

AUDIT REPORT

Date:	February 18, 2020
Department:	Human Resources
Subject:	Employee Benefits – Claims Administration Contract
Lead Auditor:	Karen Newman

OBJECTIVES

This audit was conducted to determine whether the Employee Benefits Division has effective controls in place to ensure the City's contract with Cigna Health and Life Insurance Company (Cigna) is monitored for accuracy and compliance, and that the performance expectations described in the contract are being met.

SCOPE & METHODOLOGY

We conducted this audit in accordance with Generally Accepted Government Auditing Standards, which 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.

To accomplish our objectives, we:

- Reviewed the contract and interviewed personnel to identify the requirements and processes in place for monitoring enrollment activity, claims processing, administrative fees and credits, and performance measures.
- Tested enrollment and invoice accuracy¹ for the fiscal year ended June 30, 2019².
- Reviewed vendor credit and performance results documentation.
- Performed other tests and procedures as necessary.

BACKGROUND & DISCUSSION

The Employee Benefits Division is responsible for the administration of the City's self-funded health benefits programs and related services. As such, they oversee the City's contract with Cigna for third party medical plan administration services, medical utilization management

¹ Invoice accuracy testing was limited to verifying that the amount paid to Cigna equaled the amount Cigna paid to providers and other amounts due per the contract. We were not able to test whether the amounts paid to providers were correct, as detailed claims data was not available to us.

² The City's medical plans and the Cigna contract are administered on a calendar year basis; however, by using the fiscal year, we were able to include transactions from two separate plan years, one open enrollment period and corresponding transition to the new plan year, and the most recent cost and enrollment data.

services, and provider network access. The original 3-year agreement with Cigna runs from January 1, 2018 through December 31, 2020, and can be extended for a maximum of two 1-year periods. Approximately 13,800 employees, eligible retirees, and dependents are enrolled in the City's three medical plans. For FY 2019, medical claims paid through Cigna totaled approximately \$57 million, and administrative fees paid to Cigna totaled approximately \$1.65 million.

ADDITIONAL CONSIDERATIONS

While accuracy and compliance are generally in the best interests of both Cigna and the City, it is the City that bears the risks associated with errors or fraud in claims processing. The likelihood of an error or fraud occurring during claims processing is driven by many factors including the high degree of complexity inherent in medical billing; numerous regulations; claims volume; Plan differences; and others. When a third party administrator is used, additional risk factors include the procedures, people, and systems employed by the contractor. The City has little to no control over these external factors.

With medical costs approaching \$60 million per year, and given the limited potential for preventative controls under a third party arrangement, it is critical for the City to ensure that if any fraud or errors were to occur, they would be detected and corrected in a timely manner. To do that, City staff would need to regularly test the accuracy and compliance of processed claims. It may also be helpful to use advanced data analysis to identify anomalies.

The City's standard right-to-audit clause, which allows the City to audit the work performed by a contractor, was removed from the version of the City's Standard Terms and Conditions included in the Cigna contract. Instead, the contract allows the City to use "*an independent, third-party auditor*" to conduct one audit every two years, during which the auditor may test "*a random, statistically valid sample of two-hundred twenty-five (225) claims paid during the two prior Plan Years*". In our opinion, these limitations are not in the best interests of the City. A biannual audit does not provide adequate oversight, and a predetermined sample size may not be "*statistically valid*", as it does not account for other variables, such as the total number of claims processed. While such limitations are common in this industry, they are designed to protect the contractor, not the City.

It should also be noted that the contract contains specific performance guarantees, which Cigna must meet to avoid financial penalties. However, the City relies on Cigna's self-reported performance results to determine whether these guarantees have been met.

CONCLUSION

In our opinion, additional and improved monitoring is needed to ensure that medical claims are processed and paid properly, and to verify that performance guarantees are being met. Also, the audit limitations in the contract should be renegotiated. A brief summary of our

observations and recommendations is included below. For additional details and management's response, please see the attached Issue and Action Plans (IAPs).

SUMMARY OF OBSERVATIONS & RECOMMENDATIONS

IAP #1:

Observations: The Employee Benefits Division does not routinely test completed claims to ensure accuracy and compliance. The contract would allow for this, if the City were to request it and meet certain requirements. In addition, while the contract allows for a biannual independent audit of a limited number of claims, an audit has not yet been performed. In our opinion, it is not in the City's best interest for the contract to limit the allowable frequency and scope of audits.

Recommendations: Employee Benefits Division staff should routinely test claims for accuracy and compliance with Mesa's Plan, and should consider using data analytics to identify trends and anomalies which may warrant further investigation. They should also have an independent audit performed, and should negotiate with Cigna to modify or eliminate the contract's audit restrictions.

IAP #2:

Observation: Performance results reported by the vendor are not verified for accuracy.

Recommendation: The Employee Benefits Division should implement a process or control to provide some level of assurance that performance results reported by the vendor are accurate.

Issue and Action Plan #1

Issue #1: Processed claims are not tested for accuracy and compliance.

- Observation:**
- Claims are not routinely reviewed or tested to ensure Cigna is processing them accurately and in accordance with the COM plan.
 - The Cigna contract allows for an independent (but limited) audit of claims to be conducted biannually, but an audit has not been performed.

Criteria: Management Policy 200 (Section III.D.) states, in part:
"Departments must maintain oversight of Contracts to ensure that Contractors perform in accordance with the terms, conditions, and specifications of their Contracts and Purchase Orders."

Comments: To identify claims processing inaccuracies, the City relies on members to: 1) carefully review and understand the Explanation of Benefits (EOB) reports they receive from Cigna, and 2) speak up if they have concerns. In our opinion, this process does not provide reasonable assurance that claims are processed accurately and in accordance with Plan requirements.

Currently, City staff does not have access to detailed claims data or supporting documentation; however, such access is allowable under the contract, if the City were to request it and meet specific requirements related to protected health information.

The Cigna contract contains restrictions which may prevent a thorough audit of claims. Auditors are limited to testing only 225 claims, regardless of the total number of claims processed. They may request to increase this scope, but pricing would need to be negotiated.

**Recommendations
and Management's
Action Plans:**

Recommendation #1-1: Employee Benefits Division staff should routinely test processed claims for accuracy and compliance with Mesa's Plan. They should also consider using data analytics to identify trends and anomalies which may warrant further investigation. To enable these independent oversight activities to occur, the City should request that a limited number of appropriately trained Employee Benefits staff members be given access to detailed claims data and supporting documentation.

Action Plan #1-1:

Current benefits department processes to **routinely test claims for accuracy and compliance** with Mesa's Plan:

1. Contracted independent third-party (non-Cigna) provides claims Risk Management Services and Stop-Loss Insurance management for all "trigger" diagnosis codes (codes that have the potential to require further medical services and costs to the Plan) and claimants who have the potential to reach the stop-loss insurance specific amount of \$500,000 annually.
2. Customer Advocacy services – 100% review of all claims denials or coverage questions when these are identified by a member or their representative.
3. Routine testing of "non-problematic" and lower dollar claims is not regularly performed. Benefits department will evaluate costs, staffing needs, processes and training to develop a routine claims' testing process on a monthly basis, by June 30, 2020, using Cigna client portal data/access and on-site representative services.

Benefits Consulting firm engaged in October 2019 to provide **Data Analytics technology platform and consulting** for health plan analytics and trend forecasts, including medical and prescription drug claims data. Historical data collection processes estimated to be completed by June 30, 2020, with ongoing monthly data collection and reporting thereafter.

Individual or Position Responsible:

Asst. Employee Benefits Administrator

Estimated Completion Date: 6/30/2020

Recommendation #1-2: An independent audit should be performed to ensure claims are processed accurately and in compliance with the City's Plan.

Action Plan #1-2:

Buck Global audit practice engaged to conduct Stratified Medical Plan Audit of Cigna TPA claims paid for period 1/1/2018 through 12/31/2019 – project commenced 1/31/2020 and projected to complete May 2020.

Individual or Position Responsible:

Asst. Employee Benefits Administrator

Estimated Completion Date: 5/27/2020

Recommendation #1-3: When negotiating a new contract or contract renewals, the audit provisions should be revised to allow the City to appropriately and effectively audit the services provided under the contract. For example, we recommend removing the restriction that audits may only be conducted every two years, and allowing the auditors to select the number and types of claims to be tested in accordance with auditing standards.

Action Plan #1-3:

Benefits will benchmark standard health plan claims' auditing standards and practices and incorporate recommended features into next available RFP process for future contract solicitations for medical plan administration services.

Individual or Position Responsible:

Employee Benefits Administrator

Estimated Completion Date: For contract award effective dates of 1/1/22 or 1/1/23 whichever occurs first.

Issue and Action Plan #2

Issue #2: Performance results are not verified.

Observation:	The Employee Benefits Division does not verify the accuracy of the performance data self-reported by Cigna.
Criteria:	<p>The determination of whether or not performance guarantees have been met should be decided by Mesa staff based on verifiable data.</p> <p>Relying on the "honor system" for performance reporting is of limited value, particularly when there is a financial incentive for the reporting party to meet specific guarantees.</p>
Comments:	A contractor may report inaccurate performance data in order to avoid financial penalties, which are payable if guarantees are not met. If the City is unaware that performance guarantees are not being met, the underlying issues may not be identified and addressed, which could result in lower service levels or higher costs to the Plan and its members.
Recommendation and Management's Action Plan:	<p>Recommendation #2-1: The Employee Benefits Division should verify the accuracy of performance results reported by Cigna. If verification is not possible, compensating controls should be implemented, such as requesting additional reports and/or supporting documentation, or analyzing other available data to provide some level of independent assurance that expectations are being met.</p> <p>Action Plan #2-1: Identify additional reports and back-up data that supports Cigna reporting of Performance Guarantee results. If such back-up data is not available (or is proprietary to Cigna), request Cigna to provide internal accounting/auditing data or attestation that affirms the accuracy of PG reported results.</p> <p>Individual or Position Responsible: Employee Benefits Administrator</p> <p>Estimated Completion Date: 9/30/2020</p>