Portfolio Government, Project Integration • Patricia King, Problem Management Lead, Application Development Management and Support • Deborah Medlin, Manager, State Project Team, State Administrative Services

Functional Area	Individuals Interviewed
Membership Accounting	SHP: • Linda Forsberg, Director of Health Plan Operations BCBSNC: • Nicholas Feiler , Commercial and Government Operations Compliance Area and Coordinator for Audit – Membership Accounting • Judy Poe, Manager, Membership Operations, State Administrative Services • Aldara Moum, Manager, Application Development , IS Development • Amanda Crowe, Membership Professional, State PPO Enroll/Membership • Kay Hughes Membership Professional, State PPO Enroll/Membership • Felicia Bolton, Membership Professional, State PPO Enroll/Membership • Margaret Leatherberry, Membership Accounting Team Lead • Hope Argabright Quality Analyst Associate, REBO Ops Support • Renie Palmer, Quality Analyst Associate, REBO Ops Support • Roger Henkel, Finance, Dir, Financial Dec. Support, Cost and Budget • Carol Sutton, VP, State Operations, State Administrative Services BEACON: • Ray Scerri, BEACON Representative to BCBSBN Pender County Schools: • Sheneta Dobson, Benefits Office Bladen County: • Cynthia McCoy, Benefits Office Town of Forest City: • Lisa Green, Benefits Office

Functional Area	Individuals Interviewed
Other Medical Management	SHP: • Anne Rogers, Director of Integrated Health Management, SHP BCBSNC: • Laurel Davis, RN, Onsite ECM at Wake Med and Rex, BCBSNC • Dr. John Fong, VP and Senior Medical Director, BCBSNC • Alyson Hall, RN, Onsite ECM at UNC, BCBSNC • Janet Hunker, RN, ECM, BCBSNC • Ann Kirby, SHP CGP Compliance, BCBSNC • Patty McCorquodal, RN, ECM, BCBSNC • Rhonda Parrish, LPN, Team Lead Utilization Management, BCBSNC • Gail Seyfried, RN, Nurse Manager Utilization Management, BCBSNC • LaVerne Scott, Team Lead SHP PPO Call Center, BCBSNC • Dr. John Smith, Medical Director for the SHP PPO, BCBSNC • Lillian Spinken, Director, Care Management Operations, BCBSNC • Carol Sutton, Vice President, State Operations – BCBSNC Business Owner, BCBSNC • Daryl Wansink, Director, Healthcare Research and Evaluation , BCBSNC • Jackie Wynn, Director, Medical and Reimbursement Policy, BCBSNC

Functional Area	Individuals Interviewed
Pharmacy	SHP: • Jack W. Walker, Ph.D., Executive Administrator • Tracy D. Stephenson, Director of Pharmacy Services • Sally Morton, Pharmacist Medco: • Jennifer Behrens – MAC List • Kathy Bagnuolo - Rebates • Maria Blundo – Pharmacy Audit • Alex Brumaru – MAC List • Marcia Corredor – Client Audit • Mark Crowe – Clinical Pharmacy Manager for the SHP account • Regina Dennis - Rebates • Allison Evans -- Mail Order Pharmacy/Call Center / TRC • Rob Finch – Pharmacy Network • Richie Fleg - - Mail Order Pharmacy/Call Center / TRC • Tom Fortunado - Clinical Programs & Coverage Authorization • Brent Haynes – Account Manager for the SHP account • Gene Jay - RationalMed • Alissa Kline - Clinical Programs & Coverage Authorization • Audrey Marmo – Benefit Set Up • Kathy Mercer - Mail Order Pharmacy/Call Center / TRC • Phil Merola – Pharmacy Network • Arlene Nolan – MAC List • Richard Pagano- Eligibility • Emma Rivers - Eligibility • Jeff Scott – Account Executive for the SHP account • Carolyn Simeonidis - RationalMed • Terri Walker – Clinical Programs & Coverage Authorization • Bev Watson – Eligibility BCBSNC • Joe Bauers - Director, Corporate Pricing, Planning and Analysis AON • Kevin Vieira

Functional Area	Individuals Interviewed
Provider Relations and Delivery System	SHP: • Linda Forsberg BCBSNC: • Ashley Palmer, Senior Governance Risk and Controls Advisor, ARM Management • Joe Bauers, Director, Corporate Pricing, Planning and Analysis • Karen Ayers, Strategic Reimbursement Advisor • Janet Wise, Manager, Credentialing • Ela Perry, Business Analyst, Credentialing • Fran Adams, Network Management • Betsy Parker, Network Management
Utilization Management	SHP: • Anne Rogers, Director of Integrated Health Management, SHP BCBSNC: • Laurel Davis, RN, Onsite ECM at Wake Med and Rex, BCBSNC • Dr. John Fong, VP and Senior Medical Director, BCBSNC • Alyson Hall, RN, Onsite ECM at UNC, BCBSNC • Janet Hunker, RN, ECM, BCBSNC • Ann Kirby, SHP CGP Compliance, BCBSNC • Patty McCorquodal, RN, ECM, BCBSNC • Rhonda Parrish, LPN, Team Lead Utilization Management, BCBSNC • Gail Seyfried, RN, Nurse Manager Utilization Management, BCBSNC • LaVerne Scott, Team Lead SHP PPO Call Center, BCBSNC • Dr. John Smith, Medical Director for the SHP PPO, BCBSNC • Lillian Spinken, Director, Care Management Operations, BCBSNC • Carol Sutton, Vice President, State Operations – BCBSNC Business Owner, BCBSNC • Daryl Wansink, Director, Healthcare Research and Evaluation , BCBSNC • Jackie Wynn, Director, Medical and Reimbursement Policy, BCBSNC

Appendix C: Materials Reviewed

In conducting the work for our analysis, the audit team reviewed materials such as processes and procedures documentation, training manuals, job descriptions, organizational charts and management reports for functions identified in the audit plan. Table C-1 below lists the materials that the audit team reviewed.

Table C-1: Materials Reviewed

Functional Area	Materials Reviewed
Administrative Services Agreement	• BCBSNC Administrative Services Agreement, including all amendments and communications. • Administrative service agreements for other state agencies. • Periodic performance and financial data provided by BCBSNC to the SHP during the review period.
Appeals	• BCBSNC policies and procedures – Appeals and Grievances (PPO and CMM) BCBSNC policies and procedures - Quality of Care (QOC) Concerns Process (PPO and CMM) Level I Workflow Process • Level II Workflow Process • Appeals Department training materials • List of Metrics Monitored • BCBSNC Provider Contract Templates ➢ Network Participation Agreement – Professional ➢ Intermediary Services Agreement ➢ Ancillary Services Agreement ➢ Ancillary Services Provider Agreement • BCBSNC Member Handbooks ➢ PPO – October 1, 2006 to June 30, 2007 ➢ PPO – July 1, 2007 to June 30, 2008 ➢ PPO – Changes made July 1, 2008 ➢ CMM – August 12, 2005 to June 30, 2007 ➢ CMM – July 1, 2007 to June 30, 2008 • BCBSNC Member Outreach Materials • Log of Appeals by Product and Benefit Period • Thirty Sample Level I Appeals and Grievances Files) • Thirty Sample Level II Grievances • Appeals Staffing Organizational Chart • Appeals Written Job Descriptions and Responsibilities • PPO - Appeals Staff Turnover Rate • CMM Appeals Staff Turnover Rate

Functional Area	Materials Reviewed
	• PPO Appeals Statistics • CMM Appeals Statistics *(electronic format)* • Integrated Quality Indicator Reports (IQIRs). • Relevant North Carolina General Statutes • Benchmarking Materials
Claims Administration	• Alternative setting for dental procedures • Anesthesia Benefits • Concurrent Review • Consistency of Review Process • Coordination Of Benefits (COB) • Donor Services • Emergency Room Visits • ESRD Care Coordination • Inpatient Admission Authorization • Invalid or Missing Claim Data • Letters • Maternity Delivery • Medical Director Referrals • Mental Health and Chemical Dependency • Monitoring Utilization Management Phone Results • Pre-existing conditions • Prior Plan Approval • Provider Courtesy Review • Erroneous Provider Number • Retrospective Review • Routine Newborn Services • Split Claims Processing • Timeliness Standards For Decision Making • Transplant Approval • Utilization Management Criteria Request • Verification of Professional License • Individual consideration and authorization for extra contractual benefits • Mailback denials • Reconsideration • Turnaround Time Report • Claims Front-End Process Overview

Functional Area	Materials Reviewed
	• Electronics Claims Input Process Flows • RealMed real-time processes • EDI 837 Process • *Blue e* Online Entry for non-837 Process • IPP Process • Medicare Crossover Process • NCPDP Process • Paper Claims IDC Process Overview • OCR Claims Processes • Validation Processes • Other Document Processing Viewer • Paper Non-Claims Process Overview • Other Document Process Indexing • ANSIR Workflow Queue • Buy-On-Paper Workflow Queue • MaxMC Workflow Queue • Claims Adjudication Process Flow • HCFO Routing Flows • UB Routing Flows • Medicare Part A and Be Routing Flows • Supporting Routing Processes • Adjudication Preparation process • Non-response to productivity metrics. Note that COB has biggest impact. • List of Finance Recover FTEs • Subrogation recoveries for CMM and PPO during audit period • Special Investigations Unit Settlements for both CMM and PPO from the audit period • eSolutions org chart and claim flow in an overview presentation • State Claims Org chart October 2005 • State Claims Org chart January - October 2007 • IDC Org Chart October 2005 • IDC Org Chart October 2006 • IDC Org Chart October 2007 • IDC Org Chart June 2008 • Claims Business Process Flows Table of Contents • Description of IDC processes 1

Functional Area	Materials Reviewed
	• High level IDC process flow • Job Descriptions • High level metric description of turnaround time and accuracy for IDC • State Performance Guarantee for PPO 2006 - 2007 • State Performance Guarantee for CMM July 2007 - June 2008 • State Performance Guarantee for PPO 2007 - June 2008 • Header sheet for response to data request 122 • Sign-off procedures for envision updates • List of 2007 and 2008 IT projects • Example employee evaluation report • BCBS Cost Accounting system overview • 2007 Chart of Accounts • Budget Divisions • Indirect cost allocation plan • COB for VA claims procedures • COB overview • Adjudication Flows • Example of weekly staff meeting of SHP initiatives • CMM COB Savings for June 2008 • PPO COB Savings from October 2006 - June 2008 • Adjustments Summary • Written response to questions • UCR Description • Summary of Denied Claims on CMM July 1, 2005 - June 30, 2006 • Summary of Denied Claims on CMM July 1, 2006 - June 30, 2007 • Summary of Denied Claims on CMM July 1, 2007 - June 30, 2008 • Collections, Wage Garnishment, AG, Debt Setoff for full audit period CMM/PPO • CMM Recoveries for each month during audit period, all vendors included, Special Investigations Unit included. Settlement excluded. • PPO Recoveries 12/2006 - 06/2008. Solicited and Unsolicited. • Special Investigations Unit recoveries by year, excludes settlements and unsolicited • Special Investigations Unit Organizational Charts • July 2005 - June 2006 CMM Benefits Paid • July 2007 - June 2008 PPO Benefits Paid • July 2006 - June 2007 PPO Benefits Paid

Functional Area	Materials Reviewed
	• July 2007 - June 2008 CMM Benefits Paid • July 2006 - June 2007 CMM Benefits Paid • PPO Enrollment volumes 2006 - 2008 • CMM Enrollment volumes 2005 - 2008 • Enrollment area work received • Claims Administration Work Volume for PPO 2007 - 2008 • IDC Work Volume PPO 2007 • IDC Work Volume PPO 2008 Paper • IDC Work Volume Paper vs Electronic 2006 / 2007 • IDC Work Volume Paper vs Electronic 2008 • Claims Administration Work Volume for CMM 2006 - 2008 • Adjustments and Claims by Submission Type full audit period • IDC Work Volume PPO 2008 Paper (duplicate) • IDC Work Volume PPO 2008 Paper (duplicate) • CMM Membership Volumes (duplicate) • PPO Membership Volumes (duplicate) • First Pass Rate by Year and Product • 2005 Actual Recoveries for CGI and HDI • 2006 Gross Identified Savings for CGI • 2006 Gross Identified Savings for HDI • 2007 Gross Identified Savings for CGI • 2007 Gross Identified Savings for HDI for PPO • 2007 Gross Identified Savings for Hcare • 2008 Gross Savings, fees, net savings for AIM for CMM • 2008 Gross Identified Savings for AIM for PPO • 2008 Gross Identified Savings for CGI for PPO • 2008 Gross Identified Savings for CGI for CMM • 2008 Gross Identified Savings for HDI for PPO • 2008 Gross Identified Savings for CBAS for PPO • Summary of Recovery Vendors
Customer Service	• Organizational diagrams • Organization and staffing tables • Major work flow diagrams • PPO phone metrics for 2006 – 2008 • CMM phone metrics for 2006 – 2008 • BCBSNC Quarterly Performance Reports 2005 – 2006

Functional Area	Materials Reviewed
	• BCBSNC call blockage reports 2006 - 2008 • SHP PPO Administrative Service Agreement • BCBSNC staffing reports for 2006 – 2007 • CMM product manual • PPO product manual, the 'Envision' intranet system • Staff planning algorithm and associated Microsoft Excel sheet. • BCBSNC corporate policies on the BCBSNC intranet • Avaya phone system – Customer Service Professional's phone system and management reporting system. • LSRP – CMM Customer Relationship Management (CRM) software • Siebel – PPO Customer Relationship Management (CRM) software • "MAGIC" - (Member and Group Information Console) • POWER – financial reporting systems for both CMM and PPO • MOBIUS – identification card management system
Finance	• State laws governing the SHP (North Carolina General Statutes, Section 135). • Administrative Services Agreement between BCBSNC and the SHP for both the CMM indemnity and PPO plans. • All amendments and letters authorizing changes to the ASA during the review period. • Periodic financial and reconciliation statements provided by BCBSNC to the SHP. • Accounting descriptions, including descriptions and definitions of cost centers, activities, and expenditure types. • Detailed cost center reports for selected cost centers. • Activity based costing definitions and cost drivers. • Financial data for selected periods and activities.
Governance	• North Carolina General Statute • State government organization charts • North Carolina State Auditor's Office audit reports of the SHP • Board of Trustees report pertaining to the SHP governance structure • Documents and websites containing information on leading practices utilized by other state health plans
Information Technology and Data Reporting	• PandP ISBA1, ISBA2, ISBA3 • ISBA2005, ISBA2006, ISBA2007, ISBA2008 • Org Chart DataRep1 • Org Chart DataRep2

Functional Area	Materials Reviewed
	• Org Chart ISBA1 • Org Chart ISBA2 • Chart ISBA3 • OrgChart1 • Workflow DataRep1 • Workflow DataRep2 • Workflow DataRep3 • Job Description DataRep1 • Job Description DataRep2 • Job Description ISBA1 • Job Description ISBA2 • Job Description ISBA3 • Job Description ISBA4 • Job Description ISBA5 • 129 - Job Description ISBA6 • Training ISBA1 • Data Rep Metrics1 • Metrics ISBA • Software Desc1 • Accounting Manual • Chart of Accounts • Budget Divisions • BCBSNC Data Dictionary • Inventory and Ratio • Defect Report1 • Sample Reports 1-3 • Ad hoc Report 1 • Followup1 • Staffing1-2 • Charter1-15 • SLA Outages_2007 Report (reviewed on-site) • BCBSNC PPO Contract
Membership Accounting	• Listing of error reports part 1 • Listing of error reports part 2 • MTM Metrics 2005 (State) • MTM Metrics 2006 (State)

Functional Area	Materials Reviewed
	• MTM Metrics 2007 (State) • MTM Metrics 2008 (Overall) • 2007 SAS 70 - LRSP Operating Effectiveness • 2006 SAS 70 - LRSP Operating Effectiveness • 2006 SAS 70 - Enrollment / Benefits / Network Management • 2007 SAS 70 - Enrollment / Benefits / Network Management • 2008 SAS 70 - Enrollment / Benefits / Network Management • 2008 SAS 70 - LRSP Operating Effectiveness • 2005 SAS 70 - LRSP Operating Effectiveness • 2005 SAS 70 - LRSP Operating Effectiveness • Pharmacy eligibility file process with Medco • Blue e transaction counts • Cost accounting overview • 2007 chart of accounts • 2005 budget divisions • Indirect cost allocation plan • Procedures for processing P17 forms • Incapacitated Dependent Procedures • 2008 BEACON electronic enrollment metrics • 2006 - 2008 defect log • State Membership Services Organization Chart 2006 • State membership PPO workflows • State membership CMM workflows • High level payments and maintenance workflow • High level state billing process • Receive and process application workflow • Receive and process application workflow 2 • Batch and log application workflow • Reconcile statement workflow • Business system analyst job description • Enrollment and billing specialist job description • Team leader job description • Admin assistant job description • Description of metrics and goals for accuracy and turnaround time • Description of BEACON enrollment file process • PPO workflow description • Indemnity workflow description

Functional Area	Materials Reviewed
	• State billing workflows • PPO membership volumes • CMM membership volumes • Summary of membership work received • ID card process description • Description of decision making process for implementing and making changes • 2005 state membership performance • 2008 state membership performance • Daily management report example • Daily volumes report example PPO • Daily volumes report example CMM • Delinquent account report example • Overtime volumes • ID card query screen • ID card error report • 48 month incurred payment report • 48 month incurred payment report 2 • Claim volumes • List of State Agencies that pay in variety of ways • Membership charges to state • Explanation of difference in staffing levels • Explanation of difference in staffing levels copy • Transaction error report • Transaction error report 2
Other Medical Management	• UM Standard Operating Procedures (CMM and PPO) • Nurse Licenses (CMM and PPO) • Workflows(CMM and PPO) • Organizational Charts ➢ July 2005 (CMM) ➢ July 2006 (CMM) ➢ July 2007 (CMM and PPO) ➢ July 2008 (CMM and PPO) • UM Job Descriptions (CMM and PPO) • UM Training documents • UM Operational Metrics

Functional Area	Materials Reviewed
Pharmacy	• SHP Pharmacy Benefit Management RFP 2004 • Medco original proposal to SHP for Pharmacy Benefit Management • Contract amendment to the Medco – SHP original contract: NUMBER AND DATES • AON Market Analysis 2007 • AON annual drug discount rate analysis - for the period of the audit • Medco quarterly and annual reports for the SHP during the audit period • Medco data dictionary • Medco SOP Governance Model for Business Operations, Version 1.5, Medco Business Confidential (Viewed onsite, would not copy) • Medco Siebel Request (SR) Daily Report from Audrey • Medco Pharmacy Services Manuals 2005/2006, 2006/2007, 2007/2008 • Standard Medco Pharmacy Agreement • Overview presentation of department and workflow diagrams • Medco Eligibility Process Workflow • BCBSNC Eligibility Process - process for submitting eligibility updates and refreshes to Medco • Coverage Authorization-Mail Process Workflow • Coverage Authorization-Retail Process Workflow • SOP 4.4.3 Worry Free Fills (WFF), Version 1.4, Medco Business Confidential (Viewed onsite only, not permitted to copy) • SOP for Medco Brand to Generic Copay Waiver Implementation (Viewed onsite only, not permitted to copy) • Prescription Process Workflows • Annual Performance Reports for the audit period • Annual and quarterly performance guarantee reports for the audit period • 2008 Prior Authorization Report • Onsite review of TRC presentation and capabilities – were not allowed to take copies of the presentation • Medco 2008 Annual Report • SAS 70 Reports • Thomas Gibbs Pharmacy Claim Reports • Retail Pharmacy Audit Statistics for the SHP network • SHP Benefit Books for the period of the audit • Medco Specialty Pharmacy Contract with the SHP • SHP P&T Meeting Materials during the audit period

Functional Area	Materials Reviewed
Provider Relations and Delivery System	• SAS 70 Auditor's report (September 30, 2008) • Network reports to NCDOI (2006, 2007, 2008) • Organizational charts (2006, 2007, 2008) • Provider directories (2006, 2007, 2008) • Provider manuals (2006, 2007, 2008) • Provider newsletters (2006, 2007, 2008) • Job descriptions • Applicable North Carolina code and statute: ➢ 11 N.C.A.C. 20 .0301 Provider Availability Standards ➢ 11 N.C.A.C. 20 .0302 Provider Accessibility Standards ➢ N.C.G.S. 58-3-191. Managed care reporting and disclosure requirements • Standard operating procedures • Credentialing manual • Organization chart • Job descriptions • Applicable North Carolina code and statute: ➢ 11 NCAC 20 .0405Verification of Credentials ➢ 11 NCAC 20 .0404Application • NCQA accreditation requirements
Utilization Management	• UM Standard Operating Procedures (CMM and PPO) • Nurse Licenses (CMM and PPO) • Sample d of Cases (CMM and PPO) ➢ Prior Authorizations ➢ Concurrent Authorizations ➢ Retrospective Authorizations • Workflows(CMM and PPO) • Organizational Charts ➢ July 2005 (CMM) ➢ July 2006 (CMM) ➢ July 2007 (CMM and PPO) ➢ July 2008 (CMM and PPO) • UM Job Descriptions (CMM and PPO) • UM Call Center activity reports (CMM/NCHC and PPO) • UM Training documents • UM Operational Metrics

Appendix D: History of the State Plan

In this appendix, the audit team presents an overview of the State Health Plan (SHP) organization and its history, as well as an overview of its vendor contracts.

The SHP provides health care coverage to more than 661,000 teachers, state employees, retirees, current and former lawmakers, university and community college personnel and hospital staff and their dependents. It also provides health benefits to eligible retired employees formerly employed by authorized employing units, and eligible dependents of active and retired employees. In addition, some local governments have sought legislation to be covered by the State Health Plan. To administer this benefit for its members, the SHP contracts with outside vendors: Blue Cross Blue Shield of North Carolina (BCBSNC) the medical claims processing contractor and Medco Health Solutions (Medco) is the Pharmacy Benefit Manager. These contactors are referred to by name and as the Administrative Service Organizations (ASOs) throughout this report.

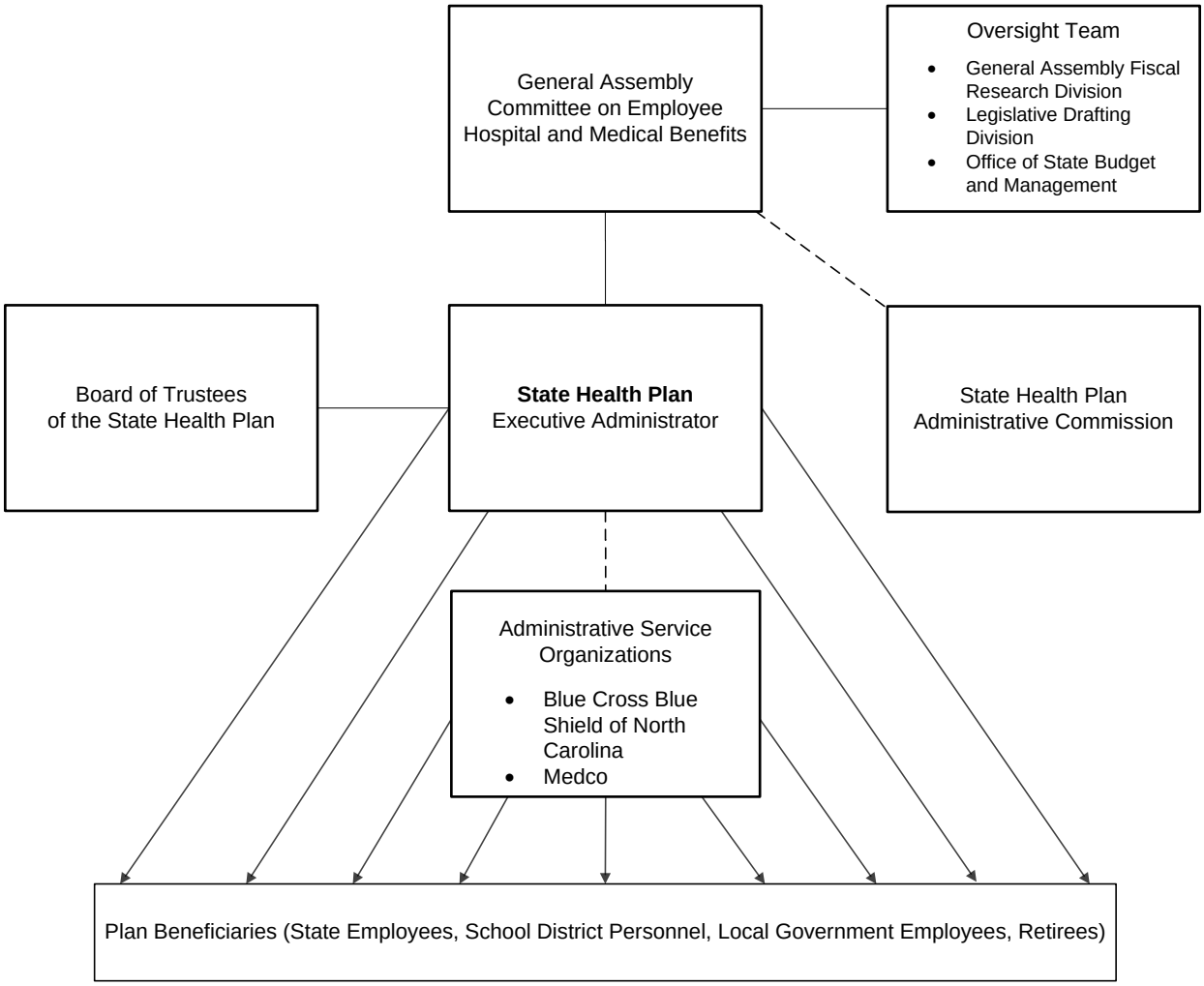
SHP Overview

The SHP began when the General Assembly enacted legislation to provide this benefit. The SHP has seen many changes to its organizational and oversight structure and the types of plans offered. At the beginning of the audit period, June 2005, the SHP offered only an indemnity plan (comprehensive major medical, or CMM plan). In February 2006, the SHP signed an Administrative Services Agreement with BCBSNC so that effective October 2006, the SHP could begin transitioning to a new benefits plan, offering three preferred provider organization (PPO) plans, with a high, medium and low option in addition to the indemnity plan. The SHP gradually transitioned all members to the PPO, with the indemnity plan being eliminated as of July 2008. Recent legislation eliminated the high or PPO plus option effective July 1, 2009, leaving two PPO options for its members.

The SHP is a self-funded program, funding the cost of health care for its members through employer and employee premium contributions. The SHP uses Blue Cross Blue Shield of North Carolina (BCBSNC) as its medical claims processing contractor. The SHP has a claims processing contractor contract (CPC) and an administrative services agreement with BCBSNC. Under the terms of these contracts, BCBSNC receives, processes and pays all medical claims; manages the PPO network and provider contracts; collects premiums from employing agencies and individuals; handles on-going and annual enrollment activities; operates a customer service call center; administers cost containment programs; provides mental health case management services through a sub-contract with Value Options; investigates fraud and abuse; and is responsible for various claims recovery activities, and data analysis and reporting.

The SHP has a unique governance structure, unlike those found in comparable health plans of other states. As depicted in Figure D-1, several entities are involved in the administration and governance of the SHP. The following paragraphs describe this structure in further detail.

Figure D-1: Governance Structure of the North Carolina State Health Plan



The SHP operates as an agency within state government. Unlike many of the other service-oriented state agencies that fall under the executive branch of government, the SHP is organized under the jurisdiction of the legislative branch. Within the North Carolina General Assembly, the Committee on Employee Hospital and Medical Benefits (oversight committee) has the primary responsibility for overseeing the SHP. The oversight committee is comprised of 12 members, 6 from the Senate and 6 from the House. The committee is chaired by the President Pro Tempore of the Senate and the Speaker of the House, or their designees, who serve on the committee for the duration of their terms in office. The remaining members serve two-year terms.

To assist in its management of the SHP, the oversight committee may use the services of the Legislative Services Office. The Legislative Services Office includes the Fiscal Research Division and the Legislative Drafting Division. The oversight committee may also request the state

budget director and the Office of State Budget and Management to monitor the SHP and its related functions. The statute refers to this collective group of entities as the Oversight Team.

The executive administrator of the State Health Plan handles the day-to-day management of the SHP. The executive administrator is responsible for all key operations of the SHP, including membership functions, provider and participant relations, communications and negotiation and execution of contracts with third- parties to carry out plan activities. The executive administrator appoints a deputy executive administrator and employs other professional staff to assist as needed. SHP currently has approximately 30 full-time employees. These employees work directly with the ASOs to ensure that benefits are properly administered to SHP participants.

State law also established the creation of the Board of Trustees of the State Health Plan (board). The board is responsible for reviewing claim appeals and providing guidance to the executive administrator in developing policies. The board is comprised of nine members, appointed as indicated in Exhibit 2. The board positions are for two-year terms.

Exhibit D-1: Board of Trustees of the State Health Plan

• Three members shall be appointed by the Governor. Terms shall be for two years. Vacancies shall be filled by the Governor. Of the members appointed by the Governor, one shall be either: 1. An employee of a State department, agency, or institution; 2. A teacher employed by a North Carolina public school system; 3. A retired employee of a State department, agency, or institution; or 4. A retired teacher from a North Carolina public school system.
• Three members shall be appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives.
• Three members shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate.

The State Health Plan Administrative Commission is an entity that has a very specific, but limited, set of responsibilities. The Commission is comprised of three members of the General Assembly (two members recommended by the Speaker of the House and one member recommended by the President Pro Tempore of the Senate), who are appointed for two-year terms. The Commissioner of Insurance serves as the secretary of the Commission, which is located administratively within the Department of Insurance. However, the Commission exercises its statutory responsibilities independent of the Commissioner of Insurance. One of the Commission's key responsibilities is to appoint the executive administrator of the SHP. Prior to July 2008, the statute designated the Commissioner of Insurance with the responsibility for hiring and firing the executive administrator, under the guidance of the oversight committee.

Administrative Services Agreement Overview

At the same time that the SHP began offering the PPO plan, it signed a new Administrative Services Agreement with BCBSNC (February 2006). The Administration Services Agreement covers the administrative services provided by BCBSNC for the SHP and is the governing document between the two parties. Prior to the new Administrative Services Agreement, the claims processing contract specified that administrative costs were to be reimbursed at a flat per member, per contract rate. Following the introduction of the PPO plan, however, the SHP agreed to a cost-plus reimbursement of administrative costs for both the PPO as well as the CMM programs using a per member month estimate.

The cost-plus agreement requires the SHP to reimburse BCBSNC for all direct and indirect costs related to providing services on behalf of the SHP, as well as a share of overhead costs, as long as these were allocated in accordance with the same methodology used to allocate costs to other BCBSNC lines of business. Further, the cost-plus agreement introduced the "plus" or profit allowance that previously had not been included in the state's payments to BCBSNC for its services. The profit percentage was relatively small (0.625 percent for the PPO and 0.85 percent for the CMM), and applied to both the existing (CMM) and new (PPO) plans. A portion of this profit percentage is dependent upon BCBSNC meeting performance guarantees—0.125 percent of the PPO profit percentage and 0.35 percent of the CMM profit percentages.

The Administrative Services Agreement expires in June 2013, with optional renewal periods until June 2016. The SHP and BCBSNC have negotiated a series of amendments to the Administrative Services Agreement in recent years. The amendments and focus of the amendments are as follows:

- Addendum 1 (August 1, 2006) – The SHP authorized BCBSNC to contract with a provider who supplied designated physicians with machines that contain generic and over-the-counter drug samples that could be provided to SHP members in the PPO plan at a significant discount.

- Amendment 1 (August 21, 2007) – The SHP and BCBSNC amended the Administrative Services Agreement to include payment of interest on amounts reimbursed to the State or paid by the State in reconciliation of actual costs against amounts collected (the Finance functional area report, Section II, overview of shared savings, provides more information).

- Amendment 2 (September 1, 2007) – The SHP and BCBSNC amended the contract to authorize BCBSNC to provide pharmacy consulting services who would provide pharmacy services to the SHP.

- Amendment 3 (April 30, 2008) – The SHP and BCBSNC amended the contract to require more frequent reconciliations of actual costs (converted from annual to quarterly reconciliations).

- Amendment 4 (October 30, 2008) – The SHP and BCBSNC amended the agreement to specify that BCBSNC would invoice the plan for PMPM estimates on a rescheduled payment amount. Further, effective January 1, 2009, the shared network savings funding mechanism was eliminated and the PMPM estimate was increased to $15.15 with quarterly reconciliations continuing.

- Amendment 5 (June 1, 2009) – The SHP and BCBSNC amended the agreement to continue authorizing BCBSNC to provide a dedicated clinical pharmacist to provide pharmacy services to the SHP.

- Amendment 6 (June 19, 2009) – The SHP and BCBSNC amended the agreement to eliminate the original audit provisions and reporting requirements in favor of providing more access to the SHP and its contractors. This amendment, as discussed in the Finance functional area, was negotiated in response to the North Carolina State Auditor's Office April 2009 report that was highly critical of the original Administrative Services Agreement audit and reporting requirements.

- Amendment 7 (August 31, 2009) – the SHP and BCBSNC amended the agreement to lower the PMPM estimate to $14.56 per member per month. The parties also agreed to conduct monthly (rather than quarterly) reconciliations.

In addition to the amendments and addendums listed above, the audit team also noted that the SHP sent several authorizations and agreements that affected the Administrative Services Agreement to BCBSNC via letter throughout the review period. These were as follows:

- March 17, 2008 – The SHP notified BCBSNC of its intent to use online data warehouse and analytics tools that are provided to the commercial customers of BCBSNC, including eInfoNow services, in both the CPC and the Administrative Services Agreement, and agreed to include the costs of these services in the cost-plus reimbursement methodology.

- April 1, 2008 – The SHP agreed to an adjustment of the PMPM estimate from 11.57 Per Member Per Month (PMPM) to 11.27 PMPM effective April 1, 2008 to more closely correlate to the actual costs.

- May 8, 2008 – The SHP notified BCBSNC that the adjustment from 11.57 PMPM to 11.27 PMPM was to begin March 1, 2008.

- August 11, 2008 – The SHP instructed BCBSNC not to conduct the 2008 Fall Member Satisfaction survey as required under exhibit H, Section Y of the Administrative Services Agreement, to reduce costs to the SHP.

- August 11, 2008 – The SHP notified BCBSNC of its intent to terminate its participation in the Blue Points program.

- September 10, 2008 – The SHP and BCBSNC agreed to adjust the PMPM fee for the amortization of transition costs from $0.65 PMPM to $0.33 PMPM effective July 1, 2008. The audit team notes that this change, because of the increase in membership, still allowed for full amortization of the transition costs during the life of the contract (through mid-2012).

Overview of the Shared Savings Requirements in the Administrative Services Agreement

At the beginning of the audit period until October 2006, the SHP reimbursed BCBSNC for administrative costs using a per member per contract rate. However, with the transition from the CMM plan to the PPO plan, the SHP modified its agreement for the CMM plan and also included in the PPO agreement a requirement that it would reimburse BCBSNC for administrative costs based on actual costs plus a percentage of costs for profit. The profit percentage allowed under the agreement was less than one percent (0.625 percent for the PPO plan and 0.850 percent for the CMM plan). The CMM plan did not convert to cost plus until July 2007.

In negotiating the agreement, the SHP agreed to pay an "estimate" of actual costs monthly, set at a rate of $11.57 PMPM. This rate was changed to $11.27 PMPM in March 2008. These costs were recorded as "administrative" charges. Additionally, the SHP agreed to pay BCBSNC five percent of provider savings which is defined as the difference between billed charges and allowed charges." These were recorded as "claims" charges. Periodically, but not less than annually, BCBSNC was to review and compare this estimate to its actual costs.[21] If the actual costs were higher than the $11.57 PMPM plus the shared savings collections, the SHP would make up the difference by paying BCBSNC. If the actual administrative costs were lower than the $11.57 PMPM administrative costs plus the five percent shared savings costs, then BCBSNC would reimburse the SHP for the amounts over-collected. In practice, the methodology has always resulted in BCBSNC refunding amounts to the SHP. Additionally, this methodology has resulted in an overstatement of claims expenses and an understatement of administrative costs.

In October 2008, the SHP and BCBSNC executed an amendment to the Administrative Services Agreement to be effective January 1, 2009. This amendment eliminated the shared network savings model and converted to a $15.15 PMPM estimate model. This amount is still reconciled quarterly with actual BCBSNC costs, with any excess amounts collected by BCBSNC being refunded to the SHP. The SHP and BCBSNC executed an amendment effective October 2009 to begin reconciling monthly.

[21] This was changed to a quarterly reconciliation in 2008.

Administrative Services Agreement Financial Requirements

The Administrative Services Agreement establishes fees and claims expenses requirements and definitions. The main requirements of the original Administrative Services Agreement are summarized as follows:

- BCBSNC will be reimbursed on a cost-plus basis for administrative services.
- The SHP agreed to pay administrative costs using PMPM estimates ($11.57 PMPM) invoiced monthly and a shared network savings model (five percent of network savings), that would be reconciled and adjusted for actual costs periodically (no less than annually).
- Cost plus components included base administrative costs, overhead, implementation costs and a profit margin of 0.625 percent (for the PPO).
- Implementation costs are the initial costs incurred by BCBSNC in developing and launching the PPO, as well as costs incurred in developing new products and services, other than base administrative costs. These costs are to be amortized over the initial term of the agreement.
- At the end of the second agreement period, BCBSNC and the SHP will work together in good faith to determine an appropriate cap on cost plus.
- The PMPM estimate of $11.57 will be updated periodically.
- For audits, BCBSNC agreed to make reasonable contractual arrangements with the CPA firm hired by SHP, including executing confidentiality agreements.
- Auditors hired by the SHP were restricted from providing anything other than the final results of their audit and a description of the methodology they used. All other confidential information, including BCBSNC's actual cost components, was strictly confidential and not to be disclosed to the SHP.

Medco Vendor Contract Overview

The audit team notes that the SHP also has a separate agreement with another entity (Medco) for the provision of pharmacy benefit management services. The specialized nature of pharmacy management often has the pharmacy benefit administered separately from health plan medical benefits. While some health plans chose to administer pharmacy benefits in-house, the SHP has contracted the management of its pharmacy program to a pharmacy benefit manager (PBM) – Medco – while contracting administration of the overall medical benefit to BCBSNC.

Medco administered more than 586 million prescriptions in 2008, which included dispensing of more than 105 million prescriptions at its mail-order pharmacies. Medco is one of the country's largest pharmacy benefits management companies and assists health plans in managing drug costs by designing drug formularies, negotiating discounts with pharmaceutical companies and processing claims.

Exhibit D-2: Medco Services Provided to the SHP

Function	Features
Pharmacy Claims Processing	• Information systems to match member eligibility information with formulary coverage and benefit rules as well as to apply drug utilization edits • Electronic claims processing (99 percent of all pharmacy claims) • Paper claims processing
Pharmacy Network Pricing	• Access to Medco's contracted retail pharmacy network and negotiated discount rates. For the SHP, Medco created a separate retail network with separate rates to meet the needs of the SHP • Access to Medco's internally owned mail order pharmacy and negotiated discount rates. • Access to Medco's internally owned specialty pharmacy, Accredo, and negotiated discount rates • Pharmacy audit program to detect aberrant prescribing by pharmacists and physicians • Maximum Allowable Cost (MAC) program creates a maximum unit cost paid for a generic drug regardless of the manufacturer. Medco manages the SHP MAC list and it is used to price generic drugs at retail, mail and specialty pharmacy outlets
Manufacturer Contracting	• Access to Medco's rebate contracts with manufacturers. The SHP has a minimum rebate guarantee and pass through of 100 percent of the rebate monies attributable to the SHP's member utilization. Rebates are revenue earned by Medco via contracts with pharmaceutical manufacturers for access to formularies and increased market share performance.
Pharmacy Program Management and Support	• Utilization management services, sometimes referred to as coverage authorization services, including prior authorization, step therapy protocols and quantity level limit protocols • Member customer service call center which functions as a single point of access for information on the pharmacy program, benefits coverage, eligibility, prescription history and status of mail order prescriptions • Reporting and analytics including standard reporting package, online access to reports and custom report development
Clinical Pharmacy Management	• Pharmacy and Therapeutic Committee support of the SHP formulary • Drug utilization management programs; concurrent and retrospective • High utilization analysis • Preferred drug education

Medco provides both PBM and specialty pharmacy services. As a PBM, Medco is an organization that applies managed care principles and procedures to pharmacy benefits to contain costs and improve quality

- Medco contracts directly with the SHP to administer and management the pharmacy benefit program for the SHP members.

- Medco act as financial and administrative intermediaries between health plans, pharmacies, manufacturers and members.

- On behalf of its clients, Medco negotiates and contracts with pharmacies to provide a network of pharmacies that can dispense the prescription drugs to the SHP members at a discounted price.

- Medco contracts directly with pharmaceutical manufacturers for rebate payments based on the ability of Medco to give manufacturers access to the SHP formularies and deliver the market share growth of targeted drugs. Those rebate monies are passed back to the SHP and reduce the overall cost of drugs.

- Medco also aggregates data and provides analytical and reporting services to third party organizations such as IMS.

As a mail order, or specialty pharmacy, Medco **c**ontracts directly with wholesalers for the delivery and acquisition of drugs. As a pharmacy, it provides the PBM Medco with discounted drug prices in return for being in the network and having access to the SHP membership.

Recent Developments Leading to Audit Request

In fiscal year 2007-08, the SHP ended the year with a significant loss—instead of a $57.9 million profit at year end, the SHP incurred a loss of $79.7 million. This prompted the North Carolina Auditor to conduct an audit of the SHP revenues and expenses to determine the reason for $137.6 million variance. In July 2008 the then-executive administrator was terminated. A new executive administrator was hired and began work in July 2008. The State Auditor released two reports – one of the SHP governance structure in October 2008 and another on the fiscal year 2007 - 2008 loss in April 2009 (and described earlier in this section).

In the April 2009 report, the State Auditor reported that many of the SHP's issues arose because of the failure by SHP officials to draft a reasonable contract with BCBSNC. The auditor reported that the current contract does not specify what costs BCBSNC is able to charge to the SHP and provides no incentives for BCBSNC to keep its costs down. In fact, according to the State Auditor's report, the current contract does the exact opposite. The SHP agrees to pay BCBSNC its costs – plus a percentage of the insurer's costs to provide a profit margin. Such a setup however, means that BCBSNC earns more as the state's costs rise. The audit report notes that the federal government stopped using such contacts in 1941.

In an August 2009 presentation to the General Assembly, the new SHP executive administrator acknowledged that there were significant deficiencies with the current contract. He reported that the Claims Processing Contract was last bid in 1996 and that BCBSNC was the sole bidder.

He also reported that the state did not competitively bid the PPO contract when the state introduced the PPO benefit plan in October 2006. The SHP instead exercised its statutory authority that allowed it an exemption from state competitive bid. The executive administrator of the SHP reported that the SHP would revise its internal contracting policy to include a review by a contract attorney with the Attorney General's office.

In April 2009, the General Assembly enacted Senate Bill 287—State Law 2009-16. Section 5(g) of this legislation required the executive administrator of the SHP to submit a request for proposal (RFP) for an independent audit of the SHP and an audit of claims paid by the SHP. The bill specified that the audit scope was to include the following specific objectives:

- Estimated or actual savings that could be achieved if changes recommended by the independent auditor were enacted by the General Assembly and how those savings should be allocated to the benefit or SHP members
- The governance structure of the SHP and whether it should be under the supervision and oversight of the Governor or a state agency
- The extent to which the failure or inability to share confidential or otherwise protected information with the Board of Directors and the General Assembly contributes to financial weaknesses in the SHP and how such data sharing should be strengthened
- The role of the Board of Directors of the SHP and whether their role should be strengthened or otherwise changed
- Past, present and potential areas of overpayment, over-utilization and under-utilization or abuse that contribute to increasing costs of SHP benefits, including deductibles, co-payments, dependent premiums and co-insurance maximums
- Safeguards to ensure the prompt reporting of claims data and trends to the actuaries under contract with the SHP and the General Assembly
- Any other matters the executive administrator, fiscal research division staff, the director for the Program Evaluation Division, or the contracting entity believes would be useful in helping to strengthen the financial integrity of the SHP and its benefits

The SHP issued an RFP in September 2009 to conduct a performance and efficiency audit. After soliciting public bids, the SHP contracted with Navigant Consulting, Inc. to conduct a performance review of the SHP and its administrative services agreement with its ASOs.

Appendix E: Findings and Recommendations as Presented in Functional Area Reports

No.	Finding	Recommendation
Governance		
1.	The current governance structure does not ensure adequate oversight and monitoring of the SHP. • The Oversight Committee Lacks the Capacity to Manage the SHP • The Board of Trustees Lacks the Authority to Govern the SHP • Other State Agencies Have Limited Involvement with the SHP • Previous Governance Reviews Have Identified Similar Issues The Governance Structure of the SHP is Unique in Comparison to State Employee Benefit Plans in Other States.	Establish the SHP as an independent agency that reports organizationally to the Governor's Office and functionally to a governing board. Discontinue the operations of the current Board of Trustees and establish a new governing board. Develop parameters to allow for an appropriate balance of representation on the governing board. Develop a formal selection process to ensure an appropriate level of competence among governing board members. Establish a formal reporting structure between the SHP and the governing board. Formalize a communications approach with the General Assembly and Governor's Office.

No.	Finding	Recommendation
Administrative Services Agreement		
1.	The current Administrative Services Agreement restricts access to cost information and to selected operational metrics.	The SHP should work to gain access to relevant BCBSNC program and cost information in the formats needed. The SHP and BCBSNC should periodically, but not less than annually, update the required data and reports exhibit or attachments to the Administrative Services Agreement. The SHP should ensure that in signing future Administrative Services Agreements that it has sufficiently incorporated the level of detail and specificity needed to ensure that it has access to the data and reports needed for effective oversight and monitoring. The SHP should consider adding provisions to any future cost-plus Administrative Services Agreements or contracts to govern the Administrative Service Organization's cost allocation methodologies to ensure these are in line with the public's interest. This includes defining unallowable costs and placing caps on certain general or administrative cost allocations to the SHP. If the SHP wishes to move from a cost-plus reimbursement methodology to a flat-fee payment in the future, it should ensure that it has provisions in future Administrative Services Agreements that, should it move to a flat fee, allow for a periodic, but not less than annual, adjustment and reconciliation of the rates to ensure that the SHP is paying reasonable rates for administrative services in future years.

No.	Finding	Recommendation
2.	The Administrative Services Agreement focuses on legal rights and obligations, but provides limited operational and management guidance in key areas.	The SHP should review the range of reports that BCBSNC provides and identify areas where it needs additional information to effectively manage and monitor the contract. The SHP should work with BCBSNC to fill the gaps. The SHP should develop and implement a plan for monitoring and management that includes policies and procedures that delineate roles and responsibilities, identify key decision makers, and provide escalation paths for both the SHP and the Administrative Service Organization (BCBSNC). The SHP should ensure it updates this plan and communicates this plan periodically but not less than annually to BCBSNC. The SHP should ensure that an interdisciplinary team assists in creating the next Administrative Services Agreement. The team should include representatives from the legal unit, and from each area overseeing key functional areas, such as Claims, Customer Service, Membership Accounting, Provider Network and Delivery Support, Utilization and Medical Management, Appeals, Information Technology and Data Reporting and Finance, among others. The SHP may also wish to include team members from other State agencies with experience in negotiating large contracts with service providers. This could include representatives from the Department of Insurance, or the Department of Health and Human Services, for example. The SHP should ensure that future Administrative Services Agreements better delineates between financial, legal, operational and procedural aspects. The SHP should develop a more inclusive performance guarantee system that includes four to five industry standard representative measures for each functional area. These new performance measures should support the goals of the SHP and the State's fiscal interests in key functional areas. The SHP should ensure that all areas that deal with members directly, such as claims, membership accounting and enrollment, and customer services have service level agreements that clearly specify the services offered, communication channels used and that conform to the SHP customer engagement strategy.

No.	Finding	Recommendation
3.	The Administrative Services Agreement lacks sufficient guidance for functional areas, and fragments the guidance throughout the document.	The SHP in subsequent Administrative Services Agreements should consolidate functional area guidance and separate out legal, policy and procedural requirements.
Provider Relations and Delivery System		
1.	Most Network Management policies, procedures, workflows and controls are adequate; however, few are documented in official standard operating procedure documents, workflows or other written sources.	Network management should have written standard operating procedures for at least some functions.
2.	The SHP does not receive information needed to monitor network adequacy, access and availability as specified in the Administrative Services Agreement.	The SHP should consider revising current Administrative Services Agreement requirements regarding network adequacy reporting.
3.	While most of BCBSNC's payment methodologies are generally comparable to those used by the industry, for some provider types or services, BCBSNC could potentially save resources and costs by moving to fully prospective methodologies used by Medicare and other payers.	BCBSNC should work to adopt fully prospective methodologies for outpatient hospital payment.
4.	Manually priced codes based on charges create a potential opportunity for providers to "game the system" or bill unethically.	Monitor payments for manually priced codes.
5.	BCBSNC has had difficulty contracting with anesthesiologists and other hospital-based physicians, which may result in higher or unpredictable costs to the SHP for out-of-network services.	BCBSNC, SHP and other health plans in the state have little influence over the contracting behavior of, or the amounts charged by, hospital-based physicians. BCBSNC and SHP are not able to address this issue individually; legislation may be necessary.
6.	BCBSNC does not contract with skilled nursing facilities which may result in access problems or higher or unpredictable costs to the SHP.	Monitor access and payments for skilled nursing facilities.

No.	Finding	Recommendation
7.	BCBSNC's process for updating the provider directory may result in inaccuracies.	BCBSNC should investigate which process might allow for mis-matched phone or address information to appear in the provider directory. BCBSNC should also perform a validation or audit of the information in the current online directory by actually calling providers.
Membership Accounting		
1.	A loss of efficiency and productivity occurred with the implementation of the PPO product on the PowerMHS administration system.	BCBSNC should make configuration, workflow and productivity enhancements to PowerMHS and establish a formal continuous improvement process for the Membership Accounting area.
2.	BCBSNC discontinued *Blue e*, a tool which gave each Agency the ability to self-service, that is, perform eligibility updates and request employee eligibility rosters.	The SHP and BCBSNC should develop and encourage use of self-service and automated enrollment capabilities.
3.	Billing and payment policy and process variations cause an increase in billing and payment reconciliation work activity for BCBSNC and SHP Agencies.	The SHP should establish and enforce a policy that encourages standard billing, payment and reconciliation practices.
4.	BCBSNC did not effectively communicate Membership Accounting area cost and service implications to SHP prior to incurring these costs.	BCBSNC should establish a process to thoroughly evaluate the cost and service implications of proposed changes to Membership Accounting systems and processes and communicate the results of the evaluation to the SHP prior to implementing changes.
5.	BCBSNC service, timeliness and accuracy performance was maintained according to Administrative Service Agreement service levels and industry standards.	Incorporate requirements in the Administrative Services Agreements that provide additional transparency into BCBSNC's performance regarding membership accounting; include requirements in the Administrative Services Agreements that cover changing business processes (for example, electronic enrollment processing).

No.	Finding	Recommendation
Utilization Management		
1.	The BCBSNC UM does not perform analyses of over- and under-utilization to determine if there was abuse of services.	BCBSNC should monitor and evaluate the appropriateness and cost-effectiveness of care and services provided to SHP members through additional utilization review activities that focus on identifying and correcting instances and patterns of over-utilization, under-utilization and mis-utilization.
2.	BCBSNC's UM department adequately fulfills timeliness and member and provider notification standards as set forth by the North Carolina General Statute.	The audit team has no recommendation for this positive finding.
3.	The audit team determined based on a review of a sample of clinical staff that all clinical staff licenses are current.	The audit team has no recommendation for this positive finding.
4.	BCBSNC does not provide the SHP with sufficient detail regarding BCBSNC's return on investment analyses of medical policies and authorization requirements.	The SHP and BCBSNC should work together to enhance the level of detail BCBSNC reports to the SHP regarding its return on investment analyses of medical policies and authorization requirements.
5.	The audit team determined that, with a few exceptions, the UM call centers for PPO and CMM products performed at or better than industry standards during the audit period.	The audit team has no recommendation regarding this finding.
Other Medical Management		
1.	The onsite UM function provided by BCBSNC provides a low cost way to manage inpatient utilization and enhance customer service to SHP members.	The audit team has no recommendation regarding this finding.

No.	Finding	Recommendation
2.	Onsite UM nurses are unable to enter data into BCBSNC's UM system (MaxMC) while on location at the hospital.	BCBSNC should work with hospitals where it is providing onsite UM for SHP members to provide a way for BCBSNC's UM nurses to have access to the MaxMC system while on location at the hospital.
Appeals		
1.	BCBSNC's appeals policies and procedures accurately reflect statutory requirements.	BCBSNC should improve policies and procedures to support communication and collaboration among parties involved in the appeals process.
2.	BCBSNC generally processed SHP member Level I and Level II appeals and grievances in compliance with statutory requirements.	The audit team has no recommendation regarding this finding.
3.	The BCBSNC training materials are clear and well-organized and provide information that accurately and comprehensively reflects statutory requirements.	The audit team has no recommendation regarding this finding.
4.	The BCBSNC Member Handbook and outreach materials are clear and well-organized and provide members with information that accurately and comprehensively reflects statutory requirements.	The audit team has no recommendation regarding this finding.

No.	Finding	Recommendation
5.	The number of medical benefit appeals and grievances per member increased significantly during the audit period.	BCBSNC should provide the SHP with an analysis of the number and nature of appeals and grievances on a routine basis and discuss the reasons for increases or decreases to the number of appeals with the SHP.
Customer Service		
1.	The average call handle time for the PPO plan in 2007 and 2008 was generally high compared to those of the five other state health plans. The average speed of answer for the CMM plan in 2006 and 2007 was high compared to those of the five other state health plans. The average call handle time for the PPO plan in 2008 was high compared to health plan industry benchmarks. The average speed of answer for the CMM plan in 2007 was high compared to health plan industry benchmarks. The contact rate for the CMM plan in 2007 was high compared to health plan industry benchmarks. The CMM plan had a high transfer rate in 2008 compared to industry benchmark figures.	BCBSNC should identify the underlying cause for the high call handle times for the PPO product in 2007 and 2008, specifically the long After Call Work time, and if the causes are present today, implement steps to reduce the call handle time to eight minutes for the PPO plan. The SHP should consider implementing performance measures related to call handle times in the Administrative Services Agreement.

No.	Finding	Recommendation
2.	BCBSNC met the performance guarantee levels for the measures specified in the Administrative Service Agreement regarding time required to resolve SHP members' inquiries. However, there was no performance measure for cases open for extended periods.	BCBSNC should provide the SHP with a detailed case latency report each month that identifies the number of cases 30 days or older, identifies the case owner and outlines the steps taken to close the case. The Administrative Services Agreement should include this requirement.
3.	Pay-to-educate, complaint, training, knowledge transfer and coaching policies and procedures either did not exist, were not noted in the administrative services agreement or lacked sufficient detail to provide appropriate guidance to BCBSNC call center staff.	BCBSNC should either discontinue its pay to educate program or seek approval from the SHP for the program, including not-to-exceed limits. BCBSNC should develop a complaint policy, pay-to-educate procedures, training and knowledge transfer policy and coaching and on-the-job training policies.
4.	BCBSNC customer service workflows were in line with industry best practices, although the referral process to other BCBSNC departments can be problematic, and the Administrative Services Agreement lacked detail and policy guidance on the expected customer experience.	BCBSNC should contact members in writing when the case is open for more than 30 days, and update them every 30 days thereafter, and develop a Service Level Agreement for the customer service function. The Service Level Agreement should be added to the Administrative Services Agreement.
5.	BCBSNC call center access to data and reporting could be improved to include control charts or Pareto charts, and the Administrative Services Agreement should include more detail on the type and levels of required performance measures.	The Administrative Services Agreement performance guarantee system should continue to report each quarter, although should be listed for each four-week period. Additionally, first call resolution should be included as a performance measure and be set at 70 percent. BCBSNC should monitor its performance on a broader range of accessibility measures for internal use, and if requested, provide the information to the SHP.
6.	BCBSNC did not have cost measures for industry standard measures, such as cost per call and cost per item of correspondence.	BCBSNC should track the cost per contact for calls, e-mails, faxes and paper correspondence.
7.	Both telephone systems used by BCBSNC to provide customer service were adequate; however, the PPO Interactive Voice Response system was more user-friendly and had greater functionality.	BCBSNC should develop a virtual queue system, and increase the number of self-service offerings in the IVR system to include, claims status and unresolved claims.

No.	Finding	Recommendation
8.	BCBSNC telephone accessibility measures decreased during high workload periods associated with member enrollment for both the PPO and CMM products.	BCBSNC should provide accessibility measures, in quarterly reports, even when they are not bound to meet performance guarantee targets, and when performance slips below targets an explanation of why the target was not met.
9.	BCBSNC increased the number of staff needed to support the PPO product in 2007 and 2008, but BCBSNC generally adjusted staffing levels consistent with the call center's workload. The BCBSNC organizational structure, staff-to-supervisor ratios, member-to-staff ratios, staff attrition rates and tiered support structures were consistent with industry standard practices. However, some BCBSNC staff positions lacked job descriptions. BCBSNC supporting technology was in line with industry best practices, and was not an impediment to efficient case handling.	BCBSNC should develop job descriptions for state service consultants.
Claims Administration		
1.	There was an increase in manual work for PPO claims due to the implementation of the PowerMHS system.	BCBSNC should improve the functionality of the PowerMHS claims system to reduce the quantity of claims requiring manual intervention.
2.	BCBSNC has not taken the appropriate steps to configure the new system for optimal use efficiency. Member and provider satisfaction remained constant due to the increase in staffing. The choice of PowerMHS is not the issue; rather it is how the system is configured.	BCBSNC should address the configuration, workflow and productivity enhancements of PowerMHS.
3.	BCBSNC underestimated the complexity associated with transition of the SHP members from CMM to PPO, resulting in greater than anticipated costs to the SHP.	BCBSNC should establish a process to thoroughly evaluate the cost and service implications of proposed changes to systems and processes and communicate the results of the evaluation to the SHP prior to implementing changes.

No.	Finding	Recommendation
4.	The retroactivity processes in place during the audit period were below industry standards.	BCBSNC should take immediate steps to improve the retroactivity process, including improving fraud and abuse recovery initiatives.
5.	The coordination of benefits process lacks transparency.	Coordination of Benefits business processes should be included in the detailed productivity study recommended as part of Finding 2.
IT and Data Reporting		
1.	BCBSNC underestimated the complexity associated with transition of the SHP members from CMM to PPO, resulting in greater than anticipated costs to the SHP.	BCBSNC should increase its rigor in planning for corporate initiatives and executing these initiatives with more cost-effective resources.
2.	Information Technology staffing resources in general remained relatively flat during the transition to the PPO product and in subsequent years.	BCBSNC should investigate resource savings based on its shared services platform. If all lines of business (commercial, state and federal) are executed on one system, then a decrease of staff is expected.
3.	There is no evidence of integrated work performed by the Information Technology and Operations areas for system configuration to support effective and efficient, end-to-end processing of SHP business.	Create a more transparent and robust coordination of system development changes and business setup changes for PowerMHS.
4.	The audit team saw no evidence that the SHP approves business and system changes that might affect its business.	Develop acceptance and sign off criteria between SHP and BCBSNC.
5.	Overall Information Technology application and system stability is evident and follows industry standards.	The audit team has no recommendation regarding this finding.
6.	BCBSNC is not in compliance with the PPO Administrative Services Agreement requirements for data reporting.	Develop reporting capabilities for compliance with article 5.2.
7.	The data reporting capabilities provided by BCBSNC are inefficient and do not address SHP needs.	Leverage current technologies and industry best practices in managing SHP data reporting needs internally.

No.	Finding	Recommendation
Finance		
1.	The SHP paid for some costs charged by for-profit affiliates to BCBSNC. However, the charges to the SHP appear to have been for services or resources purchased from these entities or for allocations of overhead costs in accordance with the methodologies BCBSNC uses for its other lines of business.	The audit team has no recommendation regarding this finding.
2.	Out of more than 300 cost centers used by BCBSNC, the SHP picked up 100 percent of the costs for 16 cost centers, all of which were cost centers that were dedicated to SHP product support and activities. The SHP shared costs—based on its use of resources—for approximately 200 cost centers. The SHP received none of the costs for almost 100 cost centers dedicated to other lines of business.	The audit team has no recommendation regarding this finding.
3.	BCBSNC's cost allocation methodology, policies and procedures for charging direct, indirect and overhead costs resulted in a consistent and equitable approach for distributing costs to various lines of business, including the SHP, and complied with Administrative Services Agreement terms. Additionally, the cost drivers assigned to the business activities occurring in the cost centers had a consistent and causal relationship to the activities performed. However, the cost-plus methodology results in a system in which BCBSNC bears no risk of loss.	The SHP in the future should closely consider whether it wishes to enter into a cost-plus contract.

No.	Finding	Recommendation
4.	BCBSNC's cost allocation methodology, policies and procedures for charging direct, indirect and overhead costs generally appear to comply with best practices and industry standards. However, unlike terms in other Administrative Services Agreements reviewed by the audit team or federal contract requirements, the Administrative Services Agreement between BCBSNC and the SHP does not define unallowable costs or place caps on amounts or percentages of overhead or indirect costs that can be charged to the SHP.	The SHP should consider adding provisions to any future Administrative Services Agreement's or renogotiaions: • Govern the BCBSNC cost allocation methodologies to be in line with the public's interest. For example, the SHP should consider adding a section for unallowable costs and to cap certain general and administrative expense allocations to the SHP • Establish baselines and ceilings for specific administrative activity costs to motivate the provider to implement continuous measures to control expense • Add incentives so that the provider can share in the benefit of any significant cost and service level improvements
5.	The SHP and BCBSNC have made some efforts to address the findings and recommendations identified in the April 2009 State Auditor's Office report. However, the SHP has further opportunities to implement additional recommendations to improve its effectiveness in overseeing the Administrative Services Agreement.	The SHP should consider requesting BCBSNC to provide financial data at the level and format suggested in Appendix A, and after it receives detailed activity reports, track and analyze this data and follow-up with BCBSNC staff regarding any discrepancies or changes in costs and trends. If the SHP wishes to move from a cost-plus reimbursement methodology to a flat fee payment in the future, it should carefully consider all cost components and (to the extent feasible) try to identify expected changes in costs for near and long term. The SHP should ensure that it has provisions in its future Administrative Services Agreements that, should it move to a flat rate, allow for a periodic, but not less than annual, adjustment and reconciliation of the rates to ensure that the SHP is paying reasonable rates for administrative services in future years.

No.	Finding	Recommendation
6.	Cost trends and analyses must be carefully considered along with the results of the productivity and other financial analyses presented in the individual functional area reports.	See functional area report for cost trend and analyses.
Pharmacy		
1.	Medco is primarily performing to its contract. Medco's operational processes and core functions and systems are efficient, standardized and highly automated.	The audit team has no recommendation regarding this finding.
2.	During the audit period, the administrative and utilization management fees charged to the SHP were consistent with industry standards; in addition, the discounts for SHP were competitive with industry standards for brand and generic drugs.	The audit team has no recommendation regarding this finding.
3.	The contract lacks provisions that would provide the SHP information that is important to its oversight of contractor performance.	In future PBM contracting, the SHP should require access to and transparency of information that is important to its management of the pharmacy program.
4.	There is a gap in alignment between the Medco contract and the SHP's current benefits and ability to take advantage of mail order savings.	The SHP should increase mail order utilization to achieve greater cost savings for it and its members.

No.	Finding	Recommendation
5.	Medco's Therapeutic Resource Centers clinical pharmacy programs that serve the needs of the population with chronic and complex medical conditions are primarily delivered to SHP members who use the mail order pharmacy channel.	Medco should extend access to its Therapeutic Resource Centers programs to SHP members with chronic and complex conditions who receive their medications at retail pharmacies.
6.	North Carolina General Statute 135-45.6 does not support the SHP in providing its members with a pharmacy benefit offering that is consistent with industry standards and that delivers significant savings.	The SHP should create incentives for mail order for certain targeted populations, implement a more comprehensive specialty pharmacy program and continue to encourage generics utilization to achieve cost savings for the SHP and its members.
7.	The SHP could improve coordination of specialty pharmacy drugs between those billed under the medical benefit and those billed under the pharmacy benefit.	The SHP should implement a process to routinely audit for duplicate billing of specialty pharmacy claims. The SHP should establish a single set of prior authorization criteria for drugs covered under both the medical and pharmacy benefits.
8.	Medco's prior authorization process generates a large number of denials due to administrative errors; appeals of these denials by Medco must then be processed by BCBSNC at the SHP's expense.	Medco should improve its prior authorization form and process to minimize the administrative errors that result in denials and courtesy appeals.