



# **Audit Committee of Brevard County**

## **Self Insurance Claims Audit**

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November 30, 2001**

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November 30, 2001

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Department of Human Resources  
2725 Judge Fran Jamieson Way  
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We hereby submit our report covering self insurance claims audit.

Our report is organized in the following sections:

<b>Background</b>	This provides an overview of self-insurance and the related issues.
<b>Objectives and Approach</b>	The internal audit objectives and focus are expanded upon in this section as well as a review of the various phases of our approach.
<b>TPA Claim Audit Results</b>	This section contains an overview, a summary of control comparisons, and any issues identified for each TPA.
<b>Overall District Issues</b>	This section gives a description of the issues as well as the impact and recommended action.
<b>Attachments</b>	The attachments contain the claim audit summary worksheets for each TPA.

We would like to thank the various departments and all those involved in assisting the Internal Auditors regarding this report on self insurance.

Respectfully Submitted,

# Background

On January 1, 2000 Brevard County adopted a self-insured health care plan with multiple options for employees and retirees. The plans and administrators were selected through the use of an outside consultant and a formal request for proposal (“RFP”) process. The RFP included requests for fully insured plans, and alternative funding arrangements. Only one fully insured plan was submitted and due to cost and benefit considerations the fully insured plans were not selected. The adoption process included a joint effort with the Brevard County School Board. By combining the groups for plan administration purposes, both entities received better benefits with cost reductions due to economies of scale. Third Party Administrators (“TPAs”) are utilized for plan administration, including claim payments.

Generally, all employees are eligible for coverage on the date of hire. The County pays the premium for the employee, and subsidizes the premium costs for employee family members. There are several options available to employees; this allows them to choose a plan and benefits, which most meet their needs. The options are summarized as follows:

TPA	Health First Health Plans, Inc. “Health First”	Aetna US Health Care Company “Aetna”	Employers Mutual, Inc./ Brevard Professional Network, Inc. “EMI / BPN”		Walgreens Health Initiatives “Walgreens”
Type of Plan	HMO	HMO	EPO	PPO	Prescription Drugs
Lifetime Maximum	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000	N/A
Deductible	\$ -	\$ -	\$ -	\$300/600 <sup>1</sup> \$400/800 <sup>2</sup>	\$ -
Out of Pocket Max.	\$1500/3500	\$1500/3500	\$1500/3500	\$2000/4000 <sup>1</sup> \$4000/8000 <sup>2</sup>	N/A
Coverage	100%	100%	100%	85% <sup>1</sup> 70% <sup>2</sup>	100%
Failure to obtain pre-certification	Provider Responsibility	Provider Responsibility	Provider Responsibility	Provider Responsibility <sup>1</sup> Member Responsibility after first \$400 <sup>2</sup>	N/A
Co-Pay	\$15	\$15	\$15	\$20	\$7 - \$60 <sup>3</sup>
Primary Hospital	Holmes Regional & Cape Canaveral	Wuesthoff	All Brevard County Hospitals	All Brevard County Hospitals	N/A

<sup>1</sup> In-network

<sup>2</sup> Out-of-network

<sup>3</sup> Varies based on:

- Retail or mail order
- Generic, brand, or non-preferred brand

## **Background, continued**

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The financial position of the plan for calendar year 2000 is as follows:

Premiums*	\$18,893,000
Claims paid	15,936,000
Administrative Expenses	1,838,000
Stop Loss Premiums	<u>467,000</u>
Total expenses	<u>18,241,000</u>
<b>NET INCOME</b>	<u><u>\$652,000</u></u>

*\*Includes any reimbursements related to stop loss coverage.*

The plan maintains Stop Loss Insurance Coverage to pay any claims over \$150,000 per member per year up to the plan lifetime maximum of \$1,000,000 per member. The premium paid by the County for this coverage is \$5.20 per single member per month and \$12.38 per family per month.

Enrollment into the plan is a manual process at this time. Plan members complete a paper enrollment form on initial entry into the plan and at any time there are changes to their plan options or member information. The completed forms are forwarded to the appropriate TPA for entry into their health plan database. Walgreen's enrollment information is sent via an Excel file.

# Objectives and Approach

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## Objectives

<input type="checkbox"/> Determine that the plan was approved, competitive bids were sought and appropriate due diligence and procedures were followed in the selection and negotiation related to the insurance companies and related fees.
<input type="checkbox"/> Evaluate the reasonableness of estimated liability for claims payable and reserves recorded on the District's financial statements.
<input type="checkbox"/> Evaluate the accuracy of claims administration being performed by third party administrators.
<input type="checkbox"/> Evaluate the accounting controls around disbursements.
<input type="checkbox"/> Evaluate the controls surrounding billing and collection for insurance premiums with regard to employees on leave and retired employees.

## Approach

Our audit approach consisted of four phases as follows:

### Understanding and Documentation of Process

We conducted interviews with the County Department Director of Human Resources, the Employee Benefits Coordinator, the Fiscal Analyst for Human Resources, and the County's outside insurance consultant. We discussed the scope and objectives of the audit work, obtained preliminary data, and established working arrangements. We also obtained copies of contracts with third party administrators, hospitals, and other providers as deemed necessary. In addition, we also met with representatives from the Brevard County School Board who assisted in developing a work program. During this process we reviewed audit provisions contained in the contracts and discussed the nature and timing of the work with the TPAs.

### Population and Sample Determination

We selected a systematic random sample of claims paid from each of the TPAs. Our sample included 30 claims from the School Board and 30 claims from the County. Included in the 30 claims were the 3 largest claims paid during 2000 for each entity.

# **Objectives and Approach, continued**

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## **Approach, continued**

### Detailed Testing

Our detailed testing focused on claims processing. The claims processing area included on-site visits with each of the TPAs. Our testing included but was not limited to the following:

#### Claims Processing

- ❑ Interviews with TPA staff
- ❑ Inquiries related to claim processing and controls
- ❑ Sufficient documentation to support the claim
- ❑ Membership eligibility
- ❑ Application of deductibles and/or co-pays in accordance with the plan
- ❑ Benefits covered under the plan document
- ❑ Payment of the claims in accordance with the provider agreement
- ❑ Coordination of benefits
- ❑ Subrogation
- ❑ Review of the claim form for accuracy
- ❑ Payment agreeing to claim

### Reporting

During this phase, we summarized our findings. We reviewed the results of our claims audit with the individual TPAs and have requested written responses from them. We have also reviewed the results of our testing with the appropriate levels of management at the County.

# TPA Claim Audit Results

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The table below gives a comparison of certain operational statistics for the three TPAs:

	<b>Health First</b>	<b>EMI / BPN</b>	<b>Aetna</b>
<b>Average Number of Members</b>	2,108	PPO - 1,312 EPO - 1,156	3,191
<b>Average Processing Time</b> <sup>1</sup>	7.5 days	14.8 days	11.2 days
<b>Total Claim Cost per Member per Month (PMPM)</b> <sup>2</sup>	\$141.38	PPO - \$240.28 EPO - \$190.49	\$102.31
<b>Claim Cost per Member per Month excluding outliers</b> <sup>3</sup>	\$130.58	PPO - \$202.00 EPO - \$163.24	\$71.36
<b>Administrative Cost per Employee per Month</b> <sup>4</sup>	\$30.78/employee	EMI: \$9.25/employee BPN: \$4.25/employee Total: \$13.50 per employee	\$35.00/employee
<b>Actual Total Administrative cost per member per month</b> <sup>5</sup>	\$18.94/member	PPO- \$7.18 <sup>6</sup> EPO- \$7.18/member	\$15.69/member

- <sup>1</sup> Average days exclude the two fastest paid and two slowest paid claims for each TPA.
- <sup>2</sup> Calculation is from calendar year 2000 data provided by the TPAs on an incurred basis. This is by service date, not paid date.
- <sup>3</sup> This calculation excludes outliers (claimants over \$25,000) and is a more comparable statistic.
- <sup>4</sup> Rates are per contract and do not include special requests etc. Health First's contractual terms are \$18.09/member per month; a cost per employee was calculated using 12/01/2000 enrollment data.
- <sup>5</sup> The calculation of administrative cost is all TPA charges, including additional services divided by the number of member months.
- <sup>6</sup> Billing is not provided by plan type.

# Claim Audit Results

# Health First

<i>On-site Fieldwork</i>	February 26, 2001
<i>Contact</i>	Mary Beattie – Director Program Audit Procedures
<i>Random Sample</i>	60
<i>Large Claims</i>	6
<i>Cost Per Member Per Month</i>	\$141.38
<i>Average Number of Members for CY 2000</i>	2,108
<i>Claim Audit Summary Results</i>	Attachment A

## Overview

**Scope of Services** Health First Health Plans, Inc. (“Health First”) is a subsidiary of Health First, Inc. Operating exclusively in Brevard County, Health First offers fully insured HMO plans, as well as TPA services, which include provider contract negotiation, claims review and processing, and case management services.

**Claims Reimbursement** The majority of the non-hospital contracts we reviewed are based on two types of reimbursement policies: 1) the lower of usual and customary charges or 110% of the Medicare rate, and 2) capitated rates. The majority of hospital services in their network are capitated.

**Claims Processing** Claims processing is generally a manual process with data entry from claims forms. Only claims from MIMA are currently processed electronically. Health First requests wire transfers throughout the month and sends a summary report at month end. A separate ZBA is utilized for Health First’s claims payments.

**Out-of-Area Providers** Health First utilizes Beech Street Network to negotiate with out-of-area providers. This results in approximately 20% savings from billed rates.

## **Overview - continued**

**Case Management** A team of case managers handles management of larger claims. Local employees who are primarily nurses (one doctor on staff) handle these services. Case managers are assigned cases for the duration of the case based on specialty. During our review we noted case management review notes in the system as well as doctor clinical analysis. Authorization included extensive notes from providers as cases became larger. It is policy for the nurses to visit local hospitals to review medical records as deemed necessary. Case Managers do not visit out-of-network hospitals.

## **Comparison with other TPAs**

**Overall Operations** Health First is a Brevard County based provider and has a greater day-to-day knowledge of the local medical community. There is greater emphasis on meeting first hand with medical providers. All functions of the TPA contract are handled out of one office resulting in greater coordination of the claims process. The School Board and Brevard County are the only true TPA clients of Health First. However, claims go through the identical process as their own plan. This consolidated approach is probably a factor in the accuracy of claims processing.

**Claims Cost** The PMPM cost is higher than the Aetna HMO. One of the factors that could have an effect on the cost comparison is that Aetna has a wider population of providers. This is two fold: 1) Aetna has the ability to negotiate lower rates with providers, and 2) 'out-of-area' providers are many times still covered under an Aetna contract and thus Aetna receives a discounted rate.

**Administrative Cost** The administrative cost per the contract is \$18.09 per member per month. Per our calculation using all incurred charges for calendar year 2000 the actual amount is \$18.94 per member per month. This is higher than Aetna (\$15.69 PMPM) and higher than the EMI/BPN plans (\$7.18 PMPM). All of the other TPA contracts quote administrative fees on a 'Per Employee Per Month'.

## Highlights of Control System

<b>Audits</b>	Health First has several different regulatory audits that are performed throughout the year. In addition, Health First has an internal audit function that audits a minimum of 2% of claims processed per month.
<b>Coordination of Benefits</b>	Each year Health First has a mass mailing to the membership for purposes of capturing ‘coordination of benefits’ information. We noted these letters in our testing.
<b>Subrogation</b>	The system is utilized to manage possible subrogation claims. Diagnostic codes that generally are associated with accidents and the like ‘pend’ in the system. A letter is generated which is sent to the member inquiring as to whether the claim is related to an accident and, if so, was any other insurance company involved. We noted these procedures in our testing.
<b>Membership Satisfaction</b>	A membership satisfaction survey is conducted annually.
<b>Stop Loss</b>	Health First notifies the County and the insurance company when the claim reaches 50% of the stop loss coverage floor. Generally, Health First has been successful in their stop/loss efforts.
<b>Contractual Performance Standards</b>	Per the contract there are no specific performance standards.

## Issues

<b>Authorization</b>	Our review of Health First’s claim payment process found one error. Under contracts with providers, Health First has a list of procedures that require pre-certification. One claim in our sample was not pre-certified per the listing and was therefore paid without proper authorization.
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# Claim Audit Results

Aetna

<i>On-site Fieldwork</i>	May 22, 2001
<i>Contact</i>	Robert Charles – Account Representative
<i>Random Sample</i>	53
<i>Large Claims</i>	7
<i>Cost Per Member Per Month</i>	\$102.31
<i>Average Number of Members for CY 2000</i>	3,191
<i>Claim Audit Summary Results</i>	Attachment B

## Overview

**Scope of Services** Aetna US Healthcare is a national provider of health care services including both traditional plans and TPA administration. Aetna was contracted to provide full TPA services to Brevard County including: provider contract negotiation, claim processing, and case management. Claims processing for the County contract are performed in Jacksonville, Florida.

**Claims Reimbursement** Per the contract with Aetna, we were not able to see the highly confidential material that included contracts with providers. We did however test claims paid noting that the claims were paid at a reasonable percentage of Medicare. Typically we noted these reimbursements to be significantly lower than the other TPAs. Aetna is a national provider that has more bargaining power to negotiate lower rates than other local TPAs. Aetna also has a larger network of providers resulting in fewer out of area claims paid at 100% of charges.

**Claims Processing** Aetna has a highly automated claims process. Electronic claims are a major source of claim information. All 'manual' claims information is optically scanned into their claims system, including the claims form and any supporting documentation. All data processing is performed at a separate data processing facility. Claims are batched by type of medical service (i.e., procedure codes). Claims processors specialize in types of claims and an individual processor will generally only process claims related to their specialty. Any claim follow-up is generally done electronically. Aetna requests wire transfers throughout the month and sends a summary report at month end. A separate ZBA is utilized for Aetna's claims payments.

## **Overview - continued**

**Out-of-Area Providers** As noted above, we were unable to review provider contracts as it was limited by contract. However, during our testing we noted out-of-area providers were paid at a considerably lower rate on average than the other TPAs. This is due to the large size of the Aetna network providers, which includes not only Brevard County and Florida but also a nationwide network.

**Case Management** Case management is done remotely by a group of nurses and doctors in Georgia. All case management information is entered electronically into the database and can be accessed online by case management specialists. The nurses utilize nationally published criteria (Milliman and Robertson) as a guide to determine medical necessity of procedures and to approve hospital stays. At one time Aetna has a nurse staffed in Brevard County to conduct on site hospital reviews however when she left they did not replace her. Therefore the case reviews are done via the telephone.

## **Comparison with other TPAs**

**Overall Operations** Claims are processed in a more automated fashion than the other TPAs. This process appears to result in more denied claims than the other TPAs. If the claim is not submitted completely and correctly it is automatically denied. The automation of the process also is a large factor in the quick payment time (average 6 days). The segmented nature of Aetna's operation can make it difficult to obtain timely resolution of pending issues for both members and providers. The claims payment process is more "systems" driven than the other TPAs. As Aetna processes their claims electronically, we could not identify any issues with the payment of member co-pays as we did with the other TPAs.

**Claims Cost** As a national provider, Aetna appears to have strong bargaining power with providers, as shown by their average claim cost. Thus the out-of-area claims are typically paid at a lower cost than the other TPAs. Aetna has included in their contract limitations certain 'highly confidential information' that will not be released. Included in that data are contracts that Aetna has with providers. Therefore, in our testing we could only review the paid amount of the claim for reasonableness as a percentage of Medicare rates.

## **Comparison with other TPAs - continued**

**Administrative Cost** The administrative cost per the contract is \$35.00 per employee per month. Per our calculation using all incurred costs for calendar year 2000 the actual amount is \$15.69 per member per month. This is lower than Health First (\$18.94 PMPM) and higher than the EMI/BPN plans (\$7.18 PMPM). Additionally, Aetna charges \$75 per hour for any special requests, i.e., reports etc. Most of these reports were requested to detect stop loss claims. See issue below.

## **Highlights of Control System**

**Audits** Aetna has several different regulatory audits that are performed throughout the year. In addition, Aetna has a Quality Review (QR) audit function. The QR unit audits a varying percentage of claims. The audit of claims over \$1,500.00 involves a complete review of the claim, while lesser claims are not reviewed as extensively.

**Coordination of Benefits** Claims forms prepared by the providers and enrollment forms prepared by the member include sections for coordination of benefits information. Through discussions with Aetna personnel there are not additional attempts to gather this information from the members.

**Subrogation** Per discussions with claims processing personnel at Aetna and the audit coordination manager, the system is not programmed to 'pend' potential subrogation based on procedure.

**Membership Satisfaction** Aetna does conduct a membership satisfaction survey and those results are analyzed statewide and by Primary Care Provider.

**Stop Loss** The County has not purchased the stop loss reporting option for the Aetna HMO. See Stop Loss below under Issues for more detailed discussion.

**Contractual Performance Standards** Per review of the contract and our testing, Aetna is in compliance with performance standards.

## **Issues**

### **Claim Payment**

In our review of claims processing, we identified one claim that was processed in error. A claim was paid even though it was submitted more than 90 days after the date of service. Providers are contractually obligated to submit claims within 90 days of service in order to receive reimbursement. The claim was included in a 'batch' and automatically adjudicated in error.

### **Stop Loss**

Through inquiry and review of the large claims, we noted that a large case with multiple claims might not be detected in a timely manner for submission to the insurance company.

Additionally, during a meeting with Aetna they expressed concern about being able to comply with the 90-day filing requirement, which is required by the stop loss insurance.

Aetna offers a separate package for identification and tracking of claims for stop loss purposes. The County has not purchased this package but has an internal individual assigned to monitor large claims on a monthly basis. We recommend the County review the cost benefit of purchasing this separate package.

# Claim Audit Results

# EMI / BPN

<i>On-site Fieldwork</i>	April 4, 2001 / April 25, 2001
<i>Contact</i>	Linda Champion – Manager Pat Levinson – Director of Operations
<i>Random Sample</i>	57
<i>Large Claims</i>	7
<i>Cost Per Member Per Month</i>	PPO – \$240.28 EPO – \$190.49
<i>Average Number of Members for CY 2000</i>	PPO – 1,312 EPO – 1,156
<i>Claim Audit Summary Results</i>	Attachment C

## Overview

**Scope of Services** Employers Mutual, Inc. (EMI) and Brevard Partnership Network (BPN), a not-for-profit corporation, are independent entities that perform separate services related to the claims process. Both have contracts with the County and have no contractual relationship with each other.

BPN, located in Brevard County, provides the medical provider network and case management. Its services are provided only in Brevard County. Authorizations for specified services are provided by BPN and entered directly into EMI's claims processing system. BPN also provides case management review.

EMI, located in Jacksonville, Florida, processes and pays claims, maintains membership eligibility and provides customer service submitted through the BPN network. They provide no ancillary services as part of their contract.

**Claims Reimbursement** The majority of the non-hospital contracts we reviewed are paid out at 110% of the Medicare rate with some 'carve out' provisions for higher cost items. The Hospital contracts are directly with the County. The payment terms vary by participating hospital with specific carve out provisions, DRG rates, and standard 40 to 45 percent discounts for specific procedures.

## **Overview - continued**

- Claims Processing** EMI requests wire transfers throughout the month and sends a summary report at month end. A separate ZBA is utilized for EMI's claims payments.
- Out-of-Area Providers** EMI/BPN utilizes Beech Street Network to negotiate with out-of-area providers. The result is approximately 20% savings from billed rates.
- Case Management** BPN has two nurses and a doctor on staff that performs the case management and utilization review for the EPO and PPO. They routinely visit the local hospitals to review the member's medical records and charts and to discuss the status of claims with hospital staff. Provider clinical notes must be included in the requests for certain authorizations, which we noted during our review. BPN utilizes a standard checklist for their approval process and we noted this in our review as well. The organization and manner of this group of nurses was extremely professional.

## **Comparison with other TPAs**

- Overall Operations** The use of two independent entities to perform different functions within claims processing makes it difficult to compare with the other TPAs. BPN's authorization process is similar to others with authorizations entered directly into EMI's claims system. However, because of the separateness and physical distance between the two entities, there appears to be some disconnect. For example, during our testing we noted more than one instance of EMI processing claims outside the authorization parameters set by BPN with no communication on EMI's part. See additional issues below.

## **Comparison with other TPAs – continued**

**Claims Cost** The PMPM cost of the PPO is noticeably higher than the others. This is primarily due to the population of the PPO, which tends to be older and require more services. The EPO was designed to be the ‘catch-all’ plan. This plan includes all of the local hospitals and can provide services to members from one end of the County to the other. Many of the contracts are negotiated directly with the County.

**Administrative Cost** The administrative cost per the contract is \$13.50 PEPM (EMI \$9.25 PEPM and BPN \$4.25 PEPM). Per our calculation using total incurred cost for calendar year 2000 the actual amount is \$7.18 PMPM for the plans. The administrative costs were not broken out for each plan. These fees are lower than Aetna (\$15.69 PMPM) and Health First (\$18.92 PMPM).

### **Highlights of Control System**

**Audits** While EMI does have an internal audit department, we found serious deficiencies in the claims processing operations of EMI, as noted in the accompanying compliance summary spreadsheets. These raise concerns about the adequacy of controls as further identified in the issues below.

**Coordination of Benefits** EMI does not conduct a mailing or other service to identify coordination of benefits.

**Subrogation** EMI does not utilize the system to identify potential subrogation.

**Membership Satisfaction** They have a site representative in the Brevard County Human Resource department for customer service relations for both the County and the School Board.

**Stop Loss** BPN and EMI identify candidates for stop/loss when it reaches 50% of the deductible. They begin to gather data at that time and contact the County and the insurance company.

## **Highlights of Control System, continued**

### **Contractual Performance Standards**

The contract guarantees average claim turnaround time not to exceed 12 days. Based on our sample the average turnaround time is 14.8 days. These performance standards have penalties associated with them. We recommend the County review these guarantees with EMI and their insurance consultant and pursue any possible remedies.

EMI guarantees the average annual payment incident accuracy will be greater than 96%. Based on our sample we calculated an average incident accuracy of 76%. We recommend the County review these guarantees with EMI and their insurance consultant and pursue any possible remedies.

The payment dollar accuracy guarantee is 98% or higher. As of the date of this report we cannot yet calculate the payment dollar accuracy.

## **Issues**

### **Coordination of Benefits with Medicare**

Medicare is the primary carrier for retirees with the County being second. This is an example of coordination of benefits. In these cases the Medicare rate for the specific procedure should be used as the baseline for reimbursement. The EMI claims processing system is not designed to directly account for these reimbursements. Therefore, operators are required to perform a manual calculation in order to determine the appropriate reimbursement amount.

In two cases, we found the reimbursement amount was based on the amount billed by the provider rather than on the base Medicare reimbursement rate. In these cases the provider was paid more than they were contractually entitled by \$3.04 and \$6.65. EMI's claim processing software should be modified to directly reflect when Medicare is the primary carrier and make appropriate adjustments. Short of this, procedures should be clearly written and provided to all operators on how to process Medicare related claims.

## **Issues -continued**

### **Authorization Procedures not Followed**

BPN is responsible for authorizing medical procedures, as appropriate, and directly entering the authorization into EMI's claim processing system. BPN has viewing rights to EMI's claims on-line. BPN can only enter data on one screen, which is the member authorization screen. Each BPN operator is assigned a unique operator ID and that ID appears next to any authorization code.

We found examples of claims that were paid without proper authorization and claims in which the authorization was modified by EMI in order to process the claim without approval.

- ❑ A claim authorization was entered for a PXA procedure. The actual claim was submitted as an OSA authorization. BPN indicated this type of discrepancy is not uncommon. However, EMI overrode the authorization to allow this claim to process as an OSA claim without first notifying BPN for permission to change the authorization. Any changes to authorizations should be noted in the comments section including identification of the BPN employee authorizing such a change.
- ❑ A claim that required authorization was paid in May 2000 utilizing an authorization entered by EMI. The procedure had not been authorized by BPN. A year later, in May 2001, an authorization was entered onto the comments screen using a BPN operator code. From our review BPN does not have the ability to make this change. In our discussions with BPN and EMI no one could account for the authorization, which was entered more than a year later using an inappropriate user code for that screen.
- ❑ A claim for hospitalization was filed with an authorization for a two-day stay. The member actually stayed in the hospital for four days without additional authorization. EMI paid the total claim resulting in a \$1,225.00 overpayment for the two additional days.

## **Issues -continued**

### **Authorization Procedures not Followed - continued**

- A large dollar claim authorized a 50-day hospital stay. The member stayed an additional day beyond those authorized by BPN. EMI processed the claim and incorrectly paid the hospital for that additional day.

EMI is strictly the claims processor and should not be overriding authorizations. The 'expertise' related to authorization comes from BPN. The system should be modified to allow only BPN operators to approve claims. In all cases such changes should be completely documented in the comments section including the name of the individual at BPN that the issue was discussed with. All such changes should be tracked and reviewed regularly to determine the reasons for non-compliance.

### **Medicare Rates not Timely Updated**

Medicare rate reimbursement tables are periodically published by HCFA. These tables are often used to determine the appropriate reimbursement to providers based on a percentage of the Medicare rate. During our review we found that the Clinical Diagnostic Laboratory Fee Schedule was not loaded in the EMI database for 2000 until late February 2000. As a result, claims processed prior to that date were processed at the Usual & Customary rate rather than based on the Medicare rate per the contract. EMI confirmed that no follow-up was done on claims processed prior to the table being corrected to determine if claims had been over or underpaid. Contractually, EMI has 90 days to correct processed claims.

### **Subrogation for Accident Claims**

Certain procedure codes are typically used for medical events related to accidents, etc. In addition claim forms provide a box to check for an accident. Since accidents may involve other parties, attempts should be made to find out details of the incident to determine if possible subrogation exists. In most cases this involves sending a letter to the member requesting additional information regarding the claim. After reviewing the facts, reimbursement from other carriers may be pursued. During our review EMI stated they have a policy of not investigating any accident claims less than \$1,000.00 for subrogation. This policy is internal to EMI and has not been discussed, reviewed, or approved by the County. Further investigation is necessary to determine the potential financial loss of not investigating claims of this type.

## **Issues -continued**

### **Membership**

We identified two cases where members were assigned to incorrect plans. For one member the enrollment form indicated they had selected EPO and claims were paid per PPO terms. For the other member the enrollment form indicated they had selected PPO and claims were paid per EPO terms. All enrollment changes should be electronically submitted and there should be an annual review process to validate membership information maintained by EMI.

### **Split Contract**

The use of two separate and independent agencies, which perform different functions of an essentially single process led to coordination and control issues, which we did not find with the other plans. Additionally, when discussing the individual cases with the nurses at BPN we noted that they never see the detailed claims. We believe a dollar threshold should be established in which BPN is to receive and review detailed claims.

# Claim Audit Results

# Walgreens

<i>On-site Fieldwork</i>	June 7, 2001
<i>Contact</i>	Shawna Turner – Account Manager
<i>Random Sample</i>	60
<i>Large Claims</i>	N/A
<i>Cost Per Member Per Month</i>	\$33.00
<i>Average Number of Members for CY 2000</i>	All members in the Health Plan
<i>Claim Audit Summary Results</i>	Attachment D

## Overview

**Scope of Services** Walgreens Health Initiative (WHI) is a subsidiary of Walgreens Company. WHI has offices in Orlando that service the District contract, while actual claims processing is performed in Illinois.

WHI provides the prescription drug card portion of the Plan. The prescription coverage service is highly automated with no manual entry except at the local pharmacy. The County meets with Walgreen representatives on a regular basis. The data provided is broken out in detail and analyses compared to benchmark data provided by WHI from its different plans. The WHI team of representatives has made significant recommendations related to plan design changes to the County to decrease costs.

**Claims Reimbursement** WHI reimburses participating pharmacists using the Average Wholesale Price (“AWP”). First Data Bank updates the AWP electronically on a weekly basis. This is the standard pricing source used in the industry.

**Claims Processing** All claims for the prescription drug plan are electronically processed. The pharmacist enters the necessary prescription data at the time the prescription is filled. Authorization is received prior to completing the transaction. Payment to the pharmacy is automatically calculated based on the contract terms.

**Out-of-Area Providers** WHI does not cover costs for non-participating pharmacists.

**Case Management** Not applicable for the pharmacy plan.

## **Highlights of Control System**

<b>Audits</b>	The parent company has an internal audit department that has conducted several independent internal audits of WHI. Additionally, WHI has contracted with an outside consulting firm to visit different pharmacies to perform audit procedures. This firm reviews the data generated and certain trends, which could identify fraud.
<b>Coordination of Benefits</b>	Not applicable for the prescription drug plan.
<b>Subrogation</b>	Not applicable for the prescription drug plan.
<b>Membership Satisfaction</b>	WHI does not conduct a membership satisfaction survey specific for the County, however they do publish overall results for their entire membership.
<b>Stop Loss</b>	There are no stop loss provisions in the contract between WHI and the plan.

## **Issues**

<b>N/A</b>	No significant issues were noted.
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<b><i>Issue #1</i></b>	<b>Action Related to TPA Testing</b>
	<p>As noted in the attachments and the detailed issues documented for each TPA, there were several instances of noncompliance found during out audit.</p> <p>Our review of the PPO and EPO plans found deficiencies in the claims processing at EMI. The number and severity of errors found raises serious concerns regarding the financial impact on the County. It should be noted that we found BPN's operations and procedures to be adequate for the areas they are responsible, including authorizations and case management.</p> <p>We found the performance of Health First and Walgreen to be within contractual performance guarantees.</p> <p>Aetna testing has not been completed for the large claims, however based on the audit results of the random selection; Aetna is performing in accordance with the contract.</p>
	<b><i>Impact</i></b>
	<p>Inadequate controls and claims processing errors would increase County cost.</p>
	<b><i>Recommended Action</i></b>
	<p>In light of the errors found and the issues raised, we recommend the following:</p> <ul style="list-style-type: none"> <li>❑ An expanded audit of the PPO and EPO plans be completed by the first quarter of calendar year 2002. These additional procedures should be paid for by EMI.</li> <li>❑ The County and the School Board should request a formal action plan from EMI.</li> <li>❑ The expanded audit should be used to assist the County in determining whether this contractual relationship continues for 2003.</li> <li>❑ In addition, the County should evaluate the errors noted and determine if any remedy is warranted through the performance guarantees. These guarantees are outlined in the EMI claim audit results.</li> </ul>

<b><i>Issue #2</i></b>	<b>Co-Payments</b>
	<p>A review of claims processed found instances of incorrect collection of co-pays. In some instances, the providers would collect a co-pay when not required and fail to collect when allowed.</p> <p>If the provider collects a co-payment from the member in error, the provider would ultimately be overpaid for services. The member would have to contact the provider directly in order to receive reimbursement.</p>
	<b><i>Impact</i></b>
	<p>There is no direct loss to the plan, however it should be viewed as an employee relation issue. The employee should be notified that they have overpaid.</p>
	<b><i>Recommended Action</i></b>
	<p>The County should have the TPAs identify those providers abusing the co-pay system. These providers should be contacted related to this issue. In any event additional training for employees and providers related to co-pays could improve the process.</p>

<b><i>Issue #3</i></b>	<b>Enrollment</b>
	Brevard County Plan enrollment is currently a manual process. Employees fill out paper forms when hired and for any subsequent changes. These forms are then copied and sent to the TPA's for entry into their plan database.
	<b><i>Impact</i></b>
	The use of paper-based forms can delay update of the TPA database. Since the updates are keyed separately into the County's Human Resource database and the TPA database, there exists the opportunity for differences due to keying errors. Reconciliation of the multiple databases is more time consuming and critical since the member data is not electronically shared.
	<b><i>Recommended Action</i></b>
	<p>The County should implement electronic transmission of plan changes to the TPA's. As part of this implementation process, a complete reconciliation of membership data between the County records and the TPA records should be completed.</p> <p>Additional steps should be taken to automate the entire enrollment process allowing employees to directly make changes to their enrollment information.</p>