REPORT OF THE

OFFICE OF THE AUDITOR GENERAL

005

A REVIEW OF COMPUTER SCIENCES CORPORATION AND THE DEPARTMENT OF HEALTH SERVICES MEDI-CAL FISCAL INTERMEDIARY OPERATIONS

MAY 1980

California Legislature

Joint Legislative Audit Committee

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May 12, 1980

005

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 Auditor General's report concerning the Medi-Cal fiscal intermediary contract between the Department of Health Services (department) and Computer Sciences Corporation (CSC).

The report generally concludes that CSC's claims processing system is not performing up to standard in certain areas and that both CSC and the department are responsible for the specific failures noted.

Contractual procedures designed to insure an acceptably functional system are not being followed. The system is not being completely tested before various claim types are put into actual operation. As a result, some payments were unnecessarily delayed and some were made in error. Certain reports designed to control program expenditures and monitor system performance are neither timely nor accurate. These reporting failures entitle the State to collect damages. The department, however, has not taken full advantage of contractual liquidated damage provisions and has passed over millions of dollars in potential assessments against CSC.

The report notes that the time required to process payments to providers could be improved. Although CSC's system has been able to process problem-free claims within contractual standards for five of the first nine months of operation, the average processing times appear to be increasing with the addition of each new claim type. Additionally, many other claims have been unnecessarily suspended and payments delayed.

The report acknowledges that CSC has provided program participants with the training and informational materials specified in the contract. However, certain communication channels to providers could be improved. In addition, CSC's billings to the State are reported to be appropriate except for a $97,893 overcharge for certain outpatient claims. The Auditor General also points out that several state-ordered changes to the system have added, or will in the future add, millions of dollars in unanticipated operational costs.

The report recommends that the department increase its contract monitoring and oversight activities. Furthermore, the department should delay the addition of the physician and medical supplier claim types until all contract system acceptance testing procedures have been followed.

The auditors are Richard C. Mahan, Audit Manager; Ann Arneill; Michael Dendorfer; Andrew Fusso; Steve Hendrickson; Noriaki Hirasuna; Mark Lowder; Ulrich Pelz; Ann Reicherter; John Schmidt; Steve Schutte; and Albert Tamayo.

Respectfully submitted,

S. FLOYD MORI
Chairman, Joint Legislative
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SUMMARY

Since the beginning of the Medi-Cal program in 1966, the State has contracted with a fiscal intermediary to provide for processing and payment of medical billings for services to Medi-Cal recipients. In 1978, the state Department of Health Services (department) awarded the contract to a new fiscal intermediary, the Computer Sciences Corporation (CSC). The purpose of establishing this new contract was to increase the contractor's financial responsibility, establish a more efficient and effective claims processing system, improve the State's ability to identify program abuses, and maximize federal reimbursement. The contract runs for 5½ years and is estimated to cost the State and Federal Government approximately $130 million.

We and our consultants, Deloitte Haskins & Sells, reviewed CSC's compliance with contract requirements. We found that, although CSC and the department have complied with certain contract requirements, CSC's system is not performing up to contract standards in many areas. Both CSC and the department are responsible for the system's not functioning as expected. CSC has not adhered to certain contract procedures. Additionally, the department has not provided CSC with certain eligibility and medical information necessary for the system to

operate properly. Finally, the department has not effectively exercised its contract authority to improve CSC's performance. Our review of CSC's system involved a number of specific topics. The following summarizes the results of our review.

Sufficiency of the Testing Process -- CSC's automated processing system is not being completely tested before various claim types are put into actual operation. Incomplete testing has caused system deficiencies which have resulted in unnecessarily suspended claims and provider overpayments. Neither CSC nor the State is following testing procedures specified in the contract. Specifically, CSC's procedures to develop adequate test designs were not thorough enough; CSC did not adequately test its systems before turning them over to the department; and the department did not enforce the required procedures to ensure a trouble-free system (see page 22).

Accuracy and Timeliness of Report Production -- The contract requires CSC to produce a number of reports that are necessary to both the State and CSC in monitoring and controlling the system's operation, in controlling provider and recipient abuses, and in maximizing federal reimbursement. We tested three of CSC's four reporting subsystems and found that some reports were not being produced. We also found that many of those reports in production are untimely and inaccurate (see page 31).

Liquidated Damages -- When CSC fails to fulfill contractual obligations, the department has the authority to assess liquidated damages in certain areas. To date, the department has imposed $195,000 in penalties. We have found, however, that the department has not levied fines against CSC in all instances of contract noncompliance that are subject to liquidated damages. Strictly interpreting the contract's liquidated damages provisions, we computed potential damages for noncompliance to be $7.5 million. We do not conclude that the department should have necessarily levied this total amount but rather that it had the prerogative to put greater pressure on CSC to conform to contractual requirements (see page 46).

EDP Controls and Audit Trails -- CSC generally has the required controls and audit trails in place and working in the areas of safeguarding software, maintaining file integrity, and documenting important transactions. Areas where general controls could be strengthened include: (1) formalizing procedures for reactivating edits/audits once they have been turned off; (2) requesting daily tapes from various keypunch service bureaus; and (3) establishing an ongoing EDP internal audit function (see page 43).

Claim Processing Time -- For four of the first nine months of operation, CSC failed to meet the 18-day contractual average monthly time standard for processing all claims. A

month-by-month comparison of processing times indicates decreased compliance with performance standards. There also appears to be a possible correlation between increased processing time and the addition of new claim types. Analysis of the processing time of individual claim types revealed noncompliance for pharmacy, long-term care, and outpatient claims during January and February 1980; and noncompliance for inpatient claims during February 1980 (see page 56).

Suspended Claims -- The contract requires that no more than 9 percent of the total claims inventory exceed 30 days in the system. Based upon an analysis of the suspended claims and weekly and daily approved claims files in March 1980, up to 32 percent of the total claims in the system were more than 30 days old. Claims which failed eligibility, provider, and Treatment Authorization Request (TAR) edits accounted for a large portion of the suspended claims. We found the number of suspended claims could be reduced if (1) county welfare offices and the department would provide eligibility data in a timely manner, (2) providers would prepare their claim forms properly, and (3) CSC would be more timely in resubmitting TARs for correction and would correct certain system problems (see page 63).

Accuracy of Payments -- During various times, processing system edits and audits were either not operational or were not operating sufficiently to control the appropriateness of payments to providers. These edits, some critical, have been turned off under written or informal approval of the department. These edits, however, were not always reactivated at appropriate times. Additionally, some other operational edits appear to have been insufficient to identify all overpayments. As a result of these conditions, large volumes of claims have been processed without undergoing certain critical edits, and at least $450,000 in claim overpayments were made by the State. Also, the department does not maintain adequate records of its orders to activate and deactivate edits and audits (see page 77).

Appropriateness of Charges to the State -- As of March 31, 1980, CSC had charged the State $21.2 million for services performed under the contract. Most of these charges were for system design, development, and installation. We generally found these charges to be appropriate except that outpatient claim operational costs were overcharged by $97,983 due to a program logic error. CSC is in the process of making restitution for these overcharges (see page 86).

We also found that the State will bear certain added costs as a result of these state-ordered changes:

- The department has postponed its request for federal certification of CSC's system because of various system problems. Federal financing, however, cannot be increased until the system is certified. If the Federal Government certifies CSC's system for increased federal reimbursement effective November 1980 and not retroactively to June 1979, the State will lose over $4 million. Should the system receive retroactive certification, the State will still lose interest earnings amounting to $210,757 (see page 92).

- Because of difficulties with the claims processing system to date, the phase-in of physician and medical supplier claim types was delayed from March 1, 1980 to June 1, 1980. The cost effect of this delay is $3.5 million, of which $600,000 is state funds (see page 94).

- The department has directed CSC to make partial payments on certain suspended claims. This interim payment process will cost the State slightly over $1,500 (see page 96).

- The department has ordered CSC to implement two contract modifications that may add an estimated $5.1 million to the total contract cost. These modifications will enhance system capabilities and will institute a new method for validating recipient eligibility (see page 97).

Provider Communications, Training, and Information -- The contract stipulates that CSC must respond within certain time limits to various provider inquiries related to billing procedures, claim status, explanation of policy, etc. Although CSC is responding to telephone inquiries within the allotted time, it is not doing so with written inquiries requiring information on specific claims. CSC's response to these type inquiries has exceeded the 15-day contract limit up to 40 percent of the time. CSC is adding staff to rectify this problem (see page 101).

CSC appears to be fulfilling contract requirements to train and provide procedural information to providers. Training sessions have included the contract-specified subjects, and the sessions have been held in the specified locations. Informational materials, manuals, and bulletins have all been sent to providers within the 15-day contractual time limit.

Based on the foregoing findings, we recommend that the department increase its contract monitoring and oversight activities. Specifically, the department should delay the addition of the physician and medical supplier claim types until all system acceptance testing procedures as outlined in the contract have been followed. Outstanding system problems for the other claim types should also be corrected. Additionally, we recommend that the department assure delivery of timely and accurate system reports; formalize procedures to monitor the operation of system edits and audits; and impose liquidated damages when necessary to motivate CSC to comply with contract terms.

CHAPTER I

INTRODUCTION

In response to Chapter 43, Statutes of 1980 and a request of the Joint Legislative Audit Committee, we reviewed the fiscal intermediary contract between the state Department of Health Services (department) and the Computer Sciences Corporation (CSC). This review was conducted under the authority vested in the Auditor General by Section 10527 of the Government Code. Our audit work included an examination of the following specific areas:

- CSC's compliance with contract terms;
- The total cost of the contract;
- The effectiveness and efficiency of claims processing procedures;
- The extent of problems outside of CSC's control which affect processing.

Because of the frequent references to certain Medi-Cal claims processing system terms in this report, we have included a list of these terms and their definitions in Appendix A. We recommend that the reader review this list before reading the remainder of the report.

BACKGROUND

In July 1965 two major amendments to the Social Security Act greatly expanded the scope of medical coverage available to various segments of the population. Title XVIII established the federal Medicare program; and Title XIX established the medical assistance program known as Medicaid, which states have the option to implement. The Medicaid program provides federal matching funds to states implementing a single comprehensive medical care program.

In March 1966, California implemented the Title XIX program by creating the California medical assistance program, Medi-Cal. The State and Federal Governments jointly fund this program: for 1979-80 the state's share is 57 percent and the federal share is 43 percent. For fiscal year 1979-80, the Medi-Cal program cost approximately $3.7 billion. Budgeted fiscal year 1980-81 program costs are $4.1 billion.

Medi-Cal beneficiaries are entitled to a variety of services rendered by health care providers. These services include outpatient visits to physicians' offices, dental services, drugs, inpatient and outpatient hospital services, nursing home care, and other health-related services.

The Department of Health Services administers Medi-Cal through an agreement with the U. S. Department of Health, Education, and Welfare (HEW). The primary Medi-Cal responsibilities of the department fall into three categories:

- Service provision -- The department operates the Medi-Cal fee-for-service program and administers and monitors prepaid health plans. The department also procures and manages the contracts with fiscal intermediaries for reviewing and paying provider claims.

- Standard and policy setting -- The department develops and issues policies on Medi-Cal benefits, implements and monitors eligibility requirements, and develops the fee structure for the fee-for-service and prepaid health plans.

- Program utilization controls -- The department exercises prepayment and postpayment controls on Medi-Cal expenditures. Prepayment controls include an authorization system prior to rendering medical services and a review system after services are delivered but before payment is made. The overpayment identification and recovery system provides the postpayment controls, those following payment of services.

Medi-Cal claims payment activities have been performed under contract by a nongovernmental fiscal intermediary since the Medi-Cal program was implemented in 1966. The State does not directly handle claims from providers of the services rendered to Medi-Cal beneficiaries since the fiscal intermediary actually processes and verifies the claims. Prior to September 1978, Blue Cross North, Blue Cross South, and Blue Shield Services Corporation, operating under joint contract as Medi-Cal Intermediary Operations (MIO), held the fiscal intermediary contract. Electronic Data Systems performed computer systems functions under subcontract to MIO. The fiscal intermediary contract required reimbursement for the intermediary's costs on a no profit/no loss basis. The contract ran on a month-to-month basis.

With the Legislature's concurrence, the department decided in 1976 to seek competitive bids for a new fiscal intermediary system. The department wanted such a system to meet the following objectives:

- To increase the financial responsibility of the contractor;

- To improve the effectiveness and efficiency of the claims processing system;

- To provide forceful state management capability;

- To ensure the State had the option to operate the contract itself;

- To develop a system allowing the State to claim the maximum amount of federal financial reimbursement;

- To ensure that the procurement process itself would be as open, competitive, and impartial as possible.

After a lengthy bidding process, the State awarded a 5½ year contract effective September 1, 1978 to the Computer Sciences Corporation, the low bidder at $129,599,728. CSC, a California-based firm, entered into a subcontract with The Computer Company of Richmond, Virginia. The Computer Company has prior experience as a Medicaid fiscal intermediary in other states.

The contract essentially requires that CSC design, develop, install, and operate the Medi-Cal claims processing system for 5½ years, and then turn it over to the department or a successor contractor.

The department incorporated the federal requirements for a Medicaid Management Information System (MMIS) into the new fiscal intermediary contract specifications. MMIS, a

computerized claims processing system provides information needed for managing Medicaid systems. HEW developed a model design of this system in 1972 in response to the rising costs of medical services and increased public demands for these services.

Title XIX of the Social Security Act establishes standards for claims processing and for administrative accountability. Title XIX also provides federal matching funds for MMIS design and operation. Before California can receive the maximum amount of matching funds available, HEW must review, test, and certify the sufficiency of the system. CSC's response to the Request for Technical Proposal indicates that its system will conform to federal MMIS requirements.

General Contract Provisions

The fiscal intermediary contract between the department and CSC calls for three types of payments to the contractor. The contractor is reimbursed a fixed price for those expenditures incurred in the design, development, installation, and turnover of the fiscal intermediary system. Additionally, the contractor recovers an administrative charge for each Adjudicated Claim Service Line (ACSL) processed. The State also reimburses the contractor for the actual cost plus appropriate overhead for postage, printing and distribution, and equipment purchased for state use.

The work required of the contractor is divided into four major tasks: design and development, installation, operation, and turnover of the California MMIS. For each task, the Request for Technical Proposal (RFP) describes the State's and the contractor's general responsibilities, the major milestones or significant events which must be accomplished, and the deliverables which the contractor must produce. These must be approved by the State in order to complete the task.

The contract allowed CSC 18 months for design, development, and installation of its system. The final phase of the system was to be implemented by March 1, 1980. However, on February 20, 1980, the Director of the Department of Health Services delayed implementation of the final provider group until June 1, 1980.

System Operation

CSC's claims processing system involves three basic operations.

Input Processing

Mail is received, sorted, and microfilmed. Approximately 60 percent of the claims received are entered into the computer by an optical character reader. The remaining 40 percent must be manually keypunched for entry. During microfilming, claims receive a claim control number

with a Julian date based upon the day of mail receipt. Claims are preliminarily screened for signature, provider identification, and recipient eligibility. They are then entered into the computer system.

Computer Operations

Once in the computer system, claims are checked by numerous edits and audits to verify the recipient's eligibility and the claim's validity. The edits and audits review claims for items such as:

- Recipient eligibility at time of service;
- Provider eligibility at time of service;
- Duplication of claims;
- Compatibility of procedures and diagnosis;
- Valid Treatment Authorization Request (TAR) for service rendered.

Claims Adjudication

If a claim or line item on certain claim types does not pass one or more of the edits and audits, it is rejected, denied, or suspended for review by a claims examiner. If input errors are detected, they can be corrected, released from the

suspense file, and recycled through the claims validation process. Certain claim information failing an edit cannot be corrected by claims examiners. In that case, a Resubmission Turnaround Document (RTD) is sent to the provider to correct the information submitted. The claim is then resubmitted for processing. Claims that successfully pass the edits and audits are listed on a payment tape, which is sent to the State Controller who then sends payment to the providers.

SCOPE AND METHODOLOGY

The general objectives of this audit were to measure the performance of CSC's claims processing system against contract performance standards; to determine the degree to which CSC has complied with contract terms; to determine the extent to which system deficiencies were beyond CSC's control; and to determine the appropriateness of payments to the contractor.

We retained the services of an international consulting firm, Deloitte Haskins & Sells, to examine audit areas requiring extensive EDP system auditing expertise. In general, their tasks were to evaluate the timeliness and accuracy of claims processing, the sufficiency of internal controls, the adequacy of system testing, and the accuracy of CSC billings for processing claims. These sections of the report are based upon Deloitte Haskins & Sells' analysis and conclusions.

To accomplish our audit objectives, we performed these audit steps:

- Reviewed the contract and its supporting addenda and bulletins;
- Reviewed compliance with various sections of the contract;
- Evaluated management information system reports;
- Interviewed both CSC and department officials and support staff;
- Randomly sampled and reviewed claims;
- Reviewed correspondence files;
- Requested legal opinions from the Legislative Counsel to interpret certain contract provisions;
- Reviewed system reports;
- Observed CSC's various systems in operation.

Factors Limiting Evaluation of the Contract

We were forced to limit the scope of our audit work due to the limited time available to complete our review. Approximately two and one-half months were available to plan,

to evaluate, and to report on a new, highly sophisticated, large-volume, EDP system responsible for controlling the expenditure of billions of dollars of public funds.

Our audit staff encountered frequent delays in obtaining documents and interviews. For example, 12 days elapsed before auditors received information on CSC's Government Health Services Division overhead rates.

Informal agreements which appear to modify certain contract requirements are yet another limiting factor. For example, physician claims testing is proceeding under an informal plan which does not conform to contract requirements. Because of such agreements, determining exact contract requirements and pinpointing responsibility for system failures are difficult.

During the audit, we could not locate certain records. For example, the department could not furnish our consultants with a copy of the contractor's system test plan for inpatient/outpatient claims. It was obtained from the contractor at a later date, but it was then too late for our consultants to evaluate it.

Moreover, some required management reports were not available. Without these reports, obtaining system performance data was difficult. In measuring response time to provider inquiries, for example, we had to rely upon manually kept records that could not be verified and were incomplete.

CHAPTER II

SUFFICIENCY OF SYSTEM TESTING, REPORTS, CONTROLS, AND MONITORING

The fiscal intermediary contract specifies procedures to ensure that CSC's automated claims processing system meets its performance criteria throughout its development and operation. However, the department and CSC are not fully complying with these procedures. Specifically, we found:

- The department and CSC did not conduct sufficient system and acceptance testing;
- CSC is not producing accurate and timely reports;
- Although CSC's internal controls and audit trails comply with certain contract specifications, some controls and operating procedures could be strengthened;
- The department has not levied liquidated damages against CSC for all instances of contract noncompliance.

THE STATE AND CSC DID NOT CONDUCT SUFFICIENT TESTING

Our consultant found that the procedures for testing the automated claims processing system are not being sufficiently followed. The responsibility for proper testing is shared by CSC and the department, both of which have not followed testing procedures specified in the contract and considered reasonable in the industry. Specifically, procedures to develop an adequate test design have not been thoroughly followed; CSC has inadequately tested its systems before turning them over to the State for acceptance testing; and the department has not required CSC to follow prescribed testing procedures and is not thoroughly acceptance testing the final system. Incomplete testing of CSC's system has caused deficiencies in operating systems, unnecessarily suspended claims, and provider overpayments.

The Testing Process

The testing process is designed to reduce subsequent operational discrepancies such as erroneous or delayed payments, billing errors, and inaccurate management information reports. The contract between CSC and the State requires the following sequential testing process to prepare the system for operation:

- Structured walk-throughs of system design;

- Development of a system test plan by CSC;

- System test plan submission to the State for approval;

- State review and approval of the system test plan;

- System testing by CSC to prepare for acceptance testing;

- Acceptance testing by the State;

- Acceptance by the State.

CSC must first conduct a structured review, called a walk-through, of its system with department staff. The walk-through allows CSC to better understand state requirements and permits department staff to assist CSC in formulating a plan for system testing, including manual support elements. CSC must then develop the system test plan and submit it to the State for approval. Once this plan is approved, CSC is required to use self-generated test data to conduct its own system testing to locate and to correct system errors. After this testing is complete, CSC turns the system over to the department for final acceptance testing. Acceptance testing is a state-designed, contractor-conducted test of the contractor's system using state-generated test data. Our consultant considered the foregoing testing process to be both sound and well-thought-out and in accordance with accepted practices within the industry.

The contract authorizes payment to CSC upon acceptance testing. As of March 31, 1980, the department had authorized payments for acceptance tests totaling $943,974.

Procedures to Ensure Adequate System Test Design Have Not Been Thoroughly Followed

CSC's system tests may not have been adequately designed because CSC and department personnel did not thoroughly review most of the systems in their early stages of development. As the system walk-throughs progressed from the first claim type implemented, pharmacy claims, on to the other claim types, the walk-throughs were held less frequently, and the process appeared less productive. Minutes of the walk-throughs for pharmacy claims, indicated that CSC personnel were neither resolving nor understanding the system requirements. Furthermore, though walk-throughs for the first claim type thoroughly reviewed each major system module, those for the subsequent claim types focused on broad subject areas. Approximately 30 walk-throughs were held prior to implementing pharmacy claims. This number declined significantly for the other claim types as seen in Table 1.

TABLE 1

NUMBER OF WALK-THROUGHS
BY CLAIM TYPE

Type of Claim	Approximate Number of Structured Walk-Throughs
Pharmacy	30
Long-term Care	5
Inpatient/Outpatient	7
Physician	1

Besides aiding CSC's detection of system design problems, the quality and number of walk-throughs are also important in the department's development of acceptance tests. During system design and development, which includes walk-throughs, department personnel should be defining the minimum processing standards they will use to determine if CSC's system is acceptable for processing Medi-Cal claims. Department personnel also prepare acceptance test data and expected output results during this phase.

System and Acceptance Testing Procedures Are Not Being Followed

CSC is performing its own system tests without getting state approval for the system test plan, and the department is not requiring CSC to follow the prescribed testing procedures. Consequently, the State is detecting an excessive number of system errors which should have been identified and corrected by CSC. Furthermore, CSC is not

turning systems over to the State for acceptance testing within required time frames or in complete packages. As a result, there is insufficient time to complete the department's acceptance testing, and claim types are being implemented with unresolved defects.

The State is supposed to approve CSC's system test plans prior to actual testing. However, the department has permitted CSC to conduct tests without an approved plan and has begun acceptance testing before CSC completed system testing. For example, the State approved the long-term care claims processing system test plans on the day acceptance testing began and evidently never approved those for the inpatient/outpatient claims processing. The department started acceptance testing for physician claims on January 28, 1980, yet the system test plan was not submitted until March 20. As of April 16, the department had still not approved it.

The large number of system problems detected during the State's acceptance testing indicates that CSC's own system testing could have been better. When the department encounters a problem in final acceptance testing, it issues a System Trouble Report (STR). Acceptance testing for the first three claim types generated over 870 STRs. These STRs documented problems ranging from individual report format deficiencies to major logic flaws in the system. Many STRs noted extensive job

control language errors.* This type of error would normally prohibit testing the system as a whole because linking individual program tests together with defective job control language is extremely difficult.

The department contract officer communicated the poor quality of the pharmacy system testing to CSC in a letter dated July 5, 1979:

> The State is concerned about the lack of preparation demonstrated by CSC during pharmacy acceptance testing. I recognize the time constraints we are working under in designing a capable claims processing system. However, the testing of the systems design is paramount to processing live claims. From the results of pharmacy acceptance testing it appears that insufficient care was taken by CSC in conducting its system testing. The number of errors (STRs) identified by the State testing team was exhorbitant and I feel that many of these errors should have been detected and corrected by CSC through its system test. The end result was that the State acceptance testing team was required to perform much of the system analysis which, according to the RFP and the Proposal, should have been completed by CSC prior to the start of acceptance testing.

The large number of STRs caused by poor quality system testing resulted in a breakdown in subsequent testing procedures. A CSC official said that because of the number of errors, CSC could not fully test the system and fix all the detected problems within the required 45-day period before

* Job control language is used to control the sequencing and execution of individual programs within a system.

installation. Therefore, CSC is turning systems over to the State which are late or incomplete. As a result, the department does not have sufficient time to conduct its own acceptance testing, and claim types are being implemented with unresolved defects.

Department personnel reported that the department began acceptance testing regardless of whether the system was ready. For example, because CSC did not deliver the long-term care claims processing system within the required 45 days before implementation, the department had to limit its acceptance tests for this system. Certain MARS and S/URS elements were not submitted for acceptance testing prior to system implementation. Furthermore, CSC's Director of Programming advised our consultant that CSC conducted system testing by module and by subsystem and delivered each one to the department as it was completed. Such a procedure, however, does not conform with contract requirements. Though the department may have conducted a full acceptance test on physician claims, this test would have been less effective than one conducted on a system which had been entirely system tested prior to the start of acceptance testing.

Adequate system tests and acceptance tests should have detected most system malfunctions prior to implementation. However, these systems actually began operations with

uncorrected malfunctions. For instance, CSC's program to convert the previous fiscal intermediary's provider file to CSC's system contained errors. These errors resulted in 16,000 inpatient claims being suspended erroneously because some of CSC's files were incomplete. Moreover, some hospitals would have been paid over four times their allowable amounts if the State Controller had not stopped payment in time. Other claims were actually paid amounts far exceeding allowable limits. For example, 11 pharmacy claims, whose total allowable amount was $54.13, were improperly paid an approximate total of $450,000.

The pharmacy claim type was also implemented with known system defects. According to department files, the following unresolved deficiencies were known to exist the day before claim processing began.

- In certain instances the system failed to edit for specific eligibility limitations such as restricted services and prepaid health plan enrollment;

- The system failed to edit for the validity of label information such as correct aid and county codes;

- The eligibility recycle process design threatened to cause unnecessary delays in claim processing cycle time;

- The program to determine the appropriate state/recipient medical cost sharing ratio was untested. This may have resulted in erroneous payments;

- There was a sporadic problem in matching certain claims with treatment authorizations. This could have caused claims to suspend unnecessarily;

- Occasionally some suspended claims with more than one system-detected error would result in multiple notifications to providers. CSC's system should send only one notification per claim. This means that providers may have to make multiple responses for the same claim;

- CSC's editing process did not distinguish between recipients enrolled in prepaid health plans and pilot projects. Consequently, providers who rendered services to recipients enrolled in pilot projects were incorrectly denied payment;

- In general, the reports produced by the system contained a large number of errors.

CSC REPORTS ARE INACCURATE AND UNTIMELY

The contract requires CSC to produce many reports for a variety of state users. These reports are necessary to both the State and CSC in monitoring and controlling the whole system's operation, in controlling provider and recipient abuses of the Medi-Cal program, and in maximizing federal reimbursement. We tested three of CSC's four reporting subsystems and found that they are not producing timely, accurate reports. The four subsystems are discussed separately in the following sections.

Surveillance and Utilization Review Subsystem

The Surveillance and Utilization Review Subsystem (S/URS), part of the federal MMIS, provides postpayment utilization review reports which identify participants who misuse the program. This subsystem's analysis and reporting aids states in policing the Medicaid program. It reports recipient and provider utilization within various classes of peer groups and provides sufficient documentation to identify abuse and to pursue the appropriate remedy. We found, however, that 36 percent of the required reports are not being produced. Furthermore, most of those reports produced are untimely, and some are inaccurate.

The subsystem to be implemented by CSC is organized into five modules: Provider, Recipient, Treatment Analysis, Special Reporting Needs, and Investigation and Action. The contract specifies implementation dates for the modules. The department, however, has modified these dates. It staggered the implementation of S/URS so that report production would begin one month after the claims processing had begun for each new claim type. This delay was needed because each claim type has to complete the monthly claims processing cycle to provide S/URS with a data base to analyze. The State and CSC agreed to further delay implementing the Provider, Recipient, Special Reporting Needs, and Investigation and Action modules to October 1, 1979 to finish acceptance testing. As of April 1980, only the Special Reporting Needs, Provider, and Recipient modules had begun production.* Appendix B summarizes the implementation schedules and production status for each module.

CSC and the State have prioritized the sequence in which work toward implementation will be done in accordance with the needs of the Surveillance and Utilization Review (SUR) Branch, the actual user of these reports. Since most of its monitoring efforts focus on physicians, implementing the Provider module is the highest priority. Progress toward implementing the lower priority modules has been delayed

* The Recipient module is not fully in production: the claim detail reports are being produced but not recipient profiling.

because, as of April 1980, CSC was still perfecting the Provider module. Consequently, 16 of the 44 reports (36 percent) required to be in production are not being produced. All but one of the 16 reports not being produced belong to the modules that have not yet been implemented.

Although the Special Reporting Needs, Provider, and Recipient modules commenced production in November 1979, their production status is unofficial. The State did not accept the S/UR subsystem after acceptance testing for the pharmacy and long-term care claim types due to continued report production problems. As of April 1980, acceptance testing for the inpatient/outpatient claim type, scheduled to start November 1979, had not commenced. Thus, none of the implementation dates have been met.

Since the SUR Branch is receiving and using some reports from the Special Reporting Needs, Provider, and Recipient modules despite their unofficial production status, we have evaluated the subsystem for compliance with production performance criteria in the contract. One such criterion is that reports must be delivered in a timely manner. CSC and the State have agreed on specific delivery schedules for the various quarterly, monthly, and weekly reports. We found, however, that CSC is not delivering reports according to schedule. Table 2 presents the results of our analysis.

TABLE 2

S/URS REPORT DELIVERY
FOR REPORTS IN PRODUCTION
OCTOBER 1979 TO APRIL 1980

Production Frequency	Number of Times Reports Should Have Been Produced	Percent Not Delivered	Percent Delivered Late	Average Number of Days Late
Weekly	50	44%	28%	14
Bimonthly	24	58%	42%	34
Monthly	25	48%	52%	30
Quarterly	10	-	100%	19

Reports were not produced for many reasons. Weekly reports were not produced for nearly three months in late 1979 due to major problems in other subsystems' programs which affect the data S/URS analyzes. Bimonthly reports were incomplete once and thus could not be used. The monthly reports have not been produced for several reasons. The November edition was skipped because the Provider report production was two months behind schedule. The November update to the Provider History File was included in the December report editions. The January and February runs have not been produced because the December run, still incomplete as of April 1980, is two months behind its production schedule.

Report editions which are produced are often delivered late. Bimonthly and quarterly reports are frequently late because personnel in CSC's Technical Operations division, where the reports are actually produced, do not run them according to schedule. Department staff explained that provider report production was initially behind schedule because of delays in acceptance testing. CSC added that these delays were aggravated when S/URS began production because CSC discovered that its computer resources were insufficient to permit S/URS to be run simultaneously with claims processing. Consequently, CSC had to use another company's computer. The logistics of this situation further delayed S/URS production. Provider report production continues to be delayed due to problems ranging from programming errors to tapes omitted from production runs.

In addition to timely report production, the contract also requires reports to be accurate. We found, however, that 12 of the 28 reports in production, 43 percent, are inaccurate. The SUR Branch places high priority on 7 reports currently in production. Two of them are accurate; five of them are inaccurate but usable. These report inaccuracies can be attributed to causes ranging from problems with S/URS programs to problems with data validity and completeness in files outside the S/UR subsystem.

The SUR Branch uses reports from this subsystem to build cases against providers and recipients abusing or misusing the Medi-Cal program. The department's efforts are hampered by untimely and inaccurate reports from this subsystem.

Management and Administrative Reporting Subsystem

The Management and Administrative Reporting Subsystem (MARS) provides the department with management information for effective Medi-Cal program planning and control and for monitoring CSC's performance. We found that some of the MARS reports are inaccurate, and most of the reports are untimely.

Reports from this subsystem can be grouped into three types. The first type includes data on claims processing, provider participation, and cost analysis. These reports are designed to meet federal MMIS requirements so that the State may receive 75 percent federal financial participation. The second set of reports monitors performance at the various data control centers. These reports for example, provide information on claims inventories and the aging of claims and generally identify processing problems. The third set of reports covers a variety of topics including information on claims adjudication, claims payments, systems security, and system edits and audits.

The contract requires CSC to produce 63 MARS reports for state use. Only two of them are not being produced. One of the two reports currently not in production has been redesigned to correct inaccuracies and will commence production soon. CSC and the department disagree about whether the other report is in fact required by the contract.

The contract requires that CSC produce MARS reports in a timely manner. The department has established specific deadlines for delivery of various report editions. Report distribution sheets, however, indicated that more than half the MARS reports distributed between August 1, 1979 and March 26, 1980 were delivered later than the specified deadlines.* Table 3 displays the results of this analysis.

TABLE 3

TIMELINESS OF MARS REPORT DELIVERY

Production Frequency	Number of Times Reports Should Have Been Produced	Number Listed On Distribution Sheets	Percent of Those Listed Delivered Late	Average Number of Days Late
Daily	3,444	2,361	50.9%	7
Weekly	408	336	78.6%	8
Monthly	128	75	61.3%	16

* MARS reports have been produced since June 1979. The report distribution documentation for June and July is incomplete. Consequently, we began our analysis with August reports when sufficient documentation became available.

Report editions may not be included on the distribution sheets for several reasons. Sometimes CSC staff deliver reports personally, and distribution is not documented. Other times reports are not produced. Some untimely reports are not produced because the information would be too late to be useful to department staff. Other reports, if not produced on time, cannot be produced at all because the system does not retain the raw data.

For report editions that were produced, CSC attributed delays in report distribution to problems in scheduling computer time and the need to perform certain processing steps manually. Additionally, CSC officials stated that correcting reports which require reprocessing historical information creates an additional workload that aggravates the current delays. Reports also became more untimely when new claim types were added to the system. The average delay in report delivery was significantly greater in December 1979 and January 1980 when the inpatient/outpatient claim type was added. Appendix B illustrates this trend.

According to CSC staff, some delays are the natural result of a large system in its developmental stages. Once the system settles into a production rather than design mode, report production should become more timely.

The contract requires CSC to produce accurate MARS reports. At the time of our review, however, the department felt that some MARS reports did not display the required data. CSC is producing 51 reports. The department and CSC agree that 3 of them are inaccurate, and CSC is correcting them. The department also maintains that 10 other reports require correction, but CSC does not concur with that assessment. The department considers these reports to be inaccurate for a variety of reasons. In some instances, the department defines required data differently than CSC. In others, the department requires changes in reports which it considers to be corrections and which CSC feels are system enhancements. Some programs for reports also have functional problems which cause inaccuracies. The department and CSC are currently negotiating to resolve these disputes.

CSC feels that many of the problems with MARS report accuracy could have been reduced by better communication with report users within the department. For example, the Early Periodic Screening, Diagnosis, and Treatment Program reports were designed with user input and have not experienced the problems other MARS reports have. In addition, both CSC and the department agreed that some MARS reports specifications in the contract were vague and led to disagreements about report definitions.

MARS reports are designed to provide information on the claims processing systems and on Medi-Cal program operations. This information is integral to management decision making. The department's and CSC's ability to plan and to monitor system operations is hindered by untimely and inaccurate MARS reports.

In addition, certain MARS reports must be produced in an accurate and timely manner before HEW will certify California's MMIS. Such a certification would allow California to receive 75 percent federal financial participation in the system's operating costs rather than 50 percent which noncertified systems receive. Department officials stated the MARS report problems could jeopardize the State's ability to obtain the higher federal financial participation rate unless they are corrected.

The Provider Subsystem

The contract requires that the Provider Subsystem produce management information and other types of reports. We found that some reports were not being produced. We also found some reports to be untimely and inaccurate.

The Provider subsystem includes a number of functions. It assists in claims processing, maintaining communications with the provider community, and management

MOST SYSTEM CONTROLS ARE SUFFICIENT

Our consultant reports that CSC generally has implemented the controls and audit trails specified in the contract except in the areas of erroneous payments and provider and recipient abuse identification. In addition, other areas were noted where general controls and operating procedures could be strengthened. These areas involve formalizing procedures for reactivating edits/audits once they have been turned off, requesting daily tapes from the various keypunch service bureaus utilized by CSC, and establishing an EDP internal audit function.

Mandated Controls

The contract lists certain specific controls and audit trails that are to be present in CSC's system. The controls and audit trails include procedures to safeguard against disaster, to ensure the integrity of provider files, to document certain transactions, to verify accuracy of reports, to safeguard against unauthorized modification to files and computer software, and to ensure that recipient records are updated properly and accurately. Appendix C provides a detailed listing of the controls and audit trails our consultant selected to review. Elsewhere in this report, audit findings demonstrate a lack of internal controls resulting in excessive payments (page 77), and nonavailability of reports used to identify abuses by providers and recipients (page 31).

Other Areas That
Could Be Strengthened

As a result of our consultant's review of general controls (which encompassed a wider scope of control than required solely by the RFP), three areas were identified where control and/or operating procedures could be strengthened. Our consultant suggests that CSC make the following improvements:

- Formalize procedures for reactivating edits/audits once they have been turned off. Currently there are no formalized procedures at CSC for reactivating edits/audits once they have been turned off. If the State indicates on the letter authorizing the turn-off of the edit when the edit is to be turned on again, a person in the claims suspense area marks this date on his calendar and at the appropriate date begins the paperwork for turning the edit on again. However, if the State does not specify a date for reactivating the edit, it remains off indefinitely. As a consequence, edits/audits may remain off, which could allow unauthorized claims to be paid.

- Request daily tapes from all keypunch service bureaus. CSC presently sends all pharmacy claims requiring manual data entry to service

bureaus for keypunching. CSC is using four service bureaus; claims are divided approximately equally between the four. The claims are sent to the service bureaus on a daily basis. Two of the service bureaus return tapes of the keyed data to CSC on only a weekly basis. In the event that these tapes fail the balancing edit prior to the claims processing run, these transactions are not processed until the following week, delaying payment to the providers whose claims are on those tapes by at least a week.

- Establish an ongoing EDP internal audit function. CSC's Medi-Cal claims processing center in Sacramento does not have an assigned EDP internal auditor. Normally an EDP installation the size of CSC's Sacramento operation benefits from the monitoring capability provided by an internal EDP audit function. Typical EDP internal audit activities include periodic review of the operations function; participation in system testing; review of documentation for programs, systems, and operations; participation in system design reviews; review of systems being developed;

review of controls over input, processing, and output of systems currently in use; and execution of independent tests on an ongoing basis.

GREATER LIQUIDATED DAMAGES COULD HAVE BEEN LEVIED

When CSC fails to fulfill contractual obligations, the State may assess liquidated damages in certain areas. As of March 31, 1980, it had imposed $195,000 in penalties. We found, however, that the State has not levied fines against CSC for all instances of contract noncompliance that are subject to liquidated damages. We have estimated the amount of damages possible for the MAR and S/UR subsystems to be $7.4 million. However, we are not concluding that this amount should have been levied but rather that the department could have put greater pressure on CSC to conform with contract specifications.

Liquidated damages apply to contracts in which actual damages sustained by the State due to contractor noncompliance are impractical and extremely difficult to determine. The contract between the State and CSC stipulates these four types of liquidated damages and the penalties associated with them:

Type of Noncompliance	Amount
Delay by CSC beyond the approved schedule for design, development, and installation of each claim type	$5,000 per day
Failure by CSC to meet any one performance criterion in the RFP after California's MMIS has been fully developed and installed by CSC	2 percent payment reduction to CSC of the adjudicated claim service price for line items affected by deficient performance
Inaccurate S/URS and MARS reports	$500 a day each day performance is not corrected
Untimely reports, including S/URS and MARS	$500 a day each day a report is late

The State and CSC dispute the meaning of the second type of liquidated damages listed above. The State maintains that damages for deficient performance may be imposed for a claim type after CSC has completed that claim type's full development and implementation. CSC, on the other hand, argues that the State cannot impose these damages until CSC has completed full development and implementation for all claim types.

The Legislative Counsel concluded that a reasonable and fair interpretation of the contract would allow for CSC to be required to pay liquidated damages for failure of performance prior to full implementation of the system. Specifically, the Legislative Counsel reports:

> We believe that it would be an unreasonable and unfair construction of the contract to excuse CSC from below par performance at particular stages of implementation of the

> system simply because all stages of the system have not yet become fully operational, and a construction which would make the agreement reasonable, fair, and just is preferred to one that, though equally consistent with the language, would make the contract unreasonable and unfair (Cohn v. Cohn, 20 Cal. 2d 65, 70).
>
> Thus, we conclude that a reasonable and fair interpretation of the contract would allow for CSC to be required to pay liquidated damages for failure of performance under Section 4.28.2 of the RFP prior to full implementation of the system.

The department, however, has not levied damages to the full extent possible under the contract. The department views liquidated damages as an incentive for CSC to improve its performance and maintains that levying damages in strict interpretation with the contract would not only remove their incentive value but would also jeopardize the department's working relationship with CSC. Because of this philosophy, as of March 31, 1980 damages totaling only $195,000 have accrued for inaccurate and untimely reporting in several MARS report groups. Table 4 summarizes those damages.

TABLE 4

LIQUIDATED DAMAGES
(ACCRUED AS OF MARCH 31, 1980)

Instances of and Reasons for Written Notification	Current CSC Compliance Status	Period of Damages Assessed	Period of Damages Terminated	Amounts
MARS				
Inaccurate presentation of data in Data Control Center (DCC) Reports	CSC complied; damages terminated	8/28/79	9/23/79	$ 13,500[a]
Inaccurate claims recycling data in DCC reports	Out of Compliance	12/06/79	To Present	58,500
Deficient MMIS reports	Out of Compliance	11/16/79	To Present	69,000
Untimely DCC reports	Out of Compliance	12/15/79	To Present	54,000
S/URS				
Delay in implementing subsystem	Out of Compliance	None Assessed		None
Total				$195,000

[a] Actual liquidated damages assessed.

Table 4 also illustrates that sending CSC written notice of contract noncompliance is not effective in prompting CSC to comply. CSC has received written notices for noncompliance in five areas yet has only improved its performance in one. Moreover, CSC does not usually improve its performance when the department levies damages in the amounts it has to date. CSC has not improved its performance sufficiently in three of the four areas for which liquidated damages were assessed to warrant their termination.

Through March 31, 1980, we have found instances of CSC noncompliance with contract performance criteria in MARS reporting and claim cycle time and with the contract installation schedule for S/URS claims processing. Applying a strict interpretation of the contract's liquidated damages provisions, we have estimated for comparative purposes the potential damages possible. We are not concluding that the department should have levied this amount, but rather that it could have put greater pressure on CSC to conform with contract specifications by assessing or threatening to assess a greater amount of damages. Table 5 compares damages assessed by the department with the maximum amounts possible.

TABLE 5

LIQUIDATED DAMAGES COMPARISON

Areas of Noncompliance	Actual Accrued Damages	Estimated Amount Possible
MARS reporting	$195,000	$5,152,000
S/URS implementation	-	2,285,000
Claims processing cycle time	-	Not calculated
Total	$195,000	$7,437,000

The department has not levied all possible damages in the MAR subsystem. As reported previously in this chapter, the MAR subsystem has not been producing timely, accurate reports. Untimely reporting and inaccurate reporting can each result in a $500 a day penalty for each day a report remains out of

compliance after the effective date of damages. We estimate that the department could have assessed at least $5,152,000 in this area. In accordance with its philosophy of using damages as an incentive, the department has not accounted for all days CSC was out of compliance. Furthermore, it is accruing liquidated damages for groups of related reports rather than for each report.

As discussed previously in this chapter, CSC has not implemented the S/UR subsystem for the pharmacy, long-term care, and inpatient/outpatient claim types in accordance with the contract's schedule. For such noncompliance, the department may assess CSC $5,000 for each day beyond the approved schedule. However, it has not done so. We have calculated that the department could have assessed CSC $2,285,000 through March 1980 for such noncompliance.

Though the department sent CSC written notification that damages would be assessed for the pharmacy and long-term care claim types commencing October 1, 1979, it never assessed those damages. The department has explained that the written notification was designed to prompt CSC into action. Because CSC appeared to be progressing more rapidly on S/URS implementation, the department did not levy damages. However, the department sent written notification in October 1979, and CSC has still not complied.

In addition, the department has not sent CSC written notification regarding their failure to meet the S/URS inpatient/outpatient claim processing implementation schedule. The department has not done so because it has yet to perform S/URS acceptance testing on this claim type. These tests were not performed as originally scheduled because the inpatient/outpatient claims processing system, which is needed to produce the data base for S/URS acceptance testing, was not fully operational.

The department has not placed CSC on formal notice for not meeting the average processing cycle time criterion, which is the subject of Chapter 3. The contract requires that the average processing cycle time for all claims not exceed 18 calendar days from the date of receipt to final disposition. CSC has exceeded that time limit in four of the months from June 1979 through February 1980. The contract provides that the department may send CSC written notification for failure to meet any one performance criterion in the contract. If CSC does not come into compliance within 60 days, the department may reduce by two percent the adjudicated claim service price for line items affected by deficient performance.

Based on our analysis of cycle times, CSC came into compliance during the 60-day period following each instance of noncompliance except during the 90-day period commencing

December 1, 1979. Had the department sent written notification, it could have assessed liquidated damages for noncompliance in February 1980. The department did not issue such a letter because it lacked accurate data on claim cycle time. We did not calculate the amount of liquidated damages which could have been assessed.

In addition to assessing a modest amount of damages when compared with our estimated amount, the department has now declared a moratorium on assessing damages by proposing to modify the contract. The letter of agreement to CSC states:

> The department will not make any new assessments of liquidated damages during the period in which the program is delayed (March 1 to May 31, 1980, inclusive). The department may give notice of liquidated damages during this period with regard to claim types other than medical services. However, no such assessment shall actually begin until after the delay period has expired.

Such a proposal, however, neutralizes the effectiveness of assessing damages to motivate CSC into improved contract compliance.

CHAPTER III

CSC'S TIMELINESS AND EFFECTIVENESS IN ADJUDICATING MEDI-CAL CLAIMS

From June 1, 1979 through February 29, 1980, CSC adjudicated approximately 15.3 million pharmacist, long-term care, inpatient, and outpatient Medi-Cal claims.* Under the terms of its contract with the State, CSC is required to meet a series of specific performance standards to ensure efficient and effective processing of these claims. Three fundamental areas of contractor performance include (1) CSC's timeliness in processing and adjudicating claims, (2) the percentage of claims inventory in the system over 30 days, and (3) the application of certain edits and audits to ensure accurate payment of claims submitted by providers. Our review of CSC's timeliness and effectiveness in processing claims indicated that

- The average number of days required to process all claims has increased with the addition of each new claim type to the system;

- From December 1979 through February 1980, CSC failed to meet the contractual average monthly processing cycle time standard of 18 days for all claim types;

* The terms claim and claim line are used synonomously.

- CSC failed to meet the individual claim processing cycle time standard for pharmacy, long-term care, and outpatient claims during January and February 1980. It also did not meet the processing standard for inpatient claims during February 1980;

- As of March 24, 1980, 32 percent of the total claims in the system valued at over $53 million had been in the system over 30 days; yet the contract requires that no more than nine percent of the total claims inventory per month exceed 30 days in the system;

- Eligibility-, provider-, and Treatment Authorization Request (TAR)-related edits caused 28 percent of the suspended claims analyzed. Generally, reducing eligibility suspensions are the department's and the counties' responsi bility; provider suspensions result from providers improperly preparing the claim form; and TAR suspenses could be significantly reduced by CSC improvements;

- At certain times, some claims processing system edits and audits either were not operational or were not operating sufficiently to review the appropriateness of claims submitted by providers. As a result, high volumes of claims

have been processed without subjection to certain critical edits, and at least $450,000 in claim overpayments were made by CSC.

CLAIM PROCESSING TIME HAS INCREASED

The U. S. Department of Health, Education, and Welfare requires Medicaid claims processing systems which it certifies for federal funding to pay 90 percent of all clean claims within 30 days of receipt.* However, the state department imposed more stringent processing cycle time standards in its contract with CSC. The department established specific processing times for each claim type. Additionally, the contract requires that the monthly average processing time for all claims not exceed 18 days from the date of receipt to final claim disposition.

The date of receipt is interpreted to mean the Julian date contained in the claim control number that is placed on each claim the day it is microfilmed for processing. Final disposition date is that which CSC calls "Claim Adjudication

* The 30-day requirements apply only to clean claims. Clean claims are defined by the Federal Government as those claims that can be processed without obtaining additional information from the provider or from a third party such as Blue Cross or a State Workers' Compensation Unit. Claims from practitioners under investigation for possible fraud and abuse in the Medicaid program and claims under review for medical necessity are not considered clean claims.

Date." This is the date on which CSC has completed all its processing, and the claim has been denied or is ready for payment by the State Controller.

Processing Times for
Individual Claim Types

Our consultant obtained data from the 15-month Adjudicated Claims History File as of February 29, 1980 and extracted information to determine (1) the total number of claims processed to a final adjudication by month adjudicated and (2) the average number of days a particular claim type was in the system. For purposes of analysis, we classified the data into these major categories:

- Claims that have been adjudicated which did not require medical review or information from locations outside CSC's control. This category includes pharmacy, long-term care, inpatient, outpatient, and Medicare crossover claims;*

- Claims that required review by CSC's medical unit;

* Crossover claim: A bill for services rendered to a recipient receiving benefits from both Medicare and Medi-Cal, where Medicare pays first and then determines amounts of unmet Medicare deductible and co-insurance to be paid by Medi-Cal.

- Claims outside of CSC's control sometime during claims processing. Claims outside CSC's control include those requiring Resubmission Turnaround Documents (RTDs), eligibility and share of cost determinations, Treatment Authorization Request corrections by field services, and state review for allowable benefits.

The contract does not specify whether claims which go outside CSC's control are included in the processing time calculation. CSC contends that these claims should be excluded totally from the processing time computation. Department personnel contend that processing times should be calculated from receipt of claim until adjudication, less the actual time that the claim was sent outside for review.

The analysis of individual claim type processing times presented in the following table excludes claims which went outside CSC's control and, therefore, reflects CSC's performance against its interpretation of the standard. The standards for each claim type are also presented in the table.

TABLE 6

NUMBER OF CLAIMS AND PROCESSING TIME
BY CLAIM TYPE
FISCAL YEAR 1979-80

	PHARMACY (17 Day Standard)		LONG-TERM CARE (8 Day Standard)		INPATIENT (21 Day Standard)		OUTPATIENT (13 Day Standard)		MEDICARE CROSSOVER (Standard not specified)		CSC MEDICAL REVIEW (30 Day Standard)	
Month	Number of Claims Processed	Average Days in System	Number of Claims Processed	Average Days in System	Number of Claims Processed	Average Days in System	Number of Claims Processed	Average Days in System	Number of Claims Processed	Average Days in System	Number of Claims Processed	Average Days in System
June	435,766	10									2,306	13
July	1,336,141	13									9,798	23
August	1,867,456	12									20,718	26
September	1,298,020	15	33	7							10,445	31
October	1,511,807	19	58,845	10							14,998	36
November	2,281,712	14	73,263	11							14,116	26
December	803,777	17	59,440	6							4,503	25
January	2,370,664	20	74,140	12	2,537	14	26,294	16	4	22	99,355	15
February	1,598,004	18	81,305	18	8,658	22	131,047	15	305	17	272,541	17
Total	13,503,387		347,026		11,195		157,341		309		448,813	

Table 6 indicates that CSC has met the individual claim processing time standards for pharmacy claims for six of nine months and has met the standard for claims requiring CSC medical review for seven of nine months. However, CSC met the processing standard for long-term care, inpatient, and outpatient claims only 50 percent of the time or less. Claim type processing times have only exceeded their individual standards by more than six days on one occasion. In February 1980, long-term care claims exceeded the standard by 10 days. The greatest noncompliance has occurred since December 1979 as Table 7 depicts.

TABLE 7

NONCOMPLIANCE WITH INDIVIDUAL CLAIM TYPE PROCESSING TIME STANDARDS

Claim Type	Number of Months Claim on System	Number of Months Out of Compliance	Number of Months Out of Compliance for Three Months Since December 1, 1979
Pharmacy	9	3	2
Long-term Care	6	4	2
Inpatient	3	1	1
Outpatient	3	2	2
Requiring Professional Medical Review	9	2	0

As previously stated, the data presented in Table 6 exclude all claims which require review by individuals outside of CSC's control. Approximately six percent of all claims processed since June 1, 1979 required an RTD, benefit review, or other review by a group outside CSC's control. Although we could not determine how long these claims were outside of CSC's control, Table 8 depicts the average processing cycle times. If the processing times for these claims were added to those in Table 6, overall processing times by claim type would increase and thus portray a less favorable picture.

TABLE 8

PROCESSING CYCLE TIMES
FOR CLAIMS REVIEWED
BY GROUPS OUTSIDE CSC

Month	Number of Claims Processed	Average Days in System
June	1,009	18
July	18,343	34
August	68,854	45
September	69,954	44
October	123,239	51
November	203,358	58
December	65,546	52
January	142,048	44
February	163,268	50
Total	855,619	

Average Processing Times for All Claims

In addition to meeting specific processing time standards for each claim type, the contract requires that "...(The) Average processing cycle time for all claims shall not exceed 18 calendar days from date of receipt to final disposition." To compare CSC's compliance with this standard, we analyzed all claims adjudicated, regardless of whether some left CSC's control during the processing cycle. Table 9 presents CSC's average processing times for all claims.

TABLE 9

AVERAGE PROCESSING TIMES
FOR ALL CLAIMS

Month	Total Number of Claims Processed	Average Days in System
June	439,081	11
July	1,364,282	14
August	1,957,068	13
September	1,378,452	17
October	1,708,889	22
November	2,572,449	18
December	933,266	19
January	2,715,075	21
February	2,255,128	20
Total	15,323,690	

CSC has successfully complied with the standard during five of the nine months evaluated, but it has failed to meet the standard during October and December 1979 and January and February 1980. The increase of days in the system appears to correlate with adding new claim types. Table 10 shows the average days in the system for adjudicated claims along with the new claim type start-up month.

TABLE 10

EFFECT OF ADDITION OF CLAIM TYPE
ON AVERAGE DAYS IN SYSTEM

Month	Claim Type Added	Average Days in System
June	Pharmacy	11
July		14
August		13
September	Long-term Care	17
October		22
November		18
December	In/Outpatient	19
January		21
February		20

Not only has the average processing time increased steadily since June 1979, but also processing time has increased significantly each month after a new claim type has entered the system.

A SIGNIFICANT NUMBER OF CLAIMS ARE IN SUSPENSE

In addition to the overall and individual claim adjudication standards presented earlier, the contract also states that the number of claims in the system over 30 days shall not exceed nine percent of the total claims inventory. To test for this standard, our consultants analyzed the suspended claims file and the weekly and daily approved claims

files to determine how many claims had been in the system over 30 days.* Our consultant analyzed these files for two days in March and determined that at least 23 percent of claims in the system were more than 30 days old. This amount exceeds the contractual limit by 14 percentage points.** They also analyzed the types of claims in suspense, length of time they had been suspended, reason for suspension, and dollar value of those claims.

Claim Suspense Process

Claims entering the system are subjected to two levels of screening known as edits and audits. The first level of review occurs daily and tests the claim for evidence that services were provided to eligible recipients and that an authorized provider rendered them. Claims failing these initial edits are suspended for manual review to determine the action required for correction and entry. Claims failing the weekly adjudication audits are manually reviewed for resolution and then entered. A claim must pass all the edits and audits before it can be paid.

* While we could not document that claims in the weekly and daily approved files which had been in the system over 30 days had been in suspense, we assumed that was the cause.

** Our analysis did not include claims awaiting data entry in calculating the size of the inventory. Additionally, our measurement is based on two one-day profiles of the file and not a measurement over a 30-day period.

Claims Suspended and in the System More Than 30 Days

Our consultant independently analyzed claims inventories on two days in March to determine the total number of claims in the system and the length of time claims suspended had been in that status. The days chosen were March 24, a Monday, and March 26, a Wednesday. These dates were used to verify the reported effect of the daily and weekly edit suspension volume changes. Our consultant found that 644,202 claims, representing 32.1 percent of the total claims inventory and valued at $53,867,983, had been in the system over 30 days as of March 24; and 262,268 claims, representing 23.8 percent of all claims and valued at $19,642,068, were in the system over 30 days on March 26.* On both days evaluated, the majority of the claims in the system over 30 days remained in suspense. Table 11 summarizes claims inventories on March 24 and 26.

* The significant difference in these two sets of data is due primarily to elimination of the weekly approved file which, on March 24, held over 200,000 claims which had been in the system over 30 days.

TABLE 11

PERCENT OF CLAIMS OVER 30 DAYS OLD TO TOTAL CLAIMS IN SYSTEM

	March 24, 1980				March 26, 1980			
	Number	Percent	Dollars	Percent	Number	Percent	Dollars	Percent
Under 30 Days Old:								
Suspense	411,752	20.5%	$ 52,923,837	35.8%	427,416	38.7%	$49,968,901	56.8%
Approved:								
Weekly	939,700	46.8	40,882,021	27.7				
Daily					409,210	37.1	18,405,214	20.9
Subtotal	1,351,452	67.3%	$ 93,805,858	63.5%	836,626	75.8%	$68,374,115	77.7%
Over 30 Days Old:								
Suspense	411,996	20.5%	$ 31,980,272	21.7%	224,218	20.4%	$16,172,601	18.4%
Approved:								
Weekly	232,206	11.6	21,887,711	14.8				
Daily					38,050	3.4	3,469,467	3.9
Subtotal	644,202	32.1%	$ 53,867,983	36.5%	262,268	23.8%	$19,642,068	22.3%
Rejected Records:[a]								
Suspense	5,845	.3%	$ -	- %	4,679	.4%	$ -	- %
Approved:								
Weekly	6,806	.3	-	-				
Daily					52	-	-	-
Subtotal	12,651	.6	$ -	-	4,731	.4	$ -	-
Total	2,008,305	100.0%	$147,673,841	100.0%	1,103,625	100.0%	$88,016,183	100.0%

[a] The consultant's analysis of the file rejected any claims that had alpha characters in the numeric only specified fields. They were unable to determine the reason alpha characters were present in the numeric fields.

The contract provides that the number of claims in the system more than 30 days cannot exceed 9 percent of the total claims inventory. On the days selected, CSC exceeded this standard by 23 and 14 percentage points, respectively.

Table 12 shows the number of suspended claims on March 24 by claim type and dollar value.

TABLE 12

NUMBER OF SUSPENDED CLAIMS
AND DOLLAR VALUE BY CLAIM TYPE

Claim Type	Count	Dollar Value
Pharmacy	399,820	$ 4,061,714.26
Long-term Care	16,253	6,215,325.97
Inpatient	31,187	61,455,598.24
Outpatient	357,540	11,781,308.34
Medicare Crossover	18,948	1,390,162.04
Total	823,748	$84,904,108.85

Although pharmacy and outpatient claims made up 92 percent of the suspended claims, inpatient claims accounted for 73 percent of the dollar value of claims in suspense.

Appendix D, depicting claims in suspense by claim type and age for March 24, 1980, shows that as of that date over 205,000 pharmacy claims valued at $2.1 million had been in

suspense more than 30 days. It also shows that more than 12,000 inpatient claims, valued at $22 million, were over 30 days old.

Causes of Suspended Claims

Our consultants analyzed the causes of claim suspensions and reviewed in detail the major edits and audits keying the suspensions. They found that three categories of edits and audits caused 28 percent of the March 26 suspensions:

- Eligibility -- those errors that can occur in information indicating the recipient's eligibility for the type and units of service provided;

- Provider -- those errors detected when services billed are compared to those the provider is authorized to render;

- TAR -- those errors resulting from missing TARs or TARs with incorrect, illogical, or missing data.

Table 13 shows the category of edits and the number of claims each one suspended.

TABLE 13

NUMBER OF SUSPENSIONS DUE TO ELIGIBILITY-, PROVIDER-, AND TAR-RELATED EDITS

Category of Edits	Number of Suspensions	Percentage
Eligibility-Related	235,832	20
Provider-Related	80,316	7
TAR-Related	12,545	1
Others[a]	860,983	72
Total	1,189,676	100

[a] Includes many categories of edits such as Medicare-related and drug or service codes not on CSC files.

Our consultants have found that the responsibility for resolution of these suspended claims varies between the department, CSC, and the providers. Generally, eligibility suspenses are the department's and the counties' responsibility; provider suspenses relate to errors made during preparation of the claim forms; and TAR suspenses could be significantly reduced by CSC improvements.

Factors Outside CSC's Control Have Caused Eligibility Suspensions

An individual's eligibility for Medi-Cal benefits is determined at county welfare offices. Each county is required to report additions and deletions of eligible persons to the department. The department, in turn, processes the data and provides CSC with a magnetic tape containing eligibility additions, corrections, and deletions. CSC uses the tape to update the Recipient Eligibility History File approximately three times each month.

When eligibility is initially determined, counties issue temporary Medi-Cal cards. For persons currently on the eligibility file, the department produces and mails them Medi-Cal "proof of eligibility" labels once a month. When providers bill Medi-Cal for services rendered, they must attach a label to the claim. When CSC processes the claim, the recipient's eligibility number is matched against the Recipient Eligibility History File to assure current eligibility. A claim suspended for failing these tests is manually reviewed for evidence of an eligibility label. If one is attached to the claim, CSC staff can override the eligibility audit and resubmit it. Those without a label are returned to the provider.

Our consultants reviewed CSC's performance in updating the eligibility file and found only one instance during the six-month period of October 1979 through March 1980 when CSC did not update the file within the two days required by the contract. Department personnel agreed that there was no problem with CSC's timeliness in updating the eligibility file.

Instead, most of the eligibility edit suspensions result primarily from delays in getting county temporary eligibility records on the file. This responsibility rests with the department. Almost 20 percent of the March 24 suspended claims relate to eligibility edits. Of those, approximately 80 percent occurred because recipient data were missing from the eligibility history file.

Two factors, operating solely or in combination, cause this delay. First, counties are not forwarding the information to the department in a timely manner. Second, the department is not processing the information and sending it to CSC in a timely manner.

The department's data control manager stated that counties issue approximately 200,000 temporary cards per month. Of these, approximately 100,000 require keypunching by the State. When a significant backlog develops, the department places a high priority on eliminating it. Prior to December 1979, the department had a keypunching backlog of 800,000

transactions. In December, the backlog was eliminated. However, in February 1980, it had risen to 600,000 items. By April 15, 1980 the backlog was again eliminated.

The State requires that counties submit temporary card information within 10 days following the month of issuance. Our consultants could not determine if the counties were meeting this standard because the department does not monitor receipt of the data from the counties.

Provider-Related Suspensions Caused by Errors in Claim Form Preparation

Provider information is contained in the Provider Master File maintained by the department. The file includes information regarding the provider's name, address, allowable categories of service, and other data relevant to claims processing. The department maintains and updates the file via computer terminal.

A provider-related suspension can occur if the provider (1) is not on the file; (2) is an invalid provider type; (3) is ineligible on the date of service; (4) does not have a valid Professional Standards Review Organization (PSRO) certification; or (5) rendered a service invalid for his provider type.

Presently, the Provider Master File is operating with sufficiently complete and accurate information for effective claims processing. Only seven percent of all suspended claims relate to provider edits, and most of those are caused by provider errors in preparing the claim form. Two edit types, PSRO certification and invalid service for provider type, constituted about 12 percent of the provider suspensions on March 24. These suspensions related to errors in converting files from the former fiscal intermediary and in programming. The department and CSC officials are satisfied that conversion problems for provider types presently on the system have been resolved. The programming error was corrected on April 3, 1980.

Our consultants found that the major suspensions caused by converting the previous fiscal intermediary files to the CSC format occurred in the PSRO validity certification edit. Apparently, the PSRO indicator on the provider record was incorrectly converted in December 1979 when the inpatient/outpatient file was implemented. This problem was identified early in February 1980 and resolved later that month by manual updates to the provider file. Current suspensions failing this edit are holdovers from the period when the file was incorrect. This error had suspended 16,000 claims by February 3, 1980. On April 4, 1980, this inventory had been reduced to 1,093.

TAR-Related Suspensions
Caused by CSC's Untimely
Forwarding of Corrections

A provider must submit a TAR to a department field office for services which require prior authorization before it can be rendered or billed. If the field office approves the TAR, it sends one copy to CSC and returns one copy to the provider. When a claim for service requiring prior authorization arrives at CSC, it is matched against the TAR file to determine if it is properly authorized. If a TAR is not on file, the claim is recycled for up to 16 days while awaiting a TAR. The claim is denied if a TAR is not found after this period of time.

TAR edits constitute about one percent of all suspended claims; but they account for over eight percent of the dollar volume because they are required on many inpatient claims. Because of delays in resubmitting TARs to field offices for correction and system deficiencies that cause an unusually high processing corrections error rate, most of the suspenses caused by TAR edits are CSC's responsibility.

Our consultants reviewed TAR Master File update transactions for the period March 20 to April 3, 1980 to determine CSC's timeliness in processing TARs. The TAR transactions fell into four categories: valid additions to the TAR Master File, additions with errors, valid corrections to the master file, and corrections with errors. Both the valid

additions and additions with errors created new master file records. Valid corrections changed the TAR from a suspended to valid status, but corrections with errors required subsequent corrections. The average weekly volume of TARs totalled 13,389, comprising 9,574 additions and 3,815 corrections.

The consultants found that TARs are processed within four to five days, but corrections averaged 42 days to process. As Table 14 indicates, they also found that approximately 70 percent of suspended TARs had been suspended for more than 30 days before being corrected. Although CSC can correct key data entry errors on a suspended TAR, in many cases the TAR must be returned to department field offices for correction.

TABLE 14

TARS IN SUSPENSE BY AGE

	Days							
	0-10	11-20	21-30	31-60	61-90	91-120	Over 121	Total
March 24	1,757	2,287	1,729	5,572	8,043	2,080	1,281	22,749
March 26	2,354	1,573	1,725	2,794	8,121	2,301	1,493	20,361

Our consultant tallied the suspended TARs CSC was responsible for correcting and those for which the department was responsible. Table 15 shows that the department is responsible for correcting approximately half the suspended TARs. While our consultant determined that CSC is responsible for correcting about 36 percent of the TARs, they have only sent 12 percent of the TARs requiring correction to the field offices. Thus, CSC has not been sending corrections in a timely manner.

TABLE 15

Responsibility for Correcting Errors	Number	Percent
CSC	11,575	35.6%
Department	16,179	49.8
Undetermined	4,748	14.6
Total	32,502	100.0%
Physical Location of Suspended TARs		
At CSC	20,121	88.4%
Sent to Department field offices	2,628	11.6
Total	22,749	100.0%

In addition, there is an unusually high error rate in processing corrections to the TAR Master File. The error rate for processing additions is approximately 9 percent, but the TAR corrections processing error rate is nearly 80 percent. CSC acknowleded that TAR correction processing had a system problem which would be resolved soon.

The contractual requirements for the TAR processing system are general in nature. To clarify them, the department identified elements the TAR system needed to modify or to enhance processing. CSC has implemented a number of these requested changes. However, it believes that implementing all the department's requests would constitute a total redesign of the TAR system and would require contract modification.

CLAIM OVERPAYMENTS MADE BY CSC

The claims processing system edit and audit procedures appropriately suspend many claims each day, but some of those edits and audits have not been operational at all times nor sufficient to ensure accuracy of payments. Many of them, including some critical ones, have been turned off under written or informal authorization from the department. CSC, however, has not always reactivated these procedures at the end of the authorized period. The insufficiency of or lack of other types of edits and audits also shed doubt on the accuracy of payments. As a result of the above conditions, high volumes

of claims have been processed without being tested by certain critical edits. Consequently, CSC has made at least $450,000 in overpayments.

Edits/Audits Status
Insufficiently Monitored

Claims submitted by Medi-Cal providers are subjected to different edits and audits before payment is approved. Such edits and audits fulfill federal MMIS requirements for certain data elements and have been specified by the State in its contract with CSC. CSC is supposed to operate these edits and audits.

From July 23, 1979 through February 8, 1980, the department formally authorized the temporary suspension of 64 edits. These edits cover all four claim types; but, the majority relate to inpatient and outpatient claims. Generally, the suspended edits check for eligibility, procedure, and provider information. Apparently, many of these edits were deemed unnecessary at the time their related claim types were being implemented.

Throughout the course of the contract, the department has also provided CSC informal authorization to turn off 51 other edits. Although department officials stated that these edits were suspended for periods of time, documentation was not

available to identify those timeframes. A majority of these edits tested for TAR-related information and eligibility data.

Neither CSC nor the department sufficiently monitors the status of deactivated edits. Many edits suspended via formal and informal authorization were not reactivated by CSC when the specified time period elapsed. Currently, CSC does not have formalized procedures for reactivating edits and audits that have been turned off. If the State indicates when edits authorized to be turned off should be turned on again, then claims suspense staff note this date on a calendar and at the appropriate date order the edit turned back on. However, if the State does not specify a date for reactivating the edit, it may remain off indefinitely. Without a formalized procedure to ensure that edits and audits are reactivated, they can remain off and thereby allow unauthorized claims to be paid.

During the course of our analysis, the department identified 15 deactivated edits which should have been in operation. In a letter dated April 11, 1980, the department ordered CSC to turn back on ten critical edits listed in Table 16.

TABLE 16

CRITICAL EDITS DEPARTMENT
REQUESTED TO BE REACTIVATED BY CSC

Error Code	Description
104	Accommodation cost center inappropriate for age of recipient
123	Discharge hour missing or invalid
313	Recipient not eligible for Medi-Cal Benefits until payment/denial information is given from Medicare
323	Los Angeles County waiver provider-recipient not on Recipient Eligibility History File
428	Ancillary code not on file
536	Primary diagnosis ICD-9-CM code not on file
539	Secondary diagnosis ICD-9-CM code not on file
809	The service exceeds the occurrences approved on the Treatment Authorization Request
812	TAR control number on adjustment not same as on history
820	The service exceeds the quantity approved on the Treatment Authorization Request

Our consultants could not determine whether suspending these audits and edits resulted in improper claim payments. To do so would have required reactivating all the edits and audits and reprocessing all the claims. Such an activity was not within the scope of our audit.

While CSC produces two daily reports on suspended edits, the department does not use them as a monitoring or reference tool. The first report, "Error Parameter Table

Listing" (RF-R-510), shows the status of each edit by claim type. The second report entitled "Amounts Billed to Edits With Off Status" (MR-O-136), reflects the number and billed amount of claims which pass through each deactivated error code. The department receives these reports but does not retain or employ them to ensure suspended edits were reactivated at the appropriate time.

Because all daily reports on suspended edits and audits were not available, our consultants could not determine the full extent to which these audits were turned off or the total number and dollar value of claims not subjected to these edits. However, they did obtain some of these reports from CSC to develop such statistics for a sample of days. For example, on July 3, 1979, 12,996 claims valued at $64,267 passed through suspended error code #0523, "Price Variance--verify code, amount charged, and/or quantity billed." On this same day, deactivated error code #0033, "Refill number missing or invalid," was not applied to 7,397 claims valued at $56,624. Sufficient time was not available to determine whether other edits accomplish the same review. Furthermore, our consultants cannot conclude whether any of these claims were paid improperly as a result of edit suspension. However, as previously mentioned, the department has deemed certain deactivated edits important and has intended them to be operational.

Insufficient Edits and Audits Have Allowed Overpayments

The claims processing system implemented by CSC has not included sufficient edits and audits for monitoring the reasonableness of claim payments. To test the sufficiency of such edit and audit programs, our consultant reviewed all pharmacy claims paid since June 1, 1979. Their analysis identified 11 paid claims over $10,000 each. These claims, which are presented in Table 17, had been paid during November and December 1979 and January 1980. The department had identified these claims in February 1980.

TABLE 17

PAID PHARMACY CLAIMS
OVER $10,000

Drug Name	Total Allowable Costs	Amount Actually Paid	Overpayment
Niaci Tabs	$ 1.13	$ 10,001.75	$ 10,000.62
Lanoxin Tabs	4.03	30,003.99	29,999.96
Hydrochlorthiazide	3.92	50,005.16	50,001.24
Promethazine Expect PL	3.68	40,004.70	40,001.02
Percadon Tabs - Cat	3.64	30,003.78	30,000.14
Eduron Tabs - Cat	a	80,000.05	80,000.05
Ergaloid - let	7.10	10,013.29	9,996.19
Ascodeen 30 tabs	4.33	40,004.20	39,999.87
Oretic tabs	5.08	60,006.80	60,001.72
Cogentin Tabs	4.68	40,004.78	40,000.10
Tussidin A-C Expect	6.54	60,006.15	60,000.11
Total	$54.13	$450,055.15	$450,001.02

[a] Included in above billing for Percadon Tabs - Cat.

Source: Department of Health Services.

Our consultant identified an additional 462 paid pharmacy claims for sums between $250 and $5,000, amounts substantially greater than the average price of a pharmacy claim. Many of the drug codes for these claims were not listed in the Formulary file or, if listed, had no unit price indicated. Therefore, our consultants were unable to determine if the claims had been paid properly. Table 18 displays the claim distribution by amount paid.

TABLE 18

PHARMACY CLAIMS PAID
BETWEEN $250 and $5,000

Range of Claim Line Amount Paid	Number of Claims
2,001 - 5,000	8
1,001 - 2,000	50
501 - 1,000	84
250 - 500	320
Total	462

The consultant randomly sampled four claims from the list of 462 and had CSC price the drug codes for the number of units indicated on the claim. CSC priced three of the drug codes based on the quantities recorded on the sample claims; they did not price the fourth drug because it was not on the drug pricing file. For the three drugs they did price, each was under ten dollars. Because our consultants did not audit

the claim itself, they cannot conclude absolutely that an overpayment occurred. Of the three claims analyzed, however, $1,295.81 in overpayments could have been made. Table 19 displays the sampled drug claim data.

TABLE 19

PHARMACY CLAIMS
SAMPLE OF APPARENT OVERPAYMENTS

Drug Name	Service Units	Amount Paid	Prices CSC Provided	Difference
Monistat Vag Cream W-Applic	47	$ 822.22	$ 8.71	$ 813.51
Flurourcil Inj - RBSUP	20	252.66	5.76	246.90
Compleat - B	4	245.00	9.60	235.40
Total		$1,319.88	$24.07	$1,295.81

Although our consultants believe many of these 462 claims were paid correctly, some of these claims may represent overpayments and, therefore, should be reviewed in detail.

As the contract provides, if CSC makes overpayments to providers through its own error or negligence, the contractor shall make reasonable efforts to recover overpayments. As of April 15, 1980, at least $122,000 had still not been recovered from the 11 pharmacy claims presented in Table 17.

CHAPTER IV

COST OF THE CONTRACT

The department awarded CSC the fiscal intermediary contract based on CSC's low bid of $129,599,728. However, the total contract price is not absolute because of the reimbursement methods included in the contract. The contractor is reimbursed a fixed price for those expenditures incurred in the design, development, installation, and turnover of the fiscal intermediary system. Additionally, the contractor is allowed to recover certain operational costs. The State also reimburses the contractor for the actual cost plus appropriate overhead for postage, printing and distribution, and certain equipment purchased for state use.

Based on our review of contract costs for the period September 1, 1978 through March 31, 1980, we found CSC's charges to the State appropriate except for those associated with outpatient claims. CSC improperly calculated the reimbursement of operational costs for those claims and overcharged the State $97,983 for the period December 15, 1979 through March 21, 1980.

In addition, we found that the contract's total cost will be increased by state-ordered changes to delay HEW's certification of the claims processing system, to delay the phase-in of physican and medical supplier claim types, to implement an interim payment system, and to modify the contract for system enhancements and changing the method of recipient eligibility validation.

NEARLY ALL CSC'S CHARGES TO THE STATE APPEAR APPROPRIATE

The contract employs three reimbursement methods. CSC is reimbursed on a fixed price basis for these tasks:

- Design and development -- Reimbursement is provided for defining system requirements, detailing system and program specifications, programming, and testing;

- Installation -- Reimbursement is provided to phase-in the provider claim types. The phase-in includes provider training sessions, acceptance testing, and all other conversion activities;

- Turnover -- Reimbursement is provided for conversion activities related to the orderly transfer of the California MMIS from CSC to the State or to another contractor at the end of the contract period or upon termination of the contract;

- Special Projects -- Reimbursement is provided for special reports requested by the department, the Legislature, or the Federal Government that fall outside CSC's normal reporting responsibilities.

The second reimbursement technique establishes a variable rate structure to reimburse CSC for operational costs. These costs depend on the units of service provided. The contract provides reimbursement based upon an Adjudicated Claim Service Line (ACSL), which is a logical detail service line on a claim form that contains a service code, service description, and service fee and has been paid or denied so that it will not be reprocessed. This reimbursement rate is a fixed price per ACSL ranging from 11¼ to 65¼ cents depending on the claim type, volume, and year of operation. The third method reimburses CSC on a cost plus overhead basis for postage expenses, equipment purchased for state use, and printing and distribution expenses.

CSC has charged the State $21.2 million dollars for the period between September 1, 1978, the contract's effective date, and March 31, 1980. Table 20 summarizes the costs incurred by reimbursement category.

TABLE 20

SUMMARY OF CONTRACT CHARGES
AS OF MARCH 31, 1980

	Total Contract Amount (Millions)	Expenditures (Millions)	Federal Financial Participation[a] (Millions)	State General Fund (Millions)
Design and Development	$ 6.5	$ 4.8[b]	$ 4.3	$ .5
Installation	8.1	6.9[b]	6.2	.7
Operations	114.8	6.7	3.0	3.7
Turnover	.1	-	-	-
Special Projects	.1	-	-	-
Cost Reimbursements[c]	See Appendix	2.8	1.3	1.5
Total	$129.6	$21.2	$14.8	$6.4

[a] Ten percent of operation and cost reimbursement expenditures are General Fund expenditures for the Medically Indigent Program. The remaining expenditures are eligible for federal financial participation (FFP) at the following rates:

Design, Development, and Installation -- 90 percent FFP

Operations and Cost Reimbursement Items -- 50 percent FFP until CSC's system is federally certified at which time FFP will be 75 percent.

[b] Expenditures for design, development, and installation generally do not include 10 percent of those costs held in retention, which will not be paid to CSC until the system has been fully operational for four months.

[c] Appendix E contains a more detailed description of these amounts. The $2.8 million shown is an estimated amount since CSC had not prepared an invoice at the conclusion of our field work.

We reviewed CSC's total contract costs for all but two components. We could not independently verify the quality of the design, development, and installation deliverables. We also could not audit contract modification costs because CSC claimed the information used to develop those costs was proprietary and, therefore, beyond the scope of our statutory authority for access to records.* Excluding those two areas, we found CSC's charges to the State appropriate except for those related to outpatient claims. Due to an error in computer program logic, the State was overbilled $97,983 for processing outpatient claims during the period December 15, 1979 through March 21, 1980. The error occurred because the claims processing system was designed to accommodate block billing and to use the quantity field on block billed claims to count ACSLs.** Because of this error, the quantity fields were counted on all claims, including those which were not block billed. The following table summarizes results of the error for a sample of outpatient claims we tested.

* Contract modification costs may impact the design, development, installation, and operational costs shown in Table 20.

** Under block billing, also called "from-through" billing, the beginning and ending dates of recurring services are the only dates which need to be entered into the computerized records. Therefore, each service that is block billed receives only one ACSL.

TABLE 21

ESTIMATION OF EXCESS ACSL COUNT
DECEMBER 1979 THROUGH MARCH 1980

1.	Number of claims reviewed	590
2.	Number of lines on reviewed claims	1,707
3.	Number of ACSLs generated under faulty program logic	1,882
4.	Excess ACSLs due to program logic error (3-2)	175
5.	Excess expressed as percentage of (2)	10.2%

CSC billed the State for outpatient claims processing based on a faulty ACSL count of 1.66 million lines for the period December 15, 1979 through March 21, 1980. Based upon the sample shown in Table 21, we estimated that the excess ACSL count could total 170,000. When CSC recounted the ACSLs after correcting the program error, it obtained a count of 1.50 million lines. The 160,000 excess ACSLs generated $97,983 in overbilling. CSC is in the process of making restitution for these overcharges.

STATE-ORDERED CHANGES WILL INCREASE OVERALL SYSTEM COSTS

Since the contract's inception, the State has delayed implementing some of the contract's original provisions has changed others and has postponed the federal MMIS certification review. The cost impact of some of these changes, though not yet fully determined, could total approximately $12.7 million. Specifically,

- The department has delayed the MMIS certification process for CSC's claims processing system. If the system is not certified retroactively to the starting date of operations, the State will lose an estimated $4 million;

- The State has delayed the phase-in of physician and medical supplier claim types. This delay will cost an estimated $3.5 million; however, the state share of this cost will be $600,000;

- The department has ordered implementation of an interim payment system. The cost to the State of such a payment system is minimal;

- The department has ordered two contract modifications to enhance system capabilities and change the recipient eligibility validation method. CSC estimated the total cost of these modifications to be $5.1 million. This amount includes both the state and federal portions of the cost.

Federal MMIS Certification is Being Delayed

The department has postponed the federal MMIS certification review of CSC's claims processing system from December 1979 until October 1980.* Until the system is certified, the State receives only 50 percent federal financial participation (FFP) for system operating costs. If the system is certified, FFP will be increased to 75 percent for the period covered by the certification. If HEW's certification is not retroactive to June 1979, the date CSC began claims processing, we estimate the State will lose $4,047,251 in federal reimbursement.

FFP is available to states for the design, development, installation, and operation of MMIS systems. Systems certified by the administrator of HEW's Health Care Financing Administration (HCFA) are reimbursed at FFP rates of 90 percent of design, development, and installation costs and 75 percent for operating costs. A noncertified system receives 50 percent FFP.

* On April 22, 1980, the HEW notified the department that they will conduct an MMIS certification site visit in June 1980. According to the regional Medicaid director, no decision has been made as to whether HEW will conduct its certification analysis for pharmacy and long-term care during that visit.

CSC's claims processing system is already certified at 90 percent FFP for its design, development, and installation. However, the parts of the claims processing system currently in operation are not certified at the 75 percent rate. The department originally wanted HCFA to conduct its certification review of the various provider operating systems on an incremental basis, certifying each system six months after it began operations. Due to systems problems in the MAR and S/UR subsystems, however, the department requested a delay for the review of the first provider operating system from December 1979 to March 1, 1980. It has now requested a delay for all system reviews until about October 1980.

Because of problems with the system's performance, HCFA may not certify it retroactively to the date operations commenced. Federal regulations require all related subsystems to be operational the entire period for which the 75 percent FFP rate has been requested. In a letter sent to the Director of the Department of Health Services, the HCFA Regional Medicaid Director expressed concern that California's MMIS may not meet that requirement:

> Because of the cancellations of the MMIS pharmacy review originally scheduled for December 1979 and the cancellation of the combined pharmacy and long-term care review scheduled for March 1980, the HCFA will be required to carefully evaluate State/CSC progress during the phase-in in order to determine the appropriate retroactive date of MMIS certification for these claim-type operations, once found to be MMIS certifiable.

If HCFA determines that the system has not been operating according to federal regulations, it may not certify the system retroactively at the 75 percent rate for the entire operating period.

If the system is certified effective November 1980 and not retroactively to June 1979, the State will lose approximately $4,047,251.* Should the system receive retroactive certification, the State will still lose interest earnings amounting to $210,757. According to the contract, the State may recover this money from CSC only if it can prove that CSC is solely at fault for failure to meet federal requirements.

The Phase-In of Physician and Medical Supplier Claim Types Has Been Delayed

Because of difficulties with the claims processing system to date, the phase-in of physician and medical supplier claim types was delayed from March 1, 1980 to June 1, 1980. The Medi-Cal Intermediary Operation (MIO) will continue to process physician and medical supplier claims until that time.

MIO's estimated increased operational costs related to this three-month extension are $7.4 million for fiscal years 1979-80 and 1980-81. These estimated costs include all aspects of the operation such as personal services, computer time, and supplies. Because of the three-month delay, CSC's operational

* Appendix F analyzes potential loss to the State.

costs will be reduced. The department estimates these costs would have been $3.9 million for fiscal years 1979-80 and 1980-81. This estimate is based on volume projections and price per ACSL in the contract. The estimated net effect of delaying the phase-in of physician and medical supplier claim types is therefore $3.5 million. The state share of this cost will be $600,000. Table 22 summarizes MIO's increased costs and CSC's cost savings.

TABLE 22

ESTIMATED COSTS OF DELAYING PHASE-IN
OF PHYSICIAN/SUPPLIER CLAIM TYPES

	Estimated Cost (Millions)	Estimated FFP[a] (Millions)	Estimated State Cost (Millions)
MIO's Operational Costs:			
Fiscal Year 1979-80	$2.1		
Fiscal Year 1980-81	5.3		
Total	$7.4	$4.7	$2.7
CSC's Cost Savings:			
Fiscal Year 1979-80	($2.8)		
Fiscal Year 1980-81	(1.1)		
Total	($3.9)	($1.8)	($2.1)
Net Effect	$3.5	$2.9	$ .6

[a] Ten percent of total expenditures are General Fund expenditures for the Medically Indigent Program. The remaining 90 percent of expenditures is eligible for FFP at the following rates:

MIO -- 75 percent FFP for qualifying costs such as personal services, computer processing, training, and travel (about 85 percent of MIO's total costs), and 50 percent FFP for nonqualifying costs (about 15 percent of MIO's total costs)

CSC -- 50 percent FFP until CSC's system is federally certified at which time FFP will be 75 percent

CSC Is Making Interim Payments To Some Providers

Since the processing of the inpatient/outpatient claim type was implemented in December 1979, a large number of those claims have been suspended. Suspended claims are not paid until after adjudication. Consequently, some hospitals are experiencing cash shortages.

To ensure cash flow to hospitals, the department directed CSC to implement a 90-day interim payment system. This system entails two check writes per month for the three-month period that began the first week in April 1980. The first check write produced approximately 1,100 warrants and each subsequent check write will produce approximately 300 warrants. An interim payment check will be issued for 60 percent of the dollar amount of a hospital's suspended claims less any accounts receivable if the amount of the payment exceeds $1,000.

Additional costs to the State from implementing the interim payment system are minimal. CSC will absorb any additional costs it incurs; the department will incur minimal costs; and the State Controller's Office will expend only an estimated $1,500 for processing the additional check writes.

Contract Modifications Will Increase Costs

The department has ordered CSC to implement two contract modifications that may add an estimated $5.1 million to the total contract cost. The department and CSC are still negotiating both modifications. These modifications will provide enhanced systems capabilities and will institute a new method for validating recipient eligibility.

The State ordered the system enhancements to ensure a successful MMIS in California. Specifically, the State wanted CSC to offer additional training to providers and to make enhancements that would reduce providers' resistance to the new claims processing system. This contract modification is scheduled for completion May 31, 1980. Table 23 presents CSC's cost proposal.

TABLE 23

SUMMARY OF ESTIMATED SYSTEM
ENHANCEMENT COSTS

Enhancement of Subsystems:		
Provider Subsystem	$ 60,100	
Recipient Subsystem	42,600	
Reference Subsystem	191,800	
Claims Processing Subsystem	492,200	
Management and Administrative Reporting Subsystem	464,100	
Surveillance/Utilization and Reporting Subsystem	39,900	
Subtotal		$1,290,700
Conversion and Development		150,900
Training:		
Provider Training	626,400	
Procedure Code (ICD-9-CM) Training	393,200	
Subtotal		$1,019,600
Total		$2,461,200

We were unable to review this modification completely because CSC claimed the information used to develop it was proprietary and, therefore, beyond the scope of our statutory authority for access to records.

The second contract modification alters the primary method for validating recipient eligibility. Currently, claims are cross-checked with the state's Recipient Eligibility History File to verify eligibility. Due to difficulties in

maintaining current and accurate information on this file, the department believes it is an insufficient source for validating eligibility. A claim label or some other proof of eligibility is sometimes required.

Under the proposed contract modification, a claim without a label will be automatically suspended and will generate a Resubmission Turnaround Document. CSC will sample a portion of claims with labels to confirm the validity of the labels.

The department and CSC are still negotiating this modification. Table 24 presents a summary of CSC's cost proposal submitted on December 20, 1979.

TABLE 24

SUMMARY OF PROPOSED COSTS FOR CHANGES
IN THE METHOD OF VALIDATING RECIPIENT ELIGIBILITY

Design, Development, and Installation	$ 230,400
Resubmission Turnaround Document Processing	556,954
Label Processing	1,624,702
Document Sampling	188,943
Total	$2,600,999

We were unable to completely audit the cost proposal because CSC claimed the information used to develop it was proprietary and, therefore, beyond the scope of our statutory authority for access to records.

CHAPTER V

PROVIDER RELATIONS

CSC's provider relations staff serves as an interface between CSC's claims processing activities and the provider community. In this capacity, CSC receives numerous inquiries each day from providers seeking information on various facets of the Medi-Cal program or the claims processing system. In addition, CSC provides training and disseminates manuals and bulletins to the provider community to notify providers on current policy and procedures relating to the Medi-Cal program claims processing.

Our review found that CSC is meeting contract standards in conducting provider training and in disseminating manuals to the provider community. However, CSC is not meeting the performance criterion for responding to provider inquiries in a timely manner. Specifically, CSC is not responding to tracer claim inquiries within the 15-day time limit established in the contract. Such untimely response to tracer claim inquiries jeopardizes an effective working relationship between CSC and the provider community.

CSC'S RESPONSE TIME HAS NOT MET PROVIDER INQUIRY CONTRACT STANDARDS

CSC is the providers' primary source of information on billing procedures, claims status, administrative appeals, explanation of Medi-Cal policy, and other areas of provider concern.

In this capacity, CSC receives numerous telephone inquiries and tracer claim inquiries each day. Although CSC is successfully responding to telephone inquiries within the allotted time, it is not doing so with tracer claim inquiries. Forty-five percent of the tracer claim inquiries we reviewed took longer to resolve than the 15-day contractual limit.

Tracer Claim Inquiries

A provider inquiry necessitates a tracer claim inquiry when CSC must extract information on the status of specific claims from various files in their claims processing system. The contract stipulates that CSC should respond to all tracer claim inquiries within 15 days of receipt.

CSC collects data each week on its performance in responding to tracer claim inquiries. Based on this data, Table 25 presents the distribution by age of the average number of pending claim inquiries between December 1979 and March 1980.

TABLE 25

DISTRIBUTION BY AGE OF MONTHLY AVERAGE OF PENDING CLAIM INQUIRIES[a]

	December 1979		January 1980		February 1980		March 1980	
Age (days)	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0-5	429	16%	552	19%	733	34%	1,071	45%
6-10	709	26	437	15	454	21	555	23
11-15	526	20	653	22	388	18	704	30
over 15	1,007	38	1,318	44	599	27	47	2
Total	2,671	100%	2,960	100%	2,174	100%	2,377	100%

[a] Unaudited

Source: Manager, CSC's Claims Research Department.

On the average, CSC received over 4,400 tracer claim inquiries per month between December 1979 and March 1980. During this time, CSC was able to resolve an average of 4,300 claim inquiries per month. However, as Table 25 shows, CSC was unable to significantly reduce the average number of pending claim inquiries over 15 days old until March 1980. From December 1979 through March 1980, the percent of tracer claim

inquiries still pending after 15 days dropped from 38 to 2 percent. This improvement may be attributed to recent increases in the number of CSC personnel assigned to handle tracer claim inquiries. In December 1979, CSC had 23 people handling tracer claim inquiries. As of March 1980, 33 people were assigned to this task.

To test CSC's timeliness in responding to tracer claim inquiries, we selected a random sample of tracer claim inquiries processed between January 29 and February 29, 1980. Table 26 presents our analysis of the sample data.

TABLE 26

SAMPLE RESPONSE TIMES FOR PROCESSING OF TRACER CLAIMS INQUIRIES

Age (days)	Number of Inquiries	Percent of Inquiries
0-5	60	46%
6-10	1	1
11-15	10	8
16-20	4	3
21-25	3	2
26-30	4	3
31+	49	37
Total	131	100%

Source: Random sample of 131 tracer claim inquiries selected from CSC's claim inquiries files.

In 45 percent of the inquiries in our sample, CSC took longer than 15 days to respond. According to a CSC official, CSC underestimated the volume of claim inquiries it would receive. Because CSC did not assign enough personnel to handle claims inquiries, backlogs developed and response time increased. As previously discussed, CSC has addressed this problem by assigning more personnel to the tracer claim research department.

Telephone Inquiries

The contract stipulates that telephone inquiries requiring no research be answered immediately. Telephone inquiries requiring further research should be answered within 15 days after the inquiry is received.

CSC received approximately 16,700 telephone inquiries between January 29 and February 29, 1980. It responded to 99 percent of them immediately. For the remaining one percent, CSC had to seek information beyond that immediately available to the communications representative receiving the call. Our review showed that CSC did respond to most of these inquiries within the 15-day time limit.

CSC IS TRAINING PROVIDERS AND DISSEMINATING PROVIDER MANUALS AS REQUIRED

To ensure proper application of Medi-Cal rules and regulations, the contract requires CSC to educate and to train providers. Specifically, it requires the contractor to schedule training sessions for providers and to conduct periodic workshops and seminars. As required by the contract, CSC training sessions included an overview of Medi-Cal, an explanation of MMIS and provider manuals, instructions on preparing forms, and other related topics.

The CSC data we reviewed showed that CSC notified providers about training sessions and conducted them before each provider type was added to the claims processing system. As specified in the contract, CSC conducted training in California's large metropolitan areas. Appendix F presents data illustrating CSC's compliance with provider training requirements.

The contract also requires CSC to conduct additional training to remedy specific problems experienced by providers or discovered by CSC and to acquaint providers with changes in policies and procedures. CSC has fulfilled this requirement by conducting additional provider training sessions in all parts of the State.

Another contractor responsibility is to plan and coordinate all activities relating to dissemination of procedural information on the Medi-Cal program. This entails developing provider manuals and bulletins for approval by the State and disseminating them to all providers. CSC provided us data which indicates that prior to systems operation, it mailed manuals and other educational materials to all active providers included on the Provider Master File which it received from the department.

Provider bulletins update materials and notify providers of policy and procedural changes in Medi-Cal practices or billing procedures. The department established criteria for the timely delivery of these bulletins in the Request for Technical Proposal:

> A maximum of 15 working days will be allowed for printing and distribution of bulletin material after receipt of a final copy approved by the State.

Timely bulletin distribution is important because the bulletins apprise providers of policy or procedural changes which affect their billing procedures. We found that CSC has furnished the bulletins to providers in the timeframe specified by the contract.

CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

The contract between CSC and the State establishes clear responsibilities for each party. It also provides specific performance standards to be achieved by the contractor and deliverables due from the contractor at various stages of design and operation. Since September 1978, CSC and the department have completed the design and development of the claims processing system and have implemented three provider claim types in accordance with scheduled milestones. CSC has conducted training sessions to prepare providers for conversion to the new system and has generally fulfilled its responsibilities for updating files critical to system operation. Since June 1979, CSC has processed over 15 million claims and has employed generally sound controls for the system. However, our staff and consultants' review of compliance with contract requirements also found that

- System and acceptance testing requirements were not followed causing significant system problems;

- The average number of days required to process all claims has increased with the addition of each claim type to the system resulting in decreased compliance with contract performance standards;

- Many management reports were either untimely or inaccurate, and some were not produced;

- A significant number of claims were in suspense. The responsibility for the suspensions was shared by the department and CSC;

- Various system edits and audits have been turned off based on formal and informal department approval;

- The system has allowed apparent overpayments of at least $450,000;

- The State was overcharged $97,983 in operational costs related to outpatient claim billing;

- Future contract modifications of more than $5 million are being considered. We were unable to fully audit these modifications because of limited time and lack of access to records;

- The department has not taken advantage of liquidated damage provisions to motivate contract compliance.

The preceding list demonstrates a weakness in the department's monitoring and oversight of several important areas of the contract. While a lack of information may have hindered the department's ability to monitor some elements of the contract, approval of system design without adequate acceptance testing was completely within the department's control.

RECOMMENDATION

We recommend that the Department of Health Services increase its contract monitoring and oversight activities to improve the efficiency and effectiveness of the claims processing system. Specifically, the department should

- Delay the addition of the physician and medical supplier claim types until all testing procedures as outlined in the contract have been followed. Further, outstanding system trouble reports for the other claim types should also be corrected;

- Assure that management reports necessary to measure CSC's compliance and performance are received in a timely manner, are accurate, and are acted upon when problems are identified. Priority should be given to claims processing times and suspended claims data;

- Monitor the operation of system edits and audits to ensure that they are turned off only upon order by the department, when the need is documented and that they are turned on when required;

- Monitor contract charges for claims processing, system installation, and change orders. Where access to records is an issue, contract audit access provisions should be tested;

- Impose liquidated damages when contract noncompliance is identified to motivate CSC's correction and compliance.

Our consultants have suggested methods to implement some of these recommendations. Their suggestions are provided in the following sections.

Acceptance Testing

- CSC should conduct structured walk-throughs which include system users from the Department of Health Services;

- Department of Health Services staff should then approve or disapprove the submitted system test plan. If disapproved, appropriate changes should be developed by CSC and all formal system tests should cease until a system test plan is approved;

- The State should not conduct any acceptance testing until a fully tested system, in accordance with the system test plan, is delivered to them as a complete package for acceptance testing;

- The State should only begin acceptance testing the physician claims system when the objectives of the system test plan have been met for all parts of the physician claim processing system;

- If excessive problems develop during the State's acceptance testing, the process should be stopped and the system returned to CSC for further system testing. Acceptance testing by

the State should not resume until the department assures itself that a properly and fully system-tested product is delivered;

- A formalized system of procedures and secured records should be established within the department to monitor all aspects of the system testing and subsequent acceptance testing. It should include logs of all correspondence with duplicate copies securely filed.

Suspended Claims

- The department should monitor and track the total number of claims exceeding 30 days in the system on a monthly basis. If greater than 9 percent of the total claims inventory exceeds 30 days in the system, penalties should be imposed;

- A detailed analytical study of the point of error originations should be conducted with emphasis on identifying the sources of the largest errors such as providers, data entry, program edits, and too restrictive audits and edits;

  These should be analyzed to determine what corrective action can be taken to remedy current claims processing delays arising out of

suspensions. Additional work to remedy problems may be required in areas such as training, forms re-design, and program modifications. Analysis would address the processing of the current four claim types. Regarding future claim types, we believe that a majority of problems could be avoided through comprehensive and rigorous state acceptance testing after a certified system test by CSC;

- The State should prepare a TAR procedures manual for use by the field offices. This manual would facilitate staff training and provide greater standardization of current procedures;

- The department should closely monitor both timeliness and accuracy in processing TARs. The department should obtain reports which show the inventory of suspended TARs by suspense error code, by age, and by physical location (at CSC or field offices). The department's staff should also monitor the error rate in processing updates to the TAR master file. CSC should provide an analysis of the reasons for the high error rate in processing corrections to the TAR file;

- The department should institute a formal procedure for monitoring the results of CSC processing of the Recipient Eligibility History File (REHF) using the appropriate reports and a control log. This procedure should involve adequate management supervision to ensure compliance;

- REHF input data to be supplied to CSC by the State should be complete as of the cut-off dates. This will reduce the number of suspensions occurring and speed up payments to providers, thus reducing the additional department staff work required to follow-up on provider complaints;

- After the above step is taken, the results should be evaluated to determine if a more frequent REHF update schedule would further reduce the number of claims suspended due to absence of eligibility data;

- Adequate key entry resources should be made available to the department to properly process REHF inputs to the eligibility file in a timely manner. Contingency plans should be developed to process backlog data in a timely fashion;

- The State should develop procedures for monitoring the receipt of temporary card data from the various counties to determine that this information is received on a timely basis;

- To prevent the mispayments and unnecessary suspensions caused by inaccuracies in converted provider file information, more thorough testing procedures should be established and more time should be allowed for testing before accepting the next claim type. The claims processing tests should include a provider file which has been created by the conversion programs from MIO data. The final acceptance of the converted provider file should be delayed until all major problems have been identified and resolved and the Provider Enrollment unit has sufficiently analyzed the converted file.

Edits and Audits

- The department and CSC should formalize procedures for reactivating audits and edits once they have been turned off. These procedures should require the State to indicate when an edit/audit is to be reactivated once it

has been turned off. The State should also verify that the edit/audit has been reactivated in a timely manner;

- The daily edits/audits and dollar value of claims passing edits/audits reports (RF-F-510 and MR-O-136) should be retained in an accessible file, possibly on microfiche. The department should devote particular attention to the financial impact of edits suspended.

Respectfully submitted,

Thomas W. Hayes

THOMAS W. HAYES
Auditor General

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May 9, 1980

Mr. Thomas W. Hayes
Auditor General
925 L Street, Suite 750
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Dear Mr. Hayes:

Thank you for the opportunity to review a draft copy of your report, "A Review of Computer Sciences Corporation and the Department of Health Services' Medi-Cal Fiscal Intermediary Operations." I have found this report to be both a comprehensive and a balanced review.

We believe the statements presented in this report to a reasonable degree reflect the status of events for the point in time at which you were conducting your field work. Significant progress has been made since your analysis was completed. For this reason, we are enclosing information pertaining to the current status of several items discussed in your report. (See Attachment 1.)

Because of the length and depth of your analysis, the Department has not had time to prepare a detailed response. Our detailed analysis will be prepared and available for you and the Legislature's review before the May 20, 1980 hearing. For your consideration, however, based upon an initial review, we have identified several audit statements which we consider to be errors in fact. This preliminary review is enclosed. (See Attachment 2.)

I have found that your report has been useful to me, providing some important new perspectives. Your report has, and will, serve as a positive management tool to improve the claims processing system. To date we have already implemented some of your recommendations and we will implement others. As an added consideration, I am making my Audits and Investigations Division responsible to periodically report to me on the effectiveness of the Department's internal controls in managing the contract.

Computer Sciences Corporation has conducted an independent analysis of the report and I am enclosing their comments. (See Attachment 3.)

In closing, I would like to compliment your staff on the professional and courteous manner in which they conducted this audit.

Sincerely,

Beverlee A. Myers
Director

Enclosures

UPDATE TO INFORMATION IN AUDITOR GENERAL'S REPORT

REHF Input Data

P. 114 (Recommendations) - "REHF input data to be supplied to CSC by the State should be as complete as the cutoff dates."

The Department has taken action to improve the quality of the input data to the REHF. Specifically, state backlog in entering temporary cards has been eliminated. Additionally, the Department is working with the counties on the entry of temporary cards to the greatest extent possible and to improve the timeliness of delivery of temporary card logs by the counties to the Department.

Contract Modifications

Pp. 7, 91, 97, 98, 99, 108 - "The department has ordered CSC to implement two contract modifications that may add an estimated $5.1 million to the total contract cost. The department and CSC are still negotiating both modifications. These modifications will provide enhanced systems capabilities and will institute a new method for validating recipient eligibility."

The current estimates for these proposed change orders are:

System Enhancements	-	$2,461,000
Validating Recipient Eligibility	-	2,029,000
Total		$4,490,000

Provider Subsystem Reports and File

P. 40 - "The contract requires that the Provider Subsystem produce management information and other types of reports. We found that some reports were not being produced."

All required monthly and weekly provider subsystem reports referred to are now available for delivery to Provider Enrollment Unit.

P. 115 (Recommendations) - "The final acceptance of the converted provider file should be delayed until all major problems have been identified and resolved and the Provider Enrollment Unit has sufficiently analyzed the converted file."

Provider enrollment is currently scheduled to analyze converted file before accepting the next claim type. Under this schedule provider enrollment will random sample selected data on converted file to make sure that provider information is accurate and complete. This analysis will begin on May 19 which is two weeks before the start up of medical services. During this pre-start up period provider enrollment will also update the PMF with provider information that could not be converted tape to tape.

TAR Procedures Manual

P. 80 - "The State should prepare a TAR procedures manual . . ."

The State Field Services Section (FSS) has provided to the various field offices instructions on the preparation of TARs, and sent out a new revised procedures manual to the Field Offices on 4/28/80.

Overcharge to State

Pgs. 5, 85, 89, 90, 108 - "The State was overcharged $97,983 in operational costs related to outpatient claim billing."

CSC has credited the State for this overcharge.

MARS Reporting

P. 36 - "The contract required that CSC produce MARS reports in a timely manner . . . Report distribution sheets, however, indicated that more than half the MARS reports distributed between August 1, 1979 and March 26, 1980 were delivered later than the specified deadlines."

The analysis indicates that MARS reports have been untimely. Significant improvements have been made in March and April. The vast majority of MARS reports are now timely in their delivery.

Provider Communications and Provider Relations

P. 7 & Pgs. 100-104 - ". . . Although CSC is responding to telephone inquiries within the allotted time, it is not doing so with written inquiries requiring information on specific claims. CSC's response to these types of inquiries has exceeded the 15-day contract limit up to 40 percent of the time . . ."

Although Claims Research experienced earlier inventory backlogs and aging, as mentioned in the audit report, it is important to note a significant and continued improvement in this area. Claims

Research Weekly Inventory Report shows a drop from 42 percent of the inventory aged over 15 days in the system on 2/11/80 to a level of only 2 percent aged over 15 days on 3/8. Except for minor variations, this level has been maintained.

In addition to a review of CSC's aging report, on April 28, the on-site monitoring staff sampled the cycle time of recently completed provider correspondence and claims inquiries. Of 217 items sampled, the average CSC cycle time was 11.9 days; 88.9 percent of all items were processed in 15 days or less; the longest period (for two items in the sample) was 22 days.

CORRECTIONS TO ERRONEOUS INFORMATION IN AUDITOR GENERAL'S REPORT

Acceptance/System Testing

P.19 "...physician claims testing is proceeding under an informal plan which does not conform to contract requirements."

The acceptance test plan for the physician vision care claim type was formally developed and documented by the Department of Health Services. Acceptance testing was conducted as outlined in this plan.

P.22 "...the department has not required CSC to follow prescribed testing procedures and is not thoroughly acceptance testing the final system."

The acceptance test of the medical/supplier-vision care claim is a fully integrated test of the entire system involving all claim types and all phases of processing from entry of the claims into the system through final adjudication and reporting. The test covers:

Input preparation
Prescreening
Key entry
Automated processing
Suspense processing, edit and medical review
RTDs
Suspense for BRU review
TARs
Automatic and manual pricing
Adjustments
Inquiries
Reporting: daily, weekly, monthly, quarterly, semi-annual and annual reports
Exception processing as well as normal processing

P.24 "CSC's system tests may not have been adequately designed because CSC and department personnel did not thoroughly review most of the systems in their early stages of development. As the system walk-throughs progressed from the first claim type implemented, pharmacy claims, on to the other claim types, the walk-throughs were held less frequently and thus the process appeared less productive."

During design and implementation of the first claim type, walk-throughs were geared to review all aspects of the newly designed system; including manual procedures and all subsystems and modules. The system was reviewed for basic systems design and comprehensiveness. All subsequent walk-throughs reviewed only those changes applicable to the new claim types, since the major sub-systems were already operational (i.e. eligibility subsystem, reference subsystem, etc.).

In addition to formal walk-throughs, the department and CSC conducted many meetings for design discussion and problem resolutions. For example, MARS, payment calculation, split billing, vision care processing, crossover processing, and TAR processing were all considered in major design meetings which were not specifically identified as walk-throughs. These meetings are considered identical in function to the walk-through.

P.28 "Adequate systems tests and acceptance tests should have detected most system malfunctions prior to implementation. However, these systems actually began operations with uncorrected malfunctions. For instance, CSC's program to convert the previous fiscal intermediary's provider file to CSC's system contained errors."

The tests and reviews did detect most system malfunctions prior to implementation. CSC's file conversion procedures were reviewed and accepted before each claim type was implemented. In addition, the converted files were sampled for completeness and accuracy.

CSC's conversion programs did contain one error concerning the identification of PSRO hospitals which resulted in suspended claims. It is not known how many of the claims which suspended also suspended for other reasons. All other problems identified with the provider master file have been identified as data errors present on the file received from the previous fiscal intermediary. All of these errors were corrected as soon as they were identified.

The examples cited do not demonstrate a lack of adequate testing. We did not anticipate the need for validity edits on operational data.

Federal MMIS Certification

Pp. 6, 91, 92, 93, 94 - "The department has postponed its request for federal certification of CSC's system because of various system problems. Federal financing, however, cannot be increased until the system is certified. If the Federal Government certifies CSC's system for increased federal reimbursement effective November 1980 and not retroactively to June 1979, the State will lose over $4 million. Should the system receive retroactive certification, the State will still lose interest earnings amounting to $210,757."

The Federal certification visit for the drug and long-term-care claim types is scheduled for July 1980.

The statement regarding the lost interest earnings is misleading. The normal procedure for Federal certification involves a complete systems review fifteen months after implementation of the total system. The Department's intent in requesting certification on an incremental basis was to expedite the receipt of the higher federal financial participation. That this anticipated "bonus" did not occur cannot fairly be said to cause an "interest loss".

Overpayments to Providers

Pp. 55-56 and pp. 82-84 - " ... at least $450,000 in claim overpayments were made by CSC." The report states that the $450,000 claim overpayment to eleven pharmacies occurred because "some claims processing system edits and audits either were not operational or were not operating sufficiently to review appropriateness of claims submitted by providers". The error which resulted in the overpayments did not occur because of a lack of reviewing the appropriateness of the claims submitted by the providers. This was a unique one-time occurrence and would not have been detected through an acceptance testing process. CSC has corrected the problem and similar overpayments have not occurred.

Claims Processing Cycle Times

Pp. 4 & 54. "From December 1979 through February 1980, CSC failed to meet the contractual average monthly processing cycle time standard of 18 days for all claim types."

The report indicates failure to meet the standards for individual claim cycle time in January and February, 1980 for pharmacy, long-term care and outpatient claims, and the standard for inpatient in February 1980. The analysis further indicates that the average number of days required to process all claims has increased with the addition of each new claim type and that there has been decreased compliance with the claims processing performance requirements.

First, the analysis fails to take into consideration data available for the months of March and April. Significant improvements in average processing time have been made in these months which must be considered in any evaluation of CSC.

The following chart* represents average cycle times reported for March and April 1980:

	Drugs	LTC	Inpatient	Outpatient	Overall
March	15.8	11.2	24	14.2	15.4
April	10.9	7.2	15.3	15.1	12.2
(RFP Requirements)	17.0	8.0	21.0	13.0	18.0

CSC has decreased its processing time to a point which now complies with the RFP.

Second, the analysis improperly includes claims which RTDed into the calculation of average processing time for all claims. While the analysis did exclude claims which were returned to the provider via a RTD for calculation of processing time for individual claim types, this exclusion was not made for determination as to whether CSC has met the overall 18-day standard. We believe that failure to exclude RTDs from this calculation unfairly requires CSC to be responsible for time that a claim is in the hands of a provider and outside CSC's control. This method of calculation is counter to a reasonable interpretation of the RFP, State law (Statutes of 1978, Chapter 1326), and federal regulations (42 CFR Section 447.45) which treat returned claims separately. An analysis which includes time that a claim is in the hands of a provider cannot be used to determine CSC's

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* Source: MR-9-325 Report. Excludes claims which went to Medical review or which were RTDed.

compliance with the RFP requirement and unfairly inflates processing time.

Based upon the data one cannot assume that CSC is in a pattern of continued decreased compliance with the RFP or that the average number of days to process a claim has constantly increased with the addition of each claim type. The data demonstrates that while there has been an initial increase in cycle time after an implementation of a claim type, CSC has been able to reduce its processing time to written RFP required norms. The implication of the report that one can anticipate the average number of days to process a claim to increase with each claim type is not supported by the data.

Suspended Claims

P.65 - "Our consultant independently analyzed claims inventories on two days in March to determine ... the length of time claims suspended had been in that status."

The analysis indicates that on March 24 and 26, 1980 CSC was out of compliance in meeting the RFP requirement that the number of claims in the system over 30 days shall not exceed nine percent of the total claim inventory. The analysis found that 32% of the claims in the system were more than 30 days old.

We believe that the analysis utilizes an unsound method to calculate CSC's compliance with this RFP requirement and by doing so unfairly represents claims aging. We have the following concerns:

1. The review was not based upon total claims in suspense, since it did not take into account those claims which are outside of the control of CSC. We believe that any analysis of claims aging must exclude claims which are in the provider's hand via an RTD. This premise is supported by Federal regulations (42 CFR 447.45). The regulation defines "clean" claims, those to be considered in evaluation, to be those that can be processed without obtaining additional information from the provider or a third party insurer or claims under Medical review. In the analysis of CSC compliance with RFP claims processing time requirements, the Auditor General excluded claims which went outside of CSC's control. This exclusion was not made for claim aging.

   As claims RTDed require longer processing time, inclusion of these claims inappropriately inflates the number of claims in the system over 30 days.

2. The analysis did not include claims inventory in the front end manual Data Control Centers (microfilm and screening, key data entry and OCR). The RFP requirement refers to claims inventory, of which these are included. Since all of these claims are under 30 days old, exclusion of this information significantly inflates the number of claims in the system over 30 days. CSC's front end inventory for March 26, 1980, 417,591 pharmacy, 1849 LTC, 24,965 inpatient, and 109,892 claim documents, if included, would substantially decrease the percentage of claims in inventory over 30 days. Using an estimated conversion of claims to claim lines for drug (1.61), LTC (2.96) and outpatient (2.97), we estimate that inclusion of the front end alone would decrease the analysis of the 23.8% listed on Table 11 for that day to approximately 12%. This percentage is further decreased by the inclusion of the aforementioned claims in RTD. On this particular day, taking into consideration the facts cited above, we believe the Auditor-General's calculations would appear to be revised to approximately the 9% of inventory figure specified in the RFP for "over 30 days" claims.

3. The review only takes into account 2 days of suspense, this methodology does not recognize the cyclical patterns inherent in a claims processing system in which the daily volumes vary depending on the day of the week,or month of the year. For example the two days selected for evaluation varied substantially. Using the Audit Report's figures the variance was from 36.5% to 23.8% over 30 days from March 24, to March 26, 1980. An alternate approach to calculating aging will be presented in our detailed response.

COMPUTER SCIENCES CORPORATION
GOVERNMENT HEALTH SERVICES (916) 920-5000
2000 EVERGREEN · P. O. BOX 15000 · SACRAMENTO, CALIFORNIA 95813

May 9, 1980

Ms. Beverlee Myers
Director
Department of Health Services
714-744 "P" Street
Sacramento, CA 95814

VIA: Mr. John Larrea, Chief
Fiscal Intermediary Management Branch
Department of Health Services
714-744 "P" Street
Sacramento, CA 98514

Dear Ms. Myers:

Enclosed is CSC's response to the Auditor General's Report of May, 1980. It is our understanding that our response will be used as an addendum to your formal response to his report. I believe that it states CSC's position clearly and concisely.

Should you find that not to be the case, please let me know immediately.

Very truly yours,

Ross E. Forncrook
Vice President and
General Manager

REF:cll

Enclosure

COMPUTER SCIENCES CORPORATION'S RESPONSE TO A REPORT OF THE OFFICE OF THE AUDITOR GENERAL TO THE JOINT LEGISLATIVE AUDIT COMMITTEE ENTITLED:

"A Review of Computer Sciences Corporation and the Department of Health Services Medi-Cal Fiscal Intermediary Operations

May 1980"

Computer Sciences Corporation (CSC) believes that the Auditor General has reached many misleading conclusions as to the manner in which CSC is performing and the Department of Health Services (DHS) is administering the contract for Medical Fiscal Intermediary Operations.

However, before addressing the specific conclusions of the Auditor General's report, CSC believes that a review of the events leading up to its contract is essential. The fact that CSC's new system is more complex and stringent results from a State mandate established four years ago, primarily by the Legislature. A legislative audit report that reviewed the Medi-Cal Intermediary Operations (MIO), coupled with concerns expressed by the "Little Hoover" Commission, triggered DHS action in procuring a new contract that would correct many deficiencies in the Medi-Cal program. The main purposes of the new contract were two-fold:

- To create a system that would assist DHS in more effectively controlling fraud and abuse within the program.

- To obtain more effective financial controls and reduce administrative costs.

The DHS procurement process resulted in the award of a contract with CSC to create and operate a Medicaid Management Information System (MMIS) that would meet the goals established by the Legislature.

CSC's MMIS clearly provides the mechanism needed by DHS to control the Medi-Cal program. Anything short of its full and complete implementation would be a retrogression in the State's historical attempts to gain control over the $4 billion program.

The Auditor General's recommendation to delay implementation of one provider group would prevent DHS from achieving its objectives of controlling fraud and abuse and reducing administrative costs. The report overlooks or misinterprets contract terms, conditions, and administrative events which should have been considered in evaluating CSC performance. In addition, the Auditor General apparently did not consider the Contracting Officer's authority to use discretionary judgment during the project's Installation Phase to most effectively achieve the major objective of successfully implementing MMIS.

CSC believes that the Auditor General's report did not deal with the primary issue: CSC and DHS readiness to process physician and physician supplier claims. The audit team only sampled history, and in some instances used an erroneous and limited sampling method to draw a final conclusion pertaining to current status.

CSC is ready to process the new claim types, whether or not the MIO Universal Claim Form (UCF) is used. Dramatic system performance improvements in March and April, coupled with successful completion of a thorough State acceptance test of CSC's system, serve as further demonstration of our readiness.

The audit team was forced by time constraints to conduct an unfortunately brief review of the current fiscal intermediary operation, a factor which the Auditor General readily concedes compromises his conclusions. Unfortunately, their conclusions were reached without due consideration for (a) the activities and operations of the prior fiscal intermediary (MIO) and their impact on CSC and the Department; (b) the history of the design, development, and installation of the new Medicaid Management Information System (MMIS); and (c) proper interpretation of Contract performance standards.

As previously stated, the most important issue to address from CSC's perspective is its readiness to begin processing physician and medical supplier claims on June 1, 1980. The Auditor General's report points out that:

- "Since September 1978, CSC and the department have completed the design and development of the claims processing system and have implemented three provider claim types in accordance with scheduled milestones."

- "CSC has conducted training sessions to prepare providers for conversion to the new system and has generally fulfilled its responsibilities for updating files critical to system operation."

- "Since June 1979, CSC has processed over 15 million claims and has employed generally sound controls for the system."

The report then takes exception to the above-stated conclusions by alleging that CSC and DHS were not in compliance with contract requirements. The findings cited are:

- "System and acceptance testing requirements were not followed, causing significant system problems"

  The report attempts to focus on contract compliance and theory, with little regard to "real world" application. The facts are that structured walk-throughs and numerous subsequent meetings were scheduled for the initial implementation of the processing system; although this was nominally in support of Drug Claim processing, the basic system structure for all claim types was reviewed. Subsequent walk-throughs were held between CSC and DHS as add-on software development reviews specific to the remaining claim types. All test schedules and walk-throughs were developed by mutual agreement between CSC and DHS, and were well within any contractual interpretation of the discretionary powers and judgment expected of the contracting officer. CSC does not agree that the system and acceptance testing process caused significant system problems; in fact, it avoided system problems.

- "The average number of days required to process all claims has increased with the addition of each claim type to the system, resulting in decreased compliance with contract performance standards"

  CSC believes the reference to "decreased compliance with contract performance standards" to have no relationship or validity when discussing the average cycle time for adjudication of claims. CSC has performed its contractual obligations in connection with all claim types implemented, and has met all of the objectives of the

new system. However, we strongly disagree with the report's legal interpretation of our contractual obligations. There are naturally certain legal issues that can only be settled by legal interpretation of the contractual terms and conditions. For example, upon advice of outside counsel, CSC believes that there is no requirement to meet performance criteria under the contract until the full implementation and installation of the Medicaid Management Information System (MMIS), including all provider claim types. However, CSC is prepared to work with the DHS legal staff at any time to settle any contractual dispute that may exist.

In addition, the report fails to recognize the major improvements achieved in cycle times in the months of March and April. In its summary statement, it ignores the fact that deficiencies in the files transmitted from MIO contributed greatly to the increases in cycle time, as well as to suspended claim lines at the point of installation of each claim type.

o "Many management reports were either untimely or inaccurate, and some were not produced"

The scope of the management reporting problem has been exaggerated far beyond the minimal number of actual discrepancies. Adequate information and data to monitor CSC performance and control the Medi-Cal Program have always been available to the State from various sources, including duplicating and overlapping MARS reports.

This statement in the report is misleading. For example, with some modifications, the detailed MARS design was accepted by the State after the required conceptual and design "walk-through" held in October of 1978. When the MAR Subsystem became operational, many State user

groups expressed dissatisfaction with certain design concepts and outputs previously accepted by DHS. MARS "inaccuracies" constituted not only certain programmatic errors in the system, but also a number of user group dissatisfactions with the design concept and output. Requests for "correction" were in many instances demands for reconfiguration or enhancement of the MAR Subsystem. Delays in completion and operation of the MAR Subsystem were due to reconfiguration of the subsytem, as well as corrective measures.

An accurate representation of the S/UR Subsystem is that there are no reports or modules, as required by DHS schedules through formal correspondence, that are not in production status by CSC. The Auditor General audit team is also the victim of common misconceptions about CSC reporting which also plague the media, Legislature, and provider community.

Contrary to the statement that retroactive MMIS certification is jeopardized by the alleged lack of timely and accurate MARS reports, Federal (retroactive) certification of the California MMIS is <u>not</u> jeopardized. These reports will be accurate by DHS definition when the HCFA review is conducted. Furthermore, DHEW/HCFA has always been willing, by its own regulations, to accept functional equivalents for these reports, which are currently available.

Although the Auditor General's staff alludes to some of these factors, they are merely reported and the conclusion is still drawn that MARS and S/URS reports were untimely and inaccurate. Worse yet, the report summary includes only the alleged deficiencies in CSC's MARS and S/URS. We believe this form of reporting on MARS and S/URS is at the least misleading.

- "A significant number of claims were in suspense. The responsibility for the suspensions was shared by the department and CSC."

  CSC does not agree that the words "A significant number" accurately portray, even in summary form, the status of the suspense file. The conclusion is drawn, for the most part, from an invalid sample of only two days of suspense. In addition, they failed to look at a valid representation of total claims in process to arrive at a percentage of claims represented as being over 30 days old.

- "Various system edits and audits have been turned off based on formal and informal department approval."

  CSC turns on or turns off edits and audits only at the specific direction of DHS.

- "The system has allowed apparent overpayments of at least $450,000."

  CSC takes exception with this finding when represented in its summary form as a major item. It is a fact as detailed in the body of the report that ten warrants were issued amounting to $449,991.48. Of the amount erroneously paid, all but $120,661.37 has been recovered as of this date. The problem that occurred was a single program logic error corrected within 24 hours of its discovery, and not an innate system problem as the statement in the report would imply. In addition, should any actual loss occur, it is CSC that is at risk, not DHS.

- "The State was overcharged $97,983 in operational costs related to outpatient claim billing."

  CSC agrees and was, in fact, the party discovering the overbilling. CSC notified DHS immediately. All monies involved have been repayed.

- "Future contract modifications of more than $5 million are being considered. We were unable to fully audit these modifications because of limited time and lack of access to records."

  The contract modifications are not due to CSC involvement. One was requested by DHS and the other was the result of legislative action that no one could anticipate.

- "The department has not taken advantage of liquidated damage provisions to motivate contract compliance."

  As previously mentioned, CSC disagrees with the Auditor General's legal interpretation that DHS should have assessed any liquidated damages. Other than the potential for assessing damages if CSC had not been able to implement the provider claim types in accordance with the scheduled milestones, there are no other contractual provisions wherein liquidated damages are applicable until full implementation of the MMIS and all claim types are operational. CSC has informed DHS of its positions on this issue.

- "Delay the addition of the physician and medical supplier claim types until all system acceptance testing procedures as outlined in the contract have been followed. Further, outstanding system trouble reports for the other claim types should also be corrected."

CSC objects to the recommendation to delay the physician and medical supplier claim types. Acceptance testing is completed and CSC is prepared to process these claims types mentioned, including the existing Universal Claims Form currently in use by MIO. CSC is dismayed by the fact that the report dealt with past history in the installation phase of CSC's contract and not our current capability to perform the processing beginning June 1, 1980. The current April statistics of our performance will unequivocally justify our confidence. In addition, CSC has taken extraordinary measures, well beyond its contractual requirements, to be ready June 1.

Current Statistics:

1. Average Cycle Time

The average cycle time for each claim type and the composite (average) excluding State Review, Medical Review, and Resubmission Turnaround Documents is as follows:

Claim Type	Average Number of Days	
	March 1980	April 1980
Drug	15.3	9.8
LTC	11.0	6.6
Inpatient	22.4	13.9
Outpatient	13.2	14.3
All Claim Types	14.8	11.2

2. Percent Suspended Over 30 Days

CSC calculated the percent of inventory over 30 days based upon new claims received from March 18 to April 2, 1980 compared to the claims from this group remaining in suspense 30 to 45 days later. A total of 5.04% of this inventory was over 30 days old. This calculation is consistent with Federal Regulations 42 CFR 447.5.

3. Payment

The total claim lines and inpatient claims plus the amount approved for payment from inception of contract are as follows:

Claim Type	Claims/Claim Lines	Dollars
Drug	20,411,118	150,242,283
LTC	572,942	452,789,745
Inpatient	212,888	196,044,426
Outpatient	2,949,902	65,996,984
Totals	24,146,850	865,073,438

4. Claims Inquiry Cycle Time

As of this date, the average is 13 days.

Extraordinary Measures:

- CSC has acquired additional computer hardware that more than triples the capacity committed to in the contract.

- CSC has increased its staffing levels in all areas, but most dramatically within the suspense processing function.

- In anticipation of possible provider start-up difficulties, CSC has accelerated its hiring plan over 30 days ahead of prior commitments.

CSC stands ready to take whatever additional measures are necessary to ensure a smooth transition for the physician and medical supplier providers beginning June 1.

AUDITOR GENERAL'S COMMENTS CONCERNING THE DEPARTMENT OF HEALTH SERVICES' AND COMPUTER SCIENCES CORPORATION'S RESPONSES

We normally do not comment on agency responses to our audit reports. In this instance, however, we believe we must comment to provide perspective and clarity.

Despite the agencies' lengthy comments, they do not refute our main conclusion that the department has not followed contractual requirements to monitor system testing, to assure CSC's product is sufficiently tested, and to acceptance test to assure CSC's ability to process the medical provider claim type. The department's and CSC's comments are silent about CSC's performance of system testing. Adequate system testing is essential to developing a product for acceptance testing which can be accepted by the department. This process is required in the contract and believed reasonable in the industry. The contract contains detailed specifications on how this testing is to be done, and these specifications have not been followed.

CSC states that we failed to consider changes in system and acceptance testing procedures authorized by the contracting officer. If such modifications took place, they were made without state monetary recovery. As such, the State is not getting what it paid for and what CSC agreed to provide when its proposal was selected. Furthermore, our consultants have concluded that the failure to follow the contract's testing procedures has resulted in system problems not being detected.

Updated Information

We were not presented with any methodology or substantiation for the updated information CSC and the department provided. Therefore, we cannot verify any of the information.

In our report we did employ the most current information available at the time of our review and drew no conclusions for which sufficient information was not available.

Generally, the update lacks specificity and consistency in certain areas. For instance, it does not describe what reports are now timely and fails to indicate any improvement in their accuracy. Furthermore, we believe that their methodology for computing March and April claims

processing times is inconsistent with the terms of the contract. Thus the times presented are artificially low. The updated statistics also reflect the continuing problem of disparate information in that CSC and the department present inconsistent claim processing times for March and April. For example, CSC reports that inpatient claims were processed in an average of 22.4 days in March, while the department reports that it took an average of 24 days. CSC and the department differ by one day in their April average processing time statistics for all claim types.

Finally, CSC contends that its claims research unit has experienced continued performance improvement. However, its data simply demonstrates that performance is erratic.

System and Acceptance Testing

The department suggests that it has performed formal acceptance testing. However, it does not state that CSC's system testing was accomplished in accordance with the contract and produced a product acceptable to the department. Without CSC's delivering a complete product to acceptance test, the department could not have completed a sufficient acceptance test. Since no formal modification of this standard exists, the department could not have executed a meaningful acceptance test.

The department and CSC state that acceptance testing would not have identified the errors we cite. Our consultant disagrees. For instance, testing an edit for high dollar amounts would have identified system deficiencies which have allowed overpayments such as the $450,000 in pharmacy claim overpayments as well as the 462 questionable pharmacy claims we identified with above average pharmacy prices (see page 83). Proper acceptance testing would also have tested the converted provider file for missing or incorrect data. Moreover, the department began processing pharmacy claims without resolving certain system errors that were found during acceptance testing (see page 29).

Additionally, the department states that it participated in more walk-throughs than were documented. Such actions, if true, are imprudent because without adequately documenting design discussion and problem resolution, agreements reached cannot be substantiated and system changes cannot be verified.

Claims Processing

Both CSC and the department contend that claims returned to providers for additional or corrected information should not be counted when calculating overall average

processing times. The contract, however, does not specify that such claims be excluded from the overall requirement for an 18 day average processing time. While claims leaving CSC's control will probably take longer to process, the wording of the contract requires that the average processing time for all claims shall not exceed 18 days.

The department has pointed out that our interpretation is stricter than that specified by federal regulations; however, federal regulations are neither referred to or included as part of the contract. Moreover, the state contract includes many standards which exceed required minimum federal standards.

We also measured processing times for individual claim types excluding those returned to providers and others outside of CSC's control. Our data still indicate that CSC failed to meet pharmacy, long-term care, and outpatient processing standards during January and February 1980, and the inpatient processing standard in February 1980 (see page 59).

Suspended Claims

The department and CSC both state that our analysis utilizes an unsound method to calculate CSC's compliance with the contract requirement because we did not exclude claims which are outside of CSC's control. The contract states that the number of claims in the system over 30 days shall not exceed nine percent of the total claims inventory. However, the contract does not state that only "clean" claims will be considered in this measurement. We believe that if the State had intended these claims to be excluded, the contract would have specified as such.

The department and CSC also discount our analysis because it did not include claims inventory in the front end manual data control centers. The department presents a set of statistics which suggest that the claims inventory was 554,297 claims larger than the figure our analysis used.

The department's statistics, however, are based upon a daily report which provides only estimated counts. CSC and the department have stated that they cannot calculate how many actual claims or claim lines are in those data control centers. Even using the department's statistics and adding 200,000 claim lines for RTD's and conversions, CSC still fails to meet the standard by over five percentage points. Moreover, the department does not present statistics for March 24. Our consultant believes that, if reviewed, an insignificant number of claims would be found in the front end of the system for that day.

The department states that our analysis does not represent the condition of suspended claims because we analyzed the file on only two days. We believe our analysis accurately reflects the level of suspended claims because it depicts a window which shows claims 30, 60, 90, and 120 days or longer in suspense. We selected these days to assure an objective representation of both weekending and midweek patterns.

Finally, although CSC does not believe our statistics on suspended claims are significant, we believe 326,000 claim lines with a value of $32 million in suspense from 30 to 60 days and 85,000 claim lines over 60 days in suspense are significant (see Appendix D-1).

Reporting

CSC states that all S/UR subsystem modules and reports specifically requested by the department are in production. As stated in our report, three of the five S/UR modules have not been implemented in accordance with the required schedule, and 16 of the 44 required reports are not being produced (see page 31). Our findings were confirmed by departmental correspondence.

Liquidated Damages

CSC disagrees with the Legislative Counsel's interpretation of the contract's liquidated damage provisions. CSC contends that liquidated damages for inaccurate or untimely reports cannot be legally assessed until all claim types are operational. CSC's payment of $148,000 in liquidated damage assessments seems, however, inconsistent with its own contract interpretation.

GLOSSARY OF TERMS

Adjudicated Claim Service Line (ACSL): A logical detail service line on a claim form that contains a service code, a service description, and a service fee and has reached a final disposition such that it has either been paid or denied and will not be reprocessed.

Adjudication Status: The status of a claim during claims processing. The status may be approved, suspended, or denied.

Adjustment: A transaction that changes the payment amount and/or units of service of a previously paid claim.

Adjudicated Claims Module: This module verifies input data and performs edits/audits which determine the dispostion of claims.

Audit: An examination of claim data in which the data is examined in relationship to applicable historical records.

Beneficiary: A person who has been determined eligible to receive Medi-Cal bnefits.

Benefits Review Unit (BRU): Unit of the Department of Health Services which verifies computation of liability and spenddown amounts, and determines whether such liabilities and spenddowns have been met for medically indigent and medically needy recipients.

Block-Billing: A billing format that allows the reporting of more than one instance of the same procedure rendered during a month by a single provider to a single recipient on one claim service line by recording the first and last date of service, the procedure code, and the number of times the service was rendered. Also known as "From-Thru Billing."

Certification for Medi-Cal: The determination by the county department (or the Department of Health Services) that a person is eligible for Medi-Cal and either has no share of cost, has met the share of cost, or is in long-term care and has a share of cost which is less than the cost of long-term care at the Medi-Cal rate.

Claim: A bill rendered by a provider for the reasonable costs of providing authorized medical services to a Medi-Cal recipient. A claim may be made up of one or more line items.

Claim Control Number (CCN): A unique number assigned to each claim used to identify the claim through processing. The number includes the Julian date of receipt.

Claims Processing Subsystem: An integrated manual and computerized system that is central to all functions of Medi-Cal claim adjudication and payment. The objective is to process and pay Medi-Cal claims in an accurate, efficient, timely, and cost-effective manner.

Contract: The term "contract" used throughout the report refers to the provisions of the request for technical proposal (RFP), the technical proposal (TP), and related documents.

Correspondence Control System (CCS): A module within the Provider Subsystem that monitors all provider inquiries, either correspondence or telephone inquiries.

Crossover Claim: A bill for services rendered to a recipient of benefits from both Medicare and Medi-Cal. Medicare pays first and then determines amounts of unmet Medicare deductible and co-insurance to be paid by Medi-Cal.

Data Control Center (DCC): A unique identifiable manual or computerized stations to which or from which claims may be routed during the adjudication process.

Data Entry: For Medi-Cal this includes Optical Character Recognition and key-to-disk data entry methods.

Deny: To determine that a billed service(s) is not covered by Medi-Cal and will not be paid.

Edit: An examination of claim data.

Edits/Audits: Edits are performed during daily adjudication. Audits are performed during weekly adjudication.

EDP: Electronic Data Processing.

Eligibility File: A computer file which maintains the current enrollment for all persons determined by the local welfare departments to be eligible for Medi-Cal benefits.

Error Suspend: A claim containing errors as determined by the Adjudication Module of the Claims Processing Subsystem. A facsimile of the claim will be returned to a provider for a correction or change that will allow it to be processed properly.

Federal Financial Participation (FFP): That portion of Medicaid funding provided by the Federal Government.

Fiscal Intermediary: An organization under contract to perform Medicaid functions for the state agency which administers the Medicaid program (such as claims processing, etc.).

From-Thru Billing: See Block-Billing.

General System Design (GSD): The federal Title XIX standards by which a state's Medicaid system can be certified. Also commonly known as the "Blue Books".

Inpatient Care: All services and procedures covered by Medicaid when the recipient requires hospitalization.

Long-Term Care (LTC): Inpatient medical care which lasts for more than the month of admission and is expected to last for at least one full calendar month after the month of admission. (Includes Medi-Cal Skilled Nursing Facilities (SNF) and Intermediate Care Facilities (ICF).)

Management and Administrative Reporting Subsystem (MARS): The means through which Medi-Cal program information requisite for effective program understanding and management is collected and reported.

Medi-Cal: The Title XIX Federal Medical Assistance Program intended to provide federal and state financial assistance for health and medical care of needy persons.

Medi-Cal Card: A computer printed or hand-typed card issued each month to a person certified to receive Medi-Cal in order to identify the person as a Medi-Cal beneficiary and authorize the receipt of Medi-Cal covered services.

Medical Review: Suspended claim review by para-medical or medical personnel to finally approve, reprice, or deny a claim.

Medicare: The Title XVIII Federal Hospital and Medical Insurance Program intended for persons 65 or older or disabled. The money used from national trust funds is financed by federal government payments and personal payroll contributions.

Medi-Cal Intermediary Operation (MIO): The joint contract arrangement of Blue Cross North, Blue Cross South, and Blue Shield Services Corporation formed in 1966 to provide Medi-Cal fiscal intermediary services.

Medicaid Management Information System (MMIS): A federally developed guideline for 75 percent federal funding of Medicaid program.

Optical Character Recognition (OCR): Data entry method which automatically translates a document into a machine-readable format without any key-entry.

Outpatient Care: All services and procedures covered by Medicaid in a hospital or clinic where the recipient does not require hospitalization.

Pended Claims: All claims within the automated system that have not reached final adjudication status. This includes suspended claims and claims awaiting weekly adjudication.

Proof of Eligibility (POE): Verification that a beneficiary is eligible to receive Medi-Cal benefits for a specific month.

Professional Standards Review Organization (PSRO): A nonprofit professional association delegated by HEW with the responsibility for the review of the professional activities of physicians and other health care practitioners, and institutional and noninstitutional providers of health care services and items for which payment may be made under the Medicare and Medicaid programs.

Provider Master File: A file which contains a record for each person, organization, or institution certified to provide health or medical care services authorized under Medi-Cal; and contains the reimbursement rates for inpatient facilities used in the daily payment of the providers' claims.

Provider Subsystem: This subsystem performs two important functions. First, it analyzes the applications of new providers to enroll the provider into the Medicaid program. Second, it keeps an up-to-date list of all certified providers.

Recipient: A person enrolled on the eligibility file by his local welfare department to receive the benefits of Medicaid under one of the aid categories.

Recipient Subsystem: A state-operated subsystem which updates and maintains an historical file of those eligible for services under the Medi-Cal program.

Reference File Subsystem: Functions as a data center for the Claims Processing Subsystem, the Management and Administrative Reporting Subsystem, the Provider Subsystem and the Surveillance and Utilization Review Subsystems. It also maintains a data base identification of duplicate or conflicting claims.

Recipient Eligibility History File (REHF): This is the recipient master file used for claims adjudication.

Resolution: The action taken to resolve suspended claims.

Resubmission Turnaround Documents (RTD): The facsimile claim generated from error suspends on the Suspense Master File that is returned to the provider for corrections and resubmission to the fiscal intermediary.

Review Suspend: A claim that is error-free but has been suspended for review and resolution by para-medical or medical personnel.

RFP: Request for Technical Proposal.

Surveillance and Utilization Review Subsystem (S/URS): This system aids in (1) identifying the extent of overutilization, abuse and fraud by Medi-Cal participants; and (2) taking appropriate corrective action when and where indicated. It also ensures that program-covered services are medically necessary, are provided in the most appropriate setting, and are provided at the lowest possible cost.

Share-of-Cost (SOC): The dollar amount which Medi-Cal recipients in certain aid categories must pay or obligate toward medical services prior to receiving Medi-Cal benefits.

STR: System Trouble Reports.

Surveillance Review: Provider-oriented reports used to investigate the expenditure of Medi-Cal funds and services.

Suspense Master File: A file of all claims that have been suspended either for errors, medical reviews, recipient eligibility recycling, or share-of-cost determination. This file is maintained by the Disposition Module of the Claims Processing Subsystem.

Title 22: The official State of California Administrative Code for Social Security including within its Division 3, the Health Care Services or California Medical Assistance Program. This book is generally considered the rules and regulations for medical services under Medi-Cal.

Title XIX: Federal Medicaid legislation.

Title XVIII: Federal Medicare legislation.

TP: Technical Proposal.

Tracer Claims: Written inquiries, excluding correspondence, from providers for claim payment status. They are currently accompanied by special tracer forms, a letter, or a photocopy of the claim.

Treatment Authorization Request (TAR): Prior approval given to a provider by a Medi-Cal consultant for a particular service to a recipient.

Warrant: The payment which the State Controller's Office prints from the fiscal intermediary payment tape.

S/URS IMPLEMENTATION AND PRODUCTION STATUS

Module	Contract Implementation Schedule	Modified Implementation Schedule[a]	Production Status
Special Reporting Needs	July 1979	October 1979	Commenced November 1979
Provider	August 1979	October 1979	Commenced November 1979
Recipient	August 1979	October 1979	Not in production
Investigation and Action	August 1979	October 1979	Not in production
Treatment Analysis	August 1979	January 1980	Not in production

[a] Due to state-ordered delays.

TIMELINESS ANALYSIS OF MARS REPORTS BY MONTH[b]

	8/79	9/79	10/79	11/79	12/79	1/80	2/80	3/80
Number of reports delivered	458	424	514	406	348	252	215	155
Number of reports delivered late	55	101	260	258	247	251	203	136
Percent delivered late	12.0	23.8	50.8	63.5	71.0	99.6	94.4	87.7
Average days late	1.0	3.2	2.3	5.0	16.2	12.6	3.9	6.5

[b] This includes all MARS reports listed on report distribution sheets.

CONTROLS AND AUDIT TRAILS SELECTED FOR ANALYSIS BY DELOITTE HASKINS & SELLS

The RFP lists certain specific controls and audit trails that are to be present in CSC's claims processing operation. The following is a summary of the items in the RFP which our consultants selected to review.

Security (ref. RFP 2.1.7.1)

The data processing facilities should be located and constructed to minimize exposure to physical disaster.

Access Control: Access to all facilities should be controlled allowing only authorized personnel.

Back-up/Recovery: All facilities should have an adequate back-up/recovery plan.

Confidentiality of Data: The contractor is responsible for having a plan for maintaining confidentiality of data.

Provider Subsystem (ref. RFP 2.2.3.2)

The Provider Correspondence File will be maintained for each provider and will contain a copy of all transactions against his record.

All data elements will be edited for consistency and completeness before updating Master Provider File.

An error suspense file will contain all error records until they are corrected.

A Pending Applications File will be maintained in the computer.

A transaction listing will be provided to account for every change to a provider's record.

All files will be labeled and checked.

Control totals and processing dates will be maintained in each file.

Reference Subsystem (ref. RFP 2.3.3.2)

Security and control measures shall be implemented to assure that Reference File Subsystem contents are not modified by unauthorized personnel or erroneous transactions.

Audit trails of all updates to the Procedure, Diagnosis, and Formulary Module shall be produced.

Audit trails produced shall be dated and retained by the location.

A record or history of each Data Control Center through which a claim has progressed prior to final disposition shall be maintained.

A listing shall be produced after each claims processing run, indicating by audit number those edits and audits which were active or inactive.

Microfilm, Microfiche Quality Standards (ref. RFP 2.4.2.1.2.3)

All claims and attachments shall be microfilmed.

A copy of the microfilm shall be stored in a permanent off-site location.

Claims Processing (ref. RFP 2.4.3.2)

A detailed audit trail of Provider and History File Updates shall be maintained.

A "warrant register" will be produced, documenting the content of the payment tape.

MAR Subsystem (ref. RFP 2.5.3.2)

Balancing and control reports will be produced.

All final output files shall be retained for at least six months.

Control reports shall be designed that crossfoot on files and other reports.

A manual accounting system will control and verify accuracy of files and processing reports.

S/UR Subsystem (ref. RFP 2.6.3.2)

Control and balancing reports will be produced.

All output reports will be maintained for six months.

A manual accounting system will control and verify the accuracy and validity of files and programs.

Controls will be developed which control files and restrict users and updating of those files.

Recipient Subsystem (ref. RFP 2.8.6.2)

All data elements on updates from the State will be edited.

An error suspense file for all transactions in error will be maintained.

A transaction report showing every change made to recipient eligibility records will be maintained.

All files will be labeled and checked by the computer.

Control totals and processing dates will be maintained.

Adequate procedures will be established to ensure update of file using only data provided by the State.

CLAIMS IN SUSPENSE
BY CLAIM TYPE AND AGE OF CLAIM

Claim Type / Claim Age in Days	March 24, 1980 Number of Claims	Total Dollar Value
Pharmacy (01)		
0 - 10 Days	24,487	$ 242,137.29
11 - 20 Days	93,703	905,324.35
21 - 30 Days	76,109	792,674.44
31 - 60 Days	160,717	1,658,928.47
61 - 90 Days	32,647	336,021.15
91 - 120 Days	8,897	91,242.27
Over 120 Days	3,260	35,386.29
Subtotal	399,820	$4,061,714.26
Long-Term Care (02)		
0 - 10 Days	2,804	$1,013,233.04
11 - 20 Days	4,839	1,902,738.54
21 - 30 Days	3,383	1,423,334.84
31 - 60 Days	4,101	1,224,267.34
61 - 90 Days	774	438,927.73
91 - 120 Days	256	132,105.39
Over 120 Days	96	60,719.09
Subtotal	16,253	$6,215,325.97
Inpatient (03)		
0 - 10 Days	2,011	$ 4,253,049.10
11 - 20 Days	9,900	20,582,013.89
21 - 30 Days	6,585	14,431,704.59
31 - 60 Days	9,744	18,721,771.39
61 - 90 Days	2,880	3,404,387.61
91 - 120 Days	67	62,671.66
Over 120 Days	-	-
Subtotal	31,187	$61,455,598.24
Outpatient (04)		
0 - 10 Days	20,745	$ 801,578.23
11 - 20 Days	89,260	3,089,506.64
21 - 30 Days	71,110	2,441,935.06
31 - 60 Days	140,752	4,439,029.91
61 - 90 Days	34,543	978,115.92
91 - 120 Days	1,130	31,142.58
Over 120 Days	-	-
Subtotal	357,540	$11,781,308.34
Medicare Crossover (06)		
0 - 10 Days	773	$ 1,390,162.04
11 - 20 Days	4,014	666,289.14
21 - 30 Days	2,273	233,118.91
31 - 60 Days	10,663	313,043.91
61 - 90 Days	1,223	32,351.77
91 - 120 Days	2	160.00
Over 120 Days	-	-
Subtotal	18,948	$ 1,390,162.04
TOTALS		
0 - 10 Days	50,820	$ 6,455,195.97
11 - 20 Days	201,716	27,145,872.56
21 - 30 Days	159,460	19,322,767.84
31 - 60 Days	325,977	26,377,041.02
61 - 90 Days	72,067	5,189,804.18
91 - 120 Days	10,352	317,321.90
Over 120 Days	3,356	96,105.38
TOTAL	823,748	$84,904,108.85

CLAIMS IN SUSPENSE
BY CLAIM TYPE AND AGE OF CLAIM

Claim Type / Claim Age in Days	March 26, 1980 Number of Claims	Total Dollar Value
Pharmacy (01)		
0 - 10 Days	60,769	$ 591,386.11
11 - 20 Days	78,416	798,526.72
21 - 30 Days	70,657	654,376.71
31 - 60 Days	61,891	677,189.25
61 - 90 Days	28,408	285,905.96
91 - 120 Days	6,642	65,779.64
Over 120 Days	2,780	31,204.87
Subtotal	309,563	$3,104,369.26
Long-term Care (02)		
0 - 10 Days	3,447	$1,175,447.37
11 - 20 Days	2,642	1,029,210.24
21 - 30 Days	2,700	1,251,619.96
31 - 60 Days	1,395	599,417.27
61 - 90 Days	622	345,957.22
91 - 120 Days	190	93,860.20
Over 120 Days	81	48,073.08
Subtotal	11,077	$4,543,585.34
Inpatient (03)		
0 - 10 Days	6,294	$14,074,678.37
11 - 20 Days	6,232	13,275,380.76
21 - 30 Days	4,728	9,984,250.56
31 - 60 Days	4,132	6,677,100.74
61 - 90 Days	2,999	3,665,520.04
91 - 120 Days	223	169,608.78
Over 120 Days	-	-
Subtotal	24,608	$47,846,539.25
Outpatient (04)		
0 - 10 Days	58,973	$ 1,944,792.14
11 - 20 Days	69,939	2,443,057.61
21 - 30 Days	56,196	1,880,585.16
31 - 60 Days	67,734	2,242,483.64
61 - 90 Days	36,319	1,055,712.95
91 - 120 Days	2,161	57,412.07
Over 120 Days	-	-
Subtotal	291,322	$ 9,624,043.57
Medicare Crossover (06)		
0 - 10 Days	2,892	$ 411,527.97
11 - 20 Days	2,036	287,389.32
21 - 30 Days	1,495	166,671.55
31 - 60 Days	7,015	109,790.79
61 - 90 Days	1,595	46,767.43
91 - 120 Days	31	817.30
Over 120 Days	-	-
Subtotal	15,064	$ 1,022,964.36
TOTALS		
0 - 10 Days	132,375	$18,197,831.96
11 - 20 Days	159,265	17,833,564.65
21 - 30 Days	135,776	13,937,503.94
31 - 60 Days	142,167	10,305,981.69
61 - 90 Days	69,943	5,399,863.60
91 - 120 Days	9,247	387,477.99
Over 120 Days	2,861	79,277.95
TOTAL	651,634	$66,141,501.78

DESCRIPTION OF COST REIMBURSEMENT ITEMS

The State will reimburse CSC for the following items:

1. Postage Expenses: Refers to U. S. Postal rates, common carrier rates, and United Parcel Service rates.

2. CRT Printers: Refers only to those CRT/Printers that shall be located on state property for state use as described in the contract. 3.

3. Printing: Refers to the printing of manuals, provider bulletins, claim forms billing envelopes and the preimprinting of claim forms. This item includes the indirect and direct cost associated with the printing and distribution of the applicable foregoing items.

4. Sales Tax: Refers to taxes imposed by the state Board of Equalization on items conveyed to the State pursuant to Title 18 of the California Administrative Code, Section 1502.

Source: Contract.

The following table presents potential losses of state funds due to delay of MMIS certification. The figures are based upon (1) the original timetable for MMIS certification, (2) the factual ACSL volume level through March 31, 1980 and contract ACSL volume estimates from April 1, 1980 through October 31, 1980, (3) the difference between the 75 percent FFP rate for a certified system and the 50 percent FFP rate for a noncertified system, and (4) interest rates based upon 13-week treasury bill rates through April 30, 1980 and an estimate of 10 percent for May 1, 1980 through October 31, 1980.

CALCULATION OF POTENTIAL LOSSES DUE TO DELAY OF MMIS CERTIFICATION

Pharmacy Providers	Loss of 25% FFP for a Noncertified System		Interest Loss		Total Loss FP and Interest	
	Monthly	Cumulative	Monthly	Cumulative	Monthly	Cumulative
June, 1979	$ 28,993	$ 28,993	$ -	$ -	$ 28,993	$ 28,993
July, 1979	117,134	146,127	-	-	117,134	146,127
August, 1979	102,018	248,145	-	-	102,018	248,145
September, 1979	90,956	339,101	-	-	90,956	339,101
October, 1979	144,018	483,119	-	-	144,018	483,119
November, 1979	129,172	612,291	-	-	129,172	612,291
December, 1979	99,489	711,780	7,165	7,165	106,654	718,945
January, 1980	151,125	862,905	8,643	15,808	159,768	878,713
February, 1980	121,047	983,952	10,504	26,312	131,551	1,010,264
March, 1980	176,952	1,160,904	14,927	41,239	191,879	1,202,143
April, 1980	157,782	1,318,686	14,220	55,459	172,002	1,374,145
May, 1980	158,754	1,477,440	12,312	67,771	171,066	1,545,211
June, 1980	159,662	1,637,102	13,643	81,414	173,305	1,718,516
July, 1980	110,826	1,747,928	14,566	95,980	125,392	1,843,908
August, 1980	111,453	1,859,381	15,495	111,475	126,948	2,970,856
September, 1980	112,080	1,971,461	16,429	127,904	128,509	2,099,365
October, 1980	112,707	$2,084,168	17,368	$145,272	130,075	$2,229,440
Subtotal	$2,084,168		$145,272		$2,229,440	
Long-Term Care Providers						
September, 1979	$ 1	$ 1	$ -	$ -	$ 1	$ 1
October, 1979	2,671	2,672	-	-	2,671	2,672
November, 1979	3,154	5,826	-	-	3,154	5,826
December, 1979	2,951	8,777	-	-	2,951	8,777
January, 1980	3,623	12,400	-	-	3,623	12,400
February, 1980	3,318	15,718	-	-	3,318	15,718
March, 1980	3,660	19,378	249	249	3,909	19,627
April, 1980	3,554	22,932	247	496	3,801	23,428
May, 1980	3,570	26,502	221	717	3,791	27,219
June, 1980	3,584	30,086	251	968	3,835	31,054
July, 1980	2,482	32,568	271	1,239	2,753	33,807
August, 1980	2,490	35,058	292	1,531	2,782	36,589
September, 1980	2,495	37,553	313	1,844	2,808	39,397
October, 1980	2,500	$ 40,053	334	$ 2,178	2,834	$ 42,231
Subtotal	$ 40,053		$ 2,178		$ 42,231	
Inpatient/Outpatient Providers						
December, 1979	$ 1,494	$ 1,494	$ -	$ -	$ 1,494	$ 1,494
January, 1980	49,553	51,047	-	-	49,553	51,047
February, 1980	104,405	155,452	-	-	104,405	155,452
March, 1980	177,782	333,234	-	-	177,782	333,234
April, 1980	161,250	494,484	-	-	161,250	494,484
May, 1980	174,921	669,405	-	-	174,921	669,405
June, 1980	184,608	854,013	7,117	7,117	191,725	861,130
July, 1980	132,693	986,706	8,223	15,340	140,916	1,002,046
August, 1980	140,825	1,127,531	9,396	24,736	150,221	1,152,267
September, 1980	148,261	1,275,792	10,632	35,368	158,873	1,311,160
October, 1980	155,404	$1,431,196	11,927	$ 47,295	167,331	$1,478,491
Subtotal	$1,431,196		$ 47,295		$1,478,491	
State Controller's Operation						
June, 1979	$ 2,493	$ 2,493	$ -	$ -	$ 2,493	$ 2,493
July, 1979	10,072	12,565	-	-	10,072	12,565
August, 1979	8,772	21,337	-	-	8,772	21,337
September, 1979	7,821	29,158	-	-	7,821	29,158
October, 1979	12,746	41,904	-	-	12,746	41,904
November, 1979	11,535	53,439	-	-	11,535	53,439
December, 1979	9,016	62,455	629	629	9,645	63,084
January, 1980	15,502	77,957	781	1,410	16,283	79,367
February, 1980	11,284	89,241	953	2,363	12,237	91,604
March, 1980	22,944	112,185	1,443	3,806	24,387	115,991
April, 1980	20,609	132,794	1,432	5,238	22,041	138,032
May, 1980	21,251	154,045	1,284	6,522	22,535	160,567
June, 1980	21,624	175,669	1,464	7,986	23,088	183,655
July, 1980	25,429	201,098	1,676	9,662	27,105	210,760
August, 1980	26,072	227,170	1,893	11,555	27,965	238,725
September, 1980	26,666	253,836	2,115	13,670	28,781	267,506
October, 1980	27,241	$ 281,077	2,342	$ 16,012	29,583	$ 297,089
Subtotal	$ 281,077		$ 10,012		$ 297,089	
Total	$3,836,494		$210,757		$4,047,251	

CSC PROVIDER TRAINING

Initial Training

Claim Type	Number of Sessions	Number in Attendance[a]	Total Number of Providers[b]	Claim Type on System	Training Notification Date	Training Date
Pharmacy	27	4,500	4,500	June 1, 1979	Feb 1979	March/May 1979
Long-Term Care	17	3,500	1,200	Sept 1, 1979	May 1979	June/July 1979
Inpatient/ Outpatient	27	6,200	2,400	Dec 1, 1979	Sept 1979	Oct/Nov 1979
Physicians	224	24,200	37,200	June 1, 1980	Sept/Oct 1979	Nov 1979/Feb 1980
Allied Health/ Vision	32	10,000	20,250	June 1, 1980	Dec 1979	Jan/Feb 1980

[a] An individual provider may have had more than one representative.

[b] CSC estimates.

ADDITIONAL PROVIDER TRAINING

Claim Type	Number of Sessions	Number in Attendance	Total Number of Providers
Pharmacy	14	317	4,500
Long-Term Care	13	1,031	1,200
Inpatient/Outpatient	19	700	2,400
Physicians	21	1,335	37,200
Allied Health and Vision	8	700	20,250

Source: CSC's State and Provider Services.

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DEPUTIES

Sacramento, California
April 16, 1980

Mr. Thomas W. Hayes
Auditor General
925 L Street, Suite 750
Sacramento, CA 95814

Medi-Cal Contract with CSC - #5830

Dear Mr. Hayes:

FACTS

The Department of Health Services (DHS) entered into a contract with Computer Sciences Corporation (CSC) on August 14, 1978. The contract provides that:

> "Contractor (CSC) agrees to design, develop, install, operate and turnover the Medi-Cal claims processing system for DHS."

You have furnished us various materials relating to this contract, including a copy of the state's Standard Agreement form used in this regard. This agreement incorporates by reference the following documents: the State Request for Proposal (RFP); the State Invitation for Bid, Addenda to the RFP (No. 1-9); State Administrative Bulletins (No. 1-7); the Contractor's Technical Proposal; the Contractor's Technical Proposal for the State's Invitation for Bid; and the Contractor's price breakdown.

Only one modification was made to the contract. On May 1, 1979, DHS and CSC agreed to amend Section 4.18.1 on page 879 of the RFP. The modification concerns insurance coverage for automobiles. The modification has virtually no impact on cost or responsibilities of the parties to the contract. Although the modification has no relevance to the scope of the audit you are performing, the contract must be read in its amended form.

You have also informed us that the RFP provides for dispute procedures in the event of disagreement between the parties and that, presently, several areas of disagreement are pending hearings for decision. In addition, one change order is currently being negotiated.

The Legislature, in Chapter 43 (S.B. 1356) of the Statutes of 1980, has directed that the Auditor General's office investigate the Medi-Cal contract between DHS and CSC and submit its findings by May 15, 1980. In order to assist your office in its investigation, you have asked our opinion regarding the interpretation of several provisions in the RFP which are currently being disputed by the parties.

It should be noted that the contract with which we are concerned is lengthy, consisting of volumes of hundreds of pages and deals extensively with technical and complex matters. It contains various provisions which purport to define the rights and duties of the parties to the contract but which may have different applications depending upon a variety of circumstances.

In view of the limited time available to us to consider this contract, we have directed our attention to the specific problem areas as requested of us, and our conclusions are based upon the materials and information you have provided to us and by no means represent a comprehensive analysis of the contract.

QUESTION NO. 3

Can CSC be fined for liquidated damages for failure of performance under Section 4.28.2 of the RFP prior to full implementation of the system?

OPINION NO. 3

A reasonable and fair interpretation of the contract would allow for CSC to be required to pay liquidated damages for failure of performance under Section 4.28.2 of the RFP prior to full implementation of the system.

ANALYSIS NO. 3

Section 1671 of the Civil Code, which provides for liquidated damages in a contract, states:

> "The parties to a contract may agree therein upon an amount which shall be presumed to be the amount of damage sustained by a breach thereof, when, from the nature of the case, it would be impracticable or extremely difficult to fix the actual damage."

Section 4.28.2 of the RFP provides as follows:

> "4.28.2--After the Contractor has completed the full development and implementation of the California MMIS [Medicare Management Information System, i.e. the Medi-Cal claims processing system] as specified in the RFP, the Contractor shall be required to perform the work in accordance with the performance criteria in the RFP. In the event the Contractor fails to meet any one of the performance criteria, the Contracting Officer will notify the Contractor in writing of the failure. The Contractor will have 60 days in which to correct the performance except when the failure to meet performance criteria is in the area of reporting including MARS [Management and Administrative Review Sub-System] and SURS [Surveillance and Utilization Review Sub-System]. If the Contractor has failed to correct the performance after 60 days, it is agreed by the State and the Contractor that such delay will cause damage to the State, and that it is and will be impractical and extremely difficult to ascertain and determine the actual damages which the State would sustain by reason of such delay; and it is, therefore, agreed that in the event of such delay, the Contracting Officer shall reduce the payment by two percent of the adjudicated claim service line price for those line items related to the functions affected by the deficient performance. When the Contractor has corrected its performance, then the State will begin payment again without the two percent reduction in price. The two percent reduction shall not be subject to recovery by the Contractor." (Emphasis added.)

Thus, this section provides that liquidated damages may be levied against CSC after "the Contractor has completed the full development and implementation of the California MMIS [Medicare Management Information System, i.e., the Medi-Cal claims processing system] as specified in the RFP, ... in the event the Contractor fails to meet any one of the performance criteria, ..."

We are informed that the claims processing system has been implemented in stages, as follows: Drug claims processing began June 1, 1979, long term care (LTC) claims processing began September 1, 1979, and hospital claims processing began December 1, 1979. Physician claims processing was scheduled to begin March 1, 1980, but was postponed by the provisions of Chapter 43 of the Statutes of 1980 to begin June 1, 1980.

At issue is whether DHS may invoke the liquidated damages provision to fine CSC for failure of performance of any or all of the drug, LTC, or hospital claims processing, or whether, until physicians are brought into the system, full development and implementation of the system is considered incomplete and liquidated damages may not be imposed under this section.

When doubts arise as to what rights and obligations are conferred by a contract, such questions are resolved by the application of the general rules of interpretation of contracts (Katz v. People's Finance and Thrift Co., 101 Cal. App. 552, 558). In construing a contract, the meaning of words in the contract is to be determined from reading the entire contract (Dix Box Co. v. Stone, 244 Cal. App. 2d 69, 76). It is presumed that the parties intended the contract to be reasonably construed, and its interpretation must be such that it will be reasonable and operative (Sec. 1743, Civ. C.; Dix Box Co. v. Stone, supra, p. 77).

In this case, the parties have included Section 4.28.2 in the RFP as a clear indication that the parties acknowledged the importance of CSC's performing the contract up to a specified standard. We believe that it would be an unreasonable and unfair construction of the contract to excuse CSC from below par performance at particular stages of implementation of the system simply because all stages of the system have not yet become fully operational, and a construction which would make the agreement reasonable, fair, and just is preferred to one that, though equally consistent with the language, would make the contract unreasonable and unfair (Cohn v. Cohn, 20 Cal. 2d 65, 70).

Thus, we conclude that a reasonable and fair interpretation of the contract would allow for CSC to be required to pay liquidated damages for failure of performance under Section 4.28.2 of the RFP prior to full implementation of the system.

cc: Members of the Legislature
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
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
California State Department Heads
Capitol Press Corps