CALIFORNIA STATE AUDITOR

Department of Health Care Services:

It Needs to Streamline Medi-Cal Treatment Authorizations and Respond to Authorization Requests Within Legal Time Limits

May 2010 Report 2009-112

Independent NONPARTISAN
TRANSPARENT Accountability

The first five copies of each California State Auditor report are free. Additional copies are $3 each, payable by check or money order. You can obtain reports by contacting the Bureau of State Audits at the following address:

California State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, California 95814
916.445.0255 or TTY 916.445.0033

OR

This report is also available on the World Wide Web http://www.bsa.ca.gov

The California State Auditor is pleased to announce the availability of an on-line subscription service. For information on how to subscribe, please contact the Information Technology Unit at 916.445.0255, ext. 456, or visit our Web site at www.bsa.ca.gov.

Alternate format reports available upon request.

For questions regarding the contents of this report,
please contact Margarita Fernández, Chief of Public Affairs, at 916.445.0255.

Elaine M. Howle
State Auditor
Doug Cordiner
Chief Deputy

CALIFORNIA STATE AUDITOR
Bureau of State Audits

555 Capitol Mall, Suite 300 Sacramento, CA 95814 916.445.0255 916.327.0019 fax www.bsa.ca.gov

May 27, 2010 2009-112

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 State Auditor's Office presents this audit report concerning the Department of Health Care Services' (Health Care Services) administration of the California Medical Assistance Program (Medi-Cal) treatment authorization request (TAR) process.

This report concludes that Health Care Services is missing opportunities to streamline the provision of Medi-Cal services and improve its level of service. Specifically, Health Care Services manually adjudicates all medical TARs even though it only denied a relatively small portion of these TARs in almost half of the instances in fiscal years 2007–08 and 2008–09. Health Care Services' data indicates that the TAR process as a whole saves substantially more money in claims it avoids having to pay to Medi-Cal providers than it costs to administer. However, despite compelling reasons for Health Care Services to perform a cost-benefit analysis of the segment of its TAR process associated with service categories with low denial rates, low service costs, or high administrative costs it has not done so. We believe a cost-benefit analysis of such TARs would identify opportunities for Health Care Services to streamline the TAR process and improve its overall response times.

Currently, Health Care Services is not processing drug TARs within legal time limits for prescriptions requiring prior approval. Specifically, it took longer than 24 hours to respond to 84 percent and 58 percent of manually adjudicated drug TARs in fiscal years 2007–08 and 2008–09, respectively. Finally, Health Care Services does not specifically monitor its processing times for prior-authorization medical TARs despite its acknowledgement that state law requires that TARs submitted for medical services not yet rendered must be processed within an average of five working days.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE, CPA
State Auditor

Blank page inserted for reproduction purposes only.

Department of Health Care Services:

It Needs to Streamline Medi-Cal Treatment Authorizations and Respond to Authorization Requests Within Legal Time Limits

May 2010 Report 2009-112

Blank page inserted for reproduction purposes only.

Contents

Blank page inserted for reproduction purposes only.

Summary

Results in Brief

The Department of Health Care Services (Health Care Services) is missing opportunities to streamline the provision of California Medical Assistance Program (Medi-Cal) services and improve its level of service. State law permits Health Care Services to require that providers receive its authorization before rendering certain services. Health Care Services instituted the treatment authorization request (TAR) process to monitor and control the provision of certain Medi-Cal services and drugs. It manually adjudicates all medical TARs even though it denied only 4 percent or fewer for categories representing 40 percent of all those reviewed in fiscal years 2007–08 and 2008–09. On the other hand, it has implemented an auto-adjudication process whereby drug TARs that meet specific criteria are approved automatically. Generally, these drugs have a historically high approval rate, have costs below a certain threshold, or Health Care Services assessed them to be of low financial risk. Health Care Services could improve its overall TAR process by establishing a similar auto-adjudication process, or removing the requirement for a TAR altogether, for medical services with low denial rates, low service costs, or high TAR administrative costs. This strategy would improve overall TAR processing times by allowing Health Care Services to reallocate its resources to higher-risk TARs.

Overall, Health Care Services' data indicates that the TAR process as a whole saves substantially more money in avoided paid claims to Medi-Cal providers than it costs to administer. There are compelling reasons for Health Care Services to perform a cost-benefit analysis of the segment of its TAR process associated with service categories with low denial rates, but it has not done so. Our analysis reveals that Health Care Services may have spent $14.5 million annually—40 percent of its total TAR-related expenditures—processing roughly 4 million medical TARs with denial rates of less than 4 percent in fiscal years 2007–08 and 2008–09. Consequently, the cost of processing this population of TARs is high. Health Care Services performed limited analyses that considered the costs and benefits of its TAR process. These analyses did not contemplate whether administrative costs to process TARs for service categories with low denial rates were greater than or equal to how much it saved, in the form of costs avoided by denying inappropriate services. In one analysis, Health Care Services estimated both the costs avoided and some of the administrative costs of denying TARs for hospital days. Health Care Services estimated that it paid providers approximately $2.5 billion in 2007 in claims for TARs for hospital days. The services costs for hospital days are very high, so we would expect that the benefits

Audit Highlights . . .

Our review of the administration of the California Medical Assistance Program treatment authorization request (TAR) process, revealed that the Department of Health Care Services:

- *Manually adjudicates all medical TARs including those rarely denied.*
- *Did not consider administrative costs to process TARs associated with service categories with low denial rates in its previous analyses.*
- *Does not separately track costs related to administering the TAR process.*
- *Is not processing drug TARs within the legal time limits for prescriptions requiring prior approval.*
- *Does not monitor its processing times for prior-authorization medical TARs even though state law requires those to be processed within an average of five working days.*

of requiring a TAR for hospital days would outweigh the costs of administering the TAR process. However, we believe a cost-benefit analysis of TARs for medical services with low service costs, low denial rates, or high TAR administrative costs would identify opportunities for Health Care Services to streamline the TAR process and improve its overall response times by redirecting its resources to more cost-beneficial TAR service categories.

Health Care Services' accounting system does not separately track expenditures related to its administration of the TAR process, so we were unable to determine precisely how much it spent on this process in fiscal years 2004–05 through 2008–09. However, we did calculate the total costs of those divisions involved in the TAR process over the five-year period and developed a methodology to estimate the expenditures of the three divisions responsible for processing TARs during fiscal years 2007–08 and 2008–09. The Medi-Cal Operations Division was responsible for processing TARs, among other functions, during the first three fiscal years, and its total TAR and non-TAR-related annual costs ranged from $61.6 million to $71 million. After the 2007 reorganization of the former Department of Health Services, the combined expenditures for the Utilization Management Division (Utilization Management) and our estimates for the expenditures related to TARs for the Systems of Care Division and Long-Term Care Division—the three divisions that currently process TARs—ranged from $35.9 million to $36.7 million in the last two fiscal years. These estimates do not include any TAR-related costs associated with Health Care Services' contract for TAR and claims processing.

We also found that Health Care Services is not processing drug TARs within legal time limits for prescriptions requiring prior approval. Federal and state law generally require that, when Health Care Services requires a prior authorization before a pharmacist may dispense a drug, it must respond within 24 hours of its receipt of the request for authorization. The TAR is the means by which Health Care Services conducts its prior-authorization process. Health Care Services took longer than 24 hours to respond to 84 percent of manually adjudicated drug TARs in fiscal year 2007–08 and 58 percent in fiscal year 2008–09. The chief of Utilization Management indicated that drug TAR processing times during this period were hampered by staffing shortages, a backlog of drug TARs, and system interruptions, such as disrupted network connections between its field offices. However, Health Care Services does not monitor its TAR processing times in such a way that it can accurately assess its compliance with legal time limits. Further, it has interpreted the 24-hour limit in law improperly to mean the *next business day*. Using this interpretation, Health Care Services could assert that it processes a TAR within the next business day even though it could take as long as 96 hours, depending on when the TAR was received.

Finally, Health Care Services does not specifically monitor its processing times for prior-authorization medical TARs despite acknowledging that state law requires that TARs submitted for medical services not yet rendered must be processed within an average of five working days. Although it has a reporting tool that allows it to monitor TAR processing times, it does not differentiate TARs requesting prior authorization to provide services from TARs requesting an authorization after services already have been provided.

Recommendations

To streamline the provision of Medi-Cal services and improve its level of service, Health Care Services should conduct cost-benefit analyses to identify opportunities to remove authorization requirements or to auto-adjudicate those medical services and drugs with low denial rates, low paid claims, or high TAR administrative costs.

To ensure that Medi-Cal recipients receive timely access to prescribed drugs, Health Care Services should abolish its policy of responding to drug TARs by the end of the next business day and should instead ensure that prior-authorization requests to dispense drugs are processed within the legally mandated 24-hour period. In addition, Health Care Services should begin recording the actual time it receives TARs through the mail or by fax, so that it can begin to measure accurately its processing times for these paper TARs. Alternatively, it should seek formal authorization from the Centers for Medicare and Medicaid Services (CMS) to deviate from the 24-hour requirement, and should seek a similar modification to state law.

To ensure that Medi-Cal recipients are receiving timely medical services from providers, Health Care Services should track prior-authorization medical TARs separately and should ensure that such TARs are processed within an average of five working days.

Agency Comments

Health Care Services generally agrees with our recommendations and indicates that it will take various corrective actions. However, Health Care Services reiterates that CMS is aware of its "next business day" practice for adjudicating drug TARs, and it does not plan to seek a modification of state law regarding the 24-hour time frame at this time.

Blank page inserted for reproduction purposes only.

Introduction

Background

The passage of Title XVIII in July 1965 amended the federal Social Security Act to create Medicare, and the passage of Title XIX that same year established a state-optional medical assistance program. As authorized in Title XIX, California implemented the California Medical Assistance Program (Medi-Cal), which provides health care services that the state and federal governments finance jointly. The objective of Medi-Cal is to provide essential medical care and services to preserve health, alleviate sickness, and mitigate handicapping conditions for individuals or families receiving public assistance or whose income is not sufficient to meet their individual needs.

The Department of Health Services administered Medi-Cal until 2007, when the State reorganized it under the California Public Health Act of 2006, which, among other things, divided the Department of Health Services into the Department of Health Care Services (Health Care Services) and the California Department of Public Health. Since the reorganization, Health Care Services has been responsible for administering Medi-Cal. Federal regulations require Health Care Services to implement a utilization program to, among other things, control the provision of Medi-Cal services to safeguard against any unnecessary or inappropriate use of those services or excess payments and to assess the quality of services rendered. State law specifies that Health Care Services may require providers to receive its authorization before rendering such services, known as "prior authorization." Health Care Services views the treatment authorization request (TAR) process as its means of conducting prior authorization and authorizing reimbursement for services already provided. Some of the other utilization controls permitted under state law allow Health Care Services to monitor the provision of services by performing post-service post-payment audits and limit the number of certain services available to a beneficiary within a specified time frame. This report focuses on its process for authorizing certain Medi-Cal services through the use of TARs.

Before July 2007 the Department of Health Services' Medi-Cal Operations Division (Operations Division) administered the Medi-Cal TAR process, along with other unrelated responsibilities. Shortly before the department reorganization, the Department of Health Services began to reorganize the Medical Care Services program. Once the Department of Health Services was split into two separate departments, these reorganizations resulted in four new divisions within Health Care Services: the Utilization Management Division (Utilization Management), the Long-Term

Care Division (Long-Term Care), the Systems of Care Division (Systems of Care), and the Safety Net Financing Division (Safety Net Financing). Utilization Management processes the vast majority of TARs, but Long-Term Care and Systems of Care also process some TARs. Utilization Management's primary function is controlling the use of Medi-Cal services, which it does by adjudicating—deciding to approve, modify, defer, or deny—TARs. Utilization Management adjudicated 97 percent of all TARs Health Care Services reviewed during fiscal years 2007–08 and 2008–09.

Although Systems of Care and Long-Term Care also adjudicated some TARs during this period, it was not their primary focus. For example, Systems of Care, which adjudicated 1.6 percent of TARs during fiscal years 2007–08 and 2008–09, also develops comprehensive health plans for vulnerable populations with chronic health conditions to improve their health care options and reduce costs. Long-Term Care, which adjudicated 0.7 percent of TARs during that time period, also provides a variety of home and community-based health care services for frail seniors and persons with disabilities. Safety Net Financing manages certain reimbursement and financing activities in support of Medi-Cal and does not process TARs. Some TARs, such as those for vision services, were adjudicated by divisions other than Utilization Management, Systems of Care, and Long-Term Care.

During the 2007 reorganization, the Department of Health Services also moved branches that were not originally part of the Operations Division into one of the four new divisions. For example, it moved the Children's Medical Services branch, which provides comprehensive health care services to children through preventive screening, diagnostic, treatment, rehabilitation, and follow-up services, into Systems of Care.

Treatment Authorization Requests

Health Care Services uses the TAR process to monitor and control the provision of certain Medi-Cal services and drugs. Medi-Cal providers (providers) submit requests to Health Care Services seeking authorization for reimbursement for those services or drugs requiring a TAR that they provided, or plan to provide, to Medi-Cal recipients. Health Care Services must approve TARs before the provider is reimbursed. Providers may seek authorization from Health Care Services before performing a service—known as prior-authorization TARs—or after—which we refer to as retroactive TARs. A provider may mail or fax TARs (paper TARs) to a specific field office based on the provider's location and the service being requested. TARs submitted electronically are routed automatically to the appropriate field office.

Health Care Services requires TARs for certain medical services in order to monitor utilization levels, and to prevent overutilization and fraud for those services. As of March 2010 Health Care Services required TARs for 3,024, or roughly 9 percent, of the 33,970 medical procedures paid for by Medi-Cal. Under certain circumstances, an additional 374 medical procedures also may require a TAR. For example, Health Care Services limits chiropractic and acupuncture services to two visits per calendar month, so providers are required to submit a TAR for beneficiaries who request three or more visits per month. Health Care Services also currently requires TARs for 98,257, or about 65 percent, of the 152,270 drugs paid for by Medi-Cal. Providers must submit a prior-authorization request for drugs not on the Medi-Cal contract drug list, which describes drugs for which providers may bill Medi-Cal directly. Additionally, a TAR may be required for 8,007 other drugs based on the quantity and strength of the drug to be dispensed, the method for administering it, the drug's brand name, or the diagnosis used to support the request. Finally, with the exception of drugs prescribed for family planning purposes, all 152,270 drugs for which Medi-Cal will pay require prior authorization when a beneficiary requests more than six prescriptions in a month.

Health Care Services processes medical TARs at field offices in Los Angeles, Sacramento, San Bernardino, San Diego, and the San Francisco Bay Area. Each field office processes core services, such as hospice or outpatient surgery, for the geographic area it serves. In addition, each field office processes requests for certain specialized services. For example, in addition to core services for regional patients, the Sacramento field office processes TARs for oxygen and respiratory-related equipment, while the San Francisco field office processes TARs for speech therapy services. Health Care Services processes TARs for drugs at one of three locations: Stockton, Los Angeles, and Rancho Cordova. The Rancho Cordova office primarily processes electronic TARs.

Various laws govern aspects of Health Care Services' TAR process. For instance, federal and state laws require that if the State requires prior authorization for drugs[1], Health Care Services must respond within 24 hours to the request for prior authorization. In addition, state law requires Health Care Services to process TARs for certain medical services that require authorization before the provider renders the service within an average of five working days; however, no legal requirement specifies a time frame within which it must process retroactive TARs. State law also dictates that, if a beneficiary is eligible for Medi-Cal, Health Care Services may base its approval of a TAR only on the medical necessity of the service.

[1] Federal law limits this requirement to outpatient drugs.

In addition, Health Care Services may only authorize Medi-Cal services that do not exceed the health care services generally received by the public for similar medical conditions. Medically necessary services are defined as services that are reasonable and necessary to protect life, prevent significant illness or disability, or to alleviate severe pain.

Health Care Services uses the Service Utilization Review, Guidance, and Evaluation (SURGE) computer application to process TARs. This system contains data about each TAR and the eligibility and history of each Medi-Cal beneficiary and provider. Health Care Services currently contracts with HP Enterprise Services to perform various data entry and data management functions. For example, when Health Care Services receives a paper TAR, its contract staff manually enter data from the TAR into a Web-based application that feeds into SURGE. TARs received electronically do not have to be keyed into SURGE manually because the provider essentially already has performed this task through the electronic submission process. Each paper TAR may contain up to six distinct requests for service, or TAR lines. In contrast, an electronic TAR may consist of up to 99 TAR lines. Regardless of how it is received, Health Care Services adjudicates each TAR line separately based on medical necessity. In the remainder of this report, we refer to TAR lines more generally as TARs.

Health Care Services' contract staff sort TARs for processing according to service category and receipt date. It also employs skilled professional medical personnel, such as doctors, nurses, and pharmacists, who manually review TARs for medical necessity and to determine whether the requested services or drugs are covered by Medi-Cal for eligible beneficiaries. This adjudication process results in one of four outcomes: medical professionals may approve a TAR as requested; they may approve it with modifications (for example, they may modify the quantity of pills or number of refills for a drug TAR); they may defer it due to insufficient documentation to assess the medical necessity of the requested treatment; or they may deny the TAR because they do not deem the requested service or drug medically necessary or because the beneficiary is ineligible for services. Utilization Management also performs quality assurance reviews on a sample of adjudicated TARs to ensure that the medical professionals are making appropriate decisions. The number of TARs for which Utilization Management performs quality assurance reviews depends on the adjudicator's level of experience and past performance.

State law also allows Health Care Services to apply a sampling methodology to process TARs. Relying on that legal authority, it implemented a sampling methodology in 2007 that it describes

as an auto-adjudication process for certain drugs identified as having a high approval rate and low financial risk. This method allows TARs for drugs that have been approved for this process to be approved automatically. However, these TARs are approved automatically only if specific prescreening criteria do not apply and if certain drug criteria are met. The prescreening criteria determine whether the TAR meets one of a number of specific conditions that would preclude it from being auto-adjudicated, such as TARs for beneficiaries that are being case managed, or TARs for drugs with certain restrictions. These TARs are rerouted from auto-adjudication to a field office for manual adjudication. However, if the prescreening criteria do not apply to the TAR, the system then will verify that it meets certain drug criteria, which limit the strength, dosage, and units that may be approved. TARs that do not meet the auto-adjudication drug criteria will also be routed to a field office for manual adjudication.

According to the chief of Utilization Management's Field Operations Support Branch (Field Operations), the Pharmacy Field Operations Branch activates the auto-adjudication process as needed to manage its work flow. He estimated that Health Care Services activated the auto-adjudication process for drug TARs 53 percent of the time during fiscal year 2007–08 and 34 percent of the time during fiscal year 2008–09. Currently, Health Care Services uses this process only for certain drug TARs; however, it is considering expanding auto-adjudication to include certain types of medical TARs, such as those for nonemergency medical transportation services. As of February 2, 2010, Health Care Services had approved 4,776 drugs for auto-adjudication.

Health Care Services mails the results of its adjudication process to providers. This notification indicates whether it approved, modified, deferred, or denied the provider's request, and includes an explanation for the decision. Providers also may inquire about the status of a TAR through Health Care Services' Web site or by telephone. Medi-Cal providers and beneficiaries have redress if they disagree with Health Care Services' decisions. Providers may appeal the results of decisions on denied or modified TARs by submitting written appeals to Utilization Management within 180 calendar days of the initial decision. Health Care Services reviews the appeals and renders decisions within 180 days of receiving the appeal. Further, through an agreement between Health Care Services and the Department of Social Services, beneficiaries disagreeing with Health Care Services' adjudication decision may request a hearing before an administrative law judge through the Department of Social Services.

Scope and Methodology

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits review Health Care Services' Medi-Cal TAR policies and procedures, including the criteria it uses to approve or reject a TAR. The audit committee also asked us to determine the number of medical service codes that currently require a TAR. In addition, it requested that we determine how much Health Care Services spent on the administration of the TAR process each year over the past five fiscal years. Further, the audit committee asked us to determine whether Health Care Services has performed a cost-benefit analysis or any other review of the TAR process. If such a review has been done, it asked us to determine whether any resulting recommendations were implemented and to what effect. In addition, the audit committee requested that, for a two-year period, we identify Health Care Services' average response time for TARs by provider category and by the method used to request the TAR. Finally, the audit committee asked us to identify the TARs that Health Care Services most and least frequently rejected, and to determine whether it followed its rejection criteria.

To obtain an understanding of Health Care Services' TAR process, including its criteria for approval or denial, we reviewed applicable laws, regulations, policies, and procedures. In addition, to determine the number of medical services and drugs that currently require a TAR, we consulted with Health Care Services' staff to identify appropriate methods for counting medical service codes and drug codes, and analyzed Health Care Services' data.

We were unable to determine precisely how much Health Care Services spent on its administration of the TAR process in fiscal years 2004–05 through 2008–09 because it does not track these expenditures separately. Therefore, we modified our planned approach and instead identified the total expenditures of the Department of Health Services' Operations Division for the first three years and the total expenditures of Utilization Management—as it processes TARs exclusively—and estimated the expenditures related to TARs for Systems of Care and Long-Term Care for the last two years because these were the divisions involved in the TAR process. Our analysis does not include any TAR-related costs associated with Health Care Services' contract for TAR and claims processing because the contract does not separately identify the cost of TAR-related activities from the contractor's costs for processing claims.

To determine whether Health Care Services performed a cost-benefit analysis or any other review of its TAR process, we interviewed its managers and reviewed any relevant documentation.

To determine the amount of time it took Health Care Services to respond to TARs in fiscal years 2007–08 and 2008–09, we obtained TAR data from its SURGE database. Using this data, we calculated Health Care Services' average response times for TARs by service description and for select high-volume TARs, by the method used to submit the TAR. We excluded dental services from our analysis because an outside vendor administers them.

Through interviews with Health Care Services' managers, we learned that it uses specific language to describe various steps in its TAR process. For example, it uses the term rejected to refer to TARs that it does not adjudicate because they lack key information, such as a valid recipient identification number. Alternatively, Health Care Services uses the term denied to refer to a service or drug for which it did not authorize reimbursement because it did not deem the requested treatment medically necessary or because the patient lacked Medi-Cal eligibility. Therefore, to identify the TARs that Health Care Services most- and least-frequently denied during a two-year period, we analyzed all the TARs that Health Care Services adjudicated in fiscal years 2007–08 and 2008–09 that did not include illogical dates. We excluded vision TARs from the analysis because they were not administered by Utilization Management, Systems of Care, or Long-Term Care, and they constituted an insignificant number of the total TARs we reviewed. We considered TARs that were identified as approved, modified, deferred, or denied as having been adjudicated. For the period July 1, 2007, through June 30, 2009, we calculated the adjudication outcome as a percentage of the total number of adjudicated TARs by service description and sorted them to identify the most and least denied service descriptions. We then identified categories of TARs with denial rates higher than 20 percent as those most-frequently denied. Likewise, we identified categories of TARs with denial rates lower than 4 percent as the least-frequently denied TARs.

To determine whether Health Care Services followed its denial criteria, we identified the denial criteria in state law. We then reviewed a sample of 40 TARs that Health Care Services denied to confirm that it denied each TAR based on the criteria identified—lack of medical necessity or Medi-Cal ineligibility. Our review did not attempt to verify Health Care Services' conclusions on the medical necessity of the requests; we instead focused on validating that the reasons for which it denied TARs were allowable. Health Care Services denied 34 of the 40 TARs because it determined that the services were not medically necessary or the patient was not eligible to receive the requested drugs or services through Medi-Cal. Health Care Services denied the remaining six TARs for administrative purposes. For example, it denied four of these TARs because the Medi-Cal providers used out-of-date

provider identification numbers on the TARs. It denied the remaining two TARs because the providers submitted TARs for direct-bill services, which do not require a TAR. We found these administrative denials appropriate.

We relied on various electronic data in performing this audit. The U.S. Government Accountability Office (GAO), whose standards we are statutorily required to follow, requires us to assess the sufficiency and appropriateness of computer-processed information. According to its guidelines, data are reliable when they are accurate—meaning that they reflect the data from source documents—and complete—meaning that they contain all data elements and records necessary for the audit. Because we used reports generated from the California State Accounting and Reporting System (CALSTARS) in our expenditure analysis, we performed a reliability assessment of these data by performing electronic testing of key data elements and tracing from the CALSTARS data to source documents. In addition, to test completeness we attempted to reconcile CALSTARS total expenditures to summarized transactional level CALSTARS data for fiscal years 2004–05 through 2008–09. The test results showed minor logic errors in key data elements and no accuracy errors. However, we were unable to ensure that our analysis captured all the administrative expenditures incurred by the five divisions we reviewed during fiscal years 2004–05 through 2006–07. To obtain additional comfort in the data's completeness, we traced from source documents to the CALSTARS data and noted no errors. Because we were unable to determine the data's completeness for three of the fiscal years we reviewed and the logic errors we encountered, we found that Health Care Services' financial data in these CALSTARS reports were of undetermined reliability for the purpose of identifying expenditures related to the five divisions for fiscal years 2004–05 through 2008–09.

Separate from our accuracy and completeness testing, we identified instances in which Health Care Services miscoded expenditures for Utilization Management, Systems of Care, Long-Term Care, and Safety Net Financing during fiscal years 2007–08 and 2008–09. For example, under its contracts with both Safety Net Financing and the Medi-Cal Managed Care Division (Managed Care), the California Medical Assistance Commission negotiates Medi-Cal reimbursement rates for contracted hospitals and managed care plans. Before fiscal year 2007–08, the Department of Health Services charged all expenditures for these contracts to the Operations Division. However, when the reorganization occurred, Health Care Services did not update its accounting procedures to charge these expenditures to Safety Net Financing and Managed Care. Consequently, for eight transactions we reviewed for services the California Medical Assistance Commission provided,

we identified expenditures totaling $559,372 that Health Care Services inappropriately charged to Utilization Management. Specifically, it miscoded five transactions totaling $437,690 to Utilization Management for services the California Medical Assistance Commission provided to Safety Net Financing and three other transactions totaling $121,682 for services provided to Managed Care. As a result, we excluded these transactions from our expenditure analysis.

Finally, we determined Health Care Services' SURGE data to be of undetermined reliability for the purposes of our audit because the data was provided from the data warehouse that Health Care Services uses to produce reports from the data, rather than the production data itself. Because the system is partly paperless, we could not assess reliability by tracing to and from source documents. Additionally, a test of system controls would not be meaningful because controls can be overridden in the data warehouse. We did not verify the reliability of the data from Health Care Services' claims subsystem of the California Medicaid Management Information System because we used this data only to provide general background information on the TAR process.

Blank page inserted for reproduction purposes only.

Audit Results

The Department of Health Care Services Can Streamline Its Processing of Medical Treatment Authorization Requests

The Department of Health Care Services (Health Care Services) manually adjudicates all medical treatment authorization requests (TARs), even though it denied a relatively small portion of these TARs in almost half of the instances in fiscal years 2007–08 and 2008–09. As shown in Table 1, Health Care Services' denial rate was 4 percent or less for categories of TARs representing 40 percent of the roughly 10 million total it reviewed during this period. For example, it denied less than 1 percent of the 1.31 million TARs for adult day health care and less than 2 percent of the 1.27 million TARs for nonemergency medical transportation (NEMT). Conversely, as shown in Table 2 on the following page, Health Care Services' denial rate was more than 20 percent for less than 0.1 percent of the TARs it reviewed during this same period. For example, Health Care Services denied about 37 percent of TARs for outpatient psychiatric services. However, it received only

Table 1
Least Frequently Denied Treatment Authorization Requests
Fiscal Years 2007–08 and 2008–09, Combined

TREATMENT AUTHORIZATION REQUEST (TAR) SERVICE CATEGORY	NUMBER OF TARs PROCESSED	PERCENTAGE OF TARs DENIED	PERCENTAGE OF ALL TARs PROCESSED
Nursing facilities (a) and (b) (short stay)	10,700	3.97%	0.11%
Hospital days	931,415	3.80	9.32
Organ transplants/acquisition	688	3.63	0.01
Incontinence supplies	63,660	3.57	0.64
Comprehensive perinatal services	1,905	3.46	0.02
Nursing facilities (a) and (b) (minimum data set attachment)	241,701	3.28	2.42
Home health	137,094	2.39	1.37
Subacute	21,332	2.39	0.22
Intermediate care facility–developmentally disabled	10,953	2.29	0.11
Nonemergency medical transportation	1,273,481	1.87	12.73
Adult day health care	1,314,464	0.97	13.14
Transitional care	1	0.00	0.00
Total	**4,007,394**		**40.09%**

Source: Bureau of State Audits' analysis of the Service Utilization Review, Guidance, and Evaluation database of the Department of Health Care Services (Health Care Services) for fiscal years 2007–08 and 2008–09.

Note: Although Health Care Services processed 10 million TARs in fiscal years 2007–08 and 2008–09, this table displays only the TAR service categories that Health Care Services least-frequently denied.

63 TARs for outpatient psychiatric services in the two-year period, which represents about 0.001 percent of all the TARs it processed during this time frame.

Table 2
Most-Frequently Denied Treatment Authorization Requests
Fiscal Years 2007–08 and 2008–09, Combined

TREATMENT AUTHORIZATION REQUEST (TAR) SERVICE CATEGORY	NUMBER OF TARs PROCESSED	PERCENTAGE OF TARs DENIED	PERCENTAGE OF ALL TARs PROCESSED
Augmentative or alternative communication	107	77.57%	0.0011%
Plasma pheresis outpatient	85	44.71	0.0008
Psychiatry, outpatient	63	36.51	0.0006
Portable x-ray, outpatient	35	34.29	0.0003
Office visit, restricted provider	845	33.96	0.0084
Nonbenefit/invalid procedures	635	26.93	0.0063
Dialysis	39	25.64	0.0004
Respiratory therapy	339	24.19	0.0034
Office visits-restricted	337	24.04	0.0034
Total	**2,485**		**0.0247%**

Source: Bureau of State Audits' analysis of the Service Utilization Review, Guidance, and Evaluation database of the Department of Health Care Services (Health Care Services) for fiscal years 2007–08 and 2008–09.

Note: Although Health Care Services processed 10 million TARs in fiscal years 2007–08 and 2008–09, this table displays only the TAR service categories that Health Care Services most-frequently denied.

To help manage its workload, the Department of Health Services established an auto-adjudication process in 2005, enabling it to process automatically TARs that meet certain criteria. However, it did not start using the automated process until February 2007 when it implemented the auto-adjudication process for certain drugs with historically high approval rates, with costs falling below a certain threshold, or that had been determined to be of low financial risk. Health Care Services auto-adjudicated 864,962, or approximately 20 percent, of the 4.3 million drug TARs it reviewed in fiscal years 2007–08 and 2008–09.

In its analysis of the 2009–10 Budget Bill, the Legislative Analyst's Office (Legislative Analyst) recommended that Health Care Services consider changing its process for authorizing certain NEMT medical services for California Medical Assistance Program (Medi-Cal) patients. The Legislative Analyst stated that Health Care Services could potentially improve the availability and quality of its NEMT services while reducing costs by contracting with a transportation broker to manage a portion of these services. Transportation brokers can offer a range of service levels, from

handling only the administrative tasks of screening transport requests to managing the full scope of the NEMT benefit. The Legislative Analyst recommended that Health Care Services conduct a pilot program by contracting with such a vendor for two years to evaluate a NEMT broker model. The Legislative Analyst noted that other states' experiences suggest savings ranging from 15 percent to 35 percent, net of brokerage fees, are possible on the cost of these medical services. In addition, the Legislative Analyst noted that significant administrative savings to the General Fund, amounting to about $1 million annually, could also result from the elimination of the expensive and cumbersome TAR process for NEMT services and other NEMT administration.

Health Care Services is not convinced that Medi-Cal would achieve savings similar to those achieved by Medicaid programs in other states, primarily due to the reimbursement rate differences that exist between California and other states. Health Care Services asserted that California has one of the lowest reimbursement rates for NEMT providers and therefore may not realize large savings from using a transportation broker. It further asserted that implementing a broker model in the current fiscal environment, even on a pilot basis, may require a vendor to achieve cost savings through unnecessary denials of medical services. Finally, Health Care Services indicated that implementing a NEMT broker model would require a good deal of work and that it does not currently have the resources to develop, implement, and monitor such a pilot program.

Health Care Services could improve its overall processing times by implementing auto-adjudication or removing the requirement for a TAR for certain medical services.

However, we believe that by implementing auto-adjudication or removing the requirement for a TAR for those medical services with low denial rates, low service costs, or high TAR administrative costs, Health Care Services could reallocate some resources to review higher-risk TARs, thus improving its overall processing times. According to its chief, the Utilization Management Division (Utilization Management) created a TAR streamlining work group in February 2009 that is analyzing the feasibility of using auto-adjudication for certain medical services currently requiring a TAR or eliminating the TAR requirement for certain services. For example, the chief asserted that Health Care Services analyzed data on NEMT TARs, which consisted of identifying the TAR receipt numbers and adjudication rates for NEMT services in which the approval rate was 90 percent or greater, in preparation for developing criteria for auto-adjudicating some of those TARs. Further, in March 2010, Health Care Services performed tests in its Service Utilization Review, Guidance, and Evaluation (SURGE) system using the criteria it developed to determine the feasibility of using auto-adjudication to process NEMT TARs for transporting

certain types of patients to and from medical appointments. According to the chief, Health Care Services is currently analyzing the results of these tests.

Health Care Services Needs to Perform a Cost-Benefit Analysis of Its Least-Frequently Denied TARs

Health Care Services spent an estimated $72.6 million over two fiscal years to administer the TAR process, including high-volume TARs with very low denial rates.

Overall, Health Care Services' data indicate that the TAR process as a whole saves more money in claims it avoids having to pay to Medi-Cal providers than it costs to administer. Specifically, its data indicate that it potentially avoided $392 million in costs in 2007 as a result of its TAR process—$334 million for medical service TARs and $58 million for drug TARs. However, Health Care Services has not performed an analysis of the costs and benefits associated with its review of TARs for service categories that have low denial rates, even though we believe there are compelling reasons to perform such an analysis. For instance, Health Care Services spent an estimated $35.9 million in fiscal year 2007–08, and an estimated $36.7 million in fiscal year 2008–09, to administer the TAR process. Health Care Services' administration of certain high-volume TARs with very low denial rates accounted for part of these costs. For example, as shown previously in Table 1, the denial rate for 4 million, or 40 percent, of all TARs was less than 4 percent during the two-year period we reviewed. Consequently, Health Care Services' costs of processing this population of rarely denied TARs are potentially high. Although TARs for some service categories are likely to be more labor-intensive and expensive to adjudicate than others, Health Care Services does not track its varying administrative costs for the different service categories. Assuming that it spent an equal amount of time and resources processing every TAR, regardless of service category or volume, it would have spent 40 percent of its TAR-related expenditures, or an annual average of $14.5 million, on its administration of these rarely denied TARs. This example highlights why it is important that Health Care Services perform a cost-benefit analysis for TARs with low denial rates.

The Joint Legislative Audit Committee asked us to determine whether Health Care Services performed a cost-benefit analysis of its TAR process. Therefore, during the preliminary phase of this audit we asked Health Care Services if it had conducted any cost-benefit analyses of its TAR process, and it stated that it had not. Throughout our fieldwork, the chief of Utilization Management reiterated that Health Care Services had not conducted any such cost-benefit analyses. However, in April 2010—during the drafting of our audit report—he provided two limited analyses that considered the costs and benefits of the TAR process. Health Care Services developed these analyses for purposes other than

determining whether its TAR process is cost-effective for all service categories. We were unable to verify the accuracy of the calculations Health Care Services included in its analyses and the data upon which those calculations were made because they were provided so late.

Health Care Services' two cost analyses did not adequately consider whether its administrative costs to process TARs for service categories with low denial rates equaled or exceeded its savings.

Although Health Care Services failed to provide these two limited analyses until April 2010, it performed them in 2008. However, because these analyses were conducted for purposes other than assessing the cost-effectiveness of TARs, neither analysis adequately considered whether its administrative costs to process TARs for service categories with low denial rates equaled or exceeded its savings in the form of service costs it avoided by denying inappropriate services. For example, in the first analysis, Health Care Services used data on all medical TARs it adjudicated in 2007 and the corresponding data on paid claims to estimate that it avoided $359 million in service costs during this one-year period by denying and modifying TARs for requested medical services that it determined were not medically necessary—however, it did not include the TAR processing cost in the analysis. Although we were not able to verify the accuracy of Health Care Services' calculations or the data upon which those calculations were made, we believe it overstated its total avoided costs by $25 million by double-counting estimated savings from deferred TARs. Specifically, the analysis counted avoided costs for TARs that were denied or modified outright, and also counted the avoided costs for those that were initially deferred but later were denied or modified when they were resubmitted. SURGE considers a resubmitted TAR as a new transaction and, as such, any avoided costs for these resubmitted TARs already are captured in the calculation of those denied or modified outright. When we questioned the chief of Utilization Management about this, he agreed that the cost-avoidance estimate was overstated by $25 million. Consequently, rather than the $359 million originally claimed, Health Care Services' data indicates that it potentially avoided $334 million in service costs through its review of all medical service TARs in 2007.

The second analysis Health Care Services provided more closely represents the type of cost-benefit analysis we would expect to see. For this analysis, it limited its focus to estimating the costs and benefits associated with processing TARs for hospital days. In its analysis, Health Care Services estimated that it paid approximately $2.5 billion in 2007 in claims for TARs for hospital days. In addition, Health Care Services estimated that it avoided costs totaling $229 million in 2007 by modifying and denying TARs for hospital days. It also considered some of its administrative costs related to these TARs, which it estimated to be $15 million. Specifically, it performed an informal survey to estimate the costs for field office and appeals section staff associated with TARs for hospital days

and estimated the overhead expenses associated with these TARs, including printing, communications, training, and other general expenses. By subtracting these administrative costs from the total costs avoided by the TAR process, Health Care Services estimated a net cost-avoidance of $214 million from requiring a TAR for hospital days.

The chief of Utilization Management acknowledged that the cost-avoidance figures were overstated because neither of its analyses considered the potential effect of denied TARs that were appealed and subsequently overturned and its administrative costs did not include the costs of its contract staff.

Although we did not verify the accuracy of Health Care Services' calculations or the data upon which those calculations were based, we noted that Health Care Services did not reduce its cost-savings estimates to account for TARs that initially were denied but later approved through the appeals process. In addition, Health Care Services' estimate of its administrative costs did not factor in the costs of any contract staff associated with the processing of TARs for hospital days. The chief of Utilization Management acknowledged that Health Care Services' cost-avoidance figures were overstated because neither of its analyses considered the potential effect of denied TARs that were appealed and subsequently overturned. The chief also acknowledged that Health Care Services' estimate of administrative costs did not include the costs of any contract staff associated with the processing of TARs for hospital days.

Although the prior two analyses may demonstrate that TARs for some services are cost-beneficial, we believe Health Care Services needs to focus future cost-benefit analyses on TARs with low denial rates, low paid claims, or high TAR administrative costs. These are the TAR categories for which Health Care Services' administrative costs may outweigh the amount it saves by denying inappropriate services. For example, as shown previously in Table 1 on page 15, Health Care Services processed approximately 1.3 million TARs for NEMT services in fiscal years 2007–08 and 2008–09, or roughly 650,000 NEMT TARs annually. Of these, it denied 1.87 percent, or approximately 12,000 NEMT TARs each year. Further, Health Care Services' cost-avoidance analysis for medical services indicates that TARs for NEMT services had an average paid claim of only $332 in 2007. Therefore, it appears that Health Care Services avoided an estimated $4 million in annual costs by denying those NEMT TARs.

However, as later shown in Table 3 on page 25, Health Care Services spent approximately $35.9 million to administer the TAR process in fiscal year 2007–08. Further, Table 1 on page 15 shows that NEMT TARs represent 12.7 percent of all the TARs Health Care Services processed that year. Assuming that Health Care Services' cost to process each TAR is equal, we estimate that it would have spent $4.6 million to administer NEMT TARs. Thus, Health Care Services spent $4.6 million to process NEMT TARs in order to avoid spending $4 million on inappropriate NEMT TARs—a net

cost of $600,000 for its administration of NEMT TARs. Further, according to its own cost avoidance analysis for medical services, Health Care Services increased its service costs by modifying NEMT TARs, and consequently spent an additional $4.1 million on them. Thus, Health Care Services' cost of administering NEMT TARs exceeded its savings through cost-avoidance by an estimated $4.7 million. This simple exercise shows why it is important that Health Care Services perform a cost-benefit analysis on TAR categories with low denial rates, low paid claims, or high TAR administrative costs to identify opportunities to streamline its TAR process further.

As demonstrated by its analysis of TARs for hospital days, Health Care Services already has developed a methodology for conducting a cost-benefit analysis of its TAR process for specific service categories. Health Care Services could use its approach for performing a cost-benefit analysis to identify those service categories where there are indications—such as a service category with a low rate of denial—that the costs of administering the TAR process meet or exceed the financial benefits. We believe that our list of the least-frequently denied TARs as shown previously in Table 1 contains many of the service categories that would make good candidates for cost-benefit analyses. However, Health Care Services should ensure that such cost-benefit analyses include a proportionate share of its contract costs associated with each TAR service category. If such cost-benefit analyses show that the cost to process TARs for a certain service category outweigh the amount of money saved by denying inappropriate services, Health Care Services should consider removing the service category from the list of services that require a TAR. Alternatively, Health Care Services could implement an auto-adjudication process for these services similar to the one used by the Pharmacy Field Operations Branch.

Although other limited reviews of the TAR process have been commissioned, none constitute the type of cost-benefit analysis we recommend.

Both Health Care Services and its predecessor, the Department of Health Services, have commissioned other limited reviews of the TAR process. However, none of these reviews constitute the type of cost-benefit analysis we just described. For example, both entities hired a consulting organization to perform two studies on the staffing levels associated with TAR processing activities. The purpose of the first study was to determine the pharmaceutical consultant 1 staffing levels that the Department of Health Services' Medi-Cal Operations Division (Operations Division) would have needed to effectively and efficiently process drug TARs received in 2006 within federal time limits. The first study was completed in June 2007, and recommended estimated pharmaceutical consultant 1 staffing levels needed to effectively and efficiently adjudicate average drug TAR workload levels in 2006. The report noted that these workloads fluctuate seasonally and vary by the day of the

week. For example, the study noted that because the Operations Division received more TARs in the winter months of 2006, its staffing requirements during the winter were generally greater than during the summer. Also, because the Operations Division did not process TARs over the weekend, its average daily TAR volumes peaked on Mondays and declined steadily throughout the week. Therefore, its staffing needs were greater earlier in the week and during the winter months. The chief of Utilization Management indicated that as of December 2009, it achieved the recommended staffing levels to meet average Wednesday TAR volumes in the winter months by filling all 59 of its authorized pharmaceutical consultant 1 positions.

In December 2008 the consultant completed a second study of Utilization Management's staffing needs based on its analysis of TARs processed from October 2007 through March 2008. In addition, the consultant used data on paid service claims to estimate the savings associated with medical TARs that were denied during the six-month period. The consultant estimated that Utilization Management avoided $91 million in service costs during this period by denying TARs for medical services, which equates to an annualized savings of roughly $182 million. The consultant's report did not include an analysis of Utilization Management's administrative costs to process these TARs. As explained previously, Utilization Management estimated that its TAR process saved $334 million in 2007, which is substantially higher than the consultant's annualized estimate. However, Utilization Management's cost-avoidance figure also included savings of $98 million associated with modified TARs, which brings the difference between the two estimates down to approximately $54 million. The assistant chief of Utilization Management attributed this remaining difference between its cost-avoidance figure and that of its consultant to differences in the time frames from which data were analyzed and the methodologies employed in each analysis.

The consultant recommended that Utilization Management repeat this study to assess its staffing requirements for processing medical service TARs one year after the system redesign that was completed during this December 2008 study. Despite its chief's assertion that Health Care Services is committed to implementing this recommendation, Utilization Management had yet to initialize plans for repeating the study as of April 2010. However, we believe that Health Care Services should first complete the cost-benefit analysis we described previously in order to identify opportunities to remove unnecessary TAR requirements or to expand its auto-adjudication process. These actions would allow Health Care Services to reallocate existing resources to higher-risk workloads, would improve its response times, and may mitigate any need for additional staff.

Appropriate analysis would allow Health Care Services to reallocate existing resources to higher-risk workloads, improve response times, and may reduce any need for additional staff.

Health Care Services Does Not Track TAR Processing Costs Separately

We were unable to determine precisely how much Health Care Services and its predecessor, the Department of Health Services, spent to administer the TAR process in fiscal years 2004–05 through 2008–09 because they did not separately track all expenditures related to the TAR process. Health Care Services generally accumulates cost data using broader categories of activities. Specifically, it maintains cost pools to track expenses for activities such as Medi-Cal case management and in-home monitoring and oversight. Using such cost pools allows Health Care Services to accumulate expenditures based on the general activity that generated them. However, it intermingles TAR expenditures with expenditures not related to the TAR process. For instance, the skilled professional medical personnel in the Long-Term Care Division (Long-Term Care) process TARs and perform other duties unrelated to the TAR process, all of which go into the same cost pool. Yet, because Long-Term Care records all costs associated with skilled professional medical personnel in the same cost pool, it cannot isolate its TAR-related costs.

Because Health Care Services does not track TAR processing costs separately, it cannot isolate its TAR-related costs and calculate its total cost to administer the TAR process.

Given the limitations of the available accounting data, we modified our planned approach and instead identified the expenditures of those divisions involved in the processing of TARs that we reviewed over the five-year period. To calculate these expenditures, we obtained California State Accounting and Reporting System (CALSTARS) reports for fiscal years 2004–05 through 2008–09. In addition, we reviewed the Department of Finance's Uniform Codes Manual and final budget summaries, and conducted interviews with Health Care Services' staff to identify methods to isolate state operation expenditures. We did this to ensure that our analysis of the expenditures for the divisions involved in the TAR process excluded nonprocessing costs, such as local assistance payments. Additionally, we interviewed managers to identify the index codes to which the Department of Health Services charged the Operation Division's expenditures during fiscal years 2004–05 through 2006–07, and the codes that Health Care Services used to charge for its Utilization Management, Systems of Care Division (Systems of Care), Long-Term Care, and Safety Net Financing Division's (Safety Net Financing) expenditures during fiscal years 2007–08 and 2008–09.

We subsequently identified expenditures coded to Utilization Management index codes during fiscal years 2007–08 and 2008–09 that related to payments to the California Medical Assistance Commission for negotiating contracts with managed health care plans and hospitals for specific Medi-Cal services on behalf of Health Care Services. We removed these payments from our analysis because they are unrelated to Health Care Services' cost

of administering the TAR process. Finally, we used the transaction, index, and reference codes that we identified to extract the annual expenditures of the five divisions for each of the five years.

As described in the Introduction, the Department of Health Services' Operations Division was responsible for processing TARs, among other unrelated functions before fiscal year 2007–08. For example, it also performed the operational aspects of hospital financing, home- and community-based services waiver programs, and medical case management programs. We were unable to isolate the expenditures for processing TARs incurred by the Operations Division for fiscal years 2004–05 through 2006–07. Consequently, we identified the total expenditures for the Operations Division for the first three years of our review and the total expenditures for Utilization Management, and the estimated expenditures related to TARs for Systems of Care and Long-Term Care for the last two years. To be complete, we also identified the expenditures for Safety Net Financing for the last two years, although it does not process any TARs.

Because Utilization Management's primary function is utilization control via the TAR process, our analysis in Table 3 assumes that all its costs, excluding the adjustments described previously, relate to its administration of the TAR process. However, recognizing that only a portion of the expenditures associated with Systems of Care and Long-Term Care are for TAR-related activities, we developed a methodology to estimate their TAR expenditures. We first determined the average cost per TAR adjudicated by Utilization Management in fiscal years 2007–08 and 2008–09. Then, assuming for the purposes of this estimation that the expense to adjudicate a TAR would remain constant in Utilization Management, Systems of Care, and Long-Term Care, we multiplied Utilization Management's average cost per TAR by the number of TARs processed by Systems of Care and Long-Term Care during each of the two years. Our analysis, shown in Table 3, also summarizes estimated non-TAR related expenditures for the four divisions for the last two years, including Safety Net Financing's expenditures. Although Safety Net Financing does not process TARs, we included its costs in this subtotal to provide consistency because the Operations Division fulfilled the function in the first three years of our analysis. The non-TAR-related subtotal also summarizes estimated expenditures not related to the TAR process for any ancillary branches that were moved under the four divisions after the reorganization.

We calculated that TAR-related expenditures ranged from $35.9 million to $36.7 million in the last two fiscal years, excluding certain contract costs for TAR-related activities.

The annual expenditures for the Operations Division, Utilization Management, Systems of Care, Long-Term Care, and Safety Net Financing generally increased over the five fiscal years we reviewed. As shown in Table 3, the Operations Division's annual expenditures ranged from $61.6 million to $71 million over the first three fiscal years, while the combined annual expenditures for Utilization Management and our estimates of expenditures related to TARs for

Systems of Care and Long-Term Care ranged from $35.9 million to $36.7 million in the last two fiscal years, averaging $36.3 million per year. Finally, the total combined TAR- and non-TAR-related annual expenditures declined slightly from $80.7 million in fiscal year 2007–08 to $80.6 million in fiscal year 2008–09. However, these amounts do not include any TAR-related costs associated with Health Care Services' contract for TAR and claims processing. The contract provides approximately 300 contract staff to assist Health Care Services in processing TARs—a staff almost as large as the number of Utilization Management's state employees. The contract does not separately quantify the cost of TAR-related activities. However, even if the excluded costs were not as great as the $35 million Utilization Management spent in each of the last two fiscal years, the amount would be substantial enough to include in a cost-benefit analysis.

Table 3
Estimated Expenditures Related to the Department of Health Services' and Health Care Services' Administration of the Treatment Authorization Request Process For Fiscal Years 2004–05 Through 2008–09

DIVISION	FISCAL YEARS					PERCENTAGE OF TREATMENT AUTHORIZATION REQUESTS (TARs) ADJUDICATED, BY DIVISION, IN FISCAL YEARS 2007–08 AND 2008–09, COMBINED*
	2004–05	2005–06	2006–07	2007–08	2008–09	
Medi-Cal Operations Division†	$62,348,485	$61,633,621	$71,013,313			
Utilization Management Division				$35,085,105	$35,805,623	97.0%
Systems of Care Division‡				$558,210	$589,028	1.6
Long-Term Care Division‡				$236,346	$281,249	0.7
TAR-related Expenditure Subtotals				**$35,879,661**	**$36,675,900**	
Expenditures not related to TARs§				44,803,379	43,895,725	
Totals‖	**$62,348,485**	**$61,633,621**	**$71,013,313**	**$80,683,040**	**$80,571,625**	**99.3%**

Sources: Bureau of State Audits' analysis of California State Accounting and Reporting System reports for fiscal years 2004–05 through 2008–09 and the Service Utilization Review, Guidance, and Evaluation database of the Department of Health Care Services for fiscal years 2007–08 and 2008–09.

* A small percentage of TARs, including those for vision services, were adjudicated by divisions outside those listed in this table.

† As described in the report text, expenditures for the Medi-Cal Operations Division include both TAR- and non-TAR-related costs, and occurred prior to fiscal year 2007–08.

‡ As described in the report text, this row identifies estimated costs for the Systems of Care and the Long-Term Care divisions' administration of the TAR process that occurred in fiscal years 2007–08 and 2008–09.

§ This row reflects non-TAR expenditures for all four divisions, including Safety Net Financing, which does not process TARs, that occurred in fiscal years 2007–08 and 2008–09.

‖ As described in the report text, the expenditures shown in this table do not include any TAR-related costs associated with Health Care Services' contract for TAR and claims processing.

Health Care Services Has Failed to Process Drug TARs Within Federal and State Time Limits

Health Care Services is not processing drug TARs within legal time limits. Federal and state law require that, when Health Care Services requires a prior authorization before a pharmacist may dispense a

Health Care Services' average response times for its manually adjudicated drug TARs significantly exceeded 24 hours in fiscal years 2007–08 and 2008–09.

drug, it must respond within 24 hours of its receipt of the request for prior authorization[2]. However, Health Care Services' average response times for its manually adjudicated drug TARs[3] significantly exceeded 24 hours in fiscal years 2007–08 and 2008–09. It took longer than 24 hours to respond to 84 percent and 58 percent of manually adjudicated drug TARs in fiscal years 2007–08 and 2008–09, respectively. As a result, Medi-Cal recipients were potentially delayed from promptly receiving prescription drugs.

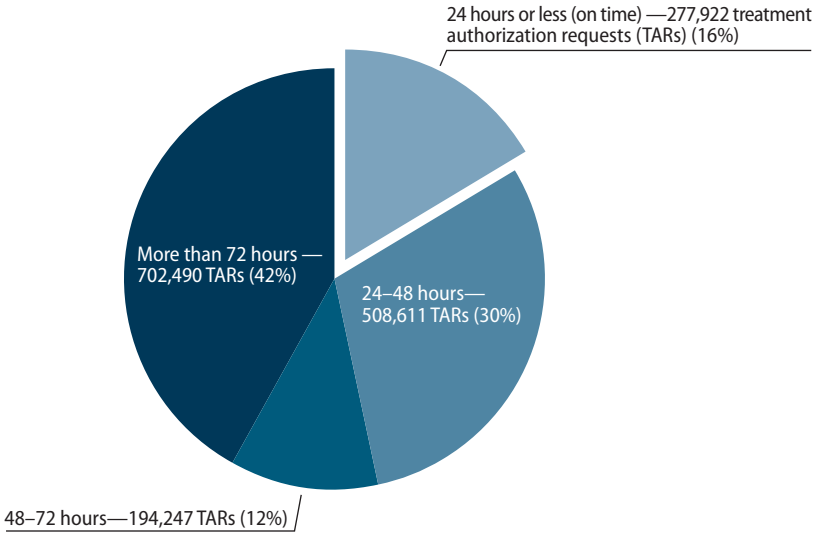
Although Health Care Services tracks the date it receives a TAR, it does not track the specific time it receives a TAR through the mail or by fax (paper TAR). Roughly half of all drug TARs are paper TARs; the remainder are submitted electronically. TARs submitted electronically feed directly into the SURGE system and consequently have date and time stamps that reflect precisely when they were received. However, Health Care Services' contract staff has to manually enter TARs received by mail or fax into a Web-based application that feeds into the SURGE system. For those, the system records the time received as 9 a.m., regardless of when they actually were received or keyed into the system. For example, a paper TAR received at 4:59 p.m. on Monday would be recorded in the system as having arrived at 9 a.m. that day—thus overstating Health Care Services' processing time by seven hours and 59 minutes. Alternately, a paper TAR arriving at 5:01 p.m. on Monday would be recorded in SURGE as arriving at 9 a.m. on Tuesday—understating processing time by 15 hours and 59 minutes. We used data from the SURGE system to calculate Health Care Services' average response times for TARs for fiscal years 2007–08 and 2008–09. Consequently, our calculations reflect the imprecision of the data contained in SURGE.

As shown in Figure 1, Health Care Services' data indicate that it took longer than 24 hours to respond to 1.4 million, or 84 percent, of the 1.7 million drug TARs manually processed during fiscal year 2007–08. It processed only 16 percent of total drug TARs within the legal time limit that year. The figure also illustrates that it took more than 72 hours to respond to 42 percent of the drug TARs processed.

[2] Federal law limits this requirement to outpatient drugs.

[3] Auto-adjudicated TARs are processed well within the 24-hour time requirement for drug TARs with prior authorizations. We focused our analysis on manually adjudicated TARs.

Figure 1
Department of Health Care Services' Drug Treatment Authorization Request Processing Times for Fiscal Year 2007–08

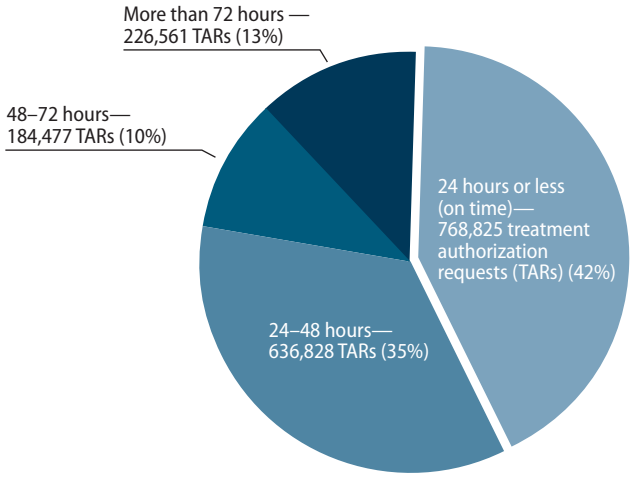


Source: Bureau of State Audits' analysis of the Service Utilization Review, Guidance, and Evaluation database of the Department of Health Care Services for fiscal year 2007–08.

Health Care Services significantly improved its overall drug TAR processing times in fiscal year 2008–09. As shown in Figure 2 on the following page, it more than doubled the percentage of drug TARs it processed manually within 24 hours—from 16 percent to 42 percent. The percentage of drug TARs it took more than 72 hours to process also decreased substantially—from 42 percent to 13 percent. However, despite these improvements, Health Care Services still did not process 58 percent of its drug TARs within the 24-hour legal limit in fiscal year 2008–09.

Federal and state law require that, when Health Care Services requires a prior authorization before a pharmacist may dispense a drug, it must respond to the request for prior authorization within 24 hours of the receipt of an authorization request. State law defines prior authorization as approval by a Health Care Services' consultant of a specified service before the rendering of that service based upon a determination of medical necessity. Some beneficiaries might receive their drugs before a TAR is approved, but in other cases providers might be unwilling to dispense drugs before Health Care Services' authorization. Health Care Services does not differentiate between these two scenarios. Rather, it views the TAR process as its means of conducting prior authorization of a drug or service before reimbursement will occur.

Figure 2
Department of Health Care Services' Drug Treatment Authorization Request Processing Times for Fiscal Year 2008–09



Source: Bureau of State Audits' analysis of the Service Utilization Review, Guidance, and Evaluation database of the Department of Health Care Services for fiscal year 2008–09.

However, Health Care Services has interpreted these requirements differently. It believes that these laws require it to process drug TARs by the end of the *next business day*. Although Health Care Services adjudicates TARs only on business days, excluding state holidays and furlough days, providers may submit them 24 hours a day, seven days a week. TARs received between midnight and 5 p.m. on a business day are considered as received on that day's date, and TARs received between 5:01 p.m. and 11:59 p.m. are considered as received the following business day. Therefore, Health Care Services considers a drug TAR received at 8 a.m. on a Monday as received that day, but a response would not be due until Tuesday at 5 p.m., 33 hours after it actually was received. However, it considers a TAR it physically receives at 5:01 p.m. on Friday as officially received on Monday, giving it until close of business on Tuesday to process the TAR. As a result, Health Care Services' next business day could be as long as 96 hours—well beyond the 24 hours the law allows.

Health Care Services stated that the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicaid program, is aware of its *next business day* practice and has not indicated that this is of concern as long as beneficiaries have access to a 72-hour emergency supply of their prescription drugs. During our 2000 audit of the Department of Health

Services' drug TAR process, we reported that CMS (formerly known as the federal Health Care Financing Administration) still upholds the 24-hour processing time, but acknowledged that in some cases processing time for drug TARs will exceed 24 hours. In these cases, CMS allowed the department to exceed the federally mandated processing time as long as emergency drugs were available to beneficiaries. Health Care Services indicates that it provides for a 72-hour supply of drugs in emergency situations. Nevertheless, Health Care Services' *next business day* practice is not consistent with the 24-hour response requirement set forth in federal and state law. Health Care Services asserts that it plans to continue using its *next business day* policy until CMS says the interpretation of federal law is incorrect. We sent a letter to the director of CMS' Division of Pharmacy, and an associate regional administrator in November 2009 asking for an interpretation of this 24-hour response requirement. However, as of May 27, 2010, we have not received a response.

The chief of Utilization Management asserted that processing times for drug TARs were affected by staffing shortages, a backlog of TARs, and system interruptions. Specifically, he stated that significant staffing shortages in 2006 and 2007 at the northern pharmacy field office had an adverse effect on drug TAR response times during fiscal year 2007–08. According to the chief, the northern pharmacy field office was understaffed by six positions in 2006 and eight positions in 2007. Although Health Care Services had difficulty recruiting pharmacists for the northern pharmacy field office, the chief said it was able to recruit eight additional pharmacists for the southern pharmacy field office. As a result, Health Care Services rerouted drug TARs to the southern office as needed in an attempt to balance the workload. The chief concluded that the staffing shortages at the northern pharmacy field office resulted in a 10- to 15-day backlog of drug TARs that carried over into 2007. According to the chief, Utilization Management had a one-day backlog of drug TARs by June 30, 2009, and eliminated that backlog by March 24, 2010.

Staffing shortages at the northern pharmacy field office resulted in a 10- to 15- day backlog of drug TARs that carried over into 2007.

Finally, the chief also told us that Utilization Management experienced technical problems when it transitioned all TAR adjudication to the SURGE system in fiscal year 2007–08. The chief indicated that the new SURGE application experienced technical problems such as freezing up and TARs getting stuck in the system or being routed back to a user's queue after being adjudicated. The chief indicated that the northern pharmacy field office experienced significant SURGE system slowdowns and interruptions, which hampered Health Care Services' overall drug TAR response times during fiscal year 2007–08. He stated that Health Care Services addressed these system slowdowns and interruptions by upgrading the system's bandwidth in fiscal year 2008–09.

Health Care Services Cannot Ensure Compliance With State Requirements for Response Times

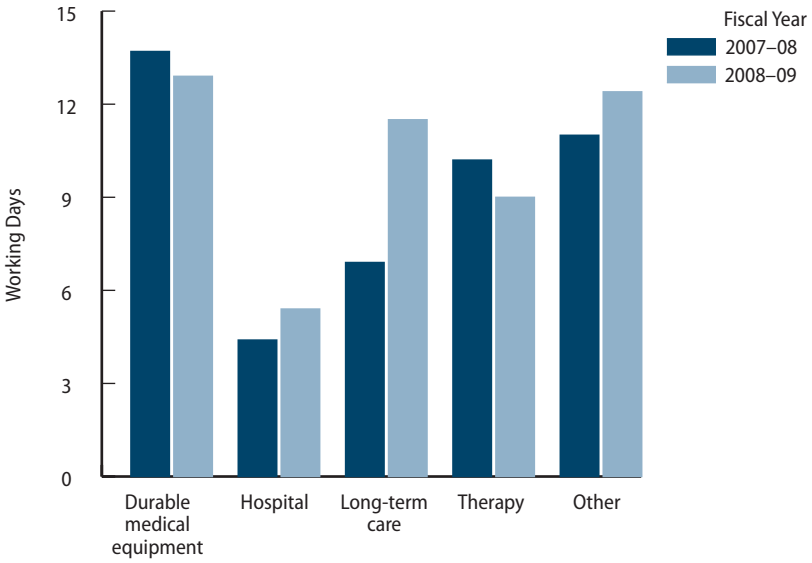
As previously stated, state law defines prior authorization as an approval by a department consultant of a specified service before the rendering of that service based upon a determination of medical necessity, but Health Care Services instead generalizes prior authorization to mean authorization before reimbursement. However, state law and regulations specifically require prior authorization, the approval of a service before the rendering of that service, for certain medical services. For example, state law requires prior authorization for inpatient hospice services, and state regulations require that intermediate care services be covered only after prior authorization is obtained from a Medi-Cal consultant. Despite this, Health Care Services indicated that it generally does not require prior authorization in practice; and that providers bear the financial risk if a TAR is submitted retroactively because the provider will not be reimbursed for the service if Health Care Services denies the TAR due to a lack of medical necessity supporting the requested service.

Further, Health Care Services acknowledges that state law requires that TARs submitted for medical services that have not yet been rendered must be processed within an average of five working days. However, it cannot demonstrate its compliance with this law because it does not specifically monitor its processing times for prior-authorization medical TARs. The Field Operations Support Branch (Field Operations) chief indicated that the SURGE system is programmed to automatically identify prior-authorization hospital TARs as *urgen*t, so that staff can identify these TARs easily and adjudicate them before other TARs. Specifically, the SURGE system identifies a hospital TAR with no service date, or a service date that is subsequent to the TAR receipt date, as a prior authorization, and flags the TAR as *urgent*. However, the SURGE system is not programmed to automatically identify prior-authorization TARs for other medical services as urgent. Further, although Health Care Services has a reporting tool that allows it to monitor TAR processing times, it does not differentiate TARs requesting prior authorization of services from TARs requesting authorization after medical services already have been provided (retroactive TARs). As a result, Health Care Services cannot ensure that it is approving prior-authorization TARs within the legal time limit and therefore may be preventing some Medi-Cal patients from receiving timely medical services.

The chief of Field Operations indicated that a provider also could indicate if a paper hospital TAR is a request for prior authorization by marking the TAR as *urgent* when submitting it. However, TARs for services other than prior authorization hospital days are adjudicated in the date order they were received, regardless of

whether the TAR is a prior or retroactive authorization. The chief of Utilization Management added that Health Care Services makes every effort to identify prior-authorization TARs at receipt and adjudicate them quickly, but he could not provide any evidence to support his assertion because Health Care Services does not track its response times separately for prior-authorization TARs. For example, Health Care Services prioritizes prior-authorization TARs for certain cancer treatments, but again, it does not track its response times for such TARs. As shown in Figure 3, Health Care Services' average response times for processing medical TARs ranged from 4.4 working days to 13.7 working days in the two years we reviewed. These figures reflect Health Care Services' average processing times for both prior-authorization TARs and for those submitted retroactively.

Figure 3
Average Processing Times in Working Days for Major Medical Categories
Fiscal Years 2007–08 and 2008–09



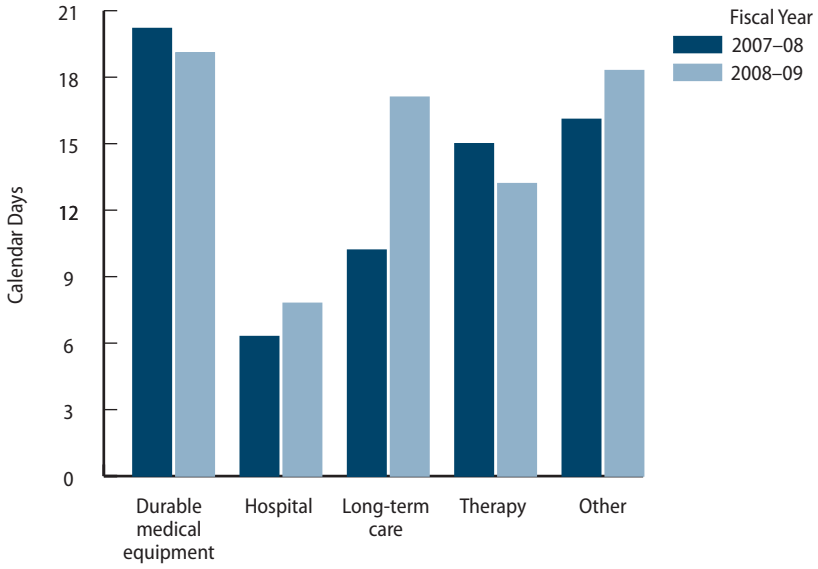
Source: Bureau of State Audits' analysis of the Service Utilization Review, Guidance, and Evaluation database of the Department of Health Care Services for fiscal years 2007–08 and 2008–09.

Note: This figure groups many different services into similar categories. For example, durable medical equipment includes oxygen and respiratory equipment; hospital includes surgery procedures and transitional care; long-term care includes nursing facility subacute care and bed holds; therapy includes respiratory and speech therapy; and other includes services such as hospice, hearing aids, and home health services.

The chief of Utilization Management further asserted that it generally makes every effort to process prior authorizations in as little time as possible, but its informal goal is to process all medical TARs within 30 days. Because the average five-working-day processing deadline is relevant only for prior-authorization TARs,

we also calculated Health Care Services' average response times for all medical TARs based on calendar days. As Figure 4 shows, its average response times for medical TARs ranged from six to 20 calendar days in the two years we reviewed. For example, Health Care Services took an average of 6.3 calendar days to respond to TARs for hospital days in fiscal year 2007–08. According to the chief, these TARs are processed on-site at hospitals and at all field offices. In contrast, Health Care Services took an average of 19.1 calendar days to process TARs for durable medical equipment in fiscal year 2008–09. TARs for durable medical equipment, long-term care, and therapy are processed only at certain field offices.

Figure 4
Average Processing Times in Calendar Days for Major Medical Categories
Fiscal Years 2007–08 and 2008–09



Source: Bureau of State Audits' analysis of the Service Utilization Review, Guidance, and Evaluation database of the Department of Health Care Services for fiscal years 2007–08 and 2008–09.

Note: This figure groups many different services into similar categories. For example, durable medical equipment includes oxygen and respiratory equipment; hospital includes surgery procedures and transitional care; long-term care includes nursing facility subacute care and bed holds; therapy includes respiratory and speech therapy; and other includes services such as hospice, hearing aids, and home health services.

Health Care Services' TAR response times also increased for some of the major categories of medical services from fiscal year 2007–08 to 2008–09. For instance, as shown in Figure 4, Health Care Services took longer on average in fiscal year 2008–09 to process TARs for services in the hospital, long-term care, and other categories. The chief of Utilization Management indicated

that the increases in response times during fiscal year 2008–09 in some service categories were due to increases in TAR volumes. For example, as shown in Table 4, TAR volumes for magnetic resonance imaging increased from 120,947 adjudications in fiscal year 2007–08, to 145,711 in fiscal year 2008–09.

Table 4
Average Processing Times by Submission Method for Select High-Volume Treatment Authorization Requests
Fiscal Years 2007–08 and 2008–09

TREATMENT AUTHORIZATION REQUEST (TAR) CATEGORY	CALENDAR DAYS				VOLUME					
	FISCAL YEAR 2007–08		FISCAL YEAR 2008–09		FISCAL YEAR 2007–08			FISCAL YEAR 2008–09		
	ELECTRONIC TAR	PAPER TAR	ELECTRONIC TAR	PAPER TAR	ELECTRONIC TAR	PAPER TAR	TOTAL TAR VOLUME	ELECTRONIC TAR	PAPER TAR	TOTAL TAR VOLUME
Adult day health care	8.2	7.1	9.6	9.1	292,022	324,975	616,997	382,069	284,021	666,090
Durable medical equipment-mobility*	19.7	15.3	22.2	20.0	107,463	76,720	184,183	128,937	52,247	181,184
Hospital days	2.8	5.5	6.1	6.0	11,598	452,847	464,445	15,346	450,753	466,099
Inpatient/outpatient magnetic resonance imaging (radiology)	10.3	11.1	16.8	11.7	72,943	48,004	120,947	104,262	41,449	145,711
Inpatient/outpatient surgery procedure	8.0	10.9	14.3	12.9	60,767	66,028	126,795	83,134	55,292	138,426
Nonemergency medical transportation	23.7	27.7	27.5	30.5	271,226	349,759	620,985	340,760	310,960	651,720
Speech/occupational/ physical therapy	18.0	13.9	18.3	10.0	35,586	93,229	128,815	53,796	87,567	141,363
Totals					**851,605**	**1,411,562**	**2,263,167**	**1,108,304**	**1,282,289**	**2,390,593**

Source: Bureau of State Audits' analysis of the Service Utilization Review, Guidance, and Evaluation database of the Department of Health Care Services (Health Care Services) for fiscal years 2007–08 and 2008–09.

Note: This table displays Health Care Services' average processing time in calendar days for specific medical services with the highest TAR volumes over the two fiscal years. The table does not include all medical services.

* Durable medical equipment-mobility includes items such as wheelchairs and accessories.

The chief also indicated that staffing shortages affected response times during fiscal year 2008–09. For example, the San Francisco field office, which adjudicates regionalized services such as durable medical equipment mobility TARs, experienced staffing shortages during fiscal year 2007–08 and was not able to fill these vacancies until fiscal year 2008–09. According to the chief, it can take six to eight months to train medical personnel to adjudicate Medi-Cal TARs. The chief also indicated that long-term-care TARs are processed at the San Bernardino field office, which experienced staffing shortages during fiscal year 2008–09. He further indicated that the time it took to recruit and train staff to adjudicate long-term-care TARs may have affected response times during this period. Conversely, response times for paper TARs for speech, occupational, and physical therapy generally improved in fiscal year 2008–09 from the prior year. The chief indicated that during fiscal year 2007–08, only one person was processing

the majority of the therapy TARs. However, he indicated that Utilization Management has trained more staff since the end of fiscal year 2008–09.

Finally, the method that a provider used to submit a TAR to Health Care Services, whether by paper or Web-based application, did not appear to affect the amount of time it took Health Care Services to respond. For example, as shown in Table 4, Health Care Services took an average of 23.7 calendar days to respond to electronic TARs for nonemergency medical transportation services in fiscal year 2007–08.

In contrast, it took an average of 27.7 days to respond to paper TARs for nonemergency medical transportation services during that same time period. Conversely, it took Health Care Services an average of 19.7 calendar days to respond to electronic TARs for durable medical equipment-mobility services, which was greater than the 15.3 average calendar days it took to respond to paper TARs for those same services in fiscal year 2007–08. Despite this, the chief indicated that electronic TARs enable Utilization Management to manage its workload better. For example, if one field office experiences a staffing shortage on a given day, Health Care Services can reroute TARs submitted electronically to other field offices for processing.

Recommendations

To streamline the provision of Medi-Cal services and improve its level of service, Health Care Services should conduct cost-benefit analyses to identify opportunities to remove authorization requirements or to auto-adjudicate those medical services and drugs with low denial rates, low paid claims, or high TAR administrative costs.

To ensure that Medi-Cal recipients receive timely access to prescribed drugs, Health Care Services should abolish its policy of responding to drug TARs by the end of the next business day and should instead ensure that prior-authorization requests to dispense drugs are processed within the legally mandated 24-hour period. Alternatively, it should seek formal authorization from CMS to deviate from the 24-hour requirement, and should seek a similar modification to state law. In addition, Health Care Services should begin recording the actual time it receives paper TARs so that it can begin to measure accurately its processing times.

To ensure that Medi-Cal recipients are receiving timely medical services from providers, Health Care Services should start tracking prior-authorization medical TARs separately and should ensure

that such TARs are processed within an average of five working days. Although state law and regulations specifically require prior authorization for certain medical services, Health Care Services generally does not require prior authorizations in practice. Consequently, Health Care Services should seek legislation to update existing laws and amend its regulations to render them consistent with its TAR practices.

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 the report.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE, CPA
State Auditor

Date: May 27, 2010

Staff: Michael Tilden, CPA, Audit Principal
Richard Power, MBA, MPP
Michelle J. Baur, CISA
Sarah Rachael Black, MBA
Carol Hand
Benjamin W. Wolfgram, ACDA

Legal Counsel: Stephanie Ramirez-Ridgeway, JD

For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at (916) 445-0255.

Blank page inserted for reproduction purposes only.

(Agency response provided as text only.)

Department of Health Care Services
1501 Capitol Avenue, Suite 71.6001
Sacramento, CA 95899-7413

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

Dear Ms. Howle:

The California Department of Health Care Services (DHCS) has prepared its response to the draft report entitled "Department of Health Care Services: It Needs to Streamline Medi-Cal Treatment Authorizations and Respond to Authorization Requests Within Legal Time Limits" (2009-112). DHCS appreciates the work performed by the Bureau of State Audits and the opportunity to respond to the draft report.

Please contact Ms. Traci Walter, Audit Coordinator, at (916) 650-0298 if you have any questions.

Sincerely,

(Signed by: David Maxwell-Jolly)

David Maxwell-Jolly
Director

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

Department of Health Care Services
Response to the Bureau of State Audits' Draft Report Entitled

Department of Health Care Services: It Needs to Streamline Medi-Cal Treatment Authorizations and Respond to Authorization Requests Within Legal Time Limits

Recommendation: To streamline the provision of Medi-Cal services and improve its level of service, Health Care Services should conduct cost-benefit analyses to identify opportunities to remove authorization requirements or to auto-adjudicate those medical services and drugs with a combination of low denial rates, low paid claims, and high administrative costs.

Response: Health Care Services agrees with this recommendation.

Health Care Services will perform a cost-benefit analysis of medical services and drugs that have a combination of low denial rates, low paid claims, and high administrative costs as a means of identifying those that could be removed from the Treatment Authorization Request (TAR) requirement or auto-adjudicated.

However, it should be noted that the TAR process, in addition to helping ensure that the Medi-Cal Program authorizes and pays for only medically necessary services, also helps prevent the provision of inappropriate services. It acts as a deterrent because a provider is less likely to provide a service if the TAR for that service would likely be denied, since the provider would be responsible for the cost of the service. This "deterrent effect" helps the Medi-Cal program avoid a significant amount of costs for services that are not medically necessary. If the TAR requirement were removed from specific services, the deterrent effect would no longer apply. ①

The TAR process also plays an important role in the Medi-Cal program's fraud and abuse prevention and detection efforts. When reviewing TARs, Health Care Services staff carefully notes anything that appears unusual or suspect. If fraud or abuse is suspected, staff refers the TAR to Health Care Services, Audits and Investigations Division, for the appropriate follow-up. If a service is no longer subject to the TAR requirement, incidents of fraud and abuse specific to that service may no longer be identified and acted upon and could potentially increase.

Recommendation: To ensure that Medi-Cal recipients receive timely access to prescribed drugs, Health Care Services should abolish its policy of responding to drug Treatment Authorization Requests (TARs) by the end of the next business day and should instead ensure that drug TARs are processed within the legally mandated 24-hour period. In addition, Health Care Services should begin recording the actual time that it receives TARs through the mail or by fax, so that it can begin to accurately measure its processing times for these paper TARs. Alternatively, it should seek formal authorization from the Centers for Medicare & Medicaid Services (CMS) to deviate from the 24-hour requirement, and should seek a similar modification to state law.

Response: Health Care Services partially agrees with this recommendation.

Health Care Services agrees with the recommendation to begin recording the actual time of receipt for drug TARs it receives through the mail or by fax. It will work with either the current or new California Medicaid Management Information System (CAMMIS) contractor to implement this change.

Health Care Services disagrees with the recommendation to abolish its existing policy of adjudicating drug TARs by the end of the next business day. Health Care Services has operationalized the 24-hour requirement as the end of the next business day because the offices where drug TARs are processed are not staffed or budgeted for 24-hour/seven-day-per-week operations like emergency health and safety facilities such as hospitals, prisons, or law enforcement agencies. Health Care Services continues to ensure that emergency drug supplies are available to Medi-Cal beneficiaries as needed and has received very few complaints from Medi-Cal providers and beneficiaries regarding timeliness in processing drug TARs. (2)

CMS is aware of Health Care Services "next business day" practice for adjudicating drug TARs and the policy to ensure that emergency drug supplies are available to Medi-Cal beneficiaries. DHCS does not plan to seek modification of existing state law regarding the 24-hour timeframe at this time.

Recommendation: To ensure that Medi-Cal recipients are receiving timely medical services from providers, Health Care Services should separately track prior-authorization medical TARs and should ensure that such TARs are processed within an average of five working days.

Response: Health Care Services agrees with this recommendation.

Health Care Services currently receives TARs either via mail or fax (paper TARs) or electronically (eTARs). For paper TARs, Health Care Services currently has a process to identify prior authorization medical TARs for hospital days. Health Care Services strives to process these TARs within an average of five working days. Health Care Services will expand this process to include prior authorization paper TARs for other medical services as well, and strive to process these TARs within an average of five working days.

Service Utilization Review Guidance and Evaluation (SURGE), the system for adjudicating eTARs, cannot currently identify prior authorization TARs. It would need to be modified to enable it to perform this function. Health Care Services will need to determine whether it would be more effective and cost-efficient to update SURGE or to build this capacity into the new system to be developed by the new CAMMIS contractor. (3)

Blank page inserted for reproduction purposes only.

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE DEPARTMENT OF HEALTH CARE SERVICES

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

We do not disagree with Health Care Services' perspective that the treatment authorization request (TAR) process serves as a deterrent to those who attempt to receive authorization for services that are not medically necessary or that are fraudulent. However, as we state on page 17 of the report, we believe that by implementing auto-adjudication or removing the requirement for a TAR for those medical services with low denial rates, low service costs, or high TAR administrative costs, Health Care Services could reallocate some of its resources to review high-risk TARs and improve its processing times. Devoting more resources to high-risk TARs would also provide more of the deterrent factor Health Care Services expressed concern about. (1)

We are aware of no legal authority that authorizes a state agency to deviate from the unambiguous, plain language of federal and state law and, in the absence of an interpretative regulation, "operationalize" the law for any purpose, including staffing and budgetary constraints. Further, although Health Care Services has asserted that the Centers for Medicare and Medicaid Services (CMS) has an awareness of Health Care Services' "next business day" practice, the department could provide no evidence that CMS actually approves of the practice. While we sought CMS' opinion about whether Health Care Services' interpretation of "24 hours" as meaning the "next business day" was appropriate, we received no official response. Accordingly, we concluded that, in the absence of any formal interpretation or guidance by the federal government, the plain language of the federal law and conforming state law controlled. We therefore stand by our recommendation that Health Care Services should abolish its policy of responding to drug TARs by the end of the next business day and comply with the legal mandate requiring it to process prior-authorization drug TARs within the specified 24-hour period. As we recommended on page 34 of the report, it may be more practical for Health Care Services to seek formal authorization from CMS to deviate from the 24-hour requirement, which could result in a change to the federal statute or implementing regulation or a formal waiver from CMS, whereupon it would be appropriate to make conforming changes to state law. (2)

③ Health Care Services' response is misleading. As we describe on page 30 of our report, the Service Utilization Review, Guidance, and Evaluation (SURGE) system currently identifies hospital TARs with no service date, or a service date that is subsequent to the TAR receipt date, as a prior authorization, and flags these TARs as urgent. Therefore, SURGE is capable of identifying prior authorization TARs. However, the system has not been programmed to automatically identify prior-authorization TARs for other medical services as urgent.

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