Review of the

Health and Hospital System (HHS) Implementation of Retroactive Medi-Cal Billing Procedures to Recover the Cost of Services Provided to General Assistance Clients Approved for SSI

Prepared by the
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March 12, 2010

County of Santa Clara

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March 12, 2010

Supervisor Ken Yeager, Chair
Supervisor Dave Cortese, Vice Chair
Board of Supervisors Finance and Government Operations Committee
70 West Hedding Street
San Jose, CA 95110

Dear Supervisors Yeager and Cortese:

At the direction of the Board of Supervisors, we have completed a Six-month tracking report on the Health and Hospital System (HHS) implementation of retroactive Medi-Cal billing procedures to recover the cost of services provided to Gneeral Assistance clients approved for SSI. This follow-up study stemmed from the March 3, 2009 management audit of the Department of Employment and Benefit Services. The purpose of this follow-up tracking report was to ensure that HHS fully implemented the audit recommendations that were approved by the Board of Supervisors to increase retroactive Medi-Cal billing by an estimated $7.8 million, annually.

This six-month follow-up review determined that most of the audit recommendations were implemented by the seven HHS billing units and resulted in increased annual retroactive Medi-Cal billing from approximately $1,420,000 prior to December 2008 to about $5,118,000 per year since December 2008. In addition, the increased rate of annual retroactive Medi-Cal billing excludes services retroactively billed that were provided within the past year, and it excludes an estimated $1,300,000 not currently being billed for retroactively billable pharmacy services provided more than one year in the past. Consequently, the Board of Supervisors should again direct the County Executive to direct HHS staff to retroactively bill Medi-Cal for all services provided to SSI approved General Assistance clients during their period of retroactive eligibility.

This follow-up review was conducted pursuant to the authority of the Board of Supervisors under the Board's power of inquiry, as provided in Article III, Section 302 (c) of the County Charter and in conformity with the auditing standards of the United States Government Accountability Office.

The written response from the Health and Hospital System begins on page 12, and the written response of the Social Services Agency begins on Page 17 of this report. We

would like to thank the Health and Hospital Patient Business Services Division staff and the Social Services Agency Eligibility Bureau staff at VMC for their cooperation and assistance throughout this follow-up review.

Respectfully Submitted,

Roger Mialocq
Board of Supervisors Management Audit Manager

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Health and Hospital System (HHS) Implementation of Retroactive Medi-Cal Billing Procedures to Recover the Cost of Services Provided to General Assistance Clients Approved for SSI

Six-month Tracking Report

On March 3, 2009, the Management Audit Division released a report entitled "Management Audit of the Department of Employment and Benefit Services." Section One of the report pertained to General Assistance (GA) clients who gain approval for federal Supplemental Security Income (SSI) and, subsequently, health care coverage through Medi-Cal. The section focused on how Medi-Cal may be retroactively billed for services that these previously unsponsored patients received from the Health and Hospital System during their period of retroactive eligibility. The HHS past practice was to "write off" the cost of these services with the County General Fund absorbing the cost.

The Finance and Government Operations Committee reviewed the audit on May 7, 2009 and directed the Management Audit Division to perform a six-month follow-up review of the implementation of the audit recommendations approved by the Board. This memo summarizes the implementation status of those recommendations.

BACKGROUND ON AUDIT REPORT

Findings

Section One of the report included the following findings:

- Based on a random sample of 101 General Assistance clients approved for SSI, it was determined that 99 percent were patients of at least one of the departments of the Health and Hospital System.
- Only a portion of the charges incurred at Valley Medical Center (VMC) for inpatient, professional and outpatient medical services were being retroactively billed to Medi-Cal. In addition, charges for mental health outpatient and inpatient services, and Outpatient Pharmacy charges for both medical and mental health drugs, as well as other Health and Hospital System service area costs, were not being reviewed at all for potential retroactive billing.
- The process undertaken by VMC to retroactively bill Medi-Cal only included review of charges dating one year prior to the date of notice of eligibility, instead of including all charges within the period of retroactive eligibility, which typically averaged two to three years, and as much as 10 years in some cases.
- An estimated $7.8 million in charges were going unbilled annually. Applying actual Medi-Cal reimbursement rates in each HHS department, this would amount to an estimated $2.9 million in Medi-Cal receipts annually.

Recommendations

The recommendations included in the audit report are listed below, along with the Board of Supervisors' position on each item.

The Social Services Agency should:

1.1 Transmit its monthly report of SSI approvals directly to each of the following Health and Hospital System billing units (in addition to the Patient Business Services (PBS) Hospital/Clinic Billing Unit), including (1) PBS-Professional Services Billing, (2) Ambulatory Pharmacy Services Billing, (3) PBS-Mental Health Services Billing, (4) Mental Health Department Administration, (5) Public Health Department Lenzen Pharmacy Billing, and (6) HHS-Fiscal Services.

Board of Supervisors Position: Agreed and Passed.

The Health and Hospital System should:

1.2 Temporarily prepare and adopt a comprehensive, detailed written procedure to govern the processing of the monthly report of SSI approvals by all billing units in the Health and Hospital System.

Board of Supervisors Position: Agreed and Passed.

1.3 Conduct procedures training of all HHS staff who are responsible to research HHS patient records for all General Assistance clients on the monthly list of SSI approvals, and to prepare and process retroactive Medi-Cal bills.

Board of Supervisors Position: Agreed and Passed.

1.4 Create a new PBS-Retroactive Medi-Cal Unit staffed with a Senior or Supervising Patient Business Services Clerk responsible to oversee the monthly processing of SSI approval lists received from the Social Services Agency, and to prepare monthly activity and collections reports. The HHS should submit an amendment to the Annual Salary Ordinance adding this position and deleting one or more of the 16 vacant positions in the Patient Business Services Division in order to make the creation and staffing of the new unit cost neutral.

Board of Supervisors Position: Agreed to assign an existing position to serve as coordinator for HHS.

FOLLOW-UP REVIEW PROCESS

Interviews: The audit team interviewed more than 10 individuals across multiple departments responsible for implementing aspects of the report's recommendations. Managers, supervisors and staff in the SSA and HHS described changes that had been implemented since the Board's action, and provided documentation for review.

Reviewed documents: The audit team reviewed documents, including written procedures, tracking logs, Medi-Cal remittance advices and other documents provided by the various departments within SSA and HHS.

Sample Testing: The audit team tested a random sample of 100 individuals who were approved for SSI between June 2009 and November 2009. The sample was tested against each of the three major databases (Invision, Unicare, and PCSI) used by HHS. There was not sufficient time available for the review to test the other databases (Signature and Diamond); however, information gathered in interviews suggest that the status of implementation for Diamond and Signature is similar to the status of implementation in Invision and Unicare (see below). Further, the audit finding from the March 2009 report estimated lost revenue attributable to these two billing systems of only $15,478 annually, out of the $2.9 million projected annual revenue loss.

RECOMMENDATION IMPLEMENTATION STATUS:

A summary of the implementation status of the audit's recommendations is presented in Attachment 1.

- **Recommendation 1.1: SSA to distribute monthly list to each of the five HHS billing units.**

  Status: Managers of six of the seven HHS billing units reported receiving the monthly reports from SSA, with the exception of the Manager of the Public Health Pharmacy, who has now been added to the distribution list. Additionally, one staff person in HHS Patient Business Services researches the approvals list and augments the list with additional pertinent information before resending it to the relevant HHS departments. As a result, the HHS department coordinators each receive the list twice. The second distribution includes the VMC patient medical record number from the Invision billing system and is provided as an additional identifier to the other billing units to assist them in identifying patients.

- **<u>Recommendation 1.2</u>: HHS should prepare comprehensive billing procedures for each of the five billing units in the HHS.**

Status:

-VMC Inpatient and Outpatient Services: Invision Billing System
-VMC Inpatient Professional Services: Signature Billing System
-Mental Health Outpatient: Unicare Billing System

Three of the seven billing units within HHS have developed written policies and procedures for the retroactive billing of Medi-Cal for SSI approved General Assistance clients. The policies developed by billing units responsible for VMC inpatient and outpatient medical services, inpatient professional services, and Mental Health outpatient services are complete, detailed, and include as attachments examples of the forms and documentation required by the procedures. The implementation of these procedures significantly increased the amount of retroactive billing of HHS services to Medi-Cal.

Based on a log maintained by the Social Services Agency – VMC Eligibility Bureau which is responsible for reviewing requests for Letters of Authorization (LOA) to retroactively bill Medi-Cal, the total amount of authorized billing for services provided more than one year in the past increased from approximately $1,420,000 annually prior December 2008, to about $5,118,000 per year since December 2008. In addition, the increased rate of annual retroactive Medi-Cal billing excludes services retroactively billed that were provided within the past year, and it excludes an estimated $1,300,000 not currently being billed for retroactively billable pharmacy services provided more than one year in the past.

-Mental Health Inpatient Services: Manual Billing
-Mental Health Inpatient Professional Services: Diamond Billing System

The billing unit responsible for billing mental health inpatient services and professional services at private hospitals has implemented new procedures, but has not prepared formal written procedures for its procedure manual that would help to ensure consistency over time as staff change in the unit.

-Pharmacy Services: PCSI Billing System
-Public Health Pharmacy: PCSI Billing System

Lastly, the Outpatient Pharmacy billing unit and the Public Health Pharmacy have issued a document for staff to use as a guideline when retroactively billing Medi-Cal. However, the HHS Pharmacy Department Supervisor and the Assistant Director of Pharmacy Services reported that the guideline is not a formal Pharmacy Department procedure, and the HHS Pharmacy Department was not given FTE staff to perform the retroactive Medi-Cal billing function.

The guideline document only provides for retroactive billing of services received by the patients within the past year. No retroactive billing of Medi-Cal for billable pharmacy services beyond one-year is occurring.

Based on a random sample, we estimate that 82 percent of General Assistance clients approved for SSI are known to the Pharmacy system, and 60 percent have unbilled pharmacy services during their period of retroactive Medi-Cal eligibility. However, because the Pharmacy is not currently retroactively billing Medi-Cal for any charges older than one year from the notice of eligibility date, our review revealed that a substantial amount of billable charges were not billed. In total, our random sample review of 50 SSI approved General Assistance clients found nearly $118,000 of unbilled charges. Extrapolating this to the 549 clients that are approved on average each year, we estimate that approximately $1.3 million of pharmaceutical charges are going unbilled annually. Based on the latest Medi-Cal remittance advice pertaining to Pharmacy Department drug charges submitted to Medi-Cal for services provided as late as October 9, 2009, the average reimbursement rate was 84.6 percent of approved charges. However, the rate would be somewhat reduced when denied claims are accounted for, and is expected to be further reduced as a result of a recent change in State Medi-Cal regulations.

- **Recommendation 1.3: HHS should conduct procedures training pertaining to the processing of retroactive SSI Medi-Cal claims**

Status: All seven billing unit managers reported having implemented training for the processing of retroactive SSI Medi-Cal claims, although procedures for the private hospital inpatient retroactive billing and the fee-for-service billing are not yet written, and the billing procedures for the HHS Outpatient Pharmacy and the Public Health Pharmacy do not provide for billing services more than one year in the past.

- **Recommendation 1.4: HHS should create a new PBS Retroactive Medi-Cal Unit to centrally oversee the monthly processing of SSI approval lists, retroactive billing of Medi-Cal and preparation of monthly activity and collection reports with annual reports to the County Executive and the Board of Supervisors.**

Status: The Board of Supervisors approved an alternative recommendation by HHS to assign a Patient Business Services Manager to oversee the retroactive billing of Medi-Cal and be responsible for the preparation and issuance of an annual activity and collection report. Internal data reporting from one of the seven billing units (the VMC hospital and outpatient *Invision* billing unit) occurs with partial data (no collections information is reported). No internal monthly billing, collections and receivables reporting is occurring from the

other four billing units to the PBS Manager. However, PBS has created a special payor category "08" for retroactive Medi-Cal bills. Although the PBS Manager does not receive a monthly report on collections for any of the seven HHS billing units, he reports that such information can be obtained from the Medi-Cal Unit revenue and collections accounting and tracking system when requested. Attachment 2 provides a suggested internal monthly reporting form to be completed by each HHS billing unit and transmitted to the PBS Manager. Attachment 3 is a suggested summary schedule intended to consolidate all retroactive Medi-Cal billing activity by billing unit on a monthly basis.

A comprehensive annual report of all retroactive Medi-Cal charges and collections and activity is due to the County Executive and the Board of Supervisors in less than 60 days on May 7, 2010. HHS Patient Business Services may want to request an extension from the Finance and Government Operations Committee to July 30, 2010, in order to make the annual report on a fiscal year basis.

CONCLUSIONS

- With the February 2010 addition of the Public Health Pharmacy Manager to the distribution list, the Social Services Agency now distributes the monthly Interim Assistance Reimbursement list of General Assistance clients approved for SSI and retroactive Medi-Cal eligibility to all the appropriate billing entities within HHS.

- As of the date of this report, HHS designated coordinator for retroactive Medi-Cal billing for SSI patients (the PBS Manager) has not fully implemented an internal monthly activity and collections monitoring and reporting process that would be necessary to compile the annual collections and activity report required by the Board's directive (Recommendation 1.4). The coordinator does not receive monthly status/monitoring reports from six of the seven HHS billing units. However, the PBS Manager reported that collections and billing data is available upon request for most of the medical and mental health areas (which account for most of the retroactive Medi-Cal billing), but not for the Outpatient Pharmacy, Public Health Pharmacy, Mental Health Private Inpatient or Mental Health Fee-for-Service retroactive Medi-Cal billing units. As a result, implementation of the Board approved recommendations to ensure complete and timely billing of retroactive Medi-Cal claims has not been fully implemented across the HHS departments. Improved monitoring and internal reporting is necessary to monitor collections, receivables and backlogs[1].

[1] We remain concerned that without ongoing internal monitoring of this process, current procedures that now ensure retroactive billing of Medi-Cal by HHS billing units (other than the Pharmacy) for services provided to SSI approved General Assistance clients, will lapse in the future, as occurred following the previous management audit of this function in 1992.

- The HHS billing units responsible for VMC hospital and professional charges and Mental Health outpatient services have successfully transitioned to reviewing accounts completely back to the date of retroactive eligibility. Sample testing in the primary databases (Invision and Unicare) did not reveal any significant amount of unbilled charges.

- The HHS billing unit responsible for billing mental health inpatient services and professional services at private hospitals has implemented new procedures to ensure all General Assistance clients approved for SSI are reviewed monthly to determine if they were the recipient of services which now could be retroactively billed to Medi-Cal. However, such procedures should be formalized to ensure ongoing continuity.

- The Outpatient Pharmacy has only partially implemented billing procedures for retroactive Medi-Cal claims for services provided within the past year, but does not review services provided one year or longer in the past, which has resulted in an estimated $1.3 million of unbilled charges annually.

- In the course of implementing the audit's recommendations, the Social Services Agency raised concerns over compliance with State confidentiality regulations while sharing client information with the Health and Hospital System in order to satisfy separate State regulations that require the County to submit specific documentation of SSI eligibility in order to obtain Medi-Cal reimbursement. A number of solutions have been proposed by staff in both agencies, the Management Audit Division, and the Office of County Counsel. This group will continue to work together to reach a solution that preserves Social Services Agency client confidentiality while satisfying the State Department of Mental Health billing documentation requirements

RECOMMENDATIONS:

It is recommended that the HHS Patient Business Services Division:

1) Require each of the seven billing units within HHS Patient Business Services to prepare a monthly activity report including, (1) the number of General Assistance clients approved for SSI during the month, (2) the number of General Assistance clients known to the billing system (3) the number of patients identified to have received services during their period of retroactive Medi-Cal eligibility that were billed this month, (4) the dollar amount that was billed, (5) the amount of revenue collected this month (6) the number of patients for whom Letters of Authorization (LOA) were requested this month, (7) the dollar amount of charges submitted this month for LOA approval, and the fiscal year to date information pertaining to the same items as shown in Attachment 2. This information should be submitted within five workdays after the end of each month to the Manager of Patient Business Services.

2) Require the Patient Business Services Division - Medi-Cal Collections Unit to prepare a monthly activity report including, (1) the amount of revenue received from Medi-Cal for billings by each of the seven billing units, (2) the amount of charges related to the revenues received for each of the seven billing units, (3) the dollar amount of outstanding Medi-Cal billings for each of the seven billing units, and a chronological listing of all outstanding Medi-Cal billings. This information should be submitted within five workdays after the end of each month to the Manager of Patient Business Services.

3) Require the PBS Manager to prepare a consolidated monthly activity report, including all of the above information (except for the detailed chronological listing of outstanding Medi-Cal billings which should be summarized by month), to facilitate preparation and issuance of an annual report to the County Executive and the Board of Supervisors by July 30th of each fiscal year.

It is recommended that the Social Services Agency-VMC Eligibility Bureau:

4) Prepare comprehensive written procedures for the processing of requests for Letters of Authorization (LOA) by the Health and Hospital System related to retroactive billing of Medi-Cal for General Assistance clients approved for SSI.

5) Monitor the backlog of LOA requests to ensure sufficient staff are available to process such requests on a timely basis. As of December 28, 2009, approximately 63 requests amounting to more than $2 million that had been received during the past three months were backlogged. In addition, HHS-Patient Business Services reported that as of February 19, 2010, the LOA request backlog had grown to a total of 91 requests amounting to about $3.3 million.

RETROACTIVE MEDI-CAL BILLING FOR GENERAL ASSISTANCE CLIENTS APPROVED FOR SSI

Recommendation	VMC Hospital and Clinics				Mental Health/Drug and Alcohol/Public Health				
	Inpatient Services	**Professional Services**	**Outpatient Services**	**Outpatient Pharmacy**	**BAP Inpatient**	**Private Hosp Inpatient**	**Outpatient Services**	**Fee-for-Svc Costs**	**Public Health Pharmacy**
Social Services:									
1.1 Transmit monthly report of Gen Asst clients approved for SSI to HHS billing units.	Done	Done	Done	Done	Done	Done	Done	Done	This unit was not receiving the monthly list, but has now been added as of 2/17/10
HHS:									
1.2 Develop written procedures for processing retroactive Medi-Cal bills	Done	Done	Done	No Written Procedures for Services More Than 1 Year Old Note 1	Done	No Written Procedures as of 2/12/10 Note 2	Done	No Written Procedures as of 2/12/10 Note 2	No Written Procedures for Services More Than 1 Year Old Note 1
1.3 Conduct procedures training for retroactive Medi-Cal billing	Done	Done	Done	Done	Done	Done (staff developed procedures, but formal written procedures not yet finalized)	Done	Done (staff developed procedures, but formal written procedures not yet finalized)	Done
1.4 PBS Manager to oversee monthly processing of SSI approval lists and track completion of research, billing and reporting, including annual reporting to the County Executvie and Board of Supervisors.	Monthly report of billings prepared, but no monthly tracking of collections and receivables	No monthly report of billings prepared or tracking of collections and receivables	Monthly report of billings prepared, but no monthly tracking of collections and receivables	Retro Medi-Cal log tracks billing and collections, but does not track receivables or report to PBS Manager	Retro Medi-Cal log of billings prepared, but no monthly tracking of collections and receivables or report to PBS Manager	Retro Medi-Cal log of billings prepared, but no monthly tracking of collections and receivables or report to PBS Manager	Retro Medi-Cal log of billings prepared, but no monthly tracking of collections and receivables or report to PBS Manager	Retro Medi-Cal log of billings prepared, but no monthly tracking of collections and receivables or report to PBS Manager	Retro Medi-Cal log tracks billing and collections, but does not track receivables or report to PBS Manager
Billing System	**Invision**	**Signature**	**Invision**	**PCSI**	**Invision**	**Manual**	**Unicare**	**Diamond**	**PCSI**

Note 1: Billing staff in the Outpatient Pharmacy Billing Unit have issued a memo for processing the monthly lists of General Assistance clients approved for SSI, but this guideline only pertains to billing for services provided within one year of the date of notification from the Social Security Administration. Services within six months are billed electronically through PCSI. Services from six months to one year are to be billed through the Retro TAR procedure. Services beyond one year are not billed. Consequently, an estimated $1.3 million of charges are not billed annually.

Note 2: Staff responsible for researching and processing retroactive billing of Medi-Cal for General Assistance Clients approved for SSI report having developed and implemented the necessary procedures, but they have not yet prepared a written Departmental procedure to ensure consistency between staff and continuity over time.

MONTHLY RETROACTIVE MEDI-CAL BILLING REPORT FOR GENERAL ASSISTANCE CLIENTS APPROVED FOR SSI

HHS OUTPATIENT PHARMACY BILLING UNIT

DECEMBER 2009

Item	Description	Amount
	Month of December	
1	Number of clients approved for SSI	50
2	Number of clients known to billing system	41
3	Number of clients known to billing system with unbilled charges during retroactive period of Medi-Cal eligibility that were billed this month	35
4	Amount of charges billed this month	$63,455
5	Amount of revenue collected this month	$49,495
6	Number of patients for whom LOAs were requested this month	$24
7	Amount of charges submitted this month for LOA approval	$12,374
	FY 2009-10 Year-to-Date	
8	Number of clients approved for SSI	302
9	Number of clients known to billing system	246
10	Number of clients known to billing system with unbilled charges during retroactive period of Medi-Cal eligibility	210
11	Amount of charges billed this fiscal year	$380,730
12	Amount of revenue collected this fiscal year	$296,969
13	Amount of charges submitted this fiscal year awaiting LOA approval	$95,183

FY 2009-10 SUMMARY

MONTHLY RETROACTIVE MEDI-CAL BILLING REPORT
FOR GENERAL ASSISTANCE CLIENTS APPROVED FOR SSI

DECEMBER 2009

		Billing System								
		Invision	Signature	PCSI	Invision	Manual	Unicare	Diamond	PCSI	
		Inpatient & Outpatient Hospital Services	Inpatient & Outpatient Professional Services	HHS Outpatient Pharmacy Services	Mental Health Inpatient (BAP)	Mental Health Inpatient Priv Hosp	Mental Health Outpatient Services	Mental Health Priv Hosp Fee-for-Svc	Public Health Pharmacy Services	Total
Item	Description	Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount	
	Month of December									
1	Number of clients approved for SSI*1	50	50	50	50	50	50	50	50	**50**
2	Number of clients known to billing system	40	40	41	40	3	43	8	41	**256**
3	Number of clients known to billing system with unbilled charges during retroactive period of Medi-Cal eligibility*2	15	2	35	3	1	33	2	3	**94**
4	Amount of charges billed this month	$586,125	$4,746	$63,455	$39,177	$0	$488,664	$1,114	$393	**$1,183,674**
5	Amount of revenue collected this month*3	$25,648	$2,106	$49,495	$15,279	$1,333	$244,332	$1,314	$263	**$339,770**
6	Number of patients for whom LOAs were requested this month	10	10	24	2	0	18	1	1	**66**
7	Amount of charges submitted this month for LOA approval	$45,287	$3,275	$12,374	$3,056	$5,730	$146,599	$0	$0	**$216,321**
	FY 2009-10 Year-to-Date									
8	Number of clients approved for SSI	302	302	302	302	302	302	302	302	**302**
9	Number of clients known to billing system	198	201	246	240	18	258	48	246	**1,455**
10	Number of clients known to billing system with unbilled charges during retroactive period of Medi-Cal eligibility	30	17	210	15	6	198	12	18	**506**
11	Amount of charges billed this fiscal year	$3,399,525	$28,476	$380,730	$235,062	$0	$2,931,984	$6,684	$2,358	**$6,984,819**
12	Amount of revenue collected this fiscal year	$1,529,786	$22,781	$296,969	$91,674	$7,998	$1,465,992	$7,884	$1,580	**$3,424,664**
13	Amount of charges submitted this fiscal year awaiting LOA approval	$168,123	$1,424	$74,242	$18,335	$34,380	$879,595	$0	$0	**$1,176,099**

*1 This is the number of General Assistance clients approved for SSI appearing on the monthly Social Services Agency Interim Assistance Reimbursement (IAR) report.
*2 The total for this number can include duplicated counts of the same client since a client may be both a medical and mental health patient who has received HHS services in multiple service categories.
*3 Revenue collected during a month may relate to retroactive billings of prior months.

County of Santa Clara
Santa Clara Valley Health & Hospital System
Valley Medical Center

HHS01 031810

Prepared by: Amy Carta
Assistant Director, SCVHHS

Submitted by: Nancy Kaatz
Chief Financial Officer

DATE: March 18, 2010

TO: Supervisor Ken Yeager, Chairperson
Supervisor Dave Cortese, Vice Chair
Finance & Government Operations Committee

FROM:

Sylvia Gallegos
Deputy County Executive / Acting Director, SCVHHS

SUBJECT: Response to "Review of the Implementation of Retroactive Medi-Cal Billing Procedures for Health and Hospital System Services Provided to General Assistance Clients Subsequently Approved for SSI"

RECOMMENDED ACTION

Accept report in response to "Review of the Implementation of Retroactive Medi-Cal Billing Procedures for Health and Hospital System Services Provided to General Assistance Clients Subsequently Approved for SSI."

FISCAL IMPLICATIONS

There are no direct fiscal implications to the County General Fund associated with this report. Actions taken in response to the "Review of the Implementation of Retroactive Medi-Cal

Billing Procedures for Health and Hospital System Services Provided to General Assistance Clients Subsequently Approved for SSI" will assist in improving reimbursements for the Mental Health Department and Santa Clara Valley Medical Center.

REASONS FOR RECOMMENDATION

In this follow-up report, the Management Audit Division presents additional findings based on a random sample of 101 General Assistance cases. Additional recommendations from the Management Audit Division and SCVHHS's responses are provided below.

It is recommended on page 7 of the Management Audit Division's report that the HHS Patient Business Services Division:

1) Require each of the seven billing units within HHS Patient Business Services to prepare a monthly activity report including, (1) the number of GA clients approved for SSI during the month, (2) the number of GA clients known to the billing system, (3) the number of patients identified to have received services during their period of retroactive Medi-Cal eligibility that were billed this month, (4) the dollar amount that was billed, (5) the amount of revenue collected this month, (6) the number of patients for whom Letters of Authorization (LOA) were requested this month, (7) the dollar amount of charges submitted this month for LOA approval and the fiscal year to date information pertaining to the same items shown in **Attachment 2**. This information should be submitted within five working days after the end of each month to the Manager of Patient Business Services.

Partially Agree. Patient Business Services can prepare monthly reports to track billing activity and collections through the data electronically available in its multiple systems (Invision, Signature and Unicare). This data is sufficient to accomplish the overall purpose of the Management Audit Division's recommendation.

Patient Business Services, Mental Health, and Pharmacy can electronically track the number of accounts, charges, and payments monthly; in addition, existing staff manually track the Letters of Authorization. Together, these four components can provide the data necessary to track progress and activity on retroactively enrolled Medi-Cal patients without the need to hire additional staff.

To track all seven (7) of the components suggested in the recommendation would require the addition of staff to manually track, collect, and report the information.

Patient Business Services would require a 0.5 FTE PBS Clerk to collect the remittance advices and match the payment back to the individual account in order to cross-walk the data.

Processes originally established as a result of the May 7, 2009 report to the Finance and Government Operations Committee have been further refined and incorporated into the daily activities of the Patient Business Services Department. Monitoring of the activity and adherence by the various Health and Hospital billing units to the policies and procedures related to the processing and submission of claims to Medi-Cal (retroactive/non-retroactive) will be the responsibility of the Director of Patient Business Services.

2) Require the Patient Business Services Division – Medi-Cal Collections Unit to prepare a monthly activity report including, (1) the amount of revenue received from Medi-Cal for billings by each of the seven billing units, (2) the amount of charges related to the revenues received from each of the seven billing units, (3) the dollar amount of outstanding Medi-Cal billings for each of the seven billing units, and a chronological listing of all Medi-Cal billings. This information should be submitted within five working days after the end of each month to the Manager of Patient Business Services.

Partially Agree. Patient Business Services can prepare monthly reports to track the number of accounts, charges, and payments for the retroactive accounts.

Given the system currently in operation in the Pharmacy department, the data cannot currently be tracked in the ways suggested by the Management Audit Division. Pharmacy can track expected payments and the results compared to expectations. This data should be sufficient to accomplish the goal set forth in the recommendation.

3) Require the PBS manager to prepare a consolidated monthly activity report, including all of the above information (except for the detailed chronological listing of outstanding Medi-Cal billings that should be summarized by month), to facilitate preparation and issuance of an annual report to the County Executive and Board of Supervisors by July 30 of each fiscal year.

Partially Agree. The Director of Patient Business Services will prepare and submit a consolidated report that describes the submission and collection results for all seven

billing units. This report would be for the entire fiscal year. In providing the results for the entire fiscal year, the County Executive and Board of Supervisors would receive the necessary information to measure progress.

In addition to these recommendations, the Management Auditors also pointed out that a "comprehensive annual report of all retroactive Medi-Cal charges and collections and activity is due to the County Executive and Board of Supervisors in less than 60 days on May 7, 2010. HHS Patient Business Services may want to request an extension from the Finance and Government Operations Committee to July 30, 2010 in order to make an annual report on a fiscal year basis." By way of this response, **HHS Patient Business Services requests an extension to July 30 in order to develop the requested annual report on retroactive Medi-Cal charges, collections and activity.**

Additional information:

In the six month follow-up report, there were a number of statements made to which the departments wish to respond.

Policies and procedures for Pharmacy retroactive Medi-Cal billing will be developed and staff trained on them.

The Pharmacy undertook retroactive billing for accounts under one-year-old only, as the electronic system only accommodates retroactive billing that far back. The Pharmacy Department will research what additional steps would be required to undertake retroactive billing through manual processes – and research whether such retroactive billing is allowable for pharmaceuticals.

In the future, Pharmacy will need to develop a system in which Pharmacy processes claims and submits reports on the results of its billing efforts to PBS.

BACKGROUND

On May 7, 2009, the Finance and Government Operations Committee reviewed the Management Audit Division's report "Review of the Implementation of Retroactive Medi-Cal Billing Procedures for Health and Hospital System Services Provided to General Assistance Clients Subsequently Approved for SSI." At that time, the Committee requested a follow-up

be conducted after six months. The Management Audit Division completed its follow-up report and this transmittal provides SCVHHS's response

CONSEQUENCES OF NEGATIVE ACTION

The Committee will not receive the requested information.

County of Santa Clara
Social Services Agency

333 West Julian Street
San Jose, California 95110-2335

March 12, 2010

TO: Roger Mailocq, Project Manager
Harvey Rose Accountancy Corporation

FROM: Will Lightbourne, Director
Social Services Agency

SUBJECT: AGENCY RESPONSE TO THE MANAGEMENT AUDIT DIVISION'S REVIEW OF THE IMPLEMENTATION OF RETROACTIVE MEDI-CAL BILLING PROCEDURES FOR HEALTH AND HOSPITAL SYSTEM SERVICES PROVIDED TO GENERAL ASSISTANCE CLIENTS SUBSEQUENTLY APPROVED FOR SSI

Below is the Social Services Agency response to the two recommendations contained in your report that deal with the Social Services Agency VMC Eligibility Bureau. I am prepared to discuss this response with the Board of Supervisors' Finance and Government Operations Committee.

REPORT RECOMMENDATIONS AND SOCIAL SERVICES AGENCY RESPONSE

Recommendation 4 – Prepare comprehensive written procedures for the processing of request for Letters of Authorization by the Health and Hospital System related to retroactive billing of Medi-Cal for General Assistance clients approved for SSI.

Response: Agree

The Social Services Agency (SSA) VMC Eligibility Bureau prioritizes the processing of Letters of Authorization (LOAs) for the Health and Hospital System (HHS). There is a dedicated Eligibility Worker assigned to receive and process LOAs and she receives an intake caseload reduction in order to do so. Section 64.8 of the Medi-Cal handbook specifies the procedures for the Non-SSI/SSP LOA process and the SSI/SSP LOA process once the LOA is received. SSA supports the recommendation to develop written procedures specifically for processing LOA requests that come from HHS Patient Billing Services (PBS) and will work with HHS to develop these procedures.

Recommendation 5 – Monitor the backlog of LOA requests to ensure sufficient staff are available to process such requests on a timely basis. As of December 28, 2009, approximately 63 requests amounting to more than $2 million that had been received during the past three months were backlogged.

Response: Agree

The VMC Bureau will continue to monitor the LOA requests submitted by the hospital to ensure they are processed in a timely manner. One of the factors that contributed to the LOA backlog that is noted in the recommendation was concerns raised about confidential client information being shared with HHS. In order to address these concerns SSA is developing a new procedure and consent form for General Assistance and Medi-Cal applicants and continuing clients. The new procedure, which will be implemented within the month, will ensure that SSA can share client information with HHS is a way that complies with State and Federal confidentiality laws such as HIPAA and Medi-Cal Personal Identifying Information regulations. In addition, SSA recently instituted a new procedure whereby SSA's Fiscal Division sends the monthly list of GA clients approved for SSI to the VMC Eligibility Bureau at the same time it sends this list to HHS, along with a required letter called the L8125. This allows the VMC Eligibility Bureau to prepare for the coming month's volume of LOA requests.