



New Hampshire Hospitals' Report on Anthem Performance

April 2023

New Hampshire
Hospital Association



Introduction

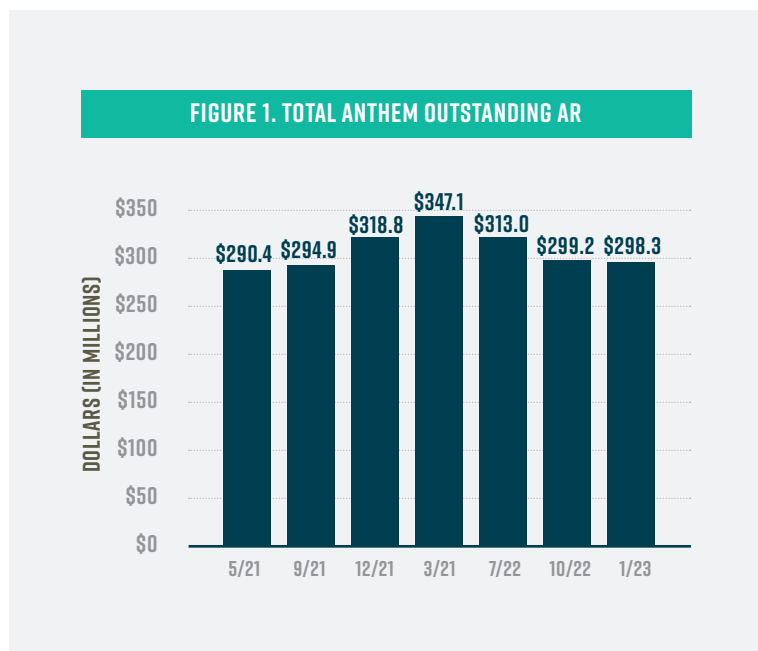
In early 2021, the New Hampshire Hospital Association (NHHA) heard frustrations from several member hospitals concerning Anthem, the largest commercial payor in the state¹. The complaints came from varying departments within hospitals on topics including outstanding Accounts Receivable (AR), company policies, and customer service. In response, NHHA conducted a survey in May 2021 to gather more information; the results painted a picture of universal dissatisfaction with Anthem’s practices, procedures, and overall performance.

NHHA sent a report to Anthem summarizing the initial survey results, and a workgroup was established shortly after with representatives from NHHA, New Hampshire hospitals, and Anthem to address the issues outlined. This group met bi-weekly or weekly from July 2021 to December 2022. Twenty-two acute care hospitals in New Hampshire responded to the initial survey request and six (6) follow-up surveys to gather trending data that would demonstrate any changes in outstanding AR and hospital experiences.

Despite a year and a half of meetings to discuss systematic issues causing significant AR, hospitals have seen minimal improvements, and unfortunately, AR remains higher than when it was initially measured in May of 2021. The January 2023 survey reported \$298 million in AR, an unacceptably high amount. The modest decrease in AR from prior surveys is not accompanied by systematic changes that would suggest the tides have turned and Anthem’s processes have improved such that hospitals can expect to be paid timely for the services they provide to Anthem beneficiaries. Anthem has yet to implement real change, has failed to improve known system failures, and continues to rely on hospitals to identify and track Anthem’s broken processes.

Anthem Outstanding Accounts Receivable

In January 2023, hospitals reported a total outstanding AR² of \$298.3 million which is a 0.3% reduction from the prior quarter’s survey. AR is still well over the \$290 million from the initial survey conducted in May 2021. (Figure 1)³.



Heading into the January 2023 survey, hospitals had hoped to see significant improvements in AR based on assurances provided by Anthem leadership in recent months. Anthem’s leaders informed hospitals that long awaited fixes for many of Anthem’s broken system issues were in place and that as a result hospitals would see claims paying correctly and aged claims being adjudicated resulting in a reduction in AR. As of the date of publication of this report, hospitals have not experienced a new and improved Anthem, in fact, they report that very little has changed. AR is still exceptionally high and as discussed in further detail below, working with Anthem to resolve matters continues to be a laborious process. These surveys do not capture the millions of dollars ultimately written off by hospitals.

1) <https://www.beckerspayer.com/payer/the-largest-commercial-payer-in-each-state-in-2022.html>

2) Total AR represents the amount billed to Anthem by the hospitals and does not necessarily represent the amount of dollars that will ultimately be paid for services rendered.

3) Figures in this report may be slightly different than those presented in prior reports due to updates made based on additional data received after publication.

AR by Age Category

As in prior surveys, the January 2023 survey found that the majority of outstanding AR is in the 0-90 day category. The January survey found that 0-90 days AR increased by 2.3% from the prior survey accounting for \$198,702,143 of AR (up from \$194,247,868 in October 2022).

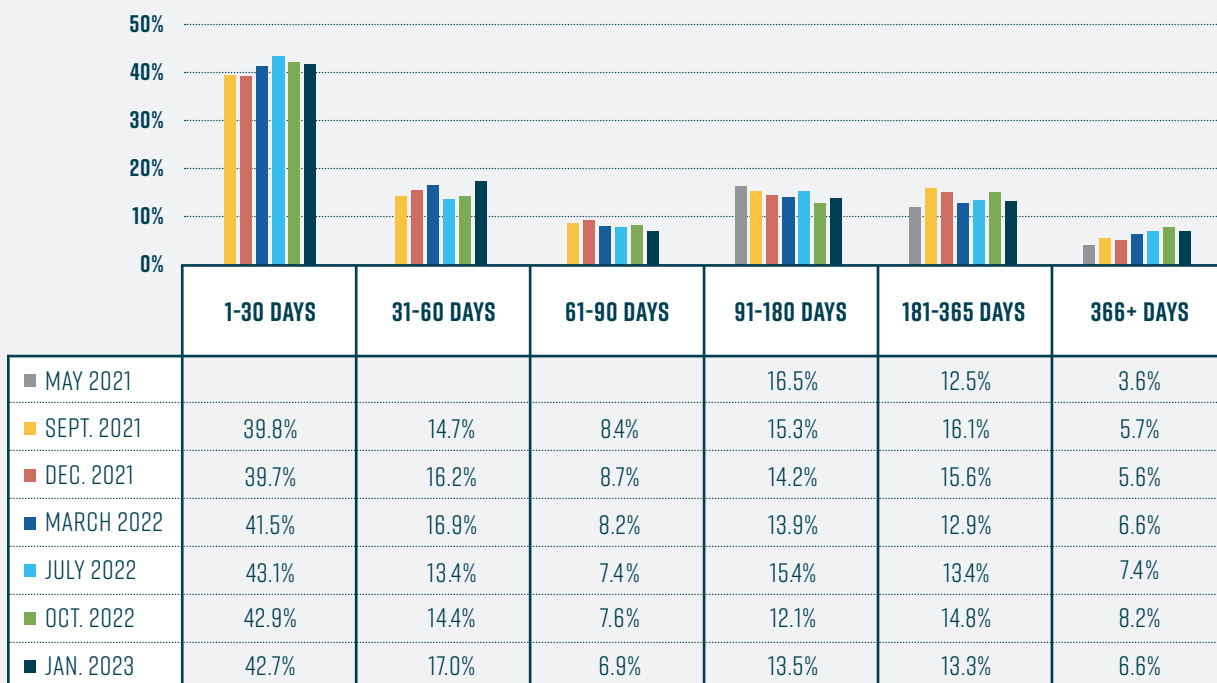
FIGURE 2. JANUARY 2023 ANTHEM AR

CATEGORY	AMOUNT	PERCENT
1-30 DAYS	\$127,463,564	42.7%
31-60 DAYS	\$50,648,017	17.0%
61-90 DAYS	\$20,590,562	6.9%
91-180 DAYS	\$40,367,205	13.5%
181-365 DAYS	\$39,566,986	13.3%
366+ DAYS	\$19,680,251	6.6%
TOTAL AR OUTSTANDING	\$298,316,585	100.0%

New Hampshire prompt pay laws ([RSA 420-J:8-a](#)) require payment of "clean" claims within 30 days for paper claims and 15 days for electronic claims. In the January 2023 survey, 57% of the \$298 million AR dollars are older than 30-days (Figure 2). Of note, 33% of Anthem's AR dollars are older than 90 days. Days in accounts receivable is a key performance indicator of financial health in the healthcare industry. It is of great concern that over one-third of total AR, accounting for \$99.6 million of total AR, is older than 90 days.

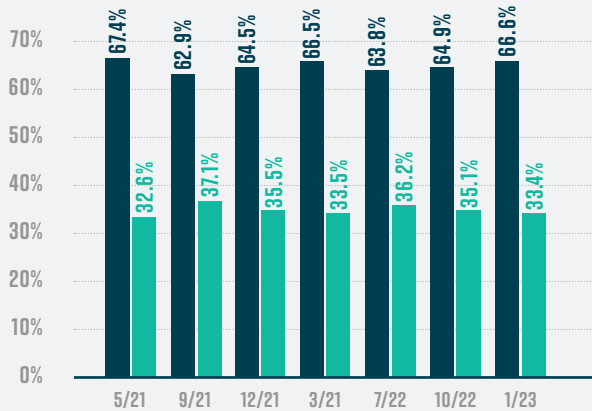
The seven (7) surveys demonstrate fluctuation of aged categories as percent of total Anthem AR dollars (Figure 3)⁴. One constant across the surveys is claims older than 30 days make up the majority of outstanding AR dollars.

FIGURE 3. PERCENT OF TOTAL OUTSTANDING AR BY AGE CATEGORY ACROSS SEVEN SURVEYS



4) May's survey did not break out the categories below 90 days.

FIGURE 4. ANTHEM % AR <90 DAYS AND >90 DAYS



CLAIMS > 90 DAYS

Figures 4 and 5 demonstrate the percentage and dollar changes for AR less than and greater than 90 days. The lack of movement over the seven (7) surveys demonstrates that Anthem’s processes for adjudicating claims and resolving known system failures remains broken.

FIGURE 5. ANTHEM AR LESS THAN 90 DAYS AND GREATER THAN 90 DAYS OVER 7 SURVEYS

CATEGORY	MAY 2021	SEPT. 2021	DEC. 2021	MARCH 2022	JULY 2022	OCT. 2022	JAN. 2023
<90 DAYS	\$195,626,585	\$185,469,628	\$205,761,954	\$230,946,341	\$199,589,566	\$194,247,868	\$198,702,143
>90 DAYS	\$94,767,337	\$109,404,999	\$113,005,884	\$116,113,143	\$113,387,983	\$104,951,837	\$99,614,422
TOTAL AR OUTSTANDING	\$290,393,922	\$294,874,627	\$318,767,838	\$347,059,484	\$312,977,549	\$299,199,705	\$298,316,585

Evidence of System Failures at Anthem

The following sections describe challenges around specific systemic failures at Anthem. This information was gathered through comments in the surveys, discussions with hospital staff, and results of the workgroup.

ENROLLED PROVIDERS

Hospitals across the state shared that medical providers who had been longstanding, enrolled Anthem providers were suddenly appearing as out-of-network.⁵ The unexplained change to out-of-network status has occurred across provider types ranging from cardiology to behavioral health to pain management. One hospital reported that an entire practice group was dropped by Anthem. Making matters even worse, when hospitals alerted Anthem to this error, Anthem often took months to remedy the status for individual providers. Hospitals report that many times when Anthem states that they have fixed the issue, hospitals learn that the status was updated for some but not all Anthem plans or some but not all dropped providers.

These inaccurate network changes have a significant impact to Anthem beneficiaries in two (2) ways. First, when an Anthem beneficiary looks up the enrolled provider network list, unenrolled providers do not appear, so the patient doesn’t know that a provider would have been in fact available to them. Second, a patient sees a provider who has always been in-network (and is in fact still in-network) but the claim processes as if the provider is out-of-network. As a result, the patient receives a bill for an out-of-network service. Sometimes the patients call the hospital to question the out-of-network status and accompanying out-of-network charge, while other times, the Anthem patient pays the bill not understanding Anthem’s mistake.

5) To be clear, this change in status is out of the blue. It is not connected to a demographic change, enrollment change, or any other triggering event. For example, one hospital shared that they had a provider who had been enrolled with Anthem since the mid-1990s. Suddenly, the hospital learned that the provider, without a change in circumstance, was showing as out-of-network.

“The amount of staff time spent on administrative work to overcome challenges is a huge drain, and staffing is critically short right now.”⁶

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“There is no root cause analysis done on Anthem’s end. They continue to deny claims incorrectly and even when you finally get one overturned, you have another round of new incorrect denials just like it.”

Hospitals do a significant amount of claims data analysis and take extraordinary steps to protect their patients from Anthem’s errors. However, this error is one that hospitals cannot predict and they only learn of these Anthem errors based on patient complaints. This error causes significant financial impact directly to the Anthem beneficiary and the provider and is extremely complicated to rectify. Hospitals do their best to protect patients from unknown and erroneous out-of-network charges but Anthem’s inability to correct these errors in a timely and complete fashion only exacerbate the confusion and anger expressed by patients. To date, Anthem has not provided an explanation for how or why this error occurred nor can they assure hospitals that it will not occur again in the future.

CARELON MEDICAL BENEFITS MANAGEMENT

Anthem utilizes Carelon Medical Benefits Management (formerly AIM Specialty Health)⁷, an online platform to manage the prior-authorization process for medically necessary services.⁸ Providers must obtain prior-authorizations for services ranging from imaging to medical and surgical procedures to diagnostic testing. Healthcare providers are well versed at working with payors to obtain the necessary approvals for many services provided as a prior-authorization process is standard across insurance markets.

Anthem’s provider manual instructs providers to seek prior-authorization approval through Carelon. However, Anthem’s and Carelon’s list of services requiring authorizations do not match up. Because of this mismatch, Anthem incorrectly denies claims for multiple services that are submitted without an authorization even though Carelon instructed the provider that an authorization was not needed. There is no reason that conflicting lists should exist given that Anthem delegates the prior-authorization process to Carelon under contract.

Incorrect denials for lack of authorizations results in an enormous amount of unnecessary work and re-work on the part of the hospitals - all to prove to Anthem that claims were submitted correctly the first time as directed by Carelon. Hospitals must engage an Anthem representative, which frequently takes multiple hours, to demonstrate that Carelon informed the hospital that an authorization was not needed. Hospitals have found it necessary to implement additional, internal workflows to maintain supporting documentation of Carelon’s prior-authorization directives. These efforts include saving screenshots of Carelon portal responses and recording call reference numbers. The hospitals have had to provide this documentation over and over again because Anthem’s own systems cannot confirm the information provided by Carelon. The hospital re-work of these claims can take upwards of 30 days and require significant staff time, all for a clean claim that was submitted correctly the first time based on Anthem’s prescribed processes in the provider manual.

6) All quotations throughout this report were drawn from hospital survey responses between May 2021 and January 2023.

7) On March 1, 2023, AIM Specialty Health changed its name to Carelon Medical Benefits Management. The change is the result of AIM joining the Carelon healthcare services company.

8) Welcome - Anthem ([carelonmedicalbenefitsmanagement.com](https://aimproviders.com/anthem/carelonmedicalbenefitsmanagement.com)) formerly <https://aimproviders.com/anthem/>

“Over the past few years, we have seen Anthem go from one of our most collaborative payors to one of the most challenging to work with.”

“

“Most other payers provide quicker response, knowledgeable representatives, and fewer claims deny in error.”

The Carelon/Anthem prior-authorization mismatch was made known to Anthem prior to the first meeting of the workgroup in July 2021 and was discussed in nearly every workgroup meeting. Beginning with the initial workgroup calls, Anthem senior staff assured the group that they were aware of the issue and that a remedy was in-process. In May 2022, Anthem leadership informed the workgroup that they had identified a solution for the prior-authorization disconnect. However, that solution did not materialize and was not put into place.

To date, this issue has not been fixed. Anthem has not identified solutions for the mismatch and they report that they are conducting root cause analyses and only once those are complete will they be able to correct the other disconnects. While Anthem continues to examine their system failures, hospitals are forced to work and re-work impacted claims, all the while seeing increasing AR. It is utterly confounding that Anthem is unable to resolve a mismatch between their own systems and that a written description of the fix cannot be supplied so that hospitals can anticipate claims payments or audit any unpaid claims that could remain.

AVAILITY

Availity is a secure, online portal designed to allow providers to engage with Anthem at all stages of claims processing, provide real-time information on the status of claims, and offer immediate responses to providers.⁹ It is intended to allow providers to look up patient insurance coverage information, submit claims electronically, and upload supporting documentation.

An ideal workflow for claims processing is for the provider to submit the claim, the payor to review the claim, provider to supply additional information when needed, and the payor to remit the contractual payment amount. Unfortunately, the workflow through Availity is flawed and inconsistent. Providers frequently must work and re-work claims because of flaws with the portal such as requiring providers to upload the same document multiple times because the system could not appropriately track documents or conflicting information between Anthem and Availity being provided.¹⁰ When an issue cannot be resolved via the Availity portal, there is no mechanism for the hospital representative to flag the issue or speak with a live person. Instead, providers receive a canned response that they will be contacted about the issue within 30 days.¹¹

Hospitals try to utilize Availity’s secure messaging as much as possible. However, the secure messaging through Availity often leads to dead ends. Chat messages are frequently unresponsive, circular, or connected to an entirely different claim because the Anthem representative is responding to multiple chats at the same time. Additionally, wait times for a chat response are lengthy, at times taking over 60 minutes for a response.

9) <https://www.anthem.com/provider/availity/>

10) For example, when a provider pulls up a claim in Availity and submits an inquiry about the claim, they receive a response from Availity that that claim does not exist.

11) Hospitals shared with Anthem leadership during workgroup meetings that they rarely receive responses within the 30 days. As a result, hospitals have to track these requests so that they can again contact Anthem in hopes of resolving the issue.

“Even though Anthem is only 13% of our revenue, we have .6 FTE devoted to them. For comparison, Medicare is 40% of our revenue and we have .75 FTE devoted to them.”



“Last Friday I called at 2:17 pm, I was still on hold when I left for the day 2 hours later. I left the phone on, and nobody ever answered. I was disconnected at midnight!”

CUSTOMER SERVICE

When utilizing Availity or Carelon doesn't resolve issues, hospitals must contact Anthem via telephone. Unfortunately, their experience with telephone calls includes lengthy hold times (frequently reporting being placed on hold for hours at a time), multiple transfers, or disconnected calls with no callback.

Eventually, when a customer service representative (CSR) is on the phone, frequently the CSR does not have the information or authority to resolve the issue at hand. When the provider requests to speak to a supervisor (the official escalation process outlined by Anthem), the CSR advises the provider that they cannot transfer the call to a supervisor, but someone will call the provider back. The return calls, if received at all, can take upwards of two weeks to be returned. This lengthy response time is often in conflict with the immediate medical need of the patient. So, the provider must end that call, call again, and hope the next CSR has the necessary skills and knowledge to resolve the issue.

KNOWN ISSUE TRACKING

The HART Grid is a system that Anthem utilizes for select hospitals (typically used by larger health systems) to track and escalate known, systematic issues with processing claims. Claims that are placed on the HART Grid are those that have already gone through the normal claims' inquiry and reconsideration processes without a successful resolution. The intent of this escalation process is for hospitals to flag categories of claims that are processing/being denied incorrectly to facilitate Anthem's undertaking of a root-cause analysis and remedy the error for all claims impacted across all providers. Once the hospitals identify an Anthem system error for the HART Grid, Anthem directs hospitals to place all future claims with that known issue on the Grid rather than submitting the claims for payment.¹²

The intent of this process makes sense. Unfortunately, in reality, Anthem takes months or even years to remedy these known issues. Hospitals that participate in the HART Grid report that they have millions of dollars' worth of claims as old as two years that have been sitting on the HART Grid awaiting resolution from Anthem. Throughout this, hospitals do not receive payment for the medically necessary services they provided in good faith to Anthem members.

Hospitals that do not participate in the HART Grid program cannot utilize a standardized Anthem process to track incorrectly paid claims because of reoccurring system issues. These hospitals escalate claim payment errors through the inquiry and reconsideration channels created by Anthem. However, when Anthem's prescribed channels fail to resolve the issue, Anthem directs the hospitals to document and track the impacted claims and categories of issues on spreadsheets. Until September 2022, during workgroup meetings, Anthem leadership endorsed the practice of utilizing spreadsheets to track issues and even went so far as to have their provider representatives ask hospitals to re-format and add data points to the spreadsheets (causing even further re-work for hospitals in their pursuit of payment). The types of claims documented on these spreadsheets are similar, if not identical to, those placed on the HART Grid.

¹²) This is yet another instance where hospitals must track and hold claims for unknown lengths of time because of Anthem's inability to fix system-wide errors.

Conclusion

Representatives from hospitals and NHHA worked with Anthem for a year and a half to break down barriers and identify paths for increased claims processing and resolution. This work looked at every stage of patient care from initial registration to claims processing. Unfortunately, the surveys demonstrate that Anthem has not made the necessary changes to their internal systems making it impossible for hospitals to consistently secure timely authorizations, clinical reviews, or responsive customer service. In an effort to mitigate financial risk to patients and providers, hospital staff spend countless hours navigating the maze of policies Anthem has put in place, identifying errors at a variety of junctures and dealing with inadequate customer service. Hospitals are seeking effective solutions to solving pervasive issues which will create a smoother experience for all parties and result in better working relationships, reduction in AR, and free up resources to focus on what matters most—patient care.