Audit and Finance Committee
Minutes – Approved
February 28, 2017
Old Jail Conference Room

Present: Steve Thayer, Chuck Rankin, Mack Cook, Rordan Hart, Laura Shawley, Bud Shattuck, Genevieve Suits (arrived at 3:57 p.m.)
Absent: Phil VanWormer, Peter Salton
Guests: Judy Drake, Board of Directors Chair; Don Barber, Executive Director; Rick Snyder, Treasurer; Steve Locey, Consultant; Ann Rider, Town of Enfield; Carolyn Guard, BMI (via conference call); Ed McDermott, BMI; Beth Miller, Mary Stubley, Excellus

Call to Order

Mr. Thayer, Chair, called the meeting to order at 3:32 p.m.

Changes to the Agenda

There were no changes to the agenda.

Approval of January 24, 2017 Minutes

It was MOVED by Mr. Cook, seconded by Mr. Thayer, and unanimously adopted by voice vote by members present, to approve the minutes of January 25, 2017 as corrected. MINUTES APPROVED.

Executive Director's Report

CanaRx

Mr. Barber said the Committee has been provided a draft copy of a resolution to move forward with CanaRx and noted the Consortium's attorney has reviewed the document. Mr. Cook said as a Board member he continues to have concerns with taking action that is counter to the attorney's opinion. He questioned whether the Consortium would be at risk by entering into an agreement even though it may be in the best interest of employees. He stated that it may be in the short-term interest of the Consortium but may put it at risk in the long-term.

When asked what the Department of Financial Services has said about this Mr. Locey said DFS has only advised it is not in violation of New York State Insurance Law and suggested the Consortium look at other municipal and education laws in New York State. He said Mr. Powers pointed out there could be some potential issues in federal law. Mr. Locey reviewed possible but unlikely scenarios that could happen: DFS could pull the Consortium's Certificate of Authority or could issue a Cease and Desist order. Mr. Barber noted the Consortium has reached out to the Department; therefore, it isn't a situation where they haven't been informed. Mr. Shattuck asked how easily the Consortium could get out of this arrangement if ordered to do so; Mr. Locey said use of CanaRx could stop immediately. It was noted that the Consortium would not have a contract with CanaRx, it would be a voluntary arrangement between a member and CanaRx.

Mr. Locey suggested bringing labor groups into the process and making them fully aware of the possibility of having to revert back to the current situation if the Consortium was ordered to stop the program.

Suggestions were made and will be incorporated in the draft resolution that will be presented at the next meeting in March.

Prescription Drug Tier 4 Discussion

Mr. Barber said as Mr. Locey and his staff have been looking into adding a fourth prescription drug tier to Consortium benefit plans they have found within New York State Insurance Law the Consortium cannot have a different copay for a tier 4 than it has for tier 3. Although ProAct is looking into what other options exist with specialty medications, moving forward with a fourth prescription drug tier is now on hold.

BMI Medical Audit

Mr. Barber introduced Ed McDermott of BMI to provide a report on the recent medical claims audit. Mr. McDermott said this was the third audit BMI has conducted for the Consortium and they have used the same process. BMI has a proprietary health benefit auditing software, Audit IQ, which is essentially a relational database that is built on a sequel server framework. It is extremely robust technology that brings in all the rules of accurate claims administration. They built into the program all plan exclusions, limitations, and parameters, therefore, there will be a different implementation of Audit IQ for each of the plans. They then bring in eligibility data followed by claims data. The claims data is run against the parameters set within the database and generally a large list is returned. Once a list is generated BMI auditors sort and go through each of the claims and particularly pays attention to the episode of care to identify patterns.

Mr. McDermott explained how they look at each claim and identify a list of claims they would like to further review on-site. For the Consortium, however, they were able to receive data electronically from Excellus. After gathering and evaluating this data, they took another look to make sure that claims being submitted as errors were indeed errors. They turned over a list of errors to the administrator (Excellus) and asked them to tell whether they agree with BMI and if they do not agree, why they paid the claim. That verbatim explanation is included in the audit report presented. This brings them to the point where they are now of working with the post audit support coordinator. He introduced Ms. Guard and explained how her experience and wealth of knowledge brings the technology, clinical knowledge, and insurance knowledge to the process.

Ms. Guard said based on the items that continue to be outstanding issues she has compiled a project management spreadsheet that she has also provided to Excellus. It contains information that will be needed from Excellus by March 10th to follow-up to ensure the Consortium's claims have been processed according to plan intent. She said Excellus has confirmed receipt of the information and will be complying with the deadline and expects to be able to report back to the Committee by its next meeting. She said they have broken the claims out into four categories: plan-related, coding-related, fraud and abuse, financial impact to the plan and timely filing of claims, and other party liability.

Mr. McDermott commented about the process timeline and said they are at the point where the first report has been published and they are entering the period of further investigation. He hopes after receiving further information from Excellus that they will be able to provide further clarity on the remaining issues.

Mr. McDermott said based on the past audit and the work that BMI did on behalf of the Consortium Ms. Guard had some concerns about the responsiveness of Excellus. While she stated she had a good relationship with the one individual she worked with for the audit project, overall the responses they have received from Excellus could not be characterized as cooperative. He said any conversation that could take place between the Consortium and

Excellus to facilitate the information being exchanged would make the post audit part of the process more effective.

Mr. McDermott read the final statement by Excellus in the audit summary response: "Overall, the audit performed by BMI was for medical appropriateness through the use of BMI's software to review medical procedures and diagnosis. The claims were reviewed judgmentally without the review of actual medical record documentation. In several cases conclusions were made based solely upon the CPT code or on diagnosis for determination of the appropriate payment of the claim benefit. There are many other components that are integrated into the claim processing system. For example, clinical edits, software, Excellus medical policies, and internal claim pends or suspends though one dimensional aspect of the audit software does not always merge easily with the complexities of a claim processing system". He said this statement is inaccurate and unwarranted in BMI's view.

He said the statement is inaccurate because BMI was performing the audit for medical appropriateness and that is a small part of what the audit was staged around. It was not only for medical appropriateness but for accuracy, administrative-correctness, and everything that goes into whether a claim should be paid and judged the way that it is. He commented the claims being reviewed "judgmentally" has a specific meaning to BMI. In this type of auditing there is a very focused audit which there is some methodology for selecting the claims that are going to be the subject for the audit. In a judgmental audit, which is specific to BMI, they build the case "from the ground up" rather than using assumptions and use evidence to make judgements about what claims are accurate and what claims are not accurate. The statement that "claims were reviewed without actual medical documentation" is incorrect because they had actual medical documentation that BMI was assisted in getting from the Excellus system by the Excellus employee who worked with BMI on the audit.

Mr. McDermott further stated that decisions were not based "solely upon the CPT code or on diagnosis for determination of the appropriate payment of the claim benefit". Also, BMI is very well-aware of the complexity of claims payments systems and although audit software does not always merge easily with the complexities of a claim processing system, the system used by BMI goes well-beyond a one-dimensional software-based system alone.

Mr. Barber said when the report was initially received from BMI there were 114 items that needed further work and that list has now been consolidated down to 37 items. Out of that list 14 are considered to have been resolved due to work done in past audits. He said six items require the Board of Directors to make decisions and they will come back to the next Committee meeting. The remaining 17 are issues that continue to be worked on with Excellus.

Mr. Locey said due to reoccurring findings, a goal from this audit will be that whenever items are identified that Excellus needs to fix that there be follow-up to mandate Excellus to fix them. Also, in cases where Excellus did not comply with national coding guidelines, they need to comply with those guidelines or bring forward their reasoning to the Board of Directors.

Ms. Guard expects to be able to report back to the Consortium on the status of the audit by March 14th. The Committee will include this on its agenda for the March 21st meeting.

Approval of Invoice

There was a brief discussion concerning the approving payment of the final invoice for BMI while the process has not yet been completed. Mr. McDermott commented that the delay is due to the amount of time BMI has had to wait to receive information from Excellus and

suggested that in the future BMI move to an interim payment system to avoid impacting the Company's accounts receivables.

On motion and duly seconded, and unanimously adopted by voice vote by members present, the final invoice dated January 4, 2017 was approved. MOTION CARRIED.

Discussion of Addition to Excellus Administrative Services Contract

Mr. Barber said there is new language within the Excellus Administrative Services Contract (Section 6.7) relating to provider quality improvement programs. It specifically states that "BlueCross BlueShield may from time-to-time enter into arrangements with participating providers that are designed to drive improvements to the cost and quality of health care delivery within the service area and such arrangements may include risk-sharing programs whereby participating providers are paid compensation and other remuneration for achieving certain performance targets as well as other programs that may result in associated vendor fees and provider receiving compensation for providing quality infrastructure and meeting certain quality operational goals. The payments described in this section may be included as a claims expense or as a separate amount charged by Excellus to the employer. In any event these payments exceed actual program costs Excellus may apply such funds to future quality improvement programs."

Mr. Barber recalled when the Consortium was approached by CAPA (Cayuga Area Physicians Alliance) with a request for $300,000 to implement their Clinical Integration program; however, the Consortium asked for further information before making a commitment to the program. At some point CAPA stopped communicating. Although it was known that CAPA was approaching insurance companies to fund Clinical Integration, we were surprised to find language incorporated into the Consortium's contract with Excellus that appears to put the Consortium on the hook for funding Clinical Integration without any input to the dollar amount or outcomes data sharing of savings.

Ms. Stubley spoke of the changes that have taken place since she reported to the Consortium a couple of years ago and said there have been many changes in the industry. Medicare and Medicaid are incentivizing providers around cost and quality. They are driving changes in the payment system and trying to move away from fee for service payment and provide for more upfront payments with goals in place. This is the first year under Medicare that providers are being measured on a composite score of quality and efficiency. They are being measured this year but their payments in 2019 can be increased or decreased based on that score.

Ms. Stubley said the Excellus ACQA (Accountable Cost and Quality Arrangement) Program is aligned with what they are seeing from the State and Federal governments. They are working to be aligned with all of those changes and why providers are looking to Excellus as an insurance company to collaborate on these cost and quality goals and to find efficiencies. She said the contract language is very general; it allows Excellus to handle the quality and incentive programs that it develops as part of the rate negotiation process. She said rate negotiations are very complex and include a lot of variables and performance in cost and quality programs is one of those areas. They identify cost and quality goals for a population and set cost and quality charges for those patients. If they hit those goals they receive a different reimbursement rate for the following year and if they miss the goals they will receive a lower reimbursement rate. She said they are seeing better performance and better quality outcomes than the non-ACQA population but it is hard to measure the return on investment as it is still evolving.

Mr. Locey asked why it is included in the contract if it is built into the reimbursement to the provider and whether there are additional monies going to the claim provider as part of the system. Ms. Stubley said there are additional monies going to the provider outside of the claim payment; however, they are seeing some rate changes in the market. The language was intended to be general because they do not know what will be coming from the State and Federal governments. Mr. Locey asked if the fees will be separated and identifiable in the bills received from Excellus to be able to gauge its effectiveness. Ms. Stubley said Excellus is not pulling it out separately, it is part of the claim payments as it is hypothetical.

Mr. Barber said the Consortium would be making a payment for a program but has no idea of what the program's objectives or accomplishments are, therefore, there is no accountability from the Consortium's standpoint. He asked if the Consortium would know if Excellus decides to make an assessment at some point in the future. She said the program doesn't currently have an assessment but is willing to report annually on the status of what they are looking and present the quality results. Mr. Locey said if there is no additional fee currently being charged he doesn't see a need to include language in the contract that authorizes Excellus to charge a fee that is currently not being charged but may be charged in the future.

Mr. Hart said he would like to know if Excellus would sign the next contract if this language was removed. He said although the Consortium is getting bigger the premiums are from taxpayer dollars and having the Consortium being subject to an open-ended cost without knowledge of what it is would be a problem. Ms. Miller said the language is intentionally vague to allow things to change if needed and may also be related to Blue Card fees; she will check with the legal department at Excellus and get an answer to Mr. Hart's question.

Ms. Stubley provided information on quality results that are being seen through the ACQA program. Slightly less than half of the Consortium's members are in an ACQA, most being in a Cayuga Area Plan. She also noted that they are seeing more of a willingness by providers to share data. Mr. Locey stated one of the big gaps that exists within the system is physicians having access to real-time information about pharmaceuticals that includes costs and effectiveness. Ms. Stubley said there is a pharmacist dedicated to ACQA and they will be adding another because the experience has been so positive; the pharmacist is looking at utilization and identifying drugs that have a lower cost alternative. Mr. Locey suggested it would be helpful if physicians had easy access to a database that included medications and pricing when issuing a prescription.

Financial Update

Mr. Locey reviewed the Treasurer's report through January 31, 2017. He noted the Consortium's contract count is up by 2.3% over 2016 and up 2.14% in covered lives. This has resulted in revenue being slightly higher 1.5% over where it was projected to be; medical claims is 47% below budget; however, results are based on only one month. Prescription drug claims are 2.9% above budget. He also called attention to the Consortium being at 5,200 covered lives and 2,400 contracts. This is an 18% increase in covered lives and 20% increase in contracts with an increase from 13 to 28 entities since the Consortium first started operations. Mr. Locey reported all incurred and paid data has been sent to the Actuary as well as updated demographic information through January, 2017.

Mr. Snyder reported on the year-end closing and said the JURAT will be provided to Bonadio within a week for review. A final JURAT should be ready at the end of March for submittal to the State by April 15th.

Process to Pay Invoices

This item was deferred to the next agenda.

Administrative Procedures for Request for Proposals

This item was deferred to the next agenda.

Invoice Approval

The Committee was presented with invoices from Hancock and Estabrook and the Department of Financial Services were presented for the Committee's information.

Mr. Locey will include a line item in the budget for the DFS Audit.

Next Agenda Items

The following items will be included on the next agenda:

Adoption of Administrative Procedures for Requests for Proposals;
CanaRx Resolution;
Invoice payment process; and
BMI Audit update

Adjournment

The meeting adjourned at 5:20 p.m.