California State Auditor

BUREAU OF STATE AUDITS

Department of Health Services:

The Department Does Not Use Its Automated Payment System To Detect Certain Ineligible Outpatient Claims

December 1997
97023

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December 16, 1997 97023

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 part of the annual financial and compliance audit of the State of California, the Bureau of State Audits presents its audit report concerning the State's controls over outpatient claims submitted by hospitals participating in the Selective Provider Contracting Program. This report concludes that the Department of Health Services (department) has not activated edits in its automated payment system to detect and prevent payments of certain ineligible outpatient claims. As a result, the department overpaid hospitals by approximately $1.6 million annually. In addition, we found several problems with the department's proposed plan for implementing edits. Unless the department addresses these problems, it will continue to make incorrect payments to hospitals.

Respectfully submitted,

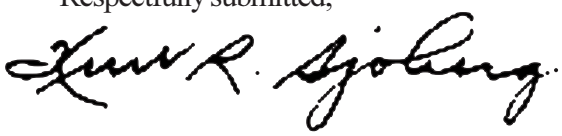

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Table of Contents

Summary

Audit Highlights . . .

The State's Selective Provider Contracting Program allows the State and federal government to pay for hospital care at negotiated rates. We found that:

- ☑ ***The department overpays hospitals $1.6 million each year because it lacks certain edits in its automated system;***
- ☑ ***Although the department plans to implement edits, its proposal contains several problems, such as inaccurate databases, faulty edit definitions, and inefficient procedures; and***
- ☑ ***The program's inadequacies result from historical lack of attention to certain contract provisions, poor coordination and planning, and lack of capacity in the automated payment system.***

Results in Brief

The Department of Health Services (department) is the state agency with overall responsibility for the $17 billion California Medical Assistance Program (Medi-Cal), which provides medical care to any person who meets the eligibility criteria established by law. The Selective Provider Contracting Program (contracting program) is a Medi-Cal subsidiary program established in 1982, which allows the State to contract with approximately 260 hospitals to provide inpatient care at a negotiated rate. The negotiated rate covers designated services during the inpatient stay and precludes separate billing on outpatient claims for those services. For fiscal year 1996-97, Medi-Cal paid approximately $2.6 billion for inpatient services, most of which was paid through the contracting program. In addition, Medi-Cal paid approximately $1.2 billion for outpatient services, some of which relates to the contracting program. Most of these claims were processed through the department's complex automated payment system.

This report focuses on the effectiveness of controls over payment of hospital claims for the contracting program. We performed our review in conjunction with the United States Department of Health and Human Services, Office of Inspector General, which proposed the collaboration because it considered the contracting program to be at high risk for errors or abuse.

Our review disclosed that the contracting program has existed for 15 years without careful attention by the department and the commission to the intent of certain contract provisions or the possibility of designing and implementing edits to enforce those provisions. As a result, the department pays ineligible claims because its automated payment system cannot identify them. The department also does not perform complete post-payment audits that include recovery of ineligible payments. Currently, if a hospital submitted a claim for an inpatient at the contracted rate and a separate outpatient claim for a service covered in the inpatient rate, it could receive payment for both.

Further, until recently, the department had not designated a program coordinator to plan and organize activities among its various units responsible for developing and implementing edits

related to hospital contracts. In addition, the department has indicated that until 1995, it did not have the capability to implement edits for the contracting program.

As a result of these deficiencies, we estimate that the department overpaid providers by approximately $1.6 million during fiscal year 1996-97. However, without controls such as edits in the automated payment system and audits of paid claims, the potential for ineligible payments is much greater. Specifically, we identified the following conditions:

- The automated database that identifies procedures covered in the contracted inpatient rate contains numerous errors. The database did not fully agree with the provisions of any of the ten contracts we reviewed.

- The department's proposed method to address related diagnoses is inadequate.

- The department has not proposed an efficient method for addressing outpatient claims covered during the pre-admission period. Its proposal involves manual adjudication of claims, a labor-intensive process.

- The department proposed to develop and implement edits before it analyzed certain relevant issues.

Until it addresses these and any other problems discovered during a thorough testing process, the department will continue to make ineligible payments and use staff resources inefficiently even after it activates edits for the contracting program.

Recommendations

To ensure that the contracting program is administered systematically, the department's program coordinator should exercise appropriate oversight of the program and the department should do the following:

- Examine the contracts the California Medical Assistance Commission has negotiated with hospitals to identify all provisions that affect the eligibility of outpatient claims for payment. This examination should be a joint effort of the commission and all department units involved in administering the contracting program. Further, the same

units should give similar attention to proposed changes in new contracts within the formal review period to assess the impact of the changes on program administration.

- Address specific concerns pertaining to the implementation of the edits. In particular, the department should develop an accurate database for use in identifying procedures covered under each hospital's contractual inpatient rate. The department should also develop a more thorough edit for identifying related diagnoses. Further, the department should design an efficient system for addressing the 24-hour pre-admission period provisions of contracts.

- Analyze the impact of all relevant issues pertaining to the edits during their development and, if necessary, refine the edits to address these special situations.

- Thoroughly test the edits and compare test results to contract provisions. The department should address any additional problems identified during this test phase.

- Establish interim procedures to be used prior to complete implementation of the edits, such as post-payment audits, that specifically assess hospitals' compliance with the provisions of the contracting program.

The department should activate the contracting program edits in the automated payment system only after completing these steps.

Agency Comments

The department agrees with the overall recommendation to implement contracting program edits in the automated payment system. The department will explore the specific recommendations mentioned above and, where appropriate, make adjustments or corrections to current procedures and programs. In addition, the department stated that it identified other potential cost-saving program modifications that it may not have identified without this audit.

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Introduction

The mission of the Department of Health Services (department) is to protect and improve the health of all California residents. To accomplish this mission, the department administers a variety of programs to promote a high-quality health care system for all residents. The department is the state agency responsible for the overall administration of the $17 billion California Medical Assistance Program (Medi-Cal), which provides medical care to any person who meets the eligibility criteria established by law. Medi-Cal typically receives one-half of its funding through federal Social Security Act Title XIX appropriations from the United States Department of Health and Human Services, with the balance supplied by the State's General Fund and other state funds. The range of services provided under Medi-Cal includes hospital inpatient and outpatient services; nursing home care; laboratory and X-ray services; home health care; and early and periodic screening, diagnosis, and treatment services for beneficiaries through age 21.

Background

With many different subsidiary programs and sources of funding, Medi-Cal is one of the most complex programs in the State. Faced with increasing taxes or cutting programs to balance the fiscal year 1982-83 budget, the State proposed a Medi-Cal cost containment and reform package that included the formation of the Selective Provider Contracting Program (contracting program). The proposal received approval from the United States Department of Health and Human Services in September 1982.

The contracting program allows the State to contract with approximately 260 hospitals that provide inpatient care to Medi-Cal beneficiaries at a negotiated rate, which is typically calculated on a per diem or per discharge basis. The negotiated rate covers designated services during the inpatient stay, allowing the hospitals to bill the Medi-Cal program at an agreed-upon rate and prohibiting the separate billing on an outpatient claim form of certain services also covered by the rate. Hospitals compete for the opportunity to serve the

Medi-Cal population within defined geographic areas of the State. The State contracts with those hospitals that can provide the necessary services at the most cost-effective rate. For fiscal year 1996-97, the State and the federal government paid approximately $2.6 billion in inpatient costs, most of which was paid through the contracting program. The State and the federal government also paid approximately $1.2 billion in outpatient costs, some of which relates to the contracting program.

Administration of the Selective Provider Contracting Program

The California Medical Assistance Commission (commission) works with the department in administering the contracting program. The governor, the speaker of the Assembly, and the president pro tempore of the Senate appoint the commission's seven members. In addition, the directors of the Department of Finance and the Department of Health Services, or their designated representatives, serve as ex-officio members. The commission is responsible for new contract negotiations and renegotiation of existing contracts with each hospital.

Once negotiations are complete, the department is responsible for implementing and monitoring all hospital contracts. Separate sections and units within the department are delegated different administrative duties. The Hospital Contracts and Technical Systems Unit (HCTSU) works directly with the commission on contract wording and amendments. Once the commission approves a contract, the HCTSU notifies the Provider Enrollment Unit of any changes to services covered in the contractual inpatient rate. The Provider Enrollment Unit inputs this information into a database that lists the specific procedures included in each hospital's inpatient rate. This list of contracted procedures is designed to identify claim payments according to the terms of the contract. The department's fiscal intermediary, Electronic Data Systems Corporation (EDS), operates the automated payment system according to the policies set by the Medi-Cal Policy Division. Finally, the Performance and Change Management Section develops edit parameters and instructs EDS to program the edits in the automated payment system. Edits are tests used in the automated payment system to ensure that the claims are eligible for payment and the policies are appropriately implemented.

Contractual Inpatient Rates

The contracts the State has negotiated for inpatient services establish flat payment rates to the hospitals that cover all hospital services incurred during the inpatient stay. An example is a hospital that has a contracted rate covering the inpatient room, pre-screening tests, blood panels, and X-rays. If the contracting program did not exist and the hospital provided all four of these services during an inpatient stay, the hospital would have to submit a separate outpatient claim for these services. Instead, the hospital simply submits an inpatient claim which effectively covers all of the services. The State, in turn, only needs to process the single claim and pay the hospital a flat amount.

The inpatient rate is also designed to limit reimbursement for inpatient-related services and prevents the hospitals from submitting additional claims. For example, if blood tests are covered under a hospital's contract, the State pays the same inpatient rate whether the hospital performs two or four blood tests. On the other hand, if a hospital provides a service not covered in the contracted inpatient rate, then it may submit a separate claim for that service.

Scope and Methodology

This audit of the contracting program is part of our fiscal year 1996-97 statewide financial and compliance audit under the Single Audit Act. It addresses the quality of the controls over this program and the extent to which the State authorizes ineligible payments for the Medi-Cal program, the largest federal program in which the State participates. We conducted this audit in conjunction with the United States Department of Health and Human Services, Office of Inspector General (OIG). The OIG proposed the collaboration as a means of jointly investigating areas of Medi-Cal that it identified as potentially at high risk for errors or abuse.

To understand the nature and requirements of the contracting program and the related systems of internal controls, we reviewed the governing laws, rules, and regulations. Further, we examined selected contracts with hospitals participating in the contracting program and inspected certain aspects of the manual and automated systems that process claims. Finally, we interviewed selected administrators and staff to determine their responsibilities for the implementation of the contracting program and their manner of meeting those responsibilities.

To assess the extent to which the department implemented appropriate internal controls to meet the objectives of the contracting program, the OIG identified pairs of inpatient and outpatient claims that potentially involved ineligible payments. The OIG identified the pairs of claims by using an audit software package to scan data from the California Medi-Cal Management Information System file of claims paid between July 1, 1996 and September 30, 1996. We reviewed a statistical sample of 100 of these pairs of claims and related documents to determine whether the department authorized ineligible payments. We also discussed with department staff each of the ineligible or questioned payments we identified to determine if a legitimate reason existed for the payments. To statistically project the results of the audit, we consulted with an expert in statistics.

To identify other instances in which the State may be authorizing ineligible payments for the contracting program, we reviewed pairings of inpatient and outpatient claims and identified situations in which two hospitals billed the State separately for multiple services provided to the same beneficiary. We interviewed department staff to assess whether they monitor these situations and determine if hospitals unnecessarily submit separate claims for services that are intended to be covered under the inpatient rate.

Analysis

The Department Is Not Using Its Automated Payment System To Detect Certain Ineligible Outpatient Claims

Summary

The Department of Health Services (department) has not activated edits in its automated payment system to detect and prevent payments of ineligible outpatient claims to hospitals contracting under the Selective Provider Contracting Program (contracting program). Although its system provides basic claims review, it lacks the detail and sophistication to detect outpatient claims for services already covered under the contracting program. As a result, we estimate the department overpaid providers by approximately $1.6 million during fiscal year 1996-97.

In addition, the department's automated payment system contains a faulty database. The department has also proposed a flawed edit for identifying related diagnoses, a characteristic of certain covered procedures. Without an accurate database or edit, the department will continue to make ineligible payments for some outpatient claims. Further, the department has proposed an inefficient method for addressing outpatient claims covered during the pre-admission period. Its proposal involves manual adjudication of certain claims, which will cause additional work in reviewing the propriety of claims. Finally, the department instructed Electronic Data Systems Corporation (EDS) to develop edits without researching certain issues that might affect their reliability. Unless these problems are corrected, the department will continue to overpay hospitals approximately $1.6 million annually.

These problems arose from the department's historical lack of attention to contract provisions and, until recently, lack of a coordinator for developing and implementing the edits. Further, the department has indicated it did not have the capability to implement edits that compare inpatient and outpatient claims until November 1995. All of these circumstances lead us to conclude that the department has not administered this program effectively.

The Automated Payment System

A key component in the State's administration of the California Medical Assistance Program (Medi-Cal) is the proper utilization of an automated payment system for paying the majority of claims for medical and other health-related services allowed under the program. Since the system is required to determine the propriety of millions of claims, it must have the capability to perform certain review functions. The system must have an accurate set of databases and files containing background and history of the beneficiaries, hospitals, and procedures. In addition, the claim documents must contain enough information for the system to evaluate their appropriateness. Finally, the system must have edits that compare the information from the claims to the information in the databases.

The department has developed an automated payment system for reviewing and paying Medi-Cal claims. Because of the administrative complexity of the Medi-Cal program, the automated payment system contains many databases and nearly 1,000 edits to determine whether the claims represent legitimate charges to the Medi-Cal program. For example, the department requires each claim to contain the beneficiary's Medi-Cal identification number and to specify the service rendered. The system runs an edit against one of its databases, the fiscal intermediary access to Medi-Cal eligibility file, to compare the claim information to that beneficiary's eligibility data. In addition, the system runs another edit against the adjudicated claims history file to ensure that the claim is for a reasonable service. For example, if the file indicates that a beneficiary had an appendectomy previously, the system will not pay a subsequent claim for the same surgery. Likewise, the system will check a different database, the procedure master file, to ensure that a provider is not paid for a pregnancy-related procedure on a male beneficiary.

The automated payment system contains many edits to evaluate the appropriateness of Medi-Cal claims.

The Health Care Financing Administration (HCFA), which administers the Medical Assistance Program at the federal level, has reviewed and rated the automated payment system every three years. In its most recent review, completed in November 1994, the HCFA reported no deficiencies that would affect federal operational funding for the automated payment system. In 1996, the HCFA reviewed the contracting program as part of the waiver renewal process. This review focused primarily on the quality of the program's services delivery and on the State's monitoring activities. However, although the 1994 review addressed claims submitted by institutional providers, neither review specifically addressed the processing of claims submitted under the contracting program.

Special Databases and Edits for the Selective Provider Contracting Program

The contracting program requires special databases and edits that distinguish which procedures billed on an outpatient claim are included in the inpatient rate and ineligible for separate payment. As seen in the figure on the following page, a covered procedure not eligible for separate payment has the following characteristics:

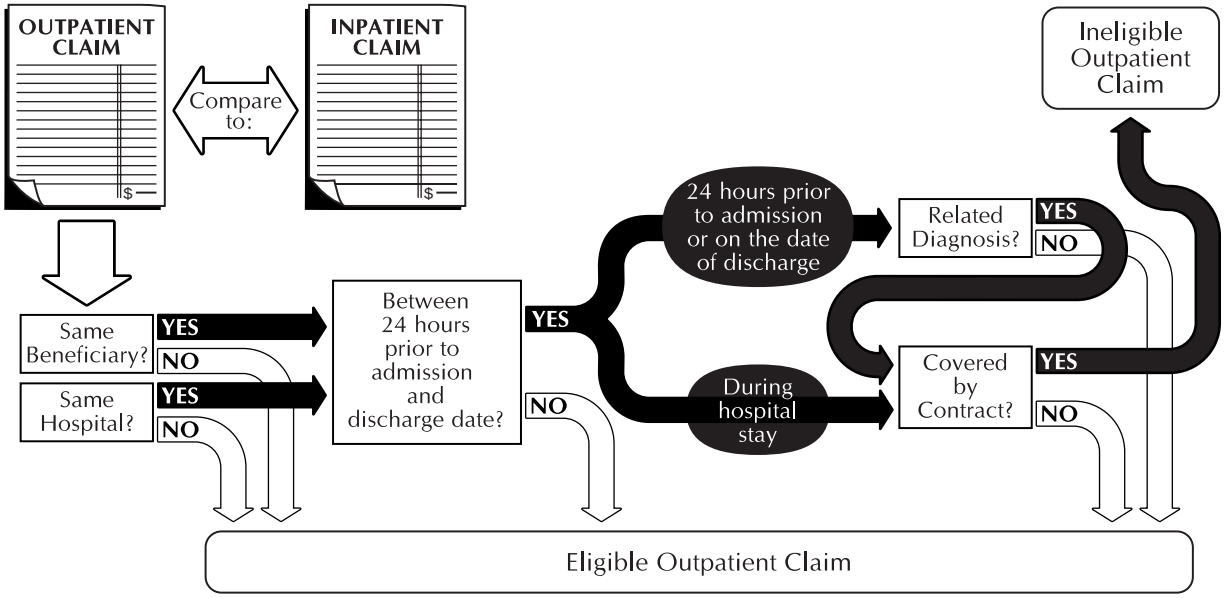
Contracts define which services are covered in inpatient rates and should not be separately paid through outpatient claims.

- Beneficiary characteristic: It is for the same beneficiary as the inpatient claim.
- Hospital characteristic: The claim for the procedure is submitted by the same hospital as the inpatient claim.
- Timing characteristic: It is performed during one of the following periods:
  - within 24 hours of inpatient admission (pre-admission period) or on the same day as the discharge date, or
  - between the inpatient admission date and the inpatient discharge date (inpatient stay).
- Diagnosis characteristic: For a procedure performed during the pre-admission period or on the same day as the discharge date, the outpatient claim diagnosis is related to the inpatient claim diagnosis.
- Contract characteristic: It is identified in the contract as a procedure covered in the inpatient rate.

The source of these characteristics is the standard hospital inpatient contract. Although contracts with hospitals vary in the types of procedures included in the inpatient rate, they are consistent in these general characteristics that identify unallowable costs.

Figure

Identification of Ineligible Claims



An effective claims payment system would identify for nonpayment any separate claims that had all of the relevant characteristics of a covered procedure. As an example, suppose that an inpatient hospital performs an X-ray during an emergency room outpatient visit and determines that the beneficiary has a broken leg requiring surgery. The same hospital immediately admits this same beneficiary and performs the surgery later that day. Although the X-ray is considered an outpatient procedure, the hospital may not submit a separate outpatient claim because the payment for that procedure is already covered under the contractual inpatient rate. Instead, the hospital is reimbursed for that beneficiary by submitting an inpatient claim for the inpatient rate. Because all applicable characteristics are present, the payment system should reject an outpatient claim for the X-ray. Accurate databases, complete claim information consistent with the requirements of hospital contracts, and appropriate edits would allow the payment system to correctly assess the appropriateness of the outpatient claim.

The Department Authorizes Ineligible Payments

The department overpaid hospitals an estimated $1.6 million in fiscal year 1996-97 for ineligible and questionable payments.

The department has not implemented the edits in the automated payment system necessary to appropriately administer the contracting program. To determine the financial impact of the lack of edits, we reviewed a statistical sample of selected combinations of inpatient and outpatient claims paid between July 1, 1996, and September 30, 1996, and identified ineligible and questionable payments. We estimate that the department overpaid providers approximately $393,000 during this time period and $1.6 million for the entire fiscal year.

For the 100 pairs of inpatient and outpatient claims in our sample, we identified ineligible services totaling $1,091 on 32 outpatient claims. These 32 claims clearly met the characteristics identified in the hospital's contract for inclusion in the inpatient rate. Therefore, the services should not have been paid separately on outpatient claims. For example, we identified one instance in which the department reimbursed a hospital for an outpatient claim for administering an intravenous solution to a pregnant beneficiary. On the same day, the beneficiary was admitted to the same hospital as an inpatient to deliver her baby. The hospital's contract included the administration of intravenous solutions in the inpatient rate. In another instance, we identified an outpatient claim for blood tests pertaining to a beneficiary diagnosed with a cerebral hemorrhage. The next day, that same hospital admitted the beneficiary as an inpatient with the same diagnosis. In both instances, the applicable characteristics for inclusion in the impatient rate were present; therefore, the department should not have paid for these procedures on the outpatient claims.

We question the propriety of an additional eight outpatient claims for services incurred within one calendar day prior to admission. At the time it authorized payment for these claims, the department did not have sufficient information to determine their eligibility because it was unclear whether the inpatient and outpatient diagnoses were related. For example, we identified a pair of inpatient and outpatient claims for which the beneficiary was the same, the hospital was identical, and the procedure on the outpatient claim was performed during the pre-admission period and was covered in the inpatient rate. The inpatient diagnosis was for a cesarean delivery and the outpatient diagnosis was for surgical complications. The department informed us that it was unable to determine the relationship of the diagnoses without getting additional information from the hospitals, which it did not plan to do. Without sufficient information on the relationship of the

diagnoses, the department should not have paid these claims. The total amount of questionable payments on these eight claims is $1,256.

We projected the amount of the ineligible and questioned payments to be approximately $393,000 for all of the paired inpatient and outpatient claims from the same hospitals that the Office of Inspector General (OIG) identified for the three-month period. We believe the activity in the three-month period we reviewed is representative of activity for the entire fiscal year, which means the impact for fiscal year 1996-97 was approximately $1.6 million. The margin of error, which represents the precision of the annual projection, is approximately $229,000. Therefore, annual ineligible payments are between $1.4 million and $1.8 million.

Although the projected annual amount of ineligible payments is not a significant portion of the Medi-Cal program, annual overpayments of $1.6 million are still substantial enough to warrant corrective action. We believe that our estimate is low because the OIG only identified inpatient and outpatient claims that were paid within the same three-month period. It did not identify inpatient claims paid outside that period that matched outpatient claims from the three-month period. Further, without edits and post-payment audits, the potential for erroneous payments is much greater.

The Department Has Not Implemented Edits To Identify Duplicate Payments of Inpatient and Outpatient Claims

The general edits in the Medi-Cal program do not address the specific requirements of the contracting program.

These annual overpayments result from the lack of edits in the automated payment system. Although the system employs edits to determine whether claims represent legitimate charges to the Medi-Cal program in general, it does not use edits that specifically address contracting program requirements. For instance, the system will check to see whether the amount claimed for a procedure is allowable under the State's standard reimbursement rates. However, the system does not compare the diagnosis pertaining to a procedure billed on an outpatient claim with the diagnosis pertaining to the inpatient stay. Thus, the system cannot determine whether these diagnoses are related and cannot assess whether the outpatient claim is eligible for payment. As another example, the automated payment system includes a database of contracted procedures, yet this database is not used to compare procedures on the outpatient claim with those in the hospital's contract.

Without edits, the State is relying on the honesty of hospital administrators to honor the terms of their contracts.

Currently, a hospital participating in the contracting program can submit claims for the inpatient rate, submit separate outpatient claims for services contractually covered in the inpatient rate, and receive payment for both. In addition, no post-payment audit exists to identify and recover ineligible payments. Electronic Data Systems Corporation (EDS), which operates the automated payment system, conducts limited post-payment audits of claims covered in the contracting program that have identified apparent ineligible payments. Nevertheless, the department has opted not to recover these payments until it resolves certain policy issues discussed later in this report. The department could not identify any other post-payment audits of the contracting program. Without edits and post-payment audits, the department relies on the integrity of the hospital administrators in honoring the terms of their contracts. As a result, both the State and the federal government will continue to be overcharged for their shares of Medi-Cal program costs.

We contacted the regional HCFA office to obtain its opinion on this issue. According to the associate regional administrator of the Division of Medicaid, the federal government also views the absence of edits as a significant concern. The HCFA plans to follow up with the State to make sure appropriate protections are put in place to allow the automated payment system to recognize acceptable outpatient claims under the current waiver provisions of the contracting program and reject further inappropriate claims.

Recognizing the need to eliminate these overpayments, in July 1995 the department prepared the first in a series of operating instruction letters to EDS that addressed the installation of edits to identify certain ineligible or questionable claims. However, the department has operated these edits on a test basis only, and as of October 1997, no edits had been activated.

The department also receives outpatient claims for the same beneficiary from hospitals other than the admitting hospital. An example is a hospital that admits a beneficiary and later determines that a special test is necessary. If that hospital does not have the required equipment for this test, it can designate another hospital that does have the necessary equipment to perform the test. The second hospital may bill the State directly by submitting a separate outpatient claim for the test. We refer to this situation as shared services. This arrangement seems reasonable if that special test is not included in the contracted inpatient rate of the first hospital. However, a hospital that has agreed to include certain services in its contractual inpatient rate should maintain the financial responsibility for these

services. If the second hospital performs a service that is covered under the first hospital's inpatient rate, it should seek reimbursement directly from the first hospital, rather than the State. Otherwise, the State is paying for the same service twice.

According to the acting chief of the Performance and Change Management Branch, the automated payment system currently cannot identify shared services when it processes claims. The department acknowledged the potential for abuse, especially in situations where multiple hospitals agree to split specific procedures from the inpatient stay and bill the State separately. If the department's automated payment system could detect shared services, it could follow up on their appropriateness, especially at those pairs of hospitals that have many such occurrences.

The Department's Proposed Edits Will Not Prevent All Ineligible Payments

In October 1997, the department submitted another instruction letter to EDS, defining the edit parameters and directing EDS to develop the necessary programming. However, we found several problems with the department's proposed system of edits to identify ineligible outpatient claims. Until the department addresses these problems, discussed in the following sections, it will continue to pay ineligible claims even when the edits are activated.

The Database Designed To Monitor Covered Procedures Is Faulty

One problem we noted is that the only database in the department's automated payment system to monitor procedures covered in the contracted inpatient rate is deficient. This database, known as the list of contracted procedures (LCP), contains procedure codes that identify the services covered under each hospital's contract. However, we noted that the existing LCP contains inaccurate information.

The automated payment system's list of procedures covered in the inpatient rate does not agree with contract provisions.

To assess the reliability of the LCP, we selected ten hospital contracts and compared the procedures covered under each contract to the procedures reported on the LCP for each corresponding hospital. None of the ten contracts completely agreed with the related LCPs. For example, one hospital contract specified physician services for radiation therapy included in the inpatient rate. However, the LCP did not identify these services in the rate. Similarly, another hospital

contract included all but three procedures for special equipment in its inpatient rate, which meant that only the three procedures could be separately billed on an outpatient claim. In contrast, the LCP indicated that no provider services were included in the inpatient rate and that all of these services could be billed separately on an outpatient claim.

The department could not explain many of the differences between the procedures specified in the contract and those in the LCP and no longer retained copies of those documents that it believed might describe the changes in procedure codes for these hospitals. In the absence of such documentation, the department could not demonstrate the accuracy of the LCP information or estimate the impact on the hospitals and the contracting program.

The Proposed Edit To Identify Related Diagnoses Is Faulty

Changes the department has proposed to accurately identify covered procedures do not adequately define related diagnoses. As previously mentioned, a related diagnosis is one of the characteristics of certain services covered under the inpatient rate. Each inpatient and outpatient claim must indicate the diagnosis that resulted in the services for which reimbursement is claimed. In its October 1997 operating instruction letter to EDS, the department defined related diagnoses as those sharing the same first three digits in the diagnosis code and instructed EDS to develop an edit using this definition.

In nearly one-half of the claims reviewed, the diagnoses appeared related yet the diagnosis codes did not match.

However, this definition does not identify all diagnoses that appear to be related. Although the first three digits in the diagnosis code signify the general type of diagnosis, sometimes similar diagnoses have entirely different codes. During our review of the 100 pairs of claims, we found 49 instances in which two diagnoses appeared related, even though the first three digits in the diagnosis codes did not match. In one instance, we identified separate inpatient and outpatient diagnoses for complications resulting from a liver transplant. However, the edit criteria suggested by the department would not have identified these diagnoses as related because the first three digits of the inpatient diagnosis code differed from the first three digits of the outpatient diagnosis code. In another instance, we identified an inpatient diagnosis for renal dialysis and an outpatient diagnosis for chronic renal failure. These diagnoses appear related even though none of the digits in the inpatient diagnosis code agrees with those in the outpatient diagnosis code.

According to the acting chief of the Performance and Change Management Branch, the department is aware of the limitations of using its proposed edit to identify related diagnoses. The acting chief stated that determining whether two diagnoses are related is very subjective. One doctor may consider two diagnoses to be related while another doctor may not. The acting chief also stated that the logic necessary to develop edits to define related diagnoses more precisely does not exist at a level acceptable for payment purposes. Further, according to a physician in the Medi-Cal Policy Division, the only way for the department to accurately conclude that two diagnoses are related is to review the beneficiary's medical records maintained at the hospital. This process would be highly labor intensive. Therefore, the department chose to use its proposed edit as a high-level method of identifying diagnoses that it believed were usually related.

The Department's Proposal for Identifying Ineligible Claims During the Pre-Admission Period Is Inefficient

Because it does not require the outpatient claim to specify the hour in which a service is rendered, the department cannot accurately determine if the service fell outside the 24-hour pre-admission period.

Erroneous payments may also occur because the department does not effectively address contract provisions for the pre-admission period. First, the department does not require outpatient claims to disclose the hour in which a service is rendered. As a result, the department cannot always accurately determine whether the services fall outside the 24-hour period prior to inpatient admission that would allow separate payment. For example, if a beneficiary is admitted to a hospital as an inpatient at 8 p.m. on August 2 but received services as an outpatient on August 1, the department cannot accurately enforce the 24-hour time limitation without knowing the time these services were rendered. If the hospital performed the services at 8 p.m. or later on August 1, it should not submit a separate outpatient claim because those services are included in the contracted inpatient rate. The automated payment system currently allows payment of outpatient claims dated the day before the beneficiary's admission as an inpatient, regardless of the time the service was actually performed. As a result, the department may be paying some ineligible outpatient claims.

In addition, in September 1995, the department sent a letter to EDS acknowledging that the automated payment system does not have the capability to recognize the time of day even if it was included on the outpatient claim form. The department's current instructions to EDS acknowledge that this condition still exists. According to the acting chief of the Performance and Change Management Branch, because the record layout of the outpatient claim cannot accommodate an additional field for

the time of day, the department was unable to address this problem by simply requesting additional information on the outpatient claim forms. Instead, it instructed EDS to develop an edit to deny outpatient claims for services provided the calendar day before the beneficiary's admission as an inpatient. Under the department's proposal, if a hospital provides a service the day before a beneficiary is admitted that falls outside of the 24-hour time period, the hospital must provide written justification for the separate outpatient claim to be reimbursed. This justification would require an additional manual review of the claim by EDS staff. According to the acting chief, the department believes this proposed policy will sufficiently address the timing characteristic in the hospital contract.

The department's proposal to identify pre-admission services is labor intensive.

We agree that, if implemented, this proposal would deny payment for those covered procedures rendered during the 24-hour pre-admission period, while allowing payment of claims outside the 24-hour period. However, we are concerned that the proposal is unnecessarily inefficient because it requires additional hospital and EDS staff time to manually justify and process these claims.

The 24-hour pre-admission policy is required only by the contracts the California Medical Assistance Commission (commission) negotiates with hospitals. It is not a federal or state requirement. Therefore, the department and the commission have some flexibility in establishing a pre-admission policy and can jointly decide on a more efficient process. However, they have not revised and implemented a policy compatible with an edit. For example, as contracts come up for renegotiation, the commission has not amended contract language to describe the pre-admission period in terms of calendar days, rather than a 24-hour period. Similarly, the department has not notified contracting hospitals that it intends to implement the pre-admission rule by excluding payments for services rendered within one calendar day of the beneficiary's admission as an inpatient.

The Department Has Not Analyzed Certain Relevant Issues Pertaining to the Proposed Edits

The department did not thoroughly analyze certain relevant issues prior to instructing EDS to develop the edits. Specifically, the department had not considered these issues until we questioned their impact on the program. As a result, the department did not know how its proposed edits would affect payments to contracting hospitals. Without this knowledge, the department runs the risk of inappropriately paying or denying

payments to hospitals, even after its edits are implemented. The department addressed these issues only after we questioned their impact on the proposed edits.

The department runs the risk of improperly paying or denying payments to hospitals even after its edits are implemented.

For example, the department did not address the impact of specific information on the LCP. The LCP contains a secondary range, known as the modifier code range, which accompanies the procedure code. The modifier provides more detail about the procedure, such as whether it was performed by a primary surgeon. According to the chief of the Program Development and Operations Section, a hospital contract can specify modifier code ranges included in the inpatient rate as well as procedure code ranges. Our review of the ten hospital contracts found no instances where modifier codes were used to determine whether specific procedures were included in the inpatient rate. If a modifier code is not needed to help define the type of service rendered, the hospital will leave the modifier information blank on the claim form.

However, the department did not know whether the automated payment system would allow a claim without modifier information to be paid, even if the procedure code by itself indicates it should not be paid. For example, if the LCP specified that a prosthetic-related procedure is included in a hospital's inpatient rate and that hospital submits an outpatient claim for this procedure but leaves the modifier code field blank on the claim form, the automated payment system may erroneously pay the claim.

The department also did not address the impact of the Los Angeles County waiver in its proposed edits. The State originally granted this waiver to Los Angeles County in 1975 to allow it greater flexibility in submitting claims for Medi-Cal beneficiaries. One component of the waiver allowed the county to bill the State an all-inclusive rate for outpatient services. Instead of submitting an outpatient claim listing individual services, a county hospital could use a general billing code which represented a level of services provided.

In 1983, the Los Angeles County hospitals collectively entered the contracting program. These hospitals agreed to include services billable on outpatient claims in their contracted inpatient rates. Although the county hospitals operate under the provisions of both the waiver and the contracting program, the department staff involved with implementing the contracting program originally could not explain how the two programs related to each other. Further, they were not able to provide us with a copy of the waiver agreement or direct us

to other department staff who might have a copy. Eventually, we obtained our own copy from one of the department's field offices.

After we provided the contracting program coordinator with a copy of the waiver agreement, we asked the coordinator to explain the relationship between the waiver and the contracting program and any impact of the waiver on the proposed edits. The coordinator informed us that the waiver has no relation to the contracting program. Furthermore, the department believed that the waiver was no longer in effect, except for the provision regarding general billing codes, and did not specifically address it in the proposed edits. Instead, it is directing EDS to deny all outpatient claims for beneficiaries that incurred services during an inpatient stay at the same hospital, including hospitals in Los Angeles County. Nevertheless, it was not until we inquired about the waiver that the department determined the effect of the waiver on the contracting program.

Inadequacies Result From Lack of Attention to Certain Contract Terms, Poor Coordination and Planning, and Lack of Capacity in the Automated Payment System

The contracting program has existed for 15 years without the department's attention to enforcing certain contract provisions.

The deficiencies we have discussed above have three primary causes. First, the contracting program has existed for 15 years without careful attention to the intent of the specific contract provisions discussed earlier and the ability of the department and EDS to design and implement edits to enforce those provisions. This condition exists even though the department and the commission have a formal process that allows for comment on proposed new contracts or amendments to existing contracts. After the commission negotiates contract language with a hospital, it submits changes to the department for review. Although the department has 35 days to assess the impact of the contract language on the administration of the program, it does not appear to have effectively used this period in many of its contracts. As a result, the department and the commission are just now clarifying with each other the intent of critical portions of the hospital contracts and the characteristics of procedures included in the inpatient rate.

Had the department thoroughly understood contract provisions, it could have acted on the results of post-payment audits, pending its ability to implement edits. The department also could have ensured that edits it proposed were efficient and consistent with contract language. For example, the 24-hour

pre-admission period language has been part of the contracts negotiated by the commission since the inception of the program. An earlier identification of the edit problems caused by this contract language could have resulted in amendments to contracts to clearly define the pre-admission period in terms compatible with a convenient edit.

A second contributing factor to contracting program deficiencies was the lack of a coordinator to plan and organize activities among the department's various units responsible for developing and implementing the proposed edits related to hospital contracts. This circumstance contributes to the problems with the LCP, the lack of an efficient proposal for addressing the pre-admission period, and the limitations of the proposed edit for related diagnoses. In August 1997, the chief of the Medi-Cal Operations Branch assumed the responsibility for overall coordination of the development and implementation of the proposed edits.

Finally, according to the acting chief of the Performance and Change Management Branch, the department did not have the capability to implement edits that compare inpatient and outpatient claims until November 1995. The computer technology required to operate these edits, which included hardware with faster processing speeds and expanded memory, was not available until the 1990s. Since the computer hardware used for claims processing is owned and operated by the existing contractor, the department believed that the most cost-effective way of obtaining the required resources for these edits was to require the claims processing contractor awarded the next contract to provide these resources. In 1994, the department initiated a competitive bid to select a contractor for the next contract cycle. One of the bid requirements stipulated that the contractor provide the required hardware and software needed to implement the edits. The competitive bid process resulted in the department selecting EDS to continue as the contractor with the provision that it provided the additional capacity.

According to the department, it did not have the capability to implement edits comparing inpatient and outpatient claims until November 1995.

Conclusion

The department's historical lack of attention to, planning, and coordination of the contracting program portion of its automated payment system has resulted in estimated annual overpayments to hospitals of approximately $1.6 million. Although the contracting program has been in existence since 1982, the department has still not implemented edits in the automated payment system to detect and prevent payments of outpatient claims for services already covered by a contracted

inpatient rate, or to detect instances of shared services between hospitals. In the absence of edits, the department must rely on the integrity of hospitals to refrain from submitting ineligible outpatient claims. Moreover, although the department has indicated that it plans to implement the edits, it has not yet addressed key components in the automated payment system, including a reliable database that lists contracted procedures for each hospital, an efficient system for addressing the 24-hour pre-admission period, and a thorough edit for related diagnoses.

Recommendations

To ensure that the contracting program is administered effectively and efficiently, the department's program coordinator should address program goals and coordinate the efforts of all responsible parties to establish edits in the automated payment system. In particular, to improve the planning and coordination of activities, the program coordinator should exercise appropriate oversight of the program and the department should do the following:

- Carefully examine the contracts the commission has negotiated with hospitals to identify all provisions that affect the eligibility of outpatient claims for payment. This examination should be a joint effort of the commission and all department units involved in administering the contracting program. Further, the same units should give similar attention to proposed changes in contracts within the department's 35-day period to assess their impact on program administration.

- Develop an accurate database for use in identifying procedures covered under each hospital's contractual inpatient rate. If the department decides to use the LCP for this purpose, update the existing information in the LCP to correctly reflect these covered procedures.

- Review instances of diagnoses which appear related but differ in the first three digits of the diagnosis code. For those pairs of diagnoses that the department has already identified as related, revise the edit to include these pairs as related diagnoses. Over time, as the department identifies additional categories of related diagnoses, it should add these to the overall edit. We recognize that using this extended definition will not always generate accurate matches of related diagnoses, just as the department's proposed plan will not always be precise. However, we believe that using the extended definition will identify more

instances of related diagnoses than the department's proposed plan and will reduce future occurrences of related diagnoses not being detected. In either case, the department should develop a procedure that allows a hospital to explain on its claim form any special circumstances specific to the claim that would demonstrate that two diagnoses were unrelated despite the diagnosis codes indicating that they were related.

- Design an efficient system for addressing the 24-hour pre-admission period provisions of contracts. Because the department's database cannot accommodate additional information on the time services were rendered for outpatient claims, the department and the commission should jointly decide on a more efficient process. We believe that a much more cost-effective procedure would be for the commission to revise contract language, as contracts come up for renegotiation, to reflect a pre-admission policy that is compatible with the proposed edits, such as one calendar day before the beneficiary's admission as an inpatient. In addition, the department should implement this policy as the contracts are renegotiated.

- Analyze the impact of all relevant issues pertaining to the edits during their development, such as modifier codes and specialized billing codes used with the Los Angeles County waiver, and, if necessary, refine the edits to address these special situations.

- Provide advance notice to administrators of hospitals participating in the contracting program that the department will activate the edits. This notice should also clarify the nature of edits it plans to implement.

- Thoroughly test the edits and compare test results to contract provisions. The department should address any additional problems identified during this test phase.

- Establish interim procedures to be used prior to complete implementation of the edits, such as post-payment audits, that specifically assess hospitals' compliance with the provisions of the contracting program.

The department should activate the contracting program edits in the automated payment system only after completing these steps.

The department should also concentrate efforts on designing edits to detect frequent occurrences of shared services between hospitals and should use this capability to follow up on potential abuse of the contracting program.

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 governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,

KURT R. SJOBERG
State Auditor

Date: December 16, 1997

Staff: Lois Benson, CPA, Audit Principal
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Mr. Kurt R. Sjoberg
State Auditor
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Dear Mr. Sjoberg:

The Department wishes to thank you for all of the time and staff effort which went in to the completion of the audit of our Selective Provider Contracting Program. With an annual budget in excess of $18 billion, the California Medicaid Program, known as Medi-Cal, provides needed medical services to California's most needy population. As you are aware, the per capita expenditure of Medicaid program dollars in California is one of the lowest in the nation. It is because of the numerous program saving techniques which have been formulated in this State that we continue to lead the nation in innovative programs, while continuing to provide necessary medical care. Although the $1.6 million in potential inappropriate payments noted in your report represents only a small portion of dollars expended for outpatient services annually, we appreciate any and all positive feedback which results in saving the taxpayers of this State unnecessary expenditures.

The draft report indicated that the hospital contracting program has existed for 15 years without the Department designing or implementing edits/audits to enforce program policy. It should be noted that during the fiscal year that was the subject of the audit, the Department's claims processing system denied over 6.3 million outpatient claims and over 216,000 inpatient claims with a combined value of approximately $921 million. These denials resulted from the application of over 1400 existing system edits and audits. Over 300 of these edits and audits apply specifically to inpatient and outpatient claims.

We concur with your recommendation that implementation of the audits previously developed by the Department to control inappropriate payments for procedures to outpatient hospital providers will result in additional savings. Your review also identified several areas where it appears improvements can be attained. It is our intention to explore your recommendations and where appropriate, make adjustments/corrections to current procedures and programs. In addition, while assisting your staff with their review, Department staff identified other potential cost saving program modifications that will be explored. These new areas of program control may not have been identified if not for your review.

Once again, I wish to thank you for your assistance and positive suggestions in improving the program. Please feel free to contact me or Mr. Virgil J. Toney, Jr., Chief, Medi-Cal Operations Division, at 657-0582, if you should have any questions or require additional information prior to the release of the final audit report.

Sincerely,

S. Kimberly Belshé
Director

cc: Members of the Legislature
Office of the Lieutenant Governor
Attorney General
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps