MICHIGAN

OFFICE OF THE AUDITOR GENERAL

AUDIT REPORT

PERFORMANCE AUDIT
OF THE

HOSPITAL AND HEALTH PLAN REIMBURSEMENT DIVISION

MEDICAL SERVICES ADMINISTRATION
DEPARTMENT OF COMMUNITY HEALTH

November 2011

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

391-0560-11

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

Hospital and Health Plan Reimbursement Division

Medical Services Administration

Department of Community Health

Report Number:
391-0560-11

Released:
November 2011

Medicaid is a program that helps certain individuals and families with low incomes and limited resources to pay for some or all of their medical bills. The Hospital and Health Plan Reimbursement Division (HHPRD) is responsible for reimbursing hospitals and other health related organizations for services provided to Medicaid eligible individuals. HHPRD is also responsible for developing the rates used to reimburse providers for services provided to Medicaid eligible individuals.

Audit Objective:
To assess the effectiveness of HHPRD's efforts to complete accurate and timely cost settlements.

Audit Conclusion:
We concluded that HHPRD's efforts to complete accurate and timely cost settlements were moderately effective. We noted four reportable conditions (Findings 1 through 4).

Reportable Conditions:
HHPRD should reevaluate the use of a semimonthly interim payment method as a means for reimbursing hospitals (Finding 1).

HHPRD should pursue an update to the Community Health Automated Medicaid Processing System (CHAMPS) to allow federally qualified health centers (FQHCs) and rural health clinics (RHCs) the ability to submit billings and receive payment for fee-for-service Medicaid beneficiaries at the prospective payment system (PPS) rate (Finding 2).

HHPRD could improve control procedures to monitor the status of outstanding and in-process cost settlements for FQHCs, RHCs, and school based services (SBS) providers (Finding 3).

HHPRD had not established sufficient controls over the SBS cost settlement process (Finding 4).

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Audit Objective:
To assess the effectiveness of HHPRD's efforts to obtain and use accurate data when setting provider reimbursement rates.

Audit Conclusion:

We concluded that HHPRD's efforts to obtain and use accurate data when setting provider reimbursement rates were effective. Our audit report does not contain any reportable conditions related to this audit objective.

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Agency Response:

Our audit report contains 4 findings and 4 corresponding recommendations. The Department of Community Health's preliminary response indicates that it agrees with the 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: http://audgen.michigan.gov

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

November 18, 2011

Ms. Olga Dazzo, Director
Department of Community Health
Capitol View Building
Lansing, Michigan

Dear Ms. Dazzo:

This is our report on the performance audit of the Hospital and Health Plan Reimbursement Division, 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; 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 response subsequent to our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agency develop a plan to comply with the audit recommendations and submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services will review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

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

Sincerely,

Thomas H. McTavish, C.P.A.
Auditor General

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MEDICAL SERVICES ADMINISTRATION
DEPARTMENT OF COMMUNITY HEALTH

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Description of Agency

Medicaid is a program that helps certain individuals and families with low incomes and limited resources to pay for some or all of their medical bills. The federal government established Medicaid under Title XIX of the Social Security Act.

The federal government establishes regulations, guidelines, and policy interpretations that describe the broad framework within which states can tailor their individual Medicaid programs. The states operate Medicaid programs according to the respective state rules and criteria that vary within this broad framework. In Michigan, the Medical Services Administration, Department of Community Health, administers Medicaid.

Medicaid is a joint federal and state funding effort. The federal government matches the funds that each state spends on Medicaid according to the state's federal medical assistance percentage (FMAP). Michigan's FMAP ranged from 65.79% through 75.57% during our audit period.

The Hospital and Health Plan Reimbursement Division (HHPRD), Bureau of Medicaid Financial Management and Administrative Services, Medical Services Administration, is responsible for reimbursing hospitals and other health related organizations for services provided to Medicaid eligible individuals. HHPRD is also responsible for developing the rates used to reimburse hospitals and other health related organizations for services provided to Medicaid eligible individuals. During our audit period, there were three sections within HHPRD that shared these responsibilities:

1. The Settlement and Payment Processing Section established and authorized payments to hospitals that elected to be reimbursed semimonthly. Medicaid interim payments* (MIPs) and capital interim payments* (CIPs) were established using historical claims data as well as cost reports* and current quarterly financial reports received from the hospitals. This Section calculated final cost settlements* based on compliance with the Michigan Medicaid State Plan or waivers, State policy, and federal regulations. Initial MIP reconciliations are calculated a minimum of 15 months after the hospital's fiscal year-end. CIP reconciliations are only

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

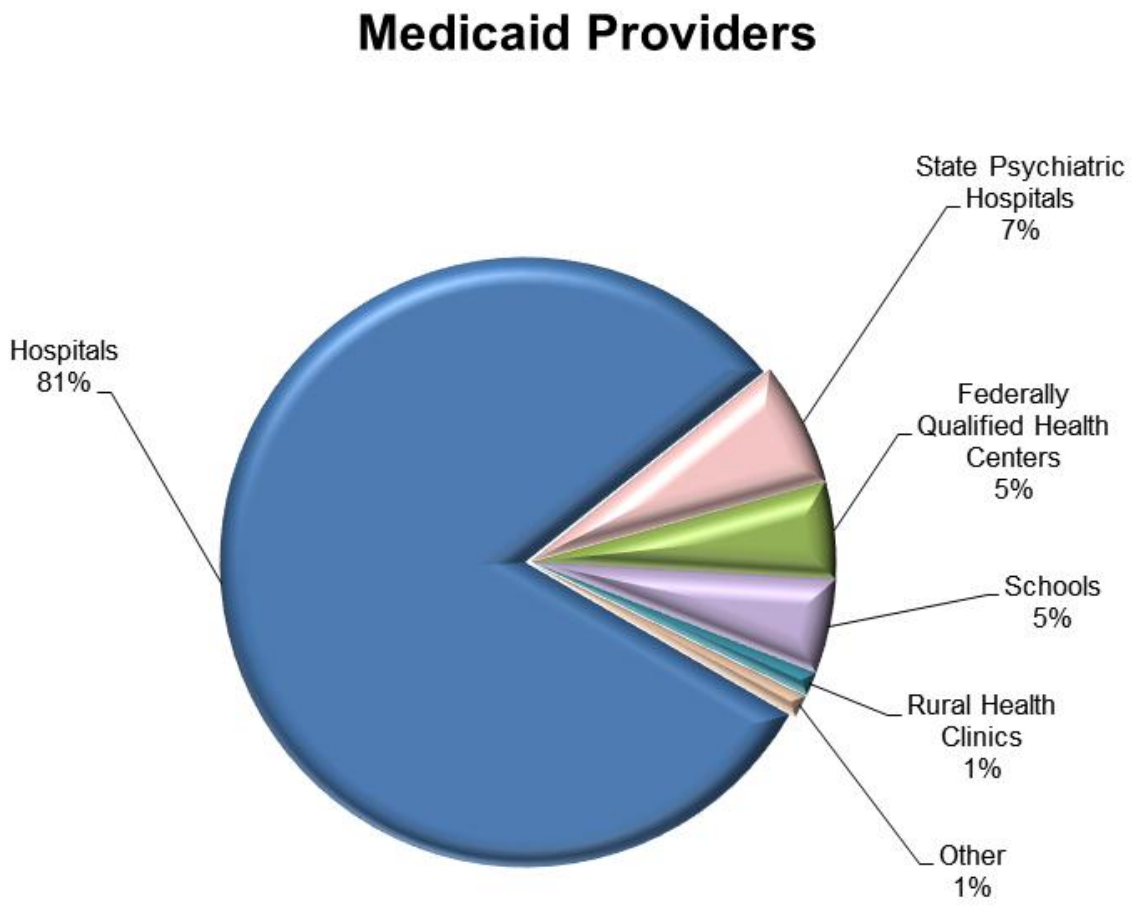
performed with the final MIP settlements. MIP reconciliations are the difference between the MIPs and the amount approved for payment from the approved claims. This Section also received and reviewed hospital cost reports.

2. The Hospital Rate Review Section established and monitored inpatient and outpatient hospital rates, completed State-owned psychiatric facility interim payments and settlements, calculated case mix and outliers/amounts for special payments, and assisted in any program implementation affecting hospitals. This Section also recalculated rates due to a change of scope or for a new clinic.

3. The Special Programs Section calculated interim, initial, and final cost settlements for federally qualified health centers (FQHCs), rural health clinics (RHCs), tribal health centers (THCs), local public health departments, county health plans, and school based services (SBS). This Section also gathered managed care organization quarterly financial data for comparison purposes, provided quarterly information for THCs and family planning, and gathered year-end accrual estimates and budget data for all these health care providers.

Toward the end of our audit, HHPRD consolidated all activity between two sections and renamed those sections the Settlement Section and the Rate Review Section. The duties previously performed by the Special Programs Section were split between the remaining two sections. The Rate Review Section performs the duties of the previously named Hospital Rate Review Section. In addition, this Section is responsible for establishing and authorizing MIPs and CIPs to hospitals, which were previously performed by the Settlement and Payment Processing Section.

For the fiscal year ended September 30, 2010, HHPRD processed $1.8 billion of payments to Medicaid providers:



As of August 31, 2011, HHPRD had 18 full-time employees, 1 student employee, and 13 contractual staff employees.

Audit Objectives, Scope, and Methodology and Agency Responses

Audit Objectives

Our performance audit* of the Hospital and Health Plan Reimbursement Division (HHPRD), Medical Services Administration, Department of Community Health (DCH), had the following objectives:

1. To assess the effectiveness* of HHPRD's efforts to complete accurate and timely cost settlements.

2. To assess the effectiveness of HHPRD's efforts to obtain and use accurate data when setting provider reimbursement rates.

Audit Scope

Our audit scope was to examine the records and processes related to selected Hospital and Health Plan Reimbursement Division activities. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Our audit procedures, conducted from May 2011 through August 2011, covered selected activities during the period October 1, 2008 through July 31, 2011.

We did not include within the scope of this audit the verification of Medicaid eligibility, as this is determined by Department of Human Services local offices and is not a responsibility of HHPRD. Also, we did not include within the scope of this audit a validation of claims, as this also is not a responsibility of HHPRD.

Audit Methodology

We conducted a preliminary review of HHPRD's operations to formulate a basis for developing our audit objectives and defining our audit scope. Our preliminary review included interviewing various HHPRD staff; reviewing applicable laws, rules,

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

regulations, policies, procedures, manuals, contracts, the Michigan Medicaid State Plan, and other information; examining reports from other external audits; obtaining and analyzing data from other State agencies; obtaining an understanding of HHPRD's internal control*; reviewing the accuracy and timeliness of cost settlements; and analyzing the rate setting methodology.

To accomplish our first objective, we reviewed DCH's description of the cost settlement process, the Medicaid Provider Manual, and the Michigan Medicaid State Plan and interviewed HHPRD staff to clarify and obtain additional information regarding the processes and procedures used in preparing payments. Also, we reviewed cost reports and variance analysis reports to ensure compliance with policies and procedures. In addition, we verified the accuracy of data used in the initial and final cost settlements for providers, analyzed cost settlement data, and reviewed provider files to determine timeliness of provider cost settlements and compliance with the Michigan Medicaid State Plan. Further, we examined HHPRD's process to ensure that total payments did not exceed the amount that is allowed to be reimbursed. In addition, we contacted other states and reviewed Internet resources to determine best practices for hospital reimbursement.

To accomplish our second objective, we reviewed DCH's description of the rate setting process and interviewed HHPRD staff to clarify and obtain additional information regarding the rate setting process and procedures applied to ensure that accurate data is used when setting reimbursement rates. Also, we reviewed the rate setting methodology to ensure compliance with the Medicaid Provider Manual and the Michigan Medicaid State Plan. In addition, we reviewed the rate calculation worksheet and verified the formulas used to calculate the final diagnosis related grouping (DRG) rate for inpatient hospitals, and we reviewed claims for 10 hospitals to assess the accuracy of the data used by HHPRD's staff when setting DRG rates. Further, we reviewed Internet resources to review best practices in establishing reimbursement rates.

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

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

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 4 findings and 4 corresponding recommendations. DCH's preliminary response indicates that it agrees with the 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 plan to comply with the audit recommendations and submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

EFFECTIVENESS IN COMPLETING ACCURATE AND TIMELY COST SETTLEMENTS

COMMENT

Audit Objective: To assess the effectiveness of the Hospital and Health Plan Reimbursement Division's (HHPRD's) efforts to complete accurate and timely cost settlements.

Audit Conclusion: We concluded that HHPRD's efforts to complete accurate and timely cost settlements were moderately effective. Our assessment disclosed four reportable conditions* related to Medicaid interim payment (MIP) process reevaluation, federally qualified health center (FQHC) and rural health clinic (RHC) reimbursement process, internal control over cost settlements, and school based services (SBS) cost settlement process (Findings 1 through 4).

FINDING

1. MIP Process Reevaluation

   HHPRD should reevaluate the use of a semimonthly interim payment method as a means for reimbursing hospitals. Reimbursing hospitals through a direct fee-for-service payment method could result in a reduction in the number of activities that staff need to perform and a more timely reimbursement, which could eliminate potential lost interest earnings for the State and some hospitals. We estimate that such a change could result in savings of 1.3 full-time equated employees, or $138,000 annually, and $63,400 and $62,400 in lost interest to the State and hospitals, respectively, per year.

   HHPRD issued MIPs and/or capital interim payments (CIPs) to 163 inpatient hospitals that volunteered to receive such payments as an alternative to receiving payments for actual claims received and processed by the Department of Community Health (DCH) weekly. HHPRD bases MIPs and CIPs on each hospital's most recent available annual cost data and issues the MIPs and CIPs on a semimonthly basis.

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

After the close of each hospital's cost reporting period, which is generally one year, HHPRD reconciles MIPs to submitted claims during two scheduled preliminary MIP reconciliations. At final cost settlement, HHPRD again reconciles MIPs, along with CIPs, to the hospital's actual cost data as reported in the hospital's Medicaid cost report package. The final cost settlement determines the State's final overpayment or underpayment to each hospital by comparing the hospital's total MIPs and CIPs to actual costs. HHPRD cost settlements for some hospitals can encompass numerous annual cost reporting periods within the same State fiscal year.

Our review of HHPRD's cost settlement process during the audit period disclosed:

a. When using a semimonthly interim payment method, staff time is spent calculating and making interim payments, performing initial and revised reconciliations, and finalizing cost settlements. This process is time consuming and, with its available resources, HHPRD had not been able to complete the process for the 163 hospitals in a timely manner. During our audit period, HHPRD had unsettled cost years dating back to fiscal year 2003-04. The table below summarizes our review of the delay in processing cost settlements:

	Delay in Processing Cost Settlements			
	Months		Years	
Fiscal Year	Range	Average	Range	Average
2009-10	42 - 75	58	3.5 - 6.3	4.8
2010-11 (through July 12, 2011)	27 - 79	62	2.2 - 6.6	5.2

b. If hospitals were paid through the direct fee-for-service method, we expect that the time spent by HHPRD making the interim payments and performing initial and revised reconciliations could be eliminated. By eliminating some of the steps needed when processing activity for MIP hospitals, staff may be able to complete final cost settlements in a timely manner.

c. Delays in the identification and collection of final cost settlements could result in potential lost interest earnings to the State and federal governments and hospitals. For example:

(1) During fiscal year 2009-10, HHPRD made 127 final cost settlements with 103 providers. The cost settlements disclosed that 67 providers owed HHPRD a total of $13.4 million. Amounts owed by individual providers were as much as $3.1 million and averaged $130,000. The cost settlements also disclosed that HHPRD owed 77 providers a total of $7.5 million. Amounts owed to individual providers were as much as $1.2 million and averaged $97,000.

Delays in final cost settlements resulted in a net interest loss to the State and federal governments of $163,000 ($70,000 General Fund/general purpose) from 53 hospitals. In addition, these delays resulted in a net interest loss of $76,000 for 39 hospitals that HHPRD identified through the cost settlement process as being owed additional funds.

(2) During fiscal year 2010-11 (through July 12, 2011), HHPRD made 74 final cost settlements with 51 providers. The cost settlements disclosed that 34 providers owed HHPRD a total of $7.5 million. Amounts owed by individual providers were as much as $2.7 million and averaged $147,000. The cost settlements also disclosed that HHPRD owed 38 providers a total of $2.6 million. Amounts owed to individual providers were as much as $286,000 and averaged $68,000.

Delays in final cost settlements resulted in a net interest loss to the State and federal governments of $57,000 ($25,000 General Fund/general purpose) from 29 hospitals. In addition, these delays resulted in a net interest loss of $18,000 for 17 hospitals that HHPRD identified through the cost settlement process as being owed additional funds.

Staff would still need to perform final cost settlements for any hospitals that receive CIPs; however, reevaluating the cost reimbursement process and identifying areas for improvement could result in efficiencies that may provide more timely settlements to providers.

RECOMMENDATION

We recommend that HHPRD reevaluate the use of a semimonthly interim payment method as a means for reimbursing hospitals.

AGENCY PRELIMINARY RESPONSE

DCH agrees that the use of a semimonthly interim payment method for reimbursing hospitals needs to be reevaluated. As part of this process, DCH informed us that it will determine if a different reimbursement method would result in efficiencies to the settlement process.

FINDING

2. FQHC and RHC Reimbursement Process

HHPRD should pursue an update to the Community Health Automated Medicaid Processing System (CHAMPS) to allow FQHCs and RHCs the ability to submit billings and receive payment for fee-for-service Medicaid beneficiaries at the prospective payment system (PPS) rate. HHPRD could save the time currently devoted to maintaining, updating, and testing the fee-for-service claims data queries each time a change is made to the CHAMPS data warehouse. In addition, cost settlements for the fee-for-service claims would no longer need to be performed for each provider.

Although the Michigan Medicaid State Plan requires that FQHCs and RHCs receive reimbursement based on the PPS rate, the Medicaid Provider Manual instructs FQHCs and RHCs to bill HHPRD at the physician fee schedule rate, which is less than the PPS rate. As a result, HHPRD expends resources to reconcile the difference between the two rates in order to ensure that FQHCs and RHCs are reimbursed at the PPS rate.

If CHAMPS could process FQHC and RHC claims at the PPS rate, which is required by the Michigan Medicaid State Plan, HHPRD staff would not need to spend time maintaining, updating, and testing the fee-for-service claims data or completing cost settlements for the fee-for-service claims. Because the fiscal year-ends for FQHCs and RHCs are staggered throughout the year, the cost settlement process takes place throughout the year and claims data must be pulled at least quarterly to ensure that each auditor has complete and accurate data when completing cost settlements. HHPRD staff informed us that, over a six-month period, staff may have to pull data five or six times because of changes to the CHAMPS data warehouse.

CHAMPS was originally programmed to reimburse FQHCs and RHCs at the physician fee schedule rate and has not been updated to allow FQHCs and RHCs to bill and receive reimbursement from HHPRD at the PPS rate, resulting in an additional use of resources.

RECOMMENDATION

We recommend that HHPRD pursue an update to CHAMPS to allow FQHCs and RHCs the ability to submit billings and receive payment for fee-for-service Medicaid beneficiaries at the PPS rate.

AGENCY PRELIMINARY RESPONSE

DCH agrees that an update to CHAMPS to allow FQHCs and RHCs the ability to submit billings and receive payment for fee-for-service beneficiaries at the PPS rate is necessary. DCH indicated that it has initiated a workgroup to discuss the changes necessary as part of the conversion.

FINDING

3. Internal Control Over Cost Settlements

HHPRD could improve control procedures to monitor the status of outstanding and in-process cost settlements for FQHCs, RHCs, and SBS providers. Although there are generally only one to two years of outstanding FQHC cost settlements, we identified seven providers with three or more years of outstanding cost settlements. For fiscal year 2009-10 and fiscal year 2010-11 (through July 2011), HHPRD processed $42.8 million and $44.7 million, respectively, in FQHC, RHC, and SBS cost settlement adjustments.

Internal control includes the processes for planning, organizing, directing, and controlling program operations. It includes the systems for measuring, reporting, and monitoring program performance. Control procedures could include monitoring data associated with the cost settlement process, such as due dates of required reports and cost settlements, days late, and documentation of follow-up performed.

Although staff responsible for FQHC and RHC cost settlements maintained their own lists of outstanding cost settlements, management monitored FQHC and RHC cost settlements by accessing a report from CardFile*. This report contains limited information, which did not allow management to view the actions taken on outstanding and in-process FQHC and RHC cost settlements beyond activity identified as interim payments, initial or initial revised cost settlements, and final or final revised cost settlements. In order to monitor any follow-up performed by staff, management must meet with staff, access the reviewer's log, or review the provider file. In addition, staff responsible for SBS did not have a complete provider list documenting cost settlements and kept track of outstanding cost settlements by using a haphazard filing system.

HHPRD informed us that it submitted a request to the on-site information technology contractor personnel to develop a more detailed report to assist management in better monitoring the status of cost settlements; however, the contractor had not started development because of other priorities.

RECOMMENDATION

We recommend that HHPRD improve control procedures to monitor the status of outstanding and in-process cost settlements for FQHCs, RHCs, and SBS providers.

AGENCY PRELIMINARY RESPONSE

DCH agrees that enhancements are necessary to the CardFile report used to track the status of outstanding and in-process cost settlements for FQHCs, RHCs, and SBS providers so that cost settlement action can be more thoroughly monitored.

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

The Special Programs Section informed us that it had identified the need for a more enhanced reporting mechanism in 2009 and that it has since elevated the priority of the implementation of these enhancements.

FINDING

4. SBS Cost Settlement Process

HHPRD had not established sufficient controls over the SBS cost settlement process. As a result, HHPRD could neither ensure the accuracy of cost settlements nor ensure the maximization of State resources. For fiscal year 2009-10 and fiscal year 2010-11 (through July 2011), HHPRD processed $92.1 million and $89.0 million, respectively, in SBS cost settlements.

The Michigan Medicaid SBS Program allows the intermediate school districts to bill Medicaid for reimbursement for health services and transportation provided by the SBS providers to special education students who are eligible for Medicaid. HHPRD requires intermediate school districts and local educational agencies to submit a Medicaid Allowable Expenditure Report (MAER) identifying allowable direct service expenditures applicable to SBS.

The MAER utilizes information from the special education medical and transportation actual cost reports that are submitted to the Michigan Department of Education (MDE). MDE performs an overall reasonableness review of the cost reports by comparing the data to a financial information database.

Our review of the SBS cost settlement process disclosed:

a. HHPRD did not obtain and utilize the finalized cost reports from MDE. To help ensure the accuracy of the information reported on the MAER, HHPRD compares the MAER to the cost reports obtained directly from the SBS providers. Therefore, HHPRD could not be assured that the reports provided were the finalized cost reports. Finalized cost reports are reviewed by MDE and, in some cases, revised as a result of that review. Using information that is not finalized could lead to inaccurate cost settlements and a reduction in funding for other Medicaid programs.

We compared the initial and finalized cost reports received by MDE for the program year ended June 30, 2009 for 142 (23%) of the 624 participating SBS providers. We identified 12 adjustments totaling $2.3 million that may have an effect on the cost settlements.

Although HHPRD pursued obtaining copies of the finalized cost reports from MDE, MDE was reluctant to share those finalized cost reports with HHPRD. We electronically obtained the cost reports for the school fiscal years ended June 30, 2009 and June 30, 2010 from MDE and obtained permission from MDE to share these reports with HHPRD.

b. HHPRD had not established an efficient process for completing yearly desk reviews. HHPRD manually enters data from the MAER and the cost reports into a template that calculates differences to follow up. HHPRD could eliminate the process of manually inputting information for the 624 SBS providers if all data was received electronically and programmed to create a template to calculate differences. This could allow staff to focus attention on identified differences and other high risk areas within SBS.

RECOMMENDATION

We recommend that HHPRD establish sufficient controls over the SBS cost settlement process.

AGENCY PRELIMINARY RESPONSE

DCH agrees that there are opportunities for improvement in the controls over the SBS cost settlement process. DCH indicated that it will work with MDE to obtain an electronic copy of the finalized cost report for use in the cost settlement process.

EFFECTIVENESS IN OBTAINING AND USING ACCURATE DATA WHEN SETTING PROVIDER REIMBURSEMENT RATES

COMMENT

Audit Objective: To assess the effectiveness of HHPRD's efforts to obtain and use accurate data when setting provider reimbursement rates.

Audit Conclusion: We concluded that HHPRD's efforts to obtain and use accurate data when setting provider reimbursement rates were effective. Our audit report does not contain any reportable conditions related to this audit objective.

GLOSSARY

capital interim payment (CIP)	A semimonthly payment made to hospitals to cover Medicaid's share of allowable capital costs.
CardFile	An application that creates, displays, and maintains information related to payments, rates, settlement tracking, MIP calculations, and general provider information.
CHAMPS	Community Health Automated Medicaid Processing System.
cost report	A detailed summary of provider activity, including an itemized list of all expenses recorded from the records of the provider.
DCH	Department of Community Health.
DRG	diagnosis related grouping.
effectiveness	Program success in achieving mission and goals.
final cost settlement	A financial reconciliation between the semimonthly MIPs and the paid claims that is performed no sooner than 27 months after the provider's fiscal year.
FMAP	federal medical assistance percentage.
FQHC	federally qualified health center.
HHPRD	Hospital and Health Plan Reimbursement Division.
internal control	The plan, policies, methods, and procedures adopted by management to meet its mission, goals, and objectives. Internal control includes the processes for planning,

organizing, directing, and controlling program operations. It includes the systems for measuring, reporting, and monitoring program performance. Internal control serves as a defense in safeguarding assets and in preventing and detecting errors; fraud; violations of laws, regulations, and provisions of contracts and grant agreements; or abuse.

MAER	Medicaid Allowable Expenditure Report.
MDE	Michigan Department of Education.
Medicaid interim payment (MIP)	A semimonthly payment made to a provider representing estimated annual claims.
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 program operations, to facilitate decision making by parties responsible for overseeing or initiating corrective action, and to improve public accountability.
PPS	prospective payment system.
reportable condition	A matter that, in the auditor's judgment, is less severe than a material condition and falls within any of the following categories: an opportunity for improvement within the context of the audit objectives; a deficiency in internal control that is significant within the context of the objectives of the audit; all instances of fraud; illegal acts unless they are inconsequential within the context of the audit objectives; significant violations of provisions of contracts or grant agreements; and significant abuse that has occurred or is likely to have occurred.
RHC	rural health clinic.

SBS	school based services.
THC	tribal health center.

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