

PERFORMANCE AND FINANCIAL RELATED AUDIT
OF THE
MEDICAID MANAGEMENT INFORMATION SYSTEM
DEPARTMENT OF COMMUNITY HEALTH

EXECUTIVE DIGEST

MEDICAID MANAGEMENT INFORMATION SYSTEM

INTRODUCTION

This report contains the results of our performance* and financial related audit* of the Medicaid Management Information System (MMIS), Department of Community Health (DCH). The financial related portion of our audit covered the period October 1, 1996 through September 30, 1998.

AUDIT PURPOSE

This performance and financial related audit was conducted as part of the constitutional responsibility of the Office of the Auditor General. Performance audits are conducted on a priority basis related to the potential for improving effectiveness* and efficiency*. Financial related audits are conducted at various intervals to permit the Auditor General to express an opinion on the State's financial statements.

BACKGROUND

The Michigan Medical Assistance (Medicaid) Program, created under Title XIX of the Social Security Act, provides medical services for 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. Title XIX, federal regulations, and the Medicaid State Plan* specify program

* See glossary at end of report for definition.

requirements for federal financial participation. MMIS is the automated management and control system for Medicaid payments. MMIS is composed of eight major subsystems, which include the Claims Processing, Management and Administrative Reporting, Prior Authorization, Provider Enrollment, Recipient Eligibility, Reference File, Surveillance and Utilization Review, and Third Party Liability Subsystems.

The DCH Medical Services Administration (MSA) administers the Michigan Medicaid Program. MSA is composed of the Office of Medical Affairs, the Quality Improvement and Eligibility Services Bureau, the Plan Administration and Customer Services Bureau, and the Actuarial and Payment Services Bureau. Also, the Management Information Systems Division, within the Budget and Finance Administration, is included under MSA's appropriations.

For fiscal year 1997-98, MSA was appropriated \$58.9 million for administrative expenditures and was authorized approximately 550 full-time equated positions. Expenditures for medical services totaled \$5.5 billion for the fiscal year ended September 30, 1998. Medical services for 1.1 million recipients were provided by 40,000 active providers.

**AUDIT OBJECTIVES,
CONCLUSIONS, AND
NOTEWORTHY
ACCOMPLISHMENTS**

Audit Objective: To assess the reliability of MMIS controls in ensuring accurate, complete, timely, and secure information for MSA and other users of MMIS.

Conclusion: Our assessment disclosed that MMIS controls were reasonably reliable in ensuring accurate, complete, timely, and secure information for MSA and other users of MMIS. However, we noted reportable

conditions* regarding deceased recipients, the Surveillance and Utilization Review Subsystem, the license verification process, and the drug file (Findings 1 through 4).

Audit Objective: To assess the effectiveness of the MMIS internal control structure* in ensuring compliance with federal program requirements.

Conclusion: Our assessment disclosed that the MMIS internal control structure was reasonably effective in ensuring compliance with federal program requirements. However, we noted reportable conditions regarding incarcerated recipients, risk assessments, and Third Party Liability Subsystem (Findings 5 through 7).

Noteworthy Accomplishments: MSA complied with almost all of the prior audit recommendations that were included in the scope of this audit. This demonstrates management commitment to ensure the implementation and operation of effective controls.

**AUDIT SCOPE AND
METHODOLOGY**

Our audit scope was to examine Medicaid Management Information System information processing and other records of the Medical Services Administration. Also, our audit scope was to examine the financial related records for the period October 1, 1996 through September 30, 1998. 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.

* See glossary at end of report for definition.

We collected background information about MMIS and obtained an understanding of the internal control structure. Also, we examined DCH's information processing and other records for the period October 1, 1996 through September 30, 1998 and conducted interviews with DCH personnel regarding MMIS application controls. We then performed analysis and testing and verified the effectiveness of the internal control structure. Our final phase was to evaluate and report on the results of our data gathering, and the detailed analysis and testing phases.

**AGENCY RESPONSES
AND PRIOR AUDIT
FOLLOW-UP**

Our audit report contains 7 findings and 10 corresponding recommendations. DCH's preliminary response indicated that it agreed with the findings and recommendations and that it would comply with all the recommendations.

MSA complied with 30 of the 32 prior audit recommendations that were included in the scope of our current audit. We repeated 1 of the prior audit recommendations in this report.

Mr. James K. Haveman, Jr., Director
Department of Community Health
Lewis Cass Building
Lansing, Michigan

Dear Mr. Haveman:

This is our report on the performance and financial related audit of the Medicaid Management Information System, Department of Community Health. The financial related portion of our audit covered the period October 1, 1996 through September 30, 1998.

This report contains our executive digest; description of agency; audit objectives, scope, and methodology and agency responses and prior audit follow-up; 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 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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TABLE OF CONTENTS

MEDICAID MANAGEMENT INFORMATION SYSTEM DEPARTMENT OF COMMUNITY HEALTH

INTRODUCTION

	<u>Page</u>
Executive Digest	1
Report Letter	5
Description of Agency	8
Audit Objectives, Scope, and Methodology and Agency Responses and Prior Audit Follow-Up	10

COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

Reliability of MMIS Controls	12
1. Deceased Recipients	12
2. Surveillance and Utilization Review Subsystem (SURS)	14
3. License Verification Process	15
4. Drug File	17
Compliance With Federal Regulations	18
5. Incarcerated Recipients	19
6. Risk Assessments	20
7. Third Party Liability Subsystem	21

GLOSSARY

Glossary of Acronyms and Terms	23
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Description of Agency

The Michigan Medical Assistance (Medicaid) Program, created under Title XIX of the Social Security Act, provides medical services for 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. Title XIX, federal regulations, and the Medicaid State Plan specify program requirements for federal financial participation. The Medicaid Management Information System (MMIS) is the automated management and control system for Medicaid payments. MMIS is composed of eight major subsystems, which include:

1. Claims Processing Subsystem - Reviews all provider invoice claims and edits them against the other MMIS subsystems for proper reimbursement.
2. Management and Administrative Reporting Subsystem - Provides management with financial and statistical data.
3. Prior Authorization Subsystem - Reviews and authorizes certain medical services prior to delivery of those services.
4. Provider Enrollment Subsystem - Processes and maintains files of qualified providers enrolled in the Medicaid Program.
5. Recipient Eligibility Subsystem - Contains comprehensive profiles of each recipient for use in invoice processing.
6. Reference File Subsystem - Consists of nine reference files that are used by the Claims Processing Subsystem to monitor and check the provider claims for proper processing in accordance with State and federal requirements.
7. Surveillance and Utilization Review Subsystem - Assists management in monitoring providers and recipients to help identify potential abuse of the Medicaid Program.

8. Third Party Liability Subsystem - Maintains files of recipients and other insurance carriers and generates post payment billings to recover payments for services covered by other insurance carriers.

The Medical Services Administration (MSA), Department of Community Health, administers the Michigan Medicaid Program. MSA is composed of one office and three operating bureaus:

- (1) Office of Medical Affairs - Consults on medical questions relating to client and provider issues.
- (2) Quality Improvement and Eligibility Services Bureau - Monitors eligibility issues and ensures that the care and services provided to Medicaid clients are medically necessary, of high quality, and in the most appropriate setting.
- (3) Plan Administration and Customer Services Bureau - Identifies, researches, develops, and implements Medicaid policy for providers of medical and other health care services. The Bureau also serves as MSA's information link with Medicaid providers.
- (4) Actuarial and Payment Services Bureau - Oversees the processing and payment of Medicaid claims. Bureau staff also perform actuarial and rate setting functions.

Also, the Management Information Systems Division, within the Budget and Finance Administration, is included under MSA's appropriations. This Division is responsible for maintaining and making enhancements to MMIS.

For fiscal year 1997-98, MSA was appropriated \$58.9 million for administrative expenditures and was authorized approximately 550 full-time equated positions. Expenditures for medical services totaled \$5.5 billion for the fiscal year ended September 30, 1998. Medical services for 1.1 million recipients were provided by 40,000 active providers.

Audit Objectives, Scope, and Methodology and Agency Responses and Prior Audit Follow-Up

Audit Objectives

Our performance and financial related audit of the Medicaid Management Information System (MMIS), Department of Community Health (DCH), had the following objectives:

1. To assess the reliability of MMIS controls in ensuring accurate, complete, timely, and secure information for the Medical Services Administration (MSA) and other users of MMIS.
2. To assess the effectiveness of the MMIS internal control structure in ensuring compliance with federal program requirements.

Audit Scope

Our audit scope was to examine Medicaid Management Information System information processing and other records of the Medical Services Administration. Also, our audit scope was to examine the financial related records for the period October 1, 1996 through September 30, 1998. 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.

Audit Methodology

Our audit fieldwork was performed between April and October 1998. To accomplish our audit objectives, our audit methodology included the following phases:

1. Data Gathering Phase

We collected background information about MMIS and obtained an understanding of the internal control structure. Also, we examined DCH's information processing and other records for the period October 1, 1996 through September 30, 1998 and conducted interviews with DCH personnel regarding MMIS application controls.

2. Detailed Analysis and Testing Phase

We performed analysis and testing and verified the effectiveness of the internal control structure of MMIS and its subsystems, including the Claims Processing, Management and Administrative Reporting, Prior Authorization, Provider Enrollment, Recipient Eligibility, Reference File, Surveillance and Utilization Review, and Third Party Liability Subsystems.

3. Evaluation and Reporting Phase

We evaluated and reported on the results of the data gathering and the detailed analysis and testing phases.

Agency Responses and Prior Audit Follow-Up

Our audit report contains 7 findings and 10 corresponding recommendations. DCH's preliminary response indicated that it agreed with the findings and recommendations and that it would comply with all the recommendations.

The agency preliminary response which 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 Department of Management and Budget Administrative Guide procedure 1280.02 require DCH to develop a formal response to our audit findings and recommendations within 60 days after release of the audit report.

MSA complied with 30 of the 32 prior audit recommendations that were included in the scope of our current audit. We repeated 1 of the prior audit recommendations in this report.

COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

RELIABILITY OF MMIS CONTROLS

COMMENT

Audit Objective: To assess the reliability of Medicaid Management Information System (MMIS) controls in ensuring accurate, complete, timely, and secure information for the Medical Services Administration (MSA) and other users of MMIS.

Conclusion: Our assessment disclosed that MMIS controls were reasonably reliable in ensuring accurate, complete, timely, and secure information for MSA and other users of MMIS. However, we noted reportable conditions regarding deceased recipients, the Surveillance and Utilization Review Subsystem, the license verification process, and the drug file.

FINDING

1. Deceased Recipients

The Department of Community Health (DCH) had not established effective control procedures to ensure timely identification and removal of deceased recipients from Medicaid enrollment. Our review of deceased recipients disclosed:

- a. DCH had not established control procedures to identify and inactivate* all deceased recipients. DCH informed us that it performs annual matches between its recipient eligibility records and the Public Health Vital Statistics Database* , which contains death certificates. However, as of August 1998, we identified 73 recipients coded as active on MMIS who had died prior to 1997.

Some deceased recipients remained coded as active on MMIS because DCH did not ensure that the Family Independence Agency (FIA) inactivated them. Through interagency agreement, FIA staff perform the eligibility determination

* See glossary at end of report for definition.

function for Medicaid. DCH is responsible for ensuring that FIA inactivates recipients identified as ineligible, such as deceased persons, for Medicaid benefits. Establishing control procedures to communicate and monitor the eligibility status of identified deceased recipients would help DCH ensure that FIA inactivates them.

Twenty-four of the 73 deceased recipients were enrolled in managed care* plans that paid to providers a recurring negotiated payment per recipient rather than payment per service provided. As a result, DCH paid \$245,000 in Medicaid benefits for these recipients subsequent to their deaths.

- b. DCH did not include in its annual match active-coded recipients for whom it did not make payments. Including such recipients in its annual match would help DCH to ensure that the eligibility status of deceased recipients is inactive.

Of the 73 deceased recipients identified in part a., DCH could have identified 38 of them had it included active recipients with no associated payments in its annual match. While DCH did not make any payments subsequent to these recipients' deaths, it did not minimize the risk of potentially inappropriate payments. MMIS may not have rejected claims by providers in the names of these 38 recipients had such claims been submitted.

- c. DCH had not developed control procedures to follow up on all identified deceased recipients in a timely manner. In November 1997, DCH identified 443 deceased recipients enrolled in managed care plans. However, DCH did not take action to inactivate the recipients until April 1998. Consequently, DCH paid an additional \$38,000 in benefit payments for these recipients already identified as deceased. Developing control procedures to follow up identified deceased recipients in a timely manner would help DCH to prevent payments for ineligible recipients.

DCH's contracts with managed care plans did not allow it to collect the \$38,000; however, new contracts have been modified to allow collection of erroneous payments.

* See glossary at end of report for definition.

RECOMMENDATIONS

We recommend that DCH establish effective control procedures to ensure timely identification and removal of deceased recipients from Medicaid enrollment by:

- (a) Establishing control procedures to identify and inactivate all deceased recipients.
- (b) Including in its annual match active-coded recipients for whom it did not make payments.
- (c) Developing control procedures to follow up on identified deceased recipients in a timely manner.

AGENCY PRELIMINARY RESPONSE

DCH agreed with the finding and recommendations. DCH informed us that, in March 1999, it implemented procedures to perform quarterly matches between its eligibility records and the Vital Statistics Database. This process included all active Medicaid cases with and without Medicaid expenditures. Information regarding deceased recipients (beneficiaries) is referred to FIA for case closure, and DCH takes appropriate action to disenroll any beneficiaries from managed care plans. Any payments made to the managed care plans subsequent to a beneficiary's death will be recovered.

FINDING

2. Surveillance and Utilization Review Subsystem (SURS)

DCH did not effectively use SURS to analyze Medicaid provider and recipient activity.

SURS is a post payment system that produces reports used to identify potential Medicaid fraud and abuse. DCH has been in the process of implementing new SURS software. Our review of SURS disclosed:

- a. Because of problems in implementing the new SURS software, DCH either did not produce SURS reports on a timely basis or did not produce them at all.

For example, DCH did not begin production of SURS reports for the period January through March 1997 until June 1998. In addition, DCH did not produce SURS reports for the period April 1997 through March 1998.

DCH was technically in compliance with federal regulations that, after December 1997, required states to produce SURS reports at least once per year. However, producing the reports on a more timely basis would help DCH to more effectively identify potential Medicaid fraud and abuse.

- b. DCH did not analyze and follow up SURS reports on a timely basis. For example, DCH produced SURS reports covering provider activity from January through March 1997. However, DCH did not conduct any analysis or follow-up of the information contained in these reports. DCH informed us that it was able to assign only one person to analyze and follow up SURS reports. Conducting timely analysis and follow-up of information contained in SURS reports would help DCH in its efforts to monitor Medicaid activities.

RECOMMENDATION

We recommend that DCH effectively use SURS to analyze Medicaid provider and recipient activity.

AGENCY PRELIMINARY RESPONSE

DCH agreed with the finding and recommendation. DCH informed us that software problems and certain administrative difficulties encountered during the period covered by the audit have been corrected. An analysis of outdated reports was not performed because it was administratively more efficient to bring the reports up to date rather than to perform an extensive analysis of reports that were already outdated. Since July 1998, SURS reports have been produced within 90 days of the previous quarter, and the analysis of those reports is started immediately.

FINDING

3. License Verification Process

DCH had not completely automated the license verification process for providers performing services for Medicaid recipients.

State rules and federal regulations require that certain Medicaid providers must hold a current State license in order to receive reimbursement for medical services. DCH previously automated the verification process for approximately 30,000 doctors and physicians licensed by the Department of Consumer and Industry Services (CIS). However, DCH did not automate the process to verify the licenses of approximately 5,000 other providers enrolled in the Medicaid Program, such as nurses and pharmacies. Consequently, DCH was unable to periodically verify the licenses of these other providers. This could result in payments to unlicensed providers, although we did not note any such payments.

Automating the license verification process for all applicable providers would help DCH ensure that the providers are eligible to provide Medicaid services.

We reported a similar finding during our audit of the Bureau of Medicaid Operations (October 1, 1989 through April 30, 1992). At that time, MSA informed us that it would continue its efforts to complete the needed system changes. MSA did request such system changes. However, because of other priorities, DCH has not pursued this alternative or requested CIS to expand the automated tape file to include other providers licensed by CIS.

RECOMMENDATION

WE AGAIN RECOMMEND THAT DCH COMPLETELY AUTOMATE THE LICENSE VERIFICATION PROCESS FOR PROVIDERS PERFORMING SERVICES FOR MEDICAID RECIPIENTS.

AGENCY PRELIMINARY RESPONSE

DCH agreed with the finding and recommendation. DCH informed us that it completed the necessary system changes required to automate the process. As soon as the explanation codes can be published and distributed, billings will be checked through system edits to ensure that all providers for whom licensure is an enrollment/participation requirement are currently licensed, before making any payments. It is anticipated that this will be completed by November 1, 1999.

FINDING

4. Drug File

DCH had not developed formal procedures for analyzing and maintaining its MMIS drug file.

The drug file is 1 of the 9 reference files in the Reference File Subsystem. DCH uses this file to determine prices and quantities associated with reimbursements for drugs. Our review of the drug file disclosed:

- a. DCH had not developed formal procedures for maintaining the drug file. DCH properly limited access to the drug file to four individuals. However, these individuals possessed specialized knowledge regarding the process of analyzing and modifying the maximum allowable cost (MAC) of multiple source drugs* . The State can modify MACs based on actual costs paid by pharmacies for commonly used generic drugs and upper limits established by the federal government. Without formal procedures, it would be difficult for DCH to maintain and control the drug file if these key individuals leave their positions.

For example, one of the individuals with access to the drug file was a pharmacist hired on a personal services contract. The responsibilities of the pharmacist included identifying, on an annual basis, some MAC prices to determine if they could be reduced. Lowering the prices of drugs reduces Medicaid expenditures for the State. If the personal services contract with the pharmacist was terminated, DCH may not be able to ensure that it will minimize drug prices because it lacks procedures explaining the process.

- b. DCH had not developed procedures to document the savings associated with reducing drug prices. For example, DCH's personal services contract with the pharmacist was for \$10,000 in 1997 and for \$13,000 in 1998. DCH justified the increase by indicating that the drug price reductions identified by the pharmacist reduced Medicaid expenditures by \$5 million. However, DCH did

* See glossary at end of report for definition.

not have documentation to support this and it did not have formal procedures explaining how to determine such savings.

Developing procedures to document the savings could help DCH ensure that it minimizes drug prices. For example, if annual savings amount to \$5 million, it may be cost beneficial for DCH to conduct a comprehensive analysis of all drug prices rather than annually reviewing only a portion of the drugs. Also, documenting such savings would help to support expenditures for personal services contracts.

RECOMMENDATION

We recommend that DCH develop formal procedures for analyzing and maintaining its MMIS drug file.

AGENCY PRELIMINARY RESPONSE

DCH agreed with the finding and recommendation. DCH informed us that formal procedures will be developed by January 1, 2000 to document the process for analyzing and maintaining the drug file.

COMPLIANCE WITH FEDERAL REGULATIONS

COMMENT

Audit Objective: To assess the effectiveness of the MMIS internal control structure in ensuring compliance with federal program requirements.

Conclusion: Our assessment disclosed that the MMIS internal control structure was reasonably effective in ensuring compliance with federal program requirements. However, we noted reportable conditions regarding incarcerated recipients, risk assessments, and Third Party Liability Subsystem.

Noteworthy Accomplishments: MSA complied with almost all of the prior audit recommendations that were included in the scope of this audit. This demonstrates management commitment to ensure the implementation and operation of effective controls.

FINDING

5. **Incarcerated Recipients**

DCH had not established control procedures to identify and inactivate incarcerated Medicaid recipients.

To determine if DCH paid Medicaid benefits for incarcerated recipients, we selected a random sample of 102 of 1,495 Medicaid recipients whom we were able to identify as having a prisoner identification number* . Our review identified 11 (10.8%) recipients for whom DCH provided Medicaid benefits while they were incarcerated. Nine of the recipients were able to receive Medicaid benefits because they were enrolled in managed care plans. The other 2 recipients were attached to electronic monitoring devices. DCH paid \$36,000 in Medicaid benefits for the 11 recipients during their incarcerations.

Federal regulations prohibit prisoners of public institutions from receiving Medicaid services. In addition, federal regulations require recipients to use other sources of available insurance or medical coverage prior to Medicaid. The Department of Corrections informed us that its health care plan covers all prisoners' medical needs. This includes, at a minimum, prisoners located in institutions, camps, and corrections centers.

Establishing control procedures to identify and inactivate incarcerated Medicaid recipients would help DCH prevent payments for ineligible recipients.

DCH's contracts with managed care plans did not allow it to collect the \$36,000; however, the new contracts have been modified to allow collection of erroneous payments.

RECOMMENDATION

We recommend that DCH establish control procedures to identify and inactivate incarcerated Medicaid recipients.

* See glossary at end of report for definition.

AGENCY PRELIMINARY RESPONSE

DCH agreed with the finding and recommendation and will implement procedures to identify and inactivate incarcerated Medicaid recipients (beneficiaries) by November 1, 1999. DCH informed us that it has instructed FIA to include Medicaid in its quarterly tape match with the Department of Corrections, which has historically been performed only to identify the inappropriate issuance of food stamps. Active beneficiaries found to be incarcerated will be inactivated and any inappropriate payments will be recouped.

FINDING

6. Risk Assessments

DCH did not establish and maintain a program for conducting periodic risk assessments of MMIS.

Risk management is the process of assessing risk, taking steps to reduce risk to an acceptable level, and maintaining that level of risk. Risk assessments are the means to ensure that appropriate, cost-effective safeguards are incorporated into major systems, such as MMIS. The federal government requires DCH to establish and maintain a program for conducting periodic risk assessments of MMIS. The federal government requires DCH, at a minimum, to conduct a risk assessment of MMIS on a biennial basis or whenever significant system changes occur.

Conducting risk assessments of MMIS would help DCH identify and reduce risks associated with software and data security, personnel security, and contingency plans to meet critical processing needs in the event of a disaster. For example, DCH had not developed contingency plans for MMIS in the event that the State's data center was unable to operate. Risk assessments would help DCH to evaluate and address such issues.

RECOMMENDATION

We recommend that DCH establish and maintain a program for conducting periodic risk assessments of MMIS.

AGENCY PRELIMINARY RESPONSE

DCH agreed with the finding and recommendation. DCH informed us that the Budget and Finance Administration will establish and maintain a program for conducting periodic risk assessments of MMIS that will be completed at least biennially or whenever significant system changes occur. Development of the program is expected to begin by April 2000, with the actual assessment completed by the end of the fiscal year.

FINDING

7. Third Party Liability Subsystem

DCH did not fully control the Third Party Liability (TPL) Subsystem post payment billing process. One of the functions of the TPL Subsystem is to help recover payments from other payers, such as insurance companies. In some instances, DCH initially pays for Medicaid benefits and then generates post payment billings to obtain reimbursement. Our review of the TPL Subsystem disclosed:

- a. DCH did not prepare all TPL Subsystem post payment billings on a timely basis in accordance with federal regulations.

Federal regulations require DCH to seek recovery of reimbursement from liable third party insurers within 60 days following the end of the month in which it makes a payment. Alternatively, federal regulations permit states to request a waiver to extend this period. DCH generated billings only every three to four months. In addition, DCH did not request a waiver from the federal government to extend its billing periods. As a result, DCH did not generate all post payment billings in accordance with the federal regulations. DCH informed us that it was unable to comply with the federal regulations because of an increased work load and reduced staffing.

Delays in generating TPL Subsystem billings could make it more difficult for DCH to recover payments from insurers. In addition, timely billings could result in earlier recovery of amounts owed to DCH.

- b. DCH did not ensure that MMIS effectively documented claims billed in an electronic format.

In fiscal year 1997-98, DCH submitted \$35 million in claims to insurance companies. DCH submitted \$29 million of these claims in an electronic format to one insurance company. Under this format, DCH could not identify documentation associated with a specific claim without great difficulty. As a result, DCH could not verify the amounts owed to it by the insurance company.

Ensuring that the system effectively documents all billings would help DCH match payments to specific claims. This would also help DCH to better monitor and follow up reimbursement efforts.

RECOMMENDATIONS

We recommend that DCH fully control the TPL Subsystem post payment billing process by:

- (a) Preparing all TPL Subsystem post payment billings on a timely basis in accordance with federal regulations.

- (b) Ensuring that MMIS effectively documents claims billed in an electronic format.

AGENCY PRELIMINARY RESPONSE

DCH agreed with the finding and recommendations. DCH informed us that, due to increased staffing levels, post payment billings are now being prepared within the time requirements set forth in the federal regulations. Post payment billings will be prepared five times during fiscal year 1998-99 and at least six times during fiscal year 1999-2000. A request has been prepared and recently submitted to develop a system that would effectively document and reconcile claims billed in an electronic format.

Glossary of Acronyms and Terms

CIS	Department of Consumer and Industry Services.
DCH	Department of Community Health.
effectiveness	Program success in achieving mission and goals.
efficiency	Achieving the most outputs and outcomes practical for the amount of resources applied or minimizing the amount of resources required to attain a certain level of outputs or outcomes.
FIA	Family Independence Agency.
financial related audit	An audit that includes determining whether (1) financial information is presented in accordance with established or stated criteria, (2) the entity has adhered to specific financial compliance requirements, or (3) the entity's internal control structure over financial reporting and/or safeguarding assets is suitably designed and implemented to achieve the control objectives.
inactivate	Coding the status of Medicaid recipients to prevent payments on their behalf.
internal control structure	The management control environment, management information system, accounting system, and control policies and procedures established by management to provide reasonable assurance that goals are met; that resources are safeguarded; that resources are used in compliance with laws and regulations; that valid and reliable performance related information is obtained and reported; and that financial transactions are properly accounted for and reported.

MAC	maximum allowable cost.
managed care	Health care systems that integrate the financing and delivery of appropriate health care services to covered individuals by arrangements with selected providers to furnish a comprehensive set of health care services, explicit standards for selection of health care providers, formal programs for ongoing quality assurance and utilization review, and significant incentives for members to use providers and procedures associated with the plan.
Medicaid State Plan	The plan by which the State agrees to administer the Medical Assistance Program as a condition for receipt of federal funds under Title XIX of the Social Security Act.
MMIS	Medicaid Management Information System.
MSA	Medical Services Administration.
multiple source drugs	Equivalent products that are available from more than one manufacturer.
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.
prisoner identification number	The number assigned by the Department of Corrections to a prisoner for identification purposes.

Public Health Vital Statistics Database	A database containing important data, such as information relating to deaths.
reportable condition	A matter coming to the auditor's attention that, in his/her judgment, should be communicated because it represents either an opportunity for improvement or a significant deficiency in the design or operation of the internal control structure or in management's ability to operate a program in an effective and efficient manner.
SURS	Surveillance and Utilization Review Subsystem.
TPL Subsystem	Third Party Liability Subsystem.