California State Auditor

BUREAU OF STATE AUDITS

Department of Health Services:

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

April 2007
2006-110

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April 17, 2007 2006-110

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

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the Bureau of State Audits presents its audit report concerning the Department of Health Services' (department) provider application and referral processes for California's Medical Assistance Program (Medi-Cal). This report concludes that because of recent policy and administrative changes, the department's Provider Enrollment Branch (branch) has seen a decrease in the number of applications it receives from providers seeking to enroll in Medi-Cal; however, the branch does not process some applications within the time periods specified in statute. For instance, during federal fiscal year 2006, the branch recommended seven applications for denial and sent each to its policy and administrative section (policy section), which generally reviews all denied applications. However, these applications remained in the policy section after their respective due dates had lapsed and because the branch does not track the length of time applications remain in its policy section, it automatically enrolled these ineligible providers. Further, we noted that branch staff enter incorrect and inaccurate data into the Provider Enrollment Tracking System (PETS), decreasing the branch's ability to effectively track the status of applications. Additionally, some applicants resubmit information to remedy their deficient applications soon after the required time period lapses, and state law requires the branch to deny these applications and treat them as new, preventing some eligible providers from offering services as soon as they otherwise could. Also, given that few applicants request preferred provider status and the branch's current low average time to process an application, the status offers applicants few benefits.

Further, the branch does not adequately track which of the department's review units it refers applications to or the reasons for these referrals. Moreover, state law does not prescribe a required number of days within which the branch must approve or deny an application it has referred for further review, and we noted that referred applications take an inordinate length of time to process. Further, although the branch uses fraud indicators to process applications that appear questionable or suspicious, these indicators generally do not align with the reasons the branch ultimately gives for referring applications in the PETS—hindering the branch's ability to track the legitimate reasons it has for referring applications and decreasing its capability to detect potential fraud trends during the enrollment process. Finally, because physicians applying to become providers in Medi-Cal and Medicare are asked to provide much of the same information, and given that the federal government is beginning two initiatives to ensure that more accurate and updated information is available about Medicare providers, the department may be able to rely on some of Medicare's data in the near future.

Respectfully submitted,

Elaine M. Howle

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SUMMARY

Audit Highlights . . .

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

- ☑ *Because of recent policy and administrative changes, the department's Provider Enrollment Branch (branch) has seen a decrease in the number of applications it receives; however, the branch does not process some applications within the time periods specified in statute.*
- ☑ *Branch staff continue to enter data incorrectly into the Provider Enrollment Tracking System (PETS), decreasing the branch's ability to track the status of applications effectively.*
- ☑ *Some applicants resubmit information to remedy their deficient applications soon after the required time period lapses, and state law requires the branch to deny these applications and treat them as new, preventing some eligible providers from offering services as soon as they otherwise could.*

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RESULTS IN BRIEF

The Department of Health Services (department) administers the State's Medicaid program, known as the California Medical Assistance Program (Medi-Cal). Medi-Cal is a federal program, funded and administered through a state and federal partnership, to benefit low-income people who lack health insurance. In July 1999 the department undertook several steps to stop individuals intent on defrauding Medi-Cal from obtaining provider numbers. One step was to organize the Provider Enrollment Task Force (task force), which developed and filed emergency regulations requiring applicants to complete a more in-depth application package, including a 10-page financial disclosure statement. In July 2000 the department replaced the task force with the Provider Enrollment Branch (branch), whose primary function has been to review applications and prevent providers with fraudulent intent from participating in Medi-Cal.

The number of applications the branch receives and processes has decreased because of recent policy and administrative changes. For instance, based on information in its Provider Enrollment Tracking System (PETS), the number of applications the branch received decreased from 2,200 in October 2005 to 1,480 in September 2006. This decrease appears to have shortened the average time the branch needs to process applications. However, although required by law to process applications and to notify applicants of its final determination within specific time periods, the branch continues to review some after the end of the required processing period and is forced to enroll other applicants into Medi-Cal automatically, on provisional status, because it cannot make a timely determination on the application. In fact, for the period October 1, 2005, through September 30, 2006 (federal fiscal year 2006), the branch did not process 108 applications within the required time periods. Of these, it automatically enrolled eight applicants into the program on provisional status as required but did not automatically enroll or appropriately notify the remaining 100. When the branch does not automatically enroll applicants when required, or

- ☑ *Given that few applicants request preferred provider status and the branch's current low average time to process an application, the status offers applicants few benefits.*
- ☑ *The branch does not adequately track which of the department's review units it refers applications to or the reasons for these referrals.*
- ☑ *State law does not prescribe a required number of days in which the branch must approve or deny referred applications, and we noted that the department takes an inordinate length of time to process referred applications.*
- ☑ *Because physicians applying to become providers in Medi-Cal and Medicare are asked to provide much of the same information, and the federal government is beginning two initiatives to ensure that more accurate and updated information is available about Medicare providers, the department may be able to streamline its application process by relying on some of Medicare's data in the near future.*

promptly process applications and notify applicants of its final determination, it may prevent or delay some eligible providers from delivering services to Medi-Cal beneficiaries.

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

Despite concerns we raised in a May 2002 audit regarding whether branch staff were entering data accurately and consistently into PETS, we noted that branch staff continue to enter data incorrectly, decreasing the branch's ability to track the status of applications effectively. For instance, branch management does not perform secondary reviews of the dates branch staff enter into PETS, such as the dates applications were received, returned to the applicant, or processed. Inaccuracies in these dates prevent the branch from tracking the status of applications effectively.

Additionally, although the branch generally notifies applicants in a timely manner that their applications are deficient, applicants often fail to correct deficiencies within the required 35-day time period, or do not resubmit their corrected applications at all. This failure is the leading reason for denied applications. In comparison, the federal Medicare program allows applicants to remedy their deficient applications by submitting additional information within a 60-day time frame—25 days longer than Medi-Cal's time frame. To determine whether applicants who missed the 35-day deadline would have met the 60-day deadline, we calculated the number of applications that were resubmitted to the branch between 11 and 25 days after the 35-day time period during federal fiscal year 2006 (we allotted an additional 10 days for mail delays).

According to PETS data, 258 applications were resubmitted within this time frame and, therefore, treated as new applications subject to the 180-day processing period—of which the branch ultimately approved 126. Had state law authorized the branch to process these resubmitted applications within a 60-day time frame rather than a new 180-day time frame, a greater number of eligible providers could have provided services to beneficiaries sooner than they otherwise did.

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

State law allows certain applicants to apply for preferred provider status. However, the only benefit to an applicant of qualifying for this status is that the branch must process the application within 90 days instead of 180 days. According to PETS, only 4 percent of the applications the branch received in federal fiscal year 2006 requested preferred provider status and, given that the branch's average time to process an application in September 2006 was just 30 days, the 90-day processing period appears to be irrelevant. The benefits to applicants appear to be marginal, so we question the value of the status. However, the processing delays that led to the state law that created preferred provider status could arise in the future. Thus, to the extent that the department chooses to keep this status, the branch should increase its efforts to convey to prospective applicants that their application packages for preferred provider status will be denied if they are lacking certain elements. Consequently, the branch could see an increase in the number of applicants that could benefit from the shorter processing period that preferred provider status offers.

Although the branch is authorized to conduct additional reviews by referring application packages to other units within the department, as well as to staff within the branch itself, it does not track referral information adequately. For example, some of the reasons that branch staff may select in PETS for referring

applications are vague or problematic. In fact, nearly one-half of the applications that the branch referred in federal fiscal year 2006 lack a specific reason for the referral. This prevents the branch from contributing to the department's Medi-Cal fraud prevention efforts on an ongoing basis because it is unable to accurately detect and track potential trends in fraud during the enrollment process. Further, branch staff failed to enter the units to which 10 percent of the applications it referred were sent in federal fiscal year 2006, which could prevent the branch from tracking the status of applications referred for secondary review.

Further, state law does not prescribe a required number of days within which the branch must approve or deny an application it has referred for further review, and we noted that referred applications take an inordinate length of time to process. For instance, PETS indicates the average number of days to process applications that the branch referred in federal fiscal years 2004 and 2005, was 322 and 255 days, respectively. Moreover, in federal fiscal year 2006, the branch approved the majority of applications it referred on which it made a final decision. Referring applications that it later approves indicates that the branch may need to reevaluate and update the high-risk indicators it uses when processing applications. Additionally, in the past six months, the branch and the Medical Review Branch within the department's Audits and Investigations division have not held their regular meetings that served to foster information sharing between the two branches—which, if they do not resume, may limit their effectiveness in contributing to the department's anti-fraud efforts because less emphasis is placed on tracking trends in fraud during the enrollment process.

Finally, the department may have the opportunity to streamline some of its enrollment processes for Medi-Cal applicants who are already Medicare providers by relying more on Medicare provider information in the future. Specifically, the federal government is beginning two initiatives intended to ensure that more accurate and updated information is available about Medicare providers. Physicians seeking to become providers in Medi-Cal and the federal Medicare program are asked to provide much of the same information in their application packages. Consequently, for those physician applicants it identifies as being in good standing with Medicare, the department may be able to rely on some of Medicare's data instead of performing redundant procedures to verify the same information. Although it is too early to determine the effectiveness of these initiatives, it could be worthwhile for the department

to periodically assess Medicare's progress and the benefits the department could derive from this centralized source of information.

RECOMMENDATIONS

To improve its application and referral processes when enrolling Medi-Cal providers, the branch should:

- Notify applicants that it has automatically enrolled them as provisional Medi-Cal providers when the branch has not processed the applications within the required time periods.
- Modify PETS to track the length of time applications it recommends for denial remain in its policy section for review to ensure that it does not automatically enroll or pay the claims of ineligible providers when the review does not occur in a timely manner.
- Include in management's secondary reviews of applications periodic reviews to ensure that staff are accurately and consistently entering into PETS the correct dates the branch received, processed, or returned the application.
- Increase its efforts to notify applicants that they must use current and appropriate application forms to avoid being denied enrollment into Medi-Cal.
- Coordinate with the department to update PETS to reflect the specific reasons that it refers applications for further review, so that they are aligned with its fraud indicators and high-risk review checklist. This will allow the branch to better identify trends in fraud during the enrollment process.

The department should seek legislation to revise state law to extend the 35-day time period applicants have to remedy deficiencies in their applications.

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

To ensure that it is referring those applicants at greatest risk of committing fraud and not preventing eligible Medi-Cal providers from providing services to beneficiaries, with direction from the department, the branch and the Medical Review Branch should:

- Reevaluate the appropriateness of the branch's high-risk fraud indicators periodically by consistently communicating and collaborating with one another.

- Place increased emphasis on processing those applications referred for further review within a reasonable time period.

In addition, the branch should monitor the implementation of Medicare's revalidation process, in which it verifies the enrollment information for all its providers. If it identifies opportunities for streamlining its application and verification procedures, the branch should make modifications as appropriate for Medicare providers seeking enrollment in Medi-Cal.

AGENCY COMMENTS

The department agrees with the recommendations in our report and states that while it is proud of the significant improvements it has made with regards to the enrollment of providers into Medi-Cal, the report highlights areas that can still be improved upon and provides valuable feedback to that effect. The department stated that it intends to incorporate the recommendations accordingly. ■

INTRODUCTION

BACKGROUND

In 1965 Congress enacted the Medicaid program, a health insurance program jointly funded by the federal government and the states. Medicaid benefits certain low-income people who lack health insurance, including low-income families with children and persons on Supplemental Security Income who are aged, blind, or disabled. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) provides regulatory oversight of Medicaid by reviewing state plans and approving and monitoring waivers of federal requirements, but each state operates its own program.

Within broad federal guidelines, the states establish their own eligibility standards; determine the type, amount, duration, and scope of services; set payment rates; and administer the program—including enrolling fee-for-service providers such as physicians, pharmacists, and optometrists. In California the Department of Health Services (department) directly administers the State's Medicaid program, the California Medical Assistance Program (Medi-Cal). Medi-Cal's fee-for-service program serves approximately 3.4 million beneficiaries and accounts for $34.7 billion in annual expenditures—slightly more than one-fourth of the State's fiscal year 2006–07 estimated budget.

A provider must obtain a valid Medi-Cal provider number in order to bill Medi-Cal for services provided to an eligible Medi-Cal beneficiary. The department's Provider Enrollment Branch (branch) reviews applications for noninstitutional providers—providers other than hospitals and long-term care facilities—including physicians, physician groups, pharmacies, podiatrists, ground medical transportation, and clinical laboratories. Between October 1, 2005, and September 30, 2006, it received more than 20,000 provider applications for enrollment into the program, including more than 14,000 applications from physicians and physician groups.

DEPARTMENT EFFORTS TO PREVENT FRAUDULENT PROVIDERS FROM ENROLLING IN MEDI-CAL

The branch was established in July 2000 and replaced the department's Provider Enrollment Task Force (task force), which the department organized in July 1999 when it undertook

several steps to stop individuals intent on defrauding Medi-Cal from obtaining provider numbers. Before 1999 California's Medi-Cal provider enrollment process was geared toward enrolling applicants quickly; one application was used for all provider types and only certain information was requested from applicants. This application process left the department susceptible to enrolling Medi-Cal providers intent on committing fraud.

As part of the department's antifraud efforts, in July 1999 the task force developed and filed emergency regulations requiring applicants to complete a more in-depth application package. This package includes applications tailored to each provider type and requiring additional information, a provider agreement that allows the department to conduct background checks and make unannounced visits, and a 10-page financial disclosure statement. The task force also established new procedures, including more comprehensive background checks to prevent applicants who have committed fraud, engaged in past abusive claim practices, or entered into arrangements with others who have done so from entering Medi-Cal.

The emergency regulations also authorized the department to require existing providers to submit new applications to ensure that they were suitable to continue participating in Medi-Cal, a process referred to as reenrollment. Currently, there are two units within the branch that concentrate most, or a portion of their time, on processing application packages for providers that are reenrolling in Medi-Cal. According to the department's September 2005 Medi-Cal fraud control strategic plan, reenrollment will be an ongoing process, and the department's Audits and Investigations division (Audits and Investigations) and its Payment Systems Division will incorporate the results of its annual Medi-Cal payment error studies into the reenrollment plan.

To conduct background checks and unannounced visits to verify the accuracy of the information applicants provide, the branch generally refers application packages to the Medical Review Branch within Audits and Investigations. The Medical Review Branch performs an additional review of the applicant, including an on-site inspection when one is warranted, and ultimately recommends that the branch approve, deny, or return

the application.[1] The branch also may refer applications to other units within the department, such as the Office of Legal Services. The applications the branch refers for further review are no longer subject to the required processing periods, and state law does not specify a time frame within which the referred application must be processed.

REQUIRED PROCESSING PERIODS FOR APPLICATIONS

Effective January 1, 2004, a state law took effect that modified the Medi-Cal provider enrollment process. As shown in Figure 1 on the following page, the branch generally is required to notify applicants within 180 days of receiving their applications that they have been granted provisional provider status for 12 months; that their application has been denied or is deficient because it is incomplete; or that their application has been referred for further review.[2] State law requires the branch to notify the applicant of a deficient application and gives the applicant 35 days to revise and resubmit the application to the branch. Additionally, state law gives the branch 60 days to process any applications that are resubmitted within the 35-day time frame, potentially allowing the branch a maximum of 275 days to process a deficient application, as shown in the text box. If the branch fails to process applications within the required time period, it must notify the applicants that it is enrolling them automatically and placing them on provisional status for 12 months, or 18 months if the applicant requested, and the branch approved them for, preferred provider status as discussed below.

Required Time Frames for Processing Applications

- New application: 180 days.
- Resubmitted application: 60 days after receipt of the revised application, provided it is received within the 35-day time frame allowed for correcting deficiencies.

Source: California Welfare and Institutions Code, Section 14043.26.

Note: These time frames do not apply to applications that are referred for further review or to applications for preferred provider status.

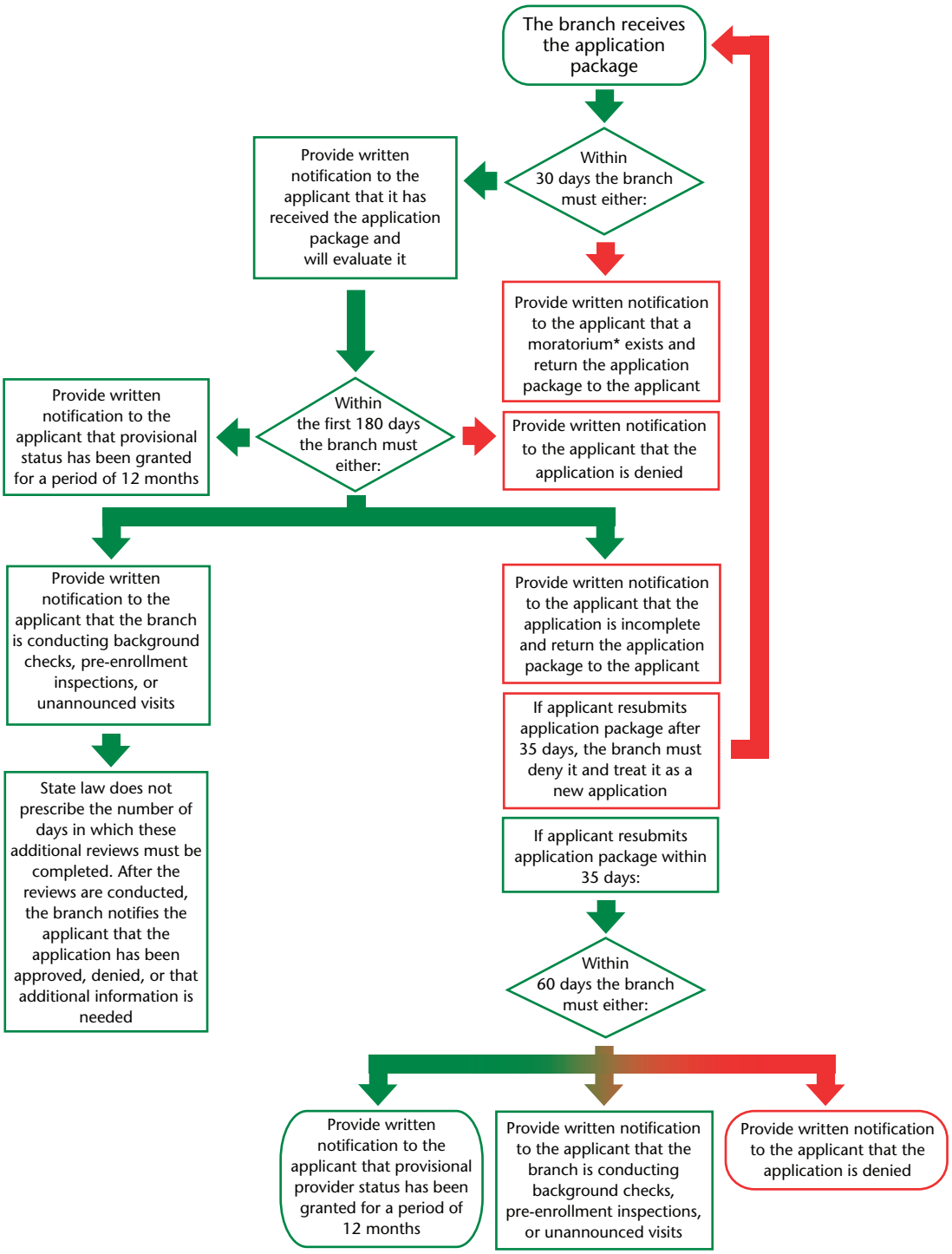
State law also allows certain providers, specifically physicians and osteopaths, to apply for preferred provider status, which requires the branch to process the application package within 90 days of its receipt. Within 90 days, the branch must notify applicants requesting preferred provider status that they have

[1] The branch generally returns applications when the applicant submits a deficient application, withdraws from the enrollment process, or is already enrolled in the program as a rendering provider—physicians and osteopaths that provide services on behalf of physician groups—and no longer need to apply.

[2] California Welfare and Institutions Code, Section 14043.29(a), specifies that if at the end of the provisional status the provider has met certain requirements, including continuing to demonstrate compliance with the standards for enrollment, the provisional status will cease and the provider will be enrolled in Medi-Cal without designation as a provisional provider.

FIGURE 1

General Process for Reviewing Medi-Cal Applications and Notifying Applicants



Sources: California Welfare and Institutions Code, Section 14043.26, California Code of Regulations, Title 22, Section 51000.50, and the Department of Health Services' Web site.

Note: This figure does not depict the application review process used for applicants seeking preferred provider status.

* Moratoriums on enrollment apply to clinical laboratories, durable medical equipment providers, nonchain-nonpharmacist-owned pharmacies in Los Angeles County, and adult day health care centers.

met the criteria for a preferred provider or that they have not met the criteria and will be subject to the regular 180-day review. State law requires the department to notify the applicant within 90 days if the applicant meets the requirements and to grant provisional status effective from the date of that notice. The branch's policy is to enroll an applicant in Medi-Cal automatically and grant the applicant provisional status for 18 months if it fails to process the application on or before the 90th day.

MEDICARE'S PROVIDER ENROLLMENT PROCESS

The federal Medicare program's enrollment process differs in some ways from the one used for Medi-Cal. Medicare is administered by the CMS and provides health insurance to people who are 65 or older, the disabled, people with end-stage renal disease, and certain others who elect to purchase Medicare coverage. Designated Medicare fee-for-service contractors (contractors) process enrollment applications and verify the information provided. The CMS outlines the requirements it has set for contractors in its *Medicare Program Integrity Manual* (manual). The manual states that contractors must process 99 percent of new provider enrollment applications within 180 days of receiving them, but it does not need to automatically enroll applicants whose applications are not reviewed within 180 days. Unlike Medi-Cal, Medicare does not allow for interruptions in the processing time period for applications that are referred to other entities, such as the U.S. Department of Health and Human Services' Office of Inspector General.

THE BUREAU OF STATE AUDITS' PAST REPORTS RELATED TO MEDI-CAL PROVIDER ENROLLMENT

In May 2002 the Bureau of State Audits (bureau) issued a report titled *Department of Health Services: It Needs to Significantly Improve Its Management of the Medi-Cal Provider Enrollment Process*, Report 2001-129, which made a variety of recommendations to improve the Medi-Cal provider enrollment process. The report concluded that the branch was not using its resources effectively to process provider applications and that it was not coordinating effectively with Audits and Investigations. Additionally, the report noted that the branch did not ensure that certain enrolled providers had current and complete disclosure statements on file, as required by federal regulations. The report recommended

that the branch use its Provider Enrollment Tracking System (PETS) more effectively; that it create strategies to ensure that all providers have current applications, disclosure statements, and agreements on file; and that applications referred to Audits and Investigations be tracked.

In December 2003 the bureau issued a report titled *Department of Health Services: It Needs to Better Plan and Coordinate Its Medi-Cal Antifraud Activities,* Report 2003-112. This report concluded that, although the branch had implemented some of the recommendations made in 2002 pertaining to the use of PETS and improving effectiveness, it had not fully implemented 10 of the 12 recommendations reviewed. The report recommended that the department improve the processing of provider applications, subject all individual Medi-Cal providers to the same screening requirements, and ensure that enrolled providers continue to be eligible to participate in the program.

SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee (audit committee) requested that the bureau review the department's Medi-Cal provider enrollment process, as well as the laws, rules, and regulations governing it. We were asked to compare the department's Medi-Cal provider application and enrollment procedures to those used for the federal Medicare program and identify similarities and differences in the applications and in the process used to verify provider information. We also were asked to determine if any information is shared between Medi-Cal and Medicare during the application process and whether opportunities exist for sharing additional information to streamline the enrollment process.

In addition, the audit committee requested that we determine whether the department tracks and monitors the average time it takes to review a physician application and to identify the number of full-time staff assigned to review physician applications and the number of hours allocated for each review. We also were asked to identify the number of applications denied over the past year and to determine the reasons for the denials. The audit committee requested that we review the department's procedures for handling deficient applications, including when it notifies applicants about deficiencies, and to identify the type of information that is most often missing from these applications.

We were asked to identify the number of applications referred to Audits and Investigations in the past year and to determine the reason for the referral and the number of referred applications that were denied. The audit committee also requested that we identify the number of applicants requesting preferred provider status in the past year and that we categorize this information by the department's enrollment decision, physician specialty, and geographic location. Lastly, the audit committee asked that we identify the total number of applicants awaiting enrollment into Medi-Cal; determine the total number of applications the department did not process within the designated review period; and categorize each group by provider type, specialty, geographic location, Medicare enrollment status, and application type.

To address the audit committee's requests, we focused our review on the processes and procedures related to the initial application stage because this stage affects whether, and how soon, eligible Medi-Cal providers can deliver services to Medi-Cal beneficiaries. Our review excluded the branch's reenrollment process because providers subject to this review are active and may continue to provide services to beneficiaries as they undergo reenrollment. Additionally, we excluded applications from out-of-state providers because they may apply as a Medi-Cal provider only after they have delivered emergency services to a Medi-Cal beneficiary.

To determine the department's Medi-Cal provider enrollment process we reviewed state law, regulations, and internal policies and procedures and interviewed staff within the branch and Audits and Investigations.

To compare the department's Medi-Cal provider application and enrollment procedures to those used for the federal Medicare program, and to determine whether any information is shared between Medi-Cal and Medicare during the application process, we interviewed staff from the branch and Audits and Investigations. Also, we interviewed staff from the federal Medicare program and obtained and reviewed Medi-Cal and Medicare physician provider applications, enrollment procedures, and reports.

To determine whether the department tracks and monitors the average time it takes to review a physician application, and to identify the number of full-time staff assigned to review physician applications and the number of hours allocated for

each review, we interviewed branch staff and obtained and reviewed applicable reports, job duty statements, and payroll data. In our review, we noted that physician applications are processed by staff members who also process other provider type applications. Because of this, and given that the branch does not allocate or track the number of hours to review physician applications, we used job duty statements and developed estimates from ad hoc time sheets and by interviewing branch staff. We applied the proportion of time we derived to the number of months worked by the branch staff to determine the number of full-time equivalent staff the branch has assigned to review physician applications. Lastly, we determined the number of applications processed by the aforementioned staff by reviewing data in PETS, the branch's application tracking database.

To identify the number of applications denied during the period October 1, 2005, through September 30, 2006 (federal fiscal year 2006) and to determine the reasons for the denials, we reviewed data in PETS, interviewed department staff, and reviewed the branch's Web site. We focused our review on federal fiscal year 2006 because it offered more up-to-date information than the period July 1, 2005, through June 30, 2006—the state fiscal year. To review the department's procedures for handling deficient applications, we interviewed branch staff and reviewed state laws and regulations. The branch does not track the reasons applications are deficient in PETS, so we judgmentally sampled 120 deficiency letters to determine the reasons for the deficiencies. Further, we reviewed data in PETS to determine how quickly the department processes resubmitted applications.

To identify the number of applications referred to Audits and Investigations' Medical Review Branch during federal fiscal year 2006, and to identify the reason for the referral and the number of referred applications that ultimately were denied, we interviewed branch staff, reviewed data in PETS, and obtained and reviewed departmental guidance on fraud indicators. Additionally, we determined the number of applications the branch referred to the Medical Review Branch during federal fiscal years 2004 and 2005 by reviewing data in PETS.

Additionally, to identify the number of applicants requesting preferred provider status during federal fiscal year 2006, as well as the number of applications approved for the status, the number of physicians by specialty and geographic location, the

number of applications denied, and the reasons for the denials, we interviewed department staff and reviewed data in PETS. The department does not track the specialty of physician applicants in PETS, so we manually reviewed physician applications to determine the specialties for physicians who applied for preferred provider status during federal fiscal year 2006. The department does not track the reasons applicants are denied preferred provider status, so we selected a statistically valid sample of applications that did not pass the department's preferred provider prescreening and manually determined the reason for the denial.

To identify the total number of applicants awaiting enrollment in Medi-Cal and the total number of applications the branch did not process within the required processing period, and to categorize each application group by provider type, specialty, geographic location, Medicare enrollment status, and type of provider application, we interviewed branch staff and reviewed data in PETS, and Medi-Cal provider enrollment applications and notification letters. The department does not track Medicare enrollment status or specialty in PETS, so we could not categorize the application groups in these ways.

Definitions of Data Reliability

Sufficiently Reliable Data: Based on audit work, an auditor can conclude that using the data would not weaken the analysis nor lead to an incorrect or unintentional message.

Not Sufficiently Reliable Data: Based on audit work, an auditor can conclude that using the data would most likely lead to an incorrect or unintentional message and the data have significant or potentially significant limitations, given the research question and intended use of the data.

Data of Undetermined Reliability: Based on audit work, an auditor can conclude that use of the data could lead to an incorrect or unintentional message and the data have significant or potentially significant limitations, given the research question and intended use of the data.

Source: *Assessing the Reliability of Computer-Processed Data* from the U.S. Government Accountability Office.

Government auditing standards issued by the U.S. Government Accountability Office require us to assess the reliability of computer-processed data. (See the text box for the definitions of data reliability.) We assessed the reliability of PETS data by performing electronic testing of selected data elements, reviewing existing information about the data and the system that produced them, interviewing department officials knowledgeable about the data, and testing the accuracy and completeness of the data. Based on our analysis, we determined that the data were of undetermined reliability for the purposes of our audit. Specifically, the branch returns many application packages to applicants seeking enrollment into the program because they lack required information. The branch does not maintain copies of these application packages, and applicants do not always resubmit them. Because we did not have these returned applications as supporting documentation, we were unable to trace some key data fields in PETS to the original document. In addition, the branch's documentation for applications that it approved or denied was not always sufficient to support the

accuracy of PETS data. Specifically, certain data fields in PETS may be populated by branch staff using their judgment, such as selecting the type of application submitted from a list of options in PETS. Further, certain information was inconclusive for applications that the branch did maintain, including the dates applications were received or processed as well as illegible document numbers.

Additionally, we determined that PETS data regarding applicants' provider type was not sufficiently reliable based on our accuracy testing. Specifically, we found that branch staff incorrectly populated the provider type field in the PETS data for three of 56 documents that we examined. At a 95 percent confidence level, this result indicates that the error rate may be as low as 1.1 percent or as high as 15.7 percent. Using our professional judgment, we have set our tolerable rate of error at 10 percent and conclude that using data with an error rate potentially greater than this threshold would weaken our analysis or lead to an incorrect or unintentional message. Thus, given that the high end of the error rate of the branch's provider type field exceeds our tolerable rate of error, we determined that this field was not sufficiently reliable for our purpose of determining an applicant's provider type. Further, we determined that the field indicating whether an applicant was applying for preferred provider status was not sufficiently reliable for applications that were still in process as of September 30, 2006. Specifically, we found that three of the nine documents we examined were recorded incorrectly in PETS as having preferred provider status. Further, we determined that the data relating to the reasons the branch refers applications for secondary review, and the units to which it refers these applications, are not sufficiently reliable for the purpose of identifying these reasons or the units to which the branch refers applications because the data were not fully populated. Because no other criteria or data were available to replace these unreliable data, we use these data, as indicated, in the Audit Results section. However, given that these error rates could materially change the number or percentage of applicants by provider type or preferred provider status, it could lead to an incorrect or unintentional message. Thus, these weaknesses are potentially significant. ■

AUDIT RESULTS

THE PROVIDER ENROLLMENT BRANCH GENERALLY ADHERES TO ITS APPLICATION PROCESS, BUT IT PROCESSES SOME APPLICATIONS LATE AND COULD PREVENT SOME FROM BEING DENIED

Because of recent policy and administrative changes, the Department of Health Services' (department) Provider Enrollment Branch (branch) has seen a decrease in the number of applications it receives from providers seeking enrollment into the California Medical Assistance Program (Medi-Cal). However, the branch does not process some applications within the required time periods, and it has not placed some of these applicants on provisional status, although it is required to do so by state law.[3] Further, despite concerns raised by the Bureau of State Audits (bureau) in May 2002 regarding whether branch staff were entering data accurately and consistently into the Provider Enrollment Tracking System (PETS), we noted that branch staff continue to enter incorrect and inaccurate data, which decreases the branch's ability to track the status of applications effectively.

The branch generally notifies applicants promptly that their applications are deficient. However, applicants often fail to resubmit information to remedy these deficiencies within the required time period; in fact, this is the leading cause for denials. Although some applicants resubmit information soon after the required time period expires, state law requires the branch to deny these applications and treat them as new, preventing some eligible providers from offering services as soon as they otherwise could. Moreover, the branch could do a better job of informing applicants that another common cause of denials is submitting an outdated application form. Finally, preferred provider status confers little benefit to the applicant, so the value of this status is minimal.

[3] At the time the branch approves and enrolls a new Medi-Cal provider, the provider is placed on provisional status or preferred provisional status—depending on the type of application submitted—for a period of 12 months or 18 months, respectively. If the department determines the existence of any grounds, such as fraud or abuse, to deactivate or suspend the provider, it may at any time terminate the status, regardless of whether the period of time for the provisional status granted has elapsed.

The Number of Applications the Branch Receives Has Decreased, Which Has Shortened Its Average Processing Time

Two primary factors appear to have contributed to the general decrease in the number of applications the branch received, processed, returned, and had in its ending inventory, as shown in Table 1, during federal fiscal year 2006.[4] The first factor is the department's implementation of regulations in December 2005 that eliminated the requirement for rendering providers—physicians who provide services as members of a provider group and bill Medi-Cal by using the provider group's number—to submit an application package each time they join a new provider group or change location. According to the chief of the branch, the second contributing factor is that the branch recently increased its efforts to remediate deficient applications by discussing deficiencies with the applicant directly, rather than returning the application for remedy. If the branch is able to remedy deficiencies quickly and avoids returning deficient applications for remedy, the number of applications the branch receives will continue to decrease. Given that rendering providers represented more than half of the more than 130,000 Medi-Cal providers in 2006, and that the chief of the branch estimates that 40 percent of the applications the branch processes are deficient, it is not surprising that the number of applications the branch received decreased from 2,200 in October 2005 to 1,480 in September 2006, according to PETS data.

This decrease appears to have improved the branch's ability to process more applications in a timely manner. For instance, as shown in Table 1, the branch took an average of 69 days to process an application in October 2005, markedly longer than the average in September 2006 of just 30 days. The chief of the branch explained that staff have processed applications more effectively since the branch increased the amount of staff training, focused on motivating staff, and encouraged staff to decrease the inventory of applications. Although we recognize these efforts, the main contribution to the branch's increased effectiveness may be that it has received fewer applications, which reduces the time applications wait until staff begin processing them. Consequently, the average number of days staff take to process an application and the branch's ending inventory of applications, according to PETS data, have decreased substantially.

[4] As mentioned in the Scope and Methodology, our review of the branch's enrollment processes and procedures focused on the initial application process, which excludes those applicants undergoing reenrollment and out-of-state applicants who already have provided services to Medi-Cal beneficiaries.

TABLE 1

Number of Applications the Branch Received, Approved or Denied, Returned, and Had in Its Ending Inventory Generally Decreased During Federal Fiscal Year 2006

	Beginning Inventory*	Number of Applications Received	Number of Applications Approved or Denied	Average Days to Approve or Deny†	Number of Applications Returned‡	Average Days to Return†	Ending Inventory§
2005							
October	5,875	2,200	1,694	69	558	71	5,823
November	5,823	2,623	1,789	66	532	71	6,125
December	6,125	2,178	1,697	63	1,308	65	5,298
2006							
January	5,298	1,620	1,248	60	1,698	59	3,972
February	3,972	1,533	1,046	61	1,005	60	3,454
March	3,454	1,854	1,192	62	1,140	74	2,976
April	2,976	1,211	1,272	51	936	54	1,979
May	1,979	1,704	1,047	41	658	54	1,978
June	1,978	1,320	1,036	39	670	29	1,592
July	1,592	1,589	990	36	486	29	1,705
August	1,705	1,507	797	40	642	40	1,773
September	1,773	1,480	880	30	607	28	1,766
Totals		**20,819**	**14,688**	**54**	**10,240**	**56**	

Source: Bureau of State Audits' analysis of the Provider Enrollment Branch's (branch) Provider Enrollment Tracking System (PETS).

Note: As we mention in the Scope and Methodology section of this report, we were unable to determine the accuracy of certain data fields in PETS because the branch does not maintain copies of all applications for which it enters information into PETS. In addition, certain data fields in PETS may be populated by branch staff using their judgment and certain information on applications the branch did maintain were inconclusive. Thus, these data are of undetermined reliability.

* Beginning Inventory is as of the first day of the month and matches the ending inventory from the previous month.

† Average number of days is based on calculations using information from each individual application to develop accurate averages.

‡ Returned applications include those that the branch determined to be deficient or needlessly submitted by an existing rendering provider, or were withdrawn by the applicant.

§ Ending inventory includes those applications that the branch has yet to process and those that it has referred for additional background checks.

In fact, as shown in Table 1, the number of applications the branch had in its ending inventory appears to have decreased significantly in just one year, from 5,823 in October 2005 to 1,766 in September 2006. The branch's ending inventory includes applications for both physicians and nonphysicians. According to PETS data, as of September 30, 2006, 50 percent, or 874, of the 1,766 applicants awaiting enrollment into Medi-Cal were physicians, including 151 existing Medi-Cal physician providers who were requesting an additional address or a change of address. Because we found that the error rate

of the provider type field in PETS data may be as high as 15.7 percent, we consider the information presented here to be not sufficiently reliable for determining the provider type. Consequently, using the branch's provider type information as the basis for determining an applicant's provider type could lead to incorrect conclusions. The purpose of displaying it is to show how the branch could use its current system to provide relevant information if it maintained accurate data.

Figure 2 provides a detailed breakdown of the branch's September 2006 ending inventory of physician applications by geographic location. As the figure shows and according to PETS data, 334, or 38 percent, of the 874 physician applications in process by the branch as of September 30, 2006, were from Los Angeles County—which is not surprising given that the county's general population represents nearly 30 percent of the State's population.[5]

The chief of the branch estimated that each full-time equivalent employee processes an average of three physician applications each day, which is consistent with the 3.3 applications our analysis indicated.

Of the branch's 78 employees who process applications, approximately 30 full-time equivalent employees were assigned to review the 14,166 physician applications the branch received in federal fiscal year 2006.[6] The chief of the branch explained that the branch does not allocate a specific number of hours that its staff will spend processing an application because each application is different and certain types generally take longer to process than others. However, he estimated that each full-time equivalent employee processes an average of three physician applications each day, which is consistent with the 3.3 applications our analysis indicated.

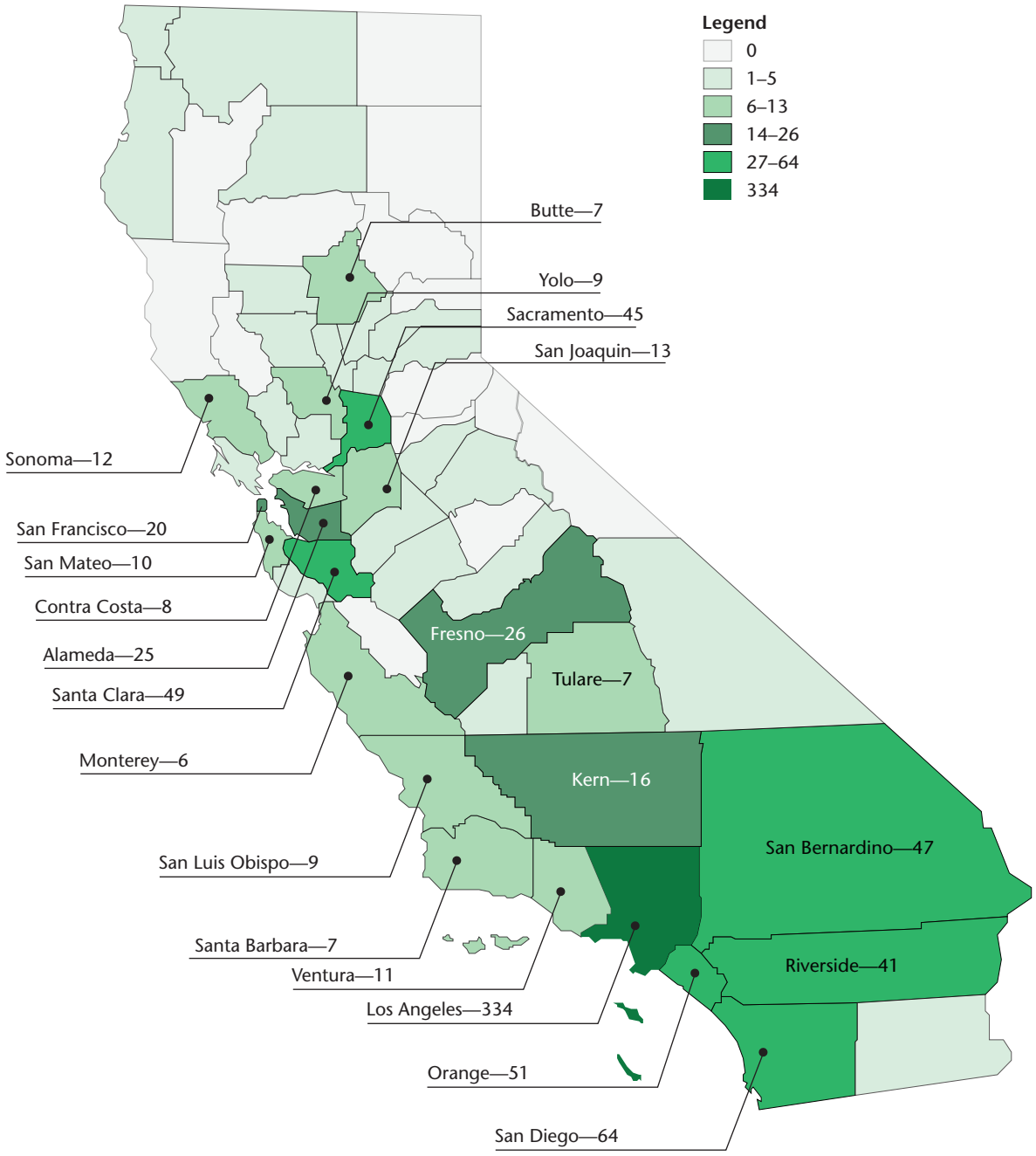
Although it does not monitor the average time it takes staff to review applications, branch management indicated that it does track the status of applications undergoing the enrollment process by using aging and inventory reports, which it generates from PETS. The aging reports list each application that is within 30 days or 60 days of the end of the applicable time period within which the branch is required to process the application. According to the chief of the reenrollment section within the branch, management uses these reports on a weekly basis to track the work that needs to be completed.

[5] Based on the Department of Finance's July 1, 2006, county population estimates.

[6] Because we found that the error rate of the provider type field in PETS data may be as high as 15.7 percent, we consider the information presented here to be not sufficiently reliable for determining the provider type. Consequently, using the branch's provider type information as the basis for determining an applicant's provider type could lead to incorrect conclusions.

FIGURE 2

Number of Physician Applicants Seeking Enrollment Into Medi-Cal by County Whose Applications the Branch Had Yet to Process as of September 30, 2006



Source: Bureau of State Audits' analysis of the Provider Enrollment Branch's (branch) Provider Enrollment Tracking System (PETS).

Note: Because we found that the error rate of the provider type field in PETS may be as high as 15.7 percent, we consider the information presented here to be not sufficiently reliable for determining the provider type. Consequently, using the branch's provider type information as the basis for determining an applicant's provider type could lead to incorrect conclusions. The purpose of displaying it is to show how the branch could use its current system to provide relevant information if it maintains accurate data.

According to the chief of the branch, management also uses inventory reports that display, twice a month, the number of applications the branch received and processed, the number of applications in its ending inventory, and the average number of days it took to process the applications. Although branch management indicated that they review this report to monitor the branch's progress in processing applications, the report has proven to contain errors. Specifically, because inventory reports did not include applications for which the completion date was entered into PETS in a subsequent reporting period, the branch was forced to correct the inventory report by reducing the number of applications in its ending inventory as of June 2006 by nearly 2,100.[7] According to the chief of the branch, this problem was remedied by performing a physical inventory of the branch's applications in June 2006 and modifying how it calculates ending inventory for the report. However, as we discuss later in this report, branch staff continue to enter incorrect application information into PETS, which affects management's ability to track the status of applications accurately.

Despite a Recent Reduction in Workload, the Branch Did Not Process Some Applications Within Required Time Periods, and Inaccurate Data in PETS Continue to Hinder the Branch's Ability to Track Application Status

Although the branch recently shortened its average time to process applications, it continues to review some after the required end of the processing period, and it automatically enrolls other applicants into Medi-Cal because it has not made a timely determination on the application. We reviewed the status of applications maintained in PETS for the period October 1, 2005, through September 30, 2006, and noted that the branch did not process 108 applications within the required processing period, as shown in Table 2. However, based on PETS data, the branch did not automatically enroll or appropriately notify 100 of these applicants as required, and automatically enrolled only eight into the program. Although we recognize that these applications represent a relatively small proportion of the total number of applications the branch processed in federal fiscal year 2006, our review identified a variety of weaknesses that could affect the branch's processing of other applications. When the branch does not process applications in a timely

[7] This adjustment is not reflected in the ending inventory shown in Table 1 on page 19 because the table is based on the Bureau of State Audits' analysis of PETS and not the branch's inventory report.

manner and does not automatically enroll or appropriately notify applicants, it may prevent or delay some eligible providers from delivering services to Medi-Cal beneficiaries.

TABLE 2

Applications Processed After the Respective Due Date Had Lapsed

Type of Application	Number of Applications the Branch Failed to Process on Time	Percent of Total	Outcome of Late Processing			
			Approved	Denied	Returned*	Referred
Resubmitted	61	57%	25	14	3	19
Preferred provider	10	9	0	0	10	0
Regular	37	34	10	2	1	24
Totals	**108**	**100%**	**35**	**16**	**14**	**43**

Source: Bureau of State Audits' analysis of the Provider Enrollment Branch's (branch) Provider Enrollment Tracking System (PETS).

Note: As we mention in the Scope and Methodology section of this report, we were unable to determine the accuracy of certain data fields in PETS because the branch does not maintain copies of all applications for which it enters information into PETS. In addition, certain data fields in PETS may be populated by branch staff using their judgment and certain information on applications the branch did maintain were inconclusive. Thus, these data are of undetermined reliability.

* Returned applications include those that the branch determined to be deficient or needlessly submitted by an existing rendering provider, or were withdrawn by the applicant.

As shown in Appendix A, according to PETS data, about two-thirds of these applications were for physicians seeking enrollment into Medi-Cal. The branch did not process these applications within the required time periods, which are listed in the text box on the following page, for several reasons. For instance, some applications remained in certain units within the branch, such as its policy and administrative section (policy section), for up to four months, while others awaited the final review and approval of branch managers for several days. These times are longer than those stated in branch policy. Specifically, effective November 2005, in an effort to ensure that branch staff review and process applications on or before the review due date, the branch instituted an internal policy that requires staff to submit applications recommended for denial to the policy section at least 40 days before the review due date,

Days Within Which Applications Must Be Processed or Referred, Upon Branch Receipt

- Provider application: 180 days
- Preferred provider application: 90 days
- Resubmitted application: 60 days

Source: California Welfare and Institutions Code, Section 14043.26.

requires the policy section to review and submit these applications to section chiefs at least 10 days before the review due date, and requires section chiefs to approve all applications recommended for denial at least five days before the application review due date. According to the chief of the policy section, the branch does not track the length of time applications remain in the policy section. Additionally, the chief of the branch stated that some applications are not processed within the required time period because branch staff sometimes enter an incorrect "application received" date into PETS, which may result in an incorrect default date.

The branch's policy of not tracking the length of time applications remain in the policy section caused some applicants whose applications were recommended for denial to be enrolled into Medi-Cal automatically because they were not processed within the required time period. When branch staff recommend that an application be denied, they generally are required to forward the application to the policy section to ensure that the determination is accurate and supported. Branch staff are instructed to enter into PETS the date they forwarded the application to the policy section, but PETS does not track how long an application remains there, and some applications stay in the policy section longer than the benchmark of 30 days that is stated in branch policy. Of the seven applications we reviewed that had been recommended for denial, each remained in the policy section after their respective due dates had lapsed, and thus the branch automatically enrolled the applicants into the program. Although the branch can remove these applicants from Medi-Cal while on provisional status if they fail to meet the standards for enrollment, they may submit claims for services provided to Medi-Cal beneficiaries from the date the branch received their application to the date of termination from the program. The department may recover payments made to ineligible providers, but it incurs additional costs when it must do so for providers who should have been denied during the enrollment process.

According to the chief of the policy section, more detailed tracking of the length of time applications remain in the policy section could help reduce the risk that some applications recommended for denial will be enrolled automatically because they were not processed within the required time period. For instance, he indicated that a report displaying certain additional dates would assist the branch in preventing the automatic

enrollment of applicants that it otherwise would deny. The report could include the date the application was submitted to the policy section, the date by which the application must be processed, the date the policy section made its final determination on the application, and the date the policy section provided the determination on the application to branch staff to draft the denial letter. He stated that this type of report would be valuable in helping the branch avoid having to enroll applicants automatically that it otherwise would deny. Additionally, a report listing these dates could help the department decrease the number of claims it pays to ineligible providers who otherwise would not have been enrolled in Medi-Cal.

Despite concerns the bureau raised in a May 2002 audit that branch staff were not entering data accurately and consistently into PETS, we noted that branch staff continue to enter data incorrectly.

Branch staff did not always enter the correct dates into PETS, which hinders the branch's ability to accurately track the status of applications it reviews. This problem also was noted in the bureau's May 2002 audit report titled *Department of Health Services: It Needs to Significantly Improve Its Management of the Medi-Cal Provider Enrollment Process*, Report 2001-129, which recommended that the branch determine whether its staff are entering data accurately and consistently into PETS. In the bureau's December 2003 audit report titled *Department of Health Services: It Needs to Better Plan and Coordinate Its Medi-Cal Antifraud Activities,* Report 2003-112, in response to the bureau's follow-up on the branch's implementation of this recommendation, branch management acknowledged that staff still may not enter the required or correct data.

During the fieldwork for this report, our detailed review of applications that the branch appeared to process after the required end of their time periods found that branch staff continue to omit dates and enter incorrect dates into PETS. Specifically, of the 179 applications that the branch appeared to process after the required period, 27 were actually processed on time but appeared to be late because branch staff had entered incorrect dates into PETS, such as the date the application was received and the date by which the branch must complete processing of the application. An additional 13 applications that the branch appeared to process after the required period were entered inadvertently into PETS by branch staff as duplicates of other applications, and were not removed from PETS until long after the original applications' due dates had lapsed. Further, in reviewing PETS data we noted 15 other applications that appeared to be long overdue and still were pending review as of September 30, 2006, while an additional 41 applications

appeared to be denied, but were still in process, in PETS. The applications remained open because branch staff did not enter the date on which they completed processing them. These errors hinder management's ability to track the status of these applications accurately.

Further, incorrect data in PETS led to improper handling of four resubmitted applications. These resubmitted applications contained deficiencies that the applicants had failed to remediate. However, because the applications had not been identified appropriately in PETS as being returned to the applicant, branch staff did not deny these applications, as required by state law, but instead returned them to the applicants for remedy a second time after the 60-day processing period had lapsed. Each of these applicants resubmitted their applications and each subsequently was enrolled into Medi-Cal. Consequently, the branch not only did not process these applications in accordance with state law, but it provided these applicants with an additional opportunity to remedy deficiencies after the 60-day processing period had lapsed that other applicants were not offered. However, the benefits of offering these applicants an additional opportunity to remedy deficiencies are noteworthy, given that all ultimately were approved and able to provide services to beneficiaries sooner than they otherwise would have had the branch denied their applications in accordance with the law.

Because four applications were not appropriately identified in PETS as being returned to the applicant, branch staff did not deny these applications, as required by state law, but instead returned them to the applicants for remedy a second time.

Although some applications are subject to secondary reviews by branch managers and more experienced staff, these reviews do not identify PETS errors like the ones just described. According to the chief of the branch, a secondary review is not always done when branch staff correspond with an applicant, such as sending a deficiency letter, or when branch staff enter application information in PETS, including the date the application was received. In fact, he explained, a secondary review is most likely to take place when new branch staff process an application. However, if branch management included in their secondary reviews of applications periodic reviews to ensure that staff are accurately and consistently entering the dates that the branch received, processed, or returned the application into PETS, the branch could gain assurance that the management reports it generates from PETS, described previously, contain accurate and complete information on the status of applications. This could improve the branch's capability to identify accurately those applications that are approaching their required processing timelines.

The branch was unable to locate two applications it subsequently closed in PETS, possibly preventing two applicants from providing services to Medi-Cal beneficiaries.

Additionally, the branch was unable to locate two of the 179 applications that it appeared to process after the required period. According to the chief of the branch's allied and physician section, the branch probably misplaced these applications shortly after it received them. She explained that for one application, the branch tried unsuccessfully to contact the applicant to request another application. She could not explain what happened to the other application. As a result, the branch closed the applications in PETS, possibly preventing two eligible applicants from providing services to Medi-Cal beneficiaries.

Further, we determined that PETS contains fictitious provider records, created as the result of staff training and branch testing of PETS, commingled with its production data. Best practices would dictate that staff training and branch testing of PETS should not occur in the production environment. Typically, it would occur in an environment that simulates the production environment, thus protecting the integrity of the production data. We identified 166 fictitious provider records in PETS data provided by the branch. As a result, we further question the integrity of PETS. The fictitious data will have to be removed from all branch management reports produced based on data from PETS. We did not include these records in our analysis of PETS for this report.

Finally, in a December 2006 feasibility study report, the branch recognized that PETS does not meet its current business needs and proposed a new system to address this and other problems. The branch specifically noted that PETS lacks key functionality such as timeliness alerts and that the branch's current processes contribute to high error rates associated with key data entry and lost documents. In response to these and other concerns, the proposed system will allow for the electronic submission of Medi-Cal provider applications and certain other integrated capabilities, which the branch anticipates will increase its ability to process them more efficiently. Under the current plan, which still requires budgetary approval, the branch projects a September 2009 implementation date for the new system. However, the types of problems previously described will continue if branch staff enter incorrect information into the new system.

The Branch Generally Identifies Deficient Applications Promptly, but Many Applicants Do Not Resubmit Corrected Applications on Time

Although the branch does not track the number of deficient applications it identifies, or the reasons for the deficiencies, it generally notifies applicants early in the required processing period that their applications are deficient. Because the branch does not track this information in PETS, we sampled 120 deficiency letters sent to applicants during federal fiscal year 2006. Our review of these letters found that the branch notified nearly 90 percent of applicants that their applications contained deficiencies before the 80th day of the required 180-day processing period.

Most Common Reasons for Deficient Applications During Federal Fiscal Year 2006

- Applicant failed to submit required document(s): 106
- Applicant's form(s) illegible or incomplete: 61
- Applicant ineligible for enrollment: 4
- Application inconsistent with state records: 8

Source: Sample of 120 deficiency notification letters, some of which had multiple deficiencies.

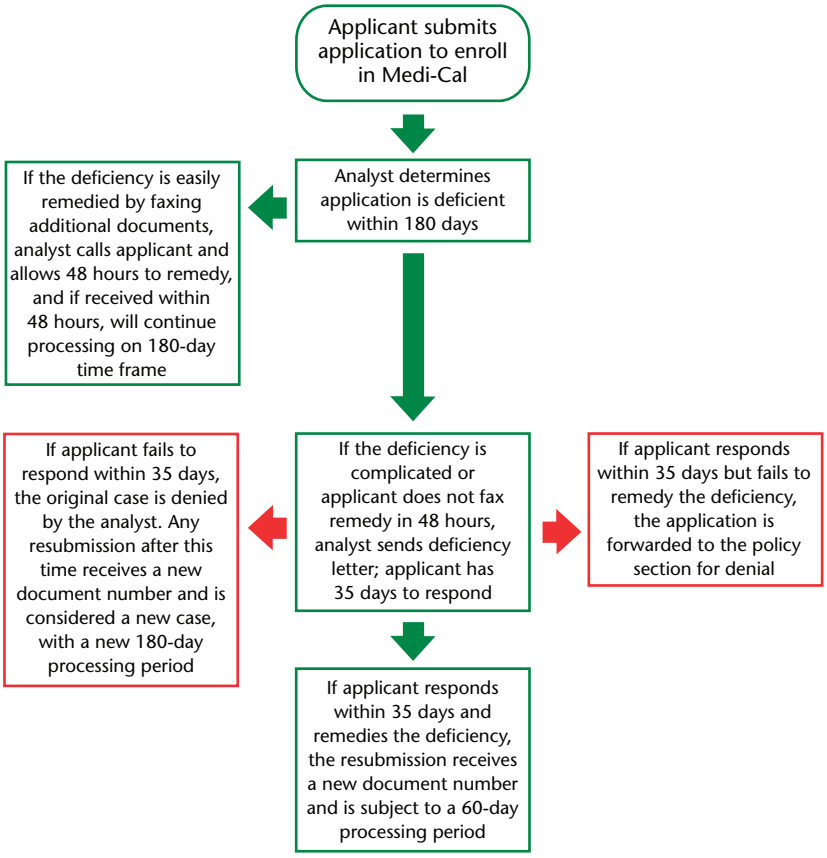
Based on this same review, and as shown in the text box, the leading reasons for deficient applications include applicants' failure to submit required documents and submission of incomplete or illegible forms. For instance, when applicants fail to submit a copy of their driver's license or proof of their tax identification number, the branch returns the application, citing that the applicant failed to submit the required documents. On the other hand, an application containing an incomplete disclosure statement will be returned to the applicant citing the forms were incomplete.

Figure 3 displays the branch's procedures for handling deficient applications. Once an applicant receives written notification that the application is deficient, the applicant must resubmit the application within 35 days. If the application is resubmitted after 35 days, state law requires the branch to deny the application and treat it as a new application. If applications are resubmitted within the 35-day period and the noted deficiency is remedied, the branch must process the application package within 60 days.

In comparison, the federal Medicare program gives applicants 60 days to remedy their deficient applications—25 days longer than Medi-Cal's time frame. This additional time could benefit Medi-Cal applicants who resubmit their applications shortly after the required 35-day time period ends. We reviewed the effect that a longer time frame would have, focusing on applicants that resubmitted their applications 11 to 25 days

FIGURE 3

The Branch's Procedures for Handling Deficient Applications



Sources: California Welfare and Institutions Code, Section 14043.26, and the Department of Health Services' policy.

after the 35-day time period, to allow for possible mail delays. According to PETS data, of the 658 applicants that resubmitted their applications 11 days or more after the 35-day period during federal fiscal year 2006, 258 (39 percent) resubmitted them within 11 to 25 days and 126 of these ultimately were approved.[8] However, because the branch treated these as new applications subject to the 180-day review period, these applicants were prevented from providing services to Medi-Cal beneficiaries as early as they otherwise could have. In fact, the branch took up to an additional 108 days, or about three

[8] As we mention in the Scope and Methodology section of this report, we were unable to determine the accuracy of certain data fields in PETS because the branch does not maintain copies of all applications for which it enters information into PETS. In addition, certain data fields in PETS may be populated by branch staff using their judgment and certain information on applications the branch did maintain were inconclusive. Thus, these data are of undetermined reliability.

and a half months, to approve these applications. Had state law authorized the branch to process these resubmitted applications within a 60-day time frame rather than a new 180-day time frame, a greater number of eligible providers could have provided services to beneficiaries sooner than they otherwise did.

Based on our review, we noted that the branch processed most resubmitted applications in a timely manner. Of the 2,973 applications that PETS indicates were resubmitted within the 35-day time period and processed during federal fiscal year 2006, the branch processed 2,912, or 98 percent, on time. Of the 61 applications that the branch did not process within the required 60-day time period, it appropriately notified eight that they were enrolled into the program automatically and placed on provisional status, but did not notify the remaining 53 applicants regarding the status of their applications within the required time period.

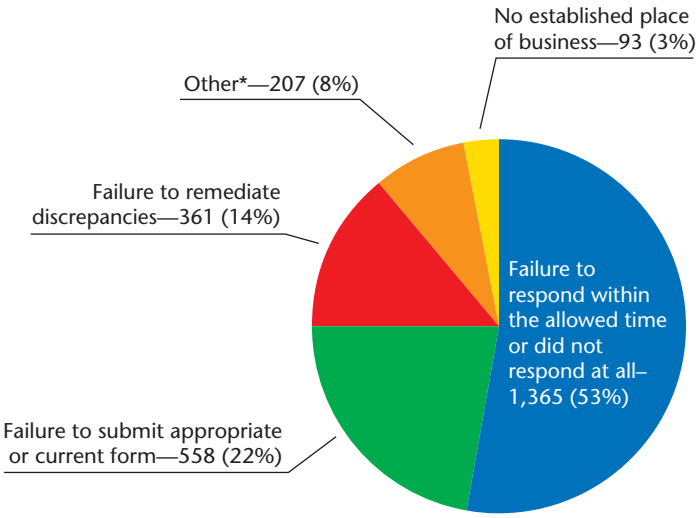
The main reason the branch denied applications during federal fiscal year 2006 is because applicants failed to resubmit remedies to their applications in a timely manner, or did not resubmit at all.

As we mentioned earlier, the branch must deny those applications that are resubmitted after the required 35-day period, or not resubmitted at all. In fact, this is the main reason the branch denied applications during federal fiscal year 2006. As shown in Figure 4, of the 2,584 applications that PETS indicates the branch denied, 1,365, or 53 percent, were denied because the applicants failed to resubmit in a timely manner, or did not resubmit at all. According to PETS, other reasons that the branch denied applications, also shown in Figure 4, include submitting an outdated or inappropriate form, failure to remediate discrepancies in the application, and lack of an established place of business.

Although PETS indicates that the second leading reason for denials is the submission of an outdated or incorrect form, the branch does not adequately inform applicants of this problem, which increases the number of applications it ultimately reviews and denies. According to the chief of the branch, several billing companies and credentialing departments, such as large provider groups and some hospitals affiliated with universities, may have an inventory of old applications on file, which their staff complete and submit on behalf of providers rather than using the most current application forms available on the department's Web site.

FIGURE 4

Reasons Why Applications Were Denied During Federal Fiscal Year 2006



Source: Bureau of State Audits' analysis of data from the Provider Enrollment Branch's (branch) Provider Enrollment Tracking System (PETS).

Note: As we mention in the Scope and Methodology section of this report, we were unable to determine the accuracy of certain data fields in PETS because the branch does not maintain copies of all applications for which it enters information into PETS. In addition, certain data fields in PETS may be populated by branch staff using their judgment and certain information on applications the branch did maintain were inconclusive. Thus, these data are of undetermined reliability.

* Includes applicants who do not hold the required license, failure to disclose required information in the application packages, fraud and abuse.

Most Common Reasons for Denying Provider Applications, According to the Department's Web Site

- Failure to respond timely.
- Failure to remediate discrepancies.
- Fraud and abuse.
- No established place of business.
- Failure to disclose required information in the application package.
- Provider does not hold the required license.

Source: Department of Health Services' Web site.

Despite this issue, the department's Web site does not list problems with forms as being among the main reasons applications are denied, as shown in the text box. The chief of the branch explained that it has presented this issue to provider associations and forums, and he agreed that the Web site should be updated to reflect that use of the incorrect form is a common cause for denial. When the branch does not notify applicants adequately that using old applications will result in denial of application packages, it increases the number of applications it must process and ultimately deny, and thus increases the length of time it takes some eligible providers to enroll in Medi-Cal. In turn, this may delay some beneficiaries' access to Medi-Cal providers.

Preferred Provider Status Offers Few Benefits to Applicants

The only benefit to an applicant of qualifying for preferred provider status is that the branch must process the application within 90 days instead of 180 days. Additionally, the application processing delays that led to the state law, effective January 1, 2004, that created preferred provider status generally no longer exist. As described previously, according to PETS, the average number of days the branch took to process an application ranged from 30 to 69 days during federal fiscal year 2006, causing the 90-day processing period to appear irrelevant. Preferred provider status also has a drawback for those providers ultimately approved for it, because state law requires the provider to remain on provisional status for 18 months—six months longer than applicants who enroll through the usual process and are subject to the 180-day review period. Given that the benefits this status offers applicants appear to be marginal, the value of the status is questionable.

TABLE 3

Reasons the Branch Denied Preferred Provider Status to Applicants Seeking Enrollment Into Medi-Cal During Federal Fiscal Year 2006

Reason for Denial	Total Number	Percent
Applicant was an active Medi-Cal rendering provider and did not need to apply	28	43%
Applicant failed to submit the required cover letter and documentation	19	29
Applicant submitted an incomplete cover letter and documentation	13	20
Applicant submitted an incomplete application package	5	8
Totals*	**65**	**100%**

Source: Bureau of State Audits' analysis of the Provider Enrollment Branch's (branch) Provider Enrollment Tracking System (PETS) and review of a sample of 60 applications requesting preferred provider status for which the status was ultimately denied.

Note: As we mention in the Scope and Methodology section of this report, we were unable to determine the accuracy of certain data fields in PETS because the branch does not maintain copies of all applications for which it enters information into PETS. In addition, certain data fields in PETS may be populated by branch staff using their judgment and certain information on applications the branch did maintain were inconclusive. Thus, these data are of undetermined reliability.

* The total number shown above is 65 because five applicants failed prescreening for more than one denial reason.

Very few applicants seeking enrollment as Medi-Cal providers benefit from preferred provider status. Specifically, PETS indicates that in federal fiscal year 2006, only 578, or 4 percent, of the 14,166 physicians seeking enrollment into Medi-Cal applied for preferred provider status. Of these applicants, the branch identified only 45 qualified for the 90-day application process, of which just 23 ultimately were approved for enrollment. Additionally, we noted that many applying for preferred provider status already were enrolled as rendering providers and subsequently were denied simply because they no longer were required to submit an application package when changing location or provider group.

Five Locations Most Commonly Reported by Those Applying for Preferred Provider Status

1. University of California, San Francisco: 186
2. San Francisco, Sunset District: 58
3. San Diego: 37
4. Elk Grove: 31
5. San Jose: 26

Five Specialties Most Commonly Reported by Those Applying for Preferred Provider Status

1. Radiology: 36
2. Internal medicine: 35
3. Anesthesiology: 30
4. Pediatrics: 30
5. Surgery (general): 17

Sources: Bureau of State Audits' analysis of the Provider Enrollment Branch's (branch) Provider Enrollment Tracking System (PETS) and review of application packages.

Note: As we mention in the Scope and Methodology section of this report, we were unable to determine the accuracy of certain data fields in PETS because the branch does not maintain copies of all applications for which it enters information into PETS. In addition, certain data fields in PETS may be populated by branch staff using their judgment and certain information on applications the branch did maintain were inconclusive. Thus, these data are of undetermined reliability.

Although the branch does not track the reasons that applicants are approved or denied preferred provider status, we were able to review checklists that branch staff use when prescreening applicants to determine whether they qualify for the 90-day application process. We randomly sampled 60 applications requesting preferred provider status to determine why they did not pass the prescreening. As shown in Table 3, nearly half of the applications we reviewed were denied because they were from rendering providers who did not even need to apply, and nearly one-half of the applications were incomplete or did not contain the required cover letter or documentation to support the applicant's eligibility for preferred provider status.

As shown in the text box, according to PETS, of the 578 applicants who did apply for preferred provider status, 186, or 32 percent, were from the University of California, San Francisco, and the cumulative total for the five most common locations accounted for 338, or 58 percent, of those applying for preferred provider status. Further, according to our review of their application packages, the most common specialties for those applying include radiology and internal medicine.

Although the application processing delays that led to the state law creating preferred provider status do not currently exist, such delays could arise in the future. If this were to occur, and given the branch denied preferred provider status to more than half of the applicants in Table 3 because their application

packages were incomplete or did not contain the required documents, it appears the branch should increase its efforts to convey to prospective applicants that their application packages will be denied if they lack these elements. Consequently, the branch could see a decrease in the number of applications it denies during the prescreening stage for preferred provider status, and thus increase the number of applicants who could benefit from the shorter processing time the status offers.

THE BRANCH'S REASONS FOR REFERRING APPLICATIONS LACK SPECIFICITY, AND REFERRED APPLICATIONS REMAIN IN PROCESSING FOR LONG PERIODS

The department is authorized to conduct, and the branch may request, additional reviews of applicants seeking enrollment into Medi-Cal to verify the accuracy of information provided in their application packages. However, the branch does not adequately track which of the department's review units it refers applications to or the reasons for these referrals. As a result, it may not be using its enrollment process effectively to help detect trends in Medi-Cal fraud. Further, state law does not prescribe the number of days within which the branch must approve or deny an application it has referred for further review. In fact, according to PETS data, we noted that the average number of days to process applications that the branch referred in federal fiscal years 2004 and 2005, from the date it received them to the date it made its final determination, was 322 and 255 days, respectively. Moreover, most applications the branch referred and processed during federal fiscal year 2006 ultimately were approved.

Units Within the Department to Which Applications Are Referred

Medical Review Branch: To conduct on-site inspections or reviews to verify applicant information.

Provider Enrollment Branch: To conduct additional research, often into processing procedures for provider types that are not already outlined in statutes or regulations, in order to determine the statutory authority for enrollment when there is not enough time remaining in the required processing period.

Office of Legal Services: To determine if an applicant's license status or past legal issues make him or her ineligible to be a Medi-Cal provider.

Licensing and Certification Program: To ensure that applicants, such as clinics, have appropriate licenses to operate as the provider type for which they are applying.

Source: Provider Enrollment Branch management.

The Branch Refers Applications to Various Units for Further Review but Does Not Track Referral Information Adequately

The branch may refer applications to other units within the department, as well as to analysts within the branch itself, to conduct background checks to verify the accuracy of information provided to the department and to prevent fraud and abuse if it finds discrepancies during the enrollment process. These secondary reviews may include on-site inspection before enrollment, review of business records, and data

searches. As the text box shows, the branch generally refers applications to several units within the department for various reasons. However, the branch failed to enter the units to which it sent 10 percent of the applications it referred in federal fiscal year 2006. Thus, we determined that PETS data relating to the units to which the branch referred applications for secondary review are not reliable because this data was not fully populated. The chief of the branch explained that this could prevent the branch from tracking the status of applications referred for secondary review. Further, in federal fiscal year 2006, the majority of the branch's 598 referrals were to the Medical Review Branch within the department's Audits and Investigations division, as shown in Figure 5 on the following page.

Once the branch refers an application for further review, state law does not prescribe the number of days within which the department must complete its review. When the unit to which the application was referred completes its review activities and reaches a determination regarding whether to recommend that the branch approve, deny, or seek additional information from the applicant, it returns the application to the branch. The branch is then responsible for reviewing the recommendation and making a final determination on the status of the application.

Although the branch uses specific review checklists and fraud indicators to process applications that appear questionable or suspicious, these checklists and fraud indicators generally do not align with the reasons the branch ultimately gives for referring applications in PETS. Branch staff are instructed to review applications using a streamlined checklist, but if they identify a fraud indicator they are to switch to a high-risk checklist.

Most Common Reasons Applications Are Referred, as Recorded in PETS

Mandated On-Site Visit: The branch automatically refers applicants from certain provider types previously identified as high-risk, such as durable medical equipment providers or certain nonchain pharmacies located in Los Angeles. Also, the Medical Review Branch requests that the branch refer certain applicants each time they apply.

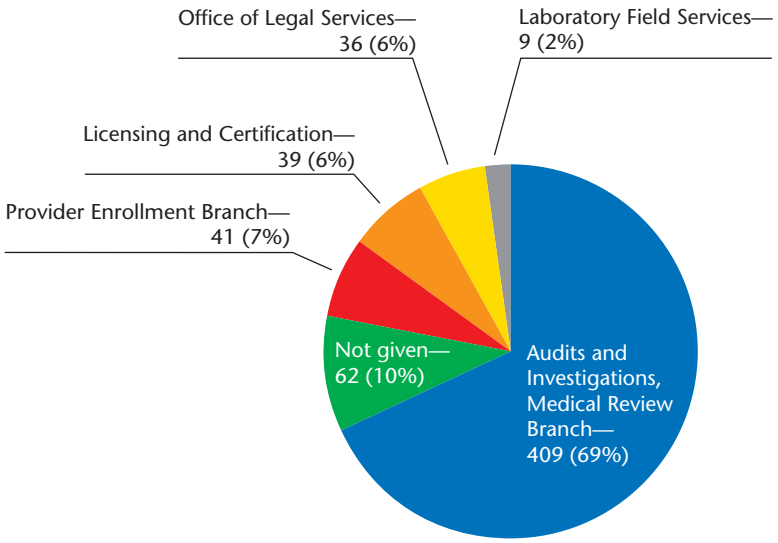
Suspicious: An analyst feels uncomfortable processing an application and has justifiable reasons for his or her concerns, such as a conversation with an applicant that raises doubts.

Source: Provider Enrollment Branch management.

Although the high-risk checklist and fraud indicators specify reasons on which to base the decision to refer an application, such as the department's previous experience with the applicant, these reasons do not align with the reasons available in PETS for staff to choose when referring an application. These reasons are shown in Table 4 on page 37, and some are explained further in the text box. Although branch staff attach a memorandum to each application they refer for further review that describes the reason for the referral and outlines the specific items

FIGURE 5

Number of Referrals by Referral Unit During Federal Fiscal Year 2006



Source Bureau of State Audits' analysis of data from the Provider Enrollment Branch's (branch) Provider Enrollment Tracking System (PETS).

Note: As we mention in the Scope and Methodology section of this report, we were unable to determine the accuracy of certain data fields in PETS because the branch does not maintain copies of all applications for which it enters information into PETS. In addition, certain data fields in PETS may be populated by branch staff using their judgment and certain information on applications the branch did maintain were inconclusive. Thus, these data are of undetermined reliability.

Note: Two referrals to the Medi-Cal Fraud Prevention Bureau are not included in this figure because they represent less than 1 percent of the total number of referrals, however, they are included in the total number of referrals in Table 4.

it would like the secondary review to address, these items are not captured in PETS. Rather, the common reasons for referring an application in PETS are not clearly tied to the branch's fraud indicators and high-risk checklists, or lack specificity, which hinders the branch's ability to track potential trends in fraud accurately. If the branch were to align the reasons available in PETS with its fraud indicators and high-risk checklists, it could better track the appropriateness of its high-risk checklists and update the fraud indicators as trends in fraud change over time.

TABLE 4

Applications Referred by Provider Type and Reason for Referral
Federal Fiscal Year 2006

Provider Type*	Reason for Referral†										Provider Type as a Percentage of Total Applications Received in Year
	Mandated On-site Visit	Suspicious	Other	Not Given	Pre-Enrollment	Address Change	Change of Owner	All Others	Totals	Percentage of Total	
Physician	10	57	52	43	28	11	3	23	227	38.0%	60.3%
Pharmacy/ pharmacist	58	14	0	0	1	1	5	2	81	13.5	4.1
Nonmedical practitioner	2	13	14	16	0	9	3	7	64	10.7	9.0
Medical transportation ground	40	0	0	0	0	7	4	1	52	8.7	0.6
Physician group	3	14	6	8	6	2	1	3	43	7.2	7.7
Clinic (exempt from license)	7	0	0	0	26	0	0	0	33	5.5	0.1
Durable medical equipment	22	8	0	0	0	0	0	1	31	5.2	1.8
Other	12	21	5	10	12	1	6	0	67	11.2	16.4
Totals	**154**	**127**	**77**	**77**	**73**	**31**	**22**	**37**	**598**	**100.0%**	**100.0%**
Percentages of Total Referrals	**25.7%**	**21.2%**	**12.9%**	**12.9%**	**12.2%**	**5.2%**	**3.7%**	**6.2%**	**100.0%**		

Source: Bureau of State Audits' analysis of the Provider Enrollment Branch's (branch) Provider Enrollment Tracking System (PETS).

* Because we found that the error rate of the provider type field in PETS may be as high as 15.7 percent, we consider the information presented here to be not sufficiently reliable for determining the provider type. Consequently, using the branch's provider type information as the basis for determinig an applicant's provider type could lead to incorrect conclusions. The purpose of displaying it is to show how the branch could use its current system to provide relevant information if it maintains accurate data.

† As mentioned in the Scope and Methodology section of this report, we determined that the data relating to the reasons the branch refers applications for secondary review are not sufficiently reliable since the data were not fully populated.

The available reasons in PETS for referring applications likely need updating. As shown in Table 4, nearly 13 percent of the applications referred by the branch give "other" as the reason, indicating that the referral reasons in PETS are no longer appropriate. Further, branch staff did not assign a reason for referring almost another 13 percent of the applications. Additionally, the chief of the policy section noted that three of the common reasons we found in PETS for referrals—"pre-enrollment," "address change," and "change of owner"—were problematic. He stated that these terms more accurately reflect the type of application being referred than the actual

In federal fiscal year 2006 nearly one-half of the referred applications were prompted by reasons that lack specifics for the referral, and another half were referred for reasons that do not clearly tie to the branch's fraud indicators or high-risk checklists.

reason for the referral. Consequently, nearly one-half of the referred applications were prompted by five reasons that lack specifics for the referral, and another half are referred for reasons that do not clearly tie to its fraud indicators or high-risk checklists. Therefore, the branch is not adequately tracking the reasons for referring applications. This shortcoming prevents it from contributing to the department's Medi-Cal fraud prevention efforts on an ongoing basis because it is unable to accurately detect and track potential trends in fraud during the enrollment process.

The Department Takes an Inordinate Amount of Time to Process Some Applications That the Branch Refers, Although Many Referrals Ultimately Are Approved

As we mentioned earlier, state law does not prescribe the number of days within which the department must complete additional review activities, such as conducting background checks and unannounced visits, on applications referred by the branch. Despite the lack of a required review period, our legal counsel has advised us that the units to which the branch refers applications, including the branch itself, have an obligation to make a good-faith effort to complete their review activities within a reasonable amount of time. However, in reviewing the applications the branch either reviewed itself or referred in federal fiscal years 2004 through 2006, we noted that the branch and the units to which it referred these applications took an inordinate amount of time to complete their additional review activities and reach a final determination on the applications, and they had yet to complete processing others. For those providers whose applications were referred and ultimately approved, these lengthy processing times may have delayed their ability to provide services to Medi-Cal beneficiaries.

For instance, and as shown in Table 5, PETS indicates the average number of days to make final determinations on applications the branch referred in federal fiscal years 2004 and 2005 was 322 days—or nearly one year—and 255 days—or almost nine months—respectively. In fact, according to PETS, three of the applications the branch referred in federal fiscal year 2004 were still in process as of September 30, 2006—averaging 1,048 days, or almost three years, of processing time—while 134 of the

TABLE 5

Number of Applications Referred by Year and Processing Outcome*

Federal Fiscal Year	Total Number of Applications Referred	Number Approved	Number Denied	Number Returned to Applicant	Number in Process	Average Number of Days to Final Determination*	Average Number of Days in Process, as of September 30, 2006*
2004	773	277	416	77	3	322	1,048
		(35.8%)	(53.8%)	(10.0%)	(0.4%)		
2005	919	282	259	244	134	255	582
		(30.7%)	(28.2%)	(26.5%)	(14.6%)		
2006	598	191	51	78	278	215	234
		(31.9%)	(8.5%)	(13.1%)	(46.5%)		

Source: Bureau of State Audits' analysis of the Provider Enrollment Branch's (branch) Provider Enrollment Tracking System (PETS).

Note: As we mention in the Scope and Methodology section of this report, we were unable to determine the accuracy of certain data fields in PETS because the branch does not maintain copies of all applications for which it enters information into PETS. In addition, certain data fields in PETS may be populated by branch staff using their judgment and certain information on applications the branch did maintain were inconclusive. Thus, these data are of undetermined reliability.

Note: These numbers may include some applications belonging to a provider group that the branch typically refers, denies, approves, or returns concurrently as a cluster. Thus, some of the final processing outcomes could reflect the branch making a final determination on a large provider group that included several applications.

* Average number of days to final determination is calculated by averaging the differences between the dates on which applications were received and the dates on which they were approved, denied, or returned to applicants. Average number of days in process applies only to applications identified as being in process in the table.

applications the branch referred in federal fiscal year 2005 were still in process as of September 30, 2006—averaging 582 days, or nearly 20 months in processing time.[9]

Similarly, in federal fiscal year 2006, the branch approved the majority of applications it referred for further review and made a final decision. As shown in Table 5, according to PETS data, the branch ultimately approved 191 and denied just 51 in that year. Our analysis of PETS data indicated that for only those 191 applications the branch approved, it took an average of 209 days after it received them to do so—or 29 days longer than the general 180-day processing period and significantly longer than the 30- to 69-day range for processing regular applications in federal fiscal year 2006.

[9] As we mention in the Scope and Methodology section of this report, we were unable to determine the accuracy of certain data fields in PETS because the branch does not maintain copies of all applications for which it enters information into PETS. In addition, certain data fields in PETS may be populated by branch staff using their judgment and certain information on applications the branch did maintain were inconclusive. Thus, these data are of undetermined reliability.

Of the applications the branch referred and made a final decision to approve or deny, it approved 191—taking an average of 209 days to do so—and denied just 51, in federal fiscal year 2006.

In addition to the analysis shown in Table 5 on the previous page, we also reviewed those referred applications, including those referred in years before federal fiscal year 2006, for which processing, including the secondary review, was completed during federal fiscal year 2006. According to PETS data, the department took an average of 233 days to process them from the date the branch referred them. Additionally, these referred applications remained in the enrollment process for an average of 318 days, ranging from 28 days to 1,178 days, from the date the branch received them to the date it made a final determination on the status of the applications. Of the applicants in this group that ultimately were approved or denied, based on PETS data, the branch approved 69 percent as Medi-Cal providers, in one case taking up to 1,007 days, or nearly three years, to approve the application.

According to the chief of the branch, the success or benefit derived from a referred application is not limited to denying applications and thus stopping the enrollment of high-risk providers. Rather, he explained, referrals, even if they result in approved applications, also serve as a deterrent to those intent on committing fraud and abuse. He stated that when referred applications are approved they may nonetheless be referred by the department to the California Medical Board or placed on special claims review when the applicant is enrolled as a provisional provider. Special claims review is a control the department uses to ensure that providers are filing accurate Medi-Cal claims by requiring them to submit documents to substantiate the nature, extent, and medical necessity of the services claimed. According to the chief of the case development unit within the Medical Review Branch, it is not common for applicants to be placed on special claims review when approved for enrollment. In fact, she stated that just seven approved applicants were placed on special claims review between October 1, 2005, and September 30, 2006. Additionally, she pointed out that five others were sent a letter identifying areas of correction that required their attention. The limited number of these additional levels of review calls into question the branch's referrals that ultimately were approved in federal fiscal year 2006, particularly because the branch's reasons for referring applications in PETS lack specificity.

The importance of the branch's ability to identify and refer those applications that are potentially high risk, and to adequately track referral reasons in PETS, has increased due to a recent shift in the priorities of the Medical Review Branch. Specifically, in

the department's 2005 Medi-Cal payment error study—which is intended to aid the department in its efforts to detect and prevent fraud and abuse in Medi-Cal as well as to help it develop appropriate fraud control strategies—it identified high-risk provider groups and recommended specific actions to review these groups and deter further abuse. As a result, the Medical Review Branch reprioritized its review efforts by focusing on conducting on-site reviews of pharmacies; expanding the number of investigational and routine field compliance audits of adult day health care facilities, physicians, and pharmacies; and providing training to various types of providers to focus on those parts of Medi-Cal at greatest risk of fraud, waste, and abuse.

According to the chief of the case development unit within the Medical Review Branch, since it reprioritized its review efforts, less time remains for secondary reviews of applications referred to it by the branch and there is currently a backlog of applications referred for secondary review.

According to the chief of the case development unit within the Medical Review Branch, since this reprioritization, less time remains for secondary reviews of applications referred to it by the branch. As a result, she indicated that there is currently a backlog of applications referred for secondary review that the Medical Review Branch has yet to assign to staff. Given this backlog and the Medical Review Branch's new priorities, it is imperative that the branch, with the department's assistance, align the reasons available in PETS for referring an application with the fraud indicators on its high-risk review checklists, and continually evaluate the frequency and applicability of the reasons given in PETS. These efforts could potentially lead to a decrease in the number of applications the branch refers for further review and thus increase the benefit of the Medical Review Branch's secondary reviews.

In fact, in the past six months the branch has not held its regular meetings with the Medical Review Branch, which served to foster information sharing between the two branches in a more formal setting than the occasional communication they may have regarding certain applications. These regular meetings included managers from the two branches, and topics discussed included the status of applications the branch had referred but the Medical Review Branch had not yet processed, as well as trends in fraud and the fraud indicators. The chief of the Medical Review Branch stated that the shift in priorities and special projects had sidetracked the regular meetings. Instead, the two branches have coordinated their efforts on a more ad hoc basis to expedite the processing of specific applications. The chief of the Medical Review Branch stated that the branch plans to resume these regular meetings in late March. We hope these meetings do resume, because without this more formal

Because the Provider Enrollment Branch and the Medical Review Branch have coordinated their application review efforts on a more ad hoc basis, we believe they limit their effectiveness in contributing to the department's antifraud efforts.

level of coordination, we believe the branch and the Medical Review Branch limit their effectiveness in contributing to the department's antifraud efforts because less emphasis is placed on tracking trends in fraud during the enrollment process.

When the branch refers applications for further review that it later approves, it could be doing a disservice to Medi-Cal beneficiaries because access to these providers and the health services they provide may not be as readily available. Moreover, because applicants that the branch refers for secondary review may have to wait for the Medical Review Branch to schedule its review, given its other priorities, the department may delay some eligible providers from providing services to Medi-Cal beneficiaries.

Finally, referring applications that it later approves indicates that the branch may need to reevaluate and update the high-risk indicators it uses when processing applications. To the extent that these high-risk indicators are no longer current and do not align with the reasons for referral available in PETS, the branch's ability to track the legitimate reasons it has for referring applications is hindered, decreasing its capability to detect potential fraud trends during the enrollment process.

THE DEPARTMENT MAY BE ABLE TO STREAMLINE ITS APPLICATION PROCESS FOR PHYSICIANS BY RELYING MORE ON MEDICARE DATA

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

The department may be able to rely on some of Medicare's data in the near future, instead of performing redundant verification procedures of applicant information.

to identify themselves as such.[10] Thus, the department can request applicants to provide their NPI on its Medi-Cal provider application, which it plans to do beginning in late May 2007. Consequently, for those physician applicants it identifies as being in good standing with Medicare, the department may be able to rely on some of Medicare's data instead of performing redundant procedures to verify the same information. Although it is too early to determine the effectiveness of these two initiatives, it could be worthwhile for the department to periodically assess Medicare's progress and the benefits the department could derive from this centralized source of information.

The State and the federal government individually administer the Medi-Cal and Medicare programs, although the two entities generally perform comparable physician enrollment procedures and require similar applicant information. In exercising its authority under state law, and in compliance with federal Medicaid regulations, the department has established regulations that require applicants seeking to participate in Medi-Cal to provide specific information in the application packages they submit to the branch. These state regulations also define the applicant information that the branch must verify as part of its enrollment process. Although Medicaid allows states to set their own standards for enrolling Medicaid providers, Medicare's contractors must follow provider enrollment standards that are uniform across all states, with the exception of licensure requirements that vary from state to state.

As shown in Appendix B, Table B.1, beginning on page 52, the federal government requires physicians seeking enrollment into the Medicare program to provide 34 of the 44 application elements that the department requires of Medi-Cal physician applicants. Further, Medicare verifies in its application review process most of the information that state regulations require the branch to verify, as shown in Table B.2 in Appendix B, on page 54.

Currently, the branch places little reliance on applicant information supplied by Medicare during its enrollment process. According to the chief of the branch, his staff use Medicare information only when they review the U.S. Department of

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

During the enrollment process, the branch does not require applicants to disclose their Medicare billing numbers and places little reliance on applicant information supplied by Medicare.

Health and Human Services' Office of Inspector General on-line Medicare Exclusion Database to verify that applicants seeking enrollment into Medi-Cal are not excluded from participating in Medicare. He explained further that the branch does not require applicants to provide their Medicare billing numbers, if enrolled. As a result, the branch does not track whether provider applicants are enrolled in Medicare and could not provide us with information that would allow us to determine the proportion of applicants who were Medicare providers at the time of application.

Moreover, the branch does not believe it could benefit from relying on Medicare information, because it believes its staff perform a more thorough review of applicants than that conducted by Medicare contractors. However, when we asked the branch to provide support that its review is more thorough, it could not provide any statistics or reports to demonstrate that Medicare's review was not sufficient.

As part of its antifraud efforts, the department has established more stringent enrollment procedures than it used in the past. For instance, to prevent fraudulent providers from enrolling and remaining enrolled in Medi-Cal, the department tightened the enrollment process by developing new regulations, applications, provider agreements, and internal security protocols to ensure the integrity of the provider enrollment process. A key element of these efforts is the reenrollment of providers to ensure that they are in good standing with Medi-Cal and do not present a high risk of fraudulent billing.

The department has not established a goal or timeline by which it plans to reenroll all providers. However, as the Medicare information on physicians becomes more current, the department may be able to rely more on this information and spend its time on those elements for which there are discrepancies between the Medi-Cal application and the Medicare information or that are unique to Medi-Cal. Although this streamlining of its physician application process may not provide large savings on an individual application basis, the cumulative savings could be significant. To the extent that this change creates time savings, the branch could allocate more staff resources to reenrolling current Medi-Cal providers, which could allow it to reenroll all providers sooner.

RECOMMENDATIONS

To ensure that it does not prevent or delay some eligible providers from delivering services to Medi-Cal beneficiaries, the branch should ensure that it promptly notifies applicants that it has automatically enrolled them as provisional Medi-Cal providers when the branch has not processed the applications within the required time periods.

The branch should modify PETS data to track the length of time applications it recommends for denial remain in the policy section for review, to ensure that it does not automatically enroll or pay the claims of ineligible providers when the review does not occur in a timely manner.

Branch management should include in the secondary reviews of applications periodic reviews to ensure that staff are accurately and consistently entering the correct dates the branch received, processed, or returned the application into PETS.

To protect the integrity of PETS data, the branch should remove all staff training and branch testing data from PETS and include it in an environment that simulates PETS, thus protecting the integrity of the production data.

To ensure that the branch does not unnecessarily increase its workload or prolong the enrollment process for eligible applicants, it should increase its efforts to notify applicants that they must use the current and appropriate application forms to avoid being denied enrollment into Medi-Cal.

The department should seek legislation to revise state law to extend the 35-day time period applicants have to remedy deficiencies in their applications to 60 days.

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

The branch, with direction from the department, should align the reasons available in PETS for which it may refer an application with its fraud indicators and high-risk checklists to better track the appropriateness of its high-risk checklists and update the fraud indicators as trends in fraud change over time.

To ensure that it is referring those applicants at greatest risk of committing fraud and not preventing eligible Medi-Cal providers from providing services to beneficiaries, the branch and the Medical Review Branch, with direction from the department, should reevaluate the appropriateness of the branch's high-risk fraud indicators periodically by consistently communicating and collaborating with one another.

The branch and the Medical Review Branch, with direction from the department, should place increased emphasis on processing those applications referred for further review within a reasonable time period, to ensure that some eligible Medi-Cal providers are not unreasonably delayed from providing services to beneficiaries.

The branch should monitor the implementation of Medicare's revalidation process in which it verifies the enrollment information for all its providers to identify opportunities for streamlining its application and verification procedures, and should make modifications as appropriate for Medicare providers seeking enrollment in Medi-Cal.

The branch should continue its plans to reenroll all its Medi-Cal providers and add any resources freed up by its streamlining of its enrollment process. ■

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

Respectfully submitted,

ELAINE M. HOWLE
State Auditor

Date: April 17, 2007

Staff: Nancy C. Woodward, CPA, Audit Principal
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APPENDIX A

Applications the Provider Enrollment Branch Processed After the Required Time Periods

The Joint Legislative Audit Committee requested that we identify the total number of applications that the Provider Enrollment Branch (branch) did not process within the required time periods, and to categorize these applications by type. We reviewed the branch's Provider Enrollment Tracking System (PETS) to identify applications that the branch did not process within the required time periods and analyzed supporting documentation for each application. Table A on the following page presents, by physician or nonphysician application, the number of resubmitted applications subject to a 60-day review period, preferred provider status applications subject to a 90-day review period, and general applications subject to a 180-day processing period that the branch did not process on time during federal fiscal year 2006.

TABLE A

Applications Processed After Their Due Date by Type of Application

Type of Application	Number of Applications the Branch Failed to Process on Time	Percent of Total
Nonphysicians—Total	36	33%
Resubmitted	19	17
Preferred provider	0	0
Regular	17	16
Physicians—Total	72	67
Resubmitted	42	39
Preferred provider	10	9
Regular	20	19
Physicians who are existing providers requesting a change of or additional address*	12	
Totals	**108**	**100%**

Source: Bureau of State Audits' analysis of the Provider Enrollment Branch's (branch) Provider Enrollment Tracking System (PETS).

Note: Because we found that the error rate of the provider type field in PETS data may be as high as 15.7 percent, we consider the information presented here to be not sufficiently reliable for determining provider type. Consequently, using the branch's provider type information as the basis for determining an applicant's provider type could lead to incorrect conclusions. The purpose of displaying it is to show how the branch could use its current system to provide relevant information if it maintains accurate data.

* The number of physicians who are existing providers requesting a change of or additional address are included in the three previous categories, but are presented as a subset to uniquely identify these types of applications.

APPENDIX B

A Comparison of Medi-Cal's and Medicare's Required Application Elements and Procedures Used to Verify the Accuracy of Applicant Information

The Joint Legislative Audit Committee requested that we compare the Department of Health Services' (department) provider application and enrollment procedures to those used for the federal Medicare program and identify any similarities and differences in the applications and the process used to verify provider information. Table B.1 on the following pages presents the application elements that both the California Medical Assistance Program (Medi-Cal) and the federal government require physicians seeking enrollment into the Medi-Cal and Medicare programs to provide.

As we mentioned in the Audit Results, the department's Provider Enrollment Branch (branch) processes applications submitted by physicians seeking enrollment into Medi-Cal, while the federal government uses designated fee-for-service contractors to process applications submitted by physicians seeking to enroll in the Medicare program. Table B.2, on page 54, presents the verification procedures used by branch staff and Medicare's contractors to confirm the accuracy and legitimacy of the information applicants provide in their Medi-Cal and Medicare application packages, respectively.

TABLE B.1

Medi-Cal and Medicare Physician Application Elements

	Medi-Cal Physician Provider Application Element	Does Medicare Physician Provider Application Include Element?
1	Enrollment action requested	Yes
2	Type of entity	Yes
3	Applicant's name	Yes
4	Business name	Yes
5	Business telephone number	Yes
6	Fictitious business name with legible copy of permit	Yes
7	Business address	Yes
8	Pay-to address	Yes
9	Mailing address	Yes
10	Medical license number with legible copy	Yes
11	Medical specialty(ies)	Yes
12	Medicare billing number	Yes
13	Taxpayer Identification Number (TIN) with legible copy of Internal Revenue Service form	Yes
14	Social Security Number, if sole proprietor not using a TIN	Yes
15	Clinical Laboratory Improvement Amendment certificate number with legible copy	Yes
16	State laboratory license/registration with legible copy	Yes
17	Driver's license or state-issued identification number and state of issuance with legible copy	No
18	Date of birth	Yes
19	Gender	Yes
20	Local business license numbers and permits with legible copies	Yes
21	Seller's permit number with legible copy or proof of exemption	Yes
22	Proof of liability insurance information with legible copy of certificate of insurance for the address given	Yes
23	Proof of professional liability insurance information with legible copy of certificate of insurance policy or coverage	Yes
24	Proof of maintenance of workers' compensation insurance, if applicable	Yes
25	Information on applicant's hospital privileges	No
26	Self-certification and statement of intent to employ a separate billing method for hospital/clinic-based physician, if practice location is a licensed facility	No
27	Original signature of applicant	Yes
28	Legal name of applicant as it appears on professional license, if applicable	Yes
29	Existing Medi-Cal provider number(s), if applicable	No
30	Whether applicant is applying as a rendering provider to a provider group	Yes
31	Lease or ownership of place of business information	No
32	Fines and debts due to federal, state, or local government related to Medicare or Medicaid	No
33	Names and locations of all health care providers in which applicant has an ownership or controlling interest	No
34	Information on conviction, liability, or settlement in lieu of conviction for fraud or abuse in any government program within the last 10 years	Yes
35	Information on past or present participation in Medi-Cal or another state's Medicaid program	No

	Medi-Cal Physician Provider Application Element	Does Medicare Physician Provider Application Include Element?
36	Information on whether applicant has ever been suspended from Medicare, Medicaid, or Medi-Cal and proof of reinstatement	Yes
37	Information on whether applicant has ever had license, certification, or other approval to provide health care suspended or revoked and written proof from licensing authority of restored privileges	Yes
38	Information on whether applicant has ever lost or surrendered a license, certification, or other approval to provide health care while a disciplinary hearing was pending	Yes
39	Information on whether applicant has ever had a license, certification, or other approval to provide health care disciplined by any licensing authority	Yes
40	Residence address, if applicant is an unincorporated sole proprietor or a rendering provider adding to a group	No
41	Information on all corporations, unincorporated associations, partnerships, or similar entities having 5 percent or more direct or indirect ownership or controlling interest, or any partnership interest in the applicant, if the applicant is not an unincorporated sole proprietor—similar to that required of the applicant in numbers 33 through 36	Yes
42	Information on all individuals having 5 percent or more direct or indirect ownership or controlling interest or any partnership interest, including all officers, directors, and managing employees of the applicant—similar to that required of the applicant in numbers 33 through 39 but also including information on any relationships and associations between individuals and the entities listed in number 41	Yes
43	Information regarding any contracts that the applicant has with subcontractors, along with information about the subcontractors' ownership or control	Yes
44	Information regarding the applicant's intent to sell or history of selling incontinence supplies	No

Sources: Medicare Enrollment Application for Physicians and Non-Physician Practitioners and the Medi-Cal Physician Application Package.

TABLE B.2

Medi-Cal and Medicare Verification Processes

	Information	Verification	Medi-Cal	Medicare
1	Medicare eligibility	Confirm that the applicant, and all individuals and entities listed on the application, are not excluded from the Medicare program by the federal Department of Health and Human Services' Office of Inspector General (OIG)	X	X
2	Corporate status	1. Review the Web site of the Secretary of State; and	X	X
		2. Review the articles of incorporation included with the application	X	X
3	Fictitious business name	Review the Web site of the Medical Board	X	X
4	Business phone number	1. Search phone directory Web sites for the phone number ownership and type; or	X	
		2. Call the number listed on the application directly	X	X
		3. Match the applicant's telephone number with known, in-service telephone numbers, using Qualifier.net to correlate applicant telephone numbers with addresses		X
5	Medical license	1. Confirm with the appropriate state agency that the license is current; or	X	X
		2. Review the notarized or "certified true" copy of the license included with the application		X
		3. Review the Qualifier.net Web site		X
6	State-issued identification	Review the copy of the applicant's driver's license or state-issued identification card to ensure the name agrees with the one on the application	X	
7	Federal Employer Identification Number	1. If a Federal Employer Identification Number is provided, confirm that the legal name on the application agrees with Internal Revenue Service documentation	X	X
		2. Review the Qualifier.net Web site to ensure that there is sufficient evidence to link the Federal Employer Identification Number with the person named on the application		X
8	Social Security Number*	1. Review the Provider Master File—the state's listing of active Medi-Cal providers—to determine whether there are other enrolled providers using the same Social Security Number, and if so, whether they are in good standing	X	
		2. If both a Social Security Number and a copy of the card are provided, ensure that the name and number on the card agree with the application	X	
		3. Review the Provider Enrollment, Chain and Ownership System to ensure the Social Security Number is linked to the applicant and that the applicant is not using more than one Social Security Number		X
		4. Review the Qualifier.net Web site to ensure that the applicant's Social Security Number has not previously been used		X
9	Liability insurance	Review the proof of professional liability and comprehensive liability insurance to ensure that it was current at the time of application	X	
10	Clinical Laboratory Improvement Amendment certification number	If a Clinical Laboratory Improvement Amendment (CLIA) certification number is provided, review the copy of the certificate included with the application to ensure that it is current, legible, and the name on the CLIA certificate agrees with the name on the application	X	X†

	Information	Verification	Medi-Cal	Medicare
11	State laboratory license/ registration	If a state laboratory license/registration number is provided, review the copy of the license/registration included with the application to ensure that it is current and legible and that the name on the license/registration matches that of applicant. If not, verify through OIG Web site and review the department's history with the applicant	X	X
12	Local business license numbers and permits	Review copy(ies) of the licenses and permits included with the application to ensure that they are current and legible	X	X‡
13	National Provider Identifier	Review notification from National Plan and Provider Enumeration System		X
14	Date of birth	Review the Qualifier.net Web site		X
15	Contact phone number	Call the number listed on the application directly		X
16	Absence of adverse legal action	Review the Qualifier.net Web site		X
17	Reinstatement after adverse legal action	1. Review proof of reinstatement	X	X
		2. Verify with the OIG and request applicant to submit written proof		X
18	Practice location	Review the Qualifier.net Web site to ensure that the location actually exists		X
19	Owners, corporate officers, partners, or managers are in good standing	1. Review the OIG Web site	X	
		2. Review the department's history of the applicant	X	
		3. Review the Provider Master File to determine whether any of the corporate officers or owners have ever been enrolled and, if so, are in good standing with the program	X	
		4. Perform a standard Web search on Google.com for information regarding disciplinary actions, disclosure information, and historical items of significance to provider enrollment	X	
		5. Review the Qualifier.net Web site		X

Sources: Department of Health Services' streamlined and high-risk physician and allied provider application review checklists and the *Medicare Program Integrity Manual* and physician and non-physician practitioner enrollment application.

Note: According to the *Medicare Program Integrity Manual*, all Medicare application data should be verified using Qualifier.net unless otherwise stated. Further, if there is a discrepancy between the information furnished by an applicant and the information on Qualifier.net, Medicare's contractors should use alternative methods to confirm the data in question. However, any information that is verified via supporting documentation, such as certifications and licenses, need not be verified through Qualifier.net. The table lists some of the elements that Medicare's contractors verify in addition to those verified by the Provider Enrollment Branch, but not all of them, since it is not the focus of this analysis.

* Neither Medicare nor Medi-Cal require that an applicant provide support for a listed Social Security Number.

† Medicare's verification of CLIA numbers with copies of CLIA certificates is implied by the Medicare application. Although this is not precisely stated in the manual, this verification procedure may fall under the broad rule, discussed in the note above, that any information that is verified by supporting documents need not be verified through Qualifier.net.

‡ Medicare requires only that applicants submit business licenses required by the applicant's state to operate as a health care facility or practice.

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Agency's comments provided as text only.

Health and Human Services Agency
California Department of Health Services
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April 2, 2007

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

Dear Ms. Howle:

The California Department of Health Services (CDHS) has prepared its response to the Bureau of State Audits (BSA) draft report entitled "Department of Health Services: It Needs To Improve Its Application and Referral Processes When Enrolling Medi-Cal Providers." The CDHS is appreciative of the work performed by the BSA and values any outside entities assessment of our programs, along with recommendations made as a result. While the CDHS is proud of the significant improvements it has made with regards to the enrollment of providers into the Medi-Cal program, the report highlights areas which can still be improved upon and provides valuable feedback to that effect. The CDHS intends to incorporate recommendations accordingly. Thank you for the opportunity to respond to the draft report.

Please contact Stan Rosenstein, Deputy Director, Medical Care Services, at (916) 440-7800 if you have any questions.

Sincerely,

(Signed by: Tom McCaffrey for Sandra Shewry)

SANDRA SHEWRY
Director

Attachment

* California State Auditor's comments begin on page 65.

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

"Department of Health Services:
It Needs to Improve Its Application and Referral Processes When Enrolling Medi-Cal Providers"

Recommendation:

To ensure that it does not prevent or delay some eligible providers from delivering services to Medi-Cal beneficiaries, the branch should ensure that it promptly notifies applicants that it has automatically enrolled them as provisional Medi-Cal providers when the branch has not processed the applications within the required time periods.

Response:

The California Department of Health Services (CDHS or Department) agrees that the Department has not immediately notified providers of their enrollment status when applications have not been processed within the required time periods. While the Department takes various measures to ensure that all applications are processed within the statutorily mandated timeframes, and continues to enhance these efforts, it recognizes that there have been a small number of instances where this was not the case. In these instances, providers received notification of enrollment status within two weeks of enrollment, and were allowed to submit claims for service retroactive to the date of application. The Department appreciates the concerns and recommendation regarding notification, and will implement a process for notifying these providers immediately upon enrollment.

Recommendation:

The branch should modify the PETS data to track the length of time applications it recommends for denial remain in the policy section for review, to ensure that it does not automatically enroll or pay the claims of ineligible providers when the review does not occur in a timely manner.

Response:

The CDHS agrees that the tracking mechanism, which is available in the Provider Enrollment Tracking System (PETS), must be better utilized by the Policy Unit to track the length of time applications are in their possession for review and denial. A report will be implemented to improve the tracking of applications that have gone to the Policy Unit for denial, ensuring that PEB Policy Unit staff do not allow applications identified for denial, to default.

Recommendation:

Branch management should include in their secondary reviews of applications periodic reviews to ensure that staff are entering the correct dates the branch received, processed, or returned the application accurately and consistently into the PETS.

Response:

The CDHS agrees that Branch management should conduct periodic reviews to ensure accuracy in entering the correct dates the branch received, processed, or returned the application in PETS.

The enrollment process currently includes a peer review process on all cases being approved for enrollment. In addition, peer reviewers and managers also review all deficiency and denial letters generated by new staff prior to release. After an application is approved, the information to be entered into the provider file is a three-step process to ensure accuracy and confidentiality. While CDHS management currently reviews new employee work and randomly samples the work of others, the branch will re-evaluate the frequency and depth of these reviews and adjust accordingly.

Recommendation:

To protect the integrity of the PETS data, the branch should remove all staff training and branch testing data from the PETS and include it in an environment that simulates the PETS, thus protecting the integrity of the production data.

Response:

The CDHS agrees with the recommendation that it must protect the integrity of the production data. The PETS system was originally developed to track a small number of applications being submitted as part of the initial re-enrollment effort. However, the number of records and purpose of the database significantly increased, resulting in limitations on system modifications. Removing current data from PETS test files can be completed by a PETS Administrator and the test cases can be deleted within a reasonable period of time. PEB will explore various alternatives for addressing the concerns, including, but not limited to, modification of testing procedures, and ensuring that future automation projects include a unique test and training environment.

Recommendation:

To ensure that the branch does not unnecessarily increase its workload or prolong the enrollment process for eligible applicants, it should increase its efforts to notify applicants that they must use the current and appropriate application forms to avoid being denied enrollment into the Medi-Cal program.

Response:

CDHS appreciates the recommendation to enhance methods of informing providers regarding the need to submit the most current and appropriate applications for enrollment. The analysis correctly identified that the frequently asked questions on the Medi-Cal website does not remind applicants that the use of outdated forms is one of the common reasons for the denial of applications. PEB is revising the frequently asked questions to include this information. These recommendations will complement the work done to date.

CDHS has taken multiple actions to reduce workload associated with the submission of incorrect applications, and the resulting delay in enrollment of providers. Among these actions, the CDHS ensures that the most current and up to date applications and forms are available on the Medi-Cal

website at www.Medi-Cal.ca.gov, as soon as the forms are made effective. In addition, the Provider Bulletin also notifies providers that a forms change is imminent and that only the newest versions of the application should be submitted. The branch has always allowed a grace period for the providers to obtain or download the newest versions. CDHS has accepted the older versions for a designated time period before denying outdated forms. The Department's fiscal intermediary Electronic Data Systems (EDS) is available to answer questions on forms and provide applicants with the most updated applications. Providers and applicants wishing to obtain the correct forms can also access the newest forms by going online to obtain the most current and correct forms. The Medi-Cal website also includes a *Frequently Asked Questions, Enrolling as a New Medi-Cal Provider and Application Tips* information links to assist providers in choosing and submitting the correct applications.

Recommendation:

The Department should seek legislation to revise state law to extend the 35-day time period applicants have to remedy deficiencies in their applications to 60 days.

Response:

The CDHS agrees with the recommendation to extend the 35-day time period applicants have to remedy deficiencies in their applications to 60 days. While most applicants do not have a problem meeting the 35-day requirement as demonstrated by the fact that in federal fiscal year 2005–06 more than 83 percent of resubmitted applications were returned within the 35 days, the Department recognizes that extending the period to remediate deficiencies, will likely result in more expeditious enrollment of some eligible providers. The Department would support legislation which expands this remedy period to 60 days.

Recommendation:

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

Response:

The CDHS acknowledges that the number of physicians applying for, and benefiting from, preferred provider status is small, and has decreased due to the introduction of the rendering provider regulations and the significant improvement in application processing times. While the majority of physicians have elected not to enroll under this status, the California Medical Association's (CMA) intent for introducing "preferred provider status" under SB 857 remains valid. SB 857 does not adversely impact the Branch's ability to process applications in a timely manner. Consequently, the Department recommends allowing physicians to weigh the cost/benefit of enrolling as preferred

providers. Should the Department identify a need to eliminate or revise preferred provider status, it will do so in cooperation with the CMA. In the interim, the Department will explore ways of increasing physician awareness of preferred provider status, and the reasons applicants under this status are not successful in meeting enrollment requirements.

Recommendation:

The branch, with direction from the department, should align the reasons available in the PETS, for which it may refer an application, with its fraud indicators and high-risk checklists to better track the appropriateness of its high-risk checklists and update the fraud indicators as trends in fraud change over time.

Response:

The CDHS concurs that it should align the referral reasons available in the PETS with its fraud indicators and high-risk checklists to better track the appropriateness of its high-risk checklists and update the fraud indicators as trends in fraud change. While referral reasons are limited in the PETS, the Medical Review Branch (MRB) and Provider Enrollment Branch (PEB) are working collaboratively to evaluate the fraud indicator checklists on a quarterly basis using findings from the on-going risk assessment analyses and the annual Medi-Cal Payment Error Study. The PEB is working to modify the reasons table in PETS to accurately reflect the referral indicators.

In addition, the Provider Enrollment Automation Project will improve PEB's ability to collect data regarding referral reasons. Currently, PETS only allows for the selection of one reason for a referral when in most instances there are multiple reasons that staff refer an application. The new system will allow staff to enter multiple referral reasons, resulting in more comprehensive data being available for analysis and trending.

Recommendation:

To ensure that it is referring those applicants at greatest risk of committing fraud and not preventing eligible Medi-Cal providers from providing services to beneficiaries, the branch and the Medical Review Branch, with direction from the department, should reevaluate the appropriateness of the branch's high-risk fraud indicators periodically by consistently communicating and collaborating with one another.

Response:

The Department concurs with the recommendation to reevaluate the appropriateness of the branch's high-risk fraud indicators periodically. PEB and MRB continue to communicate and collaborate together after the annual error rate study is completed to reevaluate high-risk fraud indicators. This allows both branches to have the advantage of the error rate study findings as we discuss issues and propose alternative procedures for the future.

Additionally, both branches are reconvening the previously established monthly meetings between branch managers in order to maintain open communications and initiate positive responses to recommendations. This meeting will include a quarterly evaluation of PEB review check sheets with findings from MRB field staff. These meetings will have a formal agenda and the minutes will be published internally.

Recommendation:

The branch and the Medical Review Branch, with direction from the department, should place increased emphasis on processing those applications referred for further review within a reasonable time period, to ensure that some eligible Medi-Cal providers are not unreasonably delayed from providing services to beneficiaries.

Response:

The Department concurs with the recommendation to have PEB and MRB process the referrals within a reasonable time period. Over the last three years, the Department has significantly improved the average processing time for cases that have been referred for further background review. We are committed to reviewing existing practices and streamlining efforts where appropriate. In a number of cases, however, extenuating circumstances prevent an expeditious review. Factors impacting this period include protracted litigation with providers under review, investigations by licensing authorities, and ongoing criminal investigation by the California Department of Justice, and or, the Federal Bureau of Investigation. Criminal investigations can be especially time consuming, often taking a year or more. To set a time limit on these cases would compromise the integrity of the investigation.

It is important to note that many of the providers referred for further background review already have a provider number, thus the delay in completing the review does not adversely impact the provider's ability to render services or submit claims for those services.

Recommendation:

The branch should monitor the implementation of Medicare's revalidation process in which it verifies the enrollment information for all of its providers to identify opportunities for streamlining its application and verification procedures, and should make modifications, as appropriate for Medicare providers seeking enrollment in the Medi-Cal program.

Response:

The CDHS agrees that it should monitor the implementation of Medicare's revalidation process and identify opportunities for streamlining its application and verification procedures as appropriate, for Medicare providers seeking enrollment in Medi-Cal. The department is committed to the efficient and effective processing of provider enrollment applications which ensure timely enrollment of qualified providers, and consistently seeks ways of improving enrollment practices. The

department, through communication with CMS has learned of Medicare's proposed regulations which attempt to mirror a great deal of the good work which has already been done in California's Medicaid program. Along with these regulatory changes, the department will monitor the progress of Medicare's revalidation process and evaluate the benefit of incorporating Medicare's review into the enrollment process.

Recommendation:

The branch should continue its plans to reenroll all of its Medi-Cal providers and add any resources freed by its streamlining of its enrollment process.

Response:

The CDHS concurs with this recommendation. CDHS commenced re-enrollment efforts in 1999 with the re-enrollment of Durable Medical Equipment (DME) providers. Since then, CDHS has initiated the re-enrollment of physicians, physician groups, optometrists, pharmacists, and providers originally enrolled prior to 1998, who may lack a current disclosure statement. Additional resources will be directed to re-enrollment as additional opportunities arise for streamlining enrollment processes.

High-risk provider types will continue to be identified through the coordinated efforts of PEB and MRB, using an on-going risk assessment analysis and the annual Medi-Cal Payment Error Study (MPES), allowing PEB to prioritize the reenrollment of these providers. This reenrollment plan, which is included in the CDHS' Medi-Cal Fraud Control Strategic Plan, consists of ongoing reenrollment efforts.

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COMMENTS

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

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

- As we report on page 26, the chief of the Provider Enrollment Branch (branch) explained that a secondary review is not always done when branch staff correspond with an applicant, such as sending a deficiency letter, or when branch staff enter application information in the Provider Enrollment Tracking System (PETS), including the date the application was received. In fact, although the chief of the branch explained a secondary review is most likely to take place when new branch staff process an application, these secondary reviews of applications do not include periodic reviews to ensure that staff are entering the dates that the branch received, processed, or returned the application accurately and consistently into PETS. Because incorrect data in PETS hinders the branch's ability to track the status of applications accurately, it is important for the branch to implement a method of verifying the accuracy of the data.

- We recognize that extenuating circumstances, including protracted litigation or criminal investigations, may prevent the department from processing certain referred applications within a reasonable time period. However, our recommendation focuses on those applications the branch refers to other units within the department that are under its control. Thus, the department has the ability to place increased emphasis on processing these applications within a reasonable time period. Additionally, our review of referred applications included those submitted by providers that may already have a provider number, but are requesting a change in address, an additional location, or a change in ownership. However, some of these providers may not render services or submit claims for these services at the new address, additional location, or under the new ownership, until the department has approved their application packages. Thus, to the extent the department delays completing its

secondary review and approval of these types of applications, it may delay some eligible providers from providing services to Medi-Cal beneficiaries.

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