Office of the Auditor General
Performance Audit Report

Capitated Rate Setting, Contracting, and Beneficiary Enrollment Processes of the Comprehensive Health Care Program

Michigan Department of Health and Human Services

April 2017

State of Michigan Auditor General
Doug A. Ringler, CPA, CIA

391-0701-16

The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

Article IV, Section 53 of the Michigan Constitution

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Report Summary

Performance Audit
Capitated Rate Setting, Contracting, and Beneficiary Enrollment Processes of the Comprehensive Health Care Program (CHCP)
Michigan Department of Health and Human Services (MDHHS)

Report Number:
391-0701-16

Released:
April 2017

CHCP was initiated as a mechanism for controlling costs and improving beneficiary care in Michigan's Medicaid program. MDHHS contracts with Medicaid Health Plans (MHPs) to provide health care and management services to the Medicaid and Healthy Michigan Plan (HMP) beneficiaries who chose or are required to be enrolled in an MHP. During fiscal year 2015, MDHHS's capitated rate payments totaled $6.6 billion for 1.6 million Medicaid and HMP beneficiaries.

Audit Objective			Conclusion
Objective #1: To assess the effectiveness of MDHHS's MHP capitated rate setting process.			Moderately effective
Findings Related to This Audit Objective	**Material Condition**	**Reportable Condition**	**Agency Preliminary Response**
MDHHS could not ensure that it provided accurate cost adjustment data to the actuary for calculating the capitated rates. We estimated that a $1 million error in the cost data would result in a 5 cent error in the capitated rates, leading to more than $700,000 of incorrect capitated rate payments annually (Finding #1).		X	Partially agrees

Audit Objective			Conclusion
Objective #2: To assess the sufficiency of MDHHS's contracting process for MHPs.			Sufficient
Findings Related to This Audit Objective	**Material Condition**	**Reportable Condition**	**Agency Preliminary Response**
None reported.	Not applicable.		

Audit Objective			Conclusion
Objective #3: To assess the effectiveness of MDHHS's enrollment process for MHP beneficiaries.			Effective
Findings Related to This Audit Objective	**Material Condition**	**Reportable Condition**	**Agency Preliminary Response**
None reported.	Not applicable.		

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April 12, 2017

Mr. Nick Lyon, Director
Michigan Department of Health and Human Services
South Grand Building
Lansing, Michigan

Dear Mr. Lyon:

I am pleased to provide this performance audit report on the Capitated Rate Setting, Contracting, and Beneficiary Enrollment Processes of the Comprehensive Health Care Program, Michigan Department of Health and Human Services.

We organize our findings and observations by audit objective. Your agency provided the preliminary response to the recommendation at the end of our fieldwork. The *Michigan Compiled Laws* and administrative procedures require an audited agency to develop a plan to comply with the recommendations and submit it within 60 days of the date above 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.

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

Sincerely,

Doug Ringler

Doug Ringler
Auditor General

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AUDIT OBJECTIVES, CONCLUSIONS, FINDINGS, AND OBSERVATIONS

MEDICAID HEALTH PLAN (MHP) CAPITATED RATE SETTING PROCESS

BACKGROUND

The Michigan Department of Health and Human Services (MDHHS) pays contracted MHPs a monthly capitated rate* for each covered beneficiary. MDHHS contracted with 13 MHPs through December 31, 2015 and dropped to 11 beginning January 1, 2016. Capitated rates vary depending on demographics, geographic location, covered services, or other characteristics.

As required by federal regulations, MDHHS contracts for actuarial services to develop and certify the soundness of the capitated rates. The methodologies and processes employed in developing the rates consider all reasonable, appropriate, and attainable costs, including the MHPs' costs of expected health benefits and capital; an administrative cost allowance percentage; the cost of government-mandated assessments, fees, and taxes; an allowance for profit, contingency, or contribution to surplus; and allowances for pass-through payments for the Hospital Reimbursement Adjustment Program*, Graduate Medical Education payments*, and the Specialty Network Access Fee* program.

The actuary utilizes historical encounter claim data* from the Enterprise Data Warehouse (EDW) to establish the rates for future periods. MDHHS's encounter quality initiative (EQI) process requires that the actuary reconcile EDW data with data reported directly to the actuary by the various MHPs. The actuary shares EQI reconciliation reports with MDHHS for follow-up of identified differences.

MDHHS paid $6.6 billion in capitated rate payments to MHPs for fiscal year 2015.

AUDIT OBJECTIVE

To assess the effectiveness* of MDHHS's MHP capitated rate setting process.

CONCLUSION

Moderately effective.

FACTORS IMPACTING CONCLUSION

- The administrative cost allowance percentage appeared reasonable based on cost data reported by the MHPs to the Department of Insurance and Financial Services (DIFS).
- MDHHS complied with the federal regulations reviewed related to the establishment of capitated rates.
- Reportable condition* related to improvements needed for data accuracy.

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

FINDING #1

Improvements needed to ensure data accuracy.

MDHHS did not have adequate procedures to help ensure that it provided accurate data to the actuary for developing the capitated rates. Inaccurate or unreported encounter claim data will affect the accuracy of the capitated rates (see Exhibit #1), which would, in turn, have a significant impact on future capitated rate payments. We estimated that a $1 million error in the encounter claim data would cause a 5 cent error in each capitated rate, leading to incorrect capitated rate payments of more than $700,000 annually.

Department of Technology, Management, and Budget (DTMB) Administrative Guide policy 0610 requires departments to manage contracts in a manner that is fiscally responsible and ensure that vendors meet contractual obligations. Also, MDHHS's actuarial contract requires the contractor to carry out the project under the direction and control of MDHHS.

Our review of MDHHS's processes and the actuary's rate development reports identified the following:

a. MDHHS did not have a process to ensure that all adjustments for overpayments*, pharmaceutical rebates*, reinsurance reimbursements*, and third party liability (TPL) reimbursements* were netted against the encounter claim data contained in the EDW. Unreported overpayments, rebates, and reimbursements will result in future capitated rate payments being improperly inflated.

   We obtained overpayment, pharmaceutical rebate, reinsurance reimbursement, and TPL reimbursement information totaling $238 million (2.9% and 3.1% of total encounter claims) from the 13 MHPs that held contracts during fiscal years 2014 and 2015, respectively (see Exhibit #2). Based on this information and the actuary's capitated rate certifications for fiscal years 2014 and 2015, we noted:

   (1) MDHHS did not request overpayment data from MHPs prior to January 2016, and the actuary did not include exclusion adjustments for overpayments. In response to a February 2016 report, issued by the Centers for Medicare and Medicaid Services, which indicated that overpayments in the industry are typically between 1% and 10% of total expenditures paid, MDHHS required MHPs to report total overpayment amounts beginning with the first quarter of calendar year 2016. However, MDHHS did not have a process to verify the accuracy of, or to reconcile, the overpayment data reported by the MHPs with the detailed encounter claim data

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

and did not plan to obtain or require MHPs to report prior overpayment data.

MHPs reported overpayment amounts to us totaling approximately $69.9 million and $102.3 million (2.1% and 2.3% of total encounter claims) for fiscal years 2014 and 2015, respectively.

(2) MDHHS did not request pharmaceutical rebate or reinsurance reimbursement data from MHPs, and the actuary did not include exclusion adjustments for such items.

MHPs reported pharmaceutical rebate and reinsurance reimbursement amounts to us totaling approximately $18.5 million and $28.1 million (0.6% and 0.6% of total encounter claims) for fiscal years 2014 and 2015, respectively.

(3) MDHHS did not request TPL reimbursement data from MHPs. The actuary generally included a 0.5% to 1% exclusion adjustment for TPL reimbursements in its Medicaid capitated rate calculations based on historical TPL reports received directly from MHPs. However, the actuary did not include an exclusion adjustment in its Healthy Michigan Plan (HMP) capitated rate calculations. Also, MDHHS could not provide support for the exclusion adjustment percentages or ensure the accuracy of the historical TPL data used by the actuary.

MHPs reported TPL reimbursement amounts to us totaling approximately $9.5 million and $10.1 million (0.3% and 0.2% of total encounter claims) in fiscal years 2014 and 2015, respectively.

The MHPs indicated that they adjusted claim data for overpayments and included pharmaceutical rebate or reinsurance reimbursement data in their company-wide statutory financial information. However, these processes did not provide MDHHS with the ability to verify the completeness or accuracy of the information reported and did not provide the actuary with the detail needed to properly adjust the data used in its calculations.

b. MDHHS did not always investigate, adjust, or require MHPs to correct reported encounter claim data used by the actuary in the rate setting process. The actuary's EQI reports identified a difference of approximately $223.7 million between the encounter claim data

reported to MDHHS and that reported directly to the actuary for October 2013 through May 2015. MDHHS indicated that it would follow up all differences. However, we noted that MDHHS investigated only 5 (45%) of the 11 differences that we reviewed and did not adjust or require MHPs to correct the reported encounter claim data.

MDHHS did not investigate 55% of encounter claim data differences.

c. MDHHS did not utilize MHP reported encounter claim data that the actuary determined to be non-credible or unreasonable and excluded from the capitated rate calculation process to help improve the accuracy of future encounter claim data.

d. MDHHS did not have a formal process to ensure that all program changes were considered by the actuary in the rate setting process. MDHHS could not provide us with a list of program changes for fiscal years 2014 or 2015 that could have impacted the capitated rate calculations or with documentation that program changes were discussed with the actuary.

e. MDHHS did not have documentation that it reviewed the reasonableness of contract deliverables, including actuarial methodologies, capitated rates, and EQI reports, or that it had approved the deliverables. Such reviews may identify limitations encountered by the actuary and help improve future calculations.

RECOMMENDATION

We recommend that MDHHS improve its processes to help ensure the accuracy of the data used for developing the capitated rates.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS acknowledges there are opportunities for incremental improvement in the procedures for ensuring the accuracy of the data used by its actuary for capitated rate setting:

a. During the audit period MDHHS relied on the processes it had in place which included the overpayment reporting historically done by the managed care organizations utilizing a claim replacement process. In their reporting to the Office of the Auditor General (OAG), the health plans explained how overpayments are reported to MDHHS through a reversal and adjustment process. Overpayments are treated the same as other claims adjustments and resubmitted through the encounter file using a frequency code of 7 (replacement). When the data is pulled for rate setting purposes, only the replacement file is sent to the actuary for use. Therefore, overpayments are excluded from the rate setting process. However, MDHHS has

worked with its actuary to implement additional reporting mechanisms for overpayments.

As indicated by the health plans, pharmacy rebates and reinsurance reimbursement are reported to the Michigan Department of Insurance and Financial Services (DIFS) and these reports are used by the actuary as part of a reasonableness check during rate setting. Also, beginning with FY17 rate setting, MDHHS and Milliman surveyed the health plans regarding a variety of financial information, including pharmacy rebates, and third party liability. This information was used in the rate setting process in FY17. MDHHS and Milliman are in the process of surveying the health plans for FY18 rate setting.

The adjustments made by the actuary were consistent with the information provided by the health plans to the OAG. The amounts reported were 0.2% and 0.3% and Milliman used 0.5% in rate setting. Milliman did not apply a TPL adjustment to the HMP rates since historical information related to third-party recoveries was not available for this new program. TPL data is part of the information requested by the survey tool MDHHS and Milliman implemented for FY17 rate setting.

b. *MDHHS agrees that any technical assistance related to the Encounter Quality Initiative (EQI) process could be provided on a more routine basis. However, the EQI process is used throughout the year with four-month data set pulls and is a totally different data pull than the final data used for the rate setting process. The EQI is designed to help health plans understand where improvements can be made in their encounter data submission process. During the audit period, MDHHS used the EQI process to provide technical assistance to health plans during onsite visits. MDHHS is working to strengthen the effectiveness of the EQI process. Changes currently underway include dispersing the responsibility of working with health plans to several individuals in the section instead of relying on a single individual. An Encounter Quality Liaison has been assigned to each health plan. These liaisons will meet monthly with their assigned health plans to discuss EQI results, volume, and timeliness reports as well as any other data quality issues.*

c. *MDHHS agrees and will develop a process to work with the health plans whose data was excluded from the rate setting process by the actuary to implement improvements in their encounter data submissions. This will be addressed by the Encounter Quality Liaisons as they work with their assigned health plan.*

d. *MDHHS believes the multiple methods it uses to track program changes for inclusion in the rate setting process serve as a formal tracking process. These methods include the following: 1) Bi-weekly meetings coordinated by the Actuarial Division to work with the Managed Care Division and other appropriate MSA staff to identify and track program changes which impact rate development. These meetings are documented with notes and agendas which identify program changes. 2) Bi-weekly meetings with the actuary and the Actuarial Division management to discuss program changes and other rate setting issues. 3) Bi-weekly Operations meetings with the health plans where upcoming program changes are discussed and documented. 4) Bi-Monthly meetings with the health plans where program changes are discussed and documented. 5) Pre-rate setting meetings where the actuary presents the rate setting methodology and program changes to the health plans prior to rate setting. 6) Bi-monthly meetings with health plan CEOs where significant program changes are discussed and documented. 7) Annual rate setting meeting with the health plans after the rates have been set where program changes are described and documented. However, MDHHS acknowledges that these documents were not provided during the audit process.*

e. *MDHHS has developed a formal approval process for contract deliverables.*

MHP CONTRACTING PROCESS

BACKGROUND

During fiscal year 2015, MDHHS, in conjunction with DTMB's procurement office, conducted a competitive bid process for Medicaid and HMP health care and care management services and awarded contracts to 11 MHPs effective January 1, 2016.

AUDIT OBJECTIVE

To assess the sufficiency of MDHHS's contracting process for MHPs.

CONCLUSION

Sufficient.

FACTORS IMPACTING CONCLUSION

- MDHHS and DTMB conducted the 2015 competitive bid process and awarded the new MHP contracts in accordance with all DTMB contracting requirements.
- The bid proposal evaluation results were consistent with MDHHS's contract monitoring results.
- MDHHS complied with selected federal regulations related to contracting with managed care organizations.

MHP BENEFICIARY ENROLLMENT PROCESS

BACKGROUND

MDHHS contracted with an enrollment broker* for enrollment activities, including providing information to beneficiaries regarding their rights, covered benefits, service area, cost sharing, and primary care physicians.

MDHHS utilizes an auto-assignment algorithm to assign beneficiaries who do not select an MHP provider within the allotted time period. The algorithm uses performance-based criteria, such as clinical performance, administrative factors, and primary care physician-to-member ratios.

AUDIT OBJECTIVE

To assess the effectiveness of MDHHS's enrollment process for MHP beneficiaries.

CONCLUSION

Effective.

FACTORS IMPACTING CONCLUSION

- The enrollment and mailing service processes were appropriately designed, beneficiaries were properly enrolled, the auto-assignment algorithm was accurately implemented, and statistical data was accurately reported.
- 100% of the Medicaid beneficiaries reviewed were enrolled in an MHP in a timely manner.
- MDHHS complied with selected federal regulations related to beneficiary enrollment.
- MDHHS's enrollment broker complied with all of the key contractual requirements reviewed.

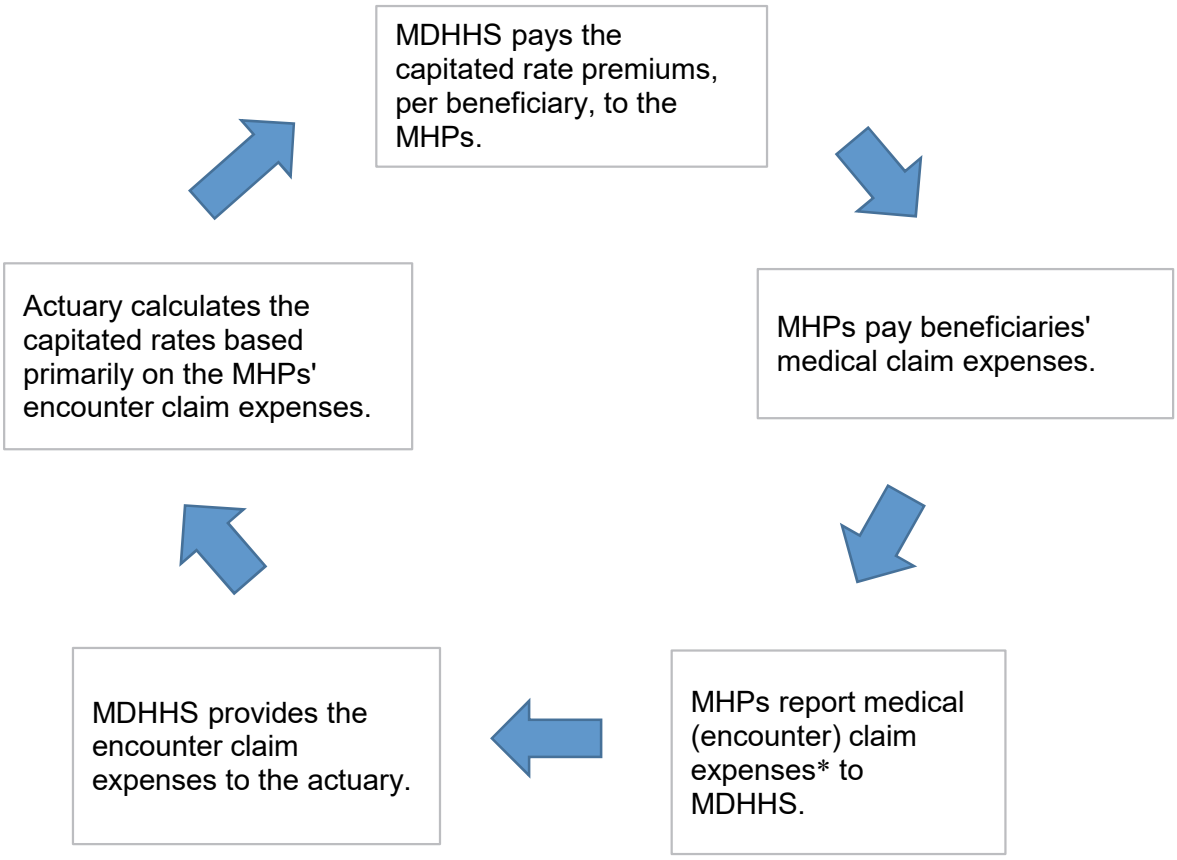
** See glossary at end of report for definition.*

SUPPLEMENTAL INFORMATION

Exhibit #1

CAPITATED RATE SETTING, CONTRACTING, AND BENEFICIARY ENROLLMENT PROCESSES OF THE COMPREHENSIVE HEALTH CARE PROGRAM
Michigan Department of Health and Human Services

Effect of Unreported Encounter Claims, Overpayments, Rebates, or Reimbursements on Capitated Rates



* If MHPs do not report all overpayments, rebates, and reimbursements, the encounter claim expenses will be overstated causing future capitated rate premiums to be inflated. Likewise, if MHPs do not report all medical (encounter) claim expenses, future capitated rate premiums will be understated.

Source: The OAG prepared this exhibit based on information obtained from MDHHS.

CAPITATED RATE SETTING, CONTRACTING, AND BENEFICIARY ENROLLMENT PROCESSES OF THE COMPREHENSIVE HEALTH CARE PROGRAM
Michigan Department of Health and Human Services

Overpayments, Rebates, and Reimbursements
For Fiscal Years 2014 and 2015

	Fiscal Year			
	2014		2015	
	Amount*	Percentage of Total Encounter Claims	Amount*	Percentage of Total Encounter Claims
Amounts reported by MHPs to the OAG:				
Overpayments	$69,939,948	2.1%	$102,336,937	2.3%
Pharmaceutical rebates	$12,867,043	0.4%	$19,553,778	0.4%
Reinsurance reimbursements	$5,669,342	0.2%	$8,536,134	0.2%
TPL reimbursements	$9,453,988	0.3%	$10,104,732	0.2%
Total encounter claims reported by MHPs to MDHHS	$3,343,552,154		$4,515,699,377	

* Includes only payments for Medicaid, HMP, and dual eligible beneficiaries. It does not include Children's Special Health Care Services (CSHCS) beneficiaries.

Source: The OAG prepared this exhibit based on data reported by the MHPs and data obtained from the Community Health Automated Medicaid Processing System (CHAMPS).

PROGRAM DESCRIPTION

The Comprehensive Health Care Program (CHCP) was initiated as a mechanism for controlling costs and improving beneficiary care in Michigan's Medicaid program. CHCP is authorized as part of the State's Waiver Program under Title XIX, Section 1915(b) of the Social Security Act, is funded through Title XIX and the State's General Fund, and is administered by MDHHS. CHCP incorporates Medicaid and HMP beneficiaries covered under an MHP. As of September 2015, approximately 1.6 million Medicaid and HMP beneficiaries were enrolled in an MHP.

In addition to the 21 staff within the Managed Care Plan Division, MDHHS staff within the Customer Service Division, Actuarial Division, Pharmacy Management Division, Managed Care Data and System Support Section, and Third Party Liability Division perform respective duties related to CHCP.

In fiscal year 2015, MDHHS paid $6.6 billion in capitated rate payments to MHPs.

AUDIT SCOPE, METHODOLOGY, AND OTHER INFORMATION

AUDIT SCOPE

To examine the records and procedures related to the MHP capitated rate setting, contracting, and beneficiary enrollment processes of CHCP. We conducted this performance audit* in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our finding and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objectives.

We did not include the verification of Medicaid eligibility; the capitated rate setting, contracting, and benefit enrollment processes related to the Children's Special Health Care Services (CSHCS) program; or services provided to Fee-For-Service beneficiaries within the scope of this audit. Medicaid eligibility is determined by MDHHS's local offices and is generally audited as part of the annual State of Michigan Single Audit. We separately audited the CSHCS program (391-0724-15) and released our report in March 2016.

PERIOD

Our audit procedures, which included a preliminary survey, audit fieldwork, report preparation, analysis of agency responses, and quality assurance, generally covered October 1, 2013 through May 31, 2016.

METHODOLOGY

We conducted a preliminary survey of the MHP capitated rate setting, contracting, and benefit enrollment processes of CHCP to formulate a basis for defining our audit objectives and methodology. During our preliminary survey, we:

- Interviewed MDHHS staff from the following areas regarding their responsibilities related to CHCP:
    - Managed Care Plan Division - Oversees the competitive bid, contract monitoring, compliance review, and the auto-assignment algorithm calculation processes.
    - Customer Service Division - Oversees the MHP beneficiary enrollment process, monitors the enrollment broker, and compiles statistical enrollment data.

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

- Actuarial Division - Oversees the capitated rate setting process and reviews the reasonableness of the encounter claim data.
- Third Party Liability Division - Identifies possible third party coverage for Medicaid beneficiaries and communicates third party information to MHPs.
- Managed Care Data and System Support Section - Oversees the receipt of encounter claim data from MHPs and ensures the accuracy of the claim edits process.

- Interviewed MDHHS Office of Inspector General staff regarding their efforts to review the program integrity of the MHPs and encounter claim data.
- Interviewed DIFS staff regarding their process to verify managed care organizations' annual and quarterly financial reports.
- Reviewed applicable federal regulations and MDHHS's Medicaid Provider Manual, Medicaid State Plan, CHCP waiver applications, and appropriations acts.

OBJECTIVE #1

To assess the effectiveness of MDHHS's MHP capitated rate setting process.

To accomplish this objective, we:

- Reviewed MDHHS's actuarial contract.
- Reviewed and analyzed the actuary's capitated rate setting methodologies.
- Interviewed Rates and Encounter Data Section staff regarding the EQI and follow-up processes.
- Analyzed EQI reports, identified the net differences between encounter claim data contained in the EDW and data reported to the actuary, and reviewed MDHHS's reconciliation efforts for 11 MHP differences. Our sample was judgmentally selected based on the most significant differences for each MHP. Therefore, we could not project the results to the entire population.
- Obtained overpayment, pharmaceutical rebate, reinsurance reimbursement, and TPL reimbursement information for fiscal years 2014 and 2015 from the 13 contracted MHPs.
- Reviewed the reasonableness of the administrative cost allowance percentage included within the capitated rate

based on the MHPs' annual financial statements filed with DIFS.

- Reviewed MDHHS's compliance with the federal regulations that we considered to be most significant related to the establishment of capitated rates.

OBJECTIVE #2

To assess the sufficiency of MDHHS's contracting process for MHPs.

To accomplish this objective, we:

- Interviewed DTMB Procurement staff regarding their facilitation of the competitive bid and contract awarding processes.
- Interviewed MDHHS Managed Care Plan Division staff regarding the various MHPs' performance evaluations.
- Compared MHPs' performance ratings with the joint evaluation committee bid proposal evaluations.
- Reviewed the request for proposal, synopsis award summary, and award recommendation letter related to the 2015 competitive bid process.
- Reviewed MDHHS's compliance with the federal regulations that we considered to be the most significant related to contracting with managed care organizations.

OBJECTIVE #3

To assess the effectiveness of MDHHS's enrollment process for MHP beneficiaries.

To accomplish this objective, we:

- Visited the contracted vendors responsible for enrollment and mailing services and observed their processes for completing beneficiary enrollment, implementing the auto-assignment algorithm, and reporting statistical data to MDHHS.
- Interviewed MDHHS enrollment services staff who monitor the enrollment broker's contract compliance.
- Tested enrollment broker compliance with key contractual requirements.
- Reviewed MDHHS's compliance with the federal regulations that we considered to be the most critical regarding beneficiary enrollment.
- Tested the timeliness of enrollment of 41 Medicaid beneficiaries who were first eligible between October 1,

2013 and May 31, 2016. Our sample was randomly selected to eliminate any bias and to enable us to project the results to this population.

CONCLUSIONS

We base our conclusions on our audit efforts and any resulting material conditions* or reportable conditions.

When selecting activities or programs for audit, we direct our efforts based on risk and opportunities to improve State government operations. Consequently, we prepare our performance audit reports on an exception basis.

AGENCY RESPONSES

Our audit report contains 1 finding and 1 corresponding recommendation. MDHHS's preliminary response indicates that it partially agrees 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 at the end of our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100) require an audited agency to develop a plan to comply with the recommendations and submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

SUPPLEMENTAL INFORMATION

Our audit report includes supplemental information presented as Exhibits #1 and #2. Our audit was not directed toward expressing a conclusion on this information.

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

GLOSSARY OF ABBREVIATIONS AND TERMS

capitated rate	A per person, per month fee, or a one-time fee for certain covered events, paid under a system of reimbursement for managed care organizations. The fees are paid for each beneficiary assigned regardless of the number or cost of services provided.
CHCP	Comprehensive Health Care Program.
CSHCS	Children's Special Health Care Services.
DIFS	Department of Insurance and Financial Services.
DTMB	Department of Technology, Management, and Budget.
EDW	Enterprise Data Warehouse.
effectiveness	Success in achieving mission and goals.
encounter claim data	Detailed data about individual services provided by an MHP. The level of detail about each service reported is similar to that of a standard claim form.
enrollment broker	An individual or entity that performs choice counseling or enrollment activities or both.
EQI	encounter quality initiative.
Graduate Medical Education payments	Payments made to teaching hospitals for the purposes of funding graduate medical education within the State.
HMP	Healthy Michigan Plan.
Hospital Reimbursement Adjustment Program	A program developed to incentivize hospitals to contract with managed care health plans to align with the State's approved supplemental hospital payment program under the fee-for-service program and to ensure continued access by Medicaid beneficiaries to high-quality hospital care.

material condition	A matter that, in the auditor's judgment, is more severe than a reportable condition and 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.
MDHHS	Michigan Department of Health and Human Services.
MHP	Medicaid Health Plan.
OAG	Office of the Auditor General.
overpayment	Any amount received under the Medicaid program to which the provider of services, supplier, or person, after applicable reconciliation, is not entitled. Overpayments may result when a payment was inappropriate according to statute, regulation, or contract or when the factual basis on which payment was sought is later determined to be incorrect.
performance audit	An audit that provides findings or conclusions based on an evaluation of sufficient, appropriate evidence against criteria. Performance audits provide objective analysis to assist management and those charged with governance and oversight in using the information to improve program performance and operations, reduce costs, facilitate decision making by parties with responsibility to oversee or initiate corrective action, and contribute to public accountability.
pharmaceutical rebate	A rebate that is paid by pharmaceutical manufacturers to insurance companies for an established listing of preferred drugs that are utilized by their beneficiaries.
reinsurance reimbursement	A reimbursement system that protects insurance companies from very high claims and normally involves a third party paying part of an insurance company's claims when they pass a certain amount.
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.

Specialty Network Access Fee	A program developed to allow greater network access for Medicaid enrollees by encouraging physicians to accept Medicaid patients through payments that are higher than Medicaid fee levels.
third party liability (TPL) reimbursement	A payment from a third party to reimburse the MHP for part or all of the medical assistance furnished under Medicaid.

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