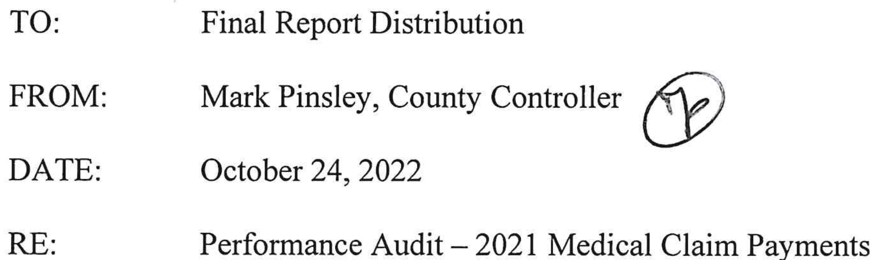
Lehigh County Pennsylvania

OFFICE OF THE CONTROLLER

Mark Pinsley, MBA — COUNTY CONTROLLER

Nanton John, CFE — DEPUTY CONTROLLER



TO: Final Report Distribution

FROM: Mark Pinsley, County Controller

DATE: October 24, 2022

RE: Performance Audit – 2021 Medical Claim Payments

We have completed a performance audit of our Medical Claim Payments for the year 2021. The audit focused on administrative responsibilities, an analysis of paid medical claims in compliance with contractual obligations, and the identification of areas of potential cost savings. Recoveries attributable to this audit totaled approx. $213k, which includes $31k identified by Highmark pertaining to 2021 claims and excludes disputed and potential recoveries/cost-savings. The audit excluded pharmacy/drug payments. Our report number 22-16 is attached. We wish to thank the Office of Administration, McGriff Insurance, Highmark Blue Shield, and John Graham Incorporated for their assistance and cooperation during the audit.

Significant items identified during our audit included:

- An external medical claim audit identified $63k in agreed recoveries (some having been identified by Highmark and reimbursed), $81k in disputed recoveries for sampled and out-of-sample claims, and $143k of additional recovery potential.

- The evaluation of potential savings from competitive medical pricing through a referenced-based structure (e.g., mark-up from Medicare negotiated rates) should be periodically assessed to realize the potential savings of $4M as noted during the County's 2022 medical plan renewal process.

- If referenced-based pricing is not pursued, the Administration should require the payment of outpatient and inpatient hospital rates to be the lower of the Highmark negotiated rates or the hospital cash rates.

- Ownership and controls over the validation of contractual obligations, compliance and payment accuracy should be strengthened.

- Recovered $106k of erroneously billed stop-loss claims.

- Identified and recovered $44k of overpaid commissions.

See *"Schedule of Audit Findings and Recommendations"* and Appendix A for further details.

COUNTY OF LEHIGH, PENNSYLVANIA

MEDICAL CLAIM PAYMENTS

Performance Audit of Medical Claims for the Year 2021

REPORT NO. 22-16

COUNTY OF LEHIGH, PENNSYLVANIA

MEDICAL CLAIM PAYMENTS

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COUNTY OF LEHIGH, PENNSYLVANIA
MEDICAL CLAIM PAYMENTS

Background

The County of Lehigh (COL) operates a self-insured group medical plan for its members, which consists of current employees, spouses, their dependents, and qualified retirees. A self-insured group health plan (referred to as 'self-funded') is one in which the employer assumes the financial risk for providing health care benefits to its employees. The COL pays for each out-of-pocket claim as they are incurred instead of paying a fixed premium to an insurance carrier. Total incurred medical claim costs in 2021 totaled $28M which included medical claims, administrative fees, stop-loss insurance premiums and recoveries, and various other associated fees.

The COL utilizes McGriff Insurance, an insurance risk management broker, to assist with insurance solutions in minimizing medical claim risks. Through this relationship, the COL has contracted with a healthcare insurer, Highmark Blue Shield (HM), to process member medical claims. HM utilizes its relationships with other health networks, hospitals, doctor offices, and third-party healthcare claims processing vendors to reduce related costs for the County.

The Office of Administration is responsible for the management of the plan which includes the selection of a healthcare insurer, negotiation of contracts, contractual compliance, and the validation of costs.

OFFICE OF THE CONTROLLER

Mark Pinsley, MBA — COUNTY CONTROLLER
Nanton John, CFE — DEPUTY CONTROLLER

Edward Hozza, Jr., Director of Administration
Lehigh County Government Center
17 South Seventh Street
Allentown, PA 18101-2400

We have recently completed a performance audit of our Medical Claim Payments for calendar year 2021. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we evaluate and determine that staff performing the audit are independent per the generally accepted government auditing standards for internal auditors. Those standards also require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The scope of our detail audit testing was medical claim payments during the calendar year 2021. Our consideration of internal control was limited to audit testing required to meet audit objective and would not necessarily identify all deficiencies in internal control that might be significant or material weaknesses. Due to the availability of 2021 medical claim data, we amended the scope to include calendar year 2021, not 2020 as originally intended.

Our audit also included sufficient and appropriate tests for fraud, waste and abuse and we included in our report any material (either quantitatively or qualitatively) instances we noted that are material to the audit objectives, however, our audit procedures would not necessarily identify all instances of fraud, waste and abuse that may be reportable. Any findings of waste, even though not material to the audit objectives, are included in writing and were brought to the attention of those in charge of governance.

Our office performed this audit based on our evaluation of county-wide risk assessment. The objective of our audit was to evaluate the adequacy of controls over medical claim costs for Lehigh County plan members. We completed our objective by obtaining and analyzing 2021 medical claim payments to determine:

- If contract requirements with HM and McGriff are transparent and if appropriate access to data is permitted;
- Evaluating HM's System and Organization Control report and findings;
- Understanding all assessed fees and related benefits;
- Testing the accuracy of assessed administration fees;
- Testing the timely removal of terminated participants;
- Reviewing Stop-Loss performance, reporting, and reconciliation;
- Reconciling paid medical claim data file from HM to paid invoices;
- Retaining a Medical Claim Audit Specialist to perform a Paid Claim Audit;
- Whether there were any employee complaints, or instances of fraud that were referred to HM's Special Investigative Unit relating to service providers used by Lehigh County plan members;
- Comparing the cost-competitiveness based on publicly available pricing information against COL paid claims;

Audit criteria and standards included compliance with Highmark contracts and Highmark Life Insurance Company policy. Audit standards applied in performing the audit included generally accepted government auditing standards, and Government Auditing Standards issued by the Comptroller General of the United States.

We achieved our objectives by examining the incurred and paid medical claim payments during 2021. We believe that the audit evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Our audit included an examination of the 2021 medical claims records and related documentation, discussions with the management of the Office of Human Resources, the County Administrator, McGriff Insurance and Highmark representatives, and other external parties. We utilized multiple auditing procedures we considered necessary in the circumstances. In addition, we retained the use of an independent medical audit specialist, John Graham Incorporated, to perform a comprehensive paid claim audit. The audit was led by John Graham who has performed and managed claims audits for self-insured employers for fifteen years and has personally led the recovery of millions of dollars for clients. John has contributed to the development of the industry by significantly increasing acceptance of comprehensive claims audits and developing unique arrangements for clients, including negotiating more aggressive audit rights, enhanced provider contract audits, and higher frequency of claims audits. John's broad healthcare consulting experience also includes financial modeling for healthcare providers and payers, contract management system development and implementation, fee schedule analysis, and strategic planning. He has served as an expert for multiple litigation support projects focused on claims accuracy and testing. John graduated from Duke University with a Bachelor of Arts degree in Economics and earned the Group Benefits Associate designation through International Foundation of Employee Benefit Plans. See Appendix A regarding nature and scope of the work performed and findings.

We concluded that the adequacy of internal controls over medical claim costs for Lehigh County plan members are inadequate. The Office of Administration needs to actively manage the validation of benefits received to paid costs, ensure the accuracy of payments in compliance with plan documents/agreements, advocate for greater transparency and accessibility to claims data, actively pursue cost effective alternatives, such as referenced-based pricing, and periodically retain a medical claim specialist to perform an independent paid claim audit to verify accuracy of claims processing.

We noted certain matters that we reported to management of the Office of Administration in a separate section titled "Schedule of Audit Findings and Recommendations". The Office of Administration's response to our audit is included in this report (page 31). We did not audit the Office of Administration's response and, accordingly, we do not express an opinion on it.

This report is intended for the information and use of the Department of Administration and other affected county offices. However, this report is a matter of public record and its distribution is not limited. If you have any questions, please feel free to contact me.

MARK PINSLEY

Lehigh County Controller

October 21, 2022
Allentown, Pennsylvania
Audited by: Joseph Buick

Final Distribution:
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Board of Commissioners
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Karina Kane, Highmark Senior Client Manager
John Graham, John Graham Inc. President
Timothy Reeves, Chief Fiscal Officer

Schedule of Audit Findings and Recommendations

1. Paid Claims Audit

Condition: The County of Lehigh's Controller's Office contracted with John Graham Incorporated to perform a paid claim audit for the year 2021. Please see attachment A for the issued audit report which includes an executive summary, an overview of the audit process, agreed findings, disputed findings, and informational findings.

Recommendations: Based on the paid claim audit findings, we recommend that the Office of Administration should pursue the following:

Agreed Recoveries:

- All agreed recoveries ($63k) should be verified as received from Highmark. This includes the reimbursement of $27k due to Highmark missing the timeframe submission to Medicare.

Disputed Findings:

- Review the intent of the Medicare Part B deductible under our Signature 65 plan and ensure alignment with our agreement/contract with Highmark. Gain understanding why some deductibles were agreed recoveries and the remaining are not.
- Highmark should be notified to recover claims on retroactive terminations ($35k – sampled and out-of-sample balances), and future contracts should include their proactive pursuit of amounts paid on claims from retroactive terminations.
- Confirm eligibility for identified newborn grandchildren coverage ($41k). If eligibility cannot be confirmed, and coverage is not included in our plan, recovery should be pursued.
- Review with Highmark the various other identified disputed findings: paying in excess of plan limit (routine examinations, nutritional counseling, maintenance care), and coverage of cochlear implants and other hearing devices.

Informational Findings:

- Evaluation of adding provisions for Medicare estimation to provide financial incentives for members to enroll in Medicare, reducing claim costs.
- Evaluation of family members with over $1M of paid drug treatment without clinical review by Highmark.
- Review the plan's intention regarding multiple co-pays per day.
- Evaluate and align the limit on skilled nursing facility coverage between 100 days and the contract year.
- Gain a greater understanding of the Quality Blue charges, their related benefits, and confirm adherence with program criteria prior to payment.

In addition, we recommend that the Office of Administration periodically request a paid claim audit with a comprehensive claims audit scope. This type of audit, by a medical claim specialist, will provide the County assurance that our medical claim insurer is processing and adjudicating our claims in compliance with our contract/agreement.

2. <u>Competitive Pricing</u>

Condition: In 2021, the County had a contract with Highmark to process and pay County employee and retiree medical claims. The County established this relationship to take advantage of Highmark's negotiated rates with health networks, hospitals, doctor offices, and third-party healthcare claims processing vendors to reduce related costs to the County.

Over the last several years there have been laws/regulations passed designed to provide increased transparency to buyers of healthcare:

- Transparency in Coverage Final Rule - aimed at insurers and plans;
- Hospital Price Transparency Final Rule - aimed at hospitals;
- Consolidated Appropriations Act of 2021 (CAA) - impacts plans, insurers, providers and plan service providers;
- No Surprises Act - governs many disputes arising from emergency care and non-network care at network hospitals and emergency rooms and dictates the behavior of providers, facilities, and payers/plans.

One of the provisions within the CAA mandates hospitals to provide clear, accessible pricing information to assist consumers to shop and compare prices across hospitals. Hospitals are supposed to provide public access to all their contract pricing and other pricing they make available to consumers. However, not all hospitals in our local area are completely compliant with this Act.

We were able to obtain 'cash pricing' also known as 'self-pay' pricing which is the price that a consumer without insurance would pay from some of our local hospitals. This information was not available for every medical procedure the County paid for in 2021; however, using pricing data from area hospitals and our paid claims data, we compared available procedure code pricing to listed 'cash-pricing' and Medicare costs. An exact savings of cash pricing could not be determined because, although requested, the 2021 claims file received from Highmark did not contain the National Provider Identifier (NPI) code. The NPI is a unique identification number that will allow reviewers to understand what hospital performed a specific procedure. However, based on the pricing data available in comparison to averaged paid procedure costs, we identified instances where the County is paying more than hospital posted cash prices, and considerably more than Medicare costs. This level of savings is consistent with a quote received by a third-party that provided referenced-based pricing during the County's 2022 Medical Renewal process at a $4M reduction in comparison to 2021 costs.

Recommendation #1

The County should require that all future audit data requests from Highmark contain NPI codes at the individual claim level to better understand cost savings achieved through Highmark for specific hospitals procedures.

Recommendation #2

With the continued accessibility to pricing data, the Office of Administration should better understand the value derived from our relationship with Highmark. Additional evaluation of alternative solutions should be pursued without eroding employee coverage. The Controller believes that all prices should be based on a mark-up from Medicare cost/rate (as the reference) rather than an insurance carrier's negotiated rates with individual hospitals and service providers.

Recommendation #3

If the County does not pursue a reference-based pricing option, it should consider requiring the payment of outpatient and inpatient hospital rates to be the lower of Highmark's negotiated rates or the hospital's cash rates.

3. Administration of Medical Claim Payments

Condition: In 2021, the County incurred approximately $28M in medical claims and associated costs. Based on our review, we noted instances of unfamiliarity of costs and processing of inaccurate payments which gives the appearance that there is a lack of understanding, and ownership/monitoring of the contractual obligations and value derived from our relationship with Highmark.

Recommendation: The Office of Administration should fully understand all aspects of Highmark's contractual obligations for our medical plan and validate them to ensure compliance prior to payment. This will reduce waste of County resources and provide greater assurance of plan effectiveness.

4. Stop-Loss Claims Erroneously Billed ($106k)

Condition: Based on our inquiry of reconciled stop-loss premium and loss payments between the carrier (Highmark Life Insurance Company), McGriff Insurance and analysis of paid invoices, we were informed that Highmark Life Insurance Company erroneously billed the County approximately $106k for claims covered under the previous insurance carrier. Once identified, a credit was applied to the 3/29/2022 Highmark medical claim invoice.

Recommendation: The Office of Administration should actively manage stop-loss premiums and loss payments to ensure compliance with the policy. Special attention is required when transitioning from one insurance carrier to another.

5. Overpayment of Commissions ($44k)

Condition: In the Controller's 2019 audit of Highmark's Prescription Drug Costs, issued in 2021, it was noted that McGriff Insurance was a representative for Highmark and not the County. Based on this finding, the County Executive issued a Producer of Record Letter notifying Highmark that commission payments (previously paid by Highmark to McGriff Insurance) would cease 3/1/2021. Based on testing, we confirmed that Highmark continued to invoice the County for commissions throughout 2021, and the County overpaid $44,123.40. After bringing this to Highmark's attention, we confirmed that a credit was applied to the County's 9/30/2022 invoice for the overpayment.

Recommendation: The Office of Administration should validate compliance with the Producer of Record Letter prior to the payment of invoices.

6. Paid Value-Based Reimbursements ($168k)

Condition: In 2021, the County was invoiced and paid $167,935.93 for Value-Based Reimbursements to Highmark. We have, on multiple occasions, reached-out to Highmark, copying McGriff Insurance and the Office of Administration, to gain an understanding of the program and determine the savings the County achieved in 2021 for the amount paid. To date, no response has been received.

Recommendation: The County should discontinue the payment of the Value-Based Reimbursement program and request a full refund of all prior paid amounts until benefits can be justified. Oversight of derived value from this payment should be continually monitored by the Office of Administration.

7. <u>College Tuition Program ($29k)</u>

Condition: In 2021, the Office of Administration opted to participate in a College Tuition program through our agreement with Highmark. Each month a fee was charged based on the number of plan participants. For 2021, the County was invoiced and paid $28,806. Based on our inquiry, Highmark admitted that they failed to establish the County's College Tuition program with Sage Benefits (the administrator). We have noted that the County continues to pay the College Tuition fees in 2022, but have not received any confirmation that Highmark has established our program with Sage Benefits.

Recommendation: The County should discontinue the payment of the College Tuition program and request a full refund of all prior paid amounts until benefits can be justified. Oversight of the Administration of the College Tuition program should be continually monitored by the Office of Administration.

8. <u>Recovery and Savings Percentage paid to Highmark</u>

Condition: Amendment 3 to the Master Health Service Agreement with Highmark indicates that the County should pay a 35% fee for recoveries and savings identified by Highmark (e.g. subrogation, audits, etc.) or their third-party vendors (Cotiviti & Optum). When asked whether the recovery fee percentage was comparable to the market, McGriff Insurance indicated that they have seen other carriers in the 30% range, and mentioned other means in which similar fees have been reduced.

Recommendation: Based on our contractual agreement, management should instruct McGriff Insurance to actively pursue opportunities to reduce the percentage fee for recoveries/savings. We are unclear as to the contractual relationships between Highmark and their third-parties (Cotiviti & Optum) with regards to fees and commissions. If recovery and savings fees cannot be reduced, consideration should be given to the use of a third party contracted directly by the County of Lehigh for the identification of recoveries and savings.

9. <u>Stop-Loss Coverage Options</u>

Condition: The County retains stop-loss coverage for individual claims that exceed $350k in a policy year. Based on past loss experience, premiums for the County's stop-loss policy have increased significantly year-over-year: 2019: $123k, or 27% increase; 2020: $62k or 11% increase; 2021: $454k or 71% increase*. (*Excludes one-time $263k credit to sign a policy with Highmark Insurance Group). McGriff Insurance indicated that due to the County's past loss experience, fewer stop-loss carriers are interested in quoting our coverage.

Recommendation: The Office of Administration should work with McGriff Insurance to identify other stop-loss options/markets (e.g., risk pools) in balancing the mitigation of risk to price.

10. Highmark Special Investigative Unit (SIU) Referred Claims

Condition: Highmark's SIU pursues, among other responsibilities, instances of potential provider and member fraud. Several requests were made to Highmark to provide a list of County claims referred to their Special Investigative Unit in 2021, and the specific actions taken from their review. To date, no response has been received.

Recommendation: As the Sponsor of our agreement with Highmark, the County should have the ability to review the handling of claims referred to Highmark's SIU and their associated outcomes. This requirement should be put into all future contracts, and monitored periodically.

11. Contract Language with Highmark is not Transparent and Restricts Access to Data

Condition: The Highmark contract is not transparent to the public, controller, or anyone outside of the Office of Administration or the Office of Human Resources. Reduced transparency allows Highmark to capture additional savings which could have offset the cost of the health care plan and ultimately, the taxpayer.
Based on our review, there were a number of contract transparency issues which included:

- Contract language prevents the disclosure of detailed claim data, excluding personal health information, to other parties for cost comparisons on a routine basis to ensure competitiveness and lowest cost borne to taxpayers.
- Highmark only allows an audit of the most recent contract year, and must be completed no later than 11-months. In addition, only 200 paid claims may be audited annually without incurring addition costs.
- The terms and conditions language in the contract are confidential and prevent the disclosure of claim spending details to ensure competitiveness
- Contracts, price lists, data reports, techniques, and actual costs are being deemed proprietary information and are not permitted to be shared with anyone without prior written consent from Highmark.
- Any audit to be completed, must be discussed with and approved by Highmark before an audit is allowed to proceed.
- Highmark and the plan sponsor (County of Lehigh Administration) must agree on the scope of the audit, before an audit is allowed to commence.

Recommendation: Management should review the contract requirements and change the language to allow greater transparency to the county controller and to the public to ensure the taxpayers are paying the lowest costs for the County of Lehigh health care plan.

12. Contract Language with McGriff Insurance does not Require Other Compensation Disclosure

Condition: The Broker Services Agreement with McGriff Insurance indicates the potential receipt of other compensation from insurers, trade organizations, or business partners, but does not require them to disclose the receipt of the compensation.

Recommendation: Agreements for services funded by taxpayer dollars should be transparent and require full disclosure of any compensation/gifts received to avoid the appearance of a conflict of interest. Management should consider the inclusion of a requirement within our agreement to disclose, on a timely basis, any and all monetary and non-monetary compensation, incentives and awards pertaining to County plans under agreement.

APPENDIX A:

MEDICAL CLAIM AUDIT REPORT

JOHN GRAHAM INCORPORATED

Lehigh County

Medical Audit Report

October 4, 2022

8011 Brooks Chapel Road #4035 | Brentwood, TN 37027

(615) 924-4663 | www.jgrahaminc.com

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EXECUTIVE SUMMARY

J. Graham Inc. performed a comprehensive claims audit for Lehigh County of claims processed by Highmark from January 2021 to December 2021. This period included total claims paid of $26,505,212. The audit included a detailed review of a data extract to detect potential payment errors in a variety of categories. A remote site visit was held to review 200 of these claims in further detail. The sample claims were selected by JGI based on results of the data mining process and our assessment of both the likelihood of error and the overall potential for a given category. Specific sample claims were included to address concerns regarding Highmark's practices around the application of member portions, contract rate adjustments and other concerns shared by Lehigh County at the outset of the project.

JGI identified $62,634 in total agreed recovery on sample claims as summarized in the chart below, with most of these agreed recoveries related to coordination of benefits. The $63,827 disputed amount is spread across all categories with the majority related to eligibility. JGI assessed out-of-sample claims for all findings as well, and the entire potential recovery amount is related to eligibility. We have also included several informational findings that highlight questions and concerns Lehigh County will need to address with Highmark.

JGI notes that the findings presented in this Draft Audit Report are based on sample claims that Highmark has already reviewed, but Highmark has not yet formally responded to the findings in this format. Once Highmark provides its responses to the Draft Audit Report, we will incorporate them into a final version of the report. Findings by category for the audit are:

Issue	Agreed Recovery	Disputed Recovery	Out-of-Sample	Recovery Potential
COB	$60,490.67	$482.36	$0.00	$60,973.03
Duplicates	$1,399.91	$367.80	$0.00	$1,767.71
Eligibility	$623.94	$61,291.24	$16,882.41	$78,797.59
Limits	$0.00	$100.00	$0.00	$100.00
Exclusions	$119.03	$1,585.18	$0.00	$1,704.21
Total	**$62,633.55**	**$63,826.58**	**$16,882.41**	**$143,342.54**

AUDIT PROCESS

The services agreement for this project included a comprehensive claims audit scope. This scope is distinguished from a random sample audit in that the claims reviewed on site are specifically selected from the results of data mining for potential issues rather than being randomly selected for statistical validity. As such, results from the site visit claims review are not projected or extrapolated to the full population but instead are used to validate and refine the initial findings from the data mining process. It is possible that JGI would have additional out-of-sample claims in a given category that are directly related to errors proven on the site visit selections, or we may have been able to resolve all claims of concern for a category within the site visit claims. These assessments are made based on the results of the site visit and are discussed in the findings sections of this Audit Report.

JGI utilized plan documents provided by Lehigh County to establish plan benefits for testing, and we used the eligibility and claims files extracted by Highmark for creating the sample and establishing facts about the claims and members to be reviewed on site. Our testing for sample claims included:

- Assistant surgeon utilization and discounting
- Coordination of benefits including claims missing coordination for members with established patterns of other insurance savings, checking the validity of secondary payment calculations on COB claims and checking Medicare primary status for COBRA and ESRD patients
- Duplicate edits at multiple line level and claim level matches
- Payments for ineligible members
- Medically unlikely edits for excessive unit counts by procedure
- Pricing of claims to contracted rates
- Outpatient services rendered in conjunction with inpatient stays for contractual limitations such as preadmission testing, day of admission and during an inpatient stay
- Inpatient readmissions and overlapping inpatient stays
- Unbundling, once-in-a-lifetime procedures and mutually exclusive procedures
- Multiple procedure reductions on facility and professional bills
- Coinsurance, deductibles and out-of-pocket maximums as applicable
- Benefit Limits including ABA therapy, chiropractic visits and private duty nursing visits
- Exclusions such as dental services, hearing devices and routine foot care

In addition to this list of algorithms that are run against the claims population, JGI also spends considerable time assessing pricing accuracy both prior to the site visit selection and on the site visit claims. This effort includes specific review of high dollar claims, claims paid with no discount and pricing patterns at the highest paid providers.

After establishing the initial results of these data mining categories, our auditors reviewed claims output to determine which appeared to have been potential errors versus those claims that were likely false positives or reasonable exceptions. This analysis resulted in the composition of the site visit selection which is shown in the first Chart attached to this Audit Report. Our auditors then reviewed these claims with Highmark to determine the accuracy of each claim. The results from the remote site visit review drove the assessment of out-of-sample impact for each category as reflected herein.

Lehigh County can be assured that it received an exceptionally detailed and thorough claims audit as reflected in both our findings and this description of the Audit Process. We would be happy to answer additional questions about how we conducted the audit at the plan's discretion. The remainder of this Audit Report details the findings of the comprehensive claims audit.

AGREED FINDINGS

JGI identified four sample claims with agreed recoveries related to coordination of benefits totaling $59,713, but these were addressed in full in the sample with no out-of-sample impact. These claims included cases where Medicare should have been primary and where claims should have been adjusted after retroactive notification of other coverage. Highmark states that Item 8 was adjusted in January 2022, but JGI notes that this was eight months after the initial paid date of the claim. We have listed this claim as an agreed recovery given that it required recovery as of the end of the audit period. Highmark states that Item 17 is past the timeframe for submission to Medicare for payment. If this is the case, alternate means of remediation with the County should be discussed given that Highmark missed this claim in the process of adjusting claims for this member. Coordination of Benefits is a highly manual category of adjudication, so we would expect to continue finding similar recoveries on future audits given that there is no programming update to be made to correct root causes on these. These findings highlight the need to continue this comprehensive external audit program that can catch such manual errors. We confirmed that there were no other claims with likely missed coordination for these members during the audit period.

For Audit Item 8 mentioned above and all other sample claims Highmark states have already been recovered, we request documented proof of credit to the County for final confirmation of completion of these transactions.

Highmark agreed to recovery of $778 on Items 44-45 and 47-49 for Medicare Part B deductibles paid in error on the Signature 65 plan. Per Highmark, the Part B deductibles were incorrectly considered under the facility line of business for these sample claims, but JGI notes the SPD does not distinguish between lines of business when it states that "the member pays Medicare Part B deductible for Most Medicare Part B covered services." While we cannot identify out-of-sample impact with accuracy, the deductible level and member count on this plan suggest that the maximum error could be $100,000 or more per year. However, we believe the likely impact is much lower given what we can observe in the claims data for secondary claim payments. Highmark will need to complete an impact analysis once the disputed finding related to this same error is resolved.

JGI identified six duplicate claim payments totaling $1,400 on Items 53, 56, 67, 70, 72 and 74, but we covered all significant concerns within the sample. Duplicate claim payments are often the result of system flags that are incorrectly waived by processors who review the potential duplicates, thus qualifying as manual errors. The volume of the duplicate claims identified on this audit does not suggest a systemic issue. JGI believes that we evaluated all material potential duplicates in the sample and therefore have no out-of-sample claims for review in this category.

Highmark recovered $624 on Item 84 for a member who was not eligible for

coverage on the date of service. Highmark acknowledged a gap in eligibility for this member including the date of service on this claim. The recovery in January 2022 was four months after initial payment of the claim. JGI identified $2,441 on out-of-sample claims for this member and a dependent that will require adjustment as well based on the same eligibility dates. We note that the recovery on this claim contrasts with Highmark's position on all other retro terms discussed in the Disputed Findings section below. Highmark may wish to explain why this claim was recovered based on eligibility when other sample claims impacted by the same activity were not.

Highmark agreed that it should not have paid $119 for an exam required for a driver's license on Item 182. One additional administrative exam payment is listed in Disputed Findings below as well.

DISPUTED FINDINGS

JGI disputes $19 on Items 12 and 19 for quality payments made to a provider for members who appear to have Medicare primary status. These payments equate to 1% of the amount paid to this provider for achieving certain quality targets according to Highmark, but we do not think it is appropriate to pay these additional amounts related to claims for which Medicare was the primary payer. Only claims paid primary by Highmark should be tied to incentive programs set up under the provider contract between Highmark and this hospital system.

In contrast to the agreed errors for incorrect payment of Medicare Part B deductibles detailed above, Highmark disagrees with the same error on Items 43, 46, 50, 57, 59 and 66. Per Lehigh County's Signature 65 Plan Summary of Benefits, the member pays the Medicare Part B deductible and the Plan pays the Medicare Part B coinsurance, but Highmark cites a difference in service line to support payment of the Part B deductibles under major medical benefits on these sample claims. We see no relevance of service line from the plan documents review, and we request further direct discussion regarding this issue so that total plan impact can be assessed.

JGI disputes $20,344 paid on Items 83 and 85-86 and $14,441 on out-of-sample claims for lack of recovery on retroactive terminations by Highmark. According to the contract between Lehigh County and Highmark executed in July 2018, the "Sponsor may request that Highmark undertake reasonable and good faith efforts to reprocess certain Claims as result of...(iii) retroactive benefit or eligibility changes that Sponsor made or in connection with other action by Sponsor, its employees or agents." Highmark responses on these claims do not seem to acknowledge any opportunity to recover claims based on retro terms, but we do not know of any reason a plan sponsor would want to fund claims paid for dates the member was not covered. Given the contract language, Lehigh County should request that Highmark recover these claims and begin doing so for all retro terms in the future. Recovery of retroactive terminations is standard in the industry and should not require a special request, but doing so will ensure that Lehigh County recaptures all expenses possible.

The payments totaling $40,947 on Items 87-91 are for newborn grandchildren who are not likely eligible for the Lehigh County plan, but Highmark is extending coverage for these newborns for up to 31 days following birth. It is highly likely that these children had other coverage available that would have paid for these claims if the County's plan did not extend coverage for children not enrolled in the plan. We would encourage the County to review these cases and confirm that it wishes to continue extending coverage given the fact that these children are likely not eligible plan members. Further, we generally recommend that plans avoid extending coverage to newborns not enrolled so that the plan which is covering the child can pay the claims instead.

Item 180 represents a second routine gynecological exam for the member in one year for an overpayment of $100 in excess of plan limits. Highmark asserts that

federal mandates allow two routine gynecological exams per year, but we know of no ACA or other requirement for coverage at this level. Further, the plan document specifically states that "Benefits are provided for one routine gynecological examination, including a pelvic and clinical breast examination, and one routine Papanicolaou smear (pap test) per calendar year." Highmark is paying in excess of this plan limit on the claim. JGI did not identify any additional out-of-sample errors, and we would not expect most members to seek two routine gyn exams within one year.

Item 183 paid $119 for a pre-employment examination, and services that are required for administrative purposes should be excluded from plan benefits as they are not medically necessary. Highmark states that the secondary diagnoses support the medical necessity of this visit, but the primary diagnosis shows that the exam was required for administrative purposes and should not be covered. One similar error was listed as an agreed recovery item above.

Highmark has no review in place to apply the plan's exclusion of maintenance care (custodial care) as evidenced by the lack of review for the members on Items 184-185 with 40+ chiropractic visits in a year. This volume of visits with the same or related diagnosis suggests that these claims would be the definition of maintenance care, yet they were paid without consideration of the maintenance care exclusion. Highmark states that this benefit does not require submission and authorization of a treatment plan, but this simply substantiates that no review is in place to administer the exclusion. JGI would recommend a small visit threshold (six visits, for example) after which medical records should be reviewed to ensure that the visits follow a reasonable treatment plan with documented recovery from injury or illness. JGI disputes $123 paid on these claims based on the lack of review, but we are not projecting out-of-sample impact given the inability to state whether or not the cases actually count under the exclusion without clinical review.

The County will need to determine plan intent for the coverage of services related to cochlear implants and other hearing devices. Item 186 paid $509 for a procedure code described as "Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming." The plan excludes hearing aid devices and does not mention coverage for cochlear implants. Some plans count cochlear implants under this type of exclusion, while others are only targeting external hearing aids for exclusion. Given that the plan documents do not mention cochlear implants and that this is a form of a hearing aid device, Lehigh County will need to clarify plan intent on this exclusion. If cochlear implants are excluded, then all related services like this payment should be excluded as well.

JGI disputes $834 paid on Item 187 for nutritional counseling, which is excluded in plan documents. Plan documents exclude "nutritional counseling, except as provided herein." There is no mention of nutritional counseling coverage in the plan document, but ACA preventive services generally require 8-10 visits to be treated as preventive. This member has 16 nutritional counseling visits for the year, so this exceeds the level we would expect under preventive benefits. Highmark does not appear to have this

plan exclusion loaded at all, so clarification will be needed to get this in place moving forward.

INFORMATIONAL FINDINGS

Highmark does not have Medicare Part B estimation in place on the Lehigh County plans, thus causing the County to continue paying primary for members who could have Medicare primary coverage for far less total cost. The County paid over $60,000 on Items 4-5, 7, 9-11, 16, 77-80 and 99 for members who are age-eligible for Medicare and on Retired or COBRA segments of eligibility. We did not dispute these claims as we have no evidence of Medicare estimation in the plan documents, but JGI considers having Medicare estimation a best practice for plans unless there are specific reasons not to include this. Medicare estimation is the practice of reducing plan payments to the amount the plan would have covered after the Medicare primary payment even if the member does not enroll in Medicare (this is generally applicable to Parts B and D since Medicare Part A enrollment is automatic and without cost to the member). The purpose of this feature is to provide financial incentive for members to enroll in Medicare so that the plan is not bearing the cost of such claims. We have even worked with some clients that have programs to cover the cost of Part B premiums as part of the Medicare estimation requirement since this is usually far lower than claims expenses. We would encourage Lehigh County to consider adding provisions for Medicare estimation to protect the plan against unnecessary costs. Highmark should have standard plan document language for this, but JGI can assist with creating this language if needed and at the appropriate time.

Items 92-95 represent four family members with well over $1 million paid for the same high dollar drug treatment without clinical review by Highmark. While it is possible that all four require the same treatment for an inherited condition, we are surprised at the lack of review of this case given this somewhat odd billing pattern and the exceptional amounts paid. JGI requested validation that all four family members were receiving the same treatment, and Highmark responded that the drug in question "does not require prior authorization. Per Highmark's medical policy, procedure code… is medically necessary when submitted with diagnosis code…" Highmark should consider adding information in response to the audit report about its review and management of this case.

Though not assessed as an error, Item 168 shows waiver of patient portions due to COVID policies at Highmark that are broader than federal mandate requirements. This sample claim is for an office visit with a diagnosis of acute sinusitis, and Highmark waived the copay based on its COVID policy. Highmark states "Due to covid/flu related diagnosis codes reported, cost share is waived for office visit when a Covid test is performed within 7 days after the visit." Federal mandates require waiver of patient portions on the day of service when a COVID test is performed or for office visits that are specifically related to establishing the need for a COVID test, so this policy is broader than the federal mandate. Lehigh County should be aware of Highmark's position and confirm its acceptance of this practice if it aligns with plan intent.

Lehigh County requested a review of Highmark's practices around the application of multiple copays per day, and we were able with several sample claims to establish that Highmark is applying copays on the individual provider and service level which means a member can be charged multiple copays per day even for two bills from the same provider group or two services in the same visit. On Item 169, Highmark assessed both a spinal manipulation and physical therapy copay on the same claim. This is an unusual position as almost all of our clients limit copays to one per visit. While the plan documents do not appear to be explicit about this topic, we would encourage Highmark and Lehigh County to talk about plan intent in relation to this claim and Items 177-178. For these two claims, Highmark applied multiple copays for therapy services rendered by two different providers within the same clinic or group. Most of our clients also limit copays to one per type per provider group, but Lehigh County would need to determine if it was comfortable with the current approach or wanted to implement a revision. Item 172 is a case where Highmark adjudicated an office visit claim with the specified copay applied but also applied deductible and coinsurance member portions to other individual lines of the claim. This example shows that Highmark is administering patient portions at the individual service line level. Once again, most of our clients have setups that waive most if not all additional patient portions incurred during a copay visit. Lehigh County will need to decide if these practices are acceptable and, if not, work with Highmark to determine if it can administer alternatives that better align with plan intent.

Highmark is administering the limit on skilled nursing facility coverage for the Signature 65 plan by the Medicare-defined benefit period rather than per contract year, but the plan document does not seem to align with this interpretation. The plan documents available to JGI state that the SNF limit is 100 days per benefit period, but the benefit period is defined as the contract year. Highmark stated in response to Item 181 that "Per the benefits, the member is eligible for 100 Inpatient Skilled Nursing Facility days per Benefit Period. Please see the attached verbiage which explains that the Benefit Period relating to Inpatient SNF stay starts on the first day of an Inpatient Facility stay, and ends when the patient has not been inpatient, either at a facility or a SNF, for 60 consecutive days." This matches the Medicare definition of the benefit period which likely makes sense for the Signature 65 plan, but Lehigh County should confirm that this limit in Signature 65 plan documents is defined in this manner. We only have a chart of benefits for this product which does not contain these definitions.

Lehigh County asked us to evaluate specific transactions with no valid claim identifier totaling over $40,000 that were all processed on the same day in 2021, and Highmark has stated that these payments are all related to a 1% incentive (Quality Blue) for a specific hospital related to claims incurred in 2020. Highmark has tied the payments on Items 188-200 to specific claims from 2020 and confirms that each is a payment of 1% additional related to this program. JGI has requested additional detail about this program including something to show how the provider met conditions supporting the additional payment. We believe it is important that the County understand the underlying logic and value of these payments given that they

occur well after completion of a contract year.

Lehigh County has expressed an interest in understanding cost variance amongst hospitals in its service area, and JGI sampled a number of claims to assist in assessing the underlying contracted rates driving payments across multiple types of services. We observed from this review that outpatient pricing appears to be fairly similar across the highest utilized facilities, but there is meaningful variance in inpatient rates. Specific discussion with Highmark about utilization and pricing of inpatient claims may offer opportunities for further cost savings if desired by the County, but JGI is not able to assess quality or the range of services offered by different facilities. It is possible that only a higher-cost facility, for example, is able to treat specific conditions, offer certain equipment or treatment or handle higher-severity cases. All of these factors would have to be part of this type of discussion, but our observations show that at least the discussion is warranted. Reporting from the Quality Blue program discussed above may assist some with this as well if such reporting can establish anything about quality measures across facilities.

Lehigh County also requested that JGI assess utilization patterns for ER visits out of concern for upcoding the level utilized. We are able to observe little to no use of ER levels one and two in the paid claims data, and a bell curve with the remaining levels with level four being the highest used. While we cannot draw conclusions about these patterns, we can offer two observations that might assist in alleviating some concerns about these trends. First, we believe the limited use of levels one and two may be due to the fact that these codes are tied to conditions that would not likely be considered emergency use of the ER. Examples generally linked to levels one and two are uncomplicated insect bites and simple trauma with no x-rays utilized. One could reasonably argue that this type of care is intended to be handled in office or other urgent care settings and not the ER. This may account for the limited use of levels one and two coding for ER visit. Second, the time period of this audit was impacted by a global pandemic that impacted the severity of many respiratory conditions and may have led to high-level use of resources in the ER. We would welcome Highmark's commentary about this concern and especially any review processes in place to ensure that providers are not upcoding ER levels given the increased revenue likely tied to the codes.

Charts

CHARTS: SITE VISIT SUMMARY

Item	Issue	Agreed Recovery	Disputed Recovery	Comment
1	Medicare	$0.00	$0.00	Spouse, Highmark primary
2	Medicare	$0.00	$0.00	Spouse, Highmark primary
3	Medicare	$0.00	$0.00	Spouse, Highmark primary
4	Medicare	$0.00	$0.00	$1k, no Part B
5	Medicare	$0.00	$0.00	$7k, no Part B
6	Medicare	$0.00	$0.00	MCR 1/21
7	Medicare	$0.00	$0.00	$6k, no Part B
8	Medicare	$29,820.08	$0.00	Adjusted 1/22
9	Medicare	$0.00	$0.00	$5k, no Part B
10	Medicare	$0.00	$0.00	$2k, no Part B
11	Medicare	$0.00	$0.00	$26k, no Part B
12	Medicare	$0.00	$0.65	Cost adj on MCR mbr
13	Medicare	$0.00	$0.00	Paid MCR PR
14	Medicare	$0.00	$0.00	Paid MCR PR
15	Medicare	$0.00	$0.00	Paid MCR PR
16	Medicare	$0.00	$0.00	$3k, no Part B
17	Medicare	$27,080.77	$0.00	Missed adj on late OI
18	Medicare	$0.00	$0.00	Active plan
19	Medicare	$0.00	$18.46	Cost adj on MCR mbr
20	Medicare	$0.00	$0.00	Highmark primary
21	Medicare	$0.00	$0.00	Retired 7/21
22	Medicare	$0.00	$0.00	Active plan
23	Medicare	$0.00	$0.00	Highmark primary
24	Medicare	$0.00	$0.00	Cost adj on MCR mbr
25	Medicare	$0.00	$0.00	Transplant 10/10, no failure
26	COB Missing	$0.00	$0.00	Primary applied ded
27	COB Missing	$0.00	$0.00	Coordinated claim
28	COB Missing	$0.00	$0.00	OI termed 12/20
29	COB Missing	$0.00	$0.00	OI termed 6/21
30	COB Missing	$0.00	$0.00	Met primary visit max
31	COB Missing	$2,386.48	$0.00	Agreed, OI primary
32	COB Missing	$0.00	$0.00	Coordinated claim
33	COB Missing	$425.39	$0.00	Agreed, OI primary
34	COB Missing	$0.00	$0.00	Highmark primary
35	COB Missing	$0.00	$0.00	Coordinated claim
36	COB Missing	$0.00	$0.00	Highmark primary
37	COB Missing	$0.00	$0.00	Primary not covered
38	COB Missing	$0.00	$0.00	OI eff 12/20
39	COB Missing	$0.00	$0.00	Coordinated claim
40	COB Missing	$0.00	$0.00	Coordinated claim
41	COB Missing	$0.00	$0.00	No OI, Medicaid

Item	Issue	Agreed Recovery	Disputed Recovery	Comment
42	High Secondary	$0.00	$0.00	Billed incorrect
43	High Secondary	$0.00	$158.62	Paid Part B ded
44	High Secondary	$203.00	$0.00	Agreed, Part B ded incorrectly paid
45	High Secondary	$203.00	$0.00	Agreed, Part B ded incorrectly paid
46	High Secondary	$0.00	$203.00	Paid Part B ded
47	High Secondary	$134.27	$0.00	Agreed, Part B ded incorrectly paid
48	High Secondary	$128.14	$0.00	Agreed, Part B ded incorrectly paid
49	High Secondary	$109.54	$0.00	Agreed, Part B ded incorrectly paid
50	High Secondary	$0.00	$101.63	Paid Part B ded
51	Duplicates	$0.00	$0.00	Correct claim
52	Duplicates	$0.00	$0.00	Multiple labs
53	Duplicates	$212.23	$0.00	Agreed duplicate
54	Duplicates	$0.00	$0.00	Corrected claim
55	Duplicates	$0.00	$0.00	Correct claim
56	Duplicates	$83.39	$0.00	Adjusted 5/3/22
57	Duplicates	$0.00	$203.00	Paid Part B ded
58	Duplicates	$0.00	$0.00	Paid MCR PR
59	Duplicates	$0.00	$82.40	Paid Part B ded
60	Duplicates	$0.00	$0.00	Paid MCR PR
61	Duplicates	$0.00	$0.00	Split claim
62	Duplicates	$0.00	$0.00	Correct claim
63	Duplicates	$0.00	$0.00	Correct claim
64	Duplicates	$0.00	$0.00	Split claim
65	Duplicates	$0.00	$0.00	Correct claim
66	Duplicates	$0.00	$82.40	Paid Part B ded
67	Duplicates	$120.33	$0.00	Adjusted 1/4/22
68	Duplicates	$0.00	$0.00	Correct claim
69	Duplicates	$0.00	$0.00	Correct claim
70	Duplicates	$158.02	$0.00	Agreed duplicate
71	Duplicates	$0.00	$0.00	Correct claim
72	Duplicates	$119.58	$0.00	Agreed duplicate
73	Duplicates	$0.00	$0.00	Correct claim
74	Duplicates	$706.36	$0.00	Agreed duplicate
75	Duplicates	$0.00	$0.00	Facility claim
76	Duplicates	$0.00	$0.00	Physician claim
77	Duplicates	$0.00	$0.00	$100, No Part B
78	Duplicates	$0.00	$0.00	$100, no Part B
79	Duplicates	$0.00	$0.00	$100, no Part B
80	Duplicates	$0.00	$0.00	$100, no Part B
81	Duplicates	$0.00	$0.00	Primary surgeon
82	Duplicates	$0.00	$0.00	Co-surgeon claim
83	Eligibility	$0.00	$1,590.90	Retro term
84	Eligibility	$623.94	$0.00	Adjusted 1/18/22

Item	Issue	Agreed Recovery	Disputed Recovery	Comment
85	Eligibility	$0.00	$551.35	Retro term
86	Eligibility	$0.00	$18,201.55	Retro term
87	Eligibility	$0.00	$3,932.18	Newborn grandchild
88	Eligibility	$0.00	$3,922.75	Newborn grandchild
89	Eligibility	$0.00	$2,970.57	Newborn grandchild
90	Eligibility	$0.00	$13,533.57	Newborn grandchild
91	Eligibility	$0.00	$16,588.37	Newborn grandchild
92	Billing Patterns	$0.00	$0.00	Four family members same drug
93	Billing Patterns	$0.00	$0.00	Four family members same drug
94	Billing Patterns	$0.00	$0.00	Four family members same drug
95	Billing Patterns	$0.00	$0.00	Four family members same drug
96	Pricing	$0.00	$0.00	ITS, flat fee
97	Pricing	$0.00	$0.00	Line detail available in system
98	Pricing	$0.00	$0.00	ITS, percent of charge
99	Pricing	$0.00	$0.00	$9k, no Part B
100	Pricing	$0.00	$0.00	ITS, percent and flat fee
101	Pricing	$0.00	$0.00	ITS, flat fee
102	Pricing	$0.00	$0.00	ITS pricing
103	Pricing	$0.00	$0.00	ITS, percent of charge
104	Pricing	$0.00	$0.00	DRG and incentive
105	Pricing	$0.00	$0.00	First dollar stop loss
106	Pricing	$0.00	$0.00	First dollar stop loss
107	Pricing	$0.00	$0.00	APC and incentive
108	Pricing	$0.00	$0.00	Semi private rate
109	Pricing	$0.00	$0.00	DRG pricing
110	Pricing	$0.00	$0.00	DRG pricing
111	Pricing	$0.00	$0.00	DRG outlier pricing
112	Pricing	$0.00	$0.00	DRG pricing
113	Pricing	$0.00	$0.00	DRG pricing
114	Pricing	$0.00	$0.00	DRG pricing, met oop max
115	Pricing	$0.00	$0.00	DRG outlier pricing
116	Pricing	$0.00	$0.00	Appeal granted additional unit
117	Pricing	$0.00	$0.00	DRG tiered pricing
118	Pricing	$0.00	$0.00	DRG pricing
119	Pricing	$0.00	$0.00	DRG pricing
120	Pricing	$0.00	$0.00	DRG pricing
121	Pricing	$0.00	$0.00	Bariatric case rate
122	Pricing	$0.00	$0.00	Bariatric case rate
123	Pricing	$0.00	$0.00	APC pricing
124	Pricing	$0.00	$0.00	Bariatric case rate
125	Pricing	$0.00	$0.00	DRG and incentive
126	Pricing	$0.00	$0.00	DRG and incentive
127	Pricing	$0.00	$0.00	Transfer outlier and incentive

Item	Issue	Agreed Recovery	Disputed Recovery	Comment
128	Pricing	$0.00	$0.00	DRG pricing, audit
129	Pricing	$0.00	$0.00	Percent MCR and outlier
130	Pricing	$0.00	$0.00	APC pricing
131	Pricing	$0.00	$0.00	Percent MCR and incentive
132	Pricing	$0.00	$0.00	No COB in data
133	Pricing	$0.00	$0.00	Paid MCR coins
134	Pricing	$0.00	$0.00	Used OON fee sched
135	Pricing	$0.00	$0.00	Confirmed to ITS
136	Pricing	$0.00	$0.00	Confirmed to ITS
137	Pricing	$0.00	$0.00	Confirmed to ITS
138	Pricing	$0.00	$0.00	Confirmed to ITS
139	Pricing	$0.00	$0.00	Confirmed to ITS
140	Pricing	$0.00	$0.00	Confirmed to ITS
141	Pricing	$0.00	$0.00	Confirmed to ITS
142	Multiple Procedures	$0.00	$0.00	Confirmed to ITS
143	Multiple Procedures	$0.00	$0.00	Initial procedure claim
144	Multiple Procedures	$0.00	$0.00	No MPR for this proc
145	Multiple Procedures	$0.00	$0.00	Initial procedure claim
146	Multiple Procedures	$0.00	$0.00	No MPR for this proc
147	Multiple Procedures	$0.00	$0.00	No MPR for this proc
148	Multiple Procedures	$0.00	$0.00	No MPR per Highmark
149	Multiple Procedures	$0.00	$0.00	No MPR per Highmark
150	Multiple Procedures	$0.00	$0.00	No MPR per Highmark
151	Multiple Procedures	$0.00	$0.00	No MPR per Highmark
152	Multiple Procedures	$0.00	$0.00	MPR applied
153	Multiple Procedures	$0.00	$0.00	No rad MPR in place
154	Multiple Procedures	$0.00	$0.00	No rad MPR in place
155	Multiple Procedures	$0.00	$0.00	No MPR per Highmark
156	Multiple Procedures	$0.00	$0.00	Confirmed to ITS
157	Multiple Procedures	$0.00	$0.00	No rad MPR in place
158	Multiple Procedures	$0.00	$0.00	No rad MPR in place
159	Multiple Procedures	$0.00	$0.00	Confirmed to ITS
160	Multiple Procedures	$0.00	$0.00	No rad MPR in place
161	Multiple Procedures	$0.00	$0.00	No rad MPR in place
162	Multiple Procedures	$0.00	$0.00	Confirmed to ITS
163	Copays	$0.00	$0.00	COVID telehealth waiver
164	Copays	$0.00	$0.00	COVID telehealth waiver
165	Copays	$0.00	$0.00	OP SA, no copay
166	Copays	$0.00	$0.00	COVID telehealth waiver
167	Copays	$0.00	$0.00	COVID telehealth waiver
168	Copays	$0.00	$0.00	COVID test within 7 days
169	Copays	$0.00	$0.00	Applying chiro and PT
170	Copays	$0.00	$0.00	OV and ER copay

Item	Issue	Agreed Recovery	Disputed Recovery	Comment
171	Copays	$0.00	$0.00	OV and ER copay
172	Copays	$0.00	$0.00	Apply copay and ded
173	Copays	$0.00	$0.00	ABA takes ded and coins
174	Copays	$0.00	$0.00	ABA takes ded and coins
175	Copays	$0.00	$0.00	PCP and specialist copay
176	Copays	$0.00	$0.00	PCP and specialist copay
177	Copays	$0.00	$0.00	ABA multi-copay per day
178	Copays	$0.00	$0.00	ABA multi-copay per day
179	Limits	$0.00	$0.00	Two preventive gyn
180	Limits	$0.00	$100.00	Two preventive gyn
181	Limits	$0.00	$0.00	Benefit period limit
182	Exclusions	$119.03	$0.00	Driver's license exam
183	Exclusions	$0.00	$119.03	Pre-employment exam
184	Exclusions	$0.00	$69.06	40+ chiro, no review
185	Exclusions	$0.00	$54.35	40+ chiro, no review
186	Exclusions	$0.00	$508.86	Cochlear programming
187	Exclusions	$0.00	$833.88	15 nutritional counseling
188	Other	$0.00	$0.00	Cost rate adj 1%
189	Other	$0.00	$0.00	Cost rate adj 1%
190	Other	$0.00	$0.00	Cost rate adj 1%
191	Other	$0.00	$0.00	Cost rate adj 1%
192	Other	$0.00	$0.00	Cost rate adj 1%
193	Other	$0.00	$0.00	Cost rate adj 1%
194	Other	$0.00	$0.00	Cost rate adj 1%
195	Other	$0.00	$0.00	Cost rate adj 1%
196	Other	$0.00	$0.00	Cost rate adj 1%
197	Other	$0.00	$0.00	Cost rate adj 1%
198	Other	$0.00	$0.00	Cost rate adj 1%
199	Other	$0.00	$0.00	Cost rate adj 1%
200	Other	$0.00	$0.00	Cost rate adj 1%
	Total	**$62,633.55**	**$63,826.58**	

CHARTS: OUT-OF-SAMPLE

Audit Items	Issue	Potential Recovery
201 - 335	Eligibility	$16,882.41
Total		**$16,882.41**

County of Lehigh
Department of Administration

Edward D. Hozza, Jr.
Director of Administration

Mark Pinsley
Lehigh County Controller
Lehigh County Government Center
17 South Seventh Street
Allentown, PA 18101-2400

Director of Administration Edward D. Hozza Jr. Response to Audit of Medical Claim Payments for 2021.

I confirm that a revised engagement letter was sent to me changing the original scope of the audit from 2020 to 2021. (Attached e-mail)

I confirm that the Controllers office retained John Graham Incorporated to perform a paid-Medical claim audit for the year 2021.

I confirm that the look back period of 2021 for this audit was during the worldwide Covid-19 pandemic when many of our Human Resource employees, and that of our medical partners were working remotely.

The Department of Administration values the working relationship that we have with medical provider Highmark and our Benefits Consultant McGriff. Since 2018, the County of Lehigh has not seen an increase in our $32 Million dollar annual spend for Medical and Prescription coverage for 2,000 Active Employees and 670 grandfathered retired employees. Recommendations have been made by McGriff our Healthcare Consultant that have resulted in maintaining our excellent medical and prescription coverage without increasing out of pocket expenses for our employees and Taxpayers.

I acknowledge the receipt of the John Graham Schedule of Audit Findings and Recommendations #1 thru 12. Pages 5 thru 9.

The Administration thanks the Controllers office staff for their diligence and recommendations in the results of this audit. We will discuss the findings and recommendations with our internal Human Resource Staff, our new Human Resource Director, the Highmark and the McGriff Teams.

Respectfully,

Edward D. Hozza Jr.

Director of Administration, County of Lehigh

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Allentown, Pennsylvania 18101-2401
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Printed on recycled paper

Highmark Health

County of Lehigh Report Responses

October 21, 2022

Dear John Graham,

Highmark Health Services (Highmark) has reviewed the draft report provided by J. Graham Inc. (JGI). as it pertains to the customer group County of Lehigh (COL). Highmark notes the period under review was paid claims from January 1, 2021, through December 31, 2021, of which a sample of 200 statistically valid claims were reviewed by the auditor. The following represents Highmark's stance and response to applicable findings and additional information sections requested by the auditor as part of the draft report.

Random Stratified Audit -200 Claims

JGI included claims that were not agreed to by Highmark in the Agreed Findings. Highmark's commentary regarding the disagreed to errors can be found in Attachment B.

The following table lists the findings cited by JGI that Highmark has researched and agrees with the errors noted. The table below is indexed by the item number used by JGI in the October 2022 audit report.

Item Number	Error Description	Error Amount	Type of Error	Audit Report Page #
17	COB Medicare	$30,241.08	Manual	
31	COB Non-Medicare	$2,410.80	Manual	
33	COB Non-Medicare	$425.39	Manual	
40	COB Non-Medicare	-$1,551.58	Manual	
44	COB Medicare	$203	Manual	
45	COB Medicare	$106.02	Manual	
47	COB Medicare	$51.87	Manual	
48	COB Medicare	$91.28	Manual	
49	COB Medicare	$27.06	Manual	
53	Duplicate	$227.23	Manual	
70	Duplicate	$158.02	Manual	
72	Duplicate	$119.58	Manual	
74	Duplicate	$706.36	Manual	
182	Excluded Services	$119.03	Benefit Coding	

To date, Highmark agreed to fourteen (14) sample errors totaling an overpayment of $33,335.14. The sample error amount includes a combined total of $34,886.72 in overpayments and $1,551.58 in underpayments. Highmark's comments regarding these errors and our remediation process can be found in Attachment A.

In addition to a detailed response to your findings, Highmark has also provided additional commentary in Attachment C regarding JGI's Informational Findings within the report.

If you have any questions or would like to discuss our response further, please contact Jamie Kramer.

Attachment A – Agreed Findings

The following table lists the Key Findings and Recommendations noted in JGI's draft audit report. Highmark's responses agreeing to the findings have been included in the table below. Page references to JGI's draft report have been included for ease of review.

John Graham Initial Observation/Conclusion	Highmark Draft Report Response
Page 16 JGI identified four sample claims with agreed recoveries related to coordination of benefits totaling $59,713, but these were addressed in full in the sample with no out-of-sample impact. These claims included cases where Medicare should have been primary and where claims should have been adjusted after retroactive notification of other coverage. Highmark states that Item 8 was adjusted in January 2022, but JGI notes that this was eight months after the initial paid date of the claim. We have listed this claim as an agreed recovery given that it required recovery as of the end of the audit period. Highmark states that Item 17 is past the timeframe for submission to Medicare for payment. If this is the case, alternate means of remediation with the County should be discussed given that Highmark missed this claim in the process of adjusting claims for this member. Coordination of Benefits is a highly manual category of adjudication, so we would expect to continue finding similar recoveries on future audits given that there is no programming update to be made to correct root causes on these. These findings highlight the need to continue this comprehensive external audit program that can catch such manual errors. We confirmed that there were no other claims with likely missed coordination for these members during the audit period.	Per email confirmation from JGI, the other two samples in this category are Items 31 & 33. Item 8 Highmark disagrees with an error being cited on this claim. Please see Highmark's commentary in the Disagreed Findings section Attachment B. Item 17 Highmark agrees claim 21454524987 should have been coordinated with Medicare. Highmark's OPL system was updated to show Medicare part A and B as the primary payer. An inquiry was sent to the claims area to adjust the impacted claims, however, this claim was missed. This was a manual error that resulted in an overpayment of $ 30,241.08. It is past the timeframe for this claim to be submitted to Medicare for payment. Item 31 Highmark agrees the claims questioned were processed as Highmark being the primary payer incorrectly. The patient questioned is the spouse under this policy. The spouse had medical coverage through their employer which should have the primary payer. Highmark's OPL system was incorrectly updated listing the other insurance as the secondary coverage. Our OPL file has been corrected. This was a manual error that resulted in an overpayment of $2,410.80. Item 33 Highmark agrees with the cited error. Sample claim 21273297966 was processed as the primary payer in error. This was a manual error that resulted in an overpayment of $425.39. This claim was corrected on 8/26/22 to coordinate with the primary insurance.

John Graham Initial Observation/Conclusion	Highmark Draft Report Response
Page 16 Highmark agreed to recovery of $778 on Items 44-45 and 47-49 for Medicare Part B deductibles paid in error on the Signature 65 plan. Per Highmark, the Part B deductibles were incorrectly considered under the facility line of business for these sample claims, but JGI notes the SPD does not distinguish between lines of business when it states that "the member pays Medicare Part B deductible for Most Medicare Part B covered services." While we cannot identify out-of-sample impact with accuracy, the deductible level and member count on this plan suggest that the maximum error could be $100,000 or more per year. However, we believe the likely impact is much lower given what we can observe in the claims data for secondary claim payments. Highmark will need to complete an impact analysis once the disputed finding related to this same error is resolved.	Item 44 Highmark agrees this claim was processed incorrectly and overpaid in the amount of $203.00. The Medicare Part B deductible is not payable under the Med/Surg or Facility line of business. The Medicare deductible of PR1=$203.00 was incorrectly considered under the facility line of business. This claim suspended for manual review and was worked incorrectly causing the error. This claim was voided on 9/23/22 due to the provider advising the service was submitted in error and withdrawn. Items 45,47,48 & 49 Highmark agrees the sample claims were processed incorrectly. These claims suspended for manual review and were worked incorrectly causing the errors. The Medicare Part B deductible is not eligible for consideration under the Medical/Surgical (Med/Surg) or Facility lines of business (LOB). Highmark standardly considers the Medicare Part B deductible under the Major Medical (MM) LOB for Signature 65 plans. Item 45 The Medicare Part B deductible was processed under the Med/Surg LOB in error. This should have been considered under the MM LOB. Overpayment $106.02. Item 47 The Medicare Part B deductible was processed under the Med/Surg LOB in error. This should have been considered under the MM LOB on lines 8 and 9. Overpayment $51.87. Item 48 The Medicare Part B deductible was processed under the Med/Surg LOB in error. This should have been considered under the MM LOB on lines 1,2 &4. Overpayment $91.28.

John Graham Initial Observation/Conclusion	Highmark Draft Report Response
	Item 49 The Medicare Part B deductible was processed under the Med/Surg LOB in error. This should have been considered under the MM LOB. Overpayment $27.06. Highmark does not generate Impact reports for manual errors.
Page 16 JGI identified six duplicate claim payments totaling $1,400 on Items 53, 56, 67, 70, 72 and 74, but we covered all significant concerns within the sample. Duplicate claim payments are often the result of system flags that are incorrectly waived by processors who review the potential duplicates, thus qualifying as manual errors. The volume of the duplicate claims identified on this audit does not suggest a systemic issue. JGI believes that we evaluated all material potential duplicates in the sample and therefore have no out-of-sample claims for review in this category.	Items 53,56 & 67 Highmark disagrees with errors being cited on these claims. Please see Highmark's commentary in the Disagreed Findings section Attachment B. Items 54 (53 Attachment B) Highmark agrees a duplicate payment was made for the services submitted on sample claims 53 and 54. Sample 54 claim 21452324795 is the duplicate payment. This was a manual error that resulted in an overpayment of $227.23. Item 70 Highmark agrees claim 21571558886 is a duplicate to claim 21568329685. These claims were submitted with different provider numbers which caused the error. This resulted in an overpayment of $158.02. The duplicate payment was corrected on 9/8/22. Item 72 Highmark agrees claim 21773413052 is a duplicate to claim 21571692150. The provider submitted one claim through BlueCard and the other claim direct to Highmark. This caused the provider numbers to be different which resulted in a duplicate payment. Overpayment of $119.58. Item 74 Highmark agrees claim 21359290073 is a duplicate to claim 21356561335. These claims were submitted with different provider numbers which caused the error. This resulted in an overpayment of $706.36.

John Graham Initial Observation/Conclusion	Highmark Draft Report Response
Pages 16 & 17 Highmark recovered $624 on Item 84 for a member who was not eligible for coverage on the date of service. Highmark acknowledged a gap in eligibility for this member including the date of service on this claim. The recovery in January 2022 was four months after initial payment of the claim. JGI identified $2,441 on out-of-sample claims for this member and a dependent that will require adjustment as well based on the same eligibility dates. We note that the recovery on this claim contrasts with Highmark's position on all other retro terms discussed in the Disputed Findings section below. Highmark may wish to explain why this claim was recovered based on eligibility when other sample claims impacted by the same activity were not.	Item 84 Highmark disagrees with an error being cited on this claim. Please see Highmark's commentary in the Disagreed Findings section Attachment B.
Page 17 Highmark agreed that it should not have paid $119 for an exam required for a driver's license on Item 182. One additional administrative exam payment is listed in Disputed Findings below as well.	Item 182 Highmark agrees diagnosis code Z024 is not eligible for reimbursement per the benefits. This was a benefit coding error that resulted in an overpayment of $119.03. The benefit coding was updated to exclude this diagnosis code in the system on 9/27/22. A clean-up report was generated identifying a total of 22 claims impacted with a financial impact of $2,170.76. The corrections have been completed.

Attachment B – Disagreed Findings

The following table lists the Key Findings and Recommendations noted in JGI's draft audit report that Highmark has researched and disagrees with. Highmark's response has been included in the table below for reference. Page references to JGI's draft report have been included for ease of review.

John Graham Initial Observation/Conclusion	Highmark Draft Report Response
Page 16 JGI identified four sample claims with agreed recoveries related to coordination of benefits totaling $59,713, but these were addressed in full in the sample with no out-of-sample impact. These claims included cases where Medicare should have been primary and where claims should have been adjusted after retroactive notification of other coverage. Highmark states that Item 8 was adjusted in January 2022, but JGI notes that this was eight months after the initial paid date of the claim. We have listed this claim as an agreed recovery given that it required recovery as of the end of the audit period. For Audit Item 8 mentioned above and all other sample claims Highmark states have already been recovered, we request documented proof of credit to the County for final confirmation of completion of these transactions.	Item 8 Highmark disagrees with an error being cited on this claim. This claim was adjusted outside of the audit on 1/19/2022 prior to the sample being selected on 7/22/2022. Highmark does not agree to errors when the claim was corrected prior to the audit. The invoice information requested for this sample was provided to JGI on 10/13/22.
Page 16 JGI identified six duplicate claim payments totaling $1,400 on Items 53, 56, and 67, but we covered all significant concerns within the sample. Duplicate claim payments are often the result of system flags that are incorrectly waived by processors who review the potential duplicates, thus qualifying as manual errors. The volume of the duplicate claims identified on this audit does not suggest a systemic issue. JGI believes that we evaluated all material potential duplicates in the sample and therefore have no out-of-sample claims for review in this category.	Items 53 (54 Attachment A) Highmark disagrees a duplicate payment was made on Sample 53 claim 21151718212. Highmark agreed a duplicate payment was made for the services submitted on sample claims 53 and 54. Sample 54 claim 21452324795 was the duplicate payment. Item 56 Highmark maintains our response disagreeing to the duplicate error cited. Highmark identified the duplicate payment outside of the audit and corrected the claim on 5/3/2022 prior to the sample being selected on 7/22/2022. Highmark does not agree to errors when the claim was corrected prior to the audit.

John Graham Initial Observation/Conclusion	Highmark Draft Report Response
	Item 67 Highmark maintains our response disagreeing to the duplicate error cited. Highmark identified the duplicate payment outside of the audit and corrected the claim on 1/4/2022 prior to the sample being selected on 7/22/2022. Highmark does not agree to errors when the claim was corrected prior to the audit.
Pages 16 & 17 Highmark recovered $624 on Item 84 for a member who was not eligible for coverage on the date of service. Highmark acknowledged a gap in eligibility for this member including the date of service on this claim. The recovery in January 2022 was four months after initial payment of the claim. JGI identified $2,441 on out-of-sample claims for this member and a dependent that will require adjustment as well based on the same eligibility dates. We note that the recovery on this claim contrasts with Highmark's position on all other retro terms discussed in the Disputed Findings section below. Highmark may wish to explain why this claim was recovered based on eligibility when other sample claims impacted by the same activity were not.	Item 84 During the audit week, JGI cited this claim stating "Claim was adjusted after the audit period. Will cite as recovery in the audit report." Highmark disagreed with the error being cited advising this claim was adjusted outside of the audit on 1/18/2022 prior to the sample being selected on 7/22/2022. Highmark does not agree to errors when the claim was corrected prior to the audit. Based on JGI's additional commentary in the audit report for this sample, Highmark performed additional research to determine why the claim was adjusted. Highmark maintains our stance regarding retro-terminations. Any claims incurred up to the date that Highmark received a cancellation notice must be considered for payment and remain paid. Highmark believes this adjustment was a one-off situation retracting the payment.
Page 18 JGI disputes $19 on Items 12 and 19 for quality payments made to a provider for members who appear to have Medicare primary status. These payments equate to 1% of the amount paid to this provider for achieving certain quality targets according to Highmark, but we do not think it is appropriate to pay these additional amounts related to claims for which Medicare was the primary payer. Only claims paid primary by Highmark should be tied to incentive programs set up under the provider contract between Highmark and this hospital system.	Items 12 & 19 Highmark maintains our response that Items 12 & 19 were handled correctly. After additional research on both members, we identified Quality Blue Incentive payments (Cost Rate Adjustment) were appropriately allocated to the facility. These claims were originally processed under group 025377-33, which is County of Lehigh's Active Non-Union Married to a Retiree Under 65 group. Because this is a Retiree Under 65 group, the Quality Blue Incentive payment applies even though Medicare is the primary payer for these members.

John Graham Initial Observation/Conclusion	Highmark Draft Report Response
Page 18 In contrast to the agreed errors for incorrect payment of Medicare Part B deductibles detailed above, Highmark disagrees with the same error on Items 43, 46, 50, 57, 59 and 66. Per Lehigh County's Signature 65 Plan Summary of Benefits, the member pays the Medicare Part B deductible and the Plan pays the Medicare Part B coinsurance, but Highmark cites a difference in service line to support payment of the Part B deductibles under major medical benefits on these sample claims. We see no relevance of service line from the plan documents review, and we request further direct discussion regarding this issue so that total plan impact can be assessed.	 Items 43,46,50,57,59 & 66 Highmark maintains our response disagreeing these samples were processed incorrectly. Highmark standardly considers the Medicare Part B deductible under the Major Medical Line of Business for Signature 65 plans. Highmark would be happy to discuss this is more detail with the client during the audit close out meeting.
Page 18 JGI disputes $20,344 paid on Items 83 and 85-86 and $14,441 on out-of-sample claims for lack of recovery on retroactive terminations by Highmark. According to the contract between Lehigh County and Highmark executed in July 2018, the "Sponsor may request that Highmark undertake reasonable and good faith efforts to reprocess certain Claims as result of...(iii) retroactive benefit or eligibility changes that Sponsor made or in connection with other action by Sponsor, its employees or agents." Highmark responses on these claims do not seem to acknowledge any opportunity to recover claims based on retro terms, but we do not know of any reason a plan sponsor would want to fund claims paid for dates the member was not covered. Given the contract language, Lehigh County should request that Highmark recover these claims and begin doing so for all retro terms in the future. Recovery of retroactive terminations is standard in the industry and should not require a special request, but doing so will ensure that Lehigh County recaptures all expenses possible.	 Items 83,85 & 86 Any claims incurred up to the date that Highmark received a cancellation notice must be considered for payment and remain paid. Item 83 At the time this claim was processed, the member had active coverage in group 025377-37. The date of service on this claim was 03/03/21-03/18/21. Highmark was notified on 07/28/21 to retro-actively terminate the member back to effective date 02/01/21. Item 85 At the time this claim was processed, the member had active coverage in group 025377-38. Highmark was notified on 2/17/21 to retro-actively terminate the member back to effective date 1/23/21. Item 86 At the time this claim was processed, the member had active coverage in group 025377-25. The date of service on this claim was 05/05/21. Highmark was notified on 05/17/21 to retro-actively terminate the member back to effective date 05/01/21.

John Graham Initial Observation/Conclusion	Highmark Draft Report Response
Page 18 The payments totaling $40,947 on Items 87-91 are for newborn grandchildren who are not likely eligible for the Lehigh County plan, but Highmark is extending coverage for these newborns for up to 31 days following birth. It is highly likely that these children had other coverage available that would have paid for these claims if the County's plan did not extend coverage for children not enrolled in the plan. We would encourage the County to review these cases and confirm that it wishes to continue extending coverage given the fact that these children are likely not eligible plan members. Further, we generally recommend that plans avoid extending coverage to newborns not enrolled so that the plan which is covering the child can pay the claims instead.	Items 87, 88, 89, 90 & 91 Highmark maintains our response these claims were processed correctly. Act 81 coverage covers grandchildren, for the first 31 days, if the mother or father is an eligible dependent on the contract. Benefits are provided to newborn children of members from the moment of birth for 31 days. Highmark would be happy to discuss this is more detail with the client during the audit close out meeting. Benefit Book verbiage: Covered services provided to the newborn child from the moment of birth, including care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity, and routine nursery care. Routine nursery care includes inpatient medical visits by a professional provider. Benefits will continue for a maximum of 31 days. To be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent under this program within such period.
Pages 18 & 19 Item 180 represents a second routine gynecological exam for the member in one year for an overpayment of $100 in excess of plan limits. Highmark asserts that federal mandates allow two routine gynecological exams per year, but we know of no ACA or other requirement for coverage at this level. Further, the plan document specifically states that "Benefits are provided for one routine gynecological examination, including a pelvic and clinical breast examination, and one routine Papanicolaou smear (pap test) per calendar year." Highmark is paying in excess of this plan limit on the claim. JGI did not identify any additional out-of-sample errors, and we would not expect most members to seek two routine gyn exams within one year.	Item 180 Highmark maintains our response this claim was processed correctly. Per the Federal Mandated Benefits for Women's Health, gynecological exams are eligible twice per calendar year. Highmark would be happy to discuss this is more detail with the client during the audit close out meeting.

John Graham Initial Observation/Conclusion	Highmark Draft Report Response
Page 19 Item 183 paid $119 for a pre-employment examination, and services that are required for administrative purposes should be excluded from plan benefits as they are not medically necessary. Highmark states that the secondary diagnoses support the medical necessity of this visit, but the primary diagnosis shows that the exam was required for administrative purposes and should not be covered. One similar error was listed as an agreed recovery item above.	Item 183 Highmark maintains our response this claim was processed correctly. The sample claim was submitted with multiple diagnosis codes. Diagnosis code Z111 is eligible for reimbursement. This claim was processed correctly. Highmark would be happy to discuss this is more detail with the client during the audit close out meeting. (Z111- Encounter for screening for Respiratory Tuberculosis)
Page 19 Highmark has no review in place to apply the plan's exclusion of maintenance care (custodial care) as evidenced by the lack of review for the members on Items 184-185 with 40+ chiropractic visits in a year. This volume of visits with the same or related diagnosis suggests that these claims would be the definition of maintenance care, yet they were paid without consideration of the maintenance care exclusion. Highmark states that this benefit does not require submission and authorization of a treatment plan, but this simply substantiates that no review is in place to administer the exclusion. JGI would recommend a small visit threshold (six visits, for example) after which medical records should be reviewed to ensure that the visits follow a reasonable treatment plan with documented recovery from injury or illness. JGI disputes $123 paid on these claims based on the lack of review, but we are not projecting out-of-sample impact given the inability to state whether or not the cases actually count under the exclusion without clinical review.	Items 184 & 185 Highmark maintains our response these claims were processed correctly. Per the benefits, authorizations & treatment plans are not required, and there are no visit limits in place for physical medicine or spinal manipulations. Providers maintain treatment plans for their patients; however, treatment plans are not required with submission of claims. Highmark would be happy to discuss this is more detail with the client during the audit close out meeting.
Page 19 The County will need to determine plan intent for the coverage of services related to cochlear implants and other hearing devices. Item 186 paid $509 for a procedure code described as "Diagnostic analysis of cochlear implant, patient	Item 186 Highmark maintains our response this claim was processed correctly. The service rendered is related to a Cochlear Implant, not a Hearing Aid.

John Graham Initial Observation/Conclusion	Highmark Draft Report Response
younger than 7 years of age; subsequent reprogramming." The plan excludes hearing aid devices and does not mention coverage for cochlear implants. Some plans count cochlear implants under this type of exclusion, while others are only targeting external hearing aids for exclusion. Given that the plan documents do not mention cochlear implants and that this is a form of a hearing aid device, Lehigh County will need to clarify plan intent on this exclusion. If cochlear implants are excluded, then all related services like this payment should be excluded as well.	(Procedure Code 92602- (Diagnostic Analysis and Reprogramming of the Cochlear Implant Device) Per Highmark's medical policy, procedure code 92602 is medically necessary when submitted with diagnosis code H903. Highmark would be happy to discuss this is more detail with the client during the audit close out meeting.
Page 19 & 20 JGI disputes $834 paid on Item 187 for nutritional counseling, which is excluded in plan documents. Plan documents exclude "nutritional counseling, except as provided herein." There is no mention of nutritional counseling coverage in the plan document, but ACA preventive services generally require 8-10 visits to be treated as preventive. This member has 16 nutritional counseling visits for the year, so this exceeds the level we would expect under preventive benefits. Highmark does not appear to have this plan exclusion loaded at all, so clarification will be needed to get this in place moving forward.	Item 187 Highmark maintains our response this claim was processed correctly. Per the benefits, Medical Nutrition Therapy is an eligible benefit with no visit limit or benefit maximum. Highmark would be happy to discuss this is more detail with the client during the audit close out meeting.

Attachment C – Informational Findings

The following table lists the Informational Findings noted in JGI's draft audit report that Highmark has researched and responded to in the table included below. Page references to JGI's draft report have been included for ease of review.

John Graham Informational Findings	Highmark Draft Report Response
Page 21 Highmark does not have Medicare Part B estimation in place on the Lehigh County plans, thus causing the County to continue paying primary for members who could have Medicare primary coverage for far less total cost. The County paid over $60,000 on Items 4-5, 7, 9-11, 16, 77-80 and 99 for members who are age-eligible for Medicare and on Retired or COBRA segments of eligibility. We did not dispute these claims as we have no evidence of Medicare	Highmark would be happy to discuss this with the client during the audit close out meeting.

John Graham Informational Findings	Highmark Draft Report Response
estimation in the plan documents, but JGI considers having Medicare estimation a best practice for plans unless there are specific reasons not to include this. Medicare estimation is the practice of reducing plan payments to the amount the plan would have covered after the Medicare primary payment even if the member does not enroll in Medicare (this is generally applicable to Parts B and D since Medicare Part A enrollment is automatic and without cost to the member). The purpose of this feature is to provide financial incentive for members to enroll in Medicare so that the plan is not bearing the cost of such claims. We have even worked with some clients that have programs to cover the cost of Part B premiums as part of the Medicare estimation requirement since this is usually far lower than claims expenses. We would encourage Lehigh County to consider adding provisions for Medicare estimation to protect the plan against unnecessary costs. Highmark should have standard plan document language for this, but JGI can assist with creating this language if needed and at the appropriate time.	
Page 21 Items 92-95 represent four family members with well over $1 million paid for the same high dollar drug treatment without clinical review by Highmark. While it is possible that all four require the same treatment for an inherited condition, we are surprised at the lack of review of this case given this somewhat odd billing pattern and the exceptional amounts paid. JGI requested validation that all four family members were receiving the same treatment, and Highmark responded that the drug in question "does not require prior authorization. Per Highmark's medical policy, procedure code... is medically necessary when submitted with diagnosis code..." Highmark should consider adding information in response to the audit report about its review and management of this case.	Items 92,93,94 & 95 Highmark disagrees these claims were processed incorrectly. Procedure code J0584 does not require prior authorization. Per Highmark's medical policy, procedure code J0584 is medically necessary when submitted with diagnosis code E8331. Diagnosis code E8331 indicates Family Hypophosphatemia which supports this service being billed for multiple family members. Item 94 This member was referred to Highmark's Case Management area on 4/12/21, 11/24/21, 1/6/22 & 9/5/22. Member has been unable to reach for every Case Management program referral. Items 92,93 & 95 These member's did not have any inpatient events, gaps in care, risk factors or procedures to be identified for a potential Case Management program.

John Graham Informational Findings	Highmark Draft Report Response
Page 21 Though not assessed as an error, Item 168 shows waiver of patient portions due to COVID policies at Highmark that are broader than federal mandate requirements. This sample claim is for an office visit with a diagnosis of acute sinusitis, and Highmark waived the copay based on its COVID policy. Highmark states "Due to covid/flu related diagnosis codes reported, cost share is waived for office visit when a Covid test is performed within 7 days after the visit." Federal mandates require waiver of patient portions on the day of service when a COVID test is performed or for office visits that are specifically related to establishing the need for a COVID test, so this policy is broader than the federal mandate. Lehigh County should be aware of Highmark's position and confirm its acceptance of this practice if it aligns with plan intent.	Item 168 Highmark maintains our response disagreeing this claim was processed incorrectly waiving cost share. Claim 21352661329 was submitted with two diagnosis codes J0190 (acute sinusitis) and Z20828 (contact with and exposure to other viral communicable diseases). The member received a COVID test (claim 21252935452) on the same date of service as the sample claim. Coronavirus (COVID-19) testing and related services, including Rapid, Antibody and Screening tests, will be covered with no member cost share for all groups and products. This includes both in-network and out-of-network, when performed by a medical provider.
Page 22 Lehigh County requested a review of Highmark's practices around the application of multiple copays per day, and we were able with several sample claims to establish that Highmark is applying copays on the individual provider and service level which means a member can be charged multiple copays per day even for two bills from the same provider group or two services in the same visit. On Item 169, Highmark assessed both a spinal manipulation and physical therapy copay on the same claim. This is an unusual position as almost all of our clients limit copays to one per visit. While the plan documents do not appear to be explicit about this topic, we would encourage Highmark and Lehigh County to talk about plan intent in relation to this claim and Items 177-178. For these two claims, Highmark applied multiple copays for therapy services rendered by two different providers within the same clinic or group. Most of our clients also limit copays to one per type per provider group, but Lehigh County would need to determine if it was comfortable with the current approach or wanted to implement a	Per the benefits, the copayment application is per visit not per day, per provider. Highmark would be happy to discuss this in detail with the client during the audit close out meeting. Items 169, 177 & 178 Highmark maintains our response these claims were processed correctly. Multiple dates of service were submitted on each sample. Benefits are applied based on the benefit category for each service submitted. Each type of therapy has a per visit copayment. Item 172 Highmark disagrees this claim was processed incorrectly. Benefits are applied on a line-by-line basis based on the benefit category for each service submitted. Line 1- office visit subject to copayment Line 2 -surgery subject to cost share Line 3- injection subject to cost share

John Graham Informational Findings	Highmark Draft Report Response
revision. Item 172 is a case where Highmark adjudicated an office visit claim with the specified copay applied but also applied deductible and coinsurance member portions to other individual lines of the claim. This example shows that Highmark is administering patient portions at the individual service line level. Once again, most of our clients have setups that waive most if not all additional patient portions incurred during a copay visit. Lehigh County will need to decide if these practices are acceptable and, if not, work with Highmark to determine if it can administer alternatives that better align with plan intent.	
Page 22 Highmark is administering the limit on skilled nursing facility coverage for the Signature 65 plan by the Medicare-defined benefit period rather than per contract year, but the plan document does not seem to align with this interpretation. The plan documents available to JGI state that the SNF limit is 100 days per benefit period, but the benefit period is defined as the contract year. Highmark stated in response to Item 181 that "Per the benefits, the member is eligible for 100 Inpatient Skilled Nursing Facility days per Benefit Period. Please see the attached verbiage which explains that the Benefit Period relating to Inpatient SNF stay starts on the first day of an Inpatient Facility stay, and ends when the patient has not been inpatient, either at a facility or a SNF, for 60 consecutive days." This matches the Medicare definition of the benefit period which likely makes sense for the Signature 65 plan, but Lehigh County should confirm that this limit in Signature 65 plan documents is defined in this manner. We only have a chart of benefits for this product which does not contain these definitions.	Item 181 Highmark maintains our response disagreeing this claim was processed incorrectly. Per the benefits, the member is eligible for 100 Inpatient Skilled Nursing Facility days per Benefit Period. The Benefit Period relating to Inpatient SNF stay starts on the first day of an Inpatient Facility stay, and ends when the patient has not been inpatient, either at a facility or a SNF, for 60 consecutive days. Therefore, a new benefit period started on 09/02/2021 for this member.
Pages 22 & 23 Lehigh County asked us to evaluate specific transactions with no valid claim identifier totaling over $40,000 that were all processed on the same day in 2021,and Highmark has stated that these payments are all related to a 1% incentive	Items 188-200 Highmark maintains our response and agrees the 1% incentive payment for (Quality Blue) is related to the incentive for Lehigh Valley. As requested by JGI, additional information was provided back to them on September 30, 2022 outlining the

John Graham Informational Findings	Highmark Draft Report Response
(Quality Blue) for a specific hospital related to claims incurred in 2020. Highmark has tied the payments on Items 188-200 to specific claims from 2020 and confirms that each is a payment of 1% additional related to this program. JGI has requested additional detail about this program including something to show how the provider met conditions supporting the additional payment. We believe it is important that the County understand the underlying logic and value of these payments given that they occur well after completion of a contract year.	qualifying metrics that were used to calculate the Incentive percentages. If additional information is needed, Highmark will be more than happy to provide additional documentation.
Page 23 Lehigh County has expressed an interest in understanding cost variance amongst hospitals in its service area, and JGI sampled a number of claims to assist in assessing the underlying contracted rates driving payments across multiple types of services. We observed from this review that outpatient pricing appears to be fairly similar across the highest utilized facilities, but there is meaningful variance in inpatient rates. Specific discussion with Highmark about utilization and pricing of inpatient claims may offer opportunities for further cost savings if desired by the County, but JGI is not able to assess quality or the range of services offered by different facilities. It is possible that only a higher-cost facility, for example, is able to treat specific conditions, offer certain equipment or treatment or handle higher-severity cases. All of these factors would have to be part of this type of discussion, but our observations show that at least the discussion is warranted. Reporting from the Quality Blue program discussed above may assist some with this as well if such reporting can establish anything about quality measures across facilities.	Highmark will facilitate a separate discussion about utilization and pricing of inpatient claims outside of this audit. Highmark's Sales team will plan to meet with Lehigh County regarding their interests in understanding cost variance.

John Graham Informational Findings	Highmark Draft Report Response
Page 23 Lehigh County also requested that JGI assess utilization patterns for ER visits out of concern for upcoding the level utilized. We are able to observe little to no use of ER levels one and two in the paid claims data, and a bell curve with the remaining levels with level four being the highest used. While we cannot draw conclusions about these patterns, we can offer two observations that might assist in alleviating some concerns about these trends. First, we believe the limited use of levels one and two may be due to the fact that these codes are tied to conditions that would not likely be considered emergency use of the ER. Examples generally linked to levels one and two are uncomplicated insect bites and simple trauma with no x-rays utilized. One could reasonably argue that this type of care is intended to be handled in office or other urgent care settings and not the ER. This may account for the limited use of levels one and two coding for ER visit. Second, the time period of this audit was impacted by a global pandemic that impacted the severity of many respiratory conditions and may have led to high-level use of resources in the ER. We would welcome Highmark's commentary about this concern and especially any review processes in place to ensure that providers are not upcoding ER levels given the increased revenue likely tied to the codes.	Highmark will facilitate a separate discussion about utilization patterns for ER visits outside of this audit. Highmark's Sales team will plan to meet with Lehigh County regarding their concerns.