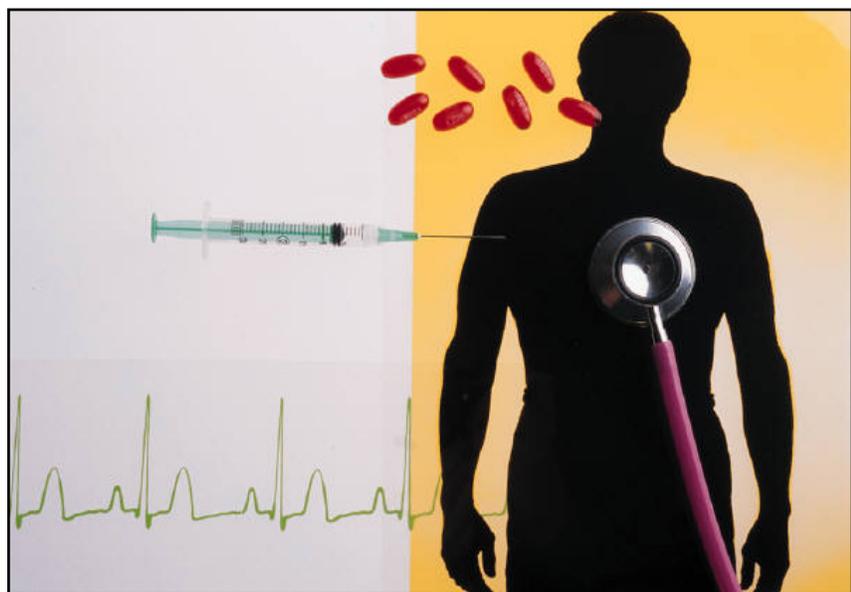




# **Internal Audit Report**

**Maricopa Senior Select Health Plan  
July 2003**



## Audit Team Members

**Eve Murillo, Audit Manager**

**Christina Black, Associate Auditor**

**Protiviti Inc.**



# Maricopa County

Internal Audit Department

301 West Jefferson St  
Suite 1090  
Phx, AZ 85003-2143  
Phone: 602-506-1585  
Fax: 602-506-8957  
www.maricopa.gov

July 31, 2003

Fulton Brock, Chairman, Board of Supervisors  
Don Stapley, Supervisor, District II  
Andrew Kunasek, Supervisor, District III  
Max W. Wilson, Supervisor, District IV  
Mary Rose Wilcox, Supervisor, District V

We have completed our Fiscal Year 2002-03 review of the Maricopa Senior Select Health Plan (MSSP) within the Maricopa Integrated Health System (MIHS). The audit was performed in accordance with the annual audit plan that was approved by the Board of Supervisors. The highlights of this report are:

- At the close of this audit, MIHS was soliciting bids from contractors to assume full risk for all MSSP member medical expenses to help minimize the financial risk associated with retaining MSSP.
- Effective July 1, 2002 the Center for Medicare and Medicaid Services (CMS) placed a membership enrollment cap sanction on MSSP resulting from CMS audit findings. Our testing showed that MIHS still does not meet CMS' claim payment timeframes.
- MIHS stresses MSSP referral contribution to the delivery system as a factor for keeping the plan, however, MSSP members do not significantly utilize MIHS' delivery system.

Attached are the report summary, detailed findings, recommendations, and MIHS' management response. We have reviewed this information with the Chief Financial Officer and Health Plans Director and appreciate the cooperation provided by management and staff. If you have questions, or wish to discuss items presented in this report, please contact Eve Murillo at 506-7245.

Sincerely,

A handwritten signature in cursive script that reads "Ross L. Tate".

Ross L. Tate  
County Auditor

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# Executive Summary

## **Health System Utilization (Page 7)**

Maricopa Senior Select Health Plan (MSSP) members' utilization of MIHS facilities is too low to significantly support the system's financial viability. Our review found that 59 percent of MSSP claims generated from July 2001 through March 2003 were paid to outside (non-MIHS) service providers. MIHS financial reports also show that MSSP members utilize the Maricopa Medical Center (MMC) significantly below budget projections. MSSP management should strive to ensure that MIHS owned and operated facilities are utilized to the fullest extent possible for providing services to plan members.

## **Duplicate Claims Testing (Page 9)**

Based on a small judgmental test sample of medical claims, we found \$3,021 (12 percent) to be duplicate MSSP claim payments. Applying this percentage to the total potential duplicate population shows that approximately \$426,000 possibly could have been lost during the period tested. However, this test sample is not statistically reliable and the actual loss may be more or less than the amount estimated. MIHS should strengthen controls over its claims payment procedures to minimize the risk of duplicate payments.

## **Prompt Payment Requirements (Page 11)**

Our testing of MSSP claims paid for compliance with the Center for Medicare and Medicaid Services (CMS) contract requirement of 30 days, found that claims paid from the previous claims payment system averaged 16 days, from receipt to payment, and current claims payment system claims paid averaged 47 days. The latter does not comply with the contract requirement. The MIHS Claims Department should reinforce the 30-day claims turnaround policy to ensure that MSSP stays in compliance with CMS requirements.

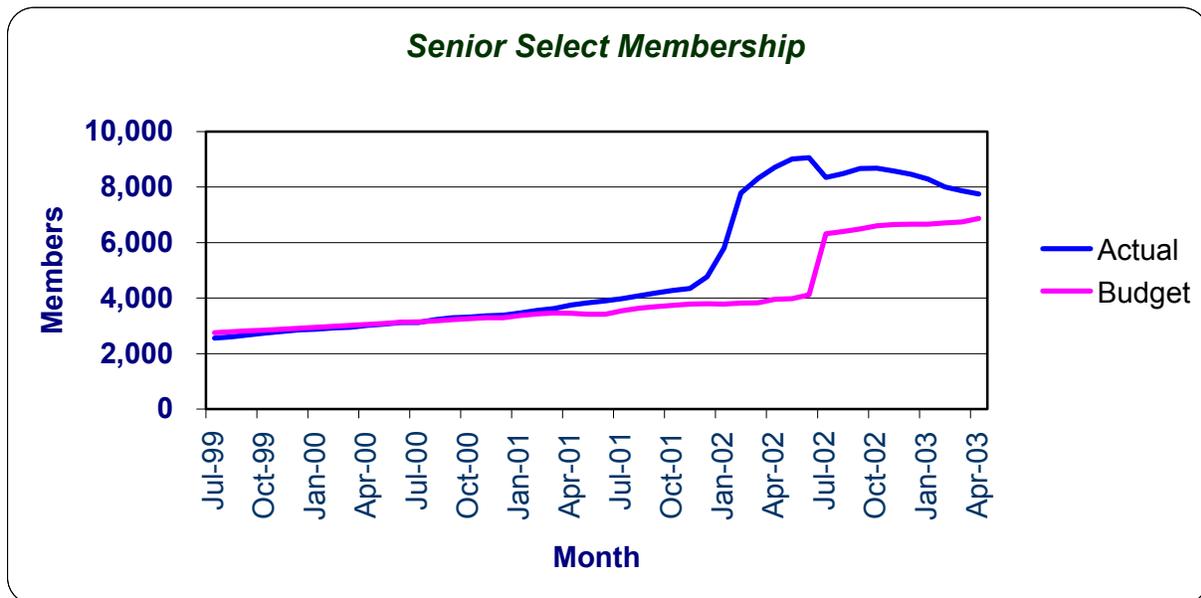
# Introduction

## Background

The Maricopa County Senior Select Health Plan (MSSP) is a “Medicare+Choice HMO” Plan offered to individuals who are eligible to receive Medicare benefits. The plan, which began in November 1993, provides additional care for qualifying Maricopa Long-Term Care Plan (MLTCP) members not traditionally covered under Medicaid. Prior to July 2002, MSSP was available to persons over 65 years old and individuals under 65 having disabilities covered by Medicare.

Medicaid fills Medicare coverage gaps for low-income elderly and some younger physically disabled beneficiaries. Medicare pays for acute-care needs (e.g., hospitalization and physician services) but generally does not cover long-term care except when accompanied by a need for skilled care, either in an institution or in the beneficiary's home. Medicaid covers long-term-care services delivered in a nursing home or the community and provides benefits generally not covered by fee-for-service Medicare benefits, such as prescription drugs. MSSP features a medical center, private physicians, and a network of health centers located throughout Maricopa County.

As of May 1, 2003, 7,754 people were enrolled in MSSP. Membership increases were curtailed (as shown below) by enrollment sanctions imposed by a federal Medicare/Medicaid regulatory agency, the Centers for Medicare and Medicaid Services (CMS), after a 2002 audit. This CMS audit is discussed later.



### Mission, Goals, and Performance Measures

MIHS established MSSP to provide needed services to eligible members and also to receive additional capitation revenue (fixed fee per person per month) for members who qualify for both Medicare and long-term care coverage. MSSP receives capitated payments from CMS in consideration for accepting the financial risk associated with providing all medically necessary contracted care. MSSP management has developed a strategic plan, with goals and objectives, as part of MIHS' "Turn Around Plan 2003." This plan is discussed in detail later.

### Organizational Structure

MSSP's organization, which consists of two divisions reporting to the Chief Health Plan/Planning Officer, is shown in the chart below:

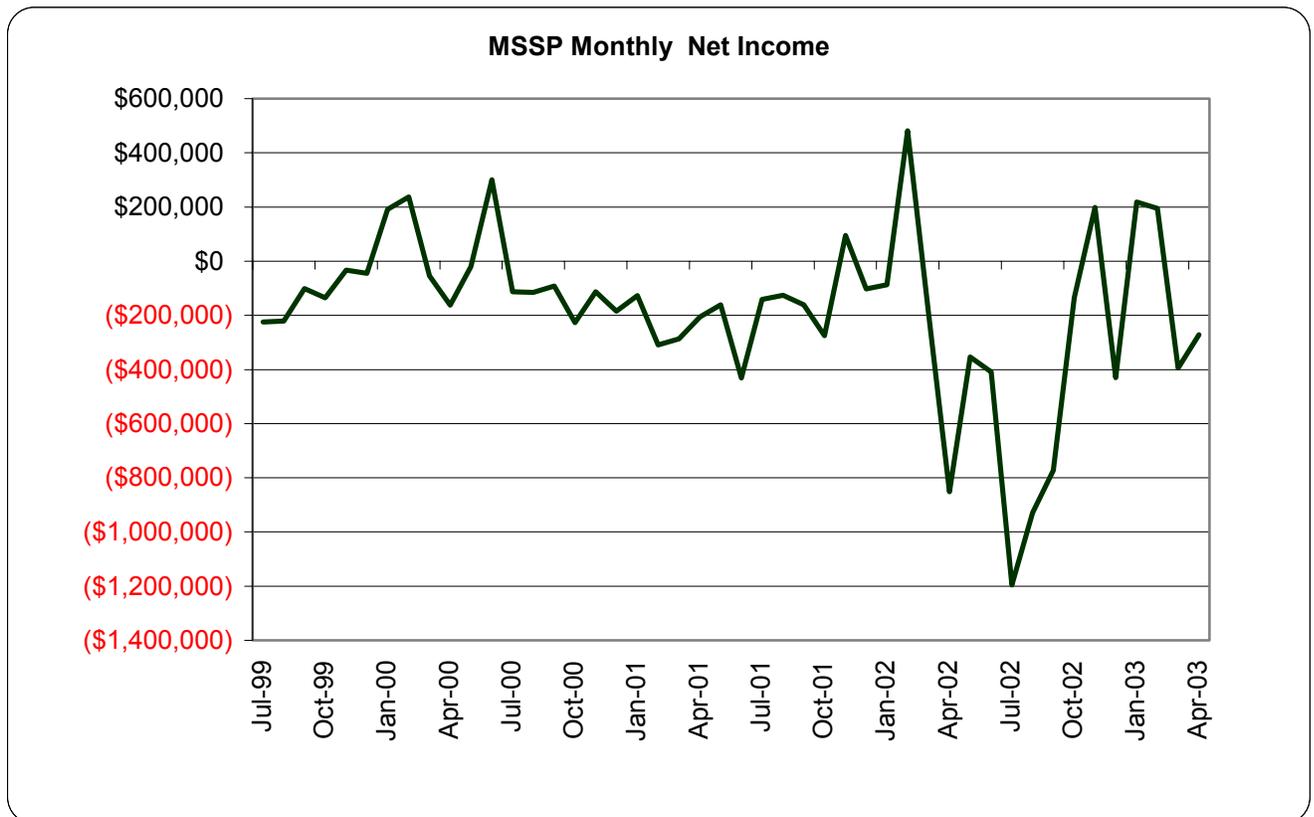


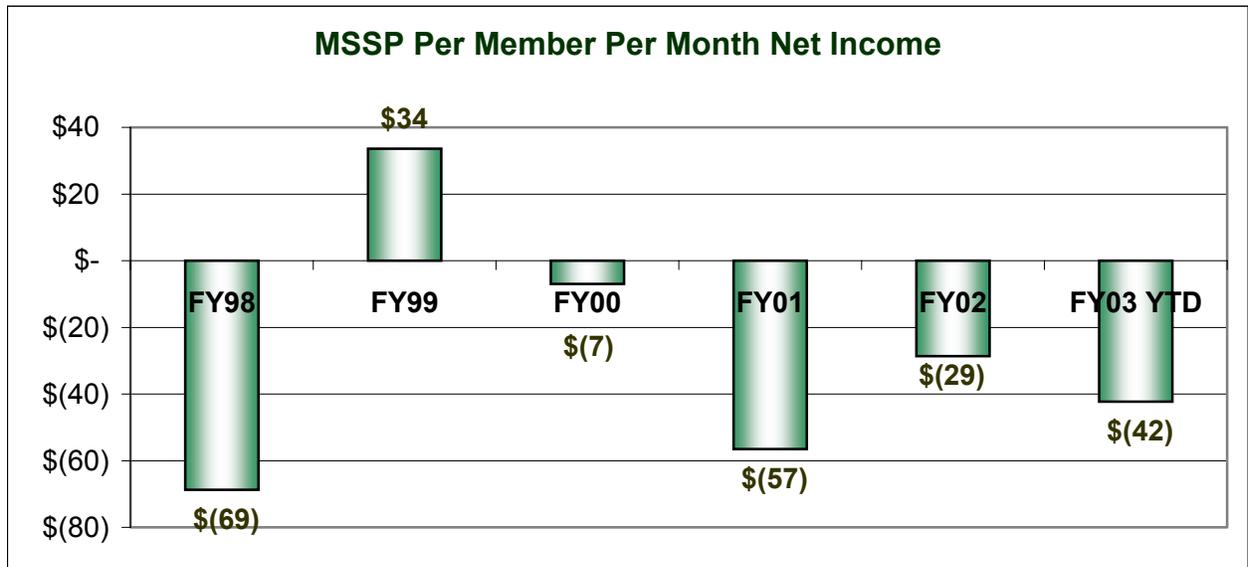
## Business Issues and Current Status

During Fiscal Year (FY) 2002, MSSP experienced explosive growth due to an aggressive enrollment program and the closure of other competitive plans. Membership more than doubled from a base of 4,000 to over 9,000. MIHS developed a strategy to increase MSSP's member pool with healthy members in order to improve utilization exposure and plan earnings. However, the benefits of this strategy have yet to be realized. MSSP, on a stand-alone basis, sustained losses of approximately \$4 million for FY 2002. Additional losses totaling \$3.5 million, incurred during the first ten months of FY 2003, make MSSP one of MIHS' most critical current business issues. Further analysis is required to determine the impact of contribution margin to the Maricopa Medical Center (MMC) generated by MSSP patients receiving care at MMC – such an analysis falls outside the scope of this review.

County officials understood that the purpose of the MIHS health plans, including MSSP, was to generate paying patients for MMC so that MIHS can cross-subsidize uncompensated care and minimize tax-supported subsidies. If the health plans become a financial drain on the health system, the County General Fund will be negatively impacted.

The following graphs show that MSSP has generated negative net income for several years, as well as, negative net per member/per month (PMPM) income. The FY 2003 PMPM graph (page 5) shows April 2003 fiscal year-to-date.





### Enrollment Freeze

CMS informed MSSP Plan Administration that a membership enrollment cap sanction was being imposed as of July 1, 2002. This action was caused by MSSP's non-compliance with contractual requirements, found by CMS in a January 2001 audit and a May 2002 on-site audit follow-up. MSSP could not add any new members after July 1, 2002 and draw upon the perceived capitation revenue benefits of the dually eligible already enrolled in MLTCP.

### **Turn Around Plan 2003**

MIHS faced an increased deficit for FY 2002 with a cash flow that was declining faster than anticipated. MIHS administration has implemented various initiatives only to face additional external challenges (i.e., Proposition 204 and the loss of State emergency services payments). Recent changes in executive management positions, resulting from termination of the external management contract in June 2002, and the above mentioned challenges have caused MIHS to initiate an FY 2003 "Turn Around Plan" to address the following issues:

- MSSP product line impact to the health system
- Calendar year 2003 MSSP benefit design
- Provider change for MSSP nursing home-based membership utilization management
- Expanding risk arrangement with nursing home-based utilization management provider
- Medical expense management
- CMS corrective action plan

## Medical Risk Services Request for Proposal (RFP)

In response to the challenges presented by maintaining MSSP, MIHS issued a Request for Proposal (RFP) for managing all medical care services provided to Maricopa Senior Select Plan members. The original proposal response due date was May 16, 2003 with a contract effective date of July 1, 2003. MIHS-Health Plans (MIHS-HP) reserves the right to contract with one or more proposer. The chosen contractor(s) will be at risk to provide all medical care services described in the RFP.

MIHS is looking for a suitable contractor(s) to help minimize the financial risk associated with retaining the Senior Select Plan by assuming full risk for all medical expenses, including pharmaceutical. The scope of services includes providing all covered medical and dental services for applicable members. The RFP also requires the contractor to use MIHS-HP's formulary for all medications ordered or, if medically necessary, use MSSP's non-formulary process to prescribe non-MIHS-HP formulary medications. The selected contractor will also provide administrative functions to support provision of services.

As of the close of our audit work, the contractor with whom MIHS administration had preliminary discussions to assume the management of the MSSP membership had decided not to propose on the medical risk services. MIHS management decided to reissue the RFP as an open proposal to all interested contractors. MIHS administration presented to the MIHS Finance Committee reasons for keeping the MSSP product open, namely the impact of MSSP membership on the delivery system (see issue 1, page 7). MIHS administration expressed confidence that a qualified contractor would be selected and that MIHS' financial risk for MSSP would be transferred. Should a qualified contractor be chosen and the contracted provider fail to perform satisfactorily or unexpectedly cease to do business, MIHS would be financially responsible for the MSSP membership. CMS recognizes MIHS as the plan sponsor and holds the system responsible for complying with the plan's business terms. Health systems entering into a Medicare+Choice plan like MSSP appear to remain fully responsible and accountable to CMS. These systems must comply with all contract terms and conditions regardless of any subcontractor relationships.

### **Scope and Methodology**

Due to MIHS management's decision to pursue an outside contractor to provide medical risk services to the remainder of the MSSP population, to effectively transfer financial risk, the scope of this audit was limited to determining:

- MIHS compliance with CMS contract prompt payment requirements
- MIHS' compliance with established policies and procedures for processing medical claims within the OAO and INC systems
- If MIHS has effectively addressed the OAO system duplicate claims cleanup process
- The extent that MSSP members utilize MIHS owned facilities

This audit was performed in accordance with generally accepted government auditing standards.

# Issue 1 Health System Utilization

## Summary

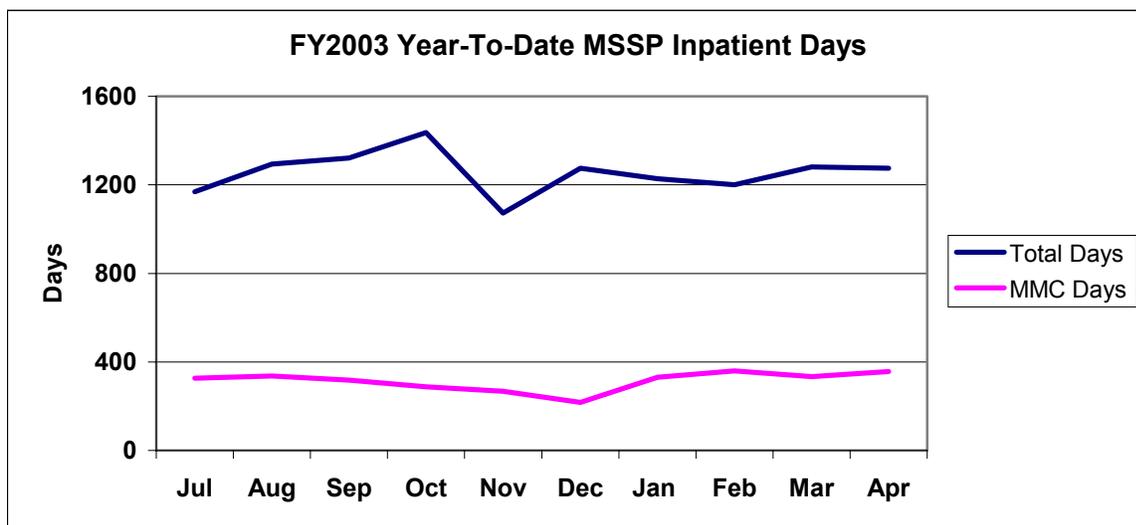
Maricopa Senior Select Health Plan (MSSP) members' utilization of MIHS facilities is too low to significantly support the system's financial viability. Our review found that 59 percent of MSSP claims generated from July 2001 through March 2003 were paid to outside (non-MIHS) service providers. MIHS financial reports also show that MSSP members utilize the Maricopa Medical Center (MMC) significantly below budget projections. MSSP management should strive to ensure that MIHS owned and operated facilities are utilized to the fullest extent possible for providing services to plan members.

## MIHS Facility Utilization

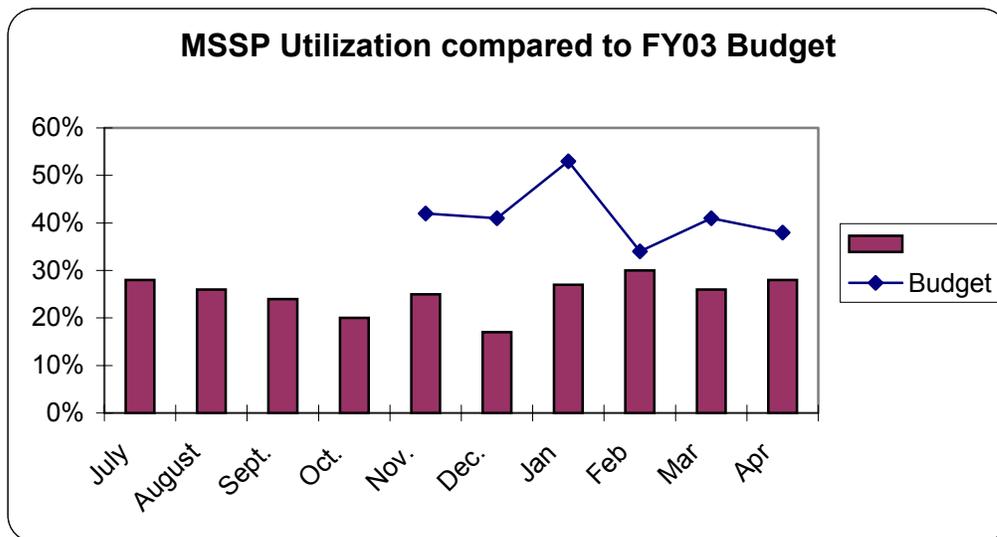
The MIHS delivery system customer base and financial health is strengthened when health plan members utilize its facilities. MIHS owned and operated facilities need to be used as much as possible to maximize internal claims payment revenue. MSSP's utilization of providers/vendors that operate outside of the system should be minimized.

MIHS management conducted a broad scope analysis of MSSP's contribution to the system in July 2002. Management analyzed the impact of MSSP's contribution margin to MMC and considered the importance of dually enrolled Maricopa Long Term Care Program (MLTCP) members. The study was presented to the Hospital/Health System Board and County Administration for consideration. The study results indicated that closing MSSP could potentially reduce MIHS annual net income by \$6.6 million. This analysis was used to support MIHS' decision to continue the MSSP Medicare Plus Choice program for calendar year 2003.

We conducted an analysis of paid members claims from July 2002 through April 2003 and found that a high percentage of MSSP members go outside MIHS for care. The graph below shows total MSSP member inpatient days during this period and the number of total days retained at MMC.



The following chart shows that MSSP utilization of MMC is well below budget:



From July 2002 through April 2003, MSSP inpatient utilization at MMC averages approximately 25 percent per month. One reason for this situation is that the MSSP population is spread across Maricopa County and the MMC is located in central Phoenix, causing some members difficulty to utilize the facility. Therefore, they go to the nearest and most convenient provider, which often is a non-MIHS owned facility.

We obtained a MIHS download of paid claims for the first three-quarters of FY 2002 to extend the testing period to include a wider range of claims expenses. The system, migrated from the INC system to the OAO system in October 2002, generated a download of:

- OAO claims for November 1, 2002 through March 31, 2003
- INC claims for July 1, 2001 through October 31, 2002

We found that \$30.7 million (64.7%) of claims paid by INC were made to vendors/providers who practice outside of MIHS. We also found that 54.2 percent of the claims paid by OAO were made to vendors/providers outside of MIHS. Our test results indicate that MIHS facilities, providers, and vendors are not being utilized to the levels desired and necessary.

### Recommendation

MSSP management should:

- A. Strive to ensure that MIHS owned and operated facilities [MMC, Family Health Centers (FHC) and Comprehensive Health Center (CHC)] are utilized to the fullest extent possible for providing services to members.
- B. Reinforce this need to MSSP employees and contractors.

# Issue 2 Duplicate Claims Testing

## Summary

Based on a small judgmental test sample of medical claims, we found \$3,021 (12 percent) to be duplicate MSSP claim payments. Applying this percentage to the total potential duplicate population shows that approximately \$426,000 possibly could have been lost during the period tested. However, this test sample is not statistically reliable and the actual loss may be more or less than the amount estimated. MIHS should strengthen controls over its claims payment procedures to minimize the risk of duplicate payments.

## Claims Payment Analysis

To conduct business efficiently and effectively, MSSP needs to process service provider billings promptly. This practice will ensure that providers do not submit more than one claim, for the same service, until payment is received and will also help MSSP avoid making duplicate payments. As a method to further avoid repaying vendors, many companies conduct tests to identify any duplicate payments and potential fraudulent activity.

We reviewed OAO claim payment downloads for the period November 1, 2002 through March 31, 2003 and INC claims from July 1, 2001 through October 1, 2002. During testing we summarized claim files where member number, amount paid, beginning date of service, procedure code, and provider are equal. We then judgmentally selected ten potential duplicates from the OAO system and ten from the INC system. We conducted further investigation to determine if the claims were duplicates. We found:

- Test sample payments taken from the OAO population contained duplicate payments totaling \$2,208, which represents 10.7 percent of the payments made.
- Duplicate payments from the INC test sample contained duplicate payments totaling \$813 which represents 19.2 percent of the payments made.

Applying these percentages to the total potential duplicate population of \$938,897 for INC and \$2,577,490 for OAO, results in a potential loss of approximately \$426,000.

We also performed a Benford's Law test on the payment download. This analysis is a mathematical test that predicts the normal pattern of payments. Displays of payments that do not conform to the norm indicate potential error or fraud. We found spikes showing an unusually high number of similar payment amounts. Due to limited audit resources we were not able to test larger amounts of the population and, therefore, limited our testing to the above sample of duplicates. Not surprising, each duplicate payment noted in our testing fell exactly within one of the anomalous spikes from the Benford's Law analysis. Further investigation is warranted to determine if possible errors or inefficiencies exist beyond what the duplicates testing showed.

## **Possible Causes**

Based on our discussions with MIHS staff, all test sample duplicate claims verified to be true were the result of human errors made in processing and inclusion of procedure modifiers. None of the duplicate claims had been reversed and the monies had not been recouped at the time of testing. Management explained that MIHS' old claims system (INC) was outdated and could not automatically detect duplicate payments. The manufacturer of INC was not responsive to provide MIHS with a duplicate report because of the contract conversion to OAO. One OAO system error occurred in March 2003. OAO automatically paid claims multiple times without the system checks being made.

## **Recommendation**

MIHS should:

- A.** Monitor duplicate claims more proactively and train processors to look for common errors. When patient ID, dates of service, provider, and amounts are identical the risk of duplicate payments is very high.
- B.** Research and adjust, if applicable, identified potential duplicate claims.
- C.** Recover any duplicate payments made.

# Issue 3 Prompt Payment Requirements

## Summary

Our testing of MSSP claims paid for compliance with the Centers for Medicare and Medicaid Services (CMS) contract requirement of 30 days, found that claims paid from the previous INC system averaged 16 days, from receipt to payment, and current OAO system claims paid averaged 47 days. The latter does not comply with the contract requirement. The MIHS Claims Department should reinforce the 30-day claims turnaround policy to ensure that MSSP stays in compliance with CMS requirements.

## Contract Requirements

MSSP's contract with CMS requires MIHS to pay 95 percent of "clean claims" (containing payment requirements such as authorization and medical documentation) within 30 days of receipt. CMS may levy the following penalties for noncompliance:

*"If CMS determines, after giving notice and opportunity for hearing, that the ...Organization has failed to make payments in accordance...of this section, CMS may provide – (i) For direct payment of the sums owed to providers; and (ii) For appropriated reduction in the amounts that would otherwise be paid to the M+C Organization, to reflect the amounts of the direct payments and the cost of making those payments."*

## Review Results

CMS audited MSSP payment performance in August 2002 for compliance with the "clean claim" payment contract requirement and found:

*"MSSP did not meet CMS's 95 percent performance standard for paying clean claims within the required 30-day time frame. All of the 36 claims tested by CMS were determined to be clean claims, given the absence of any documentation to the contrary. Only 16 (44%) of the clean claims were paid within the 30-day time frame."*

We reviewed an OAO claims download for the period November 1, 2002 through March 31, 2003 and INC claims from July 1, 2001 through October 31, 2002 for compliance with the contract requirement. The average turnaround time for INC claim payments was 16 days and the average turnaround time for OAO claim payments was 47 days. However, we were unable to determine whether a claim was "clean" from the reviewed data.

Our OAO test results supports the CMS finding; MSSP's non-compliance with the contract's timely payment requirement is still an issue. The increase in claims turnaround time appears to be due to:

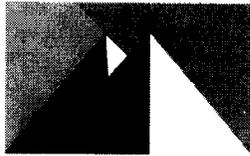
- General problems with the setup and implementation of the OAO claims system
- The need for the MIHS Claims Department to increase active monitoring of the turnaround time

**Recommendation**

The MIHS Claims Department should reinforce the 30-day claims turnaround policy to ensure that MSSP stays in compliance with CMS requirements.

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# Department Response



**MARICOPA**  
**HEALTH SYSTEM**

*Count on us to care.*

## **Maricopa Integrated Health System**

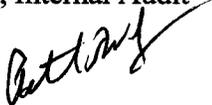
2601 E. Roosevelt

Phoenix, AZ 85008

Phone: (602) 344-8444 Fax: (602) 344-5190

**DATE:** Monday, July 14, 2003

**TO:** Ross Tate, Internal Audit

**FROM:** Pat Walz 

**SUBJECT:** **Internal Audit Report of  
Maricopa Senior Select Health Plan July 2003**

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Thank you for the opportunity to respond to this recently completed audit. Attached are our responses to the recommendations provided by your audit team.

I believe that some clarification needs to be made in the body of the document itself. While Maricopa Senior Select Plan was originally started to provide additional payments for qualifying Maricopa Long Term Care Plan members, Maricopa Senior Select has grown beyond the MLTCP patients that were part of the original group. This is essentially necessary for the survival of MSSP as the MLTCP patients were the most seriously ill. For the Senior Select Plan to be profitable MIHS needed to enroll healthier senior members.

## **Issue # 1: Health System Utilization**

**MSSP members' utilization of MIHS facilities is too low to significantly support the system's financial viability. Our review found that 59 percent of MSSP claims generated from July 2001 through March 2003 were paid outside (non-MIHS) service providers. MIHS financial reports show that MSSP member utilize the MMC significantly below budget projections. MSSP management should strive to ensure that MIHS owned and operated facilities are utilized to the fullest extent possible for providing services to plan members.**

Response: Concur to the extent that utilization can be directed to MIHS owned facilities.

**Recommendation A: Strive to ensure that MIHS owned and operated facilities (MMC, Family Health Centers (FHC), and Comprehensive Health Center (CHC)) are utilized to the fullest extend possible for providing services to members.**

Response: Concur – completed. It has been a long standing practice of MIHS to ensure that health plan members, not just MSSP, utilized MIHS owned facilities when ever feasible. For services where the health plan cannot influence the setting of the delivery, this is achieved by inclusion of FHC and CHC primary care and specialty care physicians in each of the health plan's provider network.

For services that the health plan can influence the setting of the delivery (e.g. services requiring prior authorization as shown in the attached schedule), members are directed to a MIHS owned facility when capacity, both in terms of bed availability and staffing levels, to provide the service is available and the facility is within the geographic area the member resides. Additionally, it was anticipated that the expansion of the provider network that occurred this past year would cause a decline in MIHS utilization. The decision to expand the provider network was based upon the enterprise-wide benefits of growth in membership levels across all health plans.

Target Completion Date: Not applicable.

Benefits/Costs: System-wide enhanced profitability.

**Recommendation B: Reinforce this need to MSSP employees and contractors.**

Response: Concur – completed. No action necessary as this has consistently been done as a normal course of business.

Target Completion Date: Not applicable.

Benefits/Costs: System-wide enhanced profitability.

## **Issue #2: Duplicate Claims Testing**

**Based on a small judgmental test sample of medical claims, we found \$3,021 (12 percent) to be duplicate MSSP claims payments. Applying this percentage to total potential duplicate population shows that approximately \$426,000 possibly could have been lost during the period tested. However, this test sample is not statistically reliable and the actual loss may be more or less than the amount estimated. MIHS should strengthen controls over its claims payment procedures to minimize the risk of duplicate payment.**

Response: Concur.

**Recommendation A:** Monitor duplicate claims more proactively and train processors to look for common errors. When patient ID, dates of service, provider, and amounts are identical the risk of duplicate payments is very high.

Response: Concur – completed. This has consistently been done as a normal course of business and will continue into the future. MIHS periodically runs a process that scans all claims, both pended and paid, for duplication that recovers paid claims or denies pended claims when duplicates are found to exist. We anticipate converting this from a periodic process to weekly by August 31, 2003.

Target Completion Date: August 31, 2003.

Benefits/Costs: Compliance with regulatory requirements.

**Recommendation B:** Research and adjust, if applicable, identified potential duplicate claims.

Response: Concur – completed. No action necessary as this has consistently been done as a normal course of business.

Target Completion Date: Not applicable.

Benefits/Costs: Compliance with regulatory requirements.

**Recommendation C:** Recover any duplicate payments made.

Response: Concur – completed. No action necessary as this has consistently been done as a normal course of business.

Target Completion Date: Not applicable.

Benefits/Costs: Compliance with regulatory requirements.

**Issue #3: Prompt Payment Requirements**

**Our testing of MSSP claims paid for compliance with the CMS contract's 30 day requirement found that claims paid from the previous INC system averaged 16 days, from receipt to payment, and current OAO system claims paid averaged 47 days. The latter does not comply with the contract requirement. The MIHS Claims Department should reinforce the 30-day claims turnaround policy to ensure that MSSP stays in compliance with CMS requirements.**

Response: Concur.

**Recommendation A: The MIHS claims department should reinforce the priority of MSSP claims so that turnaround time is kept within the 30-day CMS contract requirement.**

Response: Concur. All claims due in 30 days should be given equal priority as this is not only a requirement of CMS but also requirement of the MHP AHCCCS contract, the MLTCP AHCCCS contract, the Health Select IGA, and vast majority of individual provider contracts.

Target Completion Date: Not applicable.

Benefits/Costs: Compliance with contracts.

**Approved By:**

  
\_\_\_\_\_  
**Department Head/Elected Official**

7/14/03  
**Date**

  
\_\_\_\_\_  
**Chief Officer**

7/15/03  
**Date**

  
\_\_\_\_\_  
**County Administrative Officer**

7/21/03  
**Date**