



Internal Audit Report

**MIHS – HealthSelect Plan Review
July 2002**



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Don Stapley, Chairman, Board of Supervisors
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We engaged Arthur Andersen LLP, and KPMG LLP, to perform a review of the Maricopa Integrated Health Systems *HealthSelect* health plan (HealthSelect). This audit was conducted in accordance with the Board approved audit plan. The review focused primarily on the health plan's claims payments, membership accuracy, financial reporting, and strategic objectives.

The consultants found some areas needing improvement. These, along with their recommendations, are detailed in the attached report. The highlights are:

- No formal Interdepartmental Agreement (IDA) has been executed between the County and the HealthSelect health plan.
- Internal Audit and Human Resources Benefits testwork identified significant exceptions between Total Compensation and health plan membership records.
- Testing for duplicate claims payments noted a one per cent error rate resulting in potential overpayments of \$23,000.

We have attached the report package and HealthSelect's response, which we have reviewed with the department's director and managers. We appreciate their cooperation. If you have questions or wish to discuss items presented in this report, please contact Joe Seratte at 506-6092.

Sincerely,

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

Ross L. Tate
County Auditor

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Executive Summary

Formally Defined Relationship

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The County's practice has been to establish Inter-Departmental Agreements (IDAs) to clarify terms and interactions for significant inter-departmental service relationships. The current working agreement between the County and HealthSelect is in draft form only. Operating under this type of informal relationship has raised concerns over the limited reporting thus far received by the Maricopa County Benefits Department from HealthSelect management. County and HealthSelect management should review the draft IDA, ensure it is appropriate to both parties, and finalize the document.

Participant Eligibility

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Duplicate Payments

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New Managed Care Project

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Introduction

Background HealthSelect is a health plan operated by the Maricopa Integrated Health System (MIHS), a division of the Maricopa County Government. Expressly designed for eligible Maricopa County employees, dependents, and retirees, this plan is, in effect, a Health Maintenance Organization (HMO). An HMO is an organization that contracts with medical facilities, physicians, and employers to provide medical care to a group of individuals. An employer usually pays for this care at a fixed price per patient. Employees may be required to contribute premiums, but generally do not have significant "out-of-pocket" expenses.

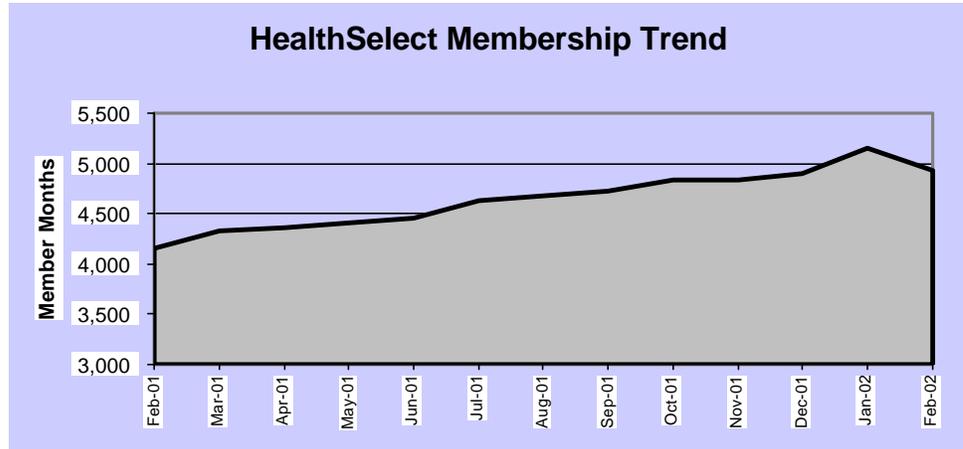
Program Offerings HealthSelect offers its members a Primary Care Physician (PCP) network of over 200 physicians and manages affiliations with ten hospitals throughout the Valley. In the past year, HealthSelect has expanded its hospital network to include St. Joseph's Hospital and Medical Center and Chandler Regional Hospital. The Avondale Family Health Center is a newly constructed, state-of-the-art, primary care location offering pharmacy, radiology, dental, mammography, ultrasound, and alternative medicine for members in the Avondale, Goodyear, Tolleson and Buckeye area. All care provided to HealthSelect members must be provided by HealthSelect-approved network physicians, hospitals, pharmacies and ancillary providers. This rule is waived only in the case of an emergency, when members may receive emergency care from appropriate providers anywhere in the world.

Program Costs The cost of premiums under HealthSelect is borne in large part by Maricopa County. The following table illustrates the County's contributions to the HealthSelect plan, and an employee's contributions to the plan based on an employee's coverage election for the 2002 plan year.

Health Select	County Contribution Per Pay Period	Employee Contribution Per Pay Period
Employee Only	\$113.01	FREE
Employee and Spouse	\$201.76	\$14.42
Employee and Child(ren)	\$171.75	\$11.23
Employee and Family	\$260.41	\$33.87

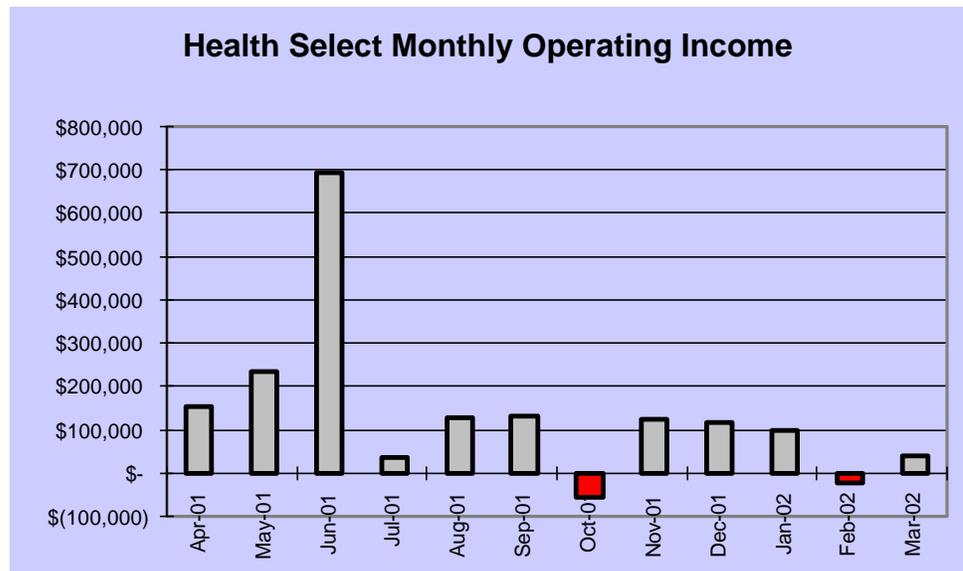
Participation

As a major health management provider for one of the largest counties in the United States, Maricopa County's HealthSelect plan enjoys substantial program membership. As of February 2002, HealthSelect served 4,934 eligible participants. The following graph illustrates how the plan has exhibited consistent growth.



Operating Results

A look at the plan's operational results shows that for the 12 months ended March 2002, the plan experienced some fluctuation in results, but mostly positive operating income levels. Overall, the plan remains relatively close to breakeven, keeping with its not-for-profit operational objective



**Timely
Payment of
Claims**

For the period under audit (January 2001 through March 2002) the consultants' testing found that 79 per cent of all claims were paid in less than 30 days. Subsequently, 98 per cent of all claims from the period tested were paid within 60 days or less. HealthSelect claims department is taking proactive measures to ensure accurate and timely payment of medical claims.

**Scope and
Methodology**

The consultants' audit steps were designed to address the following objectives:

- Develop an understanding of the relationship and contractual obligations between the Maricopa County Administration and HealthSelect.
- Understand and evaluate the HealthSelect plan's organizational objectives.
- Evaluate monitoring controls over plan participants' compliance with HealthSelect plan eligibility requirements.
- Ensure that disbursements for claims are made only to approved providers.
- Analyze HealthSelect's revenues, operating expenses and general & administrative (G&A) expenses.
- Determine the extent and impact of duplicate payments issued by HealthSelect.

This audit was performed in accordance with Government Auditing Standards.

Issue 1 Interdepartmental Agreement

Summary

The County's practice has been to establish Inter-Departmental Agreements (IDAs) to clarify terms and interactions for significant inter-departmental service relationships. The current working agreement between the County and HealthSelect is in draft form only. Operating under this type of informal relationship has raised concerns over the limited reporting thus far received by the Maricopa County Benefits Department from HealthSelect management. County and HealthSelect management should review the draft IDA, ensure it is appropriate to both parties, and finalize the document.

Current IDA Status

The service agreement between the County and HealthSelect is in the form of an IDA, and is still in a draft stage. The agreement resembles an Inter-Governmental Agreement (IGA) in that the key obligations of both parties are outlined. It differs from an IGA in the amount of detail provided and the instrument's enforceability. An IDA is comparable to an abbreviated summary of an IGA and lacks legally binding authority.

HealthSelect personnel indicated that County Administration and HealthSelect management informally agreed to the structure of reports and financial and clinical information that would be provided to County Administration on a monthly basis. The current monthly reporting output from HealthSelect is a product of that decision-making process. The creation of the IDA was an attempt by County Administration to formalize the HealthSelect service agreements.

Extent of IDA Terms

Although still in draft form, and not signed by either party, the IDA does lay out a basic outline of the parties' relationship, and purpose of the HealthSelect health plan. The following serves as the introduction to the current document:

“The purpose of this Agreement for HealthSelect – Maricopa Integrated Health System is to provide health insurance benefits to eligible County employees and their eligible dependents who elect coverage under HealthSelect for each contract year (January 1 through December 31).”

In broad terms, the IDA gives a rough idea of the plan years, the service requirements for HealthSelect and County Administration, the capitation structure, and reporting requirements.

**Reporting
Concerns**

Based on discussion with County leadership, concerns exist over the limited reporting thus far provided to County Administration by HealthSelect. Several of the reporting items listed in the IDA are not generated by HealthSelect. HealthSelect personnel indicate that reporting expectations have not been discussed at length in the recent past, and that HealthSelect resources could be organized to meet County Administration's requests for information.

Interviews with County Administration and Benefits Management suggest that plan operational data has not been sufficient to determine overall plan profitability. Historically, MIHS has provided coverage under the member-based health plans (AHCCCS), and its system is not capable of administering the type of health plan that includes dependents as well as primary members. MIHS allocates general and administrative expenses to all health plans based on plan revenue, rather than actual costs incurred.

Recommendation

County and HealthSelect management should review the draft IDA, ensure it is appropriate to both parties, and finalize the document.

Issue 2 Participant Eligibility

Summary

HealthSelect records and Total Compensation Benefits records should agree on plan membership and eligibility. The consultants' testing of plan claims, and a subsequent reconciliation performed by the Human Resources Benefits area (Benefits) and HealthSelect identified significant discrepancies between Benefits and HealthSelect records. County and HealthSelect management should continue performing reconciliations, identify and recover any erroneous claims payments, and consider an automated interface to transfer plan membership data.

Computer Assisted Audit Techniques

Benefits coverage selected and paid for by County employees should correspond to benefits coverage provided by the HealthSelect health plan. The consultants used Computer Assisted Audit Techniques (CAAT's) to determine how well this objective was being met.

The consultants used audit software to match HealthSelect claims both incurred *and* paid in March 2002 to eligible health plan members as of the March 17, 2002 payroll period. Approximately 60 per cent of claims incurred matched directly to a County or MIHS employee. Although 40 per cent of the March claims did not match directly to a County employee, this was not unexpected. Many claims are paid for employee dependents.

To test the validity of claims paid, the consultants judgmentally selected a sample of ten claims from the matching group and twenty claims from the unmatched group and traced them to original employee election forms.

The testing showed no exceptions for the matched participants. Most of the unmatched member IDs were for qualified dependents of active plan participants. However, three exceptions were noted from the sample of unmatched participants:

- One participant elected Family coverage (at a cost to the employee of \$33.87 per pay period), but was listed on the payroll system as having Single coverage (free to the employee).
- A participant's claims were paid by HealthSelect, although the employee had elected health coverage with Cigna.
- An employee who had been terminated and had not opted for COBRA was still receiving coverage from the HealthSelect plan.

While the dollar impact of the errors identified is less than \$500, the exceptions represent a 15 per cent error rate in the sample tested. In addition, the exceptions support a larger pool of errors identified in a

project conducted by the County Benefits Department and HealthSelect to reconcile eligible participants in both the Benefits and HealthSelect systems.

Reconciliation Project

The exceptions identified appear to have occurred during the transfer of enrollment data between Benefits and HealthSelect. This was corroborated by a Benefits/HealthSelect project to reconcile HealthSelect member eligibility data to Benefits' member eligibility data. Benefits staff created a *HealthSelect Subscriber Discrepancy Reconciliation* report to document the results of their reconciliation.

In April, HealthSelect provided Benefits with a discrepancy report indicating that 634 members were provided coverage by the health plan, but no premiums being remitted by Benefits. The results of the reconciliation are shown below:

TOTAL MEMBER DISCREPANCY		634
LESS:		
Retirees & COBRA	48	
Terminations	205	
Transfers to CIGNA	250	
Waived Coverage	46	
Coverage Never in Effect	45	
Other	6	
SUBTOTAL		600
REMAINDER		34

The remaining 34 members were persons who were eligible for coverage, for whom HealthSelect correctly provided services, but did not receive premium payments from Benefits. Benefits subsequently reimbursed the health plan approximately \$35,000 in premiums.

Subsequent Reconciliation

The reconciliation was repeated in May 2002, resulting in an additional 69 discrepancies. Most of the exceptions were not identified in the April 2002 reconciliation, indicating there is a systemic issue in the way eligibility data is processed. According to Benefits, HealthSelect manually keys eligibility data, provided by Benefits, into their system bi-weekly. Manual entry presents substantial risk to data accuracy.

Recommendation

Benefits should:

- A. Continue the membership reconciliation process on a monthly basis.

HealthSelect should:

- B. Research and recover claims paid in error when the member was covered by CIGNA.
- C. Consider implementing an automated interface to update membership records provided by Benefits.

Issue 3 Duplicate Payments

Summary

HealthSelect processed claims of \$2.2 million for the period of January 2001 through March 2002. The consultants' testing indicates that up to \$23,000 in duplicate claims may have been paid during this period. The error rate of approximately one per cent indicates HealthSelect's Quality Assurance function could be improved. Enhancing claims auditing procedures could result in an additional reduction in the error rate.

Benchmarking Duplicate Payments

A 2001 benchmarking survey conducted by the Institute of Management and Administration, Inc. (IOMA), reports that 95 per cent of government entities make duplicate payments less than 0.5% of the time.

Potential duplicate payments were identified by isolating records in the claims file where member number, amount paid, beginning date of service, and provider were equal. This yielded a potential population of 1,769 duplicate payments, totaling \$104,615. Based on review of a judgmental sample of the population, five exceptions were found:

Identified as part of the audit

- A claim for \$6,186 was paid three times and reversed out twice. The full claim was then paid again on a separate invoice.
- A claim for \$1,212 was improperly paid during a period of time when the INC system, that normally flags duplicates, was not functioning properly.
- A claim for \$1,182 was identified as having been resubmitted with a different modifier for all of the same information in the original claim. A payment was then issued for the resubmitted amount.

These amounts have since been recovered by HealthSelect.

Identified by service providers

- A provider submitted a claim for \$3,701 during the period when the INC system was not functioning properly. This resulted in two payments issued to the provider. The provider reported the duplicate payment to HealthSelect and the amount was reimbursed.
- A duplicate payment for \$1,854 resulted when a claim was processed with an incorrect suffix and a separate claim was processed with the correct suffix, without the original being reversed out. The provider notified HealthSelect of this at a later date and the amount was reversed out at that time.

Extrapolating the exception rate to potential duplicates indicates that about \$23,000 in duplicate payments may have been made during the period under review. To put the errors in perspective, they represent about 1 per

cent of the \$2.2 million paid in claims during the same period.

HealthSelect has a Q&A function that reviews claims prior to payment. A one per cent error rate indicates the function could be improved.

Recommendation

HealthSelect should consider enhancing the Q&A function by acquiring and implementing automated audit software.

Issue 4 New Managed Care System

Summary

Overall project management for the new managed care system (OAO) appears to be adequate; some controls need to be strengthened to help ensure a successful project. These include resource allocation, testing delays, change control, staff turnover, and decommissioning the legacy system. MIHS should improve controls in these areas.

Best Practices

IT best practices recommend that:

- Key technical and functional resources be dedicated to major project roles as their primary responsibility.
- Software updates be adequately tested in a development environment to ensure they can be successfully implemented in the test environment.
- Formal procedures be developed for the testing, approval, and implementation of vendor-supplied fixes and updates to application software.
- Multiple resources be trained in critical new skills related to the implementation project.
- Projects for implementation of application software should include plans for decommissioning the systems being replaced.

Risk

Project Resources

With the exception of the Project Manager, other MIHS personnel participate in the OAO project. These employees also perform their normal job responsibilities. Although the original budget called for 4.5 full time resources to be dedicated to the project, actual staffing allocated is significantly less. Assigning less than the budgeted number of staff to the OAO project increases the risk that scheduled work may be delayed due to ongoing operations.

Testing Delay

Our testing found that numerous custom changes made by the vendor, have failed. As a result, significant modules are unavailable for testing. Testing activities are falling behind schedule and could impact the OAO implementation date. The OAO lab system and the MIHS contain sufficient differences that appear to cause version control errors on the MIHS system.

Change Control

MIHS has established processes for maintenance of other vendor supported applications and believes similar processes will be established for the new managed care system. However, to date formal change control procedures do not exist. Adequate testing and communication with functional users is

not performed. Without formal change control procedures and effective communication with users, MIHS faces increased risk of inadequately tested modifications being implemented into production causing disruption of services.

Technical Staffing

The MIHS' lead operations person that attended specialized AS/400 Operations and System Administration training left shortly after receiving the training. Staff turnover increases the risk of project delays.

Decommission Legacy System

The Project Plan does not contain steps necessary to decommission existing legacy systems. The OAO system is being implemented to replace the INC system (currently vendor supported) and the Long Term Care system (maintained internally). INC will be responsible for discontinuing access to their system, but MIHS has made no plans to discontinue the Long Term Care System.

When explicit plans are not made to decommission an existing system, the risk increases that legacy system will continue to support one or more functions not adequately replaced by the new system. Even though three years of history are being converted to the OAO system, MIHS still plans to allow query access to the Long Term Care system to verify data and provide history.

Recommendation

MIHS should:

- A. Clearly prioritize its resources dedicated to the project and provide alternative resources to meet the requirements of ongoing operations.
- B. Continue to escalate the problem with inadequately tested changes and the effect it is having on the project schedule up through vendor management.
- C. Continue to cross train multiple individuals who are responsible for critical areas related to the AS/400 Operations and System Administration.
- D. Update the project plan to include tasks necessary to retire the use of both the INC system and the internally supported Long Term Care System.