STATE OF NORTH CAROLINA

PERFORMANCE AUDIT

STATE HEALTH PLAN RISK ASSESSMENT

SEPTEMBER 2011

OFFICE OF THE STATE AUDITOR

BETH A. WOOD, CPA

STATE AUDITOR

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The Honorable Beverly Perdue, Governor
Members of the North Carolina General Assembly
Ms. Lacey Barnes, Interim Executive Administrator, North Carolina State Health Plan for Teachers and State Employees

Ladies and Gentlemen:

We are pleased to submit this performance audit titled *State Health Plan Risk Assessment*. The audit objective was to determine if the State Health Plan is exposed to significant risks for overpaying claims. Ms. Barnes reviewed a draft copy of this report. Her written comments are included in the appendix.

The Office of the State Auditor initiated this audit to improve management controls at the State Health Plan.

We wish to express our appreciation to the staff of the State Health Plan for the courtesy, cooperation, and assistance provided us during the audit.

Respectfully submitted,

Beth A. Wood

Beth A. Wood, CPA
State Auditor

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SUMMARY

PURPOSE

This audit report evaluates the risks for overpaying medical claims and makes recommendations so State Health Plan (Plan) management can take appropriate corrective action.

RESULTS

The Plan does not have policies and procedures in place to mitigate certain risks that could result in overpayments on member medical claims.

The Plan is at risk for overpaying medical claims because the Plan does not follow up on potential overpayments identified by the Plan's external auditors. For state fiscal years 2008–10, Plan auditors identified about $251,762 in actual overpayments and estimated that there were about $48.6 million in potential overpayments. The Plan attempts to collect amounts that auditors identified as actual overpayments but does not attempt to collect on amounts identified as potential overpayments or to eliminate the root causes of the overpayments. The potential overpayments are significant and the audit reports indicate that there is a high probability (95% - 98% confidence level) that the overpayments occurred. Without proper follow-up, however, the Plan will fail to recapture a significant amount of overpayments. Additionally, the lack of follow-up will prevent the Plan from identifying and correcting the conditions that allowed the overpayments to occur.

The Plan is also at risk for overpaying medical claims because it does not adequately manage its recovery audit function.[1] Specifically, the Plan has not clearly documented and understood the services that its recovery audit vendors perform, set performance expectations or benchmarks for its recovery audit vendors, or analyzed the results of the recovery audits to determine if the Plan has received adequate value for its money. In fact, a 2010 performance review by Navigant Consulting, Inc. (Navigant)[2] noted that fraud recovery efforts by one of the Plan's vendors, Blue Cross Blue Shield of North Carolina (BCBSNC), are well below industry standards. Navigant wrote, "For every $1 the SHP [State Health Plan] spent on fraud and abuse detection, the SHP received only 10 cents in actual fraud recoveries." Failure to properly manage the recovery audit function could prevent the Plan from identifying and collecting a significant amount of overpayments. Based on the Navigant cited 3% - 5% industry standard, the Plan should expect to receive about $72 - $120 million in annual recoveries. However, the Plan only received total gross recoveries of approximately $11.9 million in 2008, $10 million in 2009, and $4.4 million in 2010. The 2010 reduction in recoveries occurred because BCBSNC, without notifying the Plan, terminated contracts with

[1] Recovery auditing is a cost containment practice used to identify and recover improper payments made due to errors such as non-covered items, duplicate payments, ineligible recipients, billing errors, and inappropriate or unnecessary services.

[2] In response to an OSA performance audit report issued in April 2009, N.C. Session Law 2009-16 Section 5.(g) required the Plan to obtain an independent audit to "determine whether savings to the Plan and to Plan members could be achieved if claims payments and processing were more efficiently and effectively administered."

some recovery audit vendors. BCBSNC did not replace those services until late 2010 and early 2011.

The Plan is also at risk for overpaying medical claims because the Plan has not taken action to prevent coordination of benefits errors. Those errors occur when BCBSNC pays a Plan member's medical claim when Medicare or another insurance provider should have paid all or part of the claim first. Plan management is aware of the risk for coordination of benefits errors because BCBSNC auditors recovered about $8.4 million in errors on the Plan's behalf between January 2007 and September 2010. However, during the audit period the Plan did not take steps to confirm whether all coordination of benefits errors were recovered or analyze the errors to determine why they occurred. Furthermore, although the Plan requested corrective action plans for errors identified by its auditor during the audit period, the Plan did not require its claims processor, BCBSNC, to conduct a detailed analysis of all errors or to develop and implement policies and procedures to prevent future coordination of benefit errors. While the Plan has recently worked with BCBSNC to develop reports to track the recovery rate of coordination of benefits errors, more work is required on root cause analysis and process improvement to prevent future coordination of benefit errors. Additionally, the Plan pays BCBSNC a fee of 22% to 24% of the amount recovered to collect on the payment errors that BCBSNC originally made. In other words, BCBSNC charges the Plan to collect on errors that BCBSNC made. Failure to take appropriate action to prevent future errors will result in additional overpayments and recovery costs for the Plan.

Lastly, the Plan is at risk for overpaying medical claims because the Plan's auditors do not have access to BCBSNC contracts and cannot independently verify that the Plan receives the proper contractual discounts from BCBSNC's provider network. Plan management is aware that medical claims are sometimes paid with the wrong discount rate because BCBSNC auditors have recovered approximately $3.5 million in improper discounts on the Plan's behalf between January 2007 and December 2009. However, because the Plan does not have access to contracts between BCBSNC and the medical providers, the Plan does not have a method for independently determining if an improper discount rate has been applied to a Plan member's claims. Although the Plan pays BCBSNC to access its provider network and to benefit from its contracted discount rates with medical providers, all contracts are between BCBSNC and its providers and are considered proprietary information. Consequently, the Plan is at risk for overpaying claims because it must rely solely on BCBSNC auditors and information from the BCBSNC computer system to identify discount errors.

RECOMMENDATIONS

The Plan should consider using software or other automated methods to perform audits focused to identify additional overpaid claims, collect the additional amounts, and identify root causes of the errors.

The Plan should clearly document the services that its recovery audit vendors perform, set performance expectations for its recovery audit vendors, and analyze the results of the recovery audits to determine if the Plan has received adequate value for its money.

The Plan should analyze coordination of benefit errors, determine why they occurred, and require additional claims processing system edits to prevent future errors.

The Plan should ensure that future contracts allow independent verification of claims pricing and discounts.

AGENCY'S RESPONSE

The Agency's response is included in the appendix.

INTRODUCTION

BACKGROUND

North Carolina General Statute Chapter 135, Article 3, authorized the creation of the North Carolina State Health Plan for Teachers and State Employees (State Health Plan or Plan), which became self-funded in October 1982. The Plan provides health care coverage to more than 662,000 teachers, state employees, retirees, current and former lawmakers, university and community college personnel, and hospital staff. The Plan also provides dependent coverage.

The Plan offers two Preferred Provider Organization (PPO)[3] benefit plans to its members. The Plan contracts with Blue Cross Blue Shield of North Carolina (BCBSNC) to act as the health benefits administrator responsible for claims processing, customer service, utilization management, and PPO network maintenance.

The Plan uses funds from member premiums and state appropriations to pay member claims. For fiscal year 2010, the Plan paid $2.4 billion in claims: $1.8 billion in medical claims and $0.6 billion in pharmacy claims.

OBJECTIVES, SCOPE, AND METHODOLOGY

The audit objective was to determine if the State Health Plan is exposed to significant risks for overpaying claims.

The Office of the State Auditor initiated this audit to improve the management controls at the Plan.

The audit scope included Plan operations for the period July 1, 2009, through June 30, 2010. We conducted the fieldwork from July 2010 through May 2011.

To determine if the State Health Plan is exposed to significant risks, we interviewed Plan personnel and reviewed Plan contracts, state policies, and management best practices. We obtained the services of a health care administration specialist to identify risk areas.

Because of the test nature and other inherent limitations of an audit, together with limitations of any system of internal and management controls, this audit would not necessarily disclose all performance weaknesses or lack of compliance.

We conducted this performance audit 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.

We conducted this audit under the authority vested in the State Auditor of North Carolina by *North Carolina General Statute* 147.64.

[3] A PPO plan is a healthcare network composed of physicians, hospitals, or other providers, which provides health care services at a reduced fee.

STATE HEALTH PLAN FACES SIGNIFICANT RISKS FOR OVERPAYMENTS

The State Health Plan (Plan) does not have policies and procedures in place to mitigate certain risks that could result in overpayments on member medical claims. Specifically, the Plan does not follow up on potential overpayments estimated by Plan auditors, does not provided adequate oversight for its recovery audit function, has not taken corrective action to eliminate or reduce potential errors, and cannot independently verify that the Plan receives the proper discount rate on medical claims.

No Follow-up on Potential Overpayments

The Plan is at risk for overpaying medical claims because the Plan does not follow up on potential overpayments identified by the Plan's external auditors. The Plan does not attempt to identify root causes of the errors or to collect the additional amounts.

For state fiscal years 2008–10, Plan auditors identified about $251,762 in actual overpayments and estimated that there were about $48.6 million in potential overpayments. Plan auditors test a random sample of about 494 medical claims out of about 10.3 million claims a year to identify actual and potential overpayments. The Plan auditors' annual reports state that the auditors used a statistical sampling method that allows the auditors to estimate the true claims error amount, plus or minus three percent, at a 95% - 98% confidence level.

However, a study of medical claims auditing methods[4] notes that the purpose of a claims audit is not simply to estimate an error rate. The study states,

> "While the 300 and 400 sample size produced statistically valid estimates of exception medical claims, that should not be the purpose of the health-plan-claims audit. The objectives of this type of audit should be to identify the root causes of the errors and, ideally, to eliminate them completely or at least minimize them."

Additionally, the Government Accountability Office (GAO) states that government managers should ensure the prompt resolution of findings from audits and other reviews.[5]

The Plan attempts to collect amounts that auditors identified as actual overpayments, but the Plan does not attempt to identify and eliminate the root causes of the overpayments or to collect on amounts identified as potential overpayments. The amounts are significant ($48.6 million), and the audit reports indicate that there is a high probability (95% - 98% confidence level) that the overpayments occurred.

The Plan could perform additional audit procedures such as audits focused to identify additional overpaid claims amounts. Focused audits would involve the Plan's auditors

[4] George P. Sillup, Ph.D., M.S. and Ronald K. Klimberg, Ph.D., M.S., Health Plan Auditing: 100-Percent-of-Claims vs. Random-Sample Audits, Look at What You're Missing, January 2010

[5] GAO, Internal Control Management and Evaluation Tool, August 2001

scanning the claims population to identify claims with characteristics similar to the characteristics of claims already identified as overpayments.

The lack of follow-up will prevent the Plan from identifying and correcting the conditions that allowed the overpayments to occur. Additionally, the Plan will fail to recapture a potentially significant amount of overpayments.

Inadequate Oversight of Recovery Audit Function

The Plan is at risk for overpaying medical claims because it does not adequately manage its recovery audit function.

Recovery auditing is a cost containment practice used to identify and recover improper payments made due to errors such as:

- Administrative non-compliance (non-covered items, duplicate payments, ineligible recipients, etc.);
- Intentional (fraudulent) and unintentional billing errors; and
- Inappropriate or unnecessary services.

The Plan does not provide adequate oversight for its vendors who perform various types of recovery audits. Specifically, the Plan has not (1) clearly documented and understood the services that its recovery audit vendors perform, (2) set performance expectations or benchmarks for its recovery audit vendors, or (3) analyzed the results of the recovery audits to determine if the Plan has received adequate value for its money.

In fact, a 2010 performance review by Navigant Consulting, Inc. (Navigant)[6] indicates that the Plan does not receive value for money on its fraud recovery audit efforts. Navigant noted that fraud recovery efforts by the Plan's vendor, Blue Cross Blue Shield of North Carolina (BCBSNC), do not meet industry standards. Navigant writes:

> "BCBSNC's level of fraud recoveries for the SHP [State Health Plan] is well below the industry average. For every $1 the SHP spent on fraud and abuse detection, the SHP received only 10 cents in actual fraud recoveries.
>
> Overall, the BCBSNC recovery dollars are equal to a little more than 1 percent of the SHP's total medical expenses, which is significantly below the industry average of 3 to 5 percent."[7]

The GAO recommends that (1) agency documentation should include "identification of the agency's activity-level functions and related objectives;" (2) objectives should be established for "all the key operational activities and the support activities;" and (3)

[6] In response to a 2009 Office of the State Auditor performance audit, North Carolina Session Law 2009-16 Section 5(g) required the Plan to obtain an independent audit to "determine whether savings to the Plan and to Plan members could be achieved if claims payments and processing were more efficiently and effectively administered."

[7] Navigant Consulting , Inc., The North Carolina State Health Plan for Teachers and State Employees Performance/Efficiency Audit Comprehensive Report, May 3, 2010

actual performance data should be "continually compared against expected/planned goals and differences …analyzed."[8]

Failure to properly manage the recovery audit function could prevent the Plan from indentifying and collecting a significant amount of overpayments. Intentional (fraudulent) and unintentional billing errors alone can result in overpayments ranging from 3% to 10% of total claim payments. For example:

- The Federal Bureau of Investigations (FBI) writes, "Estimates of fraudulent billings to health care programs, both public and private, are estimated between 3 and 10 percent of total health care expenditures;"[9]
- "The National Health Care Anti-Fraud Association (NHCAA) estimates conservatively that 3% of all health care spending—or $68 billion—is lost to health care fraud;"[10] and
- The Center for Medicare and Medicaid Services (CMS) estimated a 7.5% overpayment error rate for medical claims in the Medicare program in 2009.[11]

Based on the Navigant cited 3% - 5% industry standard, the Plan should expect to receive about $72 million to $120 million in annual recoveries. But the Plan has received a lot less. The Plan had total gross recoveries of about $11.9 million in 2008, $10 million in 2009, and only $4.4 million in 2010. Additionally, the 2010 reduction in recoveries occurred because BCBSNC terminated contracts with some recovery audit vendors without notifying the Plan. BCBSNC did not replace those services until late 2010 and early 2011.

No Corrective Action for Coordination of Benefits Errors

The Plan is at risk for overpaying medical claims because the Plan has not taken action to prevent coordination of benefits errors.

Coordination of benefits errors occur when BCBSNC pays a Plan member's medical claim when Medicare or another insurance provider should have paid all or part of the claim first. Information about other insurance coverage is usually obtained when members sign up for the Plan, change their status upon retirement or disability, or add dependents.

The GAO states that government managers should identify and analyze risks to agency objectives and implement policies and procedures to address those risks.[12]

[8] GAO, Internal Control Management and Evaluation Tool, August 2001
[9] Financial Crimes Report to the Public 2007
[10] Founded in 1985 by several private health insurers and federal and state government officials, the National Health Care Anti-Fraud Association is the leading national organization focused exclusively on the fight against health care fraud.
[11] Improper Medicare FFS Payments Report, November 2009
[12] GAO, Internal Control Management and Evaluation Tool, August 2001

Plan management is aware of the risk for coordination of benefit errors because BCBSNC auditors recover amounts paid in error on the Plan's behalf. Reports from BCBSNC to the Plan show that BCBSNC auditors recovered about $8.4 million in coordination of benefit errors on the Plan's behalf between January 2007 and September 2010.

However, during the audit period the Plan did not take steps to confirm whether all coordination of benefits errors were recovered or analyze the errors to determine why they occurred. Furthermore, although the Plan requested corrective action plans for errors identified by its auditor during the audit period, the Plan did not require its claims processor, BCBSNC, to conduct a detailed analysis of all errors or to develop and implement policies and procedures to prevent future coordination of benefit errors. While the Plan has recently worked with BCBSNC to develop reports to track the recovery rate of coordination of benefits errors, more work is required on root cause analysis and process improvement to prevent future coordination of benefit errors.

Error prevention is important because allowing errors to occur and then trying to collect improper payments, or the "pay and pursue" method, results in additional costs to the Plan. First, the Plan pays BCBSNC for processing a claim that should have been paid by another insurance provider. Second, the Plan incurs an opportunity cost because it does not have use of the funds that were improperly paid. And third, the Plan pays BCBSNC a fee of 22% to 24% of the amount recovered to collect on the payment errors that BCBSNC originally made. In other words, BCBSNC charges the Plan to collect on errors that BCBSNC made.

Navigant recommended improvements to the recovery process in its May 3, 2010, report to the Plan. The report states:

> "The retroactivity process can be improved to reduce inappropriate and incorrect claim payments to providers. The retroactivity processes at BCBSNC support 'pay and pursue' or 'retrospective analysis', that is, BCBSNC pays the provider and then attempts to collect any overpayments that have occurred based on its review of the service. A defined process to develop and continuously improve prepayment edits in the claim processing system that assure that claims are paid correctly does not exist."

Failure to analyze coordination of benefit errors, determine why they occurred, and develop system edits to prevent future errors will result in additional overpayments and costs for the Plan.

No Independent Verification of Provider Discounts

The Plan is at risk for overpaying medical claims because, although the Plan pays about $1.8 billion in medical claims a year, Plan auditors do not have access to BCBSNC contracts and cannot independently verify that the Plan receives the proper contractual discounts from BCBSNC's provider network.

The Plan's auditors rely on BCBSNC's computer system to determine if claims were properly billed and paid. The auditors select a sample of claims and enter the provider information and medical codes into a computer terminal at BCBSNC. The computer displays the rate negotiated between BCBSNC and the medical provider and the effective dates of any rate changes. The auditors then compare the amount on the display screen to the amount that the Plan paid to determine if the claim was properly paid. The display does not provide information about the discount that was negotiated between BCBSNC and the provider.

The Office of the State Controller (OSC) requires that all invoices processed for payment "are accurate as to terms, quantities, prices and extensions."[13]

Plan management is aware that medical claims are sometimes paid with the wrong discount rate because BCBSNC auditors have recovered amounts for "improper discounts" on the Plan's behalf. However, because the Plan does not have access to contracts between BCBSNC and the medical providers, the Plan does not have a method for independently determining if an improper discount rate has been applied to Plan member's claims.

For example, reports show that BCBSNC auditors recovered about $3.5 million in improper discounts on the Plan's behalf between January 2007 and December 2009. But the BCBSNC reports do not show any collections for improper discounts during the first quarter of 2010. The Plan cannot independently determine whether no additional improper discounts occurred during the first quarter of 2010 or whether BCBSNC auditors simply did not find or report additional improper discounts during that period.

Although the Plan pays BCBSNC to access its provider network and to benefit from its contracted discount rates with medical providers, all contracts are between BCBSNC and its providers and are considered proprietary information. The Plan's contract with BCBSNC states:

> "The State Health Plan acknowledges and agrees that BCBSNC shall have authority with respect to the structure, payment terms, and other contract terms in connection with its Provider networks and that the State Health Plan is not a party to any agreements between Blue Cross and its Providers. BCBSNC has all rights and responsibilities with respect to contracting with Providers and administering Provider networks under this Agreement."

Consequently, the Plan must rely on BCBSNC auditors to discover and report discount errors to the Plan when errors occur. Additionally, the Plan is at risk for overpaying claims because it must rely solely on information from BCBSNC's computer system during claims audits.

[13] OSC, Self-Assessment of Internal Controls, Purchasing and Accounts Payable Cycle, 2007

Recommendation: The Plan should consider using software or other automated methods to perform focused audits to identify additional overpaid claims, collect the additional amounts, and identify root causes of the errors.

The Plan should clearly document the services that its recovery audit vendors perform, set performance expectations for its recovery audit vendors, and analyze the results of the recovery audits to determine if the Plan has received adequate value for its money.

The Plan should analyze coordination of benefit errors, determine why they occurred, and require additional claims processing system edits to prevent future errors.

The Plan should ensure that future contracts allow independent verification of claims pricing and discounts.

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September 7, 2011

State Health Plan (Auditee) Response

The Plan agrees with the Auditor's findings. The Plan has begun making improvements to its oversight and monitoring of all contracts. The FY2008 Projected versus Actual Results Performance Audit, which was released by the Office of State Auditor in April 2009, provided recommendations to the Plan related to the BCBSNC contract, among other things. The Plan has been building on those recommendations and will continue its best efforts to implement the additional recommendations included in this report.

Lacey P. Barnes, Interim Executive Administrator — Date 9/7/11

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