REPORT OF THE
OFFICE OF THE AUDITOR GENERAL

021

THE DEPARTMENT OF HEALTH SERVICES' MONITORING OF THE MEDI-CAL CONTRACT WITH THE COMPUTER SCIENCES CORPORATION

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California Legislature

Joint Legislative Audit Committee

GOVERNMENT CODE SECTION 10500 et al

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January 8, 1981 021

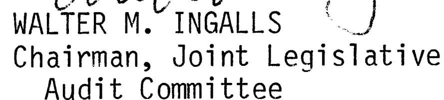
The Honorable Speaker of the Assembly
The Honorable President pro Tempore of the Senate
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members of the Legislature:

Your Joint Legislative Audit Committee respectfully submits the Auditor General's report concerning the sufficiency of the Department of Health Services' monitoring of its contract with the Computer Sciences Corporation.

The auditors are Richard C. Mahan, Audit Manager; William S. Aldrich; Albert M. Tamayo; Sylvia L. Hensley; and Sharon B. Geider.

Respectfully submitted,



WALTER M. INGALLS
Chairman, Joint Legislative
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SUMMARY

Since the Medi-Cal program began in 1966, the State has contracted with a fiscal intermediary to process and pay medical billings for services received by Medi-Cal beneficiaries. In 1978, the Department of Health Services awarded a 5 1/2-year $129 million contract to the Computer Sciences Corporation (CSC). Award of the contract necessitated significant shifts in responsibilities and resources from a project devoted to procuring a contractor to a branch mandated with designing, developing, and implementing a Medicaid Management Information System for processing millions of Medi-Cal claims each month. Since 1978, the department has focused its overall contract management efforts on implementing this system. In addition to carrying out the design, development and implementation of the system, the department is responsible for monitoring the CSC's performance.

Although the CSC began processing Medi-Cal claims over 18 months ago, the Department of Health Services has not adequately monitored the CSC's performance as specifically provided by the contract. The department (1) has not adequately planned and implemented a complete performance monitoring system and (2) has not eliminated restrictions on its monitoring activities. That is, the department has not

sufficiently monitored the accuracy of the claims processing system even though its quality control program supplies some information on the accuracy of claims payment. Neither has the department designed and implemented methods to independently review the performance of the CSC. The department also has not obtained complete access to the CSC's sites, systems documentation, and records. And the department has not defined measurements or methods to calculate performance standards necessary to determine whether the CSC has performed its contracted functions.

Because the department has not developed a complete performance monitoring plan which identifies all methods for reviewing and verifying the CSC's processing system, it has underestimated the number of staff necessary to monitor the CSC's performance. Also, due to limited staff resources, an insufficient number of existing staff has been allocated to conduct certain critical monitoring functions. Finally, the department has not provided adequate training to personnel who perform monitoring functions.

As a result, the department has limited information for adequately assessing the CSC's performance. Without complete information, the department cannot ensure that the CSC has met contract performance standards. Further, inadequate

monitoring of the CSC's performance could affect the department's ability to make decisions concerning subsequent fiscal intermediaries.

Therefore, to ensure that the CSC performs its contracted functions, we recommend that the Department of Health Services adopt the following recommendations:

- Plan and implement a comprehensive monitoring system which includes all monitoring provisions required by the contract and the federal regulations;

- Develop and implement adequate methods to independently verify information from the CSC and to monitor the performance of the CSC;

- Eliminate constraints to its monitoring activity by asserting its authority under the contract to acquire and maintain access to CSC sites, documentation, and records;

- Establish formal definitions of measurements or methods necessary to calculate performance standards and compel the CSC to meet those standards;

- Evaluate staff requirements to adequately implement the comprehensive monitoring plan recommended above;

- Actively recruit personnel with data processing expertise needed to design and implement independent review or consider using independent contractors in areas where the needed technical expertise may not be available within state resources;

- Increase training to acquaint staff with aspects of fixed-price contracts and the CSC's computer processing system.

As design, development, and implementation responsibilities have decreased, the department has initiated actions to improve its monitoring of the contract with the CSC. Beginning in June 1980, the department expanded its training for personnel through beginning development of courses on contract management and computer operations. Effective December 1, 1980, the department reorganized and began development of formal plans to improve contract monitoring.

INTRODUCTION

In response to Chapter 1129, Statutes of 1980 (AB 1414) and a request of the Joint Legislative Audit Committee, we have reviewed the Department of Health Services' performance monitoring of the state's fiscal intermediary contract with the Computer Sciences Corporation (CSC).* Performance monitoring is but one aspect of the department's management of the CSC contract. This study, conducted under the authority vested in the Auditor General by Sections 10527 and 10528 of the Government Code, is the Auditor General's second review of the fiscal intermediary contract with the CSC.

In conjunction with this review, we retained the services of the international consulting firm Coopers and Lybrand to conduct an independent review to measure the CSC's performance against contracted standards for claims processing times and aged inventory. The firm's report is entitled Review of Computer Sciences Corporation's Compliance with Medi-Cal Claims Processing Time Standards (P-021.1).

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* We also obtained information on the Health and Welfare Agency's oversight of the CSC contract; this information is detailed in Appendix A.

Background

In this section we detail the funding of the Medi-Cal program, describe the role of the Department of Health Services in administering the program, and outline the events leading to the contract with the Computer Sciences Corporation.

In March 1966, the Legislature created the California Medical Assistance Program, Medi-Cal. The State and the Federal Government jointly fund this program: in fiscal year 1979-80, the state's share was 57 percent and the federal share was 43 percent. For fiscal year 1979-80, the Medi-Cal program cost approximately $3.7 billion. Budgeted fiscal year 1980-81 program costs total $4.1 billion.

The Department of Health Services has been designated as the single state agency responsible for administering federal Medicare and Medicaid programs. Among its responsibilities, the department procures and manages the contract with the fiscal intermediary, an entity that contracts with the State to perform certain Medicaid functions, such as claims processing and payment.

The department has delegated the management and monitoring of its contract with the CSC to its Fiscal

Intermediary Management Branch (FIMB).* This branch assumes responsibility for the successful implementation, management, and monitoring of the CSC contract. The State relies on its efforts for assurance that the CSC is fulfilling its contractual obligations and that Medi-Cal claims are being properly processed.

Medi-Cal claims payment activities have been performed under contract by a nongovernmental fiscal intermediary since the Medi-Cal program was implemented in 1966. The first fiscal intermediary contract was held by the Medi-Cal Intermediary Operations (MIO) on a no profit/no loss basis; that is, the State reimbursed the MIO for the costs it incurred. With the Legislature's concurrence, the Department of Health Services began in 1976 to seek competitive bids for a new fiscal intermediary system. This system was intended to increase the financial responsibility of the contractor, to establish a more efficient and effective claims processing system, to improve the state's ability to identify program abuse, and to ensure that the State had the option to operate the claims processing system.

Following a process of competitive bidding, the Department of Health Services signed a 5 1/2-year contract worth $129 million with the Computer Sciences Corporation in

* The organizational chart of the FIMB is included in Appendix B. Effective December 1, 1980, the FIMB was elevated to division status and is undergoing reorganization.

August 1978. This contract, which became effective on September 1, 1978, provides that the CSC design, develop, install, and operate the Medi-Cal claims processing system and eventually turn over the system to the department. By December 1, 1979, the CSC had begun processing claims for hospitals, pharmacists, and long-term care facilities.

The contract further stated that the system would begin processing physician claims on March 1, 1980. However, on February 20, 1980, the director of the Department of Health Services delayed implementation of the final provider group until June 1, 1980.

Previous Auditor General Report

Chapter 43, Statutes of 1980 (SB 1356) provided that the Joint Legislative Audit Committee conduct an audit of the CSC and the Medi-Cal contract and report its findings by May 15, 1980. The Office of the Auditor General, with the aid of Deloitte, Haskins, and Sells, reviewed the operations of the CSC and in May 1980 published Report P-005, A Review of Computer Sciences Corporation and the Department of Health Services Medi-Cal Fiscal Intermediary Operations. The report included these findings:

- The CSC and the department did not perform adequate acceptance testing prior to operations;

- The CSC failed to meet specified performance standards for claims processing times and for percentage of claims inventory in the system over 30 days;
- The CSC did not accurately and promptly satisfy reporting requirements;
- The department sometimes failed to assess penalties on the CSC for its noncompliance with reporting requirements.

To improve the efficiency and effectiveness of the claims processing system, the Auditor General recommended that the department increase its contract monitoring and oversight activities. On June 1, 1980 the CSC system began processing the claims of medical providers.

Scope and Methodology

The objective of this audit was to evaluate the adequacy of the Department of Health Services' fiscal intermediary performance monitoring system. This audit does not evaluate other contract management responsibilities. To accomplish our objective, we followed these steps:

- Reviewed the contract and its supporting attachments and bulletins;

- Compared the contract to functional workload documents prepared by the FIMB;*

- Compared the workload documents to the FIMB's performance;

- Interviewed officials and personnel of the Health and Welfare Agency, the department, the FIMB, and the CSC;

- Obtained information from the Department of Social Services of New York State, the State Controller's Office, the Health Care Financing Administration, and agencies receiving information from the CSC;

- Reviewed the activities of the Medi-Cal Fiscal Intermediary Monitoring Committee.

In addition, we retained the consulting services of the firm of Coopers and Lybrand, which reported its assessments of the CSC's compliance with certain claims processing times and claims inventory standards.

* Workload documents include the monitoring responsibilities of individual units and assessments of person years required to perform assigned tasks.

Study Limitations

The Legislature specifically requested that we review the sufficiency, allocation, and management of personnel resources and the qualifications of staff employed by the FIMB. Our review of personnel resources was limited because duty statements, position justifications, and training records contained in the department's personnel files were not current. Therefore, we relied almost totally upon interviews and workload documents developed by the FIMB. Since these workload documents do not represent a complete list of all monitoring requirements and no historical output measurements exist, we were unable to fully determine the sufficiency of personnel resources.

We found the FIMB staff to be conscientious and hard-working. They recognize many of the deficiencies reported in Chapters I and II and have initiated actions in recent months to improve performance monitoring. These actions will be discussed more fully in Chapter III.

CHAPTER I

THE DEPARTMENT OF HEALTH SERVICES HAS INSUFFICIENTLY MONITORED THE CSC CONTRACT

Since the fiscal intermediary contract with the CSC was procured in 1978, the Department of Health Services has focused its overall contract management efforts on designing, developing, and implementing the claims processing system. However, since the CSC began processing claims in June 1979, the department has not monitored the CSC's contract performance on a systematic, comprehensive, or independent basis. The contract specifically provides that the State evaluate the contractor's performance on a continuing basis to assure that the CSC adheres to the contract terms. Although the contract has now been in effect for two years and the CSC began processing claims over 18 months ago, the department has not developed a complete monitoring plan or implemented a formal system for monitoring the contract. In addition, the department has not taken sufficient actions to eliminate constraints which limit its ability to monitor the CSC.

As a result of these monitoring problems, the Department of Health Services cannot ensure that the CSC claims processing system is performing those functions for which the State contracted. Further, unless it improves its monitoring

of the CSC contract, the department will be unable to make appropriate decisions about subsequent fiscal intermediaries.

The Department Has Not Planned and Implemented an Adequate System of Monitoring

Although the Fiscal Intermediary Management Branch has formed organizational units which conduct certain monitoring activities, the branch has not developed and implemented a formal plan for monitoring the contract with the CSC. Consequently, the department's monitoring has been incomplete: it has not sufficiently monitored the accuracy of the claims processing system by considering all contract provisions and by comprehensively reviewing all system components. Rather, the department primarily monitors the timeliness of claims processing.

The department's Medi-Cal Quality Control Branch samples paid claims and produces some information on the accuracy of claims payment. However, the Medi-Cal quality control program does not currently evaluate all medical policy issues by considering prior medical services received by the Medi-Cal beneficiary. Further, the FIMB has used the information produced from the samples on only a limited basis.

Because of these conditions, the department cannot sufficiently verify that the CSC is accurately processing

claims. Furthermore, the department does not independently verify the CSC's information, such as reports, tapes, and computer printouts. As a result, monitoring is almost entirely dependent upon the CSC's unverified data, some of which are untimely and inaccurate.

Since the contract became effective, the FIMB has concentrated most of its staff resources on the conversion from the MIO to the CSC claims processing system. This conversion included phasing out the MIO system and designing, developing, and installing the CSC's claims processing system. Installing each claim type on the CSC's system required that the FIMB staff focus upon resolving conversion problems. The department did not plan to concentrate staff resources on monitoring the contractor's performance until the conversion was completed. And, as stated above, no formal monitoring plan was developed.

Without a formal monitoring plan, the department cannot adequately determine the number of staff required to conduct contract performance monitoring. Since June 1978, the department has increased the number of staff responsible for managing the CSC contract but has not sufficiently identified monitoring responsibilities or assessed resources necessary to carry out those responsibilities. In addition, the department has not properly allocated staff to review system documentation nor has it conducted sufficient training. These issues are more fully discussed in Chapter II.

The Department Has Not Sufficiently Monitored the Accuracy of the Claims Processing System

As discussed in the Introduction, the department delegates management of the Medi-Cal contract to its Fiscal Intermediary Management Branch. However, the FIMB has not comprehensively monitored contract activities as provided by the Medi-Cal contract. Specifically, the FIMB reviews processing times but has not instituted or implemented a sufficient methodology for monitoring the accuracy of payments. Nor has the FIMB effectively used information generated in claims payment accuracy. Although the FIMB receives useful data on the accuracy of paid claims from the Medi-Cal Quality Control Branch, this information does not assess the accuracy of claims payment based upon all major criteria. Moreover, the FIMB only reviews the data and records trends; it does not initiate further actions based upon the data. Without comprehensive monitoring of the Medi-Cal contract, the department cannot ensure that the CSC is accurately processing claims.

Along with the CSC, the FIMB is responsible for ensuring that Medi-Cal payments are promptly and accurately processed. This responsibility is consistent with the contract and also with provisions of the federal Medicaid Management Information System (MMIS). The contract provides that the State "evaluate the contractor's performance on a continuing

basis...." Additionally, the contract articulates the priorities of the Fiscal Intermediary Management Branch in its monitoring activities:

> The Fiscal Intermediary Section directs, monitors, and evaluates the performance of the state-contracted fiscal intermediary to assure that the Contractor is complying with the terms of the contract and to ensure that providers are appropriately paid in a timely manner.

To meet the provisions of the contract, the FIMB has organized its staff to conduct performance monitoring, contract compliance and policy implementation, and provider services. The 14 units within the FIMB use a workload document that lists various monitoring and management functions to be performed by each unit. Unit managers prepared the document in 1979 by listing priorities they believed their unit should perform rather than by comprehensively listing all monitoring provisions required by the contract. Unit managers regularly perform some selected monitoring functions listed in the workload document and conduct other monitoring functions in response to department requests.

Generally, the FIMB monitors the timeliness of claims processing. For example, the branch reviews reports to evaluate claims cycle time performance. Also, it reviews

reports to identify suspension problems causing delays and then samples pre-payment claims to identify and determine causes for suspensions.*

The FIMB, however, does not sufficiently monitor the accuracy of the claims processing system partially because of inadequate planning and lack of resources to assign to identified areas which require contract performance monitoring. For instance, the FIMB does not perform these designated functions intended to ensure accuracy in processing:

- Tracing live claims to evaluate the accuracy of the CSC's claims processing system;
- Reviewing the CSC's technical capability to accurately process claims;
- Periodically testing data processing equipment to determine whether the CSC has the capability of accurately processing claims.

Assuring the accuracy of claims processing is important now that the CSC is processing claims for all provider types. In October 1980, the CSC paid over $270 million and processed over 9 million claim lines to providers. Presently, the claim types with the highest volume are pharmacy, outpatient, and physician.

* A recently added section is beginning to monitor post-payment claims.

Currently, the FIMB relies upon the Medi-Cal Quality Control Branch claims accuracy review program to assess the accuracy of claims adjudicated and approved for payment by the CSC. The program, initiated in May 1978, is required by the Federal Government. Each month, project staff randomly select 200 claims from each of the eight claim types (1,600 claims in total). Staff review these claims to determine if they have been properly paid based upon services provided, beneficiary and provider eligibility, prior authorization for the service, pricing, and computations. The Quality Control Branch produces schedules of data monthly but submits a report to the Federal Government once every six months as required.

Although the Quality Control Branch's accuracy review produces useful data, it does not evaluate claims payment accuracy based upon medical policy and beneficiary history. For example, the review would not identify a female beneficiary for whom providers had billed two hysterectomies or a beneficiary who had received more psychiatric outpatient visits than are allowable under program guidelines. The Chief of the Quality Control Branch has stated that the branch's review is designed to identify such potential inaccuracies, but problems with the CSC's data have thus far prevented them from making such determinations.

Although the Quality Control Branch produces useful data which it submits to the FIMB for review, the FIMB only reviews the reports to record trends by claim type. According to staff of the FIMB, the data is reviewed and trends recorded, but no actions are taken or further review initiated as a result of the data.

In addition to the Medi-Cal Quality Control Branch program, the FIMB's performance monitoring unit added a section in July 1980 to monitor paid claims for accuracy. The unit has produced one report indicating that out of a sample of 97 claim lines, 10 errors in claims processing were found; 5 of these were payment calculations. Although the report sample was not designed for statistical projection, it does indicate that the department needs to develop a more comprehensive methodology and to increase the testing and the monitoring of claims processing accuracy.

To adequately measure the accuracy of claims processing, the FIMB also should periodically trace claims through the system. One methodology for this accuracy check has been developed by the Federal Health Care Financing Administration. Its Medicaid bill processing system test was designed to monitor the effectiveness of claims processing systems in preventing erroneous payments. A sample of claims are periodically fed into the system and then traced to test

the system's accuracy. Although the FIMB has been reviewing the feasibility of applying such a methodology, it had not intended to implement such a program until all claim types were implemented.

These monitoring deficiencies can be partially attributed to a lack of adequate planning and implementation. The contract with the CSC was drafted in 1977 and procured in 1978; the first claim type was installed in June 1979. Throughout that time, the department inadequately planned for its performance monitoring role. Even though the last claim type was installed on the system six months ago, the department still has not developed or implemented a system of monitoring performance based upon comprehensive planning. Rather, the department has concentrated on the design, development, and installation of claim types. FIMB staff have been occupied with acceptance testing and review of installation deliverables.* Also, since inception of the contract, the department has responded to problems identified by providers, the Legislature, or administrators. FIMB staff have indicated that much of their time is spent retrieving data and preparing memoranda in response to various requests.

* Deliverables is a general term used in the contract to describe documentation that must be turned over to the State.

The FIMB has developed a workload document to delegate monitoring responsibility to its staff. However, the FIMB did not produce this document until September 1979, approximately one year after procurement of the contract and three months after claims processing had begun. Further, as already indicated, the document reflects priorities established by individual unit leaders rather than a comprehensive listing of all monitoring requirements of the contract.

Without comprehensive monitoring of the Medi-Cal contract for payment accuracy, the department cannot ensure that the CSC is accurately processing claims. For example, the department may allow overpayments to providers which could be identified and corrected. In our last report, we noted that the CSC could have made potential overpayments to providers. We identified 462 paid pharmacy claims, each totaling between $250 and $5,000--amounts substantially greater than the average price of a pharmacy claim. Of a sample of four claims, we priced three and found each under ten dollars. (The fourth claim was not priced because the itemized drug was not on the drug pricing file.) By totaling the three priced claims, we estimated almost $1,300 in potential overpayments. Although many of the remaining 459 claims may have been accurately paid, monitoring is essential in this area to assure proper payment of claims.

As a further demonstration of the need for more comprehensive review of payment accuracy, the State Controller's Office identified $3.2 million in potential overpayments to providers from February through October 1980. This office typically scans payment amounts for errors by comparing the amounts of paid claims with listed services. By examining claims amounts which appear substantially greater than what is normally expected or average for that service, the office investigates the claims for accuracy. Although we cannot determine the total extent of overpayments made by the CSC, we conclude that the $3.2 million in potential overpayments represents a conservative estimate.

The Department Has Not Independently Verified CSC Information

Although the department uses the CSC's management reports as provided by the contract to monitor processing activity and to detect problem areas, it does not independently verify the data contained in these reports. Presently, the FIMB has not developed an adequate methodology or implemented an ongoing system of testing to independently verify the accuracy of the CSC's data. As a result, there is no assurance that the data being used to assess performance is accurate. Additionally, without verification of this information, the functioning of other agencies that depend upon information from the CSC is impaired.

The contract intended that the State be able to monitor system performance by reviewing certain reports:

> Various management reports are produced... for purposes of monitoring processing activity. Various inventory reports by claim type...shall be produced and utilized to detect and resolve problem areas and/or processing bottlenecks....

As noted earlier in this section, the department reviews the CSC's reports to assess the timeliness of the CSC's claims processing and to identify areas and problems which cause claims to suspend. Additionally, the FIMB reviews reports to determine areas in which claims are suspending and to identify the causes of such suspensions. Although the department compares certain CSC reports to one another to verify the consistency of the data, it does not independently verify the accuracy of the data in those reports.

We contacted the New York State Department of Social Services which is responsible for monitoring Medicaid claims processing in that state. New York State entered into a similar Medicaid fiscal intermediary contract in 1977. Like California, New York receives the contractor's reports which it uses to monitor the contract. New York, however, has also developed its own audit programs, monitoring reports, and computer programs to retrieve information independent of the contractor. Independent verification ensures confidence in the

usefulness of data. Without this review, the department cannot assure that management decisions are based upon accurate information.

To illustrate this need for independent verification of data, we matched information from the review conducted by Coopers and Lybrand with departmental data compiled from the CSC's reports. Coopers and Lybrand submitted data on claims processing times for June through October 1980. We found that for five months, the CSC's data compiled by the department differed from the independently gathered data in 34 out of 35 instances. In three cases, the department could have found the CSC out of compliance with the contract had it conducted independent reviews rather than relying on data produced by the CSC. Without such review, the department has limited assurance that the CSC is accurately processing claims as required by the contract.

Additionally, units within and outside the department rely on data from the CSC. At least three organizational entities within the department--the Surveillance and Utilization Review Branch, the Beneficiary Utilization Review Unit, and the Recovery Section--have been affected by the CSC's inaccurate and untimely information. In addition, the Attorney General's Medi-Cal Fraud Unit has been affected because it too relies on reports produced by the CSC.

The department's Surveillance and Utilization Review Branch detects fraud and abuse in the Medi-Cal program. Under provision of the MMIS, the CSC is required to produce reports for this branch. However, many of the reports which the CSC is required to send to this branch have been inaccurate and many have been untimely. Additionally, the CSC has not produced these reports for all provider types. Because these reports are not produced, timely, or accurate, the branch relies upon information from other sources, such as reports from the previous fiscal intermediary. The branch indicates that, as a result, its ability to detect fraud and abuse is impaired.

Another departmental entity, the Beneficiary Utilization Review Unit, which identifies recipient abuse of Medi-Cal services, should receive claims detail reports from the CSC for all provider types. However, the unit currently receives only those for pharmacy and long-term care. This unit anticipates problems if these reports are not soon available. Finally, the department's Health Recovery Section, which performs collection functions for Medi-Cal, relies on payment profiles from the CSC. Using these profiles, the section determines demand for recoveries from third parties such as insurance companies. Accurate payment histories of institutional and medical providers is critical. Because the section does not receive all necessary reports from the CSC, staff must manually recreate the information which should have been received.

The Attorney General's Medi-Cal Fraud Unit investigates and prosecutes Medi-Cal fraud. An official of this unit cited a case under investigation for which claims detail reports and original claims are needed to document fraud on the part of a provider. Since the CSC is not producing needed reports nor able to promptly retrieve a reproduction of the reports, as required by the contract, the unit lacks evidence for the investigation. As a result, potential recoveries could be lost.

The Department Has Not Eliminated Constraints Which Limit Contract Monitoring

The department has not acted to eliminate certain constraints and to assert state control necessary to ensure effective monitoring of the fiscal intermediary contract. Although negotiation with the CSC may be necessary to make some contract provisions workable, the department has not asserted control over the claims processing system as provided for by the contract. Specifically, the department has not asserted the necessary authority to acquire and maintain access to the CSC's sites, systems documentation, and records.* Nor has the department defined critical measurements or methods to calculate performance standards to compel the CSC to perform according to contract specifications. As a result of the

* Systems documentation includes electronic data processing programs developed by the CSC for Medi-Cal claims processing. This information enables the department to fully review the CSC's data processing system.

department's failure to assert control and to define contract standards, it is unable to fully monitor the CSC's processing of claims for payment.

The Department Needs to Acquire Access to the CSC's Sites, Systems Documentation and Records

Although the Medi-Cal contract gives the department access to the CSC's sites, systems documentation, and records related to the Medi-Cal contract, department staff indicate that the CSC restricts the department's access to its production sites. Additionally, the CSC does not promptly deliver systems documentation and prohibits the State from reviewing certain Medi-Cal records. Because the department does not assert its authority over the CSC, the State cannot ensure that the CSC properly and correctly processes claims for payment.

The terms of the Medi-Cal contract support the State's access to the CSC's system. In fact, the contract awards the State proprietary rights to the CSC's claims processing system:

> The State of California shall have proprietary rights to the entire claims processing system and information and retrieval systems used by the contractor....

The contract also stresses that the CSC is to maintain open and effective communications with state operating management. The contract clarifies this point:

> Open communications are characterized by direct contact between individuals...as needed, with no red tape or authorization needed. Telephone or site visits are used as appropriate....

Although the Medi-Cal contract clearly allows the State access to the CSC's sites and functions, department staff indicate that the CSC limits such access. Specifically, the CSC prohibits department staff from entering its processing or production areas unless the department staff make an appointment with CSC management before the visit and are accompanied by CSC management during the visit. As a result, the department cannot make unannounced visits to monitor the quality of claims processing operations.

Yet federal Medicaid contracts in other states allow on-site government monitoring. Representatives of New York State's Health Department, for example, conduct on-site monitoring of the Medicaid fiscal intermediary to assess the performance of the claims processing system. Department officials indicate that their staff members have unrestricted access to contractor production sites and system documentation. Staff need not make appointments before visiting the site and

may freely review operations without limitations imposed by the contractor. Unannounced visits are not uncommon.

We also found that the CSC does not promptly deliver documentation to the State, although the contract directs it to do so:

> Within two months after the contractor's system is operational statewide, the contractor will deliver to the state a copy of all...systems, programming, and operations documentation.

Under the provisions of the contract, the CSC should have delivered this documentation to the department by the end of July 1980. However, as of November 18, 1980, the CSC had delivered only a portion of the detailed design specifications and data base descriptions; the CSC still has not delivered any operations documentation.

This delay in the delivery of the documentation has limited the department's ability to plan and implement comprehensive testing of the CSC system. The contract identifies a post-implementation review to be conducted by the department and the CSC six months after the full system is operational. However, the department may be unable to conduct this review in a timely manner because of the delay in receiving the documentation.

Additionally, this delay may affect the department's ability to comply with the provisions of the contract. For example, if the department is delayed in designing and implementing a system for ongoing review, it may not properly evaluate the adequacy of the system independently of the CSC's assessment. Furthermore, this may delay the department's review of program documentation prior to federal evaluation of the system; this evaluation is scheduled for March 1981.

The CSC also prohibits department access to records it considers proprietary even though the records relate to the administration of the Medi-Cal claims processing system. Specifically, the CSC will not allow the department to review employee salary schedules, incentive programs, and personnel records which would inform the department of the CSC's staffing conditions. The CSC further prohibits the State from examining cost data which would allow the department to assess the CSC's fiscal management.

Nonetheless, the Medi-Cal contract requires the CSC to provide information to the State as needed:

> The contractor shall make reasonable efforts to respond to the State's general need for information regarding the operation and management of the services provided under the contract.

Even though the contract entitles the department to proprietary rights over the CSC claims processing system, the CSC established the terms and conditions for on-site monitoring. Further, the CSC has prohibited the department from acquiring systems documentation and other pertinent records. Ultimately, the department cannot ensure that the CSC is accurately processing claims for payment consistent with state policy without acquiring and maintaining access to CSC sites, records, and documentation.

In our review of the department's present monitoring system, we identified potential effects which could result from these monitoring restrictions. The processing of suspended claims illustrates this potential effect. To implement state and federal policies, the department requires that claims undergo certain edits and audits--sets of criteria which will cause a claim to suspend if the criteria are not satisfied. Edits and audits are designated by error codes which the CSC may override, subject to the department's authorization. To override an error code, a CSC claims examiner reviews the exceptions listed in the suspense manual which is approved by the State. If one of the exceptions for that code should apply to that claim, the error code may be overridden.

When a claims examiner overrides an edit or audit code, the reason for the override is not recorded. Even though several reports currently produced by the CSC list overrides by

claim and examiner, these reports do not identify the reasons for the override. Therefore, if an examiner improperly overrides a code, the department cannot always detect what exception the claim satisfied by reviewing the CSC's reports.

Unless the department conducts adequate on-site monitoring or modifies the claims processing to include an audit trail, documenting the reasons for overrides, there is no assurance that the CSC's claims examiners are overriding only those error codes for claims which meet state-authorized exceptions. The department cannot monitor this function by reviewing reports now produced by the CSC.

The Department Needs to Clarify and Define Monitoring Standards

The department has also limited its ability to adequately monitor the contract by not clarifying, defining, and applying monitoring standards. The contract does not clearly provide measurements or methods to calculate contract standards which the department requires the CSC to meet, and the department has not supplied formal measurements or calculations for some of these standards. As a result, the department is unable to fully determine when the CSC has failed to comply with contract specifications.

The contract provides sanctions for the department's use in ensuring that the CSC meets the terms of the contract:

> If the contractor is not meeting performance standards, the state will take action in accordance with the procedures identified in Terms and Conditions, Liquidated Damages, Section 4.28.

But in some cases, the department cannot determine whether the CSC's performance levels are substandard because it has not established clear definitions.

The department has formally defined and applies some but not all contract performance standards. The department has defined the performance standards for timeliness of daily, weekly, and monthly reports. Although the department has provided interpretations of standards for claims processing times, it did not formally define them until November 1980. Even now, after two years of processing claims, the department and the CSC still have not agreed how the CSC's actual performance should be calculated.

At the same time, the CSC has provided its interpretation of contract standards. To calculate claims processing times, the CSC includes only original claims that remain entirely under its control and that are not submitted for medical review. The department includes all claims, whether originals or adjustments, but excludes the number of days any claims are outside the control of the CSC. Also, the

department does not begin calculating processing time for claims until they have been returned from the provider.

The difference in interpretation of standards produces different assessments of performance. Our contractor, Coopers and Lybrand, found that for June through October of 1980, the department and the CSC differed on claims processing times for most claim types. Time required for claims processing varied by as much as three days.

Effects of Monitoring Problems

As a result of these problems in monitoring the CSC's claim processing system, the Department of Health Services cannot ensure that the State is receiving what it contracted for in entering into the $129 million contract. Because deficient performance monitoring prohibits the State from reviewing, assessing, and evaluating the accuracy and effectiveness of the entire system, the State has an inadequate basis upon which to formulate decisions concerning the present contract or future contracts. According to department officials, the State will begin in fiscal year 1981-82 to consider fiscal intermediary options for the future--to either procure another contract through competitive bidding or provide for state operation of the Medi-Cal claims processing system.

CHAPTER II

INADEQUATE PLANNING HAS CONTRIBUTED TO INSUFFICIENT MANAGEMENT OF STAFF RESOURCES FOR PERFORMANCE MONITORING

Although the Fiscal Intermediary Management Branch has formed organizational units which conduct certain monitoring activities, the branch has not developed and implemented a formal plan for monitoring the CSC contract. The branch's incomplete development of a sufficient performance monitoring plan which identifies methods for reviewing and verifying the CSC's processing system has contributed to insufficient management of staff resources for monitoring CSC's performance. The branch's staffing levels have increased, yet branch management has not sufficiently analyzed performance monitoring responsibilities and related staffing requirements. Through planning activities which have occurred, the FIMB has identified some performance monitoring responsibilities and has assigned them to units within the branch. However, such planning activities have not sufficiently assessed the number of staff necessary to accomplish even those responsibilities and, as a result, many monitoring functions are not being performed. Insufficient planning has also affected the allocation of staff resources. Specifically, the FIMB may not have properly allocated a sufficient number of qualified staff to review critical records documenting the programming logic of the system.

Insufficient job orientation and training may also have limited the FIMB's effectiveness. Because of the complexity of the contract and the claims processing system, personnel should undergo formal training to understand the contract as well as the branch's responsibilities. However, few FIMB staff have received any formal training from either the branch or the CSC even though federal regulations require it.

Staffing Increases Made Without Sufficient Assessment of Staffing Needs

Since June 1978, the level of staff directly responsible for managing the CSC contract has increased from 39 to 104 authorized positions. (As of October 1, 1980, only 80 positions were filled.) However, the FIMB has augmented its staff without sufficiently identifying contract monitoring responsibilities or determining the resources necessary to carry out those responsibilities. In fact, the original procurement project, which became the FIMB, did not develop workload documents for estimating staffing requirements and allocating staff among units until September 1979. After contract procurement, key individuals who had developed the contract left state service. Now the FIMB is using the same

basic workload documents to support its proposal for additional staff for fiscal year 1981-82.*

As depicted in Table 1, the level of staffing for the FIMB has increased since fiscal year 1978-79.

TABLE 1

FISCAL INTERMEDIARY MANAGEMENT BRANCH
STAFFING LEVELS SINCE 1978-79

Fiscal Year	Number of Positions at Beginning of Year	Full-term Augmentations	Number of Positions at End of Year
1978-79	39	0	39
1979-80	74	0	74
1980-81	74	30[a]	104[b]

[a] The Department of Finance considers seven of these as limited-term positions; thus, the FIMB's authorized full-term total for fiscal year 1980-81 is 97 positions.

[b] This figure represents the authorized total as of October 1980.

Originally, the FIMB was allocated 39 staff positions to procure a fiscal intermediary contract. But in late 1978 and continuing through fiscal year 1979-80, branch officials realized that they had underestimated their staffing requirements. Officials began augmenting staff by shifting additional personnel to the CSC contract and by borrowing employees from a variety of other units in the department. The

* Since current workload documents do not represent a comprehensive list of all monitoring requirements and no historical output measurements existed, we were unable to determine if the 104 positions presently authorized are sufficient for managing the CSC contract.

FIMB used these borrowed employees temporarily and then returned them to their original units.

For fiscal year 1979-80, the branch was authorized 74 positions to be allocated among 14 units--an increase of 35 authorized positions over the previous year. The FIMB then requested seven additional staff members for its fiscal year 1980-81 budget. The Legislature granted this request, bringing the FIMB's total of authorized positions to 81. By October 1980, the branch had gained the remaining 23 positions as a result of staff augmentations included in AB 1414 (Chapter 1129, Statutes of 1980). This brought the FIMB's total authorized positions to 104.*

The FIMB submitted its first workload document in September 1979 as part of its budget change proposal for the fiscal year 1980-81 budget. The Department of Finance requested that the FIMB submit this document to justify its need for increased staffing. We examined the document to see if it listed the state's monitoring responsibilities, most of which are given throughout the Request For Proposal (RFP). Although the workload document makes no detailed reference to

* Appendix C arrays the 104 positions within the FIMB's range of classifications.

the contract, we found that it addressed most of the 36 general monitoring responsibilities we identified in the RFP.*

The FIMB used this same basic workload document to justify other staff increases. Based upon the original documents, the branch was granted its fiscal year 1980-81 request for seven additional staff. And in June 1980, the same document was modified and submitted to support the department's AB 1414 requests. The FIMB has used this document again in its budget change proposal which requested 13 additional staff for fiscal year 1981-82. The Department of Finance denied this request.

Twenty-three of the FIMB authorized positions were only recently funded under AB 1414. The FIMB has been attempting to fill these positions since October 1980. At the time of our review, only 80 of the 104 budgeted positions were occupied. Fifty-seven of these 80 positions were professional-level staff. We interviewed 34 of these 57 personnel. Appendix D lists the classification of these 57 positions and notes the number of staff interviewed in each position.

* We did not verify the adequacy of the workload documents; instead, we checked whether they included information on most items addressed in the RFP.

Since June 1978, the FIMB's staffing has increased from 39 to 104 budgeted positions even though contract monitoring responsibilities and assessments of the resources required to carry out those responsibilities have not been specified. As a result, there has been an insufficient number of staff in the past to accomplish all design, development, and implementation requirements and to monitor the CSC's performance. Further, without sufficient assessment of staff requirements, there will be no assurance that the number of budgeted positions, their classifications, and allocation among units are appropriate as design, development, and implementation activities decrease.

Identified Workload Responsibilities Have Not Been Performed

As discussed in Chapter I, the department has not monitored several performance areas and contract provisions because it lacks a complete plan. This lack of comprehensive planning has also resulted in the FIMB's incomplete performance of all identified workload responsibilities. For example, the FIMB has done little in regards to reviewing the CSC's responses to provider's questions. Neither has the branch monitored the CSC's implementation of operating instructions.

The FIMB generates workload documents for each unit. Currently, units do not perform all tasks detailed in their workload documents. Since the documents do not adequately list

all monitoring responsibilities, these omissions could further impair the FIMB's monitoring effectiveness. None of the FIMB units reviewed was addressing all identified workload responsibilities.*

During our review, certain unit supervisors identified approximately 24 monitoring responsibilities which were not being performed. For example, the FIMB unit responsible for provider relations is not currently reviewing the CSC's responses to providers. When providers have specific questions regarding processing procedures or a particular claim, they may phone the CSC directly. It is important to monitor the CSC's response to these providers to assure that questions are promptly and accurately resolved. By monitoring this activity, the FIMB also could learn which claims are causing providers difficulties and determine whether the CSC is following contract provisions in resolving these conflicts.

Additionally, the FIMB is not fully monitoring the CSC's implementation of operating instructions. Workload documents state that this activity is "...essential to efficient and effective change in the operation of the system." Since there has been no comprehensive review of system

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* We reviewed 11 out of 12 functioning units. We did not review the Contract Conversion Information Unit since its workload document does not include any monitoring responsibilities. It is a temporary unit established to deal with only the Legislature and provider association inquiries.

documentation and only limited access to the CSC's production sites, this monitoring responsibility is increasingly significant. Without monitoring the CSC's follow-up to operating instructions, the State may not be able to verify that Medi-Cal policies established by the FIMB are being promptly or appropriately implemented.

Unit supervisors also stated that the new MMIS certification requirements are not being reviewed. Federal procedures are expected to change to reflect yearly certification and a point-scoring method for the MMIS review. Reviewing and preparing for these changes should be stressed since compliance with this federal system is critical to the funding of the Medi-Cal claims processing system.

Other identified workload responsibilities which have not been performed include reviewing manual processes, applying policies and procedures for hearing contract disputes, monitoring performance of the CSC's computer hardware, tracing live claims, and reviewing the CSC's technical capabilities. Chapter I included discussions on the effects of some of these problems.

These conditions reflect the department's incomplete planning for and inaccurate identification of the number of positions required to perform all identified workload responsibilities. Also, staff members currently concentrate on

responsibilities other than performance monitoring. For example, staff are still working on design clean-up activities even though the system was declared fully operational on June 1, 1980. By spending time on design issues, staff cannot address monitoring responsibilities.

Also, staff spend approximately 25 percent of their time responding to immediate or ad hoc requests. Ad hoc requests may come from a variety of sources, including providers, the Legislature, the Health and Welfare Agency, and department administrators. In a recent request, staff were asked to design a method to provide immediate payment on hospital claims that were suspended for a specific error code. In addition, they have been requested to immediately answer individual provider inquiries. Branch officials have stated that these projects greatly impede the staff's ability to perform regularly scheduled assignments.

FIMB officials state that from 1978 to the present, they have underestimated the person-years required to perform workload responsibilities. Even though the FIMB is not addressing all workload responsibilities, staff overtime now extends up to 30 hours per month for analysts, 64 hours per month for first line supervisors, and 116 hours per month for branch administrators. The branch's failure to adequately evaluate workload responsibilities adversely affects the management and administration of personnel resources.

The branch's failure to perform certain workload responsibilities has resulted because it has not adequately planned for and administered its personnel resources devoted to performance monitoring. Consequently, the branch is deficient in its monitoring responsibilities. As discussed in Chapter I, because of inadequate monitoring, the State has no assurance that the CSC is processing claims as intended by the contract.

Staff Have Been Insufficiently Allocated to Review System Documentation

Because the department has not adequately planned, the FIMB may have insufficient workload projections upon which to base certain budgeted staffing requirements and to allocate those staff within the branch. Specifically, the System Monitoring and Policy Implementation Units responsible for reviewing the CSC's system documentation may not employ a sufficient number of staff with the expertise necessary to review the detailed documentation for logic, accuracy, and completeness.

System documentation contains all programming, system, and logic information which is necessary to process Medi-Cal claims. Because this documentation is comprehensive as well as technically complex, individuals with expertise in data processing are required to thoroughly review and comprehend it. To fully exercise all monitoring rights and

responsibilities over the CSC's processing system, FIMB staff must thoroughly review and understand this documentation.

The workload documents generated by the FIMB assign the responsibility of reviewing detailed system documentation to three units: Systems Monitoring, Policy Implementation Unit No. 1, and Policy Implementation Unit No. 2.* These units are responsible for assuring documentation logic, accuracy, and completeness. The system monitoring unit is responsible for a review of detailed system design and for assuring that "all system documentation used for the MMIS meet[s] and maintain[s] the federal standards described in Federal Information Processing Standard Publication Number 38." The policy implementation units are responsible in part for reviewing "system input and output documentation in the form of inventories, worksheets, system flow charts, descriptions of data flow, functional descriptions, [and] system logic...."

However, the FIMB may not have a sufficient number of qualified staff within these units. Currently, 11 personnel work within these three units. But only 2 of the 11 filled positions and 1 vacant position are classified for data processing personnel. Although the ability of these staff to review the system documentation has not yet been tested, in our opinion, the amount and complexity of work involved may require

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* Appendix E describes the functions of each unit of the FIMB.

more staff with expertise in data processing. Since the department must begin planning for the next fiscal intermediary contract or for state operation by mid-1981, it is imperative that the department through the FIMB staff develop a complete understanding of the documentation of the CSC's system.

FIMB staff primarily cite recruitment problems as the cause of their lack of data processing personnel. Generally, branch staff feel that the FIMB is seen as a negative place to work because of the attention focused upon the current Medi-Cal contract. In fact, during recent interviews the FIMB conducted, only one of 17 applicants was willing to work on-site at the CSC. In addition to these difficulties, branch staff report problems recruiting individuals with data processing expertise to assume monitoring-related work assignments.

Sufficient Job Orientation and Training Have Not Been Conducted

As previously discussed, inadequate planning has contributed to insufficient management of staff resources devoted to performance monitoring. Additionally, because the FIMB has not instituted a job orientation and training program for its staff, it may have also limited its effectiveness in monitoring the CSC contract. The Federal Government has recognized the detailed and complex nature of Medicaid claims processing systems and now requires states implementing a MMIS

to provide appropriate training to their staff. Federal financial participation (FFP) is available for such training; however, few staff have received any job orientation or formal training.

Federal regulations state that

> A State plan must provide for a program of training for Medicaid (Medi-Cal) agency personnel. The program must
>
> 1) Include initial in-service training for newly appointed staff, and continuing training opportunities to improve the operation of the program;
>
> 2) Be related to job duties performed or to be performed by the persons trained; and
>
> 3) Be consistent with the program objectives at the agency.

In addition, the CSC agreed to formally train state staff in its proposal:

> During the Installation Task, CSC will provide the State with formal training in the following areas:
>
> MMIS System
>
> MMIS System Files
>
> Computer and Ancillary Equipment
>
> S/UR Subsystem
>
> MAR Subsystem.

Training is mandatory under federal regulations because of the magnitude and complexity of the contract. The Medi-Cal contract is highly detailed and technical; it contains multiple volumes, including the RFP, bulletins, attachments, and technical specifications. The contract also contains legal provisions, data processing language, and management requirements. The need for training is magnified by the fact that the contract was drafted over three years ago and most of the key personnel involved in its formulation are no longer with the department. In addition to the 27 volumes of detailed design specifications currently provided to the FIMB, many more volumes will be issued before the contract expires.

Since entering into the contract and through almost 18 months of claims processing, the department has not assigned job orientation a high priority and, therefore, has not developed a training program for its employees. As an illustration of the FIMB's insufficient job orientation program, only one of 34 employees we interviewed possessed a desk manual or reference guide to aid in the performance of their duties. As of October 1980, only five of the FIMB staff we interviewed had received any orientation or training sponsored by the CSC. Moreover, two of the staff said that the CSC's training consisted of only a walk-through orientation rather than the detailed subsystem training promised in the proposal. Finally, 44 percent of the sample of 34 staff were not satisfied with the current training situation. Also, it is

important to note that 47 percent of these personnel have been in their current positions less than one year. (Appendix F summarizes our interviews with staff of the FIMB.)

Department officials gave several reasons for their lack of attention to training. For example, some FIMB staff who had experience in monitoring the MIO's contract felt that this experience was adequate. Through conducting interviews, we learned that 50 percent of 34 employees had held similar positions under the MIO's contract. However, under that contract, they were dealing with a cost-type contract rather than the current fixed-price agreement. Monitoring rights and responsibilities under the CSC's contract differ from those under the MIO's contract. The MIO's programming and system documentation was contractor-owned; therefore, it could not be reviewed and included in monitoring efforts. Under the CSC's contract, this information is owned by the State and monitors must be able to understand and work with the complex data processing system.

The department staff also stated that because of pressure to begin operating the CSC's system, there was no time for training programs. Also, no applicable state training program has been available. An attempt to obtain 61 percent federal funding for an internally developed training program was denied. Consequently, a training program was not implemented.

Without proper job orientation training, staff efficiency and effectiveness are impaired. Staff members are placed into the working environment with little or no knowledge of fixed-price contract monitoring. Those with MIO experience tend to operate as they would have under the MIO contract. Some may not possess a sufficient knowledge of the contract or of the state's monitoring rights and responsibilities. Finally, failure to comply with the federal training regulations could affect certification of the CSC's system.

The department has recognized the need for training. In June 1980, officials initiated several training programs which will be more fully discussed in the following conclusions and recommendations chapter.

CHAPTER III

CONCLUSIONS AND RECOMMENDATIONS

Although the Computer Sciences Corporation has been processing Medi-Cal claims for over 18 months, the Department of Health Services has not adequately monitored the CSC's performance as stipulated by the Medi-Cal contract. The department has not developed a comprehensive monitoring plan nor eliminated restrictions on its monitoring activities. Specifically, the department has not:

- Sufficiently monitored the accuracy of the claims processing system;
- Designed and implemented methods to independently review the CSC's performance;
- Asserted its authority to gain access to the CSC's sites, systems documentation, and records;
- Defined measurements or methods for calculating performance standards necessary to assess the adequacy of the CSC's performance.

Further, because it lacks an adequate monitoring plan, the department has in the past underestimated the number of staff necessary to monitor the CSC's performance and has not

allocated sufficient staff resources to conduct certain critical monitoring activities. Also, it has not provided the necessary training to personnel who perform monitoring functions.

Because of this lack of monitoring, the department has not obtained information necessary to enable it to adequately assess the CSC's performance. Without this information, the department cannot ensure that the CSC has met contract performance standards. In addition, inadequate monitoring limits the department's ability to formulate decisions about subsequent fiscal intermediaries.

RECOMMENDATIONS

To ensure that the CSC performs the functions for which the State has contracted, we recommend that the Department of Health Services adopt these measures:

- Plan and implement a comprehensive monitoring system. The plan should include all monitoring provisions required by the contract, particularly the request for technical proposal, and those required by federal regulations to ensure maximum federal funding. The plan also should structure priorities to enable the department to assign staff resources to adequately monitor the accuracy as well as the timeliness of claims processing.

- Develop and implement methods to independently verify information from the CSC and to monitor the performance of the CSC. The department should test the accuracy of the CSC system by tracing live claims through it--this is the methodology adopted by the federal Health Care Financing Administration.

- Assert control of the CSC's system by eliminating constraints to monitoring activity. The department should assert its authority under the contract to acquire and maintain access to the CSC's sites, operations documentation, and records. The department's monitoring staff should periodically make unannounced visits to operating units of the CSC.

- Establish formal definitions for measurements or methods to calculate performance standards and ensure that the CSC's performance meets these standards. The department should consider including medical review cycle times in the total 18-day cycle time for all claim types. Also, the department should consider calculating total claims inventory on a monthly rather than a daily basis; during the monthly calculation, the department should include all aged claims regardless of when they entered the system.

- Identify the staff resources necessary to implement the comprehensive monitoring system recommended above. The department should assess the overall number of positions budgeted for the FIMB, their allocation and distribution, and staff workload based upon total contract management activities, and request additional positions if necessary. The department should control staff workload by centralized review, ranking, and assignment of ad hoc requests.

- Actively recruit into the Fiscal Intermediary Management Branch personnel with electronic data processing backgrounds. Alternatively, the department should consider using independent contractors to design and install monitoring devices and to train staff to monitor technical areas of the contract.

- Increase staff training; especially instruct staff in the area of government fixed-price contracts. The department should also provide training for its staff from the CSC. Department staff should be allowed to attend the CSC's training of its own staff. Additionally, the department should consider implementing training programs taught by the State Personnel Board or by independent contractors.

Finally, the department should develop and distribute desk manuals to all FIMB staff to complement department training.

ACTIONS TAKEN BY THE DEPARTMENT

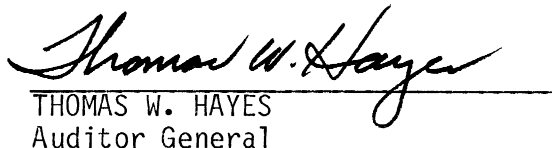
Since the beginning of our review, the department has expanded its training for personnel. The department will enter into a contract with a legal firm to develop specific training components for contract management. The department also plans to contract with a private consultant to provide a System Integrity Seminar, which will focus on the management and support of electronic data processing systems like the CSC's system. The department's Medi-Cal Division has begun a division-wide training program lasting four days. This program gives participants an overview of the Medi-Cal Division and the various responsibilities of its branches. One orientation session has been completed.

In addition, the CSC began conducting a three-hour training program for state employees in November 1980. This training program outlines the CSC's claims processing system and its capabilities. Although this training program had been attempted in early 1979 for the department's procurement staff, the State terminated this effort during the initial session due to poor presentation.

After we completed our review, the department initiated other actions to improve its management of the Medi-Cal contract. The FIMB has undergone changes in management and is now modifying its structure and organization to better coordinate management activity. The department has elevated the FIMB from a branch to a division. The FIMB will now be the Fiscal Intermediary Management Division (FIMD). This reorganization will provide a contract administration office which will review the contract compliance of both the department and the CSC. The office will work closely with the FIMD's management and an expanded legal staff of the department.

Along with the reorganization, the department will provide a comprehensive monitoring plan to coordinate the units within the FIMD and to address requirements of the contract. The department is also initiating a centralized tracking system to rank issues requiring the division's attention. The system will assign staff responsibilities and control the assignment of ad hoc requests.

Respectfully submitted,



THOMAS W. HAYES
Auditor General

Date: December 31, 1980

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STATE OF CALIFORNIA

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Mario G. Obledo
SECRETARY

James W. Connor
UNDERSECRETARY

December 19, 1980

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

Dear Mr. Hayes:

Thank you for the opportunity to comment on the draft copy of Chapter IV of your report entitled, "The Department of Health Services' Monitoring of the Medi-Cal Contract with the Computer Sciences Corporation."1/

We concur with the information presented on the two pages of the report (pages 54 and 55) submitted to us with the following clarifications:

1. Page 542/"... For example, the committee has established a task force to develop a claim form ...."

   Clarification: The Department of Health Services has established a task force; however, the committee is monitoring the progress of the task force.3/

2. Page 554/"... In addition, the committee has compiled the Interim Report on the Contract ...."

   Clarification: The Department of Health Services prepared the Interim Report and it was dated August 13, 1980. It has been over 4 months since that report was issued and the following has occurred as of mid-December. Inpatient claim volume in suspense appears to have stabilized with no significant increase in the percentage of aged claims over 60 days. Outpatient claim volume in suspense has decreased significantly since August and the percentage of aged claims over 60 days has experienced a substantial decrease since October.4/

1/ Chapter IV moved to Appendix A.
2/ Page 54 moved to page A-1.
3/ Report wording modified to reflect clarification.
4/ This paragraph was removed from the report.

Sincerely,

Mario G. Obledo

MARIO G. OBLEDO
Secretary

DEPARTMENTS OF THE AGENCY
Aging • Alcohol & Drug Programs • Data Center • Developmental Services • Employment Development • Health Services
Mental Health • Rehabilitation • Social Services • Office of Statewide Health Planning and Development

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

EDMUND G. BROWN JR., Governor

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December 29, 1980

Mr. Thomas W. Hayes
Auditor General
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Dear Mr. Hayes:

Thank you for the opportunity to review the draft of your report of December 15, 1980, "The Department of Health Services' Monitoring of the Medi-Cal Contract with the Computer Sciences Corporation".

The report covers a wide range of complex issues requiring significant staff time in order to address properly. The Department will provide a detailed response to these issues in its reply to the final report. I have enclosed comments that should be made at this time (Attachment I) to correct statements or conclusions which we believe to be erroneous. In addition, because substantial progress has been made in certain areas since your review, I wish to bring you up to date on these improved areas (Attachment II).

Of particular significance are recent efforts by the Department in organization, planning, and training. Your "Action Taken by the Department" section (p. 55) contains a brief discussion of the organizational changes that have taken place since the report was completed. A current organization chart is included for your information as Attachment IV.

In regard to planning activities, I wish to bring you up to date on our monitoring plan and to correct the misconception that the Department has not significantly monitored CSC activities beyond reviewing timeliness of processing. Attachment III contains a list of ongoing monitoring tasks, which indicates the level of detail our monitoring activities have taken in addition to merely monitoring processing times.

I have two major concerns regarding the report's handling of staffing and planning issues. First, there appears to be inadequate recognition of the different functional phases through which the fiscal intermediary management organization has passed. The original 39 staff positions were allocated to the Medi-Cal Procurement Project, whose sole purpose was to procure and evaluate proposals for the new FI system and to award the contract. As you know, this was completed in the

summer of 1978. Staffing and the organizational model for this function became inappropriate when the mission changed to one of system Design, Development and Implementation (DD & I) activities, including system testing. Additional staff were requested at that time to perform this entirely different function, and the organizational design was also changed to accommodate this different role.

As we consider the evolution of the fiscal intermediary management organization, it is important to recognize that the claims processing system has not been fully operational for 18 months. Although the implementation function began with drug claims processing in June 1979, full implementation of all claim types did not occur until June 1980 with CSC assumption of the medical claim type. Thus, final resolution of remaining system problems continues to command the attention of the monitoring team. The implication that a stable claims processing system has existed for 18 months and that the Department has failed to resolve system deficiencies and to assume a full monitoring posture, is misleading.

The report remarks (p. 42) that a great deal of staff time is spent in resolving "design issues", time which should properly be spent in monitoring the operating system. It must be recognized that *ad hoc* problem solving has often demanded high priority attention.

A great deal of influence on the setting of priorities was exerted by the Legislature, by external review entities, by organized provider groups, and the press. It would also be surprising, indeed irresponsible, if under the onslaught of outside pressures of this magnitude, the Department had not adjusted its priorities to be responsive to these concerns.

With the resolution of some of the major attention-getting issues, the Department expects to better balance issues of provider service/payment accuracy and of contract administration. As we move out of the DD&I phase and into Operations Monitoring, this emphasis will continue to shift toward close monitoring of the less controversial or spectacular parts of the system, in order to achieve maximal control.

My second area of concern is that the report does not acknowledge the significant achievement of increasing staffing for the fiscal intermediary management function at a time when most programs in government were holding the line or experiencing staff reductions. The Department recognized the need to increase staff for managing the CSC contract. The fact that we were successful in obtaining staff amidst rigorous

scrutiny by the control agencies and the pressure to reduce the workforce, confirms the Department's commitment to comprehensive management of the FI.

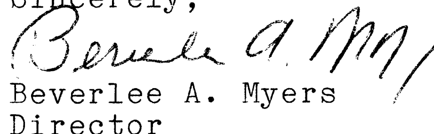
Before closing, I would also like to apprise you of the status of recent and planned training on data processing contract management and legal aspects of contract monitoring. A training session for monitoring staff was conducted the first week in December, 1980, by a private EDP consultant. The course covered the complete planning and management of data processing projects from the point of view of ensuring system integrity. A second session is planned in early February to accommodate new staff. In addition, the consultant has been engaged to conduct executive seminars on system integrity for mid-to-upper level management staff.

The Department has also contracted with the law firm of Gaston Snow and Ely Bartlett to conduct training in legal aspects of the management of the CSC contract. The first session is scheduled for January 20, 1981; a second session will be given shortly thereafter. This contract includes plans to train Department trainers by February 15, 1981, so that the results of this effort can be used on a continuing basis by the Department. The training includes a reference manual which can be used as a desk reference by FIMD. As your report points out, the Department has initiated and carried out positive steps toward providing staff with training necessary to optimize their performance in monitoring functions. Such activities will be continued.

In closing, let me commend you and your staff for the courteous and professional manner in which the review was conducted. The review will be useful to us as we plan and conduct our fiscal intermediary management activities.

Again, thank you for the opportunity to examine and comment on the draft report. I hope our comments will be useful to you in preparing your final product.

Sincerely,



Beverlee A. Myers
Director

Attachments

Attachment I

CLARIFICATIONS ON ITEMS OF FACT OR INTERPRETATION

DHS Has Not Monitored Accuracy of Claims Processing

". . . the FIMB reviews processing time but has not instituted or implemented an adequate methodology for monitoring the accuracy of payments . . . . Without comprehensive monitoring of the Medi-Cal contract, the department cannot ensure that the CSC is accurately processing claims." (p. 15)

While we acknowledge that the Department has not covered every functional area and each contractual requirement in its monitoring efforts, it is not accurate to state that FIMD has confined its monitoring efforts to a review of processing times. Attachment III contains a list of 96 functional and problem areas identified for monitoring attention. This summary list has been in use by FIMD managers since May, 1980. However, the monitoring of RFI problem reports and identification of other monitoring areas has been on-going since the first claim type was implemented.

Quality Control

"Currently, the FIMB relies upon the Medi-Cal Quality Control Branch, claims accuracy review program to assess the accuracy of claims adjudicated and approved for payment by the CSC." (p.18)

"Although the Quality Control Branch produces useful data which it submits to the FIMB for review, the FIMB only reviews the reports to record trends by claim type. . . . No actions are taken or further review initiated as a result of the data." (p.18)

The statement that FIMD relies upon the Medi-Cal Quality Control Branch to assess the accuracy of claims adjudicated and approved for payment implies that no independent monitoring of adjudicated claims by FIMD takes place. Although the report aknowledges only one formal study of adjudicated claims, Department monitoring staff continually reviews claims for payment accuracy. Some of our activity in reviewing adjudicated claims is reflected in Attachment III.

Errors identified by the Medi-Cal Quality Control Branch, which are subsequently confirmed by FIMD, are now formally directed to CSC for resolution. Recovery/restitution of any overpayments/underpayments will also be required. Such a directive is now being prepared for the MCQC sample representing the period October 1979 through December 1979 and April through June 1980. More importantly however, FIMD will be apprised of CSC's efforts to correct cited deficiencies, and will then proceed to ensure corrective action is taken.

Concerning the thoroughness of MCQC's claims review, FIMD does recognize that there are certain history-related limitations in the current process. However, the documentation to access patient history and certain aspects of medical policy application is now available for Drug claims and Long Term Care claims. Such documentation is expected to be available for hospital and medical supplier providers early in 1981.

Independent Verification of CSC Report Accuracy

". . . the department reviews the CSC's reports to assess the timeliness of the CSC's claims processing and to identify areas and problems which cause claims to suspend. Additionally, the FIMB reviews reports to determine areas in which claims are suspending and to identify the causes of such suspensions. Although the department compares certain CSC reports to one another to verify consistency of data, it does not independently verify the accuracy of the data in those reports." (p.23)

While we do not disagree that DHS data verification techniques should be improved, data verification is and has been a major department monitoring activity. As indicated during interviews by the Auditor General's staff, the Department, both through FIMD and report users, focuses primarily on verification of the most critical reports and on reports identified as having problems by users. Departmental users spend extensive staff hours in verifying report accuracy. Verification of report accuracy represents a major focus of the MMIS Ceritificatoin Unit.

Through this methodology, DHS has been able to identify numerous cases where reports have been inaccurate. Additionally, we have been able to identify those reports which can be relied upon for use in monitoring.

A number of methods are utilized to verify the accuracy of CSC produced reports:

1. Acceptance testing - At this time DHS is acceptance testing S/URS reports for inpatient/outpatient and medical claim types. Most other S/URS and MARS reports were tested prior to installation. Ongoing performance testing of production reports has not occurred. However, additional testing is planned.

2. Cross-comparison of reports - As cited by the Auditor General, FIMD reviews a number of critical reports by comparing like data on one report series to data on another generated from a separate subsystem and/or file, or by the State. This allows FIMD to identify reporting problems.

3. Review of tape dumps and reports. A critical report for DHS is the State Paid Claims tape. This tape provides DHS with the means to independently verify a number of CSC-generated reports. In order for the Department to review this data, a number of special programs have been developed to verify report information. These printouts are reviewed to verify the accuracy of the data passed to DHS. The reports also generate specific data that can be used to verify others of CSC's reports.

4. Verification of S/URS reports - S/URS report users review each report. Key statistical information on the report is tested through manual computation. Additionally, reports are verified against more detailed reports and reports from other parts of the subsystem or other systems.

5. Field Testing of Reports - In order to validate the accuracy of reports, most notably the hospital audit reports, DHS staff have validated reports against actual payments to the provider. In the case of the hospital audit reports, in order to verify reports field auditors have gone into specific hospitals to compare the reports to the provider's payment information.

6. User identification of problems - From time to time report users identify problems in report accuracy through their use of the reports.

Lastly, the Auditor General compares DHS's methods of evaluation of MARS reports with that of the New York State Department of Social Services. Based upon our discussions

with their staff, it is noteworthy to point out one additional fact. The New York SDSS currently staffs its MARS unit with six technical and two clerical staff. DHS has been able to allocate only 2.5 technical staff positions to this function.

Differences in CSC and Coopers & Lybrand Data

"Coopers and Lybrand submitted data on claims processing times for June through October 1980. We found that for five months, the CSC's data compiled by the department differed from the independently gathered data in 34 out of 35 instances." (pp. 23-24)

In order to validate the need for independent verification of data, the Auditor General compared CSC-produced cycle time reports with reports prepared by Coopers and Lybrand. The Auditor General found that these reports differed in 34 out of 35 instances.

While we find these differences deserve further investigation, we cannot determine that the differences are due to errors in CSC's reports or in Coopers and Lybrand's reports, or both. The consultants have acknowledged in their report potential data problems. These problems could have led to differences which reflect problems with CSC's methodology. Additionally, we have not been able to verify Coopers and Lybrand's methodology or reports. The Department feels that, to assume that these reporting differences clearly indicate a problem with CSC's methodology without further verification of the Coopers and Lybrand study, is risky at best.

Monitoring Standards

"The department has also limited its ability to adequately monitor the contract by not clarifying, defining, and applying monitoring standards." (p. 32)

"Even now, after two years of processing claims, the department and the CSC still have not agreed how the CSC's actual performance should be calculated." (p. 33)

Over the last several months DHS has been formulating its performance standard definitions for claims cycle time and claims inventory aging. During this time, the Department has monitored CSC's cycle time using a report which relies on CSC's definitions. The Department has finalized its definition of cycle time. Within the next few weeks, the Department will forward this policy to CSC. In addition,

the Department's policy and methodology for calculating claim inventory aging is expected to be confirmed within the next few weeks. Therefore, this policy will also be submitted to CSC for implementation.

Report modifications or the development of new reports to accurately reflect the Department's policies will then be required. Upon implementation of these reports by CSC and/or the State, the Department will actively monitor CSC's conformance to contract requirements for claims processing cycle time and claim inventory aging, utilizing DHS definitions.

DHS Review of CSC Provider Communications

". . . the department has not monitored several performance areas and contract provisions because it lacks a complete plan." (p. 40) "For example, the FIMD has done little or nothing in regards to reviewing the CSC responses to providers questions." (p. 41)

As of this time, because of higher priority activities, FIMD has not directly monitored the quality and accuracy of information given to providers via the telephone units. However, three separate studies have been conducted to sample the quality and timeliness of written responses to provider inquiries and letters. The findings of our latest review will be forwarded to CSC with a request for a plan to resolve cited deficiencies.

Tracing Live Claims

"Other identified workload responsibilities which have not been performed include . . . tracing live claims." (p. 42)

FIMD managers have planned, since Spring 1979, to implement an improved version of BPST when all major claims processing problems were resolved.

The Department has been working with the State Controller's Office to implement the federal Bill Processing System Test (BPST) in California. Many issues must be resolved, such as the elimination vs. the retention of fictitious claim data from the Department's paid claim tape; however, we plan to begin the first BPST in early 1981.

Attachment II

UPDATE TO INFORMATION IN AUDITOR GENERAL'S REPORT

Monitoring Plan

". . . the branch has not developed and implemented a formal plan for monitoring the contract with the CSC. Consequently, the department's monitoring has been incomplete. . . ." (p. 13)

Although Fiscal Intermediary Management Division (FIMD) has not yet developed a "comprehensive" monitoring plan, several plans had been prepared in the past. Admittedly these plans did not include all contractual provisions and federal requirements to provide a comprehensive plan as recommended in your report. Rather, the plans that were prepared were intended to deliniate those monitoring tasks which we felt were most critical, given the status of conversion effort and available resources at a point in time.

During the design, development and installation phase and up until July 1980, only four staff were assigned monitoring duties. The remainder of FIMD staff were assigned to DD&I tasks and MIO termination activities. The four staff available for monitoring were, however, utilized extensively in support of our acceptance testing efforts. Because of the workload during this period it was not possible to assign staff to a planning effort of the magnitude recommended in your report. (See our estimates of schedule requirements below).

With the conversion of the last claim type to the CSC system, we were able to assign three additional staff to monitoring tasks. Again, we had a choice of how best to utilize those staff. Because of the volume of claims anticipated from physicians and allied health providers and the consequences of claims backlogs should the suspense rate have been higher than expected, we made the choice to utilize our monitoring staff primarily to identify and resolve systems problems which would cause inappropriate suspensions.

Today the system is still not error free and we are still heavily involved in many DD&I related activities. However, as discussed with your staff during your review, we have begun to develop a comprehensive monitoring plan which will reflect the recent FIMD reorganization and the additional staffing made available through passage of AB 1414. This

plan will incorporate both the contractual responsibilities of the State and contractor and other non-contractually defined elements that are critical measures of CSC performance.

This planning effort is by no means an easy task. To link department goals and objectives to contractual/federal requirements and to measure the progress, a number of factors which must be incorporated into our plan have been identified.

They include:

- Objectives
- Contract/federal requirements and/or standards (the contract does not define standards in many areas, such as KDE accuracy or coding accuracy; these standards must be developed).
- Responsible section/unit.
- Functional area (i.e., claims preparation, microfilm, input, suspense processing, medical review).
- Monitoring method (observation, sample, analysis or reports, etc).
- Frequency of review (monthly, quarterly, etc.).
- Date of last review.
- Findings documented and reported.
- CSC's response.
- Verification of corrective actions.
- Followup report.

With such a tool, the Department will be better able to define all the monitoring needs to relate monitoring activity to the plan, to identify those areas we are unable to monitor due to lack of resources, and most important, to improve the overall effectiveness of the claims processing and information retrieval system.

The completion of a final contract monitoring plan will be a time consuming and laborious process. The steps involved and estimated completion dates are as follows:

Activity	Status/Estimated Completion Date
° Define broad goals and objectives.	Completed
° Identify functional areas subject to monitoring.	Completed
° Define specific objectives related to identified functional areas.	1/16/81

- Review the Request for Proposal to identify performance standards and/or contractual requirements subject to monitoring. 1/16/81
- Correlate objectives/functional areas/ RFP requirements (modify objectives/ functional areas as appropriate). 2/6/81
- Identify responsible section/unit for monitoring activity. 2/15/81
- Identify monitoring method. 2/15/81
- Define the frequency of review. 2/15/81
- Prioritize monitoring activities and make assignments consistent with available resources. 2/27/81
- Develop procedures appropriate for selected monitoring method. 2/27/81

The completion of this phase of our planning effort will allow us to monitor at least a portion of the contractual requirements as specified in the Request for Proposal as related to our objectives and identified functional areas of the system. However, for our monitoring plan to be complete, a review similar to that discussed above of CSC's response to the RFP (part of the contract) and the federal MMIS Certification Requirements must be accomplished and correlated with the objectives, RFP requirements and functional areas previously identified. Our initial estimate is 3-4 months to incorporate/correlate these requirements into our monitoring plan.

In addition to the efforts to finalize a monitoring plan, we will establish a new monitoring unit whose responsibilities will include:

- Finalizing the FIMD monitoring plan.
- Tracking all monitoring activity and related efforts to the monitoring plan.
- Tracking all identified problems, potential problems, and/or erroneous payments until satisfactorily resolved.
- Coordinating the interface between outside audit activities and FIMD monitoring units.
- Coordinating the interface between FIMD monitoring units and CSC.

This unit will be created when the new positions authorized by AB 1414 are filled, in early 1981. We plan to staff this new unit with a supervisor and three analysts to carry out the activities described above.

In order to expedite the assumption of at least a portion of the functions described above, FIMD has redirected two staff members from their current monitoring tasks to begin the development of a tracking system and associated reporting procedures to facilitiate the control and resolution of all identified problems.

Independent Verification of S/URS Data

"The Department Has Not Independently Verified CSC Information" (pp. 22)

As the Auditor General points out, in many cases S/URS reports produced by CSC have been untimely and inaccurate and reports for all provider types have not been produced. Reports for pharmacy and Long Term Care claims types have been fully installed since May 1980. However, reports of inpatient/outpatient and medical, with the exception of inpatient/outpatient recipient claim detail reports, have not been produced.

As a result of CSC's inability to perform in the S/URS area, DHS has been applying liquidated damages since August 1980 pursuant to the contractual provisions. While progress has been slow, several important improvements have occurred since the Auditor General's review. Among them are:

1. Recipient Claim Detail Reports produced for the week ending December 12, 1980, now include up-to-date CSC information for Pharmacy, LTC and I/O claims. Medical/vision claims are expected to be added shortly.

2. CSC moved to correct errors in provider profiling for drugs and long term care, the subsystem upon which provider claim detail reporting relies. Department users of S/URS report significant improvements in the October reporting cycle.

DHS Access to CSC Sites

"The Department Has Not Eliminated Constraints Which Limit Contract Monitoring," (p. 26)

"The Department Needs to Acquire Access to CSC's Sites." (p. 27)

We have reached agreement with CSC that DHS staff will have access to all operational work sites on an unannounced basis. DHS has the responsibility, however, to insure that CSC operations are not disrupted. We expect no future problems in this regard.

DHS Review of CSC Manual Processing

"Other identified workload responsibilities which have not been performed include reviewing manual proceses, applying policies and procedures for hearing contract disputes, monitoring performance of the CSC's computer hardware, tracing live claims, and reviewing the CSC's technical capabilities." (p. 42)

With the development of a more comprehensive monitoring plan, direct review of manual processes will be weighted heavily among other areas routinely scheduled for performance review. In this context, a letter (dated November 21, 1980) was sent to CSC to establish a manual process monitoring framework. The outlined procedure states that monitoring staff will have access to work stations and functional areas without prior notice by first contacting the first line supervisor.

DHS Review of MMIS Standards

"Unit supervisors also stated that the new MMIS certification requirements are not being reviewed. Federal procedures are expected to change to reflect yearly certification and a point-scoring method for the MMIS review. Reviewing and preparing for these changes should be stressed since compliance with this federal system is critical to the funding of the Medi-Cal claims processing system." (p. 42)

The monitoring section is presently reviewing the proposed federal MMIS System Performance Review (SPR), criteria with the objective of adopting as many of these techniques and performance standards to State monitoring as is practical.

The federal government is using one set of MMIS Certification Standards to review the CSC system for initial certification, and is proposing a new set of standards to be used nationally for recertification purposes. At the time of the Auditor General's review, FIMD Staff had not reviewed in detail the new MMIS certification requirements to be implemented in federal FY 1982 because workload priorities demanded they focus on achieving certification under current MMIS requirements. However, FIMD staff were familiar in depth with existing MMIS requirements.

DHS Review of Detailed Systems Design Documentation

"To fully exercise all monitoring rights and responsibilities over the CSC's processing system, FIMB staff must thoroughly review and understand this documentation." (p. 44)

FIMD is developing a plan to review the Detailed Systems Design Documentation. This plan will include a discussion of the feasibility of utilizing resources outside the division to complete this review. Purchase of consultant services to review documentation is being considered.

6

FIMD MONITORING UNIT ACTIVITIES

A. Formal Reports Prepared

1. Review of Pharmacy Error Code 200.
2. Resubmission Turnaround Document (RTD) Cycle Time Study
3. Status of Home Health Agency Claims Processing.
4. Review of Inpatient/Outpatient Claim Denials.
5. LTC Claim Suspense for Share of Cost.
6. Input Screening Quality.
7. Review of Claims Research Activity.
8. Durable medical equipment pricing problems.
9. Review of claims processing practices relating to PSRO (Professional Standards Review Organization) certified facilities.
10. Review of Edit - "Procedure billed is invalid for the billing or rendering provider type."
11. Review of Error Code - "Provider Ineligible on Date(s) of Service."
12. Review of Error Code - "Recipient Ineligible on Date(s) of Service."
13. Review of Suspended Podiatry Service Claims (Provider Type 27).
14. Review of Error Code - "Primary Diagnosis ICD-9-CM Code Missing."
15. Review of Edit "Valid Category of Service not on Provider Master File for this Provider."
16. Review of Error Code - "Provider Not Medicare Certified for Laboratory Procedure Specialty Billed."

17. Review of Error Code - "Recipient Not on Eligibility File, no POE Present-Recycle."

18. Review of Error Code - "Service Code Not on File."

19. Review of Claims for Durable Medical Equipment/Medical Supplies.

20. Review of Edit - "No Pricing Data on File for this Procedure."

21. Review of Edit - "Submitted Charge above Ceiling Price Allowed for This Procedure."

B. Monitoring Tasks Not Presented in Formal Reports

1. Investigation of "Referred for State Review" (DCC 18, 19 and 70).

2. Investigation of RTD problems experienced during the first six months of Pharmacy claim processing, June - December 1979.

3. CSC Management Report Review.

4. Claim Tracking and Auditing Review.

5. Review Implementation of New Claim Types.

6. Reviewing Medicare Crossover Claim Processing.

7. Review of Los Angeles County Hospital System Payments.

8. Evaluation of Border Provider Claim Status.

9. Developing information and reports for special requests from the Director and other agencies.

C. Ongoing Monitoring Activities

1. Ongoing sampling of claims in various stages of processing and adjudicated claims (prepayment and postpayment).

2. Sampling of Formulary, Pricing, Procedure and other reference file content for accuracy and completeness. Monitor timeliness of file updates.

3. Sampling for Specific Conditions - evaluate the suspense records in a particular DCC; perform an analysis of RTD cycle time, etc., detailed sampling of claim records meeting the defined parameters.

4. Monitor CSC administrative cost billings to verify ACSL units processed and specialized charges resulting from change orders and other sources.

5. Monitor manual operations (such as claims Input Processing and Suspense Processing) through direct observation of line activities.

6. Monitor general conditions of the system - e.g., volume of TARs in suspense; claims volume in claim recycle locations, State review and other processing locations; RTD cycle times; time in Input processing, claims re-entry, etc; suspense rate for particular edits or audits.

7. Edit/Audit Control - Control implementaton of new edits and audits; maintain ongoing review of the on/off status of edits/audits and monitor the test resuts of edits in a "test" mode.

8. Monitor the CSC application of automated pricing of unlisted and By Report items.

9. Review of suspended claims examined and processed by medical professionals and medical suspense claims examiners. The FIMD on-site medical consultants routinely review samples of claims suspending in Medical Review for specific edits and audits or special processing conditions.

10. Review of Fresno-Madera Pilot Project claims processing.

11. Validate suspect error conditions - Medi-Cal Eligibility Quality Control (MEQC) refers suspected claim line errors to FIMD on a flow basis to request confirmation that error conditions are actually present.

D. Request for Investigation (RFI) Problem Reports

Since June 1979 the Monitoring Unit has documented the following problem areas in RFI reports.

1. Report Dates
2. MARS Report Limitations
3. Inventory reports & inventory aging reports
4. Claims in system not assigned to a provider type (code 99).
5. Coding errors; provider signature and label
6. Drug Formulary Reference File
7. Coding on Recipient Eligibility History File (REHF)
8. CSC implementation of systems changes
9. Missing data elements
10. Processing of beneficiary label
11. Update of Provider Six Week Paid History File
12. Review MARS report MR-0-102
13. Review MARS report MR-0-101.
14. Update of records to CRT pend screen
15. Research capabilities via CRT screens and reports.
16. Factors contributing to key entry errors (suggested changes)
17. Review payments based on TAR/Claim match
18. RTD count on Provider Summary Screen
19. Review MARS report MR-0-145.
20. Recipient name on EOBs
21. PS-002 Provider Error List
22. Provider Master File (PMF); beginning date of status change
23. Coding sources of claim errors (provider, KDE, etc.)

(4)

24. Signature code override

25. History on Claim Paid Full Status Report

26. Coding on Provider EOB

27. DCC Reports not listing Share of Cost (DCC 19) inventory

28. Claims aging in REHF recycle

29. Providers billing with incorrect or incomplete provider numbers

30. Review Denied Claim Lines; whether listed on RA or Paid Full Status Report

31. Claim recycled for TAR vs. RTD

32. Aging in system inventories

33. RTDs; diagnostic coding

34. CP-0-06 report - dollar amounts listed for TARs

35. Itemization of provider errors on RTDs.

36. Review monthly Paid Claims History tapes

37. Processing Share of Cost against claim record

38. Inpatient denial; RA message

39. Processing outpatient claims (RVS modifier 90)

40. Payment of outpatient claims (RVS asterisk procedure)

41. Sorting and control of miscellaneous mail

42. Payments on LTC Medicare Crossover claims

43. Pricing of outpatient RVS procedures (80% payment level)

44. Processing of outside lab charges

45. Payments to Pharmacy providers

46. Institutional Crossover claims payment

(5)

47. REHF updates (Restricted label data)

48. LTC TAR processing

49. Suspense of crossover claims (2 month billing limit)

50. Processing of inpatient crossover claims.

51. Review MARS report MR-0-101.

52. REHF update procedures

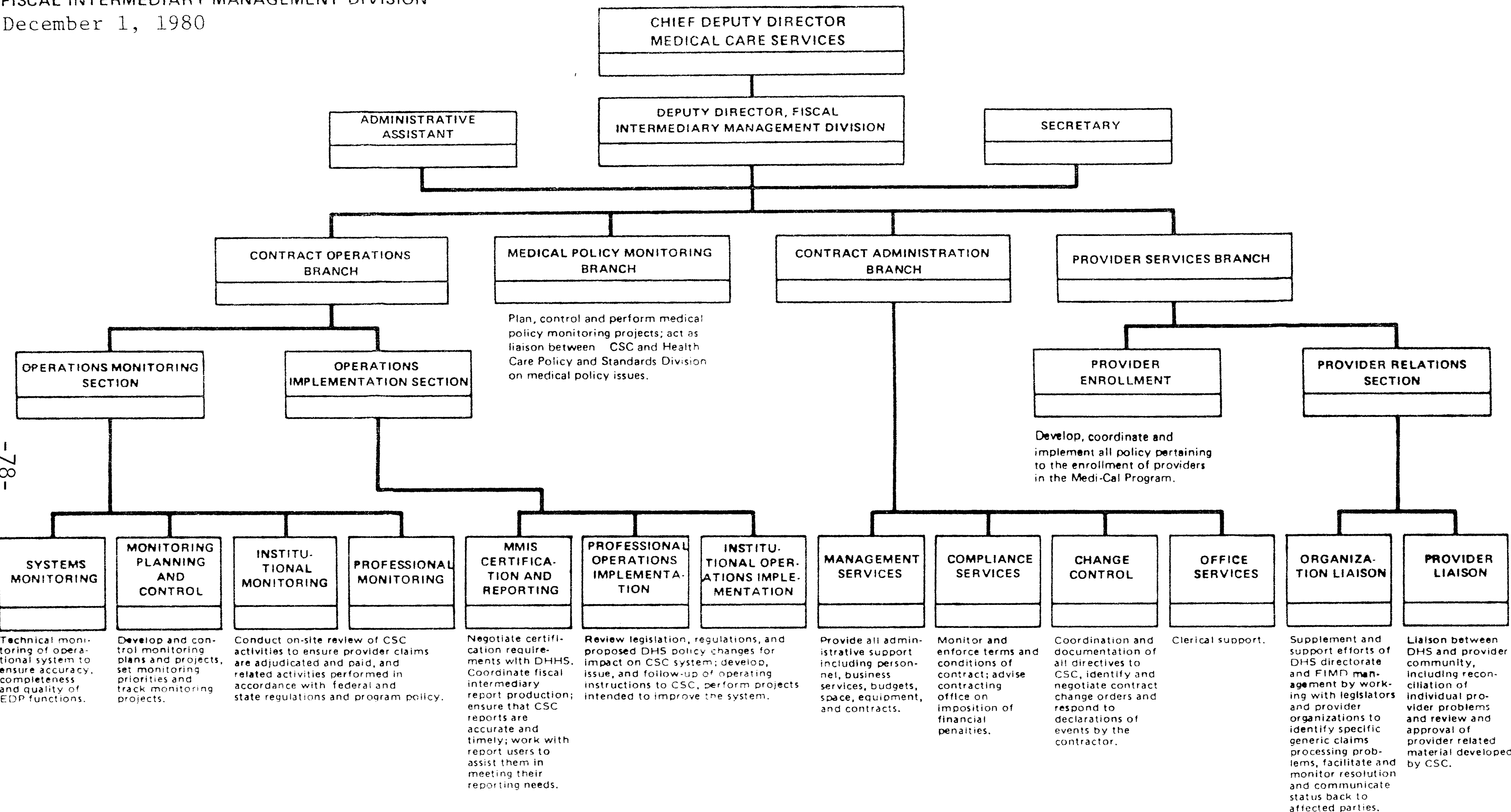
53. LA County Claims - Pricing

54. Pricing of outpatient claims

55. Update of Provider Six Week Payment Screen

(6)

FISCAL INTERMEDIARY MANAGEMENT DIVISION
December 1, 1980



APPENDIX A

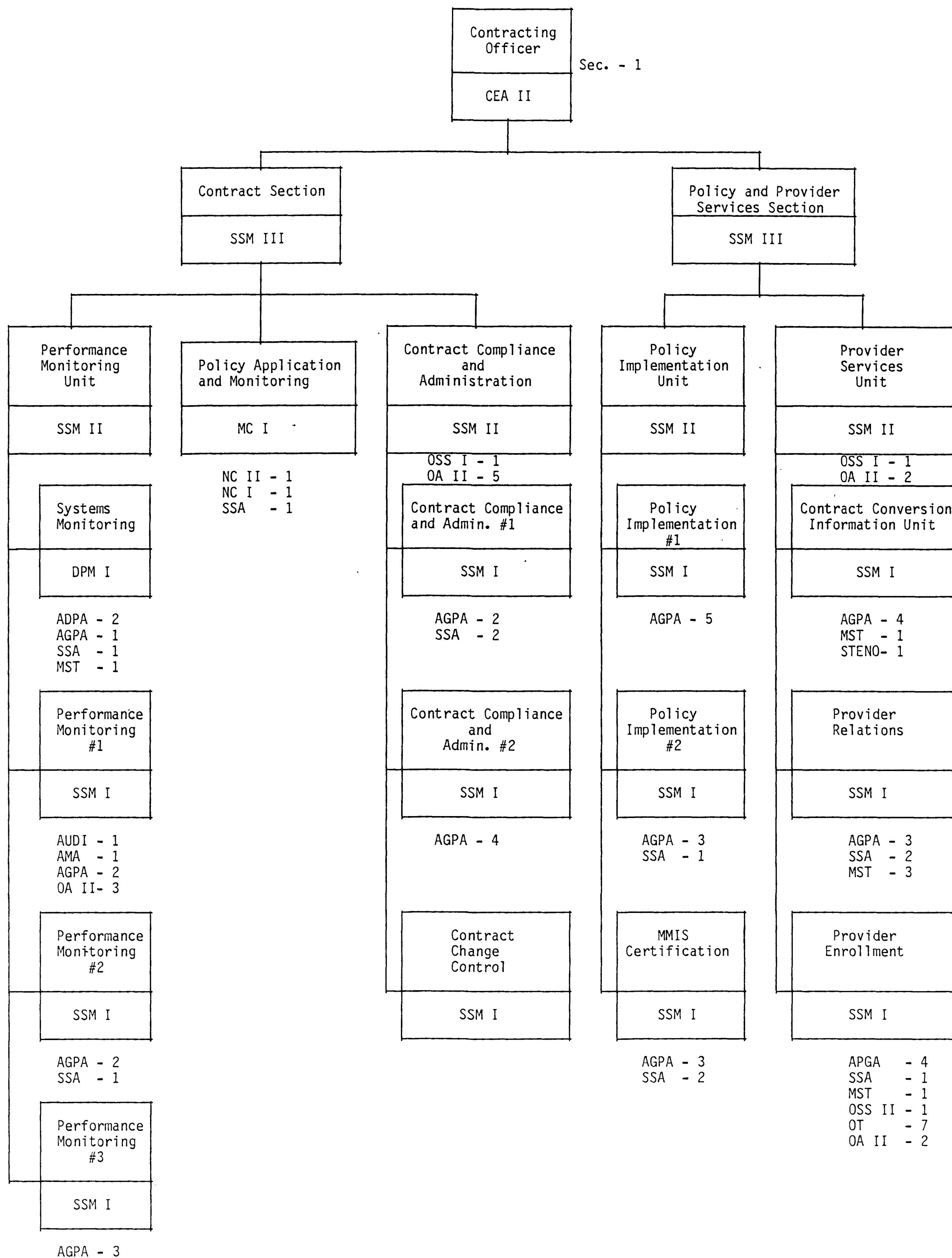
DESCRIPTION OF THE THE MEDI-CAL FISCAL INTERMEDIARY MONITORING COMMITTEE

In May 1980, a task force appointed by the Governor to review the CSC contract recommended that a top-level committee be established to review contract matters and to report on the progress of the Medi-Cal contract. Subsequently, the Governor signed Executive Order B-67-80 creating the Medi-Cal Fiscal Intermediary Monitoring Committee. The committee, chaired by the Secretary of the Health and Welfare Agency, has met regularly with representatives from provider organizations, the CSC, the department, the State Controller's Office, and the Department of Finance.

The committee examines issues of concern to the various provider groups. For example, the Department of Health Services has established a task force to develop a claim form that can be optically scanned and that is acceptable to physicians. The committee monitors the progress of the task force. The committee has also formulated a pharmacy fact-finding subcommittee which has investigated a sample of pharmacy claims. Finally, the committee's activities have also included the investigation of error codes that have caused many claims forms to suspend.

ORGANIZATIONAL CHART OF THE FISCAL INTERMEDIARY MANAGEMENT BRANCH

APPENDIX B



Source: FIMB Organizational Chart 9/23/80

STAFFING CLASSIFICATIONS FOR AUTHORIZED POSITIONS IN THE FISCAL INTERMEDIARY MANAGEMENT BRANCH

Classification	Number in the FIMB
Career Executive Assignment II	1
Staff Services Manager III	2
Staff Services Manager II	4
Staff Services Manager I	12
Data Processing Manager I	1
Associate Data Processing Analyst	2
General Auditor I	1
Associate Management Auditor I	1
Associate Governmental Program Analyst	36
Staff Services Analyst	11
Management Services Technician	6
Medical Consultant I	1
Nurse Consultant II	1
Nurse Consultant I	1
Office Services Supervisor II	1
Office Services Supervisor I	2
Office Assistant II	12
Office Technicians	7
Secretary	1
Stenographer	1
Total	104

OCCUPIED PROFESSIONAL POSITIONS IN THE FISCAL INTERMEDIARY MANAGEMENT BRANCH BY CLASSIFICATION AND NUMBERS INTERVIEWED

Classification	Number Occupied Positions in FIMB	Number Interviewed
Career Executive Assignment II	1	1
Staff Services Mgr. III	2	2
Staff Services Mgr. II	3	3
Staff Services Mgr. I	9	8
Data Processing Mgr. I	1	1
Associate Data Processing Analyst	1	1
General Auditor I	1	1
Associate Management Auditor I	1	1
Associate Governmental Program Analyst	22	9
Staff Services Analyst	10	4
Management Services Technician	4	1
Nurse Consultant I	1	1
Medical Consultant II	1	1
Total	57	34

FUNCTIONAL STATEMENTS OF THE FISCAL INTERMEDIARY MANAGEMENT BRANCH

This appendix provides a functional description of the FIMB. The administrative head of the FIMB is the contract officer. The staff members are divided into the Contract Section and the Policy and Provider Services Section. Below we describe the units in each of these sections.

Contract Section - This section addresses performance monitoring and contractual compliance and administrative issues. These are its units:

- Performance Monitoring Units 1, 2 and 3 - These units are responsible for conducting continuous on-site reviews of the Medi-Cal fiscal intermediary to ensure that provider claims are adjudicated and paid and that related activities are performed in accordance with federal and state regulations and policies.

- Systems Monitoring Unit - This unit is responsible for the technical monitoring of the operational system to ensure accuracy, completeness, and quality of the processing functions.

- Policy Application and Monitoring Unit - This unit is responsible for ensuring that medical policies developed by the State Health Department are correctly implemented and applied by the CSC.

- Contract Compliance and Administration Units 1 and 2 These units are responsible for monitoring and enforcing the contract terms and conditions and for supplying all required administrative support to the Fiscal Intermediary Management Branch.

- Contract Change Control Unit - This unit serves as a liaison between the FIMB and the other entities involved in contract change order activities.

Policy and Provider Services Section - This section addresses policy implementation and provider services issues. These are the units within this section:

- Policy Implementation Units 1 and 2 - These units are responsible for developing, issuing, and following up the implementation of the operating instructions issued to the CSC.

- Medicaid Management Information System Certification Unit - This unit is responsible for assuring that the CSC claims processing system continually meets federal requirements for MMIS certification.

- Contract Conversion Information Unit - This unit serves as a liaison between the FIMB, the Legislature, and provider associations.

- Provider Enrollment Unit - This unit is responsible for enrolling providers into the Medi-Cal program and for continually assuring the eligibility of providers.

- Provider Relations Unit - This unit is responsible for reconciling provider problems and for reviewing provider-related materials developed by the CSC.

SUMMARY OF STATISTICS GATHERED IN STAFF INTERVIEWS

We interviewed 34 of 57 persons occupying professional positions within the FIMB. The following are summary statistics compiled from information gathered during our review.

1. Longevity

47 percent were in current position less than 1 year

70 percent were in current position less than 1 1/2 years

a.	Range of time in current position	2-26 months
	SSMII and above	4-24 months
	SSMI	3-25 months
	Analysts	2-26 months
b.	Range of time in FIMB*	3-96 months
	SSMII and above	9-96 months
	SSMI	8-96 months
	Analysts	3-34 months
c.	Range of time in Department of Health Services	28-108 months
	SSMII and above	28-94 months
	SSMI	11-108 months
	Analysts	11-108 months

* These responses include time spent in the fiscal intermediary units prior to the official establishment of the current FIMB.

2. <u>Similar Experience to Present Position</u>

Similar experience in previous Fiscal Intermediary Section	13
Similar experience in previous Fiscal Intermediary Conversion Section*	4
Experience in other relevant areas	5
No prior similar experience	12

3. <u>Position Descriptions</u>

Were provided by personnel office	5
Were provided by FIMB	15
Were provided by interviewees	5
No position description available	14

4. <u>Desk Manual</u>

Received desk manual	1

5. <u>Training</u>

a. <u>Received</u>

Training by FIMB	0
Training by MIO	3
Training by CSC (walk through)	5

b. <u>Requested training</u> 6

c. <u>Satisfaction with Current Training Situation</u>

Were satisfied	19
Were not satisfied	15

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* This section was later to be reorganized into the present Fiscal Intermediary Management Branch.

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
Secretary of State
State Controller
State Treasurer
Legislative Analyst
Director of Finance
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
California State Department Heads
Capitol Press Corps