Exhibit 1

Office of the County Auditor
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March 1, 2016

TO: Mayor and Broward County Board of County Commissioners

FROM: Evan A. Lukic, County Auditor

SUBJECT: Review of Healthcare Claims Audit Report performed by Audit Recovery Management Services (ARMS)

This memorandum presents our review of the audit performed by Audit Recovery Management Services (ARMS) of the County's healthcare claims as reported by Humana Health Insurance Company of Florida (Humana) for the year ended December 31, 2013. ARMS performed the audit at our request to determine the accuracy of the $29.7 million of reported claims under the County's fully insured program. The accuracy of reported claims was important because the claims were the basis for establishing the County's premiums under the former fully insured program. With the change to a self-insured program in 2015, accuracy of claims processing is even more essential, now that the County bears a direct risk of loss for inaccurate claims.

The audit disclosed discrepancies totaling $7,269 from a sample of $4.1 million. It is important to note, the sample tested was "specific to typical areas where Health Plans overpay claims". In addition, as noted on page four of the report, both ARMS' auditors and Humana's claim processing system identified 13 claims requiring adjustments of $120,683, giving an indication of the effectiveness of Humana's monitoring process under the former fully insured program.

While the audit report includes a series of recommendations to facilitate monitoring of claims processing, we recommend the Board of County Commissioners direct the County Administrator to take appropriate steps to monitor the healthcare claim payments for accuracy.

EAL/kau/besa

cc: Bertha Henry, County Administrator
Rob Hernandez, Deputy County Administrator
Monica Cepero, Assistant County Administrator
Gretchen Cassini, Assistant to the County Administrator
Alphonso Jefferson, Assistant to the County Administrator
Joni Armstrong Coffey, County Attorney

Final Report

Broward County Government Claims Audit

February 2, 2016

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Executive Summary

At the request of Broward County Auditor's Office (the County), a healthcare claims audit was conducted to assess the accuracy of the County's claims processed by Humana Health Insurance Company of Florida, Inc. (Humana) the County's healthcare plan manager . The audit covered the County's paid claims beginning January 1, 2013 through December 31, 2013 totaling $29,698,548. This report summarizes the observations, audit findings and recommendations of the claims processing and post payment reviews necessary to ensure accuracy of claims payments to all providers.

Our audit team selected a sample of 315 paid claims totaling $4,148,535, which is specific to typical areas where Health Plan's overpay claims. The audit disclosed that 104 claims (33%) reviewed contained discrepancies with a net value of $7,269. Although the dollar amounts of discrepancies was small, the County should monitor the Healthcare claims payments on a quarterly basis or at a minimum annually. This is especially important since the County is self-funded starting January 2015.

Introduction

Purpose: At the request of Broward County Government (BG), a formal claims audit was conducted to assess the claims accuracy of Broward Government claims processed by Humana.

The claims audited represented a selection of paid claims for the time period beginning January 1, 2013 thru December 31, 2013. The paid claims data received contained 381,254 lines with paid dollars of $29,698,548.

Results: This report summarizes the audit findings, observations and recommendations to ensure effective claims processing and post payment reviews necessary to ensure accuracy of payments to all providers.

Audit Scope

The scope of the audit is completely impartial. The methodology was applied to a specific sample of claims that have been paid. Within the scope of this audit, the audit team Audit Recovery Management Services (ARMS) completed the following activities:

- Reviewed and conducted analytics of claims to verify that the applied costs are all associated with BG
- Conducted focused audit review of claims records and costs to detect discrepancies to validate amounts being charged and ensure appropriate credits are applied
- Provided guidance, recommendations and analysis to assess and improve the effectiveness of BG management of health plan
- Provided focus of the audit based on industry knowledge and experience

Claims Audit Process

- Data acquisition
- Claim record verification

- Aggregation of data
- Create algorithms for audit
- Pulled sample of claims from algorithms generated
- Onsite audit reviewing claim systems
- Audit team completed detailed review of each sample claim
- Audit team reviewed claims onsite
- Findings and Recommendations in draft report
- Final written report and audit delivery to BG

Audit Definitions

National Correct Coding Initiatives (NCCI) Edits – Center of Medicare and Medicaid Services (CMS) developed the NCCI to promote national correct coding methods and to control improper coding that leads to inappropriate payment in Medicare Part B claims. NCCI edits prevent improper payments when incorrect code combinations are reported. NCCI edits are updated quarterly. If a claim contains the two codes of an edit pair, the Column One code is eligible for payment, but CMS will deny the Column Two code. However, if both codes are clinically appropriate and you use an appropriate NCCI-associated modifier, the codes in both columns are eligible for payment. Humana has a policy to use these edits as part of their claim processing guidelines.

Inpatient Contract Compliance Audit – Re-pricing and audit of inpatient claims in accordance with the paper contract to ensure claims paid in accordance with the terms of the agreement executed by the Plan.

Outpatient Contract Compliance Audit – Re-pricing and audit of outpatient claims in accordance with the paper contract to ensure claims paid in accordance with the terms of the agreement executed by the Plan.

Duplicates Claims - Any claim submitted by a physician or facility for the same service provided to a particular individual on a specified date of service that was included in a previously submitted claim.

Outpatient claims within inpatient stay - outpatient services billed and reimbursed while the patient was within an inpatient stay, paid under the Inpatient per diem rates and charges.

Findings and Results:

1. **Reviewed and conducted analytics of claims to verify that the applied costs are all associated with BG members**

   Summary of results:
   - BG members with processed claims with services dates between January 1 through December 31, 2013 were reviewed. Our findings indicate that only BG members had paid claims for the dates of services reviewed
   - Five BG members had claims initially paid outside the coverage period but were later adjusted to recover monies paid to providers after the member had no coverage.

2. **Claims Processing Audit Results**

   ARMS generated a sample size of reports specific to typical areas where Health Plan's overpay claims. ARMS audit team attended two separate onsite auditing sessions, March 1-12 and April 13-16, 2015. During the audit sessions, ARMS had direct access to facility

contracts and Humana's claims processing systems. This enabled the audit team to access the claims information required to audit claims and validate the accuracy of the claims payment.

The chart below displays the audit category and detail findings.

Audit Category	Total Claims Sampled	Audit Findings	Sum of Discrepancy Amt	Total Paid
NCCI Edits	89	82	$ 5,448.08	$ 20,320
Duplicates	96	18	$ 871.08	$ 14,583
Inpatient Contract	63	0	$ -	$ 3,327,919
Outpatient Contract	65	3	$ 6.98	$ 774,007
Outpatient within Inpatient	2	1	$ 942.40	$ 11,705
Grand Total	315	104	$ 7,268.54	$ 4,148,535

Summary of Results:

- 315 claims audited with over $4.148 million of paid claims
- 104 claims identified discrepancies with a net value of $7,269

Humana's Response to Audit Results:

- 75 of the 82 audited claims for NCCI totaling $4,240 were upheld by auditors after receiving the following comments from Humana:
    - Humana's response notes "Claim was processed as iHealth recommended at time of processing. Claim is older than 18 months and I am unable to view the Claims Inquiry tool going thru CCP. Email has been sent to Humana asking if there is a way to view the information."
    - Humana's response notes "iHealth does not review COB claims when Humana is secondary payor"
    - Humana's response notes "Provider did not bill code 64415 on claim
        - Auditors contend the code reported as the error on the claims was 64447
- 12 of the 18 duplicate claims overpaid claims equally $478.77 dollars was confirmed by Humana and sent to their Financial Recovery Department for recovery. The other 6 flagged as payment errors, Auditors upheld these payment errors after receiving the following comment:
    - Humana's response notes "different providers on both claims. iHealth allowed both claims to pay"
        - Auditors contend the provider had same specialty within the same office this likely to be a missed bill and a duplicate payment since the same office is billing. – 5 claims totaling $ 368.86 reflects this comment
    - 1 error of $23.45 had no response from Humana

Top reasons for discrepancies

- NCCI edits
- Duplicate overpayments

The chart below lists audited claims identified with errors by auditors but after review Humana's claims system identified that Humana had also identified these payment errors. These payment errors were correctly adjusted within Humana's claims system but were not reflected in the claims data set provided to the auditors.

Discrepancy Type	Discrepancy Amout	Date of Adjustment
Contract Audit Payment	-486.73	3/13/2014
Humana Overpayment Recovery	1818.61	2/5/2014
Transplant Overpayment Recovery	5416.52	2/5/2014
Transplant Overpayment Recovery	5461.86	2/3/2014
Hospital Bill Audit Adjustment	37278.5	7/29/2014
Hospital Bill Audit Adjustment	1649.31	2/18/2014
Coordination of Benefits Overpayment Recovery	64186.11	2/13/2014
CCI Edit Overpayment	935.2	1/29/2014
CCI Edit Overpayment	25.38	2/11/2014
CCI Edit Overpayment	74	2/11/2014
Duplicate Overpayment	1173.46	5/27/2014
Duplicate Overpayment	745.69	7/7/2014
Duplicate Overpayment	1172.74	5/27/2014
Duplicate Overpayment	745.69	7/7/2014

Summary of results:

- Claim errors with adjustments within Humana's claims system but not provided in data set received:
  - 13 claims identified as having claim adjustments but were not reflected in the data set received, totaling $120,683.
  - Adjustments to the claims were made between 3-14-2014 and 7-7-14.

Top reasons for discrepancies

- Transplants and Hospital bill audits payment adjustments were not reflected with the claims data provided to auditors,

Recommendations

Based on ARMS' review of claims paid in 2013 it is highly recommended that additional focused audits continue which facilitates the internal monitoring process for Broward County Government health plan claims. The following are key recommendations:

- Expand internal monitoring processes to include cost containment audits beyond duplicate overpayments. The focused audit program should include, but not be limited to, retro termination, medically unlikely edits, hospital readmissions, national correct coding initiatives(NCCI) including anesthesia, multiple surgery and pre-admission testing
- Conduct monthly or quarterly audits specific to contract compliance reviewing different facility contracts payment methodologies and rates to ensure per diem, carve outs, DRG and percent billed charges are paid correctly

- Require monthly reporting from Plan Administrator to include identifying all subrogation activities including but not limited to subrogation cases pending and closure rate.
- Require monthly reporting from Plan Administrator on claims identified as overpayment and reporting of when overpayments are collected and posted to claims
- Require monthly reporting from Plan Administrator related to hospital audits to include scheduled audits and results of the audits conducted and reporting of when adjustments are made to the claims
- Require monthly reporting from Plan Administrator of all cost containment activities and cost of payment to vendors
- Conduct quarterly random sampling audits to validate the performance metrics reporting by Plan's Administrator to BG
- Conduct quarterly independent audits of Plan Administrator include:
  - Cost containment audits
  - Fraud & abuse profiling audits
  - Subrogation claims audits
- Ensure adjustments are paid on claims at least 30 months from the date of notification to the providers to maximize the opportunity to collect on mis-paid claims
- Validate that all the overpayment identified by Humana to ensure collection and proper reporting
- Consider hiring external auditing firm to conduct quarterly audits to ensure proper payment all claims