Office of the Auditor General
Follow-Up Report on Prior Audit Recommendations

Oversight and Encounter Claim Integrity of the Comprehensive Health Care Program

Michigan Department of Health and Human Services

September 2022

391-0702-17F

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

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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

Follow-Up Report
Oversight and Encounter Claim Integrity of the Comprehensive Health Care Program (CHCP)
Michigan Department of Health and Human Services (MDHHS)

Report Number:
391-0702-17F

Released:
September 2022

We conducted this follow-up to determine whether MDHHS had taken appropriate corrective measures in response to the two material conditions noted in our May 2019 audit report.

Prior Audit Information	Follow-Up Results		
	Conclusion	**Finding**	**Agency Preliminary Response**
Finding 1 - Material condition Monitoring of Medicaid Health Plan (MHP) encounter claim data and supporting medical records needed. Agency agreed.	Not complied	Material condition still exists. See Finding 1.	Agrees
Finding 2 - Material condition Activation and development of certain MDHHS Community Health Automated Medicaid Processing System (CHAMPS) edits needed. Agency agreed.	Complied	Not applicable	

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September 9, 2022

Ms. Elizabeth Hertel, Director
Michigan Department of Health and Human Services
South Grand Building
Lansing, Michigan

Dear Ms. Hertel:

This is our follow-up report on the two material conditions (Findings 1 and 2) and the corresponding recommendations reported in the performance audit of the Oversight and Encounter Claim Integrity of the Comprehensive Health Care Program, Michigan Department of Health and Human Services. That audit report was issued and distributed in May 2019. Additional copies are available on request or at audgen.michigan.gov.

Your agency provided the preliminary response to the follow-up recommendation included in this report. 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 Office 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 our follow-up. If you have any questions, please call me or Laura J. Hirst, CPA, Deputy Auditor General.

Sincerely,

Doug Ringler

Doug Ringler
Auditor General

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INTRODUCTION, PURPOSE OF FOLLOW-UP, AND PROGRAM DESCRIPTION

INTRODUCTION

This report contains the results of our follow-up of the two material conditions* (Findings 1 and 2) and the two corresponding recommendations reported in our performance audit* of the Oversight and Encounter Claim Integrity of the Comprehensive Health Care Program (CHCP), Michigan Department of Health and Human Services (MDHHS), issued in May 2019.

PURPOSE OF FOLLOW-UP

To determine whether MDHHS had taken appropriate corrective measures to address our corresponding recommendations.

PROGRAM DESCRIPTION

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 primarily through Title XIX, State General Fund, and State restricted funds.
- Administered by MDHHS.

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 May 2022, approximately 2.2 million Medicaid and HMP beneficiaries were enrolled in an MHP. The MDHHS Managed Care Plan Division, with its 20 staff, and the Rate and Encounter Data Section, with its 8 staff, are responsible for contract oversight and the integrity of encounter claim data*.

From June 1, 2021 through May 31, 2022, MDHHS's capitated rate* payments totaled $7.6 billion. As of June 8, 2022 and for dates of service during this same period, MHPs submitted approximately 81.9 million encounter claims representing medical services provided to MHP-enrolled beneficiaries.

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

PRIOR AUDIT FINDINGS AND RECOMMENDATIONS; AGENCY PLAN TO COMPLY; AND FOLLOW-UP CONCLUSIONS, RECOMMENDATION, AND AGENCY PRELIMINARY RESPONSE

FINDING 1

Audit Finding Classification: Material condition.

Summary of the May 2019 Finding:
MDHHS had not ensured MHP encounter claims accurately represented services provided. Specifically, neither the billing provider nor the associated MHP could provide the medical records that supported 14% of the encounter claims we reviewed.

Recommendation Reported in May 2019:
We recommended 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 PLAN TO COMPLY*

On September 18, 2019, MDHHS stated it would comply with the finding by October 1, 2019. MDHHS indicated it would enhance its compliance review process to ensure MHP's monitoring protocols adequately address the completeness and accuracy of services provided.

FOLLOW-UP CONCLUSION

Not complied. A material condition still exists.

Our follow-up noted MDHHS's efforts to address our recommendation focused on the MHP's policies and procedures instead of acknowledging MDHHS's responsibility under Title 42, Part 438, sections 242(d) and 602(e) of the *Code of Federal Regulations** to directly ensure encounter claims accurately represent medical services provided.

MDHHS indicated it had reviewed medical records associated with encounter claims during a one-time focus study of MHP contract compliance in 2020. However, MDHHS did not document which encounter claims it reviewed, how it selected the claims, what attributes it reviewed for the selected claims, or the results of its review.

Because we concluded MDHHS had not taken corrective action, we did not pursue testing of the encounter claims to the medical provider's records as conducted during the May 2019 audit.

FOLLOW-UP RECOMMENDATION

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

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

FOLLOW-UP AGENCY PRELIMINARY RESPONSE

MDHHS provided us with the following response:

MDHHS agrees that its processes to ensure encounter claims are properly supported needs to be enhanced. As the finding notes a targeted review of medical claims was conducted in 2020, however, not documented appropriately. MDHHS will further ameliorate in fiscal years 2023 and 2024 by adding the Encounter Data Validation (EDV) protocol to its contracts with their External Quality Review Organization (EQRO). The new EDV protocol includes an evaluation of the completeness and accuracy of MDHHS's encounters via a review of medical records. The EQRO will determine appropriate protocols for these reviews such as, medical record sampling, and obtaining and reviewing medical records utilizing clinical coders to ensure encounter codes are based on the diagnoses stated by the provider in the patient's medical record.

FINDING 2

Audit Finding Classification: Material condition.

Summary of the May 2019 Finding:
MDHHS had not activated or developed certain Community Health Automated Medicaid Processing System (CHAMPS) encounter claim edits. Specifically, MDHHS had not:

a. Set edits to reject claims identified as probable duplicates or as having inappropriate diagnosis codes based on the beneficiary's age or gender.

b. Established edits to identify and reject encounter claims related to services provided by medical providers who had been sanctioned or were deceased prior to the claim's date of service or services provided to beneficiaries who were deceased prior to the claim's date of service.

Recommendation Reported in May 2019:
We recommended 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 PLAN TO COMPLY

On September 18, 2019, MDHHS indicated it had:

- Developed, tested, and activated edits to reject potential duplicate encounter claims and claims where the beneficiary's date of death is before the date of service.

- Developed edits to reject encounter claims for providers with a date of death or sanction prior to the claim's date of service and planned to activate these edits on January 1, 2020.

- Developed and activated edits to identify encounter claims with inappropriate diagnosis codes. MDHHS planned to evaluate these edits for any needed improvements prior to setting the edits to reject the identified encounter claims.

FOLLOW-UP CONCLUSION

Complied.

Our follow-up noted MDHHS activated CHAMPS edits to reject encounter claims:

a. Identified as probable duplicates or as having inappropriate diagnosis codes based on the beneficiary's age or gender.

b. For medical providers with a date of death or sanction before the date of service and for beneficiaries with a date of death before the date of service.

FOLLOW-UP METHODOLOGY, PERIOD, AND AGENCY RESPONSES

METHODOLOGY

We reviewed MDHHS's corrective action plan and the follow-up report to our 2019 audit prepared by the Office of Internal Audit Services, State Budget Office, and interviewed MDHHS personnel. Also, for:

- Finding 1, we:
    - Reviewed the Fiscal Year 2021 MHP External Quality Review Technical Report, completed by Health Services Advisory Group, to determine whether it included an examination of medical records associated with MHP encounter claims.
    - Evaluated MDHHS's compliance review tool for fiscal years 2021 and 2022 to determine if MDHHS implemented process improvements, including a review of medical records, related to ensuring MHP encounter claims are properly supported and accurately represent the medical services provided.
    - Examined MDHHS's completed fiscal year 2021 and 2022 compliance reviews for three randomly selected MHPs to determine if MDHHS reviewed the MHP's policies and procedures regarding medical records being signed, dated, retained for 10 years, and compared with claims to confirm accuracy.
    - Evaluated a focus study, completed by MDHHS in October 2020, related to MHP contract compliance to determine if it included direct review by MDHHS of underlying medical records associated with MHP submitted encounter claims.
- Finding 2, we:
    - Reviewed CHAMPS encounter claim edit descriptions, as of June 3, 2022, to determine if MDHHS developed and/or activated applicable edits to identify and reject improper and duplicate encounter claims.
    - Analyzed the frequency at which applicable CHAMPS edits flagged encounter claims to verify if the edits remained active from June 1, 2021 through May 31, 2022.
    - Analyzed accepted MHP encounter claims with dates of service from June 1, 2021 through May 31, 2022 to determine whether MDHHS properly designed select CHAMPS edits and, as

necessary, appropriately reviewed claims flagged by these edits. Specifically, we:

- Reviewed 42 randomly selected potential duplicate claims to determine whether MDHHS's review process rejected or zeroed out the paid amount of the potential duplicate claim.
- Reviewed all claims with a potential inappropriate diagnosis code based on the beneficiary's age or gender to determine if the diagnosis code, although atypical, could still be appropriate.
- Matched all CHAMPS-enrolled MHP network providers with the federal and State sanctioned providers list to identify whether claims included sanctioned providers.
- Matched all CHAMPS-enrolled MHP network providers with MDHHS's death records to identify whether claims included deceased providers.
- Matched MHP-enrolled beneficiaries, who had claims during the period, with MDHHS's death records to identify claims submitted for dates of service after a beneficiary's date of death.

PERIOD

Our follow-up generally covered June 1, 2021 through May 31, 2022.

AGENCY RESPONSES

Our follow-up report contains 1 recommendation. MDHHS's preliminary response indicates it agrees with the recommendation.

The agency preliminary response to the follow-up 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 Office 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.

GLOSSARY OF ABBREVIATIONS AND TERMS

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 to submit the plan to the State Budget Office 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.
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.
Code of Federal Regulations	The codification of the general and permanent rules published by the departments and agencies of the federal government.
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.
HMP	Healthy Michigan Plan.
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.

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.

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