Audit of City of Milwaukee Basic Health Plan Administration

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City of Milwaukee, Wisconsin

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Table of Contents

City of Milwaukee

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Michael J. Daun
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June 29, 2001

To the Honorable
the Common Council
City of Milwaukee

Dear Council Members:

The attached report summarizes the results of our audit of the City of Milwaukee Basic Health Plan Administration. The audit covered the administrative services provided under contracts by Wisconsin Physicians Service Insurance Corporation, Cobalt Corporation and Innovative Resources Group. The audit objectives were to evaluate contract compliance, service delivery, and service coordination by the contractors.

The audit found that for the most part the contractors provided adequate administrative services, but improvements are needed. Also, the audit noted some important compliance exceptions. The audit makes nine recommendations concerning contract compliance, service delivery and service coordination, including more active oversight by the Department of Employee Relations.

Audit findings and recommendations are discussed in the Audit Questions, Conclusions and Recommendations section of the report, which is followed by responses from the contractors and the Department of Employee Relations.

Appreciation is expressed to the contractors and Department of Employee Relations for the cooperation extended to the auditors.

Very truly yours,

W. MARTIN MORICS
Comptroller

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AUDIT SCOPE AND OBJECTIVES

I Audit Scope and Objectives

This is an audit of the administration of the City of Milwaukee (the "City") self-funded Basic Health Plan (the "Plan"), which provides health care coverage to City employees and retirees. The Plan is administered under City contracts by the Wisconsin Physicians Service Insurance Corporation (WPS), Cobalt Corporation (Cobalt) – formerly Blue Cross & Blue Shield United of Wisconsin, and Innovative Resources Group (IRG) – formerly CNR Health (collectively referred to as the "Contractors"). Please refer to the Organizational and Fiscal Impact section of the report for more information on the Contractors and the administrative services that they provide. The objectives of the audit were to evaluate contract compliance, service delivery, and service coordination by the Contractors. A further objective was to ensure that audit results were available to the City during the current procurement process for new Plan administration contracts. Enhancements were made in the City's requests for proposals based on these audit results.

The Audit reviewed the processes and procedures used by the Contractors to administer the Plan. The Audit included site visits to the three Contractors, and interviews with staff from the Employee Benefits Division (EBD) of the City Department of Employee Relations and the Contractors. The Audit also included examination of City and Contractors records and documents for the years 1999 and 2000. The Audit did not include an evaluation of Plan benefits and coverage levels. A listing of the audited functional service areas is included in Appendix 1.

Willis of Wisconsin, Inc., a national actuarial and employee benefits consulting firm, assisted in the Audit. Separate reports by Willis of Wisconsin on the utilization management services by IRG and WPS are included in Appendices 2 and 3.

ORGANIZATIONAL AND FISCAL IMPACT

II Organizational and Fiscal Impact

The City of Milwaukee provides health coverage to about 7,500 active employees and about 5,000 retired employees, and their dependents, totaling about 31,000 individuals. Four HMOs cover about 63 percent of City employees and retirees: CompcareBlue, CompcareBlue Aurora Family Network, Humana, and United Healthcare. The remaining 4,600 active employees and retirees, along with their dependents, are enrolled in the Plan. For the twelve-month period ended March 2001, payments on Plan claims averaged about $8,000 per active employee, and about $6,000 per retiree.

WPS provides comprehensive claims administration services to the Plan, including coverage eligibility determinations, claims adjudication, coordination of benefits with other insurance carriers, and claim payment processing. WPS has administered the Plan for over eleven years. The Plan has not changed significantly over the years, except for the addition in 2001 of a prescription drug plan through ProVantage, which gives participants access to discounts on prescription drugs. In 2000 WPS adjudicated over 160,000 claims and paid over $30 million on behalf of the City.

WPS is a not-for-profit insurance company headquartered in Madison, Wisconsin. Members of the State Medical Society of Wisconsin founded WPS in 1946. Today WPS has over 2,900 employees, most employed in Dane County. WPS maintains an office in Milwaukee to administer the Plan.

The WPS InsurTec division administers health plans for non-federal government clients, including the City. InsurTec business represents roughly 15 to 20 percent of WPS' total business, with the InsurTec business being about half insured policies, and half self-funded like the City Plan.

Cobalt currently provides the City with discounts on Plan claims when health care services are obtained through physicians and hospitals in its Preferred Provider Organization (PPO) network. The merger of two companies, Blue Cross & Blue Shield United of Wisconsin and United Wisconsin Services, Inc. formed Cobalt, which is one of the nation's leading managed care companies, serving 2 million people in 49 states. Cobalt is one of four publicly traded Blue Cross companies and offers the full range of

health care plan products and services. Cobalt is headquartered in Milwaukee and employs more than 2,500 people in 15 states.

IRG currently provides utilization management services for the Plan, which include hospitalization pre-certification, concurrent review, discharge planning and large case and other medical management services. In 1998 the City contracted with IRG's predecessor organization CNR Health, Inc. IRG was formed in 1999, with the merger of five wholly owned subsidiaries of United Wisconsin Services, Inc, including CNR Health. IRG and its predecessor organization have been providing utilization management services for over 15 years. Today IRG serves over 1.4 million people in 39 states.

AUDIT QUESTIONS, CONCLUSIONS AND RECOMMENDATIONS

III Audit Questions, Conclusions and Recommendations

A. Wisconsin Physicians Service Insurance Corporation

In most contract areas, WPS complies with its contract and provides adequate Plan administration. WPS utilizes a highly automated claims processing system. WPS staff is knowledgeable and experienced in claims administration, and with the specifics of the City Plan. WPS adjudicated over 160,000 claims and paid over $30 million on behalf of the City in 2000. However, the Audit found issues that require corrective action. In particular, WPS is not in full compliance with certain contract performance and reporting requirements, including substandard claim processing accuracy that resulted in an estimated $500,000 in overpayments to health care providers during 2000. WPS asserts that about $355,000 was subsequently recovered. The Audit did not review claim processing accuracy in prior years. These and other weaknesses are reported below, along with recommendations for improvement.

1. Is WPS in compliance with the provisions of its contract? WPS has, for the most part, met compliance requirements with some significant exceptions.

The Audit determined that WPS is providing the full range of claim processing services called for in its contract, but is not in full compliance with contract performance standards and reporting requirements.

The WPS contract includes four claims processing performance standards for financial accuracy, claim-processing timeliness, and responsiveness to telephone inquiries and written inquiries. The audit found four areas of noncompliance with these contract performance standards.

- **WPS did not calculate its financial claims payment accuracy as called for in its contract.**
- WPS did not consistently meet the claims administration performance standards in its contract and in its own policies. In particular, WPS financial accuracy was below standards for 2000.
- WPS partially met the customer service performance standards in its contract.

- WPS did not report its claims administration performance to the City as required in its contract.

For financial accuracy the WPS contract specifies a claims payment accuracy measure. The WPS contract states,

> *"Financial Accuracy. Administrator [WPS] will achieve a 98% level of financial accuracy. This means that the total dollar amount of claim processing errors will not exceed two (2) percent of the total claim dollars paid out during each calendar quarter for which Administrator is responsible for administering claims. Financial accuracy is the total amount of claim dollars paid correctly divided by the total dollar amount of claims processed expressed as a percentage. Total dollar amounts correctly paid is calculated by subtracting the total dollars paid in error (overpayment plus underpayments) from the total dollars paid."*

WPS calculates financial accuracy based on dollars charged (claimed) by health care providers, rather than dollars paid to providers. WPS subtracts payment errors from dollars charged and divides the result by dollars charged. This is not a measure of payment accuracy. **The Audit estimates that WPS financial payment accuracy, as defined in the contract, was 96.3 percent for the twelve-months ended November 2000, below the 98 percent contract standard.**

In addition to not meeting the contract standard for financial payment accuracy, WPS did not meet most of its internal corporate financial accuracy and data-coding accuracy standards on Plan claims. These WPS internal standards are generally more stringent than the contract standards.

WPS selects samples of processed claims for monthly post-payment audits. These WPS audits were reviewed for the twelve months ended November 2000, the last completed monthly audit. The review indicates that WPS post-payment audit procedures are appropriate. According to the WPS audits, overall financial accuracy was 94.6 percent for the twelve-month period (based on the WPS calculation method rather than the contract calculation method). Also, 91.5 percent of the Plan claims were found to be free of payment errors. According to the WPS audits, 99.1 percent of the data fields for Plan claims were free of errors. However, only 86.3 percent of the Plan claims were free of data errors. With the exception of data field accuracy, this claims processing performance was below WPS internal standards.

The WPS audits identified a total of about $50,000 in overpayments and about $395,000 in underpayments on the Plan claims sampled during the twelve-month period. Overpayments and underpayments occur when WPS pays the wrong amount on a claim, pays the wrong health care provider, improperly denies a claim for incomplete information, or pays the same claim charge more than once. WPS corrects payment errors identified in its audits, and credits the City for recovered overpayments.

Extrapolation of WPS audit results to the population of Plan claims indicates that WPS overpaid health care providers about $500,000 for the twelve months ended November 2000. According to WPS, most of these overpayments were subsequently detected and recovered. In response to the Audit, WPS asserts that about $375,000 in overpayments were detected during 2000, and about $355,000 has been recovered and credited to the City.

The WPS contract states,

> *"Claim Processing Time. Administrator [WPS] will process within (30) calendar days of receipt 92% of all claims received during each calendar quarter..."*

WPS data for 1999 and 2000 indicate that this contract standard was met for six of the eight calendar quarters (not met in the third and fourth quarters of 2000). Overall, **for the two-year period, 95 percent of claims were processed within 30 days, which exceeds the 92 percent contract requirement.**

The WPS contract states,

> *"Telephone Inquiries. Administrator [WPS] will answer 95% of all telephone inquiries from Plan members during the initial call."*

WPS data for 1999 and 2000 indicate that this customer service contract standard was met only in the fourth quarter of 2000. Overall, **for the two-year period, 91.5 percent of telephone inquiries were answered during the initial call, which is below the 95 percent contract requirement.**

The WPS contract states,

> *"Written Inquiries. Administrator [WPS] will respond to 85% of written inquiries within fourteen (14) calendar days of initial receipt."*

WPS did not track responses consistent with its contact requirement. WPS tracked responses only within 16 days, rather than 14 days. WPS data for 1999 and 2000 indicate that, overall, 88.2 percent of written inquiries were answered by WPS within 16 days, compared to the contract requirement for 85 percent within 14 days.

Concerning the above standards, the WPS contract states,

> *"Administrator [WPS] will provide the Group [City] with quarterly performance reports. These reports will contain the results of a representative sample audit to adequately substantiate compliance with the above standards of performance... Administrator [WPS] agrees to...Conduct regular semi-annual audits to measure compliance with the terms and provisions of the Plan and this Agreement, the results of which shall be forwarded to the Employee Benefits Manager in June and December of each contract year to the Group [City]. Such audits shall include, but not be limited to, reviews of a statistically valid sample of claims as determined by the Group..."*

During 1999 and 2000 WPS submitted quarterly audit reports on financial accuracy based on the WPS calculation method rather than the contract calculation method. **WPS did not submit the performance reports or audits required by its contract. In addition, EBD has not monitored WPS compliance with the above contract performance standards and related reporting and auditing requirements.**

2. Is WPS providing adequate and effective services? WPS services have been adequate, for the most part, but some important service improvements are needed.

The audit found that, in general, WPS Plan administration services have been adequate. **However, some important service improvements are needed. Financial accuracy is not adequate, as discussed under question one on contract compliance. Coordination with the utilization management contractor IRG is not adequate, as discussed under question three on coordination. Plan activity reports to the City need revisions and improvements. Also, some key Plan documents need to be updated.**

WPS provides the City with two standard Plan activity reports, and ad-hoc reports on special request. Monthly, the City receives a comprehensive report on claims processed during the month. These monthly reports provide detail on claim charges and payments by employee group, union, health care provider, type of service, etc. Quarterly, the City receives two Enhanced Data Reports, one for "Actives" and the other for "Retirees". These quarterly reports provide information on Plan health care utilization for the most recent twelve-month period and prior twelve-month period, along with normative data.

The dollar amounts and participant counts in the quarterly reports do not agree with the monthly reports. This appears to be caused by two factors. First, according to WPS, the quarterly report on retirees includes only Plan members with Medicare coverage. Other retirees are incorrectly included in the report on active employees. Second, the dollar amounts in the quarterly reports represent neither Plan claim charges nor payments. In order to provide normative comparisons to other health plans, WPS reports composite amounts that include City payments, some employee payments, other insurance payments, but exclude drug copays and Medicare payments. WPS does not report actual Plan claim charges and payments on an annual basis. Due to these deficiencies, the WPS quarterly reports appear to be of questionable value to the City.

The Master Plan Document detailing Plan benefits has not been updated since 1998, and the Plan member benefit summary booklet has not been updated since about 1990. WPS and EBD have discussed the need to update these documents, but WPS has not taken the lead in actually updating them, as called for in its contract.

3. Is WPS adequately coordinating service delivery?
Yes, on PPO discount pricing. No, on utilization management.

WPS adequately coordinates with Cobalt (Blue Cross) for the delivery of PPO discounting services. WPS has not communicated or coordinated well with IRG on utilization management, particularly related to hospital pre-admission authorizations. Please refer to the Willis of Wisconsin reports in Appendices 2 and 3 for more information. Recommendation 8 identifies steps that should be taken to improve communication and coordination for utilization management.

Recommendation 1.

WPS should calculate and report its financial payment accuracy in accordance with its contract. The recent request for proposals for the next Plan administration contract contains appropriate performance standards, including a requirement for 99 percent financial payment accuracy (an increase over the 98 percent standard in the current contract). EBD should ensure that these performance standards are a part of the next claims administration contract.

Recommendation 2.

WPS should submit all performance reports and audits required by its contract. EBD should actively monitor and enforce WPS compliance with all contract performance standards and related reporting and auditing requirements. When WPS performance is below contract standards, EBD should obtain and evaluate WPS explanations and agree to an appropriate and time-specific performance improvement plan.

Recommendation 3.

EBD should ensure that the Plan activity reports needed by the City are specified in the next claims administration contract, and actually provided to the City consistent with the contract. These needed reports could include annual reports on Plan claim charges and City payments with useful detail for active employees, retirees, employee groups (management and unions), detail by Plan member gender and age, detail for behavioral health, and the drug-card program, etc.

Recommendation 4.

Under the next claims administration contract, EBD should specify target dates for the claims administrator to submit, for EBD approval, revisions and updates to the Master Plan document and Plan member benefit summary booklet.

The Cobalt PPO network consists of health care professionals and hospitals providing inpatient and outpatient services for Plan members. Cobalt supplies WPS with information on its discount agreements with physicians and other professional health care providers. However, apparently due to competitive concerns, Cobalt has not been required to supply WPS with information on its hospital discount agreements. This results in physician and professional provider PPO discounts being calculated automatically by the WPS claims processing system, while hospital discounts cannot be calculated automatically by the system. Cobalt manually calculates the PPO hospital discounts and then sends them to WPS for further processing. This manual discounting process is less efficient than automated processing, and probably results in greater errors.

When Cobalt is engaged to provide both claims processing and PPO services for other (non-City) clients, all provider and hospital PPO discounts are calculated automatically by the Cobalt claims processing system, and reviewed by the Cobalt internal audit function. The manually discounted Plan hospital claims have not been audited by Cobalt. When Cobalt is also the claims processor for other clients, adjustments are made to claims covered by subsequent PPO agreements with discount changes and retroactive effective dates. Cobalt does not make such retroactive adjustments for the manually discounted Plan hospital claims. Since the WPS claims processing system is used to discount PPO physician and professional provider claims, these claims are reviewed by WPS internal audit and WPS makes retroactive adjustments when necessary.

The audit reviewed the manual discounting done by Cobalt on twenty-four inpatient and outpatient hospital claims. Three claims had discounting errors, and in all three cases the City received greater discounts than called for by the PPO agreements. Another three claims were covered by subsequent PPO agreements with retroactive effective dates and lesser discounts. Since adjustments were not processed for these claims, the City retained the greater discounts. The lack of retroactive adjustments will not always benefit the City, because discounts have increased in some Cobalt PPO agreements.

Recommendation 5.

Manual calculation of PPO discounts for Plan hospital claims should stop. Cobalt should supply WPS with the information needed to process all PPO discounts using the automated WPS claims processing system.

C. Innovative Resource Group

IRG complies with the terms of its contract and generally provides adequate utilization management for the Plan. IRG has earned accreditation from the Utilization Review Accreditation Council (URAC), a coveted designation of quality that few firms have achieved. However, some service improvements are needed. Weaknesses and recommendations for improvement are reported below and in Appendix 2.

1. Is IRG in compliance with the provisions of its contract?
Yes.

The audit determined that IRG is in compliance with the provisions of its contract.

2. Is IRG providing adequate and effective services?
Yes, but some improvements are needed.

The audit determined that, in general, IRG utilization management services have been adequate and effective. However, some improvements are needed. The review process could be improved to foster a greater impact on care provided to Plan members. For example, IRG does a good job of oversight and of alerting health care providers to their presence, resulting in some impact, but the audit found no direct evidence of creative initiatives targeted toward improving care and educating providers. Finally, utilization management processes available today have not kept pace with the changing needs of the medical care environment. As a result, their ability to positively impact care and reduce costs has eroded. IRG's processes and execution are consistent with today's standard practice. However, the current IRG approach is not as effective in controlling escalating medical costs as aggressively exploring "best practices".

3. Is IRG adequately coordinating service delivery?
No, communication and coordination with WPS is inadequate.

IRG has not communicated or coordinated well with WPS on utilization management. Insufficient communication and coordination, or lack thereof, led to instances where cases were not reviewed. This caused missed opportunities to control medical service

utilization, educate patients, and control costs. Please refer to the Willis of Wisconsin reports in Appendices 2 and 3 for more information.

Recommendation 6.

EBD should work with IRG or the next utilization management contractor to review and reconfigure program reports with particular emphasis on the following:

- The utilization reports provided by the contractor should be reconciled with the Plan administrator's reports.
- A periodic report package should be created to allow EBD to monitor the performance of the contractor and the effectiveness of the utilization management program.

Recommendation 7.

EBD should work with IRG or the next contractor to enhance utilization management processes and approach to be consistent with industry "best practices" trends, as follows:

- Incorporate disease management into both utilization review and case management processes. Disease management is a proactive process of monitoring patient health risk factors and of working with patients and doctors to prevent or control disease and reduce complications. Disease management addresses the continuum of patient care. It starts by working to keep people healthy. When a medical condition is diagnosed, disease management may be useful in retarding its progress. When a condition becomes acute, disease management assures that care is adequately managed and coordinated. Lastly, if a condition is terminal, disease management emphasizes patient comfort and dignity.
- Implement processes to examine claims data to identify the best candidates for case management and target review areas.
- The selected claims data needs to be used in conjunction with review processes that look beyond managing a confinement and more broadly focus on assisting the patient across the entire disease process. For example, claims data can be used to identify patients in the early stages of diabetes where disease management may improve the long-term course of the disease and reduce costly hospitalizations.

- Implement discharge coordination processes that minimize the potential for retrospective denials. Nurse reviewers should check on patient status the day before the planned hospital discharge date.
- Reengineer call-intake processes to streamline review for targeted areas and processes to identify patients in need of help or education.
- The contractor should help identify areas of concern and suggest strategies to most efficiently utilize financial and program resources.

Recommendation 8.

There are serious deficiencies in communication and coordination between IRG and WPS for utilization management. The following steps should be taken toward correcting these deficiencies:

- IRG and WPS should jointly implement policies and procedures to assure that all medical cases are appropriately reviewed.
- IRG should specify the information needed to identify all cases that would benefit from case management. WPS should provide this information to IRG in a timely manner.
- IRG and WPS should agree on and document their respective roles in determining medical necessity.
- IRG and WPS should work together to assure that utilization reports are accurate and complete.
- EBD should actively monitor progress in improving utilization management and provide written feedback to IRG and WPS.

Recommendation 9.

EBD should work with IRG and WPS to implement the additional utilization management recommendations by Willis of Wisconsin in Appendices 2 and 3.

APPENDIX 1

Appendix 1

The Audit of City of Milwaukee Basic Health Plan Administration covered the following functional areas:

Wisconsin Physicians Service

Actuarial Services

Audit Processes and Procedures

Cobalt (Blue Cross) Preferred Provider Organization (PPO) Interface

City and WPS Contract

Claims Appeals

Coordination Of Benefits (COB) Administration

Communications

Eligibility Maintenance

Fraud Investigation

Health Plan Bank Account Process

Information Protection Administration

IRG Utilization Review Interface

Network Hospital Charges Repricing

Network Professional Charges Repricing

On Line Plan Load

Overpayment Recovery

Performance Measurement and Reporting

Performance Standards

ProVantage Prescription Drug Program

Refunds Crediting

Regulatory Compliance

Reports and Reporting

Stale Dated Checks

Subrogation

Usual Customary and Reasonable Administration

Cobalt Corporation (Blue Cross & Blue Shield)

Network Repricing Process and Procedures

Repricing Accuracy

WPS Administration Interface

Innovative Resources Group

System Automation and Reporting

Philosophy toward Utilization Management

Execution of the Utilization Management Process

- Call intake and triage
- Review process and criteria (preauthorization and case management)
- Interface and working relationship with WPS
- History maintenance and reporting

Preadmission Review

Case Management

Hospital Utilization Management Guidelines

Nurse Reviewer Quality Monitoring

Proposed Targeted Review

Diagnosis Triggers for Case Management

APPENDIX 2

Appendix 2

Background and Purpose of Audit

The City retained the services of Willis of Wisconsin to assist in performing an audit of the City's Basic Health Insurance Plan. An important part of this audit involved an evaluation of Innovative Resources Group (IRG).

IRG is responsible for providing utilization review, case management and related services for the City's Basic Health Plan. Collectively these processes are generally referred to as "utilization management."

The main purpose of utilization management is to assure that care is provided in the most appropriate setting, that individuals with several medical conditions receive appropriate and efficient care and that providers of health care are "educated" regarding how to reduce inappropriate utilization.

By utilizing these processes it is generally accepted that the overall cost of medical claims can be reduced. IRG's utilization management report for 2000 indicates direct savings (estimated cost of care not approved as medically necessary) of $400,000 and indirect savings (estimated future costs avoided) of $113,000. By comparison, fees paid to IRG in 2000 totaled $126,000.

The purpose of the audit of IRG was to test the following:

1. Determine if services are consistent with contract requirements.
2. Assess how services and execution compare with "best practices."
3. Determine whether the coordination of duties among the City, WPS and Innovative Resources Group was functioning efficiently.
4. Assess how the review process impacts care leading to improved health outcome to the patient and lower cost to the City.

The activity of "utilization management" relies heavily on interventions and processes that require clinical knowledge. As a result, it was important that the City retain outside expertise for this portion of the audit of the basic health plan.

The utilization management review was conducted by Douglas J. Ley of Willis and Dr. Michael M. Neren. Mr. Ley has 20 plus years experience in the design and operation of utilization management processes. Dr Neren is an independent physician and former assistant Medical Director at United HealthCare who has an established relationship with Willis. He provides clinical expertise and input to audits.

The audit included an on-site visit to IRG by Messrs. Ley and Neren, with interviews of key IRG staff, review of systems and procedures and review of notes and discussion of a random sample of 21 inpatient and 5 case management cases sent to IRG prior to the on-site. The review investigated system automation and quality management, philosophy toward utilization management, execution of utilization management process, including call intake and triage, review process and criteria, utilization review (UR) guidelines, nurse review quality monitoring, diagnosis triggers for case management and interface with WPS.

Audit Conclusions and Recommendations

IRG complies with its contract with the City and generally provides adequate services. IRG's staff was knowledgeable and cooperative. However, the audit uncovered some areas of weakness which, if addresses, would improve the level of service and overall financial impact associated with the program.

1. Are services consistent with contract requirements?

The audit determined that IRG is providing the reporting, utilization and case management services required in its contract with the City. The Audit found the following contract related issues:

- ✓ Reference to a medical information line should be deleted from the contract. The contract requires that IRG make available a "medical information line." Medical information lines are also referred to as demand management processes. This service allows an employee to talk with a nurse about health issues and minor medical problems. By providing access to a nurse it is generally accepted that employees will make better choices and that some physician visits can be avoided through self care. As a result, cost is reduced.

  The City does not currently purchase this service, but a City plan participant can still call informally and ask questions of an IRG review nurse. However, IRG no longer "sells" a formal "medical information line." The number of firms offering this service has declined over the past several years since they were never aggressively promoted by employers and seldom used by employees.

  It is not necessary to have the medical information line provided by the same firm that provides utilization management. If the City would desire a medical information line in the future, it would need to be purchased separately from a firm other than IRG. As a result, this requirement should be removed form the contract.

- ✓ Compliance with the insurance requirements contained in the contact should be monitored. The City's contact with IRG requires that they maintain certain insurance

coverages for items such as errors and omission and professional liability. The City has not monitored compliance with this requirement.

✓ The City should either provide the written guidelines as required under section II.A.1. of the contact or rewrite this reference in the contract.. The contract references the City will establish from time to time written guidelines under which the contractor will provide medical review. The City has not furnished these guidelines. As a result, IRG has been operating under the assumption that their standard utilization management product services were the City guidelines.

The intent of this language should be clarified with the City Attorney's office and language drafted to either allow the service provider to utilize their standard practices as the guidelines, or that specific guidelines be provided by either the DER or City Attorney's office.

✓ The section of the contract authorizing IRG access to City employee information is too broad and should be rewritten to include access solely to eligibility, demographic claims and medical information. Section IV, A authorizes IRG with broad access to financial and personal information pertaining to City employees. This language should be revised as it appears to be too broad. Access to any information beyond verifying eligibility, or obtaining demographic and claims / medical history data is not necessary for the utilization management process.

2. How do IRG's services and execution compare with "best practices"?

Services and execution are consistent with current industry "standard" practice and with what the majority of similar firms are providing today. However, IRG, like most firms in this business, has begun to explore "best practices" in a 21st century environment. These new "best practices" focus on issues beyond the setting of care and education of the patient and encompass processes that ensure that treatments for diseases follow protocols developed to improve outcome for the patient and consequently lower costs.

The audit also uncovered several other operational issues that should be addressed.

The following are recommended to move IRG's services and execution in the direction of emerging "best practices" as well as address operational issues identified during the audit.

✓ Insist that review and case management nurses be moved to the same location as soon as possible. People who take the initial calls from City members, nurses who review inpatient stays and those nurses dealing with assisting City members with serious illness should be at a common location. Currently, since the merger of four separate companies to form IRG, the nurses who help City employees with serious illnesses (case management) are separate from those that review inpatient stays.

When these processes are in separate locations there will be missed opportunities for the staff to interact and work as a team to ensure the best possible care and that opportunities to contain costs implemented.

✓ Implement enhancements in the methods used to answer and triage initial calls. The methods used to take initial calls from City members and decide what to do with them ("triage") should be redesigned and enhancements implemented. These enhancements should address the following:

- ↪ Educate the staff that answers the initial call how to assess whether a caller has concerns or issues that could benefit from intervention by a clinical professional.
- ↪ Finalize and implement target review process where the non-clinical staff who answer the initial call can pre-authorize simple, straight forward cases freeing up time for the clinical staff to concentrate on cases where it is anticipated they can better impact care and costs.
- ↪ Triage staff could be more aggressive in educating patients regarding IRG's services as well as in obtaining missing information from the physician instead of placing this burden on the patient.

✓ Implement "data mining" processes to identify patients who would benefit from case management that go beyond referrals by the City or cases identified during a inpatient stay review.

The current process to identify individuals who would benefit from case management relies on a City referral or a nurse list of "trigger" diagnosis used when reviewing a request for inpatient stay. The claims data maintained by WPS and now ProVantage contains a wealth of information that could be used to identify individuals whose health conditions warrant case or disease management.

Technologies can be used to sort pharmacy and medical claims history so individuals with certain diseases (as evidenced by pharmacy use, services or diagnosis) can be sought out and helped.

✓ Take steps to require use of, and better educate covered City Plan participants regarding using the program. Use of the utilization management program is voluntary. There are no penalties if an employee does not use the program. The vast majority of employers who include utilization management in their medical programs reduce benefits if they are not used.

The City relies on the threat of an indirect penalty to get employees to use the program. This indirect penalty results from a Basic Health Plan exclusion, which states that "non-medically necessary services" will not be paid.

This fact is not aggressively communicated to Plan participants. Worse, as is explained later in this report, IRG does not ask WPS for a record of all services that should be subject to utilization management so a retrospective review can be done. WPS will pay a service whether it is authorized or not. As a result, if the employee never uses the program their claims will be paid without question. Therefore, there is no real incentive to call.

- ✓ Require that IRG call to verify patient discharge the day it is planned not the day after, as is the current practice. If a patient is kept in the hospital an additional day, IRG will not know until it is too late if they call after the discharge should have occurred. This can result in the retrospective denial of part of a claim. This can be especially problematic since the patient never had a chance to react to the situation and request discharge or appeal.

- ✓ Monitor implementation of new utilization review software. IRG is in the process of implementing an upgraded utilization review software system. The primary benefit of this system is to allow improved access to review history information by nurse reviews. In addition it will eliminate the need to maintain paper files which can be lost and are cumbersome to use.

  This reengineering of the software systems is consistent with best practices. However, as can be the case with any new system the City should monitor progress to ensure the system *is* implemented and that no situations arise that degrade employee service occur.

3. Is the coordination between the City, WPS and IRG functioning efficiently?

There are serious deficiencies in the communication and coordination between IRG and WPS. Commitments must be required of both parties to take steps to address the deficiencies promptly. These deficiencies result in missed opportunities to avoid utilization, educate patients and thereby reduce costs.

Both WPS and IRG strongly advocate that the utilization management and claims processing functions need to work closely together. However, close coordination is lacking. Each organization works in a vacuum from the other and communication only occurs when a problem occurs.

CNR Health was the organization that the City contacted with in 1998. A company related to Blue Cross and Blue Shield United of Wisconsin subsequently acquired it. CNR was then merged with four other organizations to form IRG. Although on the surface, the two firms realize they should work together, there is now a greater undercurrent of competition between the organizations that may be affecting the relationship.

The following steps should be taken to address the deficiencies.

- ✓ IRG and WPS should meet to identify and implement processes to exchange information to ensure that all cases that should be reviewed are.

- ✓ IRG should identify to WPS the data reports necessary to identify individuals who would benefit from case management (beyond those identified by the City or the review process). These reports should be provided to IRG on a regular basis.

- ✓ IRG, WPS and the City should meet and establish guidelines for who should determine which services are medically necessary in what instances and open channels of communication to assess services that fall into "grey" areas.

- ✓ IRG and WPS should meet to review protocols for data reporting. The current reports provided by IRG cannot be reconciled with WPS reports.

- ✓ IRG and WPS should meet with the City on a predetermined schedule to report on progress and discuss emerging issues.

4. Is the review process impacting care, leading to improved health outcome to the patient and lower cost to the City?

The review process needs redesign to further its impact on care and lower cost to the City. IRG does a good job of oversight and of alerting providers to their presence. As a result, IRG has some impact as the savings report and audit revealed. In addition, IRG's process has received URAC accreditation for case management, a coveted designation of quality few firms have achieved.

However, there are areas of opportunity to improve. In the cases reviewed, the auditors saw several instances were proactive initiatives targeted toward improving care and educating providers could have been employed. Failure to act in these instances resulted in missed opportunities to improve patient outcome and potentially reduce cost. Programs to integrate disease management into the review process are also advised.

The following would help increase the impact that IRG can have on health outcome and savings to the City.

- ✓ Begin to incorporate disease management protocols and support into the utilization management process. Disease management goes a step beyond traditional case management and looks at appropriate settings for care and educates patients. Disease management focuses on what clinical processes produce the best health outcome for the patient with the most efficient application of financial resources. For example, one patient with cancer was not transferred to a hospice setting because the family was in denial.

- ✓ Enhance reviewer guidelines by incorporating information that would assist in the identification of situations that would benefit from case or disease management. Both the internal and external guidelines used by reviewers to review proposed hospitalizations are appropriate and nationally recognized. However, existing guidelines were rather cursory and would benefit from incorporating information to help reviewers identify patients that could benefit from case or disease management. In addition, quality indicators should be incorporated to assist in identifying disease management opportunities.

- ✓ Improve the level and quality of communication between the case manager, patient and patient care providers. The case managers should position themselves as a resource to the patient's physician as well as the patient, versus being simply an overseer. The initial letter to the patient authorizing case management could be made more friendly and supportive.

- ✓ IRG should periodically review the City's Basic Plan utilization and recommend strategies designed to address problem areas. Most utilization management processes are set up on a "one size fits all" approach. This can lead to missed opportunities to design interventions that are unique to the City's utilization patterns.

- ✓ Develop feedback processes to measure whether cases selected for intervention were in fact positively impacted. This feed back should go beyond measuring savings and focus on patient outcome. For example, did the process lead to an improved quality of life for the patient.

- ✓ Case management notes are kept in a paper file. We recommend electronic files since this allow access by more that one person and better guards against the loss of information from paper files.

APPENDIX 3

Appendix 3

The audit of Wisconsin Physicians Service Insurance Corporation (WPS) included a clinical audit of its medical necessity administration as well as a review of its interface with Innovative Resources Group (IRG), the utilization manager for the City Basic Health Plan (Plan).

Clinical Audit

The City retained the services of Willis of Wisconsin to assist in performing an audit of the Plan. Part of this audit involved a clinical review of WPS. WPS is responsible for providing claim payment and customer service processes. In being able to effectively administer claims, part of WPS' responsibility is to determine whether services received are consistent with what is generally accepted as "medically necessary" and appropriate with the diagnosis and age of the person.

After completing the review of IRG, Douglas Ley of Willis and Dr. Michael Neren, an independent physician consultant, traveled to Madison to meet with WPS clinical staff. The purpose of this visit was to evaluate 1) whether the systems in place were adequate to provide controls over the medical necessity and appropriateness of services provided; 2) whether the guidelines and resources utilized were appropriate and able to produce useable, quality guidelines.

Here is what we found:

- The system WPS has in place is adequate to check for the presence of unbundling (charging full price for multiple procedures performed at the same time) and upcoding (overstating the intensity of services to charge a higher fee).
- The claims processing system and guidelines in place for examiners are consistent with best industry practice and likely to properly identify medical services that may be questionable.
- The clinical input and processes utilized to develop guidelines are consistent with best industry practices.

The onsite review at WPS headquarters was conducted on March 29 and 30, 2001. During the review the following individuals from WPS were present.

David Luce, Medical Director
Susan Roy, Director of Medical Affairs
Tamara Straub, Manager – Prior Authorization

What was Reviewed, What was Found and What Should be Done About it?

WPS system controls – WPS utilizes a sophisticated software program to detect unbundling and upcoding within the insured population. The WPS audit director Craig Nelson confirmed that Milwaukee claims are currently going through the value coder.

Other interfaces and methodologies to review claims were considered extensive and appropriate with best industry practices.

WPS is in the process of combining both its pre-authorization and medical review processes. IRG currently performs the pre-authorization process. Medical review is the process put into place to determine whether a given service is payable under the medical necessity criteria of the Plan.

WPS serves as payer for Medicare B as well as several other government programs.

Dr. Luce has access to numerous working physicians, chiropractors, plus a Medicare peer review group. Dr. Luce has established a medical advisory committee made up of local physicians who provide input on medical policy.

The claim system can stop claims and specific instructions can be put in place to stop certain types of codes, certain types of claims or claims received from a certain provider.

Based on the results of our review and the discussions, we do not feel that there are any concerns related to WPS and the objectives of this audit.

Interface with IRG

The Plan has three administrative vendors: WPS is the third party administrator, Blue Cross provides the Preferred Provider Organization (PPO), and IRG provides utilization management. This combination of vendors provided the best overall service package for the City at the time of the last procurement in 1998.

This arrangement places demands on the vendors to work with other vendors, including in this case, competitors. The communication between WPS and IRG, in both directions, has been less than optimal, and has lead to inefficiency, increased errors and reporting of limited value. There seemed to be reluctance on the part of WPS to get in touch with IRG when a particular issue fell into IRG's area of responsibility.

Examples of lack of communication and coordination between WPS and IRG included:

- ✓ WPS received and paid hospital claims on which there was no IRG pre-authorization.

- ✓ WPS did not inform IRG about the hospital claims without IRG pre-authorization. Therefore, IRG was not aware of all hospitalizations, and could not track or manage these cases.
- ✓ Since all cases were not reported by WPS, IRG's utilization reports to the City were of limited value and did not agree with utilization data in WPS reports.

The Plan member benefit summary booklet states pre-authorization by IRG is required for hospitalization and certain other medical services. However, there is no benefit penalty to Plan members for not obtaining this pre-authorization.

Communication and coordination between unaffiliated claims administrators and utilization review firms is a common challenge. WPS and IRG need to take steps now to improve communication and coordination. The City, WPS and IRG should meet to set up procedures to address these matters, and meet periodically thereafter to assure proper execution.

AUDIT RESPONSES

June 26, 2001

Mr. W. Martin Morics
City Comptroller
200 East Wells St., Room 404
Milwaukee, WI 53202-3560

Dear Mr. Morics:

WPS (Wisconsin Physicians Service Insurance Corporation) appreciates the opportunity to address and respond to the audit findings and recommendations as outlined in the City of Milwaukee Basic Health Plan Administration Audit.

WPS has always welcomed audits of this nature from the City, or any of our clients. We believe this process is invaluable because it allows us:

- To expand our list of methods we use to listen to our client's specific requests.
- To communicate and clarify our position on our claims processing and customer service procedures that we base on more than 55 years of continuous experience in the health insurance and administration field.
- To re-visit and renew our service commitments to the City of Milwaukee self-funded benefit plan.

We would like to extend our appreciation to the Comptroller's office, Employee Benefits Department, Willis of Wisconsin, and other City of Milwaukee staff that participated in numerous discussions and provided us with important and valued feedback as a result of this inaugural City audit.

After reviewing the audit report, we have prepared the responses based on what we believe to be the key findings of the report, as follows:

- Financial Claims Payment Accuracy Calculation
- Financial Accuracy Performance
- Service Performance
- Performance Reporting
- Equating Quarterly & Monthly Reporting
- Plan Document Updates
- Utilization Management Interface

With these responses, WPS commits to achieving the desired contract specifications and providing customized data that may be beneficial to Senior Management at the City of Milwaukee. We also reaffirm our commitment to continue and expand our valued fourteen-year relationship with the City of Milwaukee.

Sincerely,

Mark Cronce

Mark Cronce
WPS Account Manager

The Formal Response to

The City of Milwaukee Basic Health Plan Administration Audit

Presented by

WPS Response to the Basic Health Plan Administration Audit

In responding to this audit, we have mirrored the structure of the audit. Toward that end, we will begin each section citing the major findings of the audit as it relates to our responses.

1. Is WPS in compliance with the provisions of its contract?

In this section, the audit reported:

WPS has, for the most part, met compliance requirements with some significant exceptions. The Audit determined that WPS is providing the full range of claim processing services called for in its contract, but is not in full compliance with contract performance standards and reporting requirements.

The report went on to cite specific areas where WPS could improve its compliance/performance:

- Financial Claims Payment Accuracy Calculation
- Financial Accuracy Performance
- Service Performance
- Performance Reporting

We offer responses to these items as follows.

Financial Claims Payment Accuracy Calculation

We have reported since the original effective date of the contract (1/1/88) on a dollar charged basis. Neither party was aware that this method may have been different from the contract language until this audit.

As part of our auditing function, we use an audit formula that focuses on a dollar charged basis rather than a dollar paid basis. This has been our corporate practice beyond the fourteen years we have administered the City of Milwaukee contract. We use the charged dollar basis because we believe it is the best method to accurately estimate the entire true cost to the City of Milwaukee.

It is important to note that we believe this so strongly that it is the standard that we use with our own fully insured business. In other words, we treat the City's financial resources with the same care we treat our own financial resources when insuring the risk of benefit plans.

Our audit is a dollar-value projection process. Since it is a process audit, we do not exclude zero-pays from sampling. We define zero-pays as claims where a payment is not made, such as a rejected claim, a claim that indicated the claimant has other insurance, or a claim where the payment amount is applied to a participants deductible. We audit the dollar charged, rather than a dollar paid, because that is the total risk, whether it is the City's risk or our own. The risk is any claim forwarded to us with a charge to be processed.

Since we need to audit the accuracy of all our claim processing activities, we include zero-paid claims (or those denied in full) which essentially equates to using the claim amount charged. We consider systematic and manual decisions to fully deny benefits (zero-paid which then equals the amount charged) to be critical claim processing decisions that require audit testing to determine the accuracy of those decisions. Without sampling zero-paid claims, we would be eliminating a significant volume of claim processing decisions when determining overall processing performance.

It is our position that this is the appropriate audit formula for our line of business and represents the total potential risk and reflects the true charges before the applicable zero-pays are removed. We continue to use this audit formula, as we have traditionally, since we believe it best represents the total risk to the City of Milwaukee and therefore reports the accuracy percentage using charge dollars rather than paid dollars.

It is our intent to meet with Employee Benefits Division and obtain agreement on methodology for reporting results.

Financial Accuracy Performance

We agree, to a certain extent, with the audit report findings in this area, but point out that actual dollar cost to the City is significantly less.

During the timeframe of this audit, WPS processed a total of $82,469,161 in claim charges and paid out benefits in the amount of $30,563,096 for the City of Milwaukee Plan members. The audit report estimates that up to $500,000 may have been overpaid in the audit period. We have numerous features embedded in our workflows and procedures that uncover overpayments and initiate corrective action. For example, if we retroactively terminate the eligibility of a customer, we check claims processed beyond the termination date and request applicable refunds. Or, if a subrogation investigation determines a situation is Workers' Compensation, we request appropriate refunds.

These are only two specific examples of situations, among many, that trigger our pursuit of a refund. Analysis of year 2000 refund data for the City of Milwaukee illustrated that WPS requested refunds of $374,786. To date, WPS has recovered a total of $354,716 on the refund cases.

In summary, the projected $500,000 overpayment cited in the audit report is not a true reflection on financial performance of this Plan since claims administration does not end at the time a check is issued. We continue to pursue all outstanding overpayments.

Service Performance & Reporting

We agree with your analysis in this area, and have already taken action to improve our service to the City. During the period reviewed by this audit we identified a staffing deficiency in the Milwaukee Service Center, the office where we provide the claims and customer service functions for the City.

WPS strives for perfection in all processes and employs numerous quality improvement methods. WPS initiates extensive root cause analysis in any identified situation where process or performance goals are not met or exceeded. As a result of an identified staffing deficiency, we hired and trained additional staff for our Milwaukee Service Center. WPS has also cross-trained Madison staff as a backup to cover additional turnover or inventory fluctuations that may occur in the Milwaukee Service Center.

With our commitment to process improvement, WPS will continue to evaluate other opportunities to improve the performance and cost effectiveness of the City of Milwaukee health benefit plan.

Performance Reporting

WPS understands that we have not been providing all required performance reports recently. Historically, WPS was providing all required performance reports until previous Risk Administration staff requested we cease certain reports because our performance had continually exceeded requirements. Please note that WPS currently tracks all required performance report data and will begin sending the reports to the Employee Benefit Manager at the City.

As a result of this audit, we have been informed that variations on our standard reports or customized data may be appropriate for and desired by Senior Management at the City of Milwaukee. We would be happy to work with City of Milwaukee staff to identify and discuss the types of reports desired.

2. Is WPS providing adequate and effective services?

In this section, the audit report indicates:

The audit found that, in general, WPS Plan administration services have been adequate. However, some important service improvements are needed.

The section cites two primary improvements not covered in other sections:

- Equating Quarterly and Monthly Reporting
- Plan Document updates

We offer responses to these items as follows.

Equating Quarterly and Monthly Reporting

We understand that the monthly and quarterly reports do not equate. WPS has purposely created two separate reporting packages. The first, our monthly paid package, provides a detailed report showing many of the contract's reporting requirements. The second, our quarterly Enhanced Data Report, is a custom designed package that has been time-tested through many of WPS' group customers. These reports are received favorably as they contain normative comparisons to other WPS health plans in Wisconsin. These reports are generally reported on an annual basis, with the exception for large employers, like the City, who find them more valuable on a quarterly basis. We would be happy to provide these reports on an annual basis, should the City prefer.

We did not create these reports to be redundant, but rather to provide comprehensive data for our client's personal use.

Plan Document Updates

WPS agrees that the Master Plan Document and Plan Member benefit summary booklet have not been updated. The City of Milwaukee drafts the Master Plan Document and Plan Member benefit summary booklet. WPS highly recommends that the City of Milwaukee adopt our standard plan contract customized for the specific City of Milwaukee plan requirements. We are more than willing to work with the City in updating and maintaining their own Master Plan Document and Plan Member benefit summary booklet. We will draft and provide to the City of Milwaukee a Master Plan Document and benefit summary booklet, similar to those we supply to our other clients.

3. Is WPS adequately coordinating service delivery?

In this section, the audit report indicates:

WPS adequately coordinates with Cobalt (Blue Cross) for the delivery of PPO discounting services. WPS has not communicated or coordinated well with IRG on utilization management, particularly related to hospital pre-admission authorizations.

We offer a response to the statement on utilization management interface.

Utilization Management Interface

Throughout the recent procurement process for the City of Milwaukee, WPS presented its response to this reference in the audit report by offering our in-house coordinated care program, Value Care Review. We also offered this program in previous procurements. We believe an integrated program featuring direct computer links is the best method of interaction between utilization management and claims administration. Thus far, the City of Milwaukee elected to fragment the services.

An observation in Appendix 3 of the audit report points out:

Communication and coordination between unaffiliated claims administrators and UR firms is a common challenge.

[Both] WPS and IRG need to take steps now to improve communication and coordination.

We agree. WPS is willing to cooperate in any resolution proposals the City of Milwaukee may wish to discuss.

In addition, the Administrative Agreement for the City with WPS states:

Administrator must have the capability to adapt to and incorporate the requirements of the URO and the Plan.

WPS has the capability to adapt and incorporate the requirements of the URO and the Plan. WPS makes every effort to enhance the relationship with the City of Milwaukee customers and IRG. If our Customer Service is contacted in advance of services, we advise the customers that the services require pre-certification with IRG. If a customer would benefit from Case Management, we refer them to IRG. In return, WPS enters into our automated system all pre-certification, Case Management and special arrangements IRG communicates to us. The claims interact with the pre-certifications entered, or pend a claim for review if we have entered special remarks as a result of an IRG communication.

Although these mechanisms are all in place and functional, the City of Milwaukee benefit structure does not support any punitive action should a customer choose not to contact IRG or comply with their recommendation. As a result, WPS does not force the issue with rejections or delayed claims processing. We will be happy to discuss with you the impact of rejecting or delaying claims processing.

Summary

As we indicated earlier, WPS has always welcomed audits of this nature from the City, or any of our clients. We believe this process is invaluable because it allows us:

- To expand our list of methods we use to listen to our client's specific requests.
- To communicate and clarify our position on our claims processing and customer service procedures that we base on more than 55 years of continuous experience years in the health insurance and administration field.
- To re-visit and renew our service commitments to the City of Milwaukee self-funded benefit plan.

We would like to extend our appreciation to the Comptroller's office, Employee Benefits Department, Willis of Wisconsin, and other Milwaukee staff that participated in numerous discussions and provided us with important and valued feedback as a result of this inaugural City audit.

WPS commits to achieving any desired contract specifications and providing any customized data that may be beneficial to Senior Management at the City of Milwaukee. We also reaffirm our commitment to continue and expand our valued fourteen-year relationship with the City of Milwaukee.

Cobalt Corporation (Blue Cross)

Cobalt Corporation's Response to Recommendation Number 5:

Cobalt's current operating practice related to applying preferred provider discounts on inpatient and outpatient hospital claims is in compliance with the City of Milwaukee agreement. While we understand certain efficiencies would be gained by implementing the recommendation, WPS, the City of Milwaukee's plan administrator, is a Cobalt competitor. Blue Cross' hospital contracts contain proprietary information and Blue Cross will not release them to a competitor. This is the position Blue Cross took when it entered into the contract with the City of Milwaukee and why the provisions regarding preferred provider discounts were drafted as they appear in the agreement between the parties.

INNOVATIVE
RESOURCE GROUP™

July 26, 2001

W. Martin Morics
City Comptroller
200 East Wells Street
Room 404
Milwaukee, WI 53202

Re: Response to the City of Milwaukee Audit

Dear Mr. Morics:

Innovative Resource Group is proud to serve the City of Milwaukee employees and their dependents. As the nation's leading supplier of care management solution services, we not only provide cost savings to the City of Milwaukee, but also assure that appropriate care is delivered to health plan members. We were certainly pleased to see that the Willis of Wisconsin, Inc. auditors, as we expected, concluded that Innovative Resource Group is in compliance on all contractual issues and perform to established industry standards.

There were several areas identified by the auditors, which present the potential to enhance our medical management service offerings. These recommendations fall into two broad categories. First, there is a need for better communication and reporting between Innovative Resource Group, WPS and the Employee Benefits Division of the City of Milwaukee (EBD). Our relationship with our parent organization does not impact our interaction with WPS and should not cloud their view of us. That said, we concur that the communications and reporting issues need to be addressed. Options we may wish to consider would be monthly management meetings between the three entities. These meetings could include discussions on such issues as training, reporting, guidelines on care, a clear delineation of duties and responsibilities, common terminology, contract requirements and other interaction issues of importance to the City of Milwaukee.

The second issue raised by the auditors is the pursuit of "best practices" and as such, redefining the role of Utilization Management (UM). It is our position that we currently employ the "best practices" established within the industry for this service. What it appears the auditors are referring to in their report is the future role UM needs to play in the ever-changing environment of healthcare delivery. Once again we are in agreement with Willis of Wisconsin that the services offered today may not be the services needed a year from now.

Currently, our Utilization Management services serve a threefold function. UM is the gatekeeper of service access. We certify whether requested services are medically necessary and in the best interest of the patient. Secondly, UM serves to redirect care to the most appropriate provider of service. Thirdly, UM serves as our internal care director. Through the knowledge of skilled clinicians familiar with our service capabilities, we can direct patients to those Innovative Resource Group services that can have the most impact on care. Obviously, the success of this role is determined to a large extent by the number of Innovative Resource Group's services the health plan has in place. One such product specifically mentioned in the audit is Disease Management. Innovative Resource Group does have a successful disease management program, Targeted Intervention. It is remarkably similar to the service discussed by the auditors. It involves the analysis of medical claim and prescription drug information to identify

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potential members with disease specific needs. These members are then offered the opportunity to enroll in a program that assists them with managing their disease. In fact, this product was offered to the City in the recent Request for Proposal delivered in May.

Three specific issues addressed by Willis of Wisconsin bare special notice: the recommendation to insist on the relocation of care management staff to the same building, the recommendation to require discharge verification on the planned day of discharge and a recommendation of a periodic review of the City's Basic Plan. Innovative Resource Group has grown significantly over the last three years; as such, space is at a premium. Although we believe that communications and data advancements make it unnecessary for staff to be located in the same building, there are obviously cost savings due to consolidating locations. Therefore, Innovative Resource Group has embarked on a course to consolidate locations by 2004. The recommendation to review discharge processing on the date of discharge has already been forwarded to UM senior staff for consideration to incorporate in standard practices. Innovative Resource Group has the resources to review and make plan change recommendations that address medical advances and are consistent with a managed care approach.

We are continually exploring new processes and roles for our products. Part of this function is the information we develop through our own knowledge and experience. However, a large portion entails listening to clients, members, providers, industry experts, consultants and, yes, outside auditors. We appreciate the viewpoints of others and acknowledge their expertise. We will continue to review the UM services to enhance their value to the City of Milwaukee and our other clients. Thank you for the opportunity to address the audit report and we look forward to a continued mutually beneficial relationship with the City of Milwaukee.

Sincerely,

Bob Diehl

Bob Diehl
Director of Account Services

CC: Dawn Eyre, Innovative Resource Group
Renée Lindner, Innovative Resource Group
James Michalski, City of Milwaukee

City of Milwaukee

Department of Employee Relations

John O. Norquist
Mayor

Jeffrey Hansen
Director

Florence Dukes
Deputy Director

Frank Forbes
Labor Negotiator

Michael Brady
Employee Benefits Manager

June 22, 2001

Mr. M. Wally Morics
Comptroller
City Hall, Room 400
Milwaukee, WI 53202

RE: AUDIT OF CITY OF MILWAUKEE BASIC HEALTH PLAN

Dear Mr. Morics:

Thank you for completing the audit of the City of Milwaukee Basic Health Plan, including the three components: the Third Party Administrator, the Preferred Provider Network and the Utilization Review and Case Management provider. This office appreciates the recommendations made in the audit and will work with future Basic Plan vendors to see that the recommendations are followed. The recommendations provide an excellent starting point for this office to measure future progress in controlling escalating health care costs in the basic plan.

Recommendation #1: EBD will ensure that performance standards with 99% financial payment accuracy are part of the next claims administration contract, and that the claims administrator reports their financial accuracy on a monthly basis.

Recommendation #2: EBD will ensure performance reports and audits required by the contract are monitored and enforced. If the performance is below contract standards, EBD will meet with the claims administrator to initiate a time-specific and appropriate performance improvement plan.

Recommendation #3: EBD will ensure that appropriate activity reports are specified in the next claim administration contract, especially those reports that accurately report the activity of active employees, early retirees under 65, and retirees over 65 for behavior health and for pharmacy utilization.

Recommendation #4: EBD will specify dates in the next claims administration contract for revisions and updates to the Master Plan Document and the Benefit Summary Booklet.

Recommendation #5: To the extent possible, PPO discounts for plan hospital claims will be handled by an automated claims processing system through cooperation of the claims administrator and the PPO network provider.

Recommendation #6: EBD will work with the claims administrator and the utilization management vendor to assure that reports from both groups use the same information and the same numbers. The addition of a comprehensive "disease management" program for all employees will require additional funding and the approval of City. The coordination of the utilization management efforts and the claims administration efforts is essential.

Sincerely,

Michael Brady
Employee Benefits