Office of the Inspector General
Corporation for National and Community Service

Audit of the Corporation's Oversight and Monitoring of the Health Benefits Program

Report Number 99-15
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This report was issued to Corporation management on September 14, 1999. Under the laws and regulations governing audit follow up, the Corporation must make final management decisions on the report's findings and recommendations no later than March 13, 2000, and complete its corrective actions by September 14, 2000. Consequently, the reported findings do not necessarily represent the final resolution of the issues presented.

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CORPORATION FOR NATIONAL SERVICE

Audit of the Corporation's Oversight and Monitoring of the Health Benefits Program (OIG Audit Report Number 99-15)

The Office of the Inspector General engaged PricewaterhouseCoopers, LLP, to audit and report on the Corporation's oversight and monitoring of its health benefits program, administered by Outsourced Administrative Systems, Inc. (OASYS) under Contract No. 95-743-1005. The audit covered the Corporation's oversight and monitoring practices for the period October 1, 1994 through September 30, 1998. We have reviewed the report and work papers supporting its conclusions and agree with the findings and recommendations presented.

The auditors concluded that the Corporation does not adequately oversee and monitor the health benefits program. The conditions leading to this conclusion included:

- the Corporation lacks formal policies and procedures to adequately oversee and monitor the services provided by OASYS;
- the Corporation does not perform annual compliance reviews of OASYS or perform adequate alternative procedures to review billed costs for accuracy and reasonableness;
- the Corporation does not provide OASYS with updated eligibility data on a timely basis or maintain a log of participant claims appeals; and
- the Corporation does not receive and review all management reports required under the contract.

In addition, the auditors found that the Health Benefit Analyst, assigned the responsibility for oversight and monitoring of the program, lacked the clinical knowledge and experience needed to perform all of the responsibilities of the position and inappropriately overruled decisions made by the OASYS medical review team to deny payments of claims. The report discusses these conditions in detail and provides other information related to the health benefits program.

In its response to a draft of this report, the Corporation stated that it agreed with the findings that relate to performing oversight functions for OASYS and described planned corrective actions. The Corporation disagreed with the findings that relate to activities performed by the Health Benefit Analyst. The Corporation's response is included as Appendix B. Responses to individual findings are included after each finding in the report, as appropriate.

Inspector General
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Background

On January 5, 1995, Adminastar Solutions, Inc. (subsequently known as Acordia Healthcare Solutions, Inc., and Outsourced Administrative Systems, Inc., hereinafter known as OASYS) entered into an agreement to serve as a healthcare benefits program administrator for the Corporation for National and Community Service (hereinafter known as the Corporation). This contract (#95-743-1005), retroactively effective as of October 1, 1994, had an original term of one year and was extended for three additional one-year options. Upon expiration of the original agreement, a new agreement was entered with OASYS (contract #98-743-3007), effective October 1, 1998. When OASYS signed the original contract with the Corporation, it agreed to provide the following:

1) Quality administrative services;

2) Subscriber utilization review service, to be accessed via a toll-free number; and

3) Assistance in managing the cost of this program on a day-to-day and long-term basis.

As of October 1, 1994, OASYS was servicing, on behalf of the Corporation, approximately 4,900 participants enrolled in the self-insured healthcare benefits program. By October 1, 1998, this number had increased to approximately 8,015 participants. During this time period, total annual costs associated with the health benefits program were between $5 to $6 million.

Review of Oversight and Monitoring Procedures

Scope, Methodology, and Objectives

In Task I of this project, we were engaged by the Corporation's Office of the Inspector General (OIG) to audit and report on the Corporation with respect to its oversight and monitoring of the health benefits program. This audit was limited to the performance period of the Corporation's first health benefits contract with OASYS (contract #95-743-1005), October 1, 1994 through September 30, 1998. This work will serve as a background for Task II of this project, during which we will perform an audit of the claims and administrative costs associated with the health benefits program, as well as a review of OASYS's internal claims processing and accounting systems.

We performed this audit in accordance with Generally Accepted Government Auditing Standards. Our understanding of the oversight and monitoring environment, and thus our report and findings, is based on discussions with Corporation personnel, including the Health Benefits Analyst (HBA) and VISTA State office personnel, and documentation related to the health benefits program. The documentation reviewed included, but was not limited to, the health benefits contracts with OASYS (contract #'s 95-743-1005 and 98-743-3007), the HBA position description, the HBA's personnel file, and documentation received from OASYS.

The section of our report related to the review of the Corporation's oversight and monitoring: (1) describes our understanding of the Corporation's oversight and monitoring environment; (2) discusses the general strengths and weaknesses of this environment; (3) highlights specific weaknesses present in the actual performance of the Corporation's oversight and monitoring; and (4) recommends specific corrective actions designed to improve the Corporation's oversight and monitoring environment.

Understanding of Oversight and Monitoring Environment

We developed an understanding of the Corporation's goals as related to the oversight and monitoring environment, which can be divided into the following categories: Compliance, Cost Containment, Cost Forecasting, and Benefits Maximization. We then compared these goals to documentation surrounding the HBA position, oversight and monitoring related clauses within the health benefits contract, and the oversight and monitoring activities actually being performed.

Our review determined that the HBA position description and the oversight and monitoring related contract clauses adequately facilitate the fulfillment of the Corporation's oversight and monitoring goals. However, the oversight and monitoring activities actually being performed do not fulfill some of the requirements, nor do they fully utilize the oversight and monitoring related clauses included in the contract. As a result, the performed activities provided very little coverage of the Corporation's oversight and monitoring goals.

Findings and Recommendations

1. The Corporation has no formal policies and procedures related to the oversight and monitoring function. We believe that this constitutes a serious internal control weakness for the Corporation and provides no formal guidance for fulfilling the requirements of the HBA position. Therefore, we recommend that the Corporation develop and implement a system of formal policies and procedures. (See page 22)
2. The HBA lacks clinical experience and knowledge. As such, the HBA does not have the necessary qualifications to perform some of the responsibilities described in the HBA position description. Therefore, we recommend that the Corporation either: (1) offer extensive clinical training to the HBA; (2) hire a clinical assistant to perform the more technical portions of the HBA's duties; or (3) periodically obtain outside expertise to assist in performing this technical analysis. (See page 23)
3. Not all duties specified in the HBA position description are being performed. We believe that this condition has severely limited the Corporation's ability to fulfill its oversight and monitoring goals. Therefore, we recommend that the Corporation revise the HBA's annual work plan to include a more comprehensive set of expectations that more accurately reflect the comprehensive requirements of the position. (See page 25)
4. The HBA overrules medical review decisions. We believe that this practice does not fulfill the HBA's duties to management, and exposes the Corporation to possible legal liabilities. Therefore, we recommend that the HBA stop reviewing medical decisions. (See page 28)
5. The Corporation does not perform annual compliance reviews of OASYS, nor does it have adequate alternative procedures to review billed costs for accuracy and reasonableness. We believe that without these reviews, the Corporation's ability to adequately monitor the accuracy and appropriateness of costs is severely reduced. Therefore, we recommend that the Corporation institute annual compliance reviews of OASYS. (See page 29)
6. The Corporation does not review the results of OASYS internal audits. By not reviewing the results of these audits, we believe that the Corporation is reducing its assurance as to the accuracy of billed costs. Therefore, we recommend that the Corporation review the detailed results of OASYS internal audits and take corrective actions on any findings that are discovered. (See page 30)

7. OASYS was requested to stop providing many of its contractually mandated reports to the Corporation. We believe that this has limited the Corporation's ability to adequately monitor OASYS's performance in administering the contract. Therefore, we recommend that the Corporation receive all reports required in the health benefits contract and perform all analyses required in the HBA's position description. (See page 31)

8. The Corporation does not keep a log of participant appeals. We believe that without such a log the Corporation cannot properly monitor participant complaints and appeals. Therefore, we recommend that the HBA create and maintain a formal appeals log to track complaints made by program participants. (See page 33)

9. The Corporation does not update OASYS eligibility data on a timely basis. We believe that this condition creates the risks that: (1) some ineligible claims may not be properly denied, thus creating unnecessary costs for the Corporation; and (2) some eligible claims may be denied, resulting in delays for plan participants. Therefore, we recommend that the Corporation send more frequent updates of eligibility information to OASYS. (See page 34)

10. Administrative invoices containing insufficient breakdowns of costs were consistently approved and paid by the Corporation. This indicates a lack of financial oversight on the part of the Corporation and decreases the assurance that healthcare costs are being contained. The new contract with OASYS requires that invoices provide a detailed breakdown of administrative costs. We recommend that the Corporation make full use of these invoices by checking their accuracy, tracking the different line items, and requesting more information when necessary. (See page 35)

11. The HBA certified and approved invoices for payment prior to reviewing them for accuracy and allowability. We believe that this condition exposes the Corporation to the risk of paying for unallowable costs. Therefore, we recommend that the HBA review all invoices prior to approving and certifying them and mark all erroneous invoices as "void". (See page 36)

Claims Data Analysis and Benefits Comparison

Scope, Methodology, and Objectives

We were engaged by the Corporation's OIG to analyze the types and amounts of claims paid under the Corporation's health benefits program and comment on our results with respect to relevant industry standards. Our analysis was limited to claims paid pursuant to the Corporation's contract with OASYS (contract #95-743-1005) for the period October 1, 1994 to September 30, 1999.

We performed this data analysis by looking at healthcare services utilized for the inpatient and outpatient settings during each of the four years. The data analysis was developed from claim extracts provided by OASYS. A breakdown of medical and surgical services was performed, as well as an aggregate for inpatient and outpatient services. Finally, we performed a comparison of the Corporation's benefits plan to the 1999 Federal Employee High Option Preferred Provider Organization (PPO) Plan offered by Blue Cross and Blue Shield and noted the differences.

The section of our report related to our analysis of claims data: (1) provides a narrative and graphical summary of the types and amount of claims paid over the four-year period with comparisons to industry standard, where applicable; (2) highlights possible clinical issues identified through analysis of the claims extracts; and (3) provides a comparison of the Corporation's benefits to those offered to Federal employees.

Results of Analysis

Our analysis revealed that the aggregate per capita healthcare costs have decreased by 21.9% during the period October 1, 1995 to September 30, 1997. This was the result of a 17.4% decrease in outpatient costs, and a 31.5% decrease in inpatient costs.

In comparing the Corporation's claims data to relevant industry standards, we noted that inpatient days of stay per 1,000 participants was better than industry standards in both 1996 and 1997. In addition, we noted that total admissions per 1,000 participants was better than industry standards for all three years analyzed. Finally, we noted that the Corporation's average inpatient length of stay is fairly consistent with industry standards, being slightly better in both 1996 and 1997.

While analyzing the claims extract data we noted several questionable characteristics. First, we encountered unexpected age demographics including 195 participants with birth dates on January 1, 1900. In addition, we discovered unusual disease category utilizations when considered in relation to an expected average age of 34 and the restraints of the program. These unusual categories included circulatory, mental, surgical maternity, and neoplasm. Finally, we noted a large number of claims exceeding $10,000 within each year. For example, we noted one participant with an admission costing $127,862. Furthermore, the length of stay for this admission was 61 days, 40 days longer than is allowed per year under the plan. During the on-site visit in Task II, we will review the eligibility data for participants with questionable age demographics. In addition, we will review medical records for claims with unusual disease categories or with high associated costs.

Finally, in our comparison of benefits, we determined that, barring certain time restrictions, the Corporation's benefits plan provides overall richer inpatient and outpatient benefits than those offered under the 1999 Federal Employee High Option PPO Plan. We also discovered that the Corporation's plan provides comparable emergency room (except that the Corporation requires a $25 deductible unless admitted), prescription drug (except that the Corporation requires no deductive or copayment), and dental benefits. Finally, we noted that the Corporation's benefits are generally not comparable in the areas of preventative care, well-child care, and X-ray and laboratory expenses.

The Corporation has reviewed this report and commented upon the findings and recommendations summarized above. These comments (some of which have been summarized) and our associated responses, have been included in the text of this report. A copy of the Corporation's comments are included as Appendix B.

Summary of the Corporation's Goals for Contractual Oversight

To obtain a clear understanding of the oversight and monitoring of the health benefit program, we first developed an understanding of the Corporation's goals in this area. We achieved this through discussions with the HBA and review of the related documentation, including the Corporation's contract with OASYS and the HBA position description. These goals constitute our understanding of the general purpose and role of the Corporation's health benefits program oversight.

Our understanding of the Corporation's four goals (Compliance, Cost Containment, Cost Forecasting, and Benefit Maximization), is detailed below.

1. Compliance

   A primary goal of the Corporation is to ensure that OASYS is in compliance with the terms of the health benefits contract. OASYS is required to facilitate the use of a defined set of health benefits offered to active participants, and to ensure that participants understand the benefits available to them.

   The contract provides detailed instructions on how these two general tasks are to be completed. For example, OASYS must follow a specific process in the administration of claims, including time frames in which this process is to be completed. In addition, the contract terms facilitate the Corporation's monitoring of OASYS by requiring specific reports delivered on a set schedule, the periodic completion of internal audits, and annual compliance reviews to be completed by the Corporation.

   The Corporation's management negotiated these contract terms, and is concerned with OASYS's compliance. Therefore, the Corporation's oversight and monitoring of the health benefits contract should provide this assurance.

2. Cost Containment

   The Corporation's health benefits program is self-insured. As a result, the Corporation pays all costs associated with the healthcare benefits received by participants. In addition, the Corporation must pay an administration fee to OASYS in compensation for its services. Total costs associated with this program were roughly between $5 to $6 million per year for the period under review.

   According to the HBA, the Corporation's intent is to minimize these costs. Therefore the oversight and monitoring function should provide some assurance that these costs are contained. For example, the oversight function should ensure that only reasonable and appropriate claims have been paid. This means that only eligible participants should be receiving benefits, the benefits received are priced appropriately, and the services provided meet the plan's criteria for reimbursement. In addition, the oversight function should monitor the administration of the program to reduce inefficiencies, thereby reducing administrative charges.

3. Healthcare Cost Forecasting

   The Corporation needs to be able to effectively estimate the costs associated with the benefits program when creating their budget. Thus, the oversight and monitoring function must facilitate this ability.

   In order to estimate costs associated with the health benefits program, the Corporation needs to perform claims data analysis. Through claims data analysis, cost trends can be identified and forecasts can be developed.

4. Benefit Maximization

   By creating and funding this health benefits plan, the Corporation has demonstrated a commitment to the well being of its participants. While they must limit the medical benefits available to participants due to available resources, the Corporation is committed to ensuring that participants receive the maximum amount of service available through the health benefits program.

   The final goal for the oversight and monitoring function is to ensure that its participants are receiving all the benefits to which they are entitled. The Corporation must provide assurance regarding the timeliness of OASYS's response to participant questions and concerns. This includes monitoring the efficiency of the toll-free number available to participants, the completeness and understandability of the plan documentation, and the operation of the appeals process.

Health Benefits Analyst Position Documentation

After obtaining an understanding of the Corporation's goals regarding the oversight of the health benefits plan, we reviewed the HBA position description as written by the Corporation's human resources department. We also reviewed the fiscal year 1996, 1997, and 1998 annual work plans[1] as written by the HBA and approved by Corporation management. The documents provide an outline of how the Corporation intended to achieve their goals regarding the oversight of the health benefits contract.

Summary of the Health Benefits Analyst Position Description

The HBA position description provided a detailed and comprehensive description of the responsibilities associated with this position. The major duties are as follows:

- "Determine the health priorities and medical needs of VISTA, NCCC, and AmeriCorps Leader participants. Determine and report on the adequacy and conformity of the health delivery system as related to the Corporation's long-term goals and objectives. Provide direction and advice in the area of health policies and programs for the Corporation. Serve as the primary liaison to other public and private organizations as related to healthcare and related activities.
- Develop and implement improvements in the delivery of health services based on analyses of morbidity rates and costs of health services delivery.
- Develop methods and provide cost effectiveness analyses aimed at improving service and reducing costs of the health support system. Analyses include a review of the participant medical claims payment system provided by the health contractor, analyses of cost share health billings, and analyses of customary and reasonable fee schedules of the health contractor for conformity with national physician and hospital profiles.
- Serve as the Contracting Officer Technical Representative (COTR) for the health benefits contract by assuring that the contract is administered in accordance with Federal and Corporation procurement regulations and policies.

[1] The Corporation's human resources policy requires that, on an annual basis, employees prepare and management approve a work plan describing tasks and expectations for the following year. These work plans are used in developing year-end performance assessments.

- Cooperate with the Corporation's Inspector General to support audits and, as appropriate, investigations of the health benefits program. Provide health contract data to private consultants who provide actuarial advice and analyses and project health care cost trends.
- Develop periodic reports regarding significant issues of participants' health care delivery, costs analyses, and related topics. Examples include identification and analyses of medical cost trends in participant health claims and their correlation of demographic and geographic factors; comparative analyses of annual participant medical costs versus those of previous years according to inpatient and outpatient care, diagnostic categories, average per diem costs, average lengths of stay in clinical facilities, and average inpatient case costs; and comparative analyses of participant medical costs versus costs of other subscriber plans operated by the health contractor according to the above-mentioned categories.
- Serve as the Corporation's representative for the Office of Workers' Compensation Program claims system regarding workers' compensation claims of all full-time AmeriCorps*VISTA Participants, National Civilian Community Corps (NCCC) Corpsmembers and Leaders."

Summary of Approved Work Plan

As mentioned above, we reviewed the work plans created by the HBA for fiscal years 1996, 1997, and 1998. These work plans were reviewed and approved for use by Corporation management. The contents of these work plans are summarized below:

Unit Objectives

- Monitor and analyze program and budget performance.
- Develop short and long-term program and budget plans.
- Improve headquarters/field communications.
- Ensure that all AmeriCorps*VISTA support systems are coordinated and handled in an efficient, responsive manner.
- Provide technical assistance materials to field staff.

Employee's Critical Tasks

- Review, analyze, and report on the programmatic, managerial and fiscal effectiveness of the health benefits contract.
- Review, analyze, and report on any issues pertaining to claims and costs of the Workers' Compensation Program as it relates to AmeriCorps*VISTA.
- Provide support to the unit manager and the participant support specialist on any procurement issues related to the AmeriCorps*VISTA portion of the cooperative agreement between the Corporation and the National Association of Child Care Resource and Referral Agencies (NACCRRA) for provision of child care allowance.
- Provide general procurement support for AmeriCorps*VISTA operations.

Expected Accomplishments from Employee and Unit

- Provide technical assistance to AmeriCorps*VISTA with regard to the health benefits contract, including reviewing the impact of health legislation and issues with regard to the quality of health support.
- Prepare and present periodic reports identifying costs and cost trends or any other pertinent management information related to the health benefits contract.
- Prepare quarterly adjustments to the health contract funding level based on cost share partnership billings.
- Analyze costs relating to AmeriCorps*VISTA's involvement in the cooperative agreement with NACCRRA on at least a quarterly basis.
- Prepare a short summation of procurement policies at the Corporation as they might pertain to AmeriCorps*VISTA procurement issues.
- As required, conduct research and prepare procurement instruments and documents.

Comparison of Work Plan to Position Description

After reviewing the HBA position description and the fiscal year 1996 work plan, we noted significant differences in both terminology and the level of detail. The work plan does not explicitly list the various responsibilities, analyses, and reports included in the position description. Instead, the work plan provides only a general understanding of where efforts are to be focused.

The following table presents a comparison of the duties listed in the position description to the tasks listed in the work plan:

Duty from Position Description	Related Task(s) from Work Plan	Comparability
Determine the health priorities and medical needs of participants. Determine and report on the adequacy and conformity of the health delivery system as related to the Corporation's long-term goals and objectives. Provide direction and advice in the area of health policies and programs for the Corporation.	Review, analyze and report on the programmatic, managerial and fiscal effectiveness of the health benefits contract. Provide technical assistance to AmeriCorps*VISTA with regard to the health benefits contract.	Moderate
Develop and implement improvements in the delivery of health services, based on analyses of morbidity rates and costs of health services delivery.	Review, analyze and report on the programmatic, managerial and fiscal effectiveness of the health benefits contract.	Little
Develop methods and provide cost effectiveness analyses aimed at improving service and reducing costs of the health support system.	Prepare and present periodic reports identifying costs and cost trends or any other pertinent management information related to the health benefits contract.	Strong
Serve as the COTR for the health benefits contract by assuring that the contract is administered in accordance with Federal and Corporation procurement regulations and policies.	Provide general procurement support for AmeriCorps*VISTA operation.	Little
Cooperate with the Corporation's IG to support audits and, as appropriate, investigations of the health benefits program. Provide health contract data to private consultants who provide actuarial advice and analyses and who project health care cost trends.	No related task.	None
Develop periodic reports regarding significant issues of participants' health care delivery, costs analyses and related topics.	Review, analyze and report on the programmatic, managerial and fiscal effectiveness of the health benefits contract.	Little
Serve as the Corporation's representative for the Office of Workers' Compensation Program claims system regarding workers' compensation claims of all full-time AmeriCorps*VISTA Participants, NCCC Corpsmembers and Leaders.	Review, analyze and report on any issues pertaining to claims and costs of the Workers' Compensation Program as it relates to AmeriCorps*VISTA.	Moderate

As illustrated in the above table, the tasks within the work plan do not fully address the duties listed in the position description in that several of the position description duties have either minimal or no coverage in the work plan. This is significant because the work plan represents the HBA and management's agreement as to the HBA's role in the oversight and monitoring function. Without adequate detail, the HBA might not understand his required duties and responsibilities, which could cause certain oversight and monitoring functions not to be performed.

Comparison of Corporation Oversight Goals to Position Documentation

To evaluate the Corporation's oversight and monitoring function, the duties of the HBA, as described in the position description, were compared to the four Corporation goals. The following matrix provides the comparison:

Oversight Goals Coverage by Health Benefits Analyst Duties				
Duties Listed in Health Benefits Analyst Position Description	**Oversight and Monitoring Goals**			
	Contractual Compliance	**Cost Containment**	**Cost Forecasting**	**Benefits Maximization**
Determine the health priorities and medical needs of participants. Determine and report on the adequacy and conformity of the health delivery system as related to the Corporation's long-term goals and objectives. Provide direction and advice in the area of health policies and programs for the Corporation.	Strong	Moderate	N/A	Moderate
Develop and implement improvements in the delivery of health services, based on analyses of morbidity rates and costs of health services delivery.	Moderate	Strong	N/A	Strong
Develop methods and provide cost effectiveness analyses aimed at improving service and reducing costs of the health support system.	Moderate	Strong	N/A	Strong
Serve as the COTR for the health benefits contract by assuring that the contract is administered in accordance with Federal and Corporation procurement regulations and policies.	Strong	N/A	N/A	N/A
Cooperate with the Corporation's IG to support audits and, as appropriate, investigations of the health benefits program. Provide health contract data to private consultants who provide actuarial advice and analyses and who project health care cost trends.	Moderate	Moderate	Moderate	N/A
Develop periodic reports regarding significant issues of participants' health care delivery, costs analyses and related topics.	N/A	Strong	Strong	N/A

Oversight Goals Coverage by Health Benefits Analyst Duties				
Duties Listed in Health Benefits Analyst Position Description	Oversight and Monitoring Goals			
	Contractual Compliance	Cost Containment	Cost Forecasting	Benefits Maximization
Serve as the Corporation's representative for the Office of Workers' Compensation Program claims system regarding workers' compensation claims of all full-time AmeriCorps*VISTA Participants, NCCC Corpsmembers and Leaders.	N/A	N/A	N/A	Moderate

The above comparison shows that the Corporation has developed a HBA position description that effectively addresses the Corporation's oversight and monitoring goals.

Contractual Oversight Provisions

The health benefits contract with OASYS contained specific provisions designed to facilitate the Corporation's oversight function. These provisions can be grouped into seven categories: Contract Term, Required Reports, Technical Direction, Claims Processing Schedule, Internal Claims Audits, and Annual Reviews. These categories are detailed below.

1. Contract Term

   The contract with OASYS allowed for a variable-term obligation at the discretion of the Corporation. The contract's original term was only one year. In addition to this initial term, the Corporation had the option to extend for up to three additional one-year periods. Upon expiration of either the initial contract term or any of the first two one-year extension options, the Corporation had the ability to call for termination. Written notice was required sixty calendar days before termination, with the Corporation being liable for the remaining paid claims and the associated administrative fee.

   This variable-term design was an effective escape clause for the Corporation in the event of unsatisfactory performance on the part of OASYS. It gave the Corporation the ability to demand quality service throughout its contractual relationship with OASYS.

2. Required Reports

   The health benefits contract also required OASYS to provide specified reports at stated intervals. The required reports are:

   - Monthly Financial Report of current month and year to date financial data; e.g., submitted charges, charges not covered, paid charges, administrative fees.
   - Monthly Large Claim Report listing all individuals claims, including diagnosis and dollar amount, above a pre-determined dollar level.
   - Monthly Enrollment/Eligibility Report for internal control and verification of eligibility updates.
   - Monthly Claim Detail Report indicating paid claims by plan participant.
   - Quarterly Hospital Utilization and Expenditures by hospital and MDC/DRG (Major Disease Classifications/Diagnosis Related Group), i.e. admissions, days, average length

of stay, total charges, total paid, average charges per day, average charges per admission, day of week for admissions.

- Quarterly Outpatient Utilization and Expenditures by place, type of service (including lab and prescription drugs) and type of provider.
- Quarterly Most Frequent Outpatient Surgical Report with frequency, total charges, and total paid.
- Quarterly Coordination of Benefits (COB) and Subrogation report with charges, payment amount recovered, percent savings, savings resulting from Medicare payments.
- Quarterly Claim Lag Report showing month of service and claim payment date.
- Annual Experience Report.

In addition, the contract also required that OASYS deliver Corporation-dictated custom reports on an as-requested basis.

3. Technical Direction

The health benefits contract also allowed the Corporation a certain degree of "technical direction" of OASYS. This included:

- Instruction to OASYS that redirects the contract effort, or shifts emphasis between work areas; or tasks designed to pursue certain lines of inquiry, fill in details, or otherwise serve to accomplish the contractual statement of work.
- Provision of written information to OASYS that assists in interpretation of specifications or technical portions of the work description.
- Review and, where required by the contract, approval of the technical information to be delivered by OASYS.

This clause increased the Corporation's ability to direct OASYS's performance in order to achieve the Corporation's goals for the health benefits program.

4. Claims Processing Schedule

In addition to establishing the specific procedures that OASYS must use to process claims, the contract also defined the timeframes in which OASYS had to complete these procedures. Specifically, claims must be processed according to the following averages:

- 90% of clean claims had to be processed within 14 days.
- 90% of coordination of benefits claims had to be processed within 28 days.
- 85% of ineligible claims had to be processed within 14 days.

This schedule gave the Corporation specific benchmarks to be used to evaluate OASYS's performance.

5. Internal Claims Audits

The Corporation's contract with OASYS also required that OASYS obtain internal quality assurance in the form of periodic internal audits. On a weekly basis, OASYS was to choose a statistical sample of processed claims and audit these claims through the claims processing

system. This system was required to maintain a daily log of all transactions entered; track by bill line within claim, claims processor, type of transaction, and record modification; and track date and time of transaction.

6. Annual Reviews

   Finally, the contract mandated that the Corporation perform an annual compliance review of OASYS's performance. The Corporation was to initiate this review in the seventh month of each contract year. Upon review initiation, OASYS was required to provide the Corporation with all requested information. The Corporation or their contractor was required to audit this information within the following two months.

Comparison of Oversight Goals to Contractual Oversight Provisions

In order to evaluate how successfully the contract facilitates the Corporation oversight goals, the oversight and monitoring provisions found in the OASYS contract were compared to the Corporation's goals. The following matrix provides an analysis of this issue:

Facilitation of Oversight Goals by Contractual Oversight Provisions				
Contractually Permitted Oversight Activities	**Oversight and Monitoring Goals**			
	Contractual Compliance	**Cost Containment**	**Cost Forecasting**	**Benefits Maximization**
Contract Term Structure	Moderate	Little	N/A	Moderate
Reports Required from OASYS	Strong	Strong	Strong	Strong
Technical Direction	Little	Moderate	N/A	Moderate
Claims Processing Schedule	Moderate	N/A	N/A	Strong
Internal Audits	Moderate	N/A	N/A	Moderate
Annual Compliance Reviews	Strong	Strong	N/A	Strong

The above comparison shows that the contractual oversight provisions support the Corporation's oversight and monitoring goals.

Summary of Current Oversight Activities

As shown above, both the HBA position description and the contractual oversight provisions support the Corporation's goals for the oversight and monitoring of the health benefits program. However, the activities performed by the HBA determine how effectively the oversight and monitoring goals are met. These activities (Eligibility Data Maintenance, Customer Service Monitoring, Receipt and Review of Reports, Cost Analysis and Tracking, Internal Audit Review, Annual Compliance Review, and Other Monitoring Activities) are described below.

1. Eligibility Data Maintenance

   The maintenance of participant data is critical to the Corporation's health benefits program. This data allows OASYS to determine participant eligibility. It also allows for the evaluation of other factors such as pre-existing conditions and the coordination of benefits. Thus, without reliable participant eligibility data, OASYS is unable to accurately determine benefits plan costs or to guarantee the satisfaction of plan participants.

   OASYS is limited in its ability to ensure the accuracy of its eligibility data. The data can only be as accurate as the updates received from the Corporation. The various state VISTA offices are responsible for entering new and updated participant data and appear to be doing so on a timely basis. Therefore, the accuracy of eligibility data is primarily dependent on the timeliness of the Corporation's updates to OASYS.

   The Corporation maintains participant data in one of two ways. The VISTA program comprises the majority of the health benefits program participants. Information for VISTA participants is maintained in the VISTA Management System (VMS). VMS is a real-time Oracle database updated by State Program Assistants in the various state offices. As such, once data has been entered, it is immediately available to all users in the network. Because this data is maintained in the VMS system, it must be batched before it can be sent to OASYS. This batching procedure is generally performed twice a month.[2] Once batched, the data is compressed and encrypted using pkWare pkZip 2.04g, and forwarded to OASYS via e-mail.

   Information for NCCC, AmeriCorps Leaders, and AmeriCorps Fellows is maintained in a spreadsheet maintained at Corporation headquarters. NCCC updates are sent in a spreadsheet file to OASYS via e-mail. This file is compressed and encrypted using the pkWare pkZip 2.04g package. NCCC updates are sent as necessary. AmeriCorps Leaders and AmeriCorps Fellows data updates are normally transmitted via fax or telephone, also on an as-needed basis. Data updates for the Leaders and Fellows programs do not require files transfers as their number is very small (combined total being approximately 30).

2. Customer Service Monitoring

   The HBA also monitors the overall service provided to participants by OASYS. OASYS must provide fair and complete deliberation of grievances and claim appeals, a toll-free telephone number for exclusive use by Corporation plan participants, and timely processing of participant claims. The HBA must monitor each of these services.

[2] See related finding No. 9, *The Corporation does not update OASYS eligibility data on a timely basis.*

The Corporation does not have an established system to monitor grievances and appeals.[3] Instead, they are addressed on a case-by-case basis. The state offices notify the HBA of participant concerns, and the HBA contacts OASYS to ensure the matter is being addressed. During our discussions with the HBA, he stated that he has overruled decisions made by OASYS's medical review team when he thought the final decision was unfair. In these cases, the HBA approved the payment of claims that had been denied by OASYS.[4]

To monitor other customer service activities, including the toll-free number and the timeliness of claims processing, the HBA uses reports sent by OASYS. These reports are discussed in the following section.

3. Receipt and Review of Reports

As previously stated, the Corporation was entitled to receive a number of reports detailing health benefits program activity, as well as to request other reports as deemed useful. These reports were to be sent by OASYS on a regular schedule.

The HBA's responsibility is to review these reports. Furthermore, as stated in the position description, the HBA should perform detailed analyses on the data contained within these reports and identify trends as they occur. However, the HBA stated that he found many of the reports unnecessary, and requested that OASYS stop sending most of the required reports.[5] The HBA now receives only one report, which includes several graphs and charts and:

- a Pharmacy Activity Report, including extremely detailed pharmacy-related reports such as a Therapeutic Class Summary, a Specific Therapeutic Class Summary, a Prescription Drug Utilization Report by Age/Sex, a Prescription Drug Utilization Report, a Mail Order Prescription Drug Utilization Report, a COBRA Funding Level Report, a Group Prescription Usage Summary Report, a Top 50 Drugs by Number of Prescriptions Report, a Top 50 Drugs by Cost Report; and
- a Split Report, which includes the details of each claim paid during the week. This is used to support the weekly medical invoices.

With the exception of the Pharmacy Activity and Split reports, the information received does not provide the level of detail as required in the contract. Furthermore, little if any analysis of the Pharmacy Activity and Split reports was performed.

The graphs contained in the monthly report are useful in gaining a quick understanding of certain aspects of OASYS's performance, and allow the Corporation to act on problems, as they become apparent. Minor problems have been corrected with relative ease, requiring only a telephone call to the OASYS representative. More serious problems required further action on the part of the HBA. For example, during the last few months of fiscal year 1998, claims processing timeliness and the speed of answer declined severely. The HBA quickly enacted a contract modification. This modification required OASYS to increase the staffing level to ensure the timely processing of claims. Furthermore, the HBA ensured that the new contract (beginning October 1, 1998) required OASYS to provide adequate staffing at all times. As the volume of calls fluctuates, OASYS must adjust the number of staff answering the calls.

[3] See related finding No. 8, *The Corporation does not keep a log of participant appeals.*
[4] See related finding No. 4, *The Health Benefits Analyst overrules medical review decisions.*
[5] See related finding No. 7, *OASYS was requested to stop sending many of its contractually mandated reports.*

While these reports have helped the Corporation to identify and correct problems with OASYS's service, they do not provide the Corporation with the detailed utilization information necessary to allow for a clear and comprehensive understanding of health benefits program performance and trends.[6]

4. Cost Analysis and Tracking

   Per the position description, the HBA should monitor and track costs, with a focus on cost containment. The actual activities performed in this area do not fulfill these responsibilities.

   The HBA's cost analyses have been limited to an analysis of the information included on the monthly administrative invoices[7] and in the weekly medical invoices.[8] To track the charges within these invoices, the HBA maintains two spreadsheets. The first spreadsheet divides costs by the various fund codes. The HBA then uses this spreadsheet to monitor funding under each fund code. When funding gets low, the HBA initiates a corrective contract modification. The second spreadsheet divides costs by month, program, and location. Per our discussions with the HBA, no further analysis is performed.

5. Internal Audit Review

   As previously mentioned, the Corporation's health benefits contract requires the performance of regular internal audits by OASYS. Aside from an internal control audit performed during 1997, and an internally prepared review of the costs billed for the 1994 through 1998 contract period, we saw no evidence of regular internal audits reported to the Corporation. The HBA stated that he has neither seen, nor requested documentation of regular internal audits performed by OASYS.[9]

6. Annual Compliance Review

   The Corporation is contractually mandated to perform annual compliance audits, as previously described. According to the HBA, no annual compliance audit has ever been initiated by the Corporation. The Corporation instead holds an annual meeting with OASYS to discuss performance during the previous contract year and to consider exercising an extension option of the contract.[10]

7. Other Monitoring Activities

   The HBA also monitors current events in healthcare legislation. Working in conjunction with OASYS's Government Affairs division, the HBA's counterpart at the PeaceCorps, the Office of the General Counsel, and other related Federal agencies, the HBA identifies and considers healthcare policy issues as they relate to the Corporation's health benefits program. Most recently, the HBA determined the possible effects of the Health Insurance Portability and Accountability Act (HIPPA) on the Corporation.

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[6] See related finding No. 7, *OASYS was requested to stop sending many of its contractually mandated reports.*
[7] See related finding No. 10, *Administrative invoices containing insufficient breakdowns of costs were consistently approved and paid by the Corporation.*
[8] See related finding No. 11, *The Health Benefits Analyst certifies and approves invoices for payment prior to reviewing them.*
[9] See related finding No. 6, *The Corporation does not review the results of OASYS internal audits.*
[10] See related finding No. 5, *The Corporation does not perform annual compliance reviews of OASYS.*

Mapping of Oversight Activities Performed to Performance Standards

In order to evaluate the Corporation's actual oversight of the OASYS contract, the oversight and monitoring procedures actually being performed were compared to the Corporation's goals for the oversight function, the HBA position description, and the Corporation's contractually specified rights. The three matrixes found below provide the appropriate comparisons.

The first matrix is a comparison of the Corporation's goals, as previously stated, to the actual activities performed. This comparison illustrates the Corporation's effectiveness in meeting its own standards.

Coverage of Oversight Goals by Activities Performed				
Actual Activities Performed (As Previously Defined)	**Oversight and Monitoring Goals**			
	Contractual Compliance	**Cost Containment**	**Cost Forecasting**	**Benefits Maximization**
Eligibility Data Maintenance	N/A	Little	N/A	Moderate
Customer Service Monitoring	Moderate	N/A	N/A	Moderate
Receipt and Review of Reports	Moderate	Little	N/A	Moderate
Cost Analysis and Tracking	N/A	Little	None	N/A
Internal Audit Review	None	None	N/A	N/A
Annual Compliance Review	None	None	N/A	N/A
Other Monitoring Activities	N/A	N/A	N/A	Little

This comparison shows that the Corporation's goals, as previously defined, are not being adequately achieved.

The second matrix is a comparison of the position description to the actual activities performed. This comparison shows how effectively the HBA is fulfilling his duties per the position description.

Coverage of Required Duties by Activities Actually Performed							
Duties Listed in Health Benefits Analyst Position Description	**Actual Activities Performed (As Previously Defined)**						
	Eligibility Data Maintenance	**Customer Service Monitoring**	**Receipt and Review of Reports**	**Cost Analysis & Tracking**	**Internal Audit Review**	**Annual Compliance Review**	**Other Monitoring Activities**
Determine the health priorities and medical needs of participants. Determine and report on the adequacy and conformity of the health delivery system as related to the Corporation's long-term goals and objectives. Provide direction and advice in the area of health policies and programs for the Corporation.	N/A	Mod-erate	Mod-erate	None	None	None	Mod-erate
Develop and implement improvements in the delivery of health services, based on analyses of morbidity rates and costs of health services delivery.	N/A	Little	Little	None	None	None	N/A
Develop methods and provide cost effectiveness analyses aimed at improving service and reducing costs of the health support system.	N/A	N/A	Little	None	None	None	N/A
Serve as the COTR for the health benefits contract by assuring that the contract is administered in accordance with Federal and Corporation procurement regulations and policies.	N/A	N/A	Mod-erate	None	None	None	N/A

Coverage of Required Duties by Activities Actually Performed							
Duties Listed in Health Benefits Analyst Position Description	**Actual Activities Performed (As Previously Defined)**						
	Eligibility Data Maintenance	**Customer Service Monitoring**	**Receipt and Review of Reports**	**Cost Analysis & Tracking**	**Internal Audit Review**	**Annual Compliance Review**	**Other Monitoring Activities**
Develop periodic reports regarding significant issues of participants' health care delivery, costs analyses and related topics.	N/A	N/A	None	None	N/A	N/A	N/A

This comparison shows that the activities actually performed by the HBA provide limited coverage of the duties set forth in the related position description.[11]

[11]See related finding No. 2, *The Health Benefits Analyst lacks clinical experience and knowledge*, and finding No. 3, *Not all duties specified in the Health Benefits Analyst position description are being performed.*

The third matrix is a comparison of the activities that should be performed under the contract to the activities that are actually performed. This comparison shows how effectively the Corporation is exercising their contractual rights in achieving the Corporation's goals.

Utilization of Contractually Allowed Activities by Actual Activities						
Actual Activities Performed (As Previously Defined)	**Contractually Allowed Activities (As Previously Defined)**					
	Contract Term Structure	**Reports Required from OASYS**	**Technical Direction**	**Claims Processing Schedule**	**Internal Audits**	**Annual Compliance Reviews**
Eligibility Data Maintenance	N/A	N/A	N/A	N/A	N/A	N/A
Customer Service Monitoring	N/A	N/A	Moderate	N/A	N/A	N/A
Receipt and Review of Reports	N/A	Little	Moderate	Moderate	N/A	N/A
Cost Analysis and Tracking	N/A	Little	N/A	N/A	N/A	N/A
Internal Audit Review	N/A	N/A	N/A	N/A	None	N/A
Annual Compliance Review	Moderate	N/A	N/A	N/A	N/A	None
Other Monitoring Activities	N/A	N/A	N/A	N/A	N/A	N/A

This comparison shows that the Corporation is not making full use of its contractually allowable oversight and monitoring activities.

It also clearly illustrates that the oversight and monitoring activities currently being performed by the HBA are not adequately addressing the oversight and monitoring function. Therefore, the Corporation's goals are not being fully met, the HBA is not fulfilling all the responsibilities of his position, and the Corporation is not making full use of its contractual oversight and monitoring rights.

Findings and Related Recommendations for Corrective Action

Having determined that the oversight and monitoring activities being performed do not adequately address the Corporation's related standards, we identified the specific weaknesses noted during our audit that, we believe, have contributed to this condition. We have placed the findings in order of relative importance. We have incorporated the Corporation's responses into these findings and have responded as appropriate.

1. **The Corporation has no formal policies and procedures related to the oversight and monitoring function.**

   Upon beginning our engagement to audit the Corporation's oversight of its contract with OASYS, we requested documentation to assist in gaining an initial understanding of the oversight and monitoring environment. Included in this information request was the portion of the Corporation's Policies and Procedures Manual applicable to oversight and monitoring.

   According to the HBA and the Acting Director of AmeriCorps*VISTA, no official policies and procedures exist relating to this subject. As a result, the Corporation was unable to provide us with this information.

   Best practices suggest that organizations maintain formal written policies and procedures providing guidance on every major work function.

   The lack of a complete policies and procedures manual related to oversight and monitoring constitutes a serious internal control deficiency. Currently, the HBA is the only staff member responsible for overseeing and monitoring the Corporation's health benefits contract with OASYS. When the current HBA eventually leaves this position (through personal choice, promotion, etc.), the Corporation could experience difficulties training a capable replacement. As a result, the oversight and monitoring of the health benefits contract may be further jeopardized.

   Furthermore, the lack of formal policies has left the HBA with no formal guidance for performing his job. Accordingly, the HBA has had to decide how to best meet the needs of the position, and we believe that he occasionally has made decisions that do not work to achieve the Corporation's goals. Established policies and procedures would minimize any misunderstandings of the required duties of the position.

   We recommend that the Corporation develop and implement formal policies and procedures surrounding the oversight and monitoring of its health benefits plan. These policies should be sufficiently detailed in order to eliminate confusion as to the role of the oversight and monitoring function. When developing these policies and procedures, the Corporation should consider the following: 1) reviewing its oversight and monitoring goals to ensure that the policies and procedures documented offer complete coverage of these goals; 2) reviewing the current HBA position description, as the duties listed within are extensive and offer full coverage of the Corporation's oversight and monitoring goals; 3) consulting with the current HBA, as he is the best source of specific information regarding both the health benefits program and the Corporation's relationship with OASYS; and, 4) obtaining input from an expert in the healthcare industry who is capable of applying both extensive clinical knowledge and experience with industry best practices.

Corporation's Comment

AGREE – "The Corporation intends to draft policies and procedures related to the oversight and monitoring function."

PwC Response

We recommend that the Corporation establish specific milestones to help expedite this process.

2. The Health Benefits Analyst lacks clinical experience and knowledge.

We reviewed the HBA's résumé and noted that he had no clinical or healthcare management experience. The HBA's career had focused mainly on contract procurement. We noted evidence of only one training course related to healthcare in the personnel file of the HBA after he assumed his position. This two-day course, *The Health Care Management Certificate Program*, given at Georgetown University during December 1997, is no longer offered. Instead, the University currently offers an expanded one-week course.

The Health Benefits Analyst GS-301-12 position description, Section II, *Major Duties*, states that the HBA:

- "Independently develops methods and provides cost effectiveness analyses aimed at improving service and reducing the costs of health support system. Analyses would include, but not necessarily be limited to, a review of the participant medical claims payment system provided by the contractor, analysis of customary and reasonable fee schedules of the health contract, and analysis of customary and reasonable fee schedules of the health contractor for conformity to national physician and hospital profiles.
- Develops periodic reports regarding significant issues of participant health care delivery, cost analyses, and related topics. Examples of reports include identification and analyses of medical cost trends in participant health claims and their correlation of demographic and geographic factors; comparative analyses of annual participant medical costs versus previous years according to inpatient and outpatient care, diagnostic categories, average per diem costs, average length of stay in clinical facilities, and average inpatient case costs; and comparative analysis of participant medical costs versus costs of other subscriber plans operated by the health contractor according to the above-mentioned categories."

Due to a lack of clinical expertise, the HBA does not have the qualifications required to perform some of the duties required of his position. As a result, the Corporation's oversight goals are not met.

In order to ensure a satisfactory level of oversight and monitoring, the Corporation must require that the HBA either obtain or have access to the necessary clinical expertise. We believe that the Corporation should adopt one of the following recommendations:

- Require that the HBA participate in an extensive clinical training program. The HBA is currently the person most familiar with both the Corporation's health benefits program and its relationship with OASYS. Adequate training would allow the HBA to fulfill all the requirements included in his position description.
- Hire a clinical assistant to work with the HBA in performing the more clinically technical portions of his position. While this option would most likely be the most expensive, it may also prove to be the most beneficial in the end. As the VISTA, NCCC, and

AmeriCorps Leaders and Fellows programs grow, so will the health benefits program. As a result, the duties required of the HBA may eventually require more time than is available. By hiring a clinical assistant to assume the more technical responsibilities, the Corporation could potentially avoid this situation.

- Grant the HBA the authority to obtain outside expertise to periodically assist him in performing the technical analysis of claims and claims-related costs. This periodic assistance could be obtained for the performance of its annual compliance review of OASYS as specified in the health benefits contract and to assist with the more clinical data analyses.

Corporation's Comment (Summarized)

DISAGREE – The HBA completed a certification program in Health Care Management at Georgetown University in 1997. The program was not two days in duration. It was an eight-part program lasting one academic year.

In addition, the Corporation does not agree that report development and cost analysis require clinical expertise. If the HBA required information in order to perform these tasks, OASYS may provide what is needed. The clinically trained medical staff required of OASYS has proven sufficient over time. "At no time has the HBA needed a clinical healthcare background to properly execute contract administration, keep auditable records, transmit eligibility, do financial analysis to determine what improvements to the plan are financially feasible, answer customer service calls, process invoices, or keep track of new healthcare legislation." In addition, a Registered Nurse has recently been hired at the Corporation. The HBA may utilize her abilities on a part-time basis.

PwC Response

The Corporation provided further documentation of the Health Care Management certification program offered by Georgetown University in 1997, which appears to be more extensive than the HBA's personnel file indicated. However, because this program does not appear to have covered topics related to the analysis of clinical data, the issue described above remains unresolved.

The Corporation asserts that no clinical expertise is necessary to facilitate report development and cost analysis, stating that both the current and former HBA have never needed a clinical healthcare background to "properly execute contract administration". We disagree with this assessment. The HBA's job description is quite specific as to the various reports and analyses that are required to be completed. Many of these responsibilities, including "[analyses] of customary and reasonable fee schedules of the health contractor for conformity to national physician and hospital profiles" and "comparative analyses of annual participant medical costs versus previous years according to inpatient and outpatient care, diagnostic categories, average per diem costs, average length of stay in clinical facilities, and average inpatient case costs", do require a very specialized knowledge base with at least some clinical understanding. We believe that the lack of this understanding is the reason that many of the reports and analyses required by the position description and mentioned above have not been completed.

Furthermore, the Corporation stated that, if necessary, OASYS is available to provide the HBA with assistance in performing his responsibilities. We believe this to be a seriously flawed solution. The primary role of the HBA is to objectively oversee the contractual performance of OASYS. Therefore, allowing OASYS to assist in this process would be inappropriate.

Finally, the Corporation stated that a Registered Nurse has been hired and will be available to the HBA on a part-time basis. We believe that this may be an improvement, if this Registered Nurse is familiar with utilization management and review activities.

3. Not all duties specified in the Health Benefits Analyst position description are being performed.

Through discussions with the HBA, we noted that certain responsibilities as detailed in the Corporation's HBA position description are not being completely fulfilled. Specifically, these responsibilities include:

- Developing methods and providing cost effectiveness analyses aimed at improving service and reducing the costs of the health support system;
- Assuring the contract is administered in full accordance with Federal and Corporation procurement regulations and policies; and
- Developing periodic reports regarding significant issues of participants' healthcare delivery, cost analyses, and related topics.

As described in the previous finding, the HBA is not fully qualified to perform some of the duties required in his position description. The HBA lacks a clinical background and, as a result, may not fully understand the breadth of his required duties. Furthermore, the HBA's annual work plans have contributed to the problem as they do not adequately address the responsibilities of the position. These plans are co-developed by the HBA and his supervisor and are used as benchmarks against which to assess the HBA's performance. While the terminology used in the work plans could be interpreted as including all duties as outlined in the HBA position description, the extent to which these duties must be performed is not addressed.

The Corporation's Health Benefits Analyst GS-301-12 position description, Section II, *Major Duties*, states that the HBA:

- "Independently develops methods and provides cost effectiveness analyses aimed at improving service and reducing the costs of health support system. Analyses would include, but not necessarily be limited to, a review of the participant medical claims payment system provided by the contractor, analysis of customary and reasonable fee schedules of the health contract, and analysis of customary and reasonable fee schedule of the health contractor for conformity to national physician and hospital profiles.
- Serves as the Corporation's Contracting Officer Technical Representative (COTR) for the AmeriCorps*VISTA, NCCC and Leaders' health services contract. Assures the contract is administered in full accordance with Federal and Corporation procurement regulations and policies. Serves as primary liaison with contractor on programmatic aspects of administration of health benefits contract. Independently develops Statements of Work (SOW) and other documentation as required for AmeriCorps*VISTA.
- Develops periodic reports regarding significant issues of participant health care delivery, cost analyses and related topics. Examples of reports include identification and analyses of medical cost trends in participant health claims and their correlation of demographic and geographic factors; comparative analyses of annual participant medical costs versus previous years according to inpatient and outpatient care, diagnostic categories, average per diem costs, average length of stay in clinical facilities, and average inpatient case

costs; and comparative analysis of participant medical costs versus costs of other subscriber plans operated by the health contractor according to the above-mentioned categories.

- Independently develops periodic reports for the Program and Field Support Manager, the NCCC and Corporation senior management. These reports may be prepared by the contractor at the direction of the incumbent, or may be prepared in house."

The duties enumerated in the Health Benefits Analysis position description are extensive, and specifically address all of the Corporation's goals surrounding the health benefits program. However, by not adequately including each duty in the HBA's workplan and therefore not performing all of these duties, the Corporation's oversight and monitoring goals are not being fully met.

The Corporation must provide the HBA with more guidance regarding his specific job responsibilities. We recommend that Corporation management meet with the HBA to candidly discuss the actual duties performed as compared to the duties required by the HBA position description. As mentioned above, the Corporation must also develop a definitive set of policies and procedures to assist the HBA in performing all his duties. Furthermore, the HBA's annual work plan should include a more comprehensive set of expectations to reflect the extensive requirements of the job. If it is determined that the HBA position has grown to exceed the capacity of its current staffing, the Corporation should explore other options, including training, hiring a clinical assistant, or obtaining outside assistance.

Corporation's Comment (Summarized)

DISAGREE – "The finding that the position description and work plan differ is accurate. However, these documents are intended to be different. The position description is more detailed because it must encompass all tasks that might be performed over a long period of time while the workplan is merely intended to describe those tasks the employee accomplished or will accomplish over a twelve month period."

The auditors note three responsibilities of the HBA that are not being completely fulfilled.

"With regard to the first point, it should be noted that since the HBA began working in his current capacity in 1994, the following changes have been made to the health plan. The ProVantage pharmacy network was utilized allowing members to pick up medication with their insurance card and a prescription. This made the mail order service obsolete and the need for reimbursements for pharmacy unnecessary. A $5 co-payment was utilized to reduce unnecessary trips to the doctor's office. Eligibility files have gone from using reel tape to a modem to an encrypted file which is sent over the internet. All of these changes were made in order to improve service and reduce cost.

With regard to the second point, 45 contract modifications show that the contract has been administered in full accordance with all procurement regulations and policies.

With regard to the third point, reports are readily available which address healthcare delivery and cost analysis. The monthly reports generated by the contractor address the issue of administrative efficiency while the HBA generates reports related to cost analysis.

Finally, on page 9, the auditor states that there is no related task from the work plan which corresponds to the position description requirement to cooperate with the Corporation's IG. Clearly, however, it is assumed that this will be done if necessary."

PwC Response

The Corporation's first comment addresses the inherent differences between a position description and a work plan. While we agree that these documents should differ, we do not agree with the Corporation's assessment of the purpose of a position description. This document does not list all tasks that might be performed over the long term, but instead lists the tasks that **must** be performed over the long term.

The Corporation's second point asserts that, by making changes to the health plan, the HBA has successfully fulfilled his responsibility to "[develop] methods and [provide] cost effectiveness analyses aimed at improving service and reducing the costs of the health support system". While we agree that the HBA has made efforts to improve service, we saw no evidence of potential/actual cost savings analyses associated with planned/implemented health plan changes.

The Corporation next states that by making 45 contract modifications, the HBA ensured that the contract was administered in full accordance with all procurement regulations and policies. We disagree with this assessment. The existence of 45 contract modifications proves only that the contract has been changed. It does not prove compliance with Federal and Corporation procurement regulations. While we were unable to assess the HBA's performance as compared to Corporation regulations and policies (as discussed in Finding No. 1), we did note specific examples of non-compliance with the Federal Acquisition Regulation and the contract terms. For example, as noted in Finding No. 10, during the four years under audit, OASYS consistently submitted invoices that were in non-compliance with the requirements set forth in the contract (see Contract No. 95-743-1005, Section G-3, *Invoices*) and requirements under the Federal Acquisition Regulation. These invoices were accepted, generally without question, and authorized for payment by the HBA. In addition, we noted that OASYS was consistently in non-compliance with the contract in regard to claim processing timeliness (see Contract No. 95-743-1005, Attachment 1, page 23, *Claims Processing Time*). We also noted that the HBA has not initiated the contractually required annual compliance reviews of OASYS as documented in Finding No. 5 (see Contract No. 95-743-1005, Attachment No. 1, page 28, *Review of Contractor's Performance*). Finally, we noted that the HBA requested that OASYS stop sending many of the contractually mandated reports (see Contract No. 95-743-1005, Attachment No. 1, pages 21-22, *Contractor Reports)*, as documented in Finding No. 7.

In the third point, the Corporation asserts that there are reports readily available addressing both delivery and cost analysis. While this may be true, these reports do not fulfill the requirements set forth in the HBA position description. As mentioned above, the position description requires that the HBA "[develop] periodic reports regarding significant issues of participant health care delivery, cost analyses and related topics. Examples of reports include identification and analyses of medical cost trends in participant health claims and their correlation of demographic and geographic factors; comparative analyses of annual participant medical costs versus previous years according to inpatient and outpatient care, diagnostic categories, average per diem costs, average length of stay in clinical facilities, and average inpatient case costs; and comparative analysis of participant medical costs versus costs of other subscriber plans operated by the health contractor according to the above-mentioned categories." Neither the reports generated by the HBA nor those submitted by OASYS fulfill the specific requirements set forth above.

Finally, the Corporation states that the position description requirement of cooperating with the Corporation's OIG should be "assumed" to be part of the work plan. Assumptions should not and cannot be made when performing any type of review.

4. The Health Benefits Analyst overrules medical review decisions.

Through our discussions with the HBA, we noted that he has, on occasion, overruled OASYS medical review team decisions to deny payment of claims. This is not the HBA's responsibility.

According to the HBA, he had received complaints from participants regarding these medical decisions. After hearing their cases, the HBA decided that the outcome was unfair and chose to allow payment of the claims.

Contract No. 95-743-1005, Attachment No. 1, pages 27-28, *Appeal Process,* states the following:

"To resolve claim disputes, ... participant shall write or call the VISTA/NCCC/AmeriCorps Leaders dedicated service unit. Once the [service representative] receives the call or written inquiry, he or she shall research the question or concern, retrieve copies of the claim in question, and/or other pertinent information. Coding, benefit appropriateness, pricing, and patient historical data shall be verified depending on the specific situation. Once a complete evaluation is made, the [representative] shall notify the patient of the outcome. If medical review is necessary, a nurse reviewer is assigned to the case. If a higher level review is required, a physician consultant specializing in the services performed is assigned. The average time to respond to a request for an appeal shall be ten (10) calendar days."

While the HBA is responsible for determining the health priorities and needs of the participants, he is also responsible for ensuring that the program is administered as designed and that costs are maintained. Thus, by overriding decisions made by medical clinicians, the HBA (who is not medically trained) is not fulfilling his duties to management by impeding the effective operation of the health benefits program and incurring additional and unnecessary costs. In addition, the HBA has created a potential legal liability for the Corporation by allowing unequal treatment of plan participants, and encouraging potentially unnecessary medical procedures.

Since the HBA is not qualified to make medical decisions, we recommend that he stop reviewing medical records. It is important that the HBA review the administrative details of the process used to denied claims. However, OASYS appears to be complying with the medical review process as designed by the agreement. Thus, medical decisions have been made by qualified clinicians, and the HBA should accept the judgement of these professionals.

Corporation's Comment

DISAGREE – "It is neither a matter of practice nor policy to overturn decisions made by our contractor's medical review department. If medical evidence exists which would reverse such a decision, the HBA will see that it is acquired. Occasionally, for administrative reasons, medical bills will be paid which otherwise would not have been paid. These administrative exceptions are rare. As our contractor processes approximately 50,000 health claims each year, an exception would be made about once for every two thousand claims processed. If, for example, a member is injured in an automobile accident on the way to orientation, the Corporation has no responsibility to pay the bill. However, the HBA will see

that the medical bill is paid if asked by the state staff. The logic used is that the member would not have been driving if not for the need to report to orientation.

At no time has the HBA unilaterally overturned a medical decision for medical reasons without supporting medical evidence. The Corporation administers the program in a responsible manner and maintains cost-effectiveness. In the few instances where the Corporation has made a determination different from that of [OASYS], this has been done with the review and approval of the HBA's supervisor."

PwC Response

In this comment, the Corporation gives several reasons explaining why the HBA might agree to pay a claim for which the Corporation is not responsible. While we understand that this is a self-insured health plan and that the Corporation may choose to pay for non-covered benefits, the HBA is specifically prohibited by the contract from overturning a contractually correct payment decision made by OASYS. According to the contract (No. 95-743-1005, Section G.2 – Technical Direction), "The COTR DOES NOT have the authority to and may not issue any technical direction which ... change[s] any of the expressed terms, conditions or specifications of the contract."

In addition, the Corporation states that the HBA does not overturn medical decisions without supporting medical evidence. However, at no time have either the Corporation or OASYS been able to produce documentation or an explanation as to the nature of this medical evidence. In addition, since the HBA has no clinical background, additional medical evidence should be submitted to, and the resultant decisions made by the clinically trained medical review team at OASYS.

Finally, the Corporation states that when the HBA has overturned an OASYS payment decision, it was done so with the review and approval of the HBA's supervisor. However, we saw no evidence that such a review or approval took place. In fact, while on-site at OASYS during Task II, we noted several instances where verbal payment authority had been given by the HBA over the telephone. Additionally, with the absence of policies and procedures related to the administration of this benefits plan, there is nothing to indicate that the Corporation management considers such an action by the HBA as appropriate, even with the approval of his supervisor.

5. The Corporation does not perform annual compliance reviews of OASYS.

We noted that the Corporation does not perform an annual contract compliance review of OASYS. In addition, no suitable alternate procedures are in place to test the appropriateness and reasonableness of healthcare claims processed by OASYS.

The Corporation has consistently chosen not to perform the contractually mandated annual performance review of OASYS. The Corporation instead relies on other activities, such as monitoring reports generated by OASYS and responding to claims-related problems, to obtain assurance of OASYS's compliance.

Contract No. 95-743-1005, Attachment No. 1, page 28, *Review of Contractor's Performance*, states that: "At the end of the seventh (7^{th}) month of operation of each contract year, a review of the contractor's compliance with the tasks enumerated under this statement of work will be initiated by the Corporation. The contractor shall provide all other necessary data requested by this statement of work so that the Corporation will be able to complete its review by the end of the ninth (9^{th}) month of contract operation."

As previously determined, none of the monitoring activities being performed by the Corporation provide reasonable assurance that OASYS is in substantial compliance with its contractual duties. Costs are tracked for accounting purposes. However, the billed costs are not reviewed for accuracy or reasonableness. In addition, there is no procedure in place to verify that processed claims are for eligible participants, or that only appropriate medical procedures have been allowed. Therefore, by not performing annual performance reviews, the Corporation opens itself up to the risks of unnecessarily high healthcare costs and poor administrative service.

We recommend that the Corporation make full use of its negotiated contract clauses and institute an annual compliance audit of OASYS. A statistical sample of processed claims should be selected, and certain attributes of these claims should be tested, such as the eligibility of participant receiving service, the allowability of services performed, the accuracy of medical costs billed, and the allowability of administrative costs billed. By performing this annual compliance audit, the Corporation could ensure that claims are reasonable, appropriate and processed in compliance with contractual standards. The audit would be a cost-effective method of providing the Corporation with greater assurance as to both the performance of OASYS and the accuracy of its healthcare costs. The Corporation management could request assistance from the Office of Inspector General in performing these reviews.

Corporation's Comment

AGREE – "The Corporation will explore having the HBA perform annual compliance reviews of OASYS."

PwC Response

We recommend that the Corporation immediately amend the HBA's annual workplan to include this activity.

6. The Corporation does not review the results of OASYS internal audits.

We noted that the Corporation does not review the results of the weekly internal audits performed by OASYS as required by the health benefits contract.

According to the HBA, OASYS has never sent a report on these weekly internal audits, nor has the HBA ever requested information about them.

Contract No. 95-743-1005, Attachment No. 1, page 28, *Internal Claims Audit*, states that: "Statistical samples of processed claims shall be audited on a weekly basis through the processing system which shall: maintain a daily log of all transactions entered into the system; track by bill line within claim, claims processor, type of transaction, and record modifications; and track date and time of transaction."

The internal audits required in the health benefits contract are designed to provide the Corporation with additional assurance regarding the accuracy and reasonableness of paid claims. By not reviewing the results of these audits, the Corporation is eliminating one of its oversight and monitoring functions, and reducing its assurance as to the accuracy of billed costs.

We recommend that the Corporation require OASYS to comply with its responsibility to complete weekly internal claims audits. The Corporation should also request that OASYS submit the detailed results of these audits. The Corporation should then review the audit

results and follow up on any findings noted. In addition, these internal audit results should be used in determining the scope of the Corporation's annual compliance review of OASYS.

Corporation's Comment

AGREE – "The Corporation will consider having the HBA perform a review of OASYS's internal audits."

PwC Response

The Corporation should immediately require OASYS to submit the results of these internal audits. In addition, the HBA's annual workplan should be amended to include the review of these audits.

7. OASYS was requested to stop sending many of its contractually mandated reports.

We noted that many reports required in the health benefits contract with OASYS are not being sent on a regular basis. The HBA instructed OASYS to send these reports on an "as needed" basis. The reports currently being received contain, for the most part, high level graphical data that allows only a summary understanding of certain aspects of OASYS's performance. There are only two reports being received that contain sufficient detail to allow for analysis, the Pharmacy Report and the Split Report. The HBA glances through these two reports, but does little, if any, analysis.

Contract No. 95-743-1005, Attachment No. 1, pages 21-22, *Contractor Reports*, states that "The contractor shall provide the following separate reports (one each for VISTA, NCCC, and AmeriCorps Leaders) within the times frames specified for each:

- Monthly Financial Report beginning at time of award [with] current month and year to date financial data; e.g., submitted charges, charges not covered (including separate line items for pre-existing conditions), paid charges, administrative fees.
- Monthly Large Claims Report beginning at the time of award listing all individual claims, including diagnosis and dollar amount, above a predetermined dollar level.
- Monthly Enrollment/Eligibility Report beginning at the time of award [to be used] for internal control and verification of eligibility updates.
- Quarterly Hospital Utilization and Expenditures [Report] beginning two months from date of award by hospital and MDC/DRG (admissions, days, average length of stay, total charges, total paid, average charges per day, average charges per admission, day of week for admissions).
- Quarterly Outpatient Utilization and Expenditures [Report] beginning two months from date of award by place, type of service (including lab and prescription drugs) and type of provider.
- Quarterly Most Frequent Outpatient Surgical Report [beginning] two months from the date of award with frequency, total charges, and total paid.
- Quarterly Coordination of Benefits and Subrogation Report beginning two months from date of award showing months of service and claim payment date.
- Monthly Claim Detail Report beginning two months from date of award indicating paid claims by plan participant.
- Annual Experience Report due three months from date of award.

- Special Reports as required."

The HBA is responsible for ensuring that OASYS is in compliance with the contract and for delivering an adequate level of service in administering the health benefits program. With the reports currently received, the HBA does not have the ability to fulfill this oversight function.

We recommend that the Corporation request that OASYS send all required reports on the schedule established in the contract. In addition, the Corporation should request that OASYS send reports comparing the costs of primary care providers vs. specialists, and the costs of hospitals vs. physicians. The Corporation should also ensure that the HBA is performing an adequate analysis of these reports. If the volume of paper is cumbersome or not useful for the HBA, he should request that OASYS submit the reports electronically. At a minimum, these reports should be used to perform the following:

- A review of the participant medical claims payment system provided by the health contractor.
- An analysis of customary and reasonable fee schedules of the health contractor for conformity with national physician and hospital profiles.
- A comparative analysis of annual participant medical costs versus previous years according to inpatient and outpatient care, diagnostic categories, average per diem costs, average length of stay in clinical facilities, average inpatient case costs analysis, etc.
- A comparative analysis of participant medical costs versus costs of other subscriber plans operated by the health contractor according to the above-mentioned categories.
- A comparison of medical claim costs associated with participants located outside of the PPO network as compared to the customary and reasonable fees for these claims if provided within the PPO network.

In addition, the HBA should be aggregating the data from these reports on at least a quarterly basis in order to create an analysis of medical cost trends in participant health claims and their correlation to demographic and geographic factors. These trends should then be used to forecast future costs associated with the health benefits program.

Corporation's Comment

AGREE IN PART – "At one time, the HBA received reports which listed every medical claim processed and prescription filled. These reports proved to be both cumbersome and of little use. The HBA, therefore, elected to make these reports deliverable on an "as needed" basis. The suggestion that these reports come in on a diskette will be directed to [OASYS].

However, the auditor adds that the HBA does not create an analysis of medical cost trends in participant health claims and their correlation to geographic factors. The auditor concludes that these trends should then be used to forecast future costs associated with the health benefits program. The HBA has managed this contract for over five years and has gained an in-depth understanding of the costs and trends associated with AmeriCorps*VISTA and AmeriCorps*NCCC members. In addition, he maintains data which can produce reports based on geography, AmeriCorps program and/or fiscal year."

PwC Response

The Corporation states that the "auditor concludes that [medical cost trends in participant health claims and their correlation to geographic factors] should ... be used to forecast future costs associated with the health benefits program. As written, it appears as if this is merely

our suggestion. However, this is not our suggestion, but a responsibility that is specifically mentioned in the HBA's position description.

In addition, the Corporation as serts that the HBA has an in-depth understanding of the costs and trends associated with the program, and maintains data that can produce reports based on geography. If we were to assume this assertion to be true, without documentation such as reports and policies and procedures this knowledge is lost to the Corporation in the event of a staffing change. However, we do not consider this a valid assertion because it is in direct conflict to a statement made by the HBA in a discussion regarding oversight goals held on April 7, 1999. In this discussion, the HBA specifically stated that while he had noticed basic trends based on claim type, geographic location and season, he did not have the statistical expertise to analyze the data in such a way to forecast program costs. Consequently, the HBA had not performed such an analysis.

8. The Corporation does not keep a log of participant appeals.

We noted that the Corporation does not maintain an appeals log or proactively monitor health benefits program participant appeals and grievances.

The HBA addresses participant appeals on an informal basis. After having a claim denied by OASYS, participants usually direct their grievances to the various state offices. If the state offices are unable to assist these participants, they forward the complaints to the HBA. The HBA then contacts OASYS to ensure they are resolved. However, we found no formal documentation of this process

The Corporation's Health Benefits Analyst GS-301-12 position description, Section II, *Major Duties*, states that the HBA:

- Determines the health priorities and medical needs of VISTA, NCCC, and AmeriCorps Leader participants. Determines and reports on the adequacy and conformity of the health delivery system as related to the Corporation's long-term goals and objectives. Provides direction and advice in the area of health policies and programs for the Corporation. Serves as the primary liaison to other public and private organizations as related to healthcare and related activities.
- Serves as the Corporation's Contracting Officer Technical Representative (COTR) for the AmeriCorps*VISTA, NCCC and Leaders' health services contract. Assures the contract is administered in full accordance with Federal and CNCS procurement regulations and policies. Serves as primary liaison with contractor on programmatic aspects of administration of health benefits contract. Independently develops Statements of Work (SOW) and other documentation as required for AmeriCorps*VISTA.

The HBA serves a dual role. First, the HBA is a representative for the Corporation in the administration of the health benefits program. Second, the HBA is responsible for determining the health priorities and needs of the benefits program participants. The HBA should ensure that eligible participants are receiving the full extent of healthcare that they deserve under the program in place and that OASYS processes appeals in a timely manner. By not properly monitoring participant grievances and appeals related to denied claims, the HBA is not adequately monitoring the members' health priorities and needs and is not ensuring the timely process of appeals.

We recommend that the Corporation create and maintain a formal appeals log to track all appeals filed by program participants. This log should include information such as

participant name, claim type and date, eligibility information, reasons given for denial (if applicable), as well as comments related to the appeal. The Corporation should then follow-up with OASYS on log entries to ensure that denials are justified. If performed in conjunction with the proper review and analysis of OASYS reports, the review of OASYS internal audit results, and the annual compliance review of OASYS, this log would help to ensure that all participants are receiving the full extent of benefits to which they are entitled.

Corporation's Comment

AGREE – "While appeals have been kept on telephone message pads for five years, the Corporation agrees that it is a positive suggestion to keep appeals in a more formal "log" fashion."

PwC Response

In numerous discussions with the HBA, he stated that no record of member appeals had been kept.

9. The Corporation does not update OASYS eligibility data on a timely basis.

While discussing plan eligibility updates with Corporation representatives, we noted that updates are not consistently made every two weeks. We received documentation for three updates. There was a 21-day period between two of the updates.

In order to update OASYS's eligibility data, an employee within the Corporation's Office of Information Technology batches the data at the request of the HBA. The HBA stated that he occasionally finds it difficult to reach this employee, causing delays in sending the updates.

Contract No. 95-743-1005, Attachment No. 1, page 23, *Claims Processing Time*, states: "Claims shall be processed according to the following averages: (1) clean claims – ninety percent within 14 days; (2) coordination of benefits claims – ninety percent within 28 days; and (3) ineligible claims – eighty-five percent within 14 days."

OASYS is contractually mandated to process ninety percent of clean claims within 14 days. Under the assumption that OASYS does maintain this schedule for processing claims, delays in sending eligibility updates creates two risks. First, some ineligible claims may not be properly denied, creating unnecessary costs for the Corporation. These costs are very difficult to recover. The providers who have received payment for services performed may not be inclined to return the money and then request payment from the participants. Second, some eligible claims may be denied, causing delays for healthcare program participants.

We recommend that the Corporation send more frequent eligibility updates to OASYS. The process of batching data and sending updates is not time intensive. Thus, it should not be difficult to send updates once or twice a week, instead of only twice a month. One possible solution would be to automate the batching process. VMS is an Oracle database capable of performing simple functions like batching data on a regular schedule. This change would virtually ensure that OASYS has the most up-to-date information regarding plan participant eligibility, which would tend to eliminate the denial of eligible claims and the acceptance of ineligible claims.

Corporation's Comment

AGREE – "Since the HBA took over this function five years ago, AmeriCorps*VISTA has grown by more than 1,000 members. There is justification, therefore, in sending eligibility roles to [OASYS] more often than biweekly."

10. Administrative invoices containing insufficient breakdowns of costs were consistently approved and paid by the Corporation.

During our testing of the Corporation's oversight and monitoring environment, we were provided with a copy of each administrative invoice submitted by OASYS under contract #95-743-1005. The format of these invoices was as follows:

> *Mr. _____:*
>
> *In accordance with (the) letter dated 10/19/94, we are submitting for reimbursement costs and claims processing costs incurred in the month of _____ for the health benefits program. The incurrence of the costs was necessary to comply with the proposed delivery date.*
>
> | | |
> |---|---|
> | *Reimbursement Costs* | *$XX,XXX.XX* |
> | *Claims Processing Costs* | *$XX,XXX.XX* |
> | *Please Remit* | *$XX,XXX.XX* |
>
> *Sincerely,*
>
> *Signature*

No additional documentation was provided to support the charges listed on the invoice. The amounts billed on these invoices, averaging $55,893, ranged from $10,885 to $129,395. The HBA, who was responsible for receiving and certifying the bills throughout all four contract years, was unable to explain the specific costs contained within either "Reimbursement Costs" or "Claims Processing Costs". The HBA was also unable to explain how the administrative fee charged by OASYS was determined and factored into the billings. Despite his lack of understanding as to the specific nature of the services being billed, the HBA consistently approved and certified the invoices for payment without any further inquiry to OASYS.

The HBA stated that he was dissatisfied with the lack of support provided in the invoices from OASYS. However, it was the HBA's understanding that OASYS was not contractually mandated to provide anything more informative or extensive and therefore, the Corporation could not request further detail and support.

Contract No. 95-743-1005, Section G.3, *Invoices*, states: "An invoice is a written request for payment under the contract for supplies delivered or for services rendered. In order to be proper, an invoice shall include, as applicable, the following: (i) Invoice date; (ii) Name of contractor; (iii) Contract number (including order number, if any), contract line item number, contract description of supplies or services, quantity, contract unit of measure and unit price, original tear sheet(s) and two (2) copies, and extended total; (iv) Shipment number and date of shipment (bill-of-lading number and weight of shipment will be shown for shipments on Government bills of laden); (v)Name and address to which payment is to be sent (which must be the same as that in the contract or on a proper notice of assignment); (vi) Name (where practicable), title, phone number and mailing address of person to be notified in event of a

defective invoice; and (vii) any other information or documentation required by the provisions of the contract (such as evidence of shipment)."

Without detail, a payee is unable to determine the accuracy of the bill. Consistently paying bills with inadequate or no detailed support indicates a lack of oversight and decreases the Corporation management's ability to ensure that healthcare administration costs are reasonable.

With the inception of the new contract (contract #98-743-3007, effective October 1, 1998), OASYS has begun sending more detailed administrative invoices that contain a more useful breakdown of costs. We urge the Corporation management to make use of these new invoices by checking their accuracy, tracking the different line items, and requesting more information when necessary.

Corporation's Comment

AGREE – "The audit correctly notes that the new contract provides more detailed information on administrative costs. There are now separate line items for the administrative fee, other direct costs and the health benefits brochure."

11. The Health Benefits Analyst certifies and approves invoices for payment prior to reviewing them.

In reviewing the medical claims invoices associated with the Corporation's health benefits contract with OASYS, we discovered six instances where the medical costs for specific periods were billed twice. In all cases, the duplicate bills were certified and approved for payment. In addition, we found one instance where the invoice was date-stamped as certified and approved prior to when it was date-stamped as received. The duplicate invoices were not marked in any manner that would prevent duplicate payments.

According to the HBA, the duplicate invoices contained corrections to errors contained in the original invoices. The HBA noticed these mistakes, but had already stamped them as certified and approved. The HBA makes a practice of stamping and signing invoices immediately after they are received. The HBA does so to promote the ease of clerical duties associated with processing these invoices. In the case where the certifying and approval dates were prior to the receiving dates, the HBA stated that he had forgotten to update his date-stamp.

Sound internal controls and accounting best practices suggest that invoices be checked for accuracy prior to their approval for payment. Furthermore, all duplicate invoices should be clearly marked to ensure that they are not inadvertently paid.

Certifying and approving invoices for payment before checking them for accuracy creates a risk that inaccurate invoices could be paid, or that duplicate invoices could be paid, which would increase healthcare costs.

We recommend that the HBA certify and approve invoices after reviewing them. The invoices should be reviewed for accuracy, annotated with the applicable accounting codes, and then certified before obtaining authorization for payment. In addition, we recommend that the HBA mark duplicate or erroneous invoices "void" to prevent the possibility of improper payment.

Corporation's Comment

DISAGREE – "The HBA reviews all invoices. He must do this in order to know which funding codes to draw down on for each line item in the invoice. In the past five years that contract 95-743-1005 has been in effect, approximately 300 invoices have been received. On ten occasions, errors were made requiring corrections. In six of these cases, invoices were certified and approved for payment. In each instance, correct invoices were submitted and paid. At no time was there any risk of duplicate payment being made because, as the HBA explained to the auditors, only original invoices can be paid and the HBA still has the original invoices which were in error."

PwC Response

We agree that the HBA reviews all invoices. Our concern is that he certifies and approves these invoices prior to performing this review. The Corporation states that there was never a risk that an incorrect invoice could have been paid because the HBA had kept the original invoice. However, we feel that a risk of incorrect payment does in fact exist. No policies and procedures were produced documenting the necessity of the original invoice being in the accounting department prior to payment. It was also possible for the HBA to mistakenly submit the incorrect invoice for payment. By reviewing invoices before certification and approval for payment, and marking incorrect invoices as such, the risk of incorrect payment could be easily reduced to an acceptable level.

Summary of Claims Data Analysis

To assist the Corporation's management in making informed decisions about its self-insured health benefits plan, we performed an analysis of the data claims extracts provided by OASYS for the contract years October 1, 1994 through September 20, 1998. Our methodology involved organizing the four years of claims data into a database and performing calculations to determine the costs and utilization of the healthcare services billed. We also identified prevalent diagnoses/diseases specific to the Corporation's population.

Inpatient data was compared using nationally accepted benchmarking standards such as length of stay, days per 1,000 participants, and admissions per 1,000 participants. The benchmarks used were *Milliman and Robertson Health Cost Guidelines* and are based on "loosely-managed," "moderately-managed," and "well-managed" healthcare plans. We found that for the most part the Corporation's health benefits plan fell within the standards for a well-managed healthcare plan.

Our analysis also identified several issues that we will address in, during our testing of health care claims at OASYS. These issues are: (1) accuracy of participant eligibility data, (2) unexpectedly high utilization; (3) unusual inpatient surgical admissions, (4) inpatient admissions that had lengths-of-stay beyond the plan benefit; and (5) large numbers of high cost claims.

As is customary for this type of analysis, we completed a search for benchmarks concerning ambulatory care utilization. Due to several data limitations this proved not to be feasible. One barrier encountered was industry coding. Emergency rooms, outpatient departments, clinics, and physician offices all use different coding systems. For OASYS's claims, we were only able to identify Revenue code 450 (code submitted on UB92 claim form), which was used to distinguish between emergency room visits and outpatient visits. Therefore, we instead relied on the number of days care was received by participant to approach our data analysis.

We also completed a search for ambulatory care statistics using the PricewaterhouseCoopers Healthcare Library in Chicago, Illinois. Our search identified one periodical (*Advance Data* from the Vital Statistics of the Centers for Disease Control) identifying ambulatory care statistics. Contained were statistics of outpatient utilization collected by the National Center for Health Statistics in two studies: the *National Ambulatory Medical Care Survey* (Physician office visits) and the *National Hospital Ambulatory Medical Care Survey*. However, after completing our review of this information, we determined that it was not comparable to the utilization statistics received from OASYS because the units of service were not the same.

Issues Identified in Claims Extract Analysis[12]

While analyzing the data of claims paid by OASYS, we identified several questionable characteristics including:

Accuracy of Participant Eligibility Data

We identified 195 participants whose birth dates were on January 1, 1900. These records seem questionable when considering that, according to the Corporation's Health Benefits Analyst (HBA), the average age for the membership is approximately 34 years for VISTA and NCCC. Potential causes for these eligibility issues are:

1. The claims data provided by OASYS was corrupt.

[12] For additional information regarding the detailed claims extract analysis, see Appendix A.

2. Claims have been paid for ineligible participants.
3. The claims data provided are for another client served by OASYS.

Unexpectedly High Disease Category Utilizations

During our analysis, we reviewed inpatient medical admissions for each fiscal year. Upon completion of an aggregate review for the four-year claims experience, we noted high utilization and costs incurred for the following disease categories:

1. Circulatory (includes coronary artery disease, heart attacks, congestive heart failure, hypertension, etc.): 55 admissions occurred with inpatient days totaling 239. The average per diem was $1,703. Again, given the expected average age of this population (34 years), one would not expect to see this disease category as the second highest utilization of healthcare services.
2. Mental (acute delirium, major affective depressive disorder, and depression): 56 admissions occurred with an average cost of $531 per day.

Inpatient Surgical Admissions

Inpatient surgical admissions were reviewed for each fiscal year. An aggregate of the four-year timeframe was completed and revealed the following:

1. Surgical Maternity (usually indicating cesarean section, or procedures related to miscarriages): The average length of stay for cesarean sections is usually four days. By comparison, the average length of stay based on the claims extract was 2.3 days. In addition, the average amount paid per diem was $2,737.
2. Neoplasm (includes malignant and/or benign growths): This was the fourth ranked disease category for the aggregate four-years with a utilization of 145 days and an average daily cost of $3,044. Further analysis revealed that the number one diagnosis for this population of claimants, whose average age was 42, was uterine growths.

Inpatient Admissions

The top ten high-cost admissions for the four years were identified. As previously stated, the admissions were for Circulatory (heart), Injury (fractures), Digestive (Gastric Ulcer Hemorrhage) and Respiratory (Pneumonia). High costs per day were paid, ranging from $1,685 to $12,013. Also, the pneumonia admission had a 61-day length of stay.

High Cost Claims

Finally, a review of the claims sample pulled for Task II revealed that there were a large number of claims over $10,000 during each year. For example, during 1995, one participant had 2 admissions within 20 days, with a total cost of $65,000. This participant was only 53 years old. We could not determine from this data if there was a multiple admission for the same participant or if there was duplicate claim payment. In addition, we noted that in the top ten high cost admissions, four admissions had a length of stay of more than 21 days. According to the benefits contract, only 21 days of inpatient stay are allowed per contract year, with a maximum lifetime benefit of 60 days of inpatient stay.

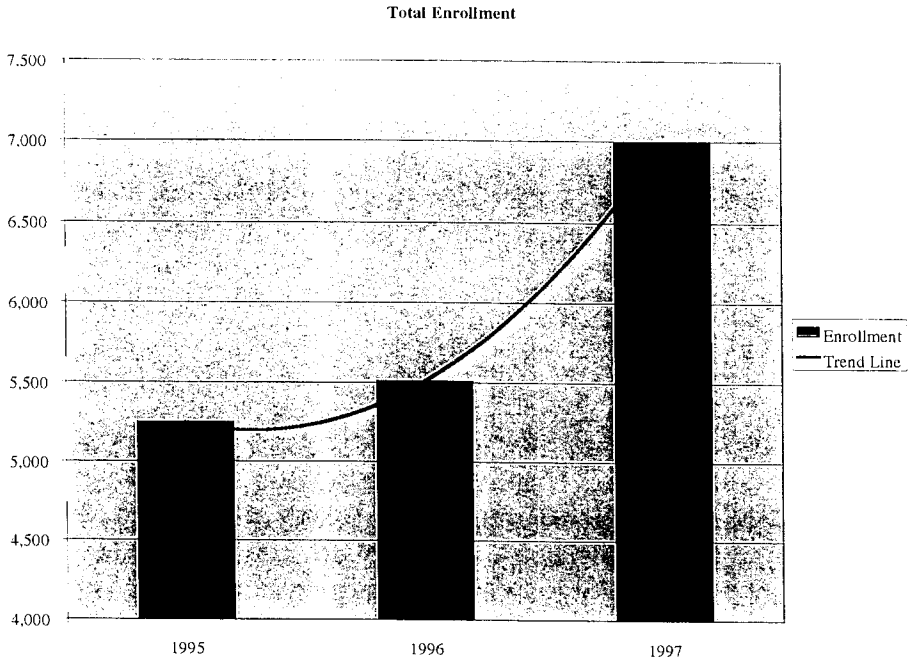
We will review eligibility data of participants, high dollar claims, and excessive lengths of stay as part of our audit of health benefit claims at OASYS.

Cost and Utilization Trends [12]

This section of the report provides the results of our analysis of the claims data extract as it relates to healthcare costs and utilization for fiscal years 1995, 1996, and 1997. Although data for fiscal year 1998 has been analyzed, it is excluded from this section of the report. The data provided by OASYS includes claims paid through December 31, 1998. Accordingly, there are an unknown number of claims incurred in fiscal year 1998 that were not processed in this time period.

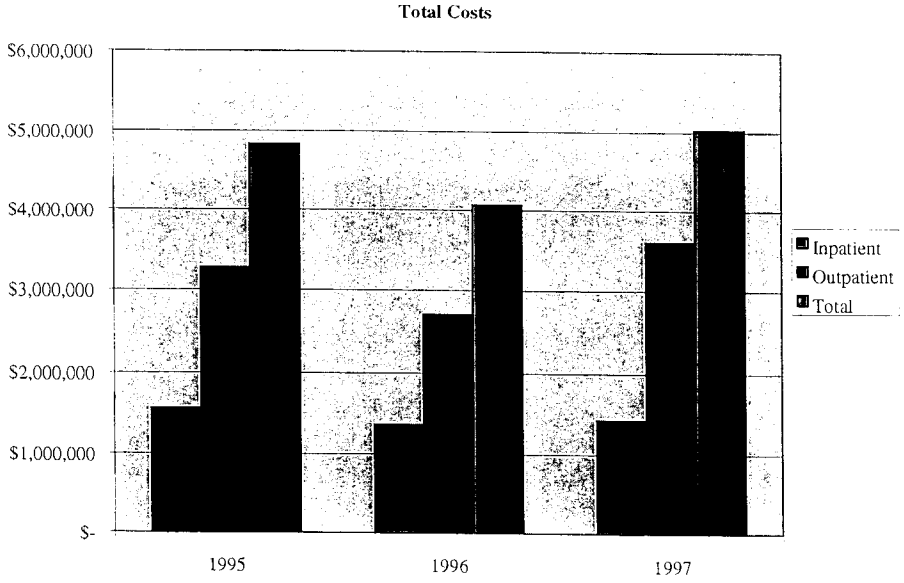
Enrollment

Enrollment in the Corporation's sponsored healthcare plans experienced a modest increase of 5.1% between 1995 and 1996, growing from 5,245 to 5,511 participants. By the end of 1997, the membership had increased substantially to 6,994 participants. This equates to a one-year increase of 26.9%.



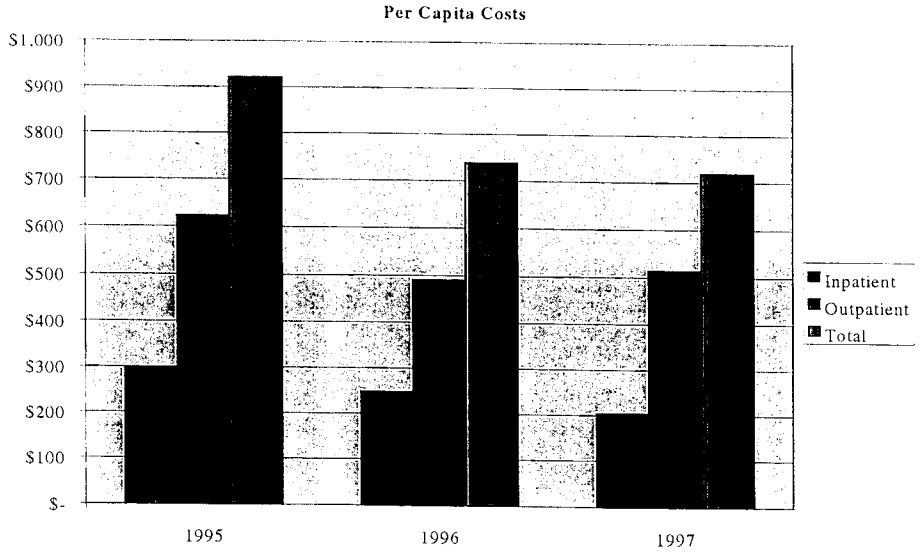
Total Costs

While the plan membership has consistently increased during the period from 1995 through 1997, total healthcare costs have not followed the same pattern. Instead, total healthcare costs decreased by 15.8%, from $4,832,400 in 1995 to $4,069,502 in 1996, before experiencing a 23.6% increase to $5,028,980 in 1997. Inpatient and outpatient costs followed a similar pattern during this period. Inpatient costs decreased by 12.9%, from $1,564,923 in 1995 to $1,363,627 in 1996, and then experienced a small increase of 4.7% to $1,428,008 in 1997. Outpatient costs decreased by 17.2%, from $3,267,477 in 1995 to $2,705,875 in 1996, before experiencing a 33.1% increase to $3,600,971 in 1997. Overall for the three-year period, total costs increased by only 7.8%. This is far below the overall growth in membership of 33.3%.



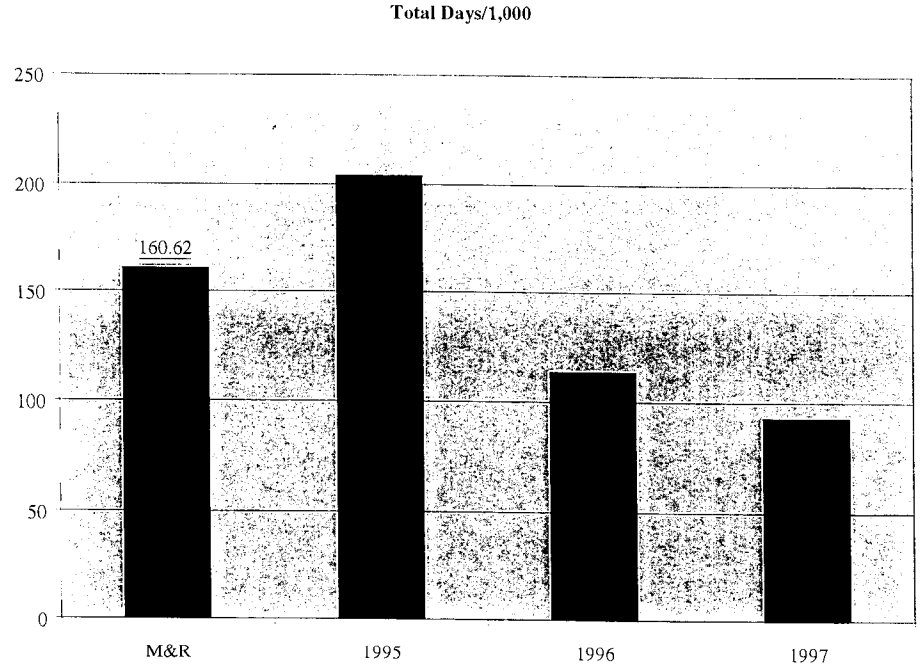
Per Capita Costs

By combining the two previous analyses, we noted that per capita costs decreased. These costs decreased by 19.9%, from $921 in 1995 to $738 in 1996. This was the result of a 17.1% decrease in inpatient costs, from $298 in 1995 to $247 in 1996, and a 21.2% decrease in outpatient costs, from $622 in 1995 to $491 in 1996. Per capita healthcare costs continued to decline in 1997, as costs decreased by 2.6% to $719. The decline in costs was a result of a 17.5% decrease in inpatient costs per capita to $204 in 1997, while outpatient costs per capita increased by 4.9% to $514 in 1997.

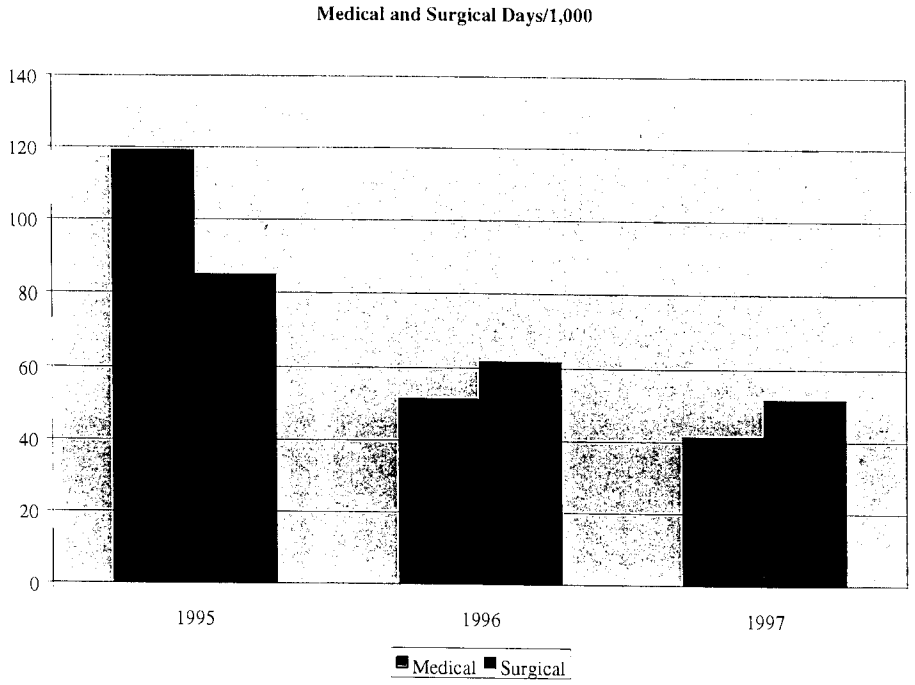


Medical/Surgical Days of Stay per 1,000

We calculated the total inpatient (combined medical and surgical) days of stay per 1,000 participants (days/1,000). This figure consistently decreased over the three-year period, moving from 203.8 in 1995 to 92.9 in 1997. This represents an overall decrease of 54.4%. As compared to the benchmarks provided in *Milliman and Robertson Healthcare Cost Guidelines* (M&R), the days/1,000 was not within the guidelines for a "Well Managed" plan during 1995 (203.8). However, for 1996 (113.2) and 1997 (92.9), days/1,000 was well within this guideline.

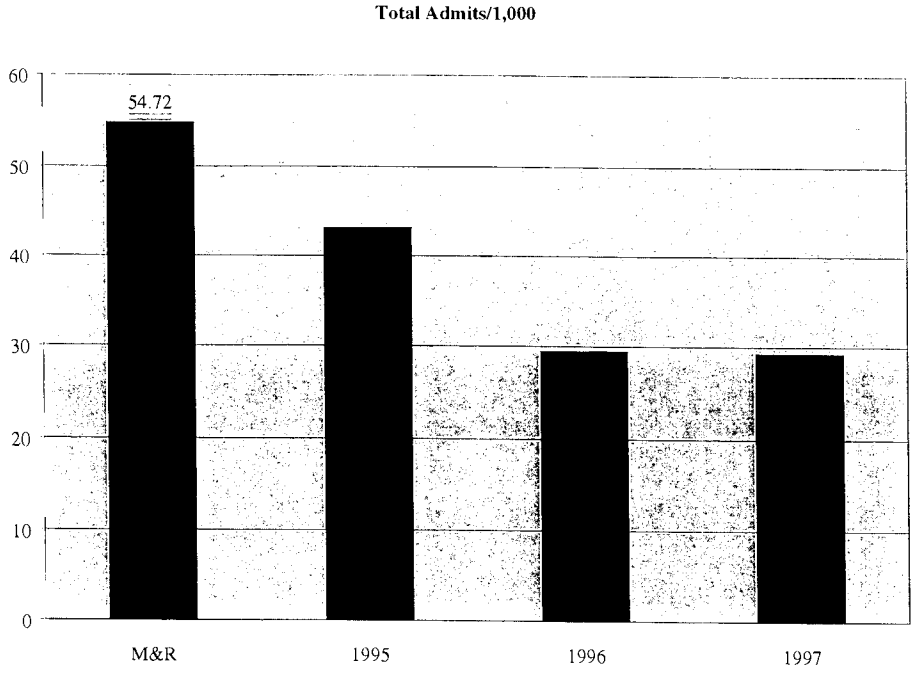


We broke total inpatient days of stay into two categories, medical and surgical, and found similar trends. Both medical and surgical days/1,000 decreased each year between 1995 and 1997. However, we noted that while medical days/1,000 exceeded surgical in 1995, this relationship reversed for both 1996 and 1997.

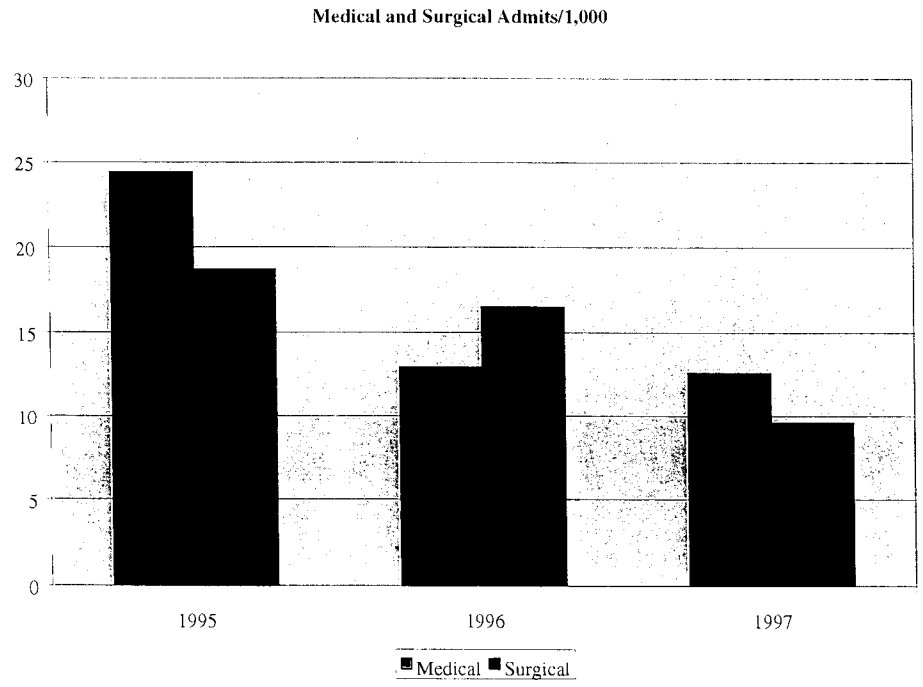


Medical/Surgical Admissions per 1,000

In addition to days/1,000, we also calculated the overall inpatient admissions per 1,000 participants (admits/1,000). This figure has steadily fallen for the Corporation's health benefits program from 43.1 in 1995 to 29.2 in 1997. As compared to M&R, the Corporation is well below the benchmark of 54.7 admits/1,000 for a "Well Managed" plan.

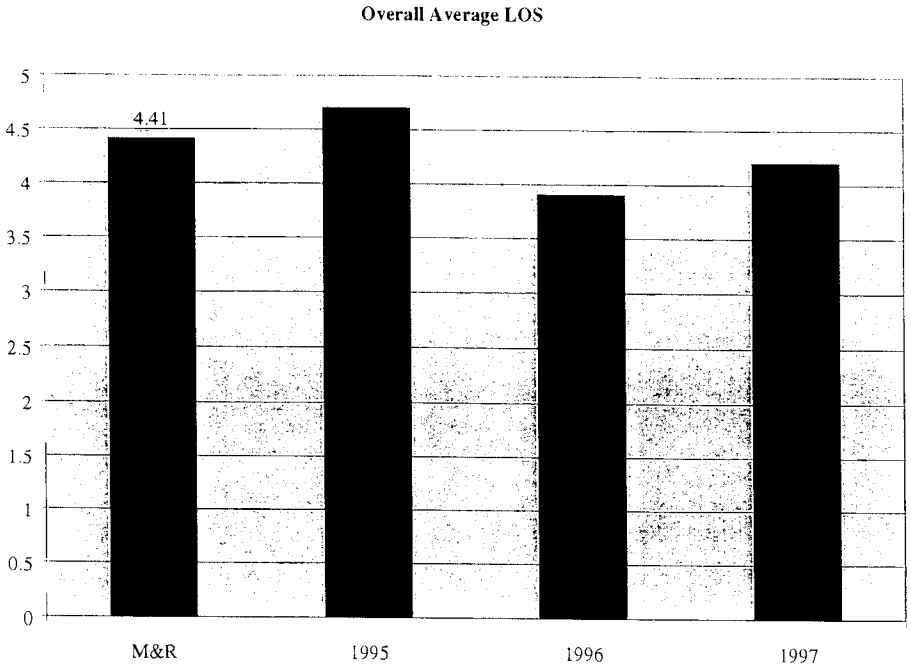


We found similar trends upon breaking our analysis out between medical and surgical. We noted that medical admits/1,000 decreased from 24.4 in 1995 to 12.6 in 1997, and surgical decreased from 18.7 in 1995 to 9.6 in 1997. This was an overall decrease of 48.0% for medical and 48.7% for surgical.

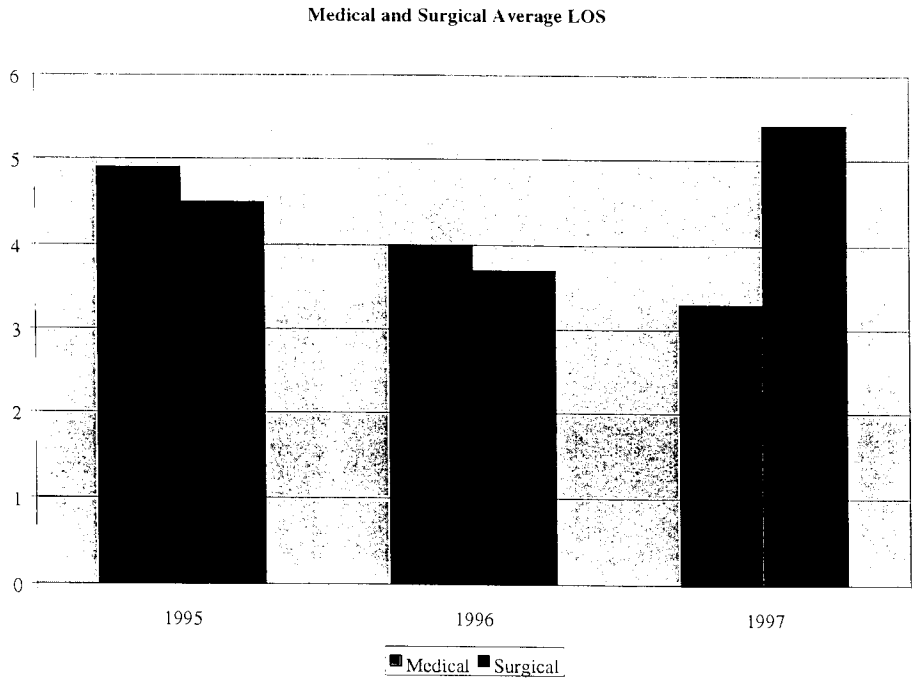


Medical/Surgical Average Length of Stay

Finally, we calculated the average length of stay (LOS) for inpatient admissions. Unlike many previous analyses however, we found no significant trends in this data. Instead, the overall average LOS was relatively constant over the three years. In addition, we noted that the Corporation's overall average LOS was close to that of M&R, exceeding it only slightly in 1995.



We did find trends when we broke the average LOS data out between medical and surgical admissions. Medical average LOS consistently decreased over the three years, moving from 4.9 days in 1995 to 3.3 in 1997. Surgical average LOS actually initially decreased from 4.5 days in 1995 to 3.7 in 1996. It then increased in 1997 to 5.4 days.



High Cost Admissions

We identified the top ten admissions for healthcare services and costs incurred. The analysis identified that four admissions were attributed to the ICD9 (International Classification of Diseases – Version 9) diagnostic category for Circulatory and accounted for $319,927.26 dollars. The discharge diagnoses were two admissions for Coronary Atherosclerosis, one admission for Subendocardial Infarct and one admission was for an Acute Myocardial Infarction.

Three admissions were classified in the Injury ICD9 diagnostic category and totaled $238,139.69 in paid claim dollars, including a Sacral/Coccyx Fracture with Spinal Cord Injury, an Intracranial Hemorrhage, and a Neck Fracture at the sixth Vertebra.

An admission for Other Shock without mention of Trauma (Ill-Defined) occurred in November 1995. The total cost of the admission was $127,862.12.

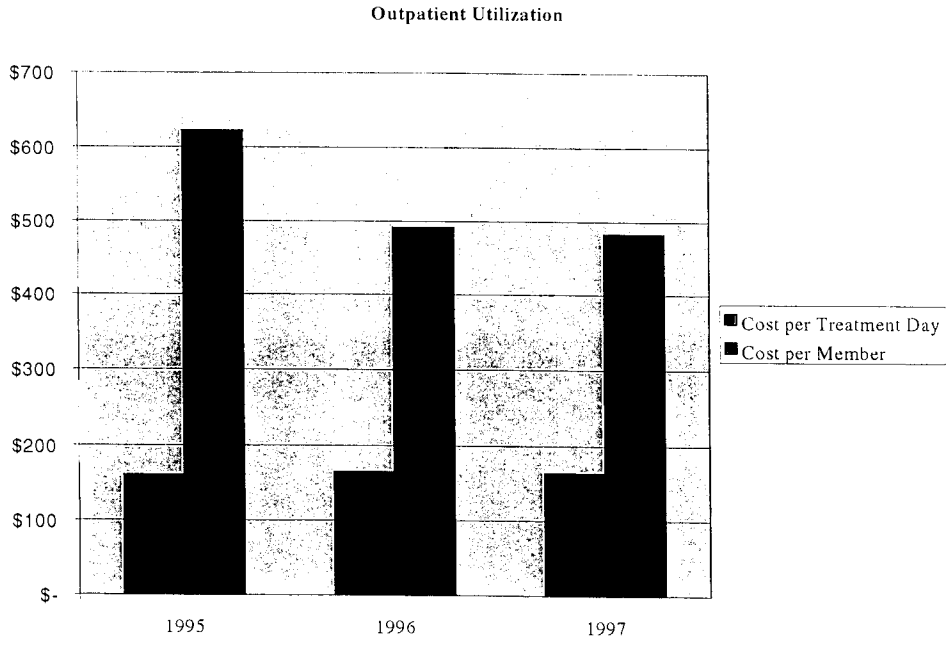
An admission in May 1997 was for Pneumococcal Pneumonia (Respiratory) and the total costs incurred were $102,809.11. This admission had a length of stay of 61 days.

Finally, there was an admission for Gastric Ulcer with Hemorrhage in October 1996, with incurred costs of $63,603.59.

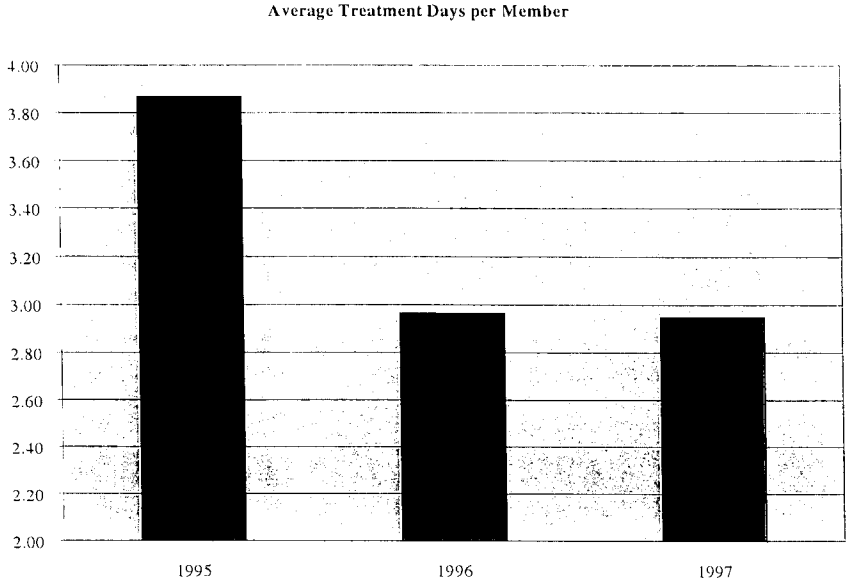
ICD9 Disease Category	Admissions Date	Discharge Date	Days	Cost	Cost per Day
Ill-Defined	26-Oct-95	19-Nov-95	24	$127,862.12	$5,327.59
Injury	19-Mar-97	24-Apr-97	36	$106,458.62	$2,957.18
Circulatory	7-Sep-96	24-Sep-96	17	$104,843.95	$6,167.29
Respiratory	3-May-97	3-Jul-97	61	$102,809.11	$1,685.40
Circulatory	17-Jan-98	1-Feb-98	15	$96,703.88	$6,446.93
Injury	6-Feb-95	8-Mar-95	30	$73,672.52	$2,455.75
Circulatory	25-Sep-96	1-Oct-96	6	$72,081.37	$12,013.56
Digestive	8-Oct-96	21-Oct-96	13	$63,603.59	$4,892.58
Injury	19-Mar-97	29-Mar-97	10	$58,008.55	$5,800.86
Circulatory	6-Feb-95	10-Feb-95	4	$46,298.06	$11,574.52

Outpatient Utilization

By analyzing the cost data related to outpatient utilization, we found an overall decline in the average cost per day of outpatient procedures. This figure decreased from $622.97 in 1995, to $491.00 in 1995, to $403.23 in 1997. The same was not the case for the average cost per participant. Instead, this figure remained relatively stable over the three-year period, varying between a low of $161.13 in 1995 and a high of $165.67 in 1996.



Outpatient units (defined as the number of days in which an outpatient service was rendered per participant) also followed a declining trend. This measure decreased by 23.3%, from 3.9 days in 1995 to 3.0 days in 1996, and then again by 0.6% to 2.9 days in 1996.



Comparison of the Corporation's PPO Plan to 1999 Federal Employee's Blue Cross Blue Shield High Option PPO

In addition to our claims data analysis presented above, we also performed a comparison of the Corporation's PPO plan to the 1999 Blue Cross Blue Shield High Option PPO plan offered to Federal employees. Particular areas of interest included coverage for:

- Inpatient Care (facility and physician expenses);
- Outpatient Care (facility and physician expenses);
- Mental Health/Substance Abuse Care;
- Emergency Care;
- Prescription Drugs;
- Dental Care;
- Preventive Care;
- X-ray and Laboratory Expenses; and
- Well Childcare.

The following table highlights the differences between the two plans according to the service categories listed above.

Service/Benefit	Corporation's Benefit Plan	1999 FEHP – BCBS High Option PPO Plan
Inpatient Care		
Hospital/Facility	100% for up to 21 days, 60 days per lifetime	100% for unlimited days; no per admission deductible
Surgical	100% of R&C	95% of allowed charges
Physician Care	100% of UCR	95% of allowed charges
Maternity	100% subject to pre-existing condition exclusion	100% of allowed charges
Mental Health: • Facility • Physician Care	100% up to 15 days per year	$75 co-pay per day, 120 days per calendar year $150/$300 deductible, 80% of allowed charges thereafter
Substance Abuse: • Facility • Physician Care	100% up to 7 days per year for detoxification	(28-day lifetime maximum) $75 copay per day, 120 days per calendar year $150/$300 deductible, 80% of allowed charges thereafter
Outpatient Care		
Hospital/Facility	100% after $5 copay	100% after $10 copay per day
Surgical	100% after $5 copay	95% of allowed charges
Physician Care	100% after $5 copay	100% after $12 copay per visit
Maternity	100% after $5 copay	100% of allowed charges
Mental Health/ Substance Abuse	100% after $5 copay Up to 3 visits	100% after $10 copay per visit
Emergency Care	100% of hospital/physician services within 72 hours of injury, subject to $25 deductible (waived upon inpatient admission)	100% for hospital/physician services within 72 hours of injury
Prescription Drugs	100% (includes oral contraceptives only)	85% of allowed charges after $50 deductible (includes oral contraceptives, IUDs, and other birth control devices)
Dental Care	Covers oral surgery, maxillofacial surgery or services due to injury only	Covers oral surgery, maxillofacial surgery or services due to injury only
Preventive Services	100% up to $100 for: ▪ Breast cancer screening ▪ Cervical cancer screening (Pap smear)	100% after $12 copay per visit for: ▪ Routine physicals ▪ Breast cancer screening ▪ Cervical cancer screening (Pap smear) ▪ Colorectal cancer screening ▪ Prostate cancer screening Immunizations
Well Child Care	Not covered	100% for child up to age 22
X-ray and Laboratory Testing	100% of UCR	100%
Percentage of Plan Costs Paid by Employer	100%	53%
Percentage of Plan Costs Paid by Employee	0%	47%

Inpatient Care

For such services as surgical, physician care, and mental health and substance abuse, the Corporation's PPO plan provides an overall richer benefit than those offered by the 1999 FEHP PPO plan. However, the 1999 FEHP PPO plan provides a 100% inpatient facility benefit with no length of stay limitation. By comparison, the Corporation's PPO plan provides a 100% inpatient facility benefit up to an annual maximum of 21 days (60 days lifetime).

Outpatient Care

Except in the category of outpatient mental health and substance abuse coverage, the Corporation's PPO plan offers a richer set of outpatient benefits with 100% coverage and a lower copayment amount. For outpatient mental health and substance abuse services under the Corporation's PPO plan, there is a limit to the number of visits the plan will cover.

Emergency Care

The two plans are very similar with respect to emergency care coverage. Both require the participant receive emergency care at a preferred facility within 72 hours of injury. However, the Corporation PPO plan requires the participant to pay a $25 deductible, which is waived if the participant is admitted to the hospital. The 1999 FEHP plan has no such deductible requirement.

Prescription Drugs

The Corporation PPO prescription drug benefit provides for 100% coverage of pharmacy and mail order prescriptions. By comparison, the 1999 FEHP prescription benefit is subject to a $50 deductible and a 15% coinsurance to be paid by the participant. Though the plan document for the Corporation PPO plan specifically notes that oral contraceptives are covered, the 1999 FEHP PPO plan document goes further to state that oral contraceptives, IUDs, Depo-Provera, Norplant and diaphragms are covered.

Dental Care

The two plans are very similar with respect to dental care coverage. Both plans provide for coverage for oral and maxillofacial surgery and services due to injury.

Preventive Care

According to the plan documentation, the 1999 FEHP PPO plan had a more comprehensive list of preventive and other services that would be covered at 100% after the application of a per visit copayment. The Corporation PPO plan provides coverage for breast cancer and cervical cancer screening only, whereas the 1999 FEHP PPO plan lists annual routine physicals, breast cancer screening, cervical cancer screening, colorectal cancer screening, prostate cancer screening and immunizations as covered services, if provided by preferred facilities or preferred providers.

Well Child Care

Unlike the 1999 FEHP PPO plan, the Corporation PPO plan does not cover well childcare services.

X-rays and Laboratory Expenses

The Corporation PPO plan covers diagnostic services at 100% of usual, customary and reasonable charges. The 1999 FEHP PPO plan covers certain diagnostic cancer testing mentioned above at 100% if performed by preferred facilities/providers. All other diagnostic testing performed by independent laboratories are paid at billed charges.

Possible Inclusion of Participants in the Office of Personnel Management's Healthcare Program

We discussed the possibility of incorporating the Corporation's health benefits program into a plan currently offered to all Federal employees through the Office of Personnel Management (OPM) with the Acting Director of AmeriCorps*VISTA. Because it serves such a large population, we believe that OPM's health benefits program could offer comparable service with administrative costs lower than the $13.75 per member per month (PMPM) currently being paid to OASYS. According to the Acting Director, this option was considered several year ago when designing the health benefits plan. Furthermore, the Acting Director stated that, per the Domestic Volunteer Service Act, the participants are not regarded as Federal employees, and therefore are not eligible to join the program.

We agree that the Domestic Volunteer Service Act specifically designates the Corporation's participants as non-employees. However, we believe that the intent of this portion of the act was merely to prohibit OPM from funding the costs associated with the Corporation's health benefits program. It may be possible for the Corporation's participants to be incorporated into this program if the Corporation was to assume the associated costs. By doing so, the Corporation could potentially maintain its benefits coverage while reducing overall costs. We recommend that the Corporation perform a cost/benefit analysis of incorporating its health benefits program into a plan currently offered to all Federal employees through OPM. If deemed beneficial, the Corporation should then determine if legislation is necessary to pursue this course of action.

Administrative Costs

According to the Corporation's October 1, 1998 contract (#98-743-3007) with OASYS, the Corporation will pay OASYS $13.75 PMPM to provide the personnel, supplies, services, equipment, and facilities necessary for the administration of the Corporation's health benefits program. This administration includes participant eligibility maintenance, utilization management, claims processing, and provider contracting on behalf of the Corporation. Based on a membership of 8,015 (as estimated in the contract), this equates to a total administrative cost of $1,322,475 for the first year. This PMPM cost is quite low when compared to industry standards. National or other large PPOs (paying in excess of $500 million in claims per year) charge between $20 to $25 PMPM.

Inpatient: Medical and Surgical Inpatient Admissions Combined by Plan Year

Fiscal Year 1995

For fiscal year 1995, 33% ($1,564,923.38) of the costs incurred was for inpatient admissions. The top five ICD9 categories of admissions by cost were Injury, Maternity, Circulatory, Digestive and Neoplasm. However, the top category for number of days/1,000 was Mental, with a total of 43.3days/1,000 and an average length of stay (ALOS) of 7.3 days, followed by Injury (34.9 days/1,000 and ALOS 8.7) and Circulatory (28.8 days/1,000 and ALOS 5.6).

Fiscal Year	ICD9 Disease Category	Total Cost	Days	Admis-sions	Avg. LOS	Cost per Day	Cost per Admission	Days per 1,000	Admits. per 1,000
1995	Injury	$290,107.92	183	21	8.7	$1,585.29	$13,814.66	34.9	4.0
	Maternity	$239,539.22	94	42	2.2	$2,548.29	$5,703.31	17.9	8.0
	Circulatory	$236,207.21	151	27	5.6	$1,564.29	$8,748.42	28.8	5.1
	Digestive	$178,498.81	88	23	3.8	$2,028.40	$7,760.82	16.8	4.4
	Neoplasm	$128,268.52	43	12	3.6	$2,982.99	$10,689.04	8.2	2.3
	Genitourinary	$112,080.53	50	16	3.1	$2,241.61	$7,005.03	9.5	3.1
	Mental	$101,835.23	227	31	7.3	$448.61	$3,285.01	43.3	5.9
	Ill-Defined	$56,203.16	29	8	3.6	$1,938.04	$7,025.40	5.5	1.5
	Respiratory	$55,189.41	46	10	4.6	$1,199.77	$5,518.94	8.8	1.9
	Infectious	$49,536.39	59	8	7.4	$839.60	$6,192.05	11.2	1.5
	Nervous	$45,505.19	19	3	6.3	$2,395.01	$15,168.40	3.6	0.6
	Endocrine	$25,060.18	23	8	2.9	$1,089.57	$3,132.52	4.4	1.5
	Musculoskeletal	$14,042.86	27	8	3.4	$520.11	$1,755.36	5.1	1.5
	Blood	$11,610.95	21	4	5.3	$552.90	$2,902.74	4.0	0.8
	Skin	$11,413.75	6	2	3.0	$1,902.29	$5,706.88	1.1	0.4
	Other	$9,824.05	3	3	1.0	$3,274.68	$3,274.68	0.6	0.6
		$1,564,923.38	1,069	226	4.7	$1,463.91	$6,924.44	203.8	43.1

Fiscal Year 1996

For fiscal year 1996, 34% ($1,363,627.78) of the costs incurred was for inpatient admissions. The top five ICD9 categories of admissions by cost were Maternity, Circulatory, Digestive, Injury and Ill-Defined classifications. The Ill-Defined classification includes symptoms, signs, and abnormal results of laboratory or other investigative procedures, and miscellaneous conditions for which no classifiable diagnosis is recorded elsewhere. Included in this classification was one admission that occurred for a 23 year-old diagnosed with "Other Shock without mention of Trauma". The charge incurred for this case was $113,071.

The top category for number of inpatient days utilized was Digestive, with a total of 16.9 days/1,000 and an average length of stay of 4.9 days, followed by Circulatory (15.8 days/1,000 and ALOS 7.3) and Maternity (15.4 days/1,000 and ALOS 2.0).

Fiscal Year	ICD9 Disease Category	Total Cost	Days	Admis-sions	Avg. LOS	Cost per Day	Cost per Admission	Days per 1,000	Admits. per 1,000
1996	Maternity	$230,871.85	85	42	2.0	$2,716.14	$5,496.95	15.4	7.6
	Circulatory	$204,044.38	87	12	7.3	$2,345.34	$17,003.70	15.8	2.2
	Digestive	$178,676.31	93	19	4.9	$1,921.25	$9,404.02	16.9	3.4
	Injury	$160,289.50	60	17	3.5	$2,671.49	$9,428.79	10.9	3.1
	Ill-Defined	$158,761.58	42	9	4.7	$3,780.04	$17,640.18	7.6	1.6
	Neoplasm	$141,058.89	45	12	3.8	$3,134.64	$11,754.91	8.2	2.2
	Genitourinary	$107,633.15	40	16	2.5	$2,690.83	$6,727.07	7.3	2.9
	Mental	$59,442.93	58	9	6.4	$1,024.88	$6,604.77	10.5	1.6
	Respiratory	$55,013.79	51	11	4.6	$1,078.70	$5,001.25	9.3	2.0
	Infectious	$25,251.12	27	5	5.4	$935.23	$5,050.22	4.9	0.9
	Musculoskeletal	$21,105.35	14	5	2.8	$1,507.53	$4,221.07	2.5	0.9
	Blood	$8,541.20	6	1	6.0	$1,423.53	$8,541.20	1.1	0.2
	Endocrine	$6,460.65	4	2	2.0	$1,615.16	$3,230.33	0.7	0.4
	Skin	$5,072.56	9	1	9.0	$563.62	$5,072.56	1.6	0.2
	Congenital	$1,404.45	3	1	3.0	$468.15	$1,404.45	0.5	0.2
		$1,363,627.71	624	162	3.9	$2,185.30	$8,417.46	113.2	29.4

Fiscal Year 1997

For fiscal year 1997, 28% ($1,428,008.60) of the costs incurred was for inpatient admissions. The top five ICD9 categories of admissions by cost were Injury, Digestive, Neoplasm, Circulatory and Maternity. However, the top category for number of inpatient days utilized was Respiratory, with a total of 14.7 days/1,000 and an average length of stay of 6.9 days, followed by Digestive (14.3 days/1,000 and ALOS 4.0) and Injury (13.3 days/1,000 and ALOS 6.2).

Fiscal Year	ICD9 Disease Category	Total Cost	Days	Admis-sions	Avg. LOS	Cost per Day	Cost per Admission	Days per 1,000	Admits. per 1,000
1997	Injury	$256,700.60	93	15	6.2	$2,760.22	$17,113.37	13.3	2.1
	Digestive	$235,158.83	100	25	4.0	$2,351.59	$9,406.35	14.3	3.6
	Neoplasm	$178,911.09	64	12	5.3	$2,795.49	$14,909.26	9.2	1.7
	Circulatory	$169,871.51	58	14	4.1	$2,928.82	$12,133.68	8.3	2.0
	Maternity	$153,108.52	48	25	1.9	$3,189.76	$6,124.34	6.9	3.6
	Respiratory	$132,356.21	103	15	6.9	$1,285.01	$8,823.75	14.7	2.1
	Genitourinary	$110,961.36	44	17	2.6	$2,521.85	$6,527.14	6.3	2.4
	Ill-Defined	$74,295.31	36	11	3.3	$2,063.76	$6,754.12	5.1	1.6
	Infectious	$31,389.26	22	3	7.3	$1,426.78	$10,463.09	3.1	0.4
	Musculoskeletal	$24,431.61	6	2	3.0	$4,071.94	$12,215.81	0.9	0.3
	Mental	$18,670.75	44	9	4.9	$424.34	$2,074.53	6.3	1.3
	Congenital	$18,141.64	7	1	7.0	$2,591.66	$18,141.64	1.0	0.1
	Nervous	$12,371.68	10	2	5.0	$1,237.17	$6,185.84	1.4	0.3
	Endocrine	$10,691.33	12	3	4.0	$890.94	$3,563.78	1.7	0.4
	Skin	$948.90	3	1	3.0	$316.30	$948.90	0.4	0.1
		$1,428,008.60	650	155	4.2	$2,196.94	$9,212.96	92.9	22.2

Fiscal Year 1998

For fiscal year 1998, 22.6% ($838,521.70) of the costs incurred was for inpatient admissions. The top five ICD9 categories of admissions by cost were Maternity, Circulatory, Genitourinary, Digestive, and Injury. The top category for number of inpatient days utilized remained Maternity, with a total of 10.6 days/1,000 and an average length of stay of 2.7 days, followed by Circulatory (6.2 days/1,000 and ALOS 3.5) and Respiratory (5.7 days/1,000 and ALOS 4.1).

Fiscal Year	ICD9 Disease Category	Total Cost	Days	Admis-sions	Avg. LOS	Cost per Day	Cost per Admission	Days per 1,000	Admits. per 1,000
1998	Maternity	$203,097.97	83	31	2.7	$2,446.96	$6,551.55	10.6	3.9
	Circulatory	$161,376.81	49	14	3.5	$3,293.40	$11,526.92	6.2	1.8
	Genitourinary	$92,114.78	43	18	2.4	$2,142.20	$5,117.49	5.5	2.3
	Digestive	$90,992.88	41	12	3.4	$2,219.34	$7,582.74	5.2	1.5
	Injury	$71,453.31	30	11	2.7	$2,381.78	$6,495.76	3.8	1.4
	Neoplasm	$54,410.02	17	3	5.7	$3,200.59	$18,136.67	2.2	0.4
	Musculoskeletal	$53,132.34	6	5	1.2	$8,855.39	$10,626.47	0.8	0.6
	Ill-Defined	$36,997.48	13	5	2.6	$2,845.96	$7,399.50	1.7	0.6
	Respiratory	$33,542.46	45	11	4.1	$745.39	$3,049.31	5.7	1.4
	Nervous	$13,218.50	6	2	3.0	$2,203.08	$6,609.25	0.8	0.3
	Mental	$12,278.91	33	7	4.7	$372.09	$1,754.13	4.2	0.9
	Blood	$8,806.90	2	1	2.0	$4,403.45	$8,806.90	0.3	0.1
	Infectious	$7,099.34	5	2	2.5	$1,419.87	$3,549.67	0.6	0.3
		$838,521.70	373	122	3.1	$2,248.05	$6,873.13	47.5	15.5

Inpatient: Medical Inpatient Admissions by Plan Year

Since medical admissions differ in nature from surgical admissions, we also analyzed medical and surgical inpatient admissions separately for each benefit year. It was noted that the top ICD9 diagnostic category for medical admissions was Circulatory. Circulatory diagnostic category covers admissions for coronary artery disease, myocardial infarctions, cerebral artery occlusions and hypertension.

For fiscal years 1995 and 1996, the second prevalent disease category was Mental and covers diagnoses such as major affective depressive orders and depression. However, Ill-Defined classifications were second in 1997 followed by Genitourinary. Genitourinary was the second prevalent disease category in 1998.

Fiscal Year 1995

For fiscal year 1995, 41% ($641,806.24) of the healthcare costs incurred were for medical admissions. The top five ICD9 categories of admissions by cost were Circulatory, Mental, Ill-Defined, Infectious and Injury. The top category for number of inpatient days utilized was Mental with a total of 43.3 days/1,000 and an average length of stay of 7.3 days, followed by Circulatory (20.4 days/1,000 and an ALOS 5.1) and Infectious (11.2 days/1,000 and ALOS 7.4).

Fiscal Year	ICD9 Disease Category	Total Cost	Days	Admis-sions	Avg. LOS	Cost per Day	Cost per Admission	Days per 1,000	Admits. per 1,000
1995	Circulatory	$172,204.85	107	21	5.1	$1,609.39	$8,200.23	20.4	4.0
	Mental	$101,835.23	227	31	7.3	$448.61	$3,285.01	43.3	5.9
	Ill-Defined	$55,013.56	26	7	3.7	$2,115.91	$7,859.08	5.0	1.3
	Infectious	$49,536.39	59	8	7.4	$839.60	$6,192.05	11.2	1.5
	Injury	$43,930.50	30	9	3.3	$1,464.35	$4,881.17	5.7	1.7
	Respiratory	$41,023.90	43	9	4.8	$954.04	$4,558.21	8.2	1.7
	Digestive	$39,590.01	27	8	3.4	$1,466.30	$4,948.75	5.1	1.5
	Maternity	$34,743.08	16	7	2.3	$2,171.44	$4,963.30	3.1	1.3
	Endocrine	$25,060.18	23	8	2.9	$1,089.57	$3,132.52	4.4	1.5
	Nervous	$24,846.18	13	2	6.5	$1,911.24	$12,423.09	2.5	0.4
	Neoplasm	$12,062.55	4	3	1.3	$3,015.64	$4,020.85	0.8	0.6
	Genitourinary	$11,847.78	8	3	2.7	$1,480.97	$3,949.26	1.5	0.6
	Blood	$11,610.95	21	4	5.3	$552.90	$2,902.74	4.0	0.8
	Other	$9,824.05	3	3	1.0	$3,274.68	$3,274.68	0.6	0.6
	Musculoskeletal	$4,556.18	15	4	3.8	$303.75	$1,139.05	2.9	0.8
	Skin	$4,120.85	2	1	2.0	$2,060.43	$4,120.85	0.4	0.2
		$641,806.24	624	128	4.9	$1,028.54	$5,014.11	119.0	24.4

Fiscal Year 1996

For fiscal year 1996, 29% ($389,501.79) of the healthcare costs incurred was for medical admissions. The top five ICD9 categories of admissions by cost were Circulatory, Mental, Respiratory Ill-Defined, and Injury. The top categories for number of inpatient days utilized was Mental, with a total of 10.5 days/1,000 and an average length of stay of 6.4 days, and Circulatory (10.5 days/1,000 and an ALOS 5.8). Respiratory was the third most prevalent disease category with 9.1 days/1,000 and ALOS 5.0.

Fiscal Year	ICD9 Disease Category	Total Cost	Days	Admis-sions	Avg. LOS	Cost per Day	Cost per Admission	Days per 1,000	Admits. per 1,000
1996	Circulatory	$99,162.07	58	10	5.8	$1,709.69	$9,916.21	10.5	1.8
	Mental	$59,442.93	58	9	6.4	$1,024.88	$6,604.77	10.5	1.6
	Respiratory	$53,941.84	50	10	5.0	$1,078.84	$5,394.18	9.1	1.8
	Ill-Defined	$30,899.46	18	8	2.3	$1,716.64	$3,862.43	3.3	1.5
	Injury	$26,431.46	12	6	2.0	$2,202.62	$4,405.24	2.2	1.1
	Infectious	$25,251.12	27	5	5.4	$935.23	$5,050.22	4.9	0.9
	Neoplasm	$23,371.14	11	4	2.8	$2,124.65	$5,842.79	2.0	0.7
	Digestive	$18,950.05	17	5	3.4	$1,114.71	$3,790.01	3.1	0.9
	Genitourinary	$17,829.14	15	6	2.5	$1,188.61	$2,971.52	2.7	1.1
	Maternity	$9,704.47	4	3	1.3	$2,426.12	$3,234.82	0.7	0.5
	Musculoskeletal	$9,516.26	4	2	2.0	$2,379.07	$4,758.13	0.7	0.4
	Blood	$8,541.20	6	1	6.0	$1,423.53	$8,541.20	1.1	0.2
	Endocrine	$6,460.65	4	2	2.0	$1,615.16	$3,230.33	0.7	0.4
		$389,501.79	284	71	4.0	$1,371.49	$5,485.94	51.5	12.9

Fiscal Year 1997

For fiscal year 1997, 28% ($402,276.20) of the healthcare costs incurred was for medical admissions. The top five ICD9 categories of admissions by cost were Circulatory, Ill-Defined, Genitourinary, Digestive and Respiratory. The top category for number of inpatient days utilized was Circulatory, with a total of 7.4 days/1,000 and an average length of stay of 4.0 days, followed by Mental (6.3 days/1,000 and an ALOS 4.9) and Respiratory (6.0 days/1,000 and ALOS 3.0).

Fiscal Year	ICD9 Disease Category	Total Cost	Days	Admis-sions	Avg. LOS	Cost per Day	Cost per Admission	Days per 1,000	Admits. per 1,000
1997	Circulatory	$97,790.14	52	13	4.0	$1,880.58	$7,522.32	7.4	1.9
	Ill-Defined	$64,215.01	22	9	2.4	$2,918.86	$7,135.00	3.1	1.3
	Genitourinary	$40,939.08	21	9	2.3	$1,949.48	$4,548.79	3.0	1.3
	Digestive	$30,032.63	35	12	2.9	$858.08	$2,502.72	5.0	1.7
	Respiratory	$29,547.10	42	14	3.0	$703.50	$2,110.51	6.0	2.0
	Neoplasm	$25,731.29	9	1	9.0	$2,859.03	$25,731.29	1.3	0.1
	Injury	$25,564.43	19	8	2.4	$1,345.50	$3,195.55	2.7	1.1
	Maternity	$19,254.80	8	5	1.6	$2,406.85	$3,850.96	1.1	0.7
	Mental	$18,670.75	44	9	4.9	$424.34	$2,074.53	6.3	1.3
	Infectious	$14,126.00	7	1	7.0	$2,018.00	$14,126.00	1.0	0.1
	Musculoskeletal	$12,393.06	5	1	5.0	$2,478.61	$12,393.06	0.7	0.1
	Nervous	$12,371.68	10	2	5.0	$1,237.17	$6,185.84	1.4	0.3
	Endocrine	$10,691.33	12	3	4.0	$890.94	$3,563.78	1.7	0.4
	Skin	$948.90	3	1	3.0	$316.30	$948.90	0.4	0.1
		$402,276.20	289	88	3.3	$1,391.96	$4,571.32	41.3	12.6

Fiscal Year 1998

For fiscal year 1998, 24% ($198,786.79) of the healthcare costs incurred was for medical admissions. The top five ICD9 categories of admissions by cost were Circulatory, Genitourinary, Respiratory, Digestive and Ill-Defined. The top category for number of inpatient days utilized was Respiratory, with a total of 5.1 days/1,000 and an average length of stay of 4.4 days, followed by Mental (4.2 days/1,000 and an ALOS 4.7) and Circulatory (2.8 days/1,000 and ALOS 2.0).

Fiscal Year	ICD9 Disease Category	Total Cost	Days	Admis-sions	Avg. LOS	Cost per Day	Cost per Admission	Days per 1,000	Admits. per 1,000
1998	Circulatory	$37,950.52	22	11	2.0	$1,725.02	$3,450.05	2.8	1.4
	Genitourinary	$29,655.73	17	6	2.8	$1,744.45	$4,942.62	2.2	0.8
	Respiratory	$26,641.25	40	9	4.4	$666.03	$2,960.14	5.1	1.1
	Digestive	$21,893.14	10	3	3.3	$2,189.31	$7,297.71	1.3	0.4
	Ill-Defined	$19,015.12	9	3	3.0	$2,112.79	$6,338.37	1.1	0.4
	Maternity	$15,781.74	12	6	2.0	$1,315.15	$2,630.29	1.5	0.8
	Mental	$12,278.91	33	7	4.7	$372.09	$1,754.13	4.2	0.9
	Injury	$12,124.94	17	4	4.3	$713.23	$3,031.24	2.2	0.5
	Nervous	$9,055.88	5	1	5.0	$1,811.18	$9,055.88	0.6	0.1
	Blood	$8,806.90	2	1	2.0	$4,403.45	$8,806.90	0.3	0.1
	Musculoskeletal	$5,577.60	2	2	1.0	$2,788.80	$2,788.80	0.3	0.3
	Infectious	$5.06	3	1	3.0	$1.69	$5.06	0.4	0.1
		$198,786.79	172	54	3.2	$1,155.74	$3,681.24	21.9	6.9

Inpatient: Surgical Admissions by Plan Year

We noted that the top ICD9 diagnostic categories by cost for surgical admissions were either Injury (fiscal years 1995 and 1997) or Maternity (fiscal years 1996 and 1998). The Injury diagnostic category covers admissions for sprains, fractures and wounds. The Digestive category was also prevalent, which covers conditions such as Gastric Ulcers, Kidney Stones, Appendicitis and Hernias. All three of these diagnostic categories were within the top three most prevalent during all four years, except in fiscal year 1997, when Neoplasm was third, and in fiscal year 1998, when Circulatory was second.

Fiscal Year 1995

For fiscal year 1995, 59% ($923,117.14) of the healthcare costs incurred was for surgical admissions. The top five ICD9 categories of admissions by cost were Injury, Maternity, Digestive, Neoplasm and Genitourinary. The top category for number of inpatient days utilized was Injury, with a total of 29.2 days/1,000 and an average length of stay of 12.8 days, followed by Maternity (14.9 days/1,000 and an ALOS 2.2) and Digestive (11.6 days/1,000 and ALOS 4.1).

Fiscal Year	ICD9 Disease Category	Total Cost	Days	Admis-sions	Avg. LOS	Cost per Day	Cost per Admission	Days per 1,000	Admits. per 1,000
1995	Injury	$246,177.42	153	12	12.8	$1,609.00	$20,514.79	29.2	2.3
	Maternity	$204,796.14	78	35	2.2	$2,625.59	$5,851.32	14.9	6.7
	Digestive	$138,908.80	61	15	4.1	$2,277.19	$9,260.59	11.6	2.9
	Neoplasm	$116,205.97	39	9	4.3	$2,979.64	$12,911.77	7.4	1.7
	Genitourinary	$100,232.75	42	13	3.2	$2,386.49	$7,710.21	8.0	2.5
	Circulatory	$64,002.36	44	6	7.3	$1,454.60	$10,667.06	8.4	1.1
	Nervous	$20,659.01	6	1	6.0	$3,443.17	$20,659.01	1.1	0.2
	Respiratory	$14,165.51	3	1	3.0	$4,721.84	$14,165.51	0.6	0.2
	Musculoskeletal	$9,486.68	12	4	3.0	$790.56	$2,371.67	2.3	0.8
	Skin	$7,292.90	4	1	4.0	$1,823.23	$7,292.90	0.8	0.2
	Ill-Defined	$1,189.60	3	1	3.0	$396.53	$1,189.60	0.6	0.2
		$923,117.14	445	98	4.5	$2,074.42	$9,419.56	84.8	18.7

Fiscal Year 1996

For fiscal year 1996, 71% ($974,125.92) of the healthcare costs was incurred for surgical admissions. The top five ICD9 categories of admissions by cost were Maternity, Digestive, Injury, Ill-Defined and Neoplasm. The top category for number of inpatient days utilized was Maternity, with a total of 14.7 days/1,000 and an average length of stay of 2.1 days, followed by Digestive (13.8 days/1,000 and an ALOS 5.4) and Injury (8.7 days/1,000 and ALOS 4.4).

Fiscal Year	ICD9 Disease Category	Total Cost	Days	Admis-sions	Avg. LOS	Cost per Day	Cost per Admission	Days per 1,000	Admits. Per 1,000
1996	Maternity	$221,167.38	81	39	2.1	$2,730.46	$5,670.96	14.7	7.1
	Digestive	$159,726.26	76	14	5.4	$2,101.66	$11,409.02	13.8	2.5
	Injury	$133,858.04	48	11	4.4	$2,788.71	$12,168.91	8.7	2.0
	Ill-Defined	$127,862.12	24	1	24.0	$5,327.59	$127,862.12	4.4	0.2
	Neoplasm	$117,687.75	34	8	4.3	$3,461.40	$14,710.97	6.2	1.5
	Circulatory	$104,882.31	29	2	14.5	$3,616.63	$52,441.16	5.3	0.4
	Genitourinary	$89,804.01	25	10	2.5	$3,592.16	$8,980.40	4.5	1.8
	Musculoskeletal	$11,589.09	10	3	3.3	$1,158.91	$3,863.03	1.8	0.5
	Skin	$5,072.56	9	1	9.0	$563.62	$5,072.56	1.6	0.2
	Congenital	$1,404.45	3	1	3.0	$468.15	$1,404.45	0.5	0.2
	Respiratory	$1,071.95	1	1	1.0	$1,071.95	$1,071.95	0.2	0.2
		$974,125.92	340	91	3.7	$2,865.08	$10,704.68	61.7	16.5

Fiscal Year 1997

For fiscal year 1997, 72% ($1,025,732.40) of the healthcare costs was incurred for surgical admissions. The top five ICD9 categories of admissions by cost were Injury, Digestive, Neoplasm, Maternity and Respiratory. The top category for number of inpatient days utilized was Injury, with a total of 10.6 days/1,000 and an average length of stay of 10.6 days, followed by Digestive (9.3 days/1,000 and an ALOS 5.0) and Respiratory (8.7 days/1,000 and ALOS 61.0).

Fiscal Year	ICD9 Disease Category	Total Cost	Days	Admis-sions	Avg. LOS	Cost per Day	Cost per Admission	Days per 1,000	Admits. per 1,000
1997	Injury	$231,136.17	74	7	10.6	$3,123.46	$33,019.45	10.6	1.0
	Digestive	$205,126.20	65	13	5.0	$3,155.79	$15,778.94	9.3	1.9
	Neoplasm	$153,179.80	55	11	5.0	$2,785.09	$13,925.44	7.9	1.6
	Maternity	$133,853.72	40	20	2.0	$3,346.34	$6,692.69	5.7	2.9
	Respiratory	$102,809.11	61	1	61.0	$1,685.40	$102,809.11	8.7	0.1
	Circulatory	$72,081.37	6	1	6.0	$12,013.56	$72,081.37	0.9	0.1
	Genitourinary	$70,022.28	23	8	2.9	$3,044.45	$8,752.79	3.3	1.1
	Congenital	$18,141.64	7	1	7.0	$2,591.66	$18,141.64	1.0	0.1
	Infectious	$17,263.26	15	2	7.5	$1,150.88	$8,631.63	2.1	0.3
	Musculoskeletal	$12,038.55	1	1	1.0	$12,038.55	$12,038.55	0.1	0.1
	Ill-Defined	$10,080.30	14	2	7.0	$720.02	$5,040.15	2.0	0.3
		$1,025,732.40	361	67	5.4	$2,841.36	$15,309.44	51.6	9.6

Fiscal Year 1998

For fiscal year 1998, 76% ($639,734.91) of the healthcare costs was incurred for surgical admissions. The top five ICD9 categories of admissions by cost were Maternity, Circulatory, Digestive, Genitourinary and Injury. The top category for number of inpatient days utilized was Maternity, with a total of 9.0 days/1,000 and an average length of stay of 2.8 days, followed by Digestive (3.9 days/1,000 and ALOS 3.4) and Circulatory (3.4 days/1,000 and ALOS 3.4).

Fiscal Year	ICD9 Disease Category	Total Cost	Days	Admis-sions	Avg. LOS	Cost per Day	Cost per Admission	Days per 1,000	Admits. per 1,000
1998	Maternity	$187,316.23	71	25	2.8	$2,638.26	$7,492.65	9.0	3.2
	Circulatory	$123,426.29	27	3	9.0	$4,571.34	$41,142.10	3.4	0.4
	Digestive	$69,099.74	31	9	3.4	$2,229.02	$7,677.75	3.9	1.1
	Genitourinary	$62,459.05	26	12	2.2	$2,402.27	$5,204.92	3.3	1.5
	Injury	$59,328.37	13	7	1.9	$4,563.72	$8,475.48	1.7	0.9
	Neoplasm	$54,410.02	17	3	5.7	$3,200.59	$18,136.67	2.2	0.4
	Musculoskeletal	$47,554.74	4	3	1.3	$11,888.69	$15,851.58	0.5	0.4
	Ill-Defined	$17,982.36	4	2	2.0	$4,495.59	$8,991.18	0.5	0.3
	Infectious	$7,094.28	2	1	2.0	$3,547.14	$7,094.28	0.3	0.1
	Respiratory	$6,901.21	5	2	2.5	$1,380.24	$3,450.61	0.6	0.3
	Nervous	$4,162.62	1	1	1.0	$4,162.62	$4,162.62	0.1	0.1
		$639,734.91	201	68	3.0	$3,182.76	$9,407.87	25.6	8.7

Outpatient Utilization of Healthcare Services

Outpatient healthcare services can occur in the physician office setting, a clinic, or the outpatient department of a hospital. It has been noted that the top two ICD9 diagnostic categories for the highest utilization of healthcare services for 1995-1998 were Ill-Defined and Injury.

Fiscal Year 1995

Outpatient benefits accounted for $3,267,477.17 of healthcare dollars in fiscal year 1995. The top five ICD9 categories of admissions by cost were Ill-Defined, Injury, Musculoskeletal, Genitourinary and Digestive. The top category for number of outpatient days utilized was Ill-Defined, with 6,928 units of service and an average cost per day of $99.84. Digestive, while having only 614 units of service, should also be noted due to its high average cost per day of $407.45.

Fiscal Year	ICD9 Disease Category	Cost	Units of Service (Days of Treatment)	Cost per day
1995	Ill-Defined	$691,711.69	6,928	$99.84
	Injury	$534,171.07	2,101	$254.25
	Musculoskeletal	$380,203.09	1,582	$240.33
	Genitourinary	$330,131.16	1,657	$199.23
	Digestive	$250,172.07	614	$407.45
	Respiratory	$249,467.01	2,360	$105.71
	Nervous	$171,361.24	851	$201.36
	Neoplasm	$146,200.16	465	$314.41
	Maternity	$99,103.51	379	$261.49
	Circulatory	$77,739.01	386	$201.40
	Skin	$69,577.82	710	$98.00
	Infectious	$67,597.33	601	$112.47
	Other	$57,568.47	193	$298.28
	Endocrine	$39,732.12	351	$113.20
	Mental	$39,303.37	353	$111.34
	Special Exams	$38,371.21	591	$64.93
	Congenital	$13,208.33	34	$388.48
	Blood	$6,783.01	49	$138.43
	General Exams	$4,749.22	71	$66.89
	Perinatal	$326.28	3	$108.76
		$3,267,477.17	20,279	$161.13

Fiscal Year 1996

Outpatient benefits accounted for $2,705,875.22 of healthcare dollars in fiscal year 1996. The top five ICD9 categories of admissions by cost were Ill-Defined, Injury, Genitourinary, Respiratory and Musculoskeletal. The top category for number of outpatient days utilized was Ill-Defined with a total of 5,620 and an average cost per day of $100.44. Neoplasm, while having only 285 units of service, should also be noted due to its high average cost per day of $647.94.

Fiscal Year	ICD9 Disease Category	Cost	Units of Service (Days of Treatment)	Cost per day
1996	Ill-Defined	$564,466.70	5,620	$100.44
	Injury	$425,958.14	1,612	$264.24
	Genitourinary	$316,470.78	1,346	$235.12
	Respiratory	$227,315.18	2,080	$109.29
	Musculoskeletal	$213,066.62	1,033	$206.26
	Digestive	$208,359.97	502	$415.06
	Neoplasm	$184,664.01	285	$647.94
	Maternity	$137,546.50	461	$298.37
	Nervous	$91,087.93	634	$143.67
	Infectious	$73,595.16	565	$130.26
	Skin	$61,311.34	663	$92.48
	Circulatory	$55,403.16	263	$210.66
	Endocrine	$39,019.83	264	$147.80
	Mental	$37,811.36	261	$144.87
	Special Exams	$28,522.64	532	$53.61
	Other	$21,273.54	101	$210.63
	Congenital	$11,251.54	23	$489.20
	Blood	$7,418.20	64	$115.91
	General Exams	$1,057.97	20	$52.90
	Perinatal	$274.65	4	$68.66
		$2,705,875.22	16,333	$165.67

Fiscal Year 1997

Outpatient benefits accounted for $3,600,971.77 of healthcare dollars spent in fiscal year 1997. The top five ICD9 categories of admissions by cost were Ill-Defined, Injury, Genitourinary, Musculoskeletal and Respiratory. The top category for number of outpatient days utilized was Ill-Defined with a total of 7,340 and an average cost per day of $96.73. Digestive, while having only 528 units of service, should also be noted due to its high average cost per day of $454.61.

Fiscal Year	ICD9 Disease Category	Cost	Units of Service (Days of Treatment)	Cost per day
1997	Ill-Defined	$709,966.09	7,340	$96.73
	Injury	$553,685.85	2,129	$260.07
	Genitourinary	$436,947.15	1,522	$287.09
	Musculoskeletal	$364,896.74	1,440	$253.40
	Respiratory	$328,952.69	2,311	$142.34
	Digestive	$240,034.80	528	$454.61
	Neoplasm	$160,801.05	380	$423.16
	Nervous	$147,504.08	716	$206.01
	Maternity	$146,755.12	455	$322.54
	Skin	$134,562.19	851	$158.12
	Infectious	$91,944.12	698	$131.73
	Circulatory	$78,272.49	316	$247.70
	Endocrine	$55,294.93	306	$180.70
	Special Exams	$53,807.20	784	$68.63
	Mental	$53,329.27	468	$113.95
	Other	$22,170.81	211	$105.07
	Congenital	$9,077.19	39	$232.75
	Blood	$8,473.96	64	$132.41
	General Exams	$2,383.24	43	$55.42
	Perinatal	$2,112.80	6	$352.13
		$3,600,971.77	20,607	$174.75

Fiscal Year 1998

Outpatient benefits accounted for $2,930,810.92 of healthcare dollars spent in fiscal year 1998. The top five ICD9 categories of admissions by cost were Ill-Defined, Injury, Musculoskeletal, Genitourinary, and Digestive. The top category for number of outpatient days utilized was Ill-Defined with a total of 5,472 and an average cost per day of $98.71. Neoplasm, while having only 460 units of service, should also be noted due to its high average cost per day of $370.42.

Fiscal Year	ICD9 Disease Category	Cost	Units of Service (Days of Treatment)	Cost per day
1998	Ill-Defined	$540,118.89	5,472	$98.71
	Injury	$489,382.42	2,029	$241.19
	Musculoskeletal	$308,782.63	1,226	$251.86
	Genitourinary	$303,044.05	1,251	$242.24
	Digestive	$242,049.57	693	$349.28
	Respiratory	$238,410.63	2,103	$113.37
	Neoplasm	$170,391.01	460	$370.42
	Nervous	$102,634.00	640	$160.37
	Skin	$97,216.42	742	$131.02
	Special Exams	$80,375.70	900	$89.31
	Maternity	$77,275.22	388	$199.16
	Circulatory	$64,733.91	187	$346.17
	Infectious	$64,130.95	579	$110.76
	Endocrine	$59,007.25	231	$255.44
	Mental	$38,409.03	359	$106.99
	Other	$29,798.09	198	$150.50
	General Exams	$14,997.90	336	$44.64
	Blood	$7,383.08	57	$129.53
	Congenital	$2,062.14	13	$158.63
	Perinatal	$608.03	6	$101.34
		$2,930,810.92	17,870	$164.01

Emergency Room Utilization

Benefit claims paid for emergency room (ER) usage appeared relatively low for the contract years covered between October 1, 1994 through September 30, 1998. For healthcare costs incurred, Emergency Rooms claims accounted for approximately 4.5% of the total dollars paid for outpatient healthcare services. The percentage of dollars paid for ER usage were 2.9% in 1995, 5.1% in 1996, 6.3% in 1997 and 3.5% in 1998.

Fiscal Year	Place of Service	Cost	%	Units	%	Cost per Unit
1995	Non ER	$3,171,576.45	97.1%	17,674	94.8%	$179.45
	Emergency Room	$95,900.72	2.9%	978	5.2%	$98.06
		$3,267,477.17		18,652		$175.18
1996	Non ER	$2,567,445.48	94.9%	13,875	93.8%	$185.04
	Emergency Room	$138,429.74	5.1%	910	6.2%	$152.12
		$2,705,875.22		14,785		$183.01
1997	Non ER	$3,375,077.33	93.7%	17,822	92.9%	$189.38
	Emergency Room	$225,894.44	6.3%	1,356	7.1%	$166.59
		$3,600,971.77		19,178		$187.77
1998	Non ER	$2,827,379.75	96.5%	15,992	94.7%	$176.80
	Emergency Room	$103,431.17	3.5%	899	5.3%	$115.05
		$2,930,810.92		16,891		$173.51

MEMORANDUM

DATE: August 19, 1999

TO: Bill Anderson
Assistant Inspector General for Audit

FROM: Peter Heinaru
Acting Director, AmeriCorps

SUBJECT: Comments on OIG Draft Report 99-15 – *Evaluation of the Corporation's Oversight and Monitoring of the Health Benefits Program*

Attached is the Corporation's response to the draft report on the results of your evaluation of the Corporation's oversight and monitoring of the health benefits program. In addition to responding to each of the eleven findings, two additional facts were noted. First, it was noted that when compared to the Federal Employee Health Plan – Blue Cross Blue Shield High Option PPO Plan, the Corporation's Benefit Plan was more generous to the member (p. 48). Second, despite this generosity, the $13.75 per member per month (PMPM) administrative cost was cited as "...quite low when compared to industry standards. National or other large PPOs...charge between $20 to $25 PMPM." (p. 51)

AmeriCorps

Corporation for National Service

An Evaluation of the Corporation's Oversight and Monitoring of the Health Benefits Program

A Response to Report Number 99-15
August 19, 1999

Pricewaterhouse Coopers, under the direction of the Office of the Inspector General, has completed Phase I of the audit of the Corporation for National and Community Service's Health Benefits Program. The audit revealed eleven findings. The Health Benefits Analyst (HBA) disagrees with four of the findings and agrees with the seven remaining findings. The comments below reflect the reasons for the HBA's opinion.

1. **The Corporation should develop and implement a system of formal policies and procedures – AGREE.**

   The Corporation intends to draft policies and procedures related to the oversight and monitoring function.

2. **The Health Benefits Analyst lacks clinical experience and knowledge – DISAGREE.**

   In the five years the HBA has worked in AmeriCorps, he has used his professional background in procurement and his Master's Degree in business on a regular basis to solve problems and improve the health plan. Understanding his need for more specialized training, he completed a certificate program in Health Care Management at Georgetown University in 1997. Participation in this program was endorsed by the Corporation which paid for 10% of the cost of this program. The HBA paid for 90% of these costs. The auditor's findings with regard to this program are inaccurate (pg. 23). The program was not two days in duration. It was an eight-part program lasting one academic year (See Appendix A). The required program of study included:

   I. Introduction to Management and Health Care Delivery Systems
   II. Strategic Planning and Management
   III. Applied Marketing and Management Information Systems
   IV. Financial Management and Reimbursement
   V. Organizational Management
   VI. Human Resource Management and labor Relations
   VII. Legal and Ethical Aspects of Health Care Management
   VIII. Integration Seminar

   The auditor claims that the HBA's position description cannot be fulfilled without clinical expertise. The following points were cited.

   > "Independently develops methods and provides cost effectiveness analyses aimed at improving service and reducing the cost of health support system. Analyses would include, but not necessarily be limited to, a review of the participant medical claims payment system provided by the contractor, analysis of customary and reasonable fee schedules of the health contractor for conformity to national physician and hospital profiles.

> Develops periodic reports regarding significant issues of participant health care delivery, cost analyses, and related topics. Examples of reports include identification and analyses of medical cost trends in participant health claims and their correlation of demographic and geographic factors; comparative analyses of annual participant medical costs versus previous years according to inpatient and outpatient care, diagnostic categories, average per diem costs, average length of stay in clinical facilities, and average inpatient case costs; and comparative analysis of participant medical costs versus costs of other subscriber plans operated by the health contractor according to the above-mentioned categories."

The Corporation does not agree that report development and cost analysis require clinical expertise. If the HBA required information in order to perform these tasks, Outsourced Administrative Systems (O.A.S.Y.S.), the third party administrator (TPA) may provide what is needed. At no time has the HBA needed a clinical healthcare background to properly execute contract administration, keep auditable records, transmit eligibility, do financial analysis to determine what improvements to the plan are financially feasible, answer customer service calls, process invoices, or keep track of new healthcare legislation. The HBA's predecessor did not have and did not need a clinical background either. In reviewing a comparable position at another agency, we determined that, for example, the Health Systems Administrator at the Peace Corps does not have this background. The clinically trained medical staff required of our TPA has proven sufficient over time. In addition, a Registered Nurse has recently been hired at the Corporation. The HBA may utilize her abilities on a part-time basis.

3. **Not all duties specified in the Health Benefits Analyst position description are being performed – DISAGREE.**

The finding that the position description and work plan differ is accurate. However, these documents are intended to be different. The position description is more detailed because it must encompass all tasks that might be performed over a long period of time while the work plan is merely intended to describe those tasks the employee accomplished or will accomplish over a twelve month period.

The auditors state on pg. 24 that the following three points are not being completely fulfilled.

> "Developing methods and providing cost effectiveness analyses aimed at improving service and reducing the costs of the health support system;
>
> Assuring the contract is administered in full accordance with Federal and Corporation procurement regulations and policies;

Developing periodic reports regarding significant issues of participants' healthcare delivery, cost analyses, and related topics."

With regard to the first point, it should be noted that since the HBA began working in his current capacity in 1994, the following changes have been made to the health plan. The ProVantage pharmacy network was utilized allowing members to pick up medication with their insurance card and a prescription. This made the mail order service obsolete and the need for reimbursements for pharmacy unnecessary. A $5 co-payment was utilized to reduce unnecessary trips to the doctor's office. Eligibility files have gone from using reel to reel tape to a modem to an encrypted file which is sent over the internet. All of these changes were made in order to improve service and reduce cost.

With regard to the second point, 45 contract modifications show that the contract has been administered in full accordance with all procurement regulations and policies.

With regard to the third point, reports are readily available which address healthcare delivery and cost analysis. The monthly reports generated by the contractor address the issue of administrative efficiency while the HBA generates reports related to cost analysis.

Finally, on pg. 9, the audit states that there is no related task from the work plan which corresponds to the position description requirement to cooperate with the Corporation's IG. Clearly, however, it is assumed that this will be done if necessary.

4. The Health Benefits Analyst overrules medical review decisions – DISAGREE.

It is neither a matter of practice nor policy to overturn decisions made by our contractor's medical review department. If medical evidence exists which would reverse such a decision, the HBA will see that it is acquired. Occasionally, for administrative reasons, medical bills will be paid which otherwise would not have been paid. These administrative exceptions are rare. As our contractor processes approximately 50,000 health claims each year, an exception would be made about once for every two thousand claims processed. If, for example, a member is injured in an automobile accident on their way to orientation, the Corporation has no responsibility to pay the bill. However, the HBA will see that the medical bill is paid if asked by state staff. The logic used is that the member would not have been driving if not for the need to report to orientation.

At no time has the HBA unilaterally overturned a medical decision for medical reasons without supporting medical evidence The Corporation administers the program in a responsible manner and maintains cost-effectiveness. In the few instances where the Corporation has made a determination different from that of the TPA, this has been done with the review and approval of the HBA's supervisor.

5. **The Corporation should institute annual compliance reviews of OASYS – AGREE.**

   The Corporation will explore having the HBA perform annual compliance reviews of OASYS.

6. **The Corporation should review the detailed results of OASYS internal audits and take corrective actions on any findings on any findings that are discovered– AGREE.**

   The Corporation will consider having the HBA perform a review of OASYS' internal audits.

7. **The Corporation should receive all reports required in the health benefits contract and perform all analyses required in the HBA's position description– AGREE, in part.**

   At one time, the HBA received reports which listed every medical claim processed and prescription filled. These reports proved to be both cumbersome and of little use. The HBA, therefore, elected to make these reports deliverable on an "as needed" basis. The suggestion that these reports come in on a diskette will be directed to the contractor.

   However, the auditor adds that the HBA does not create an analysis of medical cost trends in participant health claims and their correlation to geographic factors. The auditor concludes that these trends should then be used to forecast future costs associated with the health benefits program. The HBA has managed this contract for over five years and has gained an in-depth understanding of the costs and trends associated with AmeriCorps*VISTA and AmeriCorps*NCCC members. In addition, he maintains data which can produce reports based on geography, AmeriCorps program and/or fiscal year.

8. **The HBA should create and maintain a formal appeals log to track complaints made by program participants – AGREE.**

   While appeals have been kept on telephone message pads for five years, the Corporation agrees that it is a positive suggestion to keep appeals in a more formal "log" fashion.

9. **The Corporation should send more frequent updates of eligibility information to OASYS – AGREE.**

   Since the HBA took over this function five years ago, AmeriCorps VISTA has grown by more than 1,000 members. There is justification, therefore, in sending eligibility roles to the contractor more often than biweekly.

10. **The Corporation should make full use of these invoices by checking their accuracy, tracking the different line items, and requesting more information when necessary – AGREE.**

    The audit correctly notes that the new contract provides more detailed information on administrative costs. There are now separate line items for the administrative fee, other direct costs and the health benefits brochure.

11. **The Health Benefits Analyst certifies and approves invoices for payment prior to reviewing them – DISAGREE.**

    The HBA reviews all invoices. He must do this in order to know which funding code to draw down on for each line item in the invoice. In the five years that contract 95-743-1005 has been in effect, approximately 300 invoices have been received. On ten occasions, errors were made requiring corrections. In six of these cases, invoices were certified and approved for payment. In each instance, corrected invoices were submitted and paid. At no time was there any risk of duplicate payments being made because, as the HBA explained to the auditors, only original invoices can be paid and the HBA still has the original invoices which were in error.