Memorandum

Date OCT 24 1991

From Richard P. Kusserow
Inspector General

Subject Review of Short/Doyle Medicaid Payment Rates
(A-09-91-00076)

To Gail R. Wilensky, Ph.D.
Administrator
Health Care Financing Administration

This is to alert you to the issuance on October 25, 1991 of our final audit report to Health Care Financing Administration (HCFA) officials in Region IX concerning Medicaid payment rates under the Short/Doyle program in California. A copy is attached.

Our audit disclosed that the Medicaid rates set for Short/Doyle services exceeded reasonable limits established by Federal law and regulations.

Short/Doyle is one component of the California Medicaid program. It is a special program serving the mentally ill, and is operated by the various counties in California which arrange for hospital and clinic services.

Our prior audits of this program disclosed that California (i) overclaimed millions of dollars in Federal Medicaid funds due to accounting errors, and (ii) allowed a large backlog of unresolved audit exceptions to accumulate and had not refunded the Federal share. In addition, our review of services in San Francisco County revealed that nearly one in four claims was ineligible for Federal cost sharing. As a result of these reviews, the State has already refunded over $30 million and is in the process of identifying additional overclaims.

Our current audit, which included a detailed examination of Short/Doyle rates in San Francisco County, disclosed that expenditures were 21 percent higher (or $3.6 million more) than reasonable allowances under the Medicare program for the same or similar services. Also, expenditures were 87 percent higher (or $9.5 million more) than the maximum permitted under California's regular Medicaid program.

Since the costs in San Francisco County were generally not the highest in California, the problem appears to exist in other counties as well. San Francisco County accounted for less than 10 percent of statewide Short/Doyle costs.

Our report contains numerous examples of excessive costs for Short/Doyle services. For example, one clinic's cost for a half-hour medication visit was three and a half times the regular Medicaid rate for 24-hour care in a nursing home.

Much of the high cost of the program was for administrative and overhead expenses. More than half of the costs for 18 clinics in San Francisco County went to administrative support. At one clinic, the therapists spent 79 percent of the time on administrative support activities, as opposed to direct patient care.

The Office of General Counsel advised us that a recovery of excessive Medicaid payments for prior periods would not be appropriate since the methodology used to set Short/Doyle payment rates had been approved by HCFA. Nevertheless, Counsel concluded that the Department did have the authority to limit future Medicaid payments for Short/Doyle services to reasonable amounts. We are recommending that regional Medicaid officials do so and they have agreed.

For further information, contact:
Herbert Witt
Regional Inspector General
for Audit Services, Region IX
556-5766

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF SHORT/DOYLE MEDICAID PAYMENT RATES

Richard P. Kusserow
INSPECTOR GENERAL

A-09-91-00076

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services' **(HHS)** programs as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by three OIG operating components: the Office of Audit Services, the Office of Investigations, and the Office of Evaluation and Inspections. The OIG also informs the Secretary of HHS of program and management problems, and recommends courses to correct them.

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The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities, and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse and mismanagement and to promote economy and efficiency throughout the Department.

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The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services
Region IX

Memorandum

Date

From OIG Office of Audit Services

Subject Review of Short/Doyle Medicaid Payment Rates (A-09-91-00076)

To Mr. Gerald M. Moskowitz
Regional Administrator
Health Care Financing Administration

Enclosed for your information and use are two copies of an HHS/OIG Office of Audit Services report titled, "Review Of Short/Doyle Medicaid Payment Rates." Your attention is invited to the audit finding and recommendations contained in the report.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), HHS/OIG Office of Audit Services reports are made available, if requested, to members of the press and the general public to the extent information contained therein is not subject to exemptions in the Act, which the Department chooses to exercise. (See Section 5.71 of the Department's Public Information Regulation, dated August 1974, as revised.)

To facilitate identification, please refer to the above common identification number in all correspondence relating to this report.

HERBERT WITT
Regional Inspector General
for Audit Services

Enclosures

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EXECUTIVE SUMMARY

Our review of Short/Doyle Medicaid payment rates in San Francisco County, for the two fiscal years ended June 30, 1986, disclosed that they resulted in:

- **expenditures that were 21 percent higher - or $3.6 million more- than the maximum allowed under the Medicare program for the same or similar services;**

- **payments that were 87 percent higher - or $9.5 million more - than the maximum allowed under California's regular Medicaid program for the same or similar services.**

The Short/Doyle Medicaid payments were based on the costs of care in San Francisco, up to Statewide maximums. **No studies or audits were performed by the State to ensure that the County's costs were consistent with efficiency and economy or that the established maximum rates were reasonable.**

Since San Francisco's costs were generally not the highest in California, the problem appears to exist in other counties as well. San Francisco County accounts for less than 10 percent of total Statewide costs.

By law, each State's Medicaid plan must provide for payments that are consistent with efficiency, economy, and quality of care. Further, Medicaid regulations specifically limit Federal participation in the cost of clinic and hospital services to the amounts that Medicare would pay for the same or similar services.

California's plan for Medicaid - although approved by Federal officials - did not comply with these requirements. We are therefore recommending that the Federal officials take administrative action to limit Federal funding of the Short/Doyle program in accordance with Medicaid law and regulations. The officials agreed.

BACKGROUND

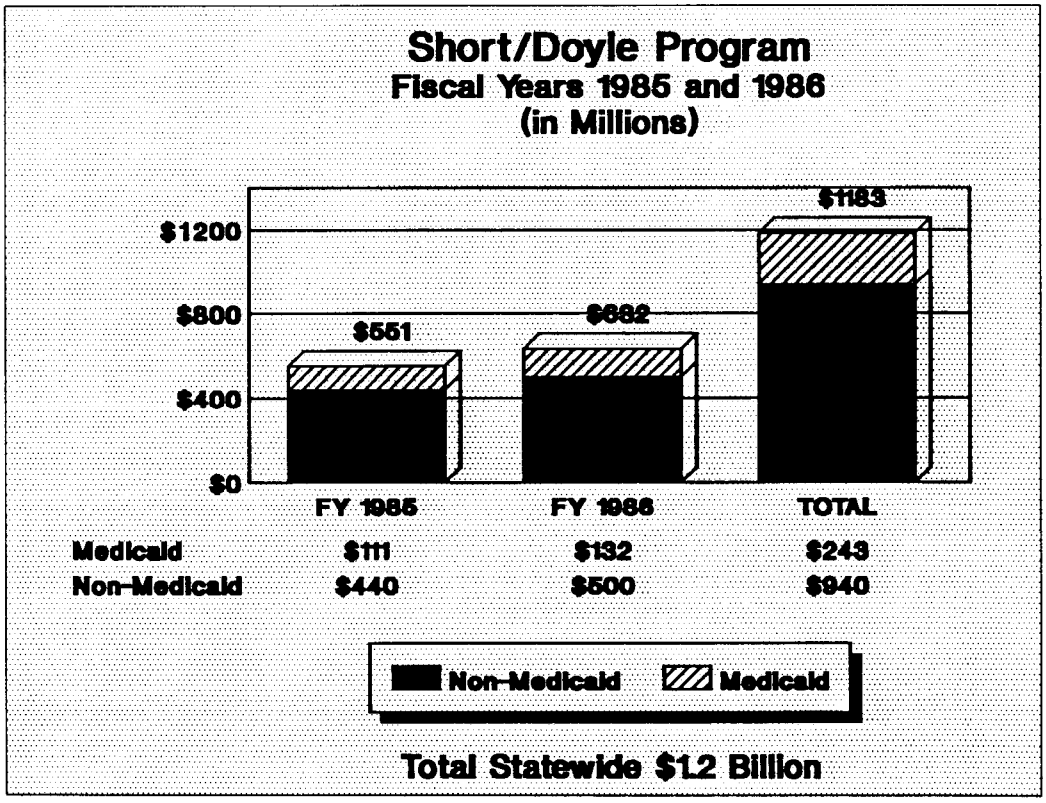
Medicaid Program

The Medicaid program, authorized under Title XIX of the Social Security Act, was established to pay for medical services on behalf of eligible low-income persons. The States arrange with medical service providers such as doctors, medical laboratories, pharmacies, hospitals, clinics, and other organizations to provide the needed medical assistance. The cost of the Medicaid program is shared by the Federal and the State governments.

California Short/Doyle

Established in 1971, the Short/Doyle program is one component of the California Medicaid program. It is a special program serving the mentally ill, and operated by the various counties in California which arrange for hospital and clinic services.

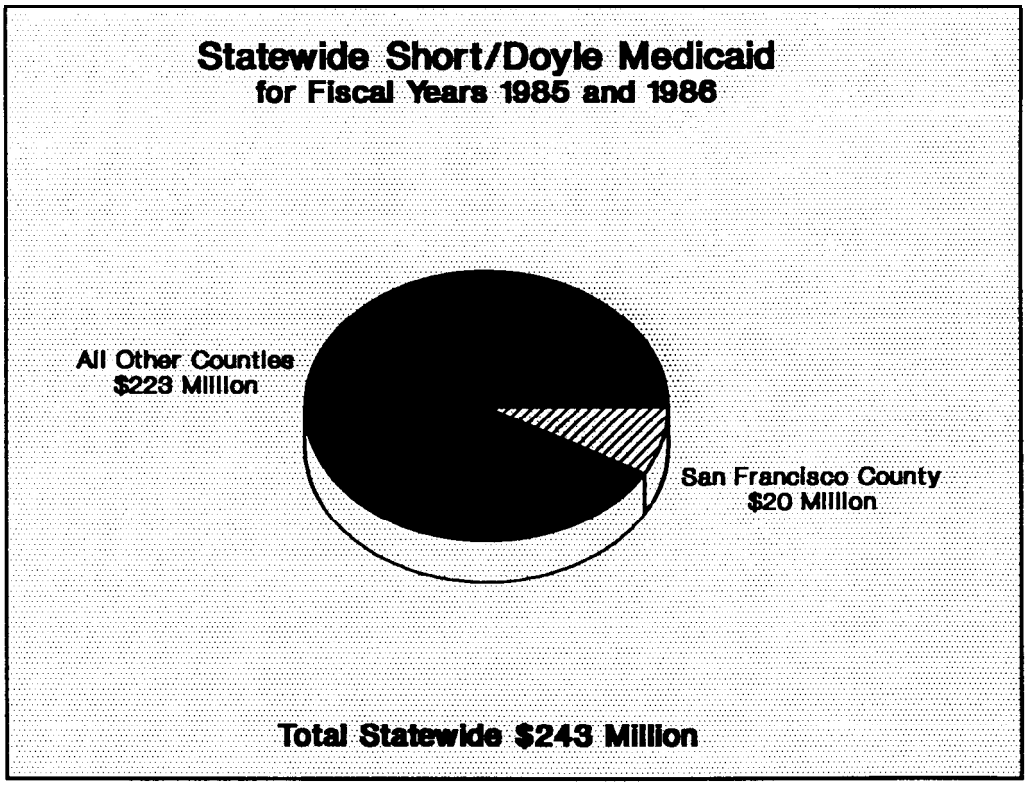
For fiscal years 1985 and 1986, Short/Doyle program expenditures totaled about $1.2 billion. The Medicaid program paid about 20 percent of these costs.



At the State level, the Department of Mental Health administered this program. The Department was responsible for setting the Statewide payment limits, approving and paying the counties' claims, and monitoring the counties' programs to assure compliance with Medicaid requirements.

The Department of Mental Health reported the counties' claims to the Department of Health Services. As the single State agency, the Department of Health Services submitted them to the Federal Health Care Financing Administration (HCFA) for payment.

As shown below, San Francisco County accounted for less than 10 percent of the total Statewide Short/Doyle Medicaid payments.



San Francisco County

San Francisco County provided mental health services to patients, some of whom were eligible for Medicaid. These services were provided through hospitals and clinics, both county-operated and privately owned.

For our audit period, the County was paid **$20,460,261** in Medicaid funds under the Short/Doyle program. The Federal and State governments each paid 50 percent, or **$10,230,130.** The following shows the type of care provided:

Type of Care:	Units of Service	Medicaid Payments
Outpatient care	107,789	$ 7,003,418
Crisis intervention	8,073	1,607,863
Day care	127,290	6,226,378
Inpatient hospital	14,507	5,622,602
Totals	257,659	$20,460,261

Outpatient care included individual and group therapy, medication, assessment and collateral services.

Crisis intervention services were face-to-face contacts with patients exhibiting acute psychiatric symptoms.

Day care services were provided in treatment programs for less than 24 hours per day. Day care clinics were required to provide all needed outpatient services other than crisis intervention.

Inpatient hospital services were provided in general hospitals (primarily the county hospital) to patients requiring intensive psychiatric care.

Medicaid Payment Limits

Medicaid law requires that payment rates be reasonable. For hospital services, each State plan must provide for rates that are:

> *"...reasonable and adequate to meet the costs which must be incurred by efficient/y and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access...to inpatient hospital services..." [Section 1902(a)(13) of the Social Security Act]*

For clinic services, a State plan must provide for payments that are:

> *"-consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available..." [Section 1902(a)(30) of the Act]*

Medicaid regulations limit Federal funding to payments which would be considered reasonable under the Medicare program. For inpatient hospital services, payments:

> *"...may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles." (42 CFR 447.272)*

For clinic services, Federal funding is:

> *"...not available for any payment that exceeds the amount that would be payable to providers under comparable circumstances under Medicare." (42 CFR 447.321)*

Short/Doyle Payment Limits

The California Medicaid plan limited payments for Short/Doyle services to the lower of:

1. The provider's actual costs of rendering the services;

2. Statewide maximum rates for each service (the maximum rates represented the average Statewide cost of each service provided two years previously multiplied by 125 percent and adjusted for inflation);

3. The provider's usual and customary charge to the general public for the same services;

4. Negotiated rates approved by the Department of Mental Health.

For fiscal years 1985 and 1986, San Francisco did not have any negotiated rates. Further, the State did not apply the customary charge rule. Therefore, Short/Doyle Medicaid payments to the County were limited to the lower of the provider's cost or the Statewide maximum rates.

Prior Audits

We previously performed three separate audits of the Short/Doyle Medicaid program. First, we audited the State's final claims under the Short/Doyle program for the five fiscal years ended June 30, 1987. This audit disclosed that the State overclaimed $17.1 million of Federal Medicaid funds due to accounting and claiming errors. The State returned the $17.1 million and implemented procedures to correct the system deficiencies noted.

Second, we performed a review of the State's audit resolution procedures for Short/Doyle Medicaid overpayments identified by its audit section. Our review disclosed that the State had allowed a large backlog of unresolved audit exceptions to accumulate over the years and had not refunded the Federal share. We recommended that the State promptly resolve this backlog and refund the Federal share of

the overpayments. As of November 1, 1990, the State had refunded $13.4 million and was continuing to resolve other overpayments.

Third, we reviewed the allowability of San Francisco County's Short/Doyle Medicaid services for fiscal years 1985 and 1986. Based on our review of a statistical sample of services, we concluded that 23 percent of the County's claims were unallowable. We estimated that the unallowable claims amounted to between $3.1 million and $4.9 million. Claims were made for (i) unnecessary hospital care, (ii) services not documented, not provided, or lacking physician involvement, and (iii) duplicates.

SCOPE OF AUDIT

The objective of our review was to determine if Medicaid payments for Short/Doyle services complied with Federal standards for efficiency and economy. In performing our review we:

- **analyzed the Federal law and regulations setting forth Medicaid rules forestablishing payment rates;**
- **evaluated California's procedures for paying Short/Doyle Medicaid services and reviewed Statewide program cost data;**
- **performed a detailed comparison of payments in San Francisco County to what Medicare and the-regular Medicaid program would have--paid for the same or similar services;**

In addition, we obtained a legal opinion from the Office of General Counsel regarding the State's compliance with Medicaid law and regulations and Federal authority to recover or limit payments in excess of applicable restrictions.

Our field work was performed at the State level at the Department of Health Services and the Department of Mental Health in Sacramento, California. In San Francisco, we visited the City and County Department of Public Health, Short/Doyle clinics, the HCFA regional office, and California Blue Shield - the local Medicare carrier. The field work was conducted from September 1989 through February 1991.

Our audit of Short/Doyle Medicaid payments to San Francisco County covered the two fiscal years ended June 30, 1986, the two most current fiscal years for which final claims were available at the start of our audit. In addition, we reviewed Statewide cost data for the four fiscal years ended June 30, 1988. Our review was done in accordance with generally accepted Government auditing standards.

RESULTS OF AUDIT

Short/Doyle Medicaid payments exceeded what Medicare would have paid for the same or similar services by 21 percent in San Francisco County. In addition, the payments were 87 percent higher than what the regular California Medicaid program would have paid other providers for the same care.

At some San Francisco providers, the cost of care was much higher than the Statewide average cost under the Short/Doyle program. For examole. the cost of a half-hour medication visit at one clinic was $189 or over three times the average Statewide cost of $57. Although Short/Doyle Medicaid payments were limited to adjusted Statewide average costs, these high costs inflated the average rates.

Much of the high cost of the program was for administrative and overhead expenses. More than half of the costs for 18 clinics in San Francisco County went to administrative support.

Even though the costs were high in San Francisco County, they were generally not the highest in California. To illustrate: 41 counties had higher costs than San Francisco for assessment services, while 30 counties had more expensive treatment for individual therapy. The cost of group therapy at one provider in another county was $210 per person, more than four and one-half times the averaoe Statewide cost of $45 and 13 times the rate for group therapy under the regular Medicaid oroaram.

Medicaid law and regulations limit Federal funding to reasonable amounts. Because Medicaid has been making payments to California in accordance with an approved State plan for the Short/Doyle program, a recovery of past overpayments would apparently not be permitted. Nevertheless, **HCFA has the authority to limit Federal funding in the future to reasonable amounts, and we are recommending that it do so.**

Short/Doyle Exceeded Medicare

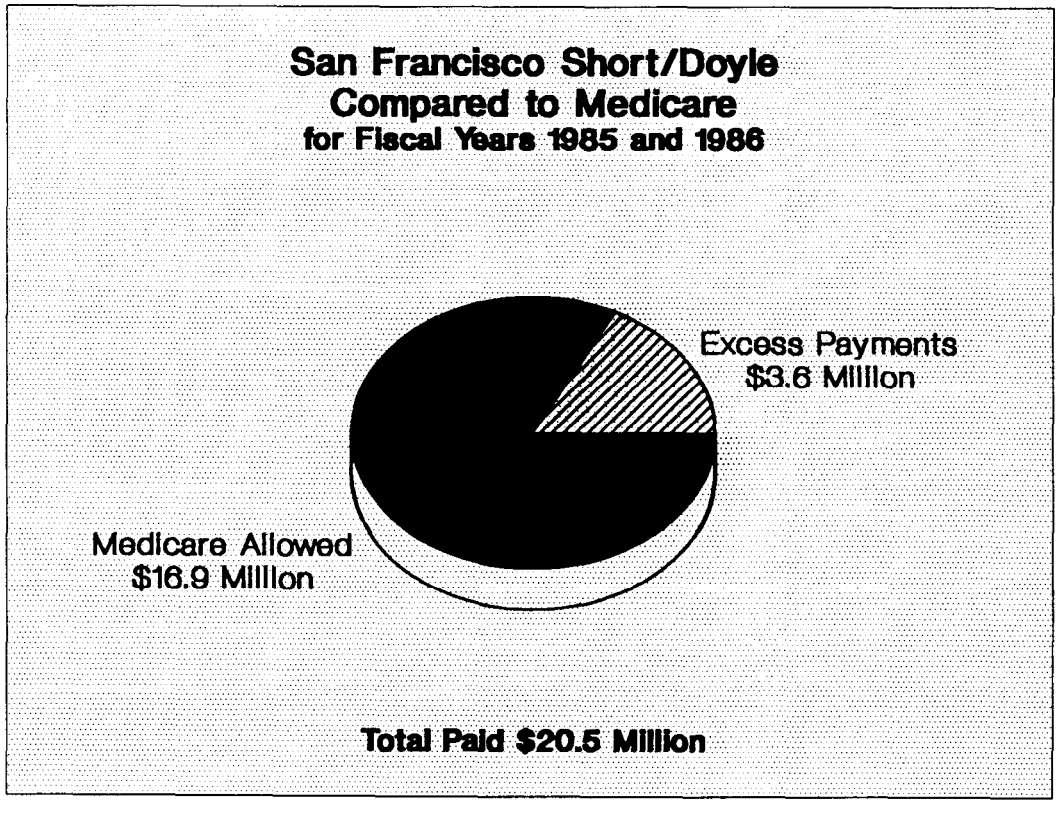
The Statewide Short/Doyle maximum rates consistently exceeded Medicare limits for the same services. The following schedule shows a comparison of these rates in fiscal year 1986:

Type of Service	Short/Doyle Maximum	Medicare Limits	Difference	Percent Over Medicare
Individual Therapy	$87	$75	$12	16%
Group Therapy	55	50	5	10
Medication	66	55	11	20
Assessment	112	60	52	87
Collateral	70	60	10	17
Crisis Intervention	205	110	95	86
Day Care Intensive	93	50	43	86
Day Care Habilitative	62	50	12	24
Inpatient Hospital	402	304	98	32

The Medicare limits for outpatient services represent the maximum amount paid to psychiatrists in the San Francisco area. Most Short/Doyle services in San Francisco County were provided by either psychologists or social workers. Since the County paid psychologists and social workers at substantially lower salaries than those paid psychiatrists, one would expect Short/Doyle services to cost less than Medicare services. This was not the case.

Under the Medicare program, payment rates are limited to reasonable charges. Medicare defines a reasonable charge as the lower of a provider's actual or customary charge, up to the prevailing charge for the service in the community. The payment rate covers the provider's professional services, plus overhead.

Our comparison of the Medicare rates to the actual payments in San Francisco County revealed that, of the total payments of $20.5 million, Medicare would have allowed no more than $16.9 million. Thus, the Short/Doyle payments exceeded the Medicare limits by $3.6 million ($1.8 million Federal share), as shown:



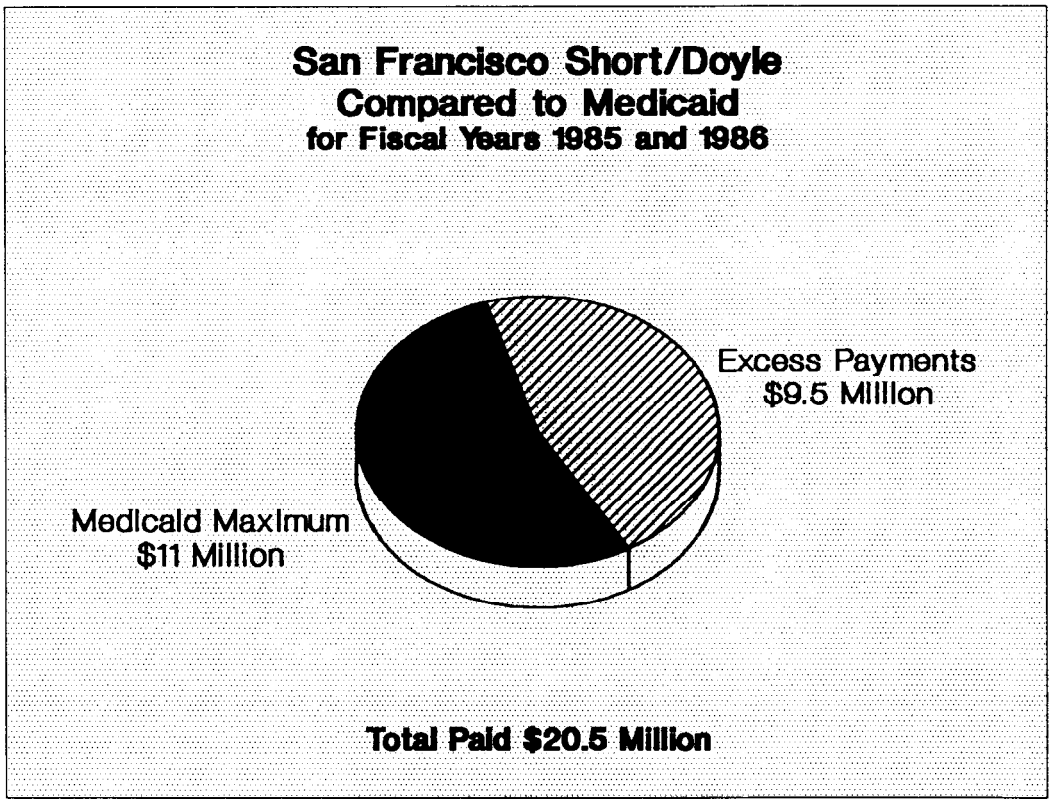
Short/Doyle Exceeded Medicaid

Short/Doyle maximum rates also substantially exceeded limits for private psychiatrists providing services under the regular Medicaid program. The following schedule shows a comparison of rates in fiscal year 1986:

Type of Service	Short/Doyle Maximum	Medicaid Limits	Difference	Percent Over Medicaid
Individual Therapy	$ 87	$ 41	$46	112%
Group Therapy	55	16	39	244
Medication	66	1 5	51	340
Assessment	112	46	66	143
Collateral	70	29	41	141
Crisis Intervention	205	41	164	400
Day Care Intensive	93	25	68	272
Day Care Habiiitative	62	25	37	148
Inpatient Hospital	402	304	98	32

In its State plan, California certified that its regular Medicaid limits were consistent with quality of care and were sufficient to enlist enough providers so that care and services were available. The limits for outpatient services represent payments to psychiatrists in private practice. The rate is designed to cover the psychiatrist's time plus overhead expenses.

Our comparison of the Short/Doyle Medicaid payments in San Francisco to the limits applicable to the regular Medicaid program disclosed that, of the total payments of $20.5 million, just $11 million would have been paid. Thus, the actual payments exceeded the regular Medicaid limits by $9.5 million, as shown:



High Cost of Care

At some County providers, the cost of care substantially exceeded Statewide averages, as shown in this table:

Type of Service	Provider	Unit cost	Statewide Average Cost	Percent Over
Individual Therapy	3842	$154	$ 67	130%
	3806	144	67	115
	8812	136	67	103
Medication	3806	$189	$ 57	232%
	3842	109	57	91
	3871	106	57	86
Crisis Intervention	8812	$502	$164	206%
	8905	350	164	113
	3848	336	164	105

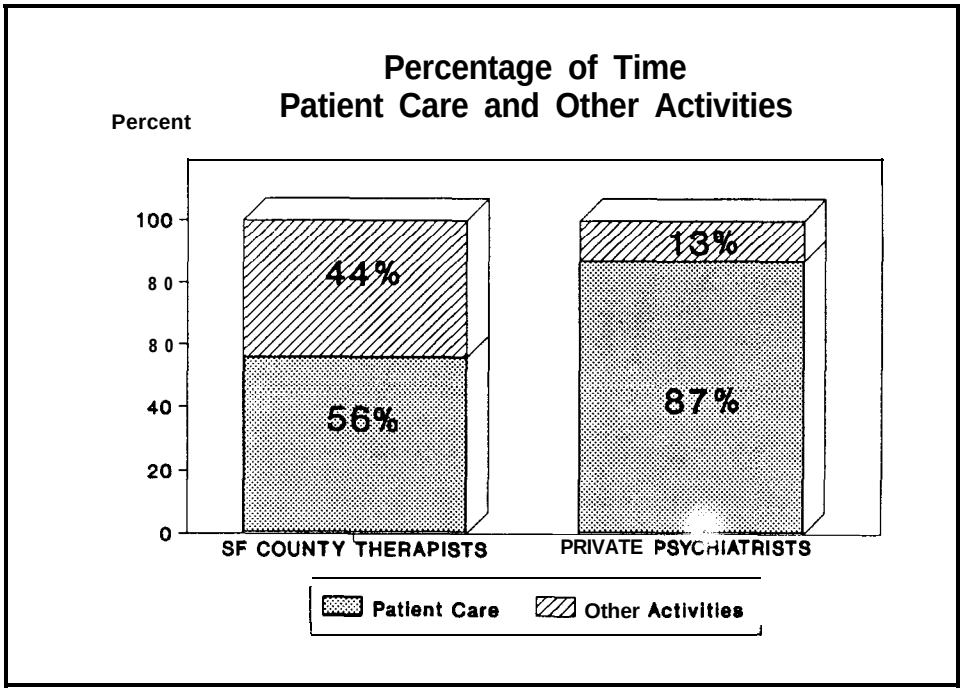
Fiscal Year 1986

The $189 for a half-hour medication visit was three and one-half times the Medicaid rate of $53 for 24-hour care in a nursing home specializing in the care of the mentally ill. Additionally, the $502 outpatient crisis service was 65 percent higher than the $304 paid by Medicare and Medicaid for acute inpatient hospital care.

Much Time Spent on Administrative support

County mental health professionals spent significant amounts of time on administrative duties. According to a County time study of 18 clinics in fiscal year 1966, 44 percent of their time was charged to administrative suooort. These therapists worked 56 percent of their time on direct and related patient care activities including the time needed to write patient progress notes. Exhibit A shows the percentage of therapists' time devoted to patient care activities and to administrative support at each clinic.

In contrast, a study of physician time showed that private psychiatrists spent on average over 87 percent of their professional time on patient care activities. (Socioeconomic Characteristics of Medical Practice, AMA Annual 1987)

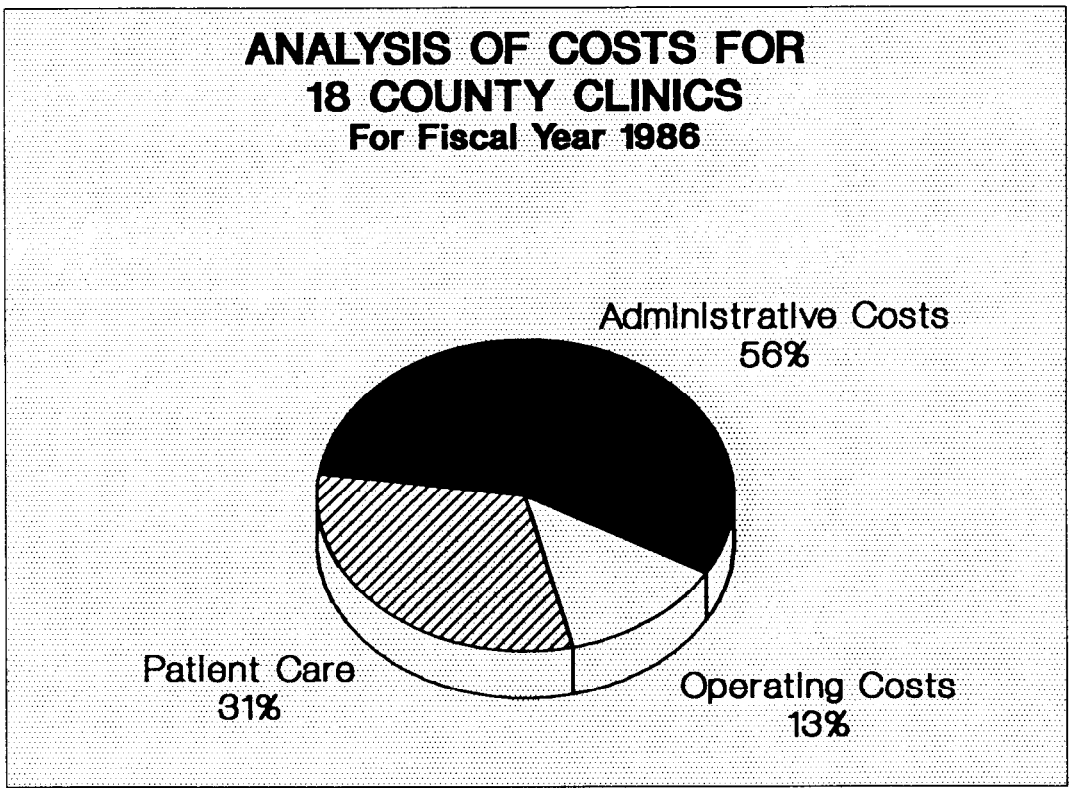


At one clinic (Provider No. 3806), only 21 percent of the therapists' time was spent for patient care. This clinic had the equivalent of 15 full-time therapists (2 psychiatrists and 13 psychologists). Based on the number of patient care hours reported for fiscal year 1986, it needed less than three full-time therapists to treat its patients.

The State's productivity requirement may have contributed to this underutilization of therapists. State officials told us that they required therapists to be productive only 50 percent of the time.

Costly Administration and Overhead

Overall, more than half (56 percent) of the clinics' costs went to administrative and County overhead expenses. Just 31 percent of their costs went to patient care activities and another 13 percent for clinic operating expenses. Exhibit B shows the percentage of each clinic's costs for patient care activities, rent and other operating costs, and administrative and overhead expenses.



At Provider No. 3806, only 13 percent of the costs went to patient care activities, while 74 percent was for administrative and overhead expenses. This resulted in an average hourly cost of $223 for patient care at this clinic.

High Costs Continued

The high cost of Short/Doyle services continued in San Francisco County after fiscal year 1986. In fiscal year 1988, the cost of a one-half hour medication visit at one County clinic was $309. At another clinic, the cost of this service was $281. These amounts were substantially higher than the Statewide average cost of $74 for this service. At yet another clinic, the cost of group therapy was $251 per person, almost four and a half times the average Statewide cost of $58.

More Expensive Care in Other Counties

San Francisco generally did not have the highest costs in the State. For example, the average cost for assessment in 41 counties was higher than in San Francisco County. Further, 30 counties had a higher average cost for individual therapy. The following schedule compares the average cost per service in San Francisco to the highest in the State:

Type of Service	Cost per Service: Highest County	Cost per Service: S F County	S F County Ranking
Assessment	$ 136	$ 79	42nd
Individual Therapy	122	70	31st
Day Treatment-Habilitative	195	53	25th
Day Treatment-Intensive	147	72	21st
Collateral Services	110	66	20th
Medication	92	71	7th
Inpatient Hospital	443	390	6th
Group Therapy	75	57	5th
Crisis Intervention	336	336	1st

Fiscal Year 1986

The cost of care at some providers in other counties was quite high, as shown:

Type of Service	Provider	Unit cost	Statewide Average Cost	Percent Over
Individual Therapy	7101	$238	$67	255%
	5673	169	67	152
	0768	150	67	124
Group Therapy	4102	$210	$45	367%
	4327	101	45	124
	0768	94	45	109
Medication	8001	$157	$57	175%
	3705	155	57	172
	3703	141	57	147

Fiscal Year 1986

The $238 cost for individual therapy was nearly six times the maximum permitted of $41 under the regular Medicaid program.

State Plan Approved

The California State plan for setting Short/Doyle payment rates was approved by HCFA officials. The Office of General Counsel advised us that, as a general rule, it is not possible to recover Federal funds for expenditures made in accordance with an approved State plan, even if the plan violates Federal law. Counsel also advised that HCFA has the authority to require the State to amend its Medicaid plan to comply with Federal law and regulations. If the State does not do so, HCFA has the authority to withhold or limit payments.

To withhold or limit payments, the Secretary of the Department of Health and Human Services must make a finding that the State plan fails to comply with Section 1902 of the Social Security Act, and must give the State notice and opportunity for a hearing.

CONCLUSION AND RECOMMENDATIONS

The law requires that each Medicaid State plan provide for payments that are consistent with efficiency, economy, and quality of care. Medicaid regulations, in turn, limit Federal funding for clinic and hospital services to what Medicare would pay for the same or similar services.

The California State plan for Short/Doyle Medicaid services does not comply with these Federal requirements. We are, therefore, recommending that HCFA require the State to amend its plan to bring it into compliance with Federal rules. If the State fails to comply, we recommend that HCFA commence a compliance proceeding on California's Medicaid plan in order to limit Federal payments to reasonable amounts.

HCFA Agreed

HCFA concurred with our recommendations. Its comments to our draft report are included in their entirety as Attatchment A.

State Indicated Willingness To Comply

The State intends to establish Short/Doyle payment rates that are consistent with Federal requirements by June 30, 1992. In the meantime, it intends to limit Short/Doyle payments to the Statewide average cost for each type of service, after eliminating skewed unit costs at both extremes.

The State's comments are included in their entirety as Attachment B.

EXHIBITS

Exhibit A

ANALYSIS OF THERAPIST TIME
FOR 18 COUNTY OPERATED CLINICS
For Fiscal Year 1986

Provider Number	Patient Care Activities	Administrative support
3806	21%	79%
3803	48	52
3847	49	51
3874	52	48
3871	53	47
3872	53	47
3804	53	47
3848	54	46
3802	55	45
3846	57	43
3870	57	43
3845	59.	41
3801	64	36
3805	64	36
3880	65	35
3881	71	29
8907	a l	19
3882	83	17
Overall	56%	44%

Exhibit B

ANALYSIS OF COSTS FOR 18 COUNTY OPERATED CLINICS For Fiscal Year 1986

Provider Number	Patient Care Activities	Administrative and Overhead	Operating costs
3806	13%	74%	13%
3803	"25	65'	10
3847	24	60..	16
3874	30	60	10
3871	28	59	13
3872	30	5 7	13
3804	29	57	14
3848	33	56.	11
3802	24	58	18
3846	32	57	11
3870	34	55	il.
3845	33	57	10
3801	38	52'	10
3805	36	53	11
3880	34	51 . .	15
3881	34	50	16
8907	43	45	12
3882	44	43	13
Overall Average	**31%**	**56%**	**13%**

ATTACHMENTS

ATTACHMENT A

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region IX
Health Care Financing Administration

Memorandum

Date MAY 9 1991

From Associate Regional Administrator
Division of Medicaid

Subject Draft Report on OIGOAS Review of Short/Doyle Medicaid Payments Rates (CIN: A-09-91-00076)

To Herbert Witt
Regional Inspector General
for Audit Services

Refer to
MCD-F-KA
FO-A-3 91-00076

We reviewed your draft report transmitted to us on April 10, 1991, and concur with your recommendation. HCFA will take the necessary action to bring the State into compliance with the State plan requirements as presented.

Any questions regarding this matter may be directed to Kenneth Adams of my staff at (415) 744-3564.

Lawrence L. McDonough

STATE OF CALIFORNIA-HEALTH AND WELFARE AGENCY

ATTACHMENT B

PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

916) 322-4060

July 11, 1991

Mr. Herbert Witt
Regional Inspector General
for Audit Services
Office of Inspector General, Region IX
Office of Audit Services
50 United Nations Plaza
San Francisco, CA 94102

Dear Mr. Witt:

DRAFT AUDIT REPORT CIN: A-09-91-00076 (DHS NUMBER 90-04)

This letter is in response to your April 10, 1991, letter addressed to Kenneth W. Kizer, M.D., M.P.H., Director, Department of Health Services (DHS) which transmitted for review and comment a draft audit report entitled "Review of Short/Doyle Medicaid Payment Rates".

The following is to apprise you of current efforts by the state to resolve various issues identified in the report. ***Our*** comments are shown after a restatement of the draft report's conclusion and recommendations.

Conclusion and Recommendations

The law requires that each Medicaid State Plan provide for payments that are consistent with efficiency, economy, and quality of care. Medicaid regulations in turn, limit federal funding for clinic and hospital services to what Medicare would pay for the same or similar services.

The California State Plan for Short/Doyle Medicaid services does not comply with these federal requirements. We are, therefore, recommending that Health Care Financing Administration (HCFA) require the state to amend its plan to bring it into compliance with federal rules. If the state fails to comply, we recommend that HCFA commence a compliance proceeding on California's Medicaid plan in order to limit federal payments to reasonable amounts.

State Response

1. Short-Doyle/Medi-Cal Services

The Department of Mental Health (DMH) and DHS have been working with Electronic Data Systems, Inc., (EDS) on the development of an automated claims processing system that will include identification of duplicate claims and an edit process for costs claimed in excess of the established provisional rates. Some questions still remain about the proposed database and presently DMH lacks the information needed to make a recommendation on the EDS proposal. Several other alternative systems, including internal solutions, have been proposed which would also address deficiencies identified in the Office of Inspector General (OIG) draft report. Cost estimates and system features are presently under review and a decision will be made within the next few months regarding which alternatives to recommend to the steering committee.

2. Short/Doyle-Medi-Cal Payment Rates

The DMH is aware of the OIG draft report finding that payment rates for Short/Doyle-Medi-Cal services exceed the amount that Medicare would pay for the same services. Because of the different service definitions (procedure codes) between the Medicare program and the Short/Doyle-Medi-Cal program, trying to apply Medicare limits to Short/Doyle-Medi-Cal services is extremely difficult. Thus, the DMH is in the process of executing a contract with a private consultant to study and development recommendations on various rate-setting methodologies that could be applied to the Short/Doyle-Medi-Cal program and would be more consistent with OIG interpretations of federal requirements (i.e., consistent with efficiency, economy, and quality of care). The DMH intends to select and approve a new rate setting methodology from the alternatives provided by the consultant prior to the end of fiscal year (FY) 1991-92.

Because the maximum rates for ***FY*** 1991-92 ***must*** be established within the next few weeks, the DMH intends to continue to utilize rate maximums established at 125 percent of the statewide average cost for each type of service covered by Medi-Cal, after eliminating skewed unit costs at both extremes. A new rate setting methodology meeting federal regulations will be applied in all subsequent years.

The intended course of action outlined in this letter demonstrates the state's desire to develop a Short/Doyle-Medi-Cal claim and reimbursement system that is in compliance with federal regulations. We will continue to keep you informed of our progress in these areas.

Thank you for the opportunity to respond to this draft report and the time extension granted. We also appreciate the cooperation and patience you and your staff have provided us on this matter.

If you have any further questions, please contact Darrell Doty at (916) 445-1708.

Sincerely,

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