STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
4/744 P STREET
ACRAMENTO, CA 95814

April 29, 1983

To: All County Welfare Directors Letter No. 83-33

CORRECTIVE ACTION INITIATIVES

The purpose of this letter is to:

1. Provide background information on federal Medicaid Quality Control (QC) requirements for State Medi-Cal corrective action initiatives.

2. Obtain data from county welfare departments on the use/effectiveness of State initiatives.

3. Request information on completed or planned county Medi-Cal corrective action initiatives.

A. BACKGROUND

Over the past several years the federal Department of Health and Human Services (DHHS) has required states to: 1) perform Medicaid QC; 2) analyze data extracted from QC case reviews; 3) undertake corrective actions designed to improve the administration of the Medicaid program.

More recently DHHS has used the result of Medi-Cal QC to determine whether the State should be sanctioned because of excessive misspent Medi-Cal funds. Such sanctions can be reduced or avoided by a demonstration of good faith effort to reduce such errors.

The State corrective action plan, for which Eligibility Branch has primary responsibility, forms the basis for demonstrating good faith efforts toward reducing the amount of misspent Medi-Cal funds. Demonstration of good faith effort becomes extremely important, both to the State and the counties, when the State QC dollar error rate exceeds federal standards.

Federal requirements for state corrective action plans have become much more detailed than in the past, requiring the collection of more data than formerly. Since DHHS judges the State's good faith effort to meet the Medicaid target error rate on the basis of the thoroughness and completeness of the State corrective action plan, we must make every effort to comply with these rules.

In order for a state corrective action plan to be acceptable, DHHS now requires, as a minimum:

1. Program Analysis — A narrative description of the major reported errors and the causes to which these error concentrations are attributed.

2. Corrective Action Planning — A description of the corrective action initiatives to be implemented including error concentration targets, major activities, evaluation procedures, expected results and resource/cost estimates.

3. Corrective Action Implementation — Includes specification of a timetable and delineation of responsible persons for implementing corrective action initiatives.

4. Corrective Action Evaluation — A report on the progress and effectiveness of program improvements described in earlier reports or since the last report.

For your information, a copy of the federal Medicaid corrective action plan requirements is attached. (Attachment 1.)

B. Evaluation of Previously Identified State Corrective Action Initiatives

The Department of Health Services (DHS) provided DHHS with a detailed corrective plan for 1982 designed to meet the federal criteria. Part of that plan included the Deprivation Training Package transmitted to counties in All County Welfare Directors Letter No. 82-67 and the RSDI Benefits Report indentified in All County Welfare Directors Letter No. 83-23.

In order to complete the evaluation portion of the 1983 State corrective action plan, we must obtain feedback from counties on these two initiatives. The attached questionnaire has been designed to capture the required information. (Attachment 2.) Please complete and return it by May 31, 1983.

C. County Medi-Cal Corrective Action Initiatives

We would like to include a representative sample of county based Medi-Cal correction action initiatives, including such things as training, targeted case review, EDP enhancements, etc., in the 1983 State corrective action plan. If your county undertook any such initiatives in the past twelve months, or plans to complete corrective action initiatives in the July 1983 through June 1984 period, please provide us a description of these initiatives when you return the questionnaire. The description must include the four requirements outlined under Section A of this letter.

We appreciate your cooperation and assistance in this matter. If you have any questions or wish further information, please contact Marlene Ratner of my staff at (916) 445-1912.

Sincerely,

ORIGINAL SIGNED BY

Jo Ann Wray
Acting Deputy Director
Health Care Policy and
Standards Division

Attachment

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants
Corrective Action Liaisons

state medicaid manual
Part 7 — Quality Control

Department of Health and Human Services
Health Care Financing Administration

Transmittal No. 13 Date June 1982

NEW MATERIAL	PAGE NO.		REPLACED PAGES	
Table of Contents				
Chapter I	7-1-1 (1 p.)		7-1-1 (1 p.)	
Sec. 7033-7055.4	7-1-7, 7-1-12.4	(10 pp.)	7-1-7, 7-1-11	(5 pp.)

CLARIFICATION—EFFECTIVE DATE: NOT APPLICABLE

Sections 7050-7055.4 provide more detailed instructions on the corrective action planning process and examples of corrective action plan initiatives.

ADMINISTRATION AND OBJECTIVES

CHAPTER I

7031. SAMPLE SELECTION
MQC sample cases are selected each month according to the specifications listed in Chapter 2. The minimum required number of completed reviews from each State is specified for a six month period. The size of the sample selected will be approximately equal in each month. The recommended selection method is either a simple random or the systematic random method. Case identifiers should be transmitted to the QC unit for review.

7032. REVIEW PROCESS
MQC reviews of sample cases cover three important functions of Medicaid control: eligibility, claims processing and third party liability.

The eligibility review documents the eligibility of sample case beneficiaries through case record reviews and field investigations. States that have opted to do an independent sample must conduct full MQC investigations on every SSI case in the sample. States with more restrictive Medicaid eligibility must verify that beneficiaries meet the more stringent requirements.

During case record reviews, specific facts are collected about the circumstances of case members. When a field investigation is required to verify the information, it includes a personal interview with the beneficiaries, or someone acting on their behalf, and contacts with other sources. The information gathered is used to make a MQC determination concerning the eligibility status of each case as of the review month.

In its reviews of claims processing, the MQC staff examines paid claims for conformance with State paid claims policies. The third party liability review may involve beneficiary interviews plus information from collateral sources.

The review findings are used to determine the dollars spent in error in each operational area of Medicaid.

7033. INDIVIDUAL CORRECTIVE ACTION
Correction of case status is an established and integral part of the ongoing State supervision of its operating units.

MQC is responsible for referring individual sample cases found to be in error to the appropriate State unit for action and follow-up after the TPL review has been completed. The MQC unit provides the local agency with information that identifies third party resources or beneficiaries unwilling to cooperate or who could not be located. In addition, appropriate agency units are notified of questionable beneficiary and/or provider actions that could indicate fraud or abuse.

7034. DATA MANAGEMENT

Data management consists of ordering, handling, and processing data collected in the review process. This involves keeping track of reviews that have and have not been completed, ensuring accurate and consistent data and preparing monthly status reports, statistical tables for Federal reports and additional tabulations, as needed, to facilitate data analysis.

7035. DATA ANALYSIS

The purpose of MQC data analysis is to provide clear and concise presentations of MQC findings for planning and evaluating corrective actions. This involves screening of MQC data to identify clusters of errors and their causes that can be corrected by specific action and to provide estimates of unduplicated dollar error rates for each of the three Medicaid program components: eligibility, TPL and CP. In addition, data analysis involves the preparation of clear and concise summaries and explanations of MQC findings for other State and Federal parties and units.

7036. DISSEMINATION OF FINDINGS

MQC findings are disseminated after the data have been analyzed to ensure that appropriate staff receive the information timely. It involves determining the specific information requirements and supplying this information to administrative and program staff, as well as local agencies and other interested parties, such as State legislatures, other State agencies or the general public.

7050. MQC AND CORRECTIVE ACTION

The MQC system provides State title XIX agency administrators with meaningful information on the causes of case and payment error in Medicaid eligibility, third party liability, and claims processing. With this type of information State agencies can assess problem areas and develop corrective actions suited to their needs and available resources.

7052. MQC CORRECTIVE ACTION PLAN REQUIREMENTS

State title XIX agencies are directed in 42 CFR 431.800 to annually report to the Administrator on error analyses and corrective actions developed from MQC findings. Corrective action planning should encompass the three aspects of the MQC review process: eligibility, third party liability, and claims processing. The plan must include both analyses and planned corrective actions based upon the previous two sampling periods for which complete MQC review data are available.

State corrective action plans must be submitted to the Regional Administrator in triplicate by July 31 of each year. The Regional Administrator will review the plans and at his/her discretion may require additional information.

7055. MQC CORRECTIVE ACTION PLAN FORMAT.
The corrective action plans submitted by States should describe prospective actions planned for the upcoming year and provide status reports on corrective actions pursued during the last year. The reports must include at a minimum the following sections:

A. Program Analysis.--This section should provide a narrative description of the major reported errors and the causes to which these error concentrations are attributed.(See 7055.1.)

B. Corrective Action Planning.--This section should provide a description of the corrective action initiatives to be implemented. Included should be the error concentration targeted, a description of major activities, evaluation procedures, expected results, and resource/cost estimates. (See 7055.2.)

C. Corrective Action Implementation.--For those corrective actions identified for implementation, specify the timetable and delineate responsibilities for involved agency components. (See 7055.3.)

D. Corrective Action Evaluation.--This section should report on the progess and effectiveness of program improvements described in earlier reports or since the last report. (See 7055.4.)

E. Suggested Federal Initiatives.--An optional section may be included that would address those actions required of HCFA regional offices or central office to assist States in corrective action efforts or implement changes to improve the administration of the program.

7055.1 Program Analysis.--This phase of the corrective action planning process is definitely the most critical as the proper identification of error causes is essential for the development of effective corrective actions. Due to the comprehensive scope and agencywide implications of corrective action planning, it is also important that the agency's top management be involved in and committed to the corrective action process from its onset. Therefore, the agency's corrective action planning group should consist of individuals representative of the diverse activities involved and able to commit agency resources to specific courses of action.

The analysis should be directed towards outlining the reported errors, defining the cause to which each error concentration is attributed, and identifying the frequencies of error cause factors. This would enable State agencies to focus actions on the error concentration(s) that has the most significant impact on the payment error rate.

For example:

1. Which agency procedure is more error prone, application or redetermination?

2. Is a certain geographic location more likely to have a certain type and/or cause of error?

3. For each concentration (income, resources, etc.) which cause is more prevalent, agency or recipient?

4. Which types of error (policy application, failure to verify, etc.) are most responsible for agency-caused error concentrations?

5. Is any coverage group (nursing home, AFDC-related, etc.) more error prone than the rest of the Medicaid population?

The MQC statistical tables including all Federal variances will provide the impetus for such analysis; part 7, Chapter 5 of the State Medicaid Manual, "Data Analysis," explains various methods in which to utilize the statistical tables for error analysis. Using tables as an indicator of major error causes, States can conduct further analyses of the data produced through MQC.

For example:

1. Test for determining if the "Most Recent Agency Action" is related to error proneness: use of Federal MQC Report, table IX-A (section 7620.1).

2. Distribution of dollar amount of claims processing errors by service type: illustration of the use of table II-B (section 7636).

Example

The majority of eligibility errors are occurring in Element 320 (Income-RSDI Benefits). In that concentration the errors are split between the beneficiary not reporting changes and the agency's failure to follow up on reported information. This situation is occurring throughout the State, primarily in the SSI-related category.

The statistical tables identify the types of errors occurring and the source of the errors; for the purpose of corrective action planning it is important to relate these errors to their actual origin in the program process. For example, recurring errors in the interpretation of an earned income policy could be the result of numerous operational factors, such as:

1. poorly written policy;

2. number of programs an eligibility worker is responsible for; or

3. the worker has not received adequate training.

In order to determine the specific causes of the error concentration it may be necessary to utilize additional State studies and reports such as State assessment reports, internal audits, and special studies. Part 7, chapter 5 of the State Medicaid Manual suggests additional analysis techniques.

Examples of additional pertinent information are:

1. workload characteristics (i.e., caseload size, number of supervisors, number of programs eligibility workers handle);

2. case technician characteristics (i.e., education level, grade/salary level, training); and

3. operational procedures (i.e., policy/procedure manual, use of computers, forms).

The end product of the analysis phase as reflected in the corrective action plan is a concise statement as to the specific causes of the major error conditions identified in the statistical tables.

7055.2 Corrective Action Planning.--The principal purpose of this phase of the corrective action planning process is the identification and development of alternative corrective action initiatives followed by the selection of those initiatives to be implemented after appropriate research and, if necessary, additional studies. For each alternative corrective action initiative identified, a briefing paper should be prepared by appropriate support staff which contains the following information:

1. a brief description of the present system;

2. a brief description of proposed changes;

3. a summary of expected results/impact on problem areas;

4. specification of necessary activities (preparation of training plans, the writing of policy changes, etc.);

5. estimated cost/resources required for implementation; and

6. a concise description of evaluation criteria expressed in measurable quantitative/qualitative terms whenever possible.

With this type of briefing material the planning group can effectively review the alternatives, assess the feasibility of implementation, and evaluate the cost/benefit of each proposed initiative. The planning group would then prepare a plan comprised of those corrective action initiatives determined to be most effective/beneficial for the agency to implement. This plan should be directed to top management for their concurrence, as a decision to approve an initiative can involve the commitment of substantial agency resources to achieve implementation.

The Correction Action Planning section of the corrective action plan should include for each initiative selected for implementation by the State a summary which consists of the following:

1. a narrative description of the scope of the initiative in terms of processes, policies, costs, benefits, constraints, and anticipated implementation problems; and

2. a comparison of the costs and benefits of present processes and practices to those of the initiative, including the cost of implementation.

Three examples follow.

Example (Eligibility)

Present System

Currently caseworkers are waiting until redetermination to check on possible changes in income or are relying entirely on beneficiary contact regarding changes in income.

Proposed Change

Initiate a match between the State's eligibility computer file and Bendex to be run on a regular basis. The resulting report would contain a listing of the individuals recorded on both files and the RSDI amounts, and would be sorted by the eligibility caseworker. The caseworker would use this information to verify changes and update income amounts.

Expected Results

This information provided regularly will ensure that income adjustments are made in a timely manner.

Necessary Activities

- Write computer program; test program.
- Run the program against Bendex and eligibility file.
- Send report to caseworker.
- Have caseworker initiate appropriate contacts.

Estimated Costs/Resources

- Cost of having computer program written and debugged.
- Cost to run computer program.
- Time for caseworkers to review report and initiate changes.

Define Evaluation Procedures

At present RSDI income errors account for 25 percent of the errors in the sample. By the next sampling period we anticipate that RSDI income errors will account for less than 10 percent of the errors with no overall increase in the error rate.

Example (Claims Processing)

Present System

The State agency is erroneously paying claims for individuals age 22 through 64 in tuberculosis and mental health facilities. Individuals age 22 through 64 are only eligible for certain services received in the first month of institutionalization in such facilities. The agency is making payments for such individuals for months other than the first month of institutionalization and for services not covered under the State plan.

Proposed Change

Develop a computer edit system that will reject all claims for individuals age 22 through 64 in tuberculosis and mental health facilities unless the service date is within the month of admission and the procedure code matches one covered under the State plan for these individuals.

Expected Results

The computer edit system will reduce the burden on claim reviewers and prevent the agency from making erroneous payments for individuals age 22 through 64 in tuberculosis and mental health facilities.

Necessary Activities

- Evaluate claim forms to ensure that necessary information is being captured. Modify claim form as needed.
- Develop computer edit system that evaluates all claims for individuals in mental health and tuberculosis facilities in relation to age, service date, admission date, and procedure code.

Estimated Costs/Resources

- Cost to redesign form if necessary.
- Cost to develop the edit system.
- Cost to run computer program.

Define Evaluation Procedures

Erroneous payments for individuals age 22 through 64 in tuberculosis and mental health facilities account for 13.8 percent of misspent claims processing dollars. These errors should no longer occur after the edit system is in place.

Example (Third Party Liability (TPL))

Present System

Currently Medicaid intake caseworkers are failing to identify TPL resources during initial interviews with beneficiaries at the local welfare offices. This is evidenced by State data which reveal that the certifying State agency is not identifying TPL adequately on a consistent basis.

Proposed Change

Initiate the use of the revised HCFA 301C (Third Party Resource Worksheet) by caseworkers during the eligibility certification process, or have the various 301C elements incorporated into the State eligibility application forms.

Expected Results

- The percentage of TPL verified would increase because of more accurate identification.
- There would be an increase in savings of Medicaid funds through cost avoidance, and more funds would be recouped through an increase in post payment recovery.

Necessary Activities

- Caseworkers must be given required training to ask the necessary questions to develop TPL leads.
- Application form must be revised, if appropriate.
- A procedure must be in place whereby the TPL leads developed by the caseworker would be incorporated in the case file and the State recovery system.

- A procedure must be in place to insure that when claims are received from providers, both the case file and the TPL resource file be searched prior to payment of the claim.

Estimated Costs/Resources

- Cost of training caseworkers.
- Cost to install or revise system.
- Cost of revising and printing new application form if applicable.
- Cost of additional time required for caseworkers to develop TPL leads.

Define Evaluation Procedures

The Department of Health and Human Services has estimated that 14 percent of the $19 billion in Medicaid benefits for 1978 was lost through the failure of State Medicaid agencies to recover or reject payment on Medicaid claims which should have been paid by liable third party insurance carriers. The State Error Cause Analysis Tables for the October 1979-March 1980 review period show that the largest source of TPL dollar errors is failure of the certifying agency to identify TPL. For that period this source accounted for 47 percent of the errors nationally. Studies have shown that subjective estimates place available TPL, excluding Medicare and CHAMPUS, at an estimated 3 percent to 4 percent of total Medicaid payments. In terms of estimated total payments of $26.68 billion for fiscal year 1980, these estimates represent $800 million to $1,067 million in available Medicaid program expenditures. The increased identification of third party claims achieved by improved caseworker identification of TPL resources would increase recoveries and reduce misspent funds. Next sample period the incidence of agency-related TPL errors should decrease.

7055.3 Corrective Action Implementation.--The principal objective of this phase of the corrective action planning process is the development of implementation plans for each initiative selected for implementation. The individual implementation plans developed during this phase of the process should succinctly describe the methodology by which the State plans to accomplish each initiative. At a minimum the implementation schedules included in the plan should:

1. describe pertinent activities;
2. assign implementation responsibilities;
3. establish target dates; and
4. identify critical areas and assistance required.

Example

Activity	Target Completion Date	Responsible Staff
Develop Computer Program		
Run Reports		
Send Report to Workers		
Workers Initiate Necessary Changes		

The implementation plan should also identify the individual, preferably someone in top management, charged with overall responsibility for monitoring each initiative's implementation.

7055.4 CORRECTIVE ACTION EVALUATION

This section of the plan affords the agency with the opportunity to describe the progess and accomplishment of previously implemented initiatives in terms of the criteria established during previous planning phases. The evaluation process required should focus on measuring the reduction of specified error(s), assessing the cost-effectiveness of the initiative, and evaluating the indirect beneficial and detrimental effects of the initiative's implementation.

For example:

1. Are target dates met?

2. Are expected results being realized (are errors in the pinpointed area decreasing)?

3. Are cost/resource estimates realistic?

4. Were additional problem areas encountered?

5. What, if any, unanticipated effects occurred (i.e., increased errors in other program areas)?

In addition to keeping the agency apprised of corrective action performance, the required evaluative process also enables the State to identify initiatives requiring modification or revision.

Attachment 2

Return to:

Department of Health Services
County Control Unit
714 P Street, Room 1692
Sacramento, CA 95814

CORRECTIVE ACTION INITIATIVES QUESTIONNAIRE

County Name _____

County Contact Person _____ Telephone _____

Deprivation Training Package

1. Did you provide training in deprivation factors during the past year? Yes ____ No ____

2. Was training provided to all eligibility workers (EW)? Yes ____ No ____

   If not, to what percent? _____

3. Did you provide written instructional materials for training in deprivation factors? Yes ____ No ____

4. Was DHS' Deprivation Training Package of use to you? Yes ____ No ____

   How?

RSDI Benefits Report

1. Was the RSDI Benefits Report distributed to all impacted EWs? Yes ____ No ____

   If no, to what percent?_____

2. Were EWs instructed to file these reports with the case record? Yes ____ No ____

3. Do you intend to use these reports to track RSDI income changes? Yes ____ No ____

   If not, why?

Please answer the following questions if the information is available to you. You are not expected to perform a retrospective survey.

1. How many cases of previously undisclosed RSDI income were identifed?

2. How many referrals to Medi-Cal Recovery for overpayment collections were made?

3. How many RSDI Benefits Reports amounts were different from the amount verified by SSA?