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TOTAL PAGES: (WITHOUT COVER)	ADDRESSEE'S FAX PHONE NUMBER:	DATE:
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REMARKS:

This is the latest version of the agreement with CA on the resolution process we will use for the embedded claims. We hope to have this final in a day or two as Roberta Ward is currently reviewing it. I will be in CA next week working with the State on the process.

cc: Boulanger
Polaski
Monahan

Drana Rattray

REQUESTOR'S INSTRUCTIONS TO RECEIVER:

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HEALTH CARE FINANCING ADMINISTRATION
Medicaid Bureau-Division of Financial Management

March 20, 1995

Ms. Roberta Ward, Esq.
Office of Legal Services
California Department of Health Services
714 P Street Room 1216
Sacramento, California 95814

Dear Roberta:

The following is our draft proposal of the agreement for resolving the retroactive Medi-Cal Administrative (MAC) claims.

Federal, State, and local jurisdiction staff met in an administrative claiming work group in Sacramento on March 8-9, 1995 and in a subsequent teleconference on March 15, 1995, to establish a process for resolving the universe of MAC claims that are described in Attachment XXX. **(Roberta, we believe that the universe we discussed on March 14 is what we are trying to resolve and this should be spelled out and made part of this agreement. We reserve the right to review and approve that document before it becomes part of the agreement)** The purpose of the work group is to design a process for identifying and documenting any allowable Medi-Cal administrative activities, as defined in existing HCFA guidance, that are embedded in the universe of MAC claims described in Attachment XXX so that payment of any allowable claims could be expedited.

As explained at the work-group meeting and subsequent teleconference, the process of identifying allowable Medi-Cal administrative costs, as defined in existing HCFA guidance, embedded in the MAC claims does not constitute an admission by the State that the MAC system as designed and implemented was incorrect or flawed. Likewise, HCFA's participation in this process does not constitute an admission by HCFA that the issues identified in the March 1, 1995 disallowance letter and February 17, 1995 deferral letter were incorrect or that the MAC system is approvable.

The process described in this letter is to be used solely to expedite payment of those expenses which are clearly reimbursable as allowable Medi-Cal administrative costs under existing law, regulations, and HCFA guidance. Disputed claims will not be handled through this process.

Finally, as part of this resolution process HCFA and the State agree to the following overall guiding principles:

(1) No Duplicate Payments--In determining allowable administrative activities, the basic principle is that duplicate payments are not allowable. See OMB Circular A-87. That is, payments for allowable Medi-Cal administrative activities must not

duplicate payments that have been (or should have been) included and paid correctly as part of outpatient clinic rates, targeted case management (TCM), part of a capitation rate, or through some other State or Federal program. It is the State's responsibility to ensure that there is no duplication in the claims prior to HCFA reviewing the revised claims.

(2) Not A Precedent--The State and HCFA intend to develop a mutually agreeable mechanism(s) which is solely for the purpose of expediting payment of clearly allowable Medi-Cal administrative costs embedded in the retroactive MAC claims. The State and HCFA do not intend this to be a precedent setting claiming mechanism for any other claims or issues, past, present, or future. Once the mechanism(s) is developed, implemented, and claims made, and paid by HCFA as allowable, no further claims can be submitted by the State/local jurisdiction, nor can HCFA review or otherwise reconsider such claims at a later date. Thus, HCFA, the State, and the local jurisdictions agree to accept the results of the mechanism chosen to resolve these claims. In addition, local jurisdictions can not use this process to develop new claims outside of the universe of claims described in Attachment XXX.

(3) State Responsibility--It is the State's responsibility to develop the revised allowable claims in readily reviewable form as detailed below before HCFA reviews them.

(4) HCFA Responsibility--It is HCFA's responsibility to provide the State with any technical assistance required during the resolution process, to provide the State with definitive written guidance and all necessary approvals at each step in the resolution process, and to review and approve allowable claims and expedite the payment to the State of those allowable claims.

With these express understandings, State staff and HCFA staff will be able to work together to expedite the payment of allowable Medi-Cal administrative costs incurred by the local jurisdictions for the universe of claims in Attachment XXX.

HCFA and the State agree on the following 4 step process to identify and resolve any allowable Medi-Cal administrative activities which are embedded in the MAC claims developed for the retroactive period:

1. Define the allowable Medi-Cal administrative activities in accordance with existing applicable HCFA guidance.

2. Document the allowable Medi-Cal administrative activities that are being performed and the percentage of time being spent on those activities for each program in each local jurisdiction in the claim universe for the retroactive period.

3. Determine the allowable Medi-Cal percentage of time for each program.

4. Determine the allowable Medi-Cal administrative costs for the allowable Medi-Cal administrative activities.

1. Define the Allowable Medi-Cal Administrative Activities in Accordance With Existing Applicable HCFA Guidance.

A. Construct Master Activity Lists--A survey form listing all the activities performed by employees who participated in the MAC time studies for each program will be constructed. Each of the programs now claiming under the MAC process (e.g. public health nursing, public guardian, mental health, probation, clinics, etc.) will develop a comprehensive, all-inclusive list of activities performed by the staff who were time studied for that program. The listing of activities needs to be specific enough so that allowable Medi-Cal administrative activities in accordance with HCFA guidance can be identified separately from unallowable activities. These activities must be more specific and descriptive than the activity codes in the MAC Cookbook and those codes will not be used as the basis for the new activity lists.

There will be one master activity list for each program statewide. Each activity in each program will be assigned a unique identifier code by the State to facilitate accumulation and summarization of the data. The lists will initially be developed by the local jurisdictions, submitted to the State for review, and then submitted to HCFA. The State and HCFA will agree and approve together the final listing of activities for each program that will be used in the resolution process.

B. Determine Allowable Activities--Once these master lists of activities by program are completed and distributed to the local jurisdictions, HCFA and the State will work together to establish which of the activities in each program are allowable Medi-Cal administrative activities in accordance with existing HCFA guidance. HCFA and the State also will establish which activities meet the skilled professional medical personnel criteria and are allowable at 75 percent FFP when performed by skilled professional medical personnel and directly supporting staff in accordance with the requirements at 42 CFR 432.50. The directly supporting staff may be claimed in the same allowable proportion as the skilled professional medical personnel that they directly support.

The master list of allowable activities produced by this process will not be provided to any of the local jurisdictions involved in using the program activity listings to implement the specific options described below. Additionally, the employees participating in the resolution process will not receive any other instruction or coaching in the actual completion of the documents involved in the resolution process other than that provided with the approved resolution process documents themselves.

C. Dispute Resolution on Allowable Activities--Disputes may arise at this point regarding the determination of which activities are allowable Medi-Cal administrative activities. If the

State and HCFA can not reach agreement regarding disputes at this point, the HCFA determination will be used for the resolution process and the State will reserve its right to appeal the disputed issues.

2. Document the Allowable Medi-Cal Administrative Activities that are Being Performed and the Percentage of Time Being Spent on Those Activities for Each Program in Each Local Jurisdiction in the Claim Universe for the Retroactive Period.

There are three options approved by the State and HCFA to complete this task. A local jurisdiction will select the option it wants to use and then will be required to use that option to document its claim. A local jurisdiction may use one option for one program and another option for a second program depending upon the circumstances of each program in the local jurisdiction. However, once an option is chosen then that option has to be consistently applied for that program for all time periods claimed. The agreed upon options are:

OPTION 1. Time Survey and Certification--Each employee who participated in the MAC time study program, for which the local jurisdiction is now allowed to submit a claim as part of this resolution process, will complete a survey form for that program. The employee will estimate the percentage of time spent on each activity for the last 12-month period of the resolution process (January 1, 1994 to December 31, 1994) for the applicable program. Where an employee did not spend any time on an activity in the list the employee must affirmatively indicate this by placing a zero next to that activity. The total percentage for the employee for the program should total 100 percent.

The survey will identify the employee by name, position description, and the beginning and ending dates that the employee has worked in that position, and whether that employee has been designated as skilled professional medical personnel or non-skilled professional medical personnel. The survey form contains instructions for its use. No additional coaching or instruction may be given.

Employees should refer to any existing contemporaneous records or other documentation for the 12-month period that is available to them to refresh their recollections of their activities and the amount of time they spent on those activities. The employees should not rely on the MAC time studies.

Upon completion of the survey the employee will sign, date, and verify the accuracy of the percentages they have included on the activity list providing certification to the best of their knowledge, information, and belief at the bottom of the survey. The signatures will be subject to penalty of perjury, and with notice that the information is to be used for filing of a claim for Federal funds and that knowing misrepresentation would constitute violation of the Federal False Claims Act. The employees should give the completed surveys to their immediate supervisor.

The immediate supervisor, with first hand knowledge of the activities performed by the employee during the applicable 12-month period, should review the survey and sign, date, and verify the accuracy of the percentages providing certification to the best of his or her knowledge, information, and belief at the bottom of the survey. The signatures will be subject to penalty of perjury, and with notice that the information is to be used for filing of a claim for Federal funds and that knowing misrepresentation would constitute violation of the Federal False Claims Act. See Attachment A for the Certification Statements that will appear at the bottom of each survey.

OPTION 2. 2-Week Time Study--Alternatively, with respect to a MAC time study program, for which the local jurisdiction is now allowed to submit a claim as part of this expedited process, the local jurisdiction may choose to complete a 2-week time study of employees in that program who participated in the MAC time study. This 2-week time study will use the statewide list of approved activities for the program being time studied. The time study log (See Attachment B for the Time Study Log) will require staff to identify the client for whom the activity is being performed, and record the client's Medi-Cal status/number, time spent by the employees, activity code from approved listing, brief description of activity performed, and the location where the activity was performed. If this option is selected, the local jurisdiction must time study for the same 2-week period for all employees in the program being time studied.

Upon completion of the time study the employee will sign, date, and verify the accuracy of the entries they have included on the time study log providing certification to the best of their knowledge, information, and belief at the bottom of the log. The signatures will be subject to penalty of perjury, and with notice that the information is to be used for filing of a claim for Federal funds and that knowing misrepresentation would constitute violation of the Federal False Claims Act. The employees should give the completed time studies to their immediate supervisor.

The immediate supervisor with first hand knowledge of the activities performed by the employee during the applicable 2-week time study period should review the time study and sign, date, and verify the accuracy of the entries providing certification to the best of his or her knowledge, information, and belief at the bottom of the time study log. The signatures will be subject to penalty of perjury, and with notice that the information is to be used for filing of a claim for Federal funds and that knowing misrepresentation would constitute violation of the Federal False Claims Act. See Attachment A for the Certification Statements that will appear at the bottom of each time study log.

OPTION 3. Contemporaneous Records Reconstruction-- Alternatively, a MAC time study program for which the local jurisdiction is now allowed to submit a claim as part of this expedited process, may choose to analyze a representative sample of contemporaneous records to extract the percentage of time that was spent on each of the activities in the approved activities listing for that program. This option is only available for those programs which have contemporaneous records such as nursing logs, activity logs, case records, other non-MAC time sheets/studies/logs, etc.. The employees and their supervisors in the

program should analyze these records to determine the activities of the employee during the sample period and indicate that percentage for the applicable activity on the approved activity listing for that program.

Each local jurisdiction using this option must submit documentation to support how its percentages were derived for each activity, describe the documentation utilized, and describe the sample period used to construct the percentages.

Upon completion of the reconstructed record the employee will sign, date, and verify the accuracy of the entries they have included on the survey providing certification to the best of their knowledge, information, and belief at the bottom of the survey. The signatures will be subject to penalty of perjury, and with notice that the information is to be used for filing of a claim for Federal funds and that knowing misrepresentation would constitute violation of the Federal False Claims Act. The employees should give the completed survey to their immediate supervisor.

The immediate supervisor, with first hand knowledge of the activities performed by the employee during the applicable sample period, should review the survey and sign, date, and verify the accuracy of the entries providing certification to the best of his or her knowledge, information, and belief at the bottom of the survey. The signatures will be subject to penalty of perjury, and with notice that the information is to be used for filing of a claim for Federal funds and that knowing misrepresentation would constitute violation of the Federal False Claims Act. See Attachment A for the for the Certification Statements that will appear at the bottom of each survey.

2(A). Compile and Submit Results to the State

After the surveys, time studies, or contemporaneous records reconstruction are completed, the jurisdictions must prepare a summary of the results for each program. In effect, this means compiling a summary activity sheet for each program which totals all of that program's results for each of the activities in that program. Upon completion of the summary sheet for each program, the person designated by the local jurisdiction to oversee the resolution process in that local jurisdiction will sign, date, and verify the accuracy of the entries that have been included on the summary sheet for each program to the best of his or her knowledge, information, and belief at the bottom of the summary sheet for each program. The signatures will be subject to penalty of perjury, and with notice that the information is to be used for filing of a claim for Federal funds and that knowing misrepresentation would constitute violation of the Federal False Claims Act. The summary sheets will then be submitted to the State according to State instructions. At the time the local jurisdiction submits its summary sheets it will also submit to the State the Medi-Cal percentage(s) it is proposing to rely on for its claim (see further discussion below).

The local jurisdictions will not be required to submit all of the supporting survey forms, time studies, or contemporaneous records with the summary sheets. Instead these must be maintained in readily reviewable form in an audit file at the local jurisdiction by program

and be made available to the State and HCFA upon request.

The State will enter the summary data by local jurisdiction, program, and activity into a computerized system (e.g. Lotus spreadsheet) for the purposes of compiling the data. Using the master list of allowable activities, the State will then calculate the allowable and unallowable percentages for each program within each jurisdiction. Once the State has completed this process and assures HCFA that the information is in readily reviewable form, HCFA staff will return to Sacramento to review and analyze the information.

2(B). HCFA Testing of the Results

HCFA will use the following methods, separately or in combination, to validate the information provided by the State: (1) HCFA will do an overall review of all the statewide summary information for each program and each activity by local jurisdiction to compare the results by program and activity across all local jurisdictions. HCFA will use this approach to establish the consistency and face validity of the information statewide for each activity and each program. (2) HCFA will use the documentation provided by each local jurisdiction in response to the March 3, 1994 State survey request to see if that documentation (e.g. position descriptions, functional statements, etc.) supports the survey results. (3) HCFA may use actual MAC time study results as it deems appropriate. (4) HCFA will review, as necessary, the actual audit files of the program which are the source documentation for the summary sheets and compiled information.

If HCFA identifies problems with any program-specific percentage as a result of this process, the State and local jurisdiction will be given the opportunity to adequately document the questioned percentage to HCFA. Based upon its review of the documentation presented, HCFA will make a final decision on the percentage. If HCFA still does not accept the submitted percentage based upon its review of the documentation presented--HCFA may: (1) allow the local jurisdiction to use the allowable statewide percentage (the allowable statewide percentage for a program is the average of all the allowable statewide percentages for that program that have been approved by HCFA)) for that program, (2) a mutually agreed upon percentage that is supported by the documentation presented, or (3) reject the entire claim as not supported.

Once HCFA has determined the allowable percentage for a program for a local jurisdiction, that percentage will be used to resolve the claim universe as described in Attachment XXX for that program in that local jurisdiction under this resolution process. HCFA, the State, and the local jurisdiction will be bound by the approved percentage and it will not be subject to further audit, review, or modification by any of the parties to the agreement.

3. Determine the Allowable Medi-Cal Percentage of Time for Each Program

HCFA will review and approve the Medi-Cal percentages submitted by the local jurisdictions. The only HCFA-approved methods for this resolution process for deriving the Medi-Cal percentages are the county-wide Medi-Cal average or actual client counts. HCFA

believes actual client counts must be used for any program for which they are available. If the local jurisdiction is using actual client counts they must be client counts for that program. Client counts unrelated to the program being claimed can not be used. In the absence of actual client counts HCFA has agreed to allow the use of the county-wide Medi-Cal average. Once a method is chosen by a local jurisdiction and approved by HCFA, it must be used consistently for that program in order to provide the most accurate representation of the amount of Medi-Cal activity for that program. A local jurisdiction can not pick and choose among methods.

4. Determine the Allowable Claim Amounts

Once HCFA and the State have approved the allowable percentages and the Medi-Cal percentages for each program for each local jurisdiction, the information will be returned to each local jurisdiction. Using the 1994/95 MAC Invoice, as modified by the State for this resolution process and approved by HCFA, each local jurisdiction will recompute its claims using the approved percentages and the applicable allowable costs. The approved program percentages will be used for all of the years for which claims are being submitted. Claims will be submitted on an annual basis. Where more then one Medi-Cal percentage is applicable to an annual claim the local jurisdiction should use the time weighted average of the approved Medi-Cal percentages applicable to the claiming period.

Claims may only be submitted for each local jurisdiction as specified in the universe of claims at Attachment XXX. Annual claims invoices may be submitted for SFY 1992/93 and SFY 1993/1994 and for the first-two quarters of SFY 1994/95. Claims for the first three quarters of SFY 1992/93 may only be resubmitted if they were previously submitted and claimed on the Form HCFA-64 by the State. If not, these claims are not allowable in accordance with the Federal two-year timely claims filing requirements at 45 CFR Part 95, Subpart A.

Once the invoices are completed and signed they should be submitted to the State according to State instructions. The State will review all of the invoices and ensure that the correct allowable percentage for each program has been applied, that the correct allowable Medi-Cal percentages have been applied, that all of the costs in the cost pools (including all applicable revenue offsets) are allowable, and that the invoices are correctly computed in all respects. The State will then prepare all of the invoices and any necessary supporting documentation in readily reviewable form for review by HCFA.

HCFA staff will then come to Sacramento to review the invoices. HCFA reserves the right to request the State to provided supporting source documentation for a sample of costs to ensure that the costs are allowable, that all applicable revenue offsets have been applied and the correct percentages used in the calculation of the invoices.

Once the invoices are approved by HCFA, the State will immediately submit a Form HCFA-64 to claim the approved amounts. Upon receipt of the Form HCFA-64, HCFA will immediately issue a grant award which provides the Federal share of the claim.

Allowability of Cost Categories

With regard to the allowability of categories of costs, the discussion in the work group focused on existing HCFA guidance and interpretations regarding Medicaid administrative claiming policy.

Key principles in determining the allowability of and making payments for costs as Medicaid administrative activities are:

- The activities must be necessary for the proper and efficient administration of the State Plan;
- The activities must be performed with respect to medical assistance services in the State plan, a Medi-Cal waiver, or expanded early and periodic screening, diagnostic and treatment services (EPSDT);
- The activities must be performed with respect to Medi-Cal eligibles;
- The activities may be performed with respect to Medi-Cal potential eligible individuals, but only with respect to eligibility outreach and intake functions. Thus, administrative activities related to facilitating access to Medi-Cal services for potential eligible individuals are not allowable as administrative activities. Once these individuals are determined eligible, activities related to facilitating access to Medi-Cal services would be allowable;
- Payments for administrative activities must not duplicate payments for activities performed and paid as medical assistance services (such as targeted case management, part of outpatient clinic rates, or part of a capitation rate) or paid through some other State, Federal or other program; and
- Only those portions of allowable activities specifically related to the Medi-Cal program, as indicated in the previous points, are allowable.

The following clarify a number of issues only for the purposes of resolving the retroactive MAC claims through this resolution process. The following clarifications relate specifically to the Medi-Cal program and to the retroactive MAC claims. They are not intended to set precedent for any other claims or issues, past, present or future, Medi-Cal or otherwise.

- Eligibility Intake--Medi-Cal eligibility intake, an allowable administrative activity, is defined as taking a Medi-Cal application and gathering information related to the application and eligibility determination from a client, including resource information and third party liability information, as a prelude to submitting a formal Medi-Cal application to the county welfare department. If translation is part of the intake activity, the costs may be claimed as eligibility intake or separately as translation, but not both. In either case, the

costs are allowable administrative costs of the Medicaid program.

- Prior Authorization--Prior authorization of certain Medi-Cal services for Medi-Cal eligibles, a traditionally allowable administrative activity, is a legally required and binding pre-requisite to the State's payment for those medical services and is generally performed by the State. However, in Alameda County only, the prior authorization function has been delegated by the State Medi-Cal program to public hospitals and may be allowable if not already otherwise paid for through some other source. It is unlikely that any other counties are performing this function for the State.

- Translation--Translation services may be allowable either as part of a medical assistance service, or as a separate administrative activity. Where the medical assistance provider receives a rate for a medical service, translation by facility employees which is contemporaneous with receipt of the service is considered by HCFA to be included in the rate for that service. In that case, costs of the translation activities cannot be unbundled and claimed again as Medi-Cal administration.

  Translation could be allowable as an administrative activity, if it is not included and paid for as part of a medical assistance service. However, it must be provided by separate units with employees performing solely translation functions for a health facility, such as at Highland Hospital in Alameda County (based upon the State staff telling us that the translation unit activity is not already included in the medical services rate), and it must facilitate access to Medi-Cal services.

- Administrative Case Management--Case management is only allowable as an administrative activity, according to HCFA's interpretation, when it involves the facilitation of access and coordination for a Medi-Cal eligible client for services which are covered under the State's Medi-Cal Plan. To assure that administrative case management activities being performed are allowable, that is, that they are being performed with respect to facilitating access to Medi-Cal services, a complete list of Medi-Cal State Plan covered services for the period of the retroactive MAC claim will be distributed to each program in a jurisdiction participating in MAC claiming for the purposes of implementing this resolution process. (NOTE: It is the position of the State that the scope of allowable Medi-Cal administrative case management is broader than HCFA's definition.)

- Referral and Follow-up--Referral of Medi-Cal eligibles to Medi-Cal services and follow-up are allowable administrative activities so long as they are not performed in connection with a medical visit for which the activities are or have been reimbursed through a Medi-Cal service rate, according to HCFA.

This means that this activity when performed by nurses and others in the clinic setting incident to a medical encounter will not be allowable as Medi-Cal administrative costs for the purposes of resolving these claims.

Referral and follow-up for medical services are allowable administrative activities which are part of case management when performed by staff who are not in a setting where there is a billable Medi-Cal rate. For example, the referral and follow-up activities of public health field nurses performed for clients with regard to medical issues would be allowable Medi-Cal administrative case management activities unless, of course, these services are provided free to all persons within the local jurisdiction. In that case, the free care issue will need to be addressed separately.

- Outreach--Outreach is traditionally an allowable Medicaid administrative function. However, according to HCFA, the only allowable outreach for purposes of Medi-Cal administrative claiming is to groups or individuals targeted to two goals:

  (1) making people eligible for Medi-Cal or,

  (2) bringing Medi-Cal eligible people into Medi-Cal services.

  Thus, although an outreach campaign can be directed to an entire population, in order for the costs to be allowable as administrative activities, the campaign must be focussed on bringing people into Medicaid services (e.g., pre-natal, healthy baby, EPSDT, AIDS, alcohol, drug, mental health counseling, etc.). Furthermore, only those portions of the outreach campaign meeting the two goals above would be claimable.

  The campaign can also inform people about the availability of Medi-Cal and the eligibility requirements. If outreach is addressed to categories of medical services which are covered for the Medicaid population but also available to non-Medicaid patients, then the costs of the outreach activity will be pro-rated to the Medi-Cal percentage.

- Health Education--(1) General health education programs or campaigns addressed to the general population (e.g. SANE, DARE, dental prevention, anti-smoking, alcohol reduction, etc.) are not allowable Medi-Cal administrative activities. However, a health education program or campaign may be allowable as an administrative cost if it is targeted specifically to Medicaid services and for Medi-Cal eligible individuals. Additionally, if a specific Medi-Cal health education program is included as part of a broader general health education program, the Medicaid portion may be allowable if pro-rated according to the Medi-Cal percentage. (2) General health education is not allowable as part of a clinic service. However, in a clinic

setting, if the health education occurs with individual patients incident to the nature of the clinic visit, according to HCFA, it is not separately claimable as an administrative activity, but is considered to be reimbursed as part of the clinic service rate.

- Non-Emergency Medical Transportation--Transportation, according to HCFA, may be claimed either as medical assistance or administration. California Medi-Cal policy does not allow transportation as an administrative activity. However, arranging for medical transportation is allowable as an administrative activity. We understand that a State plan amendment recognizing personal care services as medical services eligible for Federal matching was approved for California effective July 1, 1992. The act of accompanying a Medi-Cal client to a Medi-Cal appointment is considered a personal care service, billable from the effective date of the State plan forward. It may not be claimed as an administrative cost.

- Directly Observed Therapy--Directly observed therapy (DOT) is a medical service, if provided for in the approved State plan, and not Medi-Cal administration. However, California has submitted a Medicaid State plan amendment to include directly observed therapy (DOT) for tuberculosis (TB) as a medical service with a proposed effective date of October 1, 1994. Therefore, when the State plan amendment is approved, DOT may be claimed as a medical service. DOT applies to a medical professional observing a Medi-Cal eligible individual taking a prescribed regimen of TB medication. Since the activity is considered part of a service, not an administrative cost, the activity should be claimed in California under TB Services, which is a State Plan covered service.

- Inter-agency Coordination/Development of County-wide Initiatives--Inter-agency coordination and development of county-wide health initiatives may be allowable as administrative activities, so long as the coordination and services involve Medi-Cal services for Medi-Cal eligible individuals. The costs of this activity will be pro-rated according to the Medi-Cal percentage in the county, i.e., the county-wide average.

- Provider Coordination--Provider coordination is an allowable administrative activity, so long as the providers are Medi-Cal providers.

- Information and Referral--Information and referral may be an allowable administrative activity so long as the encounter is with Medi-Cal eligible individuals and involves discussion of Medi-Cal issues and the referrals relate to Medi-Cal services. For example, the part of the telephone encounter on a suicide prevention hotline provided by the county which involves the personal problems of the caller would not be allowable, while the time spent in facilitating access and making referrals for a Medi-Cal eligible individual

to a Medi-Cal mental health counseling/facilities would be allowable, according to HCFA.

- Inmates of Public Institutions--Medical assistance services provided to inmates of public institutions are not eligible for Medicaid payment. However, Medi-Cal eligibility intake administrative activities provided to such inmates may be allowable under certain limited circumstances. For example, an eligibility intake process has been established for inmates by their home counties in the month of their release in order to facilitate transition to Medi-Cal services in their communities. This Medi-Cal eligibility intake activity is allowable. No other administrative activities or direct Medi-Cal services are allowable.

- Public Guardians--The activities of public guardians are allowable administrative activities if they involve case management of Medi-Cal services and Medi-Cal eligibility intake for clients. The coordination and provision of legal, financial, and property management services by the public guardian's office are not allowable.

In addition, we are continuing to review the following issues:

- Veterans Activity--The are several activities done relative to veterans that need further clarification:

  (1) Eligibility intake for veterans for the purpose of developing a Medi-Cal application. This is an allowable Medi-Cal administrative activity.

  (2) Through a contract with the State, veterans and their spouses are contacted onsite at the nursing facility for purposes of developing eligibility for any veteran's benefits because this offsets the cost of Medi-Cal. This may be allowable as third party liability (TPL) activity, but could not also be claimed again separately as administration because that would be a duplicate claim. In addition, if the State is already claiming the cost of this contract as State-level administrative expense, it can not be claimed again by the local jurisdictions.

  (3) Using a list of veterans who are eligible for Medi-Cal, potential eligibility for veterans benefits are pursued. The State views this as TPL cost avoidance for Medi-Cal and allowable as an administrative claim. The State is preparing a package on the veterans issue. However, the State wants HCFA to consider these activities as TPL/cost avoidance activity for Medi-Cal and allowable as administration.

- SSI Advocacy--The State wants HCFA to pay for the Supplemental Security Income (SSI) application process, since California is a "§1634" State and the SSI application is also considered a Medicaid application. The State also

wants HCFA to pay for the costs of appeals of SSI denials. Since the primary application is for SSI not Medi-Cal, this may not be an allowable Medicaid administrative activity. Furthermore, the SSI program does not pay for the costs of the appeal in such cases. California is preparing a package on this issue.

- ACM in IMD--In California individuals can be legally detained without cause for a 72-hour assessment period in an institution for mental diseases (IMD) facility observation unit. The State believes that during the first 23 hours of the individual's stay in the IMD, medical assistance services would be allowable. However, during the 24-72 hour period in the IMD, as they continue to assess, work with the family, and develop a plan of care, the State wants to claim this as ACM. The issue here is can these activities be claimed as ACM. The HCFA position is that because of the IMD exclusion, none of these activities would be allowable, and no payment would be available.

- Short-Doyle Mental Health--Payments for claims under this process must not duplicate payments for activities and services required under the "Short-Doyle" mental health program. The State is requesting the local jurisdictions to submit documentation explaining and ensuring that ACM mental health activities claimed under MAC are different from and do not duplicate "Short-Doyle" activities. HCFA will need to review and approve the treatment of Short-Doyle mental health for this resolution process.

- Capitated Counties--Payments for claims for administrative activities and medical assistance services must not duplicate administrative activities and services which are paid for under a capitation rate. This is especially significant in counties that have full capitation program. Appropriate methodologies and documentation to ensure that no duplication takes place needs to be developed.

We believe that this agreement must be finalized before the resolution process activities began within the local jurisdiction and look forward to completing the final agreement as soon as possible. Please call me on (410) 966-2003 if you have any questions.

Sincerely yours,

Bill Lasowski

Bill Lasowski
Director

DRAFT

DRAFT PROPOSAL FOR A NEGOTIATED SETTLEMENT

This memorandum outlines the basis for a negotiated settlement of claims for case management services provided by counties in the State of California. The proposed settlement relates to claims that were submitted by the State as MediCal administrative claims, but that HCFA has determined are not allowable as administrative costs.[1/] The premises for this proposal are (i) that the underlying services could have been claimed and paid as targeted case management services if the State had had an approved targeted case management plan amendment in place at the time the services were rendered; and (ii) that the State had a substantial basis for believing that the claims were payable as administrative claims. We first discuss each of these premises and then set forth a proposal for a negotiated settlement.

No plan

No.

1. **The services delivered could have qualified as targeted case management.** The activities in question were performed by a variety of county agencies (outpatient and freestanding clinics, public health department nurses, veterans' service offices, the Department of Aging, the Department of Mental Health, the Department of Probation, etc.) and consisted of referral and linkage of MediCal-eligible persons to non-Medicaid programs or providers of

[1/]The proposal does not cover the portion of the disallowed MAC claim that the State and counties are able to establish, to HCFA's satisfaction, as valid administrative claims. Nor does it relate to claims for services provided through the SANE/DARE program or through juvenile probation departments.

social services. In clinics, the activities also entailed intensive patient and family education about the health delivery system, the prescription refill system, and health issues.

There is no question that the activities were of the type that could have been performed and reimbursed as targeted case management services:

- Case management is "activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual." State Medicaid Manual ("SMM") § 4302(A).

- Targeted case management may include assistance in gaining access to a variety of medical, social, educational, and other services. SMM § 4302(B).

- Case management may include the activities of explaining to clients with special needs how to take medications and how to follow their health plans. See the Preliminary Analysis in Maryland Department of Health and Mental Hygiene, Docket No. 88-192 (1989).

- The targeted group may be identified by "any identifiable characteristic." SMM § 4302.2(A). Here, the identifying characteristic is Medicaid eligible persons receiving health-related services through county health and social services agencies.

- Separate payment (i.e., payment that is in addition to fee-for-service payments for medical services) may be made for case management services that are not an integral, inseparable or required part of another Medicaid covered service. SMM § 4302.2(F). Intensive patient education and referral services are enhanced activities provided by county clinics but are not a required component of clinic services.

- SMM Section 4302.2(D)(3) provides that any person or entity meeting State standards for the provision of case management services must be given the opportunity to do so. Thus, county agencies may provide targeted case management services.

2. California had a substantial basis for believing that the claims were payable as administrative claims.

° Case management may be done as an administrative activity. SMM § 4302.2(G)(2).

° Where an activity may qualify as either a Medicaid service or an administrative activity, a state is free to classify the function in either category. SMM § 4302.2(G).

° Targeted and administrative case management are not mutually exclusive. SMM § 4302.2(G)

° County agencies may perform Medicaid administrative activities pursuant to interagency agreements. SMM § 4302.2(G)(2).

° Case management administrative activities need be connected only "in some way" with administering services covered under the Medicaid plan. SMM § 4302.2(G)(2).

Distinguish - limited decision: no clinical services; prp. to with special needs

° Although the State Medicaid Manual advises that case management relating to social services is not a legitimate Medicaid administrative activity, that position has been rejected by the Departmental Appeals Board ("DAB") in West Virginia Department of Human Resources, Decision No.1316 (1992).

° Prior to deferring the State's MAC claim, HCFA had never advised the states, in published guidance or otherwise, of its position that intense patient education provided on the day of a clinic visit must be reimbursed, if at all, through the clinic fee-for-service rate and could not be claimed as an administrative activity. Moreover, in its preliminary analysis in Maryland Department of Health and Mental Hygiene, Docket No. 88-192 (1989), the DAB reasoned that the activities of explaining to clients with special needs how to take medications and how to follow their health plans are valid administrative case management activities.

Properly designed dem.

yes.

° The State claimed FFP for administrative activities on the basis of county agency time studies. Time studies may be an appropriate basis for administrative claims. SMM § 4302.2(L)

° In 1992 correspondence to HCFA Region IX, the State advised that under its MAC program it would "captur[e] the costs for TCM [targeted case management] related activities by claiming administratively for them." Region IX gave no indication that administrative claiming would not be permissible for services that could be carried out through targeted case management. Region IX also reviewed and suggested revisions to the MAC time study codes, and at no time suggested that they described activities that could not be claimed as Medicaid administration.

No TCM -

° The State's approved cost allocation plan specifically referenced certain activities (by Veterans service offices) that involved referrals to other federal programs. The State reasonably understood the CAP approval as an additional indication that HCFA agreed that MediCal administration could entail referrals to non-State plan covered programs that avoided cost for the Medicaid program or that made administration of the MediCal program more efficient.

??

3. Proposed negotiated settlement.

This information will be presented at our meeting on March 29, 1995.

PROPOSED NEGOTIATED SETTLEMENT

1. All of the activities in question are legal Medicaid activities.

2. HCFA has determined that the activities in question are not allowable as administrative costs because of HCFA's interpretation of its policies.

3. If an approved state plan amendment and appropriate documentation is in place, the activities may be claimed and paid as targeted case management services eligible for funding as services at the FMAP rate.

4. As to the past claims, HFCA agrees to make a one-time equitable payment for the activities at the FMAP direct service rate.

5. As to the future claims, as of January 1, 1995, the State agrees to offer assurances that the activities will be claimed as targeted case management services and that the appropriate state plan amendments will be submitted to HCFA.

Expects to appeal ≤ 30 days
Rlt a hold on briefing papers

3/22/95

Marilyn Brown
John Rodriguez
Lisa Brandt
Sandy Spooner
Rita Ward — State lawyer
Phyllis Thompson C+B
Donna Eden

JR Disc of HCFA track - enthusiastic
MB/17 Lasorski in CA
MB Will categorize non-payable costs
JR POJ new kid on block
SS

broad def of adm costs → ongoing HCFA tr wont resolve

MB 50-50 - ph → freestdg clinics progs + op clinics ⇒ 20% clinics
Intensive educ ⟷ exp visit
vs cm

? Pt educ part of visit elsewhere
phys extenders

PT Pt educ — adm cm — DAB — Spec pop.
Donna shaking hd
2 things — 1: normal matrs
2: what ph/p.t is - st for outside
inherent admin of welf progr

SS Dist @ claim? — immig?
No — heavily
Has nada to do w/ presenting med cond
TCM — extent

PT Reas to bel adm ; if TCM, cld HV bn
Eg adj + settlemt - payable
Reason to bel pay
— no def of what cl servs are → algo done that day?
— estoppel
bSSMM sep TCM (HH ex.)

SS If cld hv low TCM
what to bring risk?

PT DAB will agree ACM – serv's we'll pay th
Reas to claim ACM, altho HCFA now says no

? Bring agreement to structure so HCFA happy,
prospectively; they want retro.

SS

MB 7 comp sp in 2 days – not months

DE TCM saw on site visit

? Guidance of WV + MD DABS – WV

PT MD

JR All payable if rate: BV; never wld hv done MAC
2 yrs ago; Reg IX thought ambiguous, OK

SS Signif legally? – estoppel, reliance
Can govt be legally bar –

? To critique codes – ! – Region shld hv seen
Early versions of codes were both

– – – – – –

PROFS notes??

SS? Coop effort, not approval

Lisa? Region says if it's wrong

?: Not outside law
In room John + Larry McD

SS If encouragmt, how get to pymt?

JR In budget, why no one says boo

MB 5/93 –

PT If illegal don't owe, but is legal + misled

MB 20 yrs – child w, EA – HHS
How can LMcD make decs? – (fool)
LMcD – yelled if he doesn't like dgs
even if reasonable
Encouragmt

MB Double b Using depreciation
(Interview Larry McD?)

SS Can't 2nd guess HCFA on all facts
Estoppel

2 TF's - em future ; mining past claims
What do
DOJ wont overrule whether inmate an
inmate

? How set rate

SS Where HCFA / S can't agree

MB

? TCM + In rate - How in both??
Good Q ;

I say algo

JR Yes, but what is process

SS Alt ways to get there $??
Rates ???
All puzzled - other/disaster

JR Discussed HIS demo ? !
retro

SS Relevance don't include ~~DDT~~ servs w/out
- Paper trail wld hv been diff PROVIDER

Next Steps - next wk

She'll report to them

? Can HCFA negot a settlement? - It can

arrive @ $ w/o pers on merits?

SS Not d-n

HCFA has auth
Compromise/Settling - pay $ HCFA helps nv gd.
HHS has ltd auth - dollar amt

PT Done it before

SS Don't know why DOJ in !!!
She's here just to be flexible
HCFA trying to be flexible

JR DOJ is right place if for no other reasons than you're here
Budg hrgs next wk, counties now
Next wk: proposal to settle ?? in advance

MB 2x/wk bloodbath - Bd Supervisors
Cong deleg - when beat up HHH
Pleadings surveys bef COB Fri

* Sacramento deals got reversed
No lawyers or policy people there

-5-

JR If no $ - let us know ASAP

SS Won't happen? (??)

MB S/Gloria don't think AG no "talked to various people"

SS Minutiae - No indep DOT judgmt
legal - in dec re whether materials be compromised
Not get sued
Own judgment on legal risk
Completely independent judgment on that
Judgmt re what court would say (not how to run prog)

? FINALLY! Risk that DAB/judge will overrule + set precedent

MY Q

RW End of April (2 tracks)

Me

JR If 1079 risky Wt policy direction - best deal you can as much as possible

Roberta Ward * HCFA → a bit of jerking around → WH

~~[illegible]~~

Other remedies

Fact of over?

Other trade

Spooner

Reminding people → role

Let

Both sides

Extremely helpful – read 1½ ft paper

Nada to reevaluate – Reg IX
- auditors not policies
- edges of problem
- casual, piecemeal
- didn't want to ask

Another mtg like that can't fly

Not legal arg to DOT – just HHS – other trade ??

THE WHITE HOUSE

WASHINGTON

March 21, 1995

MEMORANDUM FOR AB MIKVA
CAROL RASCO

FROM: STEVE NEUWIRTH
DIANA FORTUNA

RE: CALIFORNIA MEDICAID

The Justice Department has not yet begun substantive negotiations with California and L.A. County.

For the past three weeks, the Justice Department has maintained that it is in a "fact-finding" stage. While the Department has stated that it is willing to send its senior officials to meet with the State and County, it has not made any commitments to a process for substantive settlement talks.

The Department's approach has allowed the State to move slowly -- much to the consternation of L.A. County. While we do not know exactly what is motivating the State's behavior, the State does not face the short-term budget problem that the County does.

This week, the state finally agreed to meet for the first time with Justice Department attorneys. However, while the state and LA County apparently understood that this would be the first working session to address a settlement, the Justice Department takes the position that this is merely a "fact-finding" session.

L.A. County Supervisor Molina is seeking a commitment from the Justice Department to send a high level team to work for as long as it takes to reach a settlement (or determine that a settlement will not be possible.) She feels that unless the Justice Department makes such a commitment, the State (and, presumably, the County) will lose confidence in this settlement track.

OFFICE OF THE MAYOR

FRANK M. JORDAN
Mayor

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BOARD OF SUPERVISORS

KEVIN SHELLEY
President

Fax to Diana F.

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL

To: Diana F.	# of pages ▶ 1
Dept./Agency	From: John Monahan
Fax #	Phone #
NSN 7540-01-317-7368 5099-101	Fax #

GENERAL SERVICES ADMINISTRATION

March 7, 1995

TO: John Monahan
Diana Fortuna, White House

FROM: Margaret Kisliuk
City and County of San Francisco

RE: Lawsuit on State's Outpatient MediCal Rate

Late last Friday I left a message telling you that the first of the four outpatient MediCal lawsuits was not going to be heard on Monday after all. As it turns out, I was misinformed; the case was heard yesterday in District Court in Los Angeles.

Judge Wilson of the U.S. District Court granted the State summary judgment on all points; i.e., the State argument that the MediCal rates are adequate was accepted. A written decision is expected sometime around next week; I will get you a copy when I receive one.

This is the only federal case of the four lawsuits on the outpatient rate. It was brought by the California Association of Hospitals and Health Care Systems (CAHHS) on behalf of private hospitals. The other three cases are in State court, one brought by 8 counties and the other two by private providers. It was my understanding that hearings for these cases are not set until November, so that the court would have the benefit of the decision in the federal case.

The hearing on Monday was quick; there was no oral argument. The case number is 94-4764-SVW.

I will let you know if I hear anything else pertinent. Feel free to call me if I can be of any help; 916-442-0412.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 1 1995

The Honorable Pete Wilson
Governor of California
State Capitol, First Floor
Sacramento, California 95814

Dear Governor Wilson,

I am writing to inform you that, pursuant to applicable law, the U.S. Department of Health and Human Services must disallow payment of the September 2, 1994 claim for $315 million which was submitted by the State of California as additional administrative costs of the State's Medi-Cal program. This determination, and the timing of the determination, are required by the Medicaid statute. The legal basis for this decision is more fully described in the Health Care Financing Administration's letter to the California Department of Health Services, a copy of which is attached.

Although we are required to disallow the claim we received in September, let me assure you that I am extremely sensitive to the serious fiscal situation faced by several counties. This Department wishes to work with you to provide legally appropriate assistance to preserve the health care safety net in the affected counties. I want you to know that the Administration is immediately taking several steps to assist California and its counties in addressing the fiscal situation you face:

- The Administration has assembled a team that is ready to provide assistance immediately to the State and its counties regarding options to address the counties' fiscal situations. As you may know, we will meet with your staff and representatives of the affected counties tomorrow, to review ways the State could identify, independent of the MAC system, legitimately allowable activities imbedded in the MAC claim. At the meeting, we should also consider options available to the State to increase funding for the counties (including design of a targeted case management system and increases in provider reimbursement rates), and the establishment of a legally appropriate mechanism for making future administrative cost claims.

- A group of Administration officials has also scheduled a meeting in Los Angeles with Los Angeles County and State officials to discuss what options might be available following the disallowance of the State's September 1994 claim. The Administration believes it is important to make every effort, and to work as hard and as quickly as possible, to explore all avenues for addressing this situation.

As set forth more fully in HCFA's letter to the California Department of Health Services, we are required to disallow payment of the administrative claim because California's new Medi-Cal Administrative Claiming (MAC) system, which was used to identify Medi-Cal administrative costs incurred by counties, is seriously flawed. The claim generated by the MAC system includes inaccuracies and in large measure appears to represent activities that were part of clinic services for which Medicaid payment has already been made. In addition, a significant portion of the remainder reflects services unrelated to the administration of Medi-Cal.

The magnitude of the State's requested increase for administrative costs is of some concern. Nationally, the state average for Medicaid administrative costs is approximately 4.5 percent of Medicaid services costs. California's administrative costs, even without MAC, were approximately 6.3 percent of its Medicaid services costs. However, California projects that its administrative costs would run at the extraordinary rate of approximately 14 to 15.5 percent of Medicaid services costs when MAC claims are regularly submitted by all counties. This would be more than three times the average for Medicaid administrative costs in other states, and more than twice the historic rate of administrative costs for Medi-Cal.

I look forward to working with you and with county officials in our ongoing activities to assist the counties in preserving quality health care services.

Sincerely,

Donna E. Shalala

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Refer to: MCD-F-TGC

MAR 0 1 1995

Region IX
Office of the
Regional Administrator
75 Hawthorne Street
San Francisco, CA 94105

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ms. S. Kimberly Belshé
Director
Department of Health Services
714 P Street, Room 1253
Sacramento, California 95814

RE: CA-95-001-ADM

Dear Ms. Belshé:

This letter constitutes your notice of disallowance in the amount of $315,233,627 Federal financial participation (FFP) under Title XIX of the Social Security Act (the Act). These funds were claimed by the State of California and they cannot be allowed. The claims involve Medicaid administrative costs related to the Medi-Cal Administrative Claiming (MAC) system. The costs are for the period of July 1, 1992 through March 31, 1994. We deferred these claims when you submitted them earlier and we undertook an extensive review of your claim and the MAC system. Our review revealed a myriad of problems that are outlined in more detail below.

Your Department submitted a Line 7 prior period claim for $315,233,627 FFP for Medi-Cal Administrative Claiming (MAC) activities on your Quarterly Statement of Expenditures for State and Local Administration of the Medical Assistance Program (Form HCFA-64) for the quarter ended June 30, 1994. These MAC claims covered the period July 1, 1992 through March 31, 1994. A detailed schedule of the claims being disallowed is enclosed.

By letter dated October 7, 1994 you were notified of our decision to defer the entire $315,233,627 FFP in accordance with 42 CFR 430.40. This deferral was reflected in your Medicaid grant award dated October 28, 1994. By letter dated December 2, 1994, which was received by us on December 5, 1994, you provided your response to our deferral letter.

We have fully considered your December 2 response to our deferral letter. We have performed on-site reviews of the MAC claims and the MAC process in Los Angeles County (August 29 to September 1, 1994) and San Mateo and Alameda Counties (October 24-27, 1994). We have reviewed additional documentation provided by the State to our outstation staff in Sacramento. We met with State and Los Angeles County staff in San Francisco on August 17-18, 1994 and in

Washington, DC on October 18, 1994 and January 18, 1995 to discuss the MAC process. Finally, we have considered the information provided by our Office of Inspector General (OIG) regarding their review of 11 contract MAC providers in Los Angeles County which was also discussed with State staff in briefings conducted by the OIG on December 13 and 23, 1994. Based upon all of this information we are disallowing your entire claim of $315,233,627 FFP for the reasons stated below.

Applicable Law, Regulations, and Guidelines

Sections 1903(a)(2) through 1903(a)(7) of the Act identify a number of administrative costs which may be matched by the Federal government at various administrative matching rates. For the costs in issue in this claim, the statute explicitly directs payment only for costs "found necessary by the Secretary for the proper and efficient administration of the State plan." Thus the Secretary, not the individual State, determines which State administrative expenditures are to be allowed. This position is incorporated into the Medicaid regulations at 42 CFR 431.15 and 42 CFR 433.15.

Medicaid regulations at 42 CFR Parts 431 through 434 give specific guidance to States on general administration, personnel administration, fiscal administration, and contracts. Additionally, 42 CFR 430.2 provides for the applicability of 45 CFR Parts 74 and 95 to the Medicaid Program and provides guidance to the States on administration of grants. Specifically, these regulations provide as follows:

- 42 CFR 433.32 and 45 CFR 45 Parts H and I provide that States will maintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable federal requirements. In addition, States are required to have: (1) accounting records which adequately identify the source and application of funds for grant and subgrant activities, (2) procedures for determining the reasonableness, allowability, and allocability of grant costs, and (3) accounting records supported by source documentation.

- 42 CFR 433.34 and 45 CFR Part 95 Subpart E provide that the State must have an approved cost allocation plan (CAP). In addition, 45 CFR 95.505 specifically excludes medical vendor payments from the definition of State agency costs that can be included in a CAP. Also, 45 CFR 95.507 requires that the CAP contain sufficient information to permit an informed judgment on the correctness and fairness of the State's procedures for allocating costs, specify the procedures used to identify, measure, and allocate all costs to each benefitting program and activity, and that all costs

claimed are supported by an adequate accounting and statistical system.

- 45 CFR 74.53 and OMB Circular A-87, Attachment A, (A)(1), which is incorporated into the Medicaid regulations at 45 CFR 74. 171, provide that State cannot claim twice for the same service or activity.

- 42 CFR 432.45 provides for claiming 75 percent FFP for skilled professional medical personnel (SPMP) and their directly supporting staff. These requirements provide that the SPMP expenditures are for activities directly related to the administration of the Medicaid program and do not include expenditures for medical assistance and that the activities claimed require professional medical knowledge and skills.

The statute provides a completely separate mechanism for payment of the Federal share of the costs of providing medical services to Medicaid recipients. Medical assistance is defined in Section 1905(a) of the Act to mean "payment of part or all of the cost of the following care and services...." The services are defined in §§ 1905(a)(1) through (25).

Under 42 CFR 447.15, a State plan must provide that the State Medicaid agency limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the State plan to be paid by the individual. There is no exemption for administrative or overhead costs to allow these costs to be claimed separately to the Medicaid program. Additionally, 42 CFR 447 Subpart B provides that the State plan must describe the policy and methods to be used in setting payment rates for each type of service in the State's Medicaid Program and that the State must maintain documentation of the payment rates and make it available upon request.

Sections 1915(g)(1) and (g)(2) specify that targeted case management can be provided as an optional service under an approved State plan. Section 4302 of the State Medicaid Manual gives guidelines on case management services and activities and acknowledges that under certain circumstances case management services may more appropriately be claimed as administrative costs. These guidelines provide that:

- Case management provided under section 1915(g) is defined as services which will assist individuals eligible under the State plan in gaining access to needed medical, social, and other services and must be documented as any other Medicaid service.

- When case management is provided as an administrative activity, the State documentation must clearly demonstrate that the activities were provided to Medicaid applicants or eligibles, and were in some way connected with determining eligibility or administering services covered under the State plan.

- Administrative case management does not include obtaining social services not covered under the State plan. Referrals for Food Stamps, energy assistance, housing, child care or legal services are not covered even if these services may be in the best interest of the recipient.

- We must evaluate the activities for which case management FFP is claimed to determine whether the claims meet the requirements for payment either at the administrative or service case management match rate.

Finally, Section 1905(a)(24)(A) prohibits payment of medical assistance costs to Medicaid eligibles who are inmates of public institutions, except medical institutions. These requirements are incorporated into the Medicaid regulations at 42 CFR 435.1008 and 435.1009.

Discussion

Claiming Medical Services as Administration

Our site visits to locations where the MAC system was in place revealed that many activities coded by hospital outpatient clinic and freestanding county public health clinic employees were already being reimbursed by Medi-Cal through the all-inclusive clinic rate as part of a clinical encounter. However, we found that these activities were also being claimed by your Department as Medi-Cal administrative activities.

We found that the physicians at the clinics performed the actual diagnosis, treatment, and prescribing functions. They then referred the patient to a physician extender, typically a registered nurse or a pharmacist. The physician extender would then explain the diagnosis and the medication to the patient, educate the patient on the health issues surrounding the diagnosis, assist the patient in making any additional appointments, make any necessary medical referrals, and provide any additional information to the patient deemed necessary. These activities are part of the standard medical protocol and as such are direct patient care services and were reimbursed as part of the fee-for-service or managed care rate. These medical services furnished by physician extenders cannot be separated from the rate paid for medical services and claimed as Medi-Cal administration.

Additionally, a significant portion of ordinary overhead activities in the outpatient clinic setting were being coded and claimed as administrative activities under MAC. For example, routine supervision, personnel activities, training, meetings, etc. were all coded as allowable MAC activities. These types of costs are included in the all-inclusive clinic services rate and should not be claimed separately.

Claiming for Targeted Case Management

The distinction between unallowable targeted case management (TCM) activities and allowable administrative case management (ACM) activities was not defined in the MAC time study coding process nor was any distinction applied by the workers in coding their activities for the MAC process. Allowable ACM activities are those which are necessary for accessing and coordinating access only to Medi-Cal State plan covered services. We found workers coding as allowable Medi-Cal ACM, activities that were well beyond the scope of Medi-Cal State plan covered services (e.g., housing referrals, social services referrals, child care referrals, energy assistance referrals, legal service referrals, and the related liaison work with agencies providing those services). Such activities are not allowable Medi-Cal expenditures except as TCM services if provided for under an approved TCM State plan amendment covering the period of the claim. California does not have an approved State plan amendment for TCM services to general outpatient populations. Therefore, only the more limited administrative case management services, not the broader TCM services, may be claimed for federal match.

Duplicate Claiming of Agency Costs

We reviewed several social service programs claiming MAC expenditures, including the Linkages and SSI Advocacy Programs, as well as 11 contracts in Los Angeles County within the Alcohol and Drug Program Administration and the Department of Mental Health. We found that these programs commonly received other Federal and State grant funds for their activities from such sources as the State Department of Aging, the Social Security Administration and various other Federal and State aging and alcohol and drug program grants. When activities of these programs were coded as allowable MAC expenditures and were also reimbursed through these other funding sources, it resulted in duplicate claims and also in claims in excess of the total costs of the programs and activities.

Another potential source of duplicate claims was identified in those counties which have contracted with managed care providers to provide Medi-Cal services. Although these contracts commonly require and pay for primary case management, there is no mechanism in the MAC coding system to identify managed care recipients in order to avoid providing and charging for duplicate services.

Broad Public Health Activities

The activities performed by County workers as part of broad public health policy initiatives are not direct Medi-Cal administrative activities and as such are not allowable. For example, school-based alcohol and tobacco prevention programs directed toward the entire school population, adult smoking cessation programs, community-based dental disease prevention programs, developmental disabilities outreach, training, and education programs, injury prevention programs, and child passenger restraint system programs, were all being coded and charged as Medi-Cal administration through the MAC process. Such public health education campaigns would only be allowable if directed toward assisting Medicaid eligible individuals to access the Medicaid program, or if they qualify as recognized Early Periodic Screening, Diagnosis and Treatment (EPSDT) outreach and education activities.

Claiming Non-Skilled Professional Medical Personnel Activities at 75 Percent Rate.

Our review found that personnel at a number of sites coded any activity performed by a physician, registered nurse, or other person designated as "skilled professional medical personnel" (SPMP) as an activity to be claimed at the enhanced SPMP matching rate of 75 percent. The 75 percent SPMP matching rate, even when applied to SPMP, is limited to those SPMP administrative functions which require the SPMP's professional medical knowledge and skills in administering the program. When SPMP are attending meetings, performing general administrative activities, doing personnel work, doing general supervisory or administrative activities, such activities are not reimbursable at 75 percent FFP.

Inmates in Public Institutions

Activities being performed by probation or correctional officers in various juvenile or adult detention facilities were being coded as allowable MAC activities. However, such detention facilities are public penal institutions, and any medical services or MAC administrative activities provided to the inmates in such public institutions are not allowable Federal Medicaid expenditures.

Time Study and MAC Code Validity

Enough of the individual MAC codes include both allowable and unallowable activities within the same code to render the entire system invalid. For example, Code 8 includes both allowable translation services and unallowable child care services. In addition, several codes indicate that activities performed by County workers related to "other State and Federal programs" are allowable MAC activities. However, only activities performed in support of the approved Medi-Cal State plan are allowable

administrative activities.

The MAC system is modeled on time study systems approved by the Departmental Appeals Board for apportioning social workers' activities to Medicaid/non-Medicaid clients. When used by clinical service providers, however, the system identifies as administrative activities many activities which are considered clinical services. For example, the Physicians' Current Procedural Terminology, Fourth Edition (CPT4), which is a commonly used system for reporting clinical activities performed by physicians for billing and other payment purposes, identifies obtaining case histories, educating patients, providing referrals to specialists, consulting with other clinicians and service providers, and counseling patients as clinical activities. As clinical activities, these functions should be included in the clinic payment rate, and not billed as Medicaid administrative costs.

The codes also fail to distinguish between activities related to administration of the provider facilities and administration of the Medicaid program. Supervision, training, and personnel functions which are required to operate the facility regardless of the number of Medicaid eligibles served are costs of administering the provider. They may not be charged separately to the Medicaid program. Medicaid administration costs, in contrast, are costs essential to administering the Medicaid program, such as facilitating eligibility determinations, or organizing programs or services required to meet federal Medicaid standards.

Claiming for Periods Without Time Study Documentation

The State's term for retroactive claims not supported by contemporaneous time study documentation is "backcasting". The issue involves a methodology for claiming costs for time periods after the effective date of the California legislation authorizing counties to claim Medicaid administrative costs, but before the MAC Manual's time reporting system was in operation. Various counties performed time studies and accumulated documentation of Medi-Cal beneficiaries receiving services for one or more quarters during the State's fiscal year ended June 30, 1993. The State proposed to project costs for a 12 month period using the data available from the last quarter of that period. The State has not provided any documentation which supports the use of time study data from current quarters to establish the allowability of the claim for prior quarters where no time study data exists.

Conclusion

This letter constitutes notice of disallowance in the amount of $315,233,627 FFP. Please make a decreasing adjustment in that amount on line 10B of your next Quarterly Medicaid Statement of Expenditures (Form HCFA-64). However, since these funds have not

been paid to the State, this adjustment will not be used in your grant award computation.

This is my final decision. Under 45 CFR Part 16, the State has an opportunity to appeal to the Departmental Appeals Board. This decision shall be the final decision of the Department unless, within 30 days after you receive this decision, you deliver or mail (you should use registered or certified mail to establish the date) a written notice of appeal to the U.S. Department of Health & Human Services, Departmental Appeals Board, Room 637-D, Hubert H. Humphrey Building, 2nd & Independence Avenue S.W., Washington, D.C. 20201. You must attach to the notice a copy of this decision, note that you intend to appeal, state the amount in dispute, and briefly state why you think that this decision is wrong. The Board will notify you of further procedures.

Please send a copy of any notice of appeal to this office.

Should you require further details regarding this matter, please contact the Acting Associate Regional Administrator for the Division of Medicaid at (415) 744-3568.

Sincerely,

Nancy Dapper

Nancy Dapper
Acting Regional Administrator

Enclosure

SUMMARY OF MAC DISALLOWANCE BY COUNTY
QUARTER ENDED JUNE 30, 1994

County	Amount
Alameda	$ 1,458,529
Amador	12,785
Calaveras	84,522
El Dorado	79,632
Fresno	422,315
Humboldt	135,734
Imperial	97,807
Inyo	22,230
Kern	847,356
Kings	12,401
Los Angeles	289,775,816
Marin	276,965
Mendocino	77,115
Merced	370,928
Napa	1,079,624
Orange	3,805,146
Placer	947,750
Riverside	1,875,815
Sacramento	165,833
San Bernardino	1,524,474
San Diego	1,187,022
San Joaquin	539,926
San Mateo	257,332
Santa Clara	1,340,058
Santa Cruz	1,328,574
Shasta	188,078
Sonoma	888,264
Stanislaus	3,075,716
Tehama	53,350
Trinity	22,673
Tulare	17,357
Tuolumne	113,610
Ventura	3,081,028
City of Berkeley	67,862
Total	$315,233,627

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

March 1, 1995

Contact: HCFA Press Office

(202) 690-6145

FEDERAL MEDICAID FUNDS DENIED

As required by the Medicaid statute, the Health Care Financing Administration (HCFA) has determined that it must disallow the claim of $315 million in federal Medicaid matching funds submitted by California on September 2, 1994.

Although HCFA is required to disallow this claim, it is sensitive to the serious fiscal situation of the affected counties and has offered to provide any appropriate assistance to the State and to the counties to preserve the health care safety net. The Department of Health and Human Services (HHS) is moving forward on several fronts to provide assistance:

- An Administration team has been assembled that is ready to provide assistance immediately to the State and its counties regarding options to address the counties' fiscal situations. This team has scheduled a meeting with State staff and representatives of the affected counties on March 2 to review ways the State could identify, independently of the Medi-Cal Administative Claiming (MAC) system, legitimately allowable activities imbedded in the MAC claim. The group will also review options available to the State to increase funding for the counties (including design of a targeted case management system and increases in provider reimbursement rates), and the establishment of a legally appropriate mechanism for making future administrative cost claims

- A group of Administration officials has also scheduled a meeting in Los Angeles with Los Angeles County and State officials to discuss what options might be available following the disallowance of the State's September 1994 claim. The Administration believes it is important to make every effort and to work as hard and as quickly as possible to explore all avenues for addressing this situation.

The State's claim purported to cover additional administrative costs incurred by counties under the State's Medi-Cal program. However, HCFA found that:

- for the most part, the claim does not represent additional administrative costs, but rather costs that were part of clinic services for which Medicaid payment has already been made;

- federal share has already been paid for the majority of services claimed; and

- a significant number of the claims are for services not covered by Medi-Cal, including non-medical social services.

The source of the problem is California's new Medi-Cal Administrative Claiming (MAC) system, which is seriously flawed.

HISTORY AND BACKGROUND -- California recently began using an administrative claiming system which purported to identify the costs incurred by counties in the administration of the Medi-Cal program. The new system used periodic time studies to identify the activities of county employees and their contractors which were then to be claimed as Medicaid administrative costs.

- Much of the public health and human services system in California is administered by county governments. California developed the MAC system in an effort to identify county Medi-Cal administrative costs for the purpose of claiming a federal match.

- A claim of $315 million was made by the State on September 2, 1994, representing costs identified by the MAC system for 34 counties and covering the period July 1, 1992 to March 31, 1994. Los Angeles County costs represent 92 percent of the claim.

- While portions of the MAC system had been described to federal officials during its development, a full working view of the MAC system as applied was not provided to HCFA until August 1994, at which time HCFA began expressing its concerns about the system. The first request for approval of the entire MAC system was not made until October 1994, a month after the $315 million in claims were submitted to HCFA.

- HCFA conducted reviews of 30 facilities in 3 counties, as well as a MAC fiscal review in each of the counties, to determine the reliability and validity of the MAC system. The most extensive review work was carried out in Los Angeles County. In addition, a limited scope review of the system was conducted by the HHS Inspector General. The reviews established that the MAC system as applied is severely flawed and that most of the claims it has generated are not valid Medi-Cal administrative costs.

- Based on these findings, HCFA deferred payment of the $315 million MAC claim in October 1994, and gave California an opportunity to respond to HCFA's findings. The State responded, but its information does not support the validity of the MAC system claims.

- o If MAC-generated claims were approved, California would be spending, on average, three times more than other states in Medicaid administrative costs. The MAC-generated claims would also represent twice the previous rate of administrative spending by California itself.

- o The State estimates that the annualized Federal cost of MAC system claims would be approximately $750 to $825 million when MAC claims are regularly submitted by all counties.

SYSTEMIC PROBLEMS in MAC -- Among the fundamental problems with the MAC system are the following:

1. The system lacks the capability to distinguish between allowable Medicaid administrative costs and costs for services that have already been reimbursed by federal and other sources.

2. The categories of activities which the system codes as Medicaid claimable are so broad as to capture both claimable and non-claimable time, indiscriminately.

3. The time alleged to be Medicaid claimable is not directly associated with specific Medicaid eligibles, but is projected to Medicaid eligibles based on the gross percentage of eligibles served by an agency. Reviews indicated that this often results in an inaccurate and inflated attribution of costs to Medicaid.

Reviews of MAC-generated claims so far show that the largest portion of the claims to date appear to represent not administrative costs, but medical services or overhead costs for which Medicaid payment has already been made as a medical service or clinical service payment. In addition, significant portions of the claims represent activities with tangential or no connection to the Medicaid program. Examples include:

- o Pharmacists at clinics would claim the time they used in counseling patients about the drugs that had been prescribed as Medi-Cal administration, even though these activities are already reimbursed through clinic payments or pharmacy dispensing fees.

- o Nurses were claiming activities related to giving immunizations and reporting medical test results as Medi-Cal administration. Both actions are part of providing a Medicaid service and are not Medicaid administration. The cost of these actions is already reimbursed through the medical services rate and cannot be claimed again as administration.

- o Claims were submitted for activities outside the scope of services covered by Medi-Cal, such as referrals for housing, social services, child care and legal services.

- Correctional officers in juvenile or adult detention facilities were coding some of their time as allowable Medi-Cal administrative activities. But services to inmates of public institutions are not covered by Medicaid.

- Portions of general state public health education campaigns concerning alcohol, tobacco, or drug abuse prevention were being claimed as Medi-Cal administrative costs even though they had no direct relationship to the Medi-Cal program.

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THE VOICE OF THE WEST

EDITORIALS SF Chronicle 3/1/95 (5)

Counties Unfairly Dealt Medi-Cal Cuts

CALIFORNIA counties could suffer a staggering $315 million drop in federal Medi-Cal funds this year — despite every indication that most of those counties would be penalized for the misdeeds of others.

Federal officials say their refusal to reimburse hundreds of millions of dollars in county Medi-Cal claims stems from county administrative costs that the federal government considers improper. But the Health Care Financing Administration, which oversees Medi-Cal expenditures, reportedly conducted a careful audit only in Los Angeles before it made its determination.

It's only fair the federal government conduct an in-depth audit in counties that stand to lose

"The potentially disallowed practices . . . are not relevant to the majority of participating counties," Ted Lempert, president of the San Mateo County Board of Supervisors, wrote to the administrator of HCFA. "Our claims will withstand an audit, and we urge a more thorough and fair review by HCFA before disallowing the claim and damaging health care services in California."

San Mateo County stands to lose $18.1 million, San Francisco County $33 million, Santa Clara County $48.7 million and Contra Costa County $32 million under the federal cutbacks.

Although the federal government's relationship is with the state, it seems only fair that the Medi-Cal oversight agency conduct an in-depth audit in those counties that stand to lose the money in order to ensure that agencies that have complied with federal rules are not wrongly penalized for the errors of others.

In this era of find-money-wherever-you-can, counties and other local governments are getting hit from all sides. The federal government wants to cut waste and save money, as does the state, which decided last year it was entitled to $200 million in federal Medi-Cal money that the counties claim belongs to them.

San Francisco is not atypical in already receiving only 20 percent of the cost of treating a Medi-Cal patient in an outpatient setting. Additionally, the counties complain that payment rates (set by the state) are the lowest in the nation — $35 per outpatient visit.

There are going to be serious health care cuts throughout the state — including the closing of clinics and the elimination of public health nursing services — if the federal government goes through with its reported plan to disallow $315 million in Medi-Cal reimbursements. Of course, the counties can legally challenge the cutbacks, but it would take years to resolve the issue in the courts.

The Medi-Cal system deserves scrutiny, but the least the federal government can do before imposing penalties is to make sure each of the targeted counties is at fault.

Bypass Devil's Slide

San Francisco Chronicle Thursday, March 2, 1995

Medi-Cal Money Denied to Counties

(6)

By Greg Lucas
Chronicle Sacramento Bureau

Sacramento

The federal government officially refused yesterday to pay $315 million that California and its counties sought as reimbursement for providing health care services to the poor, driving the state budget $200 million into the red.

Although Bruce Vladeck, chief of the federal Health Care Financing Administration, expressed sympathy for the fiscal problems the move would cause cash-strapped counties and the state, he said that at least $284 million of the $315 million will never be paid.

The counties might be able to recoup the rest, he said.

"The folks most at risk in this process are the counties and the people they serve," Vladeck told reporters at a Capitol press conference. But, he said, "90 percent (of these claims) involve services we've already paid for."

At issue are funds distributed by the federal government to pay counties for administration of the Medi-Cal health care system. Vladeck said the main objection to the counties' claims is that various services — such as nurses to explain a patient's prescription — are already reimbursed in another part of the Medi-Cal program.

Many counties had banked on the arrival of this money to help defray the costs of operating coun-

MEDI-CAL: *Page A14 Col. 3*

MEDI-CAL

From Page A13

ty hospitals, clinics, public nursing programs and other treatment options related to Medi-Cal.

The state takes a hit because under the terms of last year's budget deal, the Wilson administration was supposed to keep $200 million of an expected $850 million in reimbursements under the program, which was created to pay half of the county administrative costs associated with operating Medi-Cal.

But with no money for the counties, there will be no money for the state.

Vladeck said 92 percent of the $315 million is claims from Los Angeles County. The remaining 8 percent is split among another 33 counties.

The denied claims were the first filed under a new system created by the state and counties to increase federal reimbursements. The state argues that it created the system in consultation with the health care financing agency, but Vladeck said yesterday that the state's reimbursement criteria was never approved.

Denial of this batch of claims jeopardizes payment of future claims. The state legislative analyst estimates that California's 58 counties could lose $2 billion in potential reimbursements through the fiscal year ending June 30, 1996.

Vladeck downplayed the impact of his agency's decision on future claims and said that claims by counties other than Los Angeles in the $315 million might be honored.

"We believe that anywhere from a small to a very large fraction (of the counties' claims) ought to be allowable," said Vladeck, adding that the federal government would examine claims submitted by other counties. "But I can't guarantee that process will produce on a dollar-for-dollar basis everything the counties hoped for."

Although Los Angeles takes the biggest hit, the financial impact is significant for Bay Area counties.

Alameda County's budget for the current fiscal year, which ends June 30, counted on $14 million in federal reimbursement, including unpaid claims from previous fiscal years.

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Number 61

County's condition critical after denial of Medi-Cal claims

Valley groups want rail line in 20-year plan

By David Bloom
Daily News Staff Writer

As transit officials near a decision on a new 20-year spending plan, San Fernando Valley groups are jockeying to get the second phase of the East-West Valley rail line back on the list of planned projects.

But with funding sharply restricted, they face tough competition from groups seeking a higher funding priority for rail lines along the Crenshaw Boulevard and Alameda Avenue corridors.

The Alameda corridor project — a high-speed rail and road link from the ports of Los Angeles and Long Beach to downtown highways and rail yards — is a particular threat to beat out the proposed East-West San Fernando Valley Rail Line.

The Alameda project is strongly backed by Los Angeles

See MTA / Page 11

By Sandy Harrison
and David Bloom
Daily News Staff Writers

The federal government on Wednesday rejected $290 million in Medi-Cal claims made by Los Angeles County for the costs of health care to the poor, pushing the county into another round of tough choices to avoid economic disaster.

Since the current year's budget anticipated payment of the $290 million in claims, their rejection creates an immediate shortfall in the county's budget.

And it could get worse if the federal government also rejects $350 million in additional Medi-Cal claims for services county departments expect to provide this year, said Robert Plasky, a county management analyst.

County officials face two basic choices in dealing with the deficit — make deep cuts in services over the remaining four months in the current fiscal year, or tap reserves set aside to offset an expected deficit next year.

While tapping the reserves would solve the immediate problem, without some other revenue source it would only delay debate about potential budget cuts, since county financial officers have forecast a significant deficit for next year.

"It means that we have to ad-

See COUNTY / Back Page

...dios.

Gus Ruelas / Daily News

Pierce College police Capt. Ken Renolds expects that the trained officers will split shifts in cars and on horseback.

Pierce College police mounting horse patrol to rein in crime

By Howard Breuer
Daily News Staff Writer

WOODLAND HILLS — Pierce College police say they are about to become the first in the state to patrol a community college by horseback — although they need to find horses large enough to carry some of the stouter members of the force.

College President Mary Lee believes the horses will give the officers a more visible presence on campus and a better vantage point to spot car thieves.

She also thinks the mounts will make it easier for the officers to reach areas of the hilly, 420-acre campus that are inaccessible to patrol cars.

"People are more friendly to officers on horseback," she said. "In parking lot surveillance you

See PIERCE / Page 9

Daily News - 3/2/95

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(8)

Government rejects county's Medi-Cal

OUNTY / From Page 1

ess a daunting shortfall as of July " said Gary Wells, the Health De- rtment's assistant finance direc- r.

But Wells said it is possible that e federal government might still mpromise and allow at least par- l payment of the rejected Medi- l expenses.

"The bright side is that (federal icials) have indicated that they'll rk with us and seek alternate ys to make sure that the health e safety net remains in force."

Anticipating that it would not re- . that money, departments and Board of Supervisors have be- scaling back operations signifi- ly — including not filling va- positions and planning to close ails.

More than $104 million in ending reductions have been ide throughout county opera- ns, and a surplus that the coun- s Health Services Department l hoped to use for next fiscal r will be spent down this year.

Administrative appeals processes take as much as several years ess there is a significant effort to ed up the review, Plasky said, ich will further complicate the nty's financial problems possi- bly well into next fiscal year.

With the denial, the county now will appeal the matter and negotiate for some portion of the funds it is claiming under the program, county officials said.

"I don't think this is particularly disheartening," said Tom Silver, chief deputy to Supervisor Michael D. Antonovich. "The key here was to get a decision so we can get on with an appeal."

County officials said they hoped for a quick appeal and negotiations that would allow at least some portion of the money the county needs to come in.

Supervisors Gloria Molina and Yvonne Brathwaite Burke were part of a group of county officials meeting late in the day with Health Care Financing Administration officials in Los Angeles over the decision.

"The financial health of Los Angeles County, and our ability to deliver critical programs to residents, depends upon the federal government's willingness to reimburse past Medi-Cal costs," Molina said in a statement. "We must take a serious look at past monies and determine a process which will avoid future problems."

The decision adds new impetus to county budget-cutting efforts, however, and will further cloud next year's already dark fiscal picture, county officials said.

State officials submit the requests for federal reimbursement on behalf of counties. In a letter to the state, the U.S. Health Care Financing Administration said the claims were denied because of flaws in the accounting system — resulting in double billing for services that already had been paid.

"The system lacks the capability to distinguish between allowable Medicaid administrative costs, and cost for services that have already been reimbursed by federal and other sources," the federal announcement said.

"It means we were asked to pay again for what we've already paid in full," said HCFA administrator Bruce Vladeck. "More than 90 percent of it involves administrative costs for clinic services we've already paid in full."

Specifically, the HCFA statement concluded that costs which were part of clinic services, for which reimbursement already has been made, were wrongly billed as administrative costs.

State Department of Health Services spokeswoman Lynda Frost said the federal denial of funding was a surprise because the state had worked with federal officials in devising its new claim procedures.

"We're disappointed and we stand by the validity of the system," Frost said. "At this point we have to keep working with the federal government to identify what can be reimbursed. We are still going to try to get a lot of that."

The claims were first filed under a new system designed by the state and counties to increase federal reimbursements by qualifying more administrative costs for reimbursement. But federal officials say that what it actually did was result in multiple reimbursements for the same expense.

Plasky said the HCFA complaints were off base.

The county used definitions of claimable activities that had been approved by the state and the regional office of HCFA, he said, and any reimbursements the county received from non-Medi-Cal programs were subtracted from claims made under the Senate Bill 910 program.

"We're not double billing," Plasky said. "The rates that Medi-Cal pays for don't cover all the costs. They pulled out some elements that are good sound bits, but we still believe our claim was based on legitimate codes that have been approved by the state and Region 9 of HCFA."

Specific items cited in the federal denial include:

- Programs in the Los Angeles County Alcohol and Drug Program Administration and Department of Mental Health receiving reimbursements from the state Department of Aging, the Social Security Administration, and other state and federal agencies that exceeded the total costs of the programs.
- Ineligible costs, such as housing referrals, child care referrals, energy assistance referrals, and legal service referrals, being billed as administrative costs.
- Services provided by nurses and pharmacists incorrectly billed as administration, even though they already were reimbursed as medical services by Medi-Cal.
- Medical services to prison inmates were improperly billed as administrative expenses.
- Public health campaigns involving alcohol, tobacco and drug abuse prevention were improperly billed as administrative costs.

This story was reported by Sandy Harrison in Sacramento and David Bloom in Los Angeles.

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Daily News 3/2/95

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U.S. denies $315 million claim for Medi-Cal reimbursement

By Brad Hayward
Bee Capitol Bureau

In a blow to the state and its financially struggling counties, the federal government Wednesday denied a $315 million reimbursement claim from California counties for the costs of running the Medi-Cal program.

Federal officials called the system used to calculate the reimbursement claims "seriously flawed." In many cases, they said, it generated requests for federal reimbursement for services the government already had funded.

The decision pokes holes in the current-year budgets of most counties, with the vast majority of the losses in Los Angeles County. The action also could tie up hundreds of millions of dollars in additional funds that counties were expecting through 1996, and it jeopardizes up to $400 million in state revenues as well.

"We are very disappointed, especially considering how closely and cooperatively we worked with (federal officials) in developing the system they are now disowning," said Lynda Frost, spokeswoman for the state Department of Health Services, who said the state is appealing the decision.

The flap is over a new process the state recently created to allow counties to recoup their costs for administering Medi-Cal, a program that provides health services to the poor.

The state forwarded the counties' first reimbursement request under the new system to the federal government in September. But when federal officials reviewed the program, they found problems.

For example, officials said, when a clinic nurse would report medical test results or discuss prescription use with a Medi-Cal patient, the system would sometimes count the time spent as administrative, thus needing reimbursement, when it was already reimbursed under clinical services payments.

"We have been asked to pay more for something we've already paid in full," said Bruce Vladeck, chief of the U.S. Health Care Financing Administration.

In other cases, Vladeck said, the system produced reimbursement claims for programs ranging from housing to drug-abuse prevention that are not part of Medi-Cal at all.

Frost said the system had been set up to avoid such problems; she added that federal officials were familiar with the system as it was developed and did not complain about it until the state asked for the reimbursement. Vladeck said the final system wasn't what federal officials had expected to see.

Vladeck said some of the denied claims may eventually be reimbursed once county officials provide better information.

Of the $315 million in denied claims, 92 percent would have gone to Los Angeles County.

But the losses to nearly all counties could increase because the decision imperils more claims that the federal government has not yet received. In the worst-case scenario, $2 billion in county revenues could be jeopardized over a two-year period, according to the Legislative Analyst's Office.

And because the state planned to skim some money off the top of those reimbursements to counties, it could lose $200 million in the current year and another $200 million in the 1995-96 fiscal year.

"Statewide, the impact is going to be very significant," said Robert Caulk, director of Health and Human Services for Sacramento County. "Many counties were hoping that these funds would offset previous costs and allow counties to backfill for other losses in state and local revenues."

But Caulk said Sacramento County would be able to handle the blow even if it gets none of the $4.3 million in reimbursements it had budgeted for the 1994-95 year. "In the flow of things, this is not that large of an impact and is within a manageable range of things we run into over the year," he said.

Officials in Yolo County said the impact could be more serious there; the county expected $482,000 in reimbursements this year. Placer County had assumed receipt of $271,000, and El Dorado County, $160,000, according to the California State Association of Counties.

Sacramento Bee 3/2/95.

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THE OAKLAND TRIBUNE
Tuesday, February 28, 1995

Medi-Cal expected to refuse

By Rachele Kanigel
STAFF WRITER

Health officials around the state are considering massive cutbacks — staff layoffs, clinic reductions and county hospital closures — in response to news they may lose millions of dollars in federal Medi-Cal funding.

The federal Health Care Financing Administration is expected to announce by Thursday that it will not pay $315 million in Medi-Cal claims the government considers inappropriate.

Alameda County stands to lose $10 million for the 1994-95 fiscal year and $12 million for the 1995-96 anticipating a shortfall of $2 million. The state of California expects to miss out on about $200 million for each year.

Altogether, the state and counties could lose more than $1.5 billion, said Bill Wehrle of the state legislative analyst's office.

"If we don't get this money it's going to be devastating to us," said Shahnaz Nikpay, director of finance for the Alameda County Health Care Services Agency. "It would mean less of everything — less staff, less hours, less responsive services. We may have to shut down some of our clinics."

In Contra Costa County, officials are considering lay-

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$315 million in claims

services, said Mark Finucane, health director for the county.

At issue is a dispute over how much the federal government should pay for the administrative costs of Medi-Cal, the government health program for the poor.

In 1992, the state Legislature passed a bill expanding the Medi-Cal administrative claims program. Since then the state and counties have begun to bill the federal government for a number of services they were already providing.

Wehrle concedes some of the counties got rather "creative" with their claims. Some billed the government for the cost of county sheriffs' departments providing drug and alcohol education program in public schools — basing their claims on the number of Medi-Cal recipients living in those districts.

Other counties billed the government for the costs of outpatient clinic services not already part of the regular Medi-Cal reimbursement; pharmacists explaining the side effects of medications; public health nurses referring Medi-Cal patients to drug treatment services.

State and county representatives said federal officials in the regional office had said in numerous meetings that the counties could bill for such services.

But last year, federal officials in Washington began to question these claims after they soared from $17 million in the 1992-93 fiscal year to $315 million for a fraction of the 1993-94 fiscal year.

U.S. officials warn counties about Medi-Cal claims

By Sam Delson
SACRAMENTO BUREAU

SACRAMENTO — Federal officials warned Wednesday that more than $1 billion in future Medi-Cal reimbursement claims by California counties could be in jeopardy.

The officials made the warning while confirming that they have disallowed $315 million in Medi-Cal reimbursement claims by state counties.

Bruce Vladeck, chief of the U.S. Health Care Financing Administration, said the counties have been billing the state for administrative costs that had already been covered by other programs.

He stopped short of accusing the counties of deliberate wrongdoing but said California's new accounting system has multiplied the counties' demands for federal reimbursements without improving services to patients.

"We won't call it fraud or double-billing," Vladeck said. "We call it maximizing federal resources."

The $315 million in denied claims included $1,458,529 for Alameda County, $539,926 for San Joaquin County, and $67,862 for the City of Berkeley.

But the counties could eventually lose much greater amounts if they fail to reach agreement with federal officials on new standards for acceptable reimbursements.

Margaret Pena of the California State Association of Counties said counties' budgets are already counting on $700 million in Medi-Cal reimbursements for the current fiscal year.

"We will see a tremendous and devastating impact on the counties as a result of the loss of these funds," Pena said.

Alameda County stands to lose $10 million this fiscal year and $12 million next year, while Contra Costa County could lose $2 million.

Bill Wehrle of the state legislative analyst's office said California could lose more than $1.5 billion from the federal decision.

U.S. Secretary of Health and Human Services Donna Shalala noted that other states' costs for administering Medicaid programs average 4.5 percent. But California's administrative costs were 6.3 percent before the new system was adopted and have topped 14 percent since its introduction.

"We are required to disallow payment of the administrative claim because California's new Medi-Cal Administrative Claiming system (MAC), which was used to identify Medi-Cal administrative costs incurred by counties, is seriously flawed," Shalala wrote in a letter to Gov. Pete Wilson.

"The claim generated by the MAC system includes inaccuracies and in large measure appears to represent activities that were part of clinic services for which Medicaid payment has already been made."

Grantland Johnson, West Coast regional director of Shalala's department, said he will meet with representatives of the counties in San Francisco today to try to work out an agreement on standards for future reimbursements.

"We're here not just to deliver notice of disallowance but to hit the ground running and work with the state and counties like Alameda to expedite the process of settling the claims," Johnson said.

More than 90 percent of the denied claims were from Los Angeles County and involved a particular accounting practice that was not used by other counties. Johnson said Alameda and other counties have a chance of eventually recouping a significant portion of the claims that were rejected this week.

"Alameda feels strongly that, upon further review and after submitting additional documentation, the bulk of their pending retroactive claims will be determined to be eligible for reimbursement," he said.

But Vladeck said it could take a while to untangle the financial mess that federal regulators found when they audited the Medi-Cal program.

"We don't see any way to get most of it to the counties any time quickly," he said, and noted that the state won't be able to submit more claims until the dispute is settled.

Vladeck said the state's increased requests for reimbursement were "entirely an effort by the counties to get the federal government to pay a larger share of the costs for existing services."

Oakland Tribune
A-3
March 9 1995

(12)

California News

Thursday, March 2, 1995

Citing flaws, U.S. rejects Medi-Cal bills

Claims totaling $315 million are denied

BY GARY WEBB
Mercury News Sacramento Bureau

SACRAMENTO — The federal government Wednesday formally refused to pay $315 million worth of Medi-Cal claims from 34 California counties because the claims are allegedly improper.

In a letter to Gov. Pete Wilson, U.S. Health and Human Services Secretary Donna Shalala said the state's current system for billing the federal government for medical services given to the poor was "seriously flawed." Recent federal audits done in Northern and Southern California show the system resulted in some counties double-billing the Medi-Cal program for clinical visits and others charging for services unrelated to Medi-Cal.

Shalala

In Los Angeles County, which was the biggest offender, more than $2.5 million worth of Medi-Cal claims were submitted for the time sheriff's deputies spent lecturing schoolchildren on drug abuse, on the theory that some of the kids probably were Medi-Cal recipients. Another $60 million was claimed for the time probation agents spent counseling criminals.

The billing system originated in San Mateo County, which had hired a Maryland consulting firm to devise it. The system is known as "MAC," Medi-Cal Administrative Claiming. State and local officials said other counties, particularly in the Bay Area, were convinced the MAC system was so foolproof that they built into their current budgets millions of additional Medi-Cal dollars.

And they weren't the only ones. In his 1995-'96 budget, Gov. Pete Wilson figured on getting $200 million back from the counties' share of the MAC money as a fee for overseeing the program.

Hancine Fisher, a Los Angeles-based consultant with the Institute for Human Services Management of Rockville, Md., said in a brief phone interview that she did not "want to get caught up in this thing" and referred questions to San Mateo County officials.

"We had a fee-for-services contract with them," Fisher said. "The process originated there."

Mary Macmillan, legislative director for San Mateo County, said the consulting firm was hired on the recommendation of the state Medi-Cal department. Macmillan said county officials were assured by the consultants — who were paid roughly $300,000 — that the billing process they were promoting was legal and had been used in other states.

Sources said the inspector general of the federal Health and Human Services Department has opened an investigation to see whether there was a conspiracy to defraud the federal government.

The impact of Wednesday's decision is considerably more far-reaching than the immediate loss of the $315 million. Roughly $1.5 billion worth of additional MAC claims are at various places in the

(B) CA News 3/2/95

pipeline between the counties and the federal government. Wednesday's announcement means it is likely many of those bills won't be paid, either.

Already, Santa Clara and Santa Cruz counties are losing $1.3 million each. Alameda County loses $1.4 million, and San Mateo County will lose $257,000. It is not clear at this point how much overall the counties have billed.

The biggest losers will be counties that bet large parts of their public health budgets on getting MAC money this year and next. Los Angeles County, for instance, budgeted $641 million, while Santa Clara County has nearly $10 million in its budget. Alameda County was planning on receiving $6.4 million this year.

In a letter Wednesday to Bruce Vladeck, head of the Health Care Financing Administration, Reps. Anna Eshoo, Norman Mineta, Tom Lantos, Pete Stark and Zoe Lofgren warned that loss of the federal funds "would be particularly devastating to San Mateo, Santa Clara and Santa Cruz counties" and said it was likely the counties would have to "make deep cuts into their mental health, public health, drug and alcohol services as well as to medical centers."

Vladeck, whose agency pays for the federal portion of Medi-Cal, agreed that "the folks most at risk in this process are the counties and the people they serve." But he said federal law prevented him from paying the claims.

"We have been asked to pay more for something we've already paid in full," Vladeck said. "The state was clearly seeking to use administrative devices . . . to bring in more federal dollars without additional county or state dollars being put up at the same time."

John Rodriguez, director of the state's Medi-Cal program, said he believed the MAC system had the blessing of Vladeck's agency, since HCFA officials from the regional office in San Francisco actively participated in planning the new billing process.

"There is no way they can say they weren't heavily involved in this process," Rodriguez said. "This whole system evolved with their help."

But Vladeck said that while it was "very clear there have been extensive conversations between the representatives of the state and HCFA" regarding the billing system, "it is also absolutely clear to us that there was never an approval granted or implied. In fact, we did not see the new system and all of its details until after the time the ($315 million) claim was submitted."

When the details finally were produced, Vladeck said, "it differed in important respects from what we thought we had been talking to the state about during the previous two years."

Vladeck said his agency will work with the counties to salvage what claims could be legally paid but that it was likely the bulk of them would be refused. He said a court challenge by the state and counties was likely.

ond time around

Marines are part of a 0-strong force sent to lia to form a protective on around 2,400 U.N. troops ey withdraw from Somalia.

Looters at the ready

■ Somali looters may interfere with the military operation and the loading of ships.

See story, Page 8A

San Jose Mercury News

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chief operating officer.

"This is a company that traditionally has managed its headcount very carefully," said Harvey Frank, who as staffing manager is faced with the task of finding qualified applicants. "This is a landmark in our history in that we are for the first time saying we have the ability to go out and find the best talent out there and invest in our future."

Most companies don't formally announce their job-creation targets, but Silicon Graphics' growth plans are thought to be among the

See JOBS, Back Page

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Santa Clara, San Mateo counties face costly Medi-Cal bill dispute

BY GARY WEBB AND HOLLY A. HEYSER
Mercury News Staff Writers

SACRAMENTO — A high-level dispute between state Medi-Cal officials and a federal health agency is expected to cost California counties nearly $2 billion in the next two years and plunge the state's debt-ridden budget an additional $400 million into the red.

Any day now, state officials are expecting to receive a letter from Washington formally refusing to pay for three years' worth of Medi-Cal bills from county public health programs. For many counties in the Bay Area — which already have spent a fortune providing services on the assumption the money eventually would be repaid by the federal government — that decision will leave gigantic holes in their budgets this year and next, possibly forcing layoffs or severe curtailment of health care programs for the poor.

In San Mateo County, health services Director Margaret Taylor said she is bracing for up to $10 million in cuts starting June 1 if federal money owed for the past three years doesn't materialize. The county could cut one-fourth of clinic services used by 24,000 people a year and eliminate half of the beds for seriously mentally ill people at the county's lock-in facility.

It could lose more than 20 public health nurses who make house calls for people with AIDS, disabled people and battered women. It could cut basic non-emergency services for abused elderly people and people with Alzheimer's disease. And the county hospital could start diverting emergency room patients to other hospitals in the area.

All told, the cuts could lead to 100 layoffs and

See MEDI-CAL, Page 11A

INDEX

How one young trader rocked financial world

■ The audacious strategy of Nicholas Leeson, a 28-year-old Briton, came crashing down Sunday night and caused the collapse of his employer, the investment bank Barings PLC. Regulators on Monday were trying to find Leeson, who disappeared last week, though as of that time he faced no criminal charges for his ill-fated gamble on Japanese stock prices.

BUSINESS, PAGE 1E

Woody-Mia miniseries unexpectedly first rate

■ He never thought he'd be doing it, but television critic Ron Miller gives a rave review to "The Mia Farrow Story." The Fox two-parter — unauthorized by the story's principals — starts tonight and concludes Thursday.

LIVING, PAGE 1D

ASSOCIATED PRESS

Nicholas Leeson put $29 billion of his bank's money on the line — and lost a billion.

WEATHER

■ Partly cloudy; highs 60-65. PAGE 8B

NEWS SUMMARY

■ Complete summary of today's news. PAGE 2A

Government disputes m

■ MEDI-CAL

from Page 1A

drastic service reductions. "It would be the worst cuts we've ever faced," Taylor said. "I know they didn't cut this much after Proposition 13."

Although Medi-Cal recipients still would be able to receive services and medication from private doctors who agreed to serve them, they would have a much harder time getting appointments at clinics or the county hospital, Taylor said.

"The private (health) community's going to end up seeing more Medi-Cal patients," she said. "This is really a problem for all of us in health care."

Santa Clara County faces a potential loss of $16 million for its three years of unpaid expenses, on top of an expected $30 million to $40 million shortfall in the county's $1.2 billion budget for the fiscal year that begins in July.

But officials there were more conservative about where the cuts might fall, noting that the $16 million makes up less than 1 percent of the annual budget. "We're not going to react by shutting anything down at this point," said Gary Graves, the county budget director. "For now, we're going to push it into next year and take a good look at services and develop a plan that makes sense."

In both counties, the Medi-Cal administrative funds have been used to pay for a wide variety of services for the needy, such as alcohol and drug prevention programs, mental health workers and services for people in homeless and battered women's shelters.

Only five counties — Alpine, Mariposa, Modoc, Mono and Sierra — did not participate in the program. All other counties are likely to wind up holding the bag.

State budget sleight of hand

The costly debacle is yet another example of what happens when state lawmakers — instead of raising taxes or cutting services — try accounting tricks to balance severely strained budgets.

In this case, a bill that was passed unanimously by the California Legislature and signed by Gov. Pete Wilson in October 1991 shifted a slew of expenses that were being paid by the counties onto the shoulders of the federal government.

"When budgets get tight, it's sort of a cottage industry to find ways to get the Medi-Cal program to pay for things," said Bill Wehrle, a Medi-Cal expert for the Legislative Analyst's Office. "This particular innovation turned out to be a little more creative than the feds cared for, at least so far."

The bill bluntly said its purpose was to restructure Medi-Cal's billing processes to achieve "maximum possible federal financial participation." Sponsored by former state Sen. Dan McCorquodale, D-Modesto, the measure reclassified a lot of the work already being done by public health nurses and social workers to make it appear they were doing work the federal government would pay for.

Officials familiar with the bill said the idea originated in San Mateo and Los Angeles counties and was eagerly seized upon by state health officials and the Wilson administration as a way of saving dwindling state resources.

There was only one problem: The federal Health Care Financing Administration, the agency that pays for Medi-Cal, never agreed to go along with it.

Assumed federal approval

Margaret Pena, a lobbyist with the California State Association of Counties, said state and county officials apparently were under the impression that HCFA had approved the scheme, since officials with HCFA's regional office in San Francisco had an active role in helping the state formulate the plan.

But at a high-level meeting in Washington in January, Pena said, top HCFA officials made it clear the idea had never been sent up the line for approval in Washington.

"We were told that it was one thing to provide input and advice but that it was something else to approve it," Pena related. She said HCFA brass told state and county officials there was no way the federal government was going to pay California's bills because that would open the floodgates to the other 49 states.

"They said they were looking at an exposure of $10 billion," Pena said.

HCFA paid the first bill the state sent it, for $17 million, but when it got a second bill for $315 million, red flags went up all over the agency, according to an HCFA official who asked not to be named.

EXPECTED IMPACT

The federal Health Care Financing Administration is expected this week to deny up to $2 billion worth of Medi-Cal reimbursement claims from most of California's 58 counties. Here are brief summaries of the impact on counties:

Alameda County

- The county faces a potential loss of $10 million this year and $12 million next year. While the loss could force the county to lay off employees and cut programs, it is too early to discuss specific cuts. The administrative funds have been used for:
- Public health nurses, mental health workers, social workers, and dental prevention programs in local schools.
- About 25 percent of the money pays for programs at county hospitals, including translation services and helping determine whether people are eligible for Medi-Cal.

San Mateo County

- The county faces $10 million in cuts starting June 1, which would precipitate about 100 layoffs. Cuts could include:
- Cutting by 25 percent outpatient clinic services for health care, mental health services and public health. Some clinics could be closed or their hours severely limited.
- Cutting in half the number of available spaces for lock-in mental health patients, from 100 beds to 50.
- Eliminating all public health nursing services, such as home visits for people with AIDS, not covered by grant funds.
- Diverting emergency patients from the county hospital to private hospitals.
- Eliminating adult and senior protective services such as care for abused elderly people or people

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Santa Clara County

- The county faces a potential loss of $16 million for the three years. That would be on top of an expected $30 million to $40 million shortfall in the county's $1.2 billion budget for fiscal 1996, which begins in July.
- Valley Medical Center Director Robert Sillen said there could be potentially serious cuts in personnel or services, but administrators hoped ongoing negotiations would lead to restoration of at least some of the funding.

Santa Cruz County

- The county faces $2.5 million in cuts and is waiting for further updates before deciding what action to take.

Source: Mercury News Staff Report

San Jose (17)
Mercury
News
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...edical bills

ADMINISTRATIVE COSTS

These figures represent the maximum reimbursements counties could seek in Medi-Cal administrative costs for this fiscal year and the total amount for four fiscal years. The amounts listed here do not represent the counties' actual budgeted expenditures.

County	1995-'96	Total
Alameda	17.0 million	49.6 million
Contra Costa	8.0 million	32.0 million
Monterey	3.2 million	10.3 million
San Benito	300,000	600,000
San Francisco	0	27.4 million
San Mateo	5.9 million	18.1 million
Santa Clara	13.2 million	48.7 million
Santa Cruz	4.2 million	14.7 million
Statewide	**829.6 million**	**2.7 billion**

Source: Legislative Analyst's Office

MERCURY NEWS

The agency dispatched a team of auditors to Los Angeles County — which turned in the biggest portion of the bill by far — and afterward announced it was withholding payment on the state's entire bill because the charges appeared improper.

The auditors found Los Angeles was charging Medi-Cal for such things as the time probation workers spent with prison inmates, the lectures deputy sheriffs gave schoolchildren on the evils of drugs, and arranging for baby sitting for indigent patients.

In response to the extensive audit findings, state Health and Welfare Director S. Kimberly Belshe said HCFA had no right to tell the state how to run its program and that the San Francisco office had given "implicit approval" to the idea.

If the money is not paid, Belshe warned, it "puts county health programs at risk of closure."

It also throws an already unbalanced state budget even further out of whack. Despite HCFA's apparent rejection of the state's claims last year, Wilson's budget writers went ahead and included in the 1995-'96 budget released in January a figure of $200 million a year they expected to receive from the counties as part of the federal Medi-Cal payments.

Pena said the counties believe they do not have to pay this money to the state unless they get the money from HCFA first, "and so far, no one from the state has disagreed with that interpretation."

That means state budget writers will have to trim the money from the budget or find another source to tap for the revenue.

Pena said the state and counties intend to appeal HCFA's decision to the courts and estimated it will be two or three years before the case is decided.

"However, they won't be paying us the money in the meantime," she said.

Mercury News Staff Writer Elizabeth Wasserman and Thomas Farragher of the Mercury News Washington Bu-

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Refer to: MCD-F-TGC

Region IX
Office of the
Regional Administrator
75 Hawthorne Street
San Francisco, CA 94105

MAR 0 1 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Ms. S. Kimberly Belshé
Director
Department of Health Services
714 P Street, Room 1253
Sacramento, California 95814

RE: CA-95-001-ADM

Dear Ms. Belshé:

This letter constitutes your notice of disallowance in the amount of $315,233,627 Federal financial participation (FFP) under Title XIX of the Social Security Act (the Act). These funds were claimed by the State of California and they cannot be allowed. The claims involve Medicaid administrative costs related to the Medi-Cal Administrative Claiming (MAC) system. The costs are for the period of July 1, 1992 through March 31, 1994. We deferred these claims when you submitted them earlier and we undertook an extensive review of your claim and the MAC system. Our review revealed a myriad of problems that are outlined in more detail below.

Your Department submitted a Line 7 prior period claim for $315,233,627 FFP for Medi-Cal Administrative Claiming (MAC) activities on your Quarterly Statement of Expenditures for State and Local Administration of the Medical Assistance Program (Form HCFA-64) for the quarter ended June 30, 1994. These MAC claims covered the period July 1, 1992 through March 31, 1994. A detailed schedule of the claims being disallowed is enclosed.

By letter dated October 7, 1994 you were notified of our decision to defer the entire $315,233,627 FFP in accordance with 42 CFR 430.40. This deferral was reflected in your Medicaid grant award dated October 28, 1994. By letter dated December 2, 1994, which was received by us on December 5, 1994, you provided your response to our deferral letter.

We have fully considered your December 2 response to our deferral letter. We have performed on-site reviews of the MAC claims and the MAC process in Los Angeles County (August 29 to September 1, 1994) and San Mateo and Alameda Counties (October 24-27, 1994). We have reviewed additional documentation provided by the State to our outstation staff in Sacramento. We met with State and Los Angeles County staff in San Francisco on August 17-18, 1994 and in

Washington, DC on October 18, 1994 and January 18, 1995 to discuss the MAC process. Finally, we have considered the information provided by our Office of Inspector General (OIG) regarding their review of 11 contract MAC providers in Los Angeles County which was also discussed with State staff in briefings conducted by the OIG on December 13 and 23, 1994. Based upon all of this information we are disallowing your entire claim of $315,233,627 FFP for the reasons stated below.

Applicable Law, Regulations, and Guidelines

Sections 1903(a)(2) through 1903(a)(7) of the Act identify a number of administrative costs which may be matched by the Federal government at various administrative matching rates. For the costs in issue in this claim, the statute explicitly directs payment only for costs "found necessary by the Secretary for the proper and efficient administration of the State plan." Thus the Secretary, not the individual State, determines which State administrative expenditures are to be allowed. This position is incorporated into the Medicaid regulations at 42 CFR 431.15 and 42 CFR 433.15.

Medicaid regulations at 42 CFR Parts 431 through 434 give specific guidance to States on general administration, personnel administration, fiscal administration, and contracts. Additionally, 42 CFR 430.2 provides for the applicability of 45 CFR Parts 74 and 95 to the Medicaid Program and provides guidance to the States on administration of grants. Specifically, these regulations provide as follows:

- 42 CFR 433.32 and 45 CFR 45 Parts H and I provide that States will maintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable federal requirements. In addition, States are required to have: (1) accounting records which adequately identify the source and application of funds for grant and subgrant activities, (2) procedures for determining the reasonableness, allowability, and allocability of grant costs, and (3) accounting records supported by source documentation.

- 42 CFR 433.34 and 45 CFR Part 95 Subpart E provide that the State must have an approved cost allocation plan (CAP). In addition, 45 CFR 95.505 specifically excludes medical vendor payments from the definition of State agency costs that can be included in a CAP. Also, 45 CFR 95.507 requires that the CAP contain sufficient information to permit an informed judgment on the correctness and fairness of the State's procedures for allocating costs, specify the procedures used to identify, measure, and allocate all costs to each benefitting program and activity, and that all costs

claimed are supported by an adequate accounting and statistical system.

- 45 CFR 74.53 and OMB Circular A-87, Attachment A, (A)(1), which is incorporated into the Medicaid regulations at 45 CFR 74. 171, provide that State cannot claim twice for the same service or activity.

- 42 CFR 432.45 provides for claiming 75 percent FFP for skilled professional medical personnel (SPMP) and their directly supporting staff. These requirements provide that the SPMP expenditures are for activities directly related to the administration of the Medicaid program and do not include expenditures for medical assistance and that the activities claimed require professional medical knowledge and skills.

The statute provides a completely separate mechanism for payment of the Federal share of the costs of providing medical services to Medicaid recipients. Medical assistance is defined in Section 1905(a) of the Act to mean "payment of part or all of the cost of the following care and services...." The services are defined in §§ 1905(a)(1) through (25).

Under 42 CFR 447.15, a State plan must provide that the State Medicaid agency limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the State plan to be paid by the individual. There is no exemption for administrative or overhead costs to allow these costs to be claimed separately to the Medicaid program. Additionally, 42 CFR 447 Subpart B provides that the State plan must describe the policy and methods to be used in setting payment rates for each type of service in the State's Medicaid Program and that the State must maintain documentation of the payment rates and make it available upon request.

Sections 1915(g)(1) and (g)(2) specify that targeted case management can be provided as an optional service under an approved State plan. Section 4302 of the State Medicaid Manual gives guidelines on case management services and activities and acknowledges that under certain circumstances case management services may more appropriately be claimed as administrative costs. These guidelines provide that:

- Case management provided under section 1915(g) is defined as services which will assist individuals eligible under the State plan in gaining access to needed medical, social, and other services and must be documented as any other Medicaid service.

- When case management is provided as an administrative activity, the State documentation must clearly demonstrate that the activities were provided to Medicaid applicants or eligibles, and were in some way connected with determining eligibility or administering services covered under the State plan.

- Administrative case management does not include obtaining social services not covered under the State plan. Referrals for Food Stamps, energy assistance, housing, child care or legal services are not covered even if these services may be in the best interest of the recipient.

- We must evaluate the activities for which case management FFP is claimed to determine whether the claims meet the requirements for payment either at the administrative or service case management match rate.

Finally, Section 1905(a)(24)(A) prohibits payment of medical assistance costs to Medicaid eligibles who are inmates of public institutions, except medical institutions. These requirements are incorporated into the Medicaid regulations at 42 CFR 435.1008 and 435.1009.

Discussion

Claiming Medical Services as Administration

Our site visits to locations where the MAC system was in place revealed that many activities coded by hospital outpatient clinic and freestanding county public health clinic employees were already being reimbursed by Medi-Cal through the all-inclusive clinic rate as part of a clinical encounter. However, we found that these activities were also being claimed by your Department as Medi-Cal administrative activities.

We found that the physicians at the clinics performed the actual diagnosis, treatment, and prescribing functions. They then referred the patient to a physician extender, typically a registered nurse or a pharmacist. The physician extender would then explain the diagnosis and the medication to the patient, educate the patient on the health issues surrounding the diagnosis, assist the patient in making any additional appointments, make any necessary medical referrals, and provide any additional information to the patient deemed necessary. These activities are part of the standard medical protocol and as such are direct patient care services and were reimbursed as part of the fee-for-service or managed care rate. These medical services furnished by physician extenders cannot be separated from the rate paid for medical services and claimed as Medi-Cal administration.

Additionally, a significant portion of ordinary overhead activities in the outpatient clinic setting were being coded and claimed as administrative activities under MAC. For example, routine supervision, personnel activities, training, meetings, etc. were all coded as allowable MAC activities. These types of costs are included in the all-inclusive clinic services rate and should not be claimed separately.

Claiming for Targeted Case Management

The distinction between unallowable targeted case management (TCM) activities and allowable administrative case management (ACM) activities was not defined in the MAC time study coding process nor was any distinction applied by the workers in coding their activities for the MAC process. Allowable ACM activities are those which are necessary for accessing and coordinating access only to Medi-Cal State plan covered services. We found workers coding as allowable Medi-Cal ACM, activities that were well beyond the scope of Medi-Cal State plan covered services (e.g., housing referrals, social services referrals, child care referrals, energy assistance referrals, legal service referrals, and the related liaison work with agencies providing those services). Such activities are not allowable Medi-Cal expenditures except as TCM services if provided for under an approved TCM State plan amendment covering the period of the claim. California does not have an approved State plan amendment for TCM services to general outpatient populations. Therefore, only the more limited administrative case management services, not the broader TCM services, may be claimed for federal match.

Duplicate Claiming of Agency Costs

We reviewed several social service programs claiming MAC expenditures, including the Linkages and SSI Advocacy Programs, as well as 11 contracts in Los Angeles County within the Alcohol and Drug Program Administration and the Department of Mental Health. We found that these programs commonly received other Federal and State grant funds for their activities from such sources as the State Department of Aging, the Social Security Administration and various other Federal and State aging and alcohol and drug program grants. When activities of these programs were coded as allowable MAC expenditures and were also reimbursed through these other funding sources, it resulted in duplicate claims and also in claims in excess of the total costs of the programs and activities.

Another potential source of duplicate claims was identified in those counties which have contracted with managed care providers to provide Medi-Cal services. Although these contracts commonly require and pay for primary case management, there is no mechanism in the MAC coding system to identify managed care recipients in order to avoid providing and charging for duplicate services.

Broad Public Health Activities

The activities performed by County workers as part of broad public health policy initiatives are not direct Medi-Cal administrative activities and as such are not allowable. For example, school-based alcohol and tobacco prevention programs directed toward the entire school population, adult smoking cessation programs, community-based dental disease prevention programs, developmental disabilities outreach, training, and education programs, injury prevention programs, and child passenger restraint system programs, were all being coded and charged as Medi-Cal administration through the MAC process. Such public health education campaigns would only be allowable if directed toward assisting Medicaid eligible individuals to access the Medicaid program, or if they qualify as recognized Early Periodic Screening, Diagnosis and Treatment (EPSDT) outreach and education activities.

Claiming Non-Skilled Professional Medical Personnel Activities at 75 Percent Rate.

Our review found that personnel at a number of sites coded any activity performed by a physician, registered nurse, or other person designated as "skilled professional medical personnel" (SPMP) as an activity to be claimed at the enhanced SPMP matching rate of 75 percent. The 75 percent SPMP matching rate, even when applied to SPMP, is limited to those SPMP administrative functions which require the SPMP's professional medical knowledge and skills in administering the program. When SPMP are attending meetings, performing general administrative activities, doing personnel work, doing general supervisory or administrative activities, such activities are not reimbursable at 75 percent FFP.

Inmates in Public Institutions

Activities being performed by probation or correctional officers in various juvenile or adult detention facilities were being coded as allowable MAC activities. However, such detention facilities are public penal institutions, and any medical services or MAC administrative activities provided to the inmates in such public institutions are not allowable Federal Medicaid expenditures.

Time Study and MAC Code Validity

Enough of the individual MAC codes include both allowable and unallowable activities within the same code to render the entire system invalid. For example, Code 8 includes both allowable translation services and unallowable child care services. In addition, several codes indicate that activities performed by County workers related to "other State and Federal programs" are allowable MAC activities. However, only activities performed in support of the approved Medi-Cal State plan are allowable

administrative activities.

The MAC system is modeled on time study systems approved by the Departmental Appeals Board for apportioning social workers' activities to Medicaid/non-Medicaid clients. When used by clinical service providers, however, the system identifies as administrative activities many activities which are considered clinical services. For example, the Physicians' Current Procedural Terminology, Fourth Edition (CPT4), which is a commonly used system for reporting clinical activities performed by physicians for billing and other payment purposes, identifies obtaining case histories, educating patients, providing referrals to specialists, consulting with other clinicians and service providers, and counseling patients as clinical activities. As clinical activities, these functions should be included in the clinic payment rate, and not billed as Medicaid administrative costs.

The codes also fail to distinguish between activities related to administration of the provider facilities and administration of the Medicaid program. Supervision, training, and personnel functions which are required to operate the facility regardless of the number of Medicaid eligibles served are costs of administering the provider. They may not be charged separately to the Medicaid program. Medicaid administration costs, in contrast, are costs essential to administering the Medicaid program, such as facilitating eligibility determinations, or organizing programs or services required to meet federal Medicaid standards.

Claiming for Periods Without Time Study Documentation

The State's term for retroactive claims not supported by contemporaneous time study documentation is "backcasting". The issue involves a methodology for claiming costs for time periods after the effective date of the California legislation authorizing counties to claim Medicaid administrative costs, but before the MAC Manual's time reporting system was in operation. Various counties performed time studies and accumulated documentation of Medi-Cal beneficiaries receiving services for one or more quarters during the State's fiscal year ended June 30, 1993. The State proposed to project costs for a 12 month period using the data available from the last quarter of that period. The State has not provided any documentation which supports the use of time study data from current quarters to establish the allowability of the claim for prior quarters where no time study data exists.

Conclusion

This letter constitutes notice of disallowance in the amount of $315,233,627 FFP. Please make a decreasing adjustment in that amount on line 10B of your next Quarterly Medicaid Statement of Expenditures (Form HCFA-64). However, since these funds have not

been paid to the State, this adjustment will not be used in your grant award computation.

This is my final decision. Under 45 CFR Part 16, the State has an opportunity to appeal to the Departmental Appeals Board. This decision shall be the final decision of the Department unless, within 30 days after you receive this decision, you deliver or mail (you should use registered or certified mail to establish the date) a written notice of appeal to the U.S. Department of Health & Human Services, Departmental Appeals Board, Room 637-D, Hubert H. Humphrey Building, 2nd & Independence Avenue S.W., Washington, D.C. 20201. You must attach to the notice a copy of this decision, note that you intend to appeal, state the amount in dispute, and briefly state why you think that this decision is wrong. The Board will notify you of further procedures.

Please send a copy of any notice of appeal to this office.

Should you require further details regarding this matter, please contact the Acting Associate Regional Administrator for the Division of Medicaid at (415) 744-3568.

Sincerely,

Nancy Dapper

Nancy Dapper
Acting Regional Administrator

Enclosure

SUMMARY OF MAC DISALLOWANCE BY COUNTY
QUARTER ENDED JUNE 30, 1994

County	Amount
Alameda	$ 1,458,529
Amador	12,785
Calaveras	84,522
El Dorado	79,632
Fresno	422,315
Humboldt	135,734
Imperial	97,807
Inyo	22,230
Kern	847,356
Kings	12,401
Los Angeles	289,775,816
Marin	276,965
Mendocino	77,115
Merced	370,928
Napa	1,079,624
Orange	3,805,146
Placer	947,750
Riverside	1,875,815
Sacramento	165,833
San Bernardino	1,524,474
San Diego	1,187,022
San Joaquin	539,926
San Mateo	257,332
Santa Clara	1,340,058
Santa Cruz	1,328,574
Shasta	188,078
Sonoma	888,264
Stanislaus	3,075,716
Tehama	53,350
Trinity	22,673
Tulare	17,357
Tuolumne	113,610
Ventura	3,081,028
City of Berkeley	67,862
Total	$315,233,627

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 1 1995

The Honorable Pete Wilson
Governor of California
State Capitol, First Floor
Sacramento, California 95814

Dear Governor Wilson,

I am writing to inform you that, pursuant to applicable law, the U.S. Department of Health and Human Services must disallow payment of the September 2, 1994 claim for $315 million which was submitted by the State of California as additional administrative costs of the State's Medi-Cal program. This determination, and the timing of the determination, are required by the Medicaid statute. The legal basis for this decision is more fully described in the Health Care Financing Administration's letter to the California Department of Health Services, a copy of which is attached.

Although we are required to disallow the claim we received in September, let me assure you that I am extremely sensitive to the serious fiscal situation faced by several counties. This Department wishes to work with you to provide legally appropriate assistance to preserve the health care safety net in the affected counties. I want you to know that the Administration is immediately taking several steps to assist California and its counties in addressing the fiscal situation you face:

- The Administration has assembled a team that is ready to provide assistance immediately to the State and its counties regarding options to address the counties' fiscal situations. As you may know, we will meet with your staff and representatives of the affected counties tomorrow, to review ways the State could identify, independent of the MAC system, legitimately allowable activities imbedded in the MAC claim. At the meeting, we should also consider options available to the State to increase funding for the counties (including design of a targeted case management system and increases in provider reimbursement rates), and the establishment of a legally appropriate mechanism for making future administrative cost claims.

- A group of Administration officials has also scheduled a meeting in Los Angeles with Los Angeles County and State officials to discuss what options might be available following the disallowance of the State's September 1994 claim. The Administration believes it is important to make every effort, and to work as hard and as quickly as possible, to explore all avenues for addressing this situation.

As set forth more fully in HCFA's letter to the California Department of Health Services, we are required to disallow payment of the administrative claim because California's new Medi-Cal Administrative Claiming (MAC) system, which was used to identify Medi-Cal administrative costs incurred by counties, is seriously flawed. The claim generated by the MAC system includes inaccuracies and in large measure appears to represent activities that were part of clinic services for which Medicaid payment has already been made. In addition, a significant portion of the remainder reflects services unrelated to the administration of Medi-Cal.

The magnitude of the State's requested increase for administrative costs is of some concern. Nationally, the state average for Medicaid administrative costs is approximately 4.5 percent of Medicaid services costs. California's administrative costs, even without MAC, were approximately 6.3 percent of its Medicaid services costs. However, California projects that its administrative costs would run at the extraordinary rate of approximately 14 to 15.5 percent of Medicaid services costs when MAC claims are regularly submitted by all counties. This would be more than three times the average for Medicaid administrative costs in other states, and more than twice the historic rate of administrative costs for Medi-Cal.

I look forward to working with you and with county officials in our ongoing activities to assist the counties in preserving quality health care services.

Sincerely,

Donna E. Shalala

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

March 1, 1995

Contact: HCFA Press Office

(202) 690-6145

FEDERAL MEDICAID FUNDS DENIED

As required by the Medicaid statute, the Health Care Financing Administration (HCFA) has determined that it must disallow the claim of $315 million in federal Medicaid matching funds submitted by California on September 2, 1994.

Although HCFA is required to disallow this claim, it is sensitive to the serious fiscal situation of the affected counties and has offered to provide any appropriate assistance to the State and to the counties to preserve the health care safety net. The Department of Health and Human Services (HHS) is moving forward on several fronts to provide assistance:

- An Administration team has been assembled that is ready to provide assistance immediately to the State and its counties regarding options to address the counties' fiscal situations. This team has scheduled a meeting with State staff and representatives of the affected counties on March 2 to review ways the State could identify, independently of the Medi-Cal Administative Claiming (MAC) system, legitimately allowable activities imbedded in the MAC claim. The group will also review options available to the State to increase funding for the counties (including design of a targeted case management system and increases in provider reimbursement rates), and the establishment of a legally appropriate mechanism for making future administrative cost claims

- A group of Administration officials has also scheduled a meeting in Los Angeles with Los Angeles County and State officials to discuss what options might be available following the disallowance of the State's September 1994 claim. The Administration believes it is important to make every effort and to work as hard and as quickly as possible to explore all avenues for addressing this situation.

The State's claim purported to cover additional administrative costs incurred by counties under the State's Medi-Cal program. However, HCFA found that:

- for the most part, the claim does not represent additional administrative costs, but rather costs that were part of clinic services for which Medicaid payment has already been made;

- federal share has already been paid for the majority of services claimed; and

- a significant number of the claims are for services not covered by Medi-Cal, including non-medical social services.

The source of the problem is California's new Medi-Cal Administrative Claiming (MAC) system, which is seriously flawed.

HISTORY AND BACKGROUND -- California recently began using an administrative claiming system which purported to identify the costs incurred by counties in the administration of the Medi-Cal program. The new system used periodic time studies to identify the activities of county employees and their contractors which were then to be claimed as Medicaid administrative costs.

- Much of the public health and human services system in California is administered by county governments. California developed the MAC system in an effort to identify county Medi-Cal administrative costs for the purpose of claiming a federal match.

- A claim of $315 million was made by the State on September 2, 1994, representing costs identified by the MAC system for 34 counties and covering the period July 1, 1992 to March 31, 1994. Los Angeles County costs represent 92 percent of the claim.

- While portions of the MAC system had been described to federal officials during its development, a full working view of the MAC system as applied was not provided to HCFA until August 1994, at which time HCFA began expressing its concerns about the system. The first request for approval of the entire MAC system was not made until October 1994, a month after the $315 million in claims were submitted to HCFA.

- HCFA conducted reviews of 30 facilities in 3 counties, as well as a MAC fiscal review in each of the counties, to determine the reliability and validity of the MAC system. The most extensive review work was carried out in Los Angeles County. In addition, a limited scope review of the system was conducted by the HHS Inspector General. The reviews established that the MAC system as applied is severely flawed and that most of the claims it has generated are not valid Medi-Cal administrative costs.

- Based on these findings, HCFA deferred payment of the $315 million MAC claim in October 1994, and gave California an opportunity to respond to HCFA's findings. The State responded, but its information does not support the validity of the MAC system claims.

- o If MAC-generated claims were approved, California would be spending, on average, three times more than other states in Medicaid administrative costs. The MAC-generated claims would also represent twice the previous rate of administrative spending by California itself.

- o The State estimates that the annualized Federal cost of MAC system claims would be approximately $750 to $825 million when MAC claims are regularly submitted by all counties.

SYSTEMIC PROBLEMS in MAC -- Among the fundamental problems with the MAC system are the following:

1. The system lacks the capability to distinguish between allowable Medicaid administrative costs and costs for services that have already been reimbursed by federal and other sources.

2. The categories of activities which the system codes as Medicaid claimable are so broad as to capture both claimable and non-claimable time, indiscriminately.

3. The time alleged to be Medicaid claimable is not directly associated with specific Medicaid eligibles, but is projected to Medicaid eligibles based on the gross percentage of eligibles served by an agency. Reviews indicated that this often results in an inaccurate and inflated attribution of costs to Medicaid.

Reviews of MAC-generated claims so far show that the largest portion of the claims to date appear to represent not administrative costs, but medical services or overhead costs for which Medicaid payment has already been made as a medical service or clinical service payment. In addition, significant portions of the claims represent activities with tangential or no connection to the Medicaid program. Examples include:

- o Pharmacists at clinics would claim the time they used in counseling patients about the drugs that had been prescribed as Medi-Cal administration, even though these activities are already reimbursed through clinic payments or pharmacy dispensing fees.

- o Nurses were claiming activities related to giving immunizations and reporting medical test results as Medi-Cal administration. Both actions are part of providing a Medicaid service and are not Medicaid administration. The cost of these actions is already reimbursed through the medical services rate and cannot be claimed again as administration.

- o Claims were submitted for activities outside the scope of services covered by Medi-Cal, such as referrals for housing, social services, child care and legal services.

- Correctional officers in juvenile or adult detention facilities were coding some of their time as allowable Medi-Cal administrative activities. But services to inmates of public institutions are not covered by Medicaid.

- Portions of general state public health education campaigns concerning alcohol, tobacco, or drug abuse prevention were being claimed as Medi-Cal administrative costs even though they had no direct relationship to the Medi-Cal program.

###

Is that right? LA will lose on Track 2, but only ½ their $ is in Track 1 $315m

Covington

3/1/95

Phyllis Sally Marilyn Brown

So they want pipeline in DOJ Track 1

mutually acceptable accomm.

~~Tomorrow~~
nuggets
~~to~~ CM
~~fast~~ track pipeline claims guarantee? not ~~[illegible]~~
other (rate rise)
→ Tofralimit

Confusion - how to talk to DOJ w/o 1st waiving + then lose DAB rights
Fear of skipping steps
Why don't we give up rt
Part of prob is only Steve is comfortable describing settlement

next month or couple of months

* When wld lawsuit be needed?
* How to get claims not yet filed on DOJ radar? → SN
Could they file lawsuit

It's a bit confusing that we aren't presenting a clearer roadmap for them - all we can do is offer to clarify promptly their questions.

202 974-4444

-2-

Should we

Offer, if LA files rest of claim now + we disallow, we will add to DOJ?

Premature?

~~How~~

Followup lawyer mtg in SF tom?

can't give absolute answer -

~~are they req'd to exhaust admin remedies?~~

probably yes, could still sue but need to confirm?

Issue:
Could state still go to fed ct if it bypasses NVS admin appeal and no settlmt achieved?

Can you call Schmidt at home now through DOJ Command center & tell him what was come up 202-514-5000?

DRAFT -- FOR DISCUSSION ONLY
PRIVILEGED AND ~~CONFIDENTIAL~~ -- ATTORNEY-CLIENT/WORK PRODUCT

TALKING POINTS FOR L.A. SETTLEMENT MEETING

Thank you for joining us today. This Administration cares greatly about the welfare of California and of L.A. County, and we are very happy to have an opportunity to meet with you in person to discuss what options might be available following HHS's decision to disallow the State's Medicaid claim for "administrative" costs.

As HHS has advised the State, the Department's decision to disallow the Medicaid claim, and the timing of that disallowance, were compelled by statute.

HHS's decision to disallow the claim is a final decision that will not be reconsidered by the Department.

Assuming the State is inclined to pursue an appeal of the disallowance of its claim, the administration is prepared to begin working immediately -- and to work diligently -- with State and County officials to see if it is possible to reach a settlement of this dispute and avoid the need for lengthy administrative hearings or court proceedings.

The principle authority of the Federal government to settle disputes rests with the Department of Justice. Normally, however, the Justice Department does not become involved in settlement discussions until after administrative remedies have been exhausted. Thus, the Justice Department normally does not discuss settlement of Medicaid reimbursement claims until after a state claimant has had its case heard and ruled on by the HHS Departmental Appeals Board.

In this case, however, the Department of Justice and HHS are prepared to explore settlement options promptly with the state. Of course, the HHS disallowance was based on the merits of the claim, and therefore the options and prospects for a meaningful settlement may be limited. But we believe it is important to make an effort, and to work as hard and as quickly as possible, to see if a mutually acceptable settlement of this dispute might be achieved.

The Department of Justice would be prepared to begin settlement talks promptly if the State is prepared to move this case immediately beyond the stage of HHS administrative proceedings. What this means, in practical terms, is that the State would waive its right to a hearing before the HHS Departmental Appeals Board so that negotiations with the Department of Justice can begin immediately.

The Department of Justice and HHS are prepared to work in good faith with you during the coming weeks. And, of course, these discussions would proceed on a confidential basis with the understanding that anything said or any actions taken during these discussions would not be used in any future proceedings concerning the validity of the state's claim that was just disallowed, or the amount of that claim.

PRIVILEGED AND ~~CONFIDENTIAL~~ -- ATTORNEY-CLIENT/WORK PRODUCT FOR DISCUSSION ONLY

TALKING POINTS FOR MEETING IN SAN FRANCISCO OR SACRAMENTO

Thank you for joining us today in this important meeting to discuss Medicaid (Medi-Cal) reimbursement for administrative costs.

As we hope experience has shown, this Administration cares greatly about the welfare of California. We are very happy to have an opportunity to meet with you in person.

As most of you are aware, HHS [yesterday] formally disallowed California's $315 million claim for federal reimbursement of "administrative expenses" generated by the state's new Medi-Cal Administrative Claiming, or "MAC," system. The bulk of this claim -- almost $300 million -- comes from MAC in L.A. County.

The disallowance by HHS, and the timing of that disallowance, were compelled by statute. Among other factors, HHS found that the greater part of the claim appeared to represent activities that were part of clinic services for which Medicaid payment had already been made. In addition, a significant portion of the remainder reflected services unrelated to the administration of Medi-Cal.

Although HHS was compelled by law to disallow the claim it received from California this past September, HHS, and this Administration as a whole, is committed to working with California officials at the state and county levels, to (1) identify legitimately allowable administrative activities imbedded in the MAC claim that are independent of the MAC system, (2) examine options available to the State and Federal government to increase funding for the counties (including design of a targeted case managment system and increases in provider reimbursement rates), and (3) to establish a legally appropriate mechanism for making future administrative cost claims.

HCFA officials are here today to discuss with you in greater detail the options available going forward. I am here, along with Diana Fortuna of the White House Domestic Policy Council, to underscore this Administration's commitment to working with California to address these difficult and important issues. I know that HHS officials are prepared to work with you as much and as promptly as necessary to see if progress can be made in avoiding the problems with the MAC system in the future.

We recognize that these problems will require efforts at both the state and county level, and that much of this work must be resolved between the state and counties themselves. But we are prepared to work with all parties to assist in the development of any new State Plan amendments or claims that may arise from this process, and to review them quickly.

The ultimate goal of this process is to determine whether we can identify legitimate activities that are eligible for Federal matching funds and to do so quickly.

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 657-1425

February 24, 1995

Mr. Bruce Vladek, Administrator
Health Care Financing Administration
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 309G
Washington, D.C. 20201

Dear Mr. Vladek:

On January 4, 1995, John Rodriguez, Deputy Director, Medical Care Services, sent a letter (enclosed) to Michael Piazza, then Acting Regional Administrator for the Health Care Financing Administration (HCFA), stating that the Department of Health Services would like to conduct a joint review with the Office of the Inspector General (OIG) auditors to address questions raised about Los Angeles County's Medicaid Administrative Claiming. As you know, the OIG has been reviewing certain county claims to determine whether they involved duplicate billing.

Since this issue has come to light, we have been very concerned that these allegations be dealt with expeditiously by both of our agencies. Knowing that you share our concern, I am troubled that we have not heard from HCFA in response to our request for joint action.

Because of the time that has already passed, I have instructed my staff to move forward with an investigation on our own immediately. However, I remain hopeful that we can do so in a joint effort with OIG, rather than as a parallel undertaking. Please let us know as soon as possible how we can facilitate such cooperation.

Sincerely,

S. Kimberly Belshé

S. Kimberly Belshé
Director

Enclosure

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 654-0391

JAN 0 4 1995

Mr. Michael A. Piazza
Acting Regional Administrator
Health Care Financing Administration
75 Hawthorne Street, Fifth Floor
San Francisco, CA 94105

Dear Mr. Piazza:

On December 23, 1994, Thom Coupar from Health Care Financing Administration (HCFA), Region IX, Doug Leonard and Jerry Hurst of the Office of Inspector General (OIG) met with me and members of my staff. The OIG presented DHS with an overview of their findings from a review of Medi-Cal Administrative claims submitted by Los Angeles County (LAC) to DHS, the single state agency, from various county contractors claiming federal reimbursement through the Title XIX Medi-Cal Administrative Claiming (MAC) program.

At the conclusion of the OIG's presentation, there remained some unanswered questions and a lack of agreement about the meaning of the findings. In order to clarify these matters, DHS is requesting that you authorize the OIG auditors to accompany DHS internal auditors and MAC staff in an expanded follow-up review.

The HCFA letter dated October 7, 1994 deferred payment of all claims submitted by DHS to HCFA for federal reimbursement under the Title XIX MAC program. Los Angeles County claims represented approximately 91.9 percent of all claims submitted by California which were deferred.

We are looking forward to your agreement to this follow-up review. Thank you for your cooperation and support. If you have any questions or concerns, please contact me at (916) 654-0391.

Sincerely,

Original signed by
John Rodriguez

John Rodriguez
Deputy Director
Medical Care Services

State

$16

$50