Special Review

Department of Budget and Management

Study of Hospital Claim Audit Methodology

August 2003

Office of Legislative Audits
Department of Legislative Services
Maryland General Assembly
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Delegate Van T. Mitchell, Co-Chair, Joint Audit Committee  
Senator Nathaniel J. McFadden, Co-Chair, Joint Audit Committee  
Members of Joint Audit Committee  
Annapolis, Maryland

Ladies and Gentlemen:

The Office of Legislative Audits conducted a study of the current methodology for auditing self-insured hospital claims for State employees. This study was conducted to identify the practicality of the Department of Budget and Management (DBM) implementing a long unresolved recommendation included in the last three fiscal/compliance audit reports of the DBM – Office of Personnel Services and Benefits (OPSB).

Specifically, our reports have commented upon the decreasing number of hospital claim audits conducted by the administrators of the State’s self-insured health plans. In conjunction with this decreased claim audit activity, the related recovery of overpayments made to providers has also significantly decreased. For example, the claim audit activity of one administrator had decreased from 423 audits in 1992 to 51 in 2000, with recoveries decreasing from $610,000 to $220,000 for those same years. Given the significance of hospital claims paid by the State, which according to OPSB totaled $145.5 million and $170 million in calendar years 2001 and 2002, respectively, we believe this is an important issue that should be resolved. We have repeatedly recommended to DBM that it require plan administrators to audit a minimum number of claims, or assess the cost/benefit of separately contracting for such audits.

The conclusion of this study is that DBM should implement a more aggressive claims audit process. By doing so, DBM could significantly increase recoveries of improper claims payments. This conclusion is based on a comparison of claim audit experience from the State’s self-insured hospital claims with that of Maryland’s Medical Care Programs Administration (MCPA), as well as with other states. For example, MCPA independently contracts with a firm to audit Medicaid hospital claims, and the firm retains a percentage of the recovered overpayments. MCPA has experienced a significantly larger percentage of recoveries compared with claims paid than the State has experienced on its employee healthcare plan hospital claim audits, even though the same hospitals serve both clienteles.
If the MCPA claim audit experience is any indication, and based on our discussions with MCPA’s independent claims auditor we believe it is, the State is likely to experience an increase in overpayment recoveries after putting a more aggressive claims audit process into place. DBM’s response to the study is included as an appendix to this report. We will follow up on the actions taken to address our recommendations during our next fiscal/compliance audit of DBM – OPSB.

Respectfully submitted,

Bruce A. Myers, CPA
Legislative Auditor
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Background

Responsibility for State Employee Healthcare Plans

The Department of Budget and Management’s Office of Personnel Services and Benefits (OPSB) is responsible for administering the State’s healthcare benefits coverage for state employees and retirees.

The State contracts with three major health plan administrators. Two of these vendors administer both preferred provider organization (PPO) and point-of-service (POS) plans, and the third administers only a POS plan. The State also provides health coverage through three health maintenance organizations (HMOs).

The State directly pays claims for the PPO plans, as well as for certain POS services, such as hospital care. It self-funds these plans and accepts the risk for all covered medical costs incurred by the plan enrollees and their dependents. For the remaining POS services and all HMO services, the State pays a premium for medical costs and is fully insured. Fully insured services have been excluded from this study. According to OPSB records, enrollment and costs paid in calendar year 2002 for State employees and retirees in the PPO and POS plans are shown in the following chart:

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Enrollment (as of 12/02)</th>
<th>Actual Claims Paid for Services Provided [in millions]</th>
<th>Administrative Expenses and Premiums Paid [in millions]</th>
<th>Total Payments Calendar Year 2002 [in millions]</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO</td>
<td>48,444</td>
<td>$200.8</td>
<td>$13.4</td>
<td>$214.1</td>
</tr>
<tr>
<td>POS</td>
<td>36,725</td>
<td>133.6</td>
<td>23.5</td>
<td>157.2</td>
</tr>
<tr>
<td>Totals</td>
<td>85,169</td>
<td>334.4</td>
<td>36.9</td>
<td>371.3</td>
</tr>
</tbody>
</table>

Just under half of the healthcare claims paid by the State related to hospital care. The chart on the following page shows the self-insured hospital care costs paid directly by the State through the PPO and POS plans during 2002, as reflected in OPSB records:
### Hospital Claim Audits

One process used by Maryland and other states to help contain the costs of their self-funded employee healthcare benefits is the hospital claim (or bill) audit. The hospital claim audit process entails comparing detailed hospital invoices with supporting documentation, including the related medical records, to determine, among other things, if the services billed by the hospital were actually received, medically necessary, and correctly coded. These audits are performed by specially trained nursing personnel. If an audit discloses discrepancies, the auditor reviews the findings with the hospital, and the hospital adjusts the bill accordingly. The State receives credit for overpayments disclosed by the audit process.

### Limited Scope of Current Hospital Claim Audits of State Employee Healthcare Benefits

This study was conducted due to conditions noted during our prior three fiscal/compliance audits of the OPSB, which were a cause for concern over the adequacy of the State’s hospital claim audit process.

OPSB does not currently contract with any independent firms to specifically perform hospital claim audits. In addition, it does not contractually require the healthcare plan administrators to perform such audits. Rather OPSB’s contracts with the plan administrators require each administrator to maintain a quality assurance process. The largest of the three plan administrators used hospital claim audits as part of its quality assurance process.

According to OPSB, the State paid hospital claims totaling $145.5 million in plan year 2001. Based on information obtained by OPSB and shown in Exhibit 2, the State’s three plan administrators collectively audited 41 hospital claims applicable

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Total of Hospital Claims Paid by State Calendar Year 2002 [in millions]</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO</td>
<td>$104.3</td>
</tr>
<tr>
<td>POS</td>
<td>65.7</td>
</tr>
<tr>
<td>Totals</td>
<td>$170.0</td>
</tr>
</tbody>
</table>
to plan year 2001, and the related recoveries totaled $119,148. The resultant recovery rate for plan year 2001 (the most recent available from OPSB) was 0.082 percent.

During our previous fiscal/compliance audits of OPSB we have commented on a downward trend in the number of hospital claim audits performed by the largest of the State’s three healthcare plan administrators. In our most recent fiscal/compliance audit report dated July 24, 2002, we noted that the total number of hospital claims audited had declined from 423 to 51 between 1992 and 2000, and that the related audit recoveries had declined from $609,876 to $219,170 during the same period. In its response to that report, OPSB stated that the plan administrator had hired an independent contractor to perform additional audits and that this contractor audited 109 more claims from plan years 1999 and 2000. The amount recovered from these 109 claims totaled $19,763. These claim audits and the related recoveries are in addition to those commented upon in the audit report, and generally relate to hospitals outside the Baltimore metropolitan area. See Exhibit 1 for an excerpt from the July 24, 2002 fiscal/compliance audit report and the related agency response.

Based on information provided by OPSB, the most significant portion of the aforementioned decrease occurred between calendar years 1992 and 1993 when the number of audits decreased from the aforementioned 423 to 183, and the amount recovered decreased from $609,876 to $225,980. This decrease occurred at a time when the plan administrator’s contract was modified to eliminate a previously existing provision that paid the plan administrator an hourly fee for audits. This provision, which served as a financial incentive to perform the audits, was deleted from the plan administrator’s contract effective in 1993.

While we do not specifically endorse any particular type of financial incentive, we believe that a successful hospital claims audit program should include some form of incentive-based compensation arrangement, such as a percentage-of-recovery contract. In a 2003 report on share-in-savings contracting, which includes percentage-of-recovery type contracts, the United States General Accounting Office noted that this type of contract was highly effective for motivating contractors to generate savings.
Scope and Methodology

We conducted a study of the current methodology used to audit self-insured hospital claims. Specifically, we wanted to determine the reasonableness of adopting a different approach for ensuring the propriety of self-insured hospital costs paid under the State employee health benefit plans.

To accomplish our task we contacted the Medical Care Programs Administration, who administers the State’s Medicaid program, to review their use of hospital claim audits. We also surveyed other states to determine if they used hospital claim audits or other similar cost containment methods. In addition, we reviewed our prior audits of OPSB. Finally, we obtained and reviewed consultant reports from OPSB related to a recent review of the use of hospital claim audits by plan administrators.

We prepared and sent a formal written survey to 48 states. We asked the states to provide information for the most recent plan year (such as calendar year 2002). The survey was intended to quantify the costs and benefits of each state’s use of hospital claim audits, and to identify operational practices (see Exhibit 4, Hospital Claim Audit Survey). Survey questions covered four areas:

- Background data about the state’s self-funded hospital claim costs and general self-funded healthcare costs
- Operation of the hospital claim audits (including who performed the audits, the timing of the audits, and what was reviewed)
- Benefits derived from the audits (such as the dollar amount of recoveries)
- Audit costs (including how the auditor was compensated)

Since fully insured states pay premiums to cover the cost of benefits and do not directly pay claims, we focused our survey on states with self-funded healthcare benefit plans (similar to Maryland).

Our study did not constitute an audit conducted in accordance with generally accepted government auditing standards.
Findings

Maryland’s Medical Care Programs Administration

As part of our study, we contacted the Maryland Department of Health and Mental Hygiene’s Medical Care Programs Administration (MCPA) to review their process for auditing hospital claims. MCPA informed us that they currently contract with an independent hospital bill auditing firm on a percentage-of-recovery basis. (This is one of the methodologies suggested in our prior audit report recommendation.) The annual hospital claim audit recoveries and hospital claim payment data, as reported by the MCPA, are shown below.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Claim Audit Recoveries [in millions]</td>
<td>$2.8</td>
<td>$1.9</td>
<td>$4.3</td>
<td>$5.2</td>
<td>$4.1</td>
</tr>
<tr>
<td>Hospital Claim Payments [in millions]</td>
<td>$429.6</td>
<td>$383.9</td>
<td>$371.2</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Recovery Rate</td>
<td>0.658%</td>
<td>0.494%</td>
<td>1.171%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

N/A – Not available

Although not conclusive evidence of the effectiveness of this type of audit process, the MCPA recovery rate (0.494 percent for fiscal year 2001) is greater than the rate achieved through the current hospital bill audits conducted by the State’s self-insured health plan administrator (0.082 percent for calendar year 2001).

When drawing a comparison between the MCPA and State employee health plan audits, we were aware that there may be dissimilarities between the benefit plans or the populations served that could materially affect the recovery rates. We noted, however, that generally both populations were served by the same hospitals. Furthermore, MCPA’s independent claims auditor advised us that the Medicaid recoveries were due to common problems, such as services billed but not rendered, and not due to problems specific to the population served.

In conclusion, we believe that if the State’s self-insured health plans adopted an audit methodology similar to that used by MCPA, the hospital claim audit recovery rate would increase.
Survey of Other States

We conducted a survey to determine the hospital claims audit experiences of other states with self-insured employee health plans. Thirty-five states responded to our survey (see Exhibit 4, Hospital Claim Audit Survey). The states’ responses fell into four general categories:

<table>
<thead>
<tr>
<th>Response Type</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performed Hospital Claim Audits</td>
<td>11</td>
</tr>
<tr>
<td>Performed Other Types of Audits¹</td>
<td>8</td>
</tr>
<tr>
<td>Performed No Audits</td>
<td>6</td>
</tr>
<tr>
<td>Did Not Have Any Self-Funded Healthcare Benefit Programs²</td>
<td>10</td>
</tr>
<tr>
<td>Totals</td>
<td>35</td>
</tr>
</tbody>
</table>

¹ Other types of audits included general claims audits, credit balance audits, and diagnosis-related group (DRG) reviews.
² Health benefit programs were funded entirely by premiums paid to insurers or third party administrators.

The detailed responses from the 11 responding states that performed hospital claim audits for self-funded programs were diverse; however we could draw some conclusions about hospital claim audit methodologies.

Background of Self-Funded Respondents

- The states that performed hospital claim audits generally had larger self-funded employee healthcare benefit programs than those that did not perform such audits. Ten of the 11 states indicated they had more than 90,000 enrollees. Eight of the 11 states reported annual total self-funded benefit costs exceeding $550 million. By comparison, Maryland had 85,000 enrollees with self-funded benefit costs totaling $334.4 million.
- States with smaller self-funded benefit programs generally did not perform audits. Three of the six states that did not conduct audits reported having 20,000 or fewer enrollees. Five of the six states indicated annual total self-funded benefits costs of $200 million or less. One of the six states did not provide statistical information.
**Operation of Hospital Claim Audits**

- The 11 respondents that performed hospital claim audits noted that they used their health plan administrator, an independently contracted auditor, a state agency, or a combination of these, to perform audits. Maryland used their health plan administrators to perform the audits.
- Most of the auditors, including Maryland’s, verified one or more of the following characteristics for tested claims: eligibility, medical necessity, receipt of service, receipt of necessary pre-approvals and pre-certifications, coordination of benefits, and correctness of payment.
- All 11 states and Maryland used claims with high dollar amounts as criteria for selecting claims to audit. In addition, some states, including Maryland, used additional criteria (including the use of certain diagnosis codes) and statistical sampling to select claims.

**Benefits of Hospital Claim Audits**

Seven of the 11 states that performed hospital claim audits provided us with the requested information regarding claims audited and related recoveries, three of the 11 only provided some of this data, and one state did not provide any of the requested data. The information provided, as outlined below, represents the most recent year as reported by the states.

- The number of claims audited ranged from 39 to 1,572, with a median of 570.
- The total claim dollars audited ranged from $833,985 to $80,575,680, with a median of $3,988,000.
- The number of claims audited that resulted in recoveries ranged from 37 to 742, with a median of 379.
- The total dollar amount of recoveries (after deducting the cost of the related audits) ranged from $79,200 to $13,354,715, with a median of $1,247,220.

These states generally performed substantially more audits and recovered more claim costs than did Maryland (see Exhibit 2, Results of States that Perform Hospital Claim Audits).

**Costs of Hospital Claim Audits**

- For all six states that provided us with the costs of audits performed, the amount of the audit recoveries exceeded the related costs (see Exhibit 3, Cost and Compensation Methods of Hospital Claim Audits).
• States used a variety of compensation methods to pay for the audits. The methods used included percentage-of-recovery, fee per dollar amount of claims audited, flat fee, or a combination of these. Some states also indicated that audit costs were included in the healthcare plan administrator’s contract cost (see Exhibit 3, Cost and Compensation Methods of Hospital Claim Audits).

Based on our survey results, Maryland’s claim audit activity appears to be less aggressive when compared to other states with large self-insured employee health plans.

**Consultant Reports**

In response to the July 2002 fiscal/compliance audit report, OPSB requested a consultant to review the hospital claims audit processes used by the three plan administrators. In its report on the largest plan’s administrator (the one that experienced the reduction from 423 audits in 1992 to 51 audits in 2000), the auditor indicated that the administrator’s audit process was consistent with those of other administrators in the industry. The consultant found that the plan administrator had an internal program in place that “satisfactorily supports” the State’s requirements that high dollar and suspect hospital billings are audited. However, the consultant did not comment on whether the number of audits conducted was satisfactory.

Our prior audit results did not take issue with the plan administrator’s audit methodology or process. Rather, we were commenting on the need for more audits, or a more aggressive audit effort, as might result from the use of a third-party auditor who receives a percentage of overpayments found—similar to the MCPA hospital audit process.

The consultant did mention that the reason for the reduction in overpayment recoveries over the past several years was because the hospitals implemented an internal nurse auditing process, which acts as a check on the findings of the plan administrator’s audit results, and often challenges the results. However, as previously noted, MCPA has experienced a significantly higher overpayment recovery-to-claims paid ratio than that of the plan administrator. Given MCPA’s audit results of the same hospitals, the internal nurse auditing process at those hospitals may not be a significant factor.

The same consultant also reviewed the State’s other two self-insured plan administrators. The consultant commented that one of these administrators was somewhat passive in its evaluation of the accuracy of hospital claims, given that only seven claim audits were conducted during the period from 1999 to 2001. However, the consultant also indicated that the administrator had a satisfactory
program of claim review prior to bill payment, and the resultant savings were substantial. We contacted the consultant who stated that it had not reviewed any documentation supporting these cost savings and would review this documentation as part of a future review. The consultant indicated that the third plan administrator did not perform any audits.

In conclusion, the consultant’s reports indicated that the plan administrators generally have processes in place to review the propriety of hospital claims, although the smallest of the administrators had no formal review process in place. However, the reports did not comment on whether the quantity reviewed by the administrators was adequate, or if adding incentives to the claims audit process could increase claims audit recoveries.
Conclusions

The recovery rate of Maryland’s employee healthcare plans’ hospital claim audits is less than the recovery rate that MCPA is experiencing for its claim audit program of similar hospitals. Furthermore, based on the size of Maryland’s health benefit programs, the survey results indicate that Maryland has less audit coverage when compared to other states with somewhat larger programs. Therefore, it is reasonable to expect that there may be significant recoveries available if a more aggressive audit process were implemented by OPSB.

Accordingly, we continue to believe that the State should increase the number of hospital claims audited. OPSB could accomplish this by either (1) contracting with an independent firm to audit hospital claims from the State’s self-funded healthcare benefit plans, or (2) including a provision in its contracts with the plan administrators requiring a certain number of such audits. In addition, if a separate contractor is used, we believe that OPSB should use a percentage-of-recovery or other shared recovery method to compensate the contractor and encourage greater effort. These types of contracts have the added benefit of not requiring the State to pay for services that do not generate results.

Also, to help identify tangible benefits, OPBS should maintain statistics regarding the number and amount of claims audited, as well as the related results (that is, recoveries and fees paid). These statistics should subsequently be used to monitor the audit effectiveness, and to determine if the process should be revised or continued.
**Exhibit 1**

**Hospital Claims Audits Report Finding and Department of Budget and Management Response**

**Report Dated July 24, 2002**

<table>
<thead>
<tr>
<th>Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Office did not require the plan administrators to audit a minimum number of hospital claims or assess the cost/benefits of independently contracting for such audits.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Although the plan administrators were contractually required to audit hospital claims, the contracts did not specify a minimum number of claims to be audited. As noted in our two preceding audit reports, the number of hospital claims audited by one large administrator and related recoveries have continued to decline. In addition, the Office did not assess the cost/benefits of continuing this arrangement or independently contracting for such audits as recommended in the preceding audit.</td>
</tr>
</tbody>
</table>

Plan administrators audited hospital claims internally by reviewing supporting documentation (such as patient records) to determine the propriety of hospital billings they paid on the State’s behalf. The number of hospital claims audited by this administrator, and the related audit recoveries have declined between 1992 and 2000. Claims audited have declined from 423 to 51 between 1992 and 2000, respectively and audit recoveries have declined from $609,876 to $219,170 during the same period. Hospital claims paid by this administrator totaled approximately $38.8 million during calendar year 2000.

In our opinion, this decrease is due at least in part to the failure to contractually require a minimum number of audits. While the health insurance auditors were required to review certain aspects of the administrators’ audit processes for hospital claims, the requirements did not include determining the cost/benefit of the process. Similar conditions have been commented upon in our two preceding audit reports.

<table>
<thead>
<tr>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>We again recommend that the Office analyze the administrators’ audit processes for hospital claims and assess the cost/benefits of continuing the current arrangement or independently contracting for such audits. If the Office determines that the current arrangement should continue, we recommend that the Office modify the existing contracts to specify a minimum number of hospital claims to be audited by the administrators. If however, the Office determines that obtaining independent contract audits of hospital claims would be cost beneficial, we again recommend that the Office procure the claims audit services and consider paying for such services on a percentage-of-recoveries basis as an incentive to the contractors.</td>
</tr>
</tbody>
</table>
DBM Response:
At the recommendation of the Legislative Auditors, the Office included language in the current audit contract for review of any internal vendor audits. The contract auditor verified that internal audits were being conducted by the administrators. However, the Office learned that the contract auditor was not performing a review of the Hospital Bill Audits to the fullest extent as specified in the audit contract, which should have included an assessment of the cost/benefits of continuing the current arrangement or independently contracting for such audits. The Office has since clarified the scope of the audit review, and the audit contractor has agreed to comply with the Office’s recommendation. We anticipated a response to the requirement for the 2000 audit by June 2000. However since the health plans were unable to retrieve historical data quickly, the report has been rescheduled for completion at the end of August 2002. The 2001 audit response due at the end of 2002 will also include this review.

The audit report noted that the number of claims audited under the Hospital Bill Audit Program by one administrator went from 423 claims to 51 claims and that the decline was due in part to not requiring a minimum number of claims to be audited. The administrator has informed the Office that their audit methodology changed. In addition to the Hospital Bill Audit Program, a High Dollar Audit Program and Outsource Audits were also being performed. The claims examined under these audits are reported separately. For instance, for the period of time, July 2001 through December 2001, there were 109 claims examined through Outsourced Audits.

This is the reason the Office believes that it appears the number of claims audited declined, not that the number of claims audited were reduced, but that the audit methodology was modified as described above. The plan administrator advised the Office that these audits are conducted on its book of business, but that any recoveries are applied to the account to which the claim was charged. Therefore, the State would receive any recoveries through these audits. It is the Office’s opinion that the audit programs in place allow for the same review as previously performed. The contract auditor will verify any recoveries as part of their review.
## Exhibit 2
### Results of States That Perform Hospital Claim Audits

<table>
<thead>
<tr>
<th>State</th>
<th>Plan Year</th>
<th>Number of Employees/Retirees Covered</th>
<th>Total Cost of Self-Insured Benefits (Excluding Pharmacy)</th>
<th>Number of Hospital Audits Performed</th>
<th>Total Costs of Hospital Claims Audited</th>
<th>Number of Hospital Claims Audited with Recoveries</th>
<th>Total Dollar Amount of Hospital Recoveries (Net of Audit Costs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>2002</td>
<td>&gt;110,000</td>
<td>$550,000,001 to $600,000,000</td>
<td>1,572</td>
<td>N/A</td>
<td>N/A</td>
<td>$13,354,715</td>
</tr>
<tr>
<td>North Carolina</td>
<td>2002</td>
<td>&gt;110,000</td>
<td>&gt;$600,000,000</td>
<td>1,500 (est.)</td>
<td>$15,000,000 (est.)</td>
<td>400 (est.)</td>
<td>$4,000,000 (est.)</td>
</tr>
<tr>
<td>Louisiana</td>
<td>2002</td>
<td>90,001 to 100,000</td>
<td>$350,000,001 to $400,000,000</td>
<td>615</td>
<td>$31,102,986</td>
<td>615</td>
<td>$3,713,597</td>
</tr>
<tr>
<td>Tennessee</td>
<td>2001</td>
<td>&gt;110,000</td>
<td>&gt;$600,000,000</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$1,800,000</td>
</tr>
<tr>
<td>Texas</td>
<td>2002</td>
<td>&gt;110,000</td>
<td>$550,000,001 to $600,000,000</td>
<td>N/A</td>
<td>N/A</td>
<td>742</td>
<td>$1,500,000</td>
</tr>
<tr>
<td>Illinois</td>
<td>2002</td>
<td>&gt;110,000</td>
<td>&gt;$600,000,000</td>
<td>524</td>
<td>$80,575,680</td>
<td>445</td>
<td>$994,440</td>
</tr>
<tr>
<td>New York</td>
<td>2001</td>
<td>&gt;110,000</td>
<td>&gt;$600,000,000</td>
<td>1,553</td>
<td>$2,400,000</td>
<td>357</td>
<td>$806,000</td>
</tr>
<tr>
<td>Georgia</td>
<td>2002</td>
<td>&gt;110,000</td>
<td>&gt;$600,000,000</td>
<td>464</td>
<td>$833,985</td>
<td>211</td>
<td>$567,702</td>
</tr>
<tr>
<td>South Carolina</td>
<td>2002</td>
<td>&gt;110,000</td>
<td>&gt;$600,000,000</td>
<td>100</td>
<td>$1,935,586</td>
<td>100</td>
<td>$453,461</td>
</tr>
<tr>
<td>Maryland</td>
<td>2001</td>
<td>80,001 to 90,000</td>
<td>$300,000,001 to $350,000,000</td>
<td>41</td>
<td>$2,300,000 (est.)</td>
<td>41</td>
<td>$119,148</td>
</tr>
<tr>
<td>South Dakota</td>
<td>2002</td>
<td>&lt;20,000</td>
<td>&lt;$100,000,000</td>
<td>39</td>
<td>$3,988,000</td>
<td>37</td>
<td>$79,200</td>
</tr>
<tr>
<td>West Virginia</td>
<td>2002</td>
<td>90,001 to 100,000</td>
<td>$350,000,001 to $400,000,000</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

N/A – Not available
## Exhibit 3
Cost and Compensation Methods of Hospital Claim Audits

<table>
<thead>
<tr>
<th>State</th>
<th>Plan Year</th>
<th>Number of Employees/Retirees Covered</th>
<th>Total Cost of Self-Insured Benefits (Excluding Pharmacy)</th>
<th>Total Costs of Hospital Claim Audits</th>
<th>Main Compensation Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>2002</td>
<td>&gt;110,000</td>
<td>$550,000,001 to $600,000,000</td>
<td>N/A</td>
<td>Percentage-of-Recovery</td>
</tr>
<tr>
<td>North Carolina</td>
<td>2002</td>
<td>&gt;110,000</td>
<td>&gt;$600,000,000</td>
<td>N/A</td>
<td>No specific fee – plan administrator’s contract requires audits</td>
</tr>
<tr>
<td>Louisiana</td>
<td>2002</td>
<td>90,001 to 100,000</td>
<td>$350,000,001 to $400,000,000</td>
<td>$263,201</td>
<td>No specific fee – state agency performs audits</td>
</tr>
<tr>
<td>Tennessee</td>
<td>2001</td>
<td>&gt;110,000</td>
<td>&gt;$600,000,000</td>
<td>N/A</td>
<td>No specific fee – plan administrator’s contract requires audits</td>
</tr>
<tr>
<td>Texas</td>
<td>2002</td>
<td>&gt;110,000</td>
<td>$550,000,001 to $600,000,000</td>
<td>N/A</td>
<td>Percentage-of-Recovery</td>
</tr>
<tr>
<td>Illinois</td>
<td>2002</td>
<td>&gt;110,000</td>
<td>&gt;$600,000,000</td>
<td>$297,040</td>
<td>Percentage-of-Recovery</td>
</tr>
<tr>
<td>New York</td>
<td>2001</td>
<td>&gt;110,000</td>
<td>&gt;$600,000,000</td>
<td>$78,189</td>
<td>No specific fee – state agency performs audits</td>
</tr>
<tr>
<td>Georgia</td>
<td>2002</td>
<td>&gt;110,000</td>
<td>&gt;$600,000,000</td>
<td>$266,283</td>
<td>Fee per dollar amount of claims audited</td>
</tr>
<tr>
<td>South Carolina</td>
<td>2002</td>
<td>&gt;110,000</td>
<td>&gt;$600,000,000</td>
<td>$260,390</td>
<td>No specific fee – plan administrator’s contract requires audits</td>
</tr>
<tr>
<td>Maryland</td>
<td>2001</td>
<td>80,001 to 90,000</td>
<td>$300,000,001 to $350,000,000</td>
<td>N/A</td>
<td>No specific fee – plan administrator’s contract requires audits</td>
</tr>
<tr>
<td>South Dakota</td>
<td>2002</td>
<td>&lt;20,000</td>
<td>&lt;$100,000,000</td>
<td>$55,500</td>
<td>Fee per dollar amount of claims audited</td>
</tr>
<tr>
<td>West Virginia</td>
<td>2002</td>
<td>90,001 to 100,000</td>
<td>$350,000,001 to $400,000,000</td>
<td>N/A</td>
<td>No specific fee – plan administrator’s contract requires audits</td>
</tr>
</tbody>
</table>

N/A – not available
The purpose of this questionnaire is to obtain information regarding your state’s procedures to identify and recover overpayments for self-insured hospital claims submitted under your state employee/retiree health care benefit plans. If your state’s self-insured hospital claims submitted under your employee/retiree health care benefit plans are not audited, then please complete questions 1 through 7 and proceed to question 18 to include any additional comments as needed. Since we are only obtaining information related to self-insured employee/retiree health benefit plans, please do not include any costs or figures that include managed care organizations (such as HMOs) or prescription benefit plans.

Please take the time to complete the questionnaire and return it to us via fax, e-mail or, if applicable, in the enclosed postage-paid envelope by February 26, 2003. Thank you for your cooperation.

1. What state are you reporting on? _____________________________

Questions 2, 3, and 4 are to obtain demographic and statistical information regarding your state’s self-insured employee/retiree health care benefit plans. Please do not include information related to managed care organizations and prescription benefit plans.

2. What was the number and related dollar amount of self-insured hospital claims paid under your employee/retiree health care benefit plans for the most recent plan year where such information is available. Please note the plan year ______________________.

<table>
<thead>
<tr>
<th>Number of self-insured hospital claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1,000</td>
</tr>
<tr>
<td>1001 to 2,000</td>
</tr>
<tr>
<td>2,001 to 3,000</td>
</tr>
<tr>
<td>3,001 to 4,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dollar value of self-insured hospital claims paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $5,000,000</td>
</tr>
<tr>
<td>$5,000,001 - $10,000,000</td>
</tr>
<tr>
<td>$10,000,001 - $15,000,000</td>
</tr>
<tr>
<td>$15,000,001 - $20,000,000</td>
</tr>
</tbody>
</table>
3. Approximately how many employees and/or retirees were covered by your state’s self-insured health care benefit plans in the most recent plan year? Please note the plan year ________________?

- Under 20,000
- 20,001 to 30,000
- 30,001 to 40,000
- 40,001 to 50,000
- 50,001 to 60,000
- 60,001 to 70,000
- 70,001 to 80,000
- 80,001 to 90,000
- 90,001 to 100,000
- 100,001 to 110,000
- Over 110,000

4. What was the approximate cost of your employee/retiree health care benefit plans for the most recent plan year, including any administrative costs but excluding managed care organizations and prescription drug plans? Please note the plan year ________________.

- Under $100,000,000
- $100,001,000 - $150,000,000
- $150,001,000 - $200,000,000
- $200,000,001 - $250,000,000
- $250,000,001 - $300,000,000
- $300,000,001 - $350,000,000
- $350,000,001 - $400,000,000
- $400,000,001 - $450,000,000
- $450,000,001 - $500,000,000
- $500,000,001 - $550,000,000
- $550,000,001 - $600,000,000
- $600,000,001 - $650,000,000
- Over $600,000,000

5. Does your state have a process for auditing self-insured hospital claims paid under your employee/retiree health care benefit plans?

- Yes
- No (Please answer questions 6. and 7. below and then proceed to question 18)

6. Do you use any other processes to ensure the accuracy and propriety of hospital claims?

- Yes (Specify) ________________________________________________
- No

7. If you do not use audits or other methods to ensure the accuracy and propriety of hospital claims, have you considered using audits?

- Yes (If “Yes”, please indicate why your state did not select this method.)
  ________________________________________________
  ________________________________________________
- No
8. Who performs the audits of self-insured hospital claims?
   _____ Health care plan administrator (e.g., Blue Cross/Blue Shield)
   _____ Independently contracted auditor
   _____ State agency  (*Please proceed to question 10*)
   _____ Other  (*Please note*) ________________________________

9. How is the health care plan administrator or the independently contracted auditor compensated for these audits?
   _____ Percentage-of-recovery (*Please note %*) _____________________
   _____ Fee-per-claim/audit (*Please note the most recent fee*) ________
   _____ Flat fee (*Please note fee*) ________________________________
   _____ No specific compensation (i.e., plan administrator contract requires audits)
   _____ Other  (*Please note*) ________________________________

10. How often are hospital claim audits performed?
    _____ Ongoing
    _____ Annually
    _____ Semi-annually
    _____ Other  (*Please note*) ________________________________

11. When are the hospital claim audits performed?
    _____ Prospectively (prior to payment)
    _____ Retrospectively (after payment)
12. What is the purpose of hospital claim audits? *(Please check all applicable answers)*

- [ ] Verification of eligibility
- [ ] Verification that services were medically necessary
- [ ] Verification that services were actually received
- [ ] Verification of all necessary pre-approvals and pre-certifications
- [ ] Verification of coordination of benefits with other third parties
- [ ] Verification of correctness of payment
- [ ] Other *(Please note )*______________________________

13. What criteria are used to select claims for review *(check off all that apply)*?

- [ ] High dollar values *(Please note $ level that triggers the audit)*
  
  ______________

- [ ] Certain medical procedures performed *(Please indicate procedures or procedure codes)*
  
  __________________________________________________________________________________________

- [ ] Random statistical sampling (e.g., stratified)

- [ ] Other *(Please note )*______________________________

14. Is there a contractually required minimum number or percentage of hospital claims that have to be audited?

- [ ] Yes *(Please note )*______________________________

- [ ] No

15. How many hospital claims were audited in the most recent plan year? What were the related costs of these claims? Please note the plan year ___________________.

  Number ___________________

  Amount $____________________
16. How many of the claims audited resulted in recoveries to the State? What was the amount of the recoveries (net of any audit recovery commissions)? Please note the plan year ___________________.

   Number ______________________
   Amount $_____________________  

17. What was the related cost for those audits that resulted in the recoveries identified in question 16? $_____________________  

18. Additional Comments – Please include any comments below that you feel are necessary to further explain the answers provided above or any other information that you believe would aid us in understanding your state’s process of ensuring the accuracy and propriety of hospital claims paid under your employee/retiree health benefit plans. Attach additional sheets as needed.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please indicate below the name, title, and phone number of the individual who completed the questionnaire.

Name (please print)

Title

Phone Number

E-mail Address (optional)
Mr. Bruce A. Myers, CPA
Legislative Auditor
Department of Legislative Services
Office of Legislative Audits
301 West Preston Street, Room 1202
Baltimore, Maryland 21201

Dear Mr. Myers:

The Department of Budget and Management has reviewed your draft special review on the Department of Budget and Management – Study of Hospital Claim Audit Methodology, submitted to the Department in July 2002. We appreciate the opportunity to provide responses and information pertaining to the findings noted in your review. Our response is attached.

We would like to acknowledge the significant value of the legislative auditor’s recommendation. We agreed to implement the auditor’s recommendation in order to enhance our programs. Also as recommended, we will maintain statistics regarding the number and amount of claims audited, as well as the related results (i.e., recoveries and fees paid) to monitor and audit effectiveness in order to determine if the process should be revised or continued.

If you have any questions or need additional information, you may contact the Executive Director of the Office of Personnel Services and Benefits, Andrea Fulton at 410-767-4715 or 410-260-6365 or me at 410-260-7041.

Sincerely,

James C. DiPaula, Jr.
Secretary

cc: Ms. Andrea M. Fulton, Executive Director, OPSB
The Department’s Office of Personnel Services and Benefits (OPSB) oversees the self-insured health care plans and monitoring of the administration (i.e., payment of claims) related to these plans, including hospital claims audits performed to verify the propriety of hospital claims paid. The study recommends that the State increase the number of hospital claims audited. It further recommends that OPSB could accomplish this by contracting with an independent firm, using a percentage-of-recovery or other shared recovery method to compensate the contractor to encourage greater effort, to audit hospital claims from the State’s self-funded healthcare benefit plans. Although the Department does not necessarily agree with all the findings or comparisons made in the auditors’ study, we do believe that improvements to the current processes could be made. To enhance these current programs in place, the Department will agree to implement the auditors’ recommendations. OPSB is currently researching the most efficient and economical way to accomplish this.

As also recommended by the study, OPSB will maintain statistics regarding the number and amount of claims audited, as well as the related results (i.e., recoveries and fees paid) to monitor and audit effectiveness in order to determine if the process should be revised or continued.

It is our understanding that using a percentage-of-recovery method would only be effective if DBM decides to contract with an independent auditor to perform the hospital claim audits. Per the results noted in the auditors’ study, only three of the 11 states that conducted hospital claim audits used a percentage-of-recovery method to compensate the contractor who conducted the hospital claim audits. In two states, the contractor who conducted these audits was also the Health Care Plan Administrator. In a previous legislative audit report, the legislative auditors recommended that a contractor hired by the State and independent of the healthcare benefits administrator should perform the hospital claim audits to preclude any possible conflicts of interest. At that time, the State’s Health Care Plan Administrator’s contract included a provision that paid the plan administrator an hourly fee for these audits, supposedly serving as an incentive to perform the audits. OPSB is, thus, concerned that placing such incentives as percentage-of-recovery or other shared recovery method on hospital claim audits conducted by the Health Care Plan Administrators may decrease the checks and reviews performed prior to payment of claims, referring to the ‘conflict of interest’ previously noted by the auditors in that there would be less of an incentive to conduct reviews of the propriety of claims paid prior to their payment. For the two states that used a percentage of recovery for hospital claim audits conducted by the health care plan administrators, it is not determined if this had an effect on any reviews of claims conducted by the health care plan administrators prior to the administrator’s payment of claims.

In their study, the auditors comment on the decline in the number of claims audited and specifically recommend that the State should increase the number of hospital claims audited. The Department feels that the audit procedures performed by the State’s health care plan administrators have caused a reduction in the number of claims necessary to be audited. For example, system edits may allow for identifying adjustments or corrections
prior to payment of claims, reducing the need for actual bill audits. In response to a
finding noted in a previous audit regarding the decline in the number of claims audited,
one administrator informed DBM that the reason for the decline was due to a change in
their audit methodology. Based on discussions with the other two Health Care Plan
Administrators and given reviews performed by OPSB’s independent auditor contracted
to audit the Health Care Plan Administrators, this change in audit methodology includes
reviews conducted prior to payment of claims, as well as other post-payment reviews or
audits conducted to verify the propriety of claims paid that are not necessarily considered
“hospital claim audits”. It appears that all of the three health plan administrators have only
counted those claims audited ‘on-site’, post-payment as an actual hospital claim audit.
However, at least two administrators have described pre-payment audits conducted and
other post-payment audits performed (e.g., desk audits conducted off-site, not at the
hospital) that would not be considered a ‘hospital claim audit’ but have resulted in savings
and/or recoveries.

One administrator uses a “High Dollar Audit Program,” in addition to its Hospital Claim
Audits, that helps to detect whether or not services were rendered. Under this program,
all claims exceeding a specific dollar amount are extracted from the database of paid
claims and reviewed to determine, based on several factors, if it is anticipated that there
will be a finding of overcharges or error and, if so, the claim is then forwarded for a field
(onsite) audit. If forwarded for a field audit, registered nurses review the detail charges on
the claims by examining supporting documentation. These audits appear to be conducted
prior to payment of the claim. Furthermore, this administrator also notified DBM that
they outsourced the hospital claim audits for hospitals where, historically, the findings
were small. The figures related to these outsourced audits are reported separately from
the internally performed hospital claim audits. Per the administrator, for the period of
time, July 2001 through December 2001, there were 109 claims examined through
outsourced audits.

Another administrator conducts post-payment desk reviews, as a part of the selection
process for the onsite reviews (i.e., actual hospital claim audits). This administrator’s
internal Claims Review Unit reviews claims exceeding a certain dollar threshold (e.g.,
$25,000) to determine if any billed items should be denied based on authorization notes or
due to plan provisions or internal policies. If further review is deemed necessary, the bill
or claim is selected for an onsite audit (i.e., hospital claim audit). This internal ‘desk
audit’ is not counted as a ‘hospital claim audit’. Furthermore, this administrator indicated
that it performs a prepayment review of all inpatient claims exceeding $3,000. This
internal review process identifies billing and coding inconsistencies. In this process, all
claims that meet the initial dollar threshold are reviewed and charges may either be denied
or additional information may be requested and only the remainder of the claim is paid
based on the providers contract and the member’s benefit. Per the administrator, for Plan
Year 2001, 1,726 claims were reviewed under this internal process (prior to payment of
the claim/bill) and the related findings were approximately $7,618,400. Finally, this
administrator also noted that extensive clinical reviews are conducted by their Clinical
Care Coordination Department with nursing and physician staff onsite.
One administrator admitted that they had not conducted any hospital claim audits. However, this administrator has contracted with an independent contract auditor to perform hospital claim audits, and is using a percentage-of-recovery method to compensate the independent contractor.

Thus, given all the above factors, the “41” hospital claim audits conducted in plan year 2001, as reported in Exhibit 2 of the auditors’ study, does not include any additional outsourced audits (per one administrator, 109 conducted during the period of July 2001 to December 2001) or any internal reviews conducted prior to payment of claim (1,726 during plan year 2001, per one administrator). Furthermore, in comparison to the figures reported by other states, it is uncertain as to whether the figures noted of hospital claim audits conducted include reviews conducted prior to and/or after payment was made.

OPS B will contact Medical Care Programs Administration (MCPA) to determine if an audit methodology similar to what they have can be used for the State’s self-insured health plans. OPSB is looking into what factors, such as the use of a health care plan administrator and their possible use of pre-payment review of claims, may have had an affect on the amount of recoveries found and may be a cause for some of the difference between the amounts recovered by MCPA vs. OPSB. This would be helpful in determining what types of results are to be expected if decided OPSB should implement a similar audit methodology for the State’s self-insured health plans. Furthermore, it is noted that although the hospital claims paid by MCPA increased from $371.2 million in FY2000 to $429.6 million in FY2002, the related amount of recoveries decreased from $4.3 million in FY2000 to $2.8 million in FY2002. OPSB will question MCPA what factors may have caused this decrease in recoveries in determine what effect this may have on implementing a similar program with the State’s self-insured health plans.

One area that OPSB will consider is the review of both outpatient as well as inpatient hospital claims. Currently, approximately two-thirds of hospital claims paid are for inpatient services, which is why hospital claim audit efforts have been focused here. However, in the future, OPSB will require review of both inpatient and outpatient claims. MCPA as well as many other states appeared to include review of both inpatient and outpatient claims in their hospital audits.

As previously stated, the Department does not necessarily agree with all the findings or comparisons made in the auditors’ study. However, we do believe that improvements to the current processes could be made. To enhance these current programs in place, the Department will agree to implement the auditors’ recommendations. OPSB is currently researching the most efficient and economical way to accomplish this.
AUDIT TEAM

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