FINANCIAL RELATED AUDIT
OF

VENDOR PAYMENTS FOR THE HEALTH CARE OF PRISONERS

DEPARTMENT OF CORRECTIONS

For the Contract Years Ended April 1, 1999 and April 1, 2000

EXECUTIVE DIGEST

VENDOR PAYMENTS FOR THE HEALTH CARE OF PRISONERS

INTRODUCTION

This report contains the results of our financial related audit of Vendor Payments for the Health Care of Prisoners, Department of Corrections (DOC), for the contract years ended April 1, 1999 and April 1, 2000.

AUDIT PURPOSE

This financial related audit was conducted as part of the constitutional responsibility of the Office of the Auditor General. Financial related audits are conducted at various intervals to provide for enhanced financial reporting of significant State programs and/or activities and to complement the annual audit of the State's financial statements.

This audit was requested in Section 1004, Act 321, P.A. 1998, and Section 1004, Act 92, P.A. 1999. These sections requested that the Auditor General conduct an annual audit of vendor payments for health care services provided to prisoners and report the amount of total vendor payments, estimated administrative costs, and the amount of outstanding payments.

BACKGROUND

Effective April 1, 1997, DOC entered into a contract to provide Statewide managed health care services for prisoners. Expenditures for contracted management health care services for the contract years ended April 1, 1999 and April 1, 2000 were $35,514,758 and $40,594,380, respectively.

AUDIT OBJECTIVE AND CONCLUSION	**Audit Objective:** To report the amount of total vendor payments, estimated administrative costs, and the amount of outstanding payments, as requested in the appropriations acts. **Conclusion: We reported the amount of total vendor payments, estimated administrative costs, and the amount of outstanding payments (see supplemental information).** Also, we noted a reportable condition related to contract monitoring.
AUDIT SCOPE	Our audit scope was to examine the financial and other records supporting the Department of Corrections' contractor's payments to vendors providing health care for prisoners, the amount of total vendor payments, estimated administrative costs, and the amount of outstanding payments for the contract years ended April 1, 1999 and April 1, 2000. Our audit covered the second year of the initial two-year contract and the first year of the first four-year extension. 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. In connection with our audit, we prepared a summary of vendor payments, administrative costs, and outstanding payments. The summary is included in this report as supplemental information. Our audit was not directed toward expressing an opinion on the supplemental information and, accordingly, we express no opinion on it.
AGENCY RESPONSES	Our audit report contains 1 finding and 1 corresponding recommendation. DOC's preliminary response indicated that it agreed with the finding and has complied with the recommendation.

September 30, 2002

Mr. William S. Overton, Director
Department of Corrections
Grandview Plaza
Lansing, Michigan

Dear Mr. Overton:

This is our financial related audit of Vendor Payments for the Health Care of Prisoners, Department of Corrections, for the contract years ended April 1, 1999 and April 1, 2000, as requested in Section 1004, Act 321, P.A. 1998, and Section 1004, Act 92, P.A. 1999.

This report contains our executive digest; description of payments; audit objective, audit scope, and agency responses; comment, finding, recommendation, and agency preliminary response; a summary of vendor payments, administrative costs, and outstanding payments, presented as supplemental information; and a glossary of acronyms and terms.

The agency preliminary response was 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 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

VENDOR PAYMENTS FOR THE HEALTH CARE OF PRISONERS
DEPARTMENT OF CORRECTIONS

Description of Payments

Per the Department of Corrections (DOC) 2000 Annual Report, DOC provided health care to 46,000 prisoners in 42 prisons and 13 camps Statewide. Effective April 1, 1997, DOC contracted with United Correctional Managed Care, Inc., to provide Statewide managed health care services for prisoners. The contract provided for a term ended April 1, 1999, with allowances for two, four-year extensions with the agreement of both parties. Because of the original contractor's financial difficulties, DOC assigned the contract to Correctional Medical Services in February 1998.

Expenditures for contracted managed health care services for the contract years ended April 1, 1999 and April 1, 2000 were $35,514,758 and $40,594,380, respectively. DOC's total prisoner health care expenditures, which included contracted management health care services, for the fiscal years ended September 30, 1998 and September 30, 1999 were $114,406,837 and $109,848,706, respectively.

The contract is administered by DOC's Bureau of Health Care Services, which had approximately 1,140 employees as of October 31, 2000.

Audit Objective, Audit Scope, and Agency Responses

Audit Objective

The objective of our financial related audit of Vendor Payments for the Health Care of Prisoners, Department of Corrections (DOC), was to report the amount of total vendor payments, estimated administrative costs, and the amount of outstanding payments, as requested in the appropriations acts.

Audit Scope

Our audit scope was to examine the financial and other records supporting the Department of Corrections' contractor's payments to vendors providing health care for prisoners, the amount of total vendor payments, estimated administrative costs, and the amount of outstanding payments for the contract years ended April 1, 1999 and April 1, 2000. Our audit covered the second year of the initial two-year contract and the first year of the first four-year extension. 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.

In connection with our audit, we prepared a summary of vendor payments, administrative costs, and outstanding payments. The summary is included in this report as supplemental information. Our audit was not directed toward expressing an opinion on the supplemental information and, accordingly, we express no opinion on it.

Agency Responses

Our audit report contains 1 finding and 1 corresponding recommendation. DOC's preliminary response indicated that it agreed with the finding and has complied with the recommendation.

The agency preliminary response that follows the 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 DOC to develop a formal response to our audit finding and recommendation within 60 days after release of the audit report.

COMMENT, FINDING, RECOMMENDATION, AND AGENCY PRELIMINARY RESPONSE

ASSESSMENT OF VENDOR PAYMENTS

COMMENT

Background: The Bureau of Health Care Services, Department of Corrections (DOC), entered into a contract to provide a Statewide managed health care system for off-site specialty services for prisoners. The cost for these services was based on a fixed rate per prisoner per month. The contract provided for a term ended April 1, 1999, with options for extension for two additional four-year periods with the agreement of both parties. The original contract provided a clinical rate of $43.62 per prisoner per month and an administrative fee of $6.04 per prisoner per month for an estimated cost of approximately $25.5 million.

This contract was originally awarded to United Correctional Managed Care, Inc. (UCMC). Within a few months, UCMC fell significantly behind in making payments to its subcontracted medical service providers. UCMC arranged for the contract's assignment to Correctional Medical Services (CMS), effective February 3, 1998. The assignment was approved by the Department of Management and Budget and the State Administrative Board and was made under the original contract terms, conditions, and rates. The per prisoner per month clinical rate was raised to $58.63, effective April 1, 1998, for the remaining portion of the contract through April 1, 1999, but the administrative fee remained at $6.04.

In February 1999, DOC and CMS agreed to extend the contract for a period of four years, beginning April 1, 1999. The clinical rate was raised to $60.00 per prisoner per month and the administrative fee was raised to $10.57 per prisoner per month for the contract year ended April 1, 2000.

Audit Objective: To report the amount of total vendor payments, estimated administrative costs, and the amount of outstanding payments, as requested in the appropriations acts.

Conclusion: We reported the amount of total vendor payments, estimated administrative costs, and the amount of outstanding payments (see supplemental information). Also, we noted a reportable condition* related to contract monitoring.

FINDING

1. Contract Monitoring

DOC needs to improve its monitoring of outstanding claims submitted to CMS from medical services providers.

Our review of DOC's monitoring efforts to ensure that medical services provider claims are processed in a timely manner disclosed:

a. DOC reviewed CMS-reported data to determine whether CMS was appropriately paying claims. This review indicated that 77% of sampled claims and 97% of clean claims* were paid within 45 days.

b. DOC reviewed CMS monthly clean claims reports* to identify claims that had not been paid within 45 days.

c. DOC notified medical services providers of DOC's and CMS's telephone hotline numbers for reporting delays in resolving disputed claims. DOC informed us that providers had reported few delays in claims resolution.

While these DOC efforts are beneficial, improvements to the process are needed to enhance the existing monitoring efforts. We identified two initiatives that could improve DOC's monitoring efforts:

(a) DOC could send inquiries to medical services providers to determine whether provider claims are being processed in a timely manner.

We sent inquiries to 104 medical services providers to determine whether they had outstanding claims with CMS. Eighteen (19%) of 94 providers who responded indicated that they had 582 outstanding claims totaling approximately $846,000.

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

We requested that CMS review these outstanding claims and respond to us regarding their status. CMS provided us with documentation to support the disposition of 345 (59%) claims from 14 providers totaling approximately $516,000. Although the providers reported that these 345 claims were unresolved, CMS documented that 302 (88%) claims totaling approximately $398,000 were paid or denied in a timely manner. CMS informed us that claims can be denied for a number of reasons, including providers submit duplicate claims, claims are determined not to be for prisoners, claims are for services that are not requested or authorized, or claims are for separately billed services that are required to be billed as bundled services*. CMS provided documentation to support that 22 (6%) claims totaling approximately $111,000 lacked the necessary information from the provider to close them and that 21 (6%) claims totaling approximately $7,000 were incorrectly denied and were being reprocessed.

We could not determine the disposition of the remaining 237 claims. However, CMS informed us that all outstanding claims had been resolved. Regular random inquiries of medical services providers from DOC would help monitor claims processing.

(b) DOC could substantiate the reliability of data used to monitor and evaluate CMS's performance.

DOC's data collection placed significant reliance on CMS clean claims reports, which were found to provide invalid data. DOC relied on the clean claims reports from CMS to ascertain whether CMS processed provider claims in a timely manner. DOC considers claims processing to be timely if the claim is processed within 45 days from when CMS receives a clean claim. The clean claims report provides data regarding when the claim was received by CMS and when it was entered into CMS's computer system. This report does not provide accurate data regarding when the claim was paid by CMS. Paid claims data is necessary for DOC to determine whether payments are timely. We reviewed 8 claims paid by CMS from April 1, 1999 through April 1, 2000 and compared the information on the clean claims report to paid claims data

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

we obtained directly from CMS. DOC concluded that the clean claims report shows that CMS paid the 8 clean claims within 3 to 35 days. However, the paid claims data shows that the 8 clean claims were actually paid within 52 to 201 days.

Subsequent to our audit, DOC informed us that it contacted CMS to obtain a more useful report for its monitoring needs.

Expanding DOC's monitoring efforts would help DOC determine whether claims are resolved timely and when DOC intervention is necessary.

RECOMMENDATION

We recommend that DOC improve its monitoring of outstanding claims submitted to CMS from medical services providers.

AGENCY PRELIMINARY RESPONSE

DOC informed us that it agreed with the finding and has complied with the recommendation. In response to preliminary recommendations made by the Office of the Auditor General, DOC's Bureau of Fiscal Management developed and implemented an annual financial audit designed to determine the timeliness and accuracy of CMS reporting of claims paid within 45 days of receipt. As recommended by the Office of the Auditor General, the audit process includes soliciting responses from vendors to determine their perceptions of payment timeliness. The Bureau has refined its audit process since auditing contract year 2001 and is about to audit contract year 2002.

DOC has also worked with CMS to improve the claims data reported, both in terms of the actual content and of the definitions of the content, to ensure that there is no misunderstanding of the data. DOC has also subsequently begun an internal audit and will use its recommendations to further substantiate the reliability of data used to monitor and evaluate CMS performance.

SUPPLEMENTAL INFORMATION

Summary of Vendor Payments, Administrative Costs, and Outstanding Payments

This information is provided pursuant to Section 1004, Act 321, P.A. 1998, and Section 1004, Act 92, P.A. 1999.

Vendor Payments and Administrative Costs

Per the Department of Corrections (DOC) 2000 Annual Report, DOC provided health care to 46,000 prisoners in 42 prisons and 13 camps Statewide. DOC assigned the contract for a Statewide managed health care system for off-site specialty services for prisoners to Correctional Medical Services (CMS) in February 1998 after the original contractor experienced financial difficulties. When the contract was assigned to CMS, the clinical rate was $58.63 per prisoner per month with an administrative fee of $6.04 per prisoner per month. Upon executing the first four-year extension for contract year 1999-2000, the clinical rate was raised to $60.00 per prisoner per month and the administrative fee was raised to $10.57 per prisoner per month.

Expenditures for contracted managed health care services for the contract years ended April 1, 1999 and April 1, 2000 were $35,514,758 and $40,594,380, respectively. DOC's total prisoner health care expenditures, which included contracted managed health care services, for the fiscal years ended September 30, 1998 and September 30, 1999 were $114,406,837 and $109,848,706, respectively.

CMS contracted care payments are based on the number of prisoners per month incarcerated by DOC. DOC's Statewide managed health care services for prisoners contract included a provision to share those medical services provider costs incurred by CMS that are greater than those paid under contracted care. At the end of the contract year, medical services provider costs to CMS greater than the payments received under contracted care were put into a risk pool* that was equally shared by CMS and the State.

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

The following table presents DOC payments to the contractor, including contracted care and administrative payments, and the contractor's payments to medical services providers for contract years 1998-99 and 1999-2000:

DOC Payments to CMS	Contract Year 2 (1998-99)	Contract Year 3 (1999-2000)	Change Between Contract Years	Percentage Change (1)
Contracted care (2)	$ 32,251,775	$ 34,784,653	$ 2,532,879	7.9%
Administrative	3,262,983	5,809,727	2,546,743	78.1%
Total DOC Payments to CMS	$ 35,514,758	$ 40,594,380	$ 5,079,622	14.3%
Total per prisoner per month cost	$ 64.67	$ 70.57	$ 5.90	9.1%
Average monthly covered prisoner population	45,019	45,805	786	1.8%
CMS Payments to Vendors				
Total CMS Payments to Vendors (3)	$ 36,096,951	$ 36,590,726	$ 493,776	1.37%

(1) The consumer price index for medical services increased 3.9% from contract year 2 to contract year 3.

(2) Contracted care payments to CMS include per prisoner per month costs plus DOC's share of risk pool costs.

(3) Total CMS payments to vendors include 100% of risk pool costs incurred by CMS.

Outstanding Payments

We requested from CMS (in February 2000 for contract year 2 and in April 2000 for contract year 3) a listing of all payments made for the contract years ended April 1, 1999 and April 1, 2000 and any outstanding payments due. CMS informed us that it had no outstanding payments due to vendors that were not within the normal 45-day payment process. We subsequently sent inquiries to 104 medical services providers to determine whether they had outstanding claims with CMS. Eighteen (19%) of 94 providers who responded indicated that they had 582 outstanding claims totaling approximately $846,000.

We requested that CMS review these outstanding claims and respond to us regarding their status. CMS provided us with documentation to support the disposition of 345 claims from 14 providers totaling approximately $516,000 (see Finding 1). Of these resolved claims, 21 claims totaling approximately $7,000 were claims from contract year 3 that were incorrectly denied and were being reprocessed. This left approximately $126,000 of contract year 2 and $204,000 of contract year 3 alleged claims unresolved.

Consequently, we could not obtain an exact accounting of the amount of outstanding payments. However, the amount of outstanding payments as of the close of each contract year appears reasonable. We also contacted DOC's liaison between CMS and the providers who informed us that DOC has not received provider complaints.

From the data we received, we ascertained an upper bound figure of all providers that may have unresolved billings with CMS that may, though unlikely, be unpaid by CMS of approximately $2.4 million in contract year 2 and $4.2 million in contract year 3:

	As of June 1, 2000	
	Contract Year 2 (1998-99)	Contract Year 3 (1999-2000)
Outstanding claims as reported by sampled medical services providers (1)	$ 131,163	$ 714,433
Less: Outstanding claims resolved by CMS and the Office of the Auditor General	5,521	510,729
Outstanding claims unresolved by CMS and the Office of the Auditor General	$ 125,642	$ 203,704
Projection to population (upper bound) (2)	$ 2,411,555	$ 4,226,224

(1) A total of 104 providers were sampled and sent inquiries to determine if they had outstanding claims against CMS.

(2) This projection equals the amount of outstanding claims unresolved with CMS divided by the percentage of medical services providers responding to total medical services providers for each contract year. This figure represents the upper bound of possible error in claims outstanding and not resolved by CMS. The actual error could be any amount from zero to the projected amount.

The following table ages the claims reported as outstanding by the vendors and the related claim resolutions provided by CMS:

	1 to 45 Days	Percentage	46 to 120 Days	Percentage	121 to 210 Days	Percentage
Claims outstanding per provider (1)	2	0.3%	86	14.8%	150	25.8%
Value of claims outstanding	$ 136	0.0%	$ 59,530	7.0%	$ 451,668	53.4%
CMS claim response:						
Paid by CMS	1		71		57	
Incorrectly classified and not paid; CMS reprocessing	0		0		0	
CMS awaiting more information from provider to process	0		0		10	
Denied by CMS	0		2		19	
Total	1		73		86	
Value of claims resolved by CMS	$ 32		$ 43,446		$ 305,345	
Claims outstanding per provider and not resolved by CMS (2)	1		13		64	
Value of claims outstanding and not resolved	$ 104		$ 16,084		$ 146,322	
Value of average claim outstanding	$ 104		$ 1,237		$ 2,286	

(1) Information regarding the number of days that the claims have been outstanding was given by medical services providers.

(2) These claims were not resolved to our satisfaction. However, CMS contends that all outstanding claims are resolved with providers.

211 to 300 Days	Percentage	301 to 480 Days	Percentage	481 to 750 Days	Percentage	More Than 751 Days	Percentage	Total
52	8.9%	110	18.9%	150	25.8%	32	5.5%	582
$ 88,407	10.5%	$ 116,572	13.8%	$ 118,710	14.0%	$ 10,574	1.3%	$ 845,596
9		23		67		1		229
0		21		0		0		21
4		5		3		0		22
19		24		8		1		73
32		73		78		2		345
$ 56,872		$ 62,012		$ 47,773		$ 769		$ 516,250
20		37		72		30		237
$ 31,535		$ 54,560		$ 70,937		$ 9,804		$ 329,346
$ 1,577		$ 1,475		$ 985		$ 327		$ 1,390

Glossary of Acronyms and Terms

bundled services	A specific group of services for which a provider receives a single rate from CMS.
clean claim	Claim for a DOC prisoner covered under the CMS contract that has been submitted on a standard billing form, is complete and accurate, and is not for unbundled services or duplicate claims.
clean claims report	A report that CMS provides to DOC monthly with information on the claims submitted by providers to CMS for medical services provided to prisoners.
CMS	Correctional Medical Services.
DOC	Department of Corrections.
reportable condition	A matter coming to the auditor's attention relating to a deficiency in the design or operation of internal control that, in the auditor's judgment, could adversely affect the entity's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial schedules and/or financial statements.
risk pool	The portion of actual expenditures above or below the amount equal to the agreed upon target amount per prisoner for clinical services in a given year times the number of prisoners in that same year.
UCMC	United Correctional Managed Care, Inc.