Memorandum

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To: Hon. Solomon C. Stinson, Chair
and Members, Miami-Dade County School Board

From: Christopher Mazzella, Inspector General
for Miami-Dade County Public Schools

Date: November 5, 2009

Subject: OIG Final Audit Report Re: *Miami-Dade County Public Schools Workers' Compensation Program*, Ref. IG08-25SB

Attached pleased find the above-captioned final audit report. This audit was initiated because of an allegation that the Miami-Dade County Public Schools (M-DCPS) Workers' Compensation (WC) Program is mismanaged. The complaint referenced a recent audit of the Broward County Public Schools (BCPS) WC program that uncovered hundreds of thousands of dollars in questionable billings. The BCPS program was administered by the same vendors that M-DCPS contracts with to provide program services. As such, we believed it was prudent to conduct a similar review, albeit with modified objectives and scope tailored to fit the current M-DCPS contract.

A copy of this report, as a draft, was provided to M-DCPS and its current service provider, Gallagher Bassett Services, Inc. (GB), for their comments on September 24, 2009. We received M-DCPS' response to the draft report on October 22 and GB's response on October 20, 2009; they are attached, in their entirety, to our final report as APPENDIX A and APPENDIX B, respectively. We have included their comments within our report. Please be advised that the OIG is requesting from the Superintendent and staff an informational report in 90 days on the status of recouping identified overpayments and the status of implementing certain other recommendations. We respectfully request that we receive this report on or before February 5, 2010.

For reading convenience, the next page contains a short abstract of our report findings.

cc: Alberto M. Carvalho, Superintendent, Miami-Dade County Public Schools
Walter J. Harvey, School Board Attorney
Jose Montes de Oca, Chief Auditor
Dr. Richard H. Hinds, Associate Superintendent and Chief Financial Officer
Scott B. Clark, Risk & Benefits Officer
Members of the School Board Audit Committee
Gallagher Bassett Services, Inc. (under separate cover)

Our report chronicles that, until this year, M-DCPS has not competitively solicited for WC claims administration services since 1994, thus giving the incumbent vendor 15 years of noncompetitive service. We believe that good public contracting practices demand that government-funded business opportunities are made available to all interested parties via competitive processes. Periodic competitive solicitations help ensure fairness in the awarding of contracts and that the contracting agency is receiving best value and quality services. We are providing observations and comments on the new Request For Proposals for *Workers' Compensation and Third Party Claims Administration Services* to the administration, and we intend on providing oversight services during the procurement process.

Quantifiably, the audit found $194,503 in questioned costs resulting from (1) GB's improper use of the imprest fund—i.e., M-DCPS money—to pay for disallowed fees, penalties, and interest that were GB's responsibilities; (2) GB overpayments of inpatient hospitalization charges and physical therapy charges; and (3) M-DCPS paying GB for contract deliverables that we believe never materialized. We also identified up to $136,000 in additional potential financial benefits to M-DCPS that will require GB to "audit" all inpatient hospitalization charges since July 2007, and all physical therapy charges since September 2008.

Lastly, the remaining OIG findings relate to our evaluation of the lack of service level specifications in the contract, other questionable contract terms, and contract administration processes and controls. We observed that M-DCPS trusts that its vendor's bill review engine will timely detect and correct payment errors, but we found that M-DCPS does not periodically verify that to be the case. We recommend this review be done. We elaborate on several aspects of the contract's pharmacy benefits program. We also note that GB was slow to respond to the growing and costly problem caused by network physicians that were self-dispensing repackaged drugs. Repackaged drugs added over $515,000 to WC program drug costs in 2008. We also observed that field case management assignments have all been directed to one preferred firm, and that this firm has received over $700,000 in fees over 18 months from M-DCPS without an executed contract. Finally, we note the lack of a loss prevention program at M-DCPS, which we believe is an important program component to prevent employee injuries, to minimize their severity, and to cut costs. We recommend that resources be re-directed towards this effort.

MIAMI-DADE COUNTY
OFFICE OF THE INSPECTOR GENERAL

FINAL AUDIT REPORT

Miami-Dade County Public Schools
Workers' Compensation Program

IG08-25SB

November 5, 2009

TABLE OF CONTENTS

I. INTRODUCTION

The Miami-Dade County Office of the Inspector General (OIG) has conducted an audit of the Miami-Dade County Public Schools (M-DCPS) Workers' Compensation (WC) program. We conducted this audit pursuant to our authority under the Interlocal Agreement between the County and the School Board. Florida Statutes, Chapters 440 and 1012, govern the M-DCPS WC program. State of Florida workers' compensation laws provide both medical and monetary benefits for employees who are injured on the job because of an accident or occupational disease. Medical benefits are provided for the cure and relief of the injury and to provide rehabilitation and retraining services to injured workers unable to return to their former jobs. Monetary benefits are referred to as indemnity benefits and provide cash payments to injured workers to replace a portion of wages lost when they are unable to work due to personal injuries or diseases sustained while performing their work duties. Additionally, indemnity benefits provide payments to injured workers for injuries that result in permanent disabilities.

The M-DCPS WC program is self-insured. M-DCPS contracts with a firm to be its WC program claims administrator. Under the current contract, the firm provides a full spectrum of WC-related core managed care services and non-core services, including access to networks and personnel that provide medical, rehabilitative, pharmacy, and case management services; a first notice of injury reporting service; bill review and re-pricing services; and claims investigation. At present, the M-DCPS WC program claims administrator and managed care services provider is Gallagher Bassett Services, Inc. (GB). GB's current contract has a three-year term, which began July 1, 2007 and will end on June 30, 2010. The Miami-Dade County School Board, at its option, can renew the contract for two additional one-year terms.

Our primary audit objective was to assess the contractual relationships between and among M-DCPS, GB, GB's various service providers, and the other parties that affect the M-DCPS WC program. We wanted to evaluate whether and how these parties addressed the services required by the contract, and how effectively GB was providing the managed care services, given its outsourcing of these components to other providers.

II. TERMS USED IN THIS REPORT

AWP	Average Wholesale Price
Coventry	Coventry Healthcare
Flex Net	Flex Net, GB's custom designed, client-specific network
First Script	Coventry's pharmacy program
GB	Gallagher Bassett Services, Inc.
GBMCS	Gallagher Bassett Managed Care Services
LOA	Letter of Agreement
M-DCPS	Miami-Dade County Public Schools
OIG	Miami-Dade County Office of the Inspector General for M-DCPS
OPPAGA	State of Florida Office of Program Policy Analysis and Government Accountability
PBM	Pharmacy Benefit Manager
PT	Physical Therapy
RF	GB's Risx-Facs Database
RFP	Request for Proposal
RM	Office of Risk and Benefits Management (M-DCPS)
RM Officer	Risk and Benefits Officer, Office of Risk and Benefits Management
Seltzer	Seltzer and Associates
SB	Miami-Dade County School Board
Siver	Siver Insurance Consultants
WC	Workers' Compensation

III. RESULTS SUMMARY

Our report has 14 findings and 31 recommendations. Our findings range from comments on M-DCPS operating practices associated with the procurement of the subject services to evaluations of its contract administration processes and controls. OIG auditors quantified $194,503 in questioned costs resulting from (1) GB's improper use of the imprest fund—i.e., M-DCPS money—to pay for disallowed fees, penalties, and interest that were GB's responsibilities; (2) GB overpayments of inpatient hospitalization charges and physical therapy charges; and (3) M-DCPS paying GB for contract deliverables that we believe never materialized. We also identified up to $136,000 in additional potential financial benefits to M-DCPS that will require GB to "audit" all inpatient hospitalization charges since July 2007, and all physical therapy charges since October 2008, to quantify more accurately GB overpayments to the service providers.

Our report chronicles how M-DCPS has not competitively solicited for WC claims administration services since 1994, thus giving the incumbent vendor 15 years of noncompetitive service. We are not saying (nor did we find evidence) that the incumbent vendor has not been performing the required services in an acceptable manner; however, we believe that public contracting good practices demand that government-funded business opportunities are made available to all interested parties via competitive processes, no matter how well an incumbent vendor is providing services. Periodic competitive solicitations help to ensure fairness in the awarding of contracts and that the contracting agency is receiving best value and quality services.

A significant issue for the OIG was that the "platform" or program envisioned by staff to provide the necessary services to M-DCPS injured workers was not a fully developed working model of proven reliability when it was approved by the SB. In part, the newness of the platform and differences arising between staff and the vendor about how to implement this platform contributed to the questioned costs noted above. In addition, the lack of contract definitions and specifications were not only at the essence of many of our findings, but also attributed to the difficulty in auditing an "evolving" WC program. We observed that during the course of our audit, M-DCPS and GB staff actually implemented new program initiatives in response to OIG auditor questions and documentation requests.

Due to the contract's vagueness and non-specificity, we needed to ascertain how the vendor was securing program services from its sub-vendors/service providers in furtherance of the M-DCPS WC program. The vendor identified to us its service providers, as they were not named in the contract; however, it would not provide us with copies of its agreements. We asked for the agreements to be redacted of all proprietary information. GB did not accede to this request, either. We were advised that the national contracts did not apply to its contract with M-DCPS. Instead, we would be provided with alternative documents, which it characterized as "two documents that should outline our agreement with MDCPS regarding their unique managed care arrangement"[1] but then GB stymied our efforts. GB imposed egregious conditions on the OIG's access to these documents (documents that were purported to define the services and procedures developed exclusively for M-DCPS). On our own and without the support of M-DCPS staff, we were unable to obtain what we considered to be essential documents. We are disheartened by staff's lack of support for acquiring—what we believe is in their best interests to have in their possession—the vendor's written documentation of the "unique managed care arrangement" that it is providing under contract to M-DCPS.

[1] Email from Emil Bravo, GB Executive Vice President to OIG, dated June 11, 2009.

The OIG developed a number of findings and recommendations related to the vendor's pharmacy benefits program. First of all, the contract calls for a pharmacy program but provides no specifications (detailed or generalized) for what M-DCPS could or should expect as program benefits. In addition, records show that most injured workers have not been participating in the program and we observed that the vendor's "redirection program" to get injured workers into the program was not effective. We also believe that GB was slow to respond to the growing and costly problem caused by network physicians that were self-dispensing repackaged drugs. This added over $515,000 to WC program drug costs in 2008 alone.

We observed that M-DCPS does not periodically verify that the vendor pays medical costs in accordance with approved contract rates or fee schedules. It trusts that the vendor's bill review "engine" will adjust provider-invoiced amounts/rates to the correct figure, but does not take reasonable steps to verify that the engine is working correctly. The questioned costs that we noted earlier were uncovered during our review of only 48 case files out of the thousands that exist containing tens of thousands of payments. We were alarmed by the error rate found in our relatively small sample and discouraged that staff did not appear to be inclined to more aggressively review vendor payments. We strongly recommend that M-DCPS incorporate spot verification checks as one element of a structured oversight process to ensure that the vendor's bill re-pricing function is timely detecting and correcting payment errors.

Additionally, field case management services are existing in a grey area. The identified service provider, Seltzer & Associates, has been paid over $711,000 between July 1, 2007 and December 31, 2008, for services rendered, albeit without a contract between it and the School Board. We note that recently (during the course of our audit) a contract was prepared with an effective service date of January 1, 2009. The contract, in the possession of M-DCPS, has been executed by Seltzer and is dated June 30, 2009, but has not been presented to the School Board for approval. While we are concerned about the delay in contract preparation, we are foremost concerned with the fact that a single provider has received all of the field case management assignments. This arrangement smacks of a no-bid contract—if there were a contract, which there is not—and is contrary to other established vendor pool models within the WC program, such as those for attorneys and investigative firms. Lastly, our audit notes the lack of a loss prevention program at M-DCPS, which we believe is an important program component to prevent employee injuries, minimize their severity, and cut costs. We recommend that resources be redirected towards this effort.

Auditee Responses and OIG Rejoinder

A copy of this report, as a draft, was provided to M-DCPS and GB for their comments on September 24, 2009. M-DCPS and GB both provided responses to the draft report and they are attached, in their entirety, to our final report as OIG APPENDIX A and OIG APPENDIX B, respectively.

M-DCPS began its response by presenting a lengthy background of the current WC program. It then addressed the OIG's report by way of finding-by-finding narratives that included references to the associated OIG recommendations. M-DCPS concurred with the two OIG findings and associated recommendations on questioned costs related to inpatient hospitalization and physical therapy charges. Based on the OIG's early communication to GB of our identified overpayments, GB has already reimbursed $67,382 to M-DCPS for inpatient hospitalization overcharges, which staff has acknowledged receiving.

Regarding our other findings, staff often acknowledged the OIG issues by agreeing that the OIG has a point but then staff makes comments that tend to confuse or minimize the impact of the issue discussed in the finding. We note, however, that notwithstanding staff's characterizations of the OIG's analysis, they typically agree with the corresponding OIG recommendation. While we recognize that staff may consider the incumbent vendor as its partner in developing and implementing a "new" WC program, we believe that they should be more accepting of comments, observations, and insights resulting from a periodic external and independent assessment of the program that are beneficial to both M-DCPS and the vendor. We have included details of M-DCPS comments within our report by excerpting from its response and including those selections with our corresponding findings and recommendations.

GB's response also contained a background section on its perspective of the M-DCPS WC program. Similar in format to the M-DCPS response, GB addressed each finding in order by presenting its own supplemental or explanatory data about the finding, but GB did not typically address the OIG recommendations. GB, however, directly addressed the questioned costs contained in Finding Nos. 5 through 8. Like with the M-DCPS response, the OIG excerpted from GB's response and included those selections with our corresponding findings and recommendations.

IV. OIG JURISDICTIONAL AUTHORITY

The OIG provides inspector general services to M-DCPS pursuant to the Interlocal Agreement (ILA) between Miami-Dade County and M-DCPS. The ILA for inspector general services is expressly authorized by M-DCPS School Board Rule 6GX13-8A-1.08. The scope and jurisdiction of the OIG's activities is dictated by the ILA. Among the authority, jurisdiction, responsibilities, and functions conferred upon the OIG through the ILA is the authority and jurisdiction to make investigations of M-DCPS affairs, including the power to review past, present and proposed programs, accounts, records, contracts and transactions. In addition, the OIG may, on a random basis, perform audits, inspections, and reviews of all School Board contracts. The OIG has the power to require reports and the production of records from the M-DCPS Superintendent, School Board members, School District departments and allied organizations, and School District officers and employees, regarding any matter within the jurisdiction of the OIG.

IV. BACKGROUND

Miami-Dade County Public Schools

M-DCPS is the largest school district in Florida and is the fourth largest school district in the nation. It has an enrollment of over 350,000 students in 323 schools.[2] The district is governed by the Miami-Dade County School Board (SB), which is comprised of nine elected members. The SB is responsible for setting district policy, appointing a superintendent, approving contracts (above certain dollar amounts), and approving the district's annual budget. The M-DCPS Superintendent is charged with managing the day-to-day operations of the school district. M-DCPS employs over 45,000 employees and is the largest employer—public and private—in Miami-Dade County.

Among the various administrative offices supporting the school district is the M-DCPS Office of Risk and Benefits Management (RM). RM administers the M-DCPS WC program. The office is headed by the Risk and Benefits Management Officer (RM Officer), who is the WC program's primary decision maker and standard setter. Additionally, there are four other RM staffers that administrate the day-to-day operations of the program (one WC supervisor and three risk benefit specialists). They meet with injured workers; place injured workers in the M-DCPS Workers' Education

[2] Source: M-DCPS website: www.dadeschools.net

Rehabilitation & Compensation Program; process payroll, settlements, and requests for personnel actions; and keep track of Florida Retirement System credits.

Gallagher Bassett Services, Inc.

Gallagher Bassett Services, Inc. (GB), founded in 1962, is a wholly-owned subsidiary of Arthur J. Gallagher & Co. (AJG), an insurance brokerage company that was founded in 1927 as an insurance agency. GB's corporate headquarters is located in Itasca, Illinois (a suburb of Chicago).

Risk management is one of AJG's three operating segments. "The Risk Management Segment provides contract claim settlements and administration services for enterprises that choose to self-insure some or all of their [property/casualty] coverage and for insurance companies that choose to outsource some or all of their [property/casualty] claims departments. Approximately 69% of the Risk Management Segment's revenues are from workers' compensation related claims."[3] This amounts to approximately $320 million in operating revenues for 2008.

The M-DCPS WC Program — Overview

The M-DCPS WC program is self-insured. M-DCPS contracts with a firm to be its WC program claims administrator. As such, this firm provides claims adjustment and reserve estimation services, makes indemnity and medical claim payments, and prepares and submits state-required reporting. This model is similar to the one used by other school districts in the State of Florida, including the Orange, Hillsborough, Palm Beach, and Duval Counties.

In addition, under the current M-DCPS contract, the vendor provides a full spectrum of WC-related core managed care services and non-core services, including access to networks and personnel that provide medical, rehabilitative, pharmacy, and case management services; a first notice of injury reporting service; bill review and re-pricing services; and claims investigation.

At present, the M-DCPS WC program claims administrator and managed care services provider is Gallagher Bassett Services, Inc. GB's current contract has a three-year term, which began July 1, 2007 and will end on June 30, 2010. The SB, at its option, can renew the contract for two additional one-year terms. GB's contract is to provide <u>both</u> workers' compensation claims administration/managed care services and

[3] AJG's 2008 Form 10-K.

third-party liability claims management services. GB's annual fee is $5,811,261, which M-DCPS pays in monthly pro-rated installments.[4]

M-DCPS WC Contract History

GB has been the claims manager for the M-DCPS WC program for the last fifteen years. The M-DCPS last held a competitive solicitation to select a WC program claims administrator in 1994, at which time they selected GB. Since then, the SB has awarded four consecutive contracts to GB without holding open competitive solicitations, i.e., not issuing a RFP.

Initially, in 1994, the SB awarded WC claims administration services to GB and simultaneously contracted with the CorVel Corporation (CorVel) to provide WC managed care services. In 1999, both vendors (GB and CorVel) were joined in one contract to provide both claims administration and managed care services.[5]

In December 2001, the SB bifurcated the services of GB and CorVel. The SB amended its 1999 contract with GB to reflect the SB's decision to opt out of the State of Florida's defined managed care arrangement, thereby allowing GB's adjusters to oversee the total handling of the claims, inclusive of the medical aspects. In other words, GB's adjusters would take the lead in all cases, supported by CorVel's nursing staff. Concurrently with the amendment, the SB entered into a new and separate contract with CorVel to provide unbundled managed care services.

In July 2004, the SB again authorized non-competitive (but negotiated) contracts with GB for third-party claim administration services (including its WC program) and with CorVel for managed care services for WC claims. The contracts were initially for three-year periods with two one-year options to renew. In July 2007, opting not to renew either contract, the SB authorized a new contract with GB.

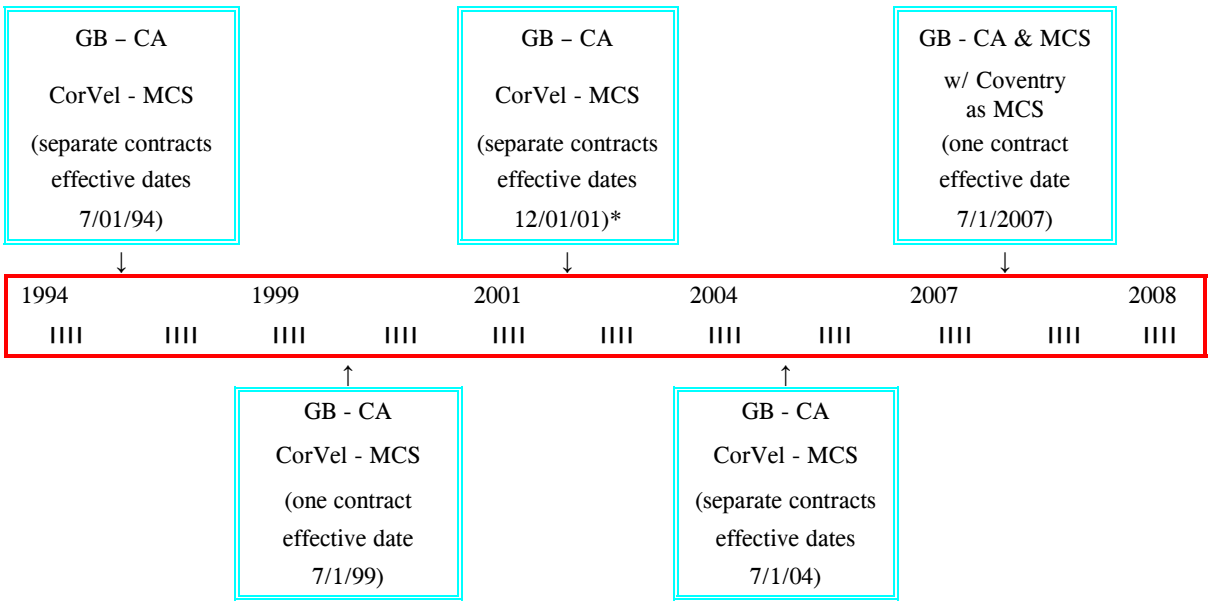
The current 2007 contract, which runs from July 1, 2007 to June 30, 2010, is with GB only. The contract encompasses all the services associated with the WC program—namely, claims administration and managed care services—and includes

[4] Of this amount, $865,200 is identified in the contract as being allocated for managed care services. The remainder of the fee applies to GB's claims administration services for WC claims and liability claims. Our visits to GB's Miami office, which exists solely to service M-DCPS, showed that GB had 25 employees for WC claims administration and seven employees for liability claims administration.
[5] The contract was actually between the SB and GB; however, the scopes of services to be provided by CorVel were expressly requested by the parties and compensation to CorVel for its services was expressly acknowledged in the agreement.

third-party liability claims administration. GB's obligations to provide M-DCPS with what the contract labels *Core Managed Care Services* include: customized network development and access; state fee scheduling; bill review; medical consultant services; a pharmacy program; and claim intake services. This time, instead of CorVel providing the managed care services, GB has outsourced these functions to Coventry Healthcare (Coventry). Coventry touts itself as the "leader in cost and care management services for workers' compensation insurance carriers, employers, and third-party administrators. Coventry offers an integrated suite of care management, pharmacy benefit management, and network services."[6] However, neither Coventry nor any other of GB's providers/contractors are identified in the contract.

Table 1 on the following page depicts the past five contracts that the SB has awarded related to the M-DCPS WC program.

Table 1 Miami-Dade County Public Schools Workers' Compensation Program Service Provider Contracts from July 1994 through December 2008



Notes:
CA – W/C Claims Administration Service Provider
MCS – Managed Care Services Provider
* The contract structure changed in Dec. 2001 due to a change in Florida law allowing employers to opt out of the state mandated managed care arrangement. Employers now had the option to establish their own more traditional managed care service arrangements. As a result, M-DCPS began contracting separately with CorVel for the managed care services portion of its WC program.

[6] Source: Coventry Health Care Workers' Compensation website: www.coventrywcs.com

The current contract term expires June 30, 2010. The contract allows two one-year options to renew. The OIG is aware that M-DCPS will be issuing a RFP to select a service provider for a replacement contract. We have been monitoring the preparation of a new RFP and have provided comments to staff regarding the content and form of the RFP and proposed contract.

Past Audits and Reviews of the M-DCPS WC Program

The OIG acknowledges that the M-DCPS WC program has not gone without review. Indeed, there have been several audits and reviews of the WC program. Scopes of review include best financial management practices reported by the Florida Office of Program Analysis and Government Accountability (OPPAGA); benefits disbursement and claims handling practices (reported by the Florida Department of Financial Services Division of Workers' Compensation [the DFS Division]); and the testing of internal controls of GB's RF database (performed by Ernst and Young [E&Y]).

In addition to these audits, we also note that there have been several M-DCPS requested reviews conducted by Deloitte & Touche, LLP (based on agreed-upon procedures) and by Siver Insurance Consultants, Inc. (Siver), which M-DCPS has retained as its insurance consultants.[7]

We note that the DFS Division report and the E&Y report, while overlapping with the OIG's audit period, did not use the same criteria and does not have the same objectives as the OIG's review. Primarily, the OIG's criteria was the 2007 contract's terms and conditions. The OIG relied upon mutual understandings, industry standards, and best practices where the contract obligations were not clear, as in the case of the managed care services and the pharmacy program. Our primary objectives were to evaluate GB's performance vis-à-vis its contract obligations and program benefits, and to assess the value of what M-DCPS was receiving.

Siver, M-DCPS' consultant, has performed various reviews of WC activities and processes occurring during the current GB contract period.[8] Siver has examined

[7] Siver Insurance Consultants, previously known as E.W. Siver & Associates, Inc., has been retained by the SB to provide insurance consulting services since 1977. It currently provides services to the SB at the rate of $150 per hour. Siver's agreement with the SB does not have an expiration date, nor does it have an established maximum compensation amount.

[8] Siver also presented a report in 2007 recommending that the SB accept the terms, conditions, and prices contained in the proposed July 2007 contract with GB. Siver's report was a high-level summary of the proposed renewal contract and did recommend its approval. However, given its expertise as the SB

the lack of participation in the First Script pharmacy (Rx) network; payment discrepancies within the bill review function; the collection of state fund recoveries; and PT program deficiencies. We believe that Siver's findings are constructive, but it also appears that some of the issues raised by Siver have not been addressed by M-DCPS since they continue to occur. For example, a large volume of prescriptions continue to be paid outside the First Script network (see Finding No. 10).

V. OBJECTIVES, SCOPE, AND METHODOLOGY

Audit Initiation

We initiated this audit in response to a complaint received by the OIG alleging that the M-DCPS WC program is mismanaged. The complainant stated that the M-DCPS WC program currently has a situation similar to one that previously existed in the Broward County Public Schools (BCPS) and that the BCPS program had been recently audited by the Office of the Chief Auditor of Broward County Public Schools. The complainant noted that the BCPS Chief Auditor, in May 2005, issued an audit report critical of the BCPS WC program and, according to the complainant, reported that hundreds of thousands of dollars were missing. The complainant also noted that the two prime contractors responsible for the reported problems were GB and CorVel, and that these were the same two providers contracted by M-DCPS to handle its WC program.

The OIG was made aware of a series of three audits performed at the request of M-DCPS by the certified public accounting firm of Deloitte and Touche, LLP. Deloitte and Touche issued audit reports dated June 20, 2003, May 18, 2004, and June 27, 2005, wherein it reported positive assurances about a number of issues. In addition, it also reported some problems that existed within the M-DCPS WC program and the practices of the WC program claims manager, GB, and its managed care services provider at that time, CorVel.

Lastly, early in our preliminary work, we learned that the contracts used by M-DCPS to obtain WC program claims management and managed care services had undergone four contract iterations in the past ten years. M-DCPS changed contracts but maintained the same providers—GB and CorVel—through the first three contracts

insurance/actuarial consultant, we question whether Siver should be performing services such as the one performed here—i.e., recommending a contract for approval. Likewise, given its subsequent reviews of GB's performance, we question Siver's objectiveness—given its earlier role in recommending that the contract be approved.

before dropping CorVel on its last change in mid-2007. At that time, M-DCPS handed over CorVel's responsibilities as the managed care services provider to GB, who previously had been functioning solely as the WC and third-party claims administrator.

The OIG believed that these factors collectively warranted a review of the M-DCPS WC program. One early OIG objective was to conduct a preliminary review in order to determine whether there were areas of concern (red flags) that were similar in nature to the findings observed in the BCPS audit. However, after learning of the changes to the 2007 contract and consolidation of services under GB's management, we opted not to look retroactively at processes and practices that were no longer occurring. Instead, we believed that a review of the current WC program would be more relevant and useful.

Audit Objectives

Our primary audit objective was to assess the contractual relationships between and among M-DCPS, GB, GB's various service providers, and the other parties that affect the M-DCPS WC program. We wanted to evaluate whether and how these parties addressed the services required by the contract, and how effectively GB was providing the managed care services, given its outsourcing of these components to other providers. In addition, we wanted to determine whether GB was complying with the terms and conditions of its contract and to determine its effectiveness as the M-DCPS WC claims manager and managed care services provider. Lastly, we wanted to evaluate the contract for outcome-based performance measures that demonstrate whether GB, as the responsible service provider, has been providing M-DCPS with a best value approach established in accordance with sound business practices and good public policy.

Audit Scope

The initial audit period covered workers' compensation claims and incidents occurring between July 1, 2003 and June 30, 2008. During our audit, when necessary, we reviewed data and events occurring before and after the initial period. Notwithstanding the five-year scope, we focused most of our efforts reviewing those transactions and activities occurring after July 1, 2007, which is the effective date of the currently operative contract, through the present time. More recently, as an ancillary function of our audit work, we reviewed and provided comments to M-DCPS on its **DRAFT** *Request for Proposals for Workers' Compensation and Third-party*

Liability Claims Administration Services. This proposal is scheduled to be presented to the School Board for consideration on November 17, 2009.

Audit Methodology

This audit was conducted in accordance with the *Principles and Standards for Offices of Inspector General* promulgated by the Association of Inspectors General (AIG), except as later described. The AIG *Principles and Standards* are in conformity with the *Government Auditing Standards* issued by the Comptroller General of the United States (2007 Revision).

To accomplish our objectives, we obtained from the M-DCPS RM Officer various documents related to the WC program, such as contracts, collective bargaining agreements, reports prepared by GB or other M-DCPS consultants regarding the WC program, WC program procedures, and other relevant information. We interviewed personnel from the M-DCPS Office of Risk & Benefits Management; GB executive personnel from its local, regional/state, and home offices; other M-DCPS WC program-related consultants; and staff from various other Florida school boards or municipal entities, including Miami-Dade County, about their interactions with the M-DCPS WC program or their experiences with their own WC programs. Our purpose was to gain an understanding of the M-DCPS WC program specifically, as well as to obtain a general understanding of WC programs provided by other public/governmental entities. We also obtained financial, operational, and programmatic data from GB related to claim filings during our initial scope period. Eventually, we expanded our data requests to include the period from July 1 through December 31, 2008.

We prepared flowcharts, tables, and schedules, as necessary, to document our understanding of the WC program processes and practices and to summarize the data into useable formats for easier analysis and reporting. Other data analysis included sorting the data to ascertain those core and non-core service providers with larger dollar billings, and reviewing selected invoices to ascertain whether GB paid them in accordance with the appropriate contract rates or fee schedule.

Among other steps, we selected a sample of 48 injured worker case files for a more in-depth review to determine whether they contained the required documentation and other records necessary for a reasonably and appropriately experienced individual to be able to ascertain current claim status, reserve estimation, and evaluate claim history. In addition, we reviewed the individual costs charged to the claim file to

ascertain whether GB paid them in accordance with the appropriate contract rates or fee schedule.

We looked at the M-DCPS and GB banking procedures related to GB's Imprest Fund, which is funded by M-DCPS and is used by GB to pay WC medical and indemnity costs, and other allocated claim expenses. Our purpose was to evaluate the internal controls surrounding the usage of this account; in particular, to evaluate the oversight that takes place to assure that GB pays only M-DCPS WC program costs out of the account.

In addition, we retained a subject matter expert to aid us in our evaluation of the M-DCPS WC process, our analysis of the documents and data obtained, and to provide us with a general understanding of the State of Florida's Workers' Compensation Statutes and Rules, and the intricacies of a WC program.

Scope Impairment

One audit objective was to evaluate the contractual relationships between and among M-DCPS, GB, and GB's various service providers that contribute services to the M-DCPS WC program, so as to determine how they address the services required by the contract and as promised by GB's Flex Net program. Flex Net was specifically touted in the May 2007 *Recommendation for Third-party Claims Administration Contract with Gallagher Bassett Services, Inc*. as a reason for approving the subject contract.

To accomplish this objective, we needed to evaluate more than GB's "base" contract with the M-DCPS. The current contract's scope of services is, in our opinion, more aspirational in nature than functional or measurable. We needed to obtain the GB contracts, under which the various managed care services (including medical, consultant, physical therapy, and pharmacy services) were actually being provided. We wanted to ascertain the scopes of services provided by the firms/individuals and the related fee structures. As GB provides none of these services itself but is, nonetheless, responsible for ensuring their inclusion in the services provided to M-DCPS, we deemed it appropriate for us to verify that it had the necessary contracts that covered the required services. This is important because of Flex Net. Flex Net is GB's unique, client-driven program providing a customized package of services and service providers

to its clients. When the subject contract was awarded, Flex Net was newly created and in its early developmental stages; thus, it was an unproven, untested product. [9]

Our evaluation was hindered by GB's refusal of our request to review its contracts, claiming that they were nationwide contracts and contained proprietary information, including fee schedules. GB did provide us with outlines of services provided by its vendors, noting: "GB has implemented procedures, specific to M-DCPS, which are currently not reflected in GB's vendor agreements." However, GB did not indicate which of the listed services it considered as being M-DCPS specific and not included in its vendor agreements. During later discussions with GB, the OIG offered that it would accept, for its review, redacted contracts to eliminate disclosure of that information considered proprietary by GB; however, GB ignored this concession.

On June 4, 2009 (as audit fieldwork was nearly complete), GB agreed to supply the OIG with agreements/contracts that pertained to the M-DCPS WC program. According to GB: "[GB has] determined that back in 2007 [it] did get a statement of work from one of [its] partners pertaining to the customization of this program."

A week later, on June 11, 2009, GB advised that it was prepared to supply the OIG with "two documents that should outline our agreement with M-DCPS regarding their unique managed care arrangement." (Emphasis added) However, GB never completely explained to the OIG exactly what these documents contained. GB also told the OIG that it could not have a copy of these two documents, take notes while reviewing them, or remove these documents from the GB office where it was stipulated the OIG review was to take place. In light of these restrictions, the OIG thought it necessary to have our consultant accompany us to interpret the documents that we would be viewing, as we would only have one limited opportunity to view them. However, GB forbade the OIG audit team from reviewing the documents with our consultant present. Under the circumstances, the OIG did not accept GB's terms. We consider GB's restrictions to be critical impairments to our access to records—records that GB characterizes as outlining its agreement with respect to the M-DCPS program. This impairment necessarily impacted our ability to conduct a contractual review under this phase of the audit.

[9] We note that the M-DCPS contract with GB does not mention or refer to Flex Net; instead, this service is listed as "customized network development and access." However, the SB agenda item seeking approval of the contract to GB specifically referred to the "newly developed Flex Net network platform" and identified Flex Net as a preferred provider organization.

VI. FINDINGS & RECOMMENDATIONS

FINDING NO. 1 **M-DCPS has not competitively solicited for third-party claims administration and managed care services for its workers' compensation program since 1994.**

Florida Statute §1010.04(1)(a) requires school districts to comply with the rules of the State Board of Education, as well as their own district board rules. As it relates to procurement, State Board of Education Rule 6A-1.012, F.A.C., generally requires district school boards to adopt rules for procurement that require competitive solicitations. However, for the acquisition of insurance, risk management programs, or third-party administrators, Rule 6A-1.012(15) allows for either competitive solicitation or direct negotiation.

M-DCPS School Board Rule 6Gx13-3F-1.021, which generally addresses the acquisition of professional services, excludes "contracted third-party claims administration . . . for which selection procedures are provided by State Statute, State Board Rule or other School Board Rule." [6Gx13-3F-1.021(F)(1)]

Specifically, the acquisition of professional services contracts for insurance or risk management programs is provided for in M-DCPS School Board Rule 6Gx13-3F-1.022, which requires a RFP process. The introduction to the rule states:

> Request for proposals shall be used when seeking to contract for insurance or risk management professional services because they are of an unusual nature, because the services may vary depending on the provider, and because the quality of services as well as the price are important. Services requiring a request for proposal are generally subjective in nature.

Since its 1994 competitive solicitation, the SB has exercised its prerogative to negotiate directly with GB to approve three additional contracts and one contract amendment for WC claims administration and managed care services. In discussions with the RM Officer, he explained that this was a conscious decision not to re-solicit for the services of a third-party claims administrator because of the school district's internal culture to continue using the services of the incumbent provider when the district is satisfied with the provider's service and performance.

We acknowledge that there may be benefits to employing the same firm repeatedly, but that there are also benefits to be gained by going to the open market, via a competitive solicitation. Because price is an important factor—and it especially should be for public entities in light of ever growing budgetary deficits—it behooves M-DCPS officials to competitively seek price proposals as part of the RFP process. In reality, this is the only way to assess that the price M-DCPS pays is a competitive price. Of course, experience and past performance are equally important; and it is only when all these factors are incorporated into a competitive procurement process that M-DCPS will get the best value for its money.

The RM Officer informed the OIG that a decision was made in August 2009 to issue a new RFP for WC claims administration and managed care services and third-party liability claims administration. The current contract with GB expires on June 30, 2010, although the contract contains two one-year options to renew.

Recommendations

None required. M-DCPS will be issuing a new RFP covering the desired services. OIG comments to the draft RFP were provided under separate cover.

Auditee Response and OIG Rejoinder

M-DCPS

"As a result of the Superintendent's initiative to review all major District contracts when he became Superintendent in September 2008, the decision was made that a Request for Proposals should be issued to seek competitive proposals at the end of the existing three year contract which expires July 1, 2010. Agenda Item E-67, Request for Authorization to Issue Request For Proposals (RFP) #006-KK10, Workers' Compensation and Third Party Claims Administration Services will be presented to the School Board of November 17, 2009. Staff would like to thank the OIG for their constructive recommendations which have been incorporated into the RFP document."

OIG

During the course of the audit, in a meeting on May 28, 2009 with the M-DCPS CFO, we expressed our concern about the historic lack of competitiveness for the WC program services contract. In a later meeting, held with the M-DCPS CFO and RM Officer, we learned that staff intended to initiate a new RFP to procure WC program

services. We are encouraged by the Superintendent's proactive review of District contracts, including the subject contract. More recently, we have been communicating with staff regarding the upcoming RFP and have issued, under separate cover, our comments regarding the content and form of the RFP and the proposed contract.

FINDING NO. 2 **Flex Net took over one year to materialize after contract execution. The first semblances of a custom network of medical providers appeared 15 months later, during the OIG auditors' fieldwork.**

SB Agenda Item E-67, appearing on the Board meeting of May 16, 2007, sought approval for the current contract that M-DCPS has with GB. The M-DCPS staff-prepared memorandum that accompanied the contract described the services under the new GB framework:

> The true value of a strategic claims administration program, inclusive of a component to adequately manage the medical aspect of workers' compensation claims, must be outcome based. The envisioned platform for this contract is one which will provide injured employees immediate and through [sic] medical care with the ability to return injured employees back to work as soon as possible.
>
> As part of the newly developed Flex Net network platform, negotiations with ancillary providers including physical therapists, diagnostic imaging, laboratory procedures, etc. will be ongoing to obtain the most attractive pricing as a function of the State of Florida Workers' Compensation Fee Schedule, while providing a proper spread of locations throughout the three county areas to service employees.

The contract, itself, does not contain the program name, Flex Net, but does refer to "custom network development and access" under the portfolio of *Core Managed Care Services* required to be provided. However, there were no further details of what this custom network would look like or how it would work. Instead, OIG auditors had to rely on the RM Officer's explanation of what he envisioned, promotional materials developed by GB, explanations provided by GB's Flex Net dedicated Assistant Vice President (VP), and the content of letters of agreement (LOAs) that were eventually entered into between the Flex Net medical providers and GB.

First, we note that Flex Net is a limited network of medical providers; however, there was no M-DCPS customized network at contract inception. There was not even a single medical provider signed-up to be a part of M-DCPS' custom network one year later. Fifteen months after contract execution, in October 2008, GB had signed-up three providers via executed LOAs (see Table 2). By the end of 2008, two more providers had executed LOAs and in January 2009, six more providers signed on. In February 2009, GB signed ten more providers, and in March 2009, three more providers had signed on. In total, OIG auditors were provided with copies of 24 executed LOAs.

Even with the 24 providers, M-DCPS primarily relies upon the medical provider network provided by GB's contractor, Coventry. According to the school district's RM Officer, he envisioned a medical provider network comprised of hand-picked doctors and specialists to treat injured M-DCPS employees. This was to be a boutique network to supplement the standard medical provider network provided by Coventry.

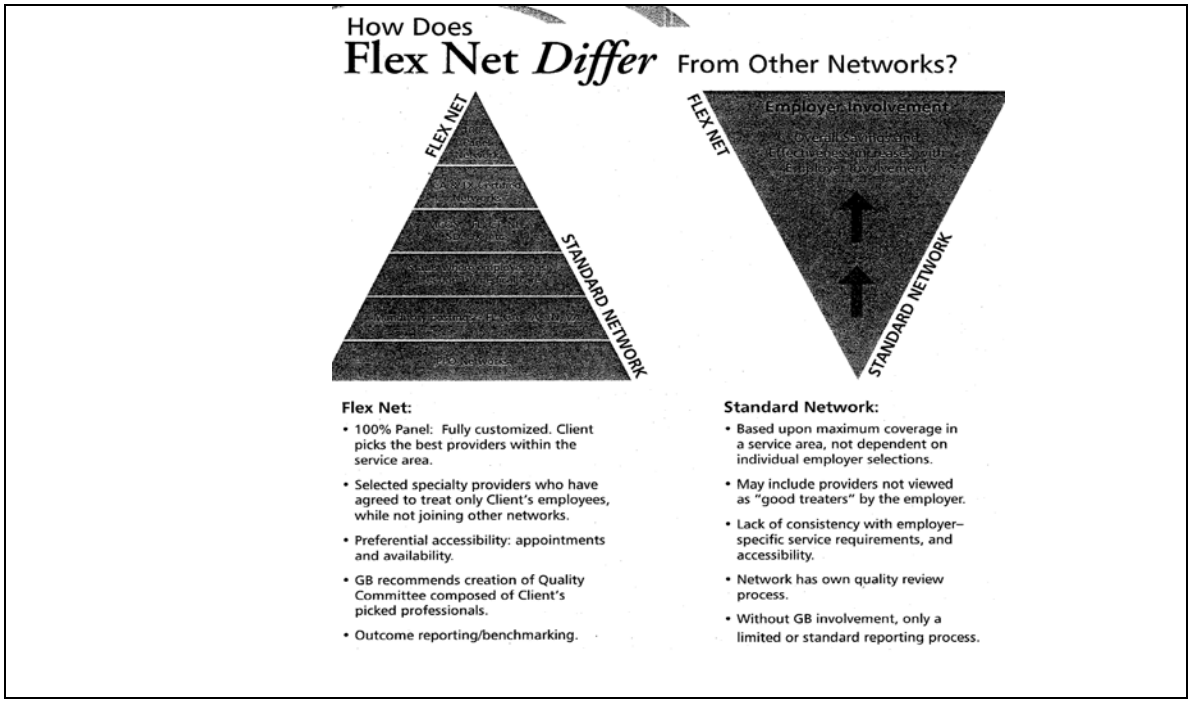
Table 2 Miami-Dade County Public Schools Workers' Compensation Program GB Flex Net Implementation Time Line

March 14, 2007	Initial recommendation to SB by RM Officer for the development of a strategic provider network
↓	↓
May 16, 2007	Final recommendation to SB by RM Officer for newly developed Flex Net network platform and subsequent approval by the SB
↓	↓
July 1, 2007	Inception of the current contract referring to custom network development and access
↓	↓
October 1, 2008	Effective date of first Letters of Agreement between GB and Flex Net program providers - post date of OIG audit initiation
↓	↓
April 29, 2009	By this date, the OIG had been provided with Letters of Agreement between GB and 24 Flex Net program providers

GB's promotional literature (undated) depicts Flex Net as standing separately and apart from other networks. According to the depiction in Table 3, it would appear that FlexNet is not meant to be a supplement to a traditional standard network, instead being a competitor to (or replacement of) the standard network (such as the one provided by Coventry).

The Assistant VP stated that Flex Net allows M-DCPS to customize its list of providers by maintaining contracts that are made directly between the providers and M-DCPS. The Flex Net brochure (see Table 3 below), along with Volume 6/08 of the *GB Advantage* newsletter, highlights its main difference from other standard networks: "Selected specialty providers who have agreed to treat only Client's employees, while not joining other networks." Our review of the executed LOA, however, did not reveal any such self-imposed limitation. In fact, the LOAs actually state that "this agreement is not exclusive."

Table 3 Flex Net Brochure



We tried to determine why it took so long for Flex Net to be implemented. The RM Officer explained that it took GB over one year to understand his [the RM Officer's] concept of how Flex Net would work and be organized for the M-DCPS WC program. However, we observe that GB hired a Flex Net dedicated Assistant VP, who

previously worked for CorVel in association with the M-DCPS contract with CorVel for managed care services. This Assistant VP would be the architect of Flex Net. Having worked for a company that serviced the school district for over 10 years, we would think that her familiarity with the M-DCPS program and her working relationship with M-DCPS staff would have accelerated Flex Net's implementation.

Flex Net is a program that has been continuously evolving but, unfortunately, is not grounded in any contractual specifications that would support and protect the interests of M-DCPS. As a *Core Managed Care Service*, i.e., a deliverable, when was M-DCPS expected to receive it? Does signing up three providers 15 months later meet expectations? How large of a network of medical providers was anticipated?

As a core service, i.e., a program/network to be delivered, its cost (or GB's profit) was undoubtedly contemplated in GB's negotiated annual lump sum fee. What part of $5.8 million annually is the price of Flex Net? [10]

We believe that M-DCPS should use the RFP process to ensure that its requirements for the WC program network are clearly defined prior to entering into a contract with a managed care vendor. In addition, future managed care service contracts need to contain more details of the terms expected by M-DCPS, including a list of tasks to be performed and reports that it wants to be provided with; the measures and outcomes upon which to base performance; and remedies in the event that the vendor does not perform. Ultimately, M-DCPS needs to ensure that it receives the services, as marketed by the managed care services provider, unlike what has taken place with Flex Net.

Recommendation

(1) Prospectively, any successor contract should clearly state M-DCPS' expectations for a customized network; the vendor's obligations to produce, administrate, and manage the network; the expected levels of participation by providers; and penalties or other remedies for failure by the vendor to provide M-DCPS with the services it contracted for.

[10] GB considers Flex Net to be a proprietary product that competes with traditional standard provider networks. As such, we believe that GB has assigned some substantial value to it.

Auditee Response and OIG Rejoinder

M-DCPS

"Staff believes that clear goals and expectations can be established and measured to assure continued success, with appropriate penalties included in the contract, if the vendor does not meet mutually agreed upon goals."

OIG

The OIG will monitor the procurement and negotiation of the WC program services contract to advocate that appropriate penalties and/or liquidated damages provisions are in place regarding the vendor's obligations to produce, administrate, and manage the network and provide M-DCPS with the services it contracted for.

FINDING NO. 3 Lack of contract transparency makes managed care services unauditable.

One audit objective was to assess the contractual relationships between and among M-DCPS, GB, GB's various service providers, and the other parties that affect the M-DCPS WC program. We wanted to evaluate whether and how these parties addressed the services required by the contract, and how effectively GB was providing the core managed care services, given its outsourcing of these components to other providers. Of interest to the OIG was how the GB contracts address the services required by the contract section *Core Managed Care Services*, and as promised by GB's Flex Net program. As earlier mentioned, Flex Net was a selling point to obtain SB approval of the current contract.

We know that GB provides none of the *Core Managed Care Services* itself but is, nonetheless, responsible for ensuring their inclusion in the services provided to M-DCPS via its promised Flex Net program. Thus, we deemed it appropriate to verify that GB had the necessary contracts covering the required services. This is important because of Flex Net. Flex Net is GB's unique, client-driven program providing a customized package of services and service providers to its clients. When the subject contract was awarded, Flex Net was newly created and in its early developmental stages; thus, it was an unproven, untested product.

To accomplish this objective, we needed to evaluate more than GB's "base" contract with M-DCPS, since neither the contract nor the service instructions provided

details as to the services to be performed and related fee structures. In particular, we needed to examine GB's contract with Coventry Healthcare, its main core managed care services provider. Coventry services include supplying medical and physical therapy provider networks, a pharmacy program, bill review and re-pricing services. In addition, we needed to obtain any other GB contract, under which its M-DCPS contract's *Core Managed Care Services* were being provided to injured workers. We wanted to ascertain the scopes of services provided by the firms/individuals and how GB had integrated these parties into its Flex Net network. Without this information, we could not evaluate the effectiveness of Flex Net.

Our concern centered on GB statements in correspondence to M-DCPS.[11] The GB official stated that:

> GB's existing contracts with these vendors do not apply to the services being provided by the M-DCPS vendors due to the customization of the services and unique financial arrangements incorporated into the GB/ M-DCPS agreement. The GB/M-DCPS agreement includes flat rate pricing for the first notice, bill review and network access services. In developing the program for M-DCPS, we have implemented procedures that are not currently reflected within the vendor contracts.

The OIG wanted to know which firms GB would identify as the "M-DCPS vendors," what customized services these "M-DCPS vendors" were providing, and what were the newly implemented procedures that GB had with these vendors.[12] Additionally, we note that to the extent that the "unique financial arrangements incorporated into the GB/M-DCPS agreement" were, as noted, the flat rate pricing for the first notice, bill review and network access services, that such pricing terms are not in the M-DCPS contract. This contract calls for GB to receive an annual fee of $5,811,261 for providing all workers' compensation and third party claims administration services for each of the first three contract years. Included in the total fee is a specific allocation for *Core Managed Care Services* amounting to $865,200.[13] However, while stated as an "allocation," it is paid as a part of the overall annual fee.

[11] GB letter to the RM Officer, dated August 25, 2008, provided to the OIG in response to our questions about GB's provider contracts.
[12] GB references "M-DCPS vendors" but, in fact, they would not be the school district's vendors. They would be GB vendors supposedly servicing M-DCPS, on behalf of GB.
[13] GB provided the OIG with an unauditable, and therefore unverifiable amount of its costs to provide managed care services (comprised of bill review, network development, and dedicated nurses) totaling $866,895 for the period from July 1, 2007 through June [30,] 2008.

In this same correspondence, GB provided a general outline of services, by provider name, but did not indicate which services it considered as being M-DCPS specific and not included in its vendor contracts. In addition, it did not include a separate listing of what services GB, or its vendors, had specifically customized for the M-DCPS contract. Moreover, our analysis of the listed services found that they were all what we believe would be typically required of a WC service provider. We found nothing unique or customized in this GB listing.

The OIG continued pressing GB for greater disclosure. We had no success in obtaining GB's contracts. Moreover, we would not accept GB's strict limitations on reviewing "two documents that should outline our agreement with M-DCPS regarding their unique managed care arrangement." (See earlier discussion in the *Scope Impairment* subsection to report Section V, *Objectives, Scope, and Methodology*.) As a result, we could not make a determination as to how well GB's contracts address the requirements of the M-DCPS contract's *Core Managed Care Services* section and as promised by GB's Flex Net program.

GB's non-transparent approach to its dealings with a public entity or its public oversight agency gives us cause to wonder why it is being so secretive about its business arrangement with M-DCPS. Unfortunately, our inability to ascertain GB's plan to provide the required *Core Managed Care Services* supports the observation that we make elsewhere in this report that the GB contract scope of services is more aspirational in nature than functional or measurable. We are not saying or even implying that GB is not providing satisfactory services. We are saying that we could not determine, to our satisfaction, what GB's core managed care services were entirely comprised of, as they relate to its contractual requirement with M-DCPS, and whether GB provided them in an objectively measurable manner.

Furthermore, our efforts to raise the veil on this non-transparency were stymied by the lack of a strongly stated contract right-to-audit provision. Contract Section H, *Audit of Files and Procedures*, within Schedule III, *Terms and Conditions*, reads:

> At the sole option of the Board, the Company shall submit to an audit by or on behalf of the Board, of the Company's files and procedures as they relate to the Board.

The contract terms do not explicitly provide M-DCPS access to contracts entered into by GB with the vendors that they are using to perform services pertaining to the M-DCPS WC program. As we noted earlier, this allowed GB to deny us access

to records that we believed were necessary to complete our audit. We believe that any future WC program services provider contract should provide stricter requirements that allow M-DCPS or its oversight agencies access to all agreements that the provider has with its vendors. Moreover, this access to records, or an associated provision, should specifically address potential issues that be can be raised by a vendor, such as protection or confidentiality of proprietary information.

Recommendation

(2) Any future M-DCPS contract for WC program services should contain a more encompassing "Access to Records" clause that would allow auditing entities, such as the State Auditor General's Office, OPPAGA, the SB's Office of the Chief Auditor, as well as the OIG, a higher degree of access to financial records, contracts, and contractor performance and cost data that is related to the provider's performance under the agreement.

Auditee Responses and OIG Rejoinder

M-DCPS

"It appears however, that some of the requests from the OIG to GB including national contracts which include proprietary terms and conditions for all GB clients may not be appropriate requirement for a firm to be compelled to provide just because they are under contract with a public entity. Staff believes that it is possible to appropriately evaluate and benchmark the work of vendor subcontractors without requiring the vendors to divulge information, which due to their proprietary nature may lead to private sector employers not wanting to conduct business with Miami-Dade County Public Schools in the future. There is also a risk of requiring this information to be divulged, resulting in vendors including an imbedded cost to cover their perceived exposure resulting from the document demands."

GB

GB states that it is not required to allow M-DCPS access to its managed care contracts, under its contract. However, it was willing to allow the OIG limited access to said contracts but "need[ed] to protect [its] shareholders' interests regarding this custom, unique, and proprietary product. On advice of our legal department, and in order to protect proprietary information, we had to limit the view to the OIG so as not

to expose this highly competitive data to those who could be in competition for this business in the future."

OIG

With all due consideration to both GB and—surprisingly—M-DCPS' positions on this matter, the OIG maintains that access to these documents is necessary to evaluate how the program operates, what impact it is having, and what are the implications of the various roles, responsibilities, and arrangements of the parties. Again, this evaluation is even more important given the vendor's development of a client specific, unique program for M-DCPS, for which GB advised us that it "did get a statement of work from one of [its] partners pertaining to the customization of this program." We reiterate that GB characterized that it had two documents that outlines its "agreement with M-DCPS regarding their uniquely managed care arrangements." Consequently, we are surprised by M-DCPS' lack of interest in these documents that are exclusive to its own uniquely-aspired arrangement.

FINDING NO. 4 **The contract does not have any performance measures or remedies.**

The OIG observed that the contract between M-DCPS and GB does not contain predetermined performance measures and related remedies in the event GB does not satisfactorily complete the agreed upon services. The use of performance measures could be used by M-DCPS to obtain the best value for its WC program. Our research found that other Florida school districts include performance measures in their contracts for WC program services.[14] In addition, we note that contained in the M-DCPS July 2004 contract with CorVel, the previous provider of core managed care services, there were performance criteria related to reporting and staffing requirements and penalties for poor performance; however, the M-DCPS July 2007 contract with GB has no such terms.

As it stands, M-DCPS is not able to use objective assessments of GB's performance as a management tool to hold GB accountable for its performance. As described in other report sections, our testing shows that GB's bill review service

[14] Contracts received from Orange and Broward County school districts contain performance measures/ standards for their WC program claims administration service providers. Moreover, GB's contract with the City of Miami contains a Performance Agreement that measures GB's performance of its obligations in seven areas.

performed poorly when reviewing/re-pricing hospitalization and physical therapy charges, but suffered no penalty for its poor performance.

Recently, the State of Florida Department of Financial Services Division of Workers' Compensation (Division) conducted an audit that addressed the benefits disbursement and claim handling practices of the M-DCPS WC program, for the period between November 2004 and May 21, 2009. In its report, the Division noted that the M-DCPS failed to comply with statutory standards regarding the untimely filing of a First Report of Injury or Illness (resulting in a $100 fine); a non-willful pattern for the untimely mailing of the Informational Brochure and Employee Notification Letter (based on a 76% compliance rate of sampled items and resulting in a $2,500 fine); a non-willful practice of not accurately reporting the First Report of Injury or Illness to the Division (based on a 60% compliance rate of sampled items and resulting in a $2,500 fine); and a failure to accurately calculate indemnity payments, which led to both overpayments (totaling $4,575.47) and underpayments (totaling $5,751.75, plus penalties and interest totaling $7,096.78). Although M-DCPS was cited for these noncompliant actions, these issues specifically correlate to how well GB is providing its claims administration services.

We ask whether M-DCPS believes that a 60% compliance rate is acceptable or whether a $2,500 fine paid to the State is adequate detriment to GB that would result in changed behavior? We mention that there were over a dozen different metrics reported by State auditors and that the above noted were the only two that did not meet standards. However, what is clearly evident is that there are many standards to which GB, or any future provider, could be a held accountable. (See Finding Nos. 9, 10, and 11 related to pharmaceuticals.) All that is required is that M-DCPS incorporate such standards into the contract.

Another program performance measure could be the provider's obligation to maintain the required staffing level. We note that during the current contract period, GB failed to maintain the minimum number of dedicated adjusters, for a period of approximately six months. However, since the contract does not contain terms to remedy occasions when M-DCPS pays for services not fully provided, GB will not have to refund any portion of the fees that it was paid during the period or suffer any other form of financial penalty.

We believe that M-DCPS must include measures in future WC program provider contracts to specifically monitor provider performance. This holds true for both claims administration and managed care service obligations to M-DCPS. The

contract must also dictate prescribed remedies if the provider fails to meet the standards set. The standards should focus on performance measures that promote the safeguarding of M-DCPS funds, the proper authorization of transactions, hiring of competent personnel, and proper documentation. We believe that a best practice would be to have periodic audits performed on behalf of M-DCPS, in order to provide a basis for the assessment of the provider's performance.

Recommendations

(3) M-DCPS must include specific performance measures in future WC program contracts, including outcome reporting of its provider's actions/performance that are directly tied to changes—both positive and negative—to lost time, claim amounts, and cost savings, and other objectively determined performance measures or outcomes.

(4) M-DCPS should periodically audit claim files and other reported data, as a basis for an objective assessment of GB's or a future provider's performance.

(5) The M-DCPS contract must prescribe remedies, should GB or a future provider fail to meet the standards.

(6) M-DCPS should require the RM Officer to report to the SB, or a designated committee, the results of any audits and periodically report on the performance measures.

Auditee Responses

M-DCPS

"Staff fully supports the establishment of appropriate performance measures in the evaluation of the District's Workers' Compensation Program. To that end, performance measures are being included in the sample contract which will be included as an exhibit to the Request For Proposals (RFP) which will be brought to the Board at its meeting of November 17, 2009 to seek competitive proposals for its Third Party Claims Administration Program."

In addition, we note that staff fully supports conducting periodic audits of claim files, the establishment of appropriate remedies in the event that the vendor does not

perform, and that audit results be reported to the Board's Audit Committee, as well as to the Board, itself.

GB

"GB acknowledges that the contract does not have any performance guarantees, however, we disagree with the statement indicating, 'as it stands, M-DCPS is not able to assess objectively, or use other objective assessments of GB's performance, as a management [tool] to hold GB accountable for its performance.'" GB goes on to explain that the various audit reports mentioned in the OIG's report, reported program results and favorable outcomes.

FINDING NO. 5 **GB improperly used over $36,316 of M-DCPS funds to pay for disallowed fees, penalties, and interest for which it was solely responsible.**

GB improperly paid interest fees, penalties, and other fees that were its responsibility out of the Imprest Fund funded by M-DCPS. These fees, penalties, and interest arose from late filings of information required by statute. The contract states that GB is responsible for "fines or penalties assessed for the late payment or reporting of claims, unless the late payment or reporting is caused primarily by the Board." According to the Branch Manager, GB has been tracking these expenses by generating a monthly report that is sent to its corporate office. The Branch Manager stated that these expenses are to be credited back to M-DCPS; however, during our fieldwork we were unable to identify whether and, if so, how M-DCPS was being reimbursed.

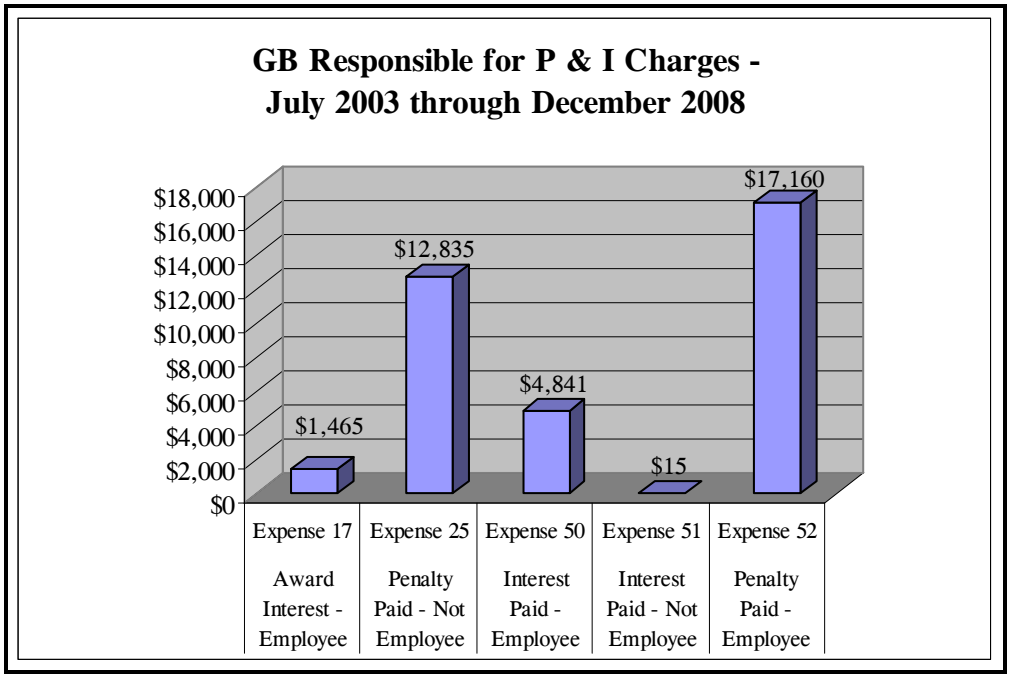
In an attempt for us to determine whether and how M-DCPS was being reimbursed for these expense payments, we asked the RM Officer to direct us to the reimbursement records. He stated that M-DCPS was not being reimbursed for this expense because he considered it a cost of doing business.[15] However, when we asked the RM Officer how much these expenses were costing M-DCPS, he was not able to readily quantify the amount, nor did he subsequently provide us with a figure.

OIG auditors decided to review 100% of the costs identified by GB through its RF database (as payments for fees, penalties, and interest) by creating a worksheet that shows a breakdown of all payments made to injured workers and the Imprest Fund for

[15] On May 21, 2009, the OIG met with the RM Officer, the M-DCPS CFO, the GB Branch Manager, and personnel from the M-DCPS Treasury Department to clarify and/or initially inquire about various issues identified while performing the audit fieldwork related to the Imprest Fund.

penalties and interest. We initially obtained from GB a listing of all payments related to workers' compensation from July 2003 through December 2008. We then sorted the payments by pay code (#s 17, 25, 50, 51, and 52) and subsequently matched the pay code number with its corresponding definition, as stated in the listing provided by GB. From our review, we were able to determine that M-DCPS paid $36,316 in penalties and interest identified as the responsibility of GB, from July 1, 2003 through December 31, 2008, as summarized in the following Table 4.

Table 4



The contract expressly states that M-DCPS will not pay for these charges. Notwithstanding the RM Officer's statement that this expense component is a cost of doing business, M-DCPS should not pay for this expense and it should seek restitution from GB for the $36,316 plus any such payments made by M-DCPS from January 2009 through the present.

Recommendations

(7) M-DCPS should require GB to account for any penalty and interest fees paid out of the Imprest Fund, from January 1, 2009 to the present and remit to M-DCPS any such charges incurred during the period.

(8) M-DCPS should promptly collect $36,316 from GB for the identified unauthorized charges.

(9) M-DCPS should enact controls to ensure that these types of unauthorized charges cannot be paid from the Imprest Account or, at a minimum, that the unauthorized charges will not go undetected.

Auditee Responses and OIG Rejoinder

M-DCPS

"Staff believes that the referenced $36,316 includes a component of benefits due an injured employee, thus reducing the interest and penalty figure even further."

GB

"GB has conducted its own review of the payment codes identified by the OIG, and has determined that there are 35 payments totaling $6,445.49 that will immediately be credited back to M-DCPS. We believe that the primary reason for the discrepancy between the OIG figure and GB's is simply the OIG's natural unfamiliarity with how these payments were issued."

OIG

Both staff and the vendor stated in their responses that they believe the $36,316 in penalties and interest identified by the OIG included a component of benefits that was due to the injured worker. This assumption is not correct. The paycodes listed in Table 4 are defined by the vendor as expenses that it is responsible for making payment and are not related to indemnity or injured worker payments. The OIG does not know how the vendor determined that the $36,316 in payments should be coded to these five paycodes labeled under the category of "Expense." Instead, the OIG sorted the Citibank Imprest Fund check register data provided and relied on the vendor's classification of the expenses according to its internally assigned paycode categories.

While $36,316 is a small fraction of the $30 million spent annually in overall WC program costs, we are surprised by staff's lack of interest in recouping from GB the payments for interests and fees that were erroneously paid out of the Citibank Imprest Fund. The July 2007 contract between M-DCPS and the vendor specifically states that the vendor is responsible for such costs, yet the audit fieldwork reveals that the M-DCPS bore the payment 100% of the time. Under separate cover, the OIG will

provide both the staff and the vendor details of the claim related payments that make-up the $36,316.

FINDING NO. 6 **GB's bill review function failed to correct $67,647 in overbillings by inpatient hospital providers and may expose M-DCPS to overbillings that may exceed an additional $80,000.**

GB did not provide acceptable bill review services related to its processing of inpatient hospital invoices. The OIG's audit of ten sampled invoices determined that M-DCPS overpaid $67,647 above the Florida fee schedule for inpatient hospitalization charges. Inpatient hospitalization charges consist of surgical and non-surgical costs related to an injured worker who has been admitted to the hospital because of emergency room services or immediately after an outpatient service. These charges are generally for large amounts. Fortunately, inpatient hospitalizations are infrequent.

The ten invoices selected for our review totaled $474,772, which equaled 44% of the total inpatient hospitalization billings of $1,085,488, during the 18-month period reviewed. OIG auditors determined that M-DCPS overpaid these ten invoices by 14%. If this same 14% overpayment ratio was applied against the remaining 56% of the invoices not reviewed, the total of overpayments made by M-DCPS during this 18-month period may well have exceeded $150,000. Our identified overpayments are depicted in Table 5.

Table 5 Inpatient Hospital Bills Overpaid

	Claim #	Payment Amount	Florida Fee Schedule Amount	Amount Overpaid
Baptist Hospital	000074-165885-WC-01	$16,593	$9,912	$6,681
Jackson Memorial	000074-159256-WC-01	$29,087	$6,608	$22,479
Westside Regional	000074-155004-WC-01	$19,973	$9,534	$10,438
Homestead Hospital	000074-167199-WC-01	$88,118	$73,431	$14,686
Palmetto General Hospital	000074-167552-WC-01	$69,040	$55,678	$13,363
Mercy Hospital	000074-167106-WC-01	$72,173	$72,173	$ - 0 -
South Miami Hospital	000074-164620-WC-01	$146,536	$146,536	$ - 0 -
Baptist Hospital	000074-162185-WC-01	$17,572	$17,572	$ - 0 -
Jackson Memorial	000074-167144-WC-01	$9,800	$9,800	$ - 0 -
Jackson Memorial	000074-166627-WC-01	$5,880	$5,880	$ - 0 -
	Totals	**$474,772**	**$407,124**	**$67,647**

On July 29, 2009, the OIG sent GB the overpayments we identified relating to inpatient hospitalization for its verification and comment. In response, GB's Assistant VP told the OIG in an August 24th email that "Coventry has performed an internal audit of the specific bills provided, and has determined that processing errors did indeed occur" and furthermore that "these errors are of a human nature." The Assistant VP went on to state that "the errors have occurred on Hospital and Acute Care bills, resulting in our request for a complete audit of all Hospital and Acute Care Center bills since 7/1/07. [GB has] already requested that Coventry initiate immediate overpayment collection. In addition, training and re-training has taken place at the processor level to educate bill processors on identified review types."

While we are encouraged by GB's comments relating to the actions it will take, we are still not confident that errors such as these—or errors of a new type—will be readily identified. We observe that there is a lack of quality assurance with regard to how GB treats the bill review database that is provided by Coventry, its contracted service provider. It appears that GB itself does nothing to ensure that the correct payment rates are applied to provider invoices. Instead, GB relies on Coventry to perform its own quality assurance that the rates are correct.[16]

Moreover, the OIG identified overpayments of $67,674, even though the November 2007 *Service Instructions* expressly states that "All medical bills will be reviewed by GBMCS. All hospital bills in excess of $5,000 will be audited by GBMCS."[17] All the payments sampled by the OIG that resulted in the aforementioned overpayments were bills in excess of $5,000. If they were audited by GBMCS, then they did a poor job in finding the errors.

M-DCPS must hold its vendor accountable, regardless of whether or not it relies on quality assurances made by the vendor's providers.

Recommendations

(10) M-DCPS should ensure that GB follows up on its request to Coventry that it complete an audit of all hospital and acute care center bills since July 1, 2007. Additionally, M-DCPS should require that the audit period be extended to the present date and that GB/Coventry provide the results to the OIG.

[16] Statement by a GB representative made during a meeting held on April 29, 2009 at GB's offices.
[17] Service Instructions released by GB in November 2007 that are intended to detail the work to be performed, and by whom, on behalf of the M-DCPS WC program.

(11) M-DCPS should require GB to "audit" its own processes and procedures and report back on what happened to the review and audit that GBMCS was required to perform and/or why these transactions were processed incorrectly.

(12) M-DCPS should initiate collection of the $67,647 in overpayments identified herein, as well as for any other overpayments identified in the aforementioned audit of all hospital and acute care bills from July 1, 2007 to the present.

Auditee Responses and OIG Rejoinder

M-DCPS

"Reimbursement of the initial $67,381 in overpayments was received by the District as of October 8, 2009."

GB

"Relative to the initial hospital bill overpayments identified by the OIG, GB has reimbursed M-DCPS. Additionally, should additional overpayments occur, GB will continue to immediately reimburse M-DCPS."

OIG

Both staff and the vendor stated in their responses that the $67,381 identified as overpayment of hospital bills has been refunded to M-DCPS and that the vendor plans to re-audit all hospital bills from July 2007 to present. However, the OIG is still concerned with the vendor's apparent failure to comply with the November 2007 Service Instructions under "Managed Care – Bill Review Vendor" that call for the vendor to audit all hospital bills over $5,000. Note that the overpayments identified by the OIG all relate to hospital invoices in amounts greater than $5,000. Moreover, the vendor, in its response, explains why these bills were re-priced incorrectly but does not explain how its audit of these bills failed to catch the re-pricing mistakes that lead to the overpayments. We can only assume, therefore, that it did not comply with the contract provision to audit hospital bills over $5,000. We reaffirm recommendations nos. 10 and 11 that all in-patient hospitalization bills are audited for possible overpayment and that GB's processes and procedures are reviewed to determine how it failed to timely detect and correct these overbillings. The results of these two reviews should be reported accordingly.

FINDING NO. 7 **GB's bill review function failed to capture contract rates leading to potential overpayments totaling up to $56,000 to physical therapy (PT) providers.**

M-DCPS failed to receive acceptable bill review services related to PT invoices, in accordance with the GB contract for *Core Managed Care Services,* which resulted in the identified overpayments. Based upon our sampling, we believe the M-DCPS overpayment exposure may be up to $56,000. This exposure was overwhelmingly caused by the failure of GB and its vendor to enter the contracted PT provider rates into Coventry's bill review engine in accordance with the LOAs that GB had entered into on behalf of M-DCPS. The overpayments identified by the OIG applied to the four PT providers that had LOAs effective September and October 2008. Instead, GB's contracted vendor, Coventry, incorrectly used preferred provider network pricing—which would have been in effect had there not been a LOA with the PT provider.

At the inception of the current contract in July 2007, M-DCPS selected GB's preferred PT provider, MedRisk, which supplied a PT provider network platform based upon a capitated program.[18] As Table 6 shows, the M-DCPS WC program, thereafter, experienced two different payment structure variations for PT providers.

Beginning in June 2008, M-DCPS began primarily using four PT providers that had contractual relationships with Coventry. Shortly thereafter, M-DCPS and GB negotiated contracts with these four PT providers to become part of the Flex Net platform. LOAs were entered into between GB and the four providers, with effective dates of either September 1 or October 1, 2008, stating rates of either $125 per visit, or the Florida Fee Schedule rate less 25%.

Table 6 M-DCPS Physical Therapy Providers

Dates	Physical Therapy Provider	Rates Available for Audit
07/01/07 - 05/08	MedRisk	Unknown, but the Florida Fee Schedule was the maximum allowed
06/08 - 09/08	Cora Rehabilitation Services	Unknown, but the Florida Fee Schedule was the maximum allowed
	Specialized Workcomp Services	
	Select Physical Therapy	
	Physiotherapy Associates	

[18] Of, relating to, participating in, or being a health-care system in which a medical provider is given a set fee per patient (as by an HMO) regardless of treatment required.

Dates	Physical Therapy Provider	Rates Available for Audit
9/1/08 - 12/31/08	Specialized Workcomp Services	$125.00 per visit Flex Net Letter of Agreement effective 9/1/08
10/1/08 - 12/31/08	Cora Rehabilitation Services	25% off Florida Fee Schedule Flex Net Letter of Agreement effective 10/1/08
	Select Physical Therapy	
	Physiotherapy Associates	

The OIG sampled 17 PT invoices, out of approximately 2,900 PT invoices, for the period October 1 through December 31, 2008 (green-shaded period). We selected for audit invoices from each of the four contracted PT providers. The 17 invoices totaled $2,232. We calculated that M-DCPS overpaid $77, amounting to an overpayment rate of 3.5%. Of importance to note is that all 17 of the invoices each had a billing rate error.

For the 3-month sample period, M-DCPS spent roughly $405,000 on PT services provided by the four contracted providers. The average PT payment is $140, and although the dollar amount of each billing error is small, errors were found in every sampled payment. Based on our extrapolation, we believe that M-DCPS may have overpaid upwards of $56,000 on PT services during the past year.

On July 29, 2009, the OIG sent the details of 14 of our sampled overpayments to GB.[19] We provided a spreadsheet showing the invoice, payment amount, the Florida Fee Schedule amount, and the service provider. We asked GB for its verification and comment related to the variances identified by the OIG. In response, GB's Flex Net dedicated Assistant VP stated that "Coventry has performed an internal audit of the specific bills provided, and has determined that processing errors did indeed occur" and furthermore "these errors are of a human nature."

In returning our spreadsheet back to us, a column was added with comments from GB's contracted vendor, Coventry. Relating to 11 of the problematic payments, the notation reads: "No LOA Information. Priced per [fee schedule] and PPO [preferred provider option]." In other words, M-DCPS did not get the benefit of its negotiated letter of agreement rates. The notes entered by Coventry for the other three invoice payments questioned by OIG state that the LOA rate was different than the rate established in the bill review engine.

[19] After receiving GB/Coventry's response, we tested invoices belonging to the fourth PT provider, thus increasing our sample size to 17.

When OIG auditors questioned GB's Branch Manager about its quality assurance measures, it was explained that the Coventry bill review database is only as good as the data that is loaded into it. The GB Branch Manager continued to say that GB does not do an independent audit of the bill review data rates; it relies on Coventry to perform their own quality assurance.

Recommendations

(13) M-DCPS must ensure that the correct PT provider rates are entered into the bill review engine and that payments are made in accordance with each PT provider's LOA.

(14) M-DCPS should require GB to perform an audit of all PT provider payments, from September 1, 2008 to the present, to exactly determine the overpayment amount and, thereafter, seek collection of the overpayment or require GB to return funds to M-DCPS, based upon the 3.5% overpayment rate as applied to the total dollar value of PT payments made from September 1, 2008 to the present.

(15) Prospectively, future contracts should ensure that the program provider/vendor is held responsible for overpayment errors and that associated penalties and interest applies.

Auditee Responses and OIG Rejoinder

M-DCPS

"Staff fully agrees that in order for the Flex Net network to be fully effective, GB must be able to accurately pay PT providers, as well as all providers with a letter of agreement, the appropriate reimbursement rates (Recommendation #13)."

GB

"The OIG audit report indicates that four PT providers had LOAs effective September and October 2008. In review of GB's LOA records, we discovered the following:

Cora Rehabilitation Services
- Both signatures secured 2/23/2009

Select Physical Therapy
- Both signatures secured 1/12/2009

Physiotherapy Associates
- Both signatures secured 12/23/2008

Specialized Workcomp Services
- Both signatures secured 1/23/2009

… Based upon the above dates of co-signatures of the agreements, OIG audited M-DCPS provider bills before the LOAs were executed and in our bill review engine."

OIG

What effect does an effective date have if it fails to control the contracted rate that M-DCPS pays? The LOAs could have used the signatory dates as the effective date for initiating the discounted pricing, but it did not. Instead, M-DCPS advised GB in the summer of 2008 that its selected PT providers would be reimbursed at the rate of: Florida Fee Schedule minus 25%. M-DCPS instructed GB to update its bill review engine accordingly. GB said that it could not.[20] *(We fail to understand why.)* Thereafter, it appears that there was a significant delay on GB's behalf in transmitting the LOAs to the PT providers for execution. But even with the delayed transmittal and execution, what is expressly clear is the effective date of the agreed to rate.

It is apparent that there was a failure by GB to communicate timely with its bill reviewer/re-pricer (Coventry) informing it of the new rates and their effective dates. Moreover, it is also apparent that had the OIG auditors not detected these overpayments, they would still be continuing to this day and would continue for who knows how long before someone realized the error. We reiterate GB's response to us: "Coventry has performed an internal audit of the specific bills provided, and has determined that processing errors did indeed occur" and that "these errors are of a human nature." (Emphasis added) Accordingly, the OIG reaffirms its Recommendation #14 that all PT invoices, since September 1, 2008 through the present date be re-priced and that GB refund all overpayments to M-DCPS.

FINDING NO. 8 **M-DCPS paid $90,540 to GB for a physical therapy custom network that was not developed.**

The $5.8 million annual fee to GB does not include *Non-Core Managed Services*. One of the non-core services is the establishment of a physical therapy program. The contract reads:

[20] Email dated June 8, 2008 from GB Assistant Vice-President to M-DCPS consultant, Siver.

> Physical therapy services will be paid at negotiated rates not to exceed Florida Fee Schedule. Effective July 1, 2007, [the SB] agrees to pay [GB] [a] physical therapy bill review fee of $20 per bill for assistance in development of custom physical therapy program and reporting.

During the first year of the contract (see light blue shaded portion on Table 6), M-DCPS paid the $20 fee 4,527 times. M-DCPS never received a custom PT program. Instead, during this time, GB provided M-DCPS with a capitated program already being offered by its preferred PT vendor, MedRisk. This was a pre-existing program; there was nothing customized about it. Access to GB's (or its vendor's) PT-provider network should be part of *Core Managed Care Services,* similar to any other medical service provider. Thus, we question the payment of the $90,540 in its entirety.

Table 7 Fees Paid to GB on Physical Therapy Invoices

Payment Time Frames	Fee per Invoice	# of Invoices	Fee Amounts
July 1, 2007 through December 31, 2007	$20	1,949	$38,980
January 1, 2008 through July 31, 2008	$20	2,578	$51,560
Totals	**$20**	**4,527**	**$90,540**

We have no doubt that M-DCPS officials questioned it, too. We found documentation early on in the contract term that called into question what M-DCPS was receiving in exchange for this fee. The arrangement was terminated in May 2008, although payments continued through July 2008. During audit interviews, the RM Officer acknowledged that this was a bad contract term. We further conclude that M-DCPS did not receive any deliverables associated with this fee and, as such, should seek return of the monies.

Recommendation

(16) M-DCPS should seek the return of $90,540 from GB for a deliverable that was never provided.

Auditee Responses and OIG Rejoinder

M-DCPS

"Although staff required Gallagher Bassett to cancel its contract with MedRisk, staff disagrees that the authorized fee of $20/bill should be reimbursed as services were provided."

GB

GB clearly disagrees with the OIG's finding. It responds that "There is an additional access fee to access this custom network (MedRisk), as outlined in the contract." GB argues that program savings far exceeded the cost to access the MedRisk network, and lastly that "the [School] Board approved this program."

OIG

The OIG would like M-DCPS to reconsider its position, since it was so dissatisfied with MedRisk's performance that it decided to terminate its services prior to reaching the one-year anniversary of the July 2007 contract. It is easy now for staff to say (in response to the audit draft report) that it disagrees with the OIG's finding and recommendation; however, we note that shortly after contract inception, in August 2007, Siver (M-DCPS' insurance consultant) specifically requested GB to provide a written description of the fees for MedRisk, along with a request as to what reports are to be provided and with what frequency. In December 2007, follow-up correspondence from Siver to GB's Assistant VP and Senior VP requested that they provide staff with information supporting the $20 per PT bill review fee.

Lastly, in July 2008 (two months after MedRisk's services were terminated), Siver again questioned the $20 per bill fee. In written correspondence between Siver and staff, Siver wrote: "we need to be provided information regarding the services provided in relation to this fee." (OIG emphasis added) Thus, it would appear, as documented by M-DCPS records, that it is not just the OIG that has concerns about this fee. Both staff and its consultant are on record as being unable to determine what services M-DCPS had received for the PT bill review fee of $20 per bill processed, even after staff had terminated MedRisk services in May 2008. That staff now maintains that services were in fact provided, thereby justifying the payment of the fee, is questionable. The OIG reaffirms its recommendation that staff request a refund from the vendor for non-performance of contract terms.

FINDING NO. 9 GB's pharmacy program has no contract standards.

Background—GB Pharmacy Program

The M-DCPS 2007 contract for the WC program claims administration and managed care services requires GB, as part of the *Core Managed Care Services*, to provide a pharmaceutical benefits program. However, the contract does not contain specific parameters defining what this program requires of the program provider. We note that GB's *Service Instructions* contain only a statement that "[a]ll prescriptions are handled by First Script."[21]

First Script, GB's pharmacy benefits manager (PBM), is a wholly owned subsidiary of Coventry, which is also GB's managed care service provider. Strategically, a PBM takes advantage of the size of its client base to negotiate rebates and discounts from drug manufacturers and pharmacies to obtain lower prices for their clients. Functionally, a PBM will process and pay pharmaceutical purchases by injured workers who use designated service providers. PBM's have the ability to offer initiatives that give value and flexibility to participants, such as tablet splitting and mail order service.

In response to our queries, GB, in a letter dated August 25, 2008, provided to the RM Officer an outline showing its vendors and services provided. The RM Officer, in turn, provided the document to us. In that document, GB listed the services that its pharmacy program manager—Coventry/First Script—provides:

- First Script's "First Fill" program will allow injured workers to receive up to a 30-day supply of medications without any out-of pocket costs
- Adjuster utilization alerts
- Redirection of injured employee's pharmacy bill back into network with GBMCS (Gallagher Bassett Managed Care Services) exclusive redirection program
- Special report sent to Consultant [Siver] and employer [M-DCPS]
- Customized pharmacy cards with the M-DCPS logo
- Direction to Rx retail provider at the time of intake

[21] *Service Instructions* are GB summaries of directions or brief supplemental data related to the special handling of various issues/conditions related to claims under the M-DCPS workers' compensation, auto, general, and professional liability coverages.

Regarding payments for pharmaceuticals, the 2008 State of Florida *Workers' Compensation Health Care Provider Reimbursement Manual* provides that licensed pharmacists or licensed dispensing practitioners are to be compensated at a rate comprised of the purchased drug's "Average Wholesale Price" [22] (AWP) plus a $4.18 dispensing fee per prescription, or a contracted reimbursement amount determined in accordance between the provider/dispenser and the insurer."

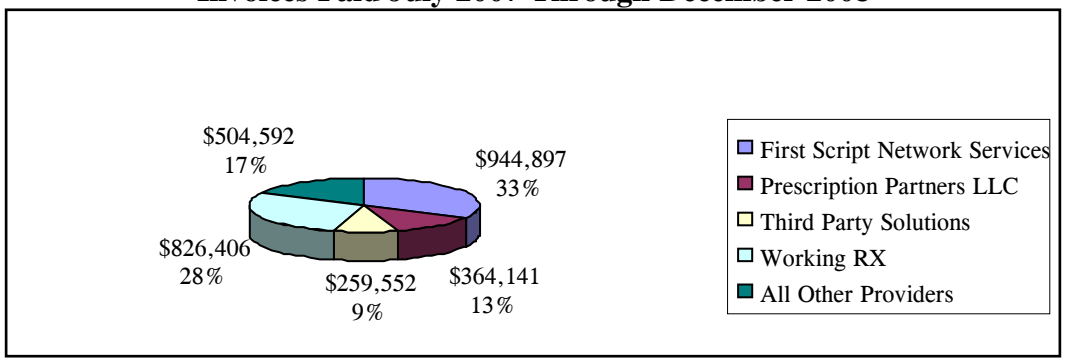
Other than requiring that GB provide a "Pharmacy Program," the contract has no standards for drug purchase pricing terms and conditions (e.g., minimum AWP discount), purchase rebates/volume discounts, and incentive payments for any added savings during the contract term due to increasing injured worker participation. In addition, we note that the M-DCPS contract does not contain a stated "contracted reimbursement amount" for pharmaceuticals purchased through GB's pharmacy program. Based on the silence of the contract terms and GB's *Service Instructions*, we requested that GB provide us with information on its pharmacy program services and pricing terms. In an April 21, 2009 email responding to the OIG's request, GB provided Coventry/First Script's pharmaceutical purchase rates:

Retail Brand Name:	AWP - 9% + $5.00 Dispensing Fee
Retail Generic:	AWP - 17% + $5.00 Dispensing Fee
Home Delivery Brand Name:	AWP - 16% + $2.00 Dispensing Fee
Home Delivery Generic:	AWP - 35% + $2.00 Dispensing Fee

Our review of pharmaceutical invoices and payments showed that GB pays for pharmaceutical purchases either by using the provisions of the Coventry/First Script pricing schedule or by using the higher priced State of Florida pricing schedule. M-DCPS has spent $2.9 million on drug purchases from contract inception to December 31, 2008 (18 months). Only $944,897, or about 33%, of those purchases were processed and invoiced by Coventry/First Script. A total of 145 other pharmacies and/or third-party billers invoiced for the remaining costs. Half of the other pharmacy purchases (50%) were processed through Prescription Partners, Third Party Solutions, and Working Rx. These firms perform third-party billing services for physicians that dispense medication directly from their offices. Table 8, on the next page, depicts the providers by the amounts paid to them.

[22] Prescription drugs are priced in the workers' compensation industry using a benchmark known as the Average Wholesale Price (AWP). A manufacturer or a repackager sets the AWP for its product. There is an eleven-digit National Drug Code and AWP for every combination of manufacturer, drug and package size, as well as for every repackaged drug.

Table 8 Lack of Participation in Pharmacy Program
Invoices Paid July 2007 Through December 2008



A large part of the disproportionate and costly pattern of pharmaceutical purchases outside of GB's pharmacy program is attributable to the lack of injured worker participation in the program. (See Finding No. 10.) Another factor is that medical providers are using the services of third-party pharmaceutical repackagers to dispense injured worker drug prescriptions that they themselves prescribed, directly from their offices.

Auditor Observed Conditions

We find that because the contract was void of any specifications, GB's obligations to provide a pharmacy program were, at best, illusionary. GB's *Service Instructions*, like the contract, provided nothing in the way of program definition, drug pricing terms, services to be provided, or even minimum service standards. The only contract, or near contract statement regarding GB's pharmacy program is that "[a]ll prescriptions are handled by First Script." Absent being able to view for ourselves GB's actual provider agreement with Coventry/First Script, the OIG could only rely on GB's email responses to our questions about the pharmacy program that its contractor, First Script, provides to the M-DCPS. Accordingly, our reliance on GB's statements is qualified, as we could not verify the substance of GB's agreement with Coventry/First Script for pharmacy program services.

In summary, we observed that GB has no responsibility to proactively manage its WC pharmacy program in such a manner that would encourage it to obtain for M-DCPS the lowest possible pharmaceutical costs. Furthermore, we note that no part of GB's compensation ties to any performance measures that would indicate the relative success (or failure) of its pharmacy program in servicing the M-DCPS injured workers

or its relative success (or failure) in maximizing cost savings for the benefit of M-DCPS.

Recommendation

(17) Any successor contract must include terms and obligations relating to a workers' compensation pharmacy program. Program specifications should include goals and objectives such as a target injured worker participation level; minimum drug purchase discounts; and, importantly, a measurement methodology that would provide the M-DCPS with accurate, real-time, and relevant data that could be used to better manage drug purchases by injured workers and to benchmark GB's performance.

Auditee Responses and OIG Rejoinder

M-DCPS

"Staff agrees that it is important to benchmark goals related to a workers' compensation pharmacy network. . . Staff will continue to make inroads into increased PBM penetration through adjuster training and expanded networks."

GB

GB disagrees with the OIG about the lack of injured worker participation. GB's response includes various statistical data about pharmacy usage and other explanatory data.

OIG

The OIG stands by its reported results. At this time, we have no ability to verify GB's reported data. Although we do not necessarily dispute its accuracy, we have no way to reconcile our results with GB's.

FINDING NO. 10 **GB has not effectively implemented a process to direct injured workers into the approved pharmaceutical benefits program, thereby increasing M-DCPS costs.**

Our review of GB's pharmaceutical program shows that only a relative few injured workers used GB's pharmacy program to obtain their drugs. Between July 2007 and May 2008, injured worker participation in this program ranged from 6% to 43%.[23] All other drug purchases were made outside of the Coventry/First Script network. Additionally, for the three months immediately following the inception of the current contract—July, August, and September 2007—more than 50% of all prescription dollars were paid to Working Rx, a workers' compensation claims management company that has no contractual relationship with the M-DCPS or GB.[24]

These figures show that from the inception of the current contract, GB, and its contractor Coventry/First Script, have had a minimally effective process for directing newly injured workers into the pharmacy program and for using what GB calls its "GBMCS [Gallagher Bassett Managed Care Services] exclusive redirection program"[25] to obtain the cooperation of non-participating injured workers. We believe that much of the responsibility for this condition lies with GB and its failure to proactively direct its providers and claims adjusters to assertively address this issue with the injured workers.

How the program is supposed to work is that First Notice staff informs the injured worker about the pharmacy program at the time the injury is reported. However, on many occasions the injured worker is not the individual making the call to report the injury. Within a few days after the report of injury, the injured worker should receive a pharmacy card in the mail. This card is good for use at all public pharmacies, i.e., there are no restrictions on which pharmacy an injured worker may use to fill his/her prescription needs. But if the injured worker does not produce the First Script card when filling a prescription, the pharmacy will remit an invoice to GB at the pharmacy's regular price. Upon payment processing, Coventry's bill review will reduce the invoice to the AWP and pay accordingly, as prescribed by the Florida Fee

[23] Data garnered from Siver's report, dated June 18, 2008, that was emailed to the RM Officer, the M-DCPS workers' compensation coordinator, GB's M-DCPS branch office manager, and GB's dedicated Assistant VP responsible for Flex Net.
[24] From the same Siver report, the total amount paid to Working Rx for the months July, August and September 2007 totaled $381,466. For the same period, the total amount paid to First Script was $95,684.
[25] From GB's August 25, 2008, letter to the RM Officer that was forwarded to the OIG.

Schedule. Although the billed amount is reduced, it is not reduced to First Script's discounted rates, which is the whole idea of a pharmacy benefits program.

During the injured worker's medical treatment, the GB adjuster is the injured worker's primary point of contact for scheduling provider visits and any necessary transportation, and approving other types of services. In addition, GB adjusters are able to review scanned copies of all invoices prior to approving their payment. GB tasks the adjuster with these responsibilities throughout the injured worker's experience, until the case file is closed. Notwithstanding their delegated duties, GB adjuster claim files show that they have not been actively instructing, educating, or persuading injured workers to use GB's pharmacy program.

OIG auditors reviewed 28 adjuster claim files that included some level of pharmacy activity. Collectively, there were 448 prescriptions. Seventy-five percent (75%) of these prescriptions were not processed through the prescribed pharmacy program. In the most egregious example, we identified one injured worker who had obtained 84 prescriptions over a ten-month period, not one of which was filled using First Script. Furthermore, our review showed no adjuster comments in the injured worker's case file regarding pharmacy usage until after the tenth month, at which time the adjuster notified Coventry/First Script of the injured worker's pharmaceutical needs. Apparently, this should have triggered GB's redirection program; however, we found nothing that would indicate there was follow-up.

GB's redirection program claims that it will redirect injured worker drug bills back into the Coventry/First Script program.[26] Like the rest of GB's services, however, what exactly this service entails, who will provide it, and under what conditions will it be provided are not stated anywhere in a contract document. There are also no service instructions regarding the Redirection Program. What we do know and report in this finding is that most injured workers do not participate in GB's pharmacy program and we found little evidence that GB has made much of an effort to make this program work. Injured worker participation is a key element in pharmacy cost savings. GB had the data needed to determine injured worker participation, but it failed to use that data as a prompt for directed action to mitigate the noted problem.

Finally, and importantly, the M-DCPS made no attempt before July 2009 to educate its injured workers regarding the use of the workers' compensation pharmacy program. Our documentation review, combined with interviews of staff and

[26] We acknowledge that Florida Statutes grant injured workers the right to freely choose where they will fill their prescriptions.

observations of meetings, shows that the M-DCPS took no action to educate its injured workers regarding the potential savings to their employer—particularly at this difficult time when additional dollars are needed in the classroom. Only at a July 8, 2009 meeting was this topic discussed, and it was suggested that those injured workers currently receiving pharmaceuticals should be encouraged to begin using the mail order pharmaceutical program. It should be noted that this action is only being taken two years after the inception of the contract.

Recommendations

(18) GB should train and educate claims adjusters and provide greater supervisory oversight on adjuster claim files.

(19) GB should survey current and former injured workers to ascertain why they did not use the WC pharmacy program and prepare an action plan to address injured worker concerns.

(20) GB should engage the M-DCPS assistance in communicating to its injured employees the desirability of their using the WC program pharmacy program provider to supply their pharmaceutical needs.

(21) In future contracts, the M-DCPS should include performance measures showing injured worker participation, including a defined acceptable performance level with a sliding scale of non-performance that results in fee reductions or other financial penalties.

Auditee Responses and OIG Rejoinder

M-DCPS

"Staff supports the recommendations to further educate GB adjusters to work towards maximum penetration in the use of network pharmacies." Staff, however, does not agree with including performance standards because the injured worker can fill his/her pharmaceutical needs anywhere, regardless of the efforts by M-DCPS or its PBM, to direct or encourage these individuals into using the approved program.

GB

GB states that Florida statutes allow injured workers to fill their prescription needs anywhere they choose. In addition, GB refers back to its response to Finding No. 9, where it believes it has shown its successes in directing injured workers into the approved program and in reducing M-DCPS drug costs. Moreover, GB touts its prescription drug re-pricing program that was just recently implemented. GB proclaims that it is its belief that it "is the only claims administrator and M-DCPS is the only Florida employer with this program."

OIG

GB's response addresses drug re-pricing. The OIG's finding and recommendations relate to injured worker participation in an approved pharmacy program. While M-DCPS acknowledges the cost savings of redirecting injured worker participation back into the First Script network, it is reluctant to hold the vendor's performance to any participation standard. We readily acknowledge the injured worker's choice in where he/she gets his/her prescription filled. However, as noted in the body of our finding, GB's adjusters are the primary point of contact for the injured worker. Its effectiveness of providing services to the M-DCPS can—and should—be evaluated by how well it directs injured workers to participate in the established pharmacy program. In the broader scheme, non-participation by the injured worker eludes data collection, care coordination, and pre-authorization opportunities by the adjuster, which, we believe, are all key components to an effective program.

FINDING NO. 11 GB has not proactively managed its Flex Net and other medical network service providers to deter them from dispensing repackaged drugs. This costly practice added over $515,000 to M-DCPS' cost of pharmaceuticals in 2008.

Background—Repackaged Prescription Drugs and Third-Party Billings

The distribution of prescription drugs involves manufacturers, wholesalers, secondary wholesalers, repackagers/relabelers, pharmacies, and sometimes includes physicians. At issue are physician dispensers who distribute repackaged medications directly to patients at the point of care, i.e., the doctor's office or an adjacent dispensing facility. "Pharmaceuticals prescribed and dispensed by physicians are often referred to as "repackaged" drugs because they are purchased by relabelers directly from manufacturers in large quantities (e.g., 1,000 - 5,000 tablets), [then] repackaged

and relabeled into single prescription sizes (e.g., 15, 30, or 60 tablets) appropriate for dispensing directly to patients, who in this case are the injured workers.[27]

Physicians dispense drugs from their offices or adjacent facilities as a convenience to their patients and to increase their medical practice revenues. A dispensing physician typically has an agreement with repackagers, who also function as third-party billers. Within the workers' compensation industry, a third-party biller is a company that may provide the following types of services for a provider: invoicing an insurer for dispensed medications; providing an automated prescription tracking system; repackaging medication for dispensing; obtaining a National Drug Code number for a repackaged medication; and collecting fees associated with dispensing the prescribed medication.

A problem arises because repackagers assign their own AWP that does not necessarily bear any resemblance to the original manufacturer's AWP. These assigned AWPs are typically much higher than the manufacturer's wholesale prices. Of interest, a study in the state of California in 2006 found that "[o]n average, physician dispensed drugs cost 490% of what is paid to pharmacies. In some cases, including the most commonly prescribed drug dispensed by physicians, the mark-up exceeds 1000%."[28]

Physician dispensing has been a particularly troublesome issue for the M-DCPS WC program; in part because Florida Statutes Section 440.13(3)(j) gives the injured worker the absolute choice to select a pharmacy of his/her choosing. Notwithstanding the injured worker's right to choose, the employer is obligated only to pay for pharmaceuticals at the Florida Fee Schedule Rate (AWP + $4.18/per dispensed prescription).

Recently, the M-DCPS staff informed us that letters were going to be sent to all medical service providers informing them that effective September 1, 2009, all repackaged/relabeled pharmaceuticals would be re-priced using the highest manufacturer AWP (a price that still would be less than the AWP assigned by a repackager).

To effect this change, the M-DCPS informed us that it directed GB to instruct Coventry, who handles GB's bill review and re-pricing function, to re-price all

[27] Taken from a July 2006 report issued by the California Commission on Health and Safety and Workers' Compensation titled *Impact of Physician-Dispensing of Repackaged Drugs on California Workers' Compensation, Employers Cost, and Workers' Access to Quality Care,* at page 6.
[28] *Id.*, at page 2.

repackaged/relabeled pharmaceutical purchases in accordance with this directive.

Auditor Observed Conditions

Our review shows that 67% of all pharmaceutical costs incurred under the current contract were processed outside of the GB pharmacy program. Specifically, 50% was submitted by only three providers: Prescription Partners, LLC; Third Party Solutions; and Working Rx (see Table 8). Our more detailed review of these payments shows that the costs of these pharmaceuticals appear unreasonable, or out-of-line with Coventry/First Script's prices. Our analysis is supported by a study completed by GB's pharmacy benefits provider, Coventry/First Script, of calendar year 2008 drug purchases.[29] Coventry/First Script concluded that the M-DCPS would have had a cost savings totaling $515,640 had these purchases been made through the Coventry/First Script pharmacy program.[30] Table 9 (see following page) compares pharmaceutical prices dispensed at medical provider offices versus First Script's rate.

Table 9 Examples of Payment Variances for Prescription Drugs Not in Pharmacy Program

Name of Provider	Prescription Fill Date	Drug Name	Dosage	Qty.	Amount Paid	PBM Payment Rate	Variance
Prescription Partners, LLC	9/8/2008	Meloxicam	15 MG	30	$227.10	$111.07	**$(116.03)**
Third Party Solutions	6/2/2008	Meloxicam	15 MG	60	$556.68	$217.15	**$(339.53)**
Prescription Partners, LLC	3/28/2008	Tramadol	15 MG	30	$43.78	$24.67	**$(19.11)**
Third Party Solutions	9/2/2008	Tramadol	50 MG	60	$104.22	$44.34	**$(59.88)**
Prescription Partners, LLC	7/7/2008	Naproxen	500 MG	60	$135.88	$56.29	**$(79.59)**
Third Party Solutions	2/25/2008	Naproxen	500 MG	60	$149.30	$56.29	**$(93.01)**

Notes:
1) **Amount Paid** is the drug's repackaged AWP plus a $4.18 dispensing fee.
2) **First Script Rate** is derived by taking the drug manufacturer's AWP less a discount percentage (9% retail name brand or 17% retail generic) plus a $5 dispensing fee. We derived the AWP using First Script invoices containing the same drug in the same period as the fill date, or via a drug price provided by a pharmacy network provider representative.
3) Negative amount in the **Variance** column denotes the savings lost by the M-DCPS WC program because the prescription was not filled by GB's pharmacy program.

We are concerned that GB, in fact, has been facilitating this condition. In the *Flex Net Provider Manual* that is co-issued by GB and M-DCPS, there is a listing of attributes that medical providers should have at their facilities. One of these attributes

[29] Data supplied by Coventry, on July 8, 2009, at a meeting attended by the OIG that was held at the M-DCPS Office of Risk and Benefits Management.
[30] Even if using the generous pricing terms offered in the September 1, 2009 re-pricing mandate, M-DCPS still would have saved $438,000 during 2008.

reads "[o]n site equipment (Pharmacy, Radiology ECT.)" This attribute is in the provider manual supplied to those medical providers that agree to become part of Flex Net. Additionally, the LOAs that were signed beginning in October 2008 state that the provider "agrees to adhere to the protocols as listed in the attached Flex Net Provider Manual." Thus, the language included in these LOAs obligates the medical providers to have, at their offices, facilities to supply pharmaceuticals to injured workers. However, the LOAs are silent as to how the billing of these pharmaceuticals should be processed. Furthermore, the LOAs do not mention GB's pharmacy program and make no requirement that pharmaceuticals be processed through this program, or at least at program prices. On the other hand, and to its credit, several months ago GB hosted two focus groups for the workers' compensation community dealing with the pharmaceutical issue. Literature attached to the invitation to attend the focus groups provided three examples showing the inflated costs of repackaged prescriptions.

Recommendations

(22) LOAs should be amended to set strict criteria for when physicians may dispense medications, such as for first fill opportunities and for other emergencies; the language should be changed in prospective LOAs.[31]

(23) Future contracts should include provisions that direct the WC program manager to include language in medical provider agreements that direct those medical providers who choose to dispense pharmaceuticals from their offices to process the pharmaceuticals through the pharmacy benefits manager under contract.

(24) Future contracts for pharmacy programs should require the WC program manager to provide that an effective mechanism is in place to ensure that reasonable efforts are made to redirect injured workers and that all prescriptions filled outside of the contracted pharmacy program are conveyed to the pharmacy benefits manager and incorporated into the pharmacy program.

Auditee Responses and OIG Rejoinder

M-DCPS

"Staff disagrees with the assertion that GB has not managed the issue of dispensing re-packaged drugs." Staff also defends the right of physicians to self-dispense their own prescriptions as being in the District's best interests and in the best

[31] This is a revised recommendation from the draft report.

interests of the injured workers, who may not be mobile or have ready access to available transportation. Staff states, "The solution is the one which is currently being developed and implemented, which is re-pricing all physician-dispensed pharmaceuticals so that the cost is no more than what would be paid if the prescription had been filled through the PBM. All physicians within the networks currently being utilized have been informed that the re-pricing model is currently in place. Therefore, OIG recommendations 23 and 24 have already been addressed by the District and GB."

GB

GB, in its response, provides additional information about the re-pricing program for repackaged drugs.

OIG

We are encouraged by the recent steps taken by staff and GB to deal with the issue of physician dispensed high-priced repackaged drugs. However, even if these drugs are re-priced based on the most expensive generic manufacturer's product AWP, the price would still be higher than the PMB's discounted price.[32] We believe that the solution lies with actively managing the physician network (whether it be Coventry's doctors or the FlexNet LOA physicians) to require them to submit to the PBM's fee schedule. In other words, what is the benefit to M-DCPS of a customized physician network, if those doctors do not agree to the District's fee schedule.[33]

As for staff's contention that Recommendations Nos. 23 and 24 have been addressed, we disagree. These recommendations pertain to contractual requirements that should be incorporated into the new contract no matter who the vendor is.

FINDING NO. 12 M-DCPS does not maintain sufficient controls over the Imprest Fund.

As required in its contract, GB is obligated to provide an Imprest Fund. This fund is established on behalf of M-DCPS to pay all WC medical and indemnity costs, and other allocated claim expenses, as well as costs associated with third-party liability claims. M-DCPS funds the account and GB makes the payment on the behalf of

[32] We note that it was during a Coventry/First Script presentation, on July 8, 2009, attended by OIG auditors, where we learned that the "New [pricing] methodology identifies the most expensive Generic manufacturer's product [AWP] and compare's [sic] to what the Repackager billed."
[33] In this case, it would be the fee schedule of the District's PBM, First Script.

M-DCPS. Payments from the Imprest Fund exceeded $36 million for calendar year 2008. That amount does not include the $5.8 million annually that is paid to GB as its fee.

The OIG observed that M-DCPS does not take an active role in analyzing or requiring periodic audits of the M-DCPS funds that flow out of the Imprest Fund. The M-DCPS Treasury Department (Treasury) monitors the Imprest Fund's balance and replenishes it when it is low, but it does not monitor or review the expenses (by type, category, or payee) that are paid from the Imprest Fund. During an interview on May 21, 2009, both the M-DCPS Treasurer and the Comptroller stated that this function is outsourced to GB. Treasury receives a monthly reconciliation that identifies the check by its check number, dollar amount, issue date, and payee. This information is sent to M-DCPS via hard copy and is voluminous, as it contains data on an average of 5,000 monthly transactions. Treasury does prepare a monthly listing of checks outstanding, but even if Treasury or RM wanted to periodically review Imprest Fund payments, it would be impossible to do so using the current format received from the bank.

OIG auditors asked the M-DCPS CFO about any other efforts and/or reviews conducted by M-DCPS staff regarding the Imprest Fund. We were advised that M-DCPS relies upon GB, its fund administrator, to oversee the account. Meanwhile, GB has failed to provide M-DCPS with advisory reports on the Imprest Fund as required by the contract:

> In addition, [GB] will analyze the account from time to time and will submit advisory reports and required adjustments to the imprest/opening balance.

During the course of the audit, both the RM Officer and the GB branch manager told us that they were not aware of these advisory reports.

Because our review has encountered errors in the processing of hospital, prescription, and physical therapy provider bills, which were not caught by the bill review engine, we believe that periodic spot-checks should be in order. We should "trust" that the bill review engine is working properly, but we must "verify" that it is indeed working.

Recommendations

(25) M-DCPS should use staff to perform frequent analysis of transactions paid out of the Imprest Fund, trace payments, and perform comparables analysis. Have periodic audits conducted of the Imprest Fund by internal and external resources.

(26) Prospectively, future contracts should list specific reports to be generated by the program provider/vendor regarding the Imprest Fund, along with deadlines for their delivery to the M-DCPS. The reports should provide useful information to the M-DCPS management; for instance, amounts paid to providers, amounts paid for certain services, and amounts paid for reimbursables/expenses.

Auditee Response and OIG Rejoinder

M-DCPS

Staff spends considerable time explaining the "ins and outs" of the Imprest Fund and that the need for advisory reports has been "virtually eliminated." Importantly, "Staff agrees that periodic audits both internal and external should be performed."

OIG

As a result of various audit fieldwork interviews, the OIG fully understands the mechanism used to fund the imprest account, as well as the roles of both the Office of the Comptroller and the Office of Treasury Management. Funding of the imprest account and preparing a monthly bank reconciliation do not constitute an analysis of transactions. Past reviews, as stated in staff's response, have reviewed the process and are infrequent at best.

Our finding specifically addressed the lack of M-DCPS analyzing cash outflows from the imprest fund and cited the billing errors observed during our review. Notwithstanding staff's agreement with our recommendation, we reiterate our basis for Recommendation #25. If implemented, these actions would help to ensure that the amounts being paid are reasonable and are being paid within established parameters, such as the Florida Fee Schedule or other agreed upon contractual amounts such reimbursement amounts included in the recently signed LOA's that have become part of Flex Net.

FINDING NO. 13 The contract for field case management services was not executed in writing for two years after the inception of GB's current contract.

The $5.8 million annual fee to GB does not include any costs related to *Non-Core Managed Services*. One of those non-core services is field case management, which utilizes nurses to coordinate healthcare services, in order to minimize the recovery period and prevent complications for injured workers. These nurses generally work in the field; they will travel with injured workers to doctor appointments and attempt to provide clarity of medical options to the injured worker. The GB contract reads:

> If field case management services are provided by [GB] or [GB] contracts with vendor to provide field case management service, fees will be $85[34] per hour plus expenses.

Field case management services have been performed for the current contract term by Seltzer & Associates (Seltzer). According to GB, it does not have a contract with Seltzer. Instead, Seltzer provides field case management services directly to M-DCPS, although it is paid through the Imprest Fund that is administered by GB. [35]

M-DCPS has paid Seltzer over $711,000 for its services from July 1, 2007 through December 31, 2008 (the first 18 months of the contract). During this time, there was no written contract between Seltzer and M-DCPS. Subsequent to a request by OIG auditors, a written agreement between Seltzer and M-DCPS materialized. The contract has an effective date of January 1, 2009 and covers the remaining 18 months of GB's contract term. Seltzer's execution of the document is dated June 30, 2009. It is unclear whether M-DCPS has executed the contract and whether it has gone before the SB for approval, although we believe not.

The written agreement is sparse on details. For example, it states that "[t]he mechanism and criteria for referral of cases shall be as it is understood orally at this time and may be codified in written form in the future." (Emphasis added).

[34] CorVel was being paid $75 per hour for field case management services immediately preceding the July 1, 2007 contract with GB. The current hourly rate being paid to Seltzer of $85 per hour is a 13% increase.
[35] According to the Imprest Fund's check register, Coventry was paid over $13,000 for field case management services for the calendar year 2008.

The contract does not have a monetary cap, in other words, there is no not-to-exceed amount. If the second 18 months of the GB contract term is similar to the first, then M-DCPS can expect to pay Seltzer another $700,000. The Seltzer contract calls for expenses to be billed at cost plus 8%. The OIG finds no justification for such a mark-up, especially when there is also an administrative fee of 5% that can be added to each invoice (not to exceed $25) to cover items such as telephone, fax, and postage expenses. Mileage is being charged by Seltzer at the prevailing rate allowed by the Internal Revenue Service. However, Seltzer's corporate office is located in Sunrise, Broward County, and the contract fails to specify any other point of origin to be used to calculate mileage incurred. These billable costs are all in addition to the billable rate of $85 per hour.

This makeshift contract with Seltzer troubles the OIG. Its delay in execution—or whether it has even been approved by the School Board—should be of concern. Likewise, the 8% mark-up should be of concern. A pool of field case managers, like SB contract attorneys handling WC cases, should be developed. We do not believe that this service is so specialized that only one firm (located in Sunrise, no less) can provide these types of services to injured M-DCPS workers. In fact, CorVel used to provide these services.[36] We are confident other firms do, too.

Recommendations

(27) The aforementioned contract should be reviewed by the SB Attorney's Office.

(28) The field case management platform should be set-up similar to the M-DCPS pool of contracted WC attorneys. This would allow the M-DCPS the option to direct service requests to the most geographically convenient provider and allow the M-DCPS to set a competitive rate.

(29) Prospectively, separate pay codes should be established for field case management services and expenses relating to these services, which would make for a more effective audit trail.

[36] CorVel's former client liaison is now associated with Seltzer & Associates.

Auditee Responses and OIG Rejoinder

M-DCPS

"Staff would prefer to issue the RFI for Field Case Management following the re-marketing of the Third Party Claims Administration RFP which will be taken to the Board meeting of November 17, 2009."

OIG

Notwithstanding staff's proposed prospective action, which we support, our review of staff's entire response is troubling. Staff states that Seltzer and Associates was selected to be the FCM, as the result of this vendor hiring one individual. This individual, Mr. Ron Andrews, is a nurse who previously worked for CorVel. Choosing a new FCM based solely on the fact that it hired an individual who had worked for the previous FCM is unacceptable. Staff is saying that they are steering all the work to this particular firm because of its employment of this one individual. This practice displays a lack of common sense and good governance for a public entity.

Furthermore, without a competitive solicitation for FCM services, M-DCPS cannot determine if the amounts paid to Seltzer are reasonable and in accordance with current market conditions. Amounts paid for FCM services from July 1, 2007 through December 31, 2008 totaled $711,000. As stated in our report, if the second 18 months of the vendor's contract term is similar to the first, then M-DCPS can expect to pay Seltzer and Associates in excess of $1.4 million for services rendered during the three-year contract period. This is a large amount of money to award to one entity based on its hiring of one individual. Finally, the OIG is pleased that M-DCPS acknowledges that its own draft contract, which it provided to the OIG is deemed unacceptable and a new contract should be drafted to memorialize the services to be provided and compensation for the services.

Lastly, we reiterate Recommendation #29. We do not see any "con" to separating fees from reimbursement costs. We believe that it adds a level of transparency. Clearly, vendor-supplied management reports that identify fees versus expenses will be helpful, but these reports should not be a substitute for an accounting internal control.

FINDING NO. 14 **M-DCPS does not have a functional WC loss prevention program.**

Preventing accidents from taking place is an important way to control WC costs. A proactive loss prevention program can prevent work place accidents or minimize the number of injuries that are processed through the M-DCPS WC program. We learned during our audit that the M-DCPS WC program does not currently have a functioning loss prevention program.

The RM Officer stated that the M-DCPS does not have the resources available to be proactive in this arena, and that due to recent budget constraints the RM department had to lay off three staffers who previously made-up the loss prevention unit. Even though there are safety officers assigned to each school location, according to the RM Officer, their focus is on the protection of people and assets, not on WC safety and prevention issues.

Arthur J. Gallagher Risk Management Services prepares a workers' compensation loss analysis summary on an annual basis and the report is made available to the RM Officer. The report provides a breakdown by location of the number and types of accidents and contains recommendations to consider for initiating a loss prevention program. During an interview with OIG auditors, the RM Officer stated that he was unable to implement any of the recommendations due to the limited resources made available to the RM.

As a result of not having a loss prevention program, the M-DCPS has incurred costs for WC claims that may have been prevented by educating its workers or by finding solutions to potential work place hazards. These claims lead to potential medical, indemnity, legal, and administrative costs.

M-DCPS needs to promote worksite safety and needs to make safety an organization-wide priority. This goal can be accomplished by ensuring that safety programs are comprehensive and consistent. Additionally, the M-DCPS should consider implementing evaluation criteria for staff in supervisory positions based on knowledge of safety prevention procedures, as well as attitudes and perceptions toward safety, rather than on the number of accidents or the workers' compensation record of the supervisor's work unit. Finally, the M-DCPS should consider providing incentives for staff to promote safety.

Recommendations

(30) M-DCPS should allocate funds and allow the RM Officer to develop an effective loss prevention program. The program should be monitored for performance and should provide training to workers on how to avoid workplace accidents common to their specific jobsite. The program should establish workshops and incorporate training on addressing injury prevention, identifying potential workplace hazards, and finding solutions to making the workplace more safe.

(31) M-DCPS should promote a district-wide safety program ensuring that knowledge of safety criteria are used in the performance evaluations of supervisors.

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As follow-up to the final audit, we request that M-DCPS provide the OIG with information relating to its adoption and implementation of certain findings. Many of these recommendations directly relate to the identified questioned costs and recoupment of those funds. These recommendations are numbers: 7, 8, 10, 12, 14, and 16. Many more recommendations relate to process and procedural enhancements that can be addressed now, and do not require deferral until the new contract. These recommendations are numbers: 4, 6, 9, 11, 13, 18, 19, 20, 22, 25, 27, 28, 29, 30, and 31. We respectfully request that M-DCPS provide us with this informational status report in 90 days, on or before February 5, 2010.

As to the remaining recommendations, these address improvements, inclusions, and enhancements that would be best addressed by the new contract. The OIG will be monitoring the selection and negotiating process for the successor contract and will reiterate these recommendations as appropriate during that process.

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The OIG appreciates the cooperation and assistance afforded us by personnel from Miami-Dade County Public Schools and Gallagher Bassett Services, Inc. during the course of our audit.

Miami-Dade County Public Schools
Office of the Inspector General

APPENDIX A

Response from Miami-Dade County Public Schools

IG08-25SB

Thursday, October 22, 2009
Item V. 4

STAFF RESPONSE
MIAMI-DADE COUNTY PUBLIC SCHOOLS
OFFICE OF THE INSPECTOR GENERAL
DRAFT AUDIT REPORT
MIAMI-DADE COUNTY PUBLIC SCHOOLS' WORKERS' COMPENSATION PROGRAM
OCTOBER, 2009

After 17 months of providing information and documentation to the Office of Inspector General (OIG), the following is staff's response to the Draft Audit Report, Miami-Dade County Public Schools' Workers' Compensation Program.

BACKGROUND

The School Board of Miami-Dade County, Florida has been self insured for workers' compensation claims since 1974. As an authorized self-insurer in the State of Florida, the District must submit to specific guidelines for its workers' compensation program administration, including providing the Division of Workers' Compensation specific financial information regarding paid claims data, payroll data, etc. Although not required to by the State of Florida, the District has traditionally purchased excess workers' compensation insurance coverage to protect it against shock losses which could include one event which affects multiple employee injures. The most glaring example of this type of shock loss is the death and injury to multiple company employees who were in the World Trade Center twin towers on September 10, 2001. The purchased excess coverage is subject to a per-loss self insured retention (SIR) of $1 million. Coverage subject to that SIR is unlimited for benefits provided pursuant Chapter 440, Florida Statute and $5 million for coverage provided as Employer Liability.

As a self insured entity for workers' compensation, an employer has two major choices for claims administration of the program. One choice is to create and maintain an in-house claims administration program (self administration). A self administered program requires the creation of a fully functional claims department consisting of licensed claims professionals who are employees of the entity. More often than not, a self administered program requires outsourcing of many claims related functions where purchasing these services is more cost effective than creating the infrastructure to provide them in house.

The other option is for an employer to outsource the majority of the claims administration to a licensed third party claims administrator. Since the District became self insured in 1974, all claims administration services have been outsourced. Over the years, the District has contracted with two third party claims administration companies which included Gallagher Bassett Services, Inc. and Alexsis Risk Management. Because the audit specifically focused on the workers' compensation claims administration and not the liability claims administration function, this response will focus solely on the workers' compensation program, although the liability claims program is a major component of the District's self insured program.

On a local basis, Miami-Dade County self administers its claims administration program for workers' compensation, and liability claims. The county employs in excess of 50 full time staff people to provide this function and has entered into outside contracts for its Risk Management Claims Information System (RMIS), and medical managed care functions including bill review, and field case management services. Current administrative costs associated with Miami-Dade County's self administered program exceed the flat annual cost of Miami-Dade County Public Schools' program.

The focus of any employers' workers' compensation claims administration program consists of the following three aspects:

1. Loss Prevention
2. Medical management of an injured employee's claim
3. Indemnity functions which include returning/keeping the injured employee at work.

All three functions are equally important and must work in concert with the other goals for the entire program to be successful. As the OIG has specifically identified Loss Prevention as an audit recommendation, staff's response to this recommendation will be provided later in that section of the report.

SERVICE STATISTICS

The following service statistics, by fiscal year, are being provided in order for the Board to completely understand the scope and complexity of its workers' compensation program, and to that end, put certain findings of the OIG into perspective:

	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009
Total Payments*	$33.5	$29.5	$31.1	$29.9	$29.0
# of Payments	69,964	67,435	67,595	68,909	64,635
Claim Count (Med. Only)	3,522	3,414	3,036	1,707**	1,443**
Claim Count (lost time)	1,409	1,258	1,406	1,476	1,261
Actuarial Projections*	$35.5	$37.1	$36.4	$34.0	$33.0

*represented in millions
**as of 7-1-07 claim count excludes incident-only

In summary, Miami-Dade County Public Schools has incurred expenditures for its self insured workers' compensation program over the period of time of the past five fiscal years totaling $153,000,000, consisting of 338,538 individual payments on 19,932 workers' compensation claims.

Over the past five years, District medical costs attributable to workers' compensation injuries have remained relatively flat. This has been achieved due to many reasons including the use of the Florida Workers' Compensation Fee Schedule as a benchmark for medical care reimbursement, and the partnership that has been achieved through Letters of Agreement (LOA) with physicians which focus on outcomes. It is important to note that medical inflation in South Florida has been running double digits, with South Florida being the highest cost area in the country for healthcare based upon the 2009 Milliman Medical Index which listed South Florida at 120% of the national average for medical costs.

The number of lost time cases and total work days lost has dropped over the past five years. The significance of these reductions are critical to the District's goal of providing first class educational opportunities for children in Miami-Dade County, as a large percentage of injured workers who miss work must be replaced by paid substitutes. The reduction in lost work days not only represents a savings to the District in not having to hire substitute teachers and bus drivers, the continuity of not interrupting the learning process with substitute teachers further enhances the learning process.

The number of injured workers' who retained the services of an attorney necessitating the need for the District to hire defense counsel to represent its interests has declined by 50% from 2003-2004 to 2007-2008. During fiscal year 2003-2004, 181 claims were assigned to outside counsel as compared to fiscal year 2008-2009 where only 90 claims were assigned.

The ultimate goal of the Office of Risk and Benefits Management is to prevent injuries from occurring, but in the event that a compensable injury occurs, making sure that the injured employee is provided all benefits coming to that employee, and returning that injured employee back to work as soon as possible. This includes benefits which are provided pursuant to the provisions of Chapter 440, Florida Statute, as well as School Board Rule 6Gx13- 4E-1.13, Illness or Injury-In-Line-Of-Duty, Instructional and Non-Instructional Employees, and applicable labor contracts. This is accomplished on a daily basis by a Workers' Compensation Supervisor and three clerical employees employed by the District, in conjunction with the resources provided by the District's Third Party Claims Administrator. This work is conducted on a daily basis with full file reviews being conducted on a quarterly basis with District staff, the claims adjusters, claims supervisors, and other professional staff to assure the best file resolutions possible.

A key indicator for workers' compensation costs is total expenditures as a percentage of total salary expenses. Within the industry, an employer who has been successful in keeping their workers' compensation expenses within 3% of total payroll expenditures is considered to have very positive outcomes. Based upon total payroll expenditures for FY 2008-2009 of $1.9 billion, the District's average expenditures for workers' compensation expenses are much closer to 2% of payroll costs.

Staff Response – Finding #1 (No OIG Recommendation)

Since the Board approved the initial contract with Gallagher-Bassett Services, effective July 1, 1994, the Board has taken the following actions with regard to its workers' compensation program:

- Board Meeting of May 25, 1994, Agenda Item Replacement G-30, Recommendation for Award – Request For Proposal (RFP)# 219-P-10, Claims Adjusting, Loss Prevention and Managed Care Services

- Board Meeting of October 21, 1998, Agenda Item Revised E-9, Request For Authorization to Extend Contract with Gallagher-Bassett Services For Claims Administration Services and Loss Prevention Services, Including Managed Care Services For Workers' Compensation Claims Provided by Corvel Corporation

- Board Meeting of November 14, 2001, Agenda Item E-6, Recommendation For Exercising the Board's Option to Opt Out of Previously Mandated Workers' Compensation Managed Care Arrangement and Replace It With Traditional Managed Care

- Board Meeting of June 19, 2002, Agenda Item G-52, Request For Authorization to Renew The Loss Prevention Contract With Gallagher Bassett Services, Inc. (This agenda item included authorization for staff to begin working on a comprehensive RFP to seek competitive proposals for a claims audit).

- Board Meeting of March 12, 2003, Agenda Item Replacement G-47, Request For Authorization to Award Request For Proposal (RFP) # 053-CC10, Casualty Claims Administrator Audit Services (Deloitte & Touche, LLP selected to conduct a three-year rolling audit)

- Board Meeting of November 19, 2003, Agenda Item F-3, Casualty Claims Administration Audit – The School Board of Miami-Dade County, Florida by Deloitte & Touche, LLP, Presented by the Office of Management and Compliance Audits

- Board Meeting of November 19, 2003, Agenda Item Replacement H-9, Recommended Changes to Current Workers' Compensation Claims Administration and Managed Care Program (Included authorization for the Superintendent to enter into negotiations with Gallagher Bassett Services and Corvel Corporation for a new contract to become effective July 1, 2004).

- Board Meeting of June 16, 2004, Agenda Item G-33, Authorization to Contract With Third Party Claims Administrator and Managed Care Provider

- Board Meeting of July 14, 2004, Agenda Item B-91, Workers' Compensation Claims Administration Audit – The School Board of Miami-Dade County, Florida, by Deloitte Consulting, LLP, Presented by The Office of Management and Compliance Audits

- Board Meeting of December 14, 2005, Agenda Item Revised E-87, Workers' Compensation and Liability Claims Review Performed by Deloitte Consulting, LLP – June, 2005 (last of the three year audits conducted by Deloitte specifically focused on Gallagher Bassett's claims reserving techniques which were found to be financially sound).

- Board Meeting of June 14, 2006, Agenda Item E-71, Request To Non-Renew the Third Party Loss Prevention Contract with Gallagher Bassett Services and Establish a Loss Prevention Section Within The Office of Risk and Benefits Management

- Board Meeting of March 14, 2007, Agenda Item E-67, Strategic Initiative of Integration of Claims Administration with Medical Management of Workers' Compensation Claims (authorized the Superintendent to negotiate an extension of the existing Gallagher Bassett Services Contract to provide claims administration services for all claims inclusive of all medical management and managed care services for workers' compensation claims).

- Board Meeting of May 16, 2007, Agenda Item E-67, Recommendation For Third Party Claims Administration Contract With Gallagher Bassett Services, Inc. (current contract through 6-30-10).

As a result of the Superintendent's initiative to review all major District contracts when he became Superintendent in September, 2008, the decision was made that a Request For Proposals should be issued to seek competitive proposals at the end of the existing three year contract which expires July 1, 2010. Agenda item E-67, Request For Authorization to Issue Request For Proposals (RFP)# 006-KK10, Workers' Compensation and Third Party Claims Administration Services will be presented to the School Board of November 17, 2009. Staff would like to thank the OIG for their constructive recommendations which have been incorporated into the RFP document.

Staff Response – Finding #2

At the Board meeting of March 14, 2007, staff sought authorization to begin negotiations for a completely new platform for managing the medical components of workers' compensation claims. Traditionally, the State of Florida's Managed Care Mandate, and the industry norm was to split the claims administration process into two parts consisting of licensed claims adjusters who handle the indemnity (lost time, return to work, legal) aspects of the claims file, while a hired nurse case manager was responsible for all aspects of the injured employee's medical care.

Having served in the claims administration industry as an Adjuster, Supervisor, and Account Manager for insurance companies and claims administration companies prior to working for Miami-Dade County Public Schools, the Risk and Benefits Officer was never convinced that the managed care platform which had developed in the industry was a best practice.

Starting with the contract in 1994 through numerous iterations of managed care, the model which placed the injured employee between two individuals who were attempting to handle all aspects of a claim did not work efficiently then and does not work now. More often than not, the injured employee when they had a question regarding their claim had no idea as to whom they should seek direction, which resulted in increased anxiety for an already injured employee. The role of the Nurse Case Managers emulated that of the broken model of early Health Maintenance Organizations (HMO's) whose entire focus was to delay medical care and micro manage treating physicians in order to save money. While this may have had an initial success in healthcare with the cost of medical claims artificially being deflated due to lack of access, the whole focus of workers' compensation claims in providing prompt, efficient medical care to return an injured employee back to work was completely lost on the managed care industry.

Many of the better physicians which had accepted workers' compensation claimants stopped seeing them due to the fact that the reimbursement rates for care was being artificially ratcheted back with discounts of 25-35% off of the State of Florida fee schedule being negotiated with the medical management company taking a fee as a percentage of the savings. This practice, although never in place for Miami-Dade County Public Schools due to its flat annual contracts for managed care services, drove many physicians and other providers out of traditional workers' compensation provider networks.

In 2007 the workers' compensation managed care industry had yet to acknowledge that the healthcare industry had abandoned the model of managed care which prohibited or delayed access to a model which began to provide direct access to quality physicians with the provider's outcomes being measured. It was this new model that staff felt would be a new and better approach moving forward for its injured employees.

As staff was not aware of any workers' compensation program which had developed a new model, meetings were held with the leadership of the existing claims administrator, Gallagher Bassett Services, Inc. (GB) to explain the idea of a new platform which would include the following components:

- Elimination of the traditional Nurse Case Manager with Nurse Consultants

- Educational program for Licensed Claims Adjusters to make them responsible for all aspects of the claims file, with medical resources as needed

- Creation of a hybrid provider network panel which specifically embraced the idea of gradually abandoning traditional managed care and managed care networks in order to recruit high quality, efficient medical providers who had stopped seeing workers' compensation claimants. This panel would be created to educate providers about the District's return to work program, District functions and objectives to maximize outcomes of efficiency and quality.

GB committed to provide the necessary resources to begin implementation of this new platform with the contract renewal of July 1, 2007. Knowing fully that the envisioned model had yet to be built, staff worked closely with GB to make sure that all functions of a claims administration program for workers' compensation claims were in place effective July 1, 2007 for continuity sake.

The creation of Flex-Net, although lengthy from a standpoint of implementation is now developing nicely. Staff was disappointed with initial setbacks including some resistance for GB to acknowledge that creation of the Flex Net Network would require them to enter into agreement with medical providers; however, once the corporate decision was made to move forward, the Flex Net Network has begun to take shape nicely. The proof of the success of this program can be demonstrated by the reduction of lost work days, decrease cost of medical care expenses, and the interest demonstrated by local provider community. We also expect further development with additional providers and improved reporting including outcome measurements.

As important as the creation of the network has been the adjuster's ability to embrace the concept of handling all aspects of the claim file, with appropriate medical resources to assist them. All adjusters when surveyed after the first year of the program felt that for the first time they had full control of the claim file and could position themselves to set goals for the claim file's successful outcome.

Staff believes that 2 ½ years after this initial effort, the idea of alternative networks and non-traditional managed care is evolving. To that end, staff agrees that the industry has now committed to produce, administer, and manage customized networks for workers' compensation programs. Staff believes that clear goals and expectations can be established and measured to assure continued success, with appropriate penalties included in the contract, if the vendor does not meet mutually agreed upon goals **(Recommendation #1).**

Staff Response – Finding #3

The Board's contract with GB for Third Party Claims Administration and Managed Care Services was negotiated and approved by the Board on a flat annual basis of $5.8 million. In a memorandum from Emil J. Bravo, GB to Mark Teitelbaum, OIG, dated April 18, 2009, the following amounts were identified as expenses paid from GB to its subcontractors for specific managed care services provide on a subcontracting arrangement:

- Bill Review, Network Development and Dedicated Nurses – GB paid Coventry $866,895 for the period of July 1, 2007 through June, 2008;

- Claim Intake – GB has paid First Notice System $96,814 for the period of July 1, 2007 through June, 2008

- First Script – GB has not paid any fees to First Script or received any payments from First Script on this account

- Administrative Fees – GB has not received any administrative fees from any managed care vendor on the MDCPS account.

Staff is fully supportive of providing adequate documents to any organization which may be auditing the District's programs including OPPAGA, the Office of Management and Compliance Audits, the Office of Inspector General (OIG), or a firm which may be selected by the District through a competitive selection process which has specific expertise in the field of claims administration audits, not unlike the comprehensive three year audit which was provided by Deloitte Consulting, LLP from 2003 through 2005.

It appears however, that some of the requests from the OIG to GB including national vendor contracts which include proprietary terms and conditions for all GB clients may not be appropriate requirement for a firm to be compelled to provide just because they are under contract with a public entity. Staff believes that it is possible to appropriately evaluate and benchmark the work of vendor subcontractors without requiring the vendors to divulge information which due to their proprietary nature may lead to private sector employers not wanting to conduct business with Miami-Dade County Public Schools in the future. There is also a risk of requiring this information to be divulged, resulting in vendors including an imbedded cost to cover their perceived exposure resulting from the document demands.

The RFP to seek competitive proposals from Third Party Claims Administrators, which will be taken to the School Board Meeting of November 17, 2009, includes wording to require companies to provide reasonable documentation to any auditor under contract to the School Board, including sensitive documents which can be reviewed in a controlled environment **(Recommendation #2).**

Staff Response - Finding #4

Staff fully supports the establishment of appropriate performance measures in the evaluation of the District's Worker's Compensation Program. To that end, performance measures are being included in the sample contract which will be included as an exhibit to the Request For Proposal (RFP) which will be brought to the Board at its meeting of November 17, 2009 to seek competitive proposals for its Third Party Claims Administration Program. The basis of these performance measures is the Risk and Insurance Management Society's (RIMS) Quality Improvement Process (QIP) Guidelines for Performance Expectations which measures specific metrics for all risk management vendor activities.

It is important to note, that appropriate performance measures include objective goals such as time frames for payments, staffing levels, bill payment accuracy, etc. The subjective nature of claims handling eliminates the possibility of measuring a third party administrator's ability to return injured employees back to work due to changes in the employee's medical condition; the existence of an employer's return to work program; available employment opportunities; and intervening legal challenges in the event the injured employee is represented **(Recommendation #3).**

As has been done routinely, staff fully supports conducting periodic audits of claims files to assess the performance of the Third Party Administrator as well as recommending changes in the program which will provide efficiencies, as did occur from 2003 through 2005 when Deloitte Consulting, LLP was under contract to provide workers' compensation and casualty claims audits **(Recommendation #4).**

Staff also supports the establishment of appropriate remedies in the event that the performance of the Third Party Administrator is not to expectations. These remedies should be based on objective performance standards and include financial remedies as well as indemnification/hold harmless provisions and cancellations provisions for non-performance **(Recommendation #5).**

Staff fully supports having the results of conducted audits being reported to the Board's Audit Committee and the School Board, which is exactly what has occurred in the past with the previous Deloitte Consulting Audits from 2003 through 2005. The results of these audits were taken to the Audit Committee and transmitted to the School Board **(Recommendation #6).**

Staff Response – Finding #5

Staff fully supports the fact that interest and penalties which accrue on a claim due to action or inaction on behalf of the Third Party Claims Administrator's performance should be paid by the administrator as is the case in the current contract with GB. It is important to put this issue into perspective as the identified penalties and interest charges of $36,316 for claim payments from 2003 through 2008 are based upon total claim payments made during that five year period of $157,199,044. Staff believes that the referenced $36,316 includes a component of benefits due an injured employee, thus reducing the interest and penalty figure even further.

The quoted comment from the Risk and Benefits Officer referencing the cost of doing business may have been misinterpreted, and in fact relates to accrued penalties and interest charges which accrue due to issues in which the Third Party Claims Administrator was not responsible for causing the penalties and interest, and therefore should not be subject to funding these payments. Claim adjusting is very much an art as opposed to being a science and requires judgment calls and claims strategies. In some instances, an injured worker may seek to have a specific benefit provided to them, which in the claim adjuster/employer's opinion is not warranted. Should this situation occur and the injured employee files a Petition For Benefits before a Judge of Compensation and is awarded these benefits, the Judge of Compensation may require the employer to pay penalties and interest on the benefits which were denied. In this instance, this is a legitimate cost which should be borne by the employer as part of its normal business operations of a self insured workers' compensation program.

The referenced $36,316 is being researched to ascertain if these charges were due to errors or omissions on GB's part, or if they relate to charges related to claim strategies and assessed by a Judge of Compensation. This same research will be done for all penalties and interest payments made since January 1, 2009. Pursuant to the current contract with GB, any charges consisting of penalties and interests which are the responsibility of the administrator, due to an errors or omission, will be recouped **(Recommendations #7,8).**

Penalties and interest due on a workers' compensation file are very time sensitive; therefore, the ability to pay these charges timely is crucial. Based upon the inordinately low percentage rate found by the OIG of possible misapplied payments over a five-year period, the risk of this occurring appears minimal. Nevertheless, staff will institute a process to conduct a periodic review of all payments for penalties and interests **(Recommendation #9).**

Staff Response – Finding #6

Staff is presently following up on the bill audit. Reimbursement of the initial $67,381.65 in overpayments was received by the District as of October 8, 2009. The review of all in patient hospitalizations through the present is currently underway and the results of this audit will be provided to the OIG. Any additional monies due, will be collected by the District. Gallagher Bassett has taken steps to rectify its bill review process with Coventry. **(Recommendations #10,11,12).**

Staff Response – Finding #7

Staff fully agrees that in order for the FlexNet network to be fully effective, GB must be able to accurately pay PT providers, as well as all providers with a letter of agreement, the appropriate reimbursement rates **(Recommendation #13).** Staff has requested Gallagher Bassett to complete a full audit of all PT provider payments from September 1, 2008 to the present and will obtain reimbursement of any overpaid bills should it be determined that overpayments actually occurred as opposed to PT bills being paid according to State Fee Schedule due to no provider Letter of Agreement (LOA) being on file **(Recommendation #14).**

Specific contract requirements have been included in the RFP which will be brought to the Board at the meeting of November 17, 2009 for Third Party Claims Administration Services **(Recommendation #15).**

Staff Response – Finding #8

Although staff required Gallagher Bassett to cancel its contract with MedRisk, staff disagrees that the authorized fee of $20/bill should be reimbursed as services were provided.

The original agreement with MedRisk included the requirement that MedRisk immediately credential and contract with physical therapy centers which had been providing adequate treatment to injured M-DCPS employees, but were not part of the MedRisk network. The negotiated fee was, as the OIG stated, partly to develop the custom network and partly to cover the cost of specific reports staff wanted in order to track the adequacy of the therapy and to assure communication between the therapists, the adjusters, and the treating physicians on outcome benchmarks.

Although some providers did contract with MedRisk, many of the existing providers were reluctant or even unwilling to become part of the MedRisk provider network, even on a customized basis, partly due to the capitated fee arrangement. Many injured workers were directed to pre-existing providers as opposed to being directed to providers who had provided excellent outcomes. The reporting from MedRisk convinced staff that the outcomes were not what was hoped for, and in conjunction with the fact that many providers who would have comprised the customized network would not contract with MedRisk, staff terminated the use of MedRisk in May, 2008. Payments made through July, 2008 represented therapies which were performed through May, 2008 but had yet to be paid (incurred but not reported).

The components which comprised the authorized fee included scheduling of injured employees, credentialing of physical therapy centers, access to MedRisk providers and bill review. Staff did not feel that the MedRisk platform was providing the anticipated outcomes and therefore canceled the program. Although the contract with MedRisk was not successful, services were provided for the authorized paid fees (**Recommendation #16).**

Staff Response – Finding #9

Staff agrees that it is important to benchmark goals related to a workers' compensation pharmacy network. A significant challenge to holding a Third Party Claims Administrator to specific penetration goals for pharmacy utilization in a network setting is that Florida Statute, Section 440.13(3)(j), provides for injured employees being entitled, at all times, to free, full and absolute choice in the selection of the pharmacy or pharmacist dispensing and filling prescriptions for medicines.

Staff believes much success has been achieved in significantly increasing the percentage of injured employees who are having prescriptions filled through the Pharmacy Benefit Manager (PBM), First Script. Nevertheless, intervening causes such as third party billers and over-priced in office dispensing, make it virtually impossible for an employer to hold a PBM accountable for attaining a specific percentage of all pharmacy charges. Staff will continue to make inroads into increased PBM penetration through adjuster training and expanded networks. Unfortunately, unlike a healthcare network, the ability does not exist to limit access to specific pharmacy venues **(Recommendation #17).**

Staff Response – Finding #10

Staff is in full support to maximize the penetration level of injured employees having prescriptions filled through the PBM. As stated in the previous response, the State of Florida has specific laws which provide injured workers the ability to have all prescriptions filled at whatever licensed pharmacy or authorized dispensing physician that they select. The goal of the District through the Third Party Administrator has been to maximize the percentage of prescriptions filled by network pharmacies. This goal serves two purposes. The first goal is to take advantage of appropriate discounts for the medication when dispensed through the authorized PBM. The second is that the PBM has a sophisticated drug interaction component which notifies medical providers when an injured employee is taking multiple medications.

District staff has not been absentee owners of the workers' compensation program, especially when it comes to pharmacy issues. As reflected in the OIG report, staff has been consistently reviewing penetration reports from the beginning of this contract starting in July, 2007 and benchmarking the amount of pharmacy claims which were being re-directed to companies such as Working RX and Third Party Solutions, rather than being processed by the District's PBM. This situation has been a significant issue within the Risk Management/Workers' Compensation administration community and is not specific solely to Miami-Dade County Public Schools. Much work has been done to maximize the re-direction of these claims to the PBM. The positive outcome of that work is the significant increase in prescription drug penetration by PBM over the past 2 ½ years.

While staff from the OIG's office may have attended a meeting where PBM penetration and the use of mail order was discussed in July, 2009, staff has been working to perfect the workers' compensation pharmacy program for many years. The lack of success in managing the District's workers' compensation pharmacy expenses was a major reason the prior contract with Corvel Corporation was not renewed.

Staff supports the recommendations to further educate GB adjusters to work towards maximum penetration in the use of network pharmacies. While staff has no objection in surveying injured workers regarding their pharmacy utilization, it must be pointed out that the manner in which these pharmacy claims are re-directed to third party billers or dispensing physicians after the injured worker has had their prescription filled, the injured worker may believe they are utilizing network pharmacies **(Recommendations #18,19,20).**

As stated previously, performance measures have been included in the sample contract which appears as an exhibit to the RFP to obtain competitive proposals for the District's Third Party Claims Administration, which will be taken to the School Board meeting of November 17, 2009. Staff believes that any performance standards must be objective and be achievable. While better education will improve injured workers use of network pharmacies, the creation of penalties should a third party administrator not meet a penetration goal seems unrealistic when by statute; the injured worker has the right to have their prescriptions filled at any licensed pharmacy.

Staff believes the better solution is to create an even playing field so that regardless of where the prescription is filled, the reimbursement remains constant, thus holding harmless the School District from varying reimbursement amounts. This is the process which is currently being implemented for all pharmacy bills incurred by District employees on workers' compensation. . This re-pricing platform is also being included in the District's 2010 Legislative Platform **(Recommendation # 21).**

Staff Response – Finding #11

This issue was brought to OIG staff members' attention by District staff and GB to inform them of a very serious issue, and what proactive steps were being taken on behalf of the District to address it.

Staff disagrees with the assertion that GB has not managed the issue of dispensing re-packaged drugs. District staff, in conjunction with GB, has been on the forefront of this issue and was instrumental in bringing this situation to the attention of The State of Florida, Division of Workers' Compensation, which issued Information Bulletin DFS-02-2009 (attached).

The School Board received a lengthy memorandum from the Superintendent of Schools on this very issue, dated August 12, 2009. In this memorandum, the Superintendent informed the Board of the issue and what steps were being taken to address it. The State of Florida issued the Informational Bulletin on the same day.

Staff disagrees with OIG's recommendation that LOA's should be amended to prohibit medical providers from self dispensing pharmaceuticals. In certain circumstances, allowing physicians to dispense medications to injured workers is in the District's best interest. An injured worker who is being treated by a contracted physician and is in need of medication may have severe pain and find it difficult to travel from the physician's office to a network pharmacy to have their prescription(s) filled. The convenience of having the medication made available to the injured employee at the physician's office alleviates the possibility that the injured worker either postpones having the prescription filled, or not having it filled at all.

Additionally, many injured employees do not have adequate transportation to travel to physician offices and/or pharmacies. Florida Statute, Chapter 440, requires the District to provide necessary transportation for medical appointments related to their workers' compensation injury. Having the medication available at the physician's office also eliminates the need for the District to incur transportation expenses of taking the injured worker to the pharmacy **(Recommendation #22).**

The most important factor in properly managing the medical portion of a workers' compensation injury is interaction with the treating physician. A major goal of the current medical management platform is working closely with contracted physicians to obtain immediate, aggressive treatment for the injuries, with the goal of returning the injured employee back to work as soon as possible.

As previously mentioned, Florida Statute, Section 440.13(3)(j), which provides free, full and absolute choice in the selection of the pharmacy or pharmacist to an injured worker, and Florida Statute, Section 465.0276 which defines a Dispensing Practitioner establish the authority for physician-dispensing of pharmaceuticals. Many of these physicians, who work closely with staff and GB in providing appropriate treatment to injured workers so that they may return to work as soon as possible, may stop seeing injured employees if the LOA prohibited them from dispensing.

This is not the solution. The solution is the one which is currently being develop developed and implemented, which is re-pricing all physician-dispensed pharmaceuticals so that the cost is no more than what would be paid if the prescription had been filled through the PBM. All physicians within the networks currently being utilized have been informed that the re-pricing model is currently in place. Therefore, OIG recommendations 23 and 24 have already been addressed by the District and GB. This re-pricing process has also been included as a component of the RFP which will be brought to the Board at its meeting of November 17, 2009 to seek competitive proposals for its Third Party Claims Administration contract **(Recommendations #23,24).**

Staff Response – Finding #12

The OIG's recommendation which would require reports to be provided to the District consisting of amounts paid to providers, amounts paid for specific services, amounts paid for reimburseables/expenses, etc. is not a function of the imprest account or Treasury Management (Treasury). These types of reports are currently provided to staff by the Third Party Claims Administrator on a very detailed level, and over the course of the last 17 months the OIG has received numerous reports of this type. The RFP which will be going to the Board meeting of November 17, 2009 includes requirements for detailed reports of this type **(Recommendation #26).**

The Office of Treasury Management has the primary responsibility for cash management function of funding checks cleared in a secure and cost effective process and the Office of the Controller has the primary responsibility of reconciling the bank account as they do with all District accounts. Controls over the Imprest Fund bank account include daily direct access to the bank's online system to access all bank transactions and balance information. The District also receives via e-mail, on a daily basis, not by hard copy, information on checks issued and voided directly from Gallagher Bassett Services, Inc. Information includes payee, claimant, claim number, accident date, invoice number or payment reference, in addition to check number and amount of the check. The claim number includes the type of claim being processed and summary reports provide the breakdown in total.

With the information provided, Treasury staff updates a daily recap of transfers and checks cleared as recorded in the bank's information reporting system for agreement with the daily bank balances. Treasury also prepares a breakdown of checks issued by payment type as per Gallagher Bassett's reports, and updates the outstanding check balances. All summaries are provided to the Office of the Controller, who also receives the automated monthly bank reconciliation hard copy reports at month end. Staff from the Office of the Controller verifies the reconciliation by agreeing bank balances and outstanding checks to pending funding balance or checks issued.

As part of the cash management function, Treasury has targeted the Imprest Fund bank balance to transfer funds on average twice a week based upon balance threshold that maintains an average balance of under $130,000. Significant variances from these norms are communicated to the staff from the Office of Risk and Benefits Management. In addition, there is an internal procedure whereby the claims administrator notifies Risk Management when claim payments will exceed specific thresholds. Risk Management staff then notifies Treasury so that they can be aware that a larger than normal claim payment volume may be forthcoming so that the account is not overdrawn.

These practices virtually eliminate the need for advisory reports of problems with the bank account. OIG's reference to the Risk Manager not knowing about the advisory reports may have been a misunderstanding. Staff is very familiar with the referenced advisory reports. Over the past 23 years, there have been only a couple of times that an advisory report has been received by the respective claims administrator. There may have also been a misunderstanding as it relates to the outsourcing of the claims management function, which includes medical management and making payments on the District's behalf. Both the Treasury and Controller's Offices perform their traditional cash management and bank reconciliation functions. Daily access to online reports or received via e-mail and at month-end provides sufficient information and controls to perform the traditional cash management and bank reconciliation functions by the Office of Treasury Management and the Office of the Controller.

For entities that outsource the claims management function, including medical management and payment of claims, to a Third Party Claims Administration Company, the function of verifying the accuracy and validity of the expense is not traditionally the responsibility of the Treasury or Controllers' Offices. It is not cost effective for either office to assume these responsibilities as resources or expertise to provide these types of audit reviews are not currently available. The verification that controls within the "bill review engine" are working properly is an audit function which needs to take into consideration error rates as a percentage of sampling totals and cost implications. The Third Party Claims Administrator has the fiduciary responsibility to pay claims appropriately and is required to be bonded specifically for this purpose. Staff agrees that periodic audits both internal and external should be performed. The District's external auditors review this process annually, and both the state auditors and internal/external auditors have reviewed the operation of the claims administrator and will continue to do so at different intervals **(Recommendation #25).**

The School Board as any self insured entity establishes a specific fund from which payments are made to cover liabilities incurred (claims). The imprest fund referred to by the OIG is a fund which is used to pay Citibank for cleared claim payments made by Gallagher Bassett Services on behalf of the Board. The funds used for these reimbursements are budgeted pursuant to an annual actuarial analysis which is performed to analyze and recommend projected claim payments for the upcoming fiscal year. As outlined in the beginning of this response under Service Statistics, the actuarial projections for claim payments has decreased over 12% from $37.I million in 2005-2006 to $33 million for 2008-2009.

Staff Response – Finding #13

Expenditures for Field Case Management are a very volatile subject within the Workers' Compensation Managed Care Industry. Field Case Management, which consists of contracted nurses doing field work to work through medical issues of injured employees are treated as allocated claims expenses and paid off of the claim file not unlike all other authorized allocated claims expenses which include medical treatment, etc. Field Case Management as a Non-Core Managed Care Service is included in the current contract with Gallagher Bassett Services, Inc. at $85/hour plus expenses if GB or their vendor provided the services.

Significant problems were found with expenditures attributable to Field Case Management in the Broward County Public School Workers' Compensation Audit, which is referenced in Section V. Objectives, Scope, and Methodology. In that audit, significant over utilization and over billing was documented. The managed care vendor, Corvel Corporation, was the same managed care vendor who provided managed care services to Miami-Dade County Public Schools under previous contracts which were in effect prior to July 1, 2007.

The District's response to the Broward County Audit were taken to the Board's Audit Committee and contained specific reference as to what steps had been taken to conduct an internal review of Miami-Dade County's Field Case Management Expenditures. A thorough review of Corvel's billing for Field Case Management was completed in 2005 and 2006 and found that some of the same over billing was occurring in Miami-Dade County. The results of this review found that Corvel had over billed the District, resulting in reimbursements from Corvel to the District totaling $81,340.

When the current contract became effective on July 1, 2007, one of the major concerns for the injured employees was the continuity of care being provided. Claims professionals are well aware that disruption in care can result in increased medical costs, coupled with extended disability periods.

The original GB proposal included Field Case Management services provided solely by Coventry. Staff was very concerned about using Coventry nurses exclusively for Field Case Management due to a lack of continuity in care. No Coventry-contracted nurses had been providing Field Case Management services to existing injured employees. Because Field Case Management nurses are traditionally independent contractors, staff wanted to have as many existing nurses continue to provide services to injured M-DCPS employees as possible. These existing nurses were independent contractors who worked for Corvel Corporation, which is located in Lake Mary, Florida (Orlando).

Seltzer and Associates had hired one of the most effective Field Case Nurses who had been providing excellent care with great outcomes to M-DCPS employees under the Corvel Corporation contract. Staff met with Seltzer and negotiated terms for providing Field Case Management with their contracted nurses for injured workers who resided in South Florida. Use of these nurses (many of whom live in Miami-Dade County) would successfully provide for continuity of services to existing injured workers, as well as developing a working understanding of the goals of the revised managed care platform. The negotiated terms were put in writing as the billing guidelines which have been used since the inception of Seltzer's services. This guideline, which is attached, was provided to the OIG and includes very succinct billing maximums for field case services. The billing amounts do not include the 8% "cost plus" provision of the draft contract reviewed by the OIG and no fees paid to Seltzer since July 1, 2007 have included the 8%. Field Case Management services for claimants outside the South Florida area are provided by Coventry, pursuant to the GB contract.

The OIG is correct that the draft contract provided to staff and shared with the OIG is unacceptable. As outlined, there are terms in that contract which do not apply to the District (8% plus costs), etc. Additionally, the billing guidelines which have been attached must be incorporated by reference into the final contract which will be reviewed by the School Board Attorney's Office prior to obtaining appropriate signatures **(Recommendation #27).**

Proper management of the Field Case Management component is crucial to obtaining the proper outcomes for the injured workers, while managing the cost of these services. Staff agrees that the preparation of a Request For Information (RFI) for Field Case Management Services should be prepared as was already been accomplished for required services such as Transportation, Surveillance, Court Reporting, Translation, and Outside Counsel.

Staff would prefer to issue the RFI for Field Case Management following the re-marketing of the Third Party Claims Administration RFP which will be taken to the Board meeting of November 17, 2009. It is staff's recommendation that the construct of the RFP allow for one vendor with a strong South Florida coverage, and one vendor with strong national coverage. Depending upon the vendor, services could be provided by the same or separate vendors. Obviously, the strength of the contracted nurses and competitive pricing will determine the best platform. As stated earlier, the provider's home office location is irrelevant to the services provided or the cost, due to the fact that services for Field Case Management are traditionally provided by local nurses who are working as independent contractors.

The $13,000 of payments noted in the OIG's report which were paid to Coventry for Field Case Management consisted of eight injured workers who now live outside South Florida including Tennessee, New York, Georgia and Southwest Florida **(Recommendation #28).**

Currently, all payments for Field Case Management Services are paid and allocated to a specific paycode 007 Medical Case Management. Staff believes that there are pros and cons to the OIG's recommendation of separating Field Case Management expenses from fees. As an alternative to separating the pay codes, staff believes that requiring the Field Case Management vendor to provide management reports which identify fees versus expenses, will provide the same goal of monitoring expenses **(Recommendation #29).**

Staff Response – Finding #14

Staff fully agrees with the OIG's observations with regard to the cost/benefits of a robust, proactive loss prevention program. As was referenced earlier in this response, the Board provided authorization in 2006 to create a Loss Prevention Section within the Office of Risk and Benefits Management. This initiative was beginning to show great returns on the District's investment when due to budget cuts, the staff which had been hired into budgeted positions were re-directed to classroom teaching positions, along with one retirement.

A major component of any well orchestrated Risk Management strategy is a well defined Loss Prevention Program which includes training on injury prevention and identification of workplace hazards. Using workplace safety as a performance measure is also an industry standard and is an initiative which is supported by staff **(Recommendations #30, 31).**

Friday, October 23, 2009
Wanda Vig -

INFORMATIONAL BULLETIN
DFS-02-2009
ISSUED
August 12, 2009
Florida Department of Financial Services
Alex Sink
Chief Financial Officer

All Employer/Carriers Providing Reimbursement for Prescription Medication Under Chapter 440, Florida Statutes

The Division of Workers' Compensation has received inquiries as to whether it is appropriate for employer/carriers to deny authorization or reimbursement for prescription medication when the medication is dispensed by a Florida physician instead of a pharmacist. The Division is unaware of any specific provision in Chapter 440, Florida Statutes, which addresses the issue. However, the following section of Florida Statutes is relevant to the issue:

> 465.0276 Dispensing practitioner.--
> (1) A person may not dispense medicinal drugs unless licensed as a pharmacist or otherwise authorized under this chapter to do so, except that a practitioner authorized by law to prescribe drugs may dispense such drugs to her or his patients in the regular course of her or his practice in compliance with this section.

The Division urges employer/carriers providing reimbursement for prescription medication under Chapter 440, Florida Statutes, to take section 465.0267(1), Florida Statutes, into consideration when making prescription provider reimbursement decisions. Reimbursement for a prescription medication shall be in accordance with section 440.13(12)(c), Florida Statutes, which provides:

> As to reimbursement for a prescription medication, the reimbursement amount for a prescription shall be the average wholesale price plus $4.18 for the dispensing fee, except where the carrier has contracted for a lower amount. Fees for pharmaceuticals and pharmaceutical services shall be reimbursable at the applicable fee schedule amount. Where the employer or carrier has contracted for such services and the employee elects to obtain them through a provider not a party to the contract, the carrier shall reimburse at the schedule, negotiated, or contract price, whichever is lower. No such contract shall rely on a provider that is not reasonably accessible to the employee.

Questions regarding this may be directed to Samuel Willis, III, Medical/Health Care Program Analyst, Division of Workers' Compensation, Office of Medical Services. Mr. Willis may be contacted by email at Samuel.Willis@myfloridacfo.com or, by phone at (850) 413-1898.

- Below are the **maximum** billable times allotted for a specific activity. Exceptions to these parameters, such as exceeding the hourly caps, must be justified and approved by Adjuster prior to completion of services. All billing will be in tenths of an hour. Any account guidelines/billing instructions supersede these standards. The Vendor will not add new product billing to invoices without the written approval of GB Corporate Managed Care Division.

Telephone Calls	**Hours**
To Gallagher Bassett	Not Billable
To Claimant	.3
To Physician	.3
To Attorney	.3
To Other Provider	.3
To Employer	.3
To Other (must identify)	.3
Attempted Call	Not Billable
Visits	
To Claimant	1.0
To Employer / job analysis	1.5
To Physician visit with claimant	.5
To Physician consult with claimant	.3
To Therapy sessions with Claimant	1.0
Provider Team Conference	1.0
To Other (must obtain Adjuster approval)	1-0
Correspondence Letter (Billing should be proportionate to length and content	.5
Reports	
Initial	1.5
Progress	1.0
Closure	1.0
Faxing reports	Not billable
Medical records review	.5
VENDOR CLERICAL SERVICES: includes postage, faxing, actual phone expenses, Internet charges, and all other operating expenses unless listed separately in this table. (Billing should be proportionate to expense content and not automatically billed at $25.)	$ 10-25 / report, including postage
Postage expense (except certified Correspondence	Not billable
Copying / Fax-in	Not billable
Copying medical records	Only with receipt
Vocational testing	5.0
Job search skill training /resume	2.0
Travel Expenses	
Travel time need Adjuster approval to exceed	3.0
Wait time	3.0
Mileage charge	Per IRS
Tolls and parking	Per IRS Guidelines
All travel should be prorated when possible	

Miami-Dade County Public Schools
Office of the Inspector General

APPENDIX B

Response from Gallagher Bassett Services, Inc.

IG08-25SB

Gallagher Bassett Services, Inc.

October 20, 2009

Mr. Christopher R. Mazzella
Inspector General for
Miami-Dade County Public Schools
19 West Flagler Street, Suite 220
Miami, Gl 33130

REF: IG09-25SB

Dear Mr. Mazzella,

Thank you for sharing your audit response with Gallagher Bassett Services, Inc. and also allowing us until October 22, 2009 to review and respond.

Gallagher Bassett Services, Inc. has reviewed the audit result and has decided to respond to those sections that may apply to us.

If you have any questions regarding our response, please feel free to contact me.

Sincerely,

Emil J. Bravo
Executive Vice President
Gallagher Bassett Services, Inc.

Encl.

Gallagher Bassett Services, Inc. (GB) acknowledges the receipt of the draft OIG audit report of September 25, 2009. We appreciate the opportunity to respond to your audit findings.

The main focus of the Miami-Dade County Public School (M-DCPS) audit was on the contractual relationship between M-DCPS and GB during the period of 7/1/2007 through 6/30/2010. It also included some analysis spanning from 7/1/2003 through the present.

As stated in your report, M-DCPS is the largest school district in Florida and is the fourth largest school district in the nation. It has an enrollment of over 350,000 students in 323 schools. The district is governed by the Miami-Dade County School Board (SB), which is comprised of nine elected members. The SB is responsible for setting district policy, appointing a superintendent, approving contracts (above a certain dollar amount), and approving the district's annual budget. The M-DCPS Superintendent is charged with managing the day-to-day operations of the school district. M-DCPS employs over 45,000 employees and is the largest employer—public or private—in Miami-Dade County.

Gallagher Bassett has been in business since 1962 and is ranked by *Business Insurance* magazine as one of the world's largest TPAs. It could also be the largest TPA in the state of Florida.

To get a better feeling of the magnitude of M-DCPS is, here are some statistics for the period of the audit:

Accident Dates	# of Claims Handled	Amount Paid Out
7/1/03 to 12/31/03	3,457	$10,378,672
1/1/04 to 12/31/04	7,586	$32,919,800
1/1/05 to 12/31/05	6,598	$24,663,223
1/1/06 to 12/31/06	7,080	$23,969,414
1/1/07 to 12/31/07	5,848	$18,867,085
1/1/08 to 12/31/08	5,116	$13,445,293
1/1/09 to 6/30/09	2,321	$ 2,595,049
Totals	**38,006**	**$126,838,536**

We believe that GB has been cooperative and compliant with all requests made by the OIG. We have supplied the OIG with numerous reports, access to claim files and even a user ID that grants them full access to any and all M-DCPS claims—including, but not limited to, copies of first report of injury, all claim notes, all payments, all managed care EOR, and all MC invoices for bill review, PPO, TCM and UR.

It is noted that none of the 14 Findings pertained to any significant claim handling issue affecting delivery of services to employees of M-DCPS. GB feels very positive about these findings, since this is the core service we provide M-DCPS and it will produce the best savings for M-DCPS. We believe this has contributed to an overall reduction in lost work days that has produced significant savings for the program.

As clarification, the 2007-2008 contract between GB and M-DCPS is for $5,811,261. That covers Workers' Compensation claim service, liability claim service and Core Managed Care Service. The amount allocated to the Core Managed Care Services is $865,200, which represents less than 15% of the total contract price. Core Managed Care Services includes review of 37,000 bills, 3,000 paid prescriptions to the PBM, two dedicated medical consultants and approximately 4,500 claim intakes with direction of care.

We understand that any audit will result in some level of adverse findings. Perfection in claims handling, as with most elements of life, is unattainable. Although the Audit did not overtly

acknowledge successful aspects of the program (Finding No. 3 seems to indicate service is satisfactory, in that the OIG is not "saying or even implying that GB is not providing satisfactory services"), taking into account the scope of the services provided by GB, we consider the lack of criticism in many areas as evidence of success.

GB does not believe that it would be productive or beneficial to respond to every comment in the report with which we disagree. Please do not take GB's lack of a response on any comment as agreement. For example, we do not believe that everything in sections I through V is completely correct.

We would, however, like to respond to Section VI Findings & Recommendations. GB stands ready to address any further questions or concerns OIG may have with respect to its audit or this response.

Finding No.1: M-DCPS has not competitively solicited for third-party claims administration and managed care services for its workers' compensation program since 1994.

Gallagher Bassett does not believe this finding or recommendation applies to us.

Finding No. 2: Flex Net took over a year to materialize after contract execution. The first semblances of a custom network of medical providers appeared 15 months later, during OIG auditor's fieldwork of the program.

In early 2007, the Risk Manager (RM) of M-DCPS met with GB senior management. He has a vision on what the managed care program should be and asked us to develop a managed care program to capture his vision. What the RM wanted was not an off-the-shelf product, but a program designed to reduce overall cost and provide quality treatments to injured employees. GB agreed to assist in this process and work with the M-DCPS RM team to make his vision reality.

For M-DCPS, Flex Net is comprised of providers that have agreed to treat M-DCPS' employees, pursuant to Florida Workers' Compensation Law 440.13. Simply stated, the provider list used by M-DCPS comprises M-DCPS-selected providers that have agreed to treat M-DCPS employees.

The Flex Net vision is to have the "best of the best" doctors, whether or not they are in a PPO network. Our initial approach was to determine to which doctors the M-DCPS wanted to direct their injured employees. We hired a full-time person to work with M-DCPS and our claims office to help select these doctors. Our new database includes contracted and non-contracted providers. The entire platform of the M-DCPS Flex Net allows a single source to a customized provider directory, and one bill review system to re-price both in-network and out-of-network providers. The creation of this type of single-entry platform is truly unique and unparalleled in the managed care industry. The clear difference is that the Flex Net platform is not a standard PPO provider list offering.

While the M-DCPS agreement with GB does not contain the name Flex Net, due to timing, there was clear reference to a custom network development. The Flex Net name was chosen by M-DCPS and GB to identify the uniqueness and flexibility of this program and work to develop the provider panel.

Our Flex Net network consists of providers under the following categories:

1. PPO contracted providers
2. Non network providers paid at the Florida Fee Schedule
3. Providers paid at a M-DCPS Letter of Agreement (LOA)

The traditional PPO network consisted of 1,400 providers. As the providers were researched, more than 500 providers were deleted. Additional research was conducted to verify providers' TINs within GB's payment system. After refining this provider selection process, meetings were scheduled (individually and in group sessions) with these providers, including subsequent interviews to establish rapport with the providers to ensure that they meet M-DCPS requirements.

Today, Flex Net consists of these provider categories:

1. 927 - In Network providers
2. 324 - Non-Coventry providers, of which 42 now have LOAs (Letter of Agreements) or are in the negotiation process for LOAs.

Just for clarification, Flex Net is not only for those providers with LOAs, but also in-network and out-of-network providers that M-DCPS and GB agreed would be part of Flex Net.

Another unique component of Flex Net is the new claim intake process, which demonstrates the flexibility to include contracted and non-contracted providers in one platform and to be able to direct to the best medical specialties available to M-DCPS.

The new claim intake workflow provides direction of care to M-DCPS Flex Net providers. It also provides direction to a PBM pharmacy with first-fill information.

We believe that GB has met and exceeded its contractual obligation to build a custom network for M-DCPS. It will never be complete. We are always looking to improve the Flex Net network.

Finding No. 3: Lack of contract transparency makes managed care services unauditable.

The contract we have in place is between M-DCPS and GB. In review of the contract, GB was to supply Core Managed Care services. Like any good general contractor, GB is totally responsible for the design and oversight of the program. GB was the architect that put together this unique, one-of-a-kind managed care program to meet the vision of M-DCPS as indicated above.

Our contract with M-DCPS indicates that the managed care fee is $865,200. GB has supplied the OIG with a detailed breakdown of our costs for the period of 7/01/2007 to 6/30/2008, which showed that our costs have exceeded the managed care fee. This cost did not include a full-time resource GB hired to build and develop Flex Net. We would be happy to have our CFO supply you with a Letter of Certification.

In our contract, we are not required to allow M-DCPS access to our Managed Care contracts. Even though it did not provide this provision, GB is still willing to allow the OIG access to the contracts. We did limit the access, since we understand that the contracts could be obtained as public record. For reasons associated with the proprietary nature of our business operations, we did ask for confidentiality with respect to certain managed care information; the OIG would not guaranty confidentiality due to the open records nature of its legal requirements. GB needs to protect our shareholders' interests regarding this custom, unique and proprietary product. On advice of our legal department, and in order to protect proprietary information, we had to limit the

view to the OIG so as not to expose this highly competitive data to those who could be in competition for this business in the future.

Had the OIG accepted GB's offer to review a redacted version of the contract, the OIG would have quickly realized that Gallagher Bassett has nothing to hide and everything to protect as a public company. Our offer to allow the OIG to review limited portions of the contracts still stands.

Finding No. 4: The contract does not have any performance measures or remedies.

GB acknowledges that the contract does not provide any performance guarantees, however we disagree with the statement indicating that "as it stands, M-DCPS is not able to assess objectively, or use other objective assessments of GB's performance, as a management to hold GB accountable for its performance." Our position is based on the following:

On page 7 of its report, "The OIG acknowledges that the M-DCPS WC program has not gone without review. Indeed, there have been several audits and reviews of the WC Program. Scopes of review include best financial management practices reported by the Florida Office of Program Analysis and Government Accountability (OPPAGA); benefits disbursement and claims handling practices (reported by the Florida Department of Financial Services Division of Workers' Compensation [the DFS Division]; and the testing of internal controls of GB's Risx-Facs database (performed by Ernst and Young [E&Y]). In-between these audits, we also note that there have been several M-DCPS requested reviews conducted by Deloitte & Touche, LLP (based on agreed-upon procedures) and by Siver Insurance Consultants, Inc. (Siver), M-DCPS' retained insurance consultants." The program has also been reviewed and evaluated by the excess carriers, all with favorable outcomes.

In addition to these external audits, which can be utilized to assess performance, M-DCPS is actively involved with the claim staff on a daily basis to assist in the delivery of benefits and services to its employees. Face-to-face quarterly file reviews are conducted on all files that have field nurse involvement, litigation activity, or where the employee is missing time from work. This affords M-DCPS an opportunity to assess adjuster performance, and to play an active role in the ultimate progression of the files. This, in large part, has been instrumental to our documented success in lowering average payout and reducing lost work days, while at the same time reducing overall medical expenses.

While we acknowledge the fines assessed during the recent Division of Workers' Compensation (DWC) audit, we believe that the OIG is inaccurate in its characterization that these two deficiencies alone "relate to how well GB is providing its claims administration services." One need only look at some of the other measurable standards noted by the audit team, or available for review on the division's Centralized Performance System (CPS) database, to assess GB's performance and how it rates against industry averages. For example:

- First Report of Injury or Illness Timely Filing: GB (M-DCPS) 98%; Industry Average 89%.
- Timely Initial Indemnity Benefit Payments: GB (M-DCPS) 95.23%; Industry Average 93%.
- Timely Medical Bill Payments: GB (M-DCPS) 99%; Industry Average 99%.

Central to any Workers' Compensation program is the quality and speed in which it delivers benefits to the injured employee. We believe that the three metrics above demonstrate that GB is providing these benefits effectively, and is doing so better than most in the industry.

The OIG asks "whether M-DCPS believes that a 60% compliance rate is acceptable or whether a $2,500 fine paid to the State is adequate detriment to GB that would result in changed behavior?" The answer to the first part of the question is no, a 60% compliance rate is unacceptable. It is

important to note, however, that this particular deficiency resulted from an acknowledged computer glitch in transmission of data that had no impact on benefit or payment administration. It has since been corrected. The answer to the second part of the question is a resounding yes. GB takes this feedback as a constructive opportunity to improve its performance and the delivery of service to its clients. In this case, the audit helped us to find an improvement opportunity in how we document sending the informational packet to the injured worker. We have subsequently revised our documentation process to eliminate exposure for future fines and penalties in the area.

With regards to adjusters staffing, the OIG indicates that there was an approximately six-month period in which the required staffing levels were not maintained. GB disagrees with this assertion, and contends that, at all times during the life of the contract, licensed adjuster staffing has remained at or above required contractual levels. GB would be willing to allow the OIG to review all adjuster's licenses should they choose to do so.

Finding No. 5: GB improperly used over $36,300 of M-DCPS funds to pay for disallowed fees, penalties and interest for which it was solely responsible.

GB has conducted its own review of the payment codes identified by the OIG, and has determined that there are 35 payments totaling $6,445.49 that will immediately be credited back to M-DCPS. We believe that the primary reason for the discrepancy between the OIG figure and GB's is simply the OIG's natural unfamiliarity with how these payments were issued. To illustrate this point, what follows is an excerpt from a payment detail on a claim file:

INDEMNITY	004 PERMANENT PARTIAL DISABILITY	$1,092.00
EXPENSE	052 PENALTY PAID TO EMPLOYEE (GB)	$46.60
	Payment Total:	$1,138.60

In this example, the adjuster issued one payment in the amount of $1,138.60, while denoting the breakdown of the payment with two distinct payment codes. The total paid to the injured worker was $1,138.60, but only $46.60 of that total was for the penalty assessed. The other amount ($1,092.00) was the injured employee's base benefit entitlement. In the end, the total reimbursement to M-DCPS in this example should be $46.60, not the full amount of $1,138.60. GB would be happy to review the OIG detail report to be assured that we have captured any funds that should be reimbursed to MDCPS.

It should also be noted that GB changed its procedure regarding the issuance of penalty and interest payments, and adjusters must now issue them separate from any base benefit that is due. As a result, we did not find any unreimbursed expense after 10/8/07.

While some might consider it unreasonable to expect perfection in claim handling, especially given the vast number of transactions completed by GB for M-DCPS, it is critically important to GB that M-DCPS be confident in GB's capability to handle claims properly. Consequently, GB stands ready to reimburse M-DCPS for penalties paid due to actions taken by GB.

Finding No. 6: GB's bill review function failed to correct $67,647 in overbillings by inpatient hospital providers; M-DCPS' exposure to additional overbillings may exceed an additional $80,000.

While acknowledging that certain errors did occur on these 10 provider bills, GB would like to explain the entire scope and breadth of the bill review process, and the large amounts of provider bills handled, before responding directly to Finding No. 6.

The following statistics will show the volume of provider payments issued for M-DCPS:

	Fiscal year 2007	Fiscal Year 2008
Total Provider Bills Reviewed	37,634	44,392
Total Provider Charges	$24,529,948	$27,607,276
Total Savings	$12,318,120	$14,792,335
Total Inpatient Hospital Bills	67	49
Total Provider Charges	$2,230,171	$2,064,450
Total Savings	$890,560	$1,257,033

The hospital bill we received from the hospital did not include the "type" of facility. Based on the type of facility, the fees schedule savings will be different. We did not pick the correct facility type and therefore re-priced the bills incorrectly. GB plans to re-audit all hospital bills from 7/1/2007 until present.

In addition GB has put the following procedures in place:

1. As of 9/1/2009, we changed the bill review platform to our new, enhanced system with clinical and hospital edits. This new platform has an improved provider file and automated edit. It will eliminate a lot of manual intervention.
2. GB agrees to review all hospital bills the month after a payment is made to insure that the bill was re-priced correctly.
3. GB has agreed to select a sampling of M-DCPS bills on a monthly basis for the purpose of a QA audit.

Relative to the initial hospital bill overpayments identified by the OIG, GB has reimbursed M-DCPS. Additionally, should additional overpayments occur, GB will continue to immediately reimburse M-DCPS.

Finding No. 7: GB's bill review function failed to capture vendor contracted rates that led to payment of overbillings by physical therapy (PT) providers; M-DCPS' potential exposure to these overbillings may be up to $56,000.

The OIG audit report indicates that four PT providers had LOAs effective September and October 2008.

In review of GB's LOA records, we discovered the following:

Cora Rehabilitation Services
- Both signatures secured 2/23/2009

Select Physical Therapy
- Both signatures secured 1/12/2009

Physiotherapy Associates
- Both signatures secured 12/23/2008

Specialized Workcomp Services

- Both signatures secured 1/23/2009
- Please note that the OIG report lists this PT vendor as Specialized Workshop Services.

Upon securing signatures from the M-DCPS provider and GB, the LOAs are reviewed in home office and then sent to Coventry to load into the provider file. This takes some time.

Based upon the above dates of co-signatures of the agreements, OIG audited M-DCPS provider bills before the LOAs were executed and in our bill review engine.

As stated before, as Flex Net evolved for M-DCPS, the inclusion of M-DCPS additional providers at different reimbursement rates resulted in the need for the LOAs. GB responded to M-DCPS' additional requirements for alternative payment schedules for selected providers, which resulted in the need for LOAs, for obtaining signatures to the LOAs, and for uploading the payment schedules in the bill review system.

Finding No. 8: M-DCPS paid $90,540 to GB for a PT custom network that was not developed.

GB offers our custom PT network as an optional service and not as part of the Core Managed Services. The custom PT network works quite differently from a normal PPO network. Our custom PT network achieves increased savings with custom day rates and custom diagnosis maximum [which controls utilization]. The traditional PPO network only provides a percentage off fee schedule, with no controls for utilization. There is an additional access fee to access this custom network (MedRisk), as outlined in the contract. It does provide additional savings and additional reporting options. For the short period of time MedRisk was used, the additional savings far exceeded the cost to access this custom network.

It is GB's understanding that the Board approved this program.

Finding No. 9: GB's pharmacy program has no contract standards.

GB's and M-DCPS's pharmacy program is managed by First Script.

Pursuant with the operation of any pharmacy benefit program (PBM), GB must adhere to the provisions of the following Florida Statute:

440.13 (3) (j) Notwithstanding anything in this chapter to the contrary, a sick or injured employee shall be entitled, at all times, to free, full, and absolute choice in the selection of the pharmacy or pharmacist dispensing and filling prescriptions for medicines required under this chapter. It is expressly forbidden for the department, an employer, or a carrier, or any agent or representative of the department, an employer, or a carrier, to select the pharmacy or pharmacist which the sick or injured employee must use; condition coverage or payment on the basis of the pharmacy or pharmacist utilized; or to otherwise interfere in the selection by the sick or injured employee of a pharmacy or pharmacist. (*emphasis added*)

OIG states that "a PBM takes advantage of the size of its client base to negotiate rebates and discounts from drug manufacturers and pharmacies to obtain lower prices for their clients." GB's PBM does not seek rebates or discounts from drug manufacturers, but does negotiate significant discounts directly from the pharmacies in their network. GB's PBM does not participate in drug manufacturer rebates or discounts because we do not want there to be a perception or semblance of manipulating the drugs available through our program for the sake of the rebates

that may be available. What we do is offer consistent pricing based on the AWP and state fee schedule.

The OIG has listed the PBM services, and those services have been provided with great success for M-DCPS.

Services listed on the OIG report:

- "Customized pharmacy card with the M-DCPS log": There is a customized informational (English & Spanish) booklet with the M-DCPS logo, with a mapped list of the closest six pharmacies to the M-DCPS employee's address and information on the pharmacy mail order program.
- "Adjuster utilization alerts": OIG did not elaborate to the extent of customization of these alerts. The alerts include: new prescriber, generic opportunity, new controlled medication, excessive amount of sustained release narcotics, and excessive amount of short acting narcotics.

Services not included in the OIG report:

- The inclusion of a dedicated, 24-hour, seven days a week, 1-800 toll-free number and customer service team which includes dedicated bi-lingual customer service representatives.
- The inclusion of the integrated mail order program.
- GB's PBM proprietary formulary, which is based upon the injury code and body part indicated on the claim file. The formulary controls the utilization of appropriate medications for the injury, thus resulting in reduced costs and leading-edge management of pharmacy usage of the injured worker.
- Our automated generic drug substitution. Where a brand is prescribed and a generic is available, the generic will automatically be dispensed in compliance with the Florida statute.
- Our Adjuster Tools, which enable the adjusters to manage their claims at the claimant level, where they can restrict physician/prescribers and medications.
- Our pharmacy review program. These reviews are initiated by the adjuster based the PBM's utilization review of the injured worker's prescription usage within the PBM.

Again with reference to 440.13 (3) (j), where the employee has unrestricted choice of his/her pharmacy, use of repackagers/third-party billers and their statistics cannot be included in any analysis of GB's PBM. Doctors and clinics associated with the third-party billers cannot be included in any PBM, as they are not in the PBM network.

A summary review of GB M-DCPS RISX-FACS pharmacy 2007-2008 pharmacy payments illustrated below demonstrates a substantial improvement to manage pharmacy bills for M-DCPS.

2007 Total Paid	$2,047,710.70	Total Payments	6,457
Top Payees	Total Paid	Total Payments	Average Payment
Working RX	$1,314,703	2,781	$472.74
First Script	**$259,207**	**1,527**	**$169.75**
Walgreens	$138,445	844	$164.03
Third Party Solutions	$123,773	468	$264.47
Innoviant Pharmacy	$92,969	402	$231.27
2008 Total Paid	$1,455,955.58	Total Payments	4,583
Top Payees	Total Paid	Total Payments	Average Payment

First Script	**$686,232**	**3,640**	**$188.52**
Prescription Partners	$293,316	693	$423.25
Working RX	$176,541	518	$340.81
Third Party Solutions	$151,835	553	$274.57
Walgreens	$44,993	309	$145.61
The Workers Pharmacy	$22,506	85	$264.77

The greater use of GB's PBM contributed to a savings of $591,755.12 in 2008 from the previous year, and the amount of pharmacy payments has decreased.

The participation rate within the PBM is governed by the following:

- Doctors and clinics using third-party billers are not participants in the PBM.
- The PBM is limited to the pharmacies that participate in the PBM network.
- For M-DCPS, the penetration rate for PBM users (injured workers) is 80%, which is five percentage points better than GB's overall book of business.

Based upon the charts above and the participation rate outlined in the above bullets, GB disagrees with the OIG assertion on page 34 about lack of injured worker participation.

Finding No. 10: GB has not effectively implemented a process to direct injured workers into the approved pharmaceutical benefits program, thereby increasing M-DCPS' costs.

As noted in the previous response, GB must adhere to the provisions of the following Florida Statute:

440.13 (3) (j) Notwithstanding anything in this chapter to the contrary, a sick or injured employee shall be entitled, at all times, to free, full, and absolute choice in the selection of the pharmacy or pharmacist dispensing and filling prescriptions for medicines required under this chapter. It is expressly forbidden for the department, an employer, or a carrier, or any agent or representative of the department, an employer, or a carrier, to select the pharmacy or pharmacist which the sick or injured employee must use; condition coverage or payment on the basis of the pharmacy or pharmacist utilized; or to otherwise interfere in the selection by the sick or injured employee of a pharmacy or pharmacist. (*emphasis added*)

In the previous responses, GB has shown success in directing the injured worker and managing the PBM has reduced M-DCPS' costs.

The OIG states "more than 50% of all prescription dollars were paid to Working RX, a workers' compensation claims management company, which has no contractual relationship with M-DCPS or GB," and a "minimally effective process for directing newly injured workers into the pharmacy program."

The nature of pharmacy billers is to release their invoices to the claims payer several weeks after the transaction occurred. In this case, for these pre-existing claims, the injured workers had already established a relationship with the physician/prescriber to use Working RX. The OIG notates the use of a redirection program. Again, while working within 440.13 (3) (j), GB introduced our PBM, First Script, and worked to build new injured worker pharmacy usage patterns towards our PBM. GB's efforts and the resulting successes are documented in the previous response. Again, GB cannot deny the injured employee's selection of the pharmacy or pharmacist dispensing and filling prescriptions for medicines.

The OIG states "Coventry's bill review will reduce the invoice to the AWP and pay accordingly, as prescribed by Florida Fee Schedule. Although the amount is not reduced to First Script's rates, which is the whole idea of a pharmacy benefits program."

The OIG is correct in the reference to the following Florida Statute:

440.13 (12) (c) As to reimbursement for a prescription medication, the reimbursement amount for a prescription shall be the average wholesale price plus $4.18 for the dispensing fee, except where the carrier has contracted for a lower amount. Fees for pharmaceuticals and pharmaceutical services shall be reimbursable at the applicable fee schedule amount. Where the employer or carrier has contracted for such services and the employee elects to obtain them through a provider not a party to the contract, the carrier shall reimburse at the schedule, negotiated, or contract price, whichever is lower. No such contract shall rely on a provider that is not reasonably accessible to the employee. (*emphasis added*)

The OIG did have an opportunity to participate in a July 8, 2009 meeting with M-DCPS and GB where the Repackaging market was covered and the GB Clinical Validation approach for repackagers was to be implemented on behalf of M-DCPS. In follow up to what was covered in that July 8 meeting, GB would like to suggest that there was no product availability in the marketplace to address these bills until GB developed their new product. GB has twice met with the Florida Department of Workers' Compensation (DWC), which has fully confirmed that no claims administrator to-date has a bill review system that will revalidate third party biller invoices to the correct NDC and reduce those bills to the contracted price of the PBM. The DWC also acknowledges and approves the Prescription Clinical Revalidation Program and bill review process that GB has built with Coventry and their PBM, which accomplishes all the facets of 440.13 (12) (c). Furthermore, the DWC stated that GB is the only claims administrator who now has this program available. The Prescription Clinical Revalidation Program, which integrates bill review to GB's PBM rates, and allowing for conversion back from the inflated and changed NDC coded third party bills to the original source NDC, was implemented for M-DCPS on 9/1/2009. Based on meetings with State of Florida DWC, it is our belief that GB is the only claims administrator and M-DCPS is the only Florida employer with this program.

Finding No. 11: GB has not proactively managed its Flex Net and other medical network service providers to deter them from dispensing repackaged drugs. This costly practice added over $515,000 to M-DCPS' cost of pharmaceuticals in 2008.

As noted in the previous responses, GB must respect a claimant's choice of pharmacy.

The same Florida statute controlling this issue applies to the GB/M-DCPS LOAs. The OIG recommendation that "LOAs should be amended to prohibit medical providers from self-dispensing pharmaceuticals; language should be changed in prospective LOAs" is problematic, when read in conjunction with the prohibition set forth in 440.13(3)(j).

GB would like to provide the OIG with additional history on this matter.

During 2008, at the direction of M-DCPS, GB began contacting M-DCPS Flex Net providers asking those providers to utilize First Script for prescriptions, instead of dispensing prescriptions from their offices. GB's received letters from Florida provider organizations, who cited 440.13 (3) (j), and stated that GB was interfering with the provider's rights within the statute.

GB then obtained several legal opinions, shared those legal opinions with M-DCPS, and worked with Coventry to develop a strategy and a solution to the issue of Repackaged Drugs and over billing. M-DCPS agreed with the legal opinions that the same course of instructing medical

providers not to dispense prescription or any attempt to change the Coventry provider agreements would increase the opportunity of legal action against M-DCPS and GB.

As stated in the previous response, M-DCPS and GB welcomed the OIG's participation in the July 8, 2009 meeting where the repackaging and dispensing of physician's medication was explained along with our approach and solution "GBMCS Clinical Validation. Since the Florida statute allows the employee unrestricted choice of his/her pharmacy, combined with the dispensing physician's use of third party billers/repackagers, M-DCPS and GB worked out a strategy that no other claims administrator has used in the Florida market.

As the Clinical Validation Program for repackaged drugs was being built and tested, and validated by the Florida DWC, GB is the only claims administrator and M-DCPS is the only Florida employer with this program. The following communication strategy was implemented:

1. Strictly adhere to Florida statute 440.13 (3) (j),
2. Send the attached letter (Exhibit 1) to all M-DCPS providers, which advised them on the benefits of using GB's PBM.
3. Implemented the strategy to operate under 440.13 (12) (c) where pharmacy bills can be re-priced, and M-DCPS and GB would be protected by the Statute. All provider disputes would fall under 440.13 (7) (a) and managed by the Florida Department of Finance, formerly the Agency of Health Care Administration.
4. Then sent the attached letter (Exhibit 2) to all M-DCPS providers, which advised the providers that their embedded prescriptions on their bills would be re-priced to our PBM contracted rate.

Another benefit of this new program is, if a provider is using a Third Party Repacking Biller and overcharging the employer, we have the right to notify the Department of Finance.

Finding No. 12: M-DCPS does not maintain sufficient controls over the Imprest Fund.

Gallagher Bassett does not believe this finding or recommendation applies to us.

Finding No. 13: The contract for Field Case Management services was not executed in writing for two years after the inception of the GB's current contract.

Gallagher Bassett does not believe this finding or recommendation applies to us.

Finding No. 14: M-DCPS does not have a functional WC loss prevention program.

Gallagher Bassett does not believe this finding or recommendation applies to us.