Office of the Auditor General
Performance Audit Report

Oversight and Encounter Claim Integrity of the Comprehensive Health Care Program

Michigan Department of Health and Human Services

May 2019

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

391-0702-17

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.

The auditor general may make investigations pertinent to the conduct of audits.

Article IV, Section 53 of the Michigan Constitution

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Report Summary

Performance Audit
Oversight and Encounter Claim Integrity of the Comprehensive Health Care Program (CHCP)
Michigan Department of Health and Human Services (MDHHS)

Report Number:
391-0702-17

Released:
May 2019

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. From October 1, 2014 through May 31, 2017, MDHHS's capitated rate payments totaled $19.3 billion for an annual average of 1.8 million Medicaid and HMP beneficiaries. During this same period, MHPs submitted approximately 230.6 million encounter claims representing medical services provided to MHP-enrolled beneficiaries.

Audit Objective	Conclusion
Objective #1: To assess the sufficiency of MDHHS's efforts to ensure that MHPs' encounter claim data met select Medicaid program criteria.	Sufficient, with exceptions

Findings Related to This Audit Objective	Material Condition	Reportable Condition	Agency Preliminary Response
Medical records were not provided or did not fully support 14% of the encounter claims reviewed, which may result in future capitated rate overpayments of up to $228.1 million annually (3.2% of annual capitated rate payments) (Finding #1).	X		Agrees
MDHHS Community Health Automated Medicaid Processing System (CHAMPS) edits did not identify or reject improper and duplicate encounter claims, which may result in future capitated rate overpayments of up to $87.8 million annually (1.2% of annual capitated rate payments) (Finding #2).	X		Agrees

Audit Objective			Conclusion
Objective #2: To evaluate the sufficiency of MDHHS's oversight efforts to ensure MHP-enrolled beneficiary access to medical care.			Sufficient, with exceptions
Findings Related to This Audit Objective	**Material Condition**	**Reportable Condition**	**Agency Preliminary Response**
MDHHS did not ensure that MHPs were sufficiently using the Benefits Monitoring Program to prevent overuse or misuse of medical services (Finding #3).		X	Agrees

Audit Objective			Conclusion
Objective #3: To assess the sufficiency of MDHHS's efforts to monitor MHPs' provider networks.			Sufficient
Findings Related to This Audit Objective	**Material Condition**	**Reportable Condition**	**Agency Preliminary Response**
See Finding #2, part b.	X		Agrees

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May 1, 2019

Mr. Robert Gordon, Director
Michigan Department of Health and Human Services
South Grand Building
Lansing, Michigan

Dear Mr. Gordon:

This is our performance audit report on the Oversight and Encounter Claim Integrity 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 preliminary responses to the recommendations 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 to submit it to the State Budget Director upon completion of an audit. Within 30 days of receipt, the Office of Internal Audit Services, State Budget Office, 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

ENCOUNTER CLAIM DATA COMPLIANCE WITH SELECT MEDICAID PROGRAM CRITERIA

BACKGROUND

The Michigan Department of Health and Human Services (MDHHS) contracted with 13 Medicaid Health Plans (MHPs) through December 31, 2015 and 11 beginning January 1, 2016. MDHHS pays contracted MHPs a monthly capitated rate* for each MHP-enrolled beneficiary. MHPs maintain a network of qualified medical providers throughout their respective service areas to provide covered medical services. MHPs are required to maintain a management information system to process and reimburse providers for medical claims on behalf of MHP-enrolled beneficiaries in accordance with Michigan's Medicaid Provider Manual and ensure that all encounter claim data* is complete and accurate. For capitated rate periods beginning after July 1, 2017, federal regulations require that MDHHS have procedures to ensure that encounter data submitted by MHPs is a complete and accurate representation of services provided.

MHPs periodically submit detailed encounter claim data into MDHHS's Community Health Automated Medicaid Processing System (CHAMPS) for medical services (encounters) provided to MHP-enrolled beneficiaries. CHAMPS subjects submitted encounter claim data to approximately 140 data quality edits prior to acceptance. Accepted encounter claim data is reported to MDHHS's contracted actuary, who uses the data to develop and certify the soundness of future capitated rates. 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.

MDHHS paid $19.3 billion in capitated rate payments to MHPs from October 1, 2014 through May 31, 2017, an average of $7.2 billion annually. MHPs submitted approximately 230.6 million professional, dental, pharmaceutical, and institutional (hospital and nursing facility) encounter claims for medical services provided on behalf of MHP-enrolled Medicaid and Healthy Michigan Plan (HMP) beneficiaries during the same period.

AUDIT OBJECTIVE

To assess the sufficiency of MDHHS's efforts to ensure that MHPs' encounter claim data met select Medicaid program criteria.

CONCLUSION

Sufficient, with exceptions.

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

FACTORS IMPACTING CONCLUSION

- Our review of 113 encounter claims associated with 91 medical providers and 101 MHP-enrolled beneficiaries noted:
    - All providers were licensed as of the encounter claim's date of service.
    - All procedure codes utilized were allowable and aligned reasonably with the claim's diagnosis code.
    - 97% of the beneficiaries were Medicaid eligible as of the encounter claim's date of service.
- Select nursing facility stays for MHP-enrolled beneficiaries were properly excluded from the capitated rate setting process used by MDHHS's actuary.
- Our match of encounter claim data with the Department of Corrections' incarceration records did not identify a significant number or amount of encounter claims with dates of service during an MHP-enrolled beneficiary's period of incarceration.
- We confirmed that MDHHS did not have a process to verify the accuracy of or to reconcile overpayment* data reported by the MHPs with the detailed encounter claim data (previously reported in Finding #1, part a., of our performance audit* of MDHHS Capitated Rate Setting, Contracting, and Beneficiary Enrollment Processes of the Comprehensive Health Care Program, issued in April 2017).
- Material conditions* related to the need to monitor MHP encounter claim data and support (Finding #1) and to activate or develop certain CHAMPS edits (Finding #2).

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

FINDING #1

MDHHS needs to monitor MHP encounter claim data and supporting medical records.

MDHHS did not monitor MHP encounter claim data to help ensure that claims were supported by medical records and accurately represented medical services provided, which may result in future excess capitated rate payments of up to $228.1 million annually.

MDHHS's contracts require MHPs to ensure that their providers maintain medical records of all medical services received by MHP-enrolled beneficiaries. Our review of medical records for 113 encounter claims noted:

a. For 7 (6%) encounter claims, totaling $111, neither the billing provider nor the associated MHP provided supporting medical records.

Medical records were not provided or did not fully support 14% of encounter claims reviewed.

b. For 9 (8%) encounter claims, totaling $343, the medical records did not support the medical provider identified on the encounter claim, potentially circumventing MDHHS provider eligibility edits. Although our follow-up determined that the medical providers identified on the medical records were all eligible providers as of the date of service, the risk of ineligible providers still exists.

MDHHS informed us that MHPs are responsible for verifying that encounter claims are adequately supported by medical records and for ensuring that claim data is accurate. However, federal regulation revisions effective shortly after the end of our audit period require that MDHHS have procedures to ensure that encounter data submitted by MHPs is a complete and accurate representation of services provided for future periods.

We consider this finding to be a material condition based on the significance of our estimate that the unsupported and not fully supported claims may result in future excess annual capitated rate payments of up to $228.1 million (approximately $78.8 million General Fund/general purpose), 3.2% of annual capitated rate payments.

RECOMMENDATION

We recommend that MDHHS implement a process to help ensure that MHP encounter claims are properly supported by medical records and accurately represent the medical services provided.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that adequate processes need to be in place to ensure encounter claims are properly supported by medical records. MDHHS will work with the MHP to ensure that their monitoring protocols adequately address the completeness and accuracy of services provided. MDHHS will review the MHP's monitoring processes and subsequent results as part of its scheduled onsite compliance reviews.

Although the OAG utilized a methodology to determine the impact on future capitation rates, MDHHS believes that the actual impact of the $111 noted in the finding would not significantly affect future rate setting because of the complex actuarial calculations used in determining the capitated rates. MDHHS's contracted actuary is one of the leading actuaries in the health care industry. They have a robust data integrity process, which requires extensive data quality and validation processes to ensure accuracy of data for rate setting purposes.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE*

Although MDHHS states that the actuary's robust data integrity process includes extensive data quality and validation processes, the actuary's capitation rate certification report did not address, and MDHHS did not provide other documentation to support, that the actuary's process accounted for encounter claims that were not supported by medical records.

We maintain that we have reasonably estimated the potential impact on future payments. Therefore, the finding stands as written.

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

FINDING #2

Activation and development of certain CHAMPS edits needed.

MDHHS had not activated or developed certain CHAMPS edits that would have identified and rejected improper encounter claims and probable duplicate encounter claims, which may result in future excess capitated rate payments of up to $87.8 million annually.

MDHHS's contracts require MHPs to verify the accuracy and completeness of encounter claim data and prohibit MHPs from reimbursing any services ordered, prescribed, or rendered by a provider who has been sanctioned by MDHHS, the Department of Licensing and Regulatory Affairs (LARA), or the U.S. Department of Health and Human Services for various exclusion criteria, such as misdemeanor convictions related to health care fraud or unlawful distribution of controlled substances.

Our review of MDHHS's CHAMPS encounter claim edits and analysis of encounter claim data submitted by MHPs for dates of service between October 1, 2014 and May 31, 2017 noted:

CHAMPS edits did not reject $330.3 million of probable duplicate encounter claims.

a. MDHHS had not set CHAMPS edits to reject:

   - 9.2 million claims, totaling $330.3 million, identified as probable duplicates.

   - 1,406 claims, totaling $303,694, identified as having inappropriate diagnosis codes based on the beneficiary's age or gender.

   MDHHS had not evaluated the appropriateness of the encounter claims identified by these edits. Instead, MDHHS accepted and provided these claims to the actuary for use in developing future capitated rates.

b. MDHHS had not established CHAMPS edits to identify and reject other encounter claims, as follows:

   - 8,196 claims, totaling $463,283, related to services provided by 6 medical providers who had been sanctioned by MDHHS or LARA at least 30 days prior to the claim's date of service.

   - 2,721 claims, totaling $385,952, related to services provided by 21 medical providers who were deceased prior to the claim's date of service.

   - 719 claims, totaling $31,303, related to services provided to 12 beneficiaries who were deceased prior to the claim's date of service.

MDHHS indicated that it was in the process of testing applicable edits prior to activation and, in the interim, relied on its actuary to use a data validation process to identify and remove potential data issues, including duplicate data. However, MDHHS did not provide us with documentation to support the actuary's validation process or whether the actuary identified duplicate claims.

We consider this finding to be a material condition based on the significance of our estimate that the improper and probable duplicate claims may result in future excess annual capitated rate payments of up to $87.8 million (approximately $30.3 million General Fund/general purpose), 1.2% of annual capitated rate payments.

RECOMMENDATION

We recommend that MDHHS activate and develop edits to identify and reject improper and duplicate encounter claims to help ensure the accuracy of capitation rates and the amount that the State pays to MHPs.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees with this finding. During the audit period the duplicate edit had not yet been set to reject; however, MDHHS does not believe this had a material impact on health plan rates as the contracted actuary has data validation and quality adjustments in place during the rate setting process. The actuary has a robust data integrity process which requires extensive data quality and validation procedures, including identifying relational data integrity issues as well as review for duplicative data.

In addition, MDHHS is currently testing and scheduling various CHAMPS encounter claim edits for implementation over the next fiscal year to coincide with upcoming changes to managed care policies. These edits will identify and reject certain encounter claims to further enhance encounter claim data accuracy.

AUDITOR'S COMMENTS TO AGENCY PRELIMINARY RESPONSE

The actuary's capitation rate certification report was comprehensive and identified the steps taken to validate the completeness, accuracy, and consistency of the data. However, the report did not specifically mention duplicate data, and in subsequent follow-up, the actuary did not identify the amount of duplicate encounters that it excluded during our audit period.

OVERSIGHT OF BENEFICIARY ACCESS TO MEDICAL CARE

BACKGROUND

According to the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, access to comprehensive, quality health care services is important for promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death, and achieving health equality for all Americans. Federal law requires MDHHS to ensure that medical services are available and accessible to beneficiaries enrolled in an MHP.

MDHHS's contracts with MHPs stipulate that MHPs must:

- Ensure that enrollees have an ongoing source of primary care appropriate to the enrollee's needs and that covered services are administered or arranged for by a formally designated primary care provider.
- Consider the geographic location of providers and enrollees, including distance, travel time, and available means of transportation, and whether the provider's location is accessible to enrollees with physical or developmental disabilities.
- Ensure that primary care provider services and hospital services are available within 30 miles or 30 minutes of travel time from the enrollee's home unless MDHHS grants an exception.
- Have policies and procedures for resolution of member grievances and appeals and advise enrollees of their rights to a fair hearing with the State.
- Participate in MDHHS's Benefits Monitoring Program (BMP) to identify and monitor beneficiaries who may be overusing and/or misusing their Medicaid services and benefits.
- Ensure that certain types of medical services are exempt from prior authorization requirements.

MDHHS's monitoring of MHPs' compliance with access to care contract requirements includes:

- Conducting annual managed care compliance reviews based on selected contract criteria in 6 areas: administrative requirements, which include a review of MHPs' policies for electing enrollee board members; provider requirements, which include a review of MHPs' contracts with their providers; member requirements, which include a review of MHPs' process for member grievances and appeal resolution; quality requirements, which include a review of MHPs' performance

improvement projects; management information system requirements, which include a review of MHPs' procedures to electronically process member enrollment and disenrollment; and fraud, waste, and abuse requirements, which include a review of MHPs' efforts to identify fraud, waste, or abuse.

- Quarterly monitoring of MHP performance relating to 26 performance measures aimed at improving the quality and efficiency of health care services provided to MHP-enrolled beneficiaries.

- Withholding 1% of MHPs' capitated payments for redistribution as an annual bonus based on MHPs' ability to meet contractually established performance standards.

AUDIT OBJECTIVE

To evaluate the sufficiency of MDHHS's oversight efforts to ensure MHP-enrolled beneficiary access to medical care.

CONCLUSION

Sufficient, with exceptions.

FACTORS IMPACTING CONCLUSION

- MDHHS ensured that the 38 MHP enrollee* grievances that we selected for review were properly addressed.

- MDHHS's performance bonus review was adequately supported for the 7 MHPs and the 12 criteria that we reviewed.

- We did not identify any services contractually prohibited from prior authorization requirements in MHPs' lists of procedure codes needing prior authorizations.

- MDHHS's compliance monitoring tool was completed and adequately supported by documentation that we obtained from MHPs for 6 of 7 MHPs and 3 criteria that we reviewed.

- Reportable condition* related to the need to improve BMP oversight (Finding #3).

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

FINDING #3

Oversight of BMP needs improvement.

MDHHS could improve its oversight of the Benefits Monitoring Program (BMP) to help ensure that MHP-enrolled beneficiaries with a higher risk of overusing medical services are properly identified, evaluated, and monitored.

Federal regulations require MDHHS to implement a Statewide utilization control program that safeguards against unnecessary or inappropriate use of Medicaid services. On a quarterly basis, MDHHS identifies MHP-enrolled beneficiaries who appear to overuse and/or misuse Medicaid benefits based on criteria such as having more than three emergency department visits in one fiscal quarter or obtaining more than five prescriptions for specific high-risk drugs in one quarter. MDHHS requires MHPs to evaluate these candidates to determine if they should be enrolled in BMP and to monitor enrollees' utilization patterns for a minimum of 24 months. Possible interventions include assigning a beneficiary to a specific primary care provider or pharmacy or preventing a beneficiary from filling or refilling certain medications until 95% of the medication would have been consumed. Identified candidates who are not evaluated and who do not meet BMP candidate criteria will drop off the candidate list the following quarter.

Our review of MDHHS's oversight of BMP from October 1, 2014 through September 30, 2017 noted:

a. MDHHS could improve its identification of BMP candidates and its metrics used to monitor MHPs' related responsibilities. Specifically, we noted:

   - MDHHS did not track identified candidates for consecutive or subsequent quarters. MDHHS prioritizes the candidate list based on how many BMP criteria a candidate has met in the most recent quarter. However, knowing how often candidates meet the various BMP criteria over a period of time may also help MHPs identify higher risk candidates.

   - MDHHS did not track the number of candidates identified or evaluated for BMP enrollment, by MHP, by quarter.

     We reviewed 29 MHP-enrolled beneficiaries who met the emergency department visit BMP criteria during our audit period. We noted that MHPs evaluated only 9 (31%) of these candidates for BMP enrollment. Two of the 9 candidates were subsequently enrolled in BMP. The remaining 7 candidates were assessed as low risk of overuse or misuse. Although we do not expect the MHPs to evaluate 100% of BMP candidates, tracking the number of candidates identified and evaluated may help MDHHS determine whether MHPs' efforts to enroll BMP candidates are sufficient.

MDHHS informed us that system limitations prevent it from including prior activity in the current prioritization process.

b. MDHHS did not ensure that MHPs initiated and enforced proper interventions for their BMP enrollees.

   We reviewed 50 MHP-enrolled beneficiaries with 40 or more emergency department visits during any quarter within our audit period and determined that MHPs enrolled 29 of these beneficiaries into BMP. However, we noted that MHPs did not properly enforce BMP interventions for 5 (17%) of the 29 beneficiaries:

   - For 4 beneficiaries who were assigned to a specific pharmacy for high-risk drugs, MHPs submitted 54 encounters, totaling $378, with dates of services subsequent to the beneficiaries' BMP enrollment. These encounters related to 21 pharmacies that were not the beneficiaries' assigned pharmacy.

   - For the remaining beneficiary, MHP submitted 2 encounters, totaling $7, for high-risk drugs that were filled prior to the beneficiary's 95% refill tolerance limit.

   MDHHS informed us that it relies on MHPs to monitor their own BMP candidates and enrollees. However, according to the federal utilization control program requirement, MDHHS is ultimately responsible for BMP.

c. MDHHS did not ensure that MHPs monitored their BMP enrollees for at least 24 months. One MHP informed us that it removed enrollees after 12 months. We verified that this MHP had removed 5 of its enrollees prior to the 24 month requirement, including 1 enrollee who was removed after 3 months and another enrollee who was removed after 4 months, both without documented justification for the removal. We also verified that these 5 beneficiaries were still Medicaid eligible and enrolled with MHP several months after being removed from BMP.

   MDHHS informed us that it does not have a policy to spot check BMP enrollees who are removed prior to 24 months and that it periodically identifies inappropriate early removals through its review of eligible candidates identified in subsequent quarters.

RECOMMENDATION

We recommend that MDHHS improve its processes for identifying BMP candidates and ensuring that BMP enrollees are properly evaluated and monitored.

AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees with the finding. MDHHS has added additional data to the BMP process to enhance the overall BMP system. MDHHS and the MHPs will use this data to enhance its tracking, reviewing, and monitoring of BMP enrollees.

The Managed Care Plan Division will work with the BMP staff to monitor MHPs through the compliance review process to ensure that they initiated and enforced proper interventions for their BMP enrollees. MDHHS will work with the MHPs and require corrective actions from those MHPs who have not enforced interventions. MDHHS has also created a report to monitor beneficiaries who have been disenrolled prior to the 24-month enrollment requirement to monitor that they were disenrolled for appropriate reasons.

MONITORING OF MHPs' PROVIDER NETWORKS

BACKGROUND

MHPs must maintain a network of Medicaid-eligible providers throughout their respective service areas for the provision of covered medical services to MHP enrollees. MHPs reimburse network providers for services provided to the MHP's respective enrollees. Medicaid provider eligibility criteria includes being properly licensed; having a valid address; and not being federally sanctioned, incarcerated, or convicted of certain criminal activity.

To monitor MHP network providers' compliance with Medicaid eligibility requirements, MDHHS matches all MHP network providers who are enrolled in CHAMPS with the Michigan Department of State Police's criminal history database, LARA's State license database, federal and State sanctioned provider lists, and MDHHS's vital records database. MDHHS also assigns risk levels to MHP network providers enrolled in CHAMPS and conducts site visits for high-risk and moderate-risk providers every 3 or 5 years, respectively, to reassess their risk level. For MHP network providers who are not enrolled in CHAMPS, MDHHS requires MHPs to ensure that network providers are eligible to provide Medicaid services in accordance with applicable federal regulations.

AUDIT OBJECTIVE

To assess the sufficiency of MDHHS's efforts to monitor the MHPs' provider networks*.

CONCLUSION

Sufficient.

FACTORS IMPACTING CONCLUSION

- Our review of 35 providers did not identify any providers with an invalid address.
- Our review of 113 encounter claims did not identify any non-licensed providers as of the claim's date of service.
- We did not identify any network providers who were incarcerated as of the encounter claims' date of service.
- MDHHS ensured that all MHP network providers who were enrolled in CHAMPS did not have criminal convictions precluding them from being Medicaid eligible.
- MDHHS documented that it had completed timely site visits for the 25 high-risk providers and the 718 moderate-risk providers that we reviewed.

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

- Material condition that included exceptions related to providers who were sanctioned as of the encounter claim's date of service and who were deceased prior to the encounter claim's date of service (Finding #2, part b.).

SUPPLEMENTAL INFORMATION

UNAUDITED

OVERSIGHT AND ENCOUNTER CLAIM INTEGRITY OF THE COMPREHENSIVE HEALTH CARE PROGRAM
Michigan Department of Health and Human Services

Number of Medicaid and Healthy Michigan Plan Beneficiaries by Medicaid Health Plan
May 2017

Medicaid Health Plan	Number of Beneficiaries	Percentage of Total Beneficiaries
Meridian Health Plan of Michigan	507,099	28%
Molina Healthcare of Michigan	369,027	20%
UnitedHealthcare Community Plan, Inc.	261,364	14%
McLaren Health Plan	194,724	11%
Blue Cross Complete of MI	191,587	11%
Priority Health Choice Inc.	127,056	7%
Total Health Care	54,749	3%
Upper Peninsula Health Plan	45,768	3%
Aetna Better Health of MI	45,119	2%
Harbor Health Plan	9,474	<1%
HAP Midwest Health Plan	2,694	<1%
Total beneficiaries	1,808,661	

Source: The OAG prepared this supplemental information using data obtained from MDHHS's publicly available Medicaid and Healthy Michigan Plan Health Plan Enrollment Report.

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.
- Funded through Title XIX and the State's General Fund.
- Administered by MDHHS.

MDHHS contracts with MHPs to provide health care and management services to the Medicaid and HMP beneficiaries who chose or are required to be covered under an MHP. During May 2017, approximately 1.8 million Medicaid and HMP beneficiaries were enrolled in an MHP (see supplemental information).

Through its contracts, MDHHS requires MHPs to comply with the Michigan Medicaid Provider Manual. The MDHHS Managed Care Plan Division, with its 21 staff, is responsible for contract oversight and the integrity of encounter claim data. In addition, MDHHS's Office of Inspector General is responsible for contract oversight related to the MHPs' program integrity activities, and MDHHS's Program Review Division is responsible for contract oversight related to BMP.

From October 1, 2014 through May 31, 2017, MDHHS received 230.6 million encounter claims from MHPs and paid $19.3 billion, approximately $7.2 billion annually, in capitated rate payments to MHPs.

AUDIT SCOPE, METHODOLOGY, AND OTHER INFORMATION

AUDIT SCOPE

To examine the records and procedures related to MDHHS's efforts pertaining to MHP encounter claim data, oversight of MHP-enrolled beneficiary access to medical care, and monitoring of MHP provider networks. 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 findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We did not include medical services provided to fee-for-service beneficiaries within the scope of this audit. Also, we did not include the verification of Medicaid beneficiary eligibility or the verification of Medicaid provider licensing requirements within the scope of this audit because these elements are determined by MDHHS local offices and LARA, respectively. Medicaid beneficiary eligibility is generally audited as part of the annual State of Michigan single audit. We separately audited the MHP capitated rate setting, contracting, and beneficiary enrollment processes of CHCP (391-0701-16) and released our report in April 2017.

PERIOD

Our audit procedures, which included a preliminary survey, audit fieldwork, report preparation, analysis of agency responses, and quality assurance, generally covered October 1, 2014 through May 31, 2017.

METHODOLOGY

We conducted a preliminary survey of CHCP's efforts pertaining to MHP encounter claim data, oversight of MHP-enrolled beneficiary access to medical care, and monitoring of MHP provider networks to formulate a basis for defining our audit objectives and methodology. During our preliminary survey, we:

- Interviewed MDHHS's Managed Care Plan Division staff regarding their responsibilities related to overseeing MHP contract requirements, completing compliance reviews, reviewing encounter claim data, and monitoring MHP performance metrics and MHP-enrolled beneficiary complaints.

- Interviewed MDHHS's Office of Inspector General staff regarding their review of quarterly MHP program integrity reports.

- Reviewed 1 judgmentally selected quarterly program integrity report for 5 randomly selected MHPs to understand MDHHS's process for monitoring program requirements. Our selections were made from the 11 MHPs and 5 quarters starting January 2016 through March 2017.

- Reviewed applicable federal regulations, MDHHS's Medicaid Provider Manual, and MHP contract requirements.

- Summarized MHP submitted encounter claims with zero paid amounts to review the frequency of zero paid claims by MHP, by procedure code, and by billing and rendering provider to identify anomalies.

- Reviewed the recent Michigan Focused Program Integrity Review report issued by the Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services, for recommendations related to MDHHS's MHP program integrity efforts and MDHHS's corresponding corrective action.

- Reviewed CMS's Medicaid and Child Managed Care Final Rule (CMS 2390-F) and applicable implementation dates.

- Reviewed other state audit reports related to managed care oversight, monitoring, and encounter claim integrity.

OBJECTIVE #1

To assess the sufficiency of MDHHS's efforts to ensure that MHPs' encounter claim data met select Medicaid program criteria.

To accomplish this objective, we:

- Randomly selected 101 beneficiaries from an average annual population of 1.8 million that were enrolled in an MHP during the period October 1, 2014 through May 31, 2017. We identified 31,396 encounter claims associated with the 101 MHP-enrolled beneficiaries and randomly selected 113 of the encounter claims. We conducted site visits of, or otherwise requested supporting documentation from, the 91 medical providers associated with the 113 encounter claims. We reviewed the provider supplied supporting documentation, other insurance coverage, MDHHS beneficiary eligibility records, and LARA licensing records to verify:

    - Medical records existed and properly supported the encounter claim.

- The procedure code was allowable in accordance with the Michigan Medicaid Provider Manual and reasonably aligned with the diagnosis code.

- Other insurance coverage was accounted for in submitted encounter claims, as applicable.

- The beneficiary was eligible in accordance with MDHHS's eligibility records to receive Medicaid services at the encounter claim's date of service.

- The medical provider was licensed in accordance with LARA's records as of the encounter claim's date of service.

- Reviewed MHP encounter claim processing edit descriptions to determine if select edits existed. We also compared MDHHS managed care encounter claim edits with MDHHS fee-for-service claim* edits to determine if select edits existed and if the encounter claim edit dispositions, such as accept or reject, were appropriate.

- Matched MHP-enrolled beneficiaries, who had encounter claims during the audit period, with MDHHS's death records to identify encounters submitted for dates of service after a beneficiary's date of death. Also, we reviewed 43 of the 1,721 beneficiaries identified by the match to verify the accuracy and reliability of MDHHS's death records.

- Matched MHP-enrolled beneficiaries, who had encounter claims during the audit period, with the Department of Corrections' incarceration records to identify encounter claims submitted with dates of service during a beneficiary's period of incarceration.

- Matched MHP-enrolled beneficiaries, who had encounter claims during the audit period, with nursing facility records to identify encounter claims submitted with dates of service during a period matching the nursing facility stay.

Our random samples were selected to eliminate bias and enable us to project the results to the respective populations.

OBJECTIVE #2

To evaluate the sufficiency of MDHHS's oversight efforts to ensure MHP-enrolled beneficiary access to medical care.

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

To accomplish this objective, we:

- Reviewed documentation obtained from 7 randomly selected MHPs, 4 from the 13 MHPs for fiscal year 2015 and 3 from the 11 MHPs for fiscal year 2016, to verify whether they had met 3 of 9 judgmentally selected member related compliance monitoring tool criteria. We judgmentally selected the criteria based on their relevance to access to care and underutilization.

- Reviewed 38 randomly selected MHP-enrolled beneficiary complaints from the 2,233 complaints related to access to care and covered services received from October 2014 through May 2017 to determine whether they were properly addressed by either MDHHS or its contracted vendor.

- Reviewed documentation obtained from 7 randomly selected MHPs, 4 from the 13 MHPs for fiscal year 2015 and 3 from the 11 MHPs for fiscal year 2016, to verify whether the MHP had met 12 of 66 judgmentally selected performance bonus criteria as indicated in MDHHS's fiscal year 2015 and 2016 performance reviews. We judgmentally selected the criteria based on risk.

- Reviewed each contracted MHP's list of procedure codes requiring prior authorizations for contract compliance, as related to family planning services, emergency services, obstetrical and prenatal care services, and tobacco cessation services.

- Reviewed BMP records for:

    - 29 randomly selected MHP-enrolled beneficiaries from the 22,592 beneficiaries who met the emergency department visit BMP criteria during the period July 1, 2017 through September 30, 2017 to determine if MHPs had evaluated the beneficiaries for BMP enrollment.

    - 50 judgmentally selected MHP-enrolled beneficiaries from the 54 beneficiaries with 40 or more emergency department visits during any quarter during our audit period to determine if the beneficiaries were enrolled in BMP and, if enrolled, to determine whether the MHPs had implemented the appropriate interventions to reduce overuse or misuse of services.

Our random samples were selected to eliminate bias and enable us to project the results to the respective populations.

OBJECTIVE #3

To assess the sufficiency of MDHHS's efforts to monitor the MHPs' provider networks.

To accomplish this objective, we:

- Identified the number of MHP network providers who were not enrolled in CHAMPS as of September 2017 and, therefore, not subjected to MDHHS's periodic data matches.
- Reviewed 113 encounter claims to verify that the providers were licensed according to LARA's records (see first bullet point under the methodology for Objective #1 for sample design, population, and period).
- Reviewed 35 randomly selected MHP network provider addresses from the 16,955 potentially invalid addresses to ensure that the address represented a physical location.
- Matched all MHP network providers who were enrolled in CHAMPS with the Department of Corrections' incarceration records, MDHHS's death records, and the Michigan Department of State Police's criminal records database to identify whether encounter claims with dates of service during the audit period included providers who were incarcerated, were deceased, or had criminal records matching MDHHS exclusion criteria.
- Matched all MHP network providers with the federal and State sanctioned providers list to identify whether encounter claims with dates of service during the audit period included sanctioned providers.
- Determined whether MDHHS had documented completed site visits in accordance with its policy for 743 of the 3,097 MHP network providers who were enrolled in CHAMPS and who were considered high-risk or moderate-risk providers. We reviewed all 718 moderate-risk providers and randomly selected 25 of the 2,379 high-risk providers.

Our random samples were selected to eliminate bias and enable us to project the results to the respective populations.

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 3 findings and 3 corresponding recommendations. MDHHS's preliminary response indicates that it agrees with all of the recommendations.

The agency preliminary response that follows each recommendation in our report was taken from the agency's written comments and oral discussion at the end of our 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 to submit it to the State Budget Director upon completion of an audit. Within 30 days of receipt, the Office of Internal Audit Services, State Budget Office, 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 a summary of the number of Medicaid and HMP beneficiaries presented as supplemental information. Our audit was not directed toward expressing a conclusion on this information.

GLOSSARY OF ABBREVIATIONS AND TERMS

auditor's comments to the agency preliminary response	Government auditing standards require auditors to evaluate the validity of the audited entity's response when it is inconsistent or in conflict with the findings, conclusions, or recommendations. If the auditors disagree with the response, they should explain in the report their reasons for disagreement. Therefore, when this situation arises, the OAG includes auditor's comments to comply with this standard.
BMP	Benefits Monitoring Program.
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.
CHAMPS	Community Health Automated Medicaid Processing System.
CHCP	Comprehensive Health Care Program.
CMS	Centers for Medicare and Medicaid Services.
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.
fee-for-service claim	A claim submitted by medical providers for services rendered to Medicaid beneficiaries.
HMP	Healthy Michigan Plan.
LARA	Department of Licensing and Regulatory Affairs.
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. Our assessment of materiality is in relation to the respective audit objective.
MDHHS	Michigan Department of Health and Human Services.

MHP	Medicaid Health Plan.
MHP enrollee	A Medicaid beneficiary enrolled and receiving services via an MHP.
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.
provider network	Listing of the doctors, other health care providers, and hospitals that an MHP has contracted with to provide medical care to its enrollees. These providers are called "network providers" or "in-network providers."
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.

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