North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

Summary of Audit Results

Board of Trustees Meeting

November 20, 2014

A Division of the Department of State Treasurer

Presentation Overview

- Audit Process
- Medical Claims Audits
- BCBSNC Administrative Costs
- 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 Workflow

Audit Plan	Conduct Audit	Findings	Finalized Audit Report	Follow Up
• Determine objective and scope • Assessment of data needs • Establish timeframes	• Review data • Onsite fieldwork	• Document findings • Root cause analysis • Establish corrective action plan	• Review • Recommend changes or improvements • Sign off	• Monitor correction plan • 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 financial accuracy rate of 99%, payment accuracy rate of 99% and a process accuracy rate of 97% for the contract ended June 30, 2014)
- **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 2013-14 reports

Medical Claims Audit Findings and Follow-up

July 2013 - June 2014						
	Performance Guarantee	QE 9/30/13	QE 12/31/13	QE 3/31/14	QE 6/30/14	Fiscal Year 2013-14
Standard Medical Claims Audit						
Processing Accuracy Rate	97%	98.00%	97%	100.00%	100.00%	98.67%
Payment Accuracy Rate	99%	99.00%	99%	100.00%	100.00%	99.33%
Financial Accuracy Rate	99%	99.93%	99.76%	100.00%	100.00%	99.89%
"Focused Audit" Duplicate Claims						
Processing Accuracy Rate	N/A	92.00%	98.67%	100.00%	100.00%	N/A
Payment Accuracy Rate	N/A	93.33%	100.00%	100.00%	100.00%	
Financial Accuracy Rate	N/A	99.79%	100.00%	100.00%	100.00%	
"Focused Audit" Coordination of Benefits						
Processing Accuracy Rate	N/A	93.33%	96.48%	99.29%	98.59%	N/A
Payment Accuracy Rate	N/A	93.33%	96.48%	100.00%	98.59%	
Financial Accuracy Rate	N/A	99.85%	99.84%	100.00%	99.99%	

Processing Accuracy Rate is the number of claims processed with no procedural errors divided by the total number of claims processed.

Payment Accuracy Rate is the number of claims with the correct benefit dollars paid divided by the total number of claims paid in the audit 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. Here is a list of TPA processes that were reviewed:
  - Duplicate Claims
  - Debt Set Off
  - Medicare Claims Processing Accuracy
  - 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 under the former Administrative Services Agreement (ASA)
  - To ensure the Plan did not reimburse BCBSNC for un-allowed costs
  - To ensure the Plan was not charged implementation costs associated with the new TPA contract that began July 1, 2013
- **Auditor**:
  - Thomas & Gibbs CPAs, PLLC
- **Frequency:**
  - Annual, following the end of each fiscal year under the "cost plus" ASA
- **Methodology:**
  - For the Fiscal Year 2012-2013 audit, auditors reviewed supporting documentation for 128 transactions totaling approximately $21 million in costs
- **Status:**
  - The Fiscal Year 2012-2013 audit was the final annual audit of the BCBSNC cost plus contract; no further BCBSNC administrative audits are planned at this time

BCBSNC Administrative Costs Findings

- **Findings (FY 2012-13 report)**
  - Administrative costs billed to the Plan totaled $108.3 million and were less than:
    - BCBSNC administrative fees in the prior fiscal year; and
    - The cost plus cap established for the fiscal year
  - None of the 128 audited transactions were found to be invalid
  - BCBSNC's methodology for excluding implementation costs provided "reasonable assurance" that implementation costs for the new TPA contract were not billed to the Plan under the cost plus ASA
    - The methodology was not applied to the costs for some of the BCBSNC staff whose time is dedicated exclusively to the Plan (BCBSNC Dedicated Unit)

BCBSNC Administrative Costs Follow-up

- **Follow-up/Outcome:**
  - In its response to the audit findings, BCBSNC stated they were working under the impression there was an understanding with the Plan that dedicated resources would not track their time relative to new contract implementation.
  - The Plan disagrees with BCBSNC and maintains there was no preexisting agreement on how to account for costs associated with BCBSNC staff specifically dedicated to administration of the Plan.
  - Because BCBSNC employees in the Dedicated Unit did not identify and record time associated with the new contract implementation, there is no way to attach a dollar amount to this finding.

Pharmacy Audits

Pharmacy Audits

Audits Conducted on the Pharmacy Benefit Manager:

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

Pharmacy Financial Audit Overview

- **Objectives:**
  - To verify the Pharmacy Benefit Manager (PBM) (Express Scripts/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, 2012- September 30, 2013 completed

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 involves 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 12/31/12	QE 3/31/13	QE 6/30/13	QE 9/30/13	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	No issues noted	No issues noted	No issues noted

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, 2013 Segal identified a $4.5 million shortfall in financial discounts for achieved discounts and dispensing fees.

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 2013-14 reports

Pharmacy Claims Audit Findings

July 2013 - June 2014					
	Performance Guarantee	QE 9/30/13	QE 12/31/13	QE 3/31/14	QE 6/30/14
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%

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.

Pharmacy Rebate Audit

- **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:**
  - Annual
- **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:**
  - Completed June 30, 2014
- **Results:**
  - The Plan received rebate payments as contracted for the 4th Quarter 2011 through the 3rd Quarter 2012 for the top eight manufactures audited

Early Retiree Reinsurance Program (ERRP) Audit

Early Retiree Reinsurance Program Audit

- **Background**:
  - ERRP was one of the components of health care reform. The program offered an incentive for employers to continue coverage for early retirees.
  - The Plan received $87 million in ERRP reimbursements for early retirees with incurred claims between $15,000 and $90,000 in a plan year between June 2010 and December 2011.
- **Objective:**
  - To ensure the Plan met ERRP program requirements and reimbursements received were for claims incurred by early retirees
- **Auditor:**
  - Centers for Medicare and Medicaid Services (CMS)
- **Frequency:**
  - One time audit
- **Status:**
  - Program requirements portion was completed in 2012
  - Claims audit (both medical and pharmacy) was conducted in February 2014

ERRP Audit Findings and Follow-Up

Validity of Claims and Eligibility of Early Retirees, Spouses, and Dependents

- **Finding*:*** Based on a paid claims universe of 552,359 items representing $86,901,860 in ERRP reimbursement, a stratified random sample of 255 items were selected to review the validity of claims submitted for ERRP reimbursement. Two (2) claims of the 255 items in the sample were identified as overstated.
- **Plan Response**: The Plan agrees that the appropriate adjustments were not submitted for these claims. While other adjustments from this period were submitted, the adjustments identified in the audit sample were processed by the Plan's Third Party Administrator after the final ERRP reimbursement for that plan year was submitted.
  - The Plan promptly reimbursed the overpayment in the amount of $1,949.29 upon receipt of payment instructions from CMS.

Completeness and Timeliness of Delivery

- **Finding:** The envelope used for the 2011 Annual Enrollment package, which included the plan participant notice (PPN), only included the plan participant's name and was not addressed to the spouse/dependents or "and family" as required by the ERRP guidance.
- **Finding:** The Plan sponsor sent out PPNs in a reasonable amount of time after the first reimbursement from the ERRP, but failed to send additional PPNs to the new participants after the initial mailing in April, 2011.
- **Plan Response**: The Plan agrees with both of these findings. The mail file should have been updated to include the appropriate information, and additional mailings should have been processed to address newly eligible members.