L.A. Times, 1/20, p. B3

Supervisors Weigh Cuts to Close Budget Gap

■ Finances: Officials seek ways to erase $641-million shortage arising from unpaid reimbursement claims for health program. Hiring freeze, layoffs are among possibilities.

By CARLA RIVERA
TIMES STAFF WRITER

Faced with a stubborn $641-million gap in this year's budget, the Los Angeles County Board of Supervisors set in motion a plan of action Thursday that could result in a reductions in health services, a hiring freeze and layoffs of county employees, possibly as early as next month.

The move toward a dramatic shake-up came as the board was buffeted with bad news about the financial outlook for the 1995-96 fiscal year, which begins July 1. All told, the county could wind up facing the new fiscal year nearly $1 billion in the red, give or take several hundred million dollars, county budget officials said.

With the specter of the Orange County bankruptcy ever present, supervisors appeared determined Thursday to try to rein in spending habits that have left the county on the brink of crisis for several years.

The county's predicament prompted newly elected supervisor Zev Yaroslavsky to condemn what he called the "Ponzi-like scheme we've been operating under."

"This should not come as a surprise to any of us that we're in this situation," Yaroslavsky said. "This is not the first year the county has been spending well beyond its means. Today's discussion is the kind that should have taken place a long time ago."

Yaroslavsky added that the county may have to mortgage its future to resolve its problems. "To the extent we get ourselves out of this hole, we've dug ourselves a Grand Canyon for 1995-96."

Yaroslavsky's heated denunciation prompted several of his colleagues to defend their actions and to argue that promised reimbursements from the federal government had seemed like "real" revenue when past budgets were replied an angry Deane Dana. "I've never seen a complete turnaround of something of this magnitude."

The latest emergency stems from a dispute with federal health authorities over Medi-Cal reimbursements the county says it was promised and that were included in the current $14.2-billion budget.

Los Angeles County is seeking $640 million in reimbursements for the administrative costs of running the health program over the last three years.

The federal Health Care Financing Administration disputes the size of the claim, contending that the county may have been double-billing the government, and argues that capitulating on the issue could set a nationwide precedent. Officials with the agency could not be reached for comment Thursday.

After months of lobbying by local officials, Chief Administrative Officer Sally Reed, who argued last year against counting the reimbursements in the budget, conceded to the board Thursday that there is little chance of the county receiving all of the money—and it may not get any.

"Our level of confidence in these . . . revenues is not as high as it was at budget time and continues to deteriorate," Reed said. "We have been advised verbally that it is their intent to deny the claim."

Beyond the rhetoric, the board knuckled down and asked Reed to come up within the next month with recommendations on how to fill the gap. Besides layoffs, other options include a moratorium on hiring consultants and on buying property and equipment.

Representatives of the county's largest employee union decried the threat of layoffs.

"We are not Orange County," said Gil Cedillo, general manager of Service Employees International Union, Local 660, which represents about half of the county work force. "We will oppose any proposals that attempt to have the workers of this county bear the burden of wrong fiscal policies."

Reed said some of the deficit could be filled by $110 million in unanticipated property taxes and several hundred million dollars in reserves in the health department.

But applying that option could

2/28/95

CALL TO GOVERNOR WILSON
TALKING POINTS

[Note: Last night HHS and White House officials informed Kim Belshe ("Bell-shay"), director of the state's Department of Health Services, that the claim will be disallowed tomorrow, so the Governor is probably aware of the disallowance. In that conversation, state officials agreed to attend both meetings we have scheduled, and were fairly constructive.]

- HHS must disallow the $315 million claim for Medicaid (Medi-Cal) administrative costs.

- The claim has serious problems:

  - The computer system (MAC system) used to generate the claim is flawed.

  - It appears to produce claims for activities for which Medi-Cal payment has already been made.

  - It also includes costs that are not related to the administration of Medi-Cal.

- HHS has no choice about this decision.

- The state's decision to assume approval of the claim, and thus to reduce state aid to counties in anticipation of that revenue, has created serious fiscal problems for the counties, particularly LA County.

- We want to work with you and the counties to ameliorate these problems and to try to preserve the health care safety net in these counties:

  - We are prepared to see what can be done to settle this matter quickly. On the assumption that you will appeal the disallowance, we have sent White House and HHS staff to meet with state and LA county officials tomorrow (Wednesday) in Los Angeles to discuss how we might expedite the legal process ahead.

    We can't control or predict what any discussions will produce. But we are cognizant of the need to move quickly, since the counties counted on these funds in this year's budget (which ends in June).

  - We are also prepared to have the White House convene high-level meetings between HHS, the state, and the counties to fast-track consideration of the merits of claims that have not yet been submitted to us; and to look for other sources of relief for the counties. We are holding a meeting on this on Thursday in San Francisco.

- We need you to work with us in this effort. It will be to no one's advantage if the counties have to close hospitals.

- HHS has a very strong case for its action:

  - claim is for activities for which the Federal government has already paid;
  - there are allegations of fraud in your system by a state employee;
  - the HHS Inspector General is conducting an investigation;
  - this can easily be presented as the latest gimmick by states to make a run on the Federal treasury;
  - approval of the claim would put administrative costs in California at 3 times the national average.

- **The bottom line is that you made a decision to put the counties on the line financially with a highly questionable strategy for new federal dollars.**

- **Nevertheless it would be prudent for you and for all of us to focus on how we can go forward from here, rather than on placing blame. In our press statements, we plan to emphasize the steps we are taking to move forward.**

Note: If/when the Governor alleges that HHS was involved in the formulation of the MAC system:

- Both sides obviously have a position on this, but I don't think it's productive for us to try to assign blame here. What I propose we do is work to solve the problem.

  [If you wish to get into the specifics: HHS staff were aware of and commented on technical aspects of the MAC system, but they had no way of knowing how the system would be used. They were never asked for, nor did they offer, an approval of the MAC system.]

cisco Chronicle
LIFORNIA'S LARGEST NEWSPAPER

NDAY, FEBRUARY 27, 1995 415-777-1111 50 CENTS

State Facing $315 Million Medi-Cal Loss

Federal officials pull back from reimbursing counties

By Greg Lucas
Chronicle Sacramento Bureau

Sacramento

In a move that could stagger California and its cash-strapped counties, the federal government is expected to refuse payment this week of up to $315 million that the counties are banking on to help pay for health care services for the poor.

Federal officials say the decision was prompted by the state's soaring claims for Medi-Cal administrative costs and some claims that the government considers improper.

The action imperils some $33 million that San Francisco hopes to receive this year. Alameda County could lose nearly $50 million, Santa Clara County as much as $48.7 million. Contra Costa faces a potential hit of $32 million. For San Mateo County, $18.1 million is at risk.

The step is likely to throw the state's current budget out of balance by at least $200 million. And in the worst-case scenario, analysts say, the counties lose $2 billion in health care funds over this fiscal year and the next.

"It will literally mean the closing of county hospitals, leaving only a trauma center," said Shahnaz Nikpay, director of finance for the Alameda County Health Care Services Agency. "All public health programs such as nursing, family planning and immunization will be in jeopardy."

According to the state legislative analyst, the greatest threat is to Los Angeles, which has Medi-Cal administrative claims through this fiscal year totaling $1.3 billion. But the losses that Bay Area counties face are also substantial.

San Francisco has claims totaling $25 million, dating to the inception of the reimbursement program in 1992, and it could lose another $8 million during the fiscal year beginning July 1.

"This is a serious cash-flow issue for us," said Dr. Sandra Hernandez, San Francisco's director of public health. "We've been delivering these programs with the expectation we would be appropriately reimbursed."

In all, the legislative analyst's office estimates, California's 58 counties could lose $2 billion in the current fiscal year and the fiscal year beginning July 1 if the federal government carries out its threat.

That would, in turn, affect the state budget. As part of a deal struck last year, the state rakes $200 million off the top of county reimbursements — and if there

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MEDI-CAL

From Page 1

are no reimbursements, the state does not get its cut.

That would drive this year's budget $200 million out of balance and do the same to next year's proposed budget.

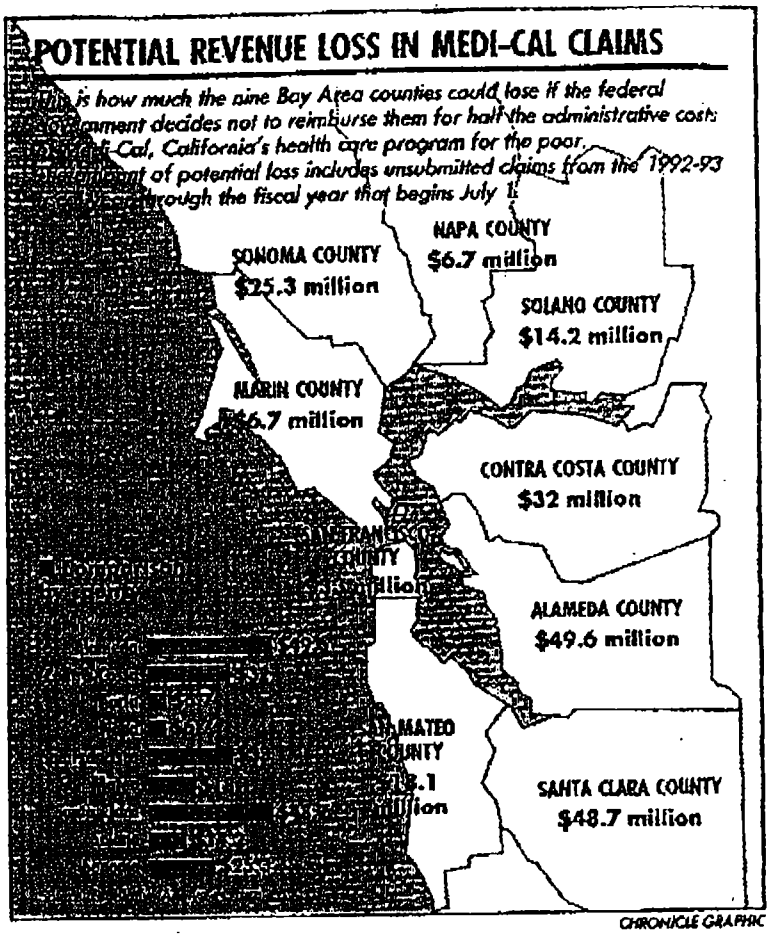
The dispute centers on the federal program that reimburses counties for half the administrative costs of Medi-Cal — determining a person's eligibility, finding sick people a doctor or referring them to a clinic for treatment. Actual health care costs are not included in the program.

In letters to the state, the federal Health Care Financing Administration said it decided to audit the state's claims after a dramatic increase in claims — from $17 million in the 1992-93 fiscal year to a projected $850 million this year and another $750 million in the fiscal year beginning July 1.

Federal officials also objected to some of the items being claimed by counties — especially by Los Angeles, which sought reimbursement for administrative costs related to outpatient care. Because of the county's size and network of clinics, Los Angeles' claims represent $220 million of the $315 million in claims at issue.

Last December, after a sample audit of some of California's $315 million in claims, federal health administrators told the state Department of Health Services that they were deferring payment on all claims pending an investigation.

The financing administration is expected to formally announce its denial of payment Thursday. Although the agency itself is officially silent on what action it will take, the state and counties say none of the $315 million will be paid.



San Francisco and other counties have argued that, unlike those of Los Angeles, their claims do not include outpatient services and so should be paid. Hernandez said that roughly 30 percent of San Francisco's claims are for public health nursing services.

"Our claims are legitimate," she said. "The costs of these health programs are going to grow if the federal government doesn't compensate us for the kind of care management we have been providing."

John Rodriguez, the state's Medi-Cal chief, complained that the federal government knew about the state's claim formula but never protested until after the claims were filed. He said the state will appeal the denial and, if necessary, sue the federal government for reimbursement.

But Rodriguez is not optimistic about a quick settlement. "My best advice to counties," he said, "is that we should expect nothing this year for planning purposes but work as hard as we can to get as much as we can as quickly as possible."

$290 of $3/5

Another $300m for LA

$600m

3/4/5 > 6?

ROLLOUT OF CALIFORNIA MEDICAID DISALLOWANCE

Monday

- o Communicate plan to LA County supervisors
- o Communicate plan to state, state legislature (Brown/Lockyer), county association, and invite them to Wednesday meeting in LA and Thursday meeting in Sacramento or San Francisco

Tuesday

- o Chief of staff calls Governor Wilson
- o Brief White House press, legislative affairs, public liaison on rollout
- o Alert selected members of Congress, broader group of state legislators
- o Tell press about briefing the next morning

Wednesday Morning

- o Vladeck informs state officials of disallowance
- o Press briefing in Sacramento (Monahan/Johnson/Vladeck)
- o Alert Hill, state legislature, interest groups (HHS staff in Washington)

Wednesday Afternoon

- o Editorial board of LA Times (Monahan/Johnson/Vladeck)
- o Meeting on settlement track in LA, led by White House, with state, LA county, HHS (who?)

Thursday

- o Meeting on other track in San Francisco, led by White House, with state, reps from all relevant counties, HHS

FAX TRANSMISSION

U.S. Department of Health and Human Services
Office of the Secretary

To: Diana Fortuna

Organization: _____

From: Pat Woodo
Intergovernmental Affairs

Date: 2/28/95

John Best Western

Intergovernmental Affairs
200 Independence Ave., SW
Room 630 F
Washington, DC 20201
phone: (202) 401-5879
fax: (202) 690-5672

Recipient's Fax Number: 456-7028

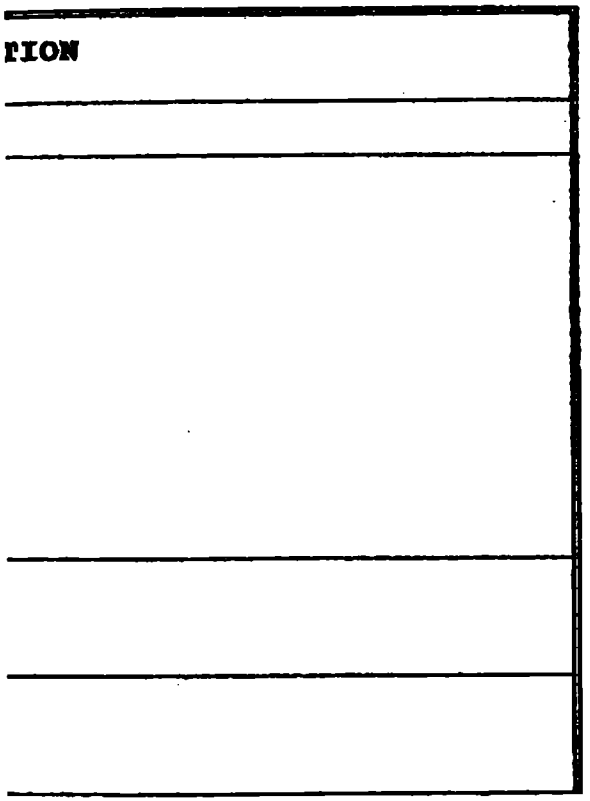
Number of pages including this sheet: 8

Remarks: Please make edits and comments and fax back by 4^00 today.

Thanks

CALIFORNIA MAC ROLLOUT
As Of February 28, 1995 at 12:45 PM

	STATE/LOCAL PROVIDERS/ADVOCACY	PUBLIC AFFAIRS	LEGISLA
MONDAY			
Afternoon		Reserve Capitol Press Room for Wednesday (Johnson) Prepare Media Advisory (Gardett) Finalize copies of public documents: Secretary Letter (Allen), Dapper Letter (Pokaski), Fact Sheet (Gardett). Arrange L.A. Times editorial board meeting (Gentry)	
6:00 PM EST	Calls to L.A. County supervisors (Johnson, Monahan, Fortuna, Emerson)		
6:45 PM EST	Call to Speaker Willie Brown (Johnson, Monahan, Fortuna, Emerson)		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LATION

	STATE/LOCAL PROVIDERS/ADVOCACY	PUBLIC AFFAIRS	LEGISLAT
TUESDAY			
8:00 AM EST		Faye Baggiano and Cam Gardett leave for Sacramento.	
9:00 AM EST		HCFA creates final version of Secretary's letter (Pokaski) and ES obtains signature by 12:30 PM (Allen). Vladeck takes originals plus 100 copies on flight at 1:00 PM. (Pokaski) Handle pre-decisional press inquiries. (Gentry, Richardson) HCFA assembles final copies of DES letter, Dapper letter, fact sheet, and Qs & As. Distribute materials to all staff and to Gardett and Baggiano. (Pokaski, Allen) Prepare talking points for post-L.A. meeting press. (Fortuna)	
10:00 AM EST			*CONFIRME* Waxman, Boxer, S Taylor)
12 Noon EST	Call L.A. County to finalize arrangements for Wednesday 4 PM meeting. (Johnson, HCFA RO)	Copies of all 3 public documents duplicated for distribution (HCFA RO)	

ION
D Background briefings for Fazio, Pelosi, Matsui, tark, Feinstein (Klepner,

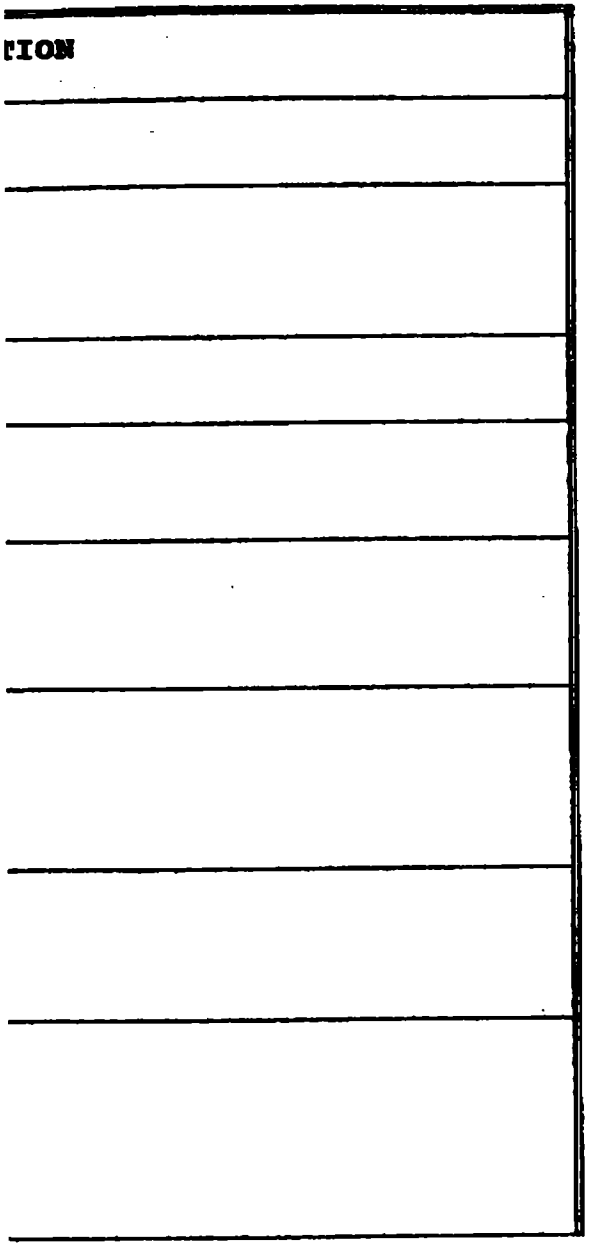
	STATE/LOCAL PROVIDERS/ADVOCACY	PUBLIC AFFAIRS	LEGISLAT
1:00 PM EST 10:00 AM PST	Calls to 2nd tier state legislators & northern California counties (Johnson, Monahan) Call SEIS and AFSCME/California. (Johnson) Calls to select provider groups. (Johnson) Vladeck departs HHS for a xxx flight to Sacramento with copies of final public documents.	Make list of contacts at major California newspapers, especially affected counties for contact on Wednesday (Gentry)	
2:00 PM EST 11:00 AM PST	Calls to California State Association of Counties (CSAC) (Johnson).	Background calls to key California media. (Gardett)	Backgrou Commerce Finance
3:00 PM EST 12:00 PM PST	Finalize list of national provider and advocacy groups to whom materials will be distributed on Wednesday (Chang) Finalize list of California provider and advocacy groups to whom materials will be distributed on Wednesday (Dapper, Johnson)	Press advisory to major newspapers with offices in state capitol (Lee) Advisory (FYI) to other key media (Gentry, Lee HCFA RO) Review room, provide media background as needed (Baggiano, Gardett).	
5:00 PM EST	Monahan departs HHS for xxxx flight from xxx.		

ION
nd Briefings for Senate Committee and Senate Committee (Taylor, Chang)

	STATE/LOCAL PROVIDERS/ADVOCACY	PUBLIC AFFAIRS	LEGISLAT
6:00 PM EST	Call to Governor Wilson (Fortuna)		
WEDNESDAY			
8:00 AM PST 11:00 AM EST	*CONFIRMED* Meeting with Belshe, et al at xxx. Hand deliver letters to Belshe. (Vladeck, Monahan, Johnson, Dapper) Fax documents to Governor's California and Washington offices and confirm receipt (Woods)		
9:00 AM PST 12:00 NOON EST	Fax materials to CSAC for distribution to counties. (HCFA RO) Call NGA, NCSL, NACo, and APWA to advise of disallowance. (Woods) Call and fax materials to national advocacy and provider groups. (Chang) Call and fax materials to California provider and interest groups. (HCFA RO)	*CONFIRMED* Sacramento Press Briefing (Johnson, Baggiano, Gardett, Vladeck, Monahan, Dapper, Eden) -- Johnson opens -- Vladeck discusses Distribution of public documents to select non-attending California press. (HCFA RO) Distribution in Washington of public documents by request. (Gentry)	
10:00 AM PST 1:00 PM EST		Press Calls (Vladeck, Johnson, Monahan, Dapper, Baggiano, Gardett) National press calls go to Vladeck; if Vladeck not available, then to Richardson. Calls to California press (Gardett)	*CONFIRME* Californ Chang, F

'ION
:D Hill briefing for entire ıia delegation (Taylor, :ichardson)

	STATE/LOCAL PROVIDERS/ADVOCACY	PUBLIC AFFAIRS	LEGISLA
10:30 AM PST 1:30 PM EST			
11:00 AM PST 2:00 PM EST	Vladeck, Monahan, Johnson, Dapper, Gardett, Bagginano leave for airport. xxx flight # departs xx, arrives LA International at xxx.		
12:xx PM PST PM EST	Ground transportation provided by HCFA RO.		
Afternoon meeting (tentative)	Brief California state legislative staff. (HCFA RO, person to be designated)		
3:00 PM PST 6:00 PM EST		*CONFIRMED* Meet with L.A. Times editorial board at Times Mirror Bldg. (Vladeck, Monahan, Johnson, Gardett)	
4:00 PM PST	*CONFIRMED* Meet with state and L.A. County officials at L.A. County Building. (Newirth, Johnson, Monahan, Dapper, Eden, Fortuna, Gardett)		
5:00 PM PST	Handle press after the meeting with the state and L.A. County officials (Johnson, Lee, Monahan)	Complete preparation of agenda, materials, and logistics for Thursday's meeting with counties (Dapper, Lee)	
X:XX PM PST	Driven to LAX by HCFA RO (xxx) for xxx flight # xxx departs xxx and arrives San Franciso at XXX. Stay at xxx Hotel; (xxx) xxx-xxxx.		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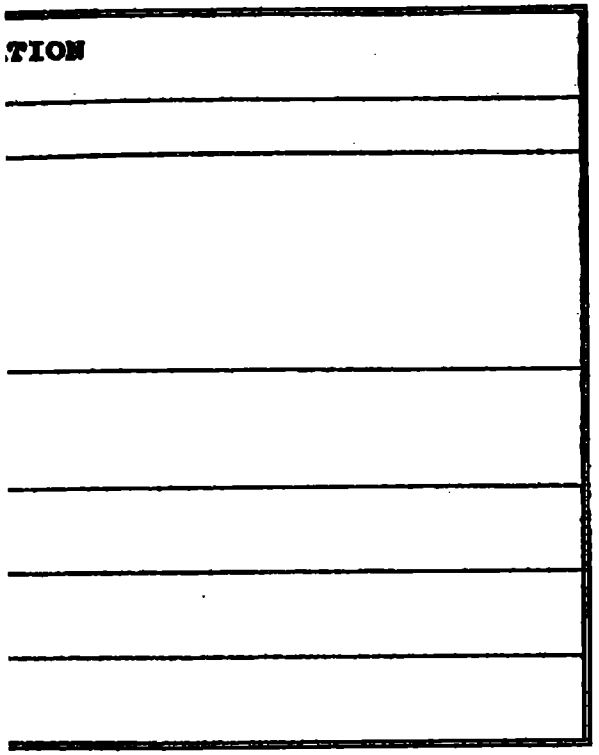
	STATE/LOCAL PROVIDERS/ADVOCACY	PUBLIC AFFAIRS	LEGISLA
THURSDAY			
10:00 AM PST 1:00 PM EST		**Meeting at the HCFA San Francisco Regional Office with California state and county officials, CSAC (Dapper, Johnson, Vladeck, Monahan, Fortuna, Newirth,+ Dapper, Eden, Lasowski, Baggiano, Gardett)**	
11:00 AM PST 2:00 PM EST		**Informal contact with reporters if present. (Johnson, Gardett, Baggiano)**	
1:00 PM PST	**Brief provider groups (Dapper Johnson)**		
2:30 PM PST	**Brief labor unions (Johnson, Dapper)**		
4:00 PM PST	**Brief advocacy groups (Johnson, Dapper)**		

NOTES

In meetings with multiple HHS/HCFA staff, the person listed first and bolded takes the lead for the meet



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DRAFT 2/24/95

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

Dear Governor Wilson,

I ~~regret~~ to inform you that 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 ~~is required~~ by the Medicaid statute ~~and~~ 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 to ~~suggest several approaches in which~~ the Administration ~~may assist you~~ in addressing the fiscal situation you face:

- ~~I have assembled an~~ 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 have scheduled a meeting with your staff and representatives of the affected counties on ___ to review ways the State could identify legitimately allowable activities imbedded in the MAC claim which are independent of the MAC system, 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 will also meet with State and Los Angeles County staff on ___ to consider any options available to make less severe the impending budget crisis in Los Angeles County.

- As you know, the Departmental appeals process is simultaneously available to the State should you choose to seek reconsideration of the disallowance. Should you choose to appeal, I will do all that is in my power to ensure that my lawyers work with yours to expedite the appeals process.

RIDER 1

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. Assuming that the state is inclined to pursue an appeal of the disallowance of its claim, the Administration is prepared to explore settlement options with the state promptly. 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.

explore all ways for addressing this si

The Admin

every

As set forth more fully in HCFA's letter to the California Dept 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 had 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.

~~Please let me know if I can be of any further assistance or if you have any questions~~ about our ongoing activities to ~~help California~~ assist the counties in preserving quality ~~health care~~ services.

Sincerely,

Donna Shalala

I look forward to working w/you + w/ county officials in our

February __, 1995
(Draft: 2-24-95)

Contact: HCFA Press Office
(202) 690-6145

FEDERAL MEDICAID FUNDS DENIED

As required by the Medicaid statute, the Health Care Financing Administration 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, ~~in order~~ to preserve the health care safety net. 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 ___ to review ways the State could identify legitimately allowable activities imbedded in the MAC claim which are independent of the MAC system, 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 will also meet with State and Los Angeles County staff on ___ to consider any options available to alleviate the impending budget crisis in Los Angeles County.

- The Departmental appeals process is simultaneously available to the State should the State choose to seek reconsideration of the disallowance. Should the State choose to appeal, the Department will do what it can to ensure that an expedited appeals process is available to the State of California.

RIDER 1 (from letter)

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 ~~associated with medical care, and most of these costs have already been federally reimbursed as medical services;~~ 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;
- 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 Medical Administrative Claiming system (MAC). ~~Following several months of intensive work, HCFA has determined that this system as applied by the State~~ 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 Medi-Cal Administrative Claiming (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 view of the MAC system and its application was not provided to HCFA until August 1994, at which time HCFA began expressing its concerns about the system. The first formal request for approval of the MAC system was not made until October 1994, a month after the $315 million in claims were submitted to HCFA. technicality? vs. informal?
- Following submission of the claim, 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 as used in several providers 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.

- 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.

- 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. These claims would be for additional Medicaid administrative costs that California would be claiming for the first time, based on an unproven new claiming system. Further, before receiving HCFA's decision on the system, the State reportedly decreased its payments to counties based on the anticipated increase in federal payment for these claims.

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 which have already been paid by federal and other sources.

2. The categories of activities which it 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. Review 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:

- 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.

- 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, and the cost of these actions is already reimbursed through the medical services rate and can not be claimed again as administration.

- 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.

- 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.

HHS ASSISTANCE -- County officials have said they may have to impose severe budget reductions if MAC claims are not approved. In part, this is due to the State reportedly withholding payments to counties in anticipation of federal reimbursement. HHS is aware of the serious problems some counties will face, and is committed to providing the legally appropriate assistance that it can. An Administration team is in California to meet with the State and the counties to review ways to identify legitimately allowable claims imbedded in the MAC claim which are independent of the MAC system and options available to the State to increase funding to the counties. The Administration team will hold a separate meeting with the State and Los Angeles County to discuss that county's particularly serious budget problem. HHS has also offered that, should the State choose to appeal the disallowance, HHS will do all that it can to ensure an expedited appeals process.

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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.

February 25, 1995

TO: John Emerson
Steve Neuwirth

FR: Diana Fortuna DF

Here is Friday night's redraft by HHS of the Secretary's letter to Governor Wilson and the press release. See especially the description of the LA County settlement track.

cc: Martha Foley

2/26
D:- DANA & STAFF + MARTHA
see my edits.
- J.E.

3/1/95

DRAFT ~~2/24/95~~

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

Dear Governor Wilson,

under applicable law,

I regret to inform you that 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 is required by the Medicaid statute and 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 to suggest several approaches in which the Administration may assist you in addressing the fiscal situation you face:

ok

- I have assembled an Administration 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 have scheduled a meeting with your staff and representatives of the affected counties on March 3rd to review ways the State could identify legitimately allowable activities imbedded in the MAC claim which are independent of the MAC system, 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 will also meet with State and Los Angeles County staff ~~on~~ ___ to consider any options available to ~~make less severe~~ address the impending budget crisis in Los Angeles County.

today March 1, 1995

- As you know, the Departmental appeals process is simultaneously available to the State should you choose to seek reconsideration of the disallowance. Should you choose to appeal, I will do all that is in my power to ensure that my lawyers work with yours to expedite the appeals process.

Let's discuss

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 had 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.

Please let me know if I can be of any further assistance or if you have any questions about our ongoing activities to help California assist the counties in preserving quality health care services.

Sincerely,

Donna Shalala

I look forward to working w/you + w/ county officials ....

Cyes

3/1/95

February __, 1995
~~(Draft:~~ 2-24-95)

Contact: HCFA Press Office
(202) 690-6145

FEDERAL MEDICAID FUNDS DENIED

As required by the Medicaid statute, the Health Care Financing Administration 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, in order to preserve the health care safety net. HHS is moving forward on several fronts to provide assistance:

- An Administration team has been assembled that is ready 3/2 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 __ to review ways the State could identify legitimately allowable activities imbedded in the MAC claim which are independent of the MAC system, 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 will also meet with State and Los Angeles County staff ~~on~~ today to consider any options available to alleviate the impending budget crisis in Los Angeles County.

- The Departmental appeals process is simultaneously available to the State should the State choose to seek reconsideration of the disallowance. Should the State choose to appeal, the Department will do what it can to ensure that an expedited appeals process is available to the State of California.

The reasons for the disallowance are as follows:

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 associated with medical care, and most of these costs have already been federally reimbursed as medical services;
- federal share has already been paid for the majority of services claimed;
- 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 Medical Administrative Claiming system (MAC). Following several months of intensive work, HCFA has determined that this system as applied by the State is seriously flawed.

Should we put language in here that repeats the written letter on the high % of admin. costs rejected by the MAC claims?

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 Medi-Cal Administrative Claiming (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 view of the MAC system and its application was not provided to HCFA until August 1994, at which time HCFA began expressing its concerns about the system. The first formal request for approval of the MAC system was not made until October 1994, a month after the $315 million in claims were submitted to HCFA.
- Following submission of the claim, 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 as used in several providers 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.

- 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.

- 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. These claims would be for additional Medicaid administrative costs that California would be claiming for the first time, based on an unproven new claiming system. Further, before receiving HCFA's decision on the system, the State reportedly decreased its payments to counties based on the anticipated increase in federal payment for these claims.

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 which have already been paid by federal and other sources.

2. The categories of activities which it 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. Review 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:

- 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.

- 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, and the cost of these actions is already reimbursed through the medical services rate and can not be claimed again as administration.

- 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.

- 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.

HHS ASSISTANCE -- County officials have said they may have to impose severe budget reductions if MAC claims are not approved. In part, this is due to the State reportedly withholding payments to counties in anticipation of federal reimbursement. HHS is aware of the serious problems some counties will face, and is committed to providing the legally appropriate assistance that it can. An Administration team is in California to meet with the State and the counties to review ways to identify legitimately allowable claims imbedded in the MAC claim which are independent of the MAC system and options available to the State to increase funding to the counties. The Administration team will hold a separate meeting with the State and Los Angeles County to discuss that county's particularly serious budget problem. HHS has also offered that, should the State choose to appeal the disallowance, HHS will do all that it can to ensure an expedited appeals process.

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and Feds?

2/23/95

CALIFORNIA MAC ROLLOUT

TIME TABLE

HHS document
- What has?
Press? - press below?
Draft alt to double billing
SW Draft smcts for after ea mtg.
* 4:45 - conf call
* Carol?? -
* Draft - message for Monday
- no client
* Can Carol come? Tuesday
* Leon mtg Mon/Tue
SW - draft smcts > ea mtg
* Leon TP - add specific steps we're req'g

Rollout Items Completed:

- o Letters notifying state:
  - Secretary letter to Governor Wilson
  - HCFA San Francisco Acting Regional Administrator (Dapper) disallowance letter to Belshe
- o Pre- and post-decisional fact sheets
- o Q&As (for internal use only)
- o Chronology (for internal use only)

Three Days before Announcement (Friday, 2/24)

- o HCFA press office to assemble lists of press:
  - Short list of press to be invited to technical briefings on the day before announcement
  - Longer list of press to be contacted on day of announcement.
- o OLIGA/ASL to determine who will make calls to Members and Committee staff.
- o OLIGA in consultation with OS/IGA, SF/RD, HCFA RO, OA, AACRC, and MB will prepare list of governmental and interest groups to be informed the day of announcement.
- o Final meeting with White House has been held, and they have had a chance to review and comment on final rollout package.
- o Disallowance letter is signed by Dapper and copy is forwarded by express mail to HCFA/ES (Somsak) by COB.

Two Days Before Announcement (Monday, 2/27)

- o All participants in CA rollout meet to walk through rollout plan.

Settlement Track
some supervisors
State
other counties - no
Monahan
Grantland
Bruce
Harriet/Darrel

Broader Track - establ fast track review
State
LA
Other counties
No staff leg.
- fix MAC
- alts

Day before Announcement (Tuesday, 2/28)

- o Hold technical/background briefings for selected Hill staff and short list of press.

- o By noon, copy of complete package of materials are provided by HCFA/ES to Secretary, CoS, OASPA, OS/ES, OS/IGA, ASL, OGC and RD.

- o Technical/background briefings for State legislators and selected county officials. (late phone calls to county supervisors)

- o Letter to Governor is signed by Secretary by COB.

- o Vladeck and HHS team fly to Sacramento.

Day of Announcement (Wednesday, 3/1)

- o In the early morning, HHS Sacramento team

  - Issues press briefing notice
  - Briefs selected state and local officials
  - schedules editorial board meetings.

- o Beginning at 2:00 am EST/ 11:00 am Pacific, the following events happen in sequential order:

  - Secretary's letter and copy of disallowance letter are faxed to Wilson by OS/ES
  - Vladeck visits/phones Belshe about disallowance letter
  - Disallowance letter (and copy of Wilson letter) is faxed by on-site team to Belshe (or handed to her by Vladeck)
  - Monahan visits/phones Governor's office about the disallowance letter
  - Simultaneously (after confirmation from Pokaski that the items above have been completed):
    - + ASL places Hill calls to Commerce Committee (majority/minority) and other key California members
    - + HCFA press office informs press contacts on short list
    - + OS/IGA, OLIGA, and SF RO inform and fax materials to relevant national governmental and interest groups, and California counties [possible conference call with Northern and Southern California counties]
  - Shortly after 11am PST, Vladeck and Sacramento team hold press briefing
  - ASL/OLIGA make calls to other California congressional delegation members

- Late Afternoon:

  - ASL/OLIGA briefings for California Delegation, other Committee staff
  - Vladeck meets with editorial boards in LA area.
  - OLIGA/IGA will place calls to NGA, NCSL, APWA and NACo

- All press calls will be directed to the HCFA Press Office and handled as follows:

  - Calls from major non-CA media (e.g., Washington Post, New York Times) will be referred to Sally Richardson for response; and

  - All other calls will be handled by Faye Baggiano and Pam Gentry.

Day After Announcement (Thursday, March 2)

- Vladeck available until early afternoon to speak to press, do editorial boards. Flies back in afternoon.

DRAFT 2/23/95

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

Dear Governor Wilson,

I regret to inform you that 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 is compelled by the Medicaid statute and 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.

California's new Medi-Cal Administrative Claiming (MAC) system, which was used to identify Medi-Cal administrative costs incurred by counties, is severely flawed. The claim generated by the MAC system includes inaccuracies and double billings. The greater part of the claim appears 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 reflects services unrelated to the administration of Medi-Cal.

The magnitude of the State's requested increase for administrative costs was particularly surprising to me. 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.

If these claims were permissible, they would represent Medi-Cal bureaucracy costs that were far too high. In fact, however, the MAC system as applied is flawed, and the claims it generates are largely not permissible. Our reviews so far indicate that most of the MAC claims represent activities that are not administrative costs, but rather are costs associated with the provision of medical care. In most of these cases federal payment has already been made for the services, either by the federal Medicaid program itself or by other federal programs. Therefore the MAC-generated claim represents double-billing.

It is unfortunate that the State of California waited until October 1994, a month after submitting the claim, to formally submit its full MAC system for our review. An earlier formal review by HCFA could have identified the serious problems associated with the State's use of MAC before critical budget actions were taken. I also understand that the State of California prematurely withheld from your counties' budgets the amount it hoped to receive from the federal government for MAC system claims. The State's actions will likely result in serious fiscal problems for some counties, particularly Los Angeles County.

Although we are compelled to disallow the claim we received in September, let me assure you that this Department wishes to work with you to provide legally appropriate assistance to preserve the health care safety net in these counties. For example:

- HHS and State and County representatives are today concluding a three-day meeting to discuss in detail ways the State could identify legitimately allowable activities imbedded in the MAC claim which are independent of the MAC system. At that meeting HHS also provided technical assistance to the State and its counties in designing a targeted case management system to increase funding to counties in the short-term.

- We have offered technical assistance to the State in increasing the reimbursement to county-operated providers (which would, of course, be matched by federal funds). This approach would also increase funding to counties in the short-term.

- PLACEHOLDER FOR ADDITIONAL INFORMATION ON ASSISTANCE TO CA.

- As you know, the Departmental appeals process is simultaneously available to the State should you choose to seek reconsideration of the disallowance. Should you choose to appeal, I will do all that is in my power to ensure that my lawyers work with your to expedite the appeals process.

In addition to these efforts, I have assembled a Departmental team that is ready to travel to Sacramento immediately to work with the State in efforts to assist the affected counties. Please let me know if you have any questions about our ongoing activities to help California assist the counties in preserving quality health care services for the poor.

Sincerely,

Donna Shalala

I think we should have a meeting later today or Monday am to discuss rollout/documents more specifically with A.

Monahan
Bruce?
Harriet?
Emerson
Newmirth
Foley?
Fortuna

February __, 1995
(Draft: 2-23-95)

Contact: HCFA Press Office
(202) 690-6145

FEDERAL MEDICAID FUNDS DENIED FOR INACCURACY AND DOUBLE BILLING

SUMMARY: The Health Care Financing Administration has determined that it must disallow the claim of $315 million in federal Medicaid matching funds submitted by California on September 2, 1994. The claim by the state 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 associated with medical care, and most of these costs have already been federally reimbursed as medical services;***
- ***because federal share has already been paid for the majority of services claimed, most of the claim would represent 'double billing' of the federal government;***
- ***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 Medical Administrative Claiming system (MAC). Following several months of intensive work, HCFA has determined that this system as applied by the state is severely flawed. ***HHS will continue to work closely with the state to develop an improved claiming method that can properly identify Medi-Cal administrative costs. HHS will also work with California to identify other state-federal actions that could improve reimbursement for county Medi-Cal services.***

fact sheet

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 Medi-Cal Administrative Claiming (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, the MAC system as it was being applied had not been submitted for approval at the time the claim was made.

- Following submission of the claim, 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 as used in several providers 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 provided no new information or arguments that support the validity of the MAC system claims.

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

- The state estimates that the annualized Federal cost of MAC system claims would be approximately $658 million. These claims would be for additional Medicaid administrative costs that California would be claiming for the first time, based on an unproven new claiming system. Further, before receiving HCFA's decision on the system, the state reportedly decreased its payments to counties based on the anticipated increase in federal payment for these claims.

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 which have already been paid by federal and other sources. Therefore, double payment would occur.

2. The categories of activities which it 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. Review 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:

- 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.

- Medical advice given to patients by non-physicians was identified as an administrative cost, even though it is already covered by medical service payments.

- 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.

- 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.

HCFA REGIONAL OFFICE INVOLVEMENT -- In its response to HCFA's deferral, the state of California argued that it had consulted with HCFA's regional office. While HCFA regional office staff did discuss some aspects of this system with the state, they did not explicitly or implicitly approve the system or its use. A full view of the MAC system and its application was not provided to HCFA until August 1994, at which time HCFA began expressing its concerns about the system. The first formal request for approval of the MAC system was not made until October 1994, a month after the $315 million in claims were submitted to HCFA.

NEXT STEPS -- County officials have said they may have to impose severe budget reductions if MAC claims are not approved. In part, this is due to the state reportedly withholding payments to counties in anticipation of federal reimbursement. Although HCFA sympathizes with the situation in which California's counties now find themselves, the state's decision to decrease payments to counties is a matter between the state and the counties.

HCFA has offered to provide any appropriate assistance to the health systems of those counties negatively impacted by the state's decision. In addition, HCFA will move forward on several fronts with the state of California to determine whether parts of the MAC claim may be reimbursable and to help design means to provide more resources for counties in the future.

- HHS will continue its effort to assist the state and counties in their identification of any retroactive claims that are separately allowable and documented independent of the MAC system.

- HHS will also work with the state to put in place new State Plan provisions and an approvable cost allocation methodology that identifies the medical service or administrative activities for which federal matching funds will be available in the future, and

- HHS has offered to send a team of Departmental officials to Sacramento immediately to provide technical assistance regarding options for addressing the counties' fiscal crisis.

HCFA is meeting with State and County representatives (February 27 - March 1) to provide technical assistance to the State on developing targeted case management state plan amendments and on identifying and documenting potentially allowable activities imbedded in the current MAC claim.

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Are we clear on DOT involvement?
Are we sure state will cvr DOT.

Mtg later today w/ Monahan Kevin? Bruce Emerson, Neuwirth, me

ROLLOUT OF CALIFORNIA MEDICAID DISALLOWANCE

Prior to Announcement:

Monahan/Emerson: Communicate outline of plan to LA County supervisors, state legislature, other relevant counties for their feedback

Begin with editorial boards?

Chief of staff: call to Governor Wilson

Neuwirth: Schedule first "Track 1" meeting with state and county officials for Thursday, March 2

DPC/Intergovernmental: Brief White House press, legislative affairs on rollout

Day of Announcement (Wednesday, March 1):

HHS staff in Sacramento, led by Grantland Johnson:
- o meets with state officials (Kim Belshe?);
- o meets with county officials;
- o does press briefing?
- o editorial boards??

Backgd Team: - Clear w/Counties - Wilson

HHS staff in Washington:
- o briefs members of Congress;
- o informs identified interest and intergovernmental groups
- o transmits official disallowance letter to state

- ed Gds ?

Who goes / What do they do

Questions Raised by HHS Rollout Package:

- o Do technical briefings for selected press the day before announcement?

Pub Affairs team; Who? Does Track 1

- o Send Secretary letter to Governor?
- o Draft press release does not emphasize up front our plan to convene meetings to try to preserve health services in the counties (release includes sentence near the end reading "although HCFA sympathizes with the situation in which California's counties now find themselves, the state's decision to decrease payments to counties is a matter between the state and the counties."

✓

- o Draft press release does not refer to any White House involvement

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

Note to: Abner Mikva
John Emerson
Martha Foley
Diana Fortuna

From: Kevin Thurm Jill Hughes for

Date: February 23, 1995

Re: California's MAC Claim

Attached are documents that HHS has assembled in preparation for the roll-out of the disallowance of California's $315 million Medicaid claim. We have left placeholders in the documents for discussion of additional actions we decide to take to work with the State to assist the counties.

The following are attached:

- Our draft rollout plan,
- a letter from the Secretary to Governor Wilson, with the official disallowance letter attached,
- pre-decisional and post-decisional fact sheets
- Q's and A's for use by spokespersons and legislative staff.

Please let me know if you have any comments by 4:30 tomorrow. Thanks.

2/23/95

CALIFORNIA MAC ROLLOUT

TIME TABLE

Rollout Items Completed:

- o Letters notifying state:
  - Secretary letter to Governor Wilson
  - HCFA San Francisco Acting Regional Administrator (Dapper) disallowance letter to Belshe
- o Pre- and post-decisional fact sheets
- o Q&As (for internal use only)
- o Chronology (for internal use only)

Three Days before Announcement (Friday, 2/24)

- o HCFA press office to assemble lists of press:
  - Short list of press to be invited to technical briefings on the day before announcement
  - Longer list of press to be contacted on day of announcement.
- o OLIGA/ASL to determine who will make calls to Members and Committee staff.
- o OLIGA in consultation with OS/IGA, SF/RD, HCFA RO, OA, AACRC, and MB will prepare list of governmental and interest groups to be informed the day of announcement.
- o Final meeting with White House has been held, and they have had a chance to review and comment on final rollout package.
- o Disallowance letter is signed by Dapper and copy is forwarded by express mail to HCFA/ES (Somsak) by COB.

Two Days Before Announcement (Monday, 2/27)

- o All participants in CA rollout meet to walk through rollout plan.

Day before Announcement (Tuesday, 2/28)

- o Hold technical/background briefings for selected Hill staff and short list of press.

- o By noon, copy of complete package of materials are provided by HCFA/ES to Secretary, CoS, OASPA, OS/ES, OS/IGA, ASL, OGC and RD.

- o Technical/background briefings for State legislators and selected county officials. (late phone calls to county supervisors)

- o Letter to Governor is signed by Secretary by COB.

- o Vladeck and HHS team fly to Sacramento.

Day of Announcement (Wednesday, 3/1)

- o In the early morning, HHS Sacramento team

  - Issues press briefing notice
  - Briefs selected state and local officials
  - schedules editorial board meetings.

- o Beginning at 2:00 am EST/ 11:00 am Pacific, the following events happen in sequential order:

  - Secretary's letter and copy of disallowance letter are faxed to Wilson by OS/ES
  - Vladeck visits/phones Belshe about disallowance letter
  - Disallowance letter (and copy of Wilson letter) is faxed by on-site team to Belshe (or handed to her by Vladeck)
  - Monahan visits/phones Governor's office about the disallowance letter
  - Simultaneously (after confirmation from Pokaski that the items above have been completed):
    + ASL places Hill calls to Commerce Committee (majority/minority) and other key California members
    + HCFA press office informs press contacts on short list
    + OS/IGA, OLIGA, and SF RO inform and fax materials to relevant national governmental and interest groups, and California counties [possible conference call with Northern and Southern California counties]
  - Shortly after 11am PST, Vladeck and Sacramento team hold press briefing
  - ASL/OLIGA make calls to other California congressional delegation members

- Late Afternoon:

  - ASL/OLIGA briefings for California Delegation, other Committee staff
  - Vladeck meets with editorial boards in LA area.
  - OLIGA/IGA will place calls to NGA, NCSL, APWA and NACo

- All press calls will be directed to the HCFA Press Office and handled as follows:

  - Calls from major non-CA media (e.g., Washington Post, New York Times) will be referred to Sally Richardson for response; and

  - All other calls will be handled by Faye Baggiano and Pam Gentry.

Day After Announcement (Thursday, March 2)

- Vladeck available until early afternoon to speak to press, do editorial boards. Flies back in afternoon.

DRAFT 2/23/95

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

Dear Governor Wilson,

I regret to inform you that 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 is compelled by the Medicaid statute and 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.

California's new Medi-Cal Administrative Claiming (MAC) system, which was used to identify Medi-Cal administrative costs incurred by counties, is severely flawed. The claim generated by the MAC system includes inaccuracies and double billings. The greater part of the claim appears 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 reflects services unrelated to the administration of Medi-Cal.

The magnitude of the State's requested increase for administrative costs was particularly surprising to me. 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.

If these claims were permissible, they would represent Medi-Cal bureaucracy costs that were far too high. In fact, however, the MAC system as applied is flawed, and the claims it generates are largely not permissible. Our reviews so far indicate that most of the MAC claims represent activities that are not administrative costs, but rather are costs associated with the provision of medical care. In most of these cases federal payment has already been made for the services, either by the federal Medicaid program itself or by other federal programs. Therefore the MAC-generated claim represents double-billing.

It is unfortunate that the State of California waited until October 1994, a month after submitting the claim, to formally submit its full MAC system for our review. An earlier formal review by HCFA could have identified the serious problems associated with the State's use of MAC before critical budget actions were taken. I also understand that the State of California prematurely withheld from your counties' budgets the amount it hoped to receive from the federal government for MAC system claims. The State's actions will likely result in serious fiscal problems for some counties, particularly Los Angeles County.

Although we are compelled to disallow the claim we received in September, let me assure you that this Department wishes to work with you to provide legally appropriate assistance to preserve the health care safety net in these counties. For example:

- HHS and State and County representatives are today concluding a three-day meeting to discuss in detail ways the State could identify legitimately allowable activities imbedded in the MAC claim which are independent of the MAC system. At that meeting HHS also provided technical assistance to the State and its counties in designing a targeted case management system to increase funding to counties in the short-term.

- We have offered technical assistance to the State in increasing the reimbursement to county-operated providers (which would, of course, be matched by federal funds). This approach would also increase funding to counties in the short-term.

- PLACEHOLDER FOR ADDITIONAL INFORMATION ON ASSISTANCE TO CA.

- As you know, the Departmental appeals process is simultaneously available to the State should you choose to seek reconsideration of the disallowance. Should you choose to appeal, I will do all that is in my power to ensure that my lawyers work with your to expedite the appeals process.

In addition to these efforts, I have assembled a Departmental team that is ready to travel to Sacramento immediately to work with the State in efforts to assist the affected counties. Please let me know if you have any questions about our ongoing activities to help California assist the counties in preserving quality health care services for the poor.

Sincerely,

Donna Shalala

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

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). The claims involve Medicaid administrative costs related to the Medi-Cal Administrative Claiming (MAC) system, 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 at 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
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

February __, 1995
(Pre-decisional fact sheet -- 2-23-95 draft)

STATUS OF CALIFORNIA'S CLAIM FOR MEDICAID ADMINISTRATIVE COSTS

- In September 1994, the state of California submitted to HCFA a claim for $315 million, which was meant to represent the additional costs which California counties incurred in administrative activities under Medi-Cal, the state's Medicaid program. The claim covered 34 counties for the period July 1, 1992 to March 31, 1994. Over 90 percent of the amount represents claims from Los Angeles County.

- The claim was generated by a new system developed by the state, the "Medi-Cal Administrative Claiming" system. The new system had not been approved by HHS at the time the $315 million claim was made.

- After an initial examination of this claim, HHS' Health Care Financing Administration on October 7, 1994 deferred payment, because it appeared that the new MAC system had generated claims that were substantially inaccurate.

- Following HCFA's deferral, the state on October 13, 1994 formally requested that HCFA approve the new MAC system. HCFA has been working intensively with the state since October to determine the validity of the MAC system and the costs being claimed.

- The final decision is still pending on payment of the $315 million claim. While no comment can be made now concerning final action on the claim, several findings have emerged regarding the MAC system itself:

  -- ***ABNORMALLY HIGH ADMINISTRATIVE CLAIM:*** The MAC system is intended to identify administrative costs. But the claims generated by this system are three times higher than the administrative costs of other state Medicaid programs -- and twice as high as California's own previous experience with administrative costs. In other states' Medicaid programs, administrative costs average 4.5 percent of Medicaid services costs. In California, administrative costs without the MAC claims have been about 6.3 percent of services costs. California projects administrative costs would be 14 to 15.5 percent of Medicaid services costs, when MAC claims are regularly submitted by all counties. *On its face, such a high proportion of spending on Medi-Cal bureaucracy instead of medical services would raise concerns. No other state has such high costs for Medicaid administration.*

-- *"DOUBLE BILLING" FOR MEDICAL SERVICE COSTS:* HCFA's review of the MAC system indicates that the system as applied has proved unable to successfully distinguish administrative costs from medical service costs. *More important, in a very substantial number of cases, medical service costs which have already received federal funding are claimed again by the MAC system as administrative costs. In such cases, the MAC claim would represent a kind of "double billing."* Reviews by HCFA indicate that such duplicate billing of Medicaid may represent the majority of the MAC claims. A limited scope review by the HHS Inspector General has also shown that the MAC system makes claims for services already funded by other federal programs.

-- *CLAIMS FOR NON-MEDICAID ACTIVITIES:* The reviews by HCFA and the Inspector General also indicate that *the MAC system is generating claims for social services and other county activities that are not covered under Medi-Cal.*

Since submission of the MAC claim in September 1994, HHS and HCFA have moved vigorously in helping the state of California analyze and untangle the claims that were generated by the new system. The situation is especially urgent for counties, and particularly for Los Angeles County. Beginning in July 1994, the state reportedly has reduced its payments to counties, promising to replace these payments with the amounts that it hoped to recover through MAC claims. If the claims are determined to be unallowable under the law, counties would have to go to the state for restitution of these payments. HHS is particularly concerned about the potential fiscal problems for county health systems, which would impact on the vulnerable populations they serve.

Final decision on the $315 million claim will be made soon. HHS will stand ready at that time to continue and redouble its assistance to California, as may be needed, to develop more accurate claims on behalf of county Medi-Cal programs. HHS will also continue technical assistance to California to ensure that the state, on behalf of its counties, is making fullest use of the federal funding available to them.

###

Contact: HCFA Press Office
(202) 690-6145

February __, 1995
(Draft: 2-23-95)

Contact: HCFA Press Office
(202) 690-6145

FEDERAL MEDICAID FUNDS DENIED FOR INACCURACY AND DOUBLE BILLING

SUMMARY: The Health Care Financing Administration has determined that it must disallow the claim of $315 million in federal Medicaid matching funds submitted by California on September 2, 1994. The claim by the state 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 associated with medical care, and most of these costs have already been federally reimbursed as medical services;***
- ***because federal share has already been paid for the majority of services claimed, most of the claim would represent 'double billing' of the federal government;***
- ***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 Medical Administrative Claiming system (MAC). Following several months of intensive work, HCFA has determined that this system as applied by the state is severely flawed. ***HHS will continue to work closely with the state to develop an improved claiming method that can properly identify Medi-Cal administrative costs. HHS will also work with California to identify other state-federal actions that could improve reimbursement for county Medi-Cal services.***

fact sheet

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 Medi-Cal Administrative Claiming (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, the MAC system as it was being applied had not been submitted for approval at the time the claim was made.

- Following submission of the claim, 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 as used in several providers 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 provided no new information or arguments that support the validity of the MAC system claims.

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

- The state estimates that the annualized Federal cost of MAC system claims would be approximately $658 million. These claims would be for additional Medicaid administrative costs that California would be claiming for the first time, based on an unproven new claiming system. Further, before receiving HCFA's decision on the system, the state reportedly decreased its payments to counties based on the anticipated increase in federal payment for these claims.

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 which have already been paid by federal and other sources. Therefore, double payment would occur.

2. The categories of activities which it 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. Review 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:

- 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.

- Medical advice given to patients by non-physicians was identified as an administrative cost, even though it is already covered by medical service payments.

- 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.

- 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.

HCFA REGIONAL OFFICE INVOLVEMENT -- In its response to HCFA's deferral, the state of California argued that it had consulted with HCFA's regional office. While HCFA regional office staff did discuss some aspects of this system with the state, they did not explicitly or implicitly approve the system or its use. A full view of the MAC system and its application was not provided to HCFA until August 1994, at which time HCFA began expressing its concerns about the system. The first formal request for approval of the MAC system was not made until October 1994, a month after the $315 million in claims were submitted to HCFA.

NEXT STEPS -- County officials have said they may have to impose severe budget reductions if MAC claims are not approved. In part, this is due to the state reportedly withholding payments to counties in anticipation of federal reimbursement. Although HCFA sympathizes with the situation in which California's counties now find themselves, the state's decision to decrease payments to counties is a matter between the state and the counties.

HCFA has offered to provide any appropriate assistance to the health systems of those counties negatively impacted by the state's decision. In addition, HCFA will move forward on several fronts with the state of California to determine whether parts of the MAC claim may be reimbursable and to help design means to provide more resources for counties in the future.

- HHS will continue its effort to assist the state and counties in their identification of any retroactive claims that are separately allowable and documented independent of the MAC system.

- HHS will also work with the state to put in place new State Plan provisions and an approvable cost allocation methodology that identifies the medical service or administrative activities for which federal matching funds will be available in the future, and

- HHS has offered to send a team of Departmental officials to Sacramento immediately to provide technical assistance regarding options for addressing the counties' fiscal crisis.

HCFA is meeting with State and County representatives (February 27 - March 1) to provide technical assistance to the State on developing targeted case management state plan amendments and on identifying and documenting potentially allowable activities imbedded in the current MAC claim.

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California Medi-Cal Administrative Claiming (MAC) Disallowance Questions and Answers

Q: What is it that is being disallowed?

A: The Department of Health and Human Services is disallowing payment of a $315 million claim by the State of California on September 2, 1994 for additional administrative costs of the State's Medi-Cal program. The claim was generated by a new system developed by the state, the "Medi-Cal Administrative Claiming" system. Payment of $489 million for allowable administrative costs has already been made to the State for FY 1994.

Q: What is the MAC System and what does it have to do with this disallowance?

A: The Medi-Cal Administrative Claiming (MAC) system was developed by California and its counties to identify, through periodic time studies of local government employees and their contractors, activities which the State would claim for additional Medicaid administrative matching payment. Reviews by the Health Care Financing Administration and HHS' Office of the Inspector General found the system to be very seriously flawed. The system does not accurately segregate activities that may be claimed for Medicaid administrative matching payment from those which may not.

Q: How much money is involved in this disallowance and how much of it is from Los Angeles County?

A: The amount of the current disallowance is $315,233,627 (claimed Federal share) approximately 92 percent of which, or about $290 million, represents Los Angeles County's share of the claim.

Q: What is the problem with the claim submitted under the MAC system?

A: The great bulk of the claim, to date, appears to represent not separate administrative costs, but medical services or overhead costs for which federal payment has already been made -- either by the Medicaid program or by other federal programs. In these cases, the MAC claim represents a form of double billing. In addition, MAC claims were made for services that are not covered by the Medi-Cal program.

Q: Do you have any specific examples of improper claims?

A: Yes:

- Nurses were claiming activities related to giving immunizations and reporting medical tests results as Medi-Cal administration. Providing immunizations is a Medicaid service not Medicaid administration, and the reporting of medical test results is already reimbursed through the medical services rate and can not be claimed again as administration.

- Pharmacists at clinics claimed the time they used in counseling patients about prescription drugs as Medi-Cal administration even though these activities are already reimbursed through the clinic rate or pharmacy dispensing fee.

- 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 have no direct relationship to the Medi-Cal program. Such general public health campaigns are not allowable unless the campaign is explicitly directed to assisting Medicaid eligible individuals to access the Medicaid program.

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

- County workers claimed activities that were well beyond the scope of Medi-Cal covered services, such as housing referrals, social service referrals, child care referrals, legal service referrals, and related liaison work they performed with the referring agencies.

- Staff at many facilities reported claiming routine, non-Medicaid activities such as training, scheduling, personnel and supervision to MAC. Such general administrative and overhead activities are already accounted for in the Medicaid reimbursement rate paid to those facilities and can not be claimed again separately as administration.

- A number of mental health workers coded all activities, except direct patient contact, to MAC whether Medi-Cal administration or not. Only those administrative activities the workers performed for Medi-Cal administration can be claimed as allowable Medicaid administrative expenditures. Administrative activities that are unrelated to Medi-Cal administration (such as arranging housing, arranging legal services, arranging other social services, etc.) are not allowable Medi-Cal administration and should not be coded to MAC.

Q: Is the problem with MAC claims just some bureaucratic nit picking? Aren't the bulk of the activities erroneously claimed as "administrative" claimable under other statutory authority?

A: No. This decision is based on very fundamental law, not bureaucratic interpretations:

- o First of all, most of these claims have been paid their federal share already. These claims do not represent, for the most part, any new or additional services provided to Medicaid beneficiaries. The federal share has been paid, and we cannot pay for the same service twice.

- o Second, there is indeed a small portion of the claim in which the federal government could contribute a share if the services were covered by Medi-Cal. However, as of now, the state has elected not to cover these services. If the state wished to amend its Medi-Cal plan, add these services, and pay its share, then the federal share would follow automatically for allowable services, in the future. But the federal program cannot make payment for services that are not covered by the state plan.

Q: By this action you have put the counties of California into a crisis situation -- they have no money to pay employees and will need to cut off vital programs. Why have you taken this action against the counties?

A: It is the state, not HHS, which has put the counties in a difficult situation:

- -- The state submitted claims under a system that is seriously flawed, and the system has been applied in such a way as to produce clearly unallowable claims.

- -- The state has further complicated the situation for counties by assuming that federal payment would be made for the MAC claims, including this assumed payment as a credit in the state budget, and reportedly withholding payments from counties on the speculative assumption that the claims would be paid.

These are choices that were made by the state and cannot be remedied by HCFA. In particular, counties must look to the state for the funds that reportedly have been reduced or withheld by the state.

We certainly understand that the counties face difficult fiscal situations as a result of this denial. We are prepared to work with the state and the counties to do all we can to help. But we cannot pay twice for the same service, and we cannot pay for services that aren't covered by Medi-Cal.

Q: What are you going to do to resolve this situation and to help California and its counties?

A: We are involved in a wide range of activities that are aimed at improving the claims by the state on behalf of its counties:

- o We are exploring with the State ways to identify legitimately allowable activities imbedded in the MAC claim which are independent of the MAC system. Since this appears to be a relatively small portion of the claim, and given the efforts needed to tease it out of this complex system, the State is working very closely with us to determine a cost-effective approach.

- o We are providing technical assistance to the state and its counties in designing methods to increase funding to counties in the short-term. Specifically, we have suggested targeted case management and increasing clinic rates for public providers. Moreover Secretary Shalala has personally written to Governor Wilson and offered to send a Departmental team that is ready to travel to Sacramento immediately to work with the State in efforts to assist the affected counties.

- o For the future, we are helping the State put in place State Plan provisions and an approvable cost allocation methodology. The cost allocation methodology will identify the medical service or administrative activities for which Federal matching funds will be available in the future.

- o HCFA met with State and County representatives earlier this week (February 27 - March 1) to assist in developing state plan amendments and identifying and documenting the allowable activities in the MAC claim.

Q: How long do you think it would take for California to receive any sort of remedy through the appeals process?

A: The length of the appeal would depend primarily on California -- that is, the State's decision regarding pursuing an appeal, and how long its attorneys wished to take to prepare their case. Secretary Shalala said in her letter to Governor Wilson that she would do all in her power to assure an expedited appeals process for this case, if the State does elect to appeal. While the Departmental Appeals Board is independent in setting its schedule, we would request that the Board move this case forward to receive immediate attention, once the State's case was prepared.

Q: California cites two other states, West Virginia and Maryland, where HCFA had disallowed the entire claim, but later settled with the state. Why couldn't you do this with the California claim?

A: In the case of West Virginia, HCFA disallowed the entire claim, then did an extensive audit and determined that about half of the claim was allowable, so HCFA paid that amount to the state. We have expressed our willingness to assist California in the same manner, that is, identifying those activities imbedded in the MAC claim which are legitimately allowable independent of the MAC system. Unfortunately, based on work with the State so far, we expect that only a very small percentage of California's claim may be allowable.

In the case of Maryland, HHS' Departmental Appeals Board issued a draft decision concluding that the administrative costs claimed by Maryland fell within the "narrow scope" of reasonable and allowable costs authorized under the law and applicable regulations. There were no issues concerning duplicate payments. Under these circumstances, HCFA paid the claim.

Q: Is the MAC system redeemable? Does it need to be replaced in full?

A: The MAC system is supposed to identify legitimate Medicaid administrative activities, the time spent on these activities for Medicaid administrative purposes, and the related costs of the time spent. However, the great bulk of the MAC-generated claim is for activities that are not Medicaid administration but Medicaid services. It is questionable whether the State and the Counties need a system as administratively complex and burdensome as MAC to support the limited amount of administrative activities that may be allowable.

We are working with the State and the Counties to put in place state plan provisions and an approvable cost allocation methodology.

Q: The State argues that approval of its cost allocation plan by the HHS Division of Cost Allocation (DCA) was "de facto" approval of MAC. Is this a reasonable argument?

A: No. Cost allocation and the claiming system are not the same entity. Cost allocation plans determine what portion of administrative costs should be charged to various different HHS programs. But approval of cost allocation does not constitute approval of the claiming system. Further, the DCA letter makes it clear that approval of a cost allocation methodology does not constitute approval of activities that would conflict with program rules or law. Even if the claiming system had been approved, we could not pay duplicate claims or claims for services not covered by Medi-Cal.

Q: Are states legally required to ask for approval of the manner in which they calculate the funds they claim?

A: In general, the answer is no, except in certain situations where the Medicaid statute requires prior approval by HHS or HCFA such as for cost allocation plans, contracts, and various state plan amendments. In addition, states will typically approach HCFA for technical assistance when they are making significant changes to their program, even if formal prior approval is not required. It was the State of California that elected to ask HCFA for approval of the MAC system, a month after submitting the MAC claim.

Of course, in all of these instances, the actual expenditures that are being claimed must meet all applicable requirements.

Q: The county alleges a "delay" in HCFA's decision on MAC claims (from July to the present). Why this 7-month "delay"?

A: The claim was submitted to HCFA September 2, 1994. HCFA officially notified the State of the decision to defer payment on October 7. This was only some 35 days after the claim was actually submitted. Since October, we have worked intensively with the state to determine what might be done to untangle the claims made under MAC.

(The first time a claim for LA County was submitted to HCFA by the State was on the Medicaid expenditure report for the quarter ended June 30, 1994. This report was submitted to HCFA by the State on September 2, 1994 and contained the claim at issue of $315 million with the LA County portion being $290 million. Even before this claim was submitted, HCFA reviewers went to LA County August 29 through September 1, 1994 to review the MAC system and the County was informed during an exit conference at the end of that review of our serious concerns with the claim. HCFA officially notified the State on October 7, 1994 of our decision to defer payment of the claim and our problems with the MAC system.)

Q: California has asserted that it was blind-sided on this disallowance since it had worked with the HCFA Regional Office for 2 years on the MAC system and had obtained HCFA's tacit approval. Is this true?

A: No. HCFA regional office staff discussed some aspects of this system with the State over time, but did not explicitly or implicitly approve the system or its use.

In particular, there was no way for HCFA to know that the state would improperly apply an "administrative claims" system in such a way as to capture medical services costs that had already been paid, and claim them again as administrative costs.

A full view of the MAC system and its application was not provided to HCFA until August 1994. It was only at that time that the improper application of the system began to be made known to HCFA. The first formal request for approval of the MAC system was not made until October, 1994 -- a month after $315 million in claims were formally submitted to HCFA. Since that time, HCFA has worked intensively with the state to identify any valid elements of the MAC system, and to suggest system changes to produce legitimate, covered claims in the future.

Of course, whether a claiming system is approved or not, HCFA cannot approve claims that are duplicative or otherwise contrary to the Medicaid statute.

Q: Will there be subsequent disallowances? Are there more claims in process?

A: Clearly there would be subsequent disallowances if the State chose to continue to submit flawed claims under the MAC system.

(In addition, the State submitted a MAC claim for approximately $10 million in federal match for various counties on its Medicaid Expenditure Report for the quarter ended September 30, 1994. This amount has been deferred.)

Q: Are you disallowing this claim because the activities were unimportant or just to save the Federal government money?

A: Neither is true. The disallowance is required by the Medicaid statute. Most of these claims are duplicative -- the federal government has already paid its share of these services. In a few other cases, the claims are for services not covered by Medi-Cal -- federal payment cannot be made for services that are not covered by the Medi-Cal program.

Q: Why does LA County cite $641 million and HCFA cite $315 million?

A: HCFA is citing $315,233,627 FFP, which is the actual Federal share amount that the State submitted for reimbursement on its expenditure report for the quarter ended June 30, 1994. The LA County portion of the claim is $289,775,816 FFP. The County may have submitted additional claims to the State which the State has not submitted to HCFA. The County should answer questions about how it computed its numbers.

Q: In one news article, Los Angeles County appears to allege that HCFA has already paid some $18 million of MAC-generated claims. Is this true? How much? When?

A: Yes. The following amounts were claimed and paid by HCFA subject to further audit and review:

Quarter	Federal Share Amount
March 31, 1993	$ 976,346
June 30, 1993	$ 4,279,670
September 30, 1993	$ 1,464,707
December 31, 1993	$ 4,795,270
March 31, 1993	$ 6,221,555
Total	$17,737,548

None of these claims were from Los Angeles County. These amounts were paid subject to further review as agreed to between the State and HCFA. This is the routine way in which we operate given the magnitude and number of claims that are submitted each quarter from a State the size of California. If a claim is not readily apparent as unallowable or questionable on its face during our very limited initial review of the State's expenditure report each quarter we will pay that claim subject to further review. This is done largely to accommodate state cash flow needs. This fact is noted on all grant awards going to all States, including California.

Q: You have said that if the MAC system were implemented nation-wide, it would cost the federal government an additional $9 billion. Where does the estimate of $9 billion come from? Isn't this a red herring because the MAC system is unique?

A: As a rough estimate, HCFA determined the worst case Federal cost if all States implemented the MAC system and claimed administrative costs at the same level as California's. California projects its Medicaid administrative costs using MAC to be between 14 and 15.5 percent of Medicaid services costs. We applied the figure of 15 percent to the current total U.S. fiscal year 1995 Medicaid service estimates, which produced an amount of approximately $13.3 billion. We subtracted the amount of total U.S. administrative costs that States were already estimating, which was approximately $4.3 billion. Thus, the potential worst case additional increment of administrative costs due to the MAC system is approximately $9 billion. Actual costs could be less depending on decisions made by each State in implementing a MAC-type program.

The MAC system is not unique. We are aware of two other states that have contracts with the consultant who helped California develop the MAC system. In addition, other states have expressed interest in learning more about the MAC system.

But it is also important to repeat: This claim is not being denied because of its cost. It is being denied because the MAC system has generated flawed claims that are mostly duplicative -- they have already been paid as medical care costs. These duplicative costs are not payable under Medicaid law.

Q: Is it true that other States are using MAC-type systems?

A: We are not aware of any other States using MAC-type systems although we do know that the contractor who worked with the Counties in California is also working with a number of other States to develop MAC-type systems. However, other States do use time study type systems to submit administrative claims to Medicaid and other Federal grant programs.

Q: Isn't it true that other States are being reimbursed for the same kinds of services that California is claiming which HCFA says are not administrative but rather medical. Are those services being covered by the Federal share of Medicaid?

A: Most of the MAC claims are unallowable because they are duplicate claims. Such claims would not be payable under any circumstances.

In addition, a portion of the MAC claims are found unallowable because they are for activities not covered by the Medi-Cal State plan. For the future, the state could indeed elect to include coverage of these services under its Medi-Cal plan, as other states have done, and then such claims could be matched with federal funds.

(In other states where such reimbursement is being made, the states have properly accounted for those activities in their medical services reimbursement rates paid to providers, or they have implemented targeted case management State plan amendments to enable them to cover the services and receive federal reimbursement. These options are available to California on a prospective basis.)

Of course, duplicative claims are not payable, and that constitutes the bulk of California's MAC claim.

Q: Isn't reimbursement too low for the medical services delivered under Medi-Cal?

A: Many health providers in California do indeed maintain that Medi-Cal reimbursement rates are too low. But these rates are set by the state, not the federal government. If the state elected to increase its reimbursement rates, the federal share would match the state payments. The initiative here lies with the state.

Q: Why doesn't California change its rates?

A: This is a question which should be answered by the state. Obviously, to raise rates would mean higher state expenditures. We have offered the State technical assistance to change its rates. However, in the end, it is up to the State to decide the rates it will pay.

Q: If the Medicaid program were block-granted, would this situation have occurred?

A: No. The concept of matching claims would be abolished under a block-grant system. The State could use its money with little oversight. However, the amount of money provided to the state would not increase to match the state's spending, as happens at present.

Thus, under a block grant system, if California sought to use its Medicaid funds for services not related to the Medicaid program (as it did under the MAC system), the State's action would directly impair its ability to take care of the health care needs of the Medi-Cal population.

Q: Is the HHS Inspector General investigating a whistle-blower's account, as reported in the 2/15 edition of BNA?

A: We can't comment on possible independent investigations by the Inspector General.