MICHIGAN

OFFICE OF THE AUDITOR GENERAL

FOLLOW-UP REPORT
ON THE

HEALTH INSURANCE LIABILITY SECTION

MEDICAL SERVICES ADMINISTRATION
DEPARTMENT OF COMMUNITY HEALTH

July 2013

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

391-0705-06F

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

July 31, 2013

Mr. James K. Haveman, Jr., Director
Department of Community Health
Capitol View Building
Lansing, Michigan

Dear Mr. Haveman:

This is our report on our follow-up of the 6 material conditions (Findings 1, 2, and 4 through 7) and 11 corresponding recommendations reported in the performance audit of the Health Insurance Cost Avoidance and Recovery Section (HICARS), Medical Services Administration, Department of Community Health (DCH). That audit report was issued and distributed in April 2009. Additional copies are available on request or at <http://www.audgen.michigan.gov>. Subsequent to our performance audit, HICARS was renamed as the Health Insurance Liability Section (HILS).

This report contains an introduction; our purpose of follow-up; a background; our scope; follow-up conclusions, results, recommendations, and agency responses; and a glossary of acronyms and terms.

Our follow-up disclosed that DCH had complied with 6 recommendations and had partially complied with 3 recommendations. We also noted that 2 recommendations were no longer applicable. A material condition still exists related to recovery of Medicaid costs (Finding 6). Reportable conditions exist related to identification of liable carriers (Finding 1) and follow-up of outstanding Post Payment Recovery System (PPRS) billings (Finding 4).

If you have any questions, please call me or Scott M. Strong, C.P.A., C.I.A., Deputy Auditor General.

Sincerely,

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

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TABLE OF CONTENTS

HEALTH INSURANCE LIABILITY SECTION
MEDICAL SERVICES ADMINISTRATION
DEPARTMENT OF COMMUNITY HEALTH
FOLLOW-UP REPORT

HEALTH INSURANCE LIABILITY SECTION
MEDICAL SERVICES ADMINISTRATION
DEPARTMENT OF COMMUNITY HEALTH
FOLLOW-UP REPORT

INTRODUCTION

This report contains the results of our follow-up of the material conditions* and corresponding recommendations reported in our performance audit* of the Health Insurance Cost Avoidance and Recovery Section* (HICARS), Medical Services Administration (MSA), Department of Community Health (DCH), 391-0705-06, which was issued and distributed in April 2009. That audit report included 6 material conditions (Findings 1, 2, and 4 through 7) and 4 reportable conditions*. This report also contains the DCH plan to comply with our prior audit recommendations, which was required by the *Michigan Compiled Laws* and administrative procedures to be developed within 60 days after release of the April 2009 audit report.

PURPOSE OF FOLLOW-UP

The purpose of this follow-up was to determine whether DCH had taken appropriate corrective measures in response to the 6 material conditions and 11 corresponding recommendations.

BACKGROUND

DCH is responsible for administering the State Medicaid Plan* in accordance with the federal Social Security Act and various federal regulations. These require state Medicaid* programs to ensure that Medicaid is the payer of last resort by identifying and pursuing recovery from other liable parties. As a condition of Medicaid eligibility, individuals are required to assign to DCH their rights to recover medical costs paid by

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

Medicaid. DCH's Third Party Liability (TPL) Division, within MSA's Bureau of Medicaid Financial Management and Administrative Services, is charged with carrying out this administrative responsibility. HICARS was one of two sections within the TPL Division at the time of our performance audit. Subsequent to our performance audit of HICARS, this section was renamed as the Health Insurance Liability Section (HILS). HILS is made up of the Cost Avoidance* Unit, the Third Party Claims Processing Unit, and the Recovery Unit.

The Cost Avoidance Unit is responsible for obtaining and verifying the accuracy of information related to third party health insurance carriers* (carriers*), excluding Medicare, with liability for Medicaid recipients' health care costs and for ensuring the timely addition of policy-related information (e.g., policy number, effective dates of coverage, and scope of service coverage) to the Third Party Liability Electronic Database (TED).

The Third Party Claims Processing Unit is responsible for ensuring that providers report other insurance appropriately for Medicaid beneficiaries* identified as having insurance coverage with another insurance provider on the TPL coverage file within TED. Certain claims with special circumstances warrant a manual review and will be suspended before a Medicaid payment is authorized. The Third Party Claims Processing Unit is responsible for manually reviewing and determining if Medicaid is liable for these suspended claims.

The Recovery Unit is responsible for pursuing reimbursement of Medicaid costs that the Cost Avoidance Unit did not identify and include in the TPL coverage file prior to payment or that federal regulations required DCH pay first and then seek recovery of Medicaid's costs.

SCOPE

Our fieldwork was performed primarily from mid-May 2012 through September 2012. To determine the status of compliance with our audit recommendations, we interviewed HILS employees and reviewed applicable policies, procedures, laws, rules, regulations, and correspondence. We reviewed the efforts of HILS to identify potentially liable third

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

parties and update its TPL coverage file. We then assessed the measures taken by HILS to improve the effectiveness* of its contract administration practices. Specifically, we reviewed the new contract for third party carrier identification and Medicaid cost recovery services effective January 1, 2010. We also reviewed the processing of payments to ensure that allowable discounts were applied prior to payment. In addition, we reviewed documentation to ensure that the vendor was providing data files as specified in the contract. Further, we analyzed the efforts implemented by HILS to monitor and timely follow up outstanding TED billings. We also analyzed the efforts taken by HILS to follow up TED billings rejected by its large not-for-profit carrier. We reviewed the policies and procedures implemented by HILS to provide oversight of its staff in reviewing these rejected billings. In addition, we analyzed provider claim adjustments processed during our audit period to determine if HILS improved is efforts to timely recover Medicaid costs that are the potential liability of Medicare and/or other carriers. Further, we reviewed various controls implemented by HILS to improve the efficiency* of the Medicaid cost recovery program.

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

FOLLOW-UP CONCLUSIONS, RESULTS, RECOMMENDATIONS, AND AGENCY RESPONSES

EFFECTIVENESS OF HICARS'S EFFORTS REGARDING TIMELY IDENTIFICATION OF CARRIERS

SUMMARY OF THE APRIL 2009 FINDING

1. Identification of Liable Carriers

HICARS did not take required actions to identify or timely identify carriers that were liable to pay for health care services provided to recipients and to timely update its TPL database with relevant information related to the carriers. We noted that DCH had unprocessed but verified third party health insurance information for over 45,000 recipients, over 21,000 quantifiable but unprocessed health insurance leads, and many thousands of other unprocessed health insurance leads that could not be accurately quantified. As a result, HICARS likely missed an opportunity for significant Medicaid cost savings. Also, the federal Centers for Medicare and Medicaid Services could require that DCH repay the federal share of Medicaid costs for provider claims for which HICARS did not establish the carriers' liability and seek reimbursement from them. Title 42, Part 433, section 138 of the *Code of Federal Regulations (CFR)* requires that HICARS take reasonable measures to determine the liability of carriers to pay for services furnished under the State Medicaid Plan.

RECOMMENDATION (AS REPORTED IN APRIL 2009)

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

AGENCY PLAN TO COMPLY*

The *Michigan Compiled Laws* and administrative procedures required DCH to develop a plan to comply with our audit recommendations within 60 days of the release of the April 2009 audit report. DCH indicated in its August 28, 2009 plan to comply that it partially complied with the recommendation by implementing corrective action for Finding 1, parts b. through e. and g. as detailed below. In

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

addition, DCH reported that it had not implemented corrective action for Finding 1, parts a. and f. as detailed below and reported that corrective action for these two parts would be delayed until after the implementation of the Community Health Automated Medicaid Processing System (CHAMPS).

Specifically, DCH reported the following in its agency plan to comply:

a. DCH has spent a significant amount of time reviewing the electronic child support data stored in the Department of Human Services' (DHS's) data warehouse to determine if a match with existing TPL data would be beneficial. Since the data in the warehouse has source codes, DCH reviewed recent insurance records with the source codes for information obtained directly from an insurance company or a national medical support notice* (NMSN). DCH and the Michigan Department of Information Technology (now part of the Department of Technology, Management, and Budget [DTMB]) compared the insurance information listed in the warehouse with the information on the insurance company Web sites. DCH noted that there were a significant number of policies in the warehouse which were listed as active; however, according to the information maintained on the insurance company Web sites, the policies were no longer active. Loading 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 Medicaid Management Information System (i.e., CHAMPS), DCH will delay further testing of this, out of necessity, until after the implementation of CHAMPS. DCH expects this issue to be resolved subsequent to the implementation of CHAMPS.

b. DCH downloads the federal Social Security Administration (SSA) files on a weekly basis and converts these files to a medium for analysis and processing. DCH verifies the SSA file data, and any useful data will be loaded to the TPL database.

c. DCH continues to receive verified health insurance information from the referenced carrier's national accounts program*.

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

d. DCH maintains a 21-day turnaround time for leads provided by DHS.

e. DCH maintains a 21-day turnaround time for leads provided by health care providers, Medicaid recipients, and others.

f. DCH has spent a significant amount of time reviewing the electronic child support data stored in DHS's data warehouse to determine if a match with existing TPL data would be beneficial. DCH noted that 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 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 Medicaid Management Information System (i.e., CHAMPS), DCH will delay further testing of this, out of necessity, until after the implementation of CHAMPS. DCH expects this issue to be resolved with the implementation of CHAMPS.

g. Since August 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 additional follow-up by TPL Division 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 provided.

FOLLOW-UP CONCLUSION

We concluded that HILS had partially complied with the recommendation. However, reportable conditions exist because HILS did not resume data matches with DHS (part a.) and HILS could not be assured that it received a complete population of all updated insurance information for the carrier's national accounts program from its large not-for-profit carrier (part c.).

FOLLOW-UP RESULTS

Our follow-up disclosed that DCH completed various analyses and implemented several processes to identify or timely identify carriers that were liable to pay for

health care services provided to recipients and to timely update its TPL database with relevant information related to the carriers.

Specifically, our follow-up disclosed:

a. In prior audit Finding 1, part a., we reported that HICARS had not conducted data matches with DHS's electronic child support files since August 2003. These files contained unverified health insurance information (i.e., health insurance leads) that local Friend of the Court offices and DHS's Office of Child Support (OCS) obtained from child support cases involving Medicaid recipients.

   Our follow-up disclosed that HILS had not resumed these data matches. HILS is currently working with DHS to obtain direct access to the electronic child support files in order to perform its own matches of the data. However, as of March 2013, HILS informed us that the agreement with DHS was not finalized and no new data matches were completed.

   HILS informed us that the match with the child support files will not result in a significant number of additional liable third parties. This is because HILS receives weekly updates for its TPL coverage files based on information provided by Michigan insurance carriers. However, HILS informed us that this match could aid in the identification efforts for out-of-State carriers. To help support this statement, HILS reviewed 209 of 36,872 child support cases that had no other insurance coverage documented in the TPL coverage file. In 7 cases (3.3%), it identified insurance coverage information that did not exist on the TPL coverage file. HILS also reviewed 84 of 54,030 child support cases that already had other insurance coverage information in the TPL coverage file. In 7 cases (8.3%), it identified additional insurance coverage information from another carrier that did not previously exist in the TPL coverage file. DCH informed us that the potential cost recovery related to the newly identified coverage for these 7 beneficiaries would be marginal given that these beneficiaries already had other insurance information contained in the TPL coverage file. Considering that, in the 209 cases reviewed that had no other insurance coverage documented, DCH identified potentially liable carriers of 3.3%, we consider this to be a reportable condition.

b. In prior audit Finding 1, part b., we reported that HICARS had not followed up on health insurance leads provided by SSA since 2001. SSA obtained these leads while processing Medicaid applications and redeterminations for Michigan residents who received federal Supplemental Security Income benefits.

Our follow-up disclosed that, in July 2012, HILS implemented an electronic process to track the receipt and follow-up of health insurance leads provided by SSA. HILS contracted for the review of the backlogged SSA leads from October 1, 2010 through September 30, 2011. Beginning in July 2012, HILS uploaded the daily SSA leads and tracked their follow-up review in TED. Our follow-up disclosed that SSA provided 405,507 leads from October 1, 2009 through August 30, 2012. HILS determined that 356,162 records did not contain enough identifying information to pursue as a viable lead. Also, HILS determined that 35,501 leads were for individuals not receiving Medicaid benefits. In addition, it identified 13,844 viable leads provided by SSA. As of October 4, 2012, HILS had reviewed 2,644 of these viable leads.

We reviewed 583 leads received from SSA on June 2, 2012 and determined that 543 did not contain enough information to pursue as a viable lead, 4 were for individuals not receiving Medicaid benefits, and 36 were potentially viable leads. We further reviewed 10 of the viable leads and verified that HILS staff performed follow-up procedures to validate the insurance information and update its TPL coverage file when appropriate. As a result, we no longer consider this to be a reportable condition.

c. In prior audit Finding 1, part c., we reported that HICARS had neither requested nor ensured that it received verified health insurance information from a large not-for-profit health insurance carrier for recipients insured through the carrier's national accounts program.

Our follow-up disclosed that the large not-for-profit health insurance carrier updated its business requirements document to require the submission of data to DCH for recipients insured through the national accounts program. However, HILS could not be assured that it received verified health insurance information for all recipients insured through the carrier's national accounts

program. HILS provided us with a list of 2,000 Medicaid members who had insurance coverage through the carrier's national accounts program that were included in the TPL coverage file to document that it is now receiving this information from the not-for-profit carrier. However, we could not verify that the carrier provided HILS with a complete population of verified health insurance information for recipients insured through the national accounts program. HILS informed us that the large not-for-profit carrier could not provide identifying account information for the program. However, the large not-for-profit carrier's updated business requirements document indicated that its monthly file updates would include national accounts program membership records. As a result, we consider this to be a reportable condition.

d. In prior audit Finding 1, parts d. and e., we reported that HICARS had not followed up on health insurance leads provided by DHS, health care providers, Medicaid recipients, and others. DHS had obtained these health insurance leads while completing Medicaid applications and redeterminations. In addition, health care providers, Medicaid recipients, and others provide leads via telephone calls.

   Our follow-up disclosed that HILS implemented an electronic database in 2008 to track the leads that it receives from DHS, health care providers, Medicaid recipients, and others and to help ensure that it follows up these leads on a timely basis. We reviewed a report generated from the database for the period September 3, 2012 through September 7, 2012 and verified that the current backlog of unreviewed leads was 1,796, with the oldest lead dated August 17, 2012. Because the backlog of unreviewed leads is less than 30 days old, we do not consider this to be a reportable condition.

e. In prior audit Finding 1, part f., we reported that HICARS paid a vendor $3.3 million to obtain carrier information for Medicaid recipients from NMSNs. However, HICARS had not updated the TPL database with the information received for 98.8% of the recipients.

   Our follow-up disclosed that HILS paid a vendor $2.1 million from October 2009 through March 2012 to again obtain carrier information for Medicaid beneficiaries from NMSNs. The vendor updated the DHS child support

system with information obtained from the NMSNs. HILS indicated that it did not obtain the data from the child support system and, as a result, did not follow up the potential leads provided by the vendor because, as noted in part a., the child support system, as a whole, contained unverified health insurance information.

In April 2012, DCH and DHS terminated the interdepartmental agreement and the NMSN clause of its vendor contract because DHS resumed the medical support enforcement activities* related to child support cases. By implementing the match with DHS's electronic child support files, identified in part a., DCH will obtain carrier information from the NMSNs. Also, because the interdepartmental agreement and the NMSN vendor clause were terminated, DCH is no longer paying for these services. For these reasons, we no longer consider this to be a reportable condition.

f. In prior audit Finding 1, part g., we reported that HICARS had not followed up on a significant amount of health insurance information provided by a not-for-profit carrier and a vendor that was inaccurate and/or incomplete. Further, we reported that HICARS should consider this information as health insurance leads and perform the follow-up that is needed to add the data to the TPL database.

Our follow-up disclosed that HILS implemented a procedure in February 2012 to complete a monthly review of approximately 10% of insurance leads provided by its vendor for accuracy. During this review, HILS staff verified insurance information contained in the records to the insurance company's Web site or through telephone calls with the insurance company. We noted that, from February 4, 2012 through August 4, 2012, HILS reviewed 4,371 of the 42,430 records received from the vendor. During this review, HILS identified 130 records that appeared to be inaccurate based on its follow-up with insurance carriers. We reviewed documentation for 28 of the 130 records and determined that HILS processed these reviews in accordance with its policy. Because HILS implemented a monthly review of the insurance leads provided by the vendor, we no longer consider this to be a reportable condition.

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

FOLLOW-UP RECOMMENDATIONS

We recommend that HILS continue to pursue actions to resume its data match with DHS's electronic child support files.

We also recommend that HILS continue to work with its large not-for-profit health insurance carrier to ensure that HILS receives a complete population of verified health insurance information for recipients insured through the carrier's national accounts program.

FOLLOW-UP AGENCY RESPONSE

HILS agrees with the first follow-up recommendation and informed us that it has continued efforts to work with DHS to obtain direct access to the child support records in order to perform its own data match. HILS indicated that it was informed that DHS is currently addressing other projects of higher priority and DHS anticipates resuming this project in 2014. HILS further noted that it cannot move forward with the electronic data match with DHS until that time. In addition, DCH informed us that it continues to believe that the manual case review process will result in minimal additional recoveries. However, if additional resources become available, DCH indicated that it will consider reviewing child support cases that have no other insurance coverage documented in the TPL coverage file.

HILS also agrees with the second follow-up recommendation. HILS informed us that it continues to work with the large not-for-profit health insurance carrier to improve the process to identify the national accounts program membership data. Once this is determined, HILS plans to match the data received to its own records to assist with the validation of completeness of the data file transmitted.

SUMMARY OF THE APRIL 2009 FINDING

2. Contract Administration

HICARS did not effectively administer a vendor contract for various TPL-related services and medical support enforcement services. We reviewed HICARS administration of selected parts of the contract and noted:

- HICARS had paid the vendor $5.5 million for medical support enforcement services that, according to the contract and federal regulation 45 *CFR* 300, were the responsibility of OCS.

- HICARS changed some of the pricing and other terms of the contract without the authority to do so.

- HICARS did not ensure that the vendor provided it with monthly update files containing new or updated carrier information, as required by the contract, and had not assessed the contractor for any liquidated damages.

- HICARS did not effectively verify the appropriateness of the vendor's contingency fees.

- HICARS did not ensure that the vendor invoices offered and that it earned and received the quick payment discount agreed to in the contract.

As a result, HICARS paid the vendor $5.5 million for services that were the financial responsibility of DHS's OCS, contributed toward the loss of $880,000 in matching federal funds, significantly overpaid the vendor, and missed an opportunity for other Medicaid cost savings.

RECOMMENDATIONS (AS REPORTED IN APRIL 2009)

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

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

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

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

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

AGENCY PLAN TO COMPLY

DCH indicated in its August 28, 2009 plan to comply that it intends to comply with the recommendations. Specifically, DCH reported the following in its agency plan to comply:

a. With regard to the first recommendation, DCH stated that an invitation to bid for the services noted in the finding was in process and that it will continue to work with the DCH Contract Management Section going forward. DCH also stated that it expected to have a new contract in place by January 1, 2010 and that quick payment provisions would be negotiated with the selected vendor.

b. With regard to the second and third recommendations, DCH stated that it is finalizing the interdepartmental agreement with DHS, which will address the Title IV-D child support fund billings and ensure that the federal match is claimed at the higher medical support enforcement rate. DCH also stated that it expects to have the interdepartmental agreement finalized by the end of the fiscal year. In addition, DCH stated that a retroactive claim for federal match at the higher rate will be filed for the maximum time period allowed.

c. With regard to the fourth recommendation, DCH stated that it notified the DCH Contract Management Section of the difference between the contract language and actual practice in regard to the frequency of file updates. DCH also stated that it initiated an invitation to bid for the services noted in the finding. In addition, DCH stated that any requested changes to the new contract will be processed according to DCH Contract Management Section and Department of Management and Budget (now part of DTMB) Acquisition Services protocols. DCH expected to have the new contract in place by January 1, 2010.

d. With regard to the fifth recommendation, DCH stated that, since May 2009, the vendor's billing and recovery information has been loaded in the Post Payment Recovery System (PPRS). DCH also stated that it was in the process of developing an automated invoice validation process to aid in the verification of the vendor's contingency fees and expected to have this process in place by September 30, 2009. In addition, DCH stated that, as time permits, it would work with the vendor to verify the appropriateness of previous contingency fees.

FOLLOW-UP CONCLUSION

We concluded that HILS had complied with the first three recommendations. In addition, we determined that the fourth and fifth recommendations are no longer applicable.

FOLLOW-UP RESULTS

To determine the disposition of each of the recommendations, we reviewed HILS's administration of selected parts of the vendor contract for various TPL-related services and medical support enforcement services.

With regard to the first recommendation, our follow-up disclosed that HILS implemented various measures that improved the effectiveness of its contract administration practices. Specifically, we verified that HILS adhered to the pricing outlined in the vendor contract effective January 1, 2010. We reviewed invoices for services from October 1, 2009 through March 31, 2012 related to medical support enforcement services and determined that HILS paid prices outlined in the contract. We also noted that HILS implemented procedures to verify the accuracy of the contingency fees paid to the vendor. In addition, we verified that HILS processed payments promptly to the vendor and, as a result, received a total discount of $146,000 for the period January 1, 2010 through May 31, 2012. As a result, a reportable condition does not exist.

With regard to the second recommendation, our follow-up disclosed that DCH was reimbursed at the federal financial participation rate of 50% for the $5.5 million contractual costs related to medical support enforcement services. Also, as noted in regard to the third recommendation, DCH obtained additional federal reimbursement of $728,000 related to these costs. However, HILS did not seek

recovery from DHS for its State share of these costs. As stated in the agency preliminary response reported in our April 2009 audit, when DHS was unable to provide funding for the vendor's medical support enforcement services, DCH management made the decision to provide the funding. We verified that DCH and DHS did implement an interdepartmental agreement for these services beginning October 1, 2008, which provided that DHS will reimburse DCH for the 66% federal share of these costs. We also verified that DHS appropriately reimbursed DCH $1,382,000 for this federal share from October 2009 through March 2012. In April 2012, DCH and DHS terminated the interdepartmental agreement because DHS resumed the medical support enforcement activities related to child support cases. As a result, a reportable condition does not exist.

With regard to the third recommendation, our follow-up disclosed that HILS obtained additional federal funding of $728,000 related to the activities of the prior audit. HILS informed us that it is likely that it could not obtain the entire amount noted in the prior audit because the federal award period had expired for a portion of the expenditures being requested for reimbursement. Because HILS recovered 83% of the $880,000 of potential federal funding identified in the prior audit, a reportable condition does not exist.

With regard to the fourth recommendation, our follow-up disclosed that HILS did not assess the vendor liquidated damages. As noted in the agency preliminary response reported in our April 2009 audit, HILS recovered the inappropriate contingency fees paid to the vendor and, as a result, considered the matter satisfactorily resolved. Section 600.5807(8) of the *Michigan Compiled Laws* established a 6-year period from the time a claim is accrued to recover damages or sums due from a breach of contract. It has been more than 6 years since the vendor violated the contract terms by not transmitting the required files at the frequency specified in the contract. Therefore, DCH can no longer take action to assess liquidated damages as recommended in the prior audit. We reviewed the new vendor contract effective January 1, 2010 and determined the required frequency of the transfer of files. We reviewed 29 file updates dated from December 31, 2011 through August 4, 2012 and verified that HILS received weekly files as required. Because more than 6 years has lapsed since the vendor violated the contract terms and, in relation to the current contract, the vendor submitted required files on a timely basis, this recommendation is no longer applicable.

With regard to the fifth recommendation, our follow-up disclosed that HILS did not seek recovery of contingency fees paid for vendor billing errors made prior to September 2, 2005. HILS informed us that this would be a labor-intensive, complex project because, at that time, documentation was primarily maintained in paper form. In addition, because such a project would be labor-intensive, DCH stated that it did not have staff to complete this review without jeopardizing current work loads. Because these contingency fees were paid to the vendor seven years ago and Section 600.5807(8) of the *Michigan Compiled Laws* established a 6-year period from the time a claim is accrued to recover damages or sums due from a breach of contract, this recommendation is no longer applicable.

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

SUMMARY OF THE APRIL 2009 FINDING

4. Follow-Up of Outstanding PPRS Billings

HICARS did not effectively monitor and timely follow up on outstanding PPRS billings. We noted that HICARS had not sent follow-up billings (i.e., second billings) or performed a meaningful amount of other follow-up activities (e.g., telephone calls or referrals to the Attorney General) for the outstanding PPRS billings. We also noted that HICARS did not maintain a record of the original billing information and did not have a reporting feature that would allow HICARS management to identify carriers that were not responding to PPRS billings. Without appropriate follow-up, HICARS diminishes its opportunity for potentially significant Medicaid cost recoveries. Federal regulations require that HICARS maintain all billing information to document that it put forth reasonable effort to recover Medicaid costs from liable carriers and, in turn, earned matching federal funding for the corresponding Medicaid costs.

RECOMMENDATION (AS REPORTED IN APRIL 2009)

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

AGENCY PLAN TO COMPLY

DCH indicated in its August 28, 2009 plan to comply that it complied with the recommendation.

Specifically, DCH stated in its plan to comply that, in December 2008, it 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 had 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, DCH "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, the claims are sent to HICARS's 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 PPRS, HICARS has added additional front-end exclusion rules to PPRS. The exclusion rules help to minimize the number of claims that are pulled into PPRS inappropriately and thus reduces the number of claims placed on an adjustment report or sent to the vendor in error.

DCH also stated that this new process significantly decreases the necessity for DCH to bill carriers and, consequently, the need to identify carriers that are not responding to PPRS billings.

FOLLOW-UP CONCLUSION

We concluded that HILS had partially complied with the recommendation. However, reportable conditions exist because HILS did not develop procedures to ensure timely follow-up of outstanding billings (part a.) and HILS did not document its monitoring of the vendor responsible for the billings to certain carriers (part c.).

FOLLOW-UP RESULTS

As part of our follow-up, we analyzed, as of August 16, 2012, the total outstanding billings of $89.8 million. This represents a decrease of $123.6 million since the prior audit. This decrease is partially attributed to provider claim adjustments of $34.7 million processed from May 1, 2009 through August 29, 2012. Provider claim adjustments result in a decrease in the outstanding billings because HILS no longer bills the insurance carrier who is potentially liable for the claim. Rather, HILS obtains payment from the provider by reducing future claims submitted by the provider for reimbursement. The provider is then responsible for obtaining payment from the insurance carrier.

We further analyzed the $89.8 million outstanding billings. HILS was directly responsible for the recovery efforts related to $4.1 million billed to its large not-for-profit carrier. HILS contracted with a vendor for the recovery efforts related to billings of $85.6 million. We identified 20 carriers with billings totaling more than $1 million, which is a decrease of 11 carriers from the prior audit. For these 20 carriers, HILS's vendor was responsible for the recovery efforts from 18 carriers and HILS was responsible for the recovery efforts from 2 carriers. In addition, we identified 34 carriers with outstanding billings totaling between $100,000 and $1 million, which is a decrease of 130 carriers from the prior audit. For these 34 carriers, the vendor was responsible for the recovery efforts from 33 carriers and HILS was responsible for the recovery efforts of 1 carrier.

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

a. In October 2010, HILS implemented the outbound file monitoring report, which was designed to document how billing files to its large not-for-profit carrier and pharmacy carriers are progressed through the billing process. Also, with the implementation of the outbound file monitoring report, HILS had the ability to identify, by individual billing file, specific carriers that were not responding to TED billings. HILS staff use reports generated from this tool to identify files that are not progressing through the billing process and, therefore, need follow-up. However, HILS had not developed procedures that specified what actions should be taken when a billing is outstanding for a specified number of days (e.g., 60, 90, or 120 days).

We obtained the August 7, 2012 outbound file monitoring report and analyzed the 248 billing files that contained claims with no response from the carriers. We identified 43,059 claims with no response. This represented 11.4% of the total 378,911 claims reported in the outbound file monitoring report that were at least 30 days outstanding as of August 7, 2012. These claims were outstanding from as few as 10 days to as much as 1,331 days, with an average of 519 days.

Although HILS had developed and implemented a monitoring tool, it had not developed procedures specifying what follow-up activities should be performed by HILS staff for these outstanding billings. As a result, we consider this to be a reportable condition.

b. In August 2011, HILS updated TED to include a status change history within each individual claim record. This information documents each attempt that HILS makes to recover Medicaid costs from its large not-for-profit carrier. We reviewed 10 claims with rebill activity since August 2011 and noted that the status change history documented the original billing information and the subsequent billings for the claims. As a result, we no longer consider this to be a reportable condition.

c. HILS did not document its monitoring of the vendor responsible for the billings to certain carriers. HILS provided us with documentation that it had various meetings with its vendor to discuss specific carriers. Also, HILS provided us with various reports documenting the amounts recovered by the vendor. However, HILS did not document that it monitored the amount of billings outstanding with the vendor.

Upon HILS's request, the vendor provided HILS with a report as of August 30, 2012 that detailed $36.5 million in outstanding claims. However, the amount documented in TED was $85.6 million. HILS and its TED contractor stated that the amount in TED contains claims that have already been processed. HILS informed us that it plans on doing a system update in TED to remove claims that have already been processed and close outstanding billings determined to be uncollectible.

Because HILS did not have a process in place to monitor its vendor responsible for the collection of outstanding billings to certain carriers, a reportable condition exists.

FOLLOW-UP RECOMMENDATIONS

We recommend that HILS develop procedures to ensure timely follow-up of outstanding billings.

We also recommend that HILS monitor the vendor responsible for billings to certain carriers and appropriately update TED for the collection activities of the vendor.

FOLLOW-UP AGENCY RESPONSE

HILS agrees with the follow-up recommendations and informed us that it has implemented a variety of controls to improve the monitoring of billings that are performed by HILS and its vendor. HILS also informed us that it has implemented new policy and procedures to ensure that outstanding billings are being followed up and recovered, if possible, in an efficient manner. In addition, HILS informed us that it has requested that the vendor provide more data related to outstanding billings, which will aid in its monitoring ability. Further, HILS noted that one of the controls in place is the method in which the vendor is paid. By paying the vendor a contingency fee, the vendor is incentivized to handle billings in an expeditious manner because the vendor's financial gain from this process is only possible if billings are done and recoveries are obtained.

SUMMARY OF THE APRIL 2009 FINDING

5. Follow-Up of Rejected PPRS Billings

HICARS did not timely follow up on some of the PPRS billing rejections that it received from a large not-for-profit carrier. Also, HICARS management did not provide effective oversight of its staff members' follow-up of these rejections. We noted that HICARS had not followed up on a significant number of pharmacy-related and professional services PPRS billings that the carrier rejected as follows:

- The carrier rejected 1.1 million pharmacy-related PPRS billings totaling $40.4 million. This included approximately 839,000 (76.3%) PPRS billings

totaling $34.5 million that the carrier rejected because of nonmatching group or cardholder identification numbers. HICARS had rebilled only 4 of the 839,000 rejections totaling $60 and claim adjusted 602 of the rejections totaling $49,572.

- The carrier rejected approximately 37,600 billings for professional services totaling $3.0 million because of missing information. HICARS had rebilled the carrier for only 4 of the 37,600 rejections totaling $139 and claim adjusted 39 of the rejections totaling $1,416.

- The carrier rejected approximately 240,700 billings for professional services totaling $18.6 million with an explanation that either the recipients' health insurance policies did not cover the specialized therapy that the provider billed for or the billings for the specialized therapy were not submitted in the proper format. HICARS had rebilled the carrier for only 228 of the 240,700 rejections totaling $8,518 and claim adjusted 10 of the rejections totaling $453.

Without timely follow-up and effective management oversight, HICARS diminished its opportunity for potentially significant Medicaid cost recoveries. Federal regulation 42 *CFR* 433.139 requires that HICARS seek recovery of Medicaid payments from liable carriers.

RECOMMENDATIONS (AS REPORTED IN APRIL 2009)

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

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

AGENCY PLAN TO COMPLY

DCH indicated in its August 28, 2009 plan to comply that it partially complied with the recommendations and planned to implement further corrective action during

fiscal year 2009-10. Specifically, the following was detailed in DCH's plan to comply:

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, 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, the claims are sent to HICARS's 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 PPRS, HICARS has added additional front-end exclusion rules to PPRS. The exclusion rules help to minimize the number of claims that are pulled into PPRS inappropriately and thus reduces the number of claims placed on an adjustment report or sent to the vendor in error.

b. The carrier sends HICARS a generic national standard Health Insurance Portability and Accountability Act (HIPAA) code, which is electronically recorded for these rejections in PPRS. Because of this generic rejection code, each claim must be reviewed manually to determine appropriate follow-up activities. Where feasible, HICARS staff replace 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 HIPAA coding for transfer to PPRS. Staff

continue to review rejections and update the HICARS coverage file and/or claim adjust the provider where appropriate. HICARS staff expect to complete their review of the rejected claims with this carrier during fiscal year 2009-10.

c. HICARS has developed and implemented written instructions for staff to use when 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 have 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.

FOLLOW-UP CONCLUSION

We concluded that HILS had complied with both recommendations.

FOLLOW-UP RESULTS

With regard to the first recommendation, in January 2011, HILS implemented its rejection audit tool within TED to track and follow up rejected billings from its large not-for-profit carrier. In addition, the number of rejected claims decreased with the implementation of additional system edits (see follow-up results for Finding 7, part b.). Upon implementation of its rejection audit tool, HILS loaded the denied billings (i.e., rejections) that it received from the large not-for-project carrier since January 2010. We analyzed the data within the rejection audit tool and determined that HILS followed up on a significant number of pharmacy-related and professional services billings that the carrier rejected from January 1, 2010 through August 31, 2012. Our follow-up disclosed that, as of September 6, 2012:

a. The carrier rejected 134,414 pharmacy-related billings totaling $23.8 million. HILS reviewed 118,771 (88.4%) of these rejected billings. As a result of these reviews, HILS rebilled 39,995 claims totaling $7.5 million.

b. The carrier rejected 47,827 professional services billings totaling $5.0 million. HILS reviewed 47,391 (99.1%) of these rejected billings. As a result of these reviews, HILS rebilled 7,312 claims totaling $942,000 and claim adjusted 7,333 claims totaling $744,000.

With regard to the second recommendation, HILS developed and implemented written instructions for staff to use when reviewing and processing rejected claims. HILS also developed a reporting tool within TED, which summarizes the reviews completed by individual HILS employees. This report, along with the aforementioned electronic audit rejection tool, allowed management to review and access the processing of rejected claims by staff.

SUMMARY OF THE APRIL 2009 FINDING

6. Recovery of Medicaid Costs

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

Specifically, we noted the following during our prior audit:

- HICARS did not attempt to recover an estimated $15.7 million from Medicare related to physician services, pharmaceutical products, and services delivered by medical clinics.

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

- HICARS had not attempted to recover Medicaid costs totaling $7.5 million for outpatient services from a large not-for-profit carrier and several of the carrier's affiliates.

- HICARS had not attempted to recover Medicaid costs totaling $5.8 million for various professional services from several carriers.

RECOMMENDATION (AS REPORTED APRIL 2009)

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

AGENCY PLAN TO COMPLY

DCH indicated in its August 28, 2009 plan to comply that it partially complied with the recommendation and planned to implement further corrective action. Specifically, DCH stated the following in its plan to comply:

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 the implementation of CHAMPS.

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 electronically bill skilled care services.

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

d. HICARS continues to electronically bill professional services to the referenced carrier on a monthly basis. Any payment or rejection received from the carrier is electronically applied to the claims in PPRS. The rejections are reviewed by staff who 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 its PPRS contractor to get the system running more efficiently.

FOLLOW-UP CONCLUSION

HILS had partially complied with the recommendation. However, a material condition still exists because HILS did not attempt to recover $18.6 million of Medicaid costs from Medicare for pharmaceutical products (part a.).

FOLLOW-UP RESULTS

Since the prior audit, HILS implemented provider claim adjustments for Medicaid services reimbursed to providers that were determined to be covered by Medicare. HILS processes all Medicaid recoveries for which Medicare was determined to be liable by provider claim adjustments. Using this process, HILS reverses the previously paid Medicaid claim to the provider and then reduces future payments to the provider for the reversed Medicaid claim. The provider is then responsible for billing Medicare. Also since the prior audit, HILS began to process provider claim adjustments whenever possible in lieu of seeking recoveries from insurance carriers determined to be liable for the services previously paid for by Medicaid. We analyzed the $34.7 million provider claim adjustments processed from May 1, 2009 through August 29, 2012 and noted:

a. HILS processed provider claim adjustments totaling $16.1 million from Medicare with $3.1 million of these attributed to physician and nursing facility related services.

   However, HILS did not attempt to recover Medicaid costs from Medicare for pharmaceutical products. HILS identified beneficiary records with retroactive Medicare coverage and accumulated the paid pharmaceutical claims from the retroactive coverage date to the date the Medicare coverage was added. Based on this analysis, HILS identified $18.6 million of pharmaceutical claims that were the potential liability of Medicare. We consider this to be a material condition.

   HILS informed us that it plans to begin submitting these claims for recovery through Medicare's Limited Income Newly Eligible Transition program (LI NET). LI NET is designed to eliminate any gaps in coverage for Medicaid beneficiaries transitioning to Medicare, or Medicare beneficiaries who become Medicaid eligible, by providing retroactive coverage. Medicaid programs that have paid prescription drug claims during these retroactive periods can submit

these claims to LI NET for recovery. HILS informed us that it is in the process of setting up the testing for the transmission of electronic files to LI NET. HILS also informed us that it hopes that recovery of these pharmaceutical claims can begin in May 2013.

b. HILS processed provider claim adjustments totaling $6.1 million from its large not-for-profit carrier and some of its affiliates, with $1.4 million attributed to covered skilled care services delivered in a recipient's home and hospital inpatient and outpatient services.

c. HILS processed provider claim adjustments totaling $12.5 million from numerous other carriers, including out-of-State affiliates of its large not-for-profit carrier, with $9.5 million attributed to various professional services and hospital inpatient and outpatient services.

FOLLOW-UP RECOMMENDATION

We recommend that HILS attempt to recover and timely recover Medicaid pharmaceutical costs that are the potential liability of Medicare.

FOLLOW-UP AGENCY RESPONSE

HILS agrees with the follow-up recommendation and informed us that it has implemented a billing recovery process that utilizes the LI NET, which enables HILS to recover Medicaid pharmaceutical costs from Medicare. HILS also informed us that the billing recovery process was implemented in April 2013 and includes a retroactive recovery period of 36 months. HILS indicated that it has begun receiving recoveries from claims submitted to LI NET for reimbursement. In addition, HILS informed us that it will identify and bill current eligible pharmaceutical claims on a monthly basis.

SUMMARY OF THE APRIL 2009 FINDING

7. Efficiency of HICARS's Cost Recovery Program

HICARS did not have controls to ensure that its Medicaid cost recovery program was efficient. During the period April 1, 2005 through September 30, 2007, HICARS sent PPRS billings totaling $495.8 million and recovered Medicaid costs totaling $20.6 million. We noted that HICARS did not conduct a comprehensive

analysis of its PPRS billings and their related remittances (including carrier explanations of benefits*) to identify commonalities that existed among the PPRS billings that consistently, and for good reason, produced no Medicaid cost recoveries. We also noted that HICARS had sent an insurance carrier approximately 15,077 paper PPRS billings totaling $24.7 million during the 30-month period ended September 30, 2007. As of October 17, 2007, the carrier had responded to only 1,022 of the PPRS billings and reimbursed Medicaid a total of $54. HICARS informed us that the carrier that we inquired about was generally not liable for the billings. In addition, we noted that HICARS sent approximately 131,000 billings to recover Medicaid costs that HICARS staff had manually reviewed and approved for Medicaid payment. The purpose of the manual review was to determine the carriers' liability before the Medicaid payment. As a result, HICARS used some of its limited resources to pursue recovery of Medicaid costs that were generally not reimbursable by carriers while simultaneously burdening carriers with processing unnecessary PPRS billings.

RECOMMENDATION (AS REPORTED APRIL 2009)

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

AGENCY PLAN TO COMPLY

DCH indicated in its August 28, 2009 plan to comply that it partially complied with the recommendation and planned to implement further corrective action. Specifically, DCH reported the following in its plan to comply:

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, 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

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

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, the claims are sent to HICARS's 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.

b. In order to reduce inappropriate claims from being extracted into PPRS, HICARS has added additional front-end exclusion rules to PPRS. The exclusion rules help to minimize the number of claims that are pulled into PPRS inappropriately and thus reduces the number of claims placed on an adjustment report or sent to the vendor in error.

c. DCH 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 the provider.

d. DCH has received responses and recoveries for a large portion of the claims mentioned in this finding. In addition, DCH has added additional exclusions to the PPRS exclusion table, such as excluding known noncovered provider types and procedure codes and eliminating dollar amounts that indicate the claim is a co-payment. 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 DCH staff. CHAMPS will allow additional capabilities for TPL editing.

FOLLOW-UP CONCLUSION

We concluded that HILS had complied with the recommendation.

FOLLOW-UP RESULTS

Since the prior audit, HILS implemented several controls that improved the efficiency of the Medicaid cost recovery program. HILS processed billings totaling $447.2 million and recovered Medicaid costs totaling $40.4 million from May 1, 2009 through August 31, 2012. This 9% recovery rate represents an increase of

5% from the recovery rate noted in the prior audit. Specifically, our follow-up disclosed:

a. HILS transitioned, when possible, from seeking recoveries from insurance carriers to processing provider claim adjustments when a liable third party is identified for a previously paid Medicaid claim. Using this process, HILS reverses the previously paid Medicaid claim to the provider and then reduces future payments to the provider for the reversed Medicaid claim. The provider is then responsible for billing the liable insurance carrier. HILS ensures that the claim adjustments occur on a timely basis so that the provider can then bill the insurance carrier for reimbursement. HILS processed claim adjustments totaling $34.7 million from May 1, 2009 through August 29, 2012, which contributed to the increased recovery rate.

b. As a result of commonalities identified by HILS that resulted in little or no Medicaid recoveries, in March 2010, HILS implemented a coverage code system edit to exclude claim types identified as not being covered by certain insurance carriers. At the time of our follow-up, we determined that HILS was using 27 different coverage code edits to exclude various claim types related to 5,681 carriers. We reviewed 20 different carriers for which specific claim types were programmed to be excluded using 4 different coverage codes and verified that HILS appropriately did not perform recovery efforts for these identified claim types. As a result of these additional system edits, HILS no longer uses resources to pursue recovery from insurance carriers for Medicaid services provided that are not covered by the insurance carrier.

c. HILS implemented several codes within CHAMPS which specifically identified claims that its staff had manually reviewed and approved for Medicaid payment. HILS then ensured that these specific codes were excluded from recovery efforts. We reviewed 15 claims that were manually reviewed and approved for payment and verified that none of these claims were subsequently billed for recovery by HILS.

d. HILS and its insurance carriers implemented various system updates that allow for the electronic processing of billings with insurance carriers. We verified that the last paper billing processed by HILS was December 15, 2008.

agency plan to comply	The response required by Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100). The audited agency is required to develop a plan to comply with Office of the Auditor General audit recommendations and submit the plan 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.
beneficiaries	Persons who are enrolled in Medicaid and who can receive medical services that are paid for with Medicaid funds.
carrier	For purposes of this report, a third party health insurance carrier (see definition).
CFR	*Code of Federal Regulations.*
CHAMPS	Community Health Automated Medicaid Processing System.
cost avoidance	A process that returns a health care claim unpaid to the health care provider for collection from a liable third party.
DCH	Department of Community Health.
DHS	Department of Human Services.
DTMB	Department of Technology, Management, and Budget.
effectiveness	Success in achieving mission and goals.

efficiency	Achieving the most outputs and outcomes practical with the minimum amount of resources.
explanation of benefits	A document that a carrier sends to a billing entity detailing the carrier's payment for billed services and/or reasons for nonpayment.
Health Insurance Cost Avoidance and Recovery Section (HICARS)	A DCH section now known as the Health Insurance Liability Section (HILS).
HILS	Health Insurance Liability Section.
HIPAA	Health Insurance Portability and Accountability Act.
LI NET	Limited Income Newly Eligible Transition program.
material condition	A reportable condition that could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment of an interested person concerning the effectiveness and efficiency of the program.
Medicaid	Created under Title XIX of the Social Security Act, this program provides medical services to indigent persons in the general categories of families with dependent children; the aged, blind, and disabled; and other targeted groups that meet income eligibility standards.
medical support enforcement services	Health insurance enrollment and national medical support notice processing.
MSA	Medical Services Administration.

national accounts program	A group of the large not-for-profit carrier's subscribers who live in more than one plan service area.
national medical support notices (NMSNs)	Notices provided to employers on how to handle medical support for dependent children included in child support actions.
OCS	Office of Child Support.
performance audit	An economy and efficiency audit or a program audit that is designed to provide an independent assessment of the performance of a governmental entity, program, activity, or function to improve public accountability and to facilitate decision making by parties responsible for overseeing or initiating corrective action.
PPRS	Post Payment Recovery System.
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 audit objectives; 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.
SSA	Social Security Administration.
State Medicaid Plan	A document that defines how Michigan will operate its Medicaid program. The State Medicaid Plan addresses the areas of State program administration, Medicaid eligibility

	criteria, service coverage, and provider reimbursement and is approved by the federal Centers for Medicare and Medicaid Services.
TED	Third Party Liability Electronic Database.
third party health insurance carriers	Health insurers, group health plans, service benefit plans, and health maintenance organizations.
TPL	third party liability.

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