Follow-up of
Audit of Self-Insurance Medical Claims

March 2016
Original audit report issued August 2014

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SUMMARY AND RESULTS

Background

The purpose of the August 2014 audit of Self-Insurance Medical Claims was to review internal controls and compliance with applicable laws, regulations, policies and procedures, and contracts. The scope of the audit included claims submitted for the period of January 1, 2012 through July, 31, 2013 (audit period).

The original audit report concluded that Employee Health and Benefits would benefit from:

- Documenting responsibilities, processes and procedures.
- Strengthening the internal monitoring of medical claims paid.
- Gaining an understanding of the Third Party Administrator (TPA) Internal Controls.
- Ensuring the proper deductibles is applied to medical claims.
- Improving verification procedures of dependent eligibility.
- Maintaining sufficient detail of claims information.
- Maintaining support for the administrative fee paid.

Objective

The objective of this follow-up audit was to evaluate the current status of observations reported in the Audit of Self-Insurance Medical Claims, dated August 2014 and corrective actions initiated by responsible management. This was achieved through independent, objective analysis to provide reasonable assurance that the previous concerns have been addressed and appropriate corrective measures implemented.

To meet the objective of the follow-up audit, the following procedures were performed:

- Performed inquiries of the Employee Health and Benefits department managers and staff.
- Obtained an understanding of changes made to Employee Health and Benefits procedures related to Medical claims since the original audit report date.
- Tested a sample of employees that requested dependents be placed on the County Plan to ensure eligibility was appropriately validated.

Overall Results

Based on the results of our follow-up audit procedures, responsible management has addressed four (4) of the seven (7) previous concerns and implemented appropriate corrective action on those conditions identified in the original audit report. Three (3) recommendations from the original report have not been addressed sufficiently.

Condition	Status
A. Lack of Documented Responsibilities, Processes and Procedures	Open/Partially Completed *
B. Strengthen Monitoring of Claims	Open
C. Understanding of Third Party Administrator (TPA) Internal Controls	Open/Partially Completed *
D. Improper Deductible Amount Applied	Closed
E. Audit Report Includes Recommendations to Improve Verification of Dependent Eligibility	Closed
F. Claims Information Not Maintained in Sufficient Detail	Closed
G. Support for Administrative Fee Amount Not Maintained	Closed

*Conditions A and C remain outstanding as corrective actions were partially completed by Employee Health and Benefits after the original audit. Corrective action is in process on the remaining portions of the management action plan. Condition B remains open as corrective action has not been completed.

Although three (3) *Opportunities for Improvement* remain open or open/partially completed, this concludes the follow-up audit process as it relates to the Audit of Self-Insurance Medical Claims.

OPEN CONDITIONS AND PENDING CORRECTIVE ACTION

Three (3) of the seven (7) conditions identified in the original report are partially complete, with actions on the open items currently being addressed by responsible management.

A. Lack of Documented Responsibilities, Processes and Procedures

Written processes and procedures are needed to ensure the County meets its Plan responsibilities.

Current Status, Follow-Up Audit dated March 2016: Employee Health and Benefits is in the process of developing and documenting Standard Operating Procedures (SOPs). As of the time of the follow-up audit fieldwork, there are twenty-two (22) SOPs, of which six (6) are adopted and sixteen (16) are in draft form, including SOPs for verifying employee and dependent eligibility and the determination of administrative fees. There are no adopted or draft SOPs in relation to the monitoring of claims, the treatment of denied claims, and document retention and destruction.

Original Audit Observation, Report dated August 2014: The County contracts with Aetna to process Plan claims and perform various functions for the Plan. The County's responsibilities include verifying that employees and dependents are eligible to participate in the Plan, calculating and approving the administrative fee paid to the TPA, monitoring claims administration, and reviewing any denied/appealed claims.

Currently, limited guidance is provided to responsible employees on how to fulfill these County duties. The County new hire enrollment documents provide some guidance; however, these documents do not include specifics on the procedures that should be performed. Personnel perform procedures that have been verbally passed down from previous employees.

Original Recommendation, Report dated August 2014: Document responsibilities for monitoring the Plan and the processes and procedures used to ensure that those responsibilities are being met. Written procedures provide a tool for existing and future employees to perform their functions effectively and can be used to communicate responsibilities and expectations to staff. At a minimum, written procedures should address the monitoring of medical claims, the treatment of denied claims, the determination of administrative fees, the processes for verifying employee and dependent eligibility, and document retention and destruction.

Management Action Plan: Staff will complete and implement the sixteen remaining SOP's currently in process by June 1, 2016. It should be noted that many of the processes to be documented in the SOP's have previously been implemented.Finally, the development and adoption of the three additional recommended SOP's will also be implemented by June 1, 2016.

B. Strengthen Monitoring of Claims

Procedures to analyze and monitor medical claims do not exist.

Current Status, Follow-Up Audit dated March 2016: Procedures for analyzing and monitoring claims have not been substantially modified since the original audit. While "spot-checks" continue to be performed on the claim details, no formal data analysis procedures have been designed or implemented. The auditor was advised by Employee Health and Benefits management that an external vendor will be procured to perform claim audits in fiscal year 2017.

Employee Health and Benefits management provided evidence that medical claims paid are tracked in total monthly by the County; however, this does not address individual claims that could be duplicate or inaccurate. Additional procedures are necessary to ensure no duplicate or inaccurate claims are processed.

Original Audit Observation, Report dated August 2014: The County contracts with Aetna to process Plan claims; however, the County is responsible for various aspects of the Plan including monitoring expenses and services performed by third parties, including Aetna. Personnel perform procedures that may include procedures that are not effective and exclude procedures that would improve internal control. For example, when the detail of claims is received from the TPA, County personnel "spot-check" the details for claims that appear to be duplicates. This check may not be as effective or efficient as a formal data analysis procedure designed to detect duplicate claims. County personnel also stated that the claims list is reviewed to identify claims over $100,000. These claims are then "verified" by asking the TPA, who provided the claims detail, to confirm that certain claim information is accurate related to these transactions.

The County does not have support or documented rationale for using $100,000 as the threshold for performing additional procedures. It is unknown if this is still a relevant parameter for additional follow-up. Also, verifying with the TPA that the information they provided is correct without viewing support or confirming the information with a separate party may not effectively detect or resolve erroneous or fraudulent claims.

Original Recommendation, Report dated August 2014: The County could benefit from performing additional procedures to analyze and monitor claims. Examples of monitoring procedures include searches for duplicate claims, reviewing claims over a high dollar threshold, and instituting routine claims audits.

Management Action Plan: Staff is in the process of procuring a claims audit firm to conduct an audit by the end of fiscal year 2016. Formal audits will be conducted every other year, at minimum, going forward. Because there are thousands of claims processed every month, the only practicable way (beyond the current spot- check process) to find duplicate or inaccurate individual claims is through a formal audit. Staff will also continue to monitor vendor performance guarantees to verify claims processing accuracy.

C. Understanding of Third Party Administrator (TPA) Internal Controls

The Service Organization's Control (SOC) Report for TPA is not obtained or reviewed.

Current Status, Follow-Up Audit dated March 2016: The SOC Report in relation to the effectiveness of internal controls designed and implemented by the TPA throughout the period April 1, 2014 to March 31, 2015, was obtained by Employee Health and Benefits and reviewed for any weaknesses identified. There was no documentation supporting that the County evaluated and addressed the suggested "user controls" provided in the report. Additionally, there is no SOP adopted or in draft to provide guidance for these processes.

Original Audit Observation, Report dated August 2014: Aetna is the TPA contracted by the County to process Plan claims and perform various functions for the Plan. Aetna's internal controls are evaluated annually by an independent CPA firm that issues a SOC report that describes and evaluates internal controls related to the TPA's claims processing functions, including any internal control weaknesses identified. The SOC report also includes a description of internal controls that are recommended for user entities, like the County.

The County does not obtain or review the report to, 1) identify any TPA internal control weaknesses that could impact the administration of the County's health plans, or 2) evaluate whether or not the County has addressed the recommended controls for "user" entities that are included in the report. As part of this audit, it was noted that the SOC report covering the year ended March 31, 2013 included a clean opinion on the design and operating effectiveness of the TPA's internal controls. The report also includes suggested "user controls", and notes that Aetna's internal controls are designed with the assumption that internal controls are implemented at the user entities. While the SOC report is extensive, the County would benefit from an in depth review of it in its entirety. Page 63 of the report lists various complimentary controls. See Appendix A.

Original Recommendation, Report dated August 2014: Each year, obtain and review the TPA's annual SOC Report which describes and evaluates internal controls related to the TPA's claims processing functions. Identify and address internal control weaknesses at the TPA that could impact the administration of the County's Plan. Also, ensure that the County has evaluated and addressed the suggested "user controls" provided in the report.

Management Action Plan: Staff is in the process of developing an SOP to document the SOC Report review process. It is the intent of staff to mirror the applicable "user controls" in the development of Employee Health & Benefits controls, which will be identified in the SOP. This SOP will be implemented by June 1, 2016.

CLOSED CONDITIONS AND FOLLOW-UP RESULTS

D. Improper Deductible Amount Applied

Incorrect amount charged to a patient.

Current Status, Follow-Up Audit dated March 2016: Supporting documentation revealed that upon further investigation by the TPA, it was determined that the deductible charged to the patient was correct. The provider was not a participant in the National Advantage Program; therefore, services rendered to the patient were not at a contracted rate.

No additional claims were reviewed, since the deductible applied was found to be accurate. Procedures for routine claim audits are under development (see Conditions A. and B.).

Original Audit Observation, Report dated August 2014: For one (1) of the 205 claims tested, a $60 deductible was charged and credited to a patient in error. The amount should have been $36. The result was an overcharge to the patient of $24. Aetna was made aware of the error and as of the date of this report, was in the process of identifying the cause of the error and any other claims that may have been impacted.

Original Recommendations, Report dated August 2014: Communicate with the TPA as to the cause and resolution of the error. Once the cause has been determined, additional claims may need to be reviewed to verify that similar errors do not exist. In addition, routine claim audits should be initiated.

E. Audit Report Includes Recommendations to Improve Verification of Dependent Eligibility

Lack of process to verify all enrolled dependents are eligible to participate in the Plan.

Current Status, Follow-Up Audit dated March 2016: Procedures were developed and implemented after the original audit to include validation of dependent's eligibility to be placed on the County Plan. The procedures include requiring that the employee provide appropriate documentation in support of dependent eligibility and monitoring of child dependents that are close to reaching the normal maximum age of eligibility. Employee Health and Benefits is in the process of documenting the responsibilities, processes, and procedures (see Condition A.).

The auditor randomly selected a sample of twenty (20) individuals from populations provided by Employee Health and Benefits that included new hires during fiscal years 2015 and 2016 (through November 2015) as well as employees who made changes to dependents covered by the County Plan, either during the audit period or during open enrollment. Results of the testing performed concluded that the procedures related to verification of the eligibility of dependents on the County Plan are functioning as intended.

Original Audit Observation, Report dated August 2014: While the verification that participating dependents were eligible for plan benefits was specifically excluded from the scope of this audit, an audit dated February 2014 of dependent eligibility was issued by HMS Employer Solutions, Inc. That audit indicated that a number of dependents in the Plan did not sufficiently support their eligibility to participate in the Plan.

In addition, discussions with County personnel indicated that the County does not routinely maintain documentation supporting dependent eligibility verifications. If ineligible dependents have participated in the Plan, the County may have incurred costs for ineligible benefits. Premiums for all participants could potentially have been impacted.

Original Recommendation, Report dated August 2014: Establish clear processes to verify that all newly enrolled dependents are eligible to participate in the Plan. In addition, develop procedures for the routine verification of participating dependents as dependent eligibility can change.

F. Claims Information Not Maintained in Sufficient Detail

County does not maintain claims details to verify or audit benefits paid.

Current Status, Follow-Up Audit dated March 2016: Employee Health and Benefits enhanced procedures to include retention of the claim ID number on the detail files received from the TPA. The auditor observed that while the archived electronic files include the claim ID number, personally identifiable information, such as name and birthdate, are excluded.

Original Audit Observation, Report dated August 2014: The County receives claims details from the TPA which support benefit amounts paid by the Plan. County personnel scan the reports for certain items as discussed in other comments, approve the funding, and then delete various columns of data that identify the patient as well as the assigned claim numbers. While the County is required to protect certain information that could identify the patient and health issues, deleting the claim number references makes it difficult to later verify that claims paid were accurate and supported.

Original Recommendation, Report dated August 2014: Maintain benefit payment details, including claim number references, to enable the County to verify or audit benefits paid. Protected health information may still be removed.

G. Support for Administrative Fee Amount Not Maintained

The County does not maintain a list of employees participating in the plan to allow for audit of administrative fees or payments.

Current Status, Follow-Up Audit dated March 2016: Employee Health and Benefits maintains two files related to the monthly administrative fee paid Atnea. One file is the invoice, which includes the total number of employees enrolled in the Plan, and the second file includes the names of all employees enrolled as of the first of the month. The total number of employees is compared on the two files prior to submitting the invoice for payment of the administrative fee.

The auditor observed that for the months of September, October, and November 2015, the total number of employees shown on the invoice agreed with the total number of employees listed on the detail report.

Original Audit Observation, Report dated August 2014: The County calculates the monthly administrative fee paid to Aetna. The fee is calculated based on the number of employees enrolled in the Plan on the first of each month. The Human Resources System tracks the number of employees enrolled in the Plan.

The system has been programmed to automatically generate a report on the first of each month of the total number of employees participating in the Plan; however, a detailed list of these employees is not generated. Once time has passed, the system is not able to generate an accurate list of eligible employees at a past point in time. This means that a post-audit of the accuracy of the number of employees enrolled and used to calculate the administrative fee cannot later be performed.

Original Recommendation, Report dated August 2014: Instead of auto-generating a report that shows only the total number of employees participating in the Plan, generate a listing of employee participants and maintain this listing to support administrative fee calculations and payments.

APPENDIX A

Following is the original *Audit of Self-Insurance Medical Claims d*ated August 2014.

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Clerk of the Circuit Court and County Comptroller

Audit of Self-Insurance Medical Claims

Audit Services

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Summary and Results

The Clerk of the Circuit Court and County Comptroller's *Internal Audit Department and Office of the Inspector General* has completed an audit of the County's self-insurance medical claims. The audit was planned and conducted in accordance with Generally Accepted Government Auditing Standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. The purpose of the audit was to review internal controls and compliance with applicable laws, regulations, policies and procedures, and contracts. The scope of this audit included claims submitted for the period of January 1, 2012 through July 31, 2013 (audit period).

Background

The Employee Health & Benefits department, within Human Resources, is responsible for overseeing administration of the self-funded employee health benefit plans of Sarasota County, including determining employee and dependent eligibility to participate in the plans and administrative fees paid to third parties who provide services to the plans. Employees are eligible for medical Plan coverage on the 31st calendar day of employment. Enrollment in a medical plan may be elected by employees within the first thirty (30) days of employment through the County's self-enrollment system. The system also allows employees to enroll dependents in the plans.

The County entered into a Master Services Agreement (MSA-876535) commencing on January 1, 2011 with Aetna Life Insurance Company, Inc. (Aetna) for Third Party Administration (TPA) of the County's self-funded employee health benefits plan (Plan). The Master Services Agreement has an initial term of three (3) years, with two (2) options to extend the agreement for additional one (1) year periods. The agreement was extended through December 31, 2014.

The County is responsible for monitoring administration of the Plan; funding claim benefits and administrative costs of the Plan; and ensuring that employees, their spouses, and dependents covered under the Plan are eligible to participate in the Plan. The County provides Aetna with participant eligibility updates, including new hires, terminations, and qualified benefit changes. As of July 2013, there were 3,338 employees participating in the Plan, not including dependents.

Aetna is responsible for claims administration including receiving benefit claims, processing claims in accordance with Plan and MSA provisions, tracking deductibles, co-payments, or co-insurance amounts, paying service providers, and reimbursing covered participants, as applicable. Medical claims (before deductibles and other adjustments) submitted for the period under audit, January 1, 2012 through July 31, 2013, totaled $122,603,492 and consisted of 376,499 claims. Of that amount, claims totaling $43,484,417 were categorized as "allowable" under the Plan, which means that the claims qualified for payment either by the Plan or through patient deductibles, co-payments or co-insurance.

The County's Internal Service Fund (Fund) accounts for health and dental plan benefits. Fund revenues are derived from health insurance premiums paid by the County and employees, retirees and Consolidated Omnibus Budget Reconciliation Act (COBRA) participants. Fund expenses include healthcare costs (medical, prescription, and dental), short-term disability claims, and administrative costs, including Aetna's administrative fees. Aetna receives administrative fees as compensation for TPA services. Administrative fees for the medical plan are calculated on a fixed "per employee per month" (PEPM) amount based on the number of enrolled employees in the medical plan on the first day of each month. The administrative fee per enrolled employee each month was $45.70 during 2012, and $46.68 during 2013. Total fees paid to Aetna for administering the medical plan for the nineteen (19) month audit period was $2,889,788.

Objectives, Scope and Methodology

The objectives of this audit were to determine if internal controls related to medical claims processing and payment are operating effectively and in compliance with applicable laws, rules, regulations, policies and procedures, and contracts. More specifically, the audit's objectives were to:

- Determine whether the County's health benefit plan medical claims and administrative fees are processed and paid in compliance with the Plan provisions and applicable agreements.

  Pharmaceutical claims, which were processed separately by a different TPA, were not included in this audit.

- Obtain reasonable assurance that there are controls in place to ensure that only eligible employees received benefits under the Plan.

  Employee dependents may be eligible to participate in the Plan and receive benefits; however, a separate audit of dependent eligibility was being conducted by an outside party at the time of this audit. In order to avoid duplicating audit efforts, this audit specifically excluded verification of dependent eligibility.

To meet the objectives of the audit, the procedures performed included, but were not limited to, the following:

- Performed inquiries of County and TPA personnel.

- Reviewed Plan documents, TPA service agreements, enrollment information provided to employees, and information on the County's intranet site related to Plan eligibility and benefits.

- Obtained and reviewed the TPA's Service Organization's Control (SOC) Report, issued by an independent CPA firm, describing and evaluating the TPA's internal controls related to TPA services and claims processing.

- Examined a sample of 205 claims totaling $13,600 to determine if co-payments, deductibles, and other adjustments were properly considered and to determine if claims were processed timely in accordance with Plan and TPA contract provisions. The sample included allowable, denied and zero paid claims. A 90% confidence level and 10% margin of error were used to determine the sample size.

  The County is responsible for any reviews of denied and/or appealed claims which were not included in the scope of this audit.

- Agreed allowable amounts, in the sample of 205 claims, to supporting fee schedules, provider contracts that define fee rates, and usual and customary charges (from Medicare and/or FairHealth Databases), as applicable, to determine the accuracy and reasonableness of claims paid.

  The County's agreement with Aetna limits the number of claims that can be audited and states that the County "…shall pay Aetna fees for any audit, which, with Aetna's approval…(ii) contains a sample size in excess of 250 claim transactions…"

- Compared the sample of claims tested to other claims for the respective plan participants to detect possible duplicate payments on claims with the same date of service.

- For the claims tested above, verified that employees were eligible to participate in the Plan. There were 101 employee claimants verified as a result.

- Selected twenty (20) medical service providers for further testing. Judgmentally selected the twenty (20) providers that were most frequently occurring in claims tested population. Providers are physicians, hospitals, laboratories and other medical service providers. Compared the sampled claim amounts to the respective fee schedules included in the contracts between Aetna and the medical service providers to ensure that the proper rates were charged to the Plan and participants.

  - Of the twenty (20) provider contracts requested, sixteen (16) provider contract fee schedules were provided by Aetna and tested; two (2) were for behavioral health services not subject to contracts with Aetna; and two (2) provider contracts were not made available for the audit by Aetna and are considered a scope limitation on the audit.

- Recalculated the administrative fee paid to Aetna in accordance with the MSA. Verified that the underlying data was accurate for June 2014 by agreeing the monthly rate per employee for the month to the rate in the MSA. Agreed the number of participating employees used to calculate the administrative fee to the Human Resources database.

- Identified opportunities for improvement.

Overall Results

For the sample of claims tested, it appears the TPA has internal controls to ensure that it correctly determines and pays medical claims for the self-insured Plans. However, for one (1)

of the 205 claims tested, an error was identified and acknowledged by Aetna who is further investigating its cause and potential impact.

The County would benefit from increased monitoring over medical claims processing and participant eligibility along with defined and documented policies and procedures. The *Opportunities for Improvement* section of this report discusses these results and recommendations in detail. The following summarizes the result of the audit:

- *Lack of Documented Responsibilities, Processes and Procedures* – The County currently has no written procedures for monitoring medical claims, reviewing denied/appealed claims, determining administrative fees, or verifying employee or dependent eligibility.

- *Strengthen Monitoring of Claims* – The County could benefit from performing additional procedures to analyze and monitor claims. Examples of monitoring procedures include searches for duplicate claims, reviewing claims over a high dollar threshold, and instituting routine claims audits.

- *Understanding of Third Party Administrator (TPA) Internal Controls* – The internal controls of the third party administrator are evaluated and reported on annually by an independent CPA firm. This Service Organization's Control (SOC) Report can provide the County with assurance regarding the internal controls of Aetna or insight into any control weaknesses. The report also includes recommended controls for "user" entities like the County that utilize Aetna's services. The County does not obtain or review the SOC report to, 1) identify any TPA internal control weaknesses that could impact the administration of the County's health plans, or 2) evaluate whether or not the County has addressed the recommended controls for "user" entities.

- *Improper Deductible Amount Applied* – For one (1) of the 205 claims tested, a $60 deductible was charged and credited to a participant in error. The amount should have been $36. The result was an overcharge to the participant of $24. Aetna was made aware of the error and as of the date of this report, was in the process of identifying the cause of the error and any other claims that may have been impacted.

- *Audit Report Includes Recommendations to Improve Verification of Dependent Eligibility* – While verifying that participating dependents were eligible for plan benefits was specifically excluded from the scope of this audit, an audit dated February 2014 of dependent eligibility was issued by HMS Employer Solutions, Inc. That audit indicated that a number of dependents in the Plan did not sufficiently support their eligibility to participate in the Plan.

- *Claims Information Not Maintained in Sufficient Detail* – The County receives claims details from the TPA. These details support benefit amounts paid by the Plan. The Employee Health & Benefits department performs a limited review of the details, approves the funding, and then deletes various sections of data including the assigned claim numbers. While the County is required to protect health information, deleting the claim number references makes it difficult to later verify or audit benefits paid.

- *Support for Administrative Fee Amount Not Maintained* – Details of those employees who were "eligible employees" used to calculate administrative fees paid to Aetna were

not maintained during the audit period. Therefore, there is not a reliable way to verify that the number of participating employees used to calculate the administrative fee was accurate.

Opportunities for Improvement

The audit disclosed that procedures and practices could be improved. The audit was neither designed nor intended to be a detailed study of every relevant system, procedure, or transaction. Accordingly, the ***Opportunities for Improvement*** presented in this report may not be all-inclusive of areas where improvement may be needed. Observations and recommendations were made in the following areas:

A. Lack of Documented Responsibilities, Processes and Procedures
B. Strengthen Monitoring of Claims
C. Understanding of Third Party Administrator (TPA) Internal Controls
D. Improper Deductible Amount Applied
E. Audit Report Includes Recommendations to Improve Verification of Dependent Eligibility
F. Claims Information Not Maintained in Sufficient Detail
G. Support for Administrative Fee Amount Not Maintained

A. Lack of Documented Responsibilities, Processes and Procedures

Written processes and procedures are needed to ensure the County meets its Plan responsibilities.

Observation

The County contracts with Aetna to process Plan claims and perform various functions for the Plan. The County's responsibilities include verifying that employees and dependents are eligible to participate in the Plan, calculating and approving the administrative fee paid to the TPA, monitoring claims administration, and reviewing any denied/appealed claims.

Currently, limited guidance is provided to responsible employees on how to fulfill these County duties. The County new hire enrollment documents provide some guidance; however, these documents do not include specifics on the procedures that should be performed. Personnel perform procedures that have been verbally passed down from previous employees.

Recommendation

Document responsibilities for monitoring the Plan and the processes and procedures used to ensure that those responsibilities are being met. Written procedures provide a tool for existing and future employees to perform their functions effectively and can be used to communicate responsibilities and expectations to staff. At a minimum, written procedures should address the monitoring of medical claims, the treatment of denied claims, the determination of administrative fees, the processes for verifying employee and dependent eligibility, and document retention and destruction.

Management Response

Management concurs that responsibilities, processes and procedures related to the ongoing administration of the program are needed to ensure smooth transitions when there is staff turnover. Employee Health & Benefits (EH&B) staff will document current practices and create a process/procedure manual that identifies responsibilities/functions of specific staff positions related to the medical claims administration for the health plans by July 31, 2015.

B. Strengthen Monitoring of Claims

Procedures to analyze and monitor medical claims do not exist.

Observation

The County contracts with Aetna to process Plan claims; however, the County is responsible for various aspects of the Plan including monitoring expenses and services performed by third parties, including Aetna. Personnel perform procedures that may include procedures that are not effective and exclude procedures that would improve internal control. For example, when the detail of claims is received from the TPA, County personnel "spot-check" the details for claims that appear to be duplicates. This check may not be as effective or efficient as a formal data analysis procedure designed to detect duplicate claims. County personnel also stated that the claims list is reviewed to identify claims over $100,000. These claims are then "verified" by asking the TPA, who provided the claims detail, to confirm that certain claim information is accurate related to these transactions.

The County does not have support or documented rationale for using $100,000 as the threshold for performing additional procedures. It is unknown if this is still a relevant parameter for additional follow-up. Also, verifying with the TPA that the information they provided is correct without viewing support or confirming the information with a separate party may not effectively detect or resolve erroneous or fraudulent claims.

Recommendation

The County could benefit from performing additional procedures to analyze and monitor claims. Examples of monitoring procedures include searches for duplicate claims, reviewing claims over a high dollar threshold, and instituting routine claims audits.

Management Response

Management concurs that additional periodic, routine scrutiny of claim payments is desirable and recommends the following actions:

1) Perform periodic, routine claim audits through a qualified, external vendor every third year (the next one would occur in calendar year 2017).

2) Confer with current contracted benefits consultant on guidelines for performing additional internal staff claim or "spot" audits and/or working with consultant partners to analyze

claim samples, i.e., dollar thresholds, diagnosis, numbers of claims, etc. Based on consultant recommendations, EH&B staff will:

   a. Include the analysis parameters and process in the documented staff Responsibilities, Processes and Procedures as previously identified in Management Response A, and
   b. Provide a written summary of the internal review findings annually.

3) Management will closely monitor the amount of time required to perform the additional functions above to determine if additional resources are needed to fulfill these requirements.

C. Understanding of Third Party Administrator (TPA) Internal Controls

The Service Organization's Control (SOC) Report for TPA is not obtained or reviewed.

Observation

Aetna is the TPA contracted by the County to process Plan claims and perform various functions for the Plan. Aetna's internal controls are evaluated annually by an independent CPA firm that issues a SOC report that describes and evaluates internal controls related to the TPA's claims processing functions, including any internal control weaknesses identified. The SOC report also includes a description of internal controls that are recommended for user entities, like the County.

The County does not obtain or review the report to, 1) identify any TPA internal control weaknesses that could impact the administration of the County's health plans, or 2) evaluate whether or not the County has addressed the recommended controls for "user" entities that are included in the report. As part of this audit, it was noted that the SOC report covering the year ended March 31, 2013 included a clean opinion on the design and operating effectiveness of the TPA's internal controls. The report also includes suggested "user controls", and notes that Aetna's internal controls are designed with the assumption that internal controls are implemented at the user entities. While the SOC report is extensive, the County would benefit from an in depth review of it in its entirety. Page 63 of the report lists various complimentary controls. See Appendix A.

Recommendation

Each year, obtain and review the TPA's annual SOC Report which describes and evaluates internal controls related to the TPA's claims processing functions. Identify and address internal control weaknesses at the TPA that could impact the administration of the County's Plan. Also, ensure that the County has evaluated and addressed the suggested "user controls" provided in the report.

Management Response

Management concurs that the SOC reports should be reviewed annually. EH&B staff will obtain the annual or latest SOC report. The EH&B manager will review and address any identified weaknesses as they may apply to the vendor's operations for the County by July 31, 2015. Vendor recommendations regarding complimentary controls will also be reviewed and, if appropriate, be added to the documented staff Responsibilities, Processes and Procedures as previously identified in Management Response A.

D. Improper Deductible Amount Applied

Incorrect amount charged to a patient.

Observation

For one (1) of the 205 claims tested, a $60 deductible was charged and credited to a patient in error. The amount should have been $36. The result was an overcharge to the patient of $24. Aetna was made aware of the error and as of the date of this report, was in the process of identifying the cause of the error and any other claims that may have been impacted.

Recommendation

Communicate with the TPA as to the cause and resolution of the error. Once the cause has been determined, additional claims may need to be reviewed to verify that similar errors do not exist. In addition, routine claim audits should be initiated.

Management Response

A) EH&B staff will verify with Aetna the cause of the above issue by September 30, 2014 and obtain assurances that steps have been taken to prevent similar occurrences going forward, and
B) Staff will also confer with the contracted benefits consultant to develop the necessary process to monitor on a routine basis, whether by internal staff or through the periodic external audit process referred to in Management Response B. Process development will be complete by July 31, 2015 and be added to the documented staff Responsibilities, Processes and Procedures previously identified in Management Response A above by September 30, 2015.

TPA Response

Aetna has agreed with the error and is pursuing a claims system correction.

E. Audit Report Includes Recommendations to Improve Verification of Dependent Eligibility

Lack of process to verify all enrolled dependents are eligible to participate in the Plan.

Observation

While the verification that participating dependents were eligible for plan benefits was specifically excluded from the scope of this audit, an audit dated February 2014 of dependent eligibility was issued by HMS Employer Solutions, Inc. That audit indicated that a number of dependents in the Plan did not sufficiently support their eligibility to participate in the Plan.
In addition, discussions with County personnel indicated that the County does not routinely maintain documentation supporting dependent eligibility verifications. If ineligible dependents have participated in the Plan, the County may have incurred costs for ineligible benefits. Premiums for all participants could potentially have been impacted.

Recommendation

Establish clear processes to verify that all newly enrolled dependents are eligible to participate in the Plan. In addition, develop procedures for the routine verification of participating dependents as dependent eligibility can change.

Management Response

A) Prior to this audit and subsequent to the HMS Employer Solutions audit, internal processes and tracking requirements were modified to preserve the integrity of the eligibility database. As of March 2014 EH&B staff has been collecting the same documentation as was required by HMS (i.e., marriage certificates, birth certificates, etc.) from newly hired employees, employees making changes during open enrollment and/or following a change in status.
B) Management concurs that external audits of all participants' dependents should continue to be performed every 3 years (standard industry practice) and will be established as previously mentioned in Management Response A. The next one will be scheduled in 2017.

F. Claims Information Not Maintained in Sufficient Detail

County does not maintain claims details to verify or audit benefits paid.

Observation

The County receives claims details from the TPA which support benefit amounts paid by the Plan. County personnel scan the reports for certain items as discussed in other comments, approve the funding, and then delete various columns of data that identify the patient as well as the assigned claim numbers. While the County is required to protect certain information that could identify the patient and health issues, deleting the claim number references makes it difficult to later verify that claims paid were accurate and supported.

Recommendation

Maintain benefit payment details, including claim number references, to enable the County to verify or audit benefits paid. Protected health information may still be removed.

Management Response

Management concurs that the claim ID number does not compromise protected health information and will include in the back-up for future payment requests.

G. Support for Administrative Fee Amount Not Maintained

The County does not maintain a list of employees participating in the plan to allow for audit of administrative fees or payments.

Observation

The County calculates the monthly administrative fee paid to Aetna. The fee is calculated based on the number of employees enrolled in the Plan on the first of each month. The Human Resources System tracks the number of employees enrolled in the Plan.

The system has been programmed to automatically generate a report on the first of each month of the total number of employees participating in the Plan; however, a detailed list of these employees is not generated. Once time has passed, the system is not able to generate an accurate list of eligible employees at a past point in time. This means that a post-audit of the accuracy of the number of employees enrolled and used to calculate the administrative fee cannot later be performed.

Recommendation

Instead of auto-generating a report that shows only the total number of employees participating in the Plan, generate a listing of employee participants and maintain this listing to support administrative fee calculations and payments.

Management Response

Management concurs that the reported eligibility should be verifiable with links to employee and dependent names. Back-up reports will be developed and securely retained for each administrative fee request for the purpose of future audits for billings occurring after March 31, 2015.

Appendix A:

Excerpt from Aetna Life Insurance Company Preferred Provider Organization, Indemnity Health and Dental Self-Funded Operations Service Auditors' Report:

- Controls should be established to identify and adhere to the Administrative Services Agreement which sets forth specific user and Company responsibilities.

- Controls should be established so that changes to plan, reimbursement policy, and enrollment and provider information are authorized, implemented and reviewed. This information should be submitted accurately and on a timely basis.

- Controls should be established so that transactions are appropriately authorized, complete and accurate. This includes appropriate access to information, segregation of duties and supervisory review.

- Controls should be established so that erroneous input data is corrected and resubmitted on a timely basis.

- Controls should be established to monitor compliance with procedures outlined in the plan's user manuals and policy and procedure documents.

- Controls should be established so that output reports are received by appropriate user personnel.

- Controls should be established to determine which system reports are needed so that system reports received from the Company are routinely balanced and/or reconciled to relevant control totals and reviewed for completeness and accuracy. All exceptions should be investigated and resolved on a timely basis.

- Controls should be established so that instructions and information provided to the Company from the user are in accordance with the provisions of applicable governing agreements or documents.

- Controls should be established to satisfy any and all plan reporting and disclosure requirements imposed by law.

- Controls should be established that protect individual plan member information.