California State Auditor

BUREAU OF STATE AUDITS

Department of Health Services:

It Needs to Significantly Improve Its Management of the Medi-Cal Provider Enrollment Process

May 2002
2001-129

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CALIFORNIA STATE AUDITOR

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May 22, 2002 2001-129

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning the Department of Health Services' (department) management of its Medi-Cal provider enrollment process. This report concludes that the department's Provider Enrollment Branch (branch), which is responsible for the enrollment process, lacks reliable data to determine the number of applications that are pending at any given time and thus cannot accurately determine the size of its backlog. In addition, the actions the branch has taken to streamline its process did not always result in an improved ability to review applications promptly, equitably, and effectively. For example, the branch did not always comply with state regulations that require it to approve applications within 180 days and could not substantiate decisions to designate certain providers as being at high risk for fraud, whose applications are subject to greater scrutiny. Furthermore, the branch did not always review disclosure statements required by the federal Health and Human Services Agency, aimed at identifying applicants with a history of defrauding or abusing the Medicaid system, increasing the risk of enrolling dishonest providers.

Finally, the branch has not developed a strategic plan that would help it address its performance deficiencies and has not fully implemented the Provider Enrollment Tracking System, which would assist its efforts to better manage its workload. Until the branch addresses these issues, it will continue to have difficulty meeting its regulatory timelines, securing additional staff, and effectively managing its operations.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE
State Auditor

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SUMMARY

Audit Highlights . . .

Our review of the Department of Health Services' Provider Enrollment Branch's (branch) management of the Medi-Cal provider enrollment process revealed that:

- ☑ *It lacks reliable data to determine the size of its backlog.*
- ☑ *It could not substantiate its decisions to designate certain providers as being at high risk for fraud.*
- ☑ *It did not always review disclosure statements required by the federal Health and Human Services Agency, aimed at identifying applicants with a history of defrauding or abusing the Medicaid system.*
- ☑ *It will continue to have difficulty effectively managing its operations until it develops a strategic plan and fully implements its data tracking system.*

RESULTS IN BRIEF

In 1999, investigations by the governor's Medi-Cal Fraud Task Force and several media reports of Medi-Cal fraud in California led to the creation of units within the Department of Health Services (department) focused on stopping fraud by Medi-Cal providers. As part of this effort, the Provider Enrollment Branch (branch) was established in July 2000. Its top priorities were to reduce the backlog of physician applications and to perform a more thorough review of applications from providers seeking to participate in the Medi-Cal program.

Since its inception, the branch's primary function has been to review the roughly 2,200 applications it receives each month. The branch has worked to streamline its application review process, develop policy manuals, and gain additional staff.

We found that the branch lacks reliable data to determine the number of applications that are pending at any given time and thus cannot accurately determine the size of its backlog. In addition, its efforts to streamline the process did not always result in an improved ability to review applications promptly, equitably, and effectively. For example, the branch did not always comply with state regulations that require it to approve applications within 180 days and it could not substantiate decisions to designate certain providers as being at high risk for fraud, whose applications are subject to greater scrutiny. Futhermore, it did not always review disclosure statements required by the federal Health and Human Services Agency aimed at identifying applicants with a history of defrauding or abusing the Medicaid system, increasing the risk of enrolling dishonest providers.

In addition, the branch has not developed a strategic plan that would help it address its performance deficiencies. For example, the branch has not established benchmarks that show how long it takes, on average, to process applications so it can determine its staffing needs. The branch also has not fully implemented the Provider Enrollment Tracking System (PETS), which would assist its efforts to manage its workload better. Until the branch

addresses these issues, it will continue to have difficulty meeting its regulatory timelines, securing additional staff, and effectively managing its operations.

RECOMMENDATIONS

To improve its management of the provider enrollment process, the branch should:

- Improve the reliability of its PETS database by requiring that staff enter data consistently and as accurately as possible. The branch also should exploit the capabilities of PETS by developing management reports to monitor its operations.

- Identify all providers whose disclosure statements were not reviewed and perform this review in accordance with federal requirements. The branch also should direct staff to continue to review all disclosure statements for all providers.

- Adopt a strategic plan to identify key responsibilities and establish priorities. This plan should clearly describe how the organization would address its many short- and long-term responsibilities, particularly those it has not fulfilled sufficiently. To do this, the branch first must determine how long it takes to process a typical application, identify its true workload, and assess whether it has sufficient staff.

In addition, the department should formalize the process whereby the branch determines which provider type should be subject to increased scrutiny and when, based upon the most recent anti-fraud trend information available.

AGENCY COMMENTS

The department generally agrees with our conclusions; however, it believes that a backlog of provider enrollment applications no longer exists. The department also believes that its efforts to hire employees to assist the branch in reducing the backlog met its contract terms and state standards for using personal services contracts. Nevertheless, the department agrees with our recommendations and states that it has already begun implementing many of them and will soon implement all others. ■

INTRODUCTION

BACKGROUND

In 1965, Congress enacted the Medicaid program, a health insurance program jointly funded by the federal government and the states for eligible low-income and medically needy people. The Health Care Financing Administration within the federal Department of Health and Human Services oversees the Medicaid program at the federal level, but each state operates its own program. Within broad federal guidelines, the states establish their own eligibility standards; determine the type, amount, duration, and scope of services; set payment rates; and administer the program—including enrolling providers such as physicians, pharmacists, and optometrists who serve beneficiaries. The state Department of Health Services (department) administers California's Medicaid program, referred to as Medi-Cal, which accounts for almost $27 billion in annual expenditures—nearly one-third of the state's estimated fiscal year 2001–02 budget—and provides health coverage for about one of every six Californians. California receives federal matching funds for its expenditures according to a formula that is based on its per capita income.

A provider must obtain a valid Medi-Cal provider number in order to bill the Medi-Cal program for services provided to an eligible Medi-Cal beneficiary. Slightly more than 140,000 providers were enrolled in the Medi-Cal program as of December 2001. The department's Provider Enrollment Branch (branch) is responsible for reviewing applications for noninstitutional providers—providers other than hospitals and long-term care facilities—including physicians, physician groups, pharmacies, podiatrists, ground medical transportation, and clinical laboratories. Noninstitutional providers represent roughly 84 percent of Medi-Cal providers. The branch received more than 27,000 applications between February 14, 2001, and January 31, 2002.

In 1998, the Federal Bureau of Investigation (FBI), in conjunction with the State Controller's Office (controller's office), identified potential health care fraud by providers. The controller's office began auditing and referring all suspect pharmacies and suppliers of durable medical equipment (DME), such as leg braces and back supports, to the FBI for investigation. Through

these referrals, the FBI began to identify and develop evidence of Medicaid fraud. In 1999, the governor established the Medi-Cal Fraud Task Force (fraud task force) to coordinate and expand the efforts of the state Departments of Health Services and Justice, the controller's office, and the U.S. Attorney General's Office.

The fraud task force found, among other things, that many pharmacies and DME providers established a shell company or used a "storefront" operation to set up their business, quickly obtain a provider number, bill Medi-Cal for large amounts in a short period of time, and then shut down. Many times these business operators would reopen in a few months under a new business name. In one flagrant case, a DME supplier was charged with defrauding Medi-Cal out of more than $9 million by submitting thousands of fraudulent claims for DME supplies that never were delivered to patients.

Media reports publicized the widespread fraud. In October 1999, the television show *60 Minutes* ran a segment describing how phony storefronts were obtaining provider numbers and submitting false claims. In February 2000, a Los Angeles television station ran a series of reports on Medi-Cal fraud by physicians and clinics that were submitting bills for patients who were undergoing medical tests they did not really need or who were pretending to be sick. The department was unable to provide an estimate of the cost of noninstitutional provider fraud and abuse.

Before 1999, California's Medi-Cal enrollment process was geared toward enrolling applicants quickly. One application was used for all provider types, and it asked the applicant to disclose any prior participation in or suspensions from a Medicare or Medicaid program and any financial interests held in a health care business by the applicant or his or her relatives. Generally, to enroll a provider, an office technician would verify the applicant's professional license information, ensure that the application did not contain inconsistencies, and enter the data into the provider master file.

Beginning in July 1999, however, the department undertook several steps to stop individuals intent on defrauding the Medi-Cal program from obtaining provider numbers. It organized the Provider Enrollment Task Force (task force), which developed and filed emergency regulations requiring applicants to complete a more in-depth application package that includes

- Applications tailored specifically to each provider type that require additional information, such as Social Security number and driver's license number;

- A provider agreement that allows the department to conduct background checks and make unannounced visits;

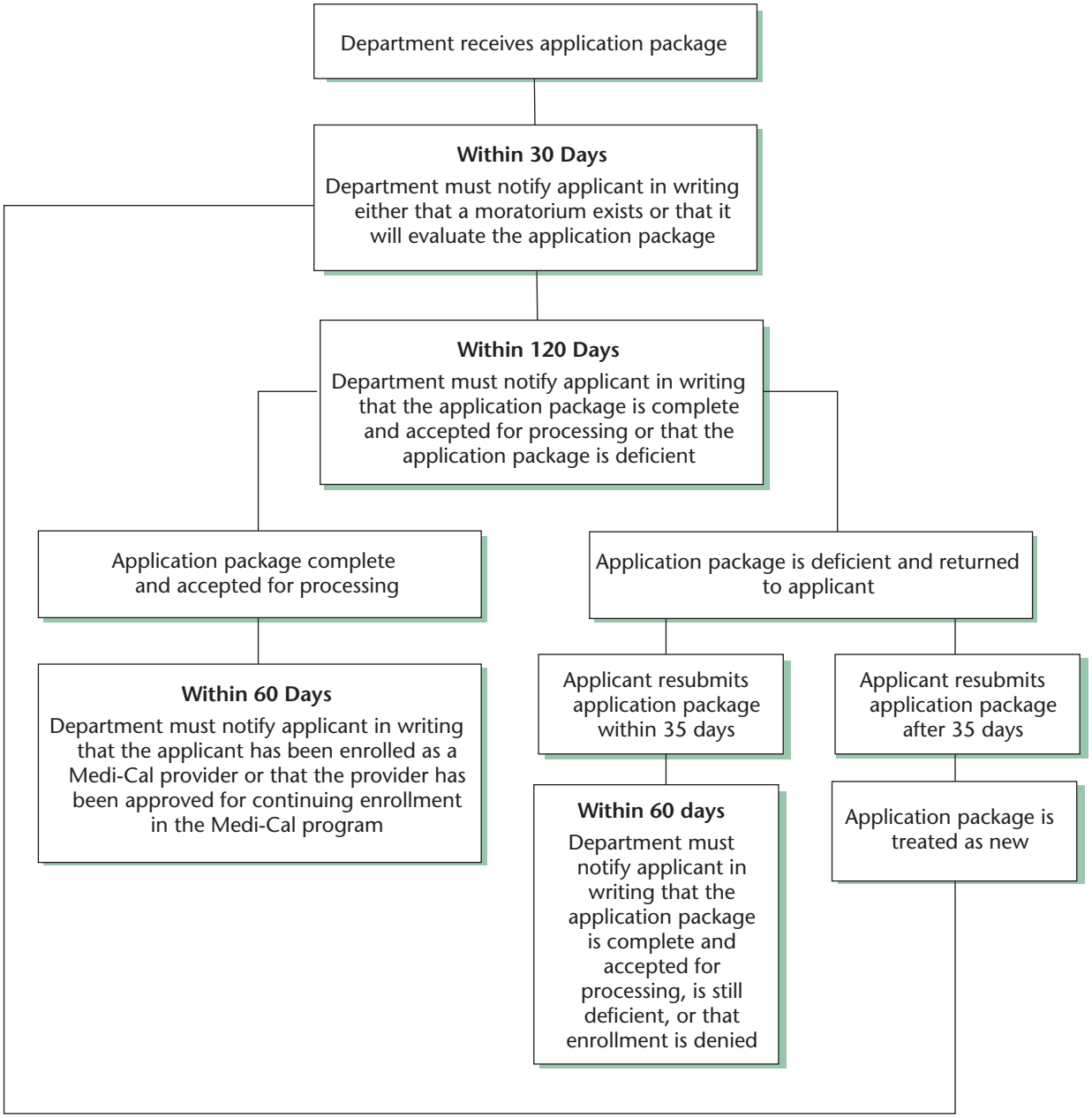
- A 10-page financial disclosure statement.

The emergency regulations also gave the department the authority to require existing providers to reenroll in the Medi-Cal program. Moreover, the emergency regulations set forth specific application review and notification criteria for the department. Although these criteria have been modified, the department generally has 180 days after it notifies an applicant of its receipt of the application package to approve or deny the package. The process can take longer if an application is deficient or requires an on-site review. Figure 1 illustrates the application review process.

The task force also established new procedures, including more-comprehensive background checks to prevent applicants who have committed fraud, engaged in abusive claiming practices in the past, or entered into arrangements with others who have done so from entering the Medi-Cal program. In July 2000, the department replaced the task force with the branch. As Figure 2 shows, the branch resides within the department's Payment Systems Division (division). The branch refers certain provider application packages that it deems to be high-risk to the department's Audits and Investigations (A&I) unit for on-site reviews.

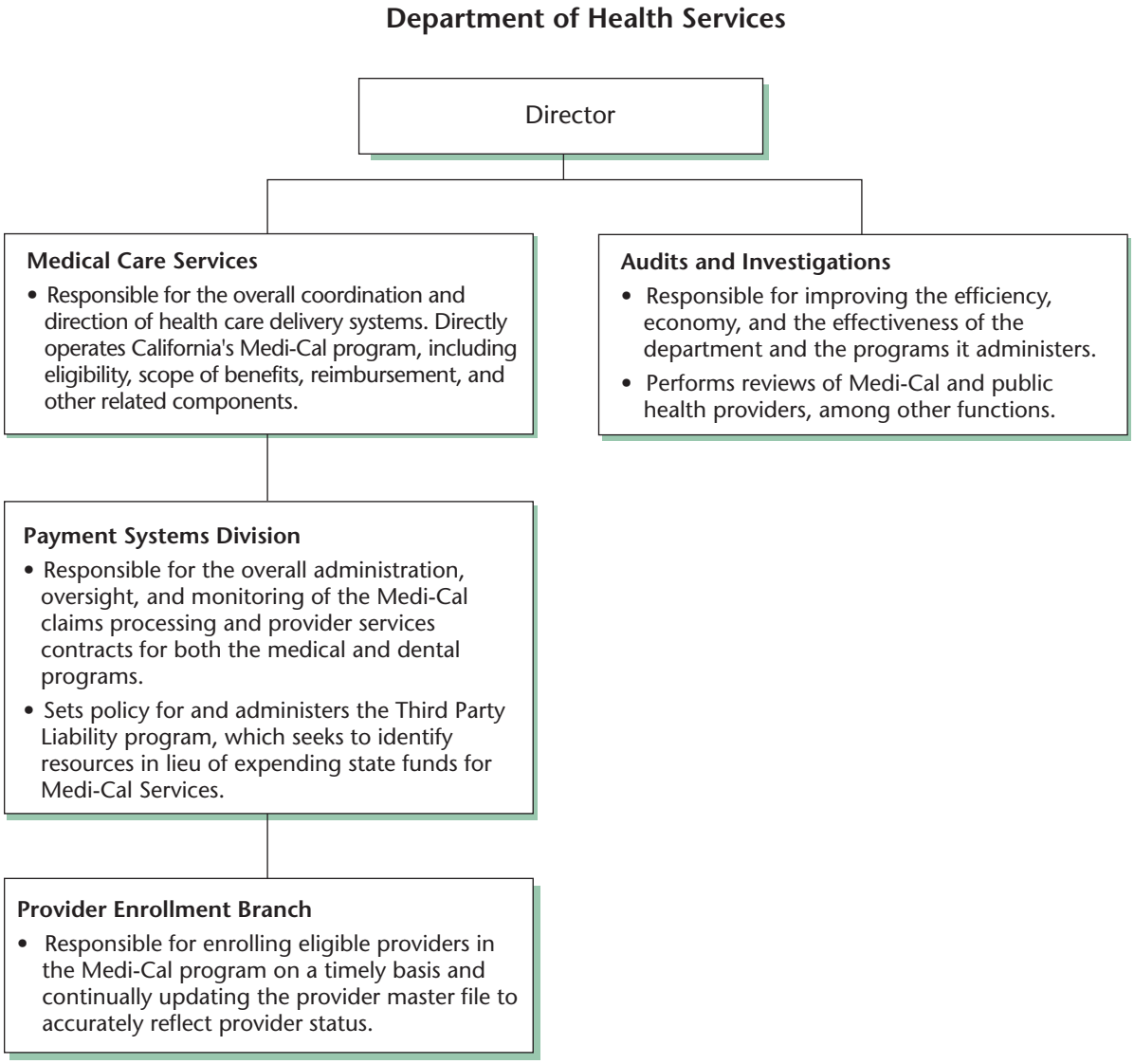
FIGURE 1

Process for Reviewing Medi-Cal Provider Applications and Notifying Applicants



Note: If an on-site inspection or unannounced visit is conducted of an applicant or provider, the regulations do not clearly state the number of days within which the department must approve or deny an application package.

FIGURE 2



The total budget for the division for fiscal year 2001–02 was more than $272 million. The division has roughly 480 authorized positions, of which about 75 are designated for the branch. Of these 75 positions, roughly 40 are responsible for processing applications from providers.

SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits examine the process used by the department for enrolling Medi-Cal providers. Specifically, we were asked to review and assess the policies,

procedures, and practices for enrolling providers; determine the average time required to complete the process by provider type; and determine whether the timelines for the enrollment process differ by provider type for corporate entities when compared to provider types for smaller independent entities or businesses. Further, the audit committee asked us to categorize the backlog of applications by provider type and, to the extent possible, to determine the causes of the backlog.

To understand the department's responsibilities and procedures for processing Medi-Cal provider enrollment applications, we interviewed department and branch staff and reviewed applicable state and federal laws and regulations, branch policies, procedures, manuals, and checklists. We also reviewed the steps the branch took to streamline its procedures and its attempts to add resources.

To determine the average time it takes to complete its review of enrollment applications by provider type, we analyzed data contained in the branch's Provider Enrollment Tracking System (PETS) for applications received between February 14, 2001, and January 31, 2002. Because we found that the branch's previous tracking system—Electronic Data Tracking System—did not contain sufficiently reliable data before February 14, 2001, we did not use it in our analyses. Although there are about 70 different provider types, the branch is responsible for reviewing applications for only 28 types. Therefore, we considered applications received by the branch for the 28 provider types only.

To assess why a large number of enrollment applications had not been approved, denied, or deemed deficient within 180 days, we selected a sample of applications, interviewed branch staff, and reviewed relevant supporting documentation.

To determine how long the department's A&I unit took to complete its on-site reviews for applications referred by the branch, we analyzed data from the log kept by A&I to track referrals for the period between February 14, 2001, and January 31, 2002. We also determined whether the branch had a process to monitor its referrals to A&I.

To evaluate the criteria the branch uses to assign risk to certain provider types, we interviewed branch staff. Using PETS data, we attempted to determine how such risk assessments affected the branch's enrollment application processing timelines.

To determine the status of the branch's provider reenrollment efforts, we interviewed branch managers and obtained data on the total number of providers expressing an intent to reenroll, the number that reenrolled, and the number that were deactivated.

To ascertain whether the branch has an adequate strategic plan, we reviewed the department's planning documents. We also identified criteria generally used in strategic planning and compared the branch's efforts to the criteria.

Finally, to determine whether the branch has established workload standards so it could assess its staffing needs, we reviewed the department's fiscal year 2000–01 anti-fraud budget change proposal and interviewed the branch chief. ■

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AUDIT RESULTS

THE BRANCH NEEDS TO IMPROVE ITS MANAGEMENT OF THE PROVIDER APPLICATION REVIEW PROCESS TO ENSURE THAT THE PROCESS IS TIMELY, EQUITABLE, AND EFFECTIVE

State regulations specify timelines within which the Department of Health Services (department) must notify physicians and others applying to enroll as Medi-Cal providers, but the department's Provider Enrollment Branch (branch) has not always met these requirements. The branch cannot ensure that it processes applications in a timely manner because it uses a flawed methodology for tracking its backlog and has failed to track referrals it makes to the department's Audits and Investigations (A&I) unit. In addition, we found that the branch cannot substantiate its risk assessments even though it has increased its scrutiny of certain provider types it designates as high-risk.

The Branch Cannot Determine the Number of Applications Remaining to Be Processed

The branch does not know how many of the roughly 27,000 applications it received between February 14, 2001, and January 31, 2002, have been approved, denied, or remain to be processed. In February 2001, the branch instituted a new database—the Provider Enrollment Tracking System (PETS)—which can provide such information. However, branch management is unable to use PETS to provide management reports that will allow it to determine the number of applications awaiting final disposition because staff have not always entered data into the database consistently. We found numerous instances in which staff did not record the completion of certain steps of the application process in PETS, as they are required to do. Further, the branch has not implemented managerial controls to ensure that staff properly and correctly enter all relevant information into PETS. Internal control is an integral part of each system that management uses to regulate and guide its operations. Ultimate responsibility for good internal control rests with management.

The branch does not track applications still in progress and, as a result, does not know its true backlog.

Since October 2000, the branch has used a weekly inventory spreadsheet to, among other things, determine its application backlog and analyst productivity and produce the Anti-Fraud Activity Report for the department's A&I unit. According to the branch's weekly inventory spreadsheet, as of the week ending February 6, 2001, it had a backlog of almost 7,300 applications that was reduced to about 550 by the week ending February 1, 2002. However, we question the accuracy of this calculation because the weekly inventory spreadsheet does not track critical data. Specifically, the branch tracks only its inventory of unassigned applications, and it reduces this balance by the total number of applications processed at the end of the week. However, the branch does not track a critical component of the backlog, which is the number of applications that have been assigned to staff and are still in progress. Moreover, an analyst cannot track data such as the number of days he or she took to approve, reject as deficient, or deny a specific application. As a result, the weekly inventory spreadsheet is not effective in measuring the branch's progress in reducing the backlog or how long its staff take to process applications, or for tracking the status of individual applications.

In September 1998, the department began using the Electronic Data Tracking System (EDTS) to track and monitor enrollment documents such as applications, correspondence, and miscellaneous records. However, a departmental review conducted by A&I in August 1999 found that EDTS was not reliable because not all correspondence for the analysts was logged, tracked, or monitored. After its inception, the branch continued to use EDTS, but it also began to partly implement the PETS database by tracking about 2,800 reenrollment applications for three provider types: durable medical equipment, nonemergency medical transportation, and orthotists and prosthetists. The branch determined that the PETS database was a useful tool to track documents, including applications, for all provider types and recommended that all staff use the database. The branch chief told us she chose to replace EDTS with PETS because of PETS' enhanced capabilities, including data security; its ability to build provider and applicant history; and its ability to produce management reports. The branch fully implemented PETS on February 14, 2001, and uses it as the primary database for tracking applications.

All applications received by the branch are entered into PETS and given an assignment number. The branch requires that staff continually update PETS regarding each application's progress

and status, such as when they receive the application, when they deny an application or determine that it is deficient, and when they complete their review. With this data, PETS can produce management reports showing, for example, the number of outstanding applications and a list of applications assigned to a specific analyst, including the date of the assignment, how long the analyst has had the application, and how many days remain to meet the required timeline for notifying the applicant.

However, the data must be reliable for PETS to produce meaningful reports. When we tested a sample of 37 applications that, according to the PETS data were still pending branch action as of January 31, 2002, and had been open for more than 180 days, we found that the branch actually had approved, denied, or returned most of these applications. Specifically, 34 of the 37 applications, or 92 percent, had been processed, but staff had not recorded this information correctly in PETS.

Although the branch has devoted time and resources to develop its tracking system and train staff, it cannot effectively use the system to manage its operations because staff do not always enter data consistently.

The branch has made efforts to provide mandatory training on PETS for staff. For example, in December 2000, staff were told that the new database would become operational effective February 2001 and that all staff responsible for the various provider types must attend the training scheduled between January 22 and January 30, 2001. It conducted an additional training course on June 11, 2001. However, it appears that staff have not consistently applied the training to their daily work. The branch chief offered several explanations on behalf of her staff, such as that many program changes were being made to PETS to accommodate the special needs of certain provider types and that a large turnover had contributed to less experienced staff.

Although the branch has devoted time and resources to develop PETS and train staff, we found no evidence that the branch management has implemented a procedure to review periodically the data that staff input into PETS. For example, each month the branch chief could perform a procedure similar to the one we used to verify the accuracy of pending applications.

Because branch staff do not enter data into PETS consistently, the branch can neither effectively track the applications it processes nor use the reports PETS is capable of producing to identify its backlog and manage its operations. For example, the branch does not track whether it notifies applicants that their application package is complete and accepted for processing, is deficient, or is approved within the requisite time frames.

According to the branch chief, when the branch achieves 100 percent staff compliance with input requirements, the PETS data will be the primary source for tracking timeliness of processing. Further, she told us that the branch is working toward developing a more independent process to sample data in PETS. She also plans to eliminate the weekly inventory spreadsheet by May 2002.

The Branch Does Not Ensure That It Reviews Applications Within 180 Days

Although PETS cannot provide meaningful information for those applications that are pending branch action, it does show that the branch frequently took more than 180 days to process some applications. We found the data was reliable when branch staff entered both the receipt and completion date. Generally, state regulations require that applicants who submit complete application packages receive written notification within 180 days that they have been enrolled or have been approved for continued enrollment as a Medi-Cal provider. Our analysis of PETS data, shown in Table 1, found that, on average, the branch was able to approve within 62 days roughly 50 percent of the 27,086 applications it received during the period we studied. The appendix shows further details of the 27,086 applications by provider type.

However, Table 1 also shows that the branch took between 201 days and 328 days to process some applications. Specifically, we found that 96 applications were processed within this range, which is significantly longer than 180 days. Further, about 34 percent of the 8,313 applications received by the branch between February 14, 2001, and January 31, 2002, that were still in progress as of January 31, 2002, had been outstanding for more than 180 days, as shown in Figure 3.

As we mentioned previously, our sample of 37 of the 8,313 applications reflected in PETS as outstanding revealed that 34, or 92 percent, of these applications should not have been shown as outstanding. However, PETS was the only available management tool that we could use to track the status of each application received and produce a summary of their status to evaluate the branch's performance. Although the branch chief initially told us on March 25, 2002, that a backlog of applications does not currently exist and that all applications are processed within the required time frames, she did not have

TABLE 1

Number of Days to Approve Medi-Cal Provider Enrollment Applications for All Provider Types* (February 14, 2001, through January 31, 2002)

	Number of Applications Received	Number of Applications Approved	Average Days to Approve Applications	Maximum Number of Days	Minimum Number of Days
2001					
February	875	496	100	293	13
March	2,173	1,272	87	328	7
April	2,346	1,468	82	271	7
May	2,228	1,478	72	253	3
June	2,345	1,529	63	245	7
July	2,368	1,549	59	201	4
August	2,576	1,556	62	175	1
September	2,282	1,281	52	146	6
October	2,829	1,425	46	122	1
November	2,435	1,172	41	90	2
December	2,235	871	31	58	5
2002					
January	2,394	171	23	30	7
Totals	**27,086**	**14,268**	**62**	**328**	**1**

Source: Department of Health Services, PETS

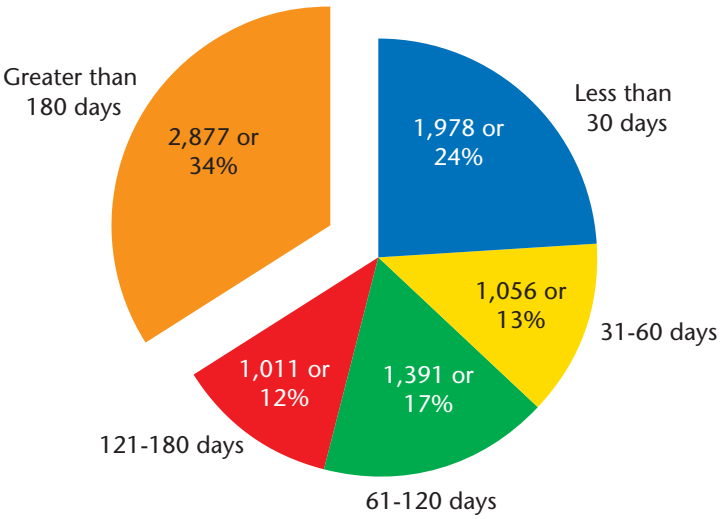
*Provider types processed by the branch as identified in the Appendix.

data readily available to support her statement. Specifically, she told us that to provide that level of detail the branch would need to select a sample of applications and verify their status.

The branch subsequently presented to us on April 11, 2002, the results of its PETS analysis of the applications it received in October 2001 that were completed. According to the branch, its average processing time for those it approved during this period was 50 days. The branch's results are consistent with the data shown in Table 1 for October 2001; however, it did not perform an aging of those applications received in October that were still in progress. We found that the branch's analysis included roughly 170 applications that were almost 180 days old and at least 46 of these applications could possibly extend beyond 180 days because branch staff had yet to complete their reviews. Therefore, we cannot concur that the branch processes virtually all its applications within the requisite time frames.

FIGURE 3

Aging of Medi-Cal Provider Enrollment Applications Still in Progress as of January 31, 2002 for All Provider Types Processed by the Provider Enrollment Branch (February 14, 2001, through January 31, 2002)



Source: Department of Health Services, PETS.

Note: Our sample of 37 applications in progress found that 92 percent should not have been shown as in progress. However, PETS was the only available management tool that we could use to track the status of each application received and produce a summary of their status to evaluate the branch's performance.

In addition to not consistently tracking the applications it processes internally, the branch also does not monitor applications it refers to A&I. Investigators from A&I perform on-site reviews by visiting the business address given on the application and determining whether the applicant's place of business is appropriate and adequate for the scope of practice, services, and supplies outlined in his or her application. According to the branch's data, it made more than 700 referrals between February 14, 2001, and January 31, 2002. PETS has the capability to track referrals made by the branch. However, the branch does not use PETS to establish or track dates indicating when it should receive a response back from the A&I so that it can meet its regulatory deadlines. The branch would be better able to track its referrals if it used PETS properly.

Further, we found that the log used by A&I did not agree with the branch's log. Specifically, the branch shows that it made more than 700 referrals, but A&I's log shows only 592 referrals during the same period.

Status of Applications Referred to A&I for On-Site Reviews as of January 31, 2002

Completed Reviews	
• On-site reviews completed	384
• Average time to complete reviews	94 days
• Reviews taking 180 days or longer to complete	19
Reviews Still Pending	
• On-site reviews in progress	207
• Average number of days in progress	159
• Reviews pending for 180 days or longer	111

Source: Unaudited A&I data

Note: A&I records for one review contained invalid data

The deputy director of A&I recognizes that there is no single system between the branch and A&I to track the total length of time an application is in progress, including the on-site reviews. She told us that A&I is developing a new system for case tracking and that the branch will have on-line access to this system. A&I expects to implement this new system in late 2002. Further, in an effort to decrease the number of days it takes A&I to complete on-site reviews, the department has entered into an interagency agreement with the State Controllers Office to assist in conducting on-site reviews. However, until the branch fully utilizes PETS and inputs data correctly, and the new A&I case-tracking system is in place and operating properly, it cannot accurately measure its effectiveness in processing applications.

The Branch Could Not Substantiate Its Decisions to Designate Certain Providers as High- or Low-Risk

The branch's objective is to prevent providers with fraudulent intent from participating in the Medi-Cal program. Consequently, it is reasonable that the branch should use relevant and available information to identify those provider types that pose a greater risk of fraud. Further, the branch should document these decisions and review them periodically to ensure that they are still relevant. However, the branch could not substantiate how it determines the risk that it assigns to certain provider types, nor does it reevaluate its risk assessment periodically.

Since its inception in July 2000, the branch has modified its provider enrollment process several times in an effort to reduce a large backlog of applications. In August 2000 the branch decided to use criteria such as past history of fraudulent activity to assign varying levels of risk to physician and physician specialty (allied) provider types such as optometrists, psychologists, and chiropractors. Applications for the physician provider type alone represent almost 65 percent of the applications the branch receives. Beginning in August 2000, the applications received from physicians and allieds designated as low-risk underwent less scrutiny than the ones received from those designated as high-risk. For example, staff did not perform a comprehensive background check, review fiscal data for suspicious billing

practices, or require a disclosure statement unless other information contained in the application was deficient. Moreover, staff did not forward low-risk applications to A&I for an on-site review.

As shown in Table 2, the branch took an average of 58 days to process applications for the physicians it approved. However, upon further analysis, we also found that the average processing time for high-risk physician applications was longer than that for low-risk physician approved applications. The branch took an average of 76 days to process approved applications for the high-risk physician provider type, compared with 52 days for the low-risk physician applications it approved.

TABLE 2

Number of Days to Approve Medi-Cal Provider Enrollment Applications for Physicians (February 14, 2001, through January 31, 2002)

	Number of Applications Received	Number of Applications Approved	Average Days to Approve Applications	Maximum Number of Days	Minimum Number of Days
2001					
February	224	117	105	293	34
March	644	335	97	265	10
April	973	633	83	268	10
May	1,618	1,137	71	253	5
June	1,759	1,208	61	245	7
July	1,818	1,268	60	196	4
August	1,880	1,227	63	175	2
September	1,659	972	52	146	7
October	2,038	1,075	43	122	1
November	1,673	833	41	90	3
December	1,476	575	32	58	5
2002					
January	1,720	152	23	30	7
Totals	**17,482**	**9,532**	**58**	**293**	**1**

Source: Department of Health Services, PETS

Due to the discovery of fraud in the Medi-Cal program in August 1999, the department began to focus its efforts on reenrolling provider types that were identified as problematic. For example, independent pharmacies—pharmacies with only one location or with no more than three or four stores—were identified as problematic as opposed to chains such as Wal-Mart, Safeway, Walgreens, and Rite-Aid. Before August 1999, the department already was referring all independent pharmacies' applications for enrollment to A&I. In July 2000, the branch reiterated this procedure in its policy memo. As shown in Table 3, the branch took an average of 50 days to process the pharmacies' applications it approved. The department did not establish separate provider type codes for independent and chain pharmacies, so we were unable to determine whether the processing times varied.

TABLE 3

Number of Days to Approve Medi-Cal Provider Enrollment Applications for Pharmacies (February 14, 2001, through January 31, 2002)

	Number of Applications Received	Number of Applications Approved	Average Days to Approve Applications	Maximum Number of Days	Minimum Number of Days
2001					
February	25	7	146	286	37
March	85	25	131	328	7
April	79	26	100	240	28
May	74	30	66	248	23
June	95	34	51	164	18
July	90	22	64	201	12
August	149	47	42	154	8
September	134	64	40	127	11
October	89	27	48	107	14
November	169	88	31	85	15
December	122	69	25	51	8
2002					
January	157	6	20	29	11
Totals	**1,268**	**445**	**50**	**328**	**7**

Source: Department of Health Services, PETS

Risk assessment decisions affect the depth of the branch's review process and can increase the length of time it takes to process an application.

Risk assessment decisions affect the depth of the branch's review process and can increase the length of time it takes to process an application. Therefore, we expected to find that the branch had performed an analysis to support its rationale for deeming certain providers to be high-risk. For example, the department has a moratorium on processing enrollment applications for most durable medical equipment (DME) providers and licensed independent non-chain, non-physician-office clinical laboratories. In its justification for imposing these moratoriums, the department analyzed data to identify suspicious billing practices and used results from its on-site reviews. However, the branch did not prepare a similar analysis when deciding to continue with the separate handling of independent pharmacies' applications. We believe it would have been prudent for the branch to reassess its rationale for continuing to perform more in-depth reviews of independent pharmacies.

In November 2001, the branch modified its procedures for reviewing applications for independent pharmacies. Specifically, the branch selected 11 criteria that it believes demonstrate that some pharmacies pose a greater risk than others. However, the branch also did not prepare an analysis to support this risk assessment, nor did it seek approval from the director's office. In some instances, the branch did seek approval from the director's office before proceeding with changes to the enrollment process based upon its risk assessments. For example, in January 2001 the branch submitted a proposal identifying certain physicians as low-risk and requested approval from staff in the director's office to use an abbreviated enrollment process. The proposal contained an evaluation of the fraud risk factor as well as the pros and cons of implementing it. The branch was asked to reevaluate the alternatives contained in the proposal and subsequently submitted another proposal on February 2, 2001, which was approved on March 14, 2001.

The branch says it relies upon routine communications with other fraud-prevention units within or outside the department in assessing the risk of fraudulent activity. For example, A&I sends to the branch Department of Justice reports highlighting problem providers. The branch receives additional information daily from the department's Office of Legal Services regarding providers suspended from the Medi-Cal program. Branch staff also meet monthly with A&I and with the Office of Legal Services regarding fraud and coordination issues. In addition, branch staff attend the monthly meetings of the department's fraud and abuse steering committee, which provide a forum for coordinating, strategizing, and sharing information.

However, the branch was unable to demonstrate how the information obtained from other departmental sources influenced its decisions to modify the enrollment process. For example, the branch chief provided us with a list of pharmacies from A&I's case-tracking system to support her rationale for continuing in-depth reviews of independent pharmacies because these pharmacies were responsible for virtually 100 percent of the pharmacy fraud found by the department. When we asked the chief of A&I's Medical Review Branch whether the list of pharmacies from its case-tracking system provides evidence of fraud committed by independent pharmacies, we were told that it did not. Moreover, according to the deputy director of A&I, the fraud and abuse steering committee does not formally make management decisions for programs in the department. Thus, while it is beneficial for the branch to obtain information from other sources concerning fraud issues, the branch is hard-pressed to justify its decisions without a formal process for documenting how it uses that new information. The branch currently is reevaluating its enrollment of independent pharmacies.

Without a formal process for documenting how it uses new information to arrive at risk assessments and modifications to its process, the branch is hard-pressed to justify its policy decisions concerning risk assessment.

Another area of concern is the branch's lack of adequate controls over the electronic spreadsheet it uses to verify certain information in the application package. Entries in the spreadsheet include information from various sources. The spreadsheet currently has more than 8,000 records dating to 1999. However, despite the fact that the branch considers the data important, it does not have a written policy regarding the updating, maintenance, and overall security of the spreadsheet. As a result, the branch's managerial oversight of this spreadsheet is inadequate. For example, currently one staff person is responsible for updating and maintaining the spreadsheet. Until the branch establishes an adequate supervisory review process, modifications or deletions to the spreadsheet by the staff member could go undetected and could render the data unreliable for assessing risk.

THE BRANCH COULD DO MORE TO ENSURE THE INTEGRITY OF POTENTIAL AND EXISTING PROVIDERS

Although the branch has acted to require applicants to submit disclosure statements and has sought the authority to require applicants to reenroll, it has not been consistent in implementing these measures. Consequently, it places the State at risk of enrolling or reenrolling providers who may be intent on defrauding the Medi-Cal program.

The Branch Needs to Rectify Its Poor Decision to Cease Reviewing Certain Provider Disclosure Statements, Which Exposes the State to the Loss of Federal Funds

Disclosure statements provide critical information regarding an applicant's or provider's financial and criminal history.

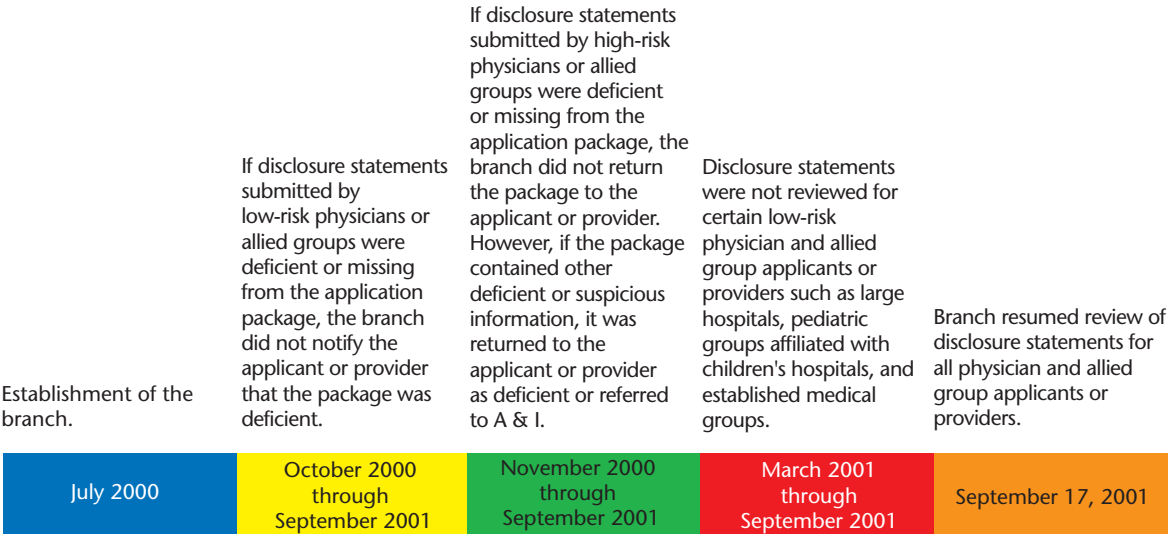
Even though both state and federal regulations require applicants or providers to submit disclosure statements with their applications, in its effort to reduce its backlog, the branch inappropriately stopped reviewing disclosure statements for certain applicants or providers. Specifically, state regulations require the department to review the applicant's or provider's completed application package for enrollment or continued enrollment in the Medi-Cal program. The application package includes the application forms, disclosure statements, and provider agreements. The disclosure statements provide critical information regarding an applicant's or provider's financial and criminal history. The applicant or provider must disclose information regarding persons who have direct or indirect ownership interests in the capital, stock, or profits of his or her entity as well as the ownership interest of those persons in other entities. Also, the applicant or provider must disclose information relating to his or her business transactions, such as significant transactions with any wholly-owned supplier or subcontractor. Finally, if a person has been convicted of a criminal offense relating to his or her involvement in any program under Medicare or Medicaid and has ownership or controlling interest in the applicant's or provider's entity or is an agent or managing employee, this information must be disclosed.

However, the branch did not review all disclosure statements received between October 2000 and September 2001 for physician and allied group applicants or providers. As a result, the branch increased the risk of enrolling providers who may have disclosed questionable financial relationships or a past history of fraud, abuse, or criminal convictions relating to other Medicare or Medicaid programs. Figure 4 shows the decisions the branch made regarding its review of disclosure statements.

Neither the branch nor the department sought federal approval before deciding to waive the review of disclosure statements. Disclosure statements are critical to ensuring the integrity of the Medicaid program. Federal regulations state that the federal government can refuse to pay for services furnished by providers who fail to comply with the disclosure statement requirement. As shown in Figure 4, in some instances, if applicants or providers submitted a deficient disclosure statement or did not include one in their application package, the branch did not

FIGURE 4

The Branch Modified Its Review of Disclosure Statements Between October 2000 and September 2001



Source: Department of Health Services, Provider Enrollment Branch

return the application package to them to correct these deficiencies. The branch could not quantify the number of disclosure statements that it failed to review between October 2000 and September 2001. Nonetheless, the branch's failure to review all disclosure statements during the period exposed the State to the loss of federal funding for the program.

Reenrollment of Existing Providers Could Strengthen the Medi-Cal Enrollment Process

To strengthen the enrollment process and weed out potentially fraudulent providers, the branch should expand its efforts to reenroll existing providers. Currently, the branch requires providers to submit a supplemental application if changes occur that affect their provider status, such as a change of business address, Medicare billing number, or financial relationships. Such supplemental applications are often the only way for the branch to become aware of significant changes in provider status, and providers who fail to complete them may stay in the program indefinitely without updating information about their status.

In August 1999, the Provider Enrollment Task Force (task force) took a more aggressive stance toward minimizing fraud in the Medi-Cal program. Specifically, it began to require existing providers to submit new applications to ensure that they were suitable to continue participating in the Medi-Cal program, a process referred to as reenrollment. The task force began to reenroll certain provider types that the department had identified as problematic. These provider types were DME, nonemergency medical transportation (NEMT), orthotists and prosthetists (O/P), and independent pharmacies. Under the authority of emergency regulations filed by the department in September 1999, it notified providers in these categories that they would need to reenroll. According to the branch, it mailed roughly 4,500 letters to these providers, and only 3,900 responded. As shown in Table 4, the branch has not been successful in its reenrollment efforts, which are aimed at weeding out its problematic providers.

TABLE 4

Status of Branch Reenrollment Efforts as of January 31, 2002

Provider Type	Number of Letters Sent	Number of Responses Expressing Intent to Continue Participation	Number Reenrolled	Number Deactivated
Durable medical equipment	1,417	1,006	501	166
Non emergency medical transportation	312	239	29	11
Orthotists and prosthetists	300	239	92	9
Independent pharmacies	2,500	2,046	0	0
Totals	**4,529**	**3,530**	**622**	**186**

Source: Department of Health Services, Provider Enrollment Branch

The branch is continuing its efforts to reenroll DME and NEMT providers. However, it does not plan to complete its review of the reenrollment application packages for the O/P providers because it no longer considers this provider type to be high-risk. According to the branch chief, the department erroneously identified O/P as a high-risk provider type because it used flawed billing data. Moreover, its review of the 40 reenrollment application packages that it received did not detect any indication

of fraudulent activity. Due to the magnitude of the workload associated with the reenrollment of the first three provider types, the branch also does not plan to reenroll the independent pharmacies until the summer of 2002.

Other states have found the reenrollment process effective in ensuring provider integrity.

According to U.S. General Accounting Office testimony before the Subcommittee on Oversight and Investigation, Committee on Commerce, and the House of Representatives on July 18, 2000, other states have found the reenrollment process effective in ensuring provider integrity. For example, starting in 1996, Florida required all noninstitutional Medicaid providers to reenroll on a staggered basis under stricter standards. When Florida began its reenrollment, there were about 80,000 Medicaid providers; when it ended, there were about 60,000. State program officials report that access to health care was not affected by the reduction in Medicaid providers. Thus, although the branch would experience an increase in its workload for a short period, it could benefit significantly from completing its current reenrollment efforts and expanding these efforts to its other provider types to screen out providers who no longer are interested in providing services or who have a history of fraudulent activity.

A STRATEGIC PLAN WOULD HELP THE BRANCH ADDRESS ITS PERFORMANCE DEFICIENCIES

Although the strategic plan of the department's Payment Systems Division includes a mission statement and top priorities for the branch, it does not include other critical information necessary for planning. Strategic planning yields information needed to guide resource allocation and to help an entity successfully accomplish its goals. The branch has addressed only a few of the essential elements of strategic planning, such as defining its mission and establishing its top priorities. The branch's mission is to enroll eligible providers in the Medi-Cal program on a timely basis and to update the provider master file continually to reflect provider status accurately. Further, its top priorities include reducing the backlog of physician applications and tightening the provider enrollment process. However, the plan does not describe the actions necessary to achieve these top priorities. For example, the branch states that it will reduce the backlog of physician applications but does not address critical questions relevant to doing so, such as how it will determine the number of applications in progress and whether it has sufficient staff.

A sound strategic planning process includes these essential elements:

- Defining a mission.
- Formulating goals consistent with the mission, including outcome goals, and establishing priorities among them.
- Establishing actions necessary to achieve goals.
- Defining quantified targets for goals, including targets for desired results, or outcomes.
- Measuring the results of operations.
- Comparing results to targets to evaluate and report performance.
- Explaining under-performance and the actions planned to meet goals.
- Revising the plan in light of performance and changing circumstances.

Since its inception, despite numerous revisions to its review process, the branch has not identified the appropriate staffing levels it needs to manage its enrollment of providers. Good management practices include establishing workload standards to determine proper staffing levels. When the task force was created in July 1999, the Payment Systems Division assigned roughly 55 employees to it to handle the enrollment of applicants and reenrollment of providers. When the department replaced the task force with the branch in July 2000, the branch received 32 positions. However, the department was not able to explain how it determined that 32 positions were sufficient to allow the branch to manage its operations. According to the branch chief, because the branch was new, the department used estimates that were based on proposed anti-fraud activities and staff duties.

It is particularly important that the branch determine its true workload and staffing needs because there have been numerous changes to its enrollment processes and staff duties. Some of the changes included, for example, reassigning staff to ensure that their duties are segregated adequately so one staff member doesn't have control over too many areas; verifying the licensure status for certain provider types; implementing the reenrollment procedures established by the task force; and establishing a supervisory review process. In order to reduce the application backlog, the branch has had to redirect one to eight staff members from its policy and special projects unit to help process Medi-Cal enrollment applications. It also has hired part-time student assistants and used eight employees from its fiscal intermediary contractor to process applications. Table 5 shows the number of staff of various types involved in processing enrollment applications.

As of May 1, 2002, the branch still had not developed workload standards and lacked reliable data on the number of applications in progress. Yet, as we pointed out earlier, it had postponed its review of about 2,000 reenrollment applications for independent pharmacies, citing workload considerations. However, until the branch identifies its true workload it will not be able to determine if it has sufficient staff to enroll Medi-Cal providers.

TABLE 5

Types of Staff Used to Process Medi-Cal Enrollment Applications

Staffing Type	9/20/00	1/31/01	9/27/01	11/28/01*
Permanent	35.0	38.0	39.0	39.0
Redirections	8.0	7.0	1.0	
Contract			8.0	8.0
Student assistants	1.0	0.5	4.5	4.0
Totals	**44.0**	**45.5**	**52.5**	**51.0**

Source: Department of Health Services, Provider Enrollment Branch

* November 28, 2001, is the most current data the branch was able to provide.

Until the branch determines its actual workload, it will not be able to identify its staffing needs.

The branch chief cited several reasons for not establishing workload standards. First, she believes that the time to process each application varies greatly, depending on the application type, provider type, licensure requirements, and complexity of the entity applying. However, we found that it is not uncommon for the department to use workload standards when justifying other staffing requests. Specifically, the Third Party Liability branch (liability branch), which also resides within the Payment Systems Division, was able to justify its staffing needs for seeking to identify third-party resources in lieu of expending state funds for Medi-Cal services. According to the chief of the liability branch, a consultant was hired to perform a time study of the activities of its tax collection representatives and program technician positions and to determine averages for each major activity. The study was conducted during a two- to three-month period. The branch could perform a similar analysis to determine workload standards for its enrollment process by using the average time it takes to process a sample of applications for various provider types.

The branch chief also said extensive backlogs hampered the branch's ability to determine workload standards. We understand the branch's concern with the backlog of applications, but the study would have helped the branch support its argument that it did not have the staffing levels necessary to reduce the backlog and stay current on processing applications.

Finally, the branch chief told us that union issues preclude the department from setting such measures of production without an enormous expenditure of staff and management time. However, according to the branch chief of the department's Personnel Management branch, using workload standards to justify the need for additional staff does not require union notification. Until the branch conducts a study to identify the average time it takes to process applications and uses this information to determine the appropriate staffing level needed, it will be unable to develop a strategic plan with sufficient detail or to justify its need for additional staff to manage its workload effectively.

THE DEPARTMENT DID NOT ADHERE TO STATE HIRING PRACTICES IN ITS EFFORTS TO SEEK ADDITIONAL RESOURCES FOR THE BRANCH

The department has incurred costs of roughly $490,000 for personal services, without seeking the appropriate approvals.

Although state laws establish the standards to use in contracting for personal services, the department did not follow these standards when attempting to secure employees to assist the branch with processing provider enrollment applications. Consequently, it has incurred costs of roughly $490,000 for personal services, without seeking the appropriate approvals.

State law governing the use of personal services contracts requires the department to clearly demonstrate that the proposed contract will result in actual overall cost savings to the State or that the services are not available within the civil service system.

Since July 2000, the branch has devoted most of its efforts toward revising its enrollment procedures to improve its efficiency, establishing the PETS database, and developing manuals for staff that contain current policies and procedures. In January 2001 the branch submitted a proposal to the department recommending six alternatives for reducing the backlog of provider enrollment applications. One alternative presented by the branch was to use local assistance contract funds to obtain staff from its Medi-Cal fiscal federal intermediary, Electronic Data Systems Federal Corporation (EDS), to perform preliminary reviews of applications, recommend approval, and prepare deficiency notices, if necessary. On March 14, 2001, the department rejected this alternative. In July 2001, however, the branch resubmitted this

alternative, and on September 1, 2001, the department authorized the temporary use of EDS staff to help reduce the backlog of enrollment applications.

The department gave us an excerpt of its contract to support its position that it has the authority to hire EDS employees to review provider enrollment applications. Specifically, the department directed us to a contract clause stating that

> **"if the workload requires more personnel than is available through the Systems Group, or if the workload may be met in a more timely manner by using a highly specialized or commercially available application, the department may use the change order process to accomplish this work, or the department may have the contractor temporarily assign additional non-Systems Group systems analysts or programmers to the Systems Group."**

Since 1986, the department has contracted with EDS to manage its claims processing systems for Medi-Cal and other health programs. The department uses the California Medicaid Management Information System (CA-MMIS) to process claims. EDS processes claims totaling roughly $13 billion annually for health care services rendered by 140,000 health care providers. The purpose of the Systems Group is to design, develop, and implement modifications to the CA-MMIS, as required by the department. It is also to provide technical support for the problem correction system, which is a method to identify and resolve operational problems within the CA-MMIS.

The department must seek approval from the state Departments of Finance and General Services if the change order will result in an annual increase of more than $50,000, or from the Legislature if there is a one-time cost of more than $250,000.

Because the review of provider enrollment applications is not part of the Systems Group's normal responsibilities, this contract clause does not give the department authority to use non-Systems Group staff in this manner. Moreover, using the change order process would have detected this lack of authority because the department must seek approval from the state Departments of Finance and General Services if the change order will result in an annual increase of more than $50,000, or from the Legislature if there is a one-time cost of more than $250,000. As of May 3, 2002, the department had not obtained approval to use up to 10 EDS staff to assist the branch during the period of July 2001 and January 2002, but had incurred costs of roughly $490,000.

Moreover, a recent independent audit of EDS found that a signed Conflict of Interest Avoidance Plan (plan) acknowledgement form was not completed and submitted by certain employees in accordance with its Medi-Cal policy. The plan consists of the completion of a conflict of interest disclosure statement to disclose any real or apparent conflict with Medi-Cal providers or any individual entity contracting with EDS. The plan also requires subsequent monitoring of each employee's information. Although EDS plans to address the deficiency, until it does so the branch cannot ensure that adequate controls are in place to prevent conflicts of interest.

Another concern is that the department may not have met the State's standards for using personal services contracts when it hired student assistants through contracts with the California State University Sacramento Foundation (foundation). Between March 1, 2001, and January 31, 2002, the branch incurred costs of more than $138,000 in salaries, employment taxes, and fees to reimburse the foundation for the 22 student assistants it hired. However, the department did not prepare an analysis to demonstrate that contracting with the foundation could result in actual overall cost savings to the State. According to the branch chief, the most important reason for contracting with the foundation was that it was faster and easier than the department's personnel process. However, if the branch had used the department's personnel process to hire the student assistants, it would have been able to save roughly $18,000 in fees paid to the foundation.

If the branch had used the department's personnel process to hire student assistants, it would have been able to save roughly $18,000 in fees paid to the foundation.

RECOMMENDATIONS

The branch should take these actions to improve its management of the Medi-Cal provider enrollment process:

- Implement its plan to discontinue its use of the weekly inventory spreadsheet by May 2002.

- Use PETS more effectively to track how long an application has been in a certain step of the enrollment process, making sure that notification is sent to the applicant at proper intervals; modify PETS so it can track the status of high- or low-risk provider types and determine whether the average processing times vary; and use PETS to track applications it refers to A&I for on-site reviews. The branch also should identify all applications that, according to PETS, are still in progress, determine their actual status, and update PETS, if necessary.

- Review PETS-generated reports at least monthly and perform analyses to determine whether staff are entering data accurately and consistently. Further, it should fully use the capabilities of PETS for developing reports on a variety of productivity indicators, including, for example, aging reports and reports showing the number of applications approved, denied, and in progress.

- Work closely with A&I to monitor the status of its referrals to ensure that the total review time for applications does not exceed regulatory requirements.

- Periodically perform an analysis to justify its existing risk assessments for high- and low-risk provider types. Submit its analysis for department approval. Upon approval of the analysis, issue a policy memo to staff.

- Develop a written policy that clearly defines appropriate procedures for safeguarding the electronic spreadsheet it uses to verify certain information in the application package. Establish an adequate supervisory review process for reviewing all changes made to the spreadsheet. Consider replacing the spreadsheet with software capable of providing a transaction log to alert management to any changes.

- Identify all physician providers who were enrolled between October 2000 and September 2001 and review their disclosure statements in accordance with federal requirements. The branch should direct staff to continue to review disclosure statements for all providers.

- Complete its current reenrollment efforts and consider expanding these efforts to include all provider types to ensure provider integrity in the Medi-Cal program.

- Develop a strategic plan to identify key responsibilities and establish priorities. This plan should clearly describe how the organization would address its many short- and long-term responsibilities, particularly those that we observed it has not sufficiently accomplished.

- Conduct a study to determine how long it takes staff, on average, to process applications for the various provider types. Using results from the study and accurate workload standards, the branch should assess whether it has the appropriate staffing levels.

To improve the effectiveness of the Medi-Cal provider enrollment process, the department should:

- Establish policies and procedures for the branch and A&I to coordinate their review processes so it is able to meet regulatory requirements.

- Ensure that A&I implements its new case-tracking system by late 2002.

- Formalize its process for determining which provider types should be subject to increased scrutiny and when, based upon the most recent anti-fraud trend information available. For example, the department should consider establishing a subgroup of its fraud and abuse steering committee to document the decision-making process. The subgroup should meet periodically to decide whether modification to the provider enrollment process is necessary and can be accomplished without imposing undue delays in processing applications.

- Discontinue its use of EDS staff to assist the branch in processing provider enrollment applications.

- Ensure that it adheres to state standards for using personal services contracts when hiring employees such as student assistants.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

ELAINE M. HOWLE
State Auditor

Date: May 22, 2002

Staff: Joanne Quarles, CPA, Audit Principal
Arn Gittleman, CPA
Sheryl Liu-Philo
Sang Park

APPENDIX

Table A1 on the following page represents a high-level analysis of enrollment applications for provider types processed by the Department of Health Services' Provider Enrollment Branch (branch) between February 14, 2001, and January 31, 2002. Although there are about 70 different provider types, the branch is responsible for reviewing applications for only 28 types. Therefore, we considered applications received by the branch for the 28 provider types only.

TABLE A1

High-Level Analysis of Enrollment Applications for Provider Types Processed by the Provider Enrollment Branch (February 14, 2001, through January 31, 2002)

Provider Type	Applications Approved	Average Days to Approve	Deficient or Denied*	In Progress†	Total Applications Received
Physician	9,532	58	2,879	5,071	17,482
Physician group	2,765	71	682	1,631	5,078
Pharmacy/pharmacist	445	50	389	434	1,268
Durable medical equipment	148	58	86	234	468
Optometrist	231	65	73	103	407
Psychologist	194	83	57	86	33
Chiropractor	164	79	50	72	286
Podiatrist	118	76	39	106	263
Certified acupuncturist	142	81	63	50	255
Medical transportation	50	33	42	147	239
Audiologist	79	78	25	72	176
Clinical laboratory	41	66	12	64	117
Dispensing opticians	86	35	5	12	103
Nurse practitioner	42	24	15	18	75
Certified nurse anesthetist	38	64	8	22	68
Physical therapist	37	87	12	17	66
Prosthetist	16	31	3	42	61
Hearing aid dispenser	37	82	6	10	53
Nonmedical practitioner	13	74	19	20	52
Orthotist	7	28	5	29	41
Certified nurse midwife	10	77	10	18	38
Optometric group	21	49	5	10	36
Nurse	14	73	6	9	29
Speech therapist	14	86	5	9	28
Occupational therapist	9	93	6	8	23
Family planning	6	85	3	12	21
Medical transportation (air)	7	57	0	4	11
Portable x-ray	2	50	0	3	5
Totals	**14,268**	**62**	**4,505**	**8,313**	**27,086**

Source: Department of Health Services, PETS

* Cannot determine the discrete numbers for deficient and denied applications because the PETS data field does not distinguish between these two categories.

† Our sample of 37 applications in progress found that 92 percent should not have been shown as in progress. However, PETS was the only available management tool that we could use to track the status of each application received and produce a summary of their status to evaluate the branch's performance.

Agency's comments provided as text only.

Health and Human Services Agency
1600 Ninth Street, Room 460
Sacramento, CA 95814

Ms. Elaine M. Howle*
State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

Thank you for forwarding a draft copy of the Bureau of State Audits' report titled, "Department of Health Services: It Needs to Significantly Improve Its Management of the Medi-Cal Provider Enrollment Process" to Secretary Johnson for review and comment. I am responding on his behalf.

To combat fraud and abuse in Medi-Cal, Governor Davis launched the administration's program integrity effort in 1999. Through this ongoing work, we have made significant strides in reducing fiscal abuse of the Medi-Cal Program.

This includes significant steps to ensure that only legitimate providers receive Medi-Cal provider numbers. This work, done through the Provider Enrollment Branch at DHS, requires us to balance to sometimes competing needs –that of providers to be able to enroll in Medi-Cal without undue burden and that of minimizing the possibility of enrolling providers who are intent on committing Medi-Cal fraud. As shown in the attached response, we have made significant progress in achieving those twin goals --without affecting access to legitimate services. In fact, not only have there been reductions in the processing time of applications, but we have also prevented hundreds of fraudulent providers from ever entering the Medi-Cal program.

Nevertheless, more remains to be done. We appreciate all of your recommendations. We have begun to implement many of them already, and we will soon implement all others. Through our continuing efforts, we will ensure that only providers who meet Medi-Cal's high standards for program integrity will serve the program. Thank you again for sharing the draft copy of your findings and recommendations. If you require further information concerning this matter, please do not hesitate to contact Peter Harbage, Assistant Secretary, Health and Human Services Agency, at (916) 654-3454.

Sincerely,

(signed by: David Maxwell-Jolly for)

GRANTLAND JOHNSON
Secretary

Attachment

* California State Auditor's comments appear on page 41.

DEPARTMENT OF HEALTH SERVICES' RESPONSE TO BUREAU OF STATE AUDITS REPORT

OVERVIEW

The Provider Enrollment Branch's (PEB) primary function is to review and process enrollment applications in a manner that balances two sometimes competing needs; that of enrolling legitimate providers on a timely basis, while ensuring the integrity of the program by minimizing the possibility of enrolling providers who are intent on participating in Medi-Cal fraud.

Prior to 1999, the Department of Health Services (DHS) simply enrolled any provider who requested enrollment, with little to no review. With the discovery of extensive fraud in the Medi-Cal program, in 1999 DHS began introducing anti-fraud measures into the enrollment process. New statutes were enacted, and regulations adopted, to strengthen program requirements for enrollment and prevent fraudulent providers from being enrolled. Extensive internal controls were implemented in provider enrollment and DHS conducted three internal audits of the enrollment process. This resulted in an extensive review process to determine eligibility for enrollment, greatly increasing the workload of enrollment staff. Therefore, a significant delay in enrollment processing occurred. Additional budgetary resources were requested to do this workload and the Legislature authorized a portion of the requested resources. As a result of this backlog, in 2001 the Legislature requested that the Bureau of State Audits (BSA) review the enrollment processes.

Prior to this audit, the branch had made significant strides in dealing with the backlog through a variety of actions: redirected staff, reorganized the assignment of work; streamlined processes; and brought in contracted staff. Through these efforts, the backlog was eliminated. PEB has gone from a workload inventory of more than seven months worth of applications unprocessed, to currently having an inventory of two and a half months of workload, which we do not consider to be a "backlog" as these applications will be processed within requisite time frames. The BSA analysis of approved applications (from February 2001 through January 2002) reflects an average processing time of 62 days, which is far less than the 180 days provided in regulation. Currently the branch is processing applications within an average of 50 days.

That audit has taken place over the last five months (from December 2001 through April 2002). There are no findings that bring in to question the validity or integrity of the enrollment processes themselves, which have been developed and implemented entirely anew since 1999. Although the BSA has a number of findings, several are related to the Provider Enrollment Tracking System (PETS), with which we agree and are already in the process of remedying. Other findings are of an administrative nature, i.e., contracting staff,

staffing standards, strategic planning, which in general are not at issue.

Following are comments specific to the BSA's recommendations.

RECOMMENDATIONS

The branch should take the following actions to improve its management of the provider enrollment process:

- **Implement its plan to discontinue its use of the weekly inventory spreadsheet by May 2002.**

  Agree; use of the weekly inventory spreadsheet was discontinued in April 2002.

- **Use PETS more effectively to track how long an application has been in a certain step of the enrollment process, making sure that notification is sent to the applicant at proper intervals; modify PETS so that it can track the status of high- or low-risk provider types and determine whether the average processing times vary; and use PETS to track applications it refers to A&I for on-site reviews. The branch should also identify all applications that, according to PETS, are still in progress, determine their actual status, and update PETS, if necessary.**

  Agree; all of the suggestions regarding the use of PETS are being implemented

- **Review PETS-generated reports at least monthly and perform analyses to determine whether staff are entering data accurately and consistently. Further, it should fully use the capabilities of PETS for developing reports on a variety of productivity indicators, including, for example, aging reports and reports showing the number of applications approved, denied, and in progress.**

  Agree; this recommendation will be fully implemented. The branch has already instituted a PETS-generated report for submission to the Deputy Director of Medical Care Services on a twice-monthly basis.

- **Work closely with A&I to monitor the status of its referrals to ensure that the total review time for applications does not exceed regulatory requirements.**

  Agree; PEB has already implemented changes to more effectively documenting and tracking A&I referrals. New aging reports, containing additional information, are being developed to replace existing reports. In addition, PEB is committed to continuing its relationship and regular meetings with A&I. Working in tandem with the new tracking

systems to be installed at A&I, and improvements to existing reports in PETS, the Department will be assured of individual case status.

- **On a periodic basis, perform an analysis to justify its existing risk assessments for high- and low-risk provider types. Submit its analysis for department approval. Upon approval of the analysis, issue a policy memo to staff.**

  Agree; evaluation of risk assessments should be done periodically. In fact, this is done informally on an ongoing basis, through liaison with A&I, meetings with the Department's anti-fraud task force, and PEB staff's findings as they process more than 2,000 applications per month. DHS will assess implementing a more formal process if it can be done in a manner that does not impede anti-fraud efforts.

- **Develop a written policy that clearly defines appropriate procedures for safeguarding the electronic spreadsheet it uses to capture data on providers who may be suspicious. Establish an adequate supervisory review process for reviewing all changes made to the spreadsheet. Consider replacing the spreadsheet with software capable of providing a transaction log to alert management to any changes.**

  Agree; a written policy will be established, supervisory review will be implemented, and the spreadsheet will be replaced with software capable of providing a transaction log.

- **Identify all physician providers who were enrolled between October 2000 and September 2001 and review their disclosure statements in accordance with federal requirements. The branch should direct staff to continue to review disclosure statements for all providers.**

  Agree; the branch will review all applications for enrollment that were received between October 2000 and September 2001 on a flow basis. As requests to update the provider master file, or any type of inquiry, are received from providers that enrolled during that period of time, staff will review the initial application. If a disclosure statement is not included, one will be requested and reviewed.

  In September 2001 the branch directed staff to review disclosure statements for all providers.

- **Complete its current reenrollment efforts and consider expanding these efforts to include all provider types to ensure provider integrity in the Medi-Cal program.**

  Agree; PEB is continuing its current re-enrollment efforts, as staffing is available this will be extended to independent pharmacies in the near future. We agree it would be

worthwhile to extend the re-enrollment effort to all provider types. However, currently we do not have the available resources to do so. As the BSA noted, there are approximately 140,000 providers in the master file, and approximately 84% of those are non-institutional. Therefore, about 117,600 would need to be re-enrolled. This would require an extensive staffing augmentation, in order to perform ongoing new enrollments while conducting a re-enrollment.

- **Develop a strategic plan to identify key responsibilities and establish priorities. This plan should clearly describe how the organization will address its many short- and long-term responsibilities, particularly those that we observed it has not sufficiently accomplished.**

  Agree; the Department, together with other departments, agencies, offices, or commissions, strives to meet the Performance and Results Act in preparing a strategic plan. As per Government Code, Section 11817, the Strategic Plan of the Department of Health Services (March 2002), sets out the Department's mission, values, vision, and key issues or priority areas on which to focus over the next five years. Key Issue Six – Improve Business Practices is a department wide commitment that includes "using resources effectively, reducing incidences of fraud, and responding promptly and appropriately to internal and external customer needs." The Act does not require the subunits of the department to prepare individual strategic plans. However, the development of the mission and goals for the branch are in line with the Department's key issue six.

- **Conduct a study to determine how long it takes staff, on average, to process applications for the various provider types. Using results from the study and accurate workload, the branch should assess whether it has the appropriate staffing levels.**

  Agree; the branch will conduct a study to establish staffing standards and assess whether it has appropriate staffing levels.

To improve the effectiveness of the provider enrollment process, the department should do the following:

- **Establish policy and procedures for the branch and A&I to coordinate their review processes so that it is able to meet regulatory requirements.**

  Agree; the branch and A&I will strive to coordinate their reviews more effectively, to better meet reasonable timeframes.

- **Ensure that A&I implements its new case-tracking system by late 2002.**

  Agree; A&I is making every effort to implement its new case-tracking system by late 2002.

- **Formalize its process for determining which provider types should be subject to increased scrutiny and when, bases upon the recent anti-fraud trend information available. For example, the department should consider establishing a subgroup of its fraud and abuse steering committee to document the decision-making process. The subgroup should meet periodically for the purpose of deciding whether modification to the provider enrollment process is necessary and can be accomplished without imposing undue delays in processing applications.**

  Agree; The Medi-Cal Program will develop a formal way of making these determinations. This will be done a manner that does not impede our ability to remain flexible and react immediately to changes in fraud trends.

- **Discontinue its use of EDS staff to assist the branch in processing provider enrollment applications.**

  Agree; use of EDS staff will be phased out in the very near future. We believe that the use of EDS staff in provider enrollment were fully within the scope of our contract with EDS and were a critical part of reducing the backlog in provider enrollment. We understand the State's Auditor's concerns, and while we do not agree with the conclusion, we will implement their recommendations.

- **Ensure that it adheres to state standards for using personal services contracts when hiring employees such as student assistants.**

  Agree; the PEB does adhere to state standards for using personal services contracts when hiring employees such as student assistants and will continue to do so.

COMMENTS

California State Auditor's Comments on the Response From the Department of Health Services

To provide clarity and perspective, we are commenting on the Department of Health Services' (department) response to our audit report. The numbers below correspond to the numbers we placed in the margins of the department's response.

1. The department's claim that it has eliminated the backlog is incorrect. As we describe on page 12, its Provider Enrollment Branch (branch) does not track a critical component of the backlog on its weekly inventory spreadsheet, which is the number of applications that have been assigned to staff and are still in progress. Moreover, as we state on page 13, because staff do not enter data into the Provider Enrollment Tracking System (PETS) consistently, the branch can neither effectively track the applications it processes nor use the reports PETS is capable of producing to identify its backlog and manage its operations. Finally, as we state on page 16, the branch does not monitor applications it refers to the department's Audits and Investigations (A&I) unit. Until the branch fully utilizes PETS and inputs data correctly, and the new A&I case-tracking system is in place, it cannot accurately measure its effectiveness in processing applications.

2. Contrary to the department's assertion, our report does cite instances where the branch's efforts to streamline the process did not always result in an improved ability to review applications. For example, on page 21 we discuss the branch's inability to demonstrate how information obtained from other departmental sources influenced its decisions to modify the enrollment process for independent pharmacies. Further, on pages 22 and 23, we highlight the branch's failure to review all disclosure statements received between October 2000 and September 2001 for physician and allied group applicants or providers.

- The department is incorrect when it states that the branch's use of Electronic Data Systems Federal Corporation (EDS) staff was fully within the scope of its contract. The department contracts with EDS to manage its claim processing systems for Medi-Cal and other health programs. As we point out on page 29, the contract clause cited by the department does not give it the authority to use non-Systems Group staff to review provider enrollment applications.

- The department asserts that it does adhere to state standards for using personal service contracts when hiring employees. However, as we state on page 30, the department did not prepare an analysis to demonstrate that contracting with the California State University Foundation could result in actual overall cost savings to the State, as state law requires.

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press