REPORT OF THE

OFFICE OF THE AUDITOR GENERAL

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

286.4

UTILIZATION CONTROL FUNCTIONS OF THE MEDI-CAL PROGRAM (U.S. TITLE XIX)

JULY 1977

Joint Legislative Audit Committee

OFFICE OF THE AUDITOR GENERAL

California Legislature

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July 19, 1977

The Honorable Speaker of the Assembly
The Honorable President pro Tempore of the Senate
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members of the Legislature:

Your Joint Legislative Audit Committee respectfully submits the fourth and final report of the Auditor General on the California Medical Assistance Program (Title XIX--Medicaid), popularly described as Medi-Cal.

Compared with previous years, the drug, medical and institutional claims processed during approximately a 12-month period was found to be 98.1 percent accurate and effective.

Abuses by myriad providers and beneficiaries, many as recent as 1976, have been identified by the Department of Health with relatively few having been subjected to statutory sanctions, i.e., kicked out of the program after due process. The Director of Health, Dr. Jerome A. Lackner, responds that the report "completely ignores the multitude of cases where postpayment controls have been effective." Presumably, documentation of the multitude of cases will be presented to the Standing Committees to which this report is referred.

By copy of this letter, the Department is requested to advise the Joint Legislative Audit Committee within sixty days of the status of implementation of the recommendations of the Auditor General that are within the statutory authority of the Department.

The auditors are Kurt R. Sjoberg, Manager; Bill Batt and Secundino M. Garcia.

Respectfully submitted,

MIKE CULLEN
Chairman

SUITE 750 • 925 L STREET • SACRAMENTO 95814 • (916) 445-0255

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SUMMARY

The State of California's Medi-Cal program is administered by the Departments of Health and Benefit Payments. The Department of Health contracted with a fiscal intermediary, Medi-Cal Intermediary Operations (MIO), to provide processing and payment of medical billings for services incurred by recipients of public assistance under the Medi-Cal program.

We reviewed selected functions which control utilization of the Medi-Cal program to determine the effectiveness of the Department of Health's administration of these areas. Some of the functions reviewed are performed under contract by the MIO.

We found that:

- The Department of Health has refused to issue Beneficiary Explanation of Medical Benefits, resulting in a net loss to the State of approximately $3.5 million annually in federal funds (page 6).

- The Department of Health has not effectively controlled provider and beneficiary abuse of the Medi-Cal program (page 13).

- The Department of Health eliminated retrospective denial of Medi-Cal consultant-approved days of acute hospital stay by the MIO, resulting in payment for services which would have otherwise been denied (page 28).

- Reports produced by MIO's Surveillance and Utilization Review system since July 1975 are inadequate for their intended purpose (page 33).

A sample of 4,014 claims paid by MIO, from a universe of approximately 37.4 million processed claims, indicated an overall error rate of only 1.9 percent in the MIO claims preparation and review functions. We conclude from this result that the claims preparation and review function of the MIO operates effectively (page 37).

The "Medical Policy Edit Audit and Procedures" system, MIO's prepayment review of claims, is also operated effectively and has been attributed by them with saving approximately $24 million in program funds during 1976. These edits and audits are regularly reviewed for effectiveness (page 39).

INTRODUCTION

In response to a resolution of the Joint Legislative Audit Committee, we reviewed various aspects of the California Medical Assistance Program (Medi-Cal). This report, the last in a recent series on the subject,* covers utilization control functions of the Medi-Cal program administered by the Department of Health and services provided to that Department by Medi-Cal Intermediary Operations.

Under the policy direction of California's Secretary of Health and Welfare, the Departments of Health and Benefit Payments are responsible for administering the Medi-Cal program. Since the inception of the Medi-Cal program in 1966, the State has contracted with three fiscal intermediaries to provide processing and payment of medical billings for services incurred by recipients of public assistance. This was done in accordance with the Basic Health Care and Extended Health Services provisions of the Welfare and Institutions Code. These code sections implement the State's operation of the Social Security Administration's Title XIX Medicaid program.

The fiscal intermediaries with which the State contracts are the California Physicians' Service (Blue Shield of California), Hospital Service of California (Blue Cross of Northern California) and Hospital

* See Costs and Revenues of the Medi-Cal Claims Processing Subcontract (286.1), dated January 1977; A Management Analysis of the Third Party Liability and Other Health Coverage Programs (286.2), dated March 1977; and Eligibility Abuses and Deficiencies in California Public Assistance Programs (286.3), dated March 1977.

Service of Southern California (Blue Cross of Southern California). In 1972, the three intermediaries became a consortium known as the Medi-Cal Intermediary Operations (MIO). The contract with MIO provides for reimbursement by the State of costs incurred by the intermediary.

Fiscal year 1975–76 administrative costs for the Medi-Cal program were as follows:

Medi-Cal Administrative Costs
for the Fiscal Year Ended June 30, 1976

State Support:	
Department of Health	$ 29,673,120
Department of Benefit Payments	3,560,000
Fiscal Intermediary--MIO Contract Costs	36,143,831
	69,376,951
County Administration	102,082,463
Total Medi-Cal Administration Costs	$171,459,414

This report does not address Medi-Cal administrative costs expended by the Department of Benefit Payments or the 58 county welfare departments.

Scope of the Review

We reviewed selected areas of the Medi-Cal program to determine the effectiveness of the fiscal intermediary function administered by the Department of Health and MIO. During this study we reviewed the following areas:

- Surveillance and Utilization Review System.

- Claims Preparation and Prepayment Review Functions.

- Audit Trails Maintained for Paid Claims.

- Medical Policy Edit Audit and Procedures.

We found that MIO has an effective claims preparation and prepayment review system. During the review we received excellent cooperation from both the Department of Health and the Medi-Cal Intermediary Operations.

AUDIT RESULTS

REFUSAL TO ISSUE EXPLANATIONS OF MEDICAL BENEFITS TO MEDI-CAL BENEFICIARIES RESULTED IN A NET LOSS OF $3.5 MILLION TO THE MEDI-CAL PROGRAM

The Department of Health (DOH) prepared budgets for fiscal years 1975–76 and 1976–77 based upon the assumption that Federal Financial Participation (FFP) in the cost of the Medi-Cal claims processing and information retrieval system would be 75 percent. However, 75 percent federal participation in systems costs is available only if the State provides Medi-Cal beneficiaries with prompt written notice of the services covered by the plan, and such items as the provider's name and address, services actually rendered, and cost. This notice is known as the "Beneficiary's Explanation of Medical Benefits" (BEOMBs). Because the Department refused to issue BEOMBs in fiscal year 1976–77, only 50 percent federal participation was received, resulting in a loss of $3.5 million in federal revenue in excess of the cost of issuing BEOMBs. The estimated loss is computed as follows:

	Millions of Dollars
Estimated 1976-77 expenditures eligible for FFP	$22.2
Federal Financial Participation:	
Expected: 75 percent	$16.7
Less actual: 50 percent	11.1
Additional federal revenue had funding been 75 percent	$ 5.6
Less: Additional General Fund cost for issuance and processing BEOMBs	2.1
Net General Fund loss resulting from refusal to issue BEOMBs	$ 3.5

In addition, federal revenues to the State of an unknown amount were also lost in the previous fiscal year for refusal to issue BEOMBs.

42 U.S.C. Section 1396b provides in part:

> (a) From the sums appropriated therefore, the Secretary...shall pay to each State which has a plan approved under this subchapter,...
>
> (3) an amount equal to --
>
> (B) 75 percent centum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A)(i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan of the specific services so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services... (Emphasis added.)

The purpose of requiring the State to periodically mail a list of services billed by providers to each Medi-Cal recipient, and having the beneficiary report any discrepancies in the billings, is to prevent providers from fraudulently billing for services that were not rendered.

In a letter dated March 3, 1975, to MIO, the DOH indicated their intent to comply with federal requirements for BEOMBs and stated:

> ...the Department's 1975–76 budget is based upon the assumption that 75% FFP will be received for the operation of our claims processing and information system. Members of my staff have met with MIO and EDSF* representatives to discuss and review measures necessary to modify our system to DHEW/SRS specifications in order to obtain 75% FFP by July 1, 1975. As the Department has reviewed MIO plans for modifying the current system and State funds are available to finance such modifications, we request that MIO staff immediately proceed with those plans necessary to obtain 75% FFP. (Emphasis added.)

However, several months later in a letter dated August 18, 1975 to DHEW, the California Health and Welfare Agency revised the position of the DOH and established why they would not issue BEOMBs. They stated:

> Since BEOMBs violates fundamental human rights, does not deter or detect fraud, is not cost-effective, and we have a viable alternative (infra), the State of California will not comply with the segment of Medi-Cal EDP that requires us to invade the homes and privacy of our citizens.

* Electronic Data Systems Federal Corporation, subcontractor to the MIO.

The DOH has developed, installed and is operating a mechanized claims processing and information retrieval system which meets the requirements of the U. S. Department of Health, Education and Welfare (DHEW) for 75 percent FFP except for the issuance of BEOMBs. The DHEW, in a letter dated November 28, 1975, stated:

> It was found that California had corrected all of the above noted deficiencies, and that their Medicaid System, with the exception of the Explanation of Benefit (EOB) issuance, meets all of the Federal criteria as defined by SRS Program Regulation. (Emphasis added.)

The Department has designed a subsystem to issue BEOMBs but it has not been implemented. The DHEW has refused to approve the additional funding until the Department of Health complies with their requirements.

The assertion of privacy invasion is the basis of a lawsuit filed by the Health and Welfare Agency in January 1977. The suit seeks declarative and injunctive relief from DHEW's refusal to approve increased financial participation in the design and operation of California's mechanized claims processing system. The lawsuit states:

> 17) California is not now sending out BEOMBs because such a program (1) results in serious constitutional invasions of Medi-Cal beneficiaries' rights of privacy, (2) is not reasonably related to the fulfillment of any compelling governmental interest, and (3) is not the least drastic means of promoting any compelling governmental interest.
>
> 21) As an alternative to the BEOMBs program, the State of California has instituted a "Surveillence [sic] and Utilization Review (SUR) Program."

The Agency's concern over privacy of certain sensitive medical services received, such as an abortion or psychiatric care, might be alleviated by directing BEOMBs covering certain sensitive diagnostic or treatment codes to the county welfare office to ensure that only the recipient saw them. Another alternative, as recommended by the Legislative Analyst,* would be to pursue a system that might exclude specific procedures and still meet federal requirements. We believe that these or other alternatives should be considered.

Another reason cited for refusing to issue BEOMBs has been the Agency's belief that the two previous attempts at issuing BEOMBs were not cost effective.

BEOMBs were issued during operation of the Medi-Cal Management System (MMS) pilot program in two counties during 1973–74. The Department reports that of 100,000 statements sent to beneficiaries, only 10 cases warranted investigation. An additional 4,000 BEOMBs were sent in August 1975 with only one warranting investigation out of 100 returned by beneficiaries. In addition, the Department believes that many beneficiaries were confused by the BEOMB, either thinking it was a bill for services received or not recognizing services actually received and returning it for investigation.

* Analysis of the Budget Bill, 1977-78

We do not believe that the full benefit of a provider control device like BEOMBs can be revealed by a limited test such as that performed during the MMS pilot program. The impact that the deterrent effect of an on-going BEOMBs system would provide--namely, having providers aware that such a statement would go to the person who supposedly received the medical service for scrutiny--would also have to be measured. Without such a valuation, a true statement of the BEOMBs cost effectiveness, or lack thereof, cannot be made.

CONCLUSION

The Department has refused to issue BEOMBs and has suggested that its Surveillance and Utilization Review program will effectively control providers. At the present time, however, DHEW will not approve this alternative program and has refused to approve 75 percent federal financial participation on the entire mechanized claims processing system until California complies with the law by issuing BEOMBs.

Refusal to implement the BEOMBs program, or obtain approval of some modification to it, results in an estimated loss to the State of $3.5 million in federal revenues in excess of the cost of issuing and processing the BEOMBs.

RECOMMENDATION

We recommend that the Department of Health comply with the requirements of 42 U.S.C. Section 1396b(a)(3)(B), or some acceptable modification to it, in order to obtain 75 percent financial participation until the U. S. Department of Health, Education and Welfare approves an alternative to the BEOMB program.

BENEFITS AND SAVINGS

Implementing this recommendation would result in additional federal revenues to the State of approximately $3.5 million annually above the cost of issuing and processing BEOMBs.

THE DEPARTMENT OF HEALTH HAS NOT EFFECTIVELY CONTROLLED MEDI-CAL PROGRAM ABUSE

Abuse of the Medi-Cal program occurs when providers perform unnecessary services, services of an unacceptable quality or bill for services not actually provided; or when a beneficiary improperly utilizes program benefits. Although procedures for administrative remedy against Medi-Cal abusers exist, the Department of Health has not effectively used them. This has resulted in Department of Health estimates that 25 to 30 percent of all providers misutilize the program, and that an estimated 50,000 beneficiaries are apparently overutilizing benefits and need to be scrutinized and possibly controlled.

In spite of the potential magnitude of these estimates, during calendar year 1976, only 22 of approximately 73,000 participating Medi-Cal providers (doctors, hospitals, etc.) were suspended from the Medi-Cal program. The suspensions ranged from seven days to an indefinite period. Further, of the approximately 2.7 million Medi-Cal recipients, no prior authorization restrictions were placed on services provided to beneficiaries. These facts exist even though numerous instances of apparent program abuse have been identified, notable examples of which are presented later in this report.

The Medi-Cal program objective as stated in the 1977-78 Governor's Budget is:

> The program's objectives include assuring that quality health care is provided to those California residents unable, either wholly or in part, to pay for their medical services, and to assure that services are delivered at a reasonable cost, under proper controls, to insure maximum utilization of public funds. (Emphasis added.)

The Department of Health created a Drug Utilization Review Unit in 1976 which covers providers of pharmaceutical services and a Surveillance and Utilization Review Section (SURS) in 1977 to review Medi-Cal providers (other than pharmacies) and all recipients. The Drug Unit has completed a number of pharmacy audits and has identified more than $300,000 in recoupable payments. The SURS reviews began in March 1977, however, we believe it is too early to evaluate the results from this major undertaking.

Provider Abuse of the Medi-Cal Program

There has been no effective procedure to suspend Medi-Cal providers whose services were in excess of accepted practice or medically unnecessary (overutilization), or whose services were of unacceptable quality as measured by community standards.

Sections 11500 through 11528 of the Government Code provide procedures for administrative remedy against Medi-Cal providers who are suspected of program overutilization or providing substandard services. Section 11503 of the code states:

> A hearing to determine whether a right, authority, license or privilege should be revoked, suspended, limited or conditioned shall be initiated by filing an accusation. The accusation shall be a written statement of charges which shall set forth in ordinary and concise language the acts or omissions with which the respondent is charged, to the end that the respondent will be able to prepare his defense. It shall specify the statutes and rules which the respondent is alleged to have violated, but shall not consist merely of charges phrased in the language of such statutes and rules. The accusation shall be verified unless made by a public officer acting in his official capacity or by an employee of the agency before which the proceeding is to be held. The verification may be on information and belief.

Providers suspected of abuse are identified through the Medi-Cal Intermediary Operations or referral from other sources. The MIO Post-Payment Utilization Review System is designed to identify providers who may be overutilizing the program.

To prove overutilization, community standards must be set for treatment of diseases or injuries for which excessive treatment is suspected. To establish this standard, the Utilization Review System separates providers of the same specialty and locality into peer groups. The individual performance of each member of the peer group is then compared with the group norm. Providers whose pattern of practice differs by a predetermined amount are identified. A list of those providers, their performance and the group norm is prepared by computer.

When a case of suspected abuse has been identified, the case disposition may be as follows:

- Provider Errors--There is no willfull intent by the provider to do wrong, i.e., billing errors or misapplication of regulations. If there was a billing error, MIO recovers funds or denies payment.

- Overutilization--When it is obvious, through a review of provider documents, that the provider clearly overutilizes or practices at an unacceptable level of quality, the case will be prepared and directed to the provider's local peer review committee for action.

- Provider Fraud--If it is documented that services billed the Medi-Cal program were not actually provided, and there appears to be willful intent to defraud the program, the case will be prepared and referred to the DOH Investigation Section for further action.

Cases of overutilization and substandard service are monitored for a period of time after referral to the peer review committee for action. If the provider does not take corrective action to change this pattern of practice, the provider is referred to the DOH Investigation Section for review.

The Investigation Section, however, has emphasized the development of fraud cases for prosecution and has not developed overutilization or substandard service cases. This has been partially due to staff limitations. As an example of overutilization and the need to control it, one provider has been under almost continuous prospective review, a post-service prepayment claims review, since 1968; yet this

provider is still treating Medi-Cal recipients and apparently overutilizing the program. During a three-month period, the provider billed the Medi-Cal program $24,213. After a claims review, MIO approved and paid only $9,605.

The following MIO developed cases are additional examples of apparent provider abuse:

Case 1

A pediatrics physician has been under continuous review since July 1972. The peer review committee evaluating the case concluded that he was an unacceptable provider under the Medi-Cal Program for the following reasons:

- Repeated overutilization of services
- Excessive diagnostic screening services
- A standard of medicine which is not in compliance with the standard of practice in the rest of the community.

The case was sent to the Department of Health in February 1976. To date no action has been taken.

Case 2

In 1973, billing patterns of a general practice physician were questioned by MIO and a conference was held with the provider to discuss the areas of overutilization. There was no further prepayment review activity until the provider exceeded the "Peer Group Norm" report for injections in September 1975. Following are some of the potential abuses a review of this provider's claims revealed:

- Without exception, at least one penicillin injection was billed for each patient.
- In many cases, 4 to 12 penicillin injections were billed within a four month span.

- With few exceptions, an abdominal X-ray was billed for each patient.

- Many members of a single family were seen on the same day.

- Patient was seen 11 times in the two months prior to her delivery (which was not indicated on the prenatal claims). She received 12 injections of penicillin and three abdominal X-rays. There did not seem to be any indication for these services according to the cited diagnoses.

During February 1976, a recommendation was made by the MIO Medical Advisor to prepare a case to be presented to the local Medical Association and, in May 1976, the case was referred to DOH for action. To date no action has been taken.

During 1972, the DOH developed procedures for preparing, documenting and presenting quality of care and overutilization cases to local peer review committees. DOH also advised MIO of the requirements for the preparation of cases to be submitted to the Office of Administrative Hearing for action. MIO did not implement these requirements and the DOH did not insist on implementation. Consequently, MIO has submitted cases of suspected provider abuse which were incomplete and required substantial additional work before the DOH could submit them for administrative action. As a result, an effective means for suspending providers suspected of overutilization and substandard care was not implemented.

Medi-Cal program funds expended for unnecessary or substandard services cannot be estimated from the information currently available. However, the DOH Surveillance and Utilization Task Force estimates that between 25 and 30 percent of the Medi-Cal providers misutilize the program.

Beneficiary Abuse of the Medi-Cal Program

Since the inception of the Medi-Cal program in 1966, no restrictions have been placed on services to beneficiaries even when it has been shown that Medi-Cal benefits have been improperly utilized.

For example, three individuals identified as suspected abusers of the Medi-Cal program also appeared on a listing of Medi-Cal recipients who received $10,000 or more in services during fiscal year 1975–76. The three received the following amounts in benefits:

Case 1	$22,059
Case 2	$16,580
Case 3	$16,355

Following is a synopsis of their suspected abuses:

Case 1

During the past 24 months or so this beneficiary has presented herself for treatment to numerous physicians, outpatient emergency rooms, and has been admitted to hospitals for at least 40 short-term stays. Her complaints are many but the major diagnoses are abdominal pain, ectopic pregnancy, hematemesis, and seizures. One report suggests drug addiction. The discharge summary indicates that in addition to these services, this beneficiary has been seen in the emergency room at least 100 times this past year.

A current beneficiary profile indicates that no further services were paid as of December 16, 1975. This seemed unlikely, and upon further investigation it was found that a new Medi-Cal identification number had been issued and the beneficiary is now eligible under both Medicare and Medi-Cal.

Case 2

Beneficiary apparently began seeking frequent emergency room services some time in 1974. Information obtained from submitted claims note that he has been to several hospitals in

the Los Angeles area seeking treatment for severe chest pain. During hospital examinations, the beneficiary often made reference to myocardial infarctions suffered in prior years; however, no medical evidence was found to support these statements.

There were multiple one and two-day hospital stays for the beneficiary due to the patient discharging himself against medical advice. Reasons for this act were not always supplied, but indications were that services rendered were, in his opinion, not satisfactory. On two occasions he refused prescribed medication attempting to get something stronger. Within one seven-day period, beneficiary was discharged from three different hospitals, never having been released for more than a few hours, leaving two of them against medical advice.

Several prescriptions for psychotherapeutic and narcotic analgesic drugs were obtained during this period, most of them prescribed by the beneficiary's regular physician.

Case 3

Since November 1975, this beneficiary has been treated in the emergency room facility of five hospitals on 19 occasions for numerous and varied diagnoses. A review of the Beneficiary Profile and hospital billings shows that on November 7, 1975, beneficiary was taken to the emergency room of two separate facilities on four occasions. This is the most extreme case; however, it is not atypical of her actions over the last several months.

Many of the above mentioned emergency room treatments have resulted in hospital confinements. In many cases, the patient is discharged from the hospital only to appear at the emergency room of another facility the same day, or within two or three days, complaining of the same or a completely unrelated illness.

In many instances, a review of the admission and discharge summaries reveals no mention of Chronic illness, i.e., Ischemic Heart Disease, Myocardial Infarction or Arthritis, which has previously required confinement. While this beneficiary has undoubtedly required treatment for these chronic conditions one would assume that much of her treatment results from her conditions diagnosed as drug dependence and alcoholism.

A review of the Beneficiary Profile for the months prior to November 1975 indicates that the beneficiary has an established pattern much like that for the last six months.

Examples of additional suspected abusers that have been identified are:

Case 4

During the period of February 4, 1975 through May 12, 1976, the beneficiary received 5,356 tablets of APC with codeine. The 129 prescriptions were filled at over a dozen different pharmacies in the Los Angeles area.

Case 5

The beneficiary is a former nurse whose license was revoked. She was arrested on April 13, 1976 (third arrest) for violation of Section 4390 of the Business and Professions Code (Forgery of Prescription). A review of the recipients' history for the period November 10, 1975 through March 1, 1976, indicates Medi-Cal paid for 14 forged prescriptions of Dexedrine.

MIO furnished DOH with more than 70 additional cases of suspected beneficiary abuse during 1976. Other sources provided DOH information on additional suspected beneficiary abuse cases. To date, however, no restrictions have been placed on any recipients.

There is existing authority for the Department to impose restrictions on beneficiaries who improperly utilize Medi-Cal program benefits. Title 22, California Administrative Code, Section 50661* states:

> Persons certified and eligible to receive benefits and services under this program may be subjected, on written order of the Director of the Department, to a requirement for prior authorization by the Medi-Cal consultant before all or any specified benefits or services are rendered in their behalf. Such action may be taken when a program beneficiary is improperly utilizing program benefits or otherwise engaging in practices inimical to the purposes of the Medi-Cal program.

In spite of what appears to be strong evidence of beneficiary misutilization of program benefits, the authority for imposing restrictions (22 Cal. Adm. Code 50661) has never been used. The DOH Investigation Section ceased to pursue beneficiary overutilization cases because DOH would not enforce Section 50661 and there was no alternative. A memorandum from the Investigation Section to Medi-Cal Division dated April 21, 1976, states:

> The action of the patient is not a crime and the only administrative sanction (Title 22, CAC 50661) has been made inoperable by executive decision.
>
> The recourse that is available is: (1) write the patient a warning letter--which warning would be unenforceable and would, therefore, be nothing more than a threatening bluff...

* Amended and reissued as Section 50793.

During July 1976, a DOH Issue Memo was prepared which would delegate authority to the Deputy Director, Legal Affairs, to impose controls on beneficiaries found to be abusing drug benefits. The Issue Memo was not approved pending completion of the DOH Field Services Section task force report on Surveillance and Utilization Review of all areas of the Medi-Cal program.

The Medi-Cal Division responded to the Issue Memo as follows:

> I agree that there has been a lack of control over beneficiary overutilization of the Medi-Cal Program; however, I am not convinced that merely subjecting those particular beneficiaries to a requirement of prior authorization is the complete or correct solution. Not only are these beneficiaries abusing the drug aspects of the program, but also physician, emergency room, and other services. Some of the problems involved with this type of an approach would be:
>
> A. Such a beneficiary placed on prior authorization status could easily obtain a new I.D. card from a different eligibility office merely by using another name, or
>
> B. Such a beneficiary could purchase someone else's card and obtain the same services. (Emphasis added.)

The above statement reinforces the recommendation regarding an improved eligibility system in our report, Eligibility Abuses and Deficiencies in California Public Assistance Programs, No. 286.3, dated March 1977, page 33.

In February 1977, the DOH approved the following policy and procedures to deal with Medi-Cal program abuse by beneficiaries:

Implementation of authority found in Title 22, California Administrative Code, Section 50661 will not occur until after:

1. The beneficiary has been formally notified of the specific benefits that have been abusive.

2. The beneficiary has rejected alternatives to resolve the abusive situation, or when attempts to control the abuse within a reasonable length of time by resolving the underlying cause have failed.

3. The beneficiary has been afforded the opportunity for a fair hearing.

The Surveillance and Utilization Review Section is in the process of implementing the approved policy and procedures on a test basis. Beginning in May 1977 the section developed ten cases of suspected abuse received from MIO and three cases transferred from the Investigation Section. It is too early to determine the results of this effort.

Medi-Cal program funds expended for overutilization of program benefits by beneficiaries cannot be determined from information currently available. However, the Department estimates that "...50,000 apparent overutilizers need to be scrutinized further and possibly controlled."

Recent Implementation of On-Site Review Functions

The DOH implemented the Drug Utilization Review Unit (DURU) in January 1976 and the Surveillance and Utilization Review Section (SURS) in January 1977. Both are on-site review functions covering Medi-Cal providers and recipients.

Drug Utilization Review Unit

DURU is an on-site review unit which covers Medi-Cal providers of pharmaceutical services. The unit is staffed with nine positions, eight of which are filled by pharmacists.

As of February 1977, the DURU had completed 317 preliminary audits and 43 in-depth audits of providers. Of the 187,944 prescriptions reviewed, 49,797 or 26 percent were questionable with $310,775 identified as recoupable. A breakdown of the recoupable dollars by cause follows:

Prescription overcharging	$ 69,924
No record of refill on service date	57,183
No record of prescription on file	52,210
False billing	45,684
Prescription splitting	29,213
Other	56,561
Total	$310,775

Included in the statistics cited above are 26 cases referred to the DOH Investigation Section for possible fraud.

Surveillance and Utilization Review Section

DOH implemented the SURS based on recommendations of the Medi-Cal Division Surveillance and Utilization Review Project. The project examined all current utilization control mechanisms including regulations, prior authorization, on-site concurrent reviews, claims review and audit screens, and post-payment utilization reports for the purpose of recommending improvements.

SURS has 44 approved positions which include physicians, an optometrist, pharmacist, psychologist, podiatrist, physical therapist and nurse. The section is responsible for on-site reviews of Medi-Cal recipients and providers, except pharmaceutical services which are covered by DURU. SURS began on-site reviews of providers in March 1977 and began on-site beneficiary reviews in May 1977.

CONCLUSION

Although authority exists, DOH efforts to reduce program misuse have consisted of suspending only 22 of approximately 73,000 providers, while not one of the 2.7 million beneficiaries has been restricted.

The new Surveillance and Utilization Review Section, the Drug Utilization Review Unit, recently adopted policy and procedures for placing beneficiaries who abuse the Medi-Cal program on prior authorization along with provider controls may, if effectively used, aid substantially in curbing Medi-Cal program abuses.

RECOMMENDATIONS

We recommend that the Surveillance and Utilization Review Section implement the procedures recommended by the DOH Investigation Section for preparing and documenting Medi-Cal provider overutilization and substandard care cases, and actively pursue administrative remedies to discipline providers who abuse the program.

We also recommend that the Surveillance and Utilization Review Section implement and actively pursue DOH policy for placing prior authorization restrictions on services to Medi-Cal beneficiaries who have been proven to be program abusers.

BENEFITS

Implementing the above recommendations will provide greater assurance that Medi-Cal services are delivered at a reasonable cost, under proper controls.

ELIMINATING RETROACTIVE DENIAL OF HOSPITAL SERVICES HAS RESULTED IN PAYMENTS WHICH WOULD HAVE OTHERWISE BEEN DENIED

The Department of Health eliminated MIO's process of retroactively challenging and denying Medi-Cal consultant-approved days of acute-care hospital stay (known as retrospective denial) on September 1, 1975. Without retroactive denial, no post-service prepayment evaluation of such Medi-Cal claims is made. As a result, the Medi-Cal program is paying for services which MIO believes should be denied and would have been denied under the defunct retroactive denial process.

All inpatient services, other than emergency hospital admission, must be approved in advance by a state Medi-Cal medical consultant. This approval is given in the form of a Treatment Authorization Request (TAR). Prior to September 1, 1975, MIO had the authority, subject to DOH approval, to reduce or deny hospital services billed which were deemed inappropriate even though approved by Medi-Cal consultants and accompanied by a TAR.

The administrative regulation for post-service prepayment review is provided in Title 22, California Administrative Code, Section 51159(b) which states:

> Utilization controls that may be applied to services set forth in this chapter include:
>
> (b) Postservice prepayment audit, which is review for medical necessity and program coverage after service was rendered but before payment is made. Payment may be withheld or reduced if the service rendered was inappropriate.

Retroactive denial of acute-care hospitalization days was eliminated by Medi-Cal Intermediary Letter No. 18-75 which states:

> Effective for admissions on or after September 1, 1975, acute hospital inpatient claims accompanied by signed approval of a Medi-Cal consultant (physician or Health Care Services Nurse) are not subject to retroactive denial by MIO if denial is based exclusively on a challenge of the approved length of stay.

MIO's ability to maintain utilization control over acute hospitalization was further hampered by Medi-Cal Intermediary Letter 3-76 which states:

> The claims review activity in this area retrospective denial should be confined to the information made available by the initial claim submission and no attempt is to be made to request additional medical documentation from the hospital. (Emphasis added.)

After the eliminating retroactive denial, DOH utilized an on-site hospital review function to review extension of stay requests in acute-care hospitals. The function is performed by licensed nurses who have authority to approve extension requests, but they must submit questionable requests to medical consultants in DOH field offices for final determination.

The on-site review function does not include all hospitals. For example, during calendar year 1976, 315,127 days or 17 percent of the total requested and approved days of acute hospitalization were not subject to on-site review. These days of hospitalization would have been reviewed under the retroactive denial process. MIO has also expressed concerns over DOH authorization for services of a cosmetic or experimental nature, emergency inpatient psychiatric care and alcohol detoxification services which require extension beyond three days. In a letter to DOH dated March 9, 1976, MIO states:

> MIO has always served an active role in reviewing the utilization of approved care and the appropriateness of the level of care provided. Consultants are, in many cases, giving advance approval for hospitalization. Subsequent to hospitalization, the Consultant has no way to verify that days are properly utilized or that the treatment authorized was actually provided, i.e., patient might be admitted and discharged next day because the operating room could not be scheduled for surgery. Because the Consultant is authorizing care prior to service, the necessary level of care might change during the period authorized. Under the proposed guidelines the provider is not motivated to bill for, or even move the patient to, a lower level of care. Furthermore, it has been our experience that Consultants sometimes authorize experimental services, cosmetic surgery or services which are not Program benefits. The proposal set forth in the MI letter makes DOH responsible for payment since a TAR will become a guarantee of payment.
>
> It is not unusual in such cases for the non-covered service to appear necessary on a prior to service basis while documentation of the actual service will clearly point out its cosmetic or experimental nature...
>
> We are also concerned about several areas that have continually presented utilization problems for the Medi-Cal Program. Inpatient psychiatric claims are generally submitted as emergency services and usually require extensions beyond three or even eight days. Our review experience has shown that frequently a portion of the stay cannot be justified as medically necessary. In many alcoholic detoxification cases, there is nothing to substantiate the emergency admission, although an extension will be necessary since three days is not an adequate period to cover the detoxification. The Department apparently intends to pay all such claims without further question, in accordance with the directive that emergencies with TAR's cannot be cut back.

The DOH requires MIO to "...subject all claims which include authorized acute hospital days to claims review activity, and when such claims are identified as inappropriate utilization, a copy of the claim and supporting documentation is to be forwarded to the Department for information." MIO has reviewed the claims and submitted questionable

claims to the Department for evaluation. The analysis of the first group of questionable claims has not been completed; however, a preliminary analysis indicates that the DOH agrees with a significant percentage of the MIO questioned days.

There is no reliable estimate of Medi-Cal funds expended on services which would have been curtailed or denied by MIO had the retroactive denial process continued. However, when the DOH Field Services Section completes the analysis of questioned claims submitted by MIO, information will be available to project an estimate.

CONCLUSION

Eliminating retroactive denial of hospital services has reduced the level of control over Medi-Cal acute-care hospital claims and allowed payment for services which apparently should have been denied. Retroactive denial is an adjunct to the on-site review function and an additional safeguard in the control of rising costs and utilization in the Medi-Cal program.

RECOMMENDATION

We recommend the Department of Health reestablish retroactive denial by the fiscal intermediary (MIO) of Medi-Cal consultant-approved days of acute-care hospitalization.

BENEFITS

Implementing the above recommendation will allow greater control of acute hospitalization days, increase the efficiency of the Medi-Cal program and promote greater economies.

THE SYSTEM USED TO IDENTIFY UNUSUAL PATTERNS OF MEDI-CAL SERVICES NEEDS SUBSTANTIAL IMPROVEMENT

The Surveillance and Utilization Review system (S/UR) was implemented by MIO in July 1975. The S/UR system is an exception reporting system designed to identify providers and recipients with unusual patterns of care and services. It is a review of utilization patterns by Medi-Cal providers and beneficiaries over a 15-month period. Based upon use and an extensive analysis of the reports generated by the S/UR system, MIO has found S/UR reports to be inadequate for their intended purpose.

The objectives of a S/UR system include:

- Developing comprehensive statistical profiles of health care delivery and utilization patterns established by provider and recipient participants.

- Revealing and investigating potential misutilization and promote correction of actual misutilization by Medi-Cal participants.

- Providing information which will reveal and facilitate investigation of potential defects in the level of care or quality of service under the program.

- Accomplishing the substantive objectives stated above with a minimum level of clerical effort and with a maximum level of flexibility with respect to management objectives.

In May 1975, the DOH instructed MIO to modify the claims processing and information retrieval system to qualify for increased Federal Financial Participation.* One of the requirements for the increased funding was a U. S. Department of Health, Education and Welfare approved S/UR system. The cost to develop and implement the S/UR system was $311,840 with an annual operating cost of $177,889.

Since the S/UR system was implemented, MIO has found numerous deficiencies in the reports generated by the system. These deficiencies include:

- Inaccuracies in current quarter statistics due to the time lag in receiving claims resulting in a distortion of the average month and trend rate statistics.

- Lack of uniform definition of medical visits for beneficiary, physician and outpatient class groups.

- Need for greater detail in certain service indicators i.e., hospital admissions should be identified by type of stay.

In the "Proposed Modifications to the MIO S/UR System," MIO states:

* See page 6 of this report.

Based on our use of the reports to date, and an extensive review of them, we find them inadequate in many ways for their intended purpose. If the present deficiencies are not remedied, we will be unable to properly identify and correct misutilization. Accordingly, we recommend certain modifications which we are convinced will greatly improve the effectiveness of the S/UR system and will permit us to better achieve the objectives for which it was designed.

The proposed modifications, estimated to cost approximately $56,000,* were sent to the DOH for review and approval in July 1976. MIO to date has not received approval to proceed with the modifications. When approved, they estimate that implementing the changes will take a minimum of nine months.

Other S/UR System Deficiencies

Each month there is a significant number of intercounty transfers and major aid code transfers by Medi-Cal recipients. When this occurs, the recipient's identification number is changed. The S/UR system does not have the capability of identifying those recipients whose identification numbers change. Consequently, the S/UR system is unable to analyze the prior history of those recipients.

This deficiency could be corrected by implementing an improved eligibility system as recommended in our report, Eligibility Abuses and Deficiencies in California Public Assistance Programs, No. 286.3, dated March 1977, page 33. The recommendation includes using the Social Security number as the recipient identification number, which would not change with intercounty transfers or major aid code transfers.

* See Appendix A for detail.

Another deficiency in the S/UR system is the inability to monitor quality of care of Medi-Cal recipients. It cannot detect under-utilization cases in which recipients have not received service they should have. For example, it will not identify individuals who have been eligible for benefits for a given period and who have received no services.

CONCLUSION

The Surveillance and Utilization Review Report is a valuable tool in the attempt to control abuse in the Medi-Cal program but system deficiencies, which are relatively inexpensive to correct, limit its use for the intended purpose.

RECOMMENDATION

We recommend that the Department of Health give high priority to reviewing the proposed modifications to the Surveillance and Utilization Review system and approve all modifications necessary to produce high quality usable reports.

BENEFITS

If the above recommendation is implemented the Medi-Cal program would benefit from the identification of suspected Medi-Cal program abusers.

OTHER PERTINENT INFORMATION

The following areas were included in our review but are not discussed in the Audit Results section of this report.

Paid Claims Evaluation

We statistically sampled Medi-Cal paid claims to determine the accuracy of the claims processing and review activity by MIO.

The review was to determine whether claims were being processed according to Medi-Cal regulations and program policy which affects claims payment. Such items as the presence of an eligibility label, attached Treatment Authorization Requests, provider signatures and diagnosis codes were tested.

The claims sample was selected from the following universe:

Drug Claims	June 1975 to May 1976
Medical Claims	May 1975 to May 1976
Institutional Claims	February 1975 to May 1976

During these periods MIO processed approximately 37.4 million claims which became the universe for the sample. The total sample size selected, which covered 18 provider types, was 4,014 claims.

Our analysis of the sample results indicates an overall error rate of only 1.9 percent which ranged from a high of 4.5 percent for physical therapist claims to a low of 0.4 percent for pharmacists claims and podiatrists claims.

We concluded from our sample that, for the period covered, the MIO claims processing and review function operated effectively.

Audit Trails Maintained for Paid Claims

As a part of the paid claims evaluation, we reviewed the audit trails maintained for paid claims. The following documents were obtained as required:

- Original claim when available or microfilm copy when not.
- Supporting claim documents.
- Beneficiary history profile.
- Paid full status microfilm.

The beneficiary history profile report provides historical information about prior Medi-Cal claims which have been paid. The report reflects information selected from the medical policy beneficiary history master file and contains each claim that was paid on behalf of the recipient for medical and dental services in the past 12 months and for hospitalization over the past 15 months.

The paid full status microfilm is designed as a reference tool when other sources are inadequate. The microfilm contains all information pertaining to a particular claim from the time it is received by MIO and numbered through filming and batching to final disposition—paid, denied or returned. The full history of the claim is presented including any suspense locations and pricing information on the files.

We found that the audit trail maintained for paid claims from receipt to final disposition was adequate.

Medical Policy Edit Audit and Procedure File

Claims submitted to MIO for payment by Medi-Cal providers for services rendered to eligible recipients are subjected to prepayment utilization review. Prepayment review is accomplished by Medical Policy Edit Audit and Procedures (MPAP). Edits and audits are defined as follows:

- Edit is a procedure for checking established requirements. If the requirement is not met, the claim will be suspended from the system for possible correction.

- Audit is a requirement for examining a service in the light of other services already provided to the patient.

The edit function was established to ensure accurate coding of claims entering the computer system; it was not designed to restrict payment to providers.

MPAP audits ensure the following:

- Accurate coding of claims entering the system.
- Uniformity of medical policy decisions throughout the users' lines of business.
- Conformity to statutory requirements of various government programs.

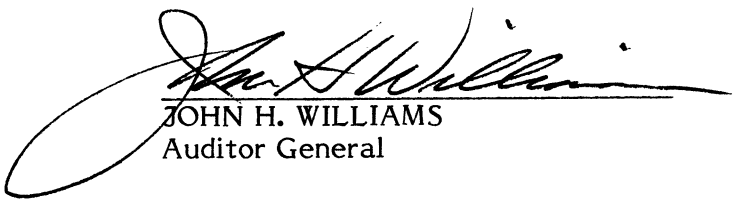
The MPAP file falls into two categories: relationship and limitation audits. Relationship audits check claim elements to ensure that certain logical relationships exist; for example, the relationship between beneficiary sex and diagnosis codes. These audits also relate the current claim to the past medical history of the recipient. Limitation audits enforce maximum dollar amounts allowed for a service and also identify claims exceeding maximum limits for various services. For example, a claim will be suspended if more than eight injections in one month are administered to the same beneficiary.

If a claim fails one or more of the MPAP audits, the claim may be denied, the amount of the claim reduced, or the claim suspended for review by a medical advisor.

MIO regularly reviews MPAP audits for effectiveness and if ineffective they are deleted from the file. They have also attributed approximately $24 million in program savings to the MPAP audits during calendar 1976.

It should be noted that, with the present eligibility system, the MPAP audits cannot analyze prior medical history on those recipients who have changed beneficiary identification number by either transferring to another county or by a change in aid code. The MPAP audits would function more effectively if the Department of Health implemented the use of the Social Security number as the beneficiary identification number as discussed on page 35 of this report.

Respectfully submitted,



JOHN H. WILLIAMS
Auditor General

Date: July 14, 1977

Staff: Kurt R. Sjoberg, Audit Manager
Bill Batt
Secundino M. Garcia

MEDI-CAL
INTERMEDIARY OPERATIONS

July 13, 1977

John H. Williams
Auditor General
Office of the Auditor General
925 L Street, Suite 750
Sacramento, California 95814

Dear Mr. Williams:

This is in response to your letter of July 7, 1977 regarding the draft report of the Auditor General pertaining to Utilization Control Functions of the Medi-Cal Program.

The subject report accurately describes the utilization controls in the MIO System. The only item which requires comment is on page 18 and relates to the Investigations Section procedures of 1970.

The procedures for preparation of cases developed by the Investigations Section were implemented by MIO. Between 1971 and 1975, the Investigations Section had staff assigned to MIO to review and approve each case prior to submission to a local peer review committee. This review served two purposes.

First, all cases that represented possible fraud or other major program violations were removed from MIO control and handled exclusively by the Investigations Section. Second, each case write-up was approved as meeting the 1970 documentation requirements. In addition, the Investigations Section was permitted to attend any local peer review meetings to assure the hearing was conducted appropriately. This arrangement was made by the Investigations Section with the California Medical Association and used on several occasions.

Since 1970, we have referred 415 cases to the Investigations Section and at no time were we advised that any one of the cases did not comply with the 1970 documentation requirements. During 1977, we have referred 452 cases to the Surveillance and Utilization Review Section and to the extent that it is deemed

continued....

BLUE CROSS OF SOUTHERN CALIFORNIA
4777 Sunset Boulevard · Los Angeles, California 90027
(213) 666-3100

BLUE CROSS OF NORTHERN CALIFORNIA
1950 Franklin Street · Oakland, California 94659
(415) 645-3000

BLUE SHIELD OF CALIFORNIA
P.O. Box 7924 · San Francisco, California 94120
(415) 445-5708

appropriate, the 1970 procedures are followed in preparing these cases. MIO believes we have consistently and accurately followed Department of Health direction in preparation of cases regarding overutilization and other program violations.

Thank you for the opportunity to review and respond to this report.

Sincerely,

Charles W. Stewart

Charles W. Stewart
Executive Director, MIO

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH
714 P STREET
SACRAMENTO, CALIFORNIA 95814

July 13, 1977

Mr. John H. Williams
Auditor General
925 L Street, Suite 750
Sacramento, CA 95814

Dear Mr. Williams:

Enclosed are the Department of Health's comments on your draft report to the Joint Legislative Audit Committee, "Certain Utilization Control Functions of the Medi-Cal Program Need Improvement", dated July, 1977. I appreciate having the opportunity to review this report prior to its final submission to the Legislature.

As you will see from our responses, considerable progress has been made in several of the areas addressed in the findings and recommendations you have made. I am particularly pleased to be able to give you an update on the progress of the Surveillance and Utilization Review Program, and to tell you that the Department is very optimistic about the future impact of this Program in controlling fraud and abuse by both providers and beneficiaries in the Program.

If you or your staff have any further questions or concerns about this report, my Associate Chief Deputy Director, Thomas Elkin, Deputy Director for Medi-Cal, Bruce Yarwood, or I will be happy to meet with you. Please give me a call at 445-1248.

Sincerely,

Jerome A. Lackner, M.D.
Director of Health

Enclosure

I. REFUSAL TO ISSUE EXPLANATIONS OF MEDICAL BENEFITS TO MEDI-CAL BENEFICIARIES RESULTED IN A NET LOSS OF $3.5 MILLION TO THE MEDI-CAL PROGRAM

1. Summary of Finding:

The Auditor General reports that because the Medi-Cal Program has refused to comply with the Federal requirement to issue statements of medical benefits (BEOMBs) to recipients of Medi-Cal services, the Department has lost $3.5 million in Federal funds for claims processing and information retrieval systems.

2. Current Status:

For the last two years, the Department has been actively opposing this requirement. Our opposition has included direct contact with former Secretary Matthews, in an effort to have the requirement modified through a change in the law, and finally led to litigation. The California Legislature has fully explored the entire issue of BEOMBs, and the decision was made by them to appropriate funds to cover the so-called loss.

Congress currently is hearing two bills, H.R. 3 and S. 143, which include revisions to the Social Security Act section dealing with BEOMBs. The Department has been in regular contact with members of the California Congressional Delegation as well as the bills' sponsors. On May 4, we were successful in having the House bill amended to permit the states to send BEOMBs to a sample of beneficiaries, rather than to all as the law now requires. More importantly, the bill was amended to permit exclusion of patients receiving confidential or sensitive services (i.e.

psychiatry, abortions, etc.) from the BEOMB requirement. If passed, these amendments would make the issuance of BEOMBs more acceptable to the Department.

As the Auditor General points out (page 91), California has sued for relief from the requirement on the grounds that issuance of BEOMBs constitutes an invasion of the patient's privacy, and that they do not achieve the intended result, that is, the detection of program abuse.

3. Future Action:

The Department takes the position that pending the outcome of the suit, and/or passage of the Congressional amendments, our opposition to compliance with this requirement will continue.

II. THE DEPARTMENT OF HEALTH HAS NOT EFFECTIVELY CONTROLLED MEDI-CAL PROGRAM ABUSE

A. Provider Abuse

1. Summary of Finding:

The Auditor General reports the Department has not effectively used existing administrative remedies; 25 to 30 percent of providers and an estimated 50,000 beneficiaries overutilize or abuse the program. Sanctions against abusing providers have been token, and for beneficiaries, nonexistent.

2. Current Status:

The Surveillance and Utilization Review Section (SURS; see also Section IV, below) is being restructured and expanded. At present, the possible actions described on page 16 of the report have been modified. Provider Errors (paragraph 1) are corrected as described. Overutilization (paragraph 2) is still handled by MIO when it involves minor problems. More extensive cases now are being prepared by MIO and referred to SURS for further review and action. Provider Fraud (paragraph 3) cases still are referred to Department of Health Investigation Section; in addition, when SURS identifies potential fraud cases in the course of a provider audit, the Investigation Section is notified immediately.

Paragraph 4, the last sentence should indicate that providers who do not take corrective action now are referred to SURS for review and corrective action.

The first sentence of paragraph 5, page 16 "The Investigation Section, however, has emphasized the development of fraud cases for prosecution and has not developed overutilization or sub-standard service cases." is no longer relevant, since SURS now has the responsibility for developing these cases. Cases such as the two briefed on page 17 now are being directed to SURS, both from cases previously referred to Investigation Section, and from MIO case development sources.

On page 18, the last paragraph comments that "between 25 and 30 percent of the Medi-Cal providers misutilize the program." The origin of this statement, as noted, was the proposal to implement the SURS program, and at present is no more than an educated guess which will not be validated until the Department has had sufficient time to complete the first phase of the SURS project and evaluate its results. However, it is important to recognize that the estimate included everything from insignificant cases stemming from misunderstanding of program requirements to overall patterns of flagrant abuse. It would be indefensible to infer from the statement that 25 to 30 percent of program expenditures are the result of abuse, and indeed, the early results of SURS audits do not confirm the estimate.

3. Future Action:

The Surveillance and Utilization Review Section implemented onsite audits of providers on March 1, 1977. With a budgeted staff of 68, comprising medical professionals and support staff, audits have been made of 88 providers through July 1, 1977. The section's Drug Utilization Review Unit, which

has been in operation since January 1976, has audited over 500 pharmacies. The early experience of SURS will be described in a summary report about September 1, 1977. The report, with recommendations for future development of the program, will be prepared for the Governor and the Legislature.

The SURS program has developed close working relationships with the Investigation and Facilities Licensing Sections of the Department, with MIO, with Medicare's Program Integrity staff, and with the various professional licensing boards of the Department of Consumer Affairs. Although its experience to date is limited, SURS is aggressively pursuing effective sanctions against abusers, including suspension from the program, referral to licensing agencies for possible revocation of licensure, recovery of improper payments, and other actions as appropriate.

4. Comments:

We are in substantial agreement with the findings presented when taken in the context of the time they were written. However, control of Medi-Cal fraud and abuse has undergone sweeping changes in the past six months, and the Department is heavily involved in future planning for refining existing controls and adding new ones. As your draft report pointed out, neither MIO nor the Investigation Section has had the capability in the past to exert meaningful control over abusive practices of providers or beneficiaries. Investigation Section has had an extremely heavy backlog of fraud cases which has precluded them from giving adequate attention to abuse. Earlier this year, the Section was augmented with 27 additional professional staff. Coupled with redirection of abuse

cases to SURS, this should greatly enhance Investigation Section's effectiveness in handling its primary responsibility of investigating fraud.

One of the highest priorities of the Department is to bring together a broad, well-integrated system for controlling and preventing future abuse, including detecting abuse, investigating aberrant provider and beneficiary practices, and taking prompt, effective action to stop existing abuse and prevent its reoccurrence.

* * * 1/

B. Beneficiary Abuse

1. Summary of Findings:

The Auditor General reports that no restrictions have been placed on services to beneficiaries even when it has been shown that Medi-Cal benefits have been improperly utilized; points out existing authority for the Department of Health to impose restrictions; notes DOH approval of policy and procedures to deal with beneficiary abuse in February 1977; and SUR's test of these procedures commencing in May 1977. The report lists five examples of suspected beneficiary abuse and recommends SUR implement and

1/ Comments deleted refer to items shown in draft report but not included in this report.

actively pursue policy for placing prior authorization restrictions on services to Medi-Cal beneficiaries who have been proven to be program abusers.

2. Current Status:

The Department concurs with the report findings on beneficiary abuse. One of the major objectives defined for the Surveillance and Utilization Review program is to develop and implement a vigorous system for identifying and controlling beneficiary abuse. Steps already have been taken to implement in September 1977 a system to require prior authorization for prescriptions issued to beneficiaries who abuse drugs.

3. Future Action:

SURS staffing to perform the preliminary beneficiary utilization review function was completed July 1, 1977. It is their responsibility to determine the numbers and kinds of beneficiary abusers and estimate staffing required for a fully operational control system by July 1, 1978.

C. Drug Utilization Review Unit (DURU)

1. Summary of Finding:

See Attachment I which is an update of the data given on page 25 of the Auditor General's report.

2. Current Status:

DURU continues to audit pharmacies and has recently implemented a statistically valid sampling method which permits the projection of findings from a limited audit to the entire Medi-Cal business of a pharmacy. Using this method, it is possible to recover inappropriate payments for a much larger number of services than the auditors are capable of examining directly.

3. Future Action:

Because of the tremendous success of the DURU program, the Department currently is expanding the unit to permit audits of more pharmacies.

D. Surveillance and Utilization Review Section (SURS)

1. Summary of Findings:

The SURS, DURU, and beneficiary review programs may substantially reduce Medi-Cal program abuses.

2. Current Status:

As discussed in Section II-A, above, SURS and DURU are proving effective in overcoming some of the program deficiencies discussed in this report. As these programs mature and refine their procedures, the Department believes they will both detect existing abuse and serve to effectively deter future abuse. With specific reference to the recommendation (page 26, paragraph 4), Investigation Section, as well as MIO, DHEW, and other states' SURS programs have all contributed generously to the development of the California SUR system. As mentioned earlier, the Department is taking a most aggressive stance regarding the application of legal and administrative remedies against abusers.

3. Future Action:

See Section II-A, 3. and 4., above.

III. ELIMINATING RETROACTIVE DENIAL OF HOSPITAL SERVICES HAS RESULTED IN PAYMENTS WHICH WOULD HAVE OTHERWISE BEEN DENIED

A. Elimination of Retroactive Denial

1. Finding:

MIO had authority to retroactively deny payments of consultant approved acute hospital days.

2. Response:

This is an inaccurate finding for both the past and the present procedural agreements existing between the Department and MIO. MIO has never had the authority to deny Medi-Cal reimbursement for acute hospital days approved by a consultant. Prior to September 1, 1975, they had the responsibility to suspend payment of claims which had been authorized but which they deemed inappropriate or questionable and to forward these claims to the Department of Health for final decision regarding their reimbursement under the Medi-Cal program. The responsibility for MIO to send questionable claims to the Department continues under the present procedure. The only change is that in cases solely involved with disagreement regarding the number of days approved, MIO now pays the facility upon approval of the consultant - i.e., does not suspend the claim - and then forwards it to the Department for internal evaluation and any corrective action required.

3. Future Action:

Based upon the above, no future action planned at this time except further refinement and improvement of the present procedures.

B. Postservice, prepayment evaluation of questionable claims

1. Finding:

Without retroactive denial, no post service, prepayment evaluation of such Medi-Cal claim is made.

2. Response:

This statement is incorrect. MIO was instructed that effective September 1, 1975, there would be no payment suspension of a claim by MIO if such suspension were based exclusively on a disagreement with the number of hospital days approved by the Medi-Cal consultant. MIO has retained retrospective review responsibility for (1) emergency admissions with stays of three days or less; (2) the initial determination of the appropriate level of care to meet the needs of the patient and (3) ancillary services provided to the patient while in the hospital for all stays. The Department of Health did not alter their review responsibility in these areas.

3. Future Action:

Based on the above, no future action planned at this time except further refinement and improvement of the present procedure.

C. Need for retrospective "denial" by MIO

1. Finding:

Retrospective "denial" (claim suspension) by MIO is needed and should be reestablished by the Department of Health for consultant-approved days of acute hospitalization.

2. Response:

Prior to the fall of 1975, hospitals mailed in Treatment Authorization Requests to the Medi-Cal consultants for prior approval and

extensions of acute hospital days of stay, other than in emergency situations. The Department instituted the MIO claims suspension and Departmental review of these approved days simply because field staff did not have regular access to all of the records documenting the patient's on-going condition and the medical services performed during the course of hospitalization.

Therefore, the postservice, prepayment review was seen as necessary to apprise the Department of the "total picture" of the hospitalization.

Following the implementation of the acute hospital on-site program, Medi-Cal consultants did have immediate and regular access to medical records documenting the patient's condition and the hospitalization. This on-site review by Department staff occurs on approximately 80-85 percent of the requests for acute hospitalization state-wide.

Certain hospitals are excluded from the on-site routes and continue to submit TARs by mail because they have a low Medi-Cal patient volume or are geographically isolated. A procedure is now in effect to conduct on-site review of TARs and records for these hospitals no less than quarterly to verify that the services requested were justified by the medical information in the patients' records.

Based on the above procedure, the policy of non-suspension of questionable but approved claims was extended to the few hospitals excluded from the regular on-site program.

The present on-site program combines review of the Treatment Authorization Request and review of all pertinent hospital medical record material, including doctor's orders, nursing notes, reports from consultant specialists, lab and x-ray findings, etc. On-site personnel also consult directly with hospital staff and the attending physician who are currently involved in rendering care to the patient.

In actuality, on-site staff have greater access to information on an immediate and regular basis than do either the field consultant reviewing the mail-in Treatment Authorization Request or the consultant reviewing claims material in MIO.

3. Future Action:

Based on the above, no future action planned at this time except further refinement and improvement of the present procedure.

D. Authorization of non-covered services.

1. Finding:

MIO has also expressed concerns over Department of Health authorization for services of a cosmetic or experimental nature, emergency in-patient psychiatric care and alcohol detoxification services which require extension beyond three days.

2. Response:

The Department has had - and retains - full authority within Federal mandates to define the benefit structure of the Medi-Cal Program. The benefits approvable under Medi-Cal are properly in a state of on-going change, reflective of advances in the practice of medicine.

The Medi-Cal consultants, under the functional, professional leadership of Medi-Cal Benefits Section physicians, form the "working arm" of the Department relative to authorizable program services. Medi-Cal Benefits Section's professional consultants continuously review and evaluate new and existing medical procedures against the accepted body of medical fact regarding their value and the legislative and regulatory parameters of the program. MIO's role has been and continues to be that of a reviewer who submits to Medi-Cal Benefits Section, those benefit authorization practices which they find questionable. Medi-Cal Benefits Section reviews these, makes the final decision as to whether the service will be reimbursed and implements any "in-house" corrective action necessary.

A further clarification must be added regarding alcohol detoxification. The treatment of medically uncomplicated alcoholism never has been a covered benefit of the Medi-Cal program. Interestingly enough, when the Department reduced the period of emergency hospitalization allowable without a Treatment Authorization Request from

eight days to three, several alcohol detoxification programs were discovered which had been providing care (1) clearly not allowable under the program and (2) subject solely to MIO's review for medical necessity and benefit coverage.

3. Future Action:

Based upon the above, no future action is planned at this time other than further refinement and improvement of the present procedure.

E. Department concurrence with MIO questions on claims

1. Summary of Finding:

Preliminary analysis indicates that the Department of Health agrees with a significant percentage of the MIO questioned days: (Page 31, paragraph 1).

2. Current Status:

Based on the Department's review of the paid claims referred by MIO to date, we believe that the decision to drop the retroactive suspension of payment for prior authorized hospital services was correct. A sample analysis of questionable claims referred to the Department by MIO showed that: (1) the total number of consultant-approved hospital days questioned by MIO represented less than 1/2 of one percent of the total number of hospital days approved during that period, and (2) that only 1/3 of the days questioned should have been disapproved by the medical consultant or were inappropriately used by the hospital. Included in these questioned days were some emergency days - exempt from prior-authorization - which

should have been denied by MIO but were in fact paid in error by them. Cases which the review showed were inappropriately authorized by a Medi-Cal Consultant were referred to those consultants for feedback to prevent future errors. However, it must be reiterated that these days represent an insignificant portion of the total number of hospital days approved (approximately 1/6 of one percent).

3. Future Action:

The review did show, however, that a number of consultant-approved hospital days were inappropriately used by the hospital, for example, for services which could have been performed on an outpatient basis. The Department is currently reviewing a proposal to allow MIO to retroactively suspend payment for days when it is apparent that the hospital did not utilize the days for the purpose authorized.

4. Conclusion:

We estimate that no significant amount of Medi-Cal funds have been expended on services which would have been denied by MIO had the retroactive denial process been continued. We believe that the on-site hospital review procedure has been a more cost-effective hospital utilization control mechanism.

F. Additional Comments

It is very important that an apparent misconception be corrected at this point. MIO and the fiscal intermediaries function as agencies under contract to the Department of Health. The Department has - now, and in the past - primary and final authority for the Medi-Cal program

and the expenditure of Medicaid monies in this state. MIO performs those functions delegated to them by the Department. Over time, those functions can - and will - be changed, based upon the Department's decisions regarding methods of improving this program and its operations. In our relationship, MIO does not exist as an entity separate and apart from the Department and it certainly has never had either monitoring or final review authority over Departmental decisions or actions.

IV. THE SYSTEM USED TO IDENTIFY UNUSUAL PATTERNS OF MEDI-CAL SERVICES NEEDS SUBSTANTIAL IMPROVEMENT

A. Structure of the (MIO) S/UR System (pages 33-35)

1. Summary of finding:

The Surveillance and Utilization Review System (S/UR) is an exception reporting system designed to identify Medi-Cal providers and recipients with unusual patterns of care and services. MIO implemented the S/UR System in July, 1975; and based upon use and extensive analysis of the reports generated, has found the S/UR reports to be inadequate for their intended purpose.

2. Current Status:

MIO's document, "Proposed Modifications to the MIO S/UR System", has been reviewed and recommendations have been made to approve it with minor qualifications, none of which should change the quality or content.

Regarding the deficiencies noted, the "Proposed Modifications to MIO S/UR System", would make the following changes:

a. Inaccuracies in current quarter statistics due to the time lag in receiving claims resulting in a distortion of the average month and trend rate statistics.

In computing both the average month and the trend rate, a downward bias is introduced when the most recent quarter is included. It is proposed that these computations be computed omitting "This Quarter" and base them on the next four prior quarters.

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b. Lack of uniform definition of medical visits for beneficiary, physician, and outpatient class groups.

Medical visits have been redefined in terms of the appropriate RVS Codes to be used for the above class groups. RVS Codes 90700 (Immunizations) and 90705 (Therapeutic Injections) have been excluded in the definition of medical visits.

c. Need for greater detail in certain service indicators, i.e. hospital admissions should be identified by type of stay.

Additional service indicators have been added to most categories of service. Hospital admissions will be divided into three categories: medical, surgical and obstetric. Medical and surgical admissions will be further separated into prior-authorized (non-urgent) and emergency admissions. Obstetric admissions are accepted as emergencies by nature, and do not require prior authorization.

3. Future Action:

Assuming that the Department approves and adopts the "Proposed Modifications to the MIO S/UR System," the deficiencies discussed in the Auditor General's report should be corrected. Implementation of the modified system will require approximately nine months from the time it is approved.

B. Other SUR System Deficiencies (page 35)

1. Summary of finding:

SURs is unable to identify and analyze the prior history of beneficiaries who transfer from one county to another because Medi-Cal currently uses a county issued beneficiary number to identify persons receiving assistance. This county issued number changes each time the beneficiary moves from one county to another county.

2. Future Action:

Medi-Cal Eligibility Section proposes to use the Social Security Account Number (SSAN) as a unique identifier for the entire Medi-Cal beneficiary population. We have already asked the Department of Health's Data Processing staff to create a program that will scan the Medi-Cal Eligibility History File and identify those beneficiaries who either do not have a SSAN or who have incorrect numbers or duplicate ones. After this information is retrieved, Systems staff will then send a notice to these persons asking them to contact their eligibility workers and provide them with the correct SSAN or go to Social Security Administration (SSA) district offices and apply for a new number. The notice sent to the beneficiaries will identify a specified time limit in which a SSAN must be provided to the counties and also serve as a Notice of Action to beneficiaries who do not report the correct number or do not provide evidence that they have applied for one at the SSA district office. We expect this phase of our program fo be operational in approximately six months.

Along with identifying incorrect/missing SSANs, we have proposed that the Social Security Administration work with our staff to establish

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a system that will validate all of the SSANs on our Eligibility History File and let us know if the number provided belongs to the individual identified. We will have no time estimate on this phase of our project until we receive a response from our letter to SSA.

3. Additional Comments:

Errors noted within this section are as follows:

a. Page 38, last paragraph - Beneficiary history profiles contain the following history; Blue Shield drug claims - 11 months, Blue Shield medical, Blue Cross crossover and Blue Cross outpatient claims - 12 months, all other Blue Cross claims - 15 months and all history since January 1, 1974 for California Dental Service.

b. Page 39, definition of Audit in error. Audits also check to insure the logic of the service (i.e. a male can not deliver a baby).

c. Page 39, last paragraph - The edit function does restrict payment to providers by cutting back billed amounts to Medi-Cal payable amounts and by checking against certain program requirements (i.e. drug is refillable, liability has been met).

DRUG UTILIZATION REVIEW UNIT

DURU is an on-site review unit which covers Medi-Cal providers of pharmaceutical services. The unit is staffed with nine positions, seven of which are filled by pharmacists.

As of May 1977, the DURU had completed 516 preliminary audits and 62 in-depth audits of providers. Of the 433,891 prescriptions reviewed, 121,590 or 28 percent were questionable with 666,109 identified as recoupable. A breakdown of the recoupments by cause follows:

Prescription overcharging	20.8%
No record of refill on service date	15.8%
No record of prescription on file	20.1%
False billing	19.3%
Prescription splitting	7.7%
Other	16.3%
TOTAL	100.0%

Included in the statistics cited above are 38 cases referred to the Department of Health Investigation Section for possible fraud.

As the amount of recoupment/cause is variable (i.e., 100 percent in some cases, less than 100 percent in others), we cannot relate the number of dollars to the percentage of each cause of recoupment.

SUMMARY

The Department of Health has reviewed the draft Report of the Office of the Auditor General to the Joint Legislative Audit Committee titled "Certain Utilization Control Functions of the Medi-Cal Program Need Improvement." Our response and comments follow.

In the interim since the beginning of the preparation of this report, there have been significant changes in the Department's compendium of controls. Programs which were in their infancy then have matured and have proven effective. Other older control systems have been reexamined and refined. The primary emphasis throughout has been to integrate all utilization controls, both old and new, into a rational, orderly system progressing from definition of the benefit structure, through preservice and postservice review, overall surveillance of both providers and beneficiaries, to investigation and correction of abuses. The control system also incorporates feedback mechanisms at numerous points to assure that when a deficiency in the system is found, it is corrected.

Under both Federal and State law and regulations, the Department always has had the responsibility to define Medi-Cal benefits, and to convey this information to providers, beneficiaries and fiscal intermediaries. Medicine is a fluid science, and the benefit structure has to be flexible enough to adapt to this fluidity. At any point in time, Medi-Cal Consultants and intermediaries alike must be fully aware of the current sturcture of benefits in order to be effective in their exercise of utilization controls.

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Once a patient is treated, so-called postservice controls come into operation. Although the bulk of these controls is applied by the intermediaries, there is no question that the Department defines what the controls are and how they are applied. And, when a judgement call is required in a specific case, the Department always has had, and has exercised, the final authority.

The fiscal intermediaries also have played a major role in the postpayment review of utilization. Each year, they have taken corrective action against hundreds of providers, through the processes of placing providers on 100 percent prepayment review, and of referring persistent abusers to local peer review organizations. They also have conducted extensive provider education services to correct minor problems. To state, as the Auditor General's report does, that some providers have been under surveillance by the intermediaries for several years, completely ignores the multitude of cases where postpayment controls <u>have</u> been effective.

The final rung in the control system has been, and is, the investigation of program participants whose activities are fraudulent. Abusive practices brought to the attention of the Department in the past often ended up in the Investigation Section. However, that Section has, as its primary mandate, the responsibility for documenting fraud cases; it never has had the resources to devote adequate attention to investigating abuse cases, nor has this been its major function.

As mentioned above, the Department has been expanding and refining the entire utilization control system. In September, 1975, preservice review by Department of Health consultants of non-emergency hospitalizations was moved from the Medi-Cal field offices to an onsite review at the hospitals themselves. Medi-Cal Consultants now have direct access to patient charts and other records, which enables them to make much more accurate assessments of the need for and course of care. The Auditor General reports that the Department now requires MIO to pay all claims for services authorized by consultants, but fails to tie this to the fact that onsite review of authorizations is far superior to remote review, after the fact, as a utilization control. Parenthetically, MIO never has had the authority to deny payment of inpatient days, but was empowered to pend payment until the Department had reviewed questionable claims and determined whether the payment was appropriate. On the other hand, MIO had, and continues to have the authority, given them by the Department, to deny both the level of care provided and the ancillary services claimed.

In January, 1976, the Medi-Cal Division of the Department introduced a program of audits of pharmacy providers. Known as the Drug Utilization Review Unit (DURU), this program has been highly effective in identifying and correcting abusive practices. To date, audits of more than 500 pharmacies have been completed, and over $600,000 in inappropriate payments have been identified for recoupment. Because of DURU's success, a similar system of audits now is being used for most other types of Medi-Cal providers. The Surveillance and Utilization Review Section (SURS) began auditing physicians, hospitals, laboratories, medical transportation, X-Ray and other providers in March, 1977. Beginning in July, staff now are available in SURS to investigate beneficiary abuse.

These new programs - SURS and DURU - fill the need, identified by the Department and others, for an organization which could go beyond the existing postpayment sanctions administered by the fiscal intermediaries, and to pursue the abuse cases which had been shunted to the Investigation Section in the past. Early experience with SURS is highly encouraging, and in September, the Section will be reporting on its progress to the Governor and the Legislature. The Department strongly supports these programs, and is applying appropriate sanctions against abusers.

As mentioned above, beneficiary abuse cases also are being investigated by SURS, and on September 1, 1977, the Department will begin issuing special Medi-Cal cards to drug abusers which will require that every prescription will require authorization by a Medi-Cal Consultant. The Department also has developed a system, to be in use in approximately nine months, which will prevent beneficiaries from securing multiple identification cards.

With regard to the issue of Beneficiary Explanations of Medi-Cal Benefits (BEOMBS), several comments are pertinent. The Department has been heavily involved for over two years in contesting this requirement. We are involved in litigation with the Department of Health, Education and Welfare, and have had considerable effect on the course of Congress' current efforts to have the law modified to lessen the burden on the States, and to protect the privacy and confidentiality of beneficiaries. Until the litigation is completed, it is premature to state that California has "lost" $3.5 million. Moreover, the entire issue was fully explored by the Legislature, and the decision was made by them to appropriate funds to cover the so-called loss.

In summary, the utilization controls in the Medi-Cal Program are effective, are responsive to change, and are subject to continual reexamination and refinement. The Department is in full support of the system of controls, and is aggressive in imposing available sanctions, and in seeking new and more effective ones.

APPENDIX A

Cost Estimates for the Proposed Modifications to the Surveillance and Utilization Review System Reports

	Summary of Changes	Estimated Cost
1.	Line Item Modifications	
	Additions, deletions and changes to the service indicators in each participating category, including the addition of 181 new items	$16,950
2.	Modifications to Class Groups	
	Modifications of class group definitions for recipients, physician specialties and teaching facilities	10,500
3.	Changes in Selection Criteria and Measurement Considerations	
	Modifications to calculations affecting selection, weighting and arraying of data	10,290
4.	Flexibility in Selection Mechanism	
	Addition of capability to suppress or force out specific participants as exceptions for review	7,800
5.	Format Modifications to Management Summary and Summary Profile Reports	1,500
6.	Format Modifications To Detail Reports	1,500
7.	Statewide Totals	
	Addition of Statewide Total to the Management Summary Report	7,800
	Total Systems Cost If All Changes Are Implemented	$56,340

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Office of the Governor
Office of the Lieutenant Governor
Secretary of State
State Controller
State Treasurer
Legislative Analyst
Director of Finance
Assembly Office of Research
Senate Office of Research
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