Tempe
Internal Audit

Memorandum

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Rebecca Strisko, Deputy Internal Services Director – HR

FROM: Bill Greene, City Auditor (X8982)

CC: Andrew Ching, City Manager
Steven Methvin, Deputy City Manager, Chief Operating Officer
Ken Jones, Deputy City Manager, Chief Financial Officer
Kathleen Broman, Manager, HR Benefits

DATE: September 30, 2020

SUBJECT: HEALTHCARE FUND REVIEW

Purpose

We performed an analysis of claims processed through the City's healthcare programs (medical and medication) to identify trends that may assist HR Benefits to operate the plan in a more efficient manner. We also reviewed the claims payments reconciliation to determine whether adequate internal controls are present to ensure payments made to third-party administrators were accurate and justified.

This review was initiated in FY2015-16 but was delayed multiple times due to changing project priorities. Because the auditor assigned to this project recently transferred to a position outside the IAO, we closed the project and are issuing this memo to present any findings and suggestions for improvement identified.

Background

The City is self-insured for healthcare. Employees' premiums, along with the City's contributions, are maintained in a healthcare fund to pay claims for employees and other covered parties. The City's healthcare process involves multiple parties, each playing a specific role as shown in the following table:

Party	Function/Role
Hays Companies	Benefits consulting firm
Cigna National Open Access Network	Network of healthcare providers
Allegiance Benefit Plan Management, Inc.	Third-party administrator for overall health plan
Express Scripts Pharmacy, Inc.	Pharmacy provider
DirectPath, LLC	Service that helps employees with any issue related to healthcare including medical coding and billing accuracy, cost comparisons for planned procedures, determination if providers are in or out of network
Sun Life Assurance Co.	City's stop-loss insurance coverage
CareCentrix, Inc.	Cigna-designated durable medical equipment and supply company
Accredo Health Group, Inc.	Express Scripts affiliated provider of specialty medicine

Rising healthcare costs, along with the complexity of the healthcare system, insurance and the administrator's plan rules make finding viable solutions to manage costs a major challenge. There are over 60,000+ diagnostic codes used to classify various health conditions. Coupled with multiple layers of providers, facilities, third-party administrators and networks, the complexity cultivates an environment where the average insured employee may struggle to understand the process. Explanation of Benefits (EOB), the need for pre-authorization of procedures, and in-network vs, out-of-network provider can also present challenges to employees. Even when employees possess the skills necessary to navigate the process, the time burden to do so can be significant. DirectPath can help with many needs of employees to obtain authorizations, evaluate if their diagnostic codes were billed correctly, provide comparison cost reports to help the employee make better informed decisions, and verify if the claims were paid consistent with the plan's rules.

Scope and Methods

The objective of this consulting engagement was to provide information as described in the purpose statement above. The work performed does not constitute an audit in accordance with *Government Auditing Standards*. An audit would have required several additional steps including documentation of an assessment of internal controls, a risk assessment, and a validation of electronic data provided to IAO. The time period covered in this review was FY2016-17 and FY2017-18 for claims data. The claims data included both medical and pharmacy claims activity for this time period. The data set was obtained directly from Allegiance (the third-party administrator for the healthcare fund). There were 302,199 claims records included in the data set. Current contracts and other documents related to the healthcare services covering the period reviewed were also evaluated.

We employed the following methods to complete this engagement:

- Claims Analysis
- Walk-throughs of Processes
- Interviews with Key Employees and Third-party Providers
- Analysis of pertinent financial data, policies and procedures, and other documentation

Results

1. A thorough reconciliation of all detailed claims transactions to the City's payment records would help ensure the accuracy of payments made to third parties.

IAO noted that current practice for recording accounting transactions related to the healthcare fund is based on weekly "Claims Batch Request for Funding Reports" which is a summary report used as the source document for payments to Allegiance and Express Scripts. However, a detailed claims listing is not provided supporting the summarized amounts. A process to compare detailed claims data (redacted for HIPAA compliance) to the weekly "Claims Batch Request for Funding Reports", including a review of variances, is necessary to verify accuracy of reports and further support entries to the City's financial records.

Recommendation:

Develop and implement a process to reconcile payments requests to supporting claims data prior to making payments to Allegiance or Express Scripts.

2. We identified potential duplicate claims that require further research to ensure the City did not overpay.

IAO identified what may be duplicate claims based on claim number, dates, diagnostic codes and potential resubmissions of claims. IAO staff is currently working with Allegiance to identify underlying reasons for the possible duplicate claims noted. It is possible that the further work may find that no actual duplications exist. Most duplicate tests attempt to identify exact matches of data, for example a claim number that matches a claim number. The potential duplicate claims we identified have *similar* but not identical attributes.

We provided the full detail of the possible duplicate claims to HR and Allegiance and recommend that either Human Resources review the data or request the help necessary to determine if these are duplicates.

Recommendation:

Request assistance from Allegiance, along with support provided by IAO, to research the potential duplicate claims identified and establish procedures to review claims data

for potential duplicates in the future.

3. A third-party processor for managing retiree payments can provide a more customer-friendly process and increase efficiency by allowing Human Resource staff to reallocate their time to other value-added areas.

Currently, the Human Resources department processes the receipt of payments from Medicare eligible retirees using United Healthcare. Checks are received in the City's mail and then processed by preparing a deposit which is handed off to the City's customer service personnel for deposit. A journal is created and then the data is entered to PeopleSoft. There are an estimated $40,000 in payments received in HR each month relating to approximately 500 individuals.

Use of a third-party provider specializing in administering and processing premium collection for retiree's payments would decrease the risk HR assumes by receiving payments and likely provide easier payment options for retirees. This change would also allow Human Resource staff to allocate the time spent processing premiums to other needs.

Recommendation:

Consider working with Procurement to identify third-party providers that could process retiree premium payments.

***4.* Routine analysis and audit of pharmacy activity and medical claims may help identify cost savings.**

We isolated claims related to the pharmacy (drug) program to determine its impact of overall cost on the healthcare fund. Total pharmacy costs for the two cycles reviewed were $8,452,892 of the total claims of $37,679,764 (or an estimated 22.5% of the fund's costs).

We sampled the 30 highest pharmacy claims and requested additional information from Express-Scripts. One expensive medication was identified whereby Express-Scripts hired a third-party to negotiate a better price. However, we could not verify, based on available data, if the savings was shared with the healthcare fund. Similarly, Express-Scripts obtains rebates from pharmaceutical companies that reduce the cost of medications. The rebates are shared with the healthcare fund and the aggregate credits were present; however, the details of the specific individual rebates, related claims and amounts could not be evaluated due to insufficient information being provided by Express-Scripts. (Note: Allegiance only acts as a claims consolidator for Express-Scripts and does not have any direct involvement in the pharmacy program).

Many of the pharmaceutical companies offer rebates that are available directly to consumers through a local pharmacy specifically to those without or not claiming through insurance. Express-Scripts may also participate with the pharmaceutical companies in these rebates. There may be opportunity for additional cost savings to

the healthcare fund through monitoring of these activities and following up with Express- Scripts on third-party negotiated savings and the pharmacy rebates to ensure they are passed on to the healthcare fund.

The IAO is currently performing additional steps to document controls in place to prevent payment of fraudulent, duplicative, and overbilled medical claims. We also plan to survey other cities to identify common payment controls employed by other jurisdictions and determine if a medical claims audit is performed (either internally or contracted out). The IAO will report on these issues in a subsequent memo.

Recommendation:

Monitor third-party negotiated savings and the pharmacy rebates by requesting regular detail about the two activities and reconciling the activity to the fund.

HR Benefits should work with Hays to coordinate a periodic medical and pharmacy claims audit (recommend an audit every three-years reviewing the prior three years of claims) to verify that claims were coded and costed correctly, and to identify trends and patterns both in medical and medication claims that are valuable to manage the fund.