ARLINGTON
VIRGINIA

Cigna Medical & Pharmacy Claims Administration Internal Audit

Report Date: April 12, 2021

RSM

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TRANSMITTAL LETTER

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Ms. Maria Meredith
Director & CFO, Department of Management and Finance

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Pursuant to the contract and related statement of work for Arlington County, Virginia ("the County"), we hereby present the summary of results related to the medical and pharmacy claims administrative internal audit. Our report is organized in the following sections:

Executive Summary	This section includes a background summary of self-insured health insurance plans, the scope, objectives and approach to the claims review process and a summary of the item(s) noted during this review.
Summary of Procedures and Results	This section provides an overview of our claims review process and procedures performed with respect to the various testing areas of our sample claims.
Objectives & Approach	This section summarizes the reconciliation of medical and pharmacy claims data extract files and our sample selection with respect to total "billed" and "paid" amounts. The approach and focus are expanded upon in this section as well.

Our review is based on our review of the processes, documents, records and information provided to us by Cigna Health and Life Insurance Company ("Cigna"). This review focused on validating that Cigna is appropriately administering the County's self-insured health plan(s). We offer no assurances that schemes or fraudulent activities have not been, or are not currently being perpetrated by any person within the areas reviewed.

We would like to thank the County and Cigna staff involved in assisting RSM US LLP during the review process.

Respectfully submitted,

RSM US LLP

RSM US LLP

Executive Summary

Background

The County has self-insured health insurance plans. With a self-insured health plan, the County runs its own health plan instead of purchasing a fully-insured plan from an insurance carrier. Although the savings on premiums can be substantial, the risks associated with self-insuring can be greater in instances when more claims are received than expected and the County has to pay the claims. These variable costs can cause financial uncertainty to the County. In addition to the variable costs, fixed costs are paid to plan administrators. Most self-insured health insurance plans are managed by an insurance carrier or third-party administrator ("TPA"). The County has contracted with Cigna to administer its self-insured health plan(s).

Objectives

RSM was engaged to provide consulting services related to the medical and pharmacy claims review for the third-party administration services provided by Cigna. The purpose was to validate that Cigna is appropriately administering the County's self-insured health plan(s), relating to accurate, timely and efficient health and pharmacy claim payments.

Scope

Cigna provided RSM with an electronic data file containing all relevant and pertinent claims information for the audit period (January 1, 2019 through December 31, 2019). RSM selected a statistically valid stratified random sample; this sampling methodology allows RSM to identify patterns of processing errors as well as gain an understanding of the overall effectiveness of the existing controls over the paid claims process. As a result, 154 medical and 71 pharmacy claims were selected to test and validate the administration of the County's self-insured health plan(s). The claims review process was virtually performed over WebEx with a Cigna "driver" rather than an on-site visit.

It is important to note that the claim payment period reviewed overlapped two benefit periods. Therefore, for each self-insured health insurance plan that was offered, two Summary Plan Description ("SPD") documents or Summary of Benefits needed to be reviewed. The periods for these documents were July 1, 2018 through June 30, 2019 and July 1, 2019 through June 30, 2020.

Approach

RSM conducted the following procedures as part of our approach for the sampled claims:

- Enrollment/Eligibility – assessed the eligibility of plan member coverage on the date of service based on Cigna system information;
- Benefits – assessed the accuracy of deductibles, coinsurances, co-pays, out-of-pocket maximums and other benefit requirements being applied;
- Coordination of Benefits – assessed the accuracy of benefits application with other insurance coverage such as Medicare or other insurance;
- Demographics – assessed the correspondence of plan member information with UB-04/1500 (provider claim statement), Explanation of Benefits (EOB) and Cigna system information;
- Referrals and Authorizations – assessed whether or not referral or authorization requirements were obtained prior to plan member receiving services, as applicable;
- Claim Reimbursement – assessed whether or not Cigna is paying claims according to its provider contract agreements;
- Claim Payment – assessed the accuracy of claim payment;
- Provider Status – assessed hospital and provider network status (i.e., in-network / out-of-network)
- Validated the use of cost controls if appropriate for each claim sample.

Overall Summary / Highlights

Medical Claims: RSM identified no errors within the medical claims sample.

Pharmacy Claims: RSM identified no errors within the pharmacy claims sample.

Fieldwork was performed from February 2021 through March 2021.

We would like to thank all Arlington County and Cigna team members who assisted us throughout the claims review process.

Summary of Procedures and Results

Overview

A claims data extract file provides details on all claims processed during a given period. The medical claims data extract file from Cigna for the County's claims included 206,859 lines of claim detail and a total "paid" amount of $25,386,049 for the period January 1, 2019 to December 31, 2019. Similarly, the pharmacy claims data extract file included 48,708 lines of claim detail and a total "paid" amount of $9,150,471 for the period January 1, 2019 to December 31, 2019. The total paid claims were recalculated in our import file and agreed to the total paid claims data extract file. All paid claim lines had service dates within our scope period from January 1, 2019 through December 31, 2019. For the medical claims, multiple claim lines make up a single claim. Each claim line selected in our sample was chosen so that the same individual claim was not tested twice. The total "billed" amount for the 154 medical claims sample was $2,809,759 and the total "paid" amount was $1,655,249. The total ingredient cost (reimbursement as determined by the plan specifications) submitted for the 71 pharmacy claims sample was $442,483 and the total "paid" amount was $438,773. "Billed" represents the total charges submitted by the provider to the plan. "Paid" represents the amount paid by the plan based on billed charges to the plan and similarly the amount reimbursed by the County for these expenses to Cigna.

Summary of Procedures and Results

1. **Enrollment/Eligibility – assessed the eligibility of plan member coverage on the date of service**

   For each claim selected for testing, RSM determined that each plan member, or dependent thereof, was eligible for benefits during the date(s) of service. This was performed by checking the date(s) of service from the claim to the related enrollment information for the time period within the Cigna claims processing system. Member and dependent eligibility is the responsibility of the County which provides regular updates to Cigna to maintain the completeness and accuracy of eligibility within their claims processing system.

   RSM found no exceptions as a result of applying these procedures.

2. **Benefits – assessed the accuracy of deductibles, coinsurances, co-pays, out-of-pocket maximums and other benefit requirements being applied**

   For each claim selected for testing, RSM determined that the out-of-pocket expenses paid by the plan member, or dependent thereof, was accurately calculated and paid in accordance with plan benefits in the Cigna claims processing system. The County maintains four plan groups with Cigna. The out-of-pocket expense payments were compared to the expected payments based on the appropriate plan and both were in agreement. RSM also re-calculated out-of-pocket accumulators for out-of-pocket maximum limit exceptions to ensure they were not exceeded.

   RSM found no exceptions as a result of applying these procedures.

3. **Coordination of Benefits – assessed the accuracy of benefits application with other insurance coverage such as Medicare or other insurance**

   For each claim selected for testing, RSM determined that the claim allowed amount from Cigna was in accordance with existing coordination of benefits for each plan member based on the plan group from the Cigna claims processing system. Based on Cigna's position (primary or secondary), RSM recalculated the allowed amount.

   RSM found no exceptions as a result of applying these procedures.

4. **Demographics – verified the plan member information with UB-04/1500 (provider claim statement) and Cigna system**

   For each claim selected for testing, RSM verified the patient demographic information from the detail claims electronic file to the patient demographic information in the Cigna claims processing system.

   RSM found no exceptions as a result of applying these procedures.

Summary of Procedures and Results (continued)

Summary of Procedures and Results (continued)

5. **Referrals/Authorizations – assessed whether or not referral or authorization requirements were obtained prior to plan member receiving services, as applicable**

   For each claim selected for testing, RSM reviewed, as applicable, that authorization was obtained prior to the service date(s) within the Cigna claims processing system.

   RSM found no exceptions as a result of applying these procedures.

6. **Claim Reimbursement – assessed whether or not Cigna is paying claims according to its provider contract agreements**

   For each claim selected for testing, RSM verified the calculation of the allowable amount from the Cigna claims system to the provider pricing system within the claim file information shown during our testing. The provider pricing system has the fee schedules and pricing information loaded. Cigna does not provide access to the hard copy provider contracts as those are proprietary. RSM's process also included the recalculation of the allowable amount, as applicable. In addition, for each claim selected for testing, RSM verified whether or not provider claims were submitted and paid in a timely manner according to the Administrative Services Agreement ("ASA"). This was achieved by calculating the days between when a claim was received and paid by Cigna to determine the claim processing time.

   RSM noted one instance in which a sampled claim's processing required 107 days which exceeds the standard timeframe of 30 days. The delay was caused by a contract update between Cigna and the provider. Please note, the ASA does not require 100% of claims to be processed within 30 calendar days. The ASA states the following regarding turnaround time, *"90% of clean claims (claims with no data missing that is required to process the claim) paid within 14 calendar days of the Contractor's receipt of the claim. 98% of claims processed in 30 calendar days, reported monthly at the account level and paid quarterly based on the average monthly metrics."*

7. **Claim Payment – assessed accuracy of claim payment**

   For each claim selected for testing, RSM recalculated the claim payment amount based on the provider pricing system and related patient payment information shown in the Cigna claims processing system in accordance with the applicable benefit group Summary Plan Description provided by the County.

   RSM found no exceptions as a result of applying these procedures.

8. **Provider Status – assessed hospital and provider network status (i.e., in-network / out-of-network)**

   For each claim selected for testing, RSM reviewed the provider network status, whether that provider was in-network or out-of-network, in the Cigna claims system. Once the provider network status was checked, RSM then verified that the correct benefits were applied and that the claim reimbursement and payment was processed at the correct provider network status.

   RSM found no exceptions as a result of applying these procedures.

9. **Validated the use of cost controls if appropriate for each claim sample**

   For each claim selected for testing, RSM reviewed, as applicable, prior authorization of high-cost procedures and drugs. RSM verified that appropriate authorization, as applicable, was obtained for procedures and drugs identified within the applicable benefit group Summary Plan Description.

   RSM found no exceptions as a result of applying these procedures.

Summary of Procedures and Results (continued)

Control Activities
Based on the Administrative Services Agreement ("ASA"), Cigna has control activities in place to minimize risks associated with claims processing. These control activities include, but may not be limited to:

- Quarterly eligibility audits/reconciliations. Cigna will periodically provide a report identifying potential discrepancies in eligibility data provided by the County, as necessary.
- As part of the claim/inquiry services, Cigna tests a sample of claims through validation of benefits (VOB) process. Before a claim is adjudicated, it goes through a series of checks, such as the application of claim validation edits, payment control, cost containment programs like ClaimCheck and fraud and abuse.
- Internal audits of claim payments on a representative, random sample basis.
- A claim review program which determines the reasonableness, appropriateness, accuracy and applicability of all charges on inpatient hospital, outpatient facility, and physician bills.

Also, we would encourage the County Department of Human Resources to enhance its control activities to minimize the risks associated with claims processing as owner of the contractual relationship with Cigna and as the user entity. These control activities would include, but may not be limited to:

- Regular audits/reviews of member eligibility, performance guarantees, discount guarantees, claims, rebates in accordance with contractual limitations to ensure proper administration compliant with contract terms.
- Review performance of cost savings programs through analytical review (change and trend analysis – monthly, quarterly, annually) compared to support and reoccurring meetings/discussion with Cigna (including the comprehensive quarterly briefings). Fees for cost containment are represented as a percentage of net savings or as a percentage of costs recovered. Both the costs and fees recovered should be included within the analysis.
- Review claim expenditures through analytical review (change analysis – monthly, quarterly, annually). Ensure that trends are appropriately explained by Cigna and related support can be provided.
- Review and mitigate customer service issues.

Objectives & Approach

Objectives
RSM performed a medical and pharmacy claims review for the third-party service provider, Cigna, of the self-insured County.

Based on a statistically valid stratified random sample of 225 paid claims, RSM validated whether Cigna is appropriately administering the County's self-insured health plan(s) design(s), including accurate and efficient health and pharmacy claim payments for the period January 1, 2019 through December 31, 2019. Using this sampling methodology allowed RSM to identify patterns of processing errors (if applicable). Cigna provided RSM with an electronic data file (claims data extract file) containing all necessary and agreed upon claims information. We also obtained an understanding of the overall effectiveness of the existing controls over the paid claims process.

Approach
Our approach included a process to attaining the set objectives, the stated scope of work and the planned deliverables. RSM gained an understanding of the County and Cigna's paid claims administration processes related to the managed health benefits through interviews and document reviews. RSM conducted the following procedures as part of our approach with the sample selection:

- Enrollment/Eligibility – Assessed the eligibility of plan member coverage on the date of service;
- Benefits – Assessed the accuracy of deductibles, coinsurances, co-pays, out-of-pocket maximums and other benefit requirements being applied;
- Coordination of Benefits – Assessed the accuracy of benefits application with other insurance coverage such as Medicare or other insurance;
- Demographics – Assessed the correspondence of plan member information with UB-04/1500 (provider claim statement), Explanation of Benefits (EOB) and Cigna system information;
- Referrals and Authorizations – Assessed whether or not referral or authorization requirements were obtained prior to plan member receiving services, as applicable;
- Claim Reimbursement – Assessed whether or not Cigna is paying claims according to its provider contract agreements;
- Claim Payment – Assessed the accuracy of claim payment;
- Provider Status – Assessed hospital and provider network status (i.e., in-network / out-of-network); and
- Validated the use of cost controls if appropriate for each claim sample.

Reporting
At the conclusion of this internal audit, we vetted the facts and exceptions noted during the review with the appropriate Stakeholder(s) and then prepared a draft report based on our findings. Per our agreement, the draft report was submitted to Cigna, and then the appropriate Stakeholder(s) for review. An exit meeting was held with the Stakeholder(s) and RSM to formally review and discuss the draft report and modify accordingly. The report was finalized upon authorization from the Department of Management and Finance.

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