



FACT SHEET

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The California State Auditor released the following report today:

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

BACKGROUND

Low-income Californians who lack health insurance can benefit from the California Medical Assistance Program (Medi-Cal)—a federal program, funded and administered by the Department of Health Services (department) through a state and federal partnership. An eligible Medi-Cal beneficiary can receive services from a provider, who in turn can bill the Medi-Cal program for services only when the provider has obtained a valid Medi-Cal provider number. The department is responsible for reviewing and approving providers, and reimbursing approved providers when services are rendered to eligible beneficiaries. Nearly seven years ago, the department established the Provider Enrollment Branch (branch), whose primary function is to review applications from potential providers and to prevent providers with fraudulent intent from participating in the Medi-Cal program.

KEY FINDINGS

Our review of the Medi-Cal provider enrollment and referral processes revealed the following key findings:

- For the period October 1, 2005, through September 30, 2006, the branch did not process 108 applications within the required time periods and of these, it did not automatically enroll or appropriately notify 100 applicants.
- Despite concerns we raised nearly five years ago, branch staff continue to enter incorrect data into the system that it uses to track the status of applications.
 - ✓ Staff omitted or entered incorrect dates.
 - ✓ Duplicate applications were created and not removed from the system until long after the original applications' due dates.
 - ✓ Four applications were improperly handled because staff did not appropriately record the information in the system.
 - ✓ Fictitious provider records were created during staff training and branch testing and were not removed from the system.
- Applications referred to other units for further review that were processed during federal fiscal year 2006 remained in the enrollment process for an average of 318 days—nearly one year—from the date of receipt to the date status was determined. One of the applications, which was ultimately approved, took 1,007 days—nearly three years. Additionally, the reasons for referral lacked specificity or did not clearly tie to fraud indicators or a high-risk checklist.

SELECT RECOMMENDATIONS

To improve its application and referral process, the department should:

- Protect the integrity of the data in the provider enrollment tracking system—eliminate fictitious data and periodically review staff entries.
- Reduce application processing time by adopting certain policies and practices, in particular, for those applications referred for further review.
- Reevaluate the high-risk checklist and fraud indicators periodically.
- Streamline its application processing process—track federal government changes and possibly rely on some of Medicare's data in the future.

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