Internal Audit Committee of
Brevard County, Florida

Internal Audit of
Medical Insurance Claims – Processing and Billings

Prepared By:
Internal Auditors
May 20, 2020

CRI CARR RIGGS & INGRAM
CPAs and Advisors

Table of Contents

Carr, Riggs & Ingram, LLC
215 Baytree Drive
Melbourne, Florida 32940
(321) 255-0088
(321) 259-8648 (fax)
www.cricpa.com

May 20, 2020

The Audit Committee of
Brevard County, Florida
2700 Judge Fran Jamieson Way
Viera, Florida 32940-6699

Pursuant to the approved internal audit plan for fiscal year 2020, we present the review of the medical insurance claims processing and billings activities performed by the third party service providers, CIGNA and Health First, during the period January 1, 2019 through November 30, 2019, for your consideration. We will be presenting this report to the Audit Committee at the next scheduled meeting on June 9, 2020.

Our report is organized in the following sections:

Executive Summary	This provides a summary of the Findings related to our internal audit of the Medical Claims Processing and Billing functions.
Background	This provides an overview of the Medical Claims Processing and Billing functions.
Objectives and Approach	The internal audit objectives and focus are expanded upon in this section as well as a review of our approach.
Findings Matrix	This section provides the results of our internal audit procedures, including our findings, recommended actions and responses from CIGNA and Health First.

We would like to thank all those involved in assisting the Internal Auditors in connection with the internal audit of the Medical Insurance Claims Processing and Billing functions.

Respectfully Submitted,

INTERNAL AUDITORS

Executive Summary

Executive Summary

Overview

We performed an internal audit of the Claims Processing and Billing Process for the period from January 1, 2019 through November 30, 2019, on the Third Party Service Providers (TPSP), CIGNA and Health First.

Objectives

The primary objectives were to assess whether the Medical Claims Processing and Billing Process for each of the TPSP's complies with the terms of the Summary Plan Description (SPD), that claims charges are properly calculated and recorded, and that the County is being appropriately billed for its share of the claims responsibility.

The County has delegated the medical claims processing functions to two major TPSP's: CIGNA and Health First. These providers are authorized by the County to withdraw funds from a specific bank account in order to cover the costs of medical claims processed by them and on behalf of the County. These providers determine the amount that represents the County's responsibility after processing the claims in accordance with the terms of the SPD. We have examined the major elements that constitute the County's financial responsibility for these claims which include:

1. The County's contribution to cover the expense of each medical claim processed.
2. The monthly administrative cost charged to the County by the service provider for processing these claims for the members of the plan.

Findings

As part of our planned internal audit procedures to address the above mentioned objectives, we examined a sample of claims and billings processed by both TPSP's during the period from January 1, 2019 through November 30, 2019. The results of our examinations disclosed a total of ___ findings related to CIGNA and ___ findings related to Health First consisting of the following:

Process	TPSP	Number of Findings
1. Claims processing	CIGNA	2
2. Billing Process of Administrative Fees	CIGNA	Under discussion
3. Claims processing	Health First	5
4. Termination of Benefits	Health First	1
5. Billing Process of Administrative Fees	Health First	1

For each of the findings, we included a recommended action. The findings were discussed with the TPSP designated liaisons and they were given the opportunity to provide their responses.

Background

Background

Overview

The County provides medical coverage benefits to eligible persons or members. Eligible members include all full time salaried and hourly employees (covered employees), their spouses, and dependents except: (a) part-time employees, (b) temporary employees, (c) seasonal employees, or (d) substitute employees, who do not meet the minimum hours as defined under the Affordable Care Act. Certain retired employees of the County could also be eligible for coverage if they meet certain conditions. Coverage is effective only after the covered employees have formally applied or enrolled for the benefits. Medical coverage for eligible members under the plan will cease on the last day of the month when the employee ceases work for the County except that the covered person's coverage may be deemed to continue in accordance with COBRA conversion.

Eligible members can enroll in one of the various plans offered by the County. These plans are administered by two third party service providers, CIGNA and Health First. The offered plans during the fiscal year ended September 30, 2019 were:

1. Exclusive Provider Organization (EPO) Plan – Administered by CIGNA
2. Exclusive Provider Organization (EPO) Plan – Administered by Health First
3. Health Reimbursement Arrangement (HRA) Plan – Administered by CIGNA
4. Health Reimbursement Arrangement (HRA) Plan – Administered by Health First
5. Preferred Organization Provider (PPO) Plan – Administered by CIGNA
6. Preferred Organization Provider (PPO) Plan – Administered by Health First

The plans offer different benefit features and coverages. In general, the EPO plan offers healthcare services through a select network (in-network coverage only) of providers who agree to supply services to members. The HRA plan is a PPO type plan that offers a wider range of healthcare services through a broad network of in-network providers and out-of-network providers. The amounts of deductibles and annual out of pocket limits are higher for the out of network providers.

Both the EPO and HRA plans offer "HRA credits" to qualified members as a benefit feature. This benefit feature is available upon completion of the wellness activities established annually by the County and after a small amount of the annual out of pocket has been satisfied.

Benefit types allowed for HRA credits:

- Medical Deductible
- Coinsurance
- Reimbursement limit applied to the Employee and Family in Aggregate

The HRA credits will vary according to the type of plan to which the plan member is enrolled. The plan members need to complete certain wellness or preventive checkups and cover a portion of the annual out of pocket before the HRA credits become available. For the HRA plan, each individual must pay the first $250 up to $500 per family out-of-pocket before the HRA credits are available. For the EPO plan, each individual must pay the first $125 up to $250 per family out-of-pocket before the HRA credits are available.

100% of the unused HRA credits can be rolled over to the next year(s) for as long as the eligible member is participating in a HRA or EPO plan.

The plans are administered by two Third Party Service Providers (TPSP), Cigna and Health First. The terms of the plans under each TPSP are the same. The differences between choosing one plan administered by Cigna or Health First is basically on the amount of available providers subscribed to each plan's network. These differences are summarized as follows:

<u>Health First</u>:

- Local coverage
- Florida Hospital network
- Parrish and Steward (Wuestoff) are not in the network.

- Provides free pro-health (gym) memberships

Cigna:

- Provides nationwide coverage
- All hospitals are in-network
- Parrish and Steward (Wuestoff) facilities have 90/10 co-insurance
- Offers discounted gym memberships

Medical service providers submit the claims for medical services rendered or medical products provided to the respective TPSP. The TPSP processes all medical claims to determine the amount of covered charges and the amount of benefit features for the plan member in accordance with the terms of the Schedule of Benefits. The County pays the benefits described in the Schedule of Benefits to or for the benefit of Covered Persons. Please refer to section II for the schedule of benefits for each plan type which details the benefit features and coverage that pertain to each plan.

I- Schedule of Benefits

EPO PLAN – CIGNA

Benefit Feature	In-Network Coverage Only
Annual Maximum	None
*Health Reimbursement Arrangement (available for covered medical services only – not rx. Member must incur first $125/individual or $250/family out of pocket before HRA reimbursement available)	Less than $35,000 salary $1,000 individual $2,000 family $35,000-$70,000 $750 individual $1,500 family Greater than $70,000 $500 individual $1,000 family Retirees $500 individual $1,000 family
Deductible	$1,500/year individual $3,000/year family
Out of Pocket Maximum Per Calendar Year	$3,000/year individual $6,000/year family
In-Patient Hospital; average semi-private rate	**Tier 1: Pays 90% after deductible Tier 2: Pays 80% after deductible
In-Patient Behavioral Health	Pays 80% after deductible
Outpatient Surgery	**Tier 1: Pays 90% after deductible Tier 2: Pays 80% after deductible
Office Visit (PCP or Specialist)	Pays 80% after deductible
MDLive Telehealth Visit	$10 Copay; deductible waived
Outpatient Behavioral Health	Pays 80% after deductible
Laboratory and Diagnostic Imaging Services	**Tier 1: Pays 90% after deductible Tier 2: Pays 80% after deductible
Allergy Injections only without Physician Visit	Pays 80% after deductible
Preventive Care Benefits*	Pays 100% deductible waived
Well Child Care as recommended by the AMA, CDC and State of Florida to age 16	Pays100% deductible waived
Annual Well-Woman Exam (including labs)	Pays 100% deductible waived
***Screening Mammography	Pays 100% deductible waived
***Screening Colonoscopy	Pays 100% deductible waived
Ambulance Services	Pays 80% after deductible
Emergency Room - Hospital	Pays 80% after deductible
Urgent Care – Preferred Urgent Care Network All other In-Network Urgent Care facilities	$30 Copay Per Visit Pays 80% after deductible
Skilled Nursing Facility (rehab hosp. & sub-acute) Limited to 120 days per calendar year	Pays 80% after deductible
Home Health Care – multiple visits can occur in one day, with a visit defined as a period of 2 hours or less (e.g. max of 8 visits/day)	**Tier 1: Pays 90% after deductible Tier 2: Pays 80% after deductible
External Prosthetic Devices	Pays 80% after deductible
Durable Medical Equipment	Pays 80% after deductible
Hospice	Pays 80% after deductible
Second Surgical Opinion	80% after deductible if requested by member; 100% if requested by Plan
Transplant Services Maximum Benefit for Transportation, Lodging and Meals $10,000, subject to guidelines in Section IV of this document	Pays 100% up to $10,000
Diabetes Supplies	Pays 80% after deductible
Chiropractic Coverage Limited to twenty (20) visits per calendar year	Pays 80% after deductible
Short-term rehabilitative Services (PT, ST, OT, Pulmonary) Limited to a combined 60 visits per calendar year	**Tier 1: Pays 90% after deductible Tier 2: Pays 80% after deductible
Cardiac Rehabilitative Services Limited to 36 visits per calendar year	**Tier 1: Pays 90% after deductible Tier 2: Pays 80% after deductible
Penalty for failure to preauthorize listed procedures	Provider responsibility

*Health Reimbursement Arrangement available only upon completion of Wellness Activities as established annually by the County
**Tier 1=Parrish and Wuesthoff facilities; Tier 2=All other in-network providers
*** Per PPACA guidelines

II- Schedule of Benefits (Continued)

EPO PLAN - HEALTH FIRST

Benefit Feature	In-Network Coverage Only
Annual Maximum	None
*Health Reimbursement Arrangement (available for covered medical services only – not rx. Member must incur first $125/individual or $250/family out of pocket before HRA reimbursement available)	Less than $35,000 salary $1,000 individual $2,000 family $35,000-$70,000 $750 individual $1,500 family Greater than $70,000 $500 individual $1,000 family Retirees $500 individual $1,000 family
Deductible	$1,500/year individual $3,000/year family
Out of Pocket Maximum Per Calendar Year	$3,000/year individual $6,000/year family
In-Patient Hospital; average semi-private rate	Pays 80% after deductible
In-Patient Behavioral Health	Pays 80% after deductible
Outpatient Surgery	Pays 80% after deductible
Office Visit (PCP or Specialist)	Pays 80% after deductible
MDLive Telehealth Visit	$10 Copay; deductible waived
Outpatient Behavioral Health	Pays 80% after deductible
Laboratory and Diagnostic Imaging Services	Pays 80% after deductible
Allergy Injections only without Physician Visit	Pays 80% after deductible
Preventive Care Benefits**	Pays 100% deductible waived
Well Child Care as recommended by the AMA, CDC and State of Florida to age 16	Pays100% deductible waived
Annual Well-Woman Exam (including labs)	Pays 100% deductible waived
**Screening Mammography	Pays 100% deductible waived
**Screening Colonoscopy	Pays 100% deductible waived
Ambulance Services	Pays 80% after deductible
Emergency Room - Hospital	Pays 80% after deductible
Urgent Care – Preferred Urgent Care Network All other In-Network Urgent Care facilities	$30 Copay Per Visit Pays 80% after deductible
Skilled Nursing Facility (rehab hosp. & sub-acute) Limited to 120 days per calendar year	Pays 80% after deductible
Home Health Care – multiple visits can occur in one day, with a visit defined as a period of 2 hours or less (e.g. max of 8 visits/day)	Pays 80% after deductible
External Prosthetic Devices	Pays 80% after deductible
Durable Medical Equipment	Pays 80% after deductible
Hospice	Pays 80% after deductible
Second Surgical Opinion	80% after deductible if requested by member; 100% if requested by Plan
Transplant Services Maximum Benefit for Transportation, Lodging and Meals $10,000, subject to guidelines in Section IV of this document	Pays 100% up to $10,000
Diabetes Supplies	Pays 80% after deductible
Chiropractic Coverage Limited to twenty (20) visits per calendar year	Pays 80% after deductible
Short-term rehabilitative Services (PT, ST, OT, Pulmonary) Limited to a combined 60 visits per calendar year	Pays 80% after deductible
Cardiac Rehabilitative Services Limited to 36 visits per calendar year	Pays 80% after deductible
Penalty for failure to preauthorize listed procedures	Provider responsibility

*Health Reimbursement Arrangement available only upon completion of Wellness Activities as established annually by the County
** Per PPACA guidelines

II- Schedule of Benefits (Continued)

HRA PLAN - Cigna or Health First

Benefit Feature	In-Network	Out of Network
Annual Maximum	None	
*Health Reimbursement Arrangement (available for covered medical services only – not rx. Member must incur first $250/individual or $500/family out of pocket before HRA reimbursement available)	Less than $35,000 salary $1,000 individual $2,000 family $35,000-$70,000 $750 individual $1,500 family Greater than $70,000 $500 individual $1,000 family Retirees $500 individual $1,000 family	
Deductible	$1,500/year individual $3,000/year family	$3,000/year individual $6,000/year family
Out of Pocket Maximum Per Calendar Year	$3,000/year individual $6,000/year family	$6,000/year individual $12,000/year family
In-Patient Hospital; average semi-private rate	Pays 80% after deductible	Pays 60% after deductible
In-Patient Behavioral Health	Pays 80% after deductible	Pays 60% after deductible
Outpatient Surgery	Pays 80% after deductible	Pays 60% after deductible
Office Visit (PCP or Specialist)	Pays 80% after deductible	Pays 60% after deductible
MDLive Telehealth Visit	$10 Copay; deductible waived	No Coverage
Outpatient Behavioral Health	Pays 80% after deductible	Pays 60% after deductible
Laboratory and Diagnostic Imaging Services	Pays 80% after deductible	Pays 60% after deductible
Allergy Injections only without Physician Visit	Pays 80% after deductible	Pays 60% after deductible
Preventive Care Benefits**	Pays 100% deductible waived	Pays 60% after deductible
Well Child Care as recommended by the AMA, CDC and State of Florida to age 16	Pays100% deductible waived	Pays 100% deductible waived
Annual Well-Woman Exam (including labs)	Pays 100% deductible waived	Pays 60% after deductible
**Screening Mammography	Pays 100% deductible waived	Pays 60% after deductible
**Screening Colonoscopy	Pays 100% deductible waived	Pays 60% after deductible
Ambulance Services	Pays 80% after deductible	Pays 80% after deductible
Emergency Room - Hospital	Pays 80% after deductible	Pays 80% after deductible
Urgent Care – Preferred Urgent Care Network All other Urgent Care facilities	$30 Copay Per Visit Pays 80% after deductible	Pays 80% after deductible
Skilled Nursing Facility (rehab hosp. & sub-acute) Limited to 120 days per calendar year	Pays 80% after deductible	Pays 60% after deductible
Home Health Care – multiple visits can occur in one day, with a visit defined as a period of 2 hours or less (e.g. max of 8 visits/day)	Pays 80% after deductible	Pays 60% after deductible
External Prosthetic Devices	Pays 80% after deductible	Pays 60% after deductible
Durable Medical Equipment	Pays 80% after deductible	Pays 60% after deductible
Hospice	Pays 80% after deductible	Pays 60% after deductible
Second Surgical Opinion	80% after deductible if requested by member; 100% if requested by Plan	Pays 60% after deductible
Transplant Services Maximum Benefit for Transportation, Lodging and Meals $10,000, subject to guidelines in Section IV of this document	Pays 100% up to $10,000	No Coverage
Diabetes Supplies	Pays 80% after deductible	Pays 60% after deductible
Chiropractic Coverage Limited to twenty (20) visits per calendar year	Pays 80% after deductible	Pays 60% after deductible
Short-term rehabilitative Services (PT, ST, OT, Pulmonary) Limited to a combined 60 visits per calendar year	Pays 80% after deductible	Pays 60% after deductible
Cardiac Rehabilitative Services Limited to 36 visits per calendar year	Pays 80% after deductible	Pays 60% after deductible
Penalty for failure to preauthorize listed procedures	Provider responsibility	First $400 excluded Member responsibility

*Health Reimbursement Arrangement available only upon completion of Wellness Activities as established annually by the County
** Per PPACA guidelines

II- Schedule of Benefits (Continued)

PPO PLAN - Cigna or Health First

Benefit Feature	In-Network	Out of Network
Annual Maximum	None	
*Annual Deductible	$1,000/year individual $2,000/year family	$2,000/year individual $4,000/year family
Out of Pocket Maximum Per Calendar Year	$2,000/year individual $4,000/year family	$4,000/year individual $8,000/year family
In-Patient Hospital; average semi-private rate	Pays 80% after deductible	Pays 60% after deductible
In-Patient Behavioral Health	Pays 80% after deductible	Pays 60% after deductible
Outpatient Surgery	Pays 80% after deductible	Pays 60% after deductible
Office Visit (PCP or Specialist)	100% after $30 copayment **	Pays 60% after deductible
MDLive Telehealth Visit	$10 Copay; deductible waived	No Coverage
Outpatient Behavioral Health	100% after $30 copayment **	Pays 60% after deductible
Laboratory and Diagnostic Imaging Services	Pays 80% after deductible	Pays 60% after deductible
Allergy Injections only without Physician Visit	Pays 100%	Pays 60% after deductible
**Preventive Care Benefits	Pays 100%	Pays 60% after deductible
**Well Child Care as recommended by the AMA, CDC and State of Florida to age 16	Pays 100%	Pays 60% deductible waived
**Annual Well-Woman Exam	Pays 100%	Pays 60% after deductible
**Screening Mammography	Pays100%	Pays 60% after deductible
**Screening Colonoscopy	Pays 100%	Pays 60% after deductible
Ambulance Services	Pays 80% after deductible	Pays 80% after deductible
Emergency Care Including Emergency Room and Urgent Care	Pays 80% after deductible	Pays 80% after deductible
Urgent Care – Preferred Urgent Care Network All other Urgent Care facilities	$30 Copay Per Visit Pays 80% after deductible	Pays 80% after deductible
Skilled Nursing Facility (includes rehab hosp. & sub-acute facilities) Limited to 120 days per calendar year	Pays 80% after deductible	Pays 60% after deductible
Home Health Care – multiple visits can occur in one day, with a visit defined as a period of 2 hours or less (e.g. max of 8 visits/day)	Pays 80% after deductible	Pays 60% after deductible
External Prosthetic Devices	Pays 80% after deductible	Pays 60% after deductible
Durable Medical Equipment	Pays 80% after deductible	Pays 60% after deductible
Hospice	Pays 80% after deductible	Pays 60% after deductible
Second Surgical Opinion	100% after $30 copayment**	Pays 60% after deductible
Transplant Services Maximum Benefit for Transportation, Lodging and Meals $10,000, subject to guidelines in Section IV of this document	Pays 100% up to the $10,000 max	No Coverage
Diabetes Supplies	Pays 80% after deductible	Pays 60% after deductible
Chiropractic Coverage Limited to twenty (20) visits per calendar year	100% after $30 copayment**	Pays 60% after deductible
Short-term rehabilitative Services (PT, ST, OT, Pulmonary) Limited to a combined 60 visits per calendar year	100% after $30 copayment**	Pays 60% after deductible
Cardiac Rehabilitative Services Limited to 36 visits per calendar year	100% after $30 copayment**	Pays 60% after deductible
Penalty for failure to preauthorize listed procedures	N/A Provider responsibility	First $400 excluded Member responsibility

*Annual Deductible will be reduced to $600/$1,200 in-network and $1,000/$2,000 out-of-network upon completion of wellness activities as established annually by the County
** Per PPACA guidelines

Objectives and Approach

Objectives and Approach

Objectives

The primary objective was to assess whether the medical claims from covered members of the County were processed in accordance with the corresponding terms of each plan's schedule of benefits and that the amounts billed and paid by the County were accurate.

The scope of our internal audit included the medical claims processed from the period from January 1, 2019 through November 30, 2019 by both Third Party Service Providers (TPSP), CIGNA and Health First, for each of the following plan options:

- EPO
- HRA
- PPO

In order to achieve proper coverage of the various claims, we requested a detail of all claims incurred and paid during the months of January through November 2019 by each of the TPSP's and for each of the above referenced plan types. From the total population of claims we selected a representative sample using haphazard selection methods. Our sample testing was disaggregated among the types of plans noted above and included the following objectives:

- Determine that the information on the TPSP's system records pertaining to the member name and other personal information was in agreement with the data on the claim data file.
- Determine that the savings amount was properly computed (difference between amount of charge and applicable coverage as per the terms of the plan).
- Determine that the amount of copay, co-insurance and deductible were properly recorded for each claim based on the applicable terms of the plan and on the nature of the charges for products or services provided.
- Determine that the out of pocket payments were properly accumulated.
- Determine that preventive charges (100% covered by the plans) were in accordance with the allowable charge codes as per the coverage terms of the plans.
- After analysis of all applicable charges and accumulators for each claim, determine that the amount billed to the County was accurate and properly represents the sponsor's responsibility.
- Determine that the amounts paid by the County were in agreement with the amounts of the processed claims.
- Ascertain that for terminated plan members, the termination date as per the County's records was consistent with the period of termination of benefits on the TPSP's system records.
- Determine the amounts billed to the County for the monthly administration charges excluded members that were not participating in the plans.

Approach

Our internal audit approach consisted of three phases:

Phase I - Understanding and Documentation of the Process

During the first phase, we held an entrance conference with key personnel of the County's Human Resource Department, CIGNA representatives, and Health First representatives, to discuss the scope and objectives of the internal audit work, to obtain preliminary data, and establish working arrangements. We reviewed the respective Administrative Services Only agreements, the Plan Summary Description, and other relevant resources. We gained an understanding of the County's billing reconciliation process and review function for each of the types of plans and the reports that CIGNA and Health First had available for claims processing.

Objectives and Approach - continued

Approach - continued

Phase II - Detailed Testing

The purpose of this phase was performance of testing procedures based on our understanding of the claims processing by the Third Party Service Providers (TPSP), and of the monthly administration fees (premiums) paid to the TPSP's by the County. Our detailed procedures included testing a sample of individual claims transactions and terminated employees.

Part 1 - Third Party Service Providers - Claims Processing

Objective: To validate that the amount of charges on the claims data population that were deemed by the Third Party Service Provider as payable by the County are accurate.

CIGNA - We obtained a detail of medical claims initiated and paid by the County for the EPO, HRA and PPO plans administered by CIGNA during the period from January 1, 2019 through November 30, 2019 that included claims initiated and paid during such period. Using haphazard sample selection techniques, we extracted a sample of 145 claims processed by CIGNA for individual testing. We distributed our sample among the various plans considering the number of plan members represented on each.

Type of Plan	# of Claims tested
EPO	62
HRA	52
PPO	31

Health First - We obtained a detail of medical claims initiated and paid by the County for the EPO, HRA and PPO plans administered by Health First during the period from January 1, 2019 through November 30, 2019. Using haphazard sample selection techniques, we extracted a sample of 180 claims processed by Health First for individual testing. The population of claims included a balanced participation among the three main plan options. Accordingly, we allocated our claims sample selection equitably for each major plan option.

Type of Plan	# of Claims tested
EPO	60
HRA	60
PPO	60

CIGNA & Health First - For the claims selected in our sample (see above), we performed the following procedures:

- Verified that the information on the claims data file was in accordance with the data on Third Party Service provider's system records.
- Verified that the amount of charges for each claim were properly processed in accordance with the terms of the respective plan as stated on the Plan Summary Description.
- Performed independent calculations of the amounts determined as co-insurance or deductible in accordance with the terms of the plan's coverage to determine that these were accurate.
- Verified that the amounts that the accumulators for each claim were properly calculated for the period.
- Verified that the charges towards the member's out of pocket limits were properly tracked and considered before any remaining outstanding charged amounts were assigned as responsibility of the County.
- Verified that the amount billed to the County was properly calculated.

Objectives and Approach - continued

Part 2 - Third Party Service Providers – Claims Billings

Objective: To validate that the amounts billed to the County for claims processed are in agreement with the validated claims charges.

Each TPSP's records were different. In order to validate that the amounts of charges on the claims in our sample agreed to the actual amount paid by the County for those claims, we took two different testing approaches as follows:

CIGNA - From the sample of 145 claims processed by CIGNA that were tested above, we selected a sub sample of 50 claims and we agreed the claim amount and description to the weekly billing detail that was paid by the County. The sub sample was selected using haphazard selection techniques.

Health First – We selected 10 weekly periods using haphazard selection techniques. For the periods selected, we reviewed the detail of claims paid during that period and matched the total charges for all claims to the amount billed to the County. We also agreed the claim numbers and amounts paid by the County for individual claims to the amounts of County responsibility as per the claims records that we validated on Part 1 of our detailed testing (see above).

Part 3 - Third Party Service Providers – Updating Active Members

Objective: To ascertain that the period of coverage for terminated members as per the Third Party Service provider's records are in agreement with the County's records.

CIGNA – We requested a detail from the County of all employees enrolled in plans administered by CIGNA and that had ceased (terminated) working with the County during the period from January 1, 2019 through November 30, 2019. From the total population of 204 terminated employees for that period, we selected 40 employees using haphazard selection techniques. We then compared the dates of termination from the County's records to the dates that were shown on CIGNA's system to ascertain that these agreed. We also verified that coverage termination period agreed to the final day of the month of termination.

Health First - We requested a detail from the County of all employees enrolled in plans administered by Health First and that had ceased (terminated) working with the County during the period from January 1, 2019 through November 30, 2019. From the total population of 90 terminated employees for that period, we selected 25 using haphazard selection techniques. We then compared the dates of termination from the County's records to the dates that were shown on Health First's system to ascertain that these agreed. We also verified that coverage termination period agreed to the final day of the month of termination.

Part 4 - Third Party Service Providers – Administrative Charges Billings

Objective: To ascertain that the amounts billed monthly for administrative charges exclude terminated employees.

For this test, we used a sample of 25 employees from the population of terminated employees for both CIGNA and Health First. These samples were taken from the same population used for the testing in Part 3 (see above).

CIGNA and Health First - We requested a detail of the monthly billing reports for administration fees that includes the names of plan members considered in the month's billing. We examined the billings for the months from January through November 2019 to determine that the amounts billed for the respective month excluded members that were terminated on a previous month or that a credit was issued subsequently to appropriately offset the charges for terminated members.

Objectives and Approach - continued

Phase III- Reporting

At the conclusion of our procedures, we documented our understanding and summarized our findings related to the medical claims processing and billing function. We conducted exit interviews with CIGNA and Health First representatives discussing our findings. They also provided responses to each of our findings. Finally, we had an exit conference with the County management. We prepared our report and related findings and provided copies to appropriate County personnel.

Findings Matrix

Findings	Recommended Action	CIGNA Response
1. Clams Processing - CIGNA		
Based on examination of the sample of 145 claims incurred and paid during the period, there were 2 claims processed incorrectly as explained below.		
(Ref sample #39- EPO Plan). The claim in question reflected that $28.04 of charges were charged to the County when they should have been applied to the plan member's coinsurance responsibility. The amount calculated by the system resulted in an overbilling to the County by such amount.	CIGNA should issue a credit to the County in the next billing period for $28.04 and should bill the plan member for that same amount.	Please refer to page 19 of this report for a copy of CIGNA's formal response to findings.
(Ref sample #64- PPO Plan). The claim in question was reprocessed due to the provider sending in a corrected claim with additional information. The corrected claim increased the allowable expense to be covered by the County by an additional $37.17. The amount calculated by the system resulted in an underpayment to the provider by such amount.	CIGNA should pay the additional $37.17 to the provider to satisfy the amount he/she is entitled to as result of this adjustment and should bill the County for such amount.	Please refer to page 19 of this report for a copy of CIGNA's formal response to findings.

Findings	Recommended Action	Health First Response
2. Claims Processing – Health First		
Based on examination of the sample of 180 claims incurred and paid during the period, there were 5 claims processed incorrectly as explained below.		
Ref: Claims #193220E08915 and 192120E02343 For two of the claims in our sample, we noted that they had been adjusted as result of a revision to the amounts charged. When performing these manual adjustments, one adjuster did not notice that maximum deductibles/out of pocket limits had already been met for the 2 claims leading to an overbilling of $6.46 to one member. Internal controls did not detect this discrepancy.	Health First should process reimbursement payment of $6.46 to the individual that was overbilled. Health First should also bill the County for such amount.	Please refer to pages 20 to 22 of this report for a copy of HF's formal response to findings.
Ref sample Claim #192250E06103 Health First uses a 3rd party service provider to assist them in processing billings. The billing data from this third party is uploaded to the Health First system and will update the recorded charges. Due to a timing error, the system applied a charge that was recorded towards the deductible when the max limit had already been met. The system apparently updated the 3rd party data transfer on a live basis which resulted in an overage of $13.69 to the max deductible charged to a member. This resulted in a over billing to that member for such amount.	Health First should reimburse the plan member for the $13.69 that was overbilled as result of this and should bill the County for such amount.	Please refer to pages 20 to 22 of this report for a copy of HF's formal response to findings

Findings	Recommended Action	Health First Response
2. Claims Processing – Health First (continued)		
Ref Claims # 190370E04575 & 192420E00272 Two of the claims in our sample reflected charges classified as preventive even though these were diagnostic charges. Preventive charges are fully covered and are payable by the County. The diagnostic charges on these two specific claims should have been the plan member's responsibility instead. Sample #24 resulted in a erroneous charge to the County for $192.81. Sample #52 resulted in an erroneous charge to the County for $331.35.	Health First should issue a credit to the County for $524.16 and reprocess the respective plan member's billings for the outstanding charges of $192.81 and $331.35 from sample #24 and #52, respectively.	Please refer to pages 20 to 22 of this report for a copy of HF's formal response to findings

Finding	Recommended Action	Health First Response
3. Termination of Benefits – Health First		
Ref Sample #25 (terminated test) The County's records showed one employee as having a termination date of 11/1/19. However, the CIGNA records reflected 10/31/19 as the termination of benefits date. According to the terms of the plan, coverage should have extended through November 30th. Administrative fees amounting to $42.50 for the month of November were not charged to the County.	Health First update their system records to reflect the date of termination of benefits for this plan member as 11/30/19, to be consistent with the County's records. Health First should also bill the County for $42.50 which represents the monthly administrative fee for the month of November 2019.	Please refer to pages 20 to 22 of this report for a copy of HF's formal response to findings.

Finding	Recommended Action	Health First Response
4. Billing Process of Administrative Fees- Health First		
Ref Sample #8 (terminated test) One plan member ceased working for the County on April 30, 2019 and coverage should have extended through the end of that month. However, administrative fees for this terminated member were billed for the months of May through October 2019, which represented an overbilling for six months. In November 2019, there was a credit processed in favor of the County that partially offset the excess billings. However, the amount of credit only offset billings in excess for three months and an additional three months remained overbilled as of the date of our examination. The remaining amount of overbilling to the County is $127.35.	Health First should process a credit on the next month's bill for administrative fees for $127.35 to offset the amount overbilled.	Please refer to pages 20 to 22 of this report for a copy of HF's formal response to findings.

Cigna's Response to the Executive Summary

Cigna would like to thank Carr Riggs & Ingram (CRI) for providing a copy of the medical claims audit report and allowing us the opportunity to review and respond to the audit findings.

Carr Riggs & Ingram conducted an audit of Brevard BOCC claims processed by Cigna during the week of April 6th, 2020. The purpose of the audit was to obtain reasonable assurance that claims are being properly processed and paid by CIGNA.

The audit consisted of a sample of 145 medical claims processed from January 01, 2019 through November 30, 2019, as well as a selection of 40 individuals that were terminated during the scope period. Benefit payments totaling $26,629,081 were paid on behalf of eligible employees and their dependents. Carr Riggs & Ingram analysis of the 145 medical claims represents benefit payments in the amount of $362,833.

Cigna is committed to a continuous quality improvement approach to ensure corrective actions are implemented. Each of Carr Riggs & Ingram's recommendations has been thoughtfully considered and Cigna's response is provided in the detailed information that follows.

CRI Recommended Action	Cigna's Response
Recommendation 1: Cigna should issue a credit to the County in the next billing period for $28.04 and should bill the plan member for that same amount.	The confirmed overpayment was referred to our recovery vendor, Accent, to initiate recovery efforts, based on the terms of Brevard's ASO agreement. No fees will be assessed to Brevard on overpayment recovery efforts. Once the refund is returned to Cigna it will be credited to Brevard's next billing statement. This was a result of the Hearing Services PCP Office Visit benefit being set up with the incorrect type code. System was corrected on 04/20/2020. Claim reports were pulled to capture similar claims processed during the impacted period and an additional 21 claims were identified totaling overpayments of $1,397.64. The confirmed overpayments were also referred to Accent.
Recommendation 2: Cigna should pay the additional $37.17 to the provider to satisfy the amount he/she is entitled to as result of this adjustment and should bill the County for such amount.	The confirmed underpayment was corrected on 05/12/2020 and the additional payment of $37.17 was sent to the provider. This was a result of a manual claim payment error assigned to a processor. Error review and coaching was provided to the claim processor to mitigate risk of making the mistake on future claims.

Group Name: Brevard County Board of County Commissioners
Group #: TPA104
Auditor: Carr, Riggs & Ingram

Claims Processing Audit	Section:	Plan Type:	Sample Number:	Claim Number:
	3	BOCC HRA	52	193220E08915
	3	BOCC HRA	53	192120E02343

CR&I Findings:
For two of the claims in our sample, we noted that they had been adjusted as result of a revision to the amounts charged. When performing these manual adjustments, one adjuster did not notice that maximum deductibles/out of pocket limits had already been met for the 2 claims leading to an overbilling of $6.46 to one member. Internal controls did not detect this discrepancy.

CR&I Questions with Health First Response:

Question 1: Were these errors the result of system or human processing?

Health First Response:
This error was associated with human processing. The examiner did not adjudicate a corrected/replacement claim after the original claim was reversed. Improper adjudication order prevented the system from resequencing the cost share to the corrected claim.

Question 2: If system error, please provide a response that would fix or prevent future occurrences. Please provide a date of implementation (if applicable)

Health First Response:
N/A- human error.

Question 3: Explain the process or controls that HF has in place detect and correct other similar errors that could exist in the population not subject to examination.

Health First Response:
Health First's Quality and Process Improvement Team performs audits on claims at random to determine processing accuracy and detect processing errors. When a claim processing error is identified, a scorecard is provided to the Examiner and their Team Lead for a learning opportunity. The Team Lead is responsible for coaching the examiner, which is logged in the auditing tool. The auditing tool tracks processing errors and Quality reports are provided on a weekly and monthly basis to the Claim department. If a reoccurring error is identified, the departments collaborate for additional training needs to improve accuracy.

Health First Final Response:

Health First agrees with the findings and responses listed above.

To correct this overage, Health First reprocessed a prior claim for the effected member to remove the $6.46 deductible overage. By reprocessing this single claim we avoided the need to process multiple claims in order to sequence the member's initial deductible, which has been met. This claim was reprocessed on 5/3/2020, which was captured in the 5/5/2020 finance funding request to Brevard County.

Claims Processing Audit	Section:	Plan Type:	Sample Number:	Claim Number:
	3	BOCC HRA	35	192250E06103

CR&I Findings:

Health First uses a 3rd party service provider to assist them in processing billings. The billing data from this third party is uploaded to the Health First system and will update the recorded charges. Due to a timing error, the system applied a charge that was recorded towards the deductible when the max limit had already been met. The system apparently updated the 3rd party data transfer on a live basis which resulted in an overage of $13.69 to the max deductible charged to a member. This resulted in a overbilling to that member for such amount.

CR&I Questions with Health First Response:

Question 1: Were these errors the result of system or human processing?

Health First Response:
This error was the result of the timing of a data file from Magellan, a 3rd party benefits administrator.

Question 2: If system error, please provide a response that would fix or prevent future occurrences. Please provide a date of implementation (if applicable)

Health First Response:
Effective 3/16/2020, the Claims Department implemented a process where accumulator reports are pulled and worked daily to correct out of pocket amounts that applied in excess due to timing issues of 3rd party data. To correct accumulators impacted by this timing issue, a Health First examiner adjusts medical claims to offset any out of pocket overages identified.

Question 3: Explain the process or controls that HF has in place detect and correct other similar errors that could exist in the population not subject to examination.

Health First Response:
In addition to the daily accumulator report, Examiners are responsible for validating member cost share applied to claims is in accordance to the member's benefits. If an overage is identified, medical claims are adjusted to correct any out of pocket amounts in excess. In addition, the Health First Quality and Process Improvement team also validates cost share applied to claims selected for auditing. If an error is identified, the audited claim is sent back to the department for review, education and correction.

Carr, Riggs & Ingram Follow-up Question to Health First Initial Response:
Also, for #2 and #3 it sounds like there is the potential for similar errors to have occurred in other claims not examined. Is there any way to go back and determine if there could be other errors in the population that would have similar issues and correct them (at least back to beginning of 2019)?

Health First Response to Follow up Question:
When a new process is put into place (for example the daily accumulator report mentioned above) there is additional look back period in which impact reports are ran to help identify effected membership. From there these reports are forwarded the appropriate team for review and correction.

Health First Final Response:
Health First agrees with the findings and responses listed above.

To correct, claim 192250E06103 was reprocessed on 5/3/2020, which was captured in the 5/5/2020 finance-funding request to Brevard County.

Claims Processing Audit	Section:	Plan Type:	Sample Number:	Claim Number:
	3	BOCC PPO	24	190370E04575
	3	BOCC PPO	52	192420E00272

CR&I Findings:

Two of the claims in our sample reflected charges classified as preventive even though these were diagnostic charges. Preventive charges are fully covered and are payable by the County. The diagnostic charges on these two specific claims should have been the plan member's responsibility instead. Sample #24 resulted in a erroneous charge to the County for $192.81. Sample #52 resulted in an erroneous charge to the County for $331.35.

CR&I Questions with Health First Response:

Question 1: If system error, please provide a response that would fix or prevent future occurrences. Please provide a date of implementation (if applicable)

Health First Response:
Both claims were associated with a benefit configuration error. When a system error is identified, a ticket is submitted to the configuration department for review. As a resolution, system configuration is updated to fix and prevent future occurrences.

Question 2: Explain the process or controls that HF has in place detect and correct other similar errors that could exist in the population not subject to examination.

Health First Response:
Health First's Quality and Process Improvement Team performs audits on claims at random to determine processing accuracy and detect processing errors. When a claim processing error is identified, notification is sent to the Claims Department to review and submit a ticket to the configuration department. In addition, system configuration errors can be identified in several departments, Claims, Quality and Process Improvement, Provider Relations, Appeals and Grievances, or under the Dispute Team- all departments have the ability to create a ticket for review. Once the error is identified and system configuration updated to prevent future occurrences, an impact report is pulled to detect impacted claims for correction.

Carr, Riggs & Ingram Follow-up Question to Health First Initial Response:
Also, for #2 and #3 it sounds like there is the potential for similar errors to have occurred in other claims not examined. Is there any way to go back and determine if there could be other errors in the population that would have similar issues and correct them (at least back to beginning of 2019)?

Health First Response to Follow up Question:
After the benefit configuration is updated and tested, we then run an impact report to identify the effected claims. This report is then passed over to our claims team for reprocessing all claims identified.

Health First Final Response:
Health First agrees with the findings and responses listed above.

To correct, Health First has pulled impact reports to identify claims that processed in error for calendar year 2019 and 2020 (which includes the samples noted above) that were incorrectly processed due to the configuration error. Please see the breakdown and detail below of the impact reports generated. Health First will work with the County to provide claims reprocessing status and repayment dates.

2019:
Claims Impacted: 268 claims
Financial Impact: $18,195.40 (Overpaid by Brevard County)

2020:
Claims Impacted: 94 claims
Financial Impact: $6,623.30 (Overpaid by Brevard County)

Total for both 2019 and 2020:
Claims Impacted: 362 claims
Financial Impact: $24,818.70 (Overpaid by Brevard County)

Enrollment (Termination of Benefits) Audit	Section:	Sample Number:
	4	25

CR&I Findings:

The County's records showed one employee as having a termination date of 11/1/19. However, the CIGNA records reflected 10/31/19 as the termination of benefits date. According to the terms of the plan, coverage should have extended through the end of that November. Administrative fees amounting to $42.50 for the month of November were not charged to the County.

Health First Final Response:

Health First agrees with the findings and responses listed above.

During the audit, it was identified that this plan member was termed in our system as of 10/31/2019 due to an email received from the County. After further review and confirmation from the County, this termination date sent through the CBiz EDI reflecting the termination date of 11/30/2019 was correct. Enrollment updated the termination date on 4/14/2020 to 11/30/2019 and requested that the back due premium be charged on the upcoming July invoice.

November Charge- $42.45 Premium invoice receipt #900378666

Billing Process of Administrative Fees	Section:	Sample Number:
	5	8

CR&I Findings:

One plan member ceased working for the County on April 30, 2019 and coverage should have extended through the end of that month. However, administrative fees for this terminated member were billed for the months of May through October 2019, which represented an overbilling for six months. In November 2019, there was a credit processed in favor of the County that partially offset the excess billings. However, the amount of credit only offset billings in excess for three months and an additional three months remained overbilled as of the date of our examination. The remaining amount of overbilling to the County is $127.35.

CR&I Questions with Health First Response:

Question 1: Was this error the result of system or human processing?

Health First Response:

Human processing error.

Question 2: If system error, please provide a response that would fix or prevent future occurrences. Please provide a date of implementation (if applicable)

Health First Response:

N/A – Human Processing Error

Question 3: Explain the process or controls that HF has in place detect and correct other similar errors that could exist in the population not subject to examination.

Health First Response:

Enrollment processes weekly reconciliations and validates all terminated members are provided credits if termination date is outside the 90 day system automatic adjustment window.

Health First Final Response:

Health First agrees with the findings and responses listed above.

The termination date for the member is 4/30/2019 in our system. The Health First Enrollment Team processed the termination timely on 9/20/2019 in the system which triggered only 3 months retroactivity of premium payment.

To correct, Health First submitted the request to have the premiums refunded through the receipt numbers below. These refunds will appear on the July Invoice Adjustments.

May Credit – $42.45 Premium invoice Receipt #900378660
June Credit – $42.45 Premium invoice Receipt #900378661
July Credit – $42.45 Premium invoice Receipt #900378662