



March 11, 2010

Health Service Board Agenda Item #06: Overview of UHC Medical Audit Results

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Background

- In 2009, Mercer conducted a performance audit that focused on United Healthcare's (UHC's) administration of The City Plan.
- This was the third audit of UHC conducted by Mercer since 2007.
- This report summarizes the results of the third UHC audit and the resulting action plan with UHC.

Overview of Audit Scope and Objectives

Scope

- *Medical Claims Review–5-month period of January 1 through May 31, 2009:*
 - Audit of statistical sample of 250 medical claims processed by UHC during the 5-month period.
 - Audit of a judgment (non-statistical) sample of the 3 highest payments for different members under the City’s 20% Plan* processed by UHC during the 5-month period.

Objectives

- Evaluate UHC’s performance following implementation of improvement actions in response to prior Mercer audits (2007 and 2008).
- Verify that claims are processed in compliance with the City Plan requirements, UHC’s procedures and controls, and UHC’s network provider rates.
- Measure the quality and timeliness of UHC’s performance, and validate UHC’s self-reported results for claims quality and designated staff utilization performance guarantee measurements.
- Identify opportunities for cost savings and service improvements.

* The 20% Plan is a benefit option available under the City Plan to a limited number of retirees who opt out of Medicare.

Audit Results

- Statistical Claims Review
 - *Error Trends*: 46% of the claim errors were processor-related, and 46% were UHC system or provider database related.
 - *Error Types*: The top category of error was coordination of benefits, which is the same as in the 2008 audit. The top categories of errors in the 2008 audit also included deductible and coinsurance, and misapplied pre-certification penalties. Only one error in these categories (pre-certification penalty) was found in the current audit, which is a notable improvement.
 - *Overpayment Rate*: UHC's estimated claim overpayment error rate decreased from 2.0% of plan payments in the 2008 audit to 1.5% in the 2009 audit.
 - *High Dollar Claims*: When compared to Mercer's 2008 audit, UHC's quality review program performance for claim payments greater than \$10,000 has declined; 9% of these claims had payment errors, compared to 4% in the 2008 audit.
- Judgment Sample (20% Plan Claims)
 - All 3 high dollar claims were overpaid a total of \$20,317 due to not coordinating benefits with estimated Medicare coverage.

UHC's Response and Improvement Actions

- UHC's response has been positive and proactive.
- UHC has taken immediate action including conducting root cause analysis of errors, and has implemented improvement actions.
- UHC will pursue recovery of any confirmed overpayments from providers, and furnish quarterly overpayment activity reports to HSS. UHC will not pursue recovery of overpayments from members.
- UHC has agreed to the following “financial concessions” totaling up to \$360,680:
 - Based on the external audit results, payout PG penalties for the period of 7/1/08–6/30/09) (\$280,680). This includes:
 - Annual payment incidence accuracy PG
 - Annual designated staff utilization PG
 - 3Q and 4Q financial payment accuracy PG
 - Fund a follow-up external audit in 2010 (\$80,000).

Next Steps

- UHC will continue to follow through on improvement actions, and provide periodic updates to HSS in the Quarterly Vendor Meetings.
- A follow-up audit will be scheduled for later this year to evaluate UHC's performance following their implementation of improvement actions (1/1/10–5/31/10 claims period).

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