North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

# State Health Plan Audits

***Board of Trustees Meeting***

September 27, 2013

A Division of the Department of State Treasurer

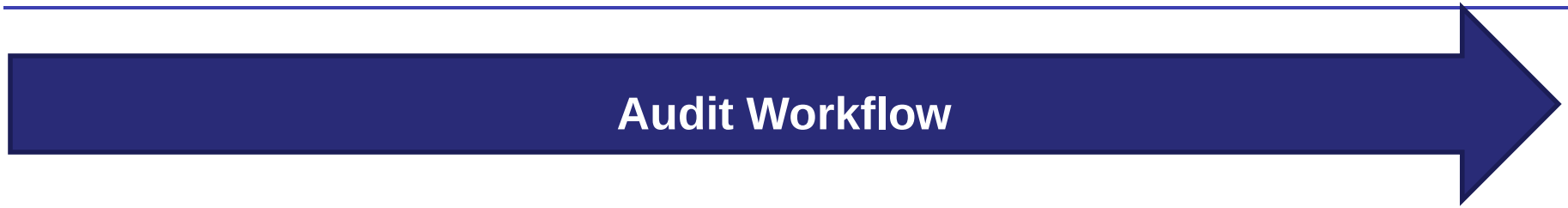
# Presentation Overview

- Audit Process
- Medical Claims Audits
- BCBSNC Administrative Costs
- ActiveHealth Management Return on Investment
- Pharmacy Audits
- ERRP Audit

# Why Do We Conduct Audits?

- To ensure contractual compliance
- To identify pricing errors
- To assess vendors' internal controls
- To validate benefit design is administered correctly
- To validate vendor performance guarantees
- To comply with State laws/regulations

# Audit Process




| Audit Plan | Conduct Audit | Findings | Finalized Audit Report | Follow Up |
|---|---|---|---|---|
| • Determine objective and scope<br>• Assessment of data needs<br>• Establish timeframes | • Review data<br>• Onsite fieldwork | • Document findings<br>• Root cause analysis<br>• Establish corrective action plan | • Review<br>• Recommend changes or improvements<br>• Sign off | • Monitor correction plan<br>• Collect funds for missed performance guarantees |

# Medical Claims Audits

# Medical Claims Audit Overview

- Objectives:
  - To determine if claims are processed and paid by the Third Party Administrator (TPA) in accordance with the contract
  - To determine whether the TPA met claims accuracy performance guarantees (an annual medical claims processing error rate of no more than 3% and an annual payment error rate of no more than 2% for the contract ended June 30, 2013)
- Auditor: Thomas & Gibbs CPAs, PLLC
- Frequency: Quarterly, with an annual report delivered at the end of each fiscal year
- Methodology: “Standard” and “focused” audits of statistically valid, random samples of medical claims are audited for processing and pricing accuracy
- Status: Thomas & Gibbs has completed the FY 2012-13 reports

# Medical Claims Audit Findings and Follow-up

| Medical Claims Audit Findings | | | | | | |
|---|---|---|---|---|---|---|
| July 2012 - June 2013 | | | | | | |
| | Performance Guarantee | QE 9/30/12 | QE 12/31/12 | QE 3/31/13 | QE 6/30/13 | Fiscal Year 2012-13 |
| **Standard Medical Claims Audit** | | | | | | |
| Processing error rate | 3% or less | 0.00% | 0.52% | 1.05% | 2.08% | 0.88% |
| Payment error rate | 2% or less | 0.00% | 0.00% | 0.008% | 0.49% | 0.12% |
| Financial accuracy | NA | 100.00% | 100.00% | 99.99% | 99.51% | 99.88% |
| **"Focused Audit" Duplicate Claims** | | | | | | |
| Processing error rate | NA | 0.00% | 0.00% | 6.67% | 2.67% | |
| Payment error rate | NA | 0.00% | 0.00% | 0.78% | 0.22% | N/A |
| Financial accuracy | NA | 100.00% | 100.00% | 99.24% | 99.78% | |
| **"Focused Audit" Coordination of Benefits** | | | | | | |
| Processing error rate | NA | 0.00% | 1.20% | 2.38% | 4.82% | |
| Payment error rate | NA | 0.00% | 0.49% | 0.13% | 4.15% | N/A |
| Financial accuracy | NA | 100.00% | 99.51% | 99.87% | 95.85% | |

**Processing error rate** is the total number of claims noted with claim payment errors divided by the total number of claims in the sample.

**Payment error rate** is the total absolute dollar amount of overpayments or underpayments resulting from errors in the claims tested divided by the total dollar amount of claims in the sample.

**Financial accuracy** is the total dollar amount in the audit sample processed accurately divided by the total dollar amount processed in the audit sample. Absolute dollar amounts are used so underpayments do not offset overpayments.

- Follow-up: Some audit errors uncover more systematic or process issues that need further review. When necessary, the Plan works with the TPA to develop a corrective action plan. Once developed, the Plan does three-month, six-month and annual follow-up reviews with BCBSNC to monitor action plan results.

# Medical Claims Audit - Quality Management Reviews

The Plan's Quality Team performs additional TPA process quality checks throughout the year. Last year the following TPA processes were reviewed:

- Financial Processing Services Check Deposit
- Appeals
- Debt Set Off
- Medicare Claims Processing Accuracy
- Enrollment Retro-Termination Processing

# BCBSNC Administrative Costs

# BCBSNC Administrative Costs

- Purpose:
  - To determine the validity of BCBSNC's administrative charges, including both direct and indirect charges
  - To ensure that the Plan has not reimbursed BCBSNC for unallowed costs
- Auditor:  Thomas & Gibbs CPAs, PLLC
- Frequency:  Annual, following the end of each fiscal year
- Methodology:  For the Fiscal Year 2011-12 audit, auditors reviewed supporting documentation for 80 transactions totaling approximately $10 million in costs
- Status: Final audit under the "cost plus" contract with BCBSNC will be conducted this fall (the cost plus contract ended June 30, 2013)
  - Most recent audit was from Fiscal Year 2011-12

# BCBSNC Administrative Costs
# Findings and Follow-up

- Findings (from FY 2011-12 report)
  - Because BCBSNC's incurred costs exceeded the cost plus cap established for FY 2011-12, administrative fees charged by BCBSNC on a PMPM basis equaled the cost-plus cap and totaled $115.2 million for the fiscal year
  - Unallowed costs:
    - A portion of BCBS Association lobbying activities may have been allocated to the Plan
    - A small portion of BCBSNC sponsorship costs were allocated to the Plan
- Follow-Up/Outcome:
  - BCBSNC agreed to modify its accounting process to exclude the unallowed items, as required by the Contract
  - Because BCBSNC incurred costs above the cost-plus cap that easily exceeded the excluded items, no adjustments were made to the amount BCBSNC charged the Plan

# Validation of ActiveHealth Management Return on Investment Calculation

# ActiveHealth Management Return on Investment Audit

- Objective:
  - To validate the return on investment (ROI) of the Plan's contract with ActiveHealth Management
  - To determine whether ActiveHealth has met its performance guarantee of a 3:1 ROI
- Auditor:  The Segal Company
- Frequency:  Annual, based on calendar year ROI calculation
- Methodology:  Actual claims costs are compared to projected costs.  The difference between projected and actual costs are compared to ActiveHealth fees in order to produce an ROI ratio
- Status:  Segal submitted the results of their ROI validation for Calendar Year 2012 in July 2013

# ActiveHealth Management Return on Investment Audit Findings and Follow-up

- Important Findings from the Calendar Year 2012 measurement
  - Per the agreed-upon methodology for calculating an expected spending trend, ActiveHealth's relationship with the Plan resulted in savings of $142.7 million relative to program fees of $24.9 million
  - The resulting ROI was calculated at 5.74:1
  - Segal's measurement of the savings generated by ActiveHealth were somewhat lower than the savings calculated by ActiveHealth
  - ActiveHealth easily exceeded the target ROI of 3:1
- Follow-Up/Outcome:  Segal, the Plan, and ActiveHealth agree that ActiveHealth has successfully met its performance guarantee

# Pharmacy Audits

# Audits conducted on the Pharmacy Benefit Manager

- Pharmacy Financial Audit
- Pharmacy Benefit Manager Rebate Audit
- Pharmacy Claims Audit

# Pharmacy Financial Audit Overview

- Objective:
  - To verify the PBM (ExpressScripts/ESI) has adjudicated pharmacy claims consistent with the pricing terms indicated in the contract
  - To determine whether the PBM met the financial performance guarantees
- Auditor: The Segal Company
- Frequency: Quarterly with an annual report delivered after the contract year
- Methodology: Detailed biweekly pharmacy claims files are analyzed for pricing and invoicing accuracy
- Status: Contract year October 1, 2011- September 30, 2012 completed
  4th Quarterly audit for FY 2012-13 due at the end of September

# Pharmacy Audit Components

- **Invoice reconciliation:** A claims data file covering the period of review is received from ESI and compared to invoice records obtained from ESI and also matched to the SHP's paid PBM invoice report.

- **Claims Average Wholesale Price (AWP):** The AWP reported for each claim by ESI is examined and compared to the AWP independently obtained from Medi-Span, using an 11-digit national drug code (NDC) and actual dispensing date for each claim.

- **Dispensing Fees:** Test of dispensing fee guarantees involved aggregating total dispensing fees paid for all non-member resubmitted claims filled at mail and retail pharmacies and comparing the actual dispensing fee changed to the amount expected based on the contractual guarantee.

- **Discount guarantees:** Claims are aggregated according to terms of the agreement. Claims excluded from discount guarantees are identified and separated from all other claims. The contract terms state that the discount and dispensing fee guarantees are guaranteed on a dollar-for-dollar basis. ESI may not offset a shortfall generated in one guarantee category (retail/mail, brand/generic) with a surplus generated in another.

- **Duplicate Claims:** Criteria is applied to identify duplicate claims, including same member ID, same date of service, and same national drug code (NDC).

# Pharmacy Audit Components Results

| | *QE 12/31/11 | *QE 3/31/12 | QE 6/30/12 | QE 9/30/12 | Contract Year |
|---|---|---|---|---|---|
| Invoice Reconciliation | No issues noted | No issues noted | No issues noted | No issues noted | No issues noted |
| AWP | No issues noted | No issues noted | No issues noted | No issues noted | No issues noted |
| Dispensing fee | Shortfall in aggregate dispensing fee noted | Shortfall in aggregate dispensing fee noted | Shortfall in aggregate dispensing fee noted | Shortfall in aggregate dispensing fee noted | Shortfall in aggregate dispensing fee noted |
| Aggregate achieved discount | Shortfall in aggregate discount noted | Shortfall in aggregate discount noted | Shortfall in aggregate discount noted | Shortfall in aggregate discount noted | Shortfall in aggregate discount noted |
| Specialty drug discount | No issues noted | No issues noted | No issues noted | No issues noted | No issues noted |
| Duplicate Claims | No issues noted | No issues noted | Potential duplicate claims identified | Potential duplicate claims identified | 960 potential duplicate claims identified |

At the end of the contract year, the PBM is required to reconcile with the Plan any shortfall of financial guarantees. For contract year ending September 30, 2012, the PBM paid the Plan $2.5 million to account for a shortfall in financial discounts for achieved discounts and dispensing fees. Potential duplicate claims are analyzed, if an adjustment of the claim occurred within the period after it is not deemed a duplicate claim.

* Identifies audits conducted by Plan's previous consultant AON Hewitt

# Pharmacy Rebate Audit Overview

- Objective:  To verify that contractual requirements between the Plan and PBM have been met and that payments provided under the Plan's rebate payment agreement validate rebate history
- Auditor:  The Segal Company
- Frequency:  As needed
- Methodology:  Auditor will select six to ten major pharmaceutical manufacturers working with the PBM and review PBM's contracts with the manufacturers to ensure that all manufacturer rebates are passed back to the Plan as required by the contract
- Status:  The Plan is finalizing contract arrangements with Segal in order to complete the audit by early 2014

# Pharmacy Claims Audit Overview

- Objectives:
  - To determine if claims are processed and paid by the PBM in accordance with the contract
  - To determine whether the PBM met the claims accuracy performance guarantee (an annual pharmacy claims processing error rate of no more than 1.5%)
- Auditor: Thomas & Gibbs CPAs, PLLC
- Frequency: Quarterly, with an annual report delivered at the end of each fiscal year
- Methodology: Statistically valid, random samples of pharmacy claims are audited for processing and pricing accuracy
- Status: Thomas & Gibbs has completed the FY 2012-13 reports

# Pharmacy Claims Audit Findings

| Pharmacy Claims Audit Findings | | | | | |
|---|---|---|---|---|---|
| July 2012 - June 2013 | | | | | |
| | Performance Guarantee | QE 9/30/12 | QE 12/31/12 | QE 3/31/13 | QE 6/30/13 |
| Processing error rate | 1.5% or less | 0.00% | 0.00% | 0.00% | 0.00% |
| Payment error rate | 1.5% or less | 0.00% | 0.00% | 0.00% | 0.00% |
| Financial accuracy | 99% or higher | 100.00% | 100.00% | 100.00% | 100.00% |

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# Early Retiree Reinsurance Program (ERRP) Audit

# Early Retiree Reinsurance Program Audit

- Background:
  - ERRP was one of the components of health care reform.
  - The Plan received $87 million in reimbursement from the Federal Government for early retirees with incurred claims greater than $15,000 in a plan year between June 2010 and December 2011.
- Objective:
  - To ensure that the Plan met ERRP program requirements and that reimbursements received were for claims incurred by early retirees
- Auditor:  Centers for Medicare and Medicaid Services (CMS)
- Frequency:  One time audit

# ERRP Audit
# Status, Findings, and Follow-Up

- Status:
  - Program requirements portion was completed in 2012
  - Claims audit (both medical and pharmacy) to be conducted in October 2013
- Findings:  None reported to date
- Follow-up:  Potential for claims resubmission and/or repayment of funds pending results of claims audit component and final audit report