Department of Health Services

It Needs to Improve Its Application and Referral Processes When Enrolling Medi-Cal Providers

REPORT NUMBER 2006-110, APRIL 2007

Department of Health Services' response as of April 2008

The Joint Legislative Audit Committee (audit committee) requested that the Bureau of State Audits review the Department of Health Services'[1] (department) provider application and referral processes for California's Medical Assistance Program (Medi-Cal). Specifically, we were asked to compare the department's enrollment and application procedures to those used by the federal Medicare program and to determine whether any information is shared between the two programs during the enrollment process. Additionally, we were asked to determine whether the department tracks and monitors the average time it takes to review a physician application and to identify the number of full-time staff assigned to review these applications. The audit committee asked us to identify the number of applications denied over the past year and the reasons for the denials. Further, we were asked to review the department's procedures for handling deficient applications and to determine when it notifies applicants about deficiencies. The audit committee requested us to identify the number of applications referred for further review in the past year, including the reason for the referral and the number that were denied. Finally, we were asked to identify the number of applicants requesting preferred provider status in the past year, the total number of applicants awaiting enrollment into the Medi-Cal program, and the number of applications the department did not process within the designated review period.

Finding #1: The department did not process some applications within required time periods, and inaccurate data in its data system continue to hinder its ability to track application status.

In July 2000 the department established the Provider Enrollment Branch (branch) whose primary function has been to review applications and to prevent providers with fraudulent intent from participating in the Medi-Cal program. Although required by law to process applications and notify applicants of its final determination within specific time periods, the branch continues to review some after the end of the required processing period and is forced to automatically enroll other applicants into Medi-Cal, on provisional status, because it cannot make a timely determination on the application. In fact, for the period October 1, 2005, through September 30, 2006 (federal fiscal year 2006), the branch did not process 108 applications within the required time periods. Of these, it automatically enrolled eight applicants into the program on provisional status as required but did not automatically enroll or appropriately notify the remaining 100. When the branch does not automatically enroll applicants into the program when required, or promptly process applications and notify applicants of its final determination, it may prevent or delay some eligible providers from delivering services to Medi-Cal beneficiaries.

[1] Effective July 1, 2007, the California Department of Health Services reorganized to form the California Department of Health Care Services.

Audit Highlights . . .

Our review of the Department of Health Services' (department) provider application and referral processes for California's Medical Assistance Program (Medi-Cal) found that:

» *Because of recent policy and administrative changes, the department's Provider Enrollment Branch (branch) has seen a decrease in the number of applications it receives; however, the branch does not process some applications within the time periods specified in statute.*

» *Branch staff continue to enter data incorrectly into the Provider Enrollment Tracking System (PETS), decreasing the branch's ability to track the status of applications effectively.*

» *Some applicants resubmit information to remedy their deficient applications soon after the required time period lapses, and state law requires the branch to deny these applications and treat them as new, preventing some eligible providers from offering services as soon as they otherwise could.*

» *Given that few applicants request preferred provider status and the branch's current low average time to process an application, the status offers applicants few benefits.*

» *The branch does not adequately track which of the department's review units it refers applications to or the reasons for these referrals.*

continued on next page . . .

» *State law does not prescribe a required number of days in which the branch must approve or deny referred applications, and we noted that the department takes an inordinate length of time to process referred applications.*

» *Because physicians applying to become providers in Medi-Cal and Medicare are asked to provide much of the same information, and the federal government is beginning two initiatives to ensure that more accurate and updated information is available about Medicare providers, the department may be able to streamline its application process by relying on some of Medicare's data in the near future.*

Further, the applications of seven of the eight automatically enrolled applicants had been recommended for denial and sent to the branch's policy and administrative section (policy section), which generally reviews all denied applications. However, their applications remained in the policy section after their respective due dates for completing processing had passed. Because the branch does not track the length of time applications recommended for denial remain in its policy section, it automatically enrolled these ineligible providers. Although these applicants can be removed from the Medi-Cal program while on provisional status, they may submit claims for services provided from the date the branch received their application to the date of their termination from the program. The department has the authority to recover payments made to ineligible providers, but it incurs additional costs when it must do so for providers whose applications should have been denied during the enrollment process.

Despite concerns we raised in a May 2002 audit regarding whether branch staff were entering data accurately and consistently into the branch's Provider Enrollment Tracking System (PETS), we noted that branch staff continue to enter data incorrectly, decreasing the branch's ability to effectively track the status of applications. For instance, branch management does not perform secondary reviews of the dates branch staff enter into PETS, such as the dates applications were received, returned to the applicant, or processed by the branch. Inaccuracies in these dates prevent the branch from effectively tracking the status of applications. Further, we noted that PETS contains 166 fictitious provider records, created as the result of staff training and branch testing of PETS that were commingled with production data.

We recommended that the branch notify applicants that it has automatically enrolled them as provisional Medi-Cal providers when it has not processed the applications within the required time periods. The branch should also modify PETS to track the length of time applications it recommends for denial remain in its policy section for review to ensure that it does not automatically enroll or pay the claims of ineligible providers when the review does not occur in a timely manner. Additionally, the branch should include in management's secondary review of applications periodic reviews to ensure that staff are accurately and consistently entering into PETS the correct dates the branch received, processed, or returned the applications. Moreover, the branch should remove all staff training and branch testing data from PETS and include it in an environment that simulates PETS, thus protecting the integrity of the production data.

Department's Action: Corrective action taken.

The branch reports that it has developed a letter and implemented a process to immediately notify applicants who have been automatically enrolled. Further, the branch states that it has updated its procedure manual with formal written procedures regarding the immediate notification of applicants who have been automatically enrolled and reports that it has implemented the procedures. In addition, the branch states that it has modified the PETS and created a policy denial report that is reviewed on a weekly basis and now includes a tracking capability to ensure that

no applications subject to denial are allowed to default. Further, the branch reports it updated its procedure manual in December 2007 to ensure correct dates are entered into the PETS and asserts that managers are reviewing the accuracy of all data entered into the PETS throughout the application process. Finally, the branch states that the training and testing data was removed from PETS in August 2007.

Finding #2: Many applicants do not resubmit corrected applications on time, which is the leading reason for denials.

Although the branch generally notifies applicants in a timely manner that their applications are deficient, applicants often fail to correct deficiencies within the required 35-day time period, or do not resubmit their corrected applications at all. This failure is the leading reason for denied applications. In comparison, the federal Medicare program allows applicants to remedy their deficient applications by submitting additional information within a 60-day time frame—25 days longer than Medi-Cal's time frame. To determine whether applicants who missed the 35-day deadline would have met the 60-day deadline, we calculated the number of applications that were resubmitted to the branch between 11 and 25 days after the 35-day time period during federal fiscal year 2006 (we allotted an additional 10 days for mail delays). According to PETS data, 258 applications were resubmitted within this time frame and, therefore, treated as new applications subject to the 180-day processing period—of which the branch ultimately approved 126. Had state law authorized the branch to process applications that were resubmitted within a 60-day time frame rather than a new 180-day time frame, a greater number of eligible providers could have provided services to beneficiaries sooner than they otherwise did.

Moreover, the branch could do a better job of informing applicants that one of the leading reasons for denial is submitting an outdated or inappropriate application form. More than 20 percent of applicants were denied during federal fiscal year 2006 for this reason. When the branch does not adequately notify applicants that using outdated or inappropriate application forms will result in denial of application packages, it increases the number of applications it must process and ultimately deny and increases the length of time before some eligible providers can be enrolled in the Medi-Cal program. In turn, this may limit some beneficiaries' access to Medi-Cal providers.

We recommended that the department seek legislation to revise state law to extend the 35-day time period applicants have to remedy deficiencies in their applications. Additionally, the branch should increase its efforts to notify applicants that they must use current and appropriate application forms to avoid being denied enrollment into Medi-Cal.

Department's Action: Corrective action taken.

Chapter 693, Statutes of 2007, effective January 1, 2008, was signed by the governor on October 14, 2007, and extends the former 35-day time period applicants had to remedy deficiencies in their applications to 60 days. Additionally, the branch has updated the Medi-Cal Web site to provide notification to applicants that they must use the current and appropriate forms to avoid being denied enrollment into the Medi-Cal program and has updated the *Top Reasons Provider Enrollment Applications are Denied* to include this information.

Finding #3: Preferred provider status offers few benefits to applicants.

State law allows certain applicants to apply for preferred provider status, however, the only benefit to an applicant of qualifying for this status is that the branch must process the application within 90 days instead of 180 days. According to PETS, only 4 percent of the applications the branch received in federal fiscal year 2006 requested preferred provider status and, given that the branch's average time to process an application in September 2006 was just 30 days, the 90-day processing period appears irrelevant. Because the benefits to applicants appear to be marginal, we question the value of the status.

Additionally, the branch denied preferred provider status to more than half of the 60 applications we reviewed because the applicants submitted application packages that were incomplete or did not contain the required documents. Thus, to the extent that the department chooses to keep this status, it appears the branch should increase its efforts to convey to prospective applicants that their application packages will be denied if they are lacking certain elements. Consequently, the branch could see an increase in the number of applicants that could benefit from the shorter processing period that preferred provider status offers.

We recommended that the department seek legislation to revise state law to eliminate preferred provider status. If it chooses to keep this status and to increase the number of applicants that could benefit from the shorter processing period that preferred provider status offers, the department should increase its efforts to notify applicants of the reasons it denies applications during the prescreening for preferred provider status.

Department's Action: Corrective action taken.

The department asserts that while the majority of physicians have elected not to enroll under preferred provider status, the California Medical Association's intent for introducing the status under Senate Bill 857 remains valid. Thus, the department recommends allowing physicians to weigh the cost/benefit of enrolling as preferred providers. To promote awareness of preferred provider status, the branch posted a bulletin to its Web site describing how physicians can request, and provide documentation and verification for, consideration for enrollment in the Medi-Cal program as a preferred provider. Further, Chapter 693, Statutes of 2007, reduces from 90 days to 60 days the time within which the branch must notify applicants of the reasons it denies applications during the prescreening for preferred provider status. The branch reports that the shorter processing period may encourage qualified providers to apply for preferred provider status. Additionally, the branch completed an analysis on denied preferred provider applications and updated its Web site to include the *Top Reasons Preferred Provider Enrollment Applications are Denied* to coincide with the July 1, 2008, effective date of the new preferred provider provisions within state law.

Finding #4: The branch does not track referral information adequately and the department takes an inordinate amount of time to process some applications that the branch refers.

Although the branch is authorized to conduct additional reviews by referring application packages to other units within the department, as well as to staff within the branch itself, it does not adequately track the reason for the referrals. For example, the reasons that branch staff may select in PETS for referring applications are vague and in some cases are problematic. In fact, nearly one-half of the applications that the branch referred in federal fiscal year 2006 lack a specific reason for the referral. This prevents the branch from contributing to the department's Medi-Cal fraud prevention efforts on an ongoing basis, because it is unable to accurately detect and track potential trends in fraud during the enrollment process.

Further, state law does not prescribe a required number of days within which the branch must approve or deny an application it has referred for further review, and we noted that referred applications take an inordinate length of time to process. For instance, in federal fiscal years 2004 and 2005, PETS indicates the average number of days to process applications that the branch referred was 322 and 255 days, respectively. Referred applications that were processed in federal fiscal year 2006, including those referred in prior years, remained in the enrollment process for an average of 318 days. According to PETS, of the applicants among this group that were ultimately approved or denied (rather than being in process or returned to the applicant as deficient or returned for other reasons), the branch approved 69 percent as Medi-Cal providers, in one case taking up to 1,007 days, thus preventing one eligible Medi-Cal provider from providing services to Medi-Cal beneficiaries for nearly three years.

Additionally, the branch and the Medical Review Branch within the department's Audits and Investigations division do little to coordinate with each other to identify and update the branch's high-risk fraud indicators or to formally track the status of referred applications. In fact, in the past six months the branch has not held its regular meeting with the Medical Review Branch, which served to foster information sharing between the two branches in a more formal setting than the occasional communication they may currently have regarding certain applications. To the extent that the branch's high-risk indicators are no longer current and do not align with the reasons for referral available in PETS, its ability to track the legitimate reasons it has for referring applications is hindered, decreasing the branch's capability to detect potential fraud trends during the enrollment process.

We recommended that the branch coordinate with the department to update PETS to reflect the specific reasons that it refers applications for further review, so that they are aligned with its fraud indicators and high-risk review checklist. Further, to ensure it is referring those applicants at greatest risk of committing fraud and not preventing eligible Medi-Cal providers from providing services to beneficiaries, the branch and the Medical Review Branch, with direction from the department, should reevaluate the appropriateness of the branch's high-risk fraud indicators periodically by consistently communicating and collaborating with one another. Finally, with direction from the department, the branch and the Medical Review Branch should place increased emphasis on processing those applications referred for further review within a reasonable time period, to ensure that some eligible Medi-Cal providers are not unreasonably delayed from providing services to beneficiaries.

Department's Action: Corrective action taken.

The branch reports that it is working collaboratively with the Medical Review Branch to evaluate the fraud indicator checklists on a quarterly basis using findings from the ongoing risk assessment analyses and the annual Medi-Cal Payment Error Study. The branch states that it established a workgroup, consisting of branch and Medical Review Branch staff, which has reviewed the current list of high-risk indicators and identified changes that need to be made to PETS. The branch reports that it updated the reasons applications are referred in the PETS to accurately reflect the referral indicators, which it asserts was completed in March 2008. Further, the branch asserts that it implemented new procedures in June 2007 to ensure that applications referred for comprehensive review are processed within 60 days of receipt of the onsite report from the Medical Review Branch. Finally, the branch claims that it will contact the Medical Review Branch within six months after a referral has been made to obtain status of any outstanding issues and perform a quarterly reconciliation of outstanding cases between the branch and the Medical Review Branch.

Finding #5: The department may be able to streamline its application process for physicians by relying more on Medicare data.

Because applicants seeking to become physician providers in Medi-Cal and the federal Medicare program are asked to provide much of the same information in their application packages, the department may have the opportunity to streamline some of its enrollment processes for Medi-Cal applicants who are already Medicare providers by relying more on Medicare provider information in the near future. The federal government is beginning two initiatives intended to ensure that more accurate and updated information is available about Medicare providers. Specifically, effective November 15, 2006, federal regulations require Medicare providers to resubmit and recertify the accuracy of their enrollment information every five years in order to maintain their billing privileges. In addition, effective May 23, 2007, federal regulations require all health care providers who bill for services to disclose their National Provider Identifier (NPI) to any entity, when requested, to identify themselves as such.[2] Thus, the department can request applicants to provide their NPI on its Medi-Cal provider application, which it plans to do beginning late May 2007. Consequently, for those physician applicants it identifies as being

[2] According to the summary text of the Standard Unique Health Identifier for Health Care Providers final rule by the U.S. Department of Health and Human Services as published in the *Federal Register*, the NPI is a unique identifier for health care providers that will improve the Medicare and Medicaid programs in part by enabling the efficient electronic transmission of health care provider data.

in good standing with Medicare, the department may be able to rely on some of Medicare's data instead of performing redundant procedures to verify the same information. Although it is too early to determine the effectiveness of these two initiatives, it could be worthwhile for the department to periodically assess Medicare's progress and the benefits the department could derive from this centralized source of information.

We recommended that the branch monitor the implementation of Medicare's revalidation process in which it verifies the enrollment information for all of its providers to identify opportunities for streamlining its application and verification procedures, and make modifications as appropriate for Medicare providers seeking enrollment in the Medi-Cal program. Further, the branch should continue its plans to reenroll—a process in which the branch requires existing providers to submit new applications to ensure that they are suitable to continue participating in the Medi-Cal program—all of its Medi-Cal providers and add any resources freed by its streamlining of its enrollment process.

Department's Action: Partial corrective action taken.

The branch indicates that it continues to monitor Medicare's implementation of its revalidation process to identify opportunities for streamlining its application and verification procedures as appropriate, with a specific focus on the implementation of Medicare's federal regulations governing its accreditation and competitive bidding process for furnishing durable medical equipment, prosthetics, orthotics, and medical supplies. In fact, the branch asserts that it attended a Medicare conference to discuss the potential for federal and state uniformity in the use of provider applications. Further, the branch states that it continues to focus on completing current reenrollment phases that are near conclusion and claims it will continue to reenroll providers that were enrolled in Medi-Cal prior to 1999 and that do not have disclosure statements on file.