To: Whom it May Concern

From: Martin Daniel

Re: Analysis of The Tennessee Health Care Plan Claims Audit of 2022 - a lost opportunity; a waste of taxpayer dollars

Date: August 11, 2022

ANALYSIS and SUMMARY of OBSERVATIONS

The AG's Health Care Plan claims audit is so deficient and flawed in so many material aspects that it is completely ineffective in determining whether the plan administrators have performed in accordance with their contractual and fiduciary duties.

The following are apparent deficiencies in the contract and in the audit itself:

1. The contract entered into between the AG and the Contractor did not set forth the elements of the claims that the TPA was to provide to the Contractor(a/k/a "the record layout"). Absent access to all available elements of a claim(80 or more), an audit as to its validity and as to accuracy of payment of that claim cannot be made;

2. It does not appear that the Contractor conducted an electronic review of 100% of the claims population. A sample size of only 300 claims was examined. That is less that 1/10 of 1% of paid claims. That is not sufficient to satisfy the express requirements of the contract, nor is it sufficient to extrapolate into probable errors in the entire claims population of the Tennessee Plan.

3. The claims population did not coincide with that of a preliminary audit made by Claim Informatics in 2020. That preliminary audit found at least $17,000,000 in payment errors made on provider claims between 2017 and 2019;

4. It does not appear that the audit examined claims for unusual payment variations for similar, uncomplicated procedures;

5. It does not appear that the audit examined variation(s) between payments made pursuant to the Plan and the average or median cost in Tennessee and nationally for specific medical procedures;

6. It does not appear that the claims were audited for "upcoding" and "unbundling";

7. The contract entered into by the AG and the Contractor did not require independent validation as to accuracy of the claims data received from the TPAs;

8. It does not appear that the audit examined any unusual billing and/or unusual payments made to specific providers and facilities;

9. Per the contract, the TPAs were allowed to examine and to comment on findings of errors prior to publication of the audit;

10. There is no assurance in the contract with the Contractor that it does not have a conflict of interest arising from a relationship with any of the TPAs.

11. The audit did not set forth any findings of errors made concerning hospital/facility billing. The likelihood of this actually occurring is so remote as to call into question the validity of the entire audit project.

12. There is no indication in the Contractor's audit report as to whether it requested information from the TPAs regarding state funds being withheld by the TPAs to settle the alleged debt of non-TN State Plan members debt, otherwise know as "offsetting plan funds".

FACTS AND BACKGROUND

The Plan and the Budget Amendment

The Tennessee state health care plan("the Plan") is a self-funded plan that provides coverage for health expenses incurred by its members, primarily current and retired state employees and their dependents, including state higher education employees and their dependents. Several hundred thousand claims are filed each year, and the annual expense to the state exceeds $500 million. The Plan is overseen by the Department of Finance & Administration and claims are managed and processed by Administrators, Blue Cross Blue Shield and Cigna. Optum administers behavioral care claims.

In the Spring of 2020, the Attorney General contracted with Claim Informatics to conduct a partial or "shallow" examination of claims made to the Plan. This examination was made at no cost to the state. Claim Informatics determined that, for claims made to providers of the Plan in 2017-2019, at least $17 million was made erroneously, and that another $22 million in claims was suspicious and warranted further review. Claim Informatics made several other findings of unusual activity concerning processing of claims made to the Plan.

In the 2020-2021 state budget, the legislature inserted an amendment that required the Attorney General of Tennessee to contract for the audit of the state health care plan. The maximum amount of the amendment was $400,000. Pursuant to an extensive RFP process, the Attorney General selected Healthcare Horizons of Knoxville, Tennessee(("HH" or "the Contractor")) to conduct an audit.

The Contract between the AG and Health Care Horizons

The Tennessee Attorney General contracted with HH on June 10, 2021 to, among other things,:

-"oversee, conduct, and provide medical and behavioral health claims audits for the State of Tennessee of each of its three third party administrators(TPAs)";

-to "conduct audits that provide a comprehensive and objective review of claims processed by the TPAs to determine if claims were adjudicated and paid according to contractual standards between the TPAs and the provider, Plan benefits, and policies, and industry standards".

Audit Contract A.3, A.4, p.1

The contract between the AG and HH was signed June 18, 2021("the Contract"). It was effective for twelve(12) months, commencing July 1, 2021. The Contract, B., p.4. Healthcare Horizons("the Contractor") was paid on an hourly basis as set forth on a schedule in the Contract. The Contract, C.3, p. 5. It required two separate claims adjudication review audits: first, for performance of an electronic review of 100% of the claims population for anomalies, and second, for a random statistically valid sample of adjudicated claims for each medial and behavioral health TPA. The Contract, A.6., p.2-3.

Per the Contract, HH was to work directly with the TPAs to "obtain the electronic claims data necessary to conduct the adjudication review and audits." The Contract, A.6., p.3. Apparently, the Contract does not set forth the time period parameters for which claims shall be audited.

The audit reports were published by the Attorney General on or about June 30, 2022.

OBSERVATIONS AND COMMENTS

1. **The Contract did not set forth the elements of the claims(the "record layout") that the TPA was to provide to the Contractor. Absent access to all available elements of a claim, an audit as to its validity and as to accuracy of payment of that claim cannot be made.**

   There are more than eighty(80) elements(or data points) of a health care plan claim. The claim elements, or the record layout, will determine if the data meets minimal standards to perform an electronic review.

   The Contract does not set forth the claim elements that the Contractor should obtain from the TPAs, and the audit does not set forth the nature of claim elements actually obtained from the TPAs. On the face of the audit report, there does not appear to be any way for the reader to determine what elements were received and examined.

   An audit of only some of the health care claim elements is fundamentally flawed. Here, there is no assurance that needed elements were obtained from the TPAs.

2. **It does not appear that the Contractor conducted an electronic review of 100% of the claims population. A sample size of only 300 claims was examined. That is less that 1/10 of 1% of paid claims. That is not statistically valid and is not sufficient to serve as the basis for an effective health care claims audit. Also, that sample size is not sufficient to extrapolate into an error rate in the entire claims population. This fact alone, the examination of a mere sample, makes the audit fundamentally and critically flawed.**

   HH states in its Executive Summary, that it received $758.983.517 in paid claims data from TPA Blue Cross Blue Shield and that it "performed a full electronic review of claims

processing". BCBS Targeted Audit, p.1. The Contractor "delivered 300 targeted sample claims to the TPA as potential errors". Id. Based on the "agreed" in sample findings, the Contractor then "queried the full claims population for additional claims with similar errors." Id.

It is not clear why the AG requested an audit of a sample when it also required an audit of the full claims population.

Apparently, the Contractor only performed an audit of the full claims population as to three(3) categories: eligibility, multiple procedure reductions, and non-covered administrative exams". BCBS Targeted Audit, pp. 1-2. No reason was given by the Contractor as to why it audited the full population as to only 3 potential classes of errors. No reason is given by the AG as to why it accepted this minimal review.

This aspect of the audit does not appear to be in compliance with the Contract, and it is not consistent best practices in the health care claims audit industry.

3. **The claims population did not coincide with that of a preliminary audit made by Claim Informatics in 2020. That preliminary audit found at least $17,000,000 in payment errors made with regard to provider claims between 2017 and 2019.**

In the Spring of 2020, pursuant to contract with the Attorney General of Tennessee, Claim Informatics performed a preliminary partial audit of claims made to the Plan by physician providers between 2017 and 2019. Claim Informatics determined that there were at least $17,000,000 in erroneous payments made from the Plan. Also, it determined that there were $22,000,000+ in suspicious claims that warranted further investigation.

The Contract does not set forth the time parameters for which claims shall be audited. Apparently, the Contractor(or the TPAs) selected the sample audited from a population of claims made between January 1, 2020 through December 31, 2020, paid through June 2021. The TPAs should have no say as to the time period of the audit. Furthermore, with the Claim Informatics analysis in hand, for comparison, the AG should have required a full and complete audit of claims made in 2017 through 2019.

4. **It does not appear that the audit examined claims for unusual payment variations for similar, uncomplicated procedures.**

5. **It does not appear that the audit examined variation between payments made pursuant to the Plan and the average or median cost in Tennessee and nationally for specific medical procedures.**

6. **It does not appear that the claims were audited for "upcoding" and "unbundling".**

   The Contract lists several "anomalies" for which the Contractor was to audit claims. Contract, A.6., p. 2. It did not, however, require an audit for potential unusual variations in amounts paid by the Plan for claims made for similar, uncomplicated procedures. To prevent fraud and error in payment, this is a basic aspect of a health claims audit, but was omitted in this case.

   Also, in the Contract, there was no requirement that the claims be compared to national or state median prices for similar medical procedures. This is a basic aspect of a health claims audit as it could identify fraud, waste or abuse.

   Providers use billing codes to communicate the services provided to various patients. Each billing code corresponds to a specific diagnosis or service while simultaneously labeling the complexity of work required by the provider and, thus, the associated costs. The Plan uses these billing codes to calculate and issue payments to healthcare providers. Upcoding and unbundling in healthcare are two forms of improper medical coding. Although the Contract requires HH to electronically review "use of CPT Codes" and "unbundling of services", there is no indication in the audit that these examinations were made.

7. **The contract entered into by the AG and the Contractor did not require independent validation as to accuracy of the claims data received from the TPAs.**

   The Contract between the AG and HH provides that "the Contractor will contact the TPA and work directly with the TPAs to obtain the electronic claims data necessary to conduct the claims adjudication review and Audits". Contract, A.7., p.3. When necessary, the state will assist in obtaining the data. Id. There is no indication in the Contractor's Audit report that the claims data was independently validated or verified.

   No reason is found as to why the claims data was to be obtained directly from the TPAs. Information and data received from an entity being audited should not be accepted on its face. Benefits Administration has custody of all the claims data, and the data should

be obtained from it. At a minimum, the Contractor should take steps to independently verify the accuracy of the claims data received from the TPAs.

8. It does not appear that the audit examined any unusual billing and/or unusual payments made to specific providers and facilities.

Applications of data analytics and data engineering can be applied to identify erroneous billings and payments. One area that can be an indication of potential fraud, waste, or abuse is when providers or facilities make unusually excessive claims(in volume or amount) to a Plan. Here, the Contract did not require HH to identify those providers and the report did not identify them. In this respect, the Audit is deficient.

9. Per the Contract, the TPAs were allowed to examine and to comment on findings of errors prior to publication of the audit.

At page 3, para. A. 11 and 12, the Contract provides that HH will provide the claims details for each issue identified to the TPA "for review and comment prior to the release of the audit", and the "TPA will have an opportunity to provide a written response to each issue" identified. From the report, it is clear that some conversation concerning issues occurred pre-report between the Contractor and the TPAs.

This provision, allowing the audited entity to comment on issues to the auditor prior to publication, seems unusual, and could be used to obscure potential issues or to redirect attention from such issues.

10. There is no assurance in the Contract with HH that it does not have a conflict of interest arising from a relationship with any of the TPAs.

The Contract provides that it shall be null and void if the Contractor has been an employee of the State and that none of its controlling persons have been an employee of the State within the past 6 months(p. 8, D.8). There does not appear, however, to be a warranty that the Contractor has not done business with the audited TPA any time period prior to the audit. An assurance that the Contractor has no conflict of interest is essential to the integrity of health care claim audits. Here, the Contract and the audit are deficient without such an assurance.

11. The audit did not set forth any findings of errors made concerning hospital/facility billing. The likelihood of this actually occurring is so remote as to call into question the validity of the entire audit project.

Even HH says on its website that the national average error rate in health care claims is 3%. Healthcare Claims Audits: Are you auditing? - Healthcare Horizons. This audit, however, found that 1/10 of 1% of provider claims were erroneous. The Contractor found no facility errors. The odds of this actually occurring are so remote that it casts doubt as to the validity of the entire audit project.

12. There is no indication in the Contractor's audit report as to whether it requested information from the TPAs regarding Tennessee State funds being withheld by the TPAs to settle the alleged debt of non-Tennessee State Plan members debt, otherwise know as "offsetting plan funds".

It is not uncommon for TPAs that administer fully insured plans and self insured plans(such as BCBS and Cigna in this case) to retain state plan dollars to satisfy the debt of non plan members and never disclose such practices to the employer. Virtually of the national carriers engage in this process. This amount could be substantial.

According to the Department of Labor, the practice of offsetting is a conflict of interest that arises when claims administrators-like BCBS and Cigna-administer both fully insured and self-insured plans.

To recover overpayments made by fully insured plans from self-insured plans, TPAs of self insured plans often withhold payment to providers from the self-insured plans and divert them to reimburse their own claims payments. In the process, a payment from an employer funding the self-insured plan, such as the State of Tennessee, is diverted to the TPA as reimbursement for overpayments made out of their own pockets.

Failure of the Contractor to audit for these common issues in the Tennessee plan is evidence that the audit is deficient.

COMMENTS AND CONCLUSION

The audit was critically flawed from its inception to its publication. While the contract requires a full electronic audit of all claims, it does not identify elements of each claim that are to be examined, and it allows the TPA to deliver the claims data directly to the Contractor.

The Contractor did not perform a full electronic audit of all claims, but only a sample audit of 300 claims. This is not in compliance with the contract, and that sample size of much too small to extrapolate into an error rate for the entire claims population.

The Contract does not set forth the time parameters for claims audit. Therefore, comparison to the 2020 partial audit by Claims Informatics that found significant errors was not done.

The failure by the Contractor to examine unusual variations in claim payments and to compare claim payments for specific procedures to national and statewide median prices causes the audit to be substantially deficient. There is no indication that a review of all claims was actually made for upcoding and unbundling.

The Attorney General did not contract for what the General Assembly intended and in accordance with best practices in the industry require. The TPAs had an unusual role in delivering data to the Contractor and in making pre-report comments concerning issues. Furthermore, the Contractor simply did not deliver what was promised.

This audit is so deficient and flawed in so many aspects that it is completely ineffective in determining whether the Plan has made accurate payments to providers and facilities and whether the TPAs have acted consistent with their duties. Unfortunately, the health care claims audit appears to be a substantial waste of taxpayer money.

The AG, in consultation with the state Comptroller, should re-engage the Contractor and, upon determining that it is competent to conduct the audit, require that it complete the review of all claims in accordance with the Contract and in accordance with industry best practices.