



*Cobb County...Expect the Best!*

***INTERNAL AUDIT DEPARTMENT***

***Report Number 2013-015***

***FINAL REPORT – Audit of Third Party  
Administrators for Health Benefit and  
Workers’ Compensation Plans***

*(performed by The Segal Company with the assistance of Internal Audit)*

***November 21, 2013***

***Latona Thomas, CPA, Director  
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# COBB COUNTY INTERNAL AUDIT

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Director

November 21, 2013

## MEMORANDUM

**TO:** David Hankerson, County Manager

**FROM:** Latona Thomas, CPA, Director

**SUBJECT:** **FINAL REPORT** – Audit of Third Party Administrators for Health Benefit and Workers' Compensation Plans

Attached is the subject final audit report. The overall objective was to determine if the Third Party Administrators (TPA) of Cobb County's (the County) Employee Benefit Plan<sup>1</sup> were administering the plan designs as intended or mandated by Georgia State Law, in compliance with contract terms and conditions, and County funds were expended properly and in a timely manner.

### *Impact on the Governance of Cobb County*

The County funded approximately \$57.7<sup>2</sup> million in medical, dental, prescription drug, and workers' compensation expenses during fiscal year 2012. The findings and recommendations in this report will strengthen the TPAs' controls over adjudicating claims, as well as Human Resources (HR) controls over monitoring the TPA contractual relationships and overall benefit program. Taxpayers can be assured that payments for self-insured benefits are paid in accordance to the benefit plans and expenses are paid in a timely manner.

### *Executive Summary*

At the recommendation of the Citizens Oversight Committee, we co-sourced an audit of the TPA vendors. The review validated that the TPAs were generally administering the plans as intended, meeting performance standards, and adjudicating claims correctly. However, discrepancy and interpretation issues were noted between benefit plan booklets and TPA adjudication systems. In addition, weaknesses in the management of the TPA contractual agreements did not detect inaccuracies in plan documents, and performance guarantees were not monitored.

<sup>1</sup> Self-insured plan which includes medical, dental, prescription drug benefits and workers' compensation.

<sup>2</sup> Source: County's Advantage Financial System

## *Recommendations*

The Segal Company made recommendations which are summarized in the 'Results of Review' section and are detailed in the respective TPA reports. See Appendices VI through IX, beginning on page 19. Internal Audit (IA) made additional recommendations for HR to meet with TPAs annually to discuss changes, clarifications, and interpretation of each plan; ensure benefit booklets are updated in a timely manner and in accordance with the outcomes from the annual meeting; develop and implement a process to monitor financial and performance guarantees; and establish a written record retention policy.

## *Responding to This Report*

The Human Resources Director provided a response to our draft report and concurred with Internal Audit's six recommendations, as well as the recommendations made by the Segal Company. Corrective actions for all recommendations will be implemented by January 2014. The complete response to the draft report is included in Appendix X.

We will perform a follow-up in six months on the implementation of corrective actions. In addition, the County Manager has requested that the Director provide periodic updates on the status of each correction action directly to his office. Please contact me at (770) 528-2559 if you have questions or Steven Harper, Auditor-in-Charge, at (770) 528-2557.

## *Background*

Cobb County Government's self-insured health benefit program has been in existence since October 1, 1985. Covered under this plan are medical, dental, prescription drug benefits, and workers' compensation. The program is funded on the County's fiscal year from October through September; however, deductibles, out-of-pocket maximums, and participant plan elections operate on a calendar year. Coverage is provided for all full-time workers, eligible retirees, COBRA<sup>3</sup> participants and their eligible dependents.

In its February 28, 2012 final report, the Citizens Oversight Committee recommended a periodic review of medical and workers' compensation claims that are processed by Third Party Pay contractors. The HR department is responsible for setting budgets and monitoring the overall benefit program; however, a comprehensive analysis was needed to ensure the County's TPAs are accurately and efficiently performing relative to the adjudication of plan benefits.

Based on the recommendation of an evaluation committee, the Board of Commissioners approved a contract with The Segal Company (Segal) for auditing consultant services. The services were performed using a co-sourced method with Internal Audit staff. Segal is an employee-owned actuarial and consulting firm which has provided benefit, compensation, and human resources consulting services since 1939. In addition, Segal partnered with Managed Care Advisors (MCA) for the audit of the workers' compensation program.

### **Third Party Administrator Arrangement**

The County has contracted with four vendors under TPA service agreements to administer our self-insured benefit programs. These vendors adjudicate and pay the claims as they occur. There are administrative service only (ASO) fees for providing these adjudication services. A review of ASO fees was covered in a previous audit, *Review of Controls Over the Processing of Benefit Payments and Invoices in the Human Resources Department*.<sup>4</sup> Below is a brief synopsis of each TPA arrangement:

#### ***Health Benefit Plan***

The County contracted with Blue Cross Blue Shield of Georgia (BCBS) under an Administrative Services Agreement (ASA) to administer the County's Benefit Plan. The contract is for the time period January 1, 2009 through December 31, 2011, with an option for two consecutive one year renewals, with an expiration date of December 31, 2013. The ASA provides for an audit including a sample size of no more than 250 claims and/or on-site hours of 40 or less.

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<sup>3</sup> 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. Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan.

<sup>4</sup> Report number 2013-001, dated April 26, 2013.

### ***Dental Benefit Plan***

The County contracted with Connecticut General Life Insurance Company (Cigna) under an ASA to administer the County's Dental Benefit Plan. The contract is for the time period January 1, 2009 through December 31, 2011, with an option for two consecutive one year renewals, with an expiration date of December 31, 2013. The ASA provides for an audit including a random, statistically valid sample size of no more than 225 claims.

### ***Prescription Drug Benefit Program***

The County contracted with Express Scripts (formerly Medco Health Solutions, Inc.) under an Integrated Prescription Drug Program Agreement to administer a prescription drug benefit program. The contract is for the time period January 1, 2009 through December 31, 2011, with an option for two consecutive one year renewals, with an expiration date of December 31, 2013. The agreement provides for an audit once annually from January through September on an agreed upon date.

### ***Workers' Compensation***

The County contracted with AmTrust North America Inc. (AmTrust) under a Claims Administration Agreement to provide claims handling and adjustment services for its Workers' Compensation Program. The current contract is for the time period October 1, 2011 through September 30, 2014. The agreement provides for periodic audits and reserve reviews of claims.

### **Other Arrangements**

In addition to the vendors listed above, the County contracted Kaiser Permanente (Kaiser) and Cigna to provide additional medical and prescription drug plans. Kaiser currently provides a fully-insured plan available to employees and retirees. Supplemental Medicare plans previously offered by both Kaiser and Cigna were discontinued effective January 1, 2013 and replaced with the new ExtendHealth plan. Under fully-insured plans, only monthly premiums are paid. There are no ASO fees or claims payments. As such, the fully-insured plan and ExtendHealth plan were not included in this audit.

The following is a historical chart of all medical (includes prescription drugs), dental and workers' compensation expenses.

| <b>5-Year History of Benefit Expenses</b> |                      |                     |                     |                     |                     |
|---|----------------------|---------------------|---------------------|---------------------|---------------------|
|   | <b>FY2012</b>        | <b>FY2011</b>       | <b>FY2010</b>       | <b>FY2009</b>       | <b>FY2008</b>       |
| <b>Medical</b>                            | \$ 53,196,401        | \$55,512,737        | \$51,024,099        | \$47,184,536        | \$42,668,366        |
| <b>Dental</b>                             | \$ 2,853,347         | \$ 3,649,466        | \$ 3,251,514        | \$ 2,534,019        | \$ 2,133,385        |
| <b>Workers' Comp</b>                      | \$ 1,624,804         | \$ 1,832,618        | \$ 2,130,870        | \$ 2,015,107        | \$ 2,755,083        |
| <b>Total</b>                              | <u>\$ 57,674,552</u> | <u>\$60,994,822</u> | <u>\$56,406,483</u> | <u>\$51,733,662</u> | <u>\$47,556,833</u> |

Source: County's Advantage Financial System. [Note: Includes fully insured and self insured plans and all associated ASO fees.]

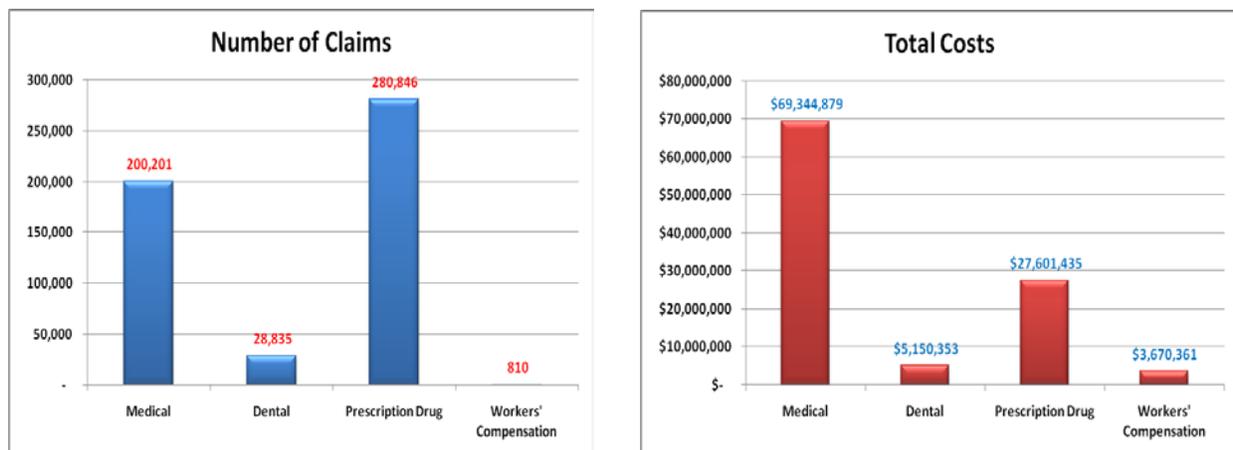
## Results of Review

Our objective was to evaluate the overall plan administration, confirm compliance with contract terms and conditions, and validate that County funds were being expended properly and in a timely manner. The audit was limited to the self-insured plans only and generally found the TPAs were adhering to the following:

- Plans were being administered as designed.
- Performance standards were being met or exceeded.
- Claims were being adjudicated correctly and in a timely manner.
- Copayments and coinsurance amounts were being applied correctly.
- Coordination of benefits (COB) was being performed as intended.

Segal did find that additional changes are needed to ensure discrepancy and interpretation issues between benefit plan booklets and TPA adjudication systems are resolved. In addition, Internal Audit found that controls over the monitoring of the TPA contractual agreements need to be improved. The following charts are the population of number of claims and the associated total costs provided by the TPAs for Segal's review.

### CY2011-2012 (combined) Claims Review Population Charts



Source: Reports of Segal's review of CY2011-2012 medical, dental, and prescription drug claims and CY2010-2011 workers' compensation claims. Workers' compensation costs are based on the average total cost per claim.

A summary of Segal's findings and recommendations for the individual TPAs are outlined in the charts on the accompanying pages, followed by Internal Audit's recommendations for the HR Department.

## *SUMMARY OF INDIVIDUAL TPA AUDIT RESULTS*

### **Medical**

BCBS administers the medical benefits for the County. Segal evaluated claims and payment procedures from calendar years 2011 and 2012 and found that BCBS is generally adjudicating medical claims in accordance to the plan designs. Segal also found BCBS exceeded performance and industry standards in each area of their performance measures.<sup>5</sup> Below is a chart of findings and recommendations from the individual claims review. See Appendix VI for Segal's complete report.

| Findings  | Recommendation  | TPA Response   | HR Comment   | Additional Action Required  |                                 |
|---|---|--|--|---|---------------------------------|
| <b>Plan Benefit Discrepancies</b>                 |   |  |  |   |                                 |
| 1   | Discrepancies were noted between the benefit booklets and BCBS's adjudication system. | BCBS needs to generate impact reports for identified plan building errors to assist the County in determining the total financial impact to the Plan.                                      | The HMO out-of-pocket amount was incorrect and an impact report has been requested. The PPO deductible was applied correctly; however the benefit booklet was changed in error.          | HR concurs with the TPA regarding the discrepancies.  | See IA recommendations 1 and 2. |
| <b>Plan Benefit Interpretation</b>                |   |  |  |   |                                 |
| 2   | There were some parts of the plan that are subject to interpretation.                 | The County and BCBS should review Plan intent for benefit interpretation issues specifically related to physician office services and medical supplies benefits.                           | Copayments are only applied when an office visit is billed. BCBS will discuss the medical supply concern with the County and take appropriate actions.                                   | HR agrees copayments should only be applied when an office visit is billed and supplies should reimburse at 100% after copayment. | N/A                             |
| <b>Referral and Precertification Requirements</b> |   |  |  |   |                                 |
| 3   | Precertification was not obtained prior to service.                                   | BCBS and the County should discuss current processing procedures administered by BCBS related to precertification requirements for specific testing procedures identified under the Plans. | Precertification procedures have been updated although the Benefit Booklet still reflects prior requirements. BCBS monitors HMO referrals through a network provider gatekeeper program. | HR agrees to discuss changes to standard practices with BCBS.   | See IA recommendation 6.        |
| <b>Other</b>                                      |   |  |  |   |                                 |
| 4   | Overpayments totaling \$3,086 need recovery.  | Refund recovery for the identified overpayments should be initiated based on the County's direction.   | BCBS agrees with the errors with the exception of one coordination of benefits (COB) totaling \$1,716.   | HR will pursue recovery of the undisputed funds.  | See IA recommendation 6.        |
| 5   | N/A   | BCBS should advise Cobb County of any modification to system programming or changes in adjudication procedures resulting from this review.   | N/A  | HR will discuss with the Account Representative.  | See IA recommendation 6.        |

<sup>5</sup> Performance measures include financial accuracy, claims processing accuracy, payment accuracy, and processing timeliness.

## Dental

Cigna administers the dental plan for the County. Claims and payment procedures for calendar years 2011 and 2012 were analyzed and evaluated. Segal found that Cigna is generally adjudicating claims accurately, in accordance to the plan design, and exceeded performance and industry standards in each area of their performance measures.<sup>6</sup> Fluoride application errors initially impacted Cigna's performance measures negatively, but subsequent research and discussions with HR resolved the issue. Below is a chart of findings and recommendations from the individual claims review. See Appendix VII for Segal's complete report.

| Findings                          | Recommendation   | TPA Response   | HR Comment   | Additional Action Required  |                                 |
|-----------------------------------|--|--|--|---|---------------------------------|
| <b>Plan Benefit Discrepancies</b> |  |  |  |   |                                 |
| 1                                 | Discrepancies were noted between the benefit booklet and Cigna's adjudication system.                                | The benefit booklet should be updated to show the correct number of fluoride treatments allowed.   | Treatments are in accordance to the provision established when the account was implemented. The benefit booklet was produced with inaccurate information.                                | HR agrees the information in the booklet was changed without County approval.               | See IA recommendations 1 and 2. |
| <b>Benefit Eligibility</b>        |  |  |  |   |                                 |
| 2                                 | Claims were paid for services rendered, after eligibility was terminated, due to retroactive notice of terminations. | Review each eligibility file for possible overpayments, provide the County with a listing of overpayments, and upon their direction begin collection procedures. | Cigna disagrees with the financial errors assessed for claims paid past eligibility termination. However, agrees that the retroactive eligibility notification resulted in overpayments. | HR will pursue the overpayments.  | See IA recommendation 6.        |
| <b>Other</b>                      |  |  |  |   |                                 |
| 3                                 | Overpayments totaling \$495 need recovery.   | Cigna should initiate refund recovery for the identified overpayments based on County direction.   | Recovery efforts for three of the claims were initiated on 4/30/13. Additional research on \$25 for COB issue is pending.  | HR will confirm recovery of the three overpayments.   | See IA recommendation 6.        |
| 4                                 | N/A  | Cigna should advise Cobb County of any modification to system programming or changes in adjudication procedures resulting from this review.                      | Cigna is committed to taking the necessary actions to correct the errors identified as a result of the audit and looks forward to reviewing the results of the audit with Cobb County.   | Contract with Cigna for Dental TPA expires 12/31/13. Issues will be addressed with new TPA. | See IA recommendation 6.        |

<sup>6</sup> Performance measures include financial accuracy, claims processing accuracy, payment accuracy, and processing timeliness.

## Prescription Drug

Express Scripts administers the prescription drug program for the County. Segal analyzed claims records electronically for calendar years 2011 and 2012. Segal found that Express Scripts is adjudicating claims according to the plan, and no system issues were found. Express Scripts underperformed in non-specialty contractual discount and dispensing fee guarantees in both 2011 and 2012, resulting in a combined shortfall total of \$281,878, but exceeded the minimum rebate guarantees by \$663,550 in both years combined. The current pharmacy benefits contract allows Express Scripts to offset surpluses in one area to make up for a shortfall in another. As such, no further action was deemed necessary. Below is a chart of findings and recommendations from the individual claims review. See Appendix VIII for Segal's complete report.

| Findings                                   | Recommendation                                  | TPA Response  | HR Comment | Additional Action Required                                |                          |
|--|---|---|------------|---|--------------------------|
| <b>Proposed Contract Negotiation Terms</b> |   |   |            |   |                          |
| 1  | Shortfalls were offset by surpluses.            | Eliminate contract clause that allows surpluses in one component to offset a shortfall in another.                | N/A        | HR will discuss with Cigna in contract review for 1/1/14. | See IA recommendation 6. |
| 2  | Generic drugs received the brand drug discount. | Eliminate the practice of categorizing generic drugs with less than three manufacturers under the brand discount. | N/A        | HR will discuss with Cigna in contract review for 1/1/14. | See IA recommendation 6. |

## Workers' Compensation

AmTrust administers the workers' compensation program for the County. Segal/MCA reviewed claims and operational procedures for calendar years 2010 and 2011 and found that AmTrust is processing claims in accordance with the County's contract and State statutes that govern the workers' compensation program. AmTrust has the proper organizational structure, workflows, and policies and procedures in place to support the County's workers' compensation program. Below is a chart of findings and recommendations from individual claims and operational review. See Appendix IX for Segal's complete report.

| Findings                                  | Recommendation  | TPA Response   | HR Comment  | Additional Action Required                 |                          |
|---|---|--|---|--|--------------------------|
| <b>Program/Operational Interpretation</b> |   |  |   |  |                          |
| 1   | Three point contact was not consistently made.              | All claims, excluding report only (RO), should receive the three point contact within 24 hours of report of the claim.   | Three point contacts are not done on all medical only (MO) claims due to the nature of the claim. All lost time or questionable cases have a three point contact performed. | HR will discuss with consultant and TPA.   | See IA recommendation 6. |
| 2   | Case reviews were not evident or documented.                | Case review and contacts should be made and documented in ANA every 30 days throughout the life of the claim.  | All lost time claims are reviewed on an automatic diary every 30 days.  | HR will address with TPA at annual review. | See IA recommendation 6. |
| 3   | Physician review of claims cases was not utilized.          | AmTrust and the County may want to consider developing criteria for clinical case review to guide case management strategy in complex cases.   | Response was not provided.  | HR will address with TPA at annual review. | See IA recommendation 6. |
| <b>Other</b>                              |   |  |   |  |                          |
| 4   | Processes were not documented.                              | Work processes should be documented to support decision making and adherence to regulatory requirements.   | AmTrust has an online claim manual and agreed, upon request of the County, to provide handling instructions.  | HR will request access to online manual.   | See IA recommendation 6. |
| 5   | Invoices were not paid in a timely manner.                  | Internal monitoring of claims payment timeliness is needed to ensure compliance with State guidelines of payment within 30 days.   | AmTrust agreed the payments were made late, but no penalties were assessed. Also, the workload on the individual responsible for approving payments was reduced.            | HR will address with TPA at annual review. | See IA recommendation 6. |
| 6   | Bill line charges were not in compliance with the contract. | A three line minimum for bill payment was included in the County's previous contract with AmTrust but not in the current one. A contract modification or clarification with AmTrust on the current contract may be required. | Response was not provided.  | HR will address with TPA at annual review. | See IA recommendation 6. |
| 7   | Lost time calculations were not documented in the system.   | The current number of lost or modified time days, primary diagnosis and estimated duration of disability for claims should be included in ANA to enable adjusters to monitor and progress cases forward.                     | Response was not provided.  | HR will address with TPA at annual review. | See IA recommendation 6. |

As stated previously, Segal performed this audit in conjunction with the County's Internal Audit staff. During the audit process, Internal Audit noted several weaknesses in HR's management of TPA relationships and contract provisions. Our recommendations are reflected in the accompanying pages.

## *Internal Vendor Management Oversight Needs Improvement*

### **Contract Management**

Every department in the County is responsible for establishing effective contract management practices, including maintaining a copy of the contract, designating staff responsible for overseeing contract compliance, and maintaining a contract-tracking database. Oversight of the contract and compliance to the terms and conditions contained within is critical to ensuring the obligations of both parties are adhered to and performance measures are met. A recommendation to develop and implement contract management procedures was addressed to HR in audit report number 2013-001.<sup>7</sup> The implementation of that recommendation will resolve the general issues noted during this audit. Recommendations specific to benefits management are outlined below.

### **Benefit Booklets**

The County is provided benefit booklets for each of its medical and dental benefit plans. The booklets describe the benefit plans and include a schedule of covered services and outline of patient financial responsibilities (copayments, coinsurance, etc). These documents serve as an annual guide of covered services and are posted on the County's intranet for employee reference. In addition to the original TPA contracts, the audit team used the booklets as the guide for reviewing claims samples.

BCBS administers three medical plans for the County which include: 1) Health Maintenance Organization (HMO), 2) Preferred Provider Option (PPO), and 3) Health Reimbursement Account (HRA). The benefit booklet for each plan was updated and published annually, but not in a timely manner. The audit sampled claims from calendar years 2011 and 2012 across all three plans. For both the 2011 HMO and PPO plans, BCBS was applying the incorrect family out-of-pocket maximum. In both instances, the benefit booklets were inconsistent with BCBS' system and adjudication process. The HMO plan was adjudicated using an incorrect out-of-pocket family maximum. The PPO plan was adjudicated by applying the annual deductible to the out-of-pocket maximum, instead of in addition to deductibles and copayments, as stated in the benefit booklet. Research and discussions between HR and BCBS revealed the booklets had been erroneously changed and distributed without agreement to the County's documentation or BCBS' system. With the HMO plan, the discrepancy resulted in additional costs to family out-of-pocket cost; however, the total financial impact was not available as of the date of this audit.

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<sup>7</sup> Review of Controls Over the Processing of Benefit Payments and Invoices in the Human Resources Department, dated April 26, 2013.

A benefit booklet discrepancy was also noted during the audit of dental benefits. The booklet indicated the topical application of fluoride is limited to one per person per calendar year for individuals less than 19 years old, but Cigna is allowing two per calendar year. Per Cigna, and with acknowledgment from HR, the claims were adjudicated according to benefit provisions established during the account implementation process. The 2011 booklet had been erroneously prepared and distributed using Cigna's standard plan language. Both Cigna and HR acknowledged the booklet had been distributed without agreement to the County's documentation or Cigna's system. Cigna also acknowledged five additional discrepancies found during their research of this issue. Again, the total financial impact of the five additional discrepancies was not available as of the date of this audit.

HR did not have a process to verify that initial benefit provisions and subsequent changes were accurately reflected in the benefit booklets distributed. Nor was there a requirement of the TPAs to create new booklets each year and attest that their systems were administering claims in accordance to them. The TPA's systems must process claims in accordance to the plan designs to ensure the County and its employees are receiving and paying for benefits as intended. Also, the documentation needs to be current and accurate so employees can make informed decisions on their healthcare choices.

## ***Recommendations***

The Human Resources Director should:

**Recommendation 1:** Meet with its benefit consultant and TPAs prior to each plan year, discuss each respective plan in detail along with changes, resolve any clarification or interpretation issues, and document the outcome. Also require each TPA to periodically validate that claims are being processed in accordance with the plan as communicated and agreed.

**Auditee Response:** **Concur** - This will be an expectation for the selected benefit consultant to coordinate. We have already mentioned to several TPAs and they indicated they were in concurrence. The Human Resources Director will coordinate with the selected consultant to initiate these annual meetings with the initiation of consultant services agreement effective January 1, 2014.

**Recommendation 2:** Require TPAs to prepare and distribute benefit booklets in a timely manner, based on the outcome of agreed upon changes.

**Auditee Response:** **Concur** - This will be coordinated with the selected benefits consultant to coordinate with TPAs. Human Resources Manager will coordinate with benefits consultant annually.

## ***Guarantees and Performance Standards***

The contract with Express Scripts contains guarantees for pricing discounts and manufacturer rebates. Pricing discounts are a percentage off of average wholesale price (AWP), depending on the type of drug being dispensed (generic or brand) and the fulfillment channel used (retail or mail order). Rebates are based on the quantity of prescriptions dispensed of each manufacturer's drugs from the formulary list. Rebates are credited against claims billings 180 days after the end of the quarter in which they were earned.

Discounts and rebates are to be calculated, reconciled, and reported within 180 days after the end of each plan year. Shortfalls to the guarantees are to be paid on a dollar-for-dollar basis; however, the current contract stipulates shortfalls from one guarantee can be offset by a surplus of the other.

Segal independently calculated the discounts and rebate guarantee amounts for the audit period and compared the results to ones provided by Express Scripts. For both plan years there were shortfalls in the pricing discounts that were offset by surpluses in the rebates paid (see Segal report for detailed results). HR should consider negotiating the elimination of the offsets in future contracts.

Also, HR does not have a process to track guarantees and rebates. During our audit, we attempted to validate the quarterly rebate amounts due for calendar years 2011 and 2012. HR was able to provide documentation to support quarterly rebate amounts for 2011 and fourth quarter 2012 only. After additional research, IA subsequently located a June 2013 payment for \$1,011,665.97 in the County's financial system. This payment represented the three missing quarters of 2012; however, this information was not readily available upon request.

In addition to the guarantees outlined above, there are other performance standards that carry a financial penalty against Express Scripts if they are not met. The measurements are for dispensing accuracy and timeliness, adjudication accuracy, customer satisfaction, etc. A Prescription Drug Plan reporting package is required to be made available online within 30 business days of the end of each quarter. Neither HR nor its benefit consultant had knowledge of the report or analyzed it for applicable standards.

Failure to monitor performance and financial guarantees in the contract allowed missing rebate payments to go unnoticed and other potential penalties to go unidentified. Although the rebates were paid, they were between three to nine months late which can negatively impact the County's interest earning potential.

## ***Recommendations***

The Human Resources Director should:

**Recommendation 3:** Determine when rebates are due to be credited and develop a process to monitor invoices for the credits and follow up with the TPA when they are not received as scheduled.

**Auditee Response:** **Concur** - This will be the responsibility of the selected benefits consultant to monitor rebates on behalf of the County. The Human Resources Director will coordinate with the selected consultant to initiate these annual meetings with the initiation of consultant services agreement effective January 1, 2014.

**Recommendation 4:** Develop and implement a process to monitor each TPA's attainment of performance guarantees. This should include steps for reviewing reconciliation packages and collecting penalties, when applicable.

**Auditee Response:** **Concur** - This will be the responsibility of the selected benefits consultant to monitor performance guarantees on behalf of the County. The Human Resources Director will coordinate with the selected consultant to initiate these annual meetings with the initiation of consultant services agreement effective January 1, 2014.

### ***Record Retention***

In all cases, HR did not maintain documentation of their communications with TPAs regarding changes to benefit plan options. IA was involved in the discussions between HR and both BCBS and Cigna regarding the benefit booklet discrepancies as described above. We noted that HR did not have documentation of their communications with the TPAs to support the County's concurrence to changes or acceptance to new booklets.

Documentation on benefit programs must be maintained to support the County's plans and decisions, and to mitigate confusion with the TPAs. Each department is responsible for ensuring it maintains appropriate records of its activities and that all employees are retaining necessary communications.

### ***Recommendation***

The Human Resources Director should:

**Recommendation 5:** Establish a written policy for the HR Department regarding record retention and orient all employees on it. The policy, at a minimum, must comply with all Georgia records laws and regulations.

**Auditee Response:** **Concur** - This will be accomplished by the Human Resources Manager responsible for Systems and Records Division by January 31, 2014.

### ***Post Audit Follow Up***

Throughout this report and the appendices, several issues remain outstanding and require additional research and discussion (i.e. overpayments, financial impacts, etc.). HR needs to review these issues and determine the final disposition, and if applicable, initiate refund or credit requests.

### ***Recommendation***

The Human Resources Director should:

**Recommendation 6:** Research and determine the final disposition of each outstanding issue. Initiate or follow up on the recovery of refunds, credits, and financial impacts, where applicable.

**Auditee Response:** **Concur** - The Human Resources Director will coordinate follow up through the Human Resources Managers to ensure all action items are addressed.

### *Detailed Objectives, Scope, and Methodology*

At the recommendation of the Citizens Oversight Committee, we co-sourced with the Segal Company to perform an audit of the County's TPA vendors. Segal's audit period covered claims from calendar years 2011 and 2012 for medical, dental, and prescription drugs, and 2010 and 2011 for workers' compensation.

The objective of the audits was to determine if the TPAs of the County's Employee Benefit Plans were administering the plan designs as intended or mandated by Georgia State Law, in compliance with contract terms and conditions, and that County funds were expended properly and in a timely manner.

In order to accomplish our objectives, we performed the following steps:

#### Medical

A data file of all medical claims processed during the audit period January 1, 2011 through December 31, 2012, representing \$69,344,879.21 in benefit payments on 200,201 claims, was provided by BCBS for Segal's sampling purposes. The claims review included the following components:

- I. An adjudication review to assess claim control measures;
- II. A stratified sample of 210 claims totaling \$4,748,866.59 in benefit payments to provide statistical validity with comparison to performance guarantees and industry standards;
- III. A targeted sample of claims to provide representation of selected individuals and potential duplicate payments; and
- IV. Sample claims in the adjudication system were reviewed for:
  - a. Eligibility;
  - b. COB;
  - c. Duplicate payments;
  - d. Copayments, deductibles, and out-of-pocket amounts;
  - e. Pre-certifications; and
  - f. Network discount fees and schedules.

#### Dental

A data file of all dental claims processed during the audit period January 1, 2011 through December 31, 2012, representing \$5,150,352.87 in benefit payments on 28,835 claims, was provided by Cigna for Segal's sampling purposes. The dollars reported reflect the benefit payment prior to reduction of other insurance reimbursement (e.g. coordination of benefits calculations).

**Dental, continued:**

Segal's claims review included the following components:

- I. An adjudication review to assess claim control measures;
- II. A stratified sample of 210 claims totaling \$59,217.01 in benefit payments to provide statistical validity with comparison to performance guarantees and industry standards;
- III. A targeted sample of 15 claims to provide representation of selected individuals and potential duplicate payments; and
- IV. Sample claims in the adjudication system were reviewed for:
  - a. Eligibility;
  - b. COB;
  - c. Duplicate payments;
  - d. Copayments, deductibles, and out-of-pocket amounts;
  - e. Pre-certifications; and
  - f. Network discount fees and schedules.

**Prescription Drug**

An electronic file detailing prescriptions issued for County employees and their dependents for the period January 1, 2011 through December 31, 2012, representing \$27,601,434.77 paid claims on 280,846 prescriptions dispensed was received from Express Scripts, Inc. The 100% pharmacy benefit claims review included the following components or focus areas:

- I. The actual performance in terms of discounts and dispensing fees achieved versus contractual guarantees;
- II. Administrative fees;
- III. Plan design adjudication;
- IV. Copayments and coinsurance amounts; and
- V. Formulary rebates.

**Workers' Compensation**

The initial case file population included 810 claims totaling \$3,670,361.10,<sup>8</sup> with dates of onset during 2010 or 2011, plus an additional 132 claims with dates of onset prior to 2010 but with medical costs incurred during 2010 or 2011. Segal/MCA selected a sample of 55 claims, and associated 337 bills, incurred by County employees.

- I. Sample claims files were reviewed from initial injury through closure for:
  - a. Required documents;
  - b. Eligibility;
  - c. Payment timeliness;
  - d. Duplicate payments; and
  - e. Subrogation, if applicable.

---

<sup>8</sup> Based on average total cost per claim (see Appendix IX).

**Workers' Compensation, continued:**

- II. Other focus areas included:
  - a. Administrative/operational procedures;
  - b. Medical bill payment;
  - c. Contract terms; and
  - d. Program performance.

Please see individual reports in the attached appendices (beginning on page 19) for additional detailed scopes and methodologies for each TPA.

*Abbreviations*

|       |   |
|-------|---|
| ASA   | Administrative Services Agreement       |
| ASO   | Administrative Service Only             |
| AWP   | Average Wholesale Price                 |
| BCBS  | Blue Cross Blue Shield                  |
| COB   | Coordination of Benefits                |
| COBRA | Consolidated Omnibus Reconciliation Act |
| HMO   | Health Maintenance Organization         |
| HR    | Human Resources                         |
| HRA   | Health Reimbursement Account            |
| IA    | Internal Audit                          |
| PPO   | Preferred Provider Option               |
| TPA   | Third Party Administrator               |

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Cobb County Audit Committee  
Internal Audit Department File

## *Outcome Measures*

This appendix presents detailed information on the measurable impact our recommended corrective actions will have on County governance. These benefits will be incorporated into our annual report to the Audit Committee, Board of Commissioners, and County Manager.

### **Type and Value of Outcome Measure:**

- Reliability of Information – Recommendations, when implemented, will provide assurance that plan documentation reflects the correct benefits (see Pages 8-11).

### **Methodology Used to Measure the Reported Benefit:**

We found discrepancies between the approved plan designs, benefit booklets, and vendor adjudication systems for both the medical and dental plans.

### **Type and Value of Outcome Measure:**

- Increased Revenue – Potential: \$3,581 in total overpayments made to BCBS and Cigna due to processing errors (see Pages 4–5).

### **Methodology Used to Measure the Reported Benefit:**

Fieldwork testing performed by Segal found claims that were not adjudicated in compliance to benefit plans resulting in overpayments of \$3,086 to BCBS and \$495 to Cigna.

### **Type and Value of Outcome Measure:**

- Increased Revenue – Potential: amendments to contract terms and conditions could result in additional savings to the County (see Page 7)
- Increased Revenue Protection – Potential: \$358,229<sup>9</sup> quarterly average of prescription drug rebates (see Pages 9-10).

### **Methodology Used to Measure the Reported Benefit:**

Based on fieldwork performed by Segal and MCA, some contractual terms allow offsets of savings against shortfalls or minimum billing charges. We traced the rebates earned to invoices from Express Scripts and found rebates from 1Q – 3Q of CY2012 had not been paid on time and had gone unnoticed by the County.

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<sup>9</sup> Average quarterly rebates from calendar years 2011 and 2012.

**COBB COUNTY**  
**BLUE CROSS BLUE SHIELD OF GEORGIA**  
**ANALYSIS OF CLAIMS PROCESSING AND**  
**PAYMENT PROCEDURES**

FOR THE PERIOD  
JANUARY 1, 2011  
THROUGH  
DECEMBER 31, 2012

**FINAL REPORT RELEASED**  
JULY 19, 2013

**SUBMITTED BY**  
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ADMINISTRATION AND TECHNOLOGY CONSULTING (ATC)

CONFIDENTIALITY STATEMENT

Release of electronic and hardcopy information for this analysis required execution of an agreement signed by The Segal Company and Blue Cross Blue Shield of Georgia on behalf of itself and its subsidiaries.

All audit information and findings prepared and presented in this report are considered confidential and proprietary. Sharing of contents with any other party or the copying of information herein is expressly prohibited without the written consent of the agreeing parties.

 SEGAL

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Final Report Released  
July 19, 2013**

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## Section I – Executive Summary

This report analyzes and evaluates the claims processing and payment procedures utilized by Blue Cross Blue Shield of Georgia (BCBSGA) in their administration of Cobb County's group health plan benefits. Carol Hoel and Lynda Sheldon conducted the onsite review with the assistance of Steven Harper from Cobb County at BCBSGA's Columbus, Georgia claims office during the week of April 8, 2013.

### Scope of Services

A data file of all medical claims processed during the audit period January 1, 2011 through December 31, 2012, representing \$69,344,879.21 in benefit payments on 200,201 claims, was provided by BCBSGA for our sampling purposes. Our claims review included the following components:

- An Adjudication Review to assess claim control measures;
- A stratified sample of 210 claims totaling \$4,748,866.59 in benefit payments to provide statistical validity with comparison to performance guarantees and industry standards;
- A targeted sample of claims to provide representation of selected individuals and potential duplicate payments.

The auditors completed a form for each claim sample selected; this worksheet was the primary documentation on which our report is based. Due to the confidentiality of names, diagnosis, etc., claims addressed within this report are referred to as "Worksheets." The letter T preceding the Worksheet number indicates the sample is a target sample selection.

### Key Findings

- **Plan Benefit Discrepancies:** The following bullet points summarize inconsistencies in system plan building identified by Segal's auditors during the individual claims review. Worksheet numbers are included for ease of reference in Exhibit A.

- » **PPO Out-of-Pocket:** The calendar year deductible is being applied to the \$1,500 out-of-pocket maximum. The 2011 Benefit Booklet states the out-of-pocket limit is in addition to the Deductible and Copayments. (WORKSHEET 188; EXHIBIT A ERROR REMOVED)

It is Segal's understanding that the County agrees with BCBSGA in applying both deductible and coinsurance to the annual out-of-pocket maximum.

- » **HMO Out-of-Pocket:** The family out-of-pocket is programmed to a \$2,000 maximum. The 2011 Benefit Booklet states the family maximum is \$3,000. (EXHIBIT A, WORKSHEET 192, PAGE 9)

Segal notes BCBSGA acknowledged the error; however, did not update their response associated with the individual sample.

- **Plan Benefit Interpretation:** These topics require clarification of Plan intent regarding BCBSGA's application of specific benefits.

- » **Physician Office Services:** The office copayment is applied only if an office visit procedure code is billed; the copayment was not applied to a medically necessary vision care service. This raises concerns that services specifically bulleted in the benefit summary (e.g., physical therapy, allergy shots, etc.) are being reimbursed at 100% without a copayment when an office visit is not billed. (EXHIBIT A, WORKSHEET 59, PAGE 8)

- » **Medical Supplies:** BCBSGA is reimbursing 100% vs. 90% of medical supply expenses in a home setting under the HMO plan. (EXHIBIT A, WORKSHEET 123, PAGE 8)

Following discussion between BCBSGA and Cobb County, it is Segal's understanding that the current administration of above benefits reflects Plan intent.

- **Referral and Precertification Requirements**

- » **HMO:** Referrals were not evidenced on all HMO claims; BCBSGA states they are monitored through a network provider gatekeeper program.
- » **PPO:** BCBSGA did not require precertification for a CT scan or MRI as stipulated in the Benefit Booklet. (EXHIBIT A, WORKSHEETS 154 AND 155, PAGES 8 AND 9)
- » **HMO:** The required precertification was not obtained for diagnostic sleep study. (EXHIBIT A, WORKSHEET 156, PAGE 9)

BCBSGA advises discussion with the County will be held to determine if currently administered precertification requirements meet the Plan's intent.

### **Statistical Achievement**

Of the 210 stratified claims audited, 204 were processed without error. Six payment errors totaled \$3,134.01 (five overpayments for \$3,085.61; one underpayment of \$48.40). The net overpayment is \$3,037.21. Five Other Claim Matters provide information on BCBSGA processing procedures; these are noted for informational purposes and are not included in the calculation of statistical achievement.

| Performance Measurement                         |                         |                       |                   |
|---|-------------------------|-----------------------|-------------------|
| Category  | Statistical Achievement | Performance Standard* | Industry Standard |
| Financial Accuracy (dollar value)               | 99.15%                  | 99.00%                | 99.00%            |
| Claims Processing Accuracy (overall incidence)  | 98.32%                  | 97.00%                | 95.00%            |
| Payment Accuracy (incidence)                    | 98.32%                  | N/A                   | 97.00%            |
| Processing Timeliness (within 10 business days) | 97.92%                  | 90.00%                | 90.00%            |

\* Originally effective January 1, 2009. Timeliness is 90% for non-investigated claims; statistical achievement is based on all claims from first received to first processed dates.

Based on the statistical findings, BCBSGA's achievement exceeded performance and/or industry standards in each category during the benefit years. Error details are included in Section II as Exhibit A. Turnaround time is presented in Exhibit B; the stratification table is Exhibit C.

A basic principle of the sampling technique is that the stratified audit findings are representative of all claims; therefore, the respective strata error rate is used to project the total errors for each stratum. The total projected errors are used to calculate the statistical accuracy levels for comparison to industry standards. With an observed error rate of 3% or less, the 210 claim sample produces a 95% confidence level with  $\pm 3\%$  precision.

Industry standards are developed through ongoing review and comparison of measures utilized by major carriers and third party administrators nationwide. Standards include acceptable performance for administration of fully-insured and self-insured corporate, public, and multi-employer plan benefits.

### Targeted Sample

Twenty five targeted claims were selected. Three claims were selected for one individual provided by the County for possible problems with non-payment of claims. The remaining twenty-two claims selected for review were identified as potential duplicates from our electronic analysis of 100% of claims. No errors were identified; the results of our review revealed:

- The County-referred individual received non-capitated benefit payments under the HMO plan until coverage was terminated effective January 1, 2012.
- Onsite review of claims documentation revealed potential duplicates were explained as subsequent voids or adjustments. Based on our findings, no further review is warranted.

### Specific Stop Loss Analysis

Our electronic analysis of all claims processed during the audit period identified nine individuals with benefits payments exceeding \$300,000 for claims incurred from January 1, 2011 through December 31, 2012 and paid in 2012. Combined medical plan payments for the nine individuals totaled \$4,188,558.08. Our list with names and dollar amounts will be provided to the County separately to maintain confidentiality of Protected Health Information (PHI).

The scope of this audit did not include verification of prescription drug benefits that were also eligible under the Symetra contract. Cobb County should ensure these claim are included on specific filings as appropriate.

### Recommendations

All questions and comments regarding the statistical and targeted claim samples were reviewed with BCBSGA personnel. The following recommendations are offered for addressing concerns identified in this report. BCBSGA was presented with a draft report for their review and comment. Their revised July 2<sup>nd</sup> response has been paraphrased in italics below with further Segal comment as indicated. BCBSGA's complete response is included as Section III.

- BCBSGA needs to generate impact reports for identified plan building errors to assist the County in determining the total financial impact to the Plan(s). (KEY FINDINGS, PAGES 1 AND 2; EXHIBIT A, PAGE 9)

*Out of Pocket: It appears that 2011 SPDs were changed in error to reflect that the maximum did not include the deductible. BCBSGA administration of this benefit meets Plan intent; the error lies in the SPD language.*

Cobb County concurs with BCBSGA. Segal recommends that the current SPD be revised to reflect the correct language.

*HMO Out of Pocket: Following discussion with Cobb County, BCBSGA agrees the 2011 family out-of-pocket maximum was \$3,000 vs. \$2,000 applied. An impact report has been requested and findings will be shared with the County.*

- The County and BCBSGA should review Plan intent for benefit interpretation issues specifically related to physician office services and medical supplies benefits under the PPO and HMO plans. (KEY FINDINGS, PAGE 2 AND EXHIBIT A, PAGE 8)

*Office Visit Copayment: BCBSGA generally will only apply a copay if an office visit is billed.*

Cobb County concurs with BCBSGA.

Medical Supplies: It is Segal's understanding that Cobb County agrees with 100% reimbursement for these services.

- BCBSGA and the County should discuss current processing procedures administered by BCBSGA related to precertification requirements for specific testing procedures identified under the Plans. (KEY FINDINGS, PAGE 2, AND EXHIBIT A, PAGES 8 AND 9)

*Precertification procedures have been updated (i.e., sleep studies without precertification) although the Benefit Booklet still reflects prior requirements.*

- Refund recovery for the identified overpayments should be initiated based on the County's direction. (EXHIBIT A, PAGES 8 AND 9)
- BCBSGA should advise Cobb County of any modification to system programming or changes in adjudication procedures resulting from this review.

\*\*\*\*\*

This report would be incomplete without recognition of the cooperation and professionalism extended to us by BCBSGA during the preparation and onsite phases of this project.

## Section II – Claims Audit Review

BCBSGA provided a data file of all medical claims processed and paid from January 1, 2011 through December 31, 2012 to use in our electronic analysis and audit preparations. Relevant claims processing information was verified through BCBSGA's responses to our adjudication questionnaire, onsite discussions, auditor observations, and the individual claims review.

### Individual Claims Review

Prior history and benefit maximums were reviewed, as applicable, on each stratified claim. In addition to verifying the amount paid, audit samples were thoroughly reviewed to determine that:

- Claims were paid in strict accordance with Plan provisions.
- Documentation (provider bills, physician statements, surgical reports, etc.) was on file for claims paid and verified when necessary.
- Claims were paid only on behalf of eligible individuals, based on eligibility data contained in the claims system.
- Amounts paid were within the designated non-contracted allowances and/or discounted fees for the area where treatment was rendered, with due consideration given for the severity of the condition treated, based on schedules utilized. We did not determine medical necessity, but did ascertain that the claims personnel properly reviewed or referred claims as appropriate.
- Benefits were paid under the proper benefit classification, diagnostic, and procedure codes, as an incorrect entry may affect payment accuracy or future benefit determinations.
- Appropriate benefit limitations, deductibles, and coinsurance were applied.
- Coordination of benefits provisions were enforced, where applicable.
- Arithmetic calculations were correct.
- Duplicate claims were properly denied.

### Selection of Claims

The selection of claims was stratified by dollar amount to give large claims more valid representation in the sample. The methodology of our stratified selection process utilizes formulae designed to take full advantage of statistical sampling procedures that allow a quantifiable degree of confidence so the results obtained in the audit sample are a true reflection of the actual way all claims were processed during the audit period.

### **Claim Control Measures**

Our audit samples review and onsite discussions revealed BCBSGA utilizes the following claim control measures in the processing and payment of claims:

- division of administrative duties; system access limited to job function
- review of claims data for adequacy of information needed to process the claim
- claims received electronically; however we are unable to verify the percentage level without requested Administrative Procedures questionnaire.
- automated duplicate checking edits
- established procedures for the denial and appeal process
- automated calculation of fee allowance based on date of service
- established internal audit procedures for quality control

BCBSGA did not complete or return our advance Administrative Procedures questionnaire to confirm consistency of processes and responses we observed onsite. Segal relied on onsite discussions, observations on sampled claims, BCBSGA responses, etc.

**Exhibit A – Error Listing**

| Worksheet   | Over/(Under) Payment | Explanation   |
|-------------|----------------------|---|
| 39A<br>HMO  | (\$48.40)            | Data entry of the discount vs. the allowable amount resulted in an underpayment during manual adjudication. The claim was adjusted outside the audit period.  |
| 47B<br>PPO  | \$66.98              | A claim denied by Medicare as being incomplete was reimbursed by BCBSGA as primary. No payment should have been issued until Medicare received the required information and reprocessed the claim.  |
| 59B<br>HMO  | Other Claim Matter   | <p><b>Possible claim overpayment.</b> Vision care services require a \$25.00 copayment per the benefit summary.</p> <p><i>BCBSGA disagrees stating the office copayment is only charged if an office visit procedure code is billed during the same visit.</i></p> <p>Segal notes this raises concerns that services specifically bulleted in the benefit summary (e.g., physical therapy, allergy shots, etc.) are being reimbursed at 100% without a copayment when an office visit is not billed. Segal recommends BCBSGA and the County discuss which application method meets the Plan’s intent.</p>                         |
| 123D<br>HMO | Other Claim Matter   | <p><b>Possible claim overpayment.</b> Medical supplies provided in a home setting were reimbursed at 100% vs. 90%. BCBSGA is applying a 100% benefit for all medical supplies in a home or office setting. BCBSGA and the County should discuss this benefit to confirm Plan intent.</p>  |
| 154F<br>PPO | \$1,715.51           | <p>Coordination of benefits was not performed with BCBSGA accepting the secondary payor role based on member COB record.</p> <p><i>BCBSGA indicates they utilize the active record to determine order of benefit. BCBSGA disagrees stating no claims evidence COB payment since 2007.</i></p> <p>Segal maintains the error based on system records available for our onsite review.</p> <p>Other Claim Matter</p> <p>The required precertification was not obtained for a diagnostic service (MRI) specifically addressed in the Benefit Booklet.</p> <p><i>BCBSGA advised they will discuss Plan intent with the County.</i></p> |

| Worksheet    | Over/(Under) Payment | Explanation  |
|--------------|----------------------|--|
| 155F<br>PPO  | Other Claim Matter   | The required precertification was not obtained for a diagnostic service (CT Scan) specifically addressed in the Benefit Booklet.<br><i>BCBSGA advised they will discuss Plan intent with the County.</i>   |
| 156F<br>HMO  | Other Claim Matter   | The required precertification was not obtained for diagnostic services (sleep studies/staging).<br><i>BCBSGA advised they will discuss Plan intent with the County.</i>  |
| 191J<br>HMO  | \$3.12               | Incorrect calculation of the paid amount during manual adjudication.   |
| 192J<br>HMO  | \$1,000.00           | Coinsurance was not applied to meet the 2011 individual \$1,000 out-of-pocket maximum. The family out-of-pocket maximum (\$3,000) was not met.<br><i>BCBSGA states the system is programmed to apply a family maximum of \$2,000 per calendar year.</i><br><br>This is a system programming issue that requires corrective action. |
| 205K<br>PPO  | \$300.00             | Copayment was not applied to this inpatient confinement during manual adjudication.  |
| <b>Total</b> | <b>\$3,134.01*</b>   | 5 Overpayments (\$3,085.61)<br>1 Underpayment (\$48.40)<br>5 Other Claim Matters   |

\*Net financial impact is \$3,037.21 in overpayments.

Segal recommends BCBSGA initiate refund recovery for the identified overpayments based on County direction. System benefit errors require additional corrective action.

**Exhibit B – Stratified Processing Timeliness**

| Business Days | Number of Claims | Individual Percent | Cumulative Percent*                 |
|---------------|------------------|--------------------|-------------------------------------|
| 0             | 23               | 12.35%             | 12.35%                              |
| 1             | 79               | 48.68%             | 61.03%                              |
| 2             | 36               | 18.61%             | 79.65%                              |
| 3             | 6                | 2.67%              | 82.32%                              |
| 4             | 7                | 3.52%              | 85.84%                              |
| 5             | 11               | 2.79%              | 88.63%                              |
| 6             | 7                | 2.48%              | 91.11%                              |
| 7             | 5                | 1.47%              | 92.58%                              |
| 8             | 9                | 3.14%              | 95.72%                              |
| 9             | 6                | 1.29%              | 97.01%                              |
| <b>10</b>     | <b>3</b>         | <b>0.91%</b>       | <b>97.92%</b>                       |
| 11            | 7                | 0.74%              | 98.66%                              |
| 12            | 1                | 0.03%              | 98.69%                              |
| 13            | 1                | 0.23%              | 98.92%                              |
| 14            | 1                | 0.08%              | 99.00%                              |
| 15            | 3                | 0.13%              | 99.13%                              |
| 17            | 1                | 0.08%              | 99.21%                              |
| 20            | 1                | 0.79%              | 100.00%                             |
| 21            | 3                | 0.00%              | 100.00%                             |
| <b>Total</b>  | <b>210</b>       | <b>100.00%</b>     | <b>*may not add due to rounding</b> |

- BCBSGA bases timeliness on business days, which excludes holidays and weekends. Performance and Industry standards both indicate 90% of all claims should be processed within 10 business days. Best practice, which follows Department of Labor regulations, requires 100% within 21 business or 30 calendar days.
- Turnaround time for the stratified selection was manually calculated from the date a claim was received to the date it was processed by payment or denial. Our analysis weights claims by strata, similar to our calculation methodology of processing accuracy (e.g., small dollar claims require less time to process than large dollar claims subject to internal reviews).
- This analysis included routine delays due to internal review; delays for draft issuance were excluded.

**Exhibit C – Stratification Table**

| Strata        | Dollar Range of Strata      | Number in Audit Selection | Number of Claims in Range | Dollar Amount in Audit Selection | Total Dollar Amount in Strata |
|---------------|-----------------------------|---------------------------|---------------------------|----------------------------------|-------------------------------|
| A             | \$0.01 - \$49.99            | 40                        | 62,891                    | \$1,160.68                       | \$1,608,001.00                |
| B             | \$50.00 - \$89.99           | 30                        | 46,099                    | \$2,031.86                       | \$3,181,747.90                |
| C             | \$90.00 - \$239.99          | 30                        | 52,895                    | \$4,343.87                       | \$7,627,828.79                |
| D             | \$240.00 - \$574.99         | 25                        | 22,904                    | \$8,321.30                       | \$8,207,118.88                |
| E             | \$575.00 - \$1,499.99       | 20                        | 9,277                     | \$17,940.10                      | \$8,320,395.15                |
| F             | \$1,500.00 - \$3,499.99     | 15                        | 3,521                     | \$34,369.93                      | \$7,897,291.60                |
| G             | \$3,500.00 - \$7,749.99     | 10                        | 1,633                     | \$55,836.28                      | \$8,204,938.60                |
| H             | \$7,750.00 - \$19,499.99    | 10                        | 686                       | \$124,895.31                     | \$8,255,380.87                |
| I             | \$19,500.00 - \$57,499.99   | 10                        | 218                       | \$355,890.66                     | \$6,670,023.83                |
| J             | \$57,500.00 - \$234,499.99  | 10                        | 67                        | \$916,207.17                     | \$6,144,283.16                |
| K             | \$234,500.00 - \$389,557.89 | 10                        | 10                        | \$3,227,869.43                   | \$3,227,869.43                |
| <b>Totals</b> |                             | 210                       | 200,201                   | \$4,748,866.59                   | \$69,344,879.21               |

- **Claim Definition:** The definition for audit purposes is the action taken by an administrator with respect to a submission (any form, bill, or other documentation submitted in one transmission), including all adjustments made after the initial transaction.
- **Stratification Process:** Our stratified sampling procedure provides a quantifiable degree of confidence (95% with  $\pm 3\%$  precision) so the sample dollar value and incidence results are a true reflection of the way all claims were processed during the audit period.
- **Zero Payments:** The data file contained 93,302 zero payment claims for the audit period, representing 31.79% of all claims. This percentage is within reasonable limits for denials (*i.e.*, duplicates, insufficient information, exceeding benefit maximums, etc.) and HMO capitated claim transactions.

## Section III – BCBSGA’s Report Response

BCBSGA’s written report is included in its entirety on the following pages.

7799471v2/13859.002

ADMINISTRATION AND TECHNOLOGY CONSULTING (ATC)

 X SEGAL <sup>12</sup>



July 2, 2013

Carol S. Hoel, HIA  
Consultant, Administration and Technology Consulting  
SEGAL  
1230 West Washington Street, Suite 501  
Tempe, Arizona 85281-1248

**RE: COBB County Medical Claims Audit**

Dear Mrs. Hoel:

Blue Cross Blue Shield of Georgia (BCBSGA) reviewed the draft report prepared by Segal for the Cobb County Audit. All agreed upon claim errors are in the process of being adjusted and recovered funds will be returned to Cobb County. Our comments regarding the audit findings are as follows:

**Benefit Plan Discrepancies**

**PPO Out of Pocket:** The calendar year deductible is being applied to the \$1500 out-of-pocket maximum. The 2011 Benefit Booklet states out-of-pocket limit is in addition to the Deductibles and Copayments. (Worksheet 188)

*Sample 188: The wording in the SPD (page ii) indicates that the individual calendar year out-of-pocket is \$1500 in addition to the deductible and copayments. BCBSGA's system is currently applying the deductible to the out-of-pocket maximum. BCBSGA acknowledge that prior to 2011, the SPD had the explicit indication that the Out of Pocket max DID include both coinsurance and deductible. For 2011 it appears that the SPD's were changed in error to reflect that the Out of Pocket max did not include the deductible. BCBSGA administration of this benefit is correct the error lies in the verbiage of the language in the SPD.*

**HMO Out of Pocket:** The family out-of-pocket is programmed to a \$2000 maximum. The 2011 Benefit Booklet states the family maximum is \$3000. (Worksheet 192)

*Sample 192: Page ii of the SPD that Segal referenced on-site reflects a \$3000 family out-of-pocket limit per calendar year. BCBSGA system is currently loaded to administer that benefit to a maximum of \$2000. After further discussion with the client, it does appear that it was Cobb's intent to have a \$3,000 family OOP max and BCBSGA, during 2011 administered a \$2,000 OOP max. BCBSGA is requesting an impact report and the findings will be shared with the client.*

**Plan Benefit Interpretation**

Physician Office Services: The office copayment is applied only if an office visit procedure code is billed; the copayment was not applied to a medically necessary vision care service. This raises concerns that services specifically bulleted in the benefit summary (e.g., physical therapy, allergy shots, etc) are being reimbursed at 100% without a copayment when an office visit is not billed. (Worksheet 59)

*Sample 59: BCBSGA generally will only apply an office visit copayment if an office visit is billed. If the County would like BCBSGA to apply this copayment to all services performed when an office visit is not billed, the County should contact BCBSGA to discuss the potential for a benefit change.*

Medical Supplies: BCBSGA is reimbursing 100% versus 90% of medical supply expense in a home or office setting under the HMP Plan. (Worksheet 123)

*Sample 123: BCBSGA will discuss this benefit with the County. If claims are not processed as intended, BCBSGA will take the appropriate actions.*

#### **Referral and Precertification Requirements**

HMO: Referrals were not evidenced on all HMO claims; BCBSGA states they are monitored through a network provider gatekeeper program.

PPO: BCBSGA did not require precertification for a CT Scan or MRI as stipulated in the Benefit Booklet. (Worksheets 154 and 155)

HMO: The required precertification was not obtained for diagnostic sleep study (Worksheet 156)

*Sample 156: Although the Benefit Booklet shows sleep studies requires precertification, BCBSGA standard processing policy allowed this procedure without precertification prior to 11/01/2012. The account management team will contact the County to discuss this benefit and determine if changes are required.*

#### **Error Listing Exhibit A**

There were 7 claims identified as possible errors and BCBSGA's comments on the audit findings are as follows:

Sample 39A HMO: Data entry of the discount versus the allowed amount resulted in an underpayment during manual adjudication.

*BCBSGA accepts a data entry error. During the verification of pricing it was noted that the amount that should have been allowed was not. Additional payment was sent to the provider on 03/29/2013. This was not a system issue but human intervention. The associate causing the underpayment was coached on 03/29/2013 as were other team members.*

Sample 47B PPO: A claim denied by Medicare as being incomplete was reimbursed by BCBSGA as primary. No payment should have been issued until Medicare received the required information and reprocessed the claim.

*BCBSGA agrees this claim was not processed according to the established guidelines for COB reimbursement with BCBSGA as secondary payor. A refund request has been initiated. This was not a system issue but human intervention. The associate processing the claim was given additional training and coaching as were other team members.*

Sample 154F PPO: Coordination of benefits was not performed with BCBSGA accepting as secondary payor role. Claims paid prior to and subsequent to this admission were coordinated and paid as secondary by BCBSGA.

*BCBSGA reviewed the participant's history and could not locate any claims processed as secondary after 09/01/2007. BCBSGA advised Segal that the COB segment contained two entries, one active and the other cancelled. COB is administered based on the information on the active segment and not the cancelled one. BCBSGA disagrees with an assessment of an error on this sample.*

Sample 188I PPO: See Plan Benefit Discrepancies

*BCBSGA is not accepting an error on this sample until the plan intent has been confirmed. This issue was discussed earlier in this response.*

Sample 191J HMO: Incorrect calculation of the paid amount during manual adjudication

*BCBSGA is not accepting an error on this sample. The claim was originally paid on 05/03/2010. The claim was selected for Hospital Bill Audit (HRI) and based on results the claim was adjusted per instructions from the HRI team on 01/02/2011.*

Sample 192JHMO: See Plan Discrepancies

*BCBSGA disagrees with the assessment of an error on this sample. This issue was discussed earlier in this response. The County made changes to the 2011 benefits reducing the family out-of-pocket maximum to \$2000.*

Sample 205 PPO: Copayment was not applied to this inpatient confinement during manual adjudication.

*BCBSGA agrees to the assessment of an error on this claim. This was a human error. The associate making the error was coached and given additional training along with other team members. The claim has been set up for recovery.*

Segal's recommendations have been noted by BCBSGA and BCBSGA is open to discuss any recommendation upon request by the group.

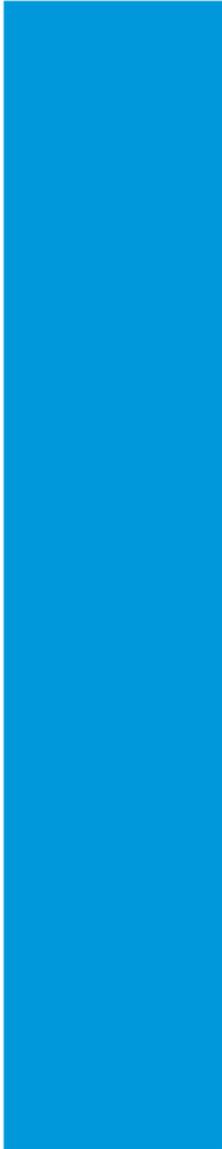
If you have any questions concerning the audit, I can be reached at 706-985-2275.

Sincerely,

*Deborah Cannon-Turner*

Deborah Cannon Turner  
External Audit Manger

cc: Jill Bromberg, BCBSGA  
Ron Kjar , BCBSGA  
Selina Robinson, BCBSGA  
Annie Harris, BCBSGA



**COBB COUNTY**

**CIGNA**

**ANALYSIS OF CLAIMS PROCESSING AND  
PAYMENT PROCEDURES**

FOR THE PERIOD  
JANUARY 1, 2011  
THROUGH  
DECEMBER 31, 2012

**FINAL REPORT**  
JULY 1, 2013

**SUBMITTED BY**

THE SEGAL COMPANY  
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 **SEGAL**

ADMINISTRATION AND TECHNOLOGY CONSULTING (ATC)

CONFIDENTIALITY STATEMENT

Release of electronic and hardcopy information for this analysis required execution of an agreement signed by The Segal Company, Cobb County, and Connecticut General Life Insurance Company on behalf of itself and its subsidiaries.

All audit information and findings prepared and presented in this report are considered confidential and proprietary. Sharing of contents with any other party or the copying of information herein is expressly prohibited without the written consent of the agreeing parties.

 SEGAL

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Final Report  
July 1, 2013

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## Section I – Executive Summary

This report analyzes and evaluates the claims processing and payment procedures utilized by Connecticut General Life Insurance Company (Cigna) in their administration of Cobb County's group dental benefits. Ms. Lynda Sheldon conducted the onsite review with the assistance of Steven Harper from Cobb County at Cigna's Denison, Texas claims office during the week of March 18, 2013.

### Scope of Services

A data file of all dental claims processed during the audit period January 1, 2011 through December 31, 2012, representing \$5,150,352.87 in benefit payments on 28,835 claims, was provided by Cigna for our sampling purposes. The dollars reported reflect the benefit payment prior to reduction for other insurance reimbursement (e.g., coordination of benefits calculation).

Our claims review included the following components:

- An Adjudication Review to assess claim control measures;
- A stratified sample of 210 claims totaling \$59,217.01 in benefit payments to provide statistical validity with comparison to performance guarantees and industry standards;
- A targeted sample of 15 claims to provide representation of selected individuals and potential duplicate payments.

The auditor completed a form for each claim sample selected; this worksheet was the primary documentation on which our report is based. Due to the confidentiality of names, diagnosis, etc., claims addressed within this report are referred to as "Worksheets." The letter T preceding the Worksheet number indicates a target sample.

### Audit Findings

All questions and comments regarding the statistical and targeted claim samples were reviewed with Cigna personnel.

- The benefit summary indicates the topical application of fluoride is limited to one per person per calendar year for individuals less than 19 years old. Cigna is allowing two per calendar year.
- Claims were paid after active eligibility had terminated due to retroactive termination notices.

### Statistical Achievement

Of the 210 stratified claims audited, 196 were processed without error. Fourteen overpayment errors totaled \$760.10. Additional overpayments were identified on out-of-sample claims totaling \$647.50 in connection with the application of an excess fluoride benefit. These are

noted for informational purposes and have not been included in the calculation of statistical achievement.

Statistical findings are presented in the following tables to reflect results prior to the resolution of the fluoride application issue.

Based on the statistical findings, Cigna’s achievement with fluoride application errors factored in exceeded industry standards in Processing Timeliness but fell below in Financial Accuracy, Claims Processing Accuracy, and Payment Accuracy during the benefit years.

| Performance Measurement                         |                         |                   |
|---|-------------------------|-------------------|
| Category  | Statistical Achievement | Industry Standard |
| Financial Accuracy (dollar value)               | 98.63%                  | 99.00%            |
| Claims Processing Accuracy (overall incidence)  | 92.78%                  | 95.00%            |
| Payment Accuracy (incidence)                    | 92.78%                  | 97.00%            |
| Processing Timeliness (within 10 business days) | 96.52%                  | 90.00%            |

The following table reflects Cigna’s achievement without factoring in payment errors associated with the fluoride application issue.

| Performance Measurement                         |                         |                   |
|---|-------------------------|-------------------|
| Category  | Statistical Achievement | Industry Standard |
| Financial Accuracy (dollar value)               | 99.45%                  | 99.00%            |
| Claims Processing Accuracy (overall incidence)  | 98.38%                  | 95.00%            |
| Payment Accuracy (incidence)                    | 98.38%                  | 97.00%            |
| Processing Timeliness (within 10 business days) | 96.52%                  | 90.00%            |

Based on Segal’s understanding of the resolution of this benefit application, the immediately preceding table accurately reflects Cigna’s achievement, whereby they exceeded industry standards in every category during the audit period.

Error details are included in Section II as Exhibit A. Turnaround time is presented in Exhibit B; the stratification table is Exhibit C. A basic principle of the sampling technique is that the stratified audit findings are representative of all claims; therefore, the respective strata error rate is used to project the total errors for each stratum. The total projected errors are used to calculate the statistical accuracy levels for comparison to industry standards. With an observed error rate of 3% or less, the 210 claim sample produces a 95% confidence level with ±3% precision.

Industry standards are developed through ongoing review and comparison of measures utilized by major carriers and third party administrators nationwide. Standards include acceptable

performance for administration of fully-insured and self-insured corporate, public, and multi-employer plan benefits.

### Targeted Sample

Fifteen targeted claims were selected. The County provided the names of three individuals for review where eligibility had terminated; the remaining 12 claims selected for review were identified as potential duplicates from our electronic analysis of 100% of claims. Target claims are not included in the statistical results.

### Recommendations

The following suggestions are offered for addressing the identified errors. Cigna was provided with a draft report for review and comment; their responses are paraphrased in italics below. The complete response is included as Section III.

- Cigna should prepare an impact report identifying all fluoride services for calendar years 2011 and 2012 which exceeded the one treatment per year maximum. (FLUORIDE TREATMENT, PAGE 6 AND EXHIBIT A, PAGE 8)

*Cigna disagrees with Segal's error assessments for fluoride services indicating the sample claims were processed in accordance with the benefit provisions established during the account implementation process. It has been determined that benefit materials produced for the 2007 and 2011 plan years incorrectly incorporated CIGNA's standard plan language. Cigna will continue to partner with Cobb County to reach resolution on this matter.*

Through further discussion with Cobb County, it is Segal's understanding that Cigna is appropriately following Plan intent to allow two treatments per calendar year. Segal recommends at this time that the SPD or Benefit Summary be updated to ensure all participants have access to the correct benefit information.

- Cigna should establish a process to review each eligibility file for possible overpayments due to receipt of a retroactive termination notice, provide the County with a listing of overpayments, and upon their direction begin collection procedures. We encourage the County to provide a directive to automatically initiate recovery efforts for all identified overpayments; waiting for approval may diminish successful recovery efforts (e.g., extends beyond provider's contracted recovery period). (ELIGIBILITY, PAGE 6)

*Cigna disagrees with the financial errors assessed for claims paid passed eligibility termination. However, agrees that the retro-active eligibility notification resulted in overpayments.*

- Cigna should initiate refund recovery for the identified overpayments based on County direction. (EXHIBIT A, PAGE 8)

*Refund recovery has been initiated for all overpayments except the error assessed on Worksheet 162 for failure to coordinate benefits. Research will continue to determine whether or not other coverage was in effect for this date of service. Cigna can provide Cobb County with updates on the recovery efforts.*

- > Cigna should advise Cobb County of any modification to system programming or changes in adjudication procedures resulting from this review.

*Cigna is committed to taking the necessary actions to correct the errors identified as a result of the audit and looks forward to reviewing the results of the audit with Cobb County.*

\*\*\*\*\*

This report would be incomplete without recognition of the cooperation and professionalism extended to us by Cigna personnel during the preparation phase and onsite portion of this review.

## Section II – Claims Audit Review

For sampling purposes, the audit period included all dental claims processed and paid from January 1, 2011 through December 31, 2012. Benefit payments for 28,835 claims during the audit period totaled \$5,150,352.87; the stratified selection represented benefits totaling \$59,217.01. The dollars reported reflect the benefit payment prior to reduction for other insurance reimbursement (*e.g.*, coordination of benefits calculation).

### Individual Claims Review

Prior history and benefit maximums were reviewed, as applicable, on each claim. In addition to verifying the amount paid, claims audited were thoroughly reviewed to determine that:

- > Claims were paid in strict accordance with Plan provisions.
- > Documentation (provider bills, dental consultant review, etc.) was on file for claims paid and verified when necessary.
- > Claims were paid only on behalf of eligible individuals, based on eligibility data contained in the claims system.
- > Amounts paid were within the designated fee schedules and/or non-contracted allowances for the area where treatment was rendered. We verified that CIGNA reviewed or referred claims to a dental consultant as appropriate.
- > Benefits were paid under the proper benefit classification (*i.e.*, preventative, restorative, and orthodontia), diagnostic, and procedure codes, as an incorrect entry may affect payment accuracy or future benefit determinations.
- > Appropriate benefit limitations and deductibles were applied.
- > Coordination of benefits provisions were enforced, where applicable.
- > Arithmetic calculations were correct.
- > Payments were made to the proper party (*i.e.*, the provider of service if benefits were assigned; the employee if benefits were not assigned).
- > Duplicate claims were properly denied.
- > Turnaround time for processing of claims was within performance guarantees and industry standards.

## **Selection of Claims**

The selection of claims was stratified by dollar amount to give large claims more valid representation in the sample. The methodology of our stratified selection process utilizes formulae designed to take full advantage of statistical sampling procedures that allow a quantifiable degree of confidence so the results obtained in the audit sample are a true reflection of the actual way all claims were processed during the audit period.

## **Audit Findings**

### *Fluoride Treatment*

The Plan's benefit summary under Diagnostic and Preventive indicates topical application of fluoride (excluding prophylaxis) is limited to persons less than 19 years old. Only one treatment per person per calendar year is allowed. Our onsite and electronic review indicates Cigna is allowing and reimbursing two fluoride treatments per person per year; details are provided in Exhibit A, Error Listing on Page 7.

### *Eligibility*

Active eligibility was verified for each date of service on the stratified and targeted sampled claims; claims histories were reviewed when an eligibility termination date was noted in the file. Our review revealed six histories had claims paid after termination. Segal recommends Cigna establish a process to review each eligibility file for possible overpayments due to receipt of a retroactive termination notice, provide the County with a listing of overpayments, and upon their direction begin collection procedures. We encourage the County to provide a directive to automatically initiate recovery efforts for all identified overpayments; waiting for approval may diminish successful recovery efforts (*e.g.*, extends beyond provider's contracted recovery period).

### *Duplicate Claims*

An electronic query was performed on 100% of the claims population to identify potential duplicate payments that had an exact match on member identification number, claimant, procedure code, and service start date. Our list was not expected to identify data entry errors (*i.e.*, incorrect patient, date of service, or provider). Onsite validation of the stratified and targeted selection identified two duplicates. It was revealed that Cigna does not use a negative indicator when adjusting claims; therefore, the remaining potential duplicates were false-positives. No further action is indicated.

## **Claim Control Measures**

Our audit samples and responses to the questionnaire revealed Cigna utilizes the following claim control measures in the processing and payment of claims:

- division of administrative duties; system access limited to job function
- review of claims data for adequacy of information needed to process the claim

- > claims received electronically (approximately 63.75%; 72% auto-adjudicate) based on Cigna's book of business
- > automated duplicate checking edits
- > documentation of pre-determination verification
- > application of benefit limitations as outlined in the Plans with the exception of fluoride treatments
- > established procedures for the denial and appeal process
- > automated calculation of fee allowance based on date of service
- > established internal audit procedures for quality control
- > contracted rate changes are automatically reviewed against processed claims

**Exhibit A – Error Listing**

| Worksheet                        | Over Payment        | Explanation   |
|----------------------------------|---------------------|---|
| <b>STRATIFIED SAMPLE</b>         |                     |   |
| 17A                              | \$28.00             | Topical application of fluoride exceeded the one per calendar year maximum.<br><br><i>Cigna advised on April 8<sup>th</sup> that their interpretation regarding application of this benefit is still under investigation and discussion.</i><br><br>Segal recommends Cigna generate impact reports to identify the number of fluoride treatments paid in error including the financial impact to the Plan.<br><br>Additionally, errors associated with the fluoride benefit maximum were identified on out-of-sampled claims; the following amounts represent the overpaid dollars by year:<br>> 2011 - \$301.75<br>> 2012 - \$337.40 |
| 18A                              | \$23.00             |   |
| 25A                              | \$17.00             |   |
| 60B                              | \$23.00             |   |
| 69B                              | \$27.00             |   |
| 87B                              | \$27.00             |   |
| 89C                              | \$28.00             |   |
| 106C                             | \$38.00             |   |
| 119D                             | \$24.00             |   |
| 131D                             | \$29.75             |   |
| <b>DUPLICATE CLAIM</b>           |                     |   |
| 20A                              | \$36.00             | Duplicate claim paid in error.  |
| 75B                              | \$113.00            |   |
| <b>COORDINATION OF BENEFITS</b>  |                     |   |
| 162F                             | \$25.00             | Coordination of benefits was not performed on the sampled claim; claims paid before and after this claim were paid by Cigna as secondary.   |
| 208J                             | \$321.35            | Incorrect coordination of benefits calculation.   |
| <b>RETRO-ACTIVE TERMINATIONS</b> |                     |   |
| 44B                              | Other Claim Matters | File overpayments. Recovery was not initiated on claims paid after active eligibility was terminated.<br><br><i>CIGNA disagrees indicating the claims were paid correctly based on eligibility on file; a retroactive termination notice was received after claims processed.</i>   |
| 64B                              |                     |   |
| 174G                             |                     |   |
| T13                              |                     |   |
| T14                              |                     |   |
| T15                              |                     |   |
| <b>Total</b>                     | \$760.10            | 14 Overpayments   |

Segal recommends CIGNA initiate refund recovery for the identified overpayments based on County direction.

**Exhibit B – Processing Timeliness**

| Business Days | Number of Claims | Individual Percent | Cumulative Percent*                 |
|---------------|------------------|--------------------|-------------------------------------|
| 0             | 146              | 76.30%             | 76.30%                              |
| 1             | 11               | 4.77%              | 81.07%                              |
| 2             | 12               | 6.04%              | 87.11%                              |
| 3             | 3                | 1.59%              | 88.69%                              |
| 4             | 1                | 0.64%              | 89.34%                              |
| 5             | 3                | 0.16%              | 89.50%                              |
| 6             | 5                | 1.79%              | 91.29%                              |
| 7             | 3                | 1.25%              | 92.54%                              |
| 8             | 3                | 1.27%              | 93.81%                              |
| 9             | 7                | 2.34%              | 96.16%                              |
| 10            | 1                | 0.36%              | 96.52%                              |
| 11            | 3                | 0.95%              | 97.47%                              |
| 13            | 1                | 0.64%              | 98.11%                              |
| 15            | 1                | 0.64%              | 98.75%                              |
| 18            | 1                | 0.36%              | 99.11%                              |
| 23            | 1                | 0.43%              | 99.54%                              |
| 28            | 1                | 0.46%              | 100.00%                             |
| <b>Total</b>  | <b>203</b>       | <b>100.00%</b>     | <b>*may not add due to rounding</b> |

- CIGNA bases timeliness on business days, which excludes holidays and weekends.
- Industry standards indicate 90% of all claims should be processed within 10 business days. Best practice, which follows Department of Labor regulations, requires 100% within 21 business days.
- Turnaround time for the stratified selection was manually calculated from the date a claim was received to the date it was processed by payment or denial. Our analysis weights claims by strata, similar to our calculation methodology of processing accuracy (e.g., small dollar claims require less time to process than large dollar claims subject to internal reviews).
- This analysis included routine delays due to internal review; delays for draft issuance were excluded. CIGNA maintains the original submission date on orthodontic claims, therefore, seven affected samples were excluded from the calculation.

**Exhibit C – Stratification Table**

| Strata        | Dollar Range of Strata  | Number in Audit Selection | Number of Claims in Range | Dollar Amount in Audit Selection | Total Dollar Amount in Strata |
|---------------|-------------------------|---------------------------|---------------------------|----------------------------------|-------------------------------|
| A             | \$0.01 - \$99.99        | 40                        | 7,399                     | \$2,450.48                       | \$486,087.22                  |
| B             | \$100.00 - \$129.99     | 35                        | 5,637                     | \$4,041.75                       | \$648,298.69                  |
| C             | \$130.00 - \$159.99     | 31                        | 4,561                     | \$4,449.80                       | \$648,071.37                  |
| D             | \$160.00 - \$199.99     | 30                        | 4,435                     | \$5,441.55                       | \$790,018.04                  |
| E             | \$200.00 - \$279.99     | 22                        | 3,160                     | \$4,998.30                       | \$729,259.74                  |
| F             | \$280.00 - \$424.99     | 13                        | 1,578                     | \$4,715.00                       | \$539,700.57                  |
| G             | \$425.00 - \$624.99     | 10                        | 1,251                     | \$5,389.50                       | \$637,789.57                  |
| H             | \$625.00 - \$999.99     | 10                        | 626                       | \$7,800.28                       | \$482,146.32                  |
| I             | \$1,000.00 - \$1,049.99 | 10                        | 179                       | \$10,000.00                      | \$179,051.00                  |
| J             | \$1,050.00 - \$1,194.75 | 9                         | 9                         | \$9,930.35                       | \$9,930.35                    |
| <b>Totals</b> |                         | 210                       | 28,835                    | \$59,217.01                      | \$5,150,352.87                |

- > **Claim Definition:** The definition for audit purposes is the action taken by an administrator with respect to a submission (any form, bill, or other documentation submitted in one transmission), including all adjustments made after the initial transaction.
- > **Stratification Process:** Our stratified sampling procedure provides a quantifiable degree of confidence (95% with  $\pm 3\%$  precision) so the sample dollar value and incidence results are a true reflection of the way all claims were processed during the audit period.
- > **Zero Payments:** The data file contained 2,678 zero payment claims for the audit period, representing 8.5% of all claims. This percentage is within reasonable limits for denials (*i.e.*, duplicates, insufficient information, exceeding benefit maximums, etc.).

## Section III – CIGNA's Report Response

7835379v1/13859.003

ADMINISTRATION AND TECHNOLOGY CONSULTING (ATC)

 SEGAL 11

**Cigna  
Response**

**Analysis of Claims Processing and  
Payment Procedures**

**Draft Report**

**For**

**Cobb County Government**

**June 2013**

**Executive Summary**

The Segal Company conducted an audit of Cobb County Government’s dental claims processed by Cigna at Cigna’s Denison service center during the week of March 18, 2013. The onsite review consisted of a statistical sample of 210 dental claims with a total payment amount of \$53,493.56, along with a targeted sampling of 15 claims, which were primarily reviewed for potential duplicate payments. The samples were selected from claims processed during the scope period of January 1, 2011 through December 31, 2012.

Specifically, the audit identified the following:

**Statistical Dental Sample**

- 14 overpayments assessed by Segal totaling \$760.10
- 23 out-of-sample overpayments totaling \$647.50

Cigna confirmed three (3) overpayments in the amount of \$470.35 from the statistical sample. The confirmed overpayments have been referred to Cigna’s overpayment recovery vendor to initiate recovery efforts.

Cigna is pleased no errors were observed in the targeted sample reviews.

**Segal Reported Results**

|   | Statistical Achievement Including Fluoride Claims | Statistical Achievement Excluding Fluoride Claims |
|---|---|---|
| Financial Accuracy                              | 98.63%  | 99.45%  |
| Processing Accuracy                             | 92.78%  | 98.38%  |
| Payment Accuracy                                | 92.78%  | 98.38%  |
| Processing Timeliness (within 10 business days) | 96.52%  | 96.52%  |

Cigna appreciates the thoroughness of Segal’s review, along with the presentation of the results to both include and exclude the potential impacts associated with a discrepancy in the administration of benefits for fluoride services. Fluoride treatments are a heavily utilized dental service, which was evident in the volume observed within the claim sample selected by Segal. As the grid above reflects, the assessment of errors associated with a discrepancy in this single plan provision significantly impacts the reported outcome of the statistical review. As the results of this audit did not identify a significant volume of accuracy errors unrelated to the fluoride benefit, the extrapolated results would be favorable in the absence of the ten errors assessed by Segal in this one category. As fluoride claims are being adjudicated consistently by Cigna in accordance with the benefit provision outlined and documented during the implementation of the account, it is our belief the results excluding the fluoride claims more accurately reflects the overall level of service being provided to Cobb County Government. As such, Cigna respectfully requests consideration of the fluoride benefit discrepancy as an outlier and not reflected in the final reported results for this review. Cigna is in the process of partnering with Cobb County Government to further discuss their intentions regarding the fluoride benefit and reach resolution. Should the outcome of the those discussion necessitate a

change, Cigna will ensure any necessary changes to plan documents and system edits are completed and claims will be processed in accordance with the direction received from Cobb County Government. Additional details regarding the history of the fluoride benefit and continuing activity are outlined within Cigna's responses to Segal's recommendations within this document. Cigna is pleased with the turn-around time results reported for the claim sample.

**Cigna Response to Segal's Comments and Recommendations:**

Cigna continues to look for ways to improve the accuracy and efficiency of claim and call handling allowing us to provide consistently high levels of service to Cobb County Government and their employees. Within this document, we will provide a response to each comment and recommendation provided by Segal in their draft audit report

Cigna looks forward to reviewing the results of this audit directly with Cobb County Government to answer any questions and provide any clarification on the details contained within the audit response.

**I. Cigna should prepare an impact report identifying all fluoride services for calendar years 2011 and 2012 which exceeded the one treatment per year maximum. (Fluoride Treatment, Page 5 and Exhibit A, Page 7)**

**Cigna Response:** Cigna respectfully disagreed with the 10 in-sample financial errors and 23 out-of-sample errors assessed by Segal indicating coverage for fluoride services should be limited to one treatment per calendar year. The sample claims were processed in accordance with the benefit provisions established during the account implementation process. When the benefit plan was implemented for 2004, Cigna was advised by Cobb County Government that the intent of the plan was to include a non-standard benefit provision permitting two fluoride services per year up through the age of 19, instead of Cigna's standard plan limitation of one fluoride treatment per year. As a non-standard benefit option, the request required review by Cigna's benefit screening board and was approved. Cigna's claim processing system and online benefit reference tool was programmed reflecting the plan provision as elected by Cobb County Government.

Cigna has determined when the benefit materials were produced by Cigna for the 2007 and 2011 plan years; the documents incorrectly incorporated Cigna's standard plan language reflecting only one fluoride treatment per year. However, Cigna had not received any notices from Cobb County Government to change the plan design from the provisions established during 2004. Additionally, no changes were made to Cigna's claim processing system, as no request from Cobb County Government for benefit changes had been received. Unfortunately, neither Cobb County Government nor Cigna identified the existence of the discrepancy between the newly produced plan documents and the initial benefit design established.

In connection with the audit, representatives from Cobb County Government and the Account Service Team with Cigna are working together to further clarify plan intent regarding fluoride benefits. At this time, the discussions are ongoing. Cigna has provided Cobb County Government with claim impact reports to aid in the discussion and final benefit determination. Once a decision has been reached regarding plan intent, Cigna will work with Cobb County Government to ensure the SPD and Benefit Summary documents properly reflect the confirmed intent, as well as, make any necessary claim system updates as warranted. Claims continue to be adjudicated in accordance with the initial plan design implemented until a further decision is reached. Cigna will continue to partner with Cobb County Government to reach resolution on this matter and would be happy to address any further questions they may have regarding the topic.

- II. **Cigna should establish a process to review each eligibility file for possible overpayments due to receipt of a retroactive termination notice, provide the County with a listing of overpayments, and upon their direction begin collection procedures. We encourage the County to provide a directive to automatically initiate recovery efforts for all identified overpayments; waiting for approval may diminish successful recovery efforts (e.g., extends beyond provider's contracted recovery period). (Eligibility, Page 5)**

**Cigna Response:** Cigna respectfully disagrees with the 6 financial errors assessed by Segal during the onsite within the random and focused reviews, as the claims were correctly processed using the eligibility on file at the time of payment. However, as Cigna agrees the retro-active changes to eligibility resulted in overpayments, the payments have been forwarded to Cigna's overpayment recovery vendor to initiate recovery efforts at this time.

Cigna would be happy to review timely submission guidelines for eligibility termination with Cobb County Government to identify areas of improvement as warranted. Currently Cigna is not made aware when Cobb County Government submits a retro-active termination via the eligibility file. Cigna understands that even a short time span of retroactive terminations can create an overpayment situation. Cigna will discuss with Cobb County Government any opportunities to pursue overpayment when the reason for the overpayment is due to the late receipt of individual termination information. Due to the limited amount of benefits issued for dental plans, it has been our experience that data-mining for potential overpayments as a result of retro-active terminations is not financially beneficial. Additionally, the client is assessed a fee based on a percentage of recoveries when the reason for overpayment is due to retro-active coverage updates.

- III. **Cigna should initiate refund recovery for the identified overpayments based on County direction. (Exhibit A, Page 7)**

Cigna

Cobb County Government

*Page 4 of 5*

**Cigna Response:** The three confirmed overpayments totaling \$470.35 for samples 20, 75 and 208 were referred to Cigna's Overpayment Recovery vendor to initiate recovery efforts on April 30, 2013. While Cigna respectfully disagreed with the error assessed for sample 162, as the claim was processed as primary in accordance with the other coverage information submitted with the claim, Cigna will perform additional research to validate whether or not other coverage was applicable and if any overpayment recovery efforts are warranted. Additionally, refunds totaling \$2,113.15 for the overpayments resulting from the retro-active termination updates for the six claims identified within the audit sample, and related claims in history, have also been requested. Cigna can provide Cobb County Government with updates on the recovery efforts for the overpayments identified in this review.

- IV. Cigna should advise Cobb County of any modification to system programming or changes in adjudication procedures resulting from this review.**

**Cigna Response:** Cigna is committed to taking the necessary actions to correct the errors identified as a result of this audit. We sincerely appreciate the insight and feedback shared by Segal in this review. In addition to providing a response to each of Segal's recommendations, the Cigna Account Service team has taken steps to address actionable items and provide feedback to our claim processing staff in order to continue to improve results. We look forward to reviewing the results of this audit directly with Cobb County Government to answer any questions and provide any clarification on the details contained within the audit response.

**Cobb County Government**

**PRESCRIPTION DRUG AUDIT**

Period: January 1, 2011 – December 31, 2012

August 30, 2013

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## Overview

On behalf of Cobb County Government (“County”), The Segal Company has completed an evaluation of the prescription drug program administered by Express Scripts (“ESI”) formerly Medco Health. This report documents the findings of our analysis of the electronic claim records provided by ESI. An electronic file detailing prescriptions issued for County employees and their dependents for the period 01/01/2011-12/31/2012 was the source of our analysis.

This analysis reviews data associated with the total plan population. Key data components and findings are illustrated throughout the report. The financial report performed is designed to:

- Identify areas where ESI is exceeding or falling short of contractual guarantees.
- Validate ESI’s administration of the County’s plan design and review overall PBM effectiveness.

The results of this financial review will provide a vehicle for the County to monitor and measure performance versus the PBM contract.

## Contract Audit

### Key Plan Data

January 1, 2011 – December 31, 2011

|                                 | Non-Specialty Claims |                |                 | Specialty Claims | Total           |
|---------------------------------|----------------------|----------------|-----------------|------------------|-----------------|
|                                 | Retail               | Mail           | Total           | Total            |                 |
| Prescriptions Dispensed         | 128,261              | 21,598         | 149,859         | 539              | 150,398         |
| Total Days of Therapy Dispensed | 3,126,455            | 1,888,405      | 5,014,860       | 23,029           | 5,037,889       |
| Total Average Wholesale Price   | \$16,805,339.64      | \$8,105,448.13 | \$24,910,787.78 | \$3,044,033.62   | \$27,954,821.40 |
| Total Ingredient Costs          | \$9,380,353.37       | \$4,991,978.76 | \$14,372,332.13 | \$2,077,671.69   | \$16,450,003.82 |
| Total Dispensing Fees           | \$166,795.48         | \$3,418.88     | \$170,214.36    | \$244.82         | \$170,459.18    |
| Total Sales Tax                 | \$66.94              | \$139.41       | \$206.35        | \$0.00           | \$206.35        |
| Gross Costs                     | \$9,547,215.79       | \$4,995,537.05 | \$14,542,752.84 | \$2,077,916.51   | \$16,620,669.35 |
| Patient Deductibles             | \$75,538.66          | \$31,354.24    | \$106,892.90    | \$0.00           | \$106,892.90    |
| Patient Copayments              | \$1,671,204.68       | \$668,483.13   | \$2,339,687.81  | \$23,940.00      | \$2,363,627.81  |
| Paid Claim Amounts              | \$7,802,624.00       | \$4,295,996.88 | \$12,098,620.88 | \$2,053,976.51   | \$14,152,597.39 |

- The table above summarizes the pharmacy benefit claims for the period between January 1, 2011 and December 31, 2011.
- For non-specialty, 85.6% of total prescriptions and 64.5% of total paid claim amounts are dispensed through retail pharmacies.
- Specialty prescriptions represented 0.4% of total prescriptions dispensed and 14.5% of total paid claim amounts.

**January 1, 2012 – December 31, 2012**

|                                 | Non-Specialty Claims |                 |                 | Specialty Claims | Total           |
|---------------------------------|----------------------|-----------------|-----------------|------------------|-----------------|
|                                 | Retail               | Mail            | Total           | Total            |                 |
| Prescriptions Dispensed         | 98,981               | 30,477          | 129,458         | 990              | 130,448         |
| Total Days of Therapy Dispensed | 2,322,944            | 2,646,249       | 4,969,193       | 41,694           | 5,010,887       |
| Total Average Wholesale Price   | \$11,647,092.18      | \$11,944,237.13 | \$23,591,329.31 | \$2,947,043.61   | \$26,538,372.92 |
| Total Ingredient Costs          | \$6,943,234.04       | \$6,763,287.79  | \$13,706,521.83 | \$2,433,600.27   | \$16,140,122.10 |
| Total Dispensing Fees           | \$120,268.50         | \$1,685.97      | \$121,954.47    | \$635.85         | \$122,590.32    |
| Total Sales Tax                 | \$219.11             | \$52.18         | \$271.29        | \$0.00           | \$271.29        |
| Gross Costs                     | \$7,063,721.65       | \$6,765,025.94  | \$13,828,747.59 | \$2,434,236.12   | \$16,262,983.71 |
| Patient Deductibles             | \$45,593.89          | \$24,032.58     | \$69,626.47     | \$1,728.98       | \$71,355.45     |
| Patient Copayments              | \$1,446,670.34       | \$1,081,346.48  | \$2,528,016.82  | \$36,658.37      | \$2,564,675.19  |
| Paid Claim Amounts              | \$5,376,982.94       | \$5,674,242.40  | \$11,051,225.34 | \$2,397,612.04   | \$13,448,837.38 |

- > The table above summarizes the pharmacy benefit claims for the period between January 1, 2012 and December 31, 2012.
- > For non-specialty, 76.5% of total prescriptions and 48.7% of total paid claim amounts are dispensed through retail pharmacies.
- > Specialty prescriptions represented 0.8% of total prescriptions dispensed and 17.8% of total paid claim amounts.

## PBM Contractual Compliance

### COMPLIANCE WITH PBM FINANCIAL GUARANTEES- RETAIL Invoice Date Period (January 1, 2011 – December 31, 2011)

|   | Retail         |                                      |                                      | Total           |
|---|----------------|--------------------------------------|--------------------------------------|-----------------|
|   | Brand          | Generic<br>01/01/2011-<br>09/24/2011 | Generic<br>09/25/2011-<br>12/31/2011 |                 |
| Total Rx's Dispensed  | 49,846         | 57,393                               | 19,354                               | 126,593         |
| Total AWP Cost  | \$9,297,774.92 | \$4,146,873.82                       | \$1,485,650.53                       | \$14,930,299.26 |
| Total Ingredient Cost   | \$7,828,273.08 | \$1,293,492.91                       | \$461,587.20                         | \$9,583,353.19  |
| Total Dispensing Fees   | \$64,835.98    | \$74,613.64                          | \$25,160.34                          | \$164,609.96    |
| AWP Discount Achieved   | 15.61%         | 67.06%                               | 67.42%                               |                 |
| AWP Discount Contracted   | 14.6995%       | 68.00%                               | 69.29%                               |                 |
| Dispensing Fee/Rx<br>Achieved                                     | \$1.30         | \$1.30                               | \$1.30                               |                 |
| Dispensing Fee/Rx<br>Contracted                                   | \$1.30         | \$1.30                               | \$1.30                               |                 |
| Discount Achieved<br>vs. Contracted-<br>(Surplus)/Shortfall       | (\$84,525.30)  | \$39,000.05                          | \$27,745.94                          | (\$17,779.31)   |
| Dispensing Fee<br>Achieved vs. Contracted-<br>(Surplus)/Shortfall | \$36.18        | \$2.74                               | \$0.14                               | \$39.06         |
| Net (Surplus)/Shortfall<br>Actual to Contracted                   | (\$84,489.12)  | \$39,002.79                          | \$27,746.08                          | (\$17,740.25)   |

- > Achieved AWP discounts and average dispensing fees charged exclude paper, mail specialty, OTC and non-drug prescriptions. Single source generics (SSGs) with less than three manufacturers are included under the brand discount.
- > The achieved retail brand discount over-performed the minimum contractual guarantee of AWP -14.6995%, generating a surplus of \$84,525.30.
- > The achieved retail generic discount from 01/01/2011-09/24/2011 under-performed the minimum contractual guarantee of AWP-68.00%, resulting in a shortfall of \$39,000.05.
- > The achieved retail generic discount from 09/25/2011-12/31/2011 under-performed the minimum contractual guarantee of AWP-69.29%, resulting in a shortfall of \$27,745.94. The revised retail generic discount guarantee effective 9/25/2011 was taken from the ESI Net Effective Discount (NED) document. Achieved retail discounts over-performed minimum contractual guarantees, generating a surplus of \$17,779.31.
- > Achieved retail dispensing fees per prescription under-performed the minimum contractual guarantee of \$1.30, resulting in a shortfall of \$39.06.

- > ESI over-performed 2011 retail contractual discount and dispensing fee guarantees generating a surplus of \$17,740.25.

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**ESI's reconciliation of the retail guarantees for the invoice date period of January 1, 2011 – December 31, 2011 showed a surplus of \$42,754.37 and Segal calculated a surplus of \$17,740.25. Segal recommends that the County accept ESI's reconciliation for these guarantees.**

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**COMPLIANCE WITH PBM FINANCIAL GUARANTEES- MAIL  
Invoice Date Period (January 1, 2011 – December 31, 2011)**

|  | Mail 1-44-day Supply |              |              | Mail 45 day Supply or Greater |                |                | Total          |
|--|----------------------|--------------|--------------|-------------------------------|----------------|----------------|----------------|
|  | Brand                | Generic      | Total        | Brand                         | Generic        | Total          |                |
| Total Rx's Dispensed   | 239                  | 305          | 544          | 10,151                        | 10,468         | 20,619         | 21,163         |
| Total AWP Cost   | \$48,280.85          | \$31,140.53  | \$79,421.38  | \$5,246,600.61                | \$2,671,574.84 | \$7,918,175.45 | \$7,997,596.83 |
| Total Ingredient Cost  | \$39,881.90          | \$5,726.53   | \$45,608.43  | \$4,041,549.47                | \$777,644.94   | \$4,819,194.41 | \$4,864,802.84 |
| Total Dispensing Fees  | \$339.19             | \$432.90     | \$772.09     | \$1,234.25                    | \$1,306.56     | \$2,540.81     | \$3,312.90     |
| AWP Discount Achieved  | 14.94%               | 74.63%       |              | 22.75%                        | 69.86%         |                |                |
| AWP Discount Contracted  | 14.6995%             | 68.00%       |              | 23.0215%                      | 72.00%         |                |                |
| Dispensing Fee/Rx Achieved                                     | \$1.42               | \$1.42       |              | \$0.12                        | \$0.12         |                |                |
| Dispensing Fee/Rx Contracted                                   | \$1.42               | \$1.42       |              | \$0.12                        | \$0.12         |                |                |
| Discount Achieved vs. Contracted-<br>(Surplus)/Shortfall       | (\$115.57)           | (\$2,064.39) | (\$2,179.96) | \$14,312.52                   | \$57,299.53    | \$71,612.04    | \$69,432.08    |
| Dispensing Fee Achieved vs. Contracted-<br>(Surplus)/Shortfall | (\$0.07)             | \$0.00       | (\$0.07)     | \$45.09                       | \$63.71        | \$108.80       | \$108.73       |
| Net (Surplus)/Shortfall Actual to Contracted                   | (\$115.64)           | (\$2,064.39) | (\$2,180.03) | \$14,357.61                   | \$57,363.24    | \$71,720.84    | \$69,540.81    |

- Achieved AWP discounts and average dispensing fees charged exclude paper, mail specialty, OTC and non-drug prescriptions. Single source generics (SSGs) with less than three manufacturers are included under the brand discount. Contracted mail 1-34-day supply dispensing fee per prescriptions is a blended rate of \$1.37 from 01/01/2011-04/15/2011 and \$1.44 from 04/16/2011-12/31/2011. Contracted mail 35-90-day supply dispensing fee per prescription is a blended rate of \$0.07 from 01/01/2011-04/15/2011 and \$0.14 from 04/16/2011-12/31/2011.
- The achieved mail 1-44-day supply brand discount over-performed the minimum contractual guarantee of AWP -14.6995%, generating a surplus of \$115.57.
- The achieved mail 1-44-day supply generic discount over-performed the minimum contractual guarantee of AWP-68.00%, generating a surplus of \$2,064.39.
- The achieved mail 45-day supply or greater brand discount under-performed the minimum contractual guarantee of AWP-23.0215%, resulting in a shortfall of \$14,312.52.
- The achieved mail 45-day supply or greater generic discount under-performed the minimum contractual guarantee of AWP-72.00%, resulting in a shortfall of \$57,299.53.

- > Achieved mail discounts under-performed minimum contractual guarantees, resulting in a shortfall of \$69,432.08.
- > Achieved mail dispensing fees per prescription under-performed minimum contractual guarantees, resulting in a shortfall of \$108.73.
- > ESI under-performed 2011 mail contractual discount and dispensing fee guarantees resulting in a shortfall of \$69,540.81.

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**ESI's reconciliation of the mail guarantees for the invoice date period of January 1, 2011 – December 31, 2011 showed a shortfall of \$94,631.49 and Segal calculated a shortfall of \$69,540.81. Segal recommends that the County accept ESI's reconciliation for these guarantees.**

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Overall, ESI under-performed 2011 retail and mail contractual discount and dispensing fee guarantees resulting in a shortfall of \$51,800.56.

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**Overall, ESI's net reconciliation of the retail and mail guarantees for the period of January 1, 2011 – December 31, 2011 showed a shortfall of \$51,877.12 and Segal calculated a shortfall of \$51,800.56. Segal recommends that the County accept ESI's reconciliation for these guarantees.**

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**COMPLIANCE WITH PBM FINANCIAL GUARANTEES- RETAIL  
Invoice Date Period (January 1, 2012 – January 31, 2012)**

|   | Retail       |              |                |
|---|--------------|--------------|----------------|
|   | Brand        | Generic      | Total          |
| Total Rx's Dispensed  | 3,544        | 5,693        | 9,237          |
| Total AWP Cost  | \$696,831.70 | \$432,553.18 | \$1,129,384.89 |
| Total Ingredient Cost                                       | \$590,597.69 | \$137,677.29 | \$728,274.98   |
| Total Dispensing Fees                                       | \$4,603.72   | \$7,400.90   | \$12,004.62    |
| AWP Discount Achieved                                       | 15.25%       | 68.17%       |                |
| AWP Discount Contracted                                     | 14.6995%     | 69.29%       |                |
| Dispensing Fee/Rx Achieved                                  | \$1.30       | \$1.30       |                |
| Dispensing Fee/Rx Contracted                                | \$1.30       | \$1.30       |                |
| Discount Achieved vs. Contracted- (Surplus)/Shortfall       | (\$3,803.24) | \$4,840.21   | \$1,036.97     |
| Dispensing Fee Achieved vs. Contracted- (Surplus)/Shortfall | (\$3.48)     | \$0.00       | (\$3.48)       |
| Net (Surplus)/Shortfall Actual to Contracted                | (\$3,806.72) | \$4,840.21   | \$1,033.49     |

- > The contractual guarantees for this period were not provided and for the purposes of this audit contracted guarantees for 2011 were assumed to be in effect. The County should confirm the pricing terms for this period.
- > Achieved AWP discounts and average dispensing fees charged exclude paper, mail specialty, OTC and non-drug prescriptions. Single source generics (SSGs) with less than three manufacturers are included under the brand discount.
- > The achieved retail brand discount over-performed the minimum contractual guarantee of AWP -14.6995%, generating a surplus of \$3,803.24.
- > The achieved retail generic discount under-performed the minimum contractual guarantee of AWP-69.29%, resulting in a shortfall of \$4,840.21
- > Achieved retail discounts under-performed minimum contractual guarantees, resulting in a shortfall of \$1,036.97.
- > Achieved retail dispensing fees per prescription over-performed the minimum contractual guarantee of \$1.30, generating a surplus of \$3.48.

- > ESI under-performed January 2012 retail contractual discount and dispensing fee guarantees resulting in a shortfall of \$1,033.49.

\*\*\*\*\*

**ESI's reconciliation of the retail guarantees for the invoice date period of January 1, 2012 – January 31, 2012 showed a shortfall of \$601.20 and Segal calculated a shortfall of \$1,033.49. Segal recommends that the County accept ESI's reconciliation for these guarantees.**

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**COMPLIANCE WITH PBM FINANCIAL GUARANTEES- MAIL  
Invoice Date Period (January 1, 2012 – January 31, 2012)**

|   | Mail 1-44-day Supply |              |              | Mail 45 day Supply or Greater |              |               | Total         |
|---|----------------------|--------------|--------------|-------------------------------|--------------|---------------|---------------|
|   | Brand                | Generic      | Total        | Brand                         | Generic      | Total         |               |
| Total Rx's Dispensed  | 14                   | 34           | 48           | 896                           | 963          | 1,859         | 1,907         |
| Total AWP Cost  | \$3,228.09           | \$5,182.53   | \$8,410.62   | \$501,584.67                  | \$248,284.72 | \$749,869.38  | \$758,280.00  |
| Total Ingredient Cost                                       | \$2,568.23           | \$620.46     | \$3,188.69   | \$378,875.23                  | \$62,935.53  | \$441,810.76  | \$444,999.45  |
| Total Dispensing Fees                                       | \$28.80              | \$48.96      | \$77.76      | \$133.24                      | \$145.22     | \$278.46      | \$356.22      |
| AWP Discount Achieved                                       | 20.44%               | 88.03%       |              | 24.46%                        | 74.65%       |               |               |
| AWP Discount Contracted                                     | 14.6995%             | 68.00%       |              | 23.0215%                      | 72.00%       |               |               |
| Dispensing Fee/Rx Achieved                                  | \$2.06               | \$1.44       |              | \$0.15                        | \$0.15       |               |               |
| Dispensing Fee/Rx Contracted                                | \$1.44               | \$1.44       |              | \$0.14                        | \$0.14       |               |               |
| Discount Achieved vs. Contracted- (Surplus)/Shortfall       | (\$185.35)           | (\$1,037.95) | (\$1,223.30) | (\$7,237.12)                  | (\$6,584.19) | (\$13,821.31) | (\$15,044.61) |
| Dispensing Fee Achieved vs. Contracted- (Surplus)/Shortfall | \$8.64               | (\$0.00)     | \$8.64       | \$7.80                        | \$10.40      | \$18.20       | \$26.84       |
| Net (Surplus)/Shortfall Actual to Contracted                | (\$176.71)           | (\$1,037.95) | (\$1,214.66) | (\$7,229.32)                  | (\$6,573.79) | (\$13,803.11) | (\$15,017.77) |

- > The contractual guarantees for this period were not provided and for the purposes of this audit contracted guarantees for 2011 were assumed to be in effect. The County may wish to confirm the pricing terms for this period.
- > Achieved AWP discounts and average dispensing fees charged exclude paper, mail specialty, OTC and non-drug prescriptions. Single source generics (SSGs) with less than three manufacturers are included under the brand discount.
- > The achieved mail 1-44-day supply brand discount over-performed the minimum contractual guarantee of AWP -14.6995%, generating a surplus of \$185.35.
- > The achieved mail 1-44-day supply generic discount over-performed the minimum contractual guarantee of AWP-68.00%, generating a surplus of \$1,037.95.
- > The achieved mail 45 day supply or greater brand discount over-performed the minimum contractual guarantee of AWP-23.0215%, generating a surplus of \$7,237.12.
- > The achieved mail 45 day supply or greater generic discount over-performed the minimum contractual guarantee of AWP-72.00%, generating a surplus of \$6,584.19.
- > Achieved mail discounts over-performed minimum contractual guarantees, generating a surplus of \$15,044.61.

- > Achieved mail dispensing fees per prescription under-performed minimum contractual guarantees, resulting in a shortfall of \$26.84.
- > ESI over-performed January 2012 mail contractual discount and dispensing fee guarantees, generating a surplus of \$15,017.77.

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**ESI's reconciliation of the mail guarantees for the invoice date period of January 1, 2012 – January 31, 2012 showed a surplus of \$1,066.12 and Segal calculated a surplus of \$15,017.77. Segal recommends that the County accept ESI's reconciliation for these guarantees.**

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Overall, ESI over-performed January 2012 retail and mail contractual discount and dispensing fee guarantees resulting in a surplus of \$13,984.28.

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**Overall, ESI's net reconciliation of the retail and mail guarantees for the period of January 1, 2012 –January 31, 2012 showed a surplus of \$464.92 and Segal calculated a surplus of \$13,984.28. Segal recommends that the County accept ESI's reconciliation for these guarantees.**

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**COMPLIANCE WITH PBM FINANCIAL GUARANTEES- RETAIL**  
**Invoice Date Period (February 1, 2012 – December 31, 2012)**

|   | Retail         |                |                 |
|---|----------------|----------------|-----------------|
|   | Brand          | Generic        | Total           |
| Total Rx's Dispensed  | 29,086         | 59,838         | 88,924          |
| Total AWP Cost  | \$6,006,110.81 | \$4,789,822.26 | \$10,795,933.06 |
| Total Ingredient Cost                                       | \$4,991,948.71 | \$1,551,799.32 | \$6,543,748.03  |
| Total Dispensing Fees                                       | \$35,184.77    | \$72,025.20    | \$107,209.97    |
| AWP Discount Achieved                                       | 16.89%         | 67.60%         |                 |
| AWP Discount Contracted                                     | 15.50%         | 71.00%         |                 |
| Dispensing Fee/Rx Achieved                                  | \$1.21         | \$1.20         |                 |
| Dispensing Fee/Rx Contracted                                | \$1.20         | \$1.20         |                 |
| Discount Achieved vs. Contracted- (Surplus)/Shortfall       | (\$83,214.92)  | \$162,750.87   | \$79,535.94     |
| Dispensing Fee Achieved vs. Contracted- (Surplus)/Shortfall | \$281.57       | \$219.60       | \$501.17        |
| Net (Surplus)/Shortfall Actual to Contracted                | (\$82,933.35)  | \$162,970.47   | \$80,037.11     |

- > Achieved AWP discounts and average dispensing fees charged exclude paper, mail specialty, OTC and non-drug prescriptions. Single source generics (SSGs) with less than three manufacturers are included under the brand discount.
- > The achieved retail brand discount over-performed the minimum contractual guarantee of AWP -15.50%, generating a surplus of \$83,214.92.
- > The achieved retail generic discount under-performed the minimum contractual guarantee of AWP-71.00%, resulting in a shortfall of \$162,750.87.
- > Achieved retail discounts under-performed minimum contractual guarantees, resulting in a shortfall of \$79,535.94.
- > Achieved retail dispensing fees per prescription under-performed the minimum contractual guarantee of \$1.20, resulting in a shortfall of \$501.17.
- > ESI under-performed February 1, 2012 – December 31, 2012 retail contractual discount and dispensing fee guarantees resulting in a shortfall of \$80,037.11.

\*\*\*\*\*

**ESI's reconciliation of the retail guarantees for the invoice date period of February 1, 2012 – December 31, 2012 showed a shortfall of \$84,327.30 and Segal calculated a shortfall of \$80,037.11. Segal recommends that the County accept ESI's reconciliation for these guarantees.**

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**COMPLIANCE WITH PBM FINANCIAL GUARANTEES- MAIL  
Invoice Date Period (February 1, 2012 – December 31, 2012)**

|   | Mail 1-44-day Supply |              |              | Mail 45 day Supply or Greater |                |                 | Total           |
|---|----------------------|--------------|--------------|-------------------------------|----------------|-----------------|-----------------|
|   | Brand                | Generic      | Total        | Brand                         | Generic        | Total           |                 |
| Total Rx's Dispensed  | 362                  | 585          | 947          | 10,990                        | 16,002         | 26,992          | 27,939          |
| Total AWP Cost  | \$87,651.41          | \$70,401.73  | \$158,053.14 | \$6,348,615.21                | \$4,529,420.58 | \$10,878,035.80 | \$11,036,088.94 |
| Total Ingredient Cost                                       | \$70,733.93          | \$15,675.19  | \$86,409.12  | \$4,816,261.36                | \$1,202,827.21 | \$6,019,088.57  | \$6,105,497.69  |
| Total Dispensing Fees                                       | \$422.20             | \$676.95     | \$1,099.15   | \$67.42                       | \$87.15        | \$154.57        | \$1,253.72      |
| AWP Discount Achieved                                       | 19.30%               | 77.73%       |              | 24.14%                        | 73.44%         |                 |                 |
| AWP Discount Contracted                                     | 15.50%               | 71.00%       |              | 23.25%                        | 75.00%         |                 |                 |
| Dispensing Fee/Rx Achieved                                  | \$1.17               | \$1.16       |              | \$0.01                        | \$0.01         |                 |                 |
| Dispensing Fee/Rx Contracted                                | \$1.20               | \$1.20       |              | \$0.00                        | \$0.00         |                 |                 |
| Discount Achieved vs. Contracted- (Surplus)/Shortfall       | (\$3,331.51)         | (\$4,741.31) | (\$8,072.82) | (\$56,300.82)                 | \$70,472.06    | \$14,171.25     | \$6,098.42      |
| Dispensing Fee Achieved vs. Contracted- (Surplus)/Shortfall | (\$12.20)            | (\$25.05)    | (\$37.25)    | \$67.42                       | \$87.15        | \$154.57        | \$117.32        |
| Net (Surplus)/Shortfall Actual to Contracted                | (\$3,343.71)         | (\$4,766.36) | (\$8,110.07) | (\$56,233.40)                 | \$70,559.21    | \$14,325.82     | \$6,215.74      |

- Achieved AWP discounts and average dispensing fees charged exclude paper, mail specialty, OTC and non-drug prescriptions. Single source generics (SSGs) with less than three manufacturers are included under the brand discount.
- The achieved mail 1-44-day supply brand discount over-performed the minimum contractual guarantee of AWP -15.50%, generating a surplus of \$3,331.51.
- The achieved mail 1-44-day supply generic discount over-performed the minimum contractual guarantee of AWP-71.00%, generating a surplus of \$4,741.31.
- The achieved mail 45-day supply or greater brand discount over-performed the minimum contractual guarantee of AWP-23.25%, generating a surplus of \$56,300.82.
- The achieved mail 45-day supply or greater generic discount under-performed the minimum contractual guarantee of AWP-75.00%, resulting in a shortfall of \$70,472.06.
- Achieved mail discounts under-performed minimum contractual guarantees, resulting in a shortfall of \$6,098.42.

- > Achieved mail dispensing fees per prescription under-performed minimum contractual guarantees, resulting in a shortfall of \$117.32.
- > ESI under-performed February 1, 2012 – December 31, 2012 mail contractual discount and dispensing fee guarantees resulting in a shortfall of \$6,215.74.

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**ESI's reconciliation of the mail guarantees for the invoice date period of February 1, 2012 – December 31, 2012 showed a shortfall of \$146,138.79 and Segal calculated a shortfall of \$6,215.74. Segal recommends that the County accept ESI's reconciliation for these guarantees.**

\*\*\*\*\*

Overall, ESI under-performed February 1, 2012 – December 31, 2012 retail and mail contractual discount and dispensing fee guarantees resulting in a shortfall of \$86,252.85 .

\*\*\*\*\*

**Overall, ESI's net reconciliation of the retail and mail guarantees for the period of February 1, 2012 – December 31, 2012 showed a shortfall of \$230,466.09 and Segal calculated a shortfall of \$86,252.85. Segal recommends that the County accept ESI's reconciliation for these guarantees.**

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## Administrative Fees

January 1, 2011 – December 31, 2011

|                          | Channel | Total Prescriptions | Administrative Fee Guarantee Per Prescription | Total Administrative Fees |
|--------------------------|---------|---------------------|---|---------------------------|
| Electronic Prescriptions | Retail  | 128,367             | \$0.00  | \$0.00                    |
|                          | Mail    | 21,971              | \$0.00  | \$0.00                    |
| Paper Prescriptions      | Retail  | 62                  | \$1.75  | \$108.50                  |
|                          | Mail    | (2)                 | \$1.75  | (\$3.50)                  |
| <b>Grand Total</b>       |         | <b>150,398</b>      |   | <b>\$105.00</b>           |

- > 2011 administrative fees for electronic and paper claims total \$105.00 and are consistent with the contract.

January 1, 2012 – December 31, 2012

|                          | Channel | Total Prescriptions | Administrative Fee Guarantee Per Prescription | Total Administrative Fees |
|--------------------------|---------|---------------------|---|---------------------------|
| Electronic Prescriptions | Retail  | 99,498              | \$0.00  | \$0.00                    |
|                          | Mail    | 30,918              | \$0.00  | \$0.00                    |
| Paper Prescriptions      | Retail  | 36                  | \$1.75  | \$63.00                   |
|                          | Mail    | (4)                 | \$1.75  | (\$7.00)                  |
| <b>Grand Total</b>       |         | <b>130,448</b>      |   | <b>\$56.00</b>            |

- > 2012 administrative fees for electronic and paper claims total \$56.00, and are consistent with the contract.

**Rebate Guarantees**

**January 1, 2011 – December 31, 2011**

|                       | Total Prescriptions | Rebate Guarantee per Prescription | Total Guaranteed Rebates | Total Rebates Paid    | Rebate (Surplus)/ Shortfall |
|-----------------------|---------------------|-----------------------------------|--------------------------|-----------------------|-----------------------------|
| Retail                | 128,261             | \$6.25                            | \$801,631.25             |                       |                             |
| Mail 1-34-day Supply  | 586                 | \$6.25                            | \$3,662.50               |                       |                             |
| Mail 35-90-day Supply | 21,012              | \$27.50                           | \$577,830.00             |                       |                             |
| <b>Total</b>          | <b>149,859</b>      |                                   | <b>\$1,383,123.75</b>    | <b>\$1,533,056.88</b> | <b>(\$149,933.13)</b>       |

- > 2011 rebate guarantees are on a “per Rx” basis.
- > Guaranteed rebates for 2011 total \$1,383,123.75 for retail and mail combined.
- > ESI paid out a total of \$1,533,056.88 in rebates from 1/1/2011 through 12/31/2011.
- > Total rebates paid in 2011 exceeded rebate guarantees by \$149,933.13.

\*\*\*\*\*

ESI’s net reconciliation of the rebate guarantees for the period of January 1, 2011 – December 31, 2011 showed guaranteed rebates to be in the amount of \$1,107,077.00 and Segal calculated guaranteed rebates to be in the amount \$1,383,123.75. Since the total paid rebates exceed both Segal’s and ESI’s calculation of the guaranteed rebates, Segal recommends that the County accept ESI’s reconciliation for this guarantee.

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**January 1, 2012 – December 31, 2012**

|   | Total Prescriptions | Rebate Guarantee per Prescription | Total Guaranteed Rebates | Total Rebates Paid    | Rebate (Surplus)/ Shortfall |
|---|---------------------|-----------------------------------|--------------------------|-----------------------|-----------------------------|
| Retail (Jan 2012)                         | 9,352               | \$6.25                            | \$58,450.00              |                       |                             |
| Mail 1-34-day Supply (Jan 2012)           | 55                  | \$6.25                            | \$343.75                 |                       |                             |
| Mail 35-90-day Supply (Jan 2012)          | 1,910               | \$27.50                           | \$52,525.00              |                       |                             |
| Retail (Feb 2012-Dec 2012)                | 19,787              | \$19.57                           | \$387,231.59             |                       |                             |
| Mail 1-34-day Supply (Feb 2012-Dec 2012)  | 314                 | \$19.57                           | \$6,144.98               |                       |                             |
| Mail 35-90-day Supply (Feb 2012-Dec 2012) | 8,994               | \$66.71                           | \$599,989.74             |                       |                             |
| <b>Total</b>                              | <b>40,412</b>       |                                   | <b>\$1,104,685.06</b>    | <b>\$1,332,658.83</b> | <b>(\$227,973.77)</b>       |

- > Jan 2012 rebate guarantees are on a “per prescription” basis. Feb 2012-Dec 2012 rebate guarantees are on a “per brand prescription” basis.
- > 2012 guaranteed rebates total \$1,104,685.06 for retail and mail combined.
- > Total rebates paid in 2012 exceeded rebate guarantees by \$227,973.77.

\*\*\*\*\*

ESI’s net reconciliation of the rebate guarantees for the period of January 1, 2012 – December 31, 2012 showed guaranteed rebates to be in the amount of \$1,095,088.98 and Segal calculated guaranteed rebates to be in the amount \$1,104,685.06. ESI reported that paid rebates for 2012 are in the amount of \$1,332,658.83. Since the total paid rebates exceed both Segal’s and ESI’s calculation of the guaranteed rebates, Segal recommends that the County accept ESI’s reconciliation for this guarantee.

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## Plan Design Analysis

### NON-HRA RETAIL AND MAIL COPAYS January 1, 2011 – December 31, 2011

|              | Drug Type           | Plan Copays | Average Copay Collected | Total Prescriptions | Total Copay Collected | Copay %       |
|--------------|---------------------|-------------|-------------------------|---------------------|-----------------------|---------------|
| Retail       | Generic             | \$10.00     | \$9.44                  | 86,380              | \$815,781.45          | 29.48%        |
|              | Preferred Brand     | \$20.00     | \$19.94                 | 29,768              | \$593,621.29          | 10.83%        |
|              | Non-Preferred Brand | \$35.00     | \$33.55                 | 8,858               | \$297,151.08          | 19.56%        |
| Mail         | Generic             | \$20.00     | \$17.46                 | 12,270              | \$214,185.73          | 19.79%        |
|              | Preferred Brand     | \$50.00     | \$49.48                 | 7,922               | \$391,969.67          | 8.32%         |
|              | Non-Preferred Brand | \$87.50     | \$77.87                 | 1,140               | \$88,773.87           | 13.69%        |
| <b>Total</b> |                     |             | <b>\$16.41</b>          | <b>146,338</b>      | <b>\$2,401,483.09</b> | <b>14.82%</b> |

- > The following table shows the number of prescriptions by channel whose copays were collected outside of plan copay parameters.

|              | Drug Type                 | Number of Prescriptions | Percent of Total Prescriptions |
|--------------|---------------------------|-------------------------|--------------------------------|
| Retail       | Generic                   | 103                     | 0.07%                          |
|              | Preferred Brand Drugs     | 81                      | 0.06%                          |
|              | Non-Preferred Brand Drugs | 148                     | 0.10%                          |
| Mail         | Generic                   | 0                       | 0.00%                          |
|              | Preferred Brand Drugs     | 0                       | 0.00%                          |
|              | Non-Preferred Brand Drugs | 0                       | 0.00%                          |
| <b>Total</b> |                           | <b>332</b>              | <b>0.23%</b>                   |

- > Another 150 claims processed with greater than a 30-days' supply at retail or greater than a 90-days' supply at mail. These claims were investigated and were found to be for unique medications that are clinically appropriate to dispense greater than a 30-days' supply at retail or greater than a 90-days' supply at mail (e.g., Quasense) and therefore were not flagged claims in our analysis.
- > Segal will forward all remaining flagged claims to ESI for their review.

**NON-HRA RETAIL AND MAIL COPAYS**  
**January 1, 2012 – December 31, 2012**

|  | Drug Type           | Plan Copays | Average Copay Collected | Total Prescriptions | Total Copay Collected | Copay %       |
|--|---------------------|-------------|-------------------------|---------------------|-----------------------|---------------|
| <b>Retail</b><br>RRA penalty on 4 <sup>th</sup> fill<br>(mail copay) | Generic             | \$10.00     | \$10.97                 | 76,077              | \$834,542.85          | 29.35%        |
|  | Preferred Brand     | \$30.00     | \$37.67                 | 17,151              | \$646,078.70          | 17.45%        |
|  | Non-Preferred Brand | \$50.00     | \$49.25                 | 5,296               | \$260,820.72          | 23.61%        |
| <b>Mail</b>  | Generic             | \$20.00     | \$16.36                 | 20,343              | \$332,887.66          | 16.72%        |
|  | Preferred Brand     | \$75.00     | \$72.62                 | 8,957               | \$650,422.83          | 11.15%        |
|  | Non-Preferred Brand | \$125.00    | \$100.02                | 1,207               | \$120,722.33          | 16.84%        |
| <b>Total</b>   |                     |             | <b>\$22.05</b>          | <b>129,031</b>      | <b>\$2,845,475.09</b> | <b>17.57%</b> |

- > The following table shows the number of prescriptions by channel whose copays were collected outside of plan copay parameters.

|               | Drug Type                 | Number of Prescriptions | Percent of Total Prescriptions |
|---------------|---------------------------|-------------------------|--------------------------------|
| <b>Retail</b> | Generic                   | 709                     | 0.55%                          |
|               | Preferred Brand Drugs     | 271                     | 0.21%                          |
|               | Non-Preferred Brand Drugs | 128                     | 0.10%                          |
| <b>Mail</b>   | Generic                   | 57                      | 0.04%                          |
|               | Preferred Brand Drugs     | 60                      | 0.05%                          |
|               | Non-Preferred Brand Drugs | 0                       | 0.00%                          |
| <b>Total</b>  |                           | <b>1,225</b>            | <b>1.21%</b>                   |

- > 135 claims processed with greater than a 30-days' supply at retail or greater than a 90-days' supply at mail. These claims were investigated and were found to be for unique medications that are clinically appropriate to dispense greater than a 30-days' supply at retail or greater than a 90-days' supply at mail (e.g., Quasense).
- > Segal will forward all remaining flagged claims to ESI for their review.

## Excluded Drug Analysis

### Excluded Prescriptions Processed for Calendar Years 2011-2012

| Excluded Drug or Drug class | Number of Prescriptions |
|-----------------------------|-------------------------|
| Anti-Obesity                | 0                       |
| Allergy Serums              | 0                       |
| Tamifu and Relenza          | 0                       |
| Fertility agents            | 2                       |
| Dental Fluoride Products    | 0                       |

- > There were 2 claims that processed for fertility agents. Segal will send sample claims to ESI to investigate this further.
- > The plan design does not allow for Tamifu and Relenza to process at mail order. While there were 474 claims for Tamifu and Relenza all were processed at retail pharmacies.

## Top Pharmacy Chain Analysis

### TOP 10 RETAIL PHARMACIES January 1, 2011 – December 31, 2011

| Pharmacy Chain         | Ingredient Cost       | PCT of Total Ingredient Cost | Total Prescriptions | Generic Dispensing Rate | Brand Discount | Generic Discount |
|------------------------|-----------------------|------------------------------|---------------------|-------------------------|----------------|------------------|
| CVS PHARMACY           | \$2,001,571.77        | 20.89%                       | 26,238              | 61.56%                  | 14.99%         | 65.84%           |
| KROGER                 | \$1,507,930.58        | 15.73%                       | 22,007              | 62.04%                  | 15.25%         | 73.14%           |
| WALGREENS              | \$1,418,254.43        | 14.80%                       | 19,507              | 60.49%                  | 15.64%         | 67.37%           |
| PUBLIX PHARMACY        | \$1,279,523.26        | 13.35%                       | 16,924              | 58.73%                  | 15.25%         | 68.15%           |
| RITE AID               | \$1,082,967.63        | 11.30%                       | 14,160              | 59.87%                  | 14.74%         | 66.49%           |
| WAL-MART PHARMACY      | \$537,242.01          | 5.61%                        | 8,585               | 62.34%                  | 15.03%         | 75.26%           |
| TARGET PHARMACY        | \$261,461.60          | 2.73%                        | 3,623               | 57.36%                  | 14.74%         | 71.86%           |
| ACCREDITO HEALTH GROUP | \$224,524.95          | 2.34%                        | 33                  | 0.00%                   | 30.47%         | NA               |
| SHAW PHARMACY          | \$131,308.94          | 1.37%                        | 1,619               | 50.96%                  | 15.94%         | 63.48%           |
| KMART PHARMACY         | \$76,354.58           | 0.80%                        | 863                 | 55.85%                  | 14.32%         | 59.06%           |
| <b>Total Top 10</b>    | <b>\$8,521,139.75</b> | <b>88.92%</b>                | <b>113,559</b>      | <b>60.55%</b>           | <b>15.76%</b>  | <b>68.77%</b>    |
| <b>Grand Total</b>     | <b>\$9,583,353.19</b> | <b>100.00%</b>               | <b>126,593</b>      | <b>60.62%</b>           | <b>15.80%</b>  | <b>68.84%</b>    |

- This report is for illustrative purposes to allow the County to see the Generic Dispensing Rate and achieved AWP discounts broken out by top pharmacy chain.
- The Top Pharmacy Analysis provides the ten most frequently utilized pharmacies and pharmacy chains, based on aggregate ingredient cost dispensed for each period. Discounts achieved, as well as percentage of generic drugs dispensed, are shown in order to gauge the effectiveness of top pharmacies in controlling and lowering plan drug costs.
- Achieved retail discounts exclude paper, mail specialty, OTC and non-drug prescriptions. Single source generics (SSGs) with less than three manufacturers are included under the brand discount.
- CVS Pharmacy is the top retail pharmacy chain making up 20.89% of total ingredient cost. CVS Pharmacy's achieved discounts exceeded the brand discount guarantee of AWP-14.6995% and fell short of the generic discount guarantee of AWP-68%.
- 88.92% of total retail ingredient costs are comprised of prescriptions filled at the top ten pharmacies.
- Wal-Mart Pharmacy has the highest generic dispensing rate of 62.34%.
- Wal-Mart Pharmacy achieved the highest retail generic discount of AWP-75.26%.
- Accredo Health Group achieved the highest retail brand discount of AWP-30.47%. Accredo is ESI's specialty pharmacy, where 33 prescriptions were coded as retail specialty.

**TOP 10 RETAIL PHARMACIES**  
**February 1, 2012 – December 31, 2012**

| Pharmacy Chain         | Ingredient Cost       | PCT of Total Ingredient Cost | Total Prescriptions | Generic Dispensing Rate | Brand Discount | Generic Discount |
|------------------------|-----------------------|------------------------------|---------------------|-------------------------|----------------|------------------|
| CVS PHARMACY           | \$1,498,782.16        | 20.61%                       | 20,625              | 67.79%                  | 16.88%         | 65.31%           |
| KROGER                 | \$1,124,285.84        | 15.46%                       | 18,049              | 68.21%                  | 16.91%         | 71.24%           |
| WALGREENS              | \$1,039,028.99        | 14.29%                       | 14,356              | 67.22%                  | 16.42%         | 66.93%           |
| PUBLIX PHARMACY        | \$901,993.65          | 12.40%                       | 13,072              | 65.72%                  | 16.57%         | 66.27%           |
| RITE AID               | \$839,064.73          | 11.54%                       | 10,803              | 64.45%                  | 15.83%         | 66.61%           |
| WAL-MART PHARMACY      | \$391,619.54          | 5.39%                        | 6,570               | 67.15%                  | 16.43%         | 72.09%           |
| ACCREDO HEALTH GROUP   | \$196,520.25          | 2.70%                        | 32                  | 0.00%                   | 17.43%         | NA               |
| TARGET PHARMACY        | \$164,282.97          | 2.26%                        | 2,627               | 64.90%                  | 16.24%         | 69.40%           |
| SHAW PHARMACY          | \$113,395.11          | 1.56%                        | 1,127               | 60.96%                  | 16.31%         | 62.82%           |
| LACEY DRUG COMPANY INC | \$72,976.15           | 1.00%                        | 612                 | 58.50%                  | 19.48%         | 59.80%           |
| <b>Total Top 10</b>    | <b>\$6,341,949.39</b> | <b>87.21%</b>                | <b>87,873</b>       | <b>66.75%</b>           | <b>16.63%</b>  | <b>67.60%</b>    |
| <b>Grand Total</b>     | <b>\$7,272,023.01</b> | <b>100.00%</b>               | <b>98,161</b>       | <b>66.76%</b>           | <b>16.71%</b>  | <b>67.65%</b>    |

- > This report is for illustrative purposes to allow the County to see the Generic Dispensing Rate and achieved AWP discounts broken out by top pharmacy chain.
- > The Top Pharmacy Analysis provides the ten most frequently utilized pharmacies and pharmacy chains, based on aggregate ingredient cost dispensed for each period. Discounts achieved, as well as percentage of generic drugs dispensed, are shown in order to gauge the effectiveness of top pharmacies in controlling and lowering plan drug costs.
- > Achieved retail discounts exclude paper, mail specialty, OTC and non-drug prescriptions. Single source generics (SSGs) with less than three manufacturers are included under the brand discount.
- > CVS Pharmacy is the top retail pharmacy chain making up 20.61% of total ingredient cost. CVS Pharmacy's achieved discounts exceeded the brand discount guarantee of AWP-15.50% and fell short of the generic discount guarantee of AWP-71.00%.
- > 87.21% of total retail ingredient costs are comprised of prescriptions filled at the top ten pharmacies.
- > Kroger has the highest generic dispensing rate of 68.21%.
- > Wal-Mart Pharmacy achieved the highest retail generic discount of AWP-72.09%.
- > Lacey Drug Company achieved the highest retail brand discount of AWP-19.48%.

## Top Therapeutic Class Summary

January 1, 2011 – December 31, 2011

| Therapeutic Class                      | PCT of Total Ing Cost | PCT of Total Days Dispensed | Generic Dispensing Rate | Generic Sub Rate | Ing Cost Per Day |
|--|-----------------------|-----------------------------|-------------------------|------------------|------------------|
| PROTON-PUMP INHIBITORS                 | 7.8%                  | 5.3%                        | 37.8%                   | 96.9%            | \$4.75           |
| HMG-COA REDUCTASE INHIBITORS           | 6.3%                  | 7.9%                        | 46.3%                   | 98.0%            | \$2.61           |
| ANTIDEPRESSANTS                        | 5.4%                  | 8.4%                        | 76.4%                   | 97.2%            | \$2.12           |
| BIOLOGIC RESPONSE MODIFIERS            | 3.8%                  | 0.1%                        | 0.0%                    | 0.0%             | \$116.78         |
| INSULINS                               | 3.2%                  | 1.2%                        | 0.0%                    | 0.0%             | \$8.72           |
| ANGIOTENSIN II RECEPTOR ANTAGONISTS    | 3.1%                  | 3.5%                        | 29.4%                   | 98.5%            | \$2.92           |
| OPIATE AGONISTS                        | 2.9%                  | 2.9%                        | 91.7%                   | 98.3%            | \$3.24           |
| DISEASE-MODIFYING ANTIRHEUMATIC AGENTS | 2.8%                  | 0.1%                        | 13.4%                   | 90.5%            | \$62.84          |
| ANTICONVULSANTS, MISCELLANEOUS         | 2.4%                  | 2.1%                        | 76.0%                   | 92.4%            | \$3.66           |
| ANTIPSYCHOTIC AGENTS                   | 2.1%                  | 0.5%                        | 26.9%                   | 91.4%            | \$12.62          |
| <b>Top 10 Totals</b>                   | <b>39.9%</b>          | <b>32.2%</b>                | <b>60.7%</b>            | <b>97.3%</b>     | <b>\$4.04</b>    |
| <b>Grand Total</b>                     | <b>100.0%</b>         | <b>100.0%</b>               | <b>67.5%</b>            | <b>96.6%</b>     | <b>\$3.26</b>    |

- > This report is for illustrative purposes to allow the County to see the Generic Dispensing Rate, Generic Substitution Rate and Ingredient Cost per Day broken out by therapeutic class.
- > The top ten therapeutic classes make up 39.9% of total ingredient cost.
- > The top therapeutic category by ingredient cost is proton-pump inhibitors, with 7.8% of total ingredient cost.
- > The opiate agonists therapeutic category has the highest generic dispensing rate (GDR) with 91.7%.
- > The angiotensin II receptor antagonists therapeutic category has the highest generic substitution rate, 98.5%.

January 1, 2012 – December 31, 2012

| AHFS Drug Category                     | PCT of Total Ing Cost | PCT of Total Days Dispensed | Generic Dispensing Rate | Generic Sub Rate | Ing Cost Per Day |
|--|-----------------------|-----------------------------|-------------------------|------------------|------------------|
| PROTON-PUMP INHIBITORS                 | 7.1%                  | 5.3%                        | 50.6%                   | 99.2%            | \$4.29           |
| HMG-COA REDUCTASE INHIBITORS           | 5.2%                  | 8.0%                        | 78.3%                   | 95.9%            | \$2.10           |
| ANTIDEPRESSANTS                        | 5.1%                  | 8.3%                        | 85.2%                   | 98.0%            | \$1.98           |
| INSULINS                               | 4.0%                  | 1.3%                        | 0.0%                    | 0.0%             | \$9.80           |
| BIOLOGIC RESPONSE MODIFIERS            | 3.6%                  | 0.1%                        | 0.0%                    | 0.0%             | \$137.50         |
| DISEASE-MODIFYING ANTIRHEUMATIC AGENTS | 3.4%                  | 0.2%                        | 20.6%                   | 91.9%            | \$67.64          |
| ANGIOTENSIN II RECEPTOR ANTAGONISTS    | 3.1%                  | 3.7%                        | 49.3%                   | 98.4%            | \$2.74           |
| OPIATE AGONISTS                        | 2.8%                  | 2.9%                        | 93.0%                   | 98.2%            | \$3.14           |
| ANTINEOPLASTIC AGENTS                  | 2.3%                  | 0.4%                        | 87.7%                   | 97.3%            | \$16.65          |
| ANTICONVULSANTS, MISCELLANEOUS         | 2.2%                  | 2.4%                        | 81.6%                   | 97.0%            | \$2.97           |
| <b>Top 10 Totals</b>                   | <b>38.8%</b>          | <b>32.5%</b>                | <b>74.4%</b>            | <b>97.7%</b>     | <b>\$3.84</b>    |
| <b>Grand Total</b>                     | <b>100.0%</b>         | <b>100.0%</b>               | <b>74.8%</b>            | <b>97.7%</b>     | <b>\$3.22</b>    |

- > This report is for illustrative purposes to allow the County to see the Generic Dispensing Rate, Generic Substitution Rate and Ingredient Cost per Day broken out by therapeutic class.
- > The top ten therapeutic classes make up 38.8% of total ingredient cost.
- > The top therapeutic category by ingredient cost is proton-pump inhibitors, with 7.1% of total ingredient cost.
- > The opiate agonists therapeutic category has the highest generic dispensing rate (GDR) with 93.0%.
- > The proton-pump inhibitors therapeutic category has the highest generic substitution rate, 99.2%.

## Summary of Findings and Recommendations

- ESI under-performed 2011 non-specialty contractual discount and dispensing fee guarantees resulting in a shortfall of \$51,800.56 (0.4% of non-specialty gross costs).
- ESI over-performed January 1, 2012- January 31, 2012 non-specialty contractual discount and dispensing fee guarantees resulting in a surplus of \$13,984.28 (0.1% of non-specialty gross costs).
- ESI under-performed February 1, 2012- December 31, 2012 non-specialty contractual discount and dispensing fee guarantees resulting in a shortfall of \$86,252.85 (0.5% of non-specialty gross costs).
- Overall, Segal recommends that the County accept ESI's reconciliation and verify payment for the total shortfall amount. (See table below).

|      |                   |           | Segal            | ESI                |                    |
|------|-------------------|-----------|------------------|--------------------|--------------------|
| 2011 | Retail            | Surplus   | \$17,740.25      | \$42,754.37        |                    |
|      |                   | Shortfall |                  |                    |                    |
|      | Mail              | Surplus   |                  |                    |                    |
|      |                   | Shortfall | \$69,540.81      | \$94,631.49        |                    |
|      | <b>2011 Total</b> |           | <b>Surplus</b>   |                    |                    |
|      |                   |           | <b>Shortfall</b> | <b>\$51,800.56</b> | <b>\$51,877.12</b> |

|                              |                                    |           |                  |                    |                 |
|------------------------------|------------------------------------|-----------|------------------|--------------------|-----------------|
| 2012<br>(1/1/12-<br>1/31/12) | Retail                             | Surplus   |                  |                    |                 |
|                              |                                    | Shortfall | \$1,033.49       | \$601.20           |                 |
|                              | Mail                               | Surplus   | \$15,017.77      | \$1,066.12         |                 |
|                              |                                    | Shortfall |                  |                    |                 |
|                              | <b>2012 (1/1/12-1/31/12) Total</b> |           | <b>Surplus</b>   | <b>\$13,984.28</b> | <b>\$464.92</b> |
|                              |                                    |           | <b>Shortfall</b> |                    |                 |

|                               |                                     |           |                  |                    |                     |
|-------------------------------|-------------------------------------|-----------|------------------|--------------------|---------------------|
| 2012<br>(2/1/12-<br>12/31/12) | Retail                              | Surplus   |                  |                    |                     |
|                               |                                     | Shortfall | \$80,037.11      | \$84,327.30        |                     |
|                               | Mail                                | Surplus   |                  |                    |                     |
|                               |                                     | Shortfall | \$6,215.74       | \$146,138.79       |                     |
|                               | <b>2012 (2/1/12-12/31/12) Total</b> |           | <b>Surplus</b>   |                    |                     |
|                               |                                     |           | <b>Shortfall</b> | <b>\$86,252.85</b> | <b>\$230,466.09</b> |

- > Total rebates paid in 2011 exceed minimum rebate guarantees by \$149,933.13 and the total rebates paid in 2012 exceeded rebate guarantees by \$227,973.77.
- > The current pharmacy benefits contract allows ESI to offset surpluses in any one component to make up for a shortfall in another. Segal recommends such offsets be eliminated in any future contract negotiations.
- > The current pharmacy benefits contract also allows ESI to categorize generic drugs with less than three manufacturers under the brand discount. Segal recommends this categorization of generic drugs be eliminated in any future contract negotiations.
- > The copays collected for members were outside of plan design for 332 prescriptions, or 0.23% of total prescriptions in 2011 and 1,225 prescriptions, or 1.21% of total prescriptions in 2012. Segal will forward all remaining flagged claims to ESI for their review.

# COBB COUNTY WORKERS' COMPENSATION AUDIT

## Final Report

July 2, 2013

**Submitted By:**

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## Section 1 – Executive Summary

Cobb County Government (County) contracted with The Segal Company (Segal) to provide comprehensive audit services of the County's Health Benefit and Workers' Compensation programs. Segal collaborated with Managed Care Advisors (MCA) to audit the Workers' Compensation program and the services provided by AmTrust North America, Inc. (AmTrust) to evaluate the overall effectiveness of the workers' compensation program, including the claims administration process, and determine if AmTrust's performance is meeting the contract requirements and is consistent with industry best practices.

### 1. Audit Scope

The audit covered the period from January 1, 2010 through December 31, 2011. MCA selected a sample of 55 claims, and associated 337 bills, incurred by the County's employees for onsite testing and review. Other areas of the audit focused on AmTrust's processes in place during the audit period as they applied to administrative/operational procedures, medical bill payment, contract terms and program performance.

### 2. Project Tasks

MCA combined their experience in workers' compensation and auditing to provide a comprehensive program review for the County. The audit included a detailed operational review focusing on program processes, procedures and structure as well as a data driven audit of program performance specific to the County's workers' compensation cases and medical billing.

Beginning on January 17, 2013 the audit team coordinated the collection of plan documents including contracts, provider listing, documented policies and procedures, sample reports, program literature and related materials directly from the County.

Also to expedite the onsite review, the audit team prepared and distributed a comprehensive information/data request to AmTrust on February 12, 2013. Because this was the initial audit of AmTrust and the County's workers compensation program, the request was structured to obtain an in-depth understanding of AmTrust's organizational structure, staffing assignments and division of responsibilities, processes and procedures, communications, claims processing, and internal control measures. AmTrust provided a loss run and fee bill reports on February 12, 2013 in response to the data request followed by a brief response to the questionnaire on February 25, 2013. Additional information was provided by AmTrust upon request.

A brief data request was also distributed to Midlands Management Corporation (Midlands), managing general agent for New York Marine and General Insurance Company (NYM), providing the County with excess workers' compensation coverage. Information was provided by Midlands on March 13, 2013. An additional information request was also distributed to the County on February 12, 2013 with all requested information being provided to MCA by February 19, 2013.

The audit team performed a detailed desk-audit of the data and information collected including questionnaire responses, policies, procedures, and reports. Flow charts including the processes for first report of injury and medical bill payment were developed based on the data collected for review during the on-site visits.

A project scope meeting with County personnel was conducted on March 13, 2013 to review the process flow charts and identify any specific concerns pertaining to the County's workers' compensation program or AmTrust of which there was none. The County reported being very pleased with the services provided by AmTrust.

The audit team, including Steven Harper of the County's Internal Audit Division, performed an on-site review at AmTrust's office located at 8995 Westside Parkway, Alpharetta, GA on March 14, 2013. The onsite visit included discussions with managers from the departments, system reviews, and extensive case and claim file reviews. MCA selected a sample of claims incurred by the County's employees for onsite testing and review. Fifty-five claims were ultimately reviewed by the team, 32 onsite and an additional 23 off-site.

AmTrust works concurrently in two separate systems to manage the County's workers compensation program. The systems include ANA Claims (ANA) and Image Right (IR). ANA includes claims information, AmTrust case notes and billing/payment information. The IR system is the document storage system and includes medical bills and supporting documentation, submitted forms and all written communications. Also in IR, claims adjusters review submitted Health Care Finance Association claim form 1500s (HCFAs) and back-up documentation and note approval to pay. Due to the lack of system integration the thorough audit performed required extensive review and back and forth between the two systems. For example, to determine the timeliness of medical bill payment, the bill with the receipt date was located in IR and ANA was reviewed to determine the payment date. During the on-site visit an audit was completed for 32 files by three auditors with an additional 23 files reviewed off-site. In follow-up to a request, AmTrust also provided an additional report including line item bill data and billed procedure codes, allowing an off-site retrospective review of the County's 6268 bills including 17,176 lines processed during the review period to assess claim processing accuracy, including review for duplicates, reduction to State Fee Schedule and Preferred Provider Organization (PPO) discounts.

AmTrust was provided with a draft report and detailed case and bill information for review on May 7, 2013. The responses provided by AmTrust on May 13th and May 28th did not include the required detail so a conference call was held on May 30<sup>th</sup> to discuss the findings presented in the report and review the additional information needed by the auditors. Additional information and clarification were provided on June 13<sup>th</sup> by AmTrust. AmTrust's responses are presented in bold throughout the report.

### **3. Audit Conclusions**

Overall, AmTrust has the staffing, technology, and experience to continue to support the County's workers' compensation contract and maintain plan costs and employee satisfaction. The results of the operational review and audit indicate that, with the exception of the sample audit findings detailed in this report and lack of evidence of thoroughly documented processes and procedures, AmTrust has the proper organizational structure, workflows and policies and procedures in place to support the County's workers' compensation program.

#### **A. Operational Review**

The review included an analysis of day-to-day operational procedures utilized by AmTrust's staff providing services to the County. Written responses to questionnaires by the County and AmTrust, interviews conducted during the onsite visit, and the review of various AmTrust documents supports that the program is operating smoothly. Additional details are presented in Section 2 – Operational Review.

#### **B. Contract Terms**

To ensure AmTrust accountability for compliance with contractual requirements, the Audit Team reviewed contract provisions as part of the comprehensive operational review and audit. The materials reviewed

and the onsite observations indicate that AmTrust is in compliance with the contract terms, as written, for the County's Workers Compensation Program. The auditor's recommendation regarding contract terms suggest more clearly defining the services required. Additional details are presented in Section 3 – Contract Terms and Services Provided.

### C. Key Audit Findings

1. Eighty-seven percent of the claims reviewed were coded appropriately as RO (report only), MED (medical only), TTD (temporary total disability) or PPD (permanent partial disability) based upon claim file documentation. The remaining 13% require additional clarification from AmTrust in order to determine if the coding was correct. The accurate coding of claims is important since the claim type impacts the service fees charged to the County.
2. Of the 55 claims reviewed, including 15 TTD/PPD claims, there were three claims, two TTD and one PPD, where the auditors felt confident in being able to say that the three-point contact was being performed based on the adjuster notes reviewed in ANA Claims.
3. Identification of 96 possible duplicates (0.5% of total bill lines) with a potential duplicate payment of \$10,682.06 when claim number, bill number, DOS and billed amount and paid amount were taken into account. ***AmTrust acknowledged that the bill file as prepared by FairPay did include duplicates but the duplicates were identified by AmTrust prior to payment being issued and payments were either voided or checks were processed at \$0.00.***
4. Potential discrepancies between the contracted bill line fee charge of \$1.25 and the bill charge appearing on the Bill Fee Analysis file provided by Am Trust for 57% of the lines. ***AmTrust initially explained the discrepancy was due to a rounding issue which is now noted on invoices.*** After further review by the auditors it was determined that the Claims Administration Agreement between AmTrust and the County effective October 2010 – September 30, 2011 and enforce for the beginning of the audit period included a per line bill processing fee of \$1.25 and a three-line minimum charge. The contract effective October 1, 2011 through 2015 does not include the three line minimum. There were 435 bills processed by FairPay under the new AmTrust contract including fewer than three lines but with a bill fee of \$3.75 showing on the FairPay bill file.
5. The detailed medical bill audit included 337 medical bills and 964 bill lines; 169 bills were reviewed in detail for timeliness of payment. One hundred and twenty, or 71%, of the bills appeared to have been paid in less than 30 days while 49, or 29%, of these bills were paid in more than 30 days from AmTrust receipt. ***AmTrust reported that there were no penalties assessed or paid in association with these payments. AmTrust has also lowered claim counts for medical only adjusters to expedite the payment process.***

### D. Comments and Recommendations

The following suggestions address comments within this report and are offered to the County and AmTrust for consideration:

1. AmTrust should have readily accessible documented standard work processes and protocols to support their staff member's decision making, ensure adherence to legislative and regulatory requirements and provide an audit trail to ensure consistent quality. The special handling instructions should include the process in place for duplicate payment review and the required

documentation for any and all voided payments. **AmTrust has an on-line claim manual for adjusters in ANA and agreed, upon request from the County, to provide written special handling instructions and comply with the documented instructions.**

2. One of the most critical aspects of a workers' compensation program is early intervention. There is significant evidence that the earlier intervention is introduced, the better the case outcome both medically and financially. Therefore, it is critical that AmTrust work quickly and proactively reach out to all employees reporting a work related injury and initial treating providers to confirm the injury type, prognosis, diagnosis and work status within 24 hours of the report. The recommendation is that all claims, excluding possibly ROs, receive the three point contact and all contact attempts and contacts are documented in ANA. **Per AmTrust ROs are entered and closed because they are not a claim at that point. 3-point contacts are not done on all mo's due to the nature of the claim. All loss time or questionable cases have a 3-point contact performed.**
3. Careful and ongoing case reviews ensure case progression and the best possible case outcomes. Industry standards and AmTrust's process in principal supports ongoing contact with the injured/ill employee, treating physician's office, supervisor, and appropriate County contact throughout the life of the claim. It is recommended that a contact be made and documented in ANA every 30 days. At a minimum documentation should include notes about the contact, current case status, plan and next action. Although not supported by the auditors' findings, **according to AmTrust all LT claims are reviewed on an automatic diary every 30 days.**
4. The current number of lost or modified time days, primary diagnosis and estimated duration of disability, based on industry guidelines, for all lost time claims should be included in ANA. These key case metrics and guidelines should be easily accessible to the adjusters in one system so the cases can be monitored and progressed accordingly.
5. Clinical reviews can be used to guide case management strategy in complex cases and communicate with the treating providers, as appropriate and allowed by State law. AmTrust and the County may want to consider developing criteria for clinical case review.
6. While a three line minimum for bill payment is an industry-standard and was included in the County's previous contract with AmTrust, it is not included in the current contract (See Article 8 – Service Fees). If the County wants it included, a contract modification may be considered. If not, clarification with AmTrust may be required.

## Section 2 – Operational Review

The review included an analysis of day-to-day operational procedures utilized by AmTrust. To expedite this review, a questionnaire was sent to AmTrust for completion prior to our onsite visit. Their written reply, onsite discussions and case reviews enabled us to evaluate AmTrust's operations and control measures that are summarized below.

### 1. Staffing

AmTrust's dedicated team comprised of nine staff members including Vice Presidents, Claims Manager, Claims Supervisor, Claims Adjuster, Marketing Customer Service and Assistants are responsible for providing services for the County. The AmTrust team servicing the County is an extremely strong and experienced team of professionals with the average tenure at AmTrust being just under 13 years and even more years of workers' compensation experience. The team members also bring to the County years of experience with the County and valuable historical knowledge of the County's workers' compensation program. The AmTrust staff providing services to the County presented as very well trained and dedicated to servicing the County in an efficient and professional manner.

Barbara White, Claims Supervisor, is the primary claims manager and has over 40 years of workers' compensation claims handling experience and has been with AmTrust for 17 years. She has managed the County's claims for the past 15 years. Mrs. White is supervised by Barr Venson with 20 years of experience. Also on AmTrust's team is Debra Thompson, Claims Manager, with approximately 20 years of claims handling experience, with the 10 most recent years at AmTrust. Jessica Veach, the Medical Only Adjuster is the newest member of the team with over two years at AmTrust. Normal business hours are 8:30 to 4:30 with voicemail available for after hours, holidays and weekends. Mrs. White reported that the County staff also has her cell number and can reach her at any time.

### 2. Case Intake

A County employee who is injured on-the-job with Cobb County must report the injury to his/her Supervisor within 24 hours or as soon as possible for the injury to be compensable. For the injury to be compensable, an employee who has suffered an on-the-job injury must seek medical treatment for that injury from an approved provider listed on the Panel of Physicians that has been approved by the Cobb County Human Resources Director and posted at each work location, and on the County intranet web site. The supervisor then completes the Supervisors' Accident Investigation Report and ensure the injured employee has signed the Statement of Understanding within 48 hours after notification of the accident/injury and forwards the forms to Human Resources who in turn submits the claim electronically or by fax to AmTrust.

Employees appear to be receiving initial treatment with approved County providers (panel physicians), with the exception of emergency services where they are allowed and encouraged to go to the facility where the medical needs can be most addressed most quickly.

### 3. Initial Assessment and Claims Management

Upon receipt the claim is reviewed by the indemnity adjuster, Barbara White, and is processed by Mrs. White or if it appears the claim is a report only (RO) or medical only, it is forwarded to medical only adjuster, Ms. Jessica Veach. According to protocol, AmTrust initiates a three-point contact to:

- Employee
- Treating provider and
- County including either the HR Department or Immediate Supervisor.

The three-point contact is discussed further in Section 4 – Audit Results.

If necessary, the state Workers' Compensation Form 1 (WC-1) is filed with the State by AmTrust. Often the medial documentation is forwarded to AmTrust as support to HCFA 1500 bills for services as bills will not be paid without supporting documentation. For medical only claims, Ms. Veach does not reach out to the employee but answers any questions the employee has when they call AmTrust.

All mail received including medical treatment notes and bills are scanned and sent to the appropriate adjuster's mailbox.

#### A. Case Management and Physician Review Services

AmTrust reported there is a physician available to review and/or provide clinical assistance on claims files, but the audit identified that this service is not routinely utilized. There is no substitute for expert clinical review, opinion and intervention as needed in progressing the most challenging cases. Objective physician reviews of the written record can assist in ensuring that needed treatment is received when medical documentation is unclear and elicit cooperation from treating providers in return to work planning or modification of inappropriate treatment plans. See Section 4 – Audit Results, Claims Summary and Management. Per AmTrust, *the County is aware of AmTrust's physician review. AmTrust will recommend but it is their call if the services are used.*

#### 4. Setting Reserves

Upon the completion of any initial contacts and investigation an initial reserve reflecting the expected costs for the life of the claim is set in the system. Reserve levels are based on the information known about that claim at the time. Reserved reviews performed for anticipated high cost claims include a reserve worksheet detailing the reserve amount and is modified when additional information about treatment or additional indemnity costs are received. The reserve amounts are reviewed every 90 days, or as additional information are obtained. AmTrust removes or closes the reserves (i.e. reserve amount shows as \$0.00 in system and on reports) once a file is closed to management by the adjuster.

#### 5. Stop Loss Carrier

The County is self-insured up to \$650,000 per occurrence for workers' compensation. Amounts exceeding this are covered by an excess workers' compensation policy administered by to Midlands Management Corporation (Midlands), managing general agent for New York Marine and General Insurance Company (NYM). The County has not paid any settlements in excess of the insurance coverage during this audit period. AmTrust reports all reportable claims to Midlands as appropriate per the terms of the excess policy. During this audit period there were five claims appropriately reported by AmTrust to Midlands/New York Marine. Four of the five claims are now closed.

#### 6. Claims and Bill Payment

FairPay Solutions (FairPay), a provider of specialty medical bill auditing and re-pricing services, is AmTrust's claims reviewer for the County. Medical bills are received by AmTrust and are scanned into IR. All bills are reviewed and approved by the adjuster and sent to FairPay for fee schedule and PPO reductions, as appropriate.

Together AmTrust and FairPay are responsible for the following:

- Adherence to the State's fee schedules
- Reductions to the appropriate PPO fee schedules

- Efforts to ensure claims payment are for eligible claimants and for eligible services related to the work related injury.
- Controls to identify aberrant billing practices and improper provider billing/coding

Bills for Carlisle Medical (the County's pharmacy benefits manager, or PBM), OneCall and ambulance services are not sent to FairPay as agreements ensure billed amounts are below fee schedule and the medical bills are processed and paid directly by AmTrust. All bill file data received from AmTrust by the auditors appears to be related to FairPay bills, and therefore generally does not include bills from Carlisle, One Call or ambulance services. However, these payments can be seen in ANA under the check register/payments made section.

AmTrust maintains a checking account funded by the County to be used for guaranteed timely payment of all legitimate and authorized expenses associated with handling the County's on duty injuries. These include medical bills, legal fees, and other allocated loss expenses. The County reviews a report of pending payments weekly on Tuesday and approves payment of bills.

## **7. Quality Review**

According to the information provided by AmTrust and the interviews on-site as part of AmTrust's process they are constantly reviewing adjuster case loads and quality of work. As part of the quality review process AmTrust reports routinely doing a self evaluation of how well they meet their established standards as well as the common standards of the industry in which they work. AmTrust identified five key areas of claims management they monitor include initial contact, documentation, diary control and litigation management. Claims Supervisors typically review at least five files per month for each claims adjuster. AmTrust did acknowledge since Mrs. White is so experienced that less quality oversight is required.

## **8. Customer Service and Program Meetings**

It is the audit team's understanding that AmTrust does not provide the County with hard copy of standard monthly, quarterly or annual reports but through the web portal the County is able to access, view and download the reports they need. Both the County and AmTrust report frequent and on-going telephone communications regarding individual claims and quarterly program meetings to discuss specific cases and overall program activities. Reports are reviewed as needed at the quarterly meetings.

AmTrust indicated in response to the questionnaire that they there have been no complaints or grievances during this audit period.

## Section 3 – Contracted Services

To ensure AmTrust accountability for compliance with contractual requirements, the Audit Team reviewed the provision of the required services as outlined in the current contract. The materials reviewed and the onsite observations indicate that AmTrust is in compliance with the contract terms for the County's Workers Compensation Program, as written and detailed below. For any services "partially confirmed" the discrepancy may be due to interpretation of the required service and expectations. To avoid discrepancies the required services could be further defined by the County and AmTrust, if necessary.

| Required Service  | Confirmed           | Comments   |
|---|---------------------|--|
| A. Review all Client's claims and loss reports for losses occurring during the term of this Agreement   | Yes                 | As described throughout this report  |
| B. Establish and reserve a file for each claim and code such claim in accordance with AmTrust's standard statistical data requirements                            | Yes                 | See Section 2 – Operational Review, Setting Reserves.  |
| C. Conduct an investigation of each claim and document the claim file   | Partially Confirmed | Notes regarding the investigation are noted in ANA. An "Initial Investigative Report Form" is described in the AmTrust Proposal for Services. There was no evidence of this form in the audited cases. Some RO and MED claims did not have any claims management notes in ANA but all claims had at least a First Report of Injury (FROI) in the IR system.  |
| D. Perform all administrative and clerical work in connection with qualified claims including the preparation of checks drawn on the loss fund established herein | Yes                 | <p>As described throughout this report.</p> <p>Overall AmTrust appears to be compliant with filing of all required forms with the Board. The audit team was able to identify that WC-1s were submitted on each claim file where a WC-3 was noted.</p> <p>The audit team was also able to confirm that a WC-1 was filed on a claim where a WC-14 was filed with the Board, although there did appear to be a several month lag time and the filing appeared to be due to the claim moving into a TTD status rather than being represented.</p> <p>From the audit team review of the ANA and IR systems there is no clear, utilized field to mark when a claim form has been filed, thus acting as a reminder of what other forms may need to be filed as well; the audit team has previously identified a field available in the ANA system called "claim forms" that appears to be infrequently used but would be suitable for this purpose.</p> |

| Required Service  | Confirmed           | Comments   |
|---|---------------------|--|
| E. Respond immediately to any inquiry, complaint or request received from an Insurance Department or other regulatory agency, Client, Claimant, Agent, Broker, or other interested party  | Yes                 | AmTrust reported receiving no complaints during this audit period. There was no evidence of the audited cases indicting otherwise.   |
| F. Process each claim in accordance with rules, regulations, restrictions and laws of each state or province involved   | Partially Confirmed | As described throughout this report. Please see Section 4 – Audit Results, Bill Payment Timeliness regarding adherence with bill payment timeliness.   |
| G. Monitor the treatment programs recommended for Claimant by physicians, specialists and other health care providers by reviewing all reports prepared by them and performing all investigative activities as may be appropriate | Partially Confirmed | Treatment programs appear to be monitored mainly by reviewing supporting documentation from HCFA 1500's and responding to provider's requests for authorization for treatment or referral. "Investigative activities" and case management actions generally appear to be passive/reactive rather than proactive. See Section 4 – Audit Results, Claims Intake and Follow-up. Per AmTrust, <b><i>in GA panel physicians controls medical, our adjusters review and authorize referrals and IME.</i></b> |
| H. Utilize cost containment methods available by referring bills to computerized bill review and utilization of Preferred Provider Organizations. Payment for these services are not included in AmTrust's service fees           | Yes                 | As described throughout this report including in Section 4 – Audit Results, Claims Summary and Management and Bill Payment.  |
| I. Adjust, resist and/or settle claims in accordance with authority levels granted by Client  | Yes                 | As described throughout this report including in Section 4 – Audit Results, Claims Summary and Management and Bill Payment.  |
| J. Pay all claims and allocated loss adjustment expenses in accordance with the authority granted and applicable statutes or regulations  | Yes                 | As described throughout this report including in Section 4 – Audit Results, Claims Summary and Management and Bill Payment.  |
| K. Make reports to excess carriers as required  | Yes                 | See Section 2 – Operational Review, Stop Loss Carrier  |
| L. Pursue SITF and subrogation claims   | Yes                 |  |
| M. Provide Client monthly loss runs   | Yes                 | Reports are available ad hoc to the client through the AmTrust website. Per AmTrust, <b><i>reports are available to client monthly. We do not send hard copies and Cobb has access to our system to see reports. They do not have to run them since they are already there.</i></b>  |

## Recommendation

The services being provided to the County by AmTrust are provided today by a very experienced team of professionals with familiarity with the County and the current processes and procedures. The audit team requested more detailed program protocols supporting the contract activities but they were not provided. To ensure services are provided consistently, especially when services are provided by less experienced staff, AmTrust should have detailed standard work processes and protocols to support their decision making, ensure adherence to legislative and regulatory requirements, and provide an audit trail to ensure consistent quality.

For any services "partially confirmed" in the table above the discrepancy may be due to the interpretation of the required service and specific expectations. For example, The County may benefit from adding specificity to clarify the expectation for the "investigation", including for example, what claim types (possibly all but RO) require an investigation, and the required contacts and forms. To ensure that the County is receiving the desired services by claim type, the services could be further defined by the County and AmTrust, as the County sees as necessary. Per AmTrust, ***indemnity claims are those claims with an indemnity payment or expected payment of indemnity benefits or any denied/questionable claims or any claim that must be sent to the state board. Medical only claims are those that do not have to be sent to the board and only require a medical or expense payment. Ro are just that incidents that are sent to us for reporting only. It is set-up and closed immediately. Ro are reported to us as such by the county. Any claim can change status at any time. An mo can become indemnity if benefits have to be paid etc.***

## Section 4 – Audit Selection Criteria and Results

### 1. Claims Selection Criteria

The initial case file population consisted of 810 claims with dates of onset during 2010 or 2011 plus an additional 132 claims with dates of onset prior to 2010 but with medical costs incurred during 2010 or 2011. The audit included a review of a sample of 55 claims including individuals with multiple claims, having potentially duplicate bills, high amounts of medical costs or indemnity costs or with medical bills with no provider name identified. The distribution of claim files audited was as follows:

TABLE: Distribution of selected claim files by code type:

| Claim Type               | Distribution of Audited Claims* |
|--------------------------|---------------------------------|
| MED                      | 56%                             |
| RO                       | 9%                              |
| TTD                      | 11%                             |
| PPD                      | 16%                             |
| Unknown – From Bill File | 7%                              |

\*Numbers do not equal 100% due to rounding

The audit team selected a higher percentage of Temporary Total Disability (TTD) and Permanent Partial Disability (PPD) claims than actually found in the population as these claims tend to have the highest associated costs as well as an increase in reporting requirements.

Thirty-two files were reviewed on-site by three auditors with an additional 23 files reviewed during a desk audit after the on-site audit. This audit sample size provides a confidence of 87% with a  $\pm 10\%$  error.

The audit team performed a comprehensive review of all bills provided on both billing files to identify potential duplicate bills, billing patterns, comparison to State fee schedule, review of PPO reductions and bill processing fees, both line charges and PPO fees. Bills (169) that were part of claims selected for detailed audit were also reviewed for bill receipt, review and payment dates to determine timeliness of bill payment by AmTrust.

### 2. Claims Summary and Management

The first step in the claims audit was a thorough review and analysis of the Loss Run report to summarize the claim types, and medical and indemnity costs for the audit period. As summarized in the table below, for claims incurred in 2010 and 2011 89% and 87% respectively, were Report or Medical only. For the two years combined the overwhelming majority of claims (82%) are coded as medical only (MED), with an additional 5% coded as report only (RO).

A very low percentage of claims (12%) are coded as temporary total disability (TTD) or permanent partial disability (PPD) while accounting for 85% of Cobb County's workers' compensation costs. Medical costs of TTD/PPD claims were often as much and more than indemnity payments while claimants that undergo surgical intervention often result in having some level of permanent partial disability. Per AmTrust, *indemnity claims should amount to the bulk of Cobb's cost as the medical treatment is more intensive.*

These summary statistics demonstrate that together AmTrust and the County are effectively managing the minor work related injuries and effectively and efficiently bringing employees injured at work back to work as quickly and safely as possible. The relatively high costs of the TTD and PPD cases also

demonstrate the need for a systematic approach supported by technology to monitor the most costly claims. Per AmTrust, *the adjusters and claim staff have and use an automated diary.*

| Claim Type           | Number of Claims | % of Total Claims | Average Medical    | Average Indemnity  | Average Legal   | Average Expenses | Average Total Cost |
|----------------------|------------------|-------------------|--------------------|--------------------|-----------------|------------------|--------------------|
| RO                   | 44               | 5%                | \$ 0               | \$ 0               | \$ 0            | \$ 0             | \$ 0               |
| MED                  | 664              | 82%               | \$ 858.94          | \$ 0               | \$ 0            | \$ 24.29         | \$ 883.24          |
| TTD                  | 43               | 5%                | \$ 6,722.15        | \$ 3,522.96        | \$740.14        | \$298.98         | \$11,282.24        |
| PPD                  | 59               | 7%                | \$29,622.58        | \$13,399.28        | \$285.32        | \$739.55         | \$44,046.72        |
| <b>Total/Average</b> | <b>810</b>       | <b>100%</b>       | <b>\$ 3,218.67</b> | <b>\$ 1,163.02</b> | <b>\$ 60.07</b> | <b>\$ 89.55</b>  | <b>\$ 4,531.31</b> |

\*Total/Average row may not sum exactly due to rounding

### A. Claims per Claimant

There were 680 unique claimants comprising the 810 claims from the two-year period, 2010 and 2011. To better understand the Cobb County claimant population, the audit team reviewed the number of claims per claimant over the two-year period. Few claimants (104) had multiple claims reported during the two-year audit period.

- Five hundred seventy six claimants (84.7% of claimants) had only one claim during the two year period.
- Eighty three claimants (12.2% of claimants) had two claims during the two year period.
- Twenty claimants (2.9% of claimants) had three claims during the two year period.
- One claimant (0.1% of claimants) had four claims during the two year period.
- Four claims (443348, 446321, 450486, 451336) had no first name and a last name of "INVALID DO NOT USE"; therefore the audit team could not identify the names of these claimants and if they did or did not have additional claims. None of these claims appear to have associated costs.

### B. Claim Type Designation

The audit team confirmed that 48 of the 55 claims reviewed (87%) were coded appropriately as RO, MED, TTD or PPD based upon claim file documentation. From documentation found in one file it does appear that adjusters have the ability to retroactively change the code status of a case (i.e. from MED to RO) if it was ultimately found that the actual claim did not meet the anticipated coding.

- Three claims were coded as MED but incurred no costs; auditor opinion was that these should have been re-coded as RO. (452264, 451820, 450114)
- Three claims were coded as TTD but documentation of a PPD payment was found in file. (448973, 450103, 444569)
- One claim was identified from the bill file and did not have a claim designation and the claim designation could not be located in ANA by the auditor. (156439)

### C. Claim Intake and Follow-up

#### i. Claims Reporting Timeliness

Industry research confirms the importance of early injury reporting. Studies have shown that the sooner a potential claim is reported, the sooner care can be initiated and monitored, and return to work is achieved,

resulting in lower cost of care and lost time. Best Practices indicate that potential claims should be reported within three days of the date of loss. Early reporting does require the employee to report the incident timely to the supervisor AND the supervisor reporting the incident in a timely fashion to the claims manager. The audit team used information available on the loss run data file (column headings LossDate and ReceivedDate) to review the average duration of time, commonly called lag time, from date of loss through receipt by AmTrust.

Overall average reporting lag time from Date of Loss to Receipt by AmTrust was 14.9 days, with a minimum lag time of zero days (meaning AmTrust was notified on the date of loss) to 508 days. Specifically:

- One hundred sixty four (20%) were reported within three days (Date of Loss to Received Date was three days or less).
- Two hundred eighteen (27%) were reported between four and seven days (Date of Loss to Received Date was four to seven days).
- Two hundred twenty four (28%) were reported between eight and 14 days (Date of Loss to Received Date was eight to 14 days).
- Six hundred six (75%) were reported within 14 days (Date of Loss to Received Date was zero to 14 days).

This measure is often skewed by delays in the injured worker reporting the injury. It can also be skewed by occupational illnesses/diseases such as repetitive use or stress, which often have dates of loss weeks, months or years prior to report. However, review of loss descriptors and types available on the loss run data report show very few of these types of occupational illnesses/diseases.

Based upon data on the loss run data report (columns titled ReceivedDate and SetupDate) electronic claims files are being set-up in ANA within four days of receipt of the first report by AmTrust, with a minimum of zero days (electronic file creation the same day as the day notification was received) to a maximum of 67 days. Specifically:

- Two hundred twelve (26%) were set-up within one day of report (Received Date to Set-Up Date was zero or one day).
- Two hundred twenty nine (28%) were set-up between two and three days of report (Received Date to Set-Up Date was two or three days).
- Three hundred six (38%) were set-up between four and seven days of report (Received Date to Set-Up Date was between four and seven days).
- 747 (92%) were set-up between zero and seven days of report.

### Recommendation

AmTrust has a unit responsible for entering the cases into the AmTrust systems. The auditors also understand that, as needed, AmTrust talks to the appropriate County representative and begins to work the case prior to it being added to the system. Although this work around addresses the immediate needs, ideally all cases would be entered into ANA within one day of AmTrust's receipt of the information and the auditors recommend AmTrust should work towards this goal.

#### *ii. Three-Point Contact*

While the AmTrust contract does not specify that a three-point contract is required, Industry Best Practices and AmTrust's stated procedures include a three-point contact with the employee, the County, and the Provider within 24 hours of claim notification. In conversations with AmTrust it was stated that employee's whose claims are coded as RO or MED upon receipt are not contacted at all by AmTrust. These types of claims constitute the vast majority of the county's workers' compensation claims, 86% and 89% in 2010 and 2011, respectively. In the detailed review of 55 claims, 36 claims were coded as RO or

MED and 15 were coded as TTD or PPD; the remaining four claims did not have a code-type identified as they were selected from a different source file that did not include the code-type.

The audit of the 55 claims indicates that there is little documented outreach to the employee or the provider, with most provider contact often being driven by the provider to obtain approval for treatment. While it is understood from conversations with both the County and AmTrust that often, the County performs the initial contact with the employee and there is often contact multiple times daily, this is not often reflected in case file notes.

In reviewing the 38 RO/MED and 15 TTD/PPD claims both on-site and through a desk audit, there were only three claims, two TTD and one PPD, or 20% of the TTD or PPD claims reviewed, where the auditors felt confident in being able to say that the three-point contact was being performed based on the adjuster notes reviewed in ANA Claims.

### Recommendation

One of the most critical aspects of a workers' compensation program is early intervention. There is significant evidence that the earlier intervention is introduced, the better the case outcome both medically and financially. Therefore it is critical that AmTrust work quickly and aggressively to reach out to all employees reporting a work related injury and initial treating providers to verify injury information, confirm the injury type, prognosis, diagnosis and work status within 24 hours of the report. The recommendation is that all claims, excluding possibly ROs, receive the three point contact and all contact attempts and contacts are documented in ANA. ***In response to AmTrust's request, the auditors provided AmTrust the list of the 55 claims reviewed. AmTrust indicated they will do further internal review and follow-up with the claims staff as needed as part of their internal quality assurance.***

### iii. Case Review and Management

The AmTrust contract does not specify the frequency of file review by a claims reviewer but the industry standard is a file review at least every 30 days. Of the 55 cases reviewed the auditors felt confident in confirming this practice on 17 cases while being confident in stating that it did not happen on 10 cases. Twelve of the claims reviewed were not open for 30 days or more, meaning that a 30 day review would obviously not occur.

Documented comprehensive case management plans, consisting of current status, plan and next actions, were not consistently located in the ANA system. The auditors could confidently state the plans were documented on five of the 55 claim files reviewed. The majority of activities reviewed by the audit team appeared to be reactive or passive in nature, such as granting approval for services after contact by provider offices or monitoring the medical progression of the case by reviewing incoming bills and office notes.

An important part of claims management is monitoring actual lost time days based on the primary diagnosis. A running total of lost time or modified time days during any one or subsequent periods of disability does not appear to be routinely stored in ANA while indemnity totals are. Determining lost time at any given time appears to require performing calculations based on wage information which is not always readily available, and identifying return to duty dates from the WC-2. Without lost time totals, AmTrust cannot easily monitor lost time and expected return to work or compare the County's lost time experience against national estimated duration of disability guidelines (EDD) for an individual case or for the program overall.

Likewise, it does not appear a record of diagnoses being treated or which diagnoses are related to the workers' compensation injury, are clearly documented in ANA. Although the audit team understands the diagnosis is included on the provider bills, this information is extremely important to case monitoring and progression and it should be readily available to the claims examiner while working the case in ANA.

### Recommendation

To support case progression the auditors recommended that AmTrust consider the following to support the resolution of the most complicated and costly cases. Each of the recommendations is supported by industry best practices:

- Review each case file at least once every 30 days and include documentation in ANA of the case file review, current case status, plan and next action.
- Remain in contact with the injured/ill employee, treating physician's office, supervisor, and appropriate County contact throughout the life of the claim.
- Include in ANA easily accessible case information including the current number of lost or modified time days and primary diagnosis.
- Capture and display in ANA estimated duration of disability based on industry guidelines for the primary diagnoses for all lost time claims so the cases can be monitored and progressed based on the guidelines.

#### *iv. Outreach/Catastrophic Nurse*

In three of the audited cases, it was observed that AmTrust used the services of a nurse named Lin Barker to meet in person with the employee and clarify the clinical situation. These appeared to occur in situations where the employee had a severe injury and/or was hospitalized (claim 448717, 439999, possibly 448901). None of these cases were reported as catastrophic to the State as they do not appear to meet the State definition of catastrophic (page two of GSBWC Rehabilitation & Managed Care Procedure Manual); however, having such clinical services available to assist the employee, employer and claims adjuster with potentially complicated medical issues is a benefit to all involved parties.

#### *v. Physician Review*

AmTrust stated that there is a physician available to review and/or provide clinical assistance on claims files, but that this service is not routinely utilized. Objective physician reviews can be useful if cases are complex or providers are not fully cooperating with the adjuster and/or employer, specifically in regards to return to work. There were six or approximately 10% of claims reviewed (Claims 448185, 450108, 409554, 450103, 449084, 437981) by the audit team where the auditors believe that a physician review would be appropriate for the review of clinical notes and opine on the treatment plan and its adherence to standard treatment guidelines.

### Recommendation

Clinical reviews can be used to guide case management strategy in complex cases and communicate with the treating providers. AmTrust and the County may want to consider developing criteria for clinical case review. The following are representative criteria that may be considered to trigger a referral to clinical staff for review:

- Medical necessity or case relationship to treatment plan appears questionable.
- Lost time days are approaching the industry standard for estimated duration of disability.
- Available documentation does not include medical evidence to support total or partial disability.
- Accepted conditions are primarily soft tissue injuries that would have been expected to resolve by date of review.
- Accepted conditions include mental health diagnoses, including but not limited to Post Traumatic Stress Disorder, Stress, and Psychosis.
- Post-operative recovery has extended beyond industry and medical standards of estimated duration of disability with no objective data to support that complications have occurred or are contributing to delay in recovery.

- Any indication of conflicts within medical opinions offered in available documentation.
- Patterns of care do not demonstrate an efficiency of the use of health care services, procedures, facilities.
- Restrictions are not consistent with medical evidence.
- Case involves multiple treating providers.

### 3. Bill Payment

Prior to the on-site audit the audit team reviewed the Bill Fee Analysis file provided by AmTrust. This file contains billing detail bills sent by AmTrust to FairPay for review against the State fee schedule and subsequent reduction, as well as review against existing PPO arrangements and subsequent reduction. The audit team also did a preliminary analysis of this file for potential duplicate bills, bill fee compliance with the contract, reductions to State fee schedule and application of PPO reductions but was unable to complete the analysis since Current Procedural Terminology (CPT) codes and descriptions were not provided. The audit team requested the additional bill data required for analysis and it was provided by AmTrust.

The bill payment information is summarized in the following table and was reviewed in detail for the bills processed during the audit period.

| Total Number of Bills | Total Charge Amount | Total Reduction to State Fee Schedule | Total PPO Reduction | Overall % of PPO Discount | Total Amount Paid |
|-----------------------|---------------------|---------------------------------------|---------------------|---------------------------|-------------------|
| 6261                  | \$4,180,791.36      | \$1,755,346.13                        | \$195,056.31        | 8%                        | \$2,230,388.92    |

#### A. Reductions to State Fee Schedule

There were 2909 bills with a total of 8075 bill lines processed in 2011. All of these bill lines were reviewed against the 2011 State fee schedule to determine if appropriate fee schedule reductions were taken by the bill processor.

Our review initially identified 327 lines, or 4%, where it appears that the reduction taken by FairPay did not reduce the bill line to the 2011 State fee schedule amount. The 2011 State fee schedule became effective April 1, 2011. Upon further review it was found that 174 (53%) of the potentially incorrect bill lines were processed on dates of service prior to the 2011 State fee schedule becoming effective. An additional 79 (24%) were processed during the month of April and could have been mis-reduced due to timing of the fee schedule change. The remaining 74 bill lines (.9% of bill lines for 2011) should be reviewed in further detail against the State fee schedule to confirm the reductions are correct.

***Follow-up by FairPay showed that bills with dates of service prior to 4/1/11 but processed after 4/1/11 (118 bills lines) were processed appropriately according to the 2010 fee schedule. Of the remaining 35 bills with dates of service after 4/1/11, 11 were paid appropriately according to modifier rules (modifiers were not available to the audit team), 22 were paid according to the fee schedule of the state where the provider was located, one was underpaid by \$.11 (paid at the usual and customary rate) and one was overpaid by \$2.25 (paid at the usual and customary rate).***

#### B. Potential Duplicate Medical Bills

Upon receipt of this file that includes CPT codes, a review of potential duplicates was completed. MCA identified 96 possible duplicates 96 (0.5% of total bill lines) with a total cost of \$21,364.12 (potential duplicate payment of \$10,682.06) when claim number, bill number, DOS and billed amount and paid amount were taken into account.

Some of the possible duplicate payments may be explained by reviewing the actual incoming bills in IR to ensure that services were not being applied bi-laterally (i.e. to right knee AND left knee) which may be appropriate. The audit team reviewed 16 of the 96 separate bills. Half of the bill lines were found to not be duplicates as actual HCFA 1500 bills contained modifiers for right and left applications of CPT billed and half of the bill lines were found by the auditors to appear to be duplicates after review of the HCFA 1500 bills and accompanying detailed notes.

***AmTrust reviewed the potential duplicate bills to identify if duplicate payments were made. AmTrust confirmed that many of the 96 potentially duplicate bills were indeed duplicates as processed by FairPay but that AmTrust identified the duplication prior to a duplicate payment being issued and checks were either voided or processed as \$0.00. AmTrust was asked for documentation of the process for identifying and recording duplicates but it was not provided to the audit team. AmTrust was also unable to provide the audit team with a list of voided payments and stated that a record of the voided checks was not routinely kept.***

### Recommendation

The auditors recommend AmTrust document for the County's review the process in place for duplicate payment review. The auditors further recommend the process outlines the requirements to save the supporting documentation for any and all voided payments.

### C. Bill Line Fee Charges

The Bill Fee Analysis file provided by AmTrust contained information on the bill fee (column BillFee) on each bill reviewed against the State fee schedule and against existing PPO arrangements. Per the contract effective through 09/30/11 there was a charge of \$1.25 per bill line with a three-line minimum (i.e. a \$3.75 minimum bill fee charge). Per the 2011 – 2014 contract, effective 10/1/11, this per line fee is also \$1.25 with no mention of a minimum. The data file also contained the number of lines per bill (column LineCtr), allowing the audit team to review the bill fee per line. There were 435 bill lines processed under the new contract with a bill fee of \$3.75 although they had less than three bill lines.

The audit team does not have available the actual bill fee charged to the County per bill for the audit period but if the auditors findings are correct and the County's payment made based on the above, this may represent an overpayment by the County of \$656.25 for bills paid under the new contract during the audit period and additional overpayments between the end of the audit period and now.

### Recommendation

The auditors recommend a review of Article 8 – Service Fees in the current contract as compared to the previous contract. While a three line minimum for bill payment is an industry-standard and was included the previous contract it is not in the current contract, as written. If the County wants it included, a contract modification may be considered. If not, clarification with AmTrust may be required.

### D. Bill Payment Timeliness

The claims reviewed as part of the detailed audit included 337 medical bills and 964 bill lines. The date of AmTrust receipt was identified on the HCFA 1500 bill on 169 of these. One hundred twenty, or 71%, of the bills were paid in less than 30 days while 49 of these bills were paid in more than 30 days from AmTrust receipt (29%). State workers' compensation guidelines state that bills should be paid within 30 days, unless sufficient information to pay the bill is not initially received, which does not appear to be the case for these bills. A detailed review of 28 of these 49 showed that there were lag times of six to 46 days, with an average of 31 days, for the claims adjuster review to certify the bill for payment. After certification the bills were paid within two to 20 days, with an average of six days.

***AmTrust reviewed the list of late payments and found that the payments that were listed were on medical only claims and they were indeed paid more than 30 days after receipt. This was mainly due to backlogs in processing through the review systems they have in place. However, some of the bills were approved late by the medical only assistant on the files at the time. AmTrust now has a new medical only assistant working the TPA /Self insured files. Her claim count is reduced from what it was during the audit period and AmTrust reported she is doing an excellent job in staying current on her tasks. AmTrust also reported that although payments were made more than 30 days after receipt of the bills, there were NO penalties assessed or paid in association with those payments.***

### **Recommendation**

AmTrust acknowledged the bills were paid greater than 30 days from receipt. They stated that they decreased the workload of the MED only adjusters to allow for more prompt review of incoming bills/documentation. The auditors recommend ongoing internal monitoring of claims payment timeliness in accordance with the Georgia State Workers' Compensation Board Rule 203 (a).

#### **Other Bill Payment Issues**

During on-site review of claim file 447470 a HCFA 1500 was found with service provider Center for Orthopedics and Sports Medicine for an MRI DOS 3/28/11. The bill information, check register and EOB for this service show payment was made to One Call Medical rather than the Center for Orthopedics indicating that the payment may have been made to the wrong provider. While the auditors were on site, AmTrust staff called Dr. Hammesfahr's (Center for Orthopedics and Sports Medicine) office to check if payment was ever received for this DOS. Receipt of payment was confirmed by the doctor's office. Possible explanations include the provider's office has an arrangement with One Call, who was able to forward payment appropriately, or One Call noticed the discrepancy and worked with FairPay to correct billing. The AmTrust system was not updated to reflect the updated information. In addition payment for this bill, issued 5/20/11, is greater than 30 days after receipt of HCFA on 4/14/11. The notes in the system were "Ok to Pay" marked by J. Price on 5/12/11, also reviewed by G. Lopez on 5/12/11.

*Auditee Response*



Anthony B. Hagler  
Director

**MEMORANDUM**

DATE: November 13, 2013

TO: Latona Thomas, CPA, Internal Audit Director 

FROM: Tony Hagler, Human Resources Director

SUBJECT: Response to the Internal Audit Division's Draft Report – Audit of Third Party Administrators for Health Benefit and Workers' Compensation Plans

This memo is in response to the subject report dated October 18, 2013. The review determined there were discrepancies and interpretation issues between the benefit booklets and third party (TPA) adjudication systems. In addition, there are weaknesses in the management of the TPA contractual agreements which allowed inaccuracies to go undetected and performance guarantees to go unmonitored. You made several recommendations and our response to those recommendations are provided below.

**The Human Resources Director should:**

**Recommendation 1:** Meet with its benefit consultant and TPAs prior to each plan year, discuss each respective plan in detail along with changes, resolve any clarification or interpretation issues, and document the outcome. Also require each TPA to periodically validate that claims are being processed in accordance with the plan as communicated and agreed.

**Response: Concur**

This will be an expectation for the selected benefit consultant to coordinate. We have already mentioned to several TPA's and they indicated they were in concurrence. The Human Resource Director will coordinate with the selected consultant to initiate these annual meetings with the initiation of consultant services agreement effective January 1, 2014.

**Recommendation 2:** Require TPAs to prepare and distribute benefit booklets in a timely manner, based on the outcome of agreed upon changes.

**Response: Concur**

This will be coordinated with the selected benefits consultant to coordinate with TPA's. Human Resources Manager will coordinate with benefits consultant annually.

**Recommendation 3:** Determine when rebates are due to be credited and develop a process to monitor invoices for the credits and follow up with the TPA when they are not received as scheduled.

**Response: *Concur***

This will be the responsibility of the selected benefits consultant to monitor rebates on behalf of the County. The Human Resource Director will coordinate with the selected consultant to initiate these annual meetings with the initiation of consultant services agreement effective January 1, 2014.

**Recommendation 4:** Develop and implement a process to monitor each TPA's attainment of performance guarantees. This should include steps for reviewing reconciliation packages and collecting penalties, when applicable.

**Response: *Concur***

This will be the responsibility of the selected benefits consultant to monitor performance guarantees on behalf of the County. The Human Resource Director will coordinate with the selected consultant to initiate these annual meetings with the initiation of consultant services agreement effective January 1, 2014.

**Recommendation 5:** Establish a written policy for the HR Department regarding record retention and orient all employees on it. The policy, at a minimum, must comply with all Georgia records laws and regulations.

**Response: *Concur***

This will be accomplished by the Human Resources Manager responsible for Systems and Records Division by January 31, 2014.

**Recommendation 6:** Research and determine the final disposition of each outstanding issue. Initiate or follow up on the recovery of refunds, credits, and financial impacts, where applicable.

**Response: *Concur***

The Human Resources Director will coordinate follow up thru the Human Resources Managers to ensure all action items are addressed.

**In addition to Internal Audit's recommendations outlined above, Segal Company made recommendations in the individual TPA reports that require corrective action plans from HR. Below is a summary of those recommendations and HR response.**

**Medical**

| Findings  |   | Recommendation   | TPA Response   | HR Comment  | Additional Action Required                                   |
|---|---|--|--|---|--|
| <b>Plan Benefit Discrepancies</b>                 |   |  |  |   |  |
| 1   | Discrepancies were noted between the benefit booklets and BCBS's adjudication system. | BCBS needs to generate impact reports for identified plan building errors to assist the County in determining the total financial impact to the Plan.                                      | The HMO out-of-pocket amount was incorrect and an impact report has been requested. The PPO deductible was applied correctly; however the benefit booklet was changed in error.          | HR concurs with the TPA regarding the discrepancies.  | See IA recommendations 1 and 2.                              |
| <b>Plan Benefit Interpretation</b>                |   |  |  |   |  |
| 2   | There were some parts of the plan that are subject to interpretation.                 | The County and BCBS should review Plan intent for benefit interpretation issues specifically related to physician office services and medical supplies benefits.                           | Copayments are only applied when an office visit is billed. BCBS will discuss the medical supply concern with the County and take appropriate actions.                                   | HR agrees copayments should only be applied when an office visit is billed and supplies should reimburse at 100% after copayment. | N/A  |
| <b>Referral and Precertification Requirements</b> |   |  |  |   |  |
| 3   | Precertification was not obtained prior to service.                                   | BCBS and the County should discuss current processing procedures administered by BCBS related to precertification requirements for specific testing procedures identified under the Plans. | Precertification procedures have been updated although the Benefit Booklet still reflects prior requirements. BCBS monitors HMO referrals through a network provider gatekeeper program. | HR agrees to discuss changes to standard practices with BCBS.   | HR corrective action plan required. See IA recommendation 6. |
| <b>Other</b>                                      |   |  |  |   |  |
| 4   | Overpayments totaling \$3,086 need recovery.  | Refund recovery for the identified overpayments should be initiated based on the County's direction.   | BCBS agrees with the errors with the exception of one coordination of benefits (COB) totaling \$1,716.   | HR corrective action plan required. – HR will pursue recovery of undisputed funds.  | See IA recommendation 6.                                     |
| 5   | N/A   | BCBS should advise Cobb County of any modification to system programming or changes in adjudication procedures resulting from this review.   | N/A  | HR corrective action plan required. – HR Will discuss with Account Rep.   | See IA recommendation 6.                                     |

**Dental**

| Findings                          | Recommendation   | TPA Response   | HR Comment   | Additional Action Required  |                                 |
|-----------------------------------|--|--|--|---|---------------------------------|
| <b>Plan Benefit Discrepancies</b> |  |  |  |   |                                 |
| 1                                 | Discrepancies were noted between the benefit booklet and Cigna's adjudication system.                                | The benefit booklet should be updated to show the correct number of fluoride treatments allowed.   | Treatments are in accordance to the provision established when the account was implemented. The benefit booklet was produced with inaccurate information.                                  | HR agrees the information in the booklet was changed without County approval.   | See IA recommendations 1 and 2. |
| <b>Benefit Eligibility</b>        |  |  |  |   |                                 |
| 2                                 | Claims were paid for services rendered, after eligibility was terminated, due to retroactive notice of terminations. | Review each eligibility file for possible overpayments, provide the County with a listing of overpayments, and upon their direction begin collection procedures. | Cigna disagrees with the financial errors assessed for claims paid passed eligibility termination. However, agrees that the retroactive eligibility notification resulted in overpayments. | HR corrective action plan required. – HR will pursue overpayment.   | See IA recommendation 6.        |
| <b>Other</b>                      |  |  |  |   |                                 |
| 3                                 | Overpayments totaling \$495 need recovery.   | Cigna should initiate refund recovery for the identified overpayments based on County direction.   | Recovery efforts for three of the claims were initiated on 4/30/13. Additional research on \$25 for COB issue is pending.  | HR corrective action plan required. – HR will confirm recovery of three overpayments.   | See IA recommendation 6.        |
| 4                                 | N/A  | Cigna should advise Cobb County of any modification to system programming or changes in adjudication procedures resulting from this review.                      | Cigna is committed to taking the necessary actions to correct the errors identified as a result of the audit and looks forward to reviewing the results of the audit with Cobb County.     | HR corrective action plan required. – Contract with Cigna for Dental TPA expires 12/31/13. Issues will be addressed with new TPA. | See IA recommendation 6.        |

**Prescription Drug**

| Findings                                   | Recommendation                                  | TPA Response  | HR Comment | Additional Action Required   |                          |
|--|---|---|------------|--|--------------------------|
| <b>Proposed Contract Negotiation Terms</b> |   |   |            |  |                          |
| 1  | Shortfalls were offset by surpluses.            | Eliminate contract clause that allows surpluses in one component to offset a shortfall in another.                | N/A        | HR corrective action plan required. – HR will discuss with Cigna in contract review for 1/1/14 | See IA recommendation 6. |
| 2  | Generic drugs received the brand drug discount. | Eliminate the practice of categorizing generic drugs with less than three manufacturers under the brand discount. | N/A        | HR corrective action plan required. - HR will discuss with Cigna in contract review for 1/1/14 | See IA recommendation 6. |

**Workers' Comp**

| Findings                                  |   | Recommendation   | TPA Response  | HR Comment   | Additional Action Required |
|---|---|--|---|--|----------------------------|
| <b>Program/Operational Interpretation</b> |   |  |   |  |                            |
| 1   | Three point contact was not consistently made.              | All claims, excluding report only (RO), should receive the three point contact within 24 hours of report of the claim.   | Three point contacts are not done on all medical only (MO) claims due to the nature of the claim. All lost time or questionable cases have a three point contact performed. | HR corrective action plan required. - HR will discuss with consultant and TPA.   | See IA recommendation 6.   |
| 2   | Case reviews were not evident or documented.                | Case review and contacts should be made and documented in ANA every 30 days throughout the life of the claim.  | All lost time claims are reviewed on an automatic diary every 30 days.  | HR corrective action plan required. - HR will address with TPA at annual review. | See IA recommendation 6.   |
| 3   | Physician review of claims cases was not utilized.          | AmTrust and the County may want to consider developing criteria for clinical case review to guide case management strategy in complex cases.   | Response was not provided.  | HR corrective action plan required. - HR will address with TPA at annual review. | See IA recommendation 6.   |
| <b>Other</b>                              |   |  |   |  |                            |
| 4   | Processes were not documented.                              | Work processes should be documented to support decision making and adherence to regulatory requirements.   | AmTrust has an online claim manual and agreed, upon request of the County, to provide handling instructions.  | HR corrective action plan required. - HR will request access to online manual.   | See IA recommendation 6.   |
| 5   | Invoices were not paid in a timely manner.                  | Internal monitoring of claims payment timeliness is needed to ensure compliance with State guidelines of payment within 30 days.   | AmTrust agreed the payments were made late, but no penalties were assessed. Also, the workload on the individual responsible for approving payments was reduced.            | HR corrective action plan required. - HR will address with TPA at annual review  | See IA recommendation 6.   |
| 6   | Bill line charges were not in compliance with the contract. | A three line minimum for bill payment was included in the County's previous contract with AmTrust but not in the current one. A contract modification or clarification with AmTrust on the current contract may be required. | Response was not provided.  | HR corrective action plan required. - HR will address with TPA at annual review  | See IA recommendation 6.   |
| 7   | Lost time calculations were not documented in the system.   | The current number of lost or modified time days, primary diagnosis and estimated duration of disability for claims should be included in ANA to enable adjusters to monitor and progress cases forward.                     | Response was not provided.  | HR corrective action plan required. - HR will address with TPA at annual review  | See IA recommendation 6.   |