DEPARTMENT OF FINANCE

ARNOLD SCHWARZENEGGER, GOVERNOR

915 L STREET ■ SACRAMENTO CA ■ 95814-3706 ■ WWW.DOF.CA.GOV

December 31, 2007

Stephen W. Mayberg, Ph.D., Director
California Department of Mental Health
1600 Ninth Street, Room 151
Sacramento, CA 95814

Dear Dr. Mayberg:

Final Report: Review of Claims Processes for the California Department of Mental Health's Short-Doyle/Medi-Cal Programs

Enclosed is the final report on our review of claims processes for the California Department of Mental Health's (DMH) Short-Doyle/Medi-Cal Programs. The Department of Finance, Office of State Audits and Evaluations, performed this review in accordance with an interagency agreement with DMH.

The final report includes a consolidated response from the DMH, the Department of Health Care Services, and the Health and Human Services Agency. We appreciate each of these organizations' assistance and cooperation with this review. If you have any questions, please contact Richard R. Sierra, Manager, or Brandon Nunes, Supervisor, at (916) 322-2985, Ext. 3159 or Ext. 3129, respectively.

Sincerely,

Original signed by:

Janet I. Rosman, Assistant Chief
Office of State Audits and Evaluations

Enclosure

cc: On following page

cc: Mr. Joe Munso, Deputy Secretary, California Health and Human Services Agency
Mr. Jim Alves, Assistant Secretary, California Health and Human Services Agency
Ms. Elaine D. Bush, Chief Deputy Director, California Department of Mental Health
Mr. Sean Tracy, Special Projects Manager, Director's Office, California Department of Mental Health
Mr. Stan Bajorin, Deputy Director, Administration, California Department of Mental Health
Mr. Mark Heilman, Acting Deputy Director, Systems of Care, California Department of Mental Health
Ms. Rita McCabe, Chief, Medi-Cal Mental Health Policy Branch, California Department of Mental Health
Mr. Stan Rosenstein, Chief Deputy Director, Health Care Programs, California Department of Health Care Services
Ms. Karen Johnson, Chief Deputy Director, Policy & Program Support, California Department of Health Care Services
Ms. Christy Quinlan, Deputy Director, Information Technology Services, California Department of Health Care Services
Mr. John Eastman, Deputy Director, Administration, California Department of Health Care Services
Mr. Irv White, Chief, Medi-Cal Benefits, Waivers, Analysis, and Rates Division, California Department of Health Care Services
Mr. Alex Kam, Chief, California Office of HIPAA Implementation

A Special Review

Report on the California Department of Mental Health

Review of Claims Processes for Short-Doyle/Medi-Cal Programs

Prepared By:
Office of State Audits and Evaluations
Department of Finance

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Executive Summary

In response to legislative and other stakeholders' concerns over late payments to Mental Health Plans (MHPs), the California Department of Mental Health (DMH) requested that the Department of Finance, Office of State Audits and Evaluations (Finance), review DMH's fiscal processes involved in the payment of local assistance claims for the Short-Doyle/Medi-Cal (SD/MC) Program, and make recommendations for streamlining and improving the payment processes.

The review confirmed that MHPs are not paid timely, and determined that the most far-reaching and mission critical weaknesses are program governance and the continued use of defective and outdated information systems. Most of the payment delays (and several of the observations in this report) stem from these over-arching deficiencies. DMH can better expedite payments to MHPs by improving governance, replacing defective systems, and eliminating inefficient manual processes. The following observations of the claims processes were identified, and the proposed recommendations, if implemented, would improve the SD/MC payment processes.

Program Governance. Governance over the SD/MC Program is fragmented, decentralized, and ineffective. Moreover, intradepartmental barriers between DMH and the Department of Health Care Services (DHCS) have impaired both organizations' ability to centrally govern and make the mission-critical changes needed to improve operations. The review found that:

- Communication and coordination between DMH and DHCS is poor.
- Performance benchmarks for critical claims processing functions do not exist.
- There is no single individual or unit with oversight responsibility for the SD/MC Program.
- A risk management process is not in place to identify threats to the SD/MC Program.

It is recommended that DMH and DHCS improve governance processes to ensure effective communication, coordination, and management of the SD/MC Program.

Information Technology. The various information technology systems used to process claims are at grave risk of failure, and contribute to significant payment delays. Moreover, delays in the implementation of a replacement for the primary system raise concerns about whether such replacement has been a high priority.

- Chief among these systems is the SD/MC System used by both DMH and DHCS to review and approve SD/MC Program claims. The review found that the SD/MC System is outdated and not compliant with the Health Insurance Portability and Accountability Act (HIPAA), and requires a cumbersome translation program to process claims. DHCS is responsible for system replacement, which is in progress but behind schedule. Further, DMH has not required MHPs to fully implement the electronic claims submission standards mandated by HIPAA which will impair any new system's effectiveness.

- Additional subsidiary systems that support the SD/MC System were also found to be deficient:

    - The HIPAA Translator has limited memory and cannot handle the current volume of claims, and as a result, is unreliable and at risk of failure. Until DHCS replaces the SD/MC System, claims processing will continue to rely on the HIPAA Translator.
    - The Access 97 Database used by DMH to process MHP claims has a history of

significant errors and periods of non operation. Substantial state resources have been expended to repair and maintain the system.

- The Invoice Processing System (IPS) used by DMH to create federal financial participation (FFP) invoices lacks sufficient controls over invoice creation and modification and may be unable to prevent duplicate payments.

DMH acknowledges the above systems weaknesses and has been working with DHCS on solutions, but progress has been slow. It is recommended that DHCS and DMH make systems replacement the top priority.

The review also determined that the lack of coordinated responsibility and a formal resolution process has impaired timely action on information technology issues.

Claims Processing. The current claims process is inefficient, slow, and poorly controlled. Serious flaws in the design and operation of the process significantly impair DMH's and DHCS's ability to effectively manage the payment function. The review found that:

- A key flaw is the bifurcated payment of state general fund (SGF) and FFP funds, whereby separate State Controller's Office (SCO) warrants are issued for the SGF and FFP portions of claimed amounts. Best practices require these funds to be combined in one payment.

- The calculation of SGF and FFP reimbursement amounts requires labor-intensive manual and semi-automated processes that can take up to a month to complete. Full automation of the reimbursement calculation process would correct this weakness.

- DMH's process of "invoicing" DHCS for the FFP due requires extensive effort by both departments to process, reconcile, and correct invoices. The process should be eliminated and replaced with an automated solution that utilizes information from the SD/MC System.

- Accounting and reporting systems do not provide timely, complete, and accurate information from which to effectively monitor and control SD/MC funds.

- DMH is at continued risk of overbilling the federal government because Early and Periodic Screening, Diagnosis and Treatment (EPSDT) claims are still included in Beneficiary Services for billing purposes, which may allow the errors to reoccur.

- Claims processing times should be improved. A limited sample revealed that the average processing times were 96 days for SGF and 109 days for FFP claims.

Cost Settlements and Audits. The cost settlement process is not timely. MHP-reported amounts may contain errors that are not discovered until the cost reports are audited years later, precluding timely and accurate expenditure forecasting. The review determined that:

- The cost settlement process is needlessly prolonged to include a small number of "good cause waivers" that result in no material difference in the total reported costs.

- Audits were not completed timely and the audit planning process could be improved.

DMH has already taken positive steps by conducting internal studies and convening special workgroups and committees to define problems and identify solutions. To further enhance these efforts, DMH and DHCS should develop a plan to address the observations and recommendations noted in this report.

BACKGROUND, SCOPE, AND METHODOLOGY

BACKGROUND

The California Department of Mental Health (DMH) leads the state's mental health system, ensuring the availability and accessibility of effective, efficient, and competent mental health services to eligible beneficiaries. To administer its programs DMH has oversight of an annual budget of more than $4 billion, including over $3 billion in local assistance funding. DMH receives more than 15 million expenditure claims from Mental Health Plans (MHP) annually. As a result of the significant increase in the number of local assistance claims in recent years and other issues, concerns have been raised by state legislators, local agencies, and other stakeholders about DMH's ability to efficiently manage its local assistance programs and timely process the related claims. This report is the result of a specific request by DMH to review payment delays and identify if there are any efficiencies to be gained.

DMH's claims processes are unusually complex, involving many stakeholders, systems, and procedures. Integral to these processes is the Short-Doyle/Medi-Cal (SD/MC) Program and the Short-Doyle/Medi-Cal System used to electronically process SD/MC Program claims (as explained more fully in Exhibit 1, SD/MC Programs consist of a group of related local assistance programs and activities). Further complicating the process is the unique relationship between DMH and the California Department of Health Care Services (DHCS). Although DMH has primary responsibility for its SD/MC Program, it relies heavily on the services provided by DHCS in connection with processing claims through the SD/MC System. DHCS owns and operates the system, adjudicates claims, and submits claims to the federal government on behalf of DMH and claimants to receive federal financial participation (FFP) funds. DMH has no control over the SD/MC System, even though this system is mission critical to its operations. This report attempts to sort through these complexities and provide management and users with information regarding the most vital claims processing issues in need of corrective action.

SCOPE AND OBJECTIVES

The Department of Finance, Office of State Audits and Evaluations, was requested to review DMH's funding, authorization, payment, accountability, and reporting of SD/MC local assistance expenditure claims, and identify ways to streamline and improve the processing of these claims. Specifically, the objectives of this review included:

- Review and evaluate the claims authorization and payment processes for the SD/MC Programs.
- Review and evaluate the information technology systems used to process SD/MC claims.
- Review and evaluate the cost settlement and audit processes.
- For the areas described above, identify activities subject to improvement and provide recommendations.

Our scope did not include an assessment of the accuracy of claims data or an inspection of supporting cost documentation. Further, this review did not assess or evaluate the efficiency or

effectiveness of the SD/MC Programs with respect to service or quality of care.
As noted in Observation 6, the lack of available documentation prevented a determination of the actual processing times for various tasks within the SD/MC claims processing function. As such, this is a limitation on the scope of our review.

METHODOLOGY

To evaluate the processing of SD/MC claims, we documented the current claims process by observing operations, reviewing policies and procedures, and conducting interviews with DMH staff, management, and consultants in the following units:

- Health Insurance Portability and Accountability Act (HIPAA) Compliance
- Information Technology
- Accounting
- Local Program Financial Support
- Medi-Cal Policy
- Medi-Cal Oversight
- Audits
- Medi-Cal, Epidemiology, Forecasting, and Support

We inspected a sample of submitted claims and accounting reports; reviewed organization charts, laws, regulations, and internal memorandums; and surveyed a sample of MHPs about their claims submission processes and interaction with DMH and DHCS. We also surveyed DMH and DHCS management in order to identify additional issues related to the fiscal oversight of the SD/MC Programs and the relationship between DMH and DHCS.

Because DMH is dependent on DHCS for a significant portion of its claims processing, we reviewed the programmatic and fiscal processes performed at DHCS. DHCS owns and operates a significant portion of the SD/MC payment system and is the single state Medicaid agency responsible for drawing federal funds; therefore, it was critical to review the role DHCS plays in the claims payment process. Interviews were conducted with representatives from the following DHCS and California Health and Human Services Agency (CHHSA) units:

- Specialty Mental Health Waiver (DHCS)
- California Office of HIPAA Implementation (CHHSA)
- Accounting (DHCS)
- Audit Analysis (DHCS)
- Office of HIPAA Compliance (DHCS)

To identify best practices, interviews were conducted with representatives from the Department of Alcohol and Drug Programs (ADP) and the Department of Social Services. Additional interviews were conducted with ADP (a user of the SD/MC System), and the Centers for Medicare and Medicaid Services (CMS), to gain an understanding about the FFP process, and in particular, DHCS's role in reviewing, approving, and paying claims.

Recommendations were developed based on data analysis, the documentation made available to us, and interviews with subject matter experts. This review was conducted during the period May 2007 through November 2007.

A review was performed of the California Department of Mental Health's (DMH) fiscal processes involved in the payment of Short-Doyle/Medi-Cal (SD/MC) Program claims. Opportunities for improvement were identified in the areas of governance, information technology, claims processing, cost settlement, and audits. Except where noted all recommendations pertain to DMH. Specifically, the following observations were noted during this review:

Program Governance

Governance is critical to ensuring that strategic direction and fiscal operations are sound, effective, and responsible. Clear performance goals and measures, communication, monitoring, and evaluation of results are all desired outcomes of effective governance. Governance establishes the tone and foundation for all of an organization's activities. The following weaknesses were identified during a review of DMH's and the Department of Health Care Services' (DHCS) governance processes:

OBSERVATION 1: Governance Over the Short-Doyle/Medi-Cal Programs, Processes, and Systems is Ineffective.

Governance over the SD/MC Programs is fragmented, decentralized, and ineffective. Fiscal infrastructure and oversight is not in place to ensure an efficient claims payment process, and institutional barriers between DMH and DHCS have impaired both organizations' ability to centrally govern and make the mission-critical changes needed to improve operations. This lack of effective governance is the primary cause of the current fiscal problems and stakeholders' loss of confidence in the state's administration of the SD/MC claims process.

A key factor is the bifurcation of management of the SD/MC claims payment process between DMH and DHCS; each department has different functions and responsibilities. For example, claims are submitted through one computer system owned by DMH and adjudicated in another system owned by DHCS. Additionally, claims are paid with a combination of state general funds (SGF) controlled by DMH and federal financial participation (FFP) funds controlled by DHCS. This is an inherent limitation that cannot be fully overcome because DHCS is the single state agency authorized to draw federal funds. Observations 2 and 5 identify information technology solutions that can help minimize the effect of this limitation.

Although DMH and DHCS are responsible for their respective parts of the SD/MC payment process, neither department has oversight of the entire program, and it is difficult for one department to implement changes if there is an impact to the other department. Due to a reluctance to cross departmental lines, there is a risk that process improvements will be delayed or avoided. The need for improved governance, communication, and coordination is a critical first step in improving the claims payment process.

The following opportunities exist for DMH and DHCS to improve program governance:

Communication

Communication needs to be improved between DMH and DHCS. Due to the division of duties described above, communication is critical to ensuring effective coordination between departments. However, in a survey sent to DHCS and DMH management, several respondents rated both communication and coordination between DHCS and DMH as "poor."

The following three situations illustrate prominent failures in communication. When DMH's Invoice Processing System (IPS) went on-line, the number of FFP invoices DMH was able to produce increased dramatically. However, DHCS was not aware that its Waiver Unit would receive a higher than usual number of invoices and so no plans were made to accommodate the increased workload. Additionally, when DMH's Access 97 Database failed periodically in recent months, DMH's ability to generate invoices for DHCS abruptly stopped. DHCS was not warned of these service interruptions. Once production resumed, DHCS was inundated with a large unanticipated backlog of invoices from DMH, resulting in significant processing delays. In another example, DHCS implemented a new duplicate claims identification process in the SD/MC System without adequately coordinating or communicating with DMH. Without an effective line of communication between DMH and DHCS, both departments will continue to experience an unpredictable workflow, unexpected delays in claims processing, confusion, frustration, and wasted staff time.

Effective communication between DMH and external stakeholders is also deficient. For example, Mental Health Plans (MHP) regularly call DMH when they need resolution on an issue or have questions regarding individual claims. However, DMH does not have an established process or a designated employee within DMH to call. Recently, a MHP employee had to go through 11 different DMH employees to answer one question regarding a claim's status. Clear communication channels would save time for both DMH and its stakeholders.

Performance Benchmarks

DMH has not established performance metrics for critical steps in high-priority processes. For example, DMH has not implemented benchmarks of acceptable processing times for the various steps in the SD/MC claims process. Benchmarks would help identify problems in a timely manner, and permit variances beyond acceptable limits to be researched and corrected. Without performance benchmarks, DMH management cannot evaluate how well its claims processes are actually performing.

Single Authority

There is no single employee or unit within DMH that has overall authority and responsibility for the SD/MC Program. The claims process is decentralized and involves several DMH units such as Medi-Cal Policy; Medi-Cal, Epidemiology, Forecasting, and Support; and Accounting. Establishing centralized control would help ensure accountability for the entire SD/MC Program and claims payment process. Further, claims processing times and procedures could be monitored at a higher level, which would allow for the timely identification of system problems and processing delays. Also, process changes that affect several units could be more effectively implemented if a single authority understands the global implications of these changes.

Risk Management

DMH does not have a formal risk management process to identify and evaluate risks to the accomplishment of strategic goals and objectives, and to ensure that programs are operating efficiently and effectively. Changes in technology, management, personnel, organizational structure, policies, procedures, regulations, and operating environment create risks that must be identified and addressed by management. The risk assessment process should be an ongoing effort and encompass critical business functions and potential failures. This is an important component of governance.

Recommendations:

A. Improve communication between DMH and DHCS. This communication should include timely notification of any issues that jointly impact both departments' daily operations. Current interdepartmental weekly meetings should be expanded to include problem identification and resolution as a regular agenda item. At these meetings, both departments should be free to air any issues that cross departmental lines. Develop a process that allows line staff to bring concerns to management for resolution immediately or at the interdepartmental meetings.

B. Improve communication between DMH and MHPs. Establish a centralized point of contact within DMH for MHPs to address concerns and questions, and to check the status of individual claims. DMH should promptly respond to MHPs with the requested information.

C. Develop performance benchmarks for SD/MC claims processing tasks, and regularly evaluate actual performance against these benchmarks. Promptly investigate significant variances and correct tasks/activities as needed.

D. Assign overall authority and responsibility for the SD/MC Program and Payment System to one individual or centralized unit within DMH.

E. Establish a formal risk assessment process of DMH's critical business functions and programs that regularly evaluates threats and timely mitigates these threats with appropriate control measures.

Information Technology

Information technology is an indispensable tool of modern government. Accordingly, each state agency is expected to seek opportunities to use this technology to increase the quality of the services it provides and reduce the overall cost of government. The following weaknesses were identified during a review of DMH's information technology infrastructure:

OBSERVATION 2: Information Technology Systems are Unreliable, Outdated, and at Risk of Failure

The information technology systems used by DMH to process claims are at grave risk of failure, contribute to significant payment delays, and cannot reliably and accurately process the large volume of claims received from the MHPs. Moreover, delays experienced in the implementation of a system replacement have increased the risk that claims processing will continue to be delayed and information could be lost upon system failure.

In addition, the unreliability of DMH's information technology systems has been the basis for multiple legal claims. Our review identified 21 pending legal cases against DMH for failure to pay mental health claims or failure to pay the claims timely, representing a potential liability to DMH of over $33 million. These cases specifically allege that DMH's and DHCS's electronic data systems are flawed. The risk of additional legal actions can be reduced by improving or replacing current information technology systems and streamlining claims processing times. Left uncorrected, these systems will continue to expose DMH to the risk of further legal action.

SD/MC claims processing relies heavily on the Short-Doyle/Medi-Cal Claims Processing System (SD/MC System), which is the responsibility of the DHCS. The current SD/MC System is outdated, not compliant with Health Insurance Portability and Accountability Act (HIPAA) standards, and requires a cumbersome translation program (HIPAA Translator system) to process claims. Furthermore, DMH's subsidiary accounting systems cannot accurately and reliably process MHP reimbursements. Although DMH and DHCS have made progress toward becoming HIPAA compliant by jointly developing a replacement system (referred to as the "SD/MC remediation project" or "new SD/MC System"), there is a heightened risk that the current system will fail before the new system can be implemented.

Significant delays in developing the new SD/MC System raise concerns on whether systems replacement has been a top priority. Development of the new system began in November 2003 and was originally scheduled to be completed in March 2005; however, that date was later revised and the new estimated implementation date is March 2009. The initial Information Technology Procurement Plan submitted to the Department of General Services in April 2006 took six months for final approval. In addition, the lack of qualifying bids for the DHCS Request for Proposal caused a further delay of eight months. The contract was finally executed on November 20, 2007. DHCS estimates that the project will take up to 18 months to complete. This estimate may be overly optimistic because the SD/MC remediation requirements were written over two years ago and did not consider subsequent technology and regulatory changes. In addition, the SD/MC remediation project will require tremendous coordination with all stakeholders, each with distinct needs and priorities. Active project monitoring and oversight by the California Health and Human Services Agency (CHHSA) would help mitigate the risk of project delays and ensure that the needs of all stakeholders are met.

The importance of replacing these information technology systems cannot be overstated. The high risk of system failure is amplified by the various subsidiary system weaknesses identified below:

HIPAA Translator

The HIPAA Translator has developed over time into a patchwork system that poses a significant risk of delayed processing, system failure, and noncompliance with state and federal requirements. These risks stem from numerous software modifications, lack of developer support, inadequate memory allocation, and a significant increase in the size and number of claims the system must process. In addition, an excessive amount of staff and consultant resources must be dedicated to operating, maintaining, and repairing the HIPAA Translator each month. Until the SD/MC System is replaced, claims processing will continue to rely on the HIPAA Translator. See Exhibit 1 for additional details.

Access 97 Database

The Access 97 Database has a history of significant errors and periods of non operation. Recently, the database failed to operate continuously for 29 days from March 13, 2007 through

April 11, 2007, and for 20 of 21 days from July 11, 2007 through August 1, 2007. In addition to lengthy delays in processing claims, these failures created huge backlogs that resulted in a surge in claims to be processed by DMH and DHCS once the database was repaired and operational. Substantial state resources have been expended to repair and maintain the system.

The database has also been responsible for various MHP payment errors. For example, during one period the database extracted disallowed claims from the Disallowed Claims System (DCS), but failed to flag them as such. As a result, the claims were extracted again and offset a second time, resulting in erroneous MHP offsets totaling $12.9 million.

Several additional issues underscore the vulnerability of this system to failure including reliance on manual processes that introduce the risk of human error, lack of reconciliation capabilities, corruptible macro commands, lack of system documentation, and insufficient access security and recovery safeguards.

DMH's Accounting Office uses the database to manually prepare paper claim schedules to the State Controllers Office (SCO), when electronic filing could save as much as ten days in processing time.

As an interim solution until a new statewide financial system is implemented, DMH has initiated the acquisition of a new commercial off the shelf (COTS) accounting system to replace the Access 97 Database currently in use. Properly designed, such a system would reduce errors, improve accountability and reporting, decrease claims processing time, and interface efficiently with CALSTARS, which remains DMH's primary accounting system.

See Exhibit 1 for additional details regarding the Access 97 Database.

Invoice Processing System

In June 2007, DMH activated the Invoice Processing System (IPS). The IPS was designed as an interim measure to improve invoice processing time until a comprehensive accounting solution could be developed, and to automate the labor intensive task of manually preparing invoices for FFP funds submitted to DHCS. Although the system effectively improves invoice processing time, we noted some areas of concern:

- The IPS allows for the creation of invoices that could include previously invoiced amounts. In addition, the system does not have supervisory controls over the invoice modification function. As a result, there is an increased risk that duplicate amounts may have been invoiced to DHCS for payment.
- The IPS was designed to extract data from the Access 97 Database, which has proven to be unreliable.

DMH acknowledges the above systems weaknesses and is already working on solutions; however, this review did not include an evaluation of systems proposed or under development.

Recommendations:

A. DHCS should make implementation of the new SD/MC System the top priority and take steps to develop and install a replacement system without delay.

B. CHHSA should take an active oversight role to monitor development and progress of the new SD/MC System, and ensure that the needs of all stakeholders are met and that the project is completed on time.

C. DMH should review and validate all invoices created within the IPS and ensure that any duplicate FFP amounts are promptly returned to DHCS.

D. DMH should expedite the acquisition and installation of the COTS claims accounting system to replace the Access 97 Database.

E. DMH should work with the SCO to implement electronic filing of claim schedules.

OBSERVATION 3: Information Technology Controls, Coordination, and Communication are Inadequate

DMH and DHCS do not adequately coordinate and communicate information technology issues and problems with each other. Further, critical information technology development at DMH and DHCS is not controlled by CHHSA resulting in user needs not always being met and lost opportunities for system integration and cost savings. Specifically, the following weaknesses were identified:

Controls Over Information Technology Development

Departments under CHHSA develop information technology solutions independently and without considering the possible benefits of collaborating with other departments on joint use solutions. These efforts represent a lost opportunity to maximize state resources and improve interdepartmental information exchange. Departments under CHHSA lack a long term road map of how technology can be leveraged to consolidate resources and improve the timeliness, accuracy, and reporting of Medi-Cal claims data. Moreover, information technology assets such as the HIPAA Translator and the Access 97 Database were developed outside the purview of DMH's Information Technology Unit. As a result, these systems lack centralized, coordinated oversight and adequate controls to ensure business needs are met and information assets are safeguarded.

Coordination and Communication

As important as communication is to the governance process as discussed in Observation 1, it is especially critical when implementing information technology changes. Our review determined that communication between DMH and DHCS needs improvement to ensure that current and future systems are developed, maintained, and operated efficiently and cost effectively. Although DMH's and DHCS's information technology staff meet regularly to discuss joint projects, coordination and communication continue to be ineffective. For example, on August 22, 2007, DHCS implemented a new duplicate claim identification process in the SD/MC System without adequately testing the process or coordinating with DMH. The upgrade failed to operate as intended and erroneously flagged a large number of claims as duplicates. Affected MHPs and DMH must now manually review over 50,000 claims to determine eligibility and, if valid, DHCS will need to manually process them for payment. The lack of coordination and communication resulted in unnecessary confusion and wasted staff time at both the MHP and state level. Although DMH and DHCS are actively working to resolve this issue, it highlights the importance of maintaining clear lines of communication between departments.

Additionally, DMH and DHCS do not have a formal process for reviewing and reprioritizing information technology service requests. The relative importance of an individual project may change over time between the initial request and project completion. Failure to periodically review service requests can result in low priority projects being completed ahead of high priority projects and state resources not being applied to the most critical information technology needs.

Recommendations:

A. CHHSA should establish an agency level information technology architect function that provides a uniform vision and guidance for all Medi-Cal departments to follow. The function should provide for the standardization of system platforms, create opportunities to leverage developmental costs, discourage development of incompatible information technology solutions, and ensure that systems development is based on legitimate business needs.

B. DMH and DHCS should develop a formal process to jointly review and discuss mutual information technology issues, including systems development, prioritization of information service requests and projects, operations, and maintenance. The communications should also include an early warning process for unresolved problems and significant threats.

OBSERVATION 4: DMH Has Not Required MHPs to Fully Implement HIPAA Requirements

MHPs have not fully implemented the electronic claims submission standards mandated by HIPAA and in some cases have not made measurable efforts to do so. Although 45 of the 58 MHPs are compliant with the Transaction and Code Sets (TCS) rule that will allow submission of electronic claims, none of the MHPs are compliant with the other rules that would allow MHPs to query the system for claims status and payment information. Further, DHCS has not yet determined a replacement identifier for the beneficiary's social security number (SSN). The lack of progress in conforming to these standards will negatively impact the effectiveness of the new SD/MC System. Specifically, claims processing times, response to MHP inquiries, fraud and error prevention, and safeguarding of confidential information will be adversely impacted.
The U.S. Department of Health and Human Services has established national standards for electronic health care transactions, national identifiers for providers, and security and privacy controls for health data. DMH must comply with certain TCS rules, the National Provider Identifier rule, and eliminate the practice of providers billing Medi-Cal claims using the beneficiary's SSN.

Recommendations:

A. DMH should develop a plan to ensure that all MHPs are fully HIPAA compliant prior to implementation of the new SD/MC System.

B. DHCS should promptly identify a new beneficiary identification standard to replace the beneficiary's SSN.

Claims Processing

Claims processing is one of DMH's core business functions. DHCS also plays an important role in DMH's claims processes. Claims received from MHPs begin the expenditure cycle and provide the basis for adjudication and disbursement. Any significant threat to the claims process must be promptly addressed by management. The following weaknesses were noted in DMH's & DHCS's claims processes:

OBSERVATION 5: The Current Claims Process is Flawed

The current claims process is inefficient, slow, and poorly controlled. There are inherent flaws in the design and operation of the process that significantly impair DMH's and DHCS's ability to effectively manage the entire SD/MC payment process and pay claims timely. Despite these flaws there are actions that DMH and DHCS can take to improve the claims process.

Bifurcated Payment Process

A key flaw is the bifurcated processing and payment of SGF and FFP claims, whereby separate SCO warrants are issued to MHPs for the SGF and FFP portions of claimed amounts. Once the claims are adjudicated, they follow separate payment tracks which effectively double the effort, time, and cost to pay claims. This process has evolved from DHCS's role as the single state agency authorized to draw federal funds, and DMH's role as the custodian of the SGF portion of the claim.

To obtain FFP funding DMH "invoices" DHCS for the FFP due. Once DHCS receives the FFP funds, it transfers the total amount to DMH. DMH then submits a claim schedule to the SCO to distribute the FFP funds to the MHPs.

Because of the time lag for receiving FFP funds, DMH will separately process and release the SGF portion as soon as adjudicated. DMH submits a separate claim schedule to the SCO to distribute the SGF portion of the claim.

To improve this process and eliminate the dual SCO warrants, DMH should combine and schedule the SGF portion for payment once the FFP funds are received and process both fund sources on the same claim schedule. This will require DMH and DHCS to closely coordinate activities and promptly request and obtain the FFP funds.

Reliance on Manual Processes

DMH relies on a number of inefficient and labor-intensive manual and semi-automated processes to calculate the SGF and FFP reimbursement amounts. Periodically DMH calculates the SGF and FFP amounts to reimburse for a given period. The entire process may take as long as one month to complete and must go through several different units at DMH to calculate, review, approve, and report the approved claim amounts. Because a portion of the process relies on Excel spreadsheets there is a significant risk of human error in the calculations. Further, DMH does not password protect the Excel information nor retain hardcopy records of the calculations to safeguard the information from unauthorized modification or loss.

Full automation of the reimbursement calculation process would correct this weakness. Such a system should be table driven to allow for periodic changes in calculation values and should be linked to the new SD/MC System as part of the claims adjudication process. DMH should retain responsibility for determining reimbursement rates, and DHCS (as part of its adjudication role) should assume responsibility for the ownership, operation, and maintenance of the reimbursement calculation system.

Weaknesses in the Invoicing Process

Invoices sent by DMH to DHCS requesting FFP funds routinely contain errors, omissions, and missing documentation. As a result, DHCS chooses to re-verify the claimed amounts by tabulating the supporting documentation and agreeing the totals to the invoiced amounts. This

laborious process involves using a ten-key calculator to add many pages of claims data for each invoice. DHCS estimates that the invoicing process takes a minimum of three to four weeks to complete. The inefficient use of staff time to manually re-verify the amounts represents an unacceptable waste of state resources.

There is also a disconnect between the FFP invoicing and claim schedule processes. DMH prepares invoices separately for each program based on claims for a specific fiscal year and service quarter. Conversely, claim schedules sent to the SCO to pay MHPs for their FFP are prepared based on combined claims for multiple programs, fiscal years, and service quarters. Because the payments are combined, DMH is unable to match FFP funds with the related claim schedule, precluding timely and effective reconciliation. DMH cannot perform reconciliations more frequently than quarterly, and only aggregate totals can be compared. As a result, there is reduced assurance that all FFP funds are received and distributed to the MHPs for the correct programs and time periods.

Elimination of the current invoicing process would solve these problems. DHCS and DMH should collaboratively develop a process to request FFP reimbursement that does not rely on the preparation of invoices by DMH. As the department responsible for adjudicating claims and calculating the FFP amounts, DHCS has immediate access to all claims data currently used to create invoices and could efficiently identify the total FFP to draw during a given period. Any changes should be implemented concurrently with the new SD/MC System. Implementation will also require coordination between DMH and DHCS to identify and resolve departmental reporting needs for the Centers for Medicare and Medicaid Services (CMS).

Recommendations:

To accomplish required changes and efficiencies, DMH and DHCS will need to reengineer existing processes (several of which will require information technology solutions); however, the benefits will exceed the costs and result in more timely payments to MHPs. The following recommendations should be implemented in conjunction with installation of the new SD/MC System:

A. DMH should combine and process both FFP and SGF amounts on one claim schedule that results in a single warrant to each MHP.

B. DHCS and DMH should jointly develop an automated SGF and FFP rate calculation system. In the interim, password protects all critical documents and retains hard copies.

C. DMH should eliminate the current "invoicing" to DHCS for the FFP due. DHCS should use information from the SD/MC System to identify and draw the appropriate FFP funds. CMS should be consulted prior to developing a new process to ensure that all federal requirements are met.

OBSERVATION 6: Accounting and Reporting Systems Do Not Provide Timely and Accurate Information

DMH's internal accounting and reporting systems do not provide timely and accurate information to effectively monitor the SD/MC Programs and ensure that funds are properly recognized and controlled. Improvement is needed in the following areas:

- DMH does not maintain subsidiary ledger accounts for each MHP showing claims submitted, claims paid, and offsets applied for each program. DMH is unable to efficiently ascertain a

given claim's status at any time during the payment process. The information is available but not readily accessible without extensive investigation and reconstruction. The lack of organized and detailed accounts by MHP and program significantly impairs DMH's control and accountability for SD/MC funds, increases staff workload to research and reconcile discrepancies, and precludes timely response to MHP inquiries. Implementation of the COTS described in Observation 2 should help mitigate this problem.

- DMH does not consistently monitor the appropriation balances for each SD/MC Program to ensure that sufficient SGF and FFP funds will be available to pay MHPs. Due to the lengthy payment delays and extended cost settlement periods noted elsewhere in this report, DMH is vulnerable to loss of spending authority through funds depletion or reversion for a given budget year.

- DMH does not establish accounts receivable for MHP offsets, and as a consequence, may be unable to determine if all amounts due have been identified and all offsets applied. Offsets can result from disallowed claims, audit findings, cost settlement, or overpayments. DMH does not record or monitor the offsets and there is no follow-up to determine if the amounts were collected.

- In connection with the above receivables issue, DMH does not have procedures in place to ensure that overstated FFP is promptly returned to CMS within 60 days as required by Title 42, Section 433.312 of the Code of Federal Regulations. Typically, overstated claims are informally offset against future claims (although no receivable is established); however, in some cases the MHPs may not have sufficient future claims to completely offset the amount overpaid. This may result in DMH not returning the FFP funds to CMS within the required timeframe, which could lead to penalties or other sanctions against the state.

- DMH does not maintain adequate records of SD/MC claims processing activities and is unable to monitor claims processing functions and performance. Specifically, task completion dates and times for each claim are not documented throughout the process, precluding accountability for individual tasks and identification of delays. A test of claims processing times was attempted with the objective of tracking selected claims through the entire payment process, to identify backlogs and their causes. However, large amounts of missing data (e.g. claim numbers, receipt dates, completion dates, etc.) and discrepancies in the available data prevented an evaluation of processing times. DMH management could not explain why some claims took over a year to process.

Recommendations:

A. In conjunction with development of the COTS, establish subsidiary ledgers for each MHP and program in sufficient detail to permit a timely determination of a given claim's payment status.

B. Monitor appropriation balances to ensure that sufficient SGF and FFP funds will be available for expenditure.

C. Record all disallowed claims, audit findings, cost settlements, overpayments, and other adjustments as accounts receivable. DMH supervisors should review and approve all offsets before they are applied against MHP claims and liquidation of the related receivable.

D. Establish procedures requiring the prompt identification, collection, and remittance to CMS of any overpaid FFP funds.

E. In conjunction with development of the COTS and installation of the new SD/MC System, establish an automated and searchable claims tracking function that identifies claims processing times and dates, from receipt through adjudication and payment. In the interim, use control logs to accurately record this information.

OBSERVATION 7: The Risk of FFP Billing Errors Still Exists

DMH is at continued risk of over billing the federal government because of insufficient corrective actions in response to previous billing errors. Additional measures must be taken to ensure that FFP claims are accurate.

Late in 2005, DMH discovered that it inadvertently double billed for FFP claims totaling $287.4 million for fiscal years 2003-04 and 2004-05. The double billing occurred because a DMH employee did not realize that EPSDT claims are a component of the total Beneficiary Services costs. As a result, FFP was billed twice: once under Beneficiary Services and again after the EPSDT portion of Beneficiary Services was calculated. EPSDT is still included in Beneficiary Services for billing purposes, which may allow the errors to reoccur. Further, the process relies on manual procedures and spreadsheets that introduce additional risk of error.

Annually, DMH prepares a credit memo which is used as a source document for making accounting adjustments at both DMH and DHCS. This credit memo separates the total cost of EPSDT claims from the Beneficiary Services category. However, the credit memo process does not prevent a double billing from occurring because it is recorded after EPSDT claims have been submitted to DHCS.

Recommendation:

Eliminate the credit memo process and implement an information technology solution that separates EPSDT claims from Beneficiary Services near the beginning of the claims payment process, and before they are submitted for FFP reimbursement. This solution should include the establishment of a program cost account (PCA) for EPSDT claims.

OBSERVATION 8: Claims Processing Times Do Not Meet State and Federal Standards

Claims processing times must be improved. A limited sample of 134 claims from January 2006 through June 2007 revealed that the average overall processing times were 96 days for SGF and 109 days for FFP claims. The extended timelines violated state and federal claims payment standards. Section 927.5 of the California Government Code requires Medi-Cal payments to be completed within 30 days; and Title 42, Section 447.45 of the Code of Federal Regulations requires 90 percent of claims be paid within 30 days and 99 percent within 90 days.

As noted in Observation 6 the lack of complete documentation prevented a determination of the timeliness of specific tasks within the overall claims process, or an identification of the actual reasons for the delays. However, based on our observations the delays can be attributed to a combination of factors as stated elsewhere in this report: lack of effective governance, information technology failures, over-reliance on manual processes, and human error.

Recommendations:

A. Reduce claims processing times to comply with state and federal standards. Observation 5 identifies actions DMH should take to improve claims processing times.

B. Establish performance benchmarks for key processing tasks and monitor compliance with those benchmarks.

Cost Settlements and Audits

Cost settlement reports are an important part of the funding process because they capture data, such as MHP administrative costs, that may not be completely reported in individual claims, but which are still appropriate and subject to reimbursement. Additionally, DMH's Audit Unit conducts fiscal audits of MHPs' cost settlement reports. These audits play an important role in ensuring the fiscal integrity of the claims process.

OBSERVATION 9: Cost Settlements and Audits Are Not Performed Timely

The cost settlement process is complex, labor intensive, and not timely. Moreover, MHP-reported amounts may contain errors that are not discovered and corrected until the cost reports are audited, which can occur up to three years after DMH's acceptance of the amended cost reports. As a result, accurate data on SD/MC costs may not be available for up to five years after the end of the reported year, precluding timely and accurate expenditure forecasting. The review identified the following weaknesses in DMH's cost settlement and audit processes.

Cost Settlement

The cost settlement of SD/MC expenditures is not performed timely. The final cost settlements are approved by DMH up to 20 months after the end of the fiscal year, and any FFP or SGF due to or from the MHPs is not paid or collected for up to 24 months. MHPs submit an initial cost report by December 31 following the end of the fiscal year. An amended cost report is submitted up to 12 months later in order to capture all submitted and paid claims. A primary cause for the delay is that the cost settlement period is left open in order to include an immaterial number of claims submitted under a good cause waiver. However, of all claims received by DMH for fiscal year 2005-06, only three percent had a good cause waiver. As a result, the process is needlessly prolonged, results in no material difference in the cost settlement amounts, and creates additional workload for DMH staff.

Recent audits performed by DMH's Audit Unit of the fiscal year 2001-02 cost settlement reports indicated that the reports included significant errors. Of the 51 MHP cost reports audited, 51 (100 percent) contained errors that resulted in overpayments of approximately $38 million in FFP expenditures and $9.7 million in SGF expenditures. These overpayments illustrate that postponing the cost settlements for good cause claims does not ensure accuracy and completeness because cost settlements are not considered accurate until they are audited.

As a best practice, good cause claims and other data should be handled separately and submitted by the MHPs to DMH's auditors as potential audit adjustments at the time of audit. This is similar to practices utilized by DHCS and results in materially accurate data being captured without delaying the cost settlement process.

Audits

- Audits are not completed timely. Of the 51 MHP cost reports audited during fiscal year 2006-07, 34 (67 percent) were not completed within three years of submission of the amended cost report. Overpayments identified as audit adjustments may be at risk of non-collection if audits are not completed within the three-year timeframe prescribed by the Welfare and Institutions Code. Untimely audits cause MHP errors to remain uncorrected and repeated on subsequent reports, and also preclude DMH from having access to accurate and complete cost data for up to five years. Audits can be accomplished more timely with existing resources by performing more desk audits, selected high risk field audits, and accepting (on a rotational basis) low risk cost reports as submitted. Using this approach over the long-term, audits could eventually be completed within 24-36 months of the fiscal year end and still allow DMH to maintain the current level of recoupments.

- There is no documented risk analysis used as a basis for selecting which cost reports to audit. A risk analysis should consider such factors as known MHP oversight problems, disallowed claims, billing errors, volume of claims, and the potential for fraud. Among the benefits of a rigorous risk assessment process are that audit resources are used more efficiently and effectively and are directed to higher risk areas.

- The audit program/plan does not include a procedure to review the MHPs' internal oversight activities. Some MHPs regularly disallow their own claims based on a self-review and/or audit of their submissions. A review of these internal oversight efforts (including the frequency of MHP-initiated provider audits) would help identify monitoring and control weaknesses. The Audit Unit's identification and reporting of these weaknesses would help improve local accountability over the claims and cost reporting processes.

Recommendations:

A. Require MHPs to submit final cost reports by December 31 following the end of the fiscal year. Eliminate the acceptance of amended reports beyond this date and use the December 31 reports as the basis for cost settlement and audit.

B. Conduct cost report audits within three years of submission of MHPs' cost reports.

C. DMH's Audit Unit should annually complete and document a comprehensive risk analysis of all MHPs as a basis for selecting which cost reports to audit. In the analysis, include all risk factors that are appropriate to effectively plan and execute the audits. Revise the audit plan/program to include a review of MHPs' internal monitoring activities.

CONCLUSION

The California Department of Mental Health (DMH) has not paid Mental Health Plans timely and needs to significantly improve the claims processing times for its Short-Doyle/Medi-Cal (SD/MC) Programs. Current claims processes are severely impaired by inadequate governance, outdated and unreliable information systems, over reliance on manual procedures, and inadequate record-keeping. It is imperative that the Department of Health Care Services makes replacement of the SD/MC System the top priority, and that DMH and DHCS take prompt corrective action on the recommendations included in this report in order to avoid continued payment delays, additional systems failures, legal liability, and potential loss of federal funds.

In addition, this report identifies opportunities for DMH and DHCS to improve fiscal operations and audit activities. Initiating improvements in these areas will further streamline the claims processes, enhance safeguards over state assets, generate timely and reliable financial information, and improve compliance with state and federal laws and regulations.

DMH has already taken positive steps to address operational weaknesses by making critical personnel changes, initiating systems replacements, seeking expert advice, and convening special workgroups to study problems and identify solutions.

Original signed by:

Janet I. Rosman, Assistant Chief
Office of State Audits and Evaluations

November 30, 2007

DESCRIPTION OF PROGRAMS AND PROCESSES

Short-Doyle/Medi-Cal History

California passed the Short-Doyle Act in 1957 which provided matching state funds to counties and cities to deliver mental health services. It was not until the 1970s that the federal government, recognizing that many of the recipients of mental health services were Medi-Cal patients, provided federal funding. The Short-Doyle Act has been amended over the years, such as in 1991 by the Bronzan-McCorquodale Act; however, the term "Short-Doyle/Medi-Cal" (SD/MC) has remained in general usage to describe the program. SD/MC services are provided by Mental Health Plans (MHPs) through a contract between DMH and the MHPs. The MHPs may provide the services themselves or outsource them to approved providers. SD/MC is basically a cost-reimbursement program, whereby MHPs submit claims to DMH for reimbursement from both federal and state funds based on a percentage formula.

SD/MC Program Categories

There are twelve service categories or programs identified for reimbursement within SD/MC. Accordingly, only these categories were evaluated for this review. Each category is funded by different levels of federal, state, and MHP funds as specified in federal regulations such as Title 42 and Title 45, and various California Codes. The following is a brief description of each of the categories:

1. Quality Assurance/Utilization Review—Includes Quality Assurance activities that must be performed by the MHP including performance improvement projects that contribute to meaningful improvements in clinical care and beneficiary service. Utilization Review assures that licensed mental health staff have substantial involvement in program implementation and includes a description of the authorization processes used by the MHP.

2. MHP Administration—This category comprises program design at the local level which maximizes participation in decision making by clients, families, and stakeholders; encourages cultural competence; conducts integrated planning of community and long-term care systems; and determines how MHP funds will be transferred among sub-accounts for mental health, public health, and social services.

3. Medi-Cal Administrative Activities (MAA)—Comprises administrative activities necessary for the proper and efficient administration of the Medi-Cal Program by local government agencies and local educational consortia. MAA activities can include Medi-Cal outreach, training, program policy and development, and other approved activities.

4. Federally-funded portion of Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)—This portion includes Medicaid's child health component which provides care to meet the special physical, emotional, and developmental needs of seriously emotionally disturbed

low-income children that meet the EPSDT medical necessity criteria and are full scope Medi-Cal beneficiaries. When specialty mental health services were consolidated under a federal waiver in fiscal year 1997-98, MHPs assumed the responsibility to provide these services to all Medi-Cal children and youth meeting the medical necessity criteria. The EPSDT program is partially funded from federal financial participation (FFP) matching funds.

5. State-funded portion of EPSDT—This portion includes SD/MC services provided to EPSDT beneficiaries as described in program #4 for outpatient specialty mental health services above a baseline expenditure level. The EPSDT program is partially funded from state general funds (SGF).

6. San Mateo Pharmacy and Laboratory—The San Mateo County Mental Health Department has been operating as the approved MHP for San Mateo County's Medi-Cal beneficiaries as a part of a Medi-Cal managed mental health care field test since April 1995. In July 2005, the San Mateo MHP became part of the Medi-Cal Specialty Mental Health Services Consolidation Waiver Program. San Mateo remains the only MHP that has a "carve-out" arrangement with the state to provide integrated pharmacy and related laboratory mental health services to Medi-Cal and indigent clients.

7. DMH Administration (HIPAA) is responsible for the successful implementation and compliance by DMH with all of the final rules under the Health Insurance Portability and Accountability Act (HIPAA).

8. DMH Administration (Other)—DMH is responsible for overseeing the delivery of public mental health services in California including system oversight, evaluation, and monitoring. In addition, DMH is also responsible for securing and ensuring the continuation of federal funds. All tasks related to the administration of federal funds such as utilization review, quality management, cost reporting, settlement, and administrative services are included in this category.

9. Refugee—This category comprises asylees, parolees, victims of trafficking, and secondary migrants eligible for Medi-Cal services. The Refugee Program also funds a subsidiary program that uses trained, culturally-sensitive interpreters to guide families through the health assessment process, and a program designed to improve follow-up and treatment of chronic health conditions identified through the initial assessment.

10. Beneficiary Services—This category comprises specialty mental health services including rehabilitative mental health services, crisis stabilization, and adult residential treatment services; psychiatric inpatient hospital services; targeted case management; psychiatrist services; psychologist services; EPSDT supplemental specialty mental health services; and psychiatric nursing facility services.

11. SD/MC Enhanced—The FFP portion for certain programs such as the Refugee program and the State Children's Health Insurance Program are "enhanced" for greater than their initially calculated and published FFP rates. The "enhanced" rate is determined by the U.S. Department of Health and Human Services (HHS).

12. Healthy Families—Title 21 of the Social Security Act (State Children's Health Insurance Program) was passed in 1997 to provide health coverage to children whose family income was above the Medicaid levels but below 200 percent of the federal poverty level. Title 21 funding could be used by states for either or both of two options: (1) Medicaid Children's Health Insurance Program (MChip) which expanded or enhanced Medicaid to children, and (2) State Children's Health Insurance Program (SChip) which is a separate health insurance program for

children. California chose to expand certain programs under MChip and also to create SChip, the Healthy Families program.

Short-Doyle/Medi-Cal Claims Processing System

The SD/MC System was developed in the 1980s to meet federal Medicaid claims processing requirements. As the single state agency authorized to process transactions with the federal government, DHCS has been responsible for building and maintaining the system since its inception. The system was designed to verify service provider authorization and recipient eligibility for all Medi-Cal claims. This mainframe COBOL application is comprised of dozens of batch programs and reports. In June 2004, DHCS began Phase II of the Health Insurance Portability and Accountability Act (HIPAA) remediation project which will create a new SD/MC System that is fully compliant with HIPAA standards. In addition to the current SD/MC System, other major subsystems provide a vital support role in data conversion, FFP invoicing, MHP payments, and the posting of transactions to DMH's accounting records. The SD/MC System processes 15 million claims representing $3 billion in claimed expenditures per year.

Information Technology Web Services (ITWS)

ITWS is a website that serves as a central storage for all MHP claims files and client data to be transmitted to the SD/MC System. DMH receives claims from each MHP via the ITWS website. ITWS generates a MHP claim file and transfers the file to the SD/MC System for adjudication. ITWS reports the processing status of the claims submitted on the Explanation of Balances file, the Error Correction Report, and the Duplicate Error Correction Report. Users of ITWS are MHP staff, MHP vendors, DMH staff, and other state departments.

HIPAA Translator

In 2003, DMH began using *SeeBeyond* integration server software (the HIPAA Translator) to translate HIPAA compliant data into the proprietary format used by the SD/MC System. The HIPAA Translator was installed as a short-term solution to allow the existing system to process claims until a new HIPAA compliant version of the SD/MC System could be developed. Additional functions have been added to the HIPAA Translator to meet new requirements that could not be met by the SD/MC System. The following risks were identified during our review of the HIPAA Translator:

- Modifications to the HIPAA Translator have made the system unstable and at risk of imminent failure.
- The growth in the number and size of claim files submitted to DMH are adding an additional strain to an already overburdened system.
- The HIPAA Translator's limited memory results in processing failures, delays, and the inability to process whole files from the largest MHPs.
- Many MHPs submit their claims just prior to the submission deadline, creating a flood of claims to be processed. This results in delayed processing and the risk that the system may reject claims because they were not processed within the required six month filing period.
- The HIPAA Translator's version of *SeeBeyond* is no longer supported by the manufacturer, and DMH has had difficulty finding and retaining information technology professionals knowledgeable in this older version.
- In addition to these risks, a significant amount of staff and consultant resources must be dedicated to operating, maintaining, and repairing the HIPAA Translator each month.

Access 97 Database

To process MHP claims, DMH's Accounting Office uses a system of manual and automated processes based on an Access 97 Database (collectively known as Eric's Database, named for the staff person that developed the system in 2003). At the heart of this system is a series of programs, databases, and macro commands. This database is used to process 15 million claims annually and thousands of disallowed claims and audit offsets each month. The following issues underscore the substantial weaknesses in the database:

- The database was not designed to process the current volume of claims and can accommodate only a few of the nearly 20 system users at a time.
- The database is no longer a cost effective means of processing claims. Over the past seven months it has cost DMH in excess of $60,000 per month on average to operate, maintain, and repair the system.
- The database relies on multiple, labor intensive manual processes that introduce a significant risk of human error.
- The database does not facilitate reconciliations or track the status of individual claims or offsets.
- The interface with CALSTARS runs through a series of macro commands that have been corrupted in the past. A lack of system documentation makes it difficult to rebuild these commands.
- The database does not provide sufficient levels of security, access control, and audit trails, or safeguards to ensure full recovery in the event of failure.
- In January 2004, Microsoft withdrew support of Access 97, leaving the system vulnerable to security risks and software incompatibilities.

Invoice Processing System (IPS)

IPS is a collection of subsystems that automates the manual process to generate FFP invoices to DHCS. IPS was implemented June 1, 2007, and has reduced time to prepare an invoice from seven days to one day. The system relies on data contained in the Access 97 Database.

Cost Reports

Cost reports are an important part of the funding process because they capture data, such as MHP administrative costs, that may not be completely reported in individual claims, but which are still appropriate and subject to reimbursement. State law[1] requires that MHPs submit a cost report by December 31 following the end of the fiscal year, and that these reports identify actual costs and revenues for all required programs. Each MHP electronically submits its final reports to DMH through ITWS. DMH then reviews and compares the reported expenditures with the paid SD/MC claims. The difference between the two amounts is the initial cost settlement for the FFP portion of SD/MC claims.

Chart Reviews/Audits

DMH's Audit Unit conducts fiscal audits of MHPs' SD/MC cost settlement reports. These audits play an important role in ensuring the fiscal integrity of the claims process. The Audit Unit may conduct a field audit, a desk review, or may accept the MHP's cost report as submitted. MHP cost reports, excluding contracted provider data, are subject to audit annually. If resources are available, contracted provider cost reports are audited every three years. The cost report audits

[1] Welfare and Institutions Code, Section 5718.

provide some assurance that reported amounts for items such as overhead and administrative costs are properly charged on Medi-Cal claims.

Chart reviews comprise medical reviews of EPSDT clients' charts and are conducted by licensed clinicians under contract to DMH. These reviewers are not part of DMH's Audit Unit. Specific claims are compared to medical charts to determine if the claim included adequate supporting documentation, was for eligible services, and whether the treatment was medically necessary.

Glossary of Acronyms and Terms

Term	Definition
Access 97 Database	See Exhibit 1 for detailed description.
ADP	**Department of Alcohol and Drug Programs:** ADP was established in 1978 and leads the state's drug prevention, treatment and recovery efforts. ADP uses the SD/MC System to process its Medi-Cal related claims and would be significantly impacted by any failure of the system.
ASR	**Approved Services Report** is generated by the SD/MC System and lists the total amount approved for each claim.
CALSTARS	**California State Accounting and Reporting System:** CALSTARS provides the DMH with an automated organization and program cost accounting system to accurately and systematically account for DMH's revenue, expenditures, receipts, disbursements, and property. DMH uploads claim batches into CALSTARS to generate a claim schedule for the issuance of payments to the MHPs.
CHHSA	**California Health and Human Services Agency:** CHHSA oversees state and federal programs for health care, social services, public assistance, and rehabilitation. Responsibility for administering major programs, which provide direct services to millions of Californians, is divided among CHHSA's 12 departments and one board. The Departments of Mental Health, Health Care Services, and Alcohol and Drug Programs are among the departments for which CHHSA provides oversight.
Claim	A **claim** is a request for the reimbursement of costs for services provided to Medi-Cal eligible clients. MHP mental health staff collect client service and cost data required for reimbursement to create a claim. MHPs submit the claims to DMH for payment through the ITWS website. The SD/MC System edits and processes each claim to determine the appropriate claim reimbursement amount.
Claim Schedule	The state uses a variety of vendor payment methods. One method is to submit **claim schedules** to the SCO for payment. Claim schedule batches are posted to CALSTARS and then the Claim Schedule Subsystem processes the batches and generates a claim schedule face sheet and remittance advice. To issue SD/MC payments to the MHPs, DMH prepares a claim schedule packet consisting of the claim schedule face sheet, MHP batch listings (a list of approved claims per MHP) and remittance advice. The claim schedule packet is sent to SCO to process and issue warrants to the MHPs.
CMS	**Centers for Medicare and Medicaid Services:** CMS is an agency within the federal Department of Health and Human Services and plays a key role in the overall direction of the health care system. CMS's mission is to ensure effective, up-to-date health care coverage and to promote quality care to beneficiaries.
COTS	**Commercial Off The Shelf:** A term for software that is ready-made and available for sale, lease, or license to the general public. It is often used as a cost-effective alternative to in-house developed applications. DMH plans to replace its Access 97 Database and IPS system with a new COTS accounting system.

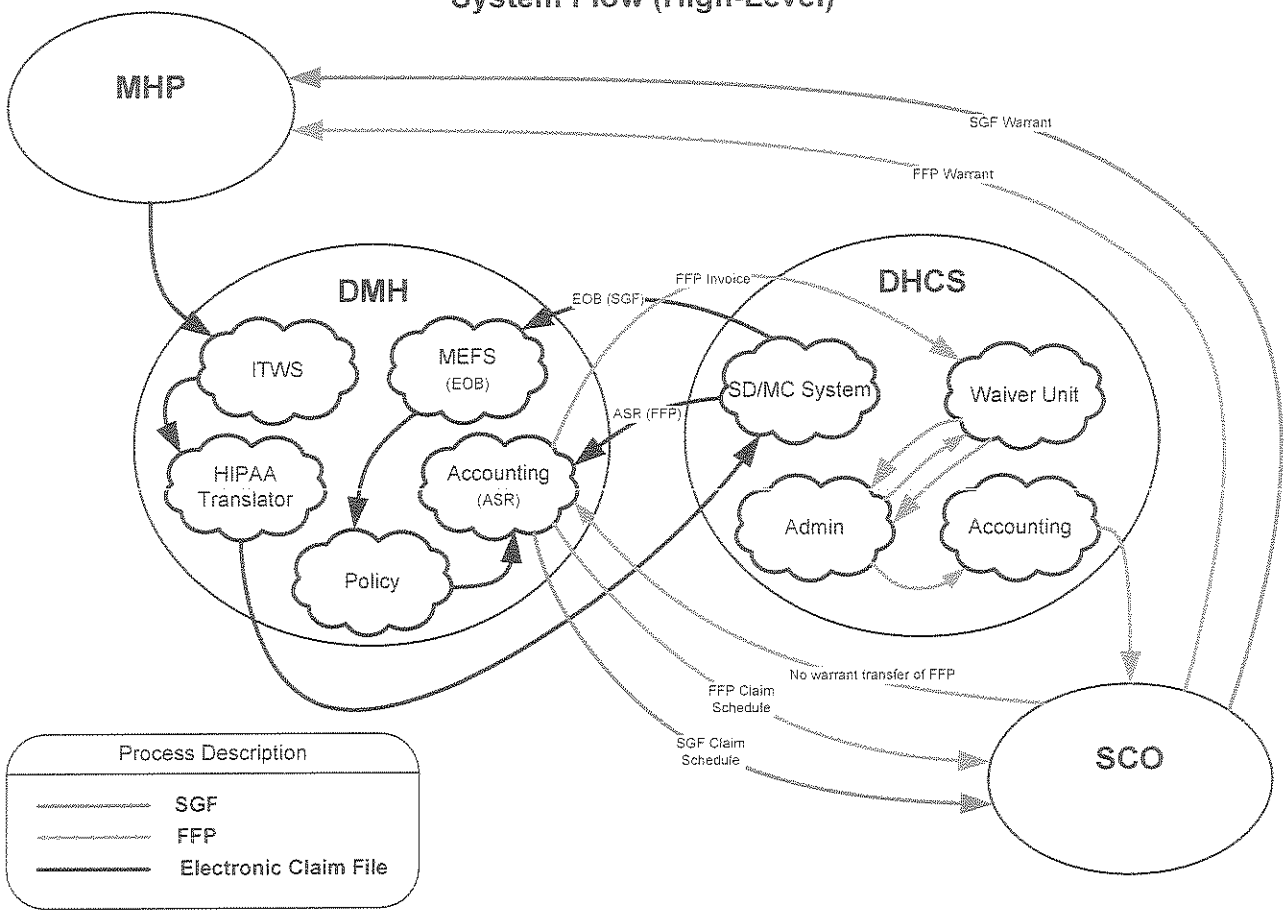
DCS	**Disallowed Claims System:** The DCS gives MHPs the ability to mark claims as disallowed, eliminating those claims from audit samples. The DCS will calculate the appropriate amount for the disallowed claim and generate an invoice to return payment to DMH for the amount owed. MHPs have two repayment options: 1) send a check to DMH, or 2) request that DMH offset the amount against future claims.
DHCS	**Department of Health Care Services:** DHCS is the single state agency for the Medi-Cal system. DHCS is responsible for monitoring and oversight of the Specialty Mental Health Consolidation Waiver, administered by DMH through an interagency agreement with DHCS. DHCS is the liaison between CMS and DMH, facilitates technical assistance to DMH, and maintains the SD/MC System. DHCS provides DMH the federal funds equal to the federal share of cost for services provided to SD/MC beneficiaries. DMH submits invoices to DHCS for review, processing, and approval for FFP reimbursement.
DMH	**Department of Mental Health:** DMH leads the state's mental health system, ensuring the availability and accessibility of effective, efficient, and culturally competent services. To administer its programs DMH has oversight of a public mental health budget of more than $4 billion, including local assistance funding. DMH is responsible for a number of local assistance programs, including the Short-Doyle/Medi-Cal Program. DMH owns and operates the ITWS and is responsible for the operation and maintenance of the HIPAA Translator. In addition, DMH administers the SGF portion of the reimbursement claim.
EOB	The **Explanation of Balances** file reports the processing status of claims submitted.
EPSDT	**Early and Periodic Screening, Diagnosis and Treatment:** Mental health related diagnostic services and treatment, other than physical health care, available under the Medi-Cal program only to persons under 21 years of age pursuant to Title 42, Section 1396d(r), United States Code, that have been determined by DHCS to meet the criteria of Title 22, Section 51340(e)(3) or (f); and that are not otherwise covered by Title 9, Chapter 11 as specialty mental health services. See Exhibit 1 for additional detail.
FFP	**Federal Financial Participation:** FFP is the federal matching funds available under the respective SD/MC Programs. DMH invoices DHCS for FFP funds and then issues FFP payment to the MHPs.
Good Cause Waiver	A **good cause waiver** occurs under specified circumstances when DMH may receive and authorize the payment of claims submitted up to 12-14 months after the date of service, depending on the cause of the late submittal. These circumstances, typically beyond the control of the provider, include failure of the patient to present identification as a Medi-Cal beneficiary, billings involving other coverage, and initiation of legal proceedings to obtain payment of a liable third party.
HIPAA	**Health Insurance Portability and Accountability Act:** HIPAA includes a section called Administrative Simplification which is specifically designed to reduce the administrative burden associated with the transfer of health information between organizations, and to increase the efficiency and cost effectiveness of the health care system. The approach is to perform electronic transactions through the establishment of nationwide standards and move from paper based administrative and financial transactions. The DMH, Office of HIPAA Compliance, is responsible for the successful implementation by DMH of all the standards under HIPAA.
HIPAA Translator	See Exhibit 1 for detailed description.
Invoice	To receive federal reimbursement for SD/MC services, DMH prepares an **invoice** for the FFP amount. DMH submits the invoices to DHCS for review, approval, and transfer of federal funds to DMH. Once the federal funds are received by DMH, MHPs will be issued the FFP payment.
IPS	**Invoice Processing System:** See Exhibit 1 for detailed description.
ITWS	**Information Technology Web Services:** See Exhibit 1 for detailed description.

Medicaid/ Medi-Cal	**Medicaid** is a health insurance program for low-income individuals established and funded through a state and federal partnership. States design their program within federal requirements through state plans or waiver requests. The federal CMS approves and monitors compliance with the state plans and, if applicable, waivers. Federal law describes the services that may be considered "medical assistance" and included in a state plan. Medical assistance includes inpatient hospital services and physician services, but also provides options for services such as targeted case management and rehabilitative services. California's Medicaid program is called **Medi-Cal**. DHCS is the single state agency responsible for the Medi-Cal program and the Medi-Cal state plan, which includes rehabilitative mental health services and targeted case management services for beneficiaries who have mental disorders. DHCS delegates responsibility for the administration of most Medi-Cal specialty mental health services, including rehabilitative mental health services (called the Rehab Option) and targeted case management, to DMH.
MEFS	The **Medi-Cal, Epidemiology, Forecasting, and Support** Unit within the Department of Mental Health.
MHP	**Mental Health Plans** are the various entities which enter into an agreement with DMH to contract, arrange, and/or provide psychiatric inpatient hospital services for beneficiaries. A MHP may be a county, counties acting jointly, or another governmental or nongovernmental entity.
PCA	**Program Cost Account:** State agencies are required to use a program cost accounting methodology to assist in financial accounting for their programs. Program cost accounting enables agencies to plan and control finances for current operations and develop program budgets for future years. A PCA provides DMH with a unique code used to identify a single program hierarchy in CALSTARS, identify fund source splits for encumbrances and program costs, and distinguish programs by type.
Providers	***Group Provider:*** An organization that provides specialty mental health services through two or more individual providers. Group providers include entities such as independent practice associations, hospital outpatient departments, health care plans, and clinics. ***Individual Provider:*** Licensed mental health professionals whose scope of practice permits the practice of psychotherapy without supervision who provide specialty mental health services directly to beneficiaries. Individual provider includes licensed physicians, licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, and registered nurses with a master's degree within their scope of practice. Individual provider does not include licensed mental health professionals when they are acting as employees of any organizational provider or contractors of organizational providers other than the MHP. ***Organizational Provider:*** A provider of specialty mental health services other than psychiatric inpatient hospital services or psychiatric nursing facility services that provides the services to beneficiaries through employed or contracting licensed mental health or waivered/registered professionals and other staff. The MHP is an organizational provider when specialty mental health services are provided to beneficiaries by employees of the MHP.
SCO	**State Controller's Office:** The SCO maintains uniform and systematic control accounts of all receipts, disbursements, and balances in DMH's funds. The SCO issues payments to the MHPs on behalf of DMH.
SD/MC System	**Short-Doyle/Medi-Cal Claims Processing System:** See Exhibit 1 for detailed description.
SGF	**State General Fund:** DMH receives an annual appropriation of state general funds to be distributed to MHPs based on various cost sharing formulas and baseline adjustments for their respective SD/MC Programs. DMH also uses SGF to fund its administrative support expenditures.
Stakeholders	**Stakeholders** include beneficiaries, family members of beneficiaries, advocates, local mental health directors, community agencies, and mental health professionals, as well as county MHPs, state agencies, state legislators, and federal agencies.

Process Flow Diagram

The following Short-Doyle/Medi-Cal claims processing diagram illustrates the interfaces between the County Mental Health Plans, Department of Mental Health, Department of Health Care Services, and the State Controller's Office. This diagram includes only the major processing steps and is intended to be a high level representation of the claims flow process.

DMH/DHCS Claims Processing System Flow (High-Level)



ASR – Approved Services Report
DHCS – Department of Health Care Services
DMH – Department of Mental Health
EOB – Explanation of Balances File
FFP – Federal Financial Participation Funds
HIPAA – Health Insurance Portability and Accountability Act
ITWS – Information Technology Web Services
MEFS – Medi-Cal, Epidemiology, Forecasting, and Support Unit
MHP – Mental Health Plan
SCO – State Controller's Office
SD/MC – Short-Doyle/Medi-Cal Program
SGF – State General Funds

CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street, Sacramento, CA 95814
(916) 654-2309

December 31, 2007

Ms. Janet I. Rosman, CPA, CGFM
Acting Chief, Office of State Audits and Evaluations
California Department of Finance
300 Capitol Mall Suite, 801
Sacramento, CA 95814

Dear Ms. Rosman:

We are in receipt of your December 2007 report, "Review of Claims Processes for the Short-Doyle/Medi-Cal Programs." As the Department of Mental Health (DMH) requested and invested in this review, we have agreed to coordinate responses on behalf of the Department of Health Care Services (DHCS), and California Health and Human Services Agency (CHHS).

We recognize that this review of the California mental health Medi-Cal claims processing system was a large and complex project. The decision to invest an extra few months to evaluate the entire Short-Doyle claims processing system that spans across the DMH, the Department of Alcohol and Drug Programs (ADP), and the DHCS produced valuable and useful results. We would like to compliment your team for a professional approach to this project, and their effective communication and collaboration with our management teams throughout your review.

The purpose of this review is to make observations and recommendations that will assist the DMH and DHCS with implementation of fiscal management and other reforms to improve our Short-Doyle/Medi-Cal claims payment services to local Mental Health Plans (MHPs) and other service partners. Using your nine observations and 28 specific recommendations, we now have a guiding document that will support our collective management efforts to:

- Focus DMH management on fiscal accountability and dedicate additional management and staff resources to our Administration Services and Fiscal Administration Division, specifically in our Accounting, Budget and Fiscal Policy Offices;

- Evaluate the centralization of the Short-Doyle/Medi-Cal program functions within DMH that will be responsible for governance, strategic direction, IT business management, and fiscal operations;

- Continue our business process reorganizing, cost/benefit, and technology analysis for the development of a Commercial Off-The-Shelf (COTS) accounting software package that would provide us with reliable traceability for Medi-Cal claims, accounts receivable, accounts payable, encumbrances and other standard accounting management tools;

- Continue to document our Accounting Office claims processes, desk procedures, supervision practices, claims payment schedules, Federal Financial Participation (FFP) requirements, and development of formal procedures between DMH and DHCS to create a future picture of our accounting and claims payment administration;

- Continue management and implementation of our DMH 2007 Medi-Cal Fiscal Services Workplan and stakeholder outreach/participation initiatives, including a new County-State Claims Processing Improvements Task Force;

- Identify appropriate levels of DMH program and IT management who will be responsible for effective coordination with DHCS to implement the new Short-Doyle II information technology project. Short-Doyle II will help reduce risks identified with the HIPAA translator, and streamline our inter-departmental transmission of claims files and invoices to meet state and federal standards for privacy and health data transactions;

- Utilize the technical and training assistance of OSAE to begin a new DMH/DHCS Control Self Assessment initiative designed to review key business objectives, risks involved to achieve these objectives, and internal controls designed to manage the risks;

- As part of the new 2008-2013 DMH Strategic Plan, Division level business plans, and IT Governance Council efforts, DMH will further emphasize financial accountability as a core business value and management expectation throughout the organization;

- Development and implementation of a Corrective Action Plan in collaboration with DHCS, MHPs and the Centers for Medicare and Medicaid Services (CMS) due to OSAE by January 31, 2008.

We are pleased that your review identified that DMH and DHCS have taken, "positive steps by conducting internal studies and convening special workgroups and committees to define problems and identify solutions." We will continue these efforts and leverage the commitment demonstrated by the partners and stakeholders to develop a better Short-Doyle/Medi-Cal claims processing system to support Californians in need of mental health services.

Again, on behalf of the California Health and Human Services Agency, California Department of Health Care Services, and California Department of Mental Health, thank you for this important review of the California Short-Doyle/Medi-Cal claims payment processing system, and the professionalism, dedication and expertise provided by your staff.

Sincerely,

STEPHEN W. MAYBERG, Ph.D.
Director