



Follow-Up Review Medical Claims Audit
Two Years Ended December 31, 2016

Office of the County Auditor

Audit Report

Robert Melton, CPA, CIA, CFE, CIG
County Auditor

Follow-Up Review Conducted by:
Laura Rogers, CIA, CFE, CGAP, CCA

Report No. 20-22
September 30, 2020



OFFICE OF THE COUNTY AUDITOR

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September 30, 2020

Honorable Mayor and Board of County Commissioners

We have conducted a follow-up review of the Medical Claims Audit, Two Years Ended December 31, 2016. The objective of our review was to determine the implementation status of our previous recommendations.

We conclude that of the two recommendations made, one was implemented, and one was partially implemented. The status of each of our recommendations is presented in this follow-up report.

We conducted this review in accordance with Generally Accepted Government Auditing Standards. Those standards require that we plan and perform the review to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our review objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our review objectives.

We appreciate the cooperation and assistance provided by the Human Resources Division throughout our review process.

Respectfully submitted,

A handwritten signature in blue ink that reads "Bob Melton".

Bob Melton
County Auditor

cc: Bertha Henry, County Administrator
Monica Cepero, Deputy County Administrator
Andrew Meyers, County Attorney
Kevin Kelleher, Assistant County Administrator
George Tablack, Director, Finance & Administrative Services
David Kahn, Director, Human Resources

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IMPLEMENTATION STATUS SUMMARY

Follow Up Review of Medical Claims Audit

Implementation Status of Previous Recommendations

PREVIOUS RECOMMENDATION	IMPLEMENTED	PARTIALLY IMPLEMENTED	NOT IMPLEMENTED	NOT APPLICABLE
Seek Recovery of Claim Adjudications Errors, Including All Disputed and Out of Sample Error Applications		✓		
Additional Informational Findings May be of Value to County in Considering its Ongoing Healthcare Plan Design	✓			

INTRODUCTION

Scope and Methodology

The Office of the County Auditor conducts audits of Broward County's entities, programs, activities, and contractors to provide the Board of County Commissioners, Broward County's residents, County management, and other stakeholders unbiased, timely, and relevant information for use in promoting government accountability and stewardship and improving government operations.

We conducted a follow-up review of the Medical Claims Audit, Two Years Ended December 31, 2016 (Report No. 18-18). The purpose of this follow-up review is to determine the status of previous recommendations.

We conducted this review 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 that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Our follow-up review included such tests of records and other auditing procedures as we considered necessary in the circumstances. The follow-up testing period was August 18, 2020 to September 15, 2020. However, transactions, processes, and situations reviewed were not limited by the audit period.

Overall Conclusion

We conclude that of the two recommendations included in the original report, one has been implemented and one has been partially implemented.

FOLLOW-UP TO PREVIOUS RECOMMENDATIONS

This section reports actions taken by management on the recommendations in our previous review. The issues and recommendations herein are those of the original review, followed by the current status of recommendations.

Based upon the unique nature of healthcare claims auditing, we engaged the services of a specialized commercial auditor, J. Graham Inc., Healthcare Claims Audits (JGI), to conduct an audit of the County's contracted healthcare services administrator for claims incurred from January 1, 2015 through December 31, 2016. During this time frame, the County's Administrative Management Services provider for Self-Insured Group Health Insurance Coverage and Benefits was Humana Health Plan, Inc. (as assignee of Humana Medical Plan Inc. and Humana Health Insurance Company of Florida, Inc.) (Humana), operating under the Second Amended and Restated Agreement (RLI #R0934602R1), as approved by the Board of County Commissioners on December 2, 2014.

The report completed by JGI was issued under a cover report completed by the Office of the County Auditor, which concurred with JGI's assessments, and contained the two following generalized recommendations.

1. Seek Recovery of Claim Adjudications Errors, Including All Disputed and Out of Sample Error Applications

The focus of JGI's review was to ensure the accuracy of Humana's claims adjudication services, based upon factors including, but not limited to, verification of amounts charged, application of deductibles, co-pays, coinsurance, coordination of benefits, and plan documents. JGI's audit procedures included use of data mining techniques to develop a judgmental sample of 300 claims for detailed review during a site visit. As applicable, identified errors in claims processing for sampled items were applied to the larger universe of all claims paid.

In summary, the total of all recovery items was \$127,206. The findings/recovery amounts were separated into three primary categories:

- 'Site Visit Recovery' reflects amounts considered as 'agreed findings' by Humana during the JGI audit. The audit identified \$9,742 in claims adjudication errors.
- 'Site Visit Disputed' reflects amounts considered 'disputed findings' by Humana during the JGI audit. The audit identified \$49,816 in claims adjudication errors.

- ‘Out of Sample’ amounts reflect likely over payments on claims not included in the original sample but adjudicated in a similar manner. The audit identified \$67,648 in claims adjudication errors.

We recommended that management:

Seek recovery of claim adjudication errors, including all disputed and out-of-sample error applications.

Status: Partially Implemented

Following the audit, management initiated, but did not complete recovery efforts. Specifically, initial requests for information were sent to Humana, and a meeting was held on April 30, 2018, which included representatives from Human Resources (HR), our Office, the County’s Healthcare Consultant, Humana and JGI. Subsequent to this meeting, management reports that additional correspondence to Humana seeking recovery of the claim adjudication errors was drafted but was not sent.

This oversight was realized at the initiation of this follow up review, and management took immediate corrective action and sent a letter to Humana on August 26, 2020. In summary, this correspondence: requested documentation that the \$9,742 in ‘Agreed Findings’ was reimbursed to the County; accepted Humana’s previously provided responses for approximately \$5,000 in Disputed Findings; and, rejected Humana’s responses for approximately \$112,500 of Disputed Findings for in- and out-of- sample claims. The correspondence also notes that “the County feels strongly that the member, provider and the County should not be penalized for Humana’s approval of non-covered services or errors in adjudication.”

As of September 15, 2020, resolution of these items is still pending.

We continue to recommend Management seek recovery claim adjudication errors, including all disputed and out-of-sample error applications.

2. Additional Informational Findings May be of Value to County in Considering its Ongoing Healthcare Plan Design.

The review conducted by JGI recognized the County no longer contracts with Humana for these services. However, the ‘Informational Findings’ section of the report reflected items from which contract language could potentially be improved or clarified to ensure appropriate and consistent application of payments for services/member benefits.

We recommended:

Additional informational findings may be of value to the County in considering its ongoing healthcare plan design.

Status: Implemented

In discussions regarding this recommendation, the HR Benefits Manager stated that there had been multiple discussions in 2018 with the County's current health plan administrator, United Healthcare, Inc. (UHC) regarding audit findings and UHC's claim adjudication processes. However, according to the HR Benefits Manager, only one instance of documentation of previous correspondence or information was readily available. In follow-up, the HR Benefits Manager reached out to the current provider, to confirm how claims adjudication would be managed for a selection of identified areas. UHC provided responses indicating, as applicable, how they would adjudicate such claims, or acknowledging in one instance that a fraud investigation would be triggered. The HR Benefits Manager states UHC responses are considered satisfactory.