



STATE OF MICHIGAN  
DEPARTMENT OF COMMUNITY HEALTH  
LANSING

JENNIFER M. GRANHOLM  
GOVERNOR

JANET OLSZEWSKI  
DIRECTOR

August 28, 2009

Mr. Doug Ringler  
Office of Internal Audit Services  
Office of the State Budget  
George W. Romney Building  
111 South Capitol, 6<sup>th</sup> Floor  
Lansing, Michigan 48913

Dear Mr. Ringler:

In accordance with the State of Michigan, Financial Management Guide, Part VII, attached are the final summary table identifying our responses and corrective action plans to address recommendations contained within the Office of the Auditor General's Performance Audit of the Health Insurance Cost Avoidance and Recovery Section, Department of Community Health.

Questions regarding the summary table or corrective action plans should be directed to me at (517) 373-1508 or [Myerspa@michigan.gov](mailto:Myerspa@michigan.gov).

Sincerely,

Signature Redacted

Pam Myers, Director  
DCH Office of Audit

Enclosure

cc: Office of the Auditor General  
House Fiscal Agency  
Senate Fiscal Agency  
Executive Office  
DCH, Janet Olszewski  
DCH, Kurt Krause  
DCH, Mary Jane Russell  
House Appropriations Committee  
House Standing Committee  
Senate Appropriations Committee  
Senate Standing Committee  
DCH, Paul Reinhart  
DCH, Stephen Fitton

PERFORMANCE AUDIT OF  
HEALTH INSURANCE COST AVOIDANCE  
AND RECOVERY SECTION

MEDICAL SERVICES ADMINISTRATION  
DEPARTMENT OF COMMUNITY HEALTH

October 1, 2003 through December 31, 2007

AUDIT RESPONSE

Approved: \_\_\_\_\_ Signature Redacted  
Janet Olszewski, Director  
Department of Community Health

Date: August 04, 2009



## AUDIT REPORT SUMMARY

DEPARTMENT: Community Health

AUDIT PERIOD: October 1, 2003 through December 31, 2007

REPORT DATED: April 2009

### DISPOSITION OF AUDIT RECOMMENDATIONS

<u>CITATIONS COMPLIED WITH</u>	<u>CITATIONS TO BE COMPLIED WITH</u>	<u>CITATIONS NOT COMPLIED WITH</u>
	1.a. *	
1.b. – 1.e.		
	1.f. *	
1.g.		
	2.	
3.a. – 3.c.		
	3.d. (9-14-09)	
4.		
5.a.		
	5.b.	
5.c.		
6.a.	6.a. **	
	6.b.***	
6.c.		
6.d.		
7.a – 7.b.		
	7.c. **	
7.c.		
7.d.	7.d. **	
8.	8.***	
9.a.	9.a. (9-14-09)	
	9.b. (9-14-09)	
	10. (9-14-09)	

\* Corrective action will be subsequent to CHAMPS implementation.

\*\* Corrective action will be within six months of CHAMPS implementation.

\*\*\* This is dependent upon the insurance carrier.

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Recommendation 1: Identification of Liable Carriers

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 accordingly with relevant information related to the carriers.

Response:

Part a: DCH has spent a significant amount of time reviewing the electronic data stored in DHS' data warehouse containing the child support files to determine if a match with existing TPL data would be beneficial. The data in the warehouse has source codes, so DCH reviewed insurance records that have source codes that indicate the information came directly from an insurance company or a National Medical Support Notice (NMSN) form recently. DCH and DIT compared the insurance information listed in the warehouse with the information on the insurance company websites. There were a significant number of policies in the warehouse which were listed as active. However, according to the insurance company web sites reviewed, the policies were no longer active. Loading of this information into DCH's TPL database, would cause significant access to care issues for beneficiaries. Because DCH is in the very time-consuming process of implementing a new MMIS system (CHAMPS), DCH out of necessity, will delay further testing of this until after CHAMPS implementation. DCH expects this issue to be resolved subsequent to CHAMPS implementation.

Part b: DCH downloads the Social Security Administration (SSA) files on a weekly basis and converts them to a medium for analysis and processing. The SSA file data is being verified and any useful data will be loaded to the TPL database. The TPL area will track numerous items as part of this process such as:

- Does the SSA record contain all of the information needed for processing? (Often the record does not contain the Medicaid ID.)
- Was the data received already in the TPL database?
- What did we find out when we verified the SSA lead?

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- Did we add the SSA record information to the TPL database?
- How long did it take to go through the record and verify the information before loading the record into the database?
- What cost avoidance or recovery benefit was realized?

Part c: Completed and ongoing. DCH continues to receive verified health insurance information from the referenced carrier's national accounts program.

Part d: Completed and ongoing. DCH maintains a 21 days turn around time for leads provided by DHS.

Part e: Completed and ongoing. DCH maintains a 21 days turn around time for leads provided by health care providers, Medicaid recipients, and others.

Part f: DCH has spent a significant amount of time reviewing the electronic data stored in DHS' data warehouse containing the child support files to determine if a match with existing TPL data would be beneficial. There were a significant number of policies in the warehouse which were listed as active; however, according to the insurance company web sites reviewed, the policies were no longer active. Loading of this information into DCH's TPL database, would cause significant access to care issues for beneficiaries. Because DCH is in the very time-consuming process of implementing a new MMIS system (CHAMPS), DCH out of necessity, will delay further testing of this until after CHAMPS implementation. DCH expects this issue to be resolved with the implementation of CHAMPS.

Part g: Since August of 2008, DCH has improved its process with the vendor for third party health insurance information provided. DCH is now able to electronically review the insurance record before loading it into the database. The vendor is reimbursed for every record that can be directly loaded into the database, and may or may not be reimbursed for records that require

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additional follow-up by TPL staff. All accurate insurance information provided by the not-for-profit carrier is loaded into the TPL database. DCH continues to meet with the not-for-profit carrier on a regular basis in an attempt to minimize errors and/or incomplete third party health insurance information they provide.

**Recommendation 2:**      **Contract Administration**

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 DHS OCS for medical support enforcement-related costs.

We further recommend that HICARS, in conjunction with DHS 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.

**Response:**

Part a: DCH is in the process of finalizing the interdepartmental agreement with DHS which will address the Title IV-D Child Support fund billings and ensure the Federal match is claimed at the higher medical support enforcement rate. DCH expects to have the interagency agreement finalized by the end of the fiscal year. A retroactive claim for Federal match at the higher rate will be filed for the maximum time period allowed.

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Part b: DCH recently initiated an invitation to bid for the services noted in the finding. HICARS will continue to work with the DCH Contract Management Section going forward. HICARS expects to have the new contract in place by January 1, 2010.

Part c: HICARS notified the DCH Contract Management Section of the difference between the contract language and actual practice in regards to the frequency of file updates. In addition, DCH recently initiated an invitation to bid for the services noted in the finding. Any requested changes to the new contract will be processed according to DCH Contract Management and DMB Acquisition Services protocols. HICARS expects to have the new contract in place by January 1, 2010.

Part d: Since May 2009 the vendor's billing and recovery information has been loaded in the Post Payment Recovery System. HICARS is in the process of developing an automated invoice validation process to aid in the verification of the vendor's contingency fees. HICARS expects to have this invoice validation process in place by September 30, 2009. As time permits, HICARS will work with the vendor to verify the appropriateness of previous contingency fees.

Part e: When the initial contract for services was bid, there was no language in the standard request for proposal (RFP) for quick payment terms for services contracts. Generally, quick payment terms were for commodity purchases. HICARS has notified the DCH Contract Management Section of the issue. In addition, DCH recently initiated an RFP for the services noted in the finding. This RFP includes quick payment provisions which will be negotiated with the selected vendor. HICARS expects to have the new contract in place by January 1, 2010.

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**Recommendation 3:      Controls Over Third Party Health Insurance Leads**

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.

**Response:**

Part a: HICARS has implemented an interim process which requires the tagging and logging of all incoming documents. The technician makes any necessary notes regarding lead activities on the paper document; once follow-up is completed, the record is marked complete in the database and the paperwork is filed. This process allows management to identify all received documents and their current processing status. The CHAMPS document imaging system will replace this interim process.

Part b: Completed and ongoing. Management continues to review staff's lead follow-up activities on a regular basis.

Part c: Completed and ongoing. The original hard-copy lead is retained and filed after lead activities are completed.

Part d: No new status to report. Implementation of the new CHAMPS processing system will allow HICARS to maintain a record of all changes to the recipients' third party health insurance information.

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Recommendation 4:      Follow-Up of Outstanding PPRS Billings

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

Response:

Part a: In December 2008 HICARS began the process of transitioning from seeking recoveries from insurance carriers to processing provider claim adjustments. This process requires the distribution of a claim adjustment report on a monthly basis to all providers that were identified with claims where other insurance coverage has been found. Providers are given 30 days to respond to the claim adjustment report with supporting documentation if the services are not covered by the insurance carrier. If the provider does not respond, then HICARS claim adjusts (reverses) the claim and the Medicaid paid amount is offset against future claims submitted by the provider for reimbursement. These claims' dates of service are within a time frame that allows the provider to then timely bill the insurance carrier for reimbursement. If the provider is not able to bill the insurance carrier because the claim adjustment process was not completed within the appropriate time frame, then the claims are sent to HICARS' billing vendor who then bills the insurance carrier. This ensures that billed claims generated in PPRS are either placed on an adjustment report and mailed to the provider, or sent to the billing vendor. In addition, in order to reduce inappropriate claims from being extracted into the PPRS system, HICARS has added additional front-end exclusion rules to the PPRS system. These exclusion rules help minimize the level of claims that are pulled into the PPRS system inappropriately and thus reduces the number of claims placed on an adjustment report or sent to the vendor in error.

Part b: HICARS continues to work with their vendor to ensure that appropriate records are maintained.

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Part c: See response to part a. This new process significantly decreases the necessity for HICARS to bill carriers and, consequently, the need to identify carriers that were not responding to PPRS billings.

Recommendation 5: Follow-Up of Rejected PPRS Billings

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.

Response:

Part a: In December 2008 HICARS began the process of transitioning from seeking recoveries from insurance carriers to processing provider claim adjustments. This process requires the distribution of a claim adjustment report on a monthly basis to all providers that were identified with claims where other insurance coverage has been found. Providers are given 30 days to respond to the claim adjustment report. When a provider responds with updated insurance information, the coverage is verified and added to the coverage database. If the provider does not respond, then HICARS claim adjusts (reverses) the claim and the Medicaid paid amount is offset against future claims submitted by the provider for reimbursement. These claims' dates of service are within a time frame that allows the provider to then timely bill the insurance carrier for reimbursement. If the provider is not able to bill the insurance carrier because the claim adjustment process was not completed within the appropriate time frame, then the claims are sent to HICARS' billing vendor who then bills the insurance carrier. This ensures that billed claims generated in PPRS are either placed on an adjustment report and mailed to the provider, or sent to the billing vendor. In addition, in order to reduce inappropriate claims from being extracted into the PPRS system, HICARS has added additional front-end exclusion rules to the PPRS

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system. These exclusion rules helps minimize the level of claims that are pulled into the PPRS system inappropriately and thus reduces the number of claims placed on an adjustment report or sent to the vendor in error.

Part b: The carrier sends HICARS a generic national standard HIPAA code which is electronically recorded for these rejections in HICARS PPRS. Because of this generic rejection code, each claim must be reviewed manually to determine appropriate follow-up activities. Where feasible, HICARS staff replaces the generic code that was electronically transferred to PPRS with the correct HIPAA code that corresponds to the carrier's proprietary rejection code.

HICARS has discussed with the carrier representatives the feasibility of the carrier submitting appropriate HIPPA coding for transfer to PPRS. Staff continue to review rejections and update the HICARS coverage file and/or claim adjusts the provider where appropriate. HICARS staff expects to complete their review of the rejected claims with this carrier during fiscal year 2010.

Part c: HICARS has developed and implemented written instruction sheets for staff to use for processing some types of rejected claims. Additional instructions are being developed and implemented as time permits. These instructions, once implemented, are reviewed and updated as necessary. HICARS staff has also developed a query to track the volume of claims that have been reviewed and closed. These changes allow HICARS management to review and assess staff follow-up efforts.

**Recommendation 6: Recovery of Medicaid Costs**

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

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Response:

Part a: HICARS has been performing recovery efforts for the majority of these services since February 2008. Because of the many different types of medical clinic claims, additional recovery efforts for these services will be delayed until after CHAMPS implementation.

Part b: HICARS has placed additional revenue codes in the maintenance tables of PPRS for services that are never covered by insurance carriers so that these services can be excluded from the PPRS billing process. HICARS continues to make improvements to this process and is diligently working with the large not-for-profit carrier to bill skilled care services electronically.

Part c: HICARS continues to electronically bill outpatient services to the large not-for-profit carrier on a monthly basis. Any payment/rejection received from the carrier is electronically applied to the claim in PPRS. The rejections are reviewed by staff that update the coverage file in PPRS and pursue recovery from the provider if necessary.

Part d: HICARS continues to electronically bill professional services to the referenced carrier on a monthly basis. Any payment/rejection received from the carrier is electronically applied to the claims in PPRS. The rejections are reviewed by staff that update the coverage file in PPRS and pursue recovery from the provider if necessary.

HICARS continues to meet on a monthly basis with the large not-for-profit carrier to get the electronic process running more efficiently. Additional front end exclusion rules have been added to PPRS to aid in the elimination of billing for services that are not covered. In addition, HICARS is continuously working with their PPRS contractor to get their system running more efficiently.

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Recommendation 7: Efficiency of HICARS' Cost Recovery Program

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

Response:

Part a: In December 2008 HICARS began the process of transitioning from seeking recoveries from insurance carriers to processing provider claim adjustments. This process requires the distribution of a claim adjustment report on a monthly basis to all providers that were identified with claims where other insurance coverage has been found. Providers are given 30 days to respond to the claim adjustment report. When a provider responds with updated insurance information, the coverage is verified and added to the coverage database. If the provider does not respond, then HICARS claim adjusts (reverses) the claim and the Medicaid paid amount is offset against future claims submitted by the provider for reimbursement. These claims' dates of service are within a time frame that allows the provider to then timely bill the insurance carrier for reimbursement. If the provider is not able to bill the insurance carrier because the claim adjustment process was not completed within the appropriate time frame, then the claims are sent to HICARS' billing vendor who then bills the insurance carrier. This ensures that billed claims generated in PPRS are either placed on an adjustment report and mailed to the provider, or sent to the billing vendor.

Part b: See response to part a. of this finding. In addition, in order to reduce inappropriate claims from being extracted into the PPRS system, HICARS has added additional front-end exclusion rules to the PPRS system. These exclusion rules help minimize the level of claims that are pulled into the PPRS system inappropriately and thus reduces the number of claims placed on an adjustment report or sent to the vendor in error.

Part c: HICARS has added additional provider types and revenue (procedure) codes to the PPRS exclusion table so that noncovered services can be excluded from any adjustment reports sent to

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the provider. Additional recovery efforts for medical clinic claims will be delayed until after CHAMPS implementation because of the many variables associated with these types of claims.

Part d: HICARS has received responses and recoveries for a large portion of the claims mentioned in this finding. In addition, HICARS has added additional exclusions to the PPRS exclusion table, such as, excluding known non-covered provider types and procedures codes, and eliminating dollar amounts that indicate the claim is a co-pay. These claims are then excluded before claim adjustment reports are printed and sent to providers. These additional exclusions help eliminate the need for manual analysis by HICARS staff. CHAMPS will allow additional capabilities for TPL editing.

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

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

Response:

HICARS continues to make recoveries on the claims mentioned in the finding. Once a beneficiary's information is updated in the TPL database, and the duplicate coverage is end dated, claims for the beneficiary process like any other TPL claims. In addition, the PPRS system searches the entire TPL database on a monthly basis and generates a report listing duplicate coverage. This report is used by TPL technicians to manually review the duplicate coverage; the inappropriate coverage record is end dated which allows claims to be appropriately processed. HICARS is still working with the carrier in an attempt to eliminate the transmission of duplicate coverage records. Until the carrier corrects this issue, TPL staff will continue this monthly process to eliminate duplicate records. HICARS has worked with their billing vendor to clear the outstanding claims that occurred during the audit period.

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Recommendation 9:      Controls Over Processing Suspended Health Care Claims

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

Response:

Part a: The supervisor of the health section has been working with staff to review the processing of suspended claims to ensure accuracy of payment or that the claim was appropriately rejected. The CHAMPS system will provide enhanced capabilities for monitoring the processing of suspended claims.

Part b: The CHAMPS system will track all activity on a claim. In addition, the CHAMPS system will allow HICARS management to review work performed by the technician prior to the release of the claim for payment. This will allow management to review the technicians work so that resolution instructions can be modified and any training needs met.

Recommendation 10:      Use of TPL Edits

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

Response:

Part a: HICARS has taken measures to have the TPL switch set to cost avoid for all medical clinic claims. This will be further enhanced with the implementation of CHAMPS.

Part b: HICARS has reviewed the four provider types noted in the finding and will ensure that the TPL switch is set appropriately prior to CHAMPS implementation.

Part c: HICARS will have direct oversight responsibilities for TPL coding within CHAMPS.