MICHIGAN

OFFICE OF THE AUDITOR GENERAL

AUDIT REPORT

PERFORMANCE AUDIT
OF THE

HEALTH INSURANCE COST AVOIDANCE AND RECOVERY SECTION

MEDICAL SERVICES ADMINISTRATION
DEPARTMENT OF COMMUNITY HEALTH

April 2009

THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

391-0705-06

The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

– Article IV, Section 53 of the Michigan Constitution

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REPORT SUMMARY

Performance Audit
Health Insurance Cost Avoidance and Recovery Section (HICARS)
Medical Services Administration
Department of Community Health (DCH)

Report Number:
391-0705-06

Released:
April 2009

HICARS obtains third party health insurance information for Medicaid recipients. Medicaid uses this information to cost avoid (i.e., reject) provider health care claims that are the potential liability of third party health insurance carriers (carriers). Also, HICARS uses the information to seek recovery of Medicaid costs from potentially liable carriers on a post payment basis. For fiscal year 2006-07, HICARS reported that it cost avoided health care claims totaling $343.9 million and recovered Medicaid costs totaling $22.6 million. Generally, 43.62% of these cost savings and recoveries accrued to the State General Fund and 56.38% accrued to the federal government.

Audit Objective:
To assess the effectiveness of HICARS's efforts to timely identify carriers with liability for all or part of a recipient's health care costs and include relevant information related to the carriers in the third party liability (TPL) database.

Audit Conclusion:
We concluded that HICARS's efforts to timely identify carriers with liability for all or part of a recipient's health care costs and include relevant information related to the carriers in the TPL database were not effective. We noted two material conditions (Findings 1 and 2) and one reportable condition (Finding 3).

Material Conditions:
HICARS did not take required actions to identify or timely identify carriers that were liable to pay for health care services provided to recipients and to timely update its TPL database with relevant information related to the carriers. As a result, HICARS likely missed an opportunity for significant Medicaid cost savings. (Finding 1)

HICARS did not effectively administer a vendor contract for various TPL-related services and medical support enforcement services. As a result, HICARS paid the vendor $5.5 million for services that were the financial responsibility of the Department of Human Services' Office of Child Support, contributed toward the loss of $880,000 in matching federal funds, significantly overpaid the vendor, and missed an opportunity for other Medicaid cost savings. (Finding 2)

Reportable Condition:
Our audit also disclosed one reportable condition related to controls over third party health insurance leads (Finding 3).

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Audit Objective:
To assess the effectiveness and efficiency of HICARS's efforts to timely recover Medicaid costs from liable carriers.

Audit Conclusion:
We concluded that HICARS's efforts to timely recover Medicaid costs from liable carriers were not effective or efficient. We noted four material conditions (Findings 4 through 7) and one reportable condition (Finding 8).

Material Conditions:
HICARS did not effectively monitor and timely follow up on outstanding Post Payment Recovery System (PPRS) billings. As of October 17, 2007, these billings totaled $213.4 million that had been outstanding an average of 412 days.

HICARS had sent out follow-up billings for only $15.2 million of these billings. (Finding 4)

HICARS did not timely follow up on some of the PPRS billing rejections that it received from a large not-for-profit carrier. Also, HICARS management did not provide effective oversight of its staff members' follow-up of these rejections. Without timely follow-up and effective management oversight, HICARS diminished its opportunity for potentially significant Medicaid cost recoveries. (Finding 5)

HICARS did not attempt to recover or timely recover some Medicaid costs that were the potential liability of Medicare or one of several other carriers. DCH records indicated that these costs totaled at least $29.0 million. (Finding 6)

HICARS did not have controls to ensure that its Medicaid cost recovery program was efficient. As a result, HICARS used some of its limited resources to pursue recovery of Medicaid costs that were generally not reimbursable by carriers while simultaneously burdening carriers with processing unnecessary PPRS billings. (Finding 7)

Reportable Condition:
Our audit also disclosed one reportable condition related to recovery of costs for recipients with duplicate insurance information in the TPL database (Finding 8).

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Audit Objective:
To assess the effectiveness of HICARS's efforts to process suspended health care claims in a timely manner and in compliance with HICARS's written procedures.

Audit Conclusion:
We concluded that HICARS's efforts to process suspended health care claims in a timely manner were effective and its efforts to process suspended health care claims in compliance with HICARS's written procedures were moderately effective. We noted one reportable condition (Finding 9).

Reportable Condition:
Our audit disclosed one reportable condition related to controls over processing suspended health care claims (Finding 9).

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Audit Objective:
To assess the effectiveness of HICARS's efforts to ensure that the Medicaid claims processing system included the necessary edits to reject provider health care claims that were the liability of carriers.

Audit Conclusion:
We concluded that HICARS's efforts to ensure that the Medicaid claims processing system included the necessary edits to reject provider health care claims that were the liability of carriers were moderately effective. We noted one reportable condition (Finding 10).

Reportable Condition:
Our audit disclosed one reportable condition related to the use of TPL edits (Finding 10).

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Agency Response:
Our audit report contains 10 findings and 16 corresponding recommendations. DCH's preliminary response indicated that it agrees with 14 recommendations and disagrees with 2 recommendations.

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A copy of the full report can be obtained by calling 517.334.8050 or by visiting our Web site at:
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THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

April 28, 2009

Ms. Janet Olszewski, Director
Department of Community Health
Capitol View Building
Lansing, Michigan

Dear Ms. Olszewski:

This is our report on the performance audit of the Health Insurance Cost Avoidance and Recovery Section, Medical Services Administration, Department of Community Health.

This report contains our report summary; description of agency; audit objectives, scope, and methodology and agency responses; comments, findings, recommendations, and agency preliminary responses; Post Payment Recovery System (PPRS) billings and recoveries by provider type, presented as supplemental information; and a glossary of acronyms and terms.

Our comments, findings, and recommendations are organized by audit objective. The agency preliminary responses were taken from the agency's responses subsequent to our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agency develop a formal response within 60 days after release of the audit report.

We appreciate the courtesy and cooperation extended to us during this audit.

AUDITOR GENERAL

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Description of Agency

The Department of Community Health (DCH) is responsible for administering the State Medicaid Plan* in accordance with the federal Social Security Act and various federal regulations. These require state Medicaid* programs to ensure that Medicaid is the payer of last resort by identifying third party health insurance carriers* (carriers*) with liability for some or all of a Medicaid recipient's* health care costs. As a condition of Medicaid eligibility, individuals are required to assign their rights to DCH to recover medical costs paid by Medicaid. Generally, when a state Medicaid program receives a health care claim for which it has established the probable existence of a liable carrier, the federal Social Security Act and federal regulations require that it return the claim unpaid to the service provider for collection from the carrier, a process known as cost avoidance*. Similarly, if a state Medicaid program learns of the existence of a liable carrier after it has paid a health care claim, the federal Social Security Act and federal regulations require it to pursue recovery of Medicaid's costs if the amount the state Medicaid program expects to recover exceeds its anticipated recovery costs. Generally, in fiscal year 2006-07, the federal government was entitled to 56.38% of the total dollar amount of Medicaid costs recoveries and the State General Fund was entitled to the remaining 43.62%. These percentages matched each party's proportionate share of the original Medicaid payments. DCH's Third Party Liability (TPL) Division, Bureau of Medicaid Financial Management and Administrative Services, Medical Services Administration, is responsible for carrying out these requirements. The Health Insurance Cost Avoidance and Recovery Section (HICARS) is one of two sections within the TPL Division. HICARS is made up of the Data Base and Cost Avoidance Unit (DBCAU) and the Program Recovery Unit.

DBCAU is responsible for obtaining and verifying the accuracy of information related to carriers, excluding Medicare, with liability for Medicaid recipients' health care costs and for ensuring the timely addition of policy-related information (e.g., policy number, effective dates of coverage, and scope of service coverage) to the TPL database. DBCAU obtains this information from Department of Human Services' caseworkers, carriers, health care providers, governmental agencies, contractors, and others. DCH's Medicare Buy-In Unit is responsible for obtaining and updating the TPL database with Medicare enrollment information for Medicaid recipients. Medicaid's claims processing system accesses the TPL database to make cost avoidance determinations for

** See glossary at end of report for definition.*

recipients receiving services on a fee-for-service* basis. This includes all services except pharmacy and all provider types except State-owned hospitals and centers.

Act 593, P.A. 2006, effective January 3, 2007, requires entities that are legally responsible for payment of health care claims, such as health insurers, health maintenance organizations, and not-for-profit health care corporations, to provide DCH with information that will enable DCH to determine the entities' enrollees that are also Medicaid recipients. The TPL Division had not finalized the logistics for this data transfer as of the end of our audit fieldwork.

The Program Recovery Unit is responsible for pursuing reimbursement of Medicaid costs for recipients receiving services on a fee-for-service basis from Medicare and other liable carriers that DBCAU did not identify and include in the TPL database prior to payment or that federal regulations required that DCH pay first and then seek recovery of Medicaid's costs. The Program Recovery Unit pursues reimbursement either by billing the liable carrier or by reducing subsequent payments to the service provider and instructing it to bill the carrier. The Program Recovery Unit is also responsible for manually reviewing and determining if Medicaid is liable for fee-for-service health care claims that suspend during claims processing for TPL considerations.

During April 2005, HICARS replaced its cost recovery system with the new Post Payment Recovery System (PPRS). DCH expects PPRS to improve the efficiency of the cost recovery program by allowing DCH to electronically bill and receive remittances from participating carriers. HICARS had some limited success getting carriers to change their payment systems and begin using the electronic billing and remittance capabilities of PPRS. As of the end of our audit fieldwork, HICARS was continuing to work with participating carriers in this regard. To enhance the effectiveness* of HICARS's cost recovery program, Act 593, P.A. 2006, also required carriers to respond to PPRS billings within established time frames, restricted the reasons that carriers could deny PPRS billings, extended the time available for DCH to seek recovery of Medicaid costs, and established fines for carriers' noncompliance with the Act's requirements.

HICARS was also primarily responsible for, among other things, establishing and maintaining the TPL-related edits that DCH used in its Medicaid claims processing system.

** See glossary at end of report for definition.*

As of September 25, 2007, HICARS had identified and recorded in its TPL database that there were one or more third party health insurance carriers, excluding Medicare, for approximately 131,200 (8.7%) of the 1.5 million active Medicaid recipients. This included recipients receiving services either on a fee-for-service basis or through a contracted managed care* organization. HICARS forwarded applicable insurance information to contracted managed care organizations for their cost avoidance and recovery of costs for their enrolled recipients. For fiscal year 2006-07, HICARS reported that it cost avoided health care claims totaling $343.9 million and recovered Medicaid costs, either directly or through contract, totaling $22.6 million. In fiscal year 2006-07, 43.62% of these cost savings and recoveries accrued to the State General Fund and 56.38% accrued to the federal government. As of September 30, 2007, HICARS had 23 full-time employees and 9 student employees.

** See glossary at end of report for definition.*

Audit Objectives

Our performance audit* of the Health Insurance Cost Avoidance and Recovery Section (HICARS), Medical Services Administration, Department of Community Health (DCH), had the following objectives:

1. To assess the effectiveness of HICARS's efforts to timely identify third party health insurance carriers (carriers) with liability for all or part of a recipient's health care costs and include relevant information related to the carriers in the third party liability (TPL) database.

2. To assess the effectiveness and efficiency* of HICARS's efforts to timely recover Medicaid costs from liable carriers.

3. To assess the effectiveness of HICARS's efforts to process suspended health care claims* in a timely manner and in compliance with HICARS's written procedures.

4. To assess the effectiveness of HICARS's efforts to ensure that the Medicaid claims processing system included the necessary edits to reject provider health care claims that were the liability of carriers.

Audit Scope

Our audit scope was to examine the program and other records of the Health Insurance Cost Avoidance and Recovery Section. Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included such tests of the records and such other auditing procedures as we considered necessary in the circumstances. Our audit procedures, conducted from July 2006 through December 2007, generally covered the period October 1, 2003 through December 31, 2007.

Audit Methodology

We conducted a preliminary review of HICARS operations to formulate a basis for developing our audit objectives and defining our audit scope. Our preliminary review

** See glossary at end of report for definition.*

included interviewing HICARS personnel; reviewing applicable laws, rules, regulations, policies, procedures, manuals, the State Medicaid Plan and third party action plan*, and other information; analyzing available records, data, and statistics; and obtaining an understanding of HICARS's management control* and operational activities.

To accomplish our first objective, we interviewed HICARS and Michigan Department of Information Technology (MDIT) staff to obtain an understanding of the entities that provided HICARS with information related to potentially liable carriers and HICARS's processes for receiving and processing this information. Also, we assessed whether HICARS obtained and utilized all required carrier information. In addition, we documented and assessed the effectiveness of HICARS controls over the receipt and processing of carrier information, including its timely addition to the TPL database. Further, we tested the effectiveness of HICARS's management of contracts and agreements for obtaining carrier information. Also, we inventoried HICARS's backlog of unprocessed carrier information.

To accomplish our second objective, we interviewed HICARS staff to gain a comprehensive understanding of HICARS's cost recovery process. Also, we performed various tests to determine whether HICARS sought to timely recover all applicable Medicaid costs and subsequently reported its recoveries to the federal Centers for Medicare and Medicaid Services. In addition, we reviewed and assessed the effectiveness of HICARS's Post Payment Recovery System (PPRS) at appropriately selecting Medicaid payments for cost recovery. Further, we examined HICARS's efforts to timely follow up on outstanding and rejected PPRS billings. Also, we assessed the appropriateness of carrier reductions to PPRS billing amounts. In addition, we reviewed the appropriateness of the cost-effective billing amounts that HICARS established for various types of services.

To accomplish our third objective, we interviewed HICARS management and staff to obtain an understanding of HICARS controls over suspended claims processing. Also, we conducted various analyses of processed suspended claims and tested selected suspended claims to determine whether HICARS processed the claims on a timely basis and in accordance with its written procedures. In addition, we analyzed suspended claims that HICARS authorized for payment but subsequently recovered.

** See glossary at end of report for definition.*

To accomplish our fourth objective, we interviewed HICARS and MDIT staff to obtain a comprehensive understanding of the various TPL-related claims processing edits and procedure code switches. We conducted various analyses of the impact of the edits and procedure code switches on cost avoidance. We tested the appropriateness of the TPL-related programming language in DCH's Medicaid claims processing system to ensure that it cost avoided provider claims that were the potential liability of carriers.

We obtained billing and recovery information from DCH's PPRS, presented as supplemental information. Our audit was not directed toward expressing an opinion on this information and, accordingly, we do not express an opinion on it.

When selecting activities or programs for audit, we use an approach based on assessment of risk and opportunity for improvement. Accordingly, we focus our audit efforts on activities or programs having the greatest probability for needing improvement as identified through a preliminary review. Our limited audit resources are used, by design, to identify where and how improvements can be made. Consequently, we prepare our performance audit reports on an exception basis.

Agency Responses

Our audit report contains 10 findings and 16 corresponding recommendations. DCH's preliminary response indicated that it agrees with 14 recommendations and disagrees with 2 recommendations.

The agency preliminary response that follows each recommendation in our report was taken from the agency's written comments and oral discussion subsequent to our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100) require DCH to develop a formal response to our audit findings and recommendations within 60 days after release of the audit report.

COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

EFFECTIVENESS OF HICARS'S EFFORTS REGARDING TIMELY IDENTIFICATION OF CARRIERS

COMMENT

Background: Title 42, Part 433, section 138 of the *Code of Federal Regulations* (*CFR*) requires that the Health Insurance Cost Avoidance and Recovery Section (HICARS) take reasonable measures, including certain minimum prescribed actions, to identify third party health insurance carriers (carriers) that are liable to pay for health care services furnished to recipients under the State Medicaid Plan. Also, it requires HICARS to follow up on information related to potentially liable carriers and incorporate relevant information related to carriers into the Third Party Liability (TPL) database within prescribed time frames. The Department of Community Health (DCH) uses the TPL database for cost avoidance and cost recovery purposes. HICARS obtains information related to potentially liable carriers from governmental agencies, a vendor with access to the enrollment information of numerous carriers, and a large not-for-profit carrier. DCH's Medicare Buy-In Unit is responsible for obtaining and updating the TPL database with Medicare enrollment information for Medicaid recipients. Generally, HICARS has to verify the accuracy and completeness of carrier information that the governmental agencies provide to it before it can add the information to the TPL database. HICARS accomplishes this by contacting recipients, employers, or carriers or by accessing carrier enrollment information on-line. Generally, the carrier information that the nongovernmental entities provide to HICARS is accurate and complete and can be incorporated into the TPL database without follow-up.

Audit Objective: To assess the effectiveness of HICARS's efforts to timely identify carriers with liability for all or part of a recipient's health care costs and include relevant information related to the carriers in the TPL database.

Audit Conclusion: We concluded that HICARS's efforts to timely identify carriers with liability for all or part of a recipient's health care costs and include relevant

information related to the carriers in the TPL database were not effective. Our assessment disclosed two material conditions*:

- HICARS did not take required actions to identify or timely identify carriers that were liable to pay for health care services provided to recipients and to timely update its TPL database with relevant information related to the carriers (Finding 1).

- HICARS did not effectively administer a vendor contract for various TPL-related services and medical support enforcement services* (Finding 2).

Our assessment also disclosed one reportable condition* related to controls over third party health insurance leads (Finding 3).

FINDING

1. Identification of Liable Carriers

   HICARS did not take required actions to identify or timely identify carriers that were liable to pay for health care services provided to recipients and to timely update its TPL database with relevant information related to the carriers. As a result, HICARS likely missed an opportunity for significant Medicaid cost savings. Also, the Centers for Medicare and Medicaid Services could require that DCH repay the federal share of Medicaid costs for provider claims for which HICARS did not establish the carriers' liability and seek reimbursement from them.

   HICARS reported that it cost avoided health care claims totaling $343.9 million and recovered Medicaid costs totaling $22.6 million in fiscal year 2006-07. Using carrier information recorded in the TPL database on September 25, 2007, we estimated that these savings averaged $3,529 for each of the 103,880 recipients with a third party health insurance carrier other than Medicare, which received services on a fee-for-service basis. DCH would have also had TPL-related savings for recipients receiving services through its contracted managed care health plans. DCH would have recognized these savings through a reduction in the fixed monthly rates that it paid the managed care health plans for their expected cost savings from third party cost avoidance and recovery activities. As noted in parts a. through g. of this finding, we noted that DCH had (a) unprocessed but verified third party health insurance information for over 45,000 recipients, (b) over 21,000

** See glossary at end of report for definition.*

quantifiable but unprocessed health insurance leads, and (c) many thousands of other unprocessed health insurance leads that could not be accurately quantified. However, because DCH did not maintain data related to the percentage of health insurance information and leads that generally resulted in its identification of new health insurance information for recipients, it could not estimate the additional annual Medicaid cost savings that the information and leads would generate.

Federal regulation 42 *CFR* 433.138 requires that HICARS take reasonable measures to determine the liability of carriers to pay for services furnished under the State Medicaid Plan. At a minimum, these measures must include the collection of information related to potentially liable carriers identified during the Medicaid application and annual redetermination processes and through data matches with other governmental agencies. HICARS must follow up on this information and update its TPL database with newly identified or updated information within 45 or 60 days, depending on the source of the information. Federal regulation 42 *CFR* 433.140 states that federal financial participation is not available for Medicaid payments if DCH fails to fulfill the requirements of federal regulation 42 *CFR* 433.138. In fiscal year 2006-07, the federal government's Medicaid payment participation rate was 56.38%. The State General Fund was responsible for the remaining 43.62%. Our review of HICARS compliance with federal regulation 42 *CFR* 433.138 disclosed:

a. HICARS had not conducted required data matches with the Department of Human Services' (DHS's) electronic child support files since August 2003. These files contained unverified health insurance information (i.e., health insurance leads) that local Friend of the Court offices and DHS's Office of Child Support (OCS) obtained from child support cases involving Medicaid recipients. Summary records maintained by the Michigan Department of Information Technology (MDIT), which had conducted the data matches prior to August 2003, showed that the data matches resulted in a total of approximately 64,000 additions to the TPL database during fiscal years 1999-2000 and 2000-01 and 29,600 updates during fiscal years 2001-02 and 2002-03.

   HICARS informed us that it terminated the data matches with the electronic child support files because the files contained too much inaccurate information. HICARS also informed us that, because DHS had recently established a new electronic child support system, it expected to have a new

data match operational by December 2006. However, as of November 2007, there was no new data match.

b. HICARS had not followed up on health insurance leads provided by the federal Social Security Administration (SSA) since 2001. SSA obtained these leads while processing Medicaid applications and redeterminations for Michigan residents who received federal Supplemental Security Income benefits.

HICARS stated that it stopped following up on the leads because it was not the most efficient use of its limited staffing resources. In support of this position, HICARS provided us with an analysis of 60 health insurance leads that SSA provided to HICARS on February 11, 2006. The analysis noted that 9 (15.0%) of the health insurance leads resulted in HICARS identifying new or updated carrier information. However, because the analysis did not compare the average amount of time it took HICARS to identify each new or updated carrier with like information for health insurance leads provided by other sources, the analysis neither supported nor refuted HICARS's position. Notwithstanding, federal regulation 42 *CFR* 433.138 does not make the follow-up of this information optional.

For the four-year period ended September 30, 2007, we estimated that SSA provided HICARS with 84,600 health insurance leads. If HICARS's analysis accurately reflects the usefulness of these leads, we estimate that HICARS could have used the leads to identify new or updated carrier information for 12,690 (84,600 x 15.0%) recipients.

c. HICARS had neither requested nor ensured that it received verified health insurance information from a large not-for-profit health insurance carrier for recipients insured through the carrier's national accounts program. The number of recipients insured through this program would likely be meaningful because it insures employees of large companies, such as Michigan-based automobile manufacturers and suppliers with operations located in multiple states.

HICARS's failure to obtain the health insurance information from the carrier may have been due, in part, to its lack of a written agreement with the carrier

that specifically described the information that HICARS expected to receive from it.

d. As of April 9, 2007, HICARS had not followed up on approximately 7,600 health insurance leads that DHS had provided to HICARS primarily in calendar years 2005 and 2006. DHS had obtained these health insurance leads while completing Medicaid applications and redeterminations for DCH. HICARS stated us that it was using its limited staffing resources to follow up on the most current health insurance leads first and would follow up on the older health insurance leads as time permitted.

e. As of April 9, 2007, HICARS had not followed up on approximately 1,800 health insurance leads that health care providers, Medicaid recipients, and others provided to HICARS via telephone calls between 63 and 375 days earlier.

f. HICARS paid the vendor $3.3 million to obtain carrier information for Medicaid recipients from national medical support notices*. From April 2005 through May 2007, the vendor provided HICARS with complete or nearly complete verified carrier information for approximately 32,900 Medicaid recipients. However, as of July 30, 2007, HICARS had not updated the TPL database with the information for approximately 32,500 (98.8%) of the 32,900 recipients.

g. HICARS had not followed up on a significant amount of health insurance information provided by a not-for-profit carrier (noted in part c.) and a vendor (noted in part f.) that was inaccurate and/or incomplete. As a result, MDIT could not enter this information into the TPL database. For example, we estimated that HICARS had not followed up on a total of approximately 12,200 unique insurance policies that the vendor provided to it during fiscal years 2003-04 through 2006-07. When feasible, HICARS should treat this information as health insurance leads and obtain the additional information that it needs to add it to the TPL database.

Failure to follow up on the health insurance leads and update its TPL database in a timely manner prevented DCH from cost avoiding some provider claims and, consequently, required HICARS to attempt to recover Medicaid's costs using more

** See glossary at end of report for definition.*

expensive cost recovery procedures. In addition to the increased direct costs associated with these procedures (e.g., billing, processing, or remittances), the procedures often resulted in less than full reimbursement of Medicaid's costs because many carriers reimbursed Medicaid for only a designated percentage of each claim. If DCH had cost avoided these claims, it would not have incurred any direct costs for them. Further, many carriers prohibited reimbursement for services not billed within 12 to 18 months of the service date.

In some instances, HICARS received the same health insurance lead or verified health insurance information from more than one source. However, we could not determine how much this duplication impacted the numbers cited in parts a. through f. of this finding. Nevertheless, it is important that HICARS follow up on all health insurance leads and enter carrier information into the TPL database in a timely manner. HICARS stated that a lack of staffing prevented it from following up on the aforementioned leads and updating the TPL database in a timely manner.

RECOMMENDATION

We recommend that HICARS take required actions to identify or timely identify carriers that are liable to pay for health care services provided to recipients and to timely update its TPL database with relevant information related to the carriers.

AGENCY PRELIMINARY RESPONSE

DCH agrees that it did not always take required actions to identify or timely identify carriers that were liable to pay for health care services provided to Medicaid recipients and update its TPL database accordingly. DCH also agrees that it may have missed an opportunity for Medicaid cost savings. In addition, DCH agrees that following up on leads and updating its TPL database in a timely manner would have allowed it to cost avoid some additional provider claims. Further, DCH acknowledges that updating the TPL database with relevant information related to carriers could result in cost savings through a reduction in the fixed monthly rates paid to Medicaid managed care health plans. Also, DCH agrees that although it took measures to determine the liability of carriers to pay for services furnished

under the State Medicaid Plan, improvements are necessary to fulfill requirements of the cited federal regulation. Specifically:

a. DCH acknowledges that it discontinued the data match with DHS's child support system in August 2003. DCH stated that the loading of incorrect information to the TPL database was causing recipient access-to-care issues and erroneous disenrollments from Medicaid managed care health plans. DCH also stated that it recently determined that a new combined data match with DHS records may allow DCH to capture the insurance information that would have been available through the discontinued data match, as well as insurance information from the national medical support notices. In addition, DCH stated that if this data match is successful, DCH will not reinstate the discontinued data match.

b. DCH agrees that it stopped following up on health insurance leads provided by SSA due to the large number of inaccuracies discovered. DCH stated that it will resume following up on health insurance leads provided by SSA.

c. DCH agrees that it had not ensured that it received verified health insurance information from a carrier's national accounts program. DCH stated that it entered into a written agreement with the carrier specifying the information to be provided to HICARS. DCH also stated that the carrier has been providing HICARS with the verified health insurance information since January 2008.

d. DCH agrees that it had not followed up on approximately 7,600 leads that DHS had provided to it primarily in 2005 and 2006. DCH stated that HICARS completed following up on all of these leads in October 2007.

e. DCH agrees that it had not followed up on approximately 1,800 leads provided by health care providers, Medicaid recipients, and others. DCH stated that HICARS completed following up on all of these leads in October 2007.

f. DCH agrees that it did not timely update its TPL database with the complete or nearly complete verified carrier information provided by its vendor. DCH stated that the combined file process noted in its response to part a., if successful, will allow HICARS to capture better data and presents an opportunity for improved cost savings.

g. DCH agrees that opportunities exist to improve follow-up on inaccurate and/or incomplete third party health insurance information provided by the referenced carrier and vendor. DCH also agrees, when feasible, to treat this information as health insurance leads and obtain the additional information needed to add it to the TPL database.

DCH stated that it constantly reviews its internal operations, best practices of other states, and national trends for opportunities to improve its overall performance. DCH also stated that these actions have improved its ability to identify carriers and to timely update its TPL database.

FINDING

2. Contract Administration

HICARS did not effectively administer a vendor contract for various TPL-related services and medical support enforcement services. As a result, HICARS paid the vendor $5.5 million for services that were the financial responsibility of DHS's OCS, contributed toward the loss of $880,000 in matching federal funds, significantly overpaid the vendor, and missed an opportunity for other Medicaid cost savings.

In November 2004, the Department of Management and Budget (DMB) entered into a $7.0 million vendor contract for carrier identification and Medicaid cost recovery services for HICARS and optional health insurance identification and medical support enforcement services for OCS. On February 4, 2005, DMB issued a contract change order making DCH responsible for administering the entire contract. Shortly thereafter, DHS and DCH entered into a memorandum of understanding (MOU), which stated that DCH was participating in the OCS medical support enforcement project to identify private insurances covering Medicaid recipients. Subsequently, DMB issued contract change orders that added other services to the contract, extended the contract to October 31, 2008, and increased the total amount of the contract to $14.6 million. We reviewed HICARS administration of selected parts of the contract and noted:

a. As of December 31, 2007, HICARS had paid the vendor $5.5 million for medical support enforcement services that, according to the contract and federal regulation 45 *CFR* 300, were the responsibility of OCS. The MOU did not specify that HICARS's participation in the medical support enforcement

project would result in increased project costs or that DCH and DHS had any related cost sharing or cost shifting agreement. Instead, the MOU specifically stated that it did not modify any parts of the original contract and that there were no other understandings, oral or otherwise, regarding the MOU that exist to bind either party. Moreover, we noted that only $1.8 million (32.7%) of the $5.5 million that HICARS paid for medical support enforcement services involved Medicaid recipients.

The federal Social Security Act provides federal matching funds at a rate of 66% for medical support enforcement services. Similarly, it provides federal matching funds at a rate of 50% for TPL-related services. Because HICARS's costs are categorized as TPL-related costs for federal reporting purposes, the State received $880,000 less in federal funding than if OCS had correctly paid for and reported the $5.5 million as medical support enforcement costs.

b. HICARS changed some of the pricing and other terms of the contract without the authority to do so. For example, in a June 22, 2005 letter to the vendor, HICARS increased the unit price it agreed to pay for certain medical support enforcement services from $9 to $14. The change represented a 55.6% increase over the contracted price. Also, HICARS increased the unit price it agreed to pay the vendor for medical support enforcement-related data entry services from $0.75 to $2.75. The change represented a 266.7% increase over the contracted price. We estimate that these changes inappropriately increased HICARS's contract-related costs by over $2.0 million between April 1, 2005 and December 31, 2007.

   Section I-D of the contract stated that DMB is the only entity authorized to change, modify, amend, alter, or clarify the terms and conditions of the contract. Also, section II-E of the contract stated that all prices/rates will be firm for the duration of the contract and that no price changes will be permitted. DMB informed us that DCH had not requested that DMB issue a change order to modify the original pricing terms in the contract.

c. HICARS did not ensure that the vendor provided it with monthly update files containing new or updated carrier information, as required by the contract. During the 48-month period ended September 30, 2007, the vendor had provided HICARS with only 24 (50.0%) monthly update files. Also, when we

began our analysis, the vendor had not provided HICARS with an update file in approximately seven months.

By matching Medicaid eligibility files with the eligibility files of various commercial and not-for-profit carriers, the vendor identified potential carriers covering Medicaid recipients. To determine if a potential carrier was liable for a recipient's medical costs, the contractor obtained the applicable recipient's paid Medicaid claims from HICARS and billed them to the carrier on behalf of Medicaid. If the carrier reimbursed Medicaid, the policy was considered valid. The contract required that the vendor report the validated policy-related information to HICARS, via a monthly coverage update file. MDIT loaded the information from the coverage update file into the TPL database, which DCH then used to cost avoid subsequent claims and to recover Medicaid costs incurred after the vendor validated the policy but before MDIT loaded the carrier information into the TPL database.

HICARS informed us that it had a verbal agreement with the vendor that the vendor would provide HICARS with an update file bimonthly rather than monthly, as stated in the written contract. HICARS also informed us that it did not know that the vendor had not provided HICARS with an update file during the aforementioned seven-month period.

The contract required that HICARS pay the vendor a contingency fee equal to 5.5% of the Medicaid cost recoveries resulting from the vendor's billings as payment for identifying a liable carrier. To protect HICARS in the event that the vendor failed to comply with its contractual responsibilities, the contract also included a provision for assessing liquidated damages equal to a one percentage point reduction in the agreed upon contingency fee rate (i.e., from 5.5% to 4.5%). The liquidated damages would compensate HICARS for its costs to recover Medicaid payments that DCH would have otherwise cost avoided if the vendor had provided it with carrier information in a timely manner. As of September 30, 2007, HICARS had not assessed the contractor for any liquidated damages.

d. HICARS did not effectively verify the appropriateness of the vendor's contingency fees for Medicaid cost recoveries generated by the Medicaid billings that the vendor sent to carriers as described in part c. of this finding. After we questioned HICARS about the vendor's contingency fees, HICARS

questioned the vendor about them. The vendor analyzed the Medicaid cost recoveries generated by the September 2, 2005 through June 29, 2007 billings that it sent to carriers and noted that it had overcharged HICARS approximately $90,000. The vendor later credited HICARS with this amount. Although DCH had contracted with this vendor since 1994 for these services, HICARS had not attempted to identify and recover overpayments made for Medicaid cost recoveries made prior to September 2, 2005.

e. HICARS did not ensure that the vendor invoices offered and that it earned and received the quick payment discount agreed to in the contract. The contract required that the vendor offer a 2% discount on invoices that HICARS paid in full within 10 days of receipt. Contrary to this requirement, the vendor's invoices requested immediate payment with no mention of a quick payment discount. HICARS's contract manager was not aware of the contract's discount provision. As a result, over the four-year term of this contract, HICARS missed the opportunity for purchase discounts totaling approximately $292,000.

RECOMMENDATIONS

We recommend that HICARS implement measures to improve the effectiveness of its contract administration practices.

We also recommend that HICARS seek recovery of $5.5 million from OCS for medical support enforcement-related costs.

We further recommend that HICARS, in conjunction with OCS, seek the $880,000 in additional federal funding.

We also recommend that HICARS assess the vendor for liquidated damages for the vendor's failure to comply with the contract.

We further recommend that HICARS seek recovery of contingency fees paid for vendor billing errors made prior to September 2, 2005.

AGENCY PRELIMINARY RESPONSE

DCH agrees that there are opportunities for improvement over its administration of its vendor contract. However, DCH disagrees that it significantly overpaid its vendor. Specifically:

a. DCH agrees that it paid the vendor for medical support enforcement services that are the responsibility of DHS. DCH stated that it is important to recognize that one of the Governor's top priorities has been to ensure that health care coverage is available to as many people as possible. DCH also stated that in the Governor's 2008 State of the State address, the Governor indicated she took great pride in the fact that Michigan had the highest rate of insured children in the country. In addition, DCH stated that when DHS was unable to provide funding for the vendor's medical support enforcement services, DCH management made the decision to provide the funding.

   DCH acknowledges that additional federal funding would have been available had expenses for medical support enforcement services been claimed against child support funding rather than Medicaid. DCH stated that it is working with DHS to pursue options for claiming the higher federal match rate allowed for medical support enforcement services, both retrospectively and prospectively.

b. DCH acknowledges that although the unit price changes were done with the support and agreement of DCH management, DCH did not follow DMB Acquisition Services' protocol for requesting these changes. DCH stated that, in the future, the TPL Division will work with the DCH Contract Management Section to process the appropriate paperwork to request any contract changes.

c. DCH acknowledges that it verbally agreed with the vendor to a change in the frequency of the file updates from what was indicated in the contract and that it did not follow Acquisition Services' protocol for making this change. DCH stated that the TPL Division will work with the DCH Contract Management Section to process the appropriate paperwork to rectify the situation.

   In addition, DCH stated that it recovered the inappropriate contingency fee payments made to the vendor. DCH also stated that it considers the matter satisfactorily resolved and does not intend to assess liquidated damages.

d. DCH agrees that it did not effectively verify the appropriateness of the vendor's contingency fee billings for Medicaid cost recoveries during the audit period. DCH stated that the Post Payment Recovery System (PPRS) was implemented in April 2005, in part, to provide HICARS with much more detailed information. DCH also stated that it has verified the appropriateness of the vendor's contingency fees from September 2005 through June 2007 and will explore options with its vendor for identification of any overpayments associated with recoveries outside this period. In addition, DCH stated that it will begin to routinely verify contingency fees.

e. DCH agrees that it did not ensure that the vendor offered the quick payment discount terms agreed to in the contract. DCH also agrees to explore options for capitalizing on this discount.

DCH stated that it will continue to explore opportunities to improve the effectiveness of its contract administration process. DCH also stated that the TPL Division has hired a financial manager, who will be integrally involved in contract oversight.

FINDING

3. Controls Over Third Party Health Insurance Leads

HICARS did not have controls to ensure the appropriate follow-up of health insurance leads. Also, HICARS did not maintain third party health insurance records in accordance with DCH's records retention and disposal schedule. As a result, HICARS limited its ability to effectively manage its TPL functions.

On a daily basis, HICARS received health insurance leads from health care providers, Medicaid recipients, governmental agencies, and others. HICARS received the health insurance leads in a variety of ways, such as conventional mail, e-mail, telephone, and facsimile. After following up on the health insurance leads, HICARS input verified health insurance information into the TPL database for cost avoidance and recovery purposes. Our review of HICARS's controls over the

receipt and follow-up of health insurance leads and the maintenance of records related to them disclosed:

a. HICARS did not establish accountability for each health insurance lead immediately upon receipt. As a result, HICARS did not have a way to identify health insurance leads that may have been lost or discarded without appropriate follow-up.

b. HICARS management did not periodically review and assess the appropriateness of its staff members' follow-up efforts for health insurance leads. Regular review of each staff member's follow-up efforts is necessary to timely identify staff training needs and, ultimately, to help ensure the accuracy of the TPL database.

c. HICARS did not retain copies of the original hard-copy health insurance leads after it finished its follow-up work on them. The ability of HICARS management to assess the appropriateness of its staff members' follow-up efforts would be limited without the original health insurance leads. HICARS informed us that it did not have adequate space to store the hard-copy health insurance leads.

d. HICARS did not maintain a historical record of the changes that it made to each recipient's health insurance information stored in the TPL database. A comprehensive record of the changes made to recipients' health insurance information is necessary for proper claims management, effective management oversight, and postaudit activities. HICARS informed us that the TPL database was not capable of retaining this information.

DCH's records retention and disposal schedule requires that HICARS keep Medicaid records for a period of at least six years.

RECOMMENDATIONS

We recommend that HICARS implement controls to ensure the appropriate follow-up of health insurance leads.

We also recommend that HICARS maintain third party health insurance records in accordance with DCH's records retention and disposal schedule.

AGENCY PRELIMINARY RESPONSE

DCH agrees that there are opportunities for improving its controls to ensure the appropriate follow-up of third party health insurance leads. DCH also agrees that it did not always maintain third party health insurance records in accordance with its records retention and disposal schedule. Specifically:

a. DCH agrees that it did not establish accountability for each lead immediately upon receipt. However, DCH stated that approximately 59% of the leads that it receives are accounted for through an automated tracking system. DCH also stated that the scheduled spring 2009 implementation of the document imaging component of the new Medicaid claims processing system will allow HICARS to track all leads from receipt through completion.

b. DCH agrees that HICARS management did not adequately assess its staff members' lead follow-up activities. DCH stated that periodic review of staff members' efforts is now occurring so that appropriate training needs are identified and addressed.

c. DCH agrees that it did not retain copies of the original hard-copy leads after follow-up efforts were completed. DCH stated that it now retains all hard-copy leads according to its records retention and disposal schedule.

d. DCH agrees that it did not maintain a historical record of all changes that it made to each recipient's third party health insurance information in the TPL database. DCH indicated that implementation of the new Medicaid claims processing system in 2009 will allow HICARS to maintain a record of all changes to the recipients' third party health insurance information.

EFFECTIVENESS AND EFFICIENCY OF HICARS'S EFFORTS REGARDING TIMELY RECOVERY OF MEDICAID COSTS

COMMENT

Background: Federal regulation 42 *CFR* 433.139 requires that when DCH has established the existence of a potentially liable carrier at the time it receives a provider's claim, it must reject the claim and return it unpaid to the provider for determination of the carrier's liability. There are allowable exceptions to this requirement that permit DCH to

pay the claim and then seek recovery of Medicaid's costs thereafter. For these exceptions and when DCH learns of the existence of a potentially liable carrier or when benefits become available after DCH has paid a claim, DCH must seek to recover Medicaid's costs within 60 days after the end of the month that it paid the claim, that it learns of the existence of a potentially liable carrier, or that benefits become available, respectively. Federal regulation 42 *CFR* 433.139 permits DCH to request a waiver of these requirements if DCH determines that cost recovery would not be cost effective.

Audit Objective: To assess the effectiveness and efficiency of HICARS's efforts to timely recover Medicaid costs from liable carriers.

Audit Conclusion: We concluded that HICARS's efforts to timely recover Medicaid costs from liable carriers were not effective or efficient. Our assessment disclosed four material conditions:

- HICARS did not effectively monitor and timely follow up on outstanding Post Payment Recovery System (PPRS) billings (Finding 4).

- HICARS did not timely follow up on some of the PPRS billing rejections that it received from a large not-for-profit carrier. Also, HICARS management did not provide effective oversight of its staff members' follow-up of these rejections. (Finding 5)

- HICARS did not attempt to recover or timely recover some Medicaid costs that were the potential liability of Medicare or one of several other carriers (Finding 6).

- HICARS did not have controls to ensure that its Medicaid cost recovery program was efficient (Finding 7).

Our assessment also disclosed one reportable condition related to recovery of costs for recipients with duplicate insurance information in the TPL database (Finding 8).

FINDING

4. Follow-Up of Outstanding PPRS Billings

   HICARS did not effectively monitor and timely follow up on outstanding PPRS billings. As of October 17, 2007, these billings totaled $213.4 million. Without

appropriate follow-up, HICARS diminishes its opportunity for potentially significant Medicaid cost recoveries.

The State Medicaid Plan states that when a carrier does not respond to a billing seeking recovery of Medicaid costs, DCH will send at least one follow-up billing within one year of the original billing date.

During April 2005, HICARS replaced its existing cost recovery system with the new PPRS. The following table shows an aging of the PPRS billings:

Number of Days Outstanding	Number of Outstanding PPRS Billings	Dollar Amount of Outstanding PPRS Billings	Percentage of Total Dollar Amount of Outstanding PPRS Billings	Average Number of Days Since Last PPRS Billing
0 - 29	28,552	$ 14,778,450	6.93%	5
30 - 59	75,034	21,273,697	9.97%	38
60 - 89	22,544	7,397,008	3.47%	77
90 - 119	14,132	12,364,305	5.79%	95
120 - 364	99,167	28,064,799	13.15%	261
365 - 730	100,615	39,712,640	18.61%	556
> 730	132,772	89,788,747	42.08%	806
Total	472,816	$213,379,646	100.00%	412

We reviewed HICARS's monitoring and follow-up of these billings and noted:

a. When we began our analysis, HICARS had not sent follow-up billings (i.e., second billings) or performed a meaningful amount of other follow-up activities (e.g., telephone calls or referrals to the Attorney General) for the outstanding PPRS billings that, as previously noted, dated back to April 2005. After we began questioning HICARS staff about their follow-up activities, but before we compiled data for the previous table, HICARS rebilled outstanding PPRS billings totaling $15.2 million. Consequently, in the table, the $15.2 million is reported as being outstanding for less than 60 days even though the original billings had been outstanding for significantly longer when HICARS rebilled them. For example, we reviewed $11.5 million (75.7%) of the rebillings and noted that, on average, the original billings had been outstanding for 510 days when HICARS rebilled them.

HICARS informed us that an automatic follow-up billing feature (i.e., a follow-up billing was automatically sent after 60 days) was not operational in PPRS. To the contrary, MDIT and PPRS developers informed us that the automatic follow-up billing feature had been operational since shortly after HICARS began using PPRS. Notwithstanding, HICARS used a rebilling feature (versus a follow-up billing) within PPRS, with some manual intervention, to rebill the $15.2 million mentioned previously.

b. HICARS did not maintain a record of the original billing information for the $15.2 million rebilled Medicaid costs identified in part a. of this finding. Federal regulations require that HICARS maintain all billing information to document that it put forth reasonable effort to recover Medicaid costs from liable carriers and, in turn, earned matching federal funding for the corresponding Medicaid costs.

c. As of October 17, 2007, HICARS's PPRS did not have a reporting feature that would allow HICARS management to identify carriers that were not responding to PPRS billings. Consequently, HICARS management stated that it was difficult to ensure that HICARS staff followed up with these carriers in a timely manner. We reviewed the outstanding PPRS billings included in the previous table and identified 31 carriers each with outstanding PPRS billings totaling more than $1 million and 164 carriers each with outstanding PPRS billings totaling between $100,000 and $1 million. The total outstanding billings for the 31 and 164 carriers were $59.7 million and $51.0 million, respectively. The outstanding billings for 118 (60.5%) of these 195 carriers represented more than 50% of all the PPRS billings that HICARS had sent to the carriers during the 31-month period.

RECOMMENDATION

We recommend that HICARS effectively monitor and timely follow up on outstanding PPRS billings.

AGENCY PRELIMINARY RESPONSE

DCH agrees that it did not effectively monitor and timely follow up on outstanding PPRS billings and, consequently, its opportunity for Medicaid cost recoveries was diminished. However, DCH disagrees that the amount of cost recoveries would necessarily have been potentially significant. DCH stated that it is important to

note that the amount recovered from insurance carriers is often considerably less than the amount sought, because the recovered amount is dependent upon various factors unique to each individual claim. Specifically:

a. DCH agrees that there was a delay in the follow-up activities for the claims listed on the PPRS aging schedule presented in the finding; however, DCH stated that is important to recognize that the table includes a large number of billings that DCH should not have sent to insurance carriers, such as duplicate billings and claims already processed by a commercial carrier. DCH acknowledges that these types of billings should not have been sent and continues to implement front-end controls to ensure that these types of inappropriate billings no longer occur.

b. DCH agrees that it did not maintain adequate records of the original billing information. DCH stated that HICARS will work with its TPL contractor to ensure that adequate records are maintained.

c. DCH agrees that it did not have a reporting feature that allowed HICARS management to identify carriers that were not responding to PPRS billings and agrees to develop such a feature. DCH stated that HICARS is transitioning from seeking recoveries from insurance carriers to processing provider claim adjustments. DCH also stated that through this process, HICARS recovers money from providers and the providers are then responsible for seeking reimbursement from insurance carriers. In addition, DCH stated that these claim adjustments, as well as the use of the TPL contractor, will significantly reduce the need for HICARS to rebill carriers.

FINDING

5. Follow-Up of Rejected PPRS Billings

HICARS did not timely follow up on some of the PPRS billing rejections that it received from a large not-for-profit carrier. Also, HICARS management did not provide effective oversight of its staff members' follow-up of these rejections. Without timely follow-up and effective management oversight, HICARS diminished its opportunity for potentially significant Medicaid cost recoveries.

Federal regulation 42 *CFR* 433.139 requires that HICARS seek recovery of Medicaid payments from liable carriers. Implicit within this federal regulation is that HICARS timely follow up on rejected PPRS billings and continue to seek recovery when there is still a reasonable potential for recovery. Often, carriers reject PPRS billings because the billings contain inaccurate or incomplete information or for reasons that may not always be appropriate. In these instances, HICARS should attempt to obtain the correct or missing information or conduct other necessary follow-up work and continue to seek recovery from either the carrier or the health care provider, whichever is most appropriate.

HICARS informed us that the carrier provided it with both a paper and an electronic copy of the explanation of benefits* (EOB). Each EOB detailed the carrier's payment or rejection for one or more PPRS billings. HICARS informed us that it identified and followed up on rejected PPRS billings using only the paper copy of each EOB. However, we noted that HICARS staff responsible for follow-up of the rejected PPRS billings received only the paper copy of the EOB that contained a carrier payment for at least one of the billed services included therein. Consequently, when a rejection was included on an EOB that did not contain at least one paid claim, HICARS would not have followed up on the rejection. We reviewed HICARS's follow-up of PPRS billings that the carrier rejected, along with HICARS oversight of these follow-up efforts, and noted:

a. HICARS had not followed up on a significant number of pharmacy-related PPRS billings that the carrier rejected from April 1, 2005 through October 17, 2007. During this period, the carrier rejected 1.1 million pharmacy-related PPRS billings totaling $40.4 million. This included approximately 839,000 (76.3%) PPRS billings totaling $34.5 million that the carrier rejected because of nonmatching group or cardholder identification numbers. For these rejections, HICARS should have attempted to obtain the correct group and cardholder identification numbers and continued to seek recovery, as appropriate. As of October 17, 2007, HICARS had only rebilled 4 of the 839,000 rejections totaling $60 and claims adjusted 602 of the rejections totaling $49,572. Because HICARS did not document that it followed up on a rejected billing if its follow-up efforts did not result in rebilling or claims adjustment, the actual number of rejections that HICARS had not followed up

** See glossary at end of report for definition.*

on could not be determined. However, we determined that HICARS had not followed up on at least 128,000 (15.3%) rejected billings totaling $5.3 million because the HICARS staff responsible for follow-up had not received the paper copy of the EOB for them.

b. HICARS had not followed up on a significant number of professional services billings that the carrier rejected. Professional services include services provided by physicians, podiatrists, clinical laboratories, and others. Although we were unable to determine the total number and dollar amount of professional services billings that the carrier rejected, we noted:

(1) As of November 15, 2007, HICARS had four records boxes full of EOBs with rejected professional claims dating back to September 2005 that it had not followed up.

HICARS informed us that when the carrier rejected PPRS billings for professional services, it generally did so because the recipient's insurance policy either had terminated or did not cover the billed services. Consequently, HICARS informed us that, because these rejections likely presented little opportunity for recovery, it used its limited staffing resources on more productive activities and would follow up on these rejections as time permitted.

(2) For the period April 1, 2005 through October 17, 2007, we identified approximately 37,600 billings for professional services totaling $3.0 million that the carrier rejected because of missing information. As of October 17, 2007, HICARS had only rebilled the carrier for 4 of the 37,600 rejections totaling $139 and claims adjusted 39 of the rejections totaling $1,416.

(3) For the period April 1, 2005 through October 17, 2007, we identified approximately 240,700 billings for professional services totaling $18.6 million that the carrier rejected with an explanation that either the recipients' health insurance policies did not cover the specialized therapy that the provider billed for or the billings for the specialized therapy were not submitted in the proper format. Based on our review of the billing procedures, it did not appear that many of these billings were for the specialized therapy that served as the basis for the carrier's rejections.

Regardless of the reason for rejection, HICARS had only rebilled the carrier for 228 of the 240,700 rejections totaling $8,518 and claims adjusted 10 of the rejections totaling $453.

We could not readily determine if the remaining 278,019 rejections from parts b.(2) and b.(3) were in the four records boxes awaiting HICARS follow-up mentioned in part b.(1) because HICARS had not filed the paper EOB in a manner that was conducive to review. Also, because HICARS did not document that it followed up on a rejected billing if its follow-up efforts did not result in rebilling or claims adjustment, the number of the 278,019 rejections that HICARS had not followed up could not be determined.

c. HICARS management did not periodically review and assess the appropriateness of staff follow-up efforts for rejected PPRS billings. Periodic review of each staff member's follow-up efforts is necessary to timely identify staff training needs and ultimately to ensure that HICARS maximizes its Medicaid cost recoveries.

HICARS stated that a lack of staffing prevented it from timely following up on rejected PPRS billings.

RECOMMENDATIONS

We recommend that HICARS timely follow up on the PPRS billing rejections that it received from the large not-for-profit carrier.

We also recommend that HICARS management provide effective oversight of its staff members' follow-up of these rejections.

AGENCY PRELIMINARY RESPONSE

DCH agrees that it did not follow up timely on some PPRS billing rejections that it received from the referenced carrier and that there are opportunities for improvement in regards to oversight of staff members' follow-up activities. DCH acknowledges that its opportunity for Medicaid cost recoveries was diminished. However, DCH disagrees that the amount of cost recoveries would necessarily have been potentially significant. DCH stated that it is important to note that the amount recovered from insurance carriers is often considerably less than the

amount billed, because the recovered amount is dependent upon various factors unique to each individual claim.

DCH stated that it enhanced its ability to recover Medicaid costs through a verbal agreement with the carrier. DCH also stated that the agreement waived the time limits for providers to submit claims to the carrier relating to the carrier's rejection of a certain type of PPRS billing. In addition, DCH stated that the agreement allows additional time for DCH to process adjustments to providers' claims and for providers to then bill the carrier, resulting in more timely recoveries by DCH. Further, DCH stated that HICARS continues to explore ways to improve the electronic billing and recovery process with this carrier as well as develop more efficient internal procedures for managing claim rejections. Specifically:

a. DCH agrees that it did not follow up on a significant number of pharmacy-related PPRS billings that the carrier rejected for nonmatching group or cardholder identification numbers. DCH stated that to address pharmacy rejections from the State's largest commercial carrier that occur due to incorrect group and cardholder identification numbers, HICARS meets weekly with the carrier to improve the monthly file match process. DCH also stated that additional PPRS editing and improvement of internal control have resulted from these meetings.

b. DCH agrees that it did not follow up on a number of professional services billings rejected by the carrier because of termination of beneficiaries' policies, missing information, noncovered services, and improper formats. DCH stated that, historically, rejections caused by lapsed coverage, noncovered services, and services with carrier-required protocols different from Medicaid protocols are not rebilled, as the rejections are valid. DCH also stated that it would not expect to recover money from rebilling in these instances. In addition, DCH stated that these rejections continue to be reviewed and processed as time permits and as appropriate.

c. DCH agrees that HICARS management did not periodically review and assess the appropriateness of its staff members' follow-up efforts for rejected PPRS billings. DCH stated that a planned reorganization of duties will allow management to focus greater attention on this process.

FINDING

6. Recovery of Medicaid Costs

HICARS did not attempt to recover or timely recover some Medicaid costs that were the potential liability of Medicare or one of several other carriers. DCH records indicated that these costs totaled at least $29.0 million.

Our review of HICARS compliance with federal Medicaid cost recovery requirements disclosed:

a. HICARS did not attempt to recover an estimated $15.7 million from Medicare related to physician services, pharmaceutical products, and services delivered by medical clinics between October 1, 2003 and June 27, 2007 that were generally covered by Medicare.

b. HICARS did not attempt to recover Medicaid costs from Medicare and a large not-for-profit carrier and some of its affiliates for covered skilled care services delivered in a recipient's home.

c. HICARS had not attempted to recover Medicaid costs totaling $7.5 million for outpatient services delivered between October 1, 2003 and March 27, 2007 from a large not-for-profit carrier and several of the carrier's affiliates.

d. As of March 27, 2007, HICARS had not attempted to recover Medicaid costs totaling $5.8 million for various professional services delivered between October 1, 2003 and March 27, 2007 from several carriers.

HICARS stated that it was not cost-effective to seek recovery of the Medicaid costs noted in parts a. through c. of this finding. However, HICARS could not provide us with documentation to support this position. Also, HICARS informed us that it delayed seeking recovery of the Medicaid costs noted in part d. until its PPRS was capable of electronically billing and receiving electronic remittances from the applicable carriers. Notwithstanding, HICARS had not presented this rationale and supporting documentation to the Centers for Medicare and Medicaid Services and requested and received a waiver from pursuing recovery of the Medicaid costs or for exceeding the required 60-day billing requirement, as required by federal regulation 42 *CFR* 433.139.

Because the actual recovery of a Medicaid payment is dependent upon various factors unique to each individual claim, we could not accurately estimate how much of the $29.0 million HICARS could likely recover.

RECOMMENDATION

We recommend that HICARS attempt to recover and timely recover Medicaid costs that are the potential liability of Medicare and/or other carriers.

AGENCY PRELIMINARY RESPONSE

DCH agrees that it did not attempt to recover or timely recover some Medicaid costs that were the potential liability of Medicare or one of several other carriers. DCH stated that it is important to note that the amount recovered from insurance carriers is often considerably less than the amount sought, because the recovered amount is dependent upon various factors unique to each individual claim. Specifically:

a. DCH agrees that it did not attempt to recover costs from Medicare for physician services, pharmaceutical products, and services delivered by medical clinics for the specified period. DCH stated that after implementing changes to PPRS, HICARS began recovery efforts for these types of services in February 2008.

b. DCH agrees that it did not attempt to recover Medicaid costs for skilled care services delivered in a recipient's home. DCH stated that because Medicaid reimbursement policies for these services often differ from those of Medicare and other insurance carriers, the majority of these services would be denied for reimbursement by Medicare and carriers as noncovered services. Consequently, DCH stated that it will continue to commit its resources to areas of recovery that are more cost effective. DCH also stated that it will monitor the situation and pursue recovery if circumstances change.

c. DCH agrees that it did not attempt to recover Medicaid costs for outpatient services from a large not-for-profit carrier and several of its affiliates for the specified period. DCH stated that after implementing changes to PPRS, HICARS began recovery efforts for these types of services in September 2007.

d. DCH agrees that it did not attempt to recover Medicaid costs for various professional services from a large not-for-profit's affiliate for the period specified. DCH indicated that HICARS began recovery efforts for these services in September 2007.

DCH agrees that it should have appropriately documented its position that recovery would not be cost effective. DCH acknowledges that it did not request a waiver from the Centers for Medicare and Medicaid Services for exceeding the 60-day billing requirement. As noted above, DCH indicated that it is in the process of pursuing recovery where appropriate.

FINDING

7. Efficiency of HICARS's Cost Recovery Program

HICARS did not have controls to ensure that its Medicaid cost recovery program was efficient. As a result, HICARS used some of its limited resources to pursue recovery of Medicaid costs that were generally not reimbursable by carriers while simultaneously burdening carriers with processing unnecessary PPRS billings.

During the period April 1, 2005 through September 30, 2007, HICARS sent PPRS billings totaling $495.8 million and recovered Medicaid costs totaling $20.6 million. A chart of the PPRS billings and recoveries by provider type is presented as supplemental information. Because the dollar amount of HICARS's Medicaid cost recoveries was small in relation to the PPRS billings, we reviewed HICARS's Medicaid cost recovery program and noted:

a. HICARS did not conduct a comprehensive analysis of its PPRS billings and their related remittances (including carrier EOBs) to identify commonalities that existed among the PPRS billings that consistently, and for good reason, produced no Medicaid cost recoveries. By analyzing the billing procedure codes, provider types, carriers, explanation and rejection codes included on carrier EOBs, etc., HICARS could identify services, service types, etc., that carriers were not liable for and that it should exclude from subsequent Medicaid cost recovery activities.

HICARS informed us that each of its cost recovery staff members worked with the PPRS billings and remittances of specific health insurance carriers.

HICARS also informed us that, when a cost recovery staff member noted that a carrier consistently rejected PPRS billings for a particular type of service, HICARS could exclude the services from subsequent PPRS billings. However, because of the large volume of PPRS billings, the multiple variables affecting carrier reimbursement, and the small dollar amount of Medicaid cost recoveries in relation to the dollar amount of PPRS billings, a more comprehensive analysis is necessary to improve the efficiency of the Medicaid cost recovery program.

b. HICARS sent PPRS billings to at least one carrier despite knowing that the carrier was generally not liable for payment. We noted that HICARS had sent a carrier approximately 15,077 paper PPRS billings totaling $24.7 million during the 30-month period ended September 30, 2007. As of October 17, 2007, the carrier had responded to only 1,022 of the PPRS billings and reimbursed Medicaid a total of $54. When we questioned HICARS about the lack of recoveries from this carrier, HICARS informed us that the carrier that we inquired about was generally not liable for the billings. HICARS also stated that it had simultaneously billed this carrier and another related carrier for all 15,077 claims. At the time of our questioning, HICARS was continuing to bill both carriers.

c. HICARS sent PPRS billings to carriers to recover Medicaid costs for services that it had already determined were not the carriers' liability. From October 1, 2003 through February 28, 2007, HICARS sent approximately 131,000 billings to recover Medicaid costs that HICARS staff had manually reviewed and approved for Medicaid payment. The purpose of the manual review was to determine the carriers' liability before the Medicaid payment. The manual review included analysis of EOBs and other documentation that the providers had received from the carriers related to the billed procedure(s) before billing Medicaid and/or the recipients' policy-related information on the carriers' Web sites. HICARS policy requires that HICARS authorize payment for only those manually reviewed claims that it is sure are not the liability of another carrier.

d. HICARS did not ensure that approximately 274,000 paid claims were appropriate for cost recovery before it printed 110 boxes of PPRS billings for mailing to a single carrier. Subsequent to printing, HICARS exhausted hundreds of staff hours over a five-month period manually assessing the appropriateness of the paper PPRS billings. Based on its review, HICARS

discarded at least 165,454 (60.4%) of the paper PPRS billings because the billings were incomplete, inaccurate, or not the liability of the carrier. If HICARS had conducted an electronic analysis of the billing information before it printed the actual billings, it may have meaningfully reduced the costs associated with processing them.

As noted in Findings 1 and 5 in this report, HICARS informed us that it did not have sufficient staffing to complete or timely complete some of its critical responsibilities. By improving the efficiency of its Medicaid cost recovery program, HICARS should be able to redirect some of its staffing resources to complete and/or more timely complete some of these responsibilities.

RECOMMENDATION

We recommend that HICARS implement controls to ensure that its Medicaid cost recovery program is efficient.

AGENCY PRELIMINARY RESPONSE

DCH agrees that it did not have controls to ensure that its Medicaid cost recovery program was efficient. DCH stated that, as the chart in the supplemental information section of the report shows, the amount recovered from insurance carriers is often considerably less than the amount billed. DCH also stated that each claim is dependent upon various unique factors. In addition, DCH indicated that one of the main reasons for the significant difference between the amount billed and the amount recovered is noncoverage of the service by the carrier. For example, DCH stated that most carriers do not cover nursing home services and many have limitations on coverage of durable medical equipment. DCH also stated that Medicaid's utilization guidelines may differ significantly from those used by carriers, such as for home health services. In addition, DCH mentioned that another reason is due to the extremely restricted time line for billing carriers for pharmaceuticals. Further, DCH stated that it is often not made aware of beneficiaries' insurance coverage until after the time limit has already passed for submission to the carrier for reimbursement. Specifically:

a. While DCH agrees that it did not conduct a comprehensive analysis of its PPRS billings and their related remittances, DCH was aware of some commonalities that existed among PPRS billings that consistently produced little or no Medicaid cost recoveries. Consequently, DCH stated that HICARS

either excluded affected services or developed system enhancements to improve the cost recovery process whenever possible.

DCH indicated that HICARS has transitioned from seeking recoveries from insurance carriers to processing provider claim adjustments, whenever possible. Through this process, DCH stated that HICARS recovers the amount that Medicaid (DCH) paid the provider and the providers are then responsible for seeking reimbursement from insurance carriers. DCH also stated that providers often benefit from this process because they usually receive higher reimbursement from carriers than they would from Medicaid.

b. DCH agrees that it sent some PPRS billings to a carrier for which it knew the carrier was generally not liable for payment. DCH stated that it has addressed this issue by exploring how it can enhance PPRS to avoid these types of billings and process more provider claim adjustments, as noted in part a.

c. DCH agrees that it sent PPRS billings to carriers to recover Medicaid costs for services that it had already determined were not the carriers' liability. DCH indicated that it implemented an edit in June 2008 to ensure that DCH no longer billed carriers for these types of claims.

d. DCH agrees that it did not ensure that some claims were appropriate for cost recovery before printing billings to the carrier. DCH stated that with very few exceptions, billings to carriers by DCH or its vendor are now performed electronically; therefore, an electronic analysis is not necessary.

FINDING

8. Recovery of Costs for Recipients With Duplicate Insurance Information in the TPL Database

HICARS did not seek recovery of Medicaid costs for recipients whose third party health insurance information was recorded twice in the TPL database. We estimate that HICARS did not seek recovery of Medicaid costs totaling $10.8 million for services delivered between August 28, 2005 and February 28, 2007.

Each month, a large not-for-profit carrier provided HICARS with an electronic file listing the recipients that the carrier insured, along with each recipient's policy-

related information (e.g., policy number and effective dates). MDIT loaded this file into the TPL database for cost avoidance and recovery purposes. However, in 2006, the carrier began changing the structure of its policy numbers. This change resulted in some recipients' insurance information being recorded in the TPL database twice (albeit with different policy numbers). This resulted in HICARS sending two PPRS billings to the carrier for applicable recipients: one for each policy number recorded in the TPL database. To alleviate this problem, HICARS stated that it removed both of the original PPRS billings from its cost recovery process. HICARS also stated that it subsequently created a third single PPRS billing for each applicable recipient, which it then sent to the carrier. However, our testing disclosed that HICARS had not created and sent the third single PPRS billings.

Although HICARS continues to get a mix of old and new policy numbers from the carrier, HICARS has been working with the carrier to stop this occurrence.

RECOMMENDATION

We recommend that HICARS seek recovery of Medicaid costs for recipients whose third party health insurance information is recorded twice in the TPL database.

AGENCY PRELIMINARY RESPONSE

DCH agrees that it did not seek recovery of Medicaid costs for recipients whose third party health insurance information appeared more than once in the TPL database. DCH stated that subsequent to the audit, it initiated billings for the claims identified in the audit and has made significant progress in seeking recovery. However, DCH indicated that HICARS would like to note that the actual amount recovered from carriers is often considerably less than the amount sought, because the recovered amount is dependent upon various factors unique to each individual claim. In addition, DCH stated that HICARS continues to work with the carrier to minimize its reporting of old and new policy numbers.

EFFECTIVENESS OF HICARS'S EFFORTS REGARDING PROCESSING OF SUSPENDED HEALTH CARE CLAIMS

COMMENT

Background: The Medical Services Administration's (MSA's) claims processing system placed provider claims through a series of TPL-related edits. For example, if a claim referenced a potentially liable carrier, and the carrier did not pay at least two-thirds of what Medicaid's payment amount would be if there were no carrier, the system suspended the claim from payment processing. It was HICARS's responsibility to review available documentation and determine whether to force payment of the claim or return it unpaid to the provider.

Audit Objective: To assess the effectiveness of HICARS's efforts to process suspended health care claims in a timely manner and in compliance with HICARS's written procedures.

Audit Conclusion: We concluded that HICARS's efforts to process suspended health care claims in a timely manner were effective and its efforts to process suspended health care claims in compliance with HICARS's written procedures were moderately effective. Our assessment disclosed one reportable condition related to controls over processing suspended health care claims (Finding 9).

FINDING

9. Controls Over Processing Suspended Health Care Claims

HICARS did not have sufficient controls over its processing of suspended health care claims. As a result, HICARS could not ensure that it rejected suspended health care claims that were the liability of carriers.

Federal regulation 42 *CFR* 433.139 requires HICARS to reject a provider's health care claim when there is a good probability that a carrier is liable for payment. To comply with this federal regulation, Medicaid required that providers bill all applicable carriers before billing Medicaid for services delivered to recipients. Medicaid required providers to document their billing actions and carrier payments and/or reasons for nonpayment on all applicable claims submitted to Medicaid. In addition, Medicaid required that providers sending paper claims to Medicaid (versus electronic claims) include a copy of the EOBs that the carriers sent to the providers as proof of the carriers' billing actions.

DCH's claims processing system rejected provider claims that did not state that the provider billed all applicable carriers. Also, Medicaid's claims processing system suspended claims for manual review by HICARS staff when carriers rejected provider claims or carrier payments were less than a calculated minimum amount. HICARS staff were required to review EOBs and/or other available documentation to determine whether Medicaid should pay or reject provider claims.

During the 41-month period ended February 28, 2007, DCH records indicated that HICARS approved payment for approximately 247,000 (82.3%) of the 300,000 suspended claims that it had reviewed. Medicaid payments totaled $32.0 million for these claims. We reviewed 47 of the suspended claims (both electronic and paper claims) that HICARS had approved for payment. We also reviewed the 19 suspended paper claims that accounted for HICARS's largest individual cost recoveries of provider claims submitted in paper format. We noted:

a. HICARS management did not review suspended claims, on a test basis, to ensure that HICARS staff processed the claims in compliance with HICARS procedures and correctly decided to pay or reject the claims. We noted the following instances of noncompliance with HICARS suspended claims processing procedures:

   (1) HICARS approved 20 suspended paper claims (of the 66 claims reviewed) for payment that did not include the EOBs from potentially liable carriers. HICARS should have rejected these suspended claims.

   (2) HICARS approved 3 (4.5%) of the 66 claims for payment without ensuring that the claims identified the amount of a carrier's payment, as required by HICARS procedures. This resulted in Medicaid overpaying the providers $23,358. In 2 of the 3 instances totaling $23,244, the provider identified and refunded the overpayments to Medicaid over one year later.

b. HICARS did not document which staff member processed each suspended claim. Without this information, HICARS could not identify the employees responsible for suspended claims processing errors and who may require additional training. MDIT staff informed us that the claims processing system had unused data fields that HICARS could have used to capture this information.

RECOMMENDATION

We recommend that HICARS establish sufficient controls over its processing of suspended health care claims.

AGENCY PRELIMINARY RESPONSE

DCH agrees that it could not ensure that it rejected suspended health care claims that were the liability of carriers. DCH acknowledges that opportunities exist to improve controls over its processing of suspended health care claims. Specifically:

a. DCH agrees that HICARS management did not review suspended claims, on a test basis, to ensure that staff processed the claims appropriately. DCH stated that it is currently developing a review protocol to improve control over this process. In addition:

   (1) DCH acknowledges that some suspended paper claims were approved without accompanying EOBs. DCH indicated that HICARS staff frequently utilize information from sources other than an EOB to determine if a suspended paper claim should be approved for payment or rejected; however, DCH agrees that HICARS could have done a better job documenting the utilization of these other sources. In addition, DCH stated that HICARS will explore available documentation options as part of the implementation of the new Medicaid claims processing system as well as any necessary policy changes.

   (2) DCH acknowledges that it approved three claims for payment without ensuring that the claims identified the amount of the carrier's partial payment.

b. DCH agrees that it did not document which staff member processed each suspended claim during the audit period. DCH indicated that implementation of the new Medicaid claims processing system will correct this deficiency.

DCH stated that HICARS will review written policies and procedures to address needed improvements in the processing of suspended claims.

EFFECTIVENESS OF HICARS'S EFFORTS REGARDING THE MEDICAID CLAIMS PROCESSING SYSTEM

COMMENT

Audit Objective: To assess the effectiveness of HICARS's efforts to ensure that the Medicaid claims processing system included the necessary edits to reject provider health care claims that were the liability of carriers.

Audit Conclusion: We concluded that HICARS's efforts to ensure that the Medicaid claims processing system included the necessary edits to reject provider health care claims that were the liability of carriers were moderately effective. Our assessment disclosed one reportable condition related to the use of TPL edits (Finding 10).

FINDING

10. Use of TPL Edits

HICARS did not ensure that TPL edits in the Medicaid claims processing system resulted in the rejection of some provider claims that were the potential liability of carriers. As a result, Medicaid likely incurred significant costs for services that were the financial liability of carriers.

Federal regulations 42 *CFR* 433.138 and 42 *CFR* 433.139 require that HICARS take reasonable measures to determine if carriers are liable for paying for health care services delivered to recipients. To help make these determinations, DCH established various edits within its claims processing system.

We reviewed the TPL editing process and noted:

a. DCH established a bypass of its TPL edits for all claims submitted by medical clinics even though some services provided by the medical clinics were covered by carriers. MDIT informed us that the bypass was established around October 2004. Medical clinics were a provider type that included family planning clinics, rural health centers, health departments, and others. Prior to establishing the bypass, HICARS had conducted TPL editing on and therefore cost avoided billings for 819 different procedure codes used by medical clinics. DCH records indicated that from October 1, 2004 through

June 30, 2007, Medicaid paid $99.4 million for services billed using the 819 procedure codes.

HICARS informed us that it did not know that this bypass existed or who was responsible for establishing it.

b. Medicaid did not eliminate an old and unnecessary bypass of its TPL edits for some claims submitted by any of four different provider types. DCH records indicated that Medicaid paid $10.2 million for provider claims impacted by the bypass.

c. MSA did not ensure that HICARS, or another organizational unit within MSA, assigned the correct TPL coding to billing procedure codes. We noted that MSA had improperly coded 134 of the billing procedure codes to skip all TPL editing. As a result, DCH records indicated that approximately $1.4 million in Medicaid costs that should have been subject to TPL editing had not been subject to TPL editing.

The many variables involved in the TPL editing process, along with the variety of coverage and payment provisions applicable to each recipient's health insurance coverage, precluded an accurate estimate of the Medicaid costs that were the financial liability of carriers.

RECOMMENDATION

We recommend that HICARS ensure that TPL edits in the Medicaid claims processing system reject provider claims that are the potential liability of carriers.

AGENCY PRELIMINARY RESPONSE

DCH agrees that it did not ensure that TPL edits in the Medicaid claims processing system resulted in the rejection of some provider health care claims that were the potential liability of carriers. However, DCH indicated that it disagrees that it likely incurred significant costs for services that were the financial liability of others. DCH stated that it is important to note that even though bypasses of some TPL edits

existed, they did not necessarily result in claims being paid inappropriately. Specifically:

a. DCH agrees that an edit bypass was in place during the audit period for all claims submitted by medical clinics. DCH stated that this bypass had both TPL and non-TPL related purposes. In addition, DCH agrees to determine if the TPL-related purpose is still valid and to discontinue using the bypass for TPL purposes if it is not. However, DCH indicated that it is in the process of implementing a new Medicaid claims processing system and this new system precludes action on service requests relating to the old system.

b. DCH agrees that an unnecessary bypass of TPL editing that affected four different provider types was in place during the audit period. HICARS agrees to have this bypass removed, if it is still not necessary, at the appropriate time during the implementation of the new Medicaid claims processing system. DCH stated that the new system is expected to greatly enhance the entire TPL editing process.

c. DCH agrees that it did not ensure that HICARS or another organizational entity within DCH assigned the correct TPL coding to billing procedure codes. DCH stated that HICARS will be responsible for assigning TPL coding once the new Medicaid claims processing system is implemented.

SUPPLEMENTAL INFORMATION

UNAUDITED

HEALTH INSURANCE COST AVOIDANCE AND RECOVERY SECTION
Medical Services Administration
Department of Community Health
Post Payment Recovery System (PPRS) Billings and Recoveries by Provider Type
For the Period April 1, 2005 through September 30, 2007

Provider Type	Number of PPRS Billings	Dollar Amount of PPRS Billings	Dollar Amount Recovered	Percentage of Dollar Amount of PPRS Billings That HICARS Recovered
Physician, M.D., and physical therapist	188,995	$ 12,080,159	$ 1,621,848	13.43%
Physician, D.O.	47,261	2,623,354	320,085	12.20%
Dentist	48,747	4,078,914	319,099	7.82%
Podiatrist/chiropodist	2,560	67,675	2,868	4.24%
Chiropractor	3,835	95,968	6,337	6.60%
Home health agency	47,017	22,330,871	808,847	3.62%
Clinical laboratory	8,799	303,082	54,379	17.94%
Ambulance	2,139	507,830	79,485	15.65%
Community mental health board	497	103,878		0.00%
State psychiatric hospital	69	971,138		0.00%
Family planning clinic	9,782	392,463	30,493	7.77%
Inpatient hospital	6,119	18,781,811	2,203,832	11.73%
Outpatient hospital	86,936	8,560,102	930,822	10.87%
Pharmacy	2,337,911	109,673,423	11,280,717	10.29%
Nursing home	66,903	188,254,300	1,388,771	0.74%
County medical care facility	12,856	50,528,828	236,318	0.47%
Hospital long-term care	3,691	15,908,567	106,816	0.67%
Pediatric nursing home	267	2,677,768	10,049	0.38%
State mental retardation facility - inpatient	115	1,740,581		0.00%
Dental clinic	14,415	915,291	85,505	9.34%
Medical clinic	80,912	26,371,657	410,213	1.56%
Hearing and speech center	4,856	294,252	6,135	2.09%
Orthotist and prosthetist	3,678	1,059,388	66,145	6.24%
Optical company	1,681	46,252	513	1.11%
Medical supplier	204,810	24,724,307	605,133	2.45%
Hearing aid supplier	6,152	1,896,093	26,806	1.41%
Optometrist, O.D.	13,036	456,950	15,306	3.35%
Optical house	14,444	326,337	6,063	1.86%
Total	3,218,483	$ 495,771,241	$ 20,622,584	4.16%

Source: Extracted from PPRS by Office of the Auditor General staff.

GLOSSARY

carrier	For purposes of this report, a third party health insurance carrier (see definition).
CFR	*Code of Federal Regulations.*
cost avoidance	A process that returns a health care claim unpaid to the health care provider for collection from a liable third party.
DBCAU	Data Base and Cost Avoidance Unit.
DCH	Department of Community Health.
DHS	Department of Human Services.
DMB	Department of Management and Budget.
effectiveness	Success in achieving mission and goals.
efficiency	Achieving the most outputs and outcomes practical with the minimum amount of resources.
explanation of benefits (EOB)	A document that a carrier sends to a billing entity detailing the carrier's payment for billed services and/or reasons for nonpayment.
fee-for-service	The method of paying a medical provider for each service that it delivers.
HICARS	Health Insurance Cost Avoidance and Recovery Section.
managed care	The method of paying a provider using managed care health plans (a.k.a., managed care organizations). DCH pays managed care health plans a capitated rate per month per eligible Medicaid beneficiary. Managed care health plans, in

	turn, pay medical providers for contractually specified medical services provided to beneficiaries enrolled in the plans.
management control	The plan of organization, methods, and procedures adopted by management to provide reasonable assurance that goals are met; resources are used in compliance with laws and regulations; valid and reliable data is obtained and reported; and resources are safeguarded against waste, loss, and misuse.
material condition	A reportable condition that could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program.
MDIT	Michigan Department of Information Technology.
Medicaid	Created under Title XIX of the Social Security Act, this program provides medical services to indigent persons in the general categories of families with dependent children; the aged, blind, and disabled; and other targeted groups that meet income eligibility standards.
medical support enforcement services	Health insurance enrollment and national medical support notice processing.
MOU	memorandum of understanding.
MSA	Medical Services Administration.
national medical support notices	Notices provided to employers on how to handle medical support for dependent children included in child support actions.
OCS	Office of Child Support.

performance audit	An economy and efficiency audit or a program audit that is designed to provide an independent assessment of the performance of a governmental entity, program, activity, or function to improve public accountability and to facilitate decision making by parties responsible for overseeing or initiating corrective action.
PPRS	Post Payment Recovery System.
recipients	Persons who are enrolled in Medicaid and who can receive medical services that are paid for with Medicaid funds.
reportable condition	A matter that, in the auditor's judgment, represents either an opportunity for improvement or a significant deficiency in management's ability to operate a program in an effective and efficient manner.
SSA	Social Security Administration.
State Medicaid Plan	A document that defines how Michigan will operate its Medicaid program. The State Medicaid Plan addresses the areas of State program administration, Medicaid eligibility criteria, service coverage, and provider reimbursement and is approved by the federal Centers for Medicare and Medicaid Services.
suspended health care claims	Health care claims that require a manual review by HICARS during claims processing to determine if a carrier may be liable for payment.
third party action plan	A plan required by Title 42, Part 433, section 138 of the *Code of Federal Regulations* that details DCH's plans for third party identification, third party liability determination, cost avoidance, cost recovery, and recordkeeping.

third party health insurance carriers	Health insurers, group health plans, service benefit plans, and health maintenance organizations.
TPL	third party liability.

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OFFICE of the AUDITOR GENERAL