A REPORT
TO THE
ARIZONA LEGISLATURE

Financial Audit Division

Management Letter

Maricopa Managed Care Systems' MHP and ALTCS Funds

Year Ended June 30, 2005

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

Debra K. Davenport
Auditor General

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STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

DEBRA K. DAVENPORT, CPA
AUDITOR GENERAL

WILLIAM THOMSON
DEPUTY AUDITOR GENERAL

December 22, 2006

Board of Supervisors
Maricopa County
County Administration Building
301 West Jefferson Street
Phoenix, AZ 85003

Members of the Board:

In connection with our engagement to audit the Maricopa Managed Care Systems' Maricopa Health Plan (MHP) and Arizona Long-Term Care System (ALTCS) Funds for the year ended June 30, 2005, we performed the following as required by U.S. generally accepted auditing standards and the *Arizona Administrative Code*, Title 9, Chapters 22 and 28, as detailed in the *Reporting Guide for Acute Health Care Contractors with the Arizona Health Care Cost Containment System* (AHCCCS) and the *Financial Reporting Guide for Arizona Long-Term Care System Program Contractors with the Arizona Health Care Cost Containment System*:

- Considered the Systems' internal controls over financial reporting for the MHP and ALTCS Funds, and
- Tested their compliance with laws and regulations that could have a direct and material effect on the Systems' financial statements for the MHP and ALTCS Funds.

Our engagement disclosed material internal control weaknesses and a material instance of noncompliance with laws and regulations. As a result, we were unable to determine if the Maricopa Managed Care Systems' financial statements for the MHP and ALTCS Funds were fairly stated and could be relied upon. Management should have corrected these deficiencies to ensure that it fulfills its responsibility to establish and maintain adequate internal controls and comply with laws and regulations. Our recommendations are described in the accompanying summary.

This letter is intended solely for the information of the Maricopa County Board of Supervisors, the Arizona Health Care Cost Containment System, and the Maricopa Managed Care Systems Run-Out Team and is not intended to be and should not be used by anyone other than the specified parties. However, this letter is a matter of public record, and its distribution is not limited.

Should you have any questions concerning its contents, please let us know.

Sincerely,

Debbie Davenport
Auditor General

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INTRODUCTION & BACKGROUND

The Maricopa Managed Care Systems (Systems) contracted with the Arizona Health Care Cost Containment System (AHCCCS) Administration to provide healthcare services to eligible enrollees of the Acute Health Care and Arizona Long-Term Care System (ALTCS) programs. For financial reporting purposes, the Systems comprised the Maricopa Health Plan (MHP) Fund for the Acute Health Care program and the ALTCS Fund for the ALTCS program. The MHP Fund accounted for both inpatient and outpatient medical and nursing services provided to eligible enrollees of the Acute Health Care program. The ALTCS Fund accounted for inpatient and outpatient medical and nursing services in addition to managed institutional, home, and community-based long-term care services provided to eligible ALTCS program enrollees. The Systems received monthly capitation payments from the AHCCCS Administration for all eligible enrollees under the respective Acute Health Care and ALTCS programs.

For the year ended June 30, 2004, we reported material internal control weaknesses and a material instance of noncompliance with AHCCCS requirements in our Management Letter to the Systems dated February 17, 2006. Specifically, the Systems had inadequate internal controls for processing medical claims and accounting for prepayments made to medical providers that resulted in significant overpayments to the providers. As a result, the auditors were unable to determine whether the information reported in the MHP and ALTCS Funds' financial statements was accurate and, therefore, were unable to opine on the MHP and ALTCS Funds' financial statements for fiscal year 2004. Auditors noted similar internal control weaknesses for the MHP and ALTCS Funds for the year ended June 30, 2005, and again, we were unable to opine on those financial statements.

During fiscal year 2006, the Maricopa County Board of Supervisors transferred the AHCCCS Acute Health Care program to the Maricopa County Special Health Care District and discontinued the AHCCCS ALTCS program effective October 1, 2005. Consequently, Maricopa County terminated the Systems on October 1, 2005, and appointed the Maricopa Managed Care Systems Run-Out Team to close the Systems' operations.

The Systems should have established effective controls over their contracted services

The Systems contracted with the Arizona Health Care Cost Containment System (AHCCCS) Administration to administer the AHCCCS Acute Health Care and Arizona Long-Term Care System (ALTCS) programs. For healthcare claims, the Systems contracted with outside service organizations to process and pay all medical, dental, prescription drug, and group home claims of the programs. These outside service organizations processed approximately $193.4 million in services received in fiscal year 2005. Therefore, it was critical that the Systems required these outside service organizations to have an effective system of internal controls in place to ensure that payments were accurate and properly supported.

However, the Systems did not effectively monitor their contracted service organizations. Specifically, only one of the six contracted service organizations received an independent audit of its claims processing system because the Systems did not include contractual provisions in the service organizations' contracts requiring them. Also, the Systems failed to review and evaluate the report of the contracted service organization that received an audit. Independent audits are a customary way to determine if transactions are being appropriately processed and safeguarded. Further, the Systems only monitored one of the contracted service organizations. This monitoring was required by AHCCCS since the contractor implemented a new claims processing system. In addition, the Systems did not ensure that paid claims data were received from the service organizations was accurate and complete. These deficiencies are considered to be material internal control weaknesses and resulted in a disclaimer of opinions on the Funds' financial statements.

To strengthen controls over the contracted service organizations' claims processing and payments, the Systems should have the following policies and procedures listed below:

- Establish contractual provisions requiring outside service organizations to have an effective internal control system that accurately and appropriately processed and paid claims.

- Review the audit reports of their service organizations and require corrective action plans for deficiencies noted.

- Develop procedures to monitor the service organizations' claims processing and payment systems to ensure that claims were paid for only allowable services to eligible plan members, in accordance with AHCCCS or contracted fee schedules and the proper application of coordination of benefits and share of costs.

- Require contracted service organizations to submit accurate and complete claims data, and establish verification procedures to ensure the data's appropriateness, completeness, and accuracy. In addition, compare provider billing statements to supporting claims reports in a timely manner.

The Systems should have required contractors to follow appropriate standards for system development

During fiscal year 2005, the Systems contracted their acute care claims processing function to an outside service organization. This outside service organization processed approximately 83 percent of the MHP and 26 percent of the ALTCS Funds' total medical expenses during the period of December 2004 through June 2006. Therefore, it was crucial that the Systems took the necessary steps to ensure that this contractor's claims processing system was properly configured and fully tested prior to processing medical claims for the Systems. However, the Systems did not meet this objective. Specifically, auditors noted that the Systems' quality control audit reports revealed that the claims processed from December 2004 through July 2005 did not pass their statistical claim accuracy standard. The Systems paid approximately $82.4 million during that period and, therefore, medical expenses could be misstated. This deficiency is considered a material internal control weakness and resulted in a disclaimer of opinions on the Funds' financial statements.

The Systems should have required the contracted service organization to have fully tested its claims processing system before implementation. Specifically, the Systems should have required the outside service organization to have followed the detailed control objectives as described in the IT Governance Institute's *COBIT® 4.0: Control Objectives, Management Guidelines, Maturity Models*, which requires documentation, authorization, testing, reviewing, and approvals prior to implementation, as well as proper monitoring following implementation. These controls would have provided reasonable assurance that the claims processing system implementation specifications and application development were achieved prior to implementation.

The Systems should have developed internal control policies and procedures to maintain and report accurate financial information

The Maricopa County Board of Supervisors and the Systems' management depend on accurate information so they can fulfill their oversight responsibility and report accurate information to AHCCCS, the public, and other interested parties. To achieve this objective, the Systems should maintain accurate accounting records. The Systems use their trial balance report to prepare the MHP and ALTCS Funds' financial statements. However, the Systems did not reconcile paid claims to the trial balance report monthly to ensure their accounting records were maintained accurately. Auditors found irreconcilable differences between the paid claims summaries, the trial balance reports, and the financial statements for fiscal year 2005. The most significant irreconcilable difference was $18.6 million for the ALTCS Fund and $5 million for the MHP Fund. In addition, the Systems did not reconcile prepayments to claims paid at the provider level monthly to ensure that all prepayments issued were accounted for and adjudicated claims were properly applied against prepayments. These deficiencies are considered to be material internal control weaknesses and resulted in a disclaimer of opinions on the Funds' financial statements.

To maintain accurate financial information, the Systems should have developed internal control polices and procedures to reconcile their accounting records. Specifically, the Systems should have reconciled the paid claims to the trial balance report monthly, and investigated and resolved all reconciling differences. In addition, the Systems should have paid providers on a timely basis to avoid making payments to providers prior to claims adjudication. However, when prepayments were made, the Systems should have established and followed specific policies and procedures to reconcile prepayments and adjudicated claims monthly for each provider to help ensure that providers were paid the proper amounts and that prepaid and medical expenses were properly accounted for and reported.

The Systems should continue to identify and recover all overpayments

As previously reported in our Management Letter to the Systems dated February 17, 2006, the Systems had inadequate internal controls for processing medical claims and accounting for prepayments made to medical providers. As a result, the Systems made improper payments for uncovered medical services, ineligible enrollees, and at incorrect rates; made payments for some services more than once;

and overpaid claims. In addition, the Systems made prepayments to providers, but did not reconcile the prepayments to the adjudicated claims to ensure that all prepayments issued were accounted for and adjudicated claims were properly applied against prepayments. Again, this resulted in overpayments to providers.

Consequently, the Systems hired a consulting firm to identify and attempt to recover overpayments from the Systems' medical providers. Auditors reviewed the firm's recovery methodology and determined that it was feasible to identify overpayments and outstanding prepayments made to individual providers. However, both the Systems and the firm only analyzed approximately $130 million (22 percent) of $586 million in medical providers' claims adjudicated through the OAO system. The remaining 78 percent represents claims that were previously settled with the providers through a written agreement that neither party would seek recovery from the other. Because of these written agreements with providers, the Systems decided not to analyze the remaining 78 percent of claims paid for overpayments and outstanding prepayments. Further, the Systems did not analyze payments to providers between the OAO and the prior claims processing systems for possible duplicate payments to providers.

Because of the failure to analyze and pursue collection efforts for all potential overpayments and outstanding prepayments, the Systems may not have identified all likely amounts due them. These overpayments and outstanding prepayments represent a gift of public monies since there was no public purpose served and the amounts paid to medical providers exceed the value received.

To help ensure that the Systems collect all likely overpayments and account for outstanding prepayments, the Systems should consult with their attorneys regarding the validity of the written agreements with its medical providers for the settlement of paid claims. If these agreements are void or voidable because they constitute a gift of public monies, the Systems should then continue to seek recovery. In addition, the Systems should analyze payments to providers between the OAO and the prior claims processing systems for duplicate payments and seek to recover any overpayments found.

Because of the above deficiencies, the prepayments reported as prepaid expenses could be understated on the Funds' financial statements as of June 30, 2005. These deficiencies are considered to be material internal control weaknesses and resulted in a disclaimer of opinions on the Funds' financial statements.

The Systems should have complied with AHCCCS requirements

The Systems' management is responsible for ensuring that medical and nursing facility claims are accurately processed, paid, and reported to AHCCCS in a timely manner. AHCCCS requires that 90 percent of all approved medical claims be paid within 30 days and paid claims information (encounters) be reported to AHCCCS within 120 days. However, the Systems were not paying claims or reporting paid claims to AHCCCS within required timelines. Also, auditors noted paid claims of approximately $24 million for the MHP Fund and $6 million for the ALTCS Fund that were either rejected or not submitted to AHCCCS as of June 19, 2006. As a result, the Systems may not have received the full amount they were eligible to receive for reinsurance claims. So far, AHCCCS has fined the Systems $125,000 for untimely encounter submissions for the contract period ended September 30, 2004. To date, AHCCCS has not completed the Systems' encounter measurements for the contract period October 1, 2004 to September 30, 2005.

The Systems should have paid claims within 30 days of approval and reported paid claims information to AHCCCS within 120 days of payment. In addition, the Systems should have investigated and resolved all pending encounters and resubmitted them to AHCCCS. These deficiencies are considered material internal control weaknesses and material noncompliance with AHCCCS requirements. A similar recommendation was previously provided in our Management Letter to the Systems dated February 17, 2006.

MARICOPA MANAGED CARE SYSTEMS

Run-Out Team

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December 12, 2006

Debbie Davenport
Auditor General
2910 North 44th Street, Suite 410
Phoenix, AZ 85018

Dear Ms. Davenport:

In response to your management letter for the year ended June 30, 2005, our responses are as follows:

First Recommendation: The Systems should have established effective controls over their contracted services

The Systems implemented multiple new claims processing systems during FY 05 to address deficiencies with the previous claims processing system. The majority of the system solutions were to contract with Third Party Administrators (TPA's) to process the medical claims of the System. This solution allowed the Systems to take advantage of the processing and business knowledge and experience that the TPA's possessed.

The implementation of the TPA systems was completed quickly, due to the overwhelming problems the previous medical claims payment system contained. The Systems selected the TPA's based on their knowledge and proven ability to provide services that they had been contracted to perform. The contracts with these industry experts allowed for the Systems to perform audits as the system required, but did not mandate the internal control functions that the TPA's were required to maintain.

The Systems relied on the expertise of the TPA's and the internal audit results to review contracted services. Had the Systems continued, additional controls would have been developed to assume the correctness and completes of the contracted services.

Second Recommendation: The Systems should have required contractors to follow appropriate standards for system development

The Systems put significant effort into the configuration and implementation of the Facets claims processing system that was put into production in December of 2004. The Systems hired industry experts to assist with the initial implementation and subsequent review of daily activity. As is the norm, the system was approved in stages, as defined activity was tested and approved. The Systems were unaware of the detailed control requirements that have been presented as industry standards. Armed with this information, more appropriate controls and contract requirements could have been established.

Third Recommendation: The Systems should have developed internal control policies and procedures to maintain and report accurate financial information

The Systems have developed many subsidiary ledgers to handle the extensive tracking needs of the business. The accounting needs of a managed care business involve projecting both costs and revenue. The Systems recognize that the historical and ongoing problems with both claims payments and reconciling prepayments have led to inaccuracies in the financial statements. They Systems recognize that errors occurred in the tracking of activity which resulted contributes to a lack of confidence in the financials.

The timing of the claims payment system conversions mandated a gap in routine processing and payment of claims to providers. To mitigate the financial impact on the providers, the Systems advanced the providers' funds until the system could process the claims. These prepayments issued in FY 2005 were tracked outside the system and input into the correct claims processing systems. The prepayments and system input were reconciled and materially correct by the end of the fiscal year.

Fourth Recommendation: The Systems should continue to identify and recover all overpayments

The Systems were aware of the problems created by the previous claims processing system. The complexity of these problems and the impact on the provider community required the Systems to handle the reconciliation in a two-step approach. Within the first six months of the OAO system processing claims, the Systems did load claim activity for INC and VAX into the OAO system although there are concerns about the validity of that data. The Systems were not able to load 100 percent of the data into the OAO system. OAO created a program to test for claims previously paid on either of the two previous systems and reverse the claim payment in OAO.

The Systems reconciled the major providers through internal analysis with activity supplied by both the internal claims system and the provider's information. The major providers were selected and this process was completed before the Systems terminated their Medicaid managed care contract with AHCCCS. These providers were settled and both parties agreed to a mutual release of no further liability. The unsettled activity has been turned over to an outside agency that is attempting to identify and/or correct additional payment discrepancies. The information the outside agency received from the OAO system did include the information from the INC and VAX systems, and the Systems acknowledge that data may have been missing

from this download as previously discussed. If overpayments have been identified, the agency is tasked with recovering the excess funds. Not all discrepancies found have been overpayments.

Fifth Recommendation: The Systems should have complied with AHCCCS requirements

The conversion of multiple claims payments systems delayed the timely adjudication of medical claims, as required by AHCCCS. The Systems were forced to discontinue processing on a previous system, due to system errors, and were aware that a delay in normal processing was the result. With full knowledge of AHCCCS requirements, the Systems provided prepayments to providers. One of the main reasons for timely processing of claims is cash flow to the providers. This criterion was met by these prepayments.

The conversions of the claims processing systems created delays in properly submitting encounters to AHCCCS. The Systems had contracted with an outside firm to assist in properly submitting and correcting encounters. The Systems has just recently received a report from AHCCCS acknowledging compliance with the Encounter Submission requirements for the Arizona Long-Term Care program for the contract year ended September 30, 2004.

Sincerely,

Linda Polan
Chief Financial Officer
Maricopa Managed Care Systems
Run Out Team