



A REPORT
TO THE
ARIZONA LEGISLATURE

Financial Audit Division

Management Letter

Maricopa Managed Care Systems' MHP and ALTCS Funds

(Formerly titled Maricopa County
AHCCCS and ALTCS Plans)

Year Ended June 30, 2004



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

February 17, 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, (formerly titled Maricopa County AHCCCS and ALTCS Plans) for the year ended June 30, 2004, 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 *Reporting Guide for Arizona Long-Term Care System (ALTCS) Program Contractors with the Arizona Health Care Cost Containment System*:

- Considered the Maricopa Managed Care 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 Maricopa Managed Care 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 correct 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 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

TABLE OF CONTENTS



Recommendation 1: The Systems should establish internal control policies and procedures over their claims process	1
Recommendation 2: The Systems should implement internal control policies and procedures over their accounting for prepayments	2
Recommendation 3: The Systems' financial information should be accurate	3
Recommendation 4: The Systems need to improve timeliness and accuracy of claims processing	4
Recommendation 5: The Systems need to prepare an up-to-date disaster recovery plan	4
Recommendation 6: The Systems need to improve their record retention procedures	5
Systems Response	

The Systems should establish internal control policies and procedures over their claims process

Medical expenses represent more than 90 percent of the MHP and ALTCS Funds' operating expenses. Therefore, it is imperative that the Systems maintain effective internal control policies and procedures over their claims process to ensure medical claims are accurately paid. The Systems' adjudication process should be designed to efficiently and effectively evaluate medical claims for propriety and determine the amounts to be paid. However, the claims processing system did not meet this objective because it did not always identify duplicate claims, apply proper pay rates, or adjust payments for enrollees' shares of cost during the adjudication process.

Further, the Systems made configuration changes to their claims processing system in October 2003 to comply with the 2004 contract year's Arizona Health Care Cost Containment System (AHCCCS) rules, such as rules for coordination of benefits, share of patient costs, and pay rates, and to correct some previous contract years' rules that were incorrectly programmed into the claims processing system. However, the Systems did not adequately test or document these changes before processing medical claims to ensure that only authorized claims were paid and correct rates were used. In addition, the claims processing system was not updated for changes in the case management system for information such as level of qualifying services or service authorization dates. Consequently, the claims processing system adjudicated claims improperly and, as a result, the Systems made improper payments for uncovered medical services, to ineligible enrollees, and at incorrect rates. The Systems also denied payment for some covered services, made payments for some services more than once, and overpaid claims by the amount of the enrollees' shares of cost.

To illustrate these problems, the Systems overpaid the Maricopa Medical Center by approximately \$7.7 million and more than 60 nursing homes by a total of approximately \$10.6 million. However, the Systems were not aware of these overpayments until these providers notified the Systems. Similar overpayments were made to other providers; however, the Systems were unable to identify and correct the amounts of those overpayments. As a result, the Systems recorded bad debt expenses of approximately \$10.1 million for the ALTCS Fund and \$9.2 million for the MHP Fund on their financial statements and hired a consulting firm in April 2005 to identify and attempt to recover all overpayments.

Because of the deficiencies noted above, the Funds' records were not reliable, and as a result, auditors were unable to determine whether medical expenses and medical claims payable were accurate. These deficiencies are considered to be a material internal control weakness and resulted in a disclaimer of opinions on the Funds' financial statements.

The Systems should take the steps necessary to fix the existing deficiencies and resolve the resulting incorrect payments as well as establish effective internal controls to ensure that future claims are accurately paid and reported. To correct the existing problems, the Systems should identify all incorrect payments, attempt to recover all overpayments, and make necessary adjustments to the 2005 financial statements. Specifically, the Systems should reconcile checks issued to claims processed for each vendor to identify the incorrect payments. To establish effective internal controls for claims processing, the Systems should select and review paid claims processed by the outside claims processing organizations on a test basis to ensure that they are paid to eligible members, for authorized services, and at correct rates.

The Systems should implement internal control policies and procedures over their accounting for prepayments

The Systems are required to pay claims to providers in a timely manner; however, because of the claims processing deficiencies previously identified, the Systems were unable to do so. Since providers requested payment for past due amounts and considered denying services to enrollees, the Systems made advances to providers until the related claims could be processed. Such prepayments were recorded as prepaid expenses. However, the Systems did not reconcile the prepayments to the adjudicated claims at the provider level to ensure that all prepayments issued were accounted for and adjudicated claims were properly applied against prepayments. As a result, prepaid expenses and medical expenses could be misstated. Auditors noted approximately \$20 million in unresolved prepayments for which the Systems were unable to provide supporting documentation.

Because of the inadequacy of the Funds' records, auditors were unable to obtain sufficient evidence to determine that amounts recorded as prepaid expenses and medical expenses were accurate. These deficiencies are considered to be a material internal control weakness and resulted in a disclaimer of opinions on the Funds' financial statements.

The Systems should pay providers on a timely basis to avoid making payments to providers prior to claims adjudication. If, however, the Systems elect to engage in such a practice, the Systems should establish and follow specific procedures to reconcile prepayments and adjudicated claims for each provider to help ensure that providers are paid the proper amounts and that prepaid and medical expenses are properly accounted for and reported.

The Systems' financial information should be accurate

The County's 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 current and accurate accounting records. The Systems use "lag" tables to track medical claims payment history, which is used to calculate the balance of medical claims payable. However, the Systems did not adjust the lag tables for claims that were negotiated and settled with providers and for underpayments and overpayments. Further, paid dates for claims that were applied to prepayments were not accurate. Because of these deficiencies, the Systems' lag tables were not reliable, and as a result, auditors were unable to determine whether the medical claims payable balance was accurate at June 30, 2004. These deficiencies are considered to be a material internal control weakness and resulted in a disclaimer of opinions on the Funds' financial statements.

The following procedures can help the Systems accurately record and report medical claims payable. The Systems should:

- Pay providers on a timely basis to avoid making settlements with or prepayments to providers.
- Adjudicate and post all medical claims to the lag tables.
- Make adjustments to the lag tables for all known prepayments, underpayments, and overpayments.

The Systems need to improve timeliness and accuracy of claims processing

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. As a result, AHCCCS fined the Systems \$625,000. Also, the Systems may not have received the full amount they were eligible to receive for reinsurance claims. Auditors noted paid claims of approximately \$43.8 million for the ALTCS Fund and \$10.3 million for the MHP Fund that were either rejected or not submitted to AHCCCS at June 30, 2004.

The Systems need to take immediate action to ensure claims are paid within 30 days of approval, and paid claims information is reported to AHCCCS within 120 days of payment. Specifically, the Systems should investigate and resolve all pending encounters and resubmit them to AHCCCS. Further, the Systems need to prescribe specific timelines for outside claims processing organizations to send the Systems their paid claims information.

These deficiencies are considered a material internal control weakness and material noncompliance with AHCCCS laws and regulations. A similar recommendation was previously provided in our Management Letter to the Systems dated October 28, 2003.

The Systems need to prepare an up-to-date disaster recovery plan

The Systems use computerized systems to process medical claims and other financial transactions and submit paid claims information to AHCCCS. Therefore, it is essential that the Systems should have an up-to-date, properly designed disaster recovery plan to help ensure that procedures are in place to provide for the continuity of operations and that the electronic files are not lost in the event of a disaster or other business interruption. However, the Systems did not have a current and tested disaster recovery plan and there was no designated off-site location to store backup electronic data files or process transactions in the event of a disaster or other business interruption.

To help ensure that the Systems can provide for the continuity of its financial operations and help prevent the loss of data in the event of a system or equipment failure, the Systems should prepare an up-to-date disaster recovery plan that is stored at an off-site location and updated and tested on an annual basis. The disaster recovery plan should include the following:

- A listing of employees assigned to disaster teams, including telephone numbers.
- Operating procedures, including employee assignments and responsibilities.
- A risk analysis identifying critical transaction cycles and exposures.
- Arrangements for a designated alternative computer facility.
- Arrangements with vendors to support the needed hardware and software requirements.
- Necessary forms and other documents.
- Details of off-site storage locations, including a listing of backup electronic data files.

The Systems need to improve their record retention procedures

It is essential that the Systems maintain complete and accurate records to support medical claims paid. In fact, the Records Management Manual for Arizona Counties, issued by the State of Arizona, Department of Library, Archives and Public Records, requires that documentation be retained for 3 years. However, the Systems did not have effective control procedures to ensure that all medical claims information supporting amounts paid were retained. Auditors tested numerous claims for which the Systems could not locate documentation supporting those paid claims.

The Systems need to improve their record retention procedures to help ensure that all claim documents are retained for at least 3 years. For example, the Systems should retain claims documents such as the UB-92 form for hospital inpatient services, the UB-82 form for nursing facilities, and the CMS 1500 form for other medical services. Specifically, the Systems should inform their claims personnel of the Records Management Manual for Arizona Counties and enforce these procedures.

A similar recommendation was previously provided in our Management Letter to the Systems dated October 28, 2003.

MARICOPA MANAGED CARE SYSTEMS

Run - Out Team

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January 18, 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, 2004, our responses are as follows:

First Recommendation: The Systems should establish internal control policies and procedures over their claims process.

The Systems continued to work on correcting system problems that were identified after the claims processing system implementation in October, 2002. Regrettably the first attempts to correct configuration problems through a global correction tool created additional problems, rather than fix the identified problems. The use of that tool ceased when the problems were discovered, but identifying all of the issues was highly complex and many left unidentified.

The Systems took a multi pronged approach to correct this problem. The Systems identified claim types (such as a Universal Claim form) or service types (such as nursing homes) that could not be properly processed on the existing system. Certain types of claims were contracted to be processed by a third part vendor. For other types, an internally developed system was established. There are multiple checks on that data, some internal and a cross-check by the Encounter Process at AHCCCS. These solutions dealt with unprocessed claims.

The Systems began to identify providers that had been incorrectly processed. An initiative was begun to settle, provider by provider, balances due or owing. That process continues and is handled both internally and by an outside vendor.

Second Recommendation: The Systems should implement internal control policies and procedures over their accounting of prepayments.

The Systems' difficulty in processing claims timely resulted in a number of providers requesting an advance payment for services provided. The Systems handled these checks in two distinct ways – one through the claims adjudication system, one through the normal Accounts Payable

path. The latter also was added to the claims adjudication system. These checks, for many providers, created a credit balance.

The credit balances are updated by normal claims processing activity – reduced by processed claims due the provider, and increased by claim adjustments that are recouping money. This activity makes credit balance detail difficult to track, but not impossible, as demonstrated to the audit staff for numerous providers. During the course of the audit, the Systems demonstrated to the auditors that the process does work, but it was a painstaking process for a small select group of providers. The task of properly analyzing all the provider activity was determined best handled by an automated system using an outside vendor rather than manually, given time constraints.

The Systems significantly reduced the need for advance payments issued by the end of FY 04.

Third Recommendation: The Systems should maintain and report accurate financial information

The Systems had put considerable effort into properly recording advance payment activity. The difficulties created by the claims processing system in place at the end of FY 04 made the analysis of the credit balance detail difficult. This, along with other previously noted problems, led the Systems in early 2004 to select a new claims processing system. All claims with a date of service July 1, 2004 and forward were processed on the new system.

The Systems began a process of settling provider activity outside of the claims processing system. These settlements therefore were not part of the claim information used to update the triangulation lag schedules. The use of separate claims adjudication systems have assisted with more accurate lag tables, but it was difficult to correct history.

The information gathering for the issues raised during the audit required the Systems to get outside assistance to help address and analyze the items raised. This team of consultants and Systems staff worked for six months to address the concerns raised by the audit staff but were unable to clear all of the raised issues.

Fourth Recommendation: The Systems need to improve timeliness and accuracy of claims processing

The Systems acknowledge that adhering to the AHCCCS requirements of prompt pay and timely encounter reporting were difficult with the new claims system in place during FY 04. As previously discussed, these issues added to the reason for converting to a different system.

Fifth Recommendation: The Systems need to prepare an up-to-date disaster recovery plan

The Systems had addressed the need to enhance the Disaster Recovery process during the previous fiscal year, and had begun a process for compliance. That process was eventually terminated by the decision of the County to transfer the AHCCCS Acute program to the Special Healthcare District and discontinued the operation of the ALTCS program effective October 1, 2005.

Sixth Recommendation: The Systems need to improve their record retention procedures

The Systems adopted a record retention policy effective October 6th, 2003 which provides for retention of all claims and supporting documentation a minimum of three years subsequent to receipt, or according to AHCCCS requirements. The Systems followed the County and/or AHCCCS retention guidelines for record retention when the Systems were discontinued September 30, 2005.

Sincerely,

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