Legislative Audit Division

State of Montana

Report to the Legislature

December 1999

Limited Scope Review

Medicaid Partnership Plan

Medicaid Third Party Liability

Department of Public Health & Human Services

This report discusses procedures used by DPHHS and the Medicaid contractor to ensure Medicaid is the payer of last resort. Audit work confirmed Montana's MMIS has controls in place to ensure Medicaid is the payer of last resort. Recommendations contained in the report include:

- **Compliance with uniform accounting system and expenditure controls and collection of claims.**
- **Develop formal procedures to ensure second bills are sent.**
- **Analysis of process used for recovery of Medicaid dollars.**

Direct comments/inquiries to:
Legislative Audit Division
Room 135, State Capitol
PO Box 201705
Helena MT 59620-1705

98P-03

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LIMITED SCOPE REVIEW

This limited scope study was a joint project performed by performance audit staff and federal audit personnel to look for cost savings opportunities in the state's Medicaid system. Technical support from federal audit personnel was made available through the Medicaid Partnership Plan.

Legislative Audit Division
Room 135 State Capitol
PO Box 201705
Helena MT 59620-1705

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December 1999

The Legislative Audit Committee
of the Montana State Legislature:

This is our performance audit of the Department of Public Health and Human Services' Third Party Liability Unit.

This report contains recommendations concerning compliance with uniform accounting and expenditure controls and collection of claims, the development of formal billing procedures, and the importance for the department to analyze the recovery of Medicaid dollars to ensure maximum recovery of their collection efforts.

We thank the department personnel for their cooperation and assistance throughout the audit.

Respectfully submitted,

(Signature on File)

Scott A. Seacat
Legislative Auditor

Room 135, State Capitol Building, PO Box 201705 Helena MT 59620-1705
Phone (406) 444-3122 FAX (406) 444-9784 E-Mail lad@state.mt.us

Legislative Audit Division

Performance Audit

Medicaid Third Party Liability

Department of Public Health and Human Services

Members of the audit staff involved in this audit were Susan Jensen, Kris Wilkinson, and Mary Zednick.

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List of Figures & Tables

Appointed and Administrative Officials

Department of Public Health and Human Services	Laurie Ekanger, Director
	Denzel Davis, Administrator, Quality Assurance Division
	Erich Merdinger, Chief, Audit and Compliance Bureau

Introduction

The Social Security Act requires states to take all reasonable measures to identify legally responsible third parties and ensure they pay their legal obligation for medical services furnished to Medicaid recipients. Third parties include Medicare and health and accident insurers. Federal regulations also mandate Medicaid be the payer of last resort. This means all other available insurers, including Medicare, must be billed for payment before Medicaid pays. It is the responsibility of participating Medicaid health care providers to recover charges for medical services from liable third parties before billing Medicaid.

States are required to ensure a third party liability function is in place and is cost effective. DPHHS contracts with a private firm for the processing of Medicaid claims and for billing responsible third parties.

The Legislative Audit Committee requested a performance audit of the Third Party Liability (TPL) program as part of the Medicaid Partnership Plan. Montana's TPL program is located within the Department of Public Health and Human Services (DPHHS), under the direction of the Quality Assurance Division.

Objectives of this performance audit were to:

- Review and assess controls used to ensure Medicaid is the payer of last resort.
- Evaluate procedures used by the Medicaid contractor to record and follow-up on billings to liable third parties.
- Assess compliance with applicable sections of the Social Security Act.

Medicaid is the Payer of Last Resort

We evaluated medical claims for services provided to dual eligible recipients and medical claims for recipients with medical insurance. Overall, our evaluation of these claims found that the Montana Management Information System (MMIS) properly denied payment for medical services that were the responsibility of a third party and appropriately denied claims that were submitted for the same services, ensuring Medicaid is the payer of last resort.

Report Summary

Noncompliance with State Law and Policy

There are some instances when MMIS authorizes payment for claims, even though reimbursement from a third party is likely. This payment method is known as "pay and chase." Audit work found that DPHHS does not completely comply with state law or policy in regards to the recording and collection of third party pay and chase receivables. State law requires DPHHS input all necessary transactions to the accounting system established by the Department of Administration (section 17-1-102 (4), MCA). In addition, Title 17, chapter 4, part 1, Debt Collection Service outlines the appropriate disposition of collections. Furthermore, the Montana Operations Manual provides criteria for the recording of receivables and the "uncollectability" of revenues.

Audit work found neither the TPL program nor DPHHS Fiscal Support has policy for the recording and collection of pay and chase receivables. The Medicaid contractor is not required to report the status or disposition of outstanding or past due receivables to TPL or Fiscal Bureau. DPHHS does not transfer past due pay and chase collections to the Department of Revenue. In addition, all pay and chase uncollected receivables are deleted from the Third Party Recovery and Claims System (TRACS) after 12 months. *DPHHS should establish policies to ensure compliance with statute requiring the recording of accounts receivable and disposition of uncollectible revenue*.

Improvements are Needed for Recovery of Medicaid Pay and Chase

MMIS creates monthly bills for recovery of Medicaid pay and chase dollars. Contractor staff send two bills, the initial bill approximately one month after the medical service is provided and a second bill 90 to 120 days after the first.

Audit work found the following concerns with the recovery of pay and chase dollars:

- There are no formal controls to ensure second bills are sent on a consistent basis. The contractor's system does not automatically generate second bills.
- Outside of a periodic manual review of the accounts, there are no formal procedures established to determine when bills are due.

- The department does not complete periodic analysis of the contractor's pay and chase recovery process to determine if the process maximizes collection efforts.

Overall, the department should develop a formal process for the recording and recovery of Medicaid dollars. More effective tracking can provide an accurate measurement of outcomes and improve the effectiveness of the recovery methods used. *The department should require the Medicaid contractor develop formal procedures to ensure second bills are sent out in a timely, consistent manner. The department should also complete an analysis of the recovery of Medicaid dollars to determine if the procedures used for recovery maximize their collection efforts.*

Chapter I - Introduction

Introduction

The Social Security Act requires states to take all reasonable measures to identify legally responsible third parties and ensure they pay their legal obligation for medical services furnished to Medicaid recipients. Medicaid is a joint federal/state program that provides medical aid for individuals with limited income and resources. Third parties include Medicare and health and accident insurers.

Federal regulations mandate Medicaid be the payer of last resort. This means all other available insurers, including Medicare, must be billed for payment before Medicaid pays. Medicare is a federal program designed to subsidize the medical care of the aged.

Federal law requires Montana to have a Third Party Liability (TPL) program in place and ensure it is cost-effective. Montana's TPL program is located within the Department of Public Health and Human Services (DPHHS), under the direction of the Quality Assurance Division.

The Legislative Audit Committee requested a performance audit of the Third Party Liability program as part of the Medicaid Partnership Plan. The Partnership Plan outlines suggested joint federal and state audits of Medicaid programs that saved money in other states. This audit was conducted in cooperation with federal auditors who provided technical support. Copies of this report are transmitted to the federal Department of Health and Human Services, Office of the Inspector General. The Inspector General transmits the report to the administrator of the federal Health Care Financing Administration (HCFA).

Audit Objectives

Objectives of this performance audit were to:

- Review and assess controls used to ensure Medicaid is the payer of last resort.
- Evaluate procedures used by the Medicaid contractor to record and follow-up on billings to liable third parties.
- Assess compliance with applicable sections of the Social Security Act.

Chapter I - Introduction

Audit Scope and Methodology

DPHHS contracts with a private firm that processes Medicaid claims and bills responsible third parties. The computer system used by the firm is called Montana Medicaid Management Information System (MMIS).

We interviewed DPHHS and contractor staff associated with Montana's third party program to gain an understanding of the third party processes and evaluate third party tasks completed. Audit work included a review of the contractor's procedures used for processing Medicaid claims with an identified third party and the process used by the contractor for billing and recovery of Medicaid dollars from third parties.

We accessed MMIS to test two samples of claims submitted by providers. These samples allowed us to evaluate MMIS claim processing controls to ensure Medicaid is the payer of last resort. The first was a statistical sample of services provided to clients eligible for both Medicaid and Medicare (dual eligible). The Office of the Inspector General (OIG) provided a list of medical services paid by Medicare for Montana dual eligible recipients.

We reviewed a sample of 104 of 24,387 medical services provided to dual eligible recipients during the period June 1, 1996, through December 31, 1996. Providers have up to one year to submit claims for payment from Medicare. At the time OIG selected the services, 1996 was the most recent year of claims available. The services were reviewed to verify the amount paid by Medicare and to confirm if Medicaid paid or denied the medical services.

The second sample reviewed was of claims for Medicaid recipients with group health insurance coverage. We tested all claims of 41 of 260 recipients for the time period of December 1, 1998, through May 31, 1999. This sample was reviewed to ensure MMIS did not pay claims that were the responsibility of a third party.

We also tested contractor procedures for billing and recovering third party claims paid by MMIS. There are instances when MMIS authorizes certain medical claims, then bills a liable third party. This process is called "pay and chase". We assessed the timeliness

for sending bills. In addition, we evaluated the procedures used for monitoring and collecting receivables.

We requested and reviewed payment denial documentation submitted by third parties to ensure the contractor received and verified the explanation of denials prior to submission of claims through the Medicaid process.

This audit was completed in accordance with government auditing standards for performance audits.

This report does not address all management control issues identified during audit work. Other findings from this audit are included in the Audit and Compliance Bureau Report, 99P-03.

Compliance

We found DPHHS is generally in compliance with regulatory requirements related to TPL. Non-compliance with some of the general administration and debt collection statute section was identified and is addressed in Chapter III.

Disclosure

Our review identified that DPHHS was not in full compliance with Section 1906 of Title XIX of the Social Security Act (the act). The act requires Medicaid agencies to pay the premiums, deductibles, and coinsurance of Medicaid eligible recipients as required by the act.

According to the Denver regional HCFA office, most states are not in full compliance with Section 1906. HCFA staff said Montana could continue with its current procedures of not paying deductibles and co-insurance by operating under Section 1905 of the act. Section 1905 would allow Montana to use Medicaid funds to pay Medicaid recipients' insurance and continue to not pay deductibles and co-insurance.

We informed DPHHS management of this non-compliance issue during the audit. The department submitted an amendment to the State Plan, effective January 1999, approved by HCFA March 1999. The department also initiated repeal of applicable rules July 1999. Final adoption of the repeal was completed September 1999.

DPHHS is now operating under Section 1905 of the Social Security Act. As a result of these changes, individuals are now no longer mandated to enroll in available insurance policies to maintain Medicaid eligibility.

Report Organization

This report is presented in three chapters. Chapter I defines why and how audit work was completed. Chapter II provides third party background information. Chapter III addresses our review of MMIS claim processing and the procedures used by the contractor for the recovery of Medicaid dollars, and our evaluation of the department's compliance with general administration and debt collection statute.

Chapter II - Background

Introduction

States are required to ensure a third party liability function is in place and is cost-effective. A third party liability is the legal obligation of other agencies (including Medicare) or other organizations (such as insurers) to pay Medicaid recipients' medical claims before the claims are paid by Medicaid.

Montana's third party function is housed within the Department of Public Health and Human Services (DPHHS), in the Quality Assurance Division, under the administration of the Audit and Compliance Bureau. The TPL program is responsible for:

- Monitoring the third party claims processing and recovery contract.
- Monitoring the lien and estate recovery contract.
- Operation of the Health Insurance Premium Payment Program.
- Recovery of Medicaid dollars expended for accident related-services.
- Operation of the Medicaid Buy-In program.

This audit report concentrates on our review of the contractor's procedures associated with third party claims processing and recovery and the department's compliance with state statute.

According to department records, as of March 1999 there were approximately 70,000 Medicaid recipients. Of those Medicaid eligible recipients, approximately 14,000 were also Medicare eligible and approximately 7,000 had some type of health insurance coverage.

Medicaid expenditures for the 1997-98 state fiscal year were $345,958,800. This amount excludes Medicare Buy-in, Indian Health Service, and the Developmentally Disabled Waiver.

Table 1 shows the amounts billed and recovered by the Medicaid contractor from liable third parties for fiscal years 1996-97, 1997-98, and 1998-99. In 1998, the contractor programmed a new system

for recording and monitoring of recoveries. The new system was not designed to compile the amounts billed to the third parties.

Table 1
Pay and Chase Recoveries

	FY 1997	FY 1998	FY 1999
Billed to Third Parties	$4,070,537	Amounts no longer compiled	Amounts no longer compiled
Recoveries	$1,689,608	$1,789,568	$1,859,062

Source: Compiled by the Legislative Audit Division from DPHHS records.

Third Party Processes

The third party process consists of three components:

- Gathering of third party information at application/re-determination by county public assistance staff.
- Medicaid claims processing by the MMIS system.
- Recovery of certain medical claims previously paid with Medicaid dollars.

The following sections describe the three components.

Gathering Third Party Information

According to federal regulations it is the responsibility of a state's third party program to identify legally liable third parties of Montana Medicaid recipients. This is the responsibility of DPHHS county public assistance personnel.

Most third party liability information is obtained at the time of application or redetermination for Medicaid services. Recipient eligibility information, including any third party coverage, is input by county staff on DPHHS's Economic Assistance Management System (TEAMS). TEAMS is an information system designed to assist in determining recipient eligibility and the calculation of economic assistance. Within two to three days of initial input on TEAMS, third party information is downloaded to the Montana

Medicaid Management Information System (MMIS). MMIS is designed to perform claims processing and reporting functions for the Medicaid program.

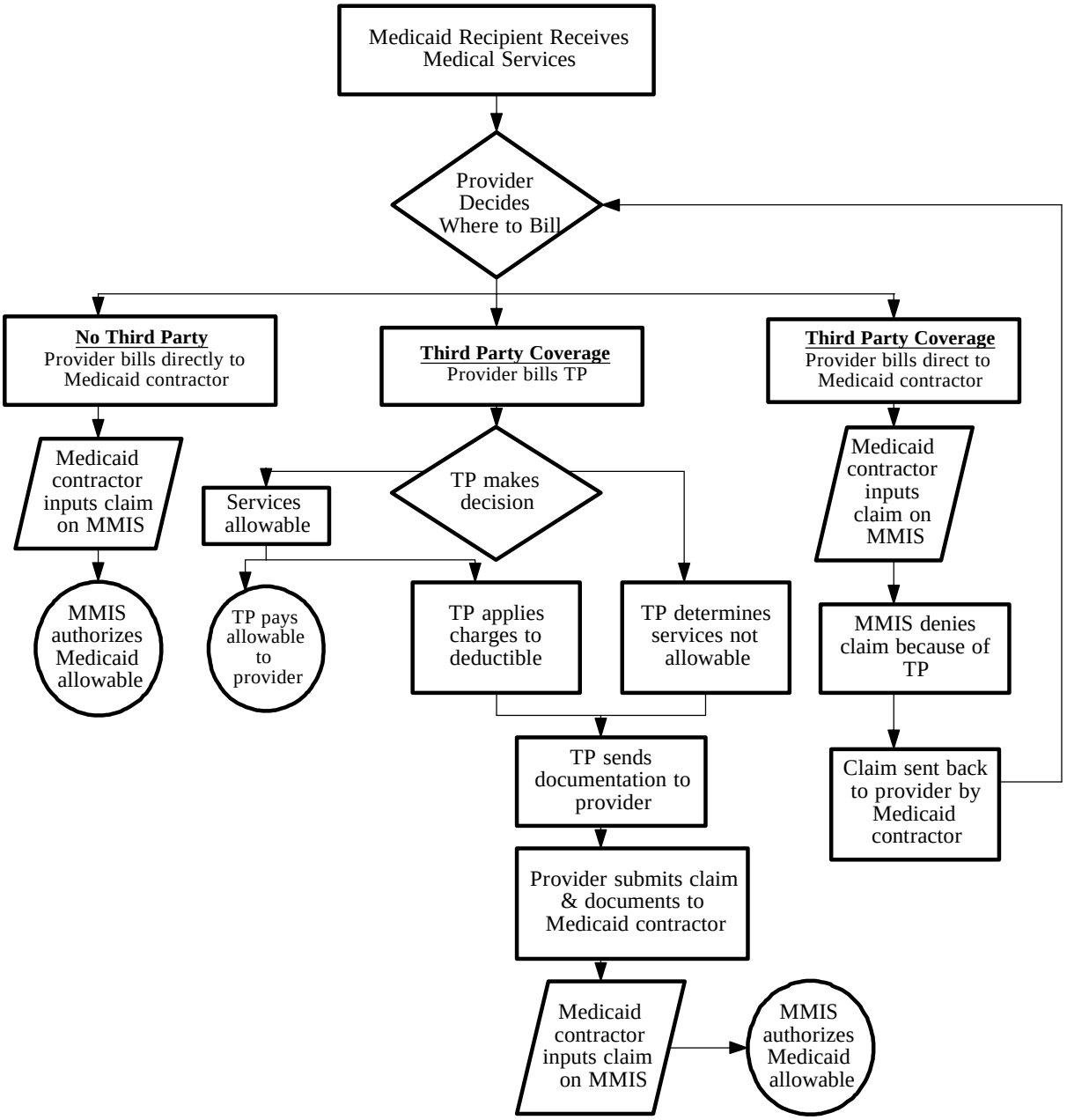
The applicant is given a card when he/she is deemed eligible for Medicaid. If the recipient has health insurance/Medicare the third party is identified on the Medicaid eligibility card.

We did not evaluate the process used to gather third party information at the time of application or re-determination. We tested controls over third party information once it was on the MMIS system. The following two sections describe the processes reviewed.

Claims Processing on MMIS

Any third parties listed on the Medicaid eligibility cards are to be billed for medical services prior to submitting the bill for Medicaid payment. Flow chart #1 shows the claim processing procedures when there is an identified third party. TP denotes third party.

Figure 1
Medicaid Claims Processing



Source: Compiled by the Legislative Audit Division.

At the time Medicaid eligible recipients receive medical services they are required to present their Medicaid cards to the provider. It is the responsibility of participating Medicaid health care providers to bill any identified third party prior to submitting a claim for payment from Medicaid.

If providers receive a denial from the third party, they are to submit the claim with the appropriate documentation of denial to Medicaid. If a provider submits the claim to Medicaid prior to billing an identified third party, MMIS is designed to deny most claims.

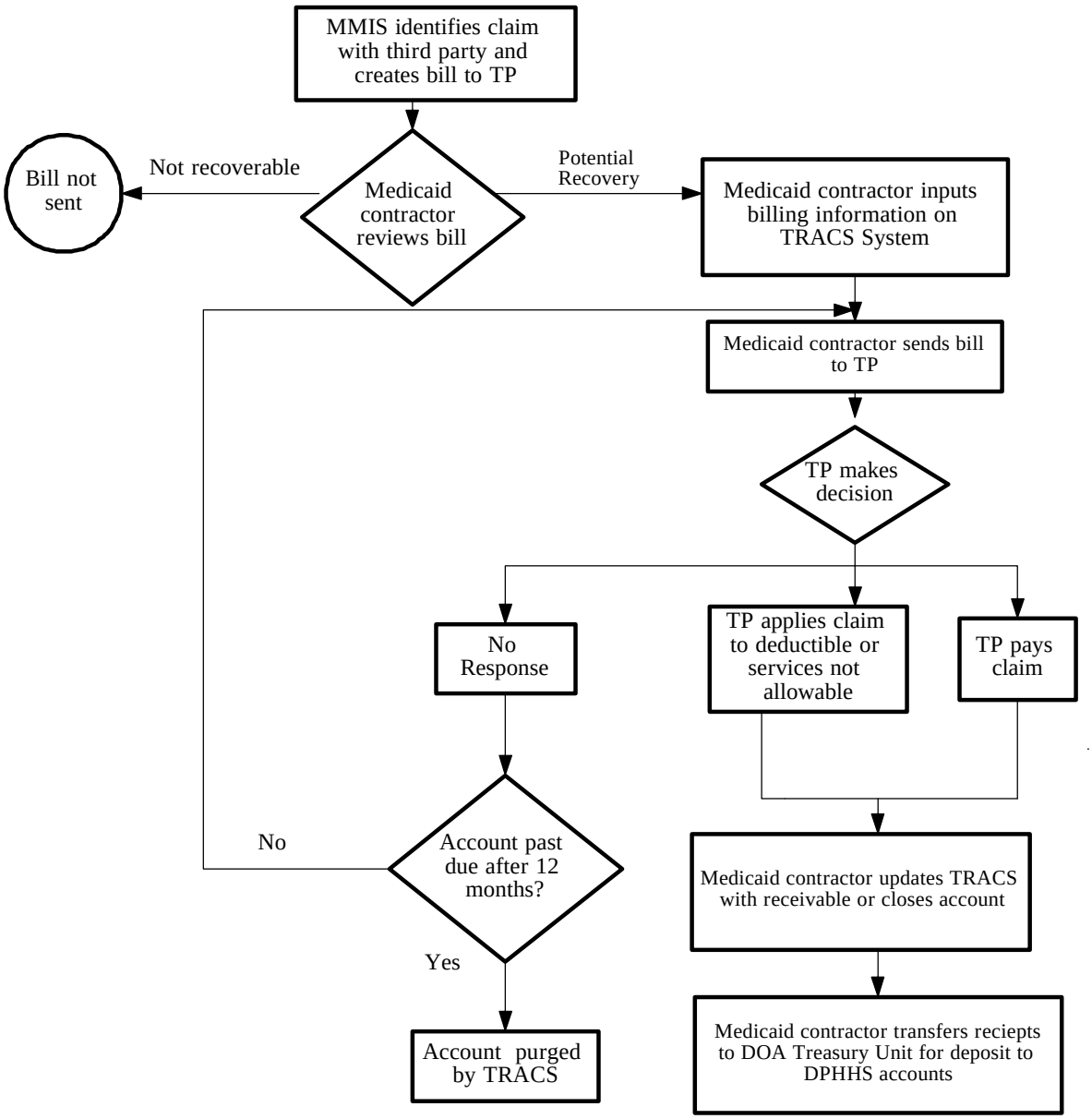
In some cases, a third party denies payment of a claim because the cost of the services provided is applied to the deductible or the services are not covered by the third party. In the event this happens, the provider is to submit the claim to Medicaid along with the documentation of denial from the third party. Upon receipt of the documentation, the claim is processed through MMIS. The system evaluates the claim for allowed charges and if applicable, MMIS will authorize payment for services.

Recovery of Medicaid "Pay and Chase" Claims

There are instances when MMIS authorizes payment for claims, even though reimbursement from a third party is likely. This post-payment method is known as "pay and chase". Under "pay and chase", certain medical services are paid with Medicaid funds without requiring the providers to initially submit the claim to the identified third party. Montana has federal authority to pay and chase certain services based on a waiver. These services include: drugs and dental; nursing home; audiology, hearing aids and batteries; personal care, home and community-based waiver services; non-emergency transportation; optometric services and eye glasses; and oxygen and oxygen-related services in a nursing home. The waiver was requested by DPHHS because most insurance carriers do not cover the services outlined by the waiver. Montana is also required to pay and chase claims when the primary diagnosis is related to pre-natal or certain pediatric preventive care.

The following flow chart illustrates the process used by the Medicaid contractor to recover pay and chase claims. TP denotes third party.

Figure 2
Recovery of Pay & Chase Claim



Source: Compiled by the Legislative Audit Division.

MMIS creates monthly bills for recovery of Medicaid dollars. In addition, whenever a third party is added to a recipient's file, the system completes a history check of all paid claims, then prints a bill. Contractor staff review each bill to determine if it meets established threshold limits and to determine if there is potential for recovery. There are circumstances when bills are not sent. An example is a bill for recovery of drug charges. If drug coverage is not included as a service of the third party, staff do not send a bill.

The billing information is input to a stand-alone system called the Third Party Recovery and Claims System (TRACS). TRACS is maintained by the contractor and is designed to document recovery of Medicaid dollars.

The contractor sends the bill to the third party. One of four things can happen. The third party can: 1) pay the bill based upon their allowable costs, 2) apply the amounts to the recipients deductible, 3) deny coverage of the services because it is not an allowable service, or 4) not respond to the bill. In all but the last option, the third party provides documentation of their action to the contractor. Using this documentation, the contractor will update TRACS with the applicable information.

If the third party does not respond to the bill within 90 to 120 days policy states contractor staff will send a second bill. The TRACS system purges all accounts past due for 12 months.

Chapter III - Audit Findings

Introduction

The Social Security Act requires State Medicaid agencies take all reasonable measures to obtain payment from liable third parties. It is the responsibility of participating Medicaid health care providers to recover charges for medical services from liable third parties before billing Medicaid.

Audit work included a review of Medicaid claims processed by the Medicaid Management Information System (MMIS). We examined medical claims of Medicaid recipients to verify MMIS denies payment of claims that are the responsibility of a liable third party. In addition, we evaluated procedures used by the contractor to recover pay and chase dollars. We also reviewed the department's compliance with accounting and statutes. The following sections summarize completed audit work.

Medical Claims Reviewed

We reviewed two samples of medical claims of Medicaid recipients. One sample was of medical services provided to Montana's dual eligible recipients and the other sample was for medical services provided to Medicaid recipients with health insurance. We reviewed these claims to ensure Medicaid is the payer of last resort, i.e. all reasonable attempts were made to have the third party pay medical services before Medicaid paid.

Dual Eligible Sample

The first claim samples reviewed were for services provided to Montana's dual eligible recipients. Individuals eligible for both Medicaid and Medicare are considered dual eligible recipients. We evaluated a sample of 104 medical services paid by Medicare. When a dual eligible recipient receives medical services from a provider, the provider directly bills Medicare. Medicare processes the claim and pays its allowable. Medicare claim and payment information is electronically transferred to MMIS on a weekly basis.

We reviewed a sample of medical services provided to dual eligible recipients on Montana's MMIS. We verified the amount paid by Medicare and determined the amount paid or denied by Medicaid for each service. The intent of this review was to determine if the Montana MMIS system has procedures/edits in place to assure

Medicaid does not pay for services already paid by Medicare or are Medicare's responsibility.

Conclusion: Medicaid Payer of Last Resort

In all the claims we sampled we found MMIS authorized payment for the services only after Medicare denied coverage. In addition, we were able to verify that if claims for the same services were sent through MMIS a second or third time, the system denied the claims as duplicates. In all sampled services, we verified Medicaid paid only as the payer of last resort.

Group Insurance Claim Sample

The second claim sample was a random selection of Medicaid recipients with health insurance. We reviewed all claims for 41 of 260 recipients with medical insurance. We evaluated the claims to ensure MMIS did not authorize payment for services that were ultimately the responsibility of a third party insurance company. We reviewed relevant documents to verify MMIS authorized payment for claims after receipt and verification of third party denial documentation.

Conclusion: Third Parties Pay Prior to Medicaid

Evaluation of these claims found MMIS authorized payment for recipient medical services only after all third party resources were pursued. We verified MMIS denied claims that did not contain appropriate denial documentation from the insurance carrier. As a result of this evaluation, we confirmed there were controls in place to assure third parties paid prior to Medicaid.

Recording, Collection, and Disposition of Pay and Chase Receivables

Neither the Third Party Liability Program nor DPHHS Fiscal Support has established formal policy to assure compliance with state law requiring recording and collection of third party pay and chase receivables. State law requires DPHHS to input all necessary transactions to the accounting system established by the Department of Administration (section 17-1-102 (4), MCA). The department also has no policies to ensure disposition of collections are in compliance with Title 17, chapter 4, part 1, Debt Collection Service. The following sections discuss our concerns and recommendations.

Receivables not Recorded or Transferred

DPHHS Fiscal Bureau's involvement with third party recoveries is limited to preparing deposits and recording amounts recovered. Fiscal Bureau is not provided with information related to the total amount billed to third parties so the potential receivable amounts are not recorded on the state accounting system as required by statute.

The Medicaid contractor is not required to report the status or disposition of outstanding or past due receivables to the Third Party Liability Program or Fiscal Bureau. There is also no transfer of past due pay and chase collections to the Department of Revenue as required under the debt collection statutes.

Montana Operations Manual (MOM) provides the criteria for the recording of receivables and the "uncollectability" of revenues. All pay and chase uncollected receivables are deleted from the Third Party Recovery and Claims System (TRACS). As result, the department does not know the total amount of uncollected accounts.

TPL and Fiscal Bureau should develop procedures to ensure there is a system in place that assures financial control of pay and chase receivable and recovery amounts. Currently, the department is understating their accounts receivable on the statewide accounting system. Since there were no records of the amounts billed in fiscal years 1997-98 and 1998-99, we do not know the current fiscal impact. By not transferring the bad debt, the accounting records are incomplete. Again, we do not know the fiscal impact since the amounts are purged from TRACS.

The department has completed preliminary discussions with the Medicaid contractor to initiate proper recording of receivables and disposition of uncollectible revenue.

Recommendation #1

We recommend DPHHS establish polices to ensure compliance with statute requiring the recording of receivables and disposition of uncollectible revenue.

Chapter III - Audit Findings

Recovering Pay and Chase Dollars

The pay and chase recovery process currently used by contractor staff consists of sending two bills. The initial bill is to be sent a month after the medical service is provided and a second bill is to be sent between 90 and 120 days after the initial bill. Prior to our audit work, TRACS did not have the capability to routinely calculate total amount billed to third parties, only the total amount collected.

Ensure Contractor Sends Second Bills

There are no formal controls to ensure second bills are sent to responsible third parties on a consistent basis. TRACS does not automatically generate second bills. Outside of a periodic manual review of the accounts, there are no formal procedures established to determine when bills are due.

Audit work included a review of a list of outstanding bills more than 90 days old. Additional programming of TRACS was necessary to obtain this information. Contractor staff provided the follow-up dates associated with each account. According to staff, follow-up includes different forms. For example, follow-up could be a letter requesting information from a recipient or a second bill to the liable third party.

As of August 1999, 263 accounts totaling $187,237 were over 90 days past due. Two hundred-five or seventy eight percent of the 263 accounts ($121,714) showed a second bill was sent to the third party or contact was initiated with the recipient within 90 to 120 days of the issuance of the initial bill. The remaining 58 accounts totaled $65,523 (22 percent of the past due accounts and 54 percent of the past due dollars) and were over 120 days old. The following table shows past due bills with follow-up initiated after the 120 day follow-up criteria established by DPHHS.

Table 2
Follow-up of Bills Over 120 Days

Months Between Bill and Follow-up	Number of Past Due Accounts	Past Due Amount
5	13	$17,931
6	18	5,086
7	7	1,107
8	8	2,245
9	6	37,607
10	4	1,023
11	2	524
Total	58	$65,523

Source: Compiled by the Legislative Audit Division from department records.

Our review of these accounts found one bill for $36,719 that had no follow-up initiated for nine months after the first bill was sent out. Review of another past due bill determined follow-up was not initiated until five months after the bill was created. That bill was for $15,362. The department should require the contractor develop formal procedures to ensure second bills are sent out in a timely manner.

Analysis of Recovery Process

The department does not complete periodic analysis of the pay and chase recovery process used by its contractor. No analysis of the number of bills sent or the time between issuance of bills is completed. Also there is no analysis to determine if there are certain services that are not recoverable, ultimately reducing billing of unrecoverable services.

In a discussion with staff from the state of Wyoming, we found they complete a periodic analysis of their billing and recovery of third party pay and chase dollars. They analyze the number of bills sent and the time between issuance of bills to determine if there is a correlation with recovered amounts. Wyoming has determined that sending three bills is the most cost effective for recovery of pay and chase dollars: the initial bill, another at 120 days, and a third at 180 days.

DPHHS should complete a cost-effective analysis of the recovery of Medicaid pay and chase dollars. The analysis could include the assessment of the different types of medical services billed, recovered, and uncollected. For example, these types of analyses could help determine if it is more cost-effective to send more or less than two bills in the attempt to recover Medicaid dollars. DPHHS could also evaluate past due receivables by type of service. This could help determine if there is a specific type of medical service that is unrecoverable from identified third parties.

Without the periodic analysis of the pay and chase recovery process, the department may not be maximizing its collection efforts.

Summary

Overall, the department should develop a formal process for recording and recovery of Medicaid dollars. More effective tracking can provide an accurate measurement of outcomes and prove the effectiveness of the recovery methods used. Pay and chase recoveries increased from $1.5 million to $1.8 million from fiscal years 1996-97 to 1998-99, but we found limited evidence to assure maximum recovery is achieved.

DPHHS receives limited guidance from HCFA for recording and collection of TPL claims and HCFA does not require agencies to report the status of outstanding TPL recoverables. Lack of federal guidelines does not preclude the department from developing their

own cost-effective monitoring and collection methods. Active management of third party recoveries could help maximize overall collection efforts and ensure accountability of Medicaid dollars.

Recommendation #2
We recommend DPHHS:

A. Require the contractor develop formal procedures to ensure second bills are sent out in a timely manner.

B. Complete an analysis of the recovery of Medicaid dollars to determine if procedures used for recovery maximize collection efforts.

Agency Response

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES
DIVISION OF QUALITY ASSURANCE

MARC RACICOT
GOVERNOR

LAURIE EKANGER
DIRECTOR

STATE OF MONTANA

(406) 444-2037
FAX (406) 444-1742

Cogswell Bldg., 1400 BROADWAY
PO Box 202951
HELENA, MONTANA 59620-2951

DEC - 2 1999

December 1, 1999

Jim Pellegrini
Legislative Audit Division
Room 135, State Capitol Bldg
PO Box 201705
Helena, MT 59620

Dear Mr. Pellegrini:

This letter is responding to your November 4, 1999 draft report audit number 98P-03. We agree with the findings and recommendations of the report.

Recommendation #1 discusses the need to improve the recording of account receivables and properly disposing of uncollectible revenue. In our previous response to your IAC of 9/2/1999, we indicated we would initiate an analysis of these areas to determine what needs to be done to make these improvements. One of our primary focuses will be on how to determine what is truly uncollectible revenue and the cost of making those determinations.

A large portion of our total billed amounts consists of expenses that are not covered by the third party. These are mostly drug claims. In many cases, we already know the claims are not covered so we do not mail the bill to the third party. A system enhancement which would eliminate generating these unmailed claims has already been requested. This will reduce the difference between billed and collected by a substantial amount. Also, we will start recciving a report listing total billed amounts within six months.

We will need to develop an efficient way to determine those claims that really do comprise bad debt so we do not record expenses that are not an obligation of a third party. Our first goal is to eliminate claims which have no potential. Next, we will conduct a detailed study of claims that are left unpaid after six months. The results of this study will help us develop a method to determine which claims need follow-up with the third party, which are not covered by the third party, and which claims the third party should have paid but has refused. The final category will comprise amounts for account receivables which need to be established in the state accounting system.

We estimate it will take 12 to 18 months to conduct the study and to implement permanently needed changes to most accurately reflect the disposition of claims. Most changes will require establishing manual processes to analyze unpaid claims and making decisions on what the appropriate next step for each claim should be.

The Department's Third Party Liability Manager and the MMIS TPL Unit, which process the claims, both believe the amount of bad debt identified will be minimal but agree that a process should be developed to confirm their beliefs.

Recommendation #2 discusses follow-up activities to the billing process. A system enhancement has been completed that insures second billing requests will be generated after 90 days. The system now generates another bill to the third party if the initial bill does not prompt a response within 90 days. Item A has already been addressed and we are now in compliance with the recommendation.

We will evaluate Item B in conjunction with Recommendation #1. Once we have determined the most efficient process for conducting follow-up analysis of uncollected claims we will request both a system enhancement and a contract operations change to perform the functions needed to be in compliance. This will be part of the same process developed in Recommendation #1.

We would like to thank the staff of the Legislative Audit Division for their efforts in identifying areas where we can improve our performance in recovering Medicaid expenditures from other insurers.

Sincerely,

Laurie Ekanger, Director
Department of Public Health and Human Services

cc: Denzel Davis, Administrator