



AUG 11 2004

Office of Audit Services  
Region IX  
50 United Nations Plaza, Rm. 171  
San Francisco, CA 94102  
(415) 437-8360 FAX (415) 437-8372

Report Number: A-09-04-00026

Ms. Phyllis Biedess  
Health Plan CEO  
Maricopa Integrated Health System  
2502 E. University Dr., Suite 125  
Phoenix, Arizona 85034

Dear Ms. Biedess:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) report entitled "Review of Maricopa Integrated Health System's Compliance With Medicare+Choice Prompt Payment Regulations During the Period May 1, 2003 Through October 31, 2003." A copy of this report will be forwarded to the HHS action official named on page 2 for review and any action deemed necessary.

The action official will make final determination as to the actions taken on all matters reported. We request that you respond to the action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 552, as amended by Public Law 104-231), OIG reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-09-04-00026 in all correspondence.

Sincerely,

Lori A. Ahlstrand  
Regional Inspector General  
for Audit Services

Enclosures – as stated

**Direct Reply to HHS Action Official:**

Jeff Flick, Regional Administrator  
Centers for Medicare & Medicaid Services, Region IX  
75 Hawthorne Street, Room 408  
San Francisco, California 94105

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MARICOPA INTEGRATED  
HEALTH SYSTEM'S COMPLIANCE  
WITH MEDICARE+CHOICE  
PROMPT PAYMENT REGULATIONS  
DURING THE PERIOD MAY 1, 2003  
THROUGH OCTOBER 31, 2003**



**AUGUST 2004  
A-09-04-00026**

# *Office of Inspector General*

<http://oig.hhs.gov>

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The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the department.

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The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. The OEI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

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The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the department.

The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

# *Notices*

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THIS REPORT IS AVAILABLE TO THE PUBLIC  
at <http://oig.hhs.gov>

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

## **OAS FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.



## **EXECUTIVE SUMMARY**

### **BACKGROUND**

The Balanced Budget Act of 1997 amended Title XVIII of the Social Security Act to establish the Medicare+Choice (M+C) program. The program provides Medicare beneficiaries the option of obtaining their Medicare health coverage from private health plans under contract with the Centers for Medicare & Medicaid Services (CMS). These plans provide services directly to beneficiaries, through arrangements with contracted providers, or by purchasing services from noncontracted providers. Federal regulations at 42 CFR § 422 require plans to make timely payment to, or on behalf of, plan enrollees for services obtained from noncontracted providers.

### **OBJECTIVE**

Our objective was to determine whether Maricopa Integrated Health System Health Plans (Maricopa) complied with M+C prompt payment regulations to timely pay or deny claims submitted by noncontracted providers.

### **SUMMARY OF FINDINGS**

Maricopa's compliance with prompt payment regulations could not be determined because its claims processing data was inaccurate and incomplete. The data was inaccurate and incomplete because Maricopa did not (1) design and implement an electronic claims processing system that properly processed M+C claims and (2) establish adequate policies and procedures to record information necessary to properly track claims in its manual claims processing system. After completion of our fieldwork, Maricopa initiated a search for an outside contractor to process claims.

### **RECOMMENDATIONS**

We recommend Maricopa:

1. design and implement an electronic system, or contract with an outside organization, to process M+C claims correctly
2. establish adequate policies and procedures to ensure that all information recorded in the M+C claims processing systems is accurate and complete

### **MARICOPA COMMENTS**

In its written response to our draft report, Maricopa concurred with our findings. Maricopa stated that it has delegated responsibility for claims processing to a third-party administrator and is working with CMS to transfer its contractual obligations to another Medicare carrier. Maricopa's response is included in its entirety as an appendix.

## INTRODUCTION

### BACKGROUND

#### The Medicare+Choice Program

The Balanced Budget Act of 1997 amended Title XVIII of the Social Security Act to establish the M+C program.<sup>1</sup> The program provides Medicare beneficiaries the option of obtaining their Medicare health coverage from private health plans under contract with CMS. These plans, known as M+C organizations, are required to provide enrollees with the same health care services offered under the traditional Medicare program plus additional benefits.<sup>2</sup> These organizations provide services directly to beneficiaries, through arrangements with contracted providers, or by purchasing services from noncontracted providers.<sup>3</sup> Claims for services are processed by the M+C organization or through agreements with delegated entities.<sup>4</sup>

#### Maricopa Integrated Health System Health Plans

Maricopa provides medical services to the citizens of Maricopa County in Arizona. CMS contracted with Maricopa as an M+C organization to provide health care coverage to approximately 7,400 Medicare enrollees during our audit period.

#### CMS Reviews

CMS conducts a detailed review of each M+C organization at least once every 2 years. The reviews include internal control and substantive tests of an M+C organization's claims processing systems and compliance with prompt payment provisions. CMS reviewed Maricopa's claims processing in 2001, 2002, and 2003 and found it out of compliance with prompt payment regulations. These reviews disclosed that Maricopa:

- paid less than 95 percent of all clean<sup>5</sup> claims within the required 30 days
- did not make a decision to pay or deny all other claims within 60 calendar days of receipt

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<sup>1</sup> The M+C program will be replaced by the Medicare Advantage Program under the Medicare Prescription Drug, Improvement and Modernization Act of 2003, effective January 1, 2006.

<sup>2</sup> Additional benefits are health care services not covered by Medicare and reductions in premiums or cost sharing for Medicare-covered services.

<sup>3</sup> A noncontracted provider does not have a written agreement with an M+C organization to provide services to an M+C organization's enrollees.

<sup>4</sup> A delegated entity is contracted by an M+C organization to provide administrative or health care services to Medicare-eligible individuals enrolled in the M+C organization's service plan.

<sup>5</sup> A clean claim does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether Maricopa complied with M+C prompt payment regulations to timely pay or deny claims submitted by noncontracted providers.

### **Scope**

We reviewed a database of noncontracted Medicare claims paid or denied by Maricopa during the period May 1, 2003 through October 31, 2003.

We did not review the M+C claims processed by Maricopa's single delegated entity because the number of noncontracted claims processed was immaterial. We limited our review of internal controls to Maricopa's processing of M+C claims.

We conducted our fieldwork from November 2003 through June 2004, which included visits to Maricopa's office in Phoenix, AZ.

### **Methodology**

To accomplish our objective, we:

- reviewed Federal regulations, policies, and procedures relevant to the prompt payment of noncontracted claims
- consulted with CMS officials to understand CMS's implementation of the M+C program monitoring requirements and prompt payment regulations
- reviewed Maricopa's claims processing system and procedures

We performed our audit in accordance with generally accepted government auditing standards.

## **FINDINGS AND RECOMMENDATIONS**

Maricopa's compliance with prompt payment regulations could not be determined because its claims processing data was inaccurate and incomplete. The data was inaccurate and incomplete because Maricopa did not (1) design and implement an electronic claims processing system that properly processed M+C claims and (2) establish adequate policies and procedures to record information necessary to properly track claims in its manual claims processing system. After completion of our fieldwork, Maricopa initiated a search for an outside contractor to process claims.



## **FEDERAL REGULATIONS FOR PROMPT PAYMENT**

Federal regulations at 42 CFR § 422.100(b) require M+C organizations to make timely payment to, or on behalf of, plan enrollees for services obtained from noncontracted providers.

## **PROGRAM GUIDANCE FOR CLAIMS PROCESSING**

Chapter 7, section 20.2 of the CMS Medicare Managed Care Manual requires M+C organizations to implement a claims processing system capable of processing claims without error. This system should also track claims from receipt to final resolution.

## **ELECTRONIC CLAIMS PROCESSING DATA INACCURATE**

Maricopa's electronic claims processing data was inaccurate because its electronic system did not properly process M+C claims. When Maricopa implemented its current system in October 2002, processing rules were not designed correctly, causing claims to be paid or denied inappropriately. To correct the problems, Maricopa implemented new processing rules and reprocessed claims. However, when Maricopa reprocessed the claims, it did not ensure that the original payment and denial information was retained in the database. Many of the claim receipt and payment or denial dates were changed when the claims were reprocessed.

After completion of our fieldwork, Maricopa initiated a search for an outside contractor to process claims.

## **MANUAL CLAIMS PROCESSING DATA INACCURATE AND INCOMPLETE**

Maricopa's manual claims processing data was inaccurate and incomplete because Maricopa did not have adequate policies and procedures for recording information to track compliance with prompt payment regulations. Maricopa used the manual claims processing system to process payments issued directly to enrollees but did not always record the correct dates of receipt or denial.

## **RECOMMENDATIONS**

We recommend Maricopa:

1. design and implement an electronic system, or contract with an outside organization, to process M+C claims correctly
2. establish adequate policies and procedures to ensure that all information recorded in the M+C claims processing systems is accurate and complete

## **MARICOPA COMMENTS**

In its written response to our draft report, Maricopa concurred with our findings. Maricopa stated that it has delegated responsibility for claims processing to a third-party administrator and is working with CMS to transfer its contractual obligations to another Medicare carrier. Maricopa's response is included in its entirety as an appendix.

# **APPENDIX**



**MARICOPA  
INTEGRATED  
HEALTH SYSTEM**

*Count on us to care.*

**Maricopa Medical Center**  
2601 E. Roosevelt St.  
Phoenix, AZ 85008  
(602) 344-5011

**Desert Vista Behavioral  
Health Center**  
570 W. Brown Rd.  
Mesa, AZ 85201  
(480) 344-2000

**MIHS Health Plans**  
• HealthSelect  
• Maricopa Health Plan  
• Maricopa Long Term Care Plan  
• Maricopa Senior Select Plan  
2502 E. University Dr., #125  
Phoenix, AZ 85034  
(602) 344-8700

**Maricopa Home Health  
Care / Attendant Care**  
2611 E. Pierce St.  
Phoenix, AZ 85008  
(602) 344-2600

**Arizona Integrated  
Pharmacy**  
2611 E. Pierce St.  
Phoenix, AZ 85008  
(602) 344-2500

**Comprehensive  
Healthcare Center**  
2525 E. Roosevelt St.  
Phoenix, AZ 85008  
(602) 344-1015

**Family Health Centers**

Avondale  
(623) 344-6800

Chandler  
(480) 344-6100

El Mirage  
(623) 344-6500

Glendale  
(623) 344-6700

Guadalupe  
(480) 344-6000

Maryvale  
(602) 344-6900

McDowell  
(602) 344-6550

Mesa  
(480) 344-6200

Seventh Avenue  
(602) 344-6600

South Central  
(602) 344-6400

Sunnyslope  
(602) 344-6300

August 5, 2004

Lori A. Ahlstrand  
Regional Inspector General for Audit Services  
Office of Audit Services  
Region IX  
50 United Nations Plaza, Rm. 171  
San Francisco, CA 94102

Dear Ms. Ahlstrand:

We appreciate the professional and courteous manner in which you and your agency performed your review of our organization.

In response to your findings in the June 2004 "Review of Maricopa Integrated Health System's Compliance with Medicare+Choice Prompt Payment Regulations During the Period May1, 2003 Through October 31, 2003", we concur with your findings.

As stated in your review, Maricopa has engaged a new TPA service to process claims. However, Maricopa is working with CMS to novate the Medicare plan to another carrier.

In addition, since your audit was completed a new Executive Director, Phyllis Biedess, has been appointed to the Health Plan at Maricopa. Please direct all future correspondence to her at the same address as before.

Should you have any questions or comments please do not hesitate to contact me.

Sincerely,

James E. Chisolm  
Consultant to MIHS Health Plans

Cc: Phyllis Biedess, Health Plans CEO