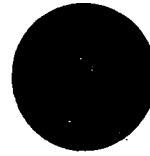


ISSUES TO BE RESOLVED

- o Message on day disallowance is announced:
 - How much to criticize state (HHS expects to hit them hard)
 - How to distinguish county role from state role?
 - Press inquiries answered from HHS or White House?
 - Can DOJ effort be announced at that time?
 - Some at HHS believe that plan is to announce bad news first, and follow up with any good news a few days later
 - Should Bruce Vladeck travel to Sacramento that day to show level of concern/interest? editorial boards?
 - what is message, in a few sentences?
- o Role of DOJ: Are we clear that we can bring them in unilaterally, or do we require the State's cooperation to do so? What steps are necessary, and does the timing work with a Wednesday announcement of the disallowance?
- o What do we expect the outcome of the two-track process to be?
 - DOJ track depends on DOJ
 - Other track: just put pressure on state, or do we expect significant relief

THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY

CAROL H. RASCO
Assistant to the President for Domestic Policy



To: To: DANA FORUM

Draft response for POTUS
and forward to CHR by: _____

Draft response for CHR by: _____

Please reply directly to the writer
(copy to CHR) by: _____

Please advise by: _____

Let's discuss: _____

For your information: ☒ _____

Reply using form code: _____

File: _____

Send copy to (original to CHR): _____

Schedule ? : ☐ Accept ☐ Pending ☐ Regret

Designee to attend: _____

Remarks: _____

COUNTY OF LOS ANGELES
Chief Administrative Office
Strategic Planning Branch

FEB 21 1995

PLEASE DELIVER TO:Date: February 16, 1995Name: John EmersonAgency: Special AssistantTelecopier Number: 1 (202) 456-5558**FROM:**Name: Gerald A. RoosTelephone Number: 1 (213) 974-1151

Subject: Five-Signature Letter to Governor Pete Wilson, Speaker
Willie Brown, and Pro Tem Bill Lockyer RE: Medi-Cal Administrative
Fee

Number of Pages (not including cover sheet) 2**NOTE**

C.C. Card Rasco
Martha Foley

File 5/19/95/HRPA

We are sending from a Xerox Telecopier 7021, telephone number (213) 626-7827. Please call us if the telecopy you receive is incomplete or illegible. Our telephone number is (213) 974-1115.



**BOARD OF SUPERVISORS
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303 KENNETH HAHN HALL OF ADMINISTRATION / LOS ANGELES, CALIFORNIA 90012

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JOANNE STURGES, EXECUTIVE OFFICER
(213) 974-1411

February 15, 1995

Honorable Pete Wilson
Governor, State of California
1st Floor, State Capitol
Sacramento, California 95814

Honorable Willie Brown, Jr.
Speaker, State Assembly
219 Capitol Building
Sacramento, California 95814

Honorable Bill Lockyer
Pro Tem, State Senate
2032 Capitol Building
Sacramento, California 95814

Gentlemen:

MEDI-CAL ADMINISTRATIVE FEE

We are writing to request your assistance in resolving the problems that are being encountered by the State Department of Health Services in obtaining payment for Medi-Cal Administrative claims (MAC). Due to the Health Care Financing Administration's (HCFA) deferral action of October 7, 1994, approximately \$800 million annually is in jeopardy for the counties of California. The State could help to positively resolve this issue by taking the following actions on an urgency basis. Specifically:

- Help break the current negotiation logjam with the Federal government by enacting legislation which would repeal the MAC administrative fee of \$200 million annually.
- Help ensure fiscal stability of the counties throughout the State and maintain the health safety net by proactively resolving the deadlock.
- Ensure that the State proceed with immediate implementation of a revised claiming methodology, for this program, that meets with the approval of the HCFA and will provide comparable revenues to counties.

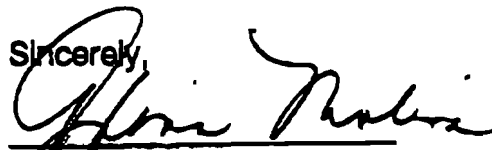
It has become very clear that if the above actions are not taken, it may not be possible to resolve this issue in a satisfactory manner. That would result in the loss of hundreds of millions of dollars that counties and schools have claimed in good faith over a

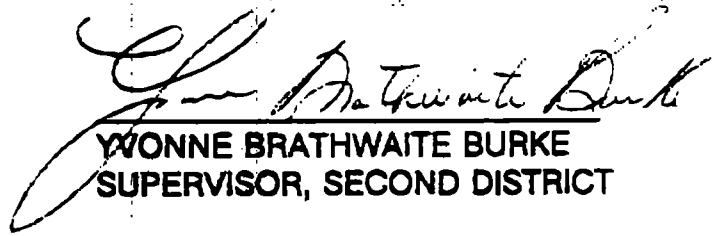
Honorable Pete Wilson
February 15, 1995
Page 2

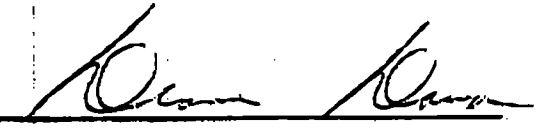
three-year period. While it is very probable that the State could prevail on the issues, counties do not have the luxury of waiting two years for the outcome of litigation. Time is of the essence in resolving this issue as counties' budgets are in grave jeopardy.

We look forward to your prompt and favorable reply to this request.

Sincerely,


GLORIA MOLINA, CHAIR
BOARD OF SUPERVISORS


YVONNE BRATHWAITE BURKE
SUPERVISOR, SECOND DISTRICT


DEANE DANA
SUPERVISOR, FOURTH DISTRICT


ZEV YAROSLAVSKY
SUPERVISOR, THIRD DISTRICT


MICHAEL D. ANTONOVICH
SUPERVISOR, FIFTH DISTRICT

c: California State Association of Counties

THE WHITE HOUSE
WASHINGTON

FAX COVER SHEET

OFFICE OF THE ASSISTANT TO THE PRESIDENT FOR DOMESTIC POLICY
SECOND FLOOR, WEST WING
THE WHITE HOUSE
WASHINGTON, DC 20500
(202) 456-2216 PHONE
(202) 456-2878 FAX

TO: Diana Fortuna
FAX #: x67028
FROM: CAROL H. RASCO
DATE: 2/21/95
NUMBER OF PAGES (including cover sheet): 4
COMMENTS: _____

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Katherine at (202) 456-2216.

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COUNTY OF LOS ANGELES
Chief Administrative Office
Strategic Planning Branch

FEB 21 1995

PLEASE DELIVER TO:

Date: February 16, 1995

Name: John Emerson

Agency: Special Assistant

Telecopier Number: 1 (202) 456-5558

FROM:

Name: Gerald A. Roos

Telephone Number: 1 (213) 974-1151

Subject: Five-Signature Letter to Governor Pete Wilson, Speaker
Willie Brown, and Pro Tem Bill Lockyer RE: Medi-Cal Administrative
Fee

Number of Pages (not including cover sheet) 2

NOTE

*CC: Card Pasco
Martha Foley*

File 5-14-95/HR PA

We are sending from a Xerox Telecopier 7021, telephone number (213) 626-7827. Please call us if the telecopy you receive is incomplete or illegible. Our telephone number is (213) 974-1115.

Does Ab know Leon
may want to roll out

TF/whatever in his
own way + that

it has not yet been
revealed to HHS?



BOARD OF SUPERVISORS COUNTY OF LOS ANGELES

383 KENNETH MAHN HALL OF ADMINISTRATION / LOS ANGELES, CALIFORNIA 90012

MEMBERS OF THE BOARD

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February 15, 1995

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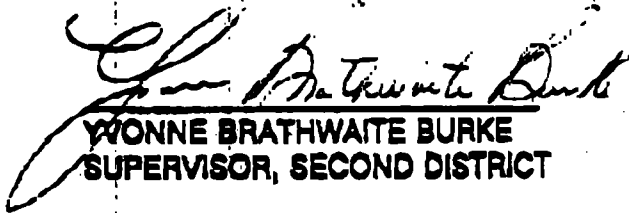
Honorable Pete Wilson
February 15, 1985
Page 2

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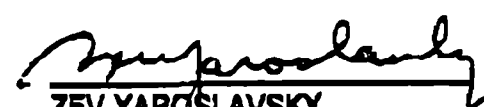
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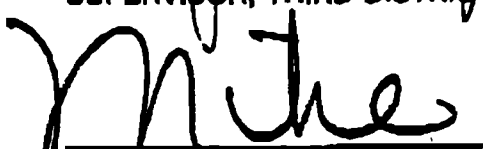
Sincerely,


GLORIA MOLINA, CHAIR
BOARD OF SUPERVISORS


WONNE BRATHWAITE BURKE
SUPERVISOR, SECOND DISTRICT


DEANE DANA
SUPERVISOR, FOURTH DISTRICT


ZEV YAROSLAVSKY
SUPERVISOR, THIRD DISTRICT


MICHAEL S. ANTONOVICH
SUPERVISOR, FIFTH DISTRICT

c: California State Association of Counties

TO:

Diana Fortuna

FAX #:

X67028FROM: CAROL E. RASCO

DATE:

2/21/95

NUMBER OF PAGES (including cover sheet):

4

COMMENTS:

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2/20/95

THE WHITE HOUSE
WASHINGTON

TO: CAROL PASCO; MARTHA FORCE

Attached are 2 letters
from HHS that
LA County points to
as part of their
case for tacit
n

approval

— J. E. Emerson

OCT 11 '94 02:51PM DCR WESTERN OFFICE

P.2/6



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the
Regional DirectorRegion IX
50 United Nations Plaza
San Francisco, CA 94102

JAN 13 1993

Victor J. Bianchini, Chief
Financial Management Branch
California Department of Health Services
714/744 P Street
Sacramento, CA 94234-7320

Dear Mr. Bianchini:

This letter provides approval of your department's revised Medical Assistance Program Cost Allocation Plan effective July 1, 1992, which was transmitted to us by your letter dated November 30, 1992.

Acceptance of actual costs claimed in accordance with the approved plan is subject to the following conditions:

- 1. The information contained in the plan and provided by the State in connection with our review of the plan is complete and accurate in all material respects.
- 2. The actual costs claimed by the State are allowable under prevailing cost principles, program regulations and law.
- 3. The claims conform with the administrative and statutory limitations against which they are made.

This approval relates only to the methods of identifying and allocating costs to programs, and nothing contained herein should be construed as approving activities not otherwise authorized by approved program plans or Federal legislation and regulations.

Implementation of the approved Cost Allocation Plan may have to be reviewed by authorized Federal staff. The discussion of inequities during such reviews may require changes to the Plan.

If you have any questions concerning the contents of this letter, please contact Richard Hirsch at 717/221-1111 or 1-800-368-1704.

Sincerely,



David S. Low

Director

Division of Cost Allocation

cc: Lawrence L. McDonough
HCTA/Medicaid

2/17/95

UPDATE ON CALIFORNIA MEDICAID CLAIM

Since Monday's meeting with the Chief of Staff, HHS has done the following:

- o John Monahan spoke for 90 minutes with Yvonne Burke of the LA County Board of Supervisors. She is personally very committed to the county's position that the claim is legitimate. She plans to send Monahan information showing that the HCFA regional staff were complicit in the system. She expressed pessimism about the strategy of trying to pressure the state to raise provider rates. Monahan indicated that our strategy might be to emphasize that these are double billings, but she said LA County would defend itself by trotting out people who performed legitimate Medicaid-eligible work. She recommended that HHS talk to each of the five supervisors, which Monahan has been trying to do.
- o John Monahan is in California today to speak to Willie Brown; Democratic Senate leader Bill Lockyear; representatives from San Francisco and Alameda counties; and State Human Services head Kim Belshe.
- o HHS has talked with Rep. Waxman, who expressed sympathy with HHS's position, but said that he did not think he could be helpful with Republicans or with the public message. He was not optimistic about the likelihood of Sacramento agreeing to raise Medicaid rates because of state budget problems and Wilson's likely stance on such a proposal.
- o HHS plans to meet with Sen. Boxer on Wednesday.

HHS/Monahan has been trying to reach Gloria Molina to walk her through the situation and HHS's probable strategy, but has not yet done so. Assuming that you do not wish to get into the details during this meeting with her, it would make sense to recommend that she speak to HHS/Monahan. Yvonne Burke told Monahan that she would call Molina and urge her to speak to HHS/Monahan.

Molina is now chair of the LA county board of supervisors, and one of the highest ranking Hispanic elected officials in LA County.

THE WHITE HOUSE
WASHINGTON

January 13, 1995

MEMORANDUM FOR LEON PANETTA

FROM: Carol H. Rasco 
SUBJECT: California Medicaid Claim

In preparation for the upcoming trip to California, I want to update you on the \$315 million Medicaid claim submitted by the state and Los Angeles County for administrative costs.

Background: The claim is based on a new computerized system for identifying Medicaid administrative costs that are eligible for federal matching payments. Known as the MAC system, it has been under development for a few years and is now being implemented throughout the state. Additional claims are now being received from other counties, with the annual value of claims state-wide expected to be approximately \$700 million. The MAC system purports to identify through time studies the eligible activities of county employees and contractors but, based on several site visits, HCFA believes that the system is flawed and cannot generate valid claims.

HCFA asked the state to respond to its concerns, but did not find the state response persuasive. HCFA's preliminary review suggests that the entire claim should be denied, along with any subsequent claims based on the MAC system. There is a statutory deadline of March 2 to take action on the claim.

Although this claim is for new federal dollars, the state assumed it would be approved for the purposes of its budget. In fact, the state has already cut aid to counties based on an expected increase in Federal payment. Therefore, denial would create significant budget problems for the counties. Los Angeles County asserts that it would have to close all or part of a few public hospitals if the claim is denied. As a result, county officials from around the state are lobbying intensively for approval.

HCFA is concerned that, were other states to follow suit, Medicaid spending would increase nation-wide by \$10 billion, creating a new "donations and taxes" or "disproportionate share hospital" phenomenon, with federal Medicaid spending spiraling without a concomitant increase in services.

Problems with the MAC System: The federal government provides Medicaid matching payments for certain types of administrative activities. In an effort to maximize these payments, the MAC system requires county employees to keep track of their activities and allocate their time in various categories. HCFA alleges that the categories are so broad that activities that are claimable and those that are not are placed in the same category. Also, the system can't distinguish costs that have already been paid by federal and other sources, resulting in double payment.

Much of the claim is for overhead costs of public hospitals and clinics that should be paid as medical services rather than administrative claims. However, the state is reluctant to increase payments to public providers because of the pressure that would create to increase rates to private providers. (The state is being sued because it has not increased clinic rates since 1985.) Much of the claim also appears to be for activities such as adult protective services, juvenile corrections, and child care that have little connection to the Medicaid program.

A former state employee contacted the Department Inspector General and made allegations of fraud and abuse in the system. The IG is following up with an investigation.

Another difficulty is that the state alleges that they consulted with HCFA's regional office in the design of the system. HCFA responds that they provided some technical assistance but in no way approved any aspect of the system.

Next Steps: HCFA has looked at alternative ways to give the state Medicaid relief, but they would only work prospectively, and only for a portion of the current claim. This would leave the counties with significant and immediate budget problems. HCFA is meeting with the state on January 18, and plans to use the meeting to listen to the state's arguments once again. Counties and the state are pressing for a quick decision so that they can resolve their budget situations.

If this issue comes up during the upcoming trip, all that we can say at this time is that HHS and HCFA are studying the matter and are working with the state to evaluate the claim.

In case you have any questions about this issue over the weekend or on Monday, I can be reached at (703)370-1329 or on White House Pager #4046. You can also reach Jeremy Ben-Ami at (202)244-0845 or on White House Pager #4588.

cc: John Emerson
Tom Epstein
Marcia Hale
John Angell
Martha Foley
Michael McCurry



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

JAN 13 1985

MEMO TO: Carol Rasco

FROM: Kevin Thurn *K-T*

SUBJECT: California Administrative Claiming (MAC) System

ISSUE -- Second quarter 1984 claims presented by California for Federal Medicaid matching payments through its MAC system do not constitute valid costs for the administration of the Medi-Cal program. Therefore, we intend to deny these claims totaling approximately \$315 million. We have examined other legal alternatives to provide relief under Medicaid. While none can be employed retrospectively, several hold promise prospectively. If California wishes, we will work closely with them on these alternatives.

We will be meeting with State representatives on Wednesday, January 18. We intend to listen to the State's arguments, but unless we are presented with new information, we will inform the State of our denial of its claims a few days later.

HISTORY AND BACKGROUND -- California recently began using a computerized system to generate claims for Federal Medicaid matching payments for costs which it asserts should be "found necessary by the Secretary for the proper and efficient administration of the State [Medicaid] plan."

- o This "MAC" system purports to identify, through periodic time studies, the activities of county employees and their contractors which should be claimable as Medicaid administration.
- o Both the HCFA regional office and central office staff 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. This activity was supplemented by a review of part of the system by the Department's Inspector General.
- o The reviews established that the MAC system is fundamentally flawed and that most of the claims it generates are not valid administrative costs of the Medicaid program.

- o Based on these findings, we deferred payment of the initial \$315 million MAC claim in October and gave California an opportunity to respond to our findings. The State responded but provided no new information or arguments to support the validity of the MAC system claims. (See attached memo from the Department's Office of General Counsel. The attached memo should not be further disseminated.)
- o We estimate the annualized cost of this system's claims to be approximately \$688 million based on the State's most recent estimates. These costs would be increased costs that California would be claiming for the first time; yet, the State assumed this speculative revenue in balancing its budget for fiscal year 1994. While not relevant to the California decision, we estimate that, were this system used more broadly by other States, it would result in \$10 billion in additional Medicaid costs nation-wide per year.
- o The State has already decreased its payments to its counties based on the anticipated increase in Federal payment for these claims. As a result, the counties are lobbying strongly for the approval of these claims. The \$315 million claim we deferred in October was for Los Angeles County, which was the first to submit a claim under the new system. County officials have told us that they will have to impose severe budget reductions if the claim is not approved.
- o California is actively notifying members of Congress regarding their situation. They are indicating that the billing is legal and that they 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. See point #2 on page 2 of attached memo.) Congressional staff are inclined to side with California at this time. However, they are holding judgement until we let them know our position. The sooner this can happen, the better off we will be.

SYSTEMIC PROBLEMS in MAC -- There are three fundamental problems with the MAC system design.

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

- o The time alleged to be Medicaid claimable is never directly associated with specific Medicaid eligibles, but is imputed to Medicaid eligibles based on the gross percentage of eligibles served by an agency. Our observations indicated that this often resulted in an inaccurate and inflated attribution of costs to Medicaid.
- o The system lacks the capability to distinguish between uncompensated costs and costs which have already been paid by Federal and other sources; therefore, double payment may occur.

ERRONEOUS CLAIMS PRODUCED -- Most of the claims produced by the MAC system are not legitimate Medicaid administrative costs.

- o The largest portion of the claims, to date, appear to represent the overhead costs of providing outpatient hospital or clinic services for which Medicaid payment has already been made as a medical service payment. The State's assertion that the rates paid to providers did not cover costs is contradicted in other State documents and, even if true, does not legitimize an additional payment outside the provider payment system. Moreover, this appears to be a mechanism to increase Federal payments to public hospitals without making similar payments to private providers.
- o Significant portions of the claims represent activities with tangential or no connection to the Medicaid program. These include such things as adult protective services, juvenile corrections, and even child care.
- o A former employee of the State MAC office has contacted the Inspector General and requested it investigate allegations of fraud and abuse in the MAC.

PROBLEM RESOLUTION -- We can find no means to provide retroactive relief to California with regard to the erroneous claims generated by the MAC system. Medicaid law does not permit the types of retroactive changes to a State Medicaid plan needed to resolve California's problem. However, prospectively, a number of solutions are available:

- o The State could increase its payments to clinics and hospitals to recover any uncompensated costs. Unlike the MAC system, this approach would not result in dual payment for overhead costs of providing medical services. However, increasing rates for public providers would result in demands from private providers which the State would find difficult to meet. California is currently in State court defending its continued use of outpatient clinic rates established in 1985.

- o The State could bill for targeted case management for those specific Medicaid eligibles who require assistance in accessing and coordinating medical, educational, and social services. However, billing for these services is more complex than administrative claiming and it would not yield the level of revenue claimed under MAC.
- o The State could restructure its system to isolate claimable administrative activities. However, the bona fide claim resulting from such restructuring would be a small fraction of the inflated MAC claim.

CONCLUSION -- Based on our examination of the MAC system and the claims it has generated for Federal Medicaid matching payments, we intend to do the following:

1. The \$315 million in claims presently deferred (from the quarter ending June 1994) will be disallowed and subsequent claims will be disallowed until such time as California's system is proven capable of generating valid claims for administrative costs.
2. We will offer assistance to the State to develop a valid administrative claiming system and mechanisms to obtain Medicaid service match for activities which are claimable only on that basis.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the General Counsel
Health Care Financing Division

DEC 14 1994

Room 800 East High Rise
6335 Security Boulevard
Baltimore, MD 21207

SUBJECT TO ATTORNEY/CLIENT AND WORK PRODUCT
PRIVILEGES -- DO NOT DISCLOSE

MEMORANDUM

TO : Sally Richardson
Director, Medicaid Bureau

FROM : Donna Eden
Attorney, Office of the General Counsel

SUBJECT: Proposed response to California's reply to deferral of
Medicaid Administrative Claiming (MAC) system claims

Your staff and I have reviewed California's response, dated December 2, 1994, to the deferral of Medicaid claims based on the MAC system. The response makes no new arguments nor does it address a number of the concerns raised by the deferral letter. You may therefore wish to prepare a formal disallowance letter for all claims based on the MAC system. A rough outline of the arguments to support such a disallowance and to defend the subsequent litigation are outlined below, beginning with possible brief replies to California's response. The various elements which could be considered in crafting a settlement are also identified. As we have previously discussed, the options for retroactive relief are far more limited than the options for prospective relief.

California's Response

For the quarter ending June 30, 1994, California submitted a claim which included \$315,293,267 (Federal Share) for prior period expenditures for administrative expenses based on information collected through the MAC system. This system, which was described in more detail in earlier memos, purports to identify administrative expenses incurred by county providers of Medicaid services in performing certain functions related to the administration of the Medicaid plan--outreach, health education, eligibility and case management. The claim was deferred based on issues and concerns identified from review of the MAC system materials, which were first received by central office at the end of the summer of 1994, and a site visit to review implementation of the MAC system in Los Angeles County (LAC).

California's response to the deferral letter is organized around ten points. Each of the State's arguments, and the outline of a proposed HCFA response, is given below.

30 days to appeal to ~~the~~ involvement
They file
We have
usually 6 mo process

Have they proved promising edited
Backcasting opinion? -
- 70 MA OK

71 best - write - Are they right?
- Admin 70% 14% vs 50%

What other states have OK'd timeliness?

1/2 is taking care of pts

Outreach informing

what was CIP approval?
RO - narrow approvals - which any erroneous?
↳ policy vs fin met / depends on instructions

Process - yes/no
by Activity Code? Elements of claim - how structured?
Def of what normally allowable

Are all AC's reimbursed? Prel mtg w/ HCFA?
- TCM

No way to go back + sep wheat from chaff - pay ~~more~~?
Is on a %?
Backcasting?

P4 - % all incorp costs of county providers?
(only county?)

P5 - 4 cost pools

P6 - DAB?

True we would pay much if TCM?
OK as either service or admin
P15 - "only % timeliness" - i.e. no \$ = no claim?
P19 - ACM vs TCM

Long zip code in LA
State

75% of BIS is LA
since then, 40%

Page 2 - Sally Richardson

**SUBJECT TO ATTORNEY/CLIENT AND WORK PRODUCT
PRIVILEGES -- DO NOT DISCLOSE**

1. HCFA has ignored the state's discretion to claim costs administratively.

Section 1903(a)(7) gives authority to determine what administrative costs are "necessary and proper for the general administration of the State plan" to the Secretary, not the State. The State does not have the discretion to segregate certain portions of the Medicaid service cost to claim as Medicaid administration.

HCFA regulations and manuals require administrative costs to be documented, able to be audited, and able to be segregated from costs properly charged to other programs. The MAC system is unable to make this segregation accurately.

2. HCFA Staff actively participated in and implicitly approved the MAC system.

One branch of the Region IX staff was in fact very helpful in providing technical assistance to the group developing the MAC time study system and the MAC manual. That staff, however, was not asked to approve the entire MAC system, nor does it have the authority to do so even if asked. (See, in Chronology of Medical Administrative Claiming prepared by Region IX, various letters from Region IX to the State clearly indicating that approvals of specific allocation methodologies relate only to those methodologies, and that actual payment of claims is contingent on actual costs claimed by the state being allowable under prevailing cost principles, program regulations and law.)

The first formal request for approval of the MAC system was not made until October, 1994, two years after initial implementation of MAC in some counties, and three months after the \$315,000,000 in MAC claims were submitted to HCFA. The Cost Allocation Plan (CAP) approval which California alleges shows approval of MAC, actually refers only to proposed use of targeted case management and other specific changes.

3. California has historically underclaimed federal Medicaid dollars and absorbed health care costs locally.

This point, if true, is irrelevant. HCFA can only pay for those claims which meet the statutory standard for payment: FMAP for claims for medical assistance and administrative costs "necessary and proper, etc." It has no authority to increase a claim one quarter to make up for previously underclaimed amounts which were not covered by the State plan in the previous quarters.

Were
any
(narrow)
approvals
enormous?

Page 3 - Sally Richardson

**SUBJECT TO ATTORNEY/CLIENT AND WORK PRODUCT
PRIVILEGES -- DO NOT DISCLOSE**

4. California's unique demographics require a higher level of administrative support services to Medicaid beneficiaries/ therefore MAC costs are unlikely to be duplicated in other states.

California has failed to link its demographics to specific additional costs of providing Medicaid services to its unusual population. If the State wants to provide additional case management services to particular groups, Congress established payment for targeted case management as a service. CA has not submitted state plan amendment(s) required to implement this option.

Even though California appears to be arguing that additional payment is needed to compensate for additional costs incurred in delivery of services to non-English speaking persons from minority cultures, they do not limit the increases to these clients, but claim them for the English speaking, non-immigrant Medicaid beneficiaries as well.

Also, as to the special problems encountered by the Roybal Clinic (see, affidavit of Irene Recendez, Director of Nursing at Roybal Comprehensive Health Center, Los Angeles County, Tab F of the California response), the manager of the clinic told the site visit team proudly that all the non-physician staff is bi-lingual in English and Spanish because the clinic is targeted to the Spanish population.

5. The deferred claim includes administrative case management and other activities which are clearly allowable.

There may well be some truth in this statement. However, the amount appears to be a very small fraction of the total claim. The difficulty in claiming this amount is that the MAC system is unable to accurately identify and account for these allowable costs. Other documentation would be necessary. Given the poor state of documentation in LA, it may not be readily available.

6. County clinic administrative activity is necessary to facilitate access and effective utilization of services for special needs Medi-Cal beneficiaries and should not be included in rates.

- A. The administrative activities coded by county clinic employees are not "standard medical protocol."

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Some of the activities indeed may not be standard. The MAC system does not accurately identify and account for these activities. Neither the services provided nor the persons served appear on the MAC claim. The accounting for percentage of Medicaid patients varies from gross estimates to actual counts. Since CA has no targeted case management amendments, other than for the developmentally disabled, there is no basis for paying for these additional services directly. The present time study system confuses services such as referral to other Medicaid providers, which is clearly allowable as an administrative cost if not performed as part of clinical encounter, with arranging baby sitting or housing, which are clearly not allowable.

- B. The clinic activities performed by nurses, social workers, and pharmacists were properly coded and claimed as Medi-Cal administrative activities.

There is no definitive evidence to support or refute this assertion. The very limited site visit observations do not support this statement, but these visits were not intended to be a statistically valid sample of MAC units. The provider sites and personnel were selected by county staff, not by the federal team. In any case, the MAC claiming sheets clearly indicate that MAC is seeking reimbursement of a Medicaid share of all uncompensated costs of operating these providers.

- C. The administrative activities coded by county clinic employees should not be reimbursed through the clinic rate.

This statement contradicts a fundamental requirement of the Medicaid provider agreement. 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.

The State argues that county clinic rates should not include administrative functions related to management of unique needs of the Medi-Cal population. The county hospitals and clinics provide care almost exclusively to low income, indigent and uninsured patients who have problems with language, educational, cultural and socio-economic barriers to understanding the health care system and health care issues. This population requires more extensive counseling and guidance by medical staff than the

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average population. Consequently, the State believes that case management is necessary to providing appropriate medical care.

The State agrees that to require it to roll all administrative activities provided in the county outpatient clinics into the direct service rate would force an inappropriate mixing of two entirely different reimbursement systems. However, the State's "MAC Manual, A Handbook for Local Jurisdictions", appears to do just that. It accumulates provider operating costs and compares them to revenues received from Medi-Cal, Medicare, commercial insurers, grant programs, and patient fees. The Manual instructions describe the offsetting of revenues received against operating costs as if funding for the subject clinics was based on cost reimbursement principles rather than on a rate setting methodology established in the State Medicaid plan.

The MAC Manual's cost reimbursement procedures are based on the accumulation of all provider costs in four cost pools, and the offset of these costs by revenues accumulated in four revenue pools. Costs attributable to staff who were time studied are charged directly to MAC in proportion to the time spent on MAC claimable activities. Costs attributable to all other aspects of the provider's operation--travel, training and costs of staff not time studied, including supervisory personnel--are then distributed proportionately to MAC. Revenues are then applied to the cost pools.

Review of the cost and revenue segments of the MAC claiming process demonstrates that the MAC program, in essence, claims unreimbursed program costs as MAC administrative costs. The State, in its December 2 letter, notes that it is not required to reimburse direct service providers, including county health facilities, for their actual costs of providing services. Yet the State is asking HCFA to reimburse "unreimbursed" program costs as administrative costs through the MAC claim. Through the MAC system, the State is attempting to have Medicaid reimburse public providers on a cost reimbursement basis, in clear violation of the requirement that Medicaid provider must accept, as payment in full, the rates paid by the agency.

7. Public health education, outreach, and coordination activities are allowable Medicaid expenditures.

HCFA agrees that some of these costs may be legitimate Medicaid administrative costs. Public health education campaigns, for example, would not be allowable if directed toward an entire population, such as all elderly persons or all seventh graders, but would be allowable if explicitly directed toward

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informing Medicaid eligible persons about a health issue and assisting them to access the Medicaid program.

8. MAC codes and time studying are valid.

Enough of the individual MAC codes include both allowable and unallowable activities within the same code, such as Code 8, which includes allowable translation and unallowable child care services, to render the entire system invalid. The 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 included by the CPT4 as clinical activities, such as obtaining case histories, educating patients, providing referrals to specialists, consulting with other clinicians and service providers, and counseling patients. The codes also fail to distinguish between activities related to administration of the provider facilities--supervision, training, personnel--and administration of the Medicaid program--facilitating eligibility determinations, organizing programs or services required to meet federal Medicaid standards.

9. Medicaid administration may entail referrals to other state and federal programs; there is no duplicate claiming for activities.

The first part of this statement concerning referrals is certainly true and not disputed insofar as the referrals are for services provided under the State Plan. We believe medical referrals from one service provider to another are included in the fee or rate for that service. The second part of this statement is not supported by the observations of the site visit teams or limited review provided by the Office of Inspector General of LAC contract activities.

10. Backcasting is an approvable method of claiming.¹

No. Neither HCFA nor the DAB has approved the use of backcasting. The DAB has said, in three different cases, that backcasting could be approvable, if properly done under certain circumstances. The DAB has never approved use of backcasting in an actual case.

¹"Backcasting" is the use of data, such as a time study, from one quarter to establish a claim for a previous quarter, on the theory that the activities performed and population served have not changed from one quarter to the next.

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HCFA's Position

HCFA's position is developing around two main themes: 1) California's claim is not for administrative case management costs, but the uncompensated costs of operating county direct service providers; such costs may not be paid as administrative costs by the Medicaid program and 2) California's position that it needs additional funds in order to continue providing services to Medicaid beneficiaries directly contradicts the position the State took in two recent cases that the rates for outpatient services are adequate.

1. The costs claimed by the MAC system are not bona fide costs of administering the Medicaid state plan and therefore should not be matched by the Medicaid program at the 50% administrative cost matching rate; they are the uncompensated costs of operating county direct service providers.

The Medicaid program's obligation to pay matching funds on any claim is limited to the statutory authority to pay a percentage of either medical assistance costs or administrative costs, as these terms are defined in statute, regulation and manual. To the extent that the MAC system seeks payment for uncompensated costs of operating county-run providers, it is seeking payments that Medicaid has no obligation or authority to pay.

- A. The Medicaid statute requires or permits payment only for specified expenses. The MAC claims do not fit any of these areas.

(i). Medical Assistance.

Medical assistance is defined in § 1905(a) 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). The federal government has no authority to set state rates; the rate setting method or methods must be set out in the State plan; and federal officials have no authority to retroactively approve rate changes.

Social services are not claimable for matching as medical assistance except:

--where expressly provided as a service under a waiver program for functionally disabled elderly or developmentally disabled under §§ 1929 and 1930;

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--where identified as targeted case management service under § 1915(g), to be provided to a specific population and paid as if medical assistance. This option requires a state plan amendment, and cannot be approved retroactively.

(ii). Administrative Expenses

Section 1903(a)(2) identifies the following as costs to be matched by the federal government at various rates:

--compensation and training of skilled professional medical personnel of the State agency or other public agency*;

--nurse aide training programs*;

--preadmission screening programs*;

--design, development and installation of mechanized claims processing and information systems;

--operation of claims payment system;

--utilization and quality control systems*;

--drug use review systems*;

--immigration status verification systems;

--family planning services and supplies;

--fraud control programs*; and

--other costs of administration*.

Statutory language for items marked with an asterisk includes the phrase: "(as found necessary by the Secretary for the proper and efficient administration of the State plan)." This language indicates that the Secretary, not the individual states, is to determine which claims are to be matched.

B. The MAC claims do not follow the guidance issued by HCFA on payment for administrative expenses:

(i). Regulations on general administrative expenses.

42 CFR 431, Parts 431 through 434 give specific HCFA guidance on general administration, personnel administration, fiscal administration, and contracts. 45 CFR Part 74,

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Administration of Grants, provides guidance for all HHS grant programs, including Medicaid. These regulations include:

- prohibition against double billing of the federal government for the same items or services at 45 CFR 74.53(a).
- requirement that accounting systems used to determine overhead and make appropriate cost allocations among various programs must be able to be audited. 45 CFR Subpart H.
- requirement for accurate reporting and claiming. 45 CFR Subpart I.
- requirement that grant funds be expended for purpose of grant, and not for ineligible persons or unapproved services or functions. 45 CFR Subpart O.

(ii). Targeted case management guidance

HCFA has issued a proposed regulation permitting claiming of case management as a service which can be claimed for FFP. The final regulation will further clarify what is allowable as targeted case management. HCFA received numerous comments on the proposed regulation, many of which questioned the distinction between what should be claimed as targeted case management and what could be claimed as administrative case management. HCFA will be able to clarify this issue in responding to the comments, but will not be able to limit or redefine administrative case management through this regulation.

The DAB has taken a very expansive view of what can be claimed as administrative case management in New Virginia Department of Health & Human Resources, DAB No. 1217 (1992) and Maryland Dep't of Health and Mental Hygiene, DAB Preliminary Analysis (1989). A new, separate regulation defining administrative case management is the only effective way to overturn or modify their interpretation.

(iii). Administrative case management instructions

The difficulty of distinguishing targeted case management from administrative case management, currently articulated at section 4302.2(g) of the State Medicaid Manual, needs further clarification, given the DAB's interpretation of administrative case management. An all-States letter has already been drafted on this subject.

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(iv). EPSDT

The MAC system justifies inclusion of any activity that can be described as intensive informing or health education. These activities are indeed required and reimbursed under EPSDT for eligible children, but are not required for the adult population. They are also not allowable if they are provided to an ineligible population, such as illegal aliens or inmates of public institutions.

- C. The statute does not permit payment under MAC or any other system for duplicate claims, claims for ineligible, or claims for services which are not allowable services:

The MAC system alleges that it removes all other federal and state revenues. The site visits and OIG initial audit identified numerous areas where federal and state revenues were not offset properly. They also identified several areas where the federal government appears to have been billed twice for the same service.

The MAC system does not require accurate counting of the number of Medicaid eligibles served by individual programs. It gives counties and programs the option to use actual numbers of persons served, numbers from previous time periods, or various approximations of the Medicaid eligible population. The site visit teams found a wide range in the accuracy of these approximations.

The MAC system permits counties to submit claims related to services provided to inmates of detention facilities who are awaiting final court placement. Section 1905(a)(25)(A) prohibits payment of medical assistance costs to Medicaid eligibles who are inmates of public institutions, except medical institutions.

- D. Miscellaneous claims made under MAC which should not be paid without further scrutiny now and which would require further refinement if system were to be approved:

(i). Disproportionate hospital share payments.

MAC accounting does not address the portion of disproportionate hospital share payments received by outpatient clinics of hospitals. This issue should be investigated further.

(ii). Capitation payment services.

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San Mateo County has all Medicaid recipients in a managed care program. Primary physicians receive a monthly capitation payment for coordinating all care provided to enrollees. Yet, San Mateo public health nurses and other county personnel are also claiming MAC costs for providing "administrative case management" to precisely the same population. San Mateo personnel argue that they are providing different services: outreach to persons who are eligible but not yet enrolled, which may be properly claimed, and education to ensure that eligibles have access to needed services, which appears to be an activity for which the managed care plan is responsible.

- (iii). Inclusion of all supervisory personnel in MAC administrative cost pool, with proportionate share charged to MAC.
- (iv). Drug utilization review counseling program.

The cost of providing the drug utilization review and counseling program, required by § 1927(g), is charged to MAC at county facilities. Private pharmacists do not get additional fees for DUR counseling; the drug dispensing fee is considered to cover all required services.

2. The State's position that MAC funds are essential to keep county providers in operation directly contradicts the position taken in a recent court case, Orthopaedic Hospital v. Rizer.

California hospitals challenged the adequacy and legitimacy of the Medi-Cal hospital outpatient service rates in two cases, consolidated into Orthopaedic Hospital, et al. v. Rizer, Central District of California, October 8, 1992. It is undisputed that the current Medi-Cal outpatient rates were set in 1981, and increased by only 2% in 1985. With seven minor exceptions, the rates have not changed since. Moreover, the rates paid to outpatient clinics of hospitals are essentially the same rates paid to physicians for performing the same services in an office setting, with the exception of rates paid to hospitals in LAC. Outpatient rates for LAC hospitals are negotiated separately. They also haven't been increased since the early 1980's.

After reviewing the rate-making records, the court found that the State had not considered the federally mandated factors of efficiency, economy, and quality of care in adopting almost all of the Medi-Cal payment rates for hospital outpatient services. It ordered the State to conduct a full rate setting hearing, which the State did on December 16, 1992. On April 18,

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1994, the State Department of Health Services issued its final administrative decision in which it concluded:

Based upon the Rate Study, public comments submitted, and the addendum to the Rate Study, the Department has determined that there is no basis for changing existing Medi-Cal reimbursement for hospital outpatient services, based upon a consideration of efficiency, economy, quality of care, and access. Therefore, the Department hereby readopts Medi-Cal reimbursement levels for hospital outpatient services currently set forth in Medi-Cal regulations.

We believe that the position taken in the rate setting hearing concerning the adequacy of the hospital outpatient rates directly contradicts the State's claim for additional administrative payments to those same hospital outpatient providers and to other county providers whose rates are based on the outpatient rates.

- A. The rates include administrative and overhead costs as well as direct physician's services.

The early California rate studies were conducted in the middle and late 1960's as part of relative value scale studies by simply asking physicians and hospitals what they charged for specific procedures. There was no separate inquiry for administrative charges. Indeed, one adjustment to the 1969 study was made expressly to account for "increases in the costs of nurses and other support staff." This indicates that non-physician staffing costs were included within the rates.

- B. MAC would permit payment of additional amounts to public providers without a parallel increase in payments to private providers for the same service.

The State is attempting to use the administrative cost claiming process to provide additional funding to public providers rather than raising their outpatient or clinic rates. These rates have not been increased since the early 1980's and have not kept pace with inflation of medical costs over the last 10 years. Testimony provided in conjunction with the rate hearing in 1993 indicated that while Medi-Cal costs per visit increased 74 percent from 1982 to 1992, the rates per visit have not increased. Medi-Cal rates have gone from covering 75 percent of costs of outpatient departments in 1982 to 41 percent in 1992,

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private payments per visit have increased from \$120 to \$369, while Medi-Cal payments have essentially remained constant at \$85 per visit; Medicare rates increased from \$135 to \$229.² Comparison of rates paid by different payors for the same services, however, is only one possible measure of the overall adequacy of rates.

The State does not wish to raise its outpatient or clinic rates because of the large expenditures that would be required if these rate increases applied to both public and private providers. Admission of the inadequacy of the rates would moreover obligate the State to make retroactive corrective payments to outpatient providers dating from either 1982 or 1985. Since retroactive relief cannot be claimed against the Medicaid program as a federal program, California would have to bear the burden of these payments by itself.

- C. If a portion of the California population does have special needs requiring case management, California should amend its State Plan to adopt the Targeted Case Management option or devise another methodology to reimburse providers for demonstrated additional costs of treating these beneficiaries.

The program which grew into MAC started as a simple targeted case management program to permit counties to claim the costs of targeted case management as medical assistance, under the provisions of § 1915(g). California abandoned this approach when it decided that the MAC approach offered the possibility of far greater income without the need for a State Plan amendment, identification of the target populations, or identification of dates of service and other burdensome accounting and documentation requirements. Nonetheless, the site visit teams observed that many of the populations served by county staff who were time studying for MAC would be appropriate candidates for targeted case management. These included groups of frail elderly, tuberculosis patients, certain groups of mentally ill persons, and groups with specific chronic diseases such as hypertension and diabetes. We note that this approach also would ensure that beneficiaries actually receive bona fide case management services. Under MAC, no additional services are provided to beneficiaries.

²Testimony on Rate Study by the California Department of Health Services, provided by Henry W. Zaratsky, consulting health economist, December 16, 1993.

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Alternatively, the State might adjust its payment rates for public providers. This may be accomplished through a modification of its State plan if the State could justify the need for increasing the rates of public outpatient providers (and the amount of that increase), over those rates used to reimburse private providers.

Settlement Options

You also asked for possible settlement options on this claim. Prospectively, we can encourage California to a) increase its outpatient rates and b) pursue use of targeted case management options to permit claiming of case management expenses for groups with special needs. Both options could increase federal matching revenue substantially. Both options require state plan amendments and may only take effect prospectively.

Retroactively, there is no sound basis for paying the current claim. The evidence to date indicates that the MAC system is so seriously flawed in both design and application that it should not be used as the basis for Medicaid administrative claiming. Some counties may well have separate documentation to support at least a small portion of their retrospective claims. They should be encouraged to submit this documentation as soon as possible. Other counties, including LAC, will not have such documentation and thus will not be able to support their existing claims.

Furthermore, we believe there is no basis for approving any of California's claim based on backcasting. Instead, we recommend letting the DAB decide whether this case presents the circumstances appropriate for use of backcasting.

Please call me at (410) 965-8859 for further information.

Streamlining of Child Welfare Programs: On January 23, the Ways and Means Subcommittee on Oversight will hold a hearing to examine whether federal child welfare programs could be streamlined to better help children. **Mary Jo Bane, Assistant Secretary for Children and Families**, will testify (Date: January 23 Time: 10:00 a.m.; Location: 1100 Longworth).

January 24

Contract with America: On January 24, 25, and 26, the House Ways and Means Committee will continue its series of hearings on the provisions of the "Contract with America" that affect taxes, savings and investment. (Time: 10:00AM, Location: 1100 Longworth).

January 25

Welfare Reform: On January 25, the Senate Governmental Affairs Committee will hold a hearing on proposed revisions to the welfare system as part of a plan to reinvent government. **Mary Jo Bane, Assistant Secretary for Children and Families**, will testify. (Date: January 23 Time: 9:30 AM Location: 342 Dirksen).

January 27

Changing Eligibility for SSI: On January 27, the Ways and Means Subcommittee on Human Resources will hold a hearing on changing eligibility requirements for SSI as it relates to the Contract with America. A Department witness is not expected to testify. (Date: January 27 Time: 10:00AM Location: 1100 Longworth).

Diana -
I plan to
send an intern
unless you want
to go for some
season!

-T.

NGA Sat pm

System - county clinic wks

- time study codes - 2 yrs ago

- either faout social servs

} admin case
mgt

→ DAB

- RO involvement ^{or} provider/in rates

- "TCM" ^{to} SPA

- IG

- precedent #2-10b

- Prem estoppel

- TCM

- Rate rise

(-DAB)

retra SPA'S

- Sampling each code - 10-15¢ on dollar

March - IG invest done

1/4 LAC budget 600/2.4b - 1/2 way thru

Stark, Waxman, Frazee, Matsui

Double-billing →

Confusion over ACM/TCM -
clarification?

ACM/TCM

Options

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

20-Jan-1995 08:56am

TO: Jeremy D. Benami
FROM: Julie E. Demeo
 Domestic Policy Council
CC: Diana M. Fortuna
SUBJECT: RE: Attendees at California meeting Monday

CALIFORNIA MEDICAID MEETING:

So far here's the list:

1. CHR
2. Ben-Ami
3. Fortuna
4. Hale
5. Min
6. Foley
7. Neuwirth
8. Vladeck
9. Monahan
10. Thurm

11. Klepner
12. Harriet Rabb (or deputy)

FYI Diana: there are regularly 12 seats at Carol's table, however 14 can fit somewhat comfortably. I'd say that your absolute max for meetings in her office is 15 to 16. If you know beforehand there will be 15 people, we should try to get another room, because inevitably more people than are planned for/invited end up coming!

ALSO: Diana, let me know if you definately want Klepner and Rabb. I will need to know TWO THINGS:

1. If you are calling them or want me to.
2. If you call them then either their Dates of Birth (in order to sign them in), or the okay for me to call them to get it (I don't want to call if for some reason you decide they are not invited).

Let me know!

THANKS!

P.S. JEREMY & DIANA: Please take a final look at the list I have above and make sure it is correct. If someone is not listed that should be, it means they were not invited by me yet.

TO: Julie
FR: Diana
RE: Scheduling meeting on "California Medicaid Claim"

The meeting on this subject should include:

Carol
Jeremy
Me
John Angell and/or Martha Foley
Marcia Hale or John Hart
Invite OMB (Nancy-Ann Min or representative)
Invite John Podesta or representative
Invite a rep from GC (Steve Neuwirth is coming to our
pre-meeting today)

For those people where I said "invite", it's not a disaster if they can't be there, though it would be really nice if they could.

Carol said that we may or may not invite John Emerson and Tom Epstein, so hold off on those until you hear from Jeremy.

From HHS: call Kevin Thurm or John Monahan, and tell whoever that we need them plus Bruce Vladeck. If they want to bring more people (which they probably will), check with me when I get back or check with Jeremy, so we can see how crowded the room will be.

I am back around 3 on Wednesday, but I could be delayed due to plane delays (I'll be in Puerto Rico). I will check my home message machine once or twice a day (202) 797-3620.

There is one other time I would really ask that you not schedule it. I have a doctor's appointment at 11:15 on Friday that I would really like to make. I will leave at 10:45 and be back by around 12:45. I know these times looked promising on Carol's schedule, so sorry about that.

cc: Jeremy



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

JAN 13 1995

MEMO TO: Carol Rasco

FROM: Kevin Thurn *K-T*

SUBJECT: California Administrative Claiming (MAC) System

ISSUE -- Second quarter 1994 claims presented by California for Federal Medicaid matching payments through its MAC system do not constitute valid costs for the administration of the Medi-Cal program. Therefore, we intend to deny these claims totaling approximately \$315 million. We have examined other legal alternatives to provide relief under Medicaid. While none can be employed retrospectively, several hold promise prospectively. If California wishes, we will work closely with them on these alternatives.

We will be meeting with state representatives on Wednesday, January 18. We intend to listen to the State's arguments, but unless we are presented with new information, we will inform the State of our denial of its claims a few days later.

HISTORY AND BACKGROUND -- California recently began using a computerized system to generate claims for Federal Medicaid matching payments for costs which it asserts should be "found necessary by the Secretary for the proper and efficient administration of the State [Medicaid] plan."

- o This "MAC" system purports to identify, through periodic time studies, the activities of county employees and their contractors which should be claimable as Medicaid administration.
- o Both the HCFA regional office and central office staff 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. This activity was supplemented by a review of part of the system by the Department's Inspector General.
- o The reviews established that the MAC system is fundamentally flawed and that most of the claims it generates are not valid administrative costs of the Medicaid program.

- o Based on these findings, we deferred payment of the initial \$315 million MAC claim in October and gave California an opportunity to respond to our findings. The State responded but provided no new information or arguments to support the validity of the MAC system claims. (See attached memo from the Department's Office of General Counsel. The attached memo should not be further disseminated.)
- o We estimate the annualized cost of this system's claims to be approximately \$688 million based on the State's most recent estimates. These costs would be increased costs that California would be claiming for the first time; yet, the State assumed this speculative revenue in balancing its budget for fiscal year 1994. While not relevant to the California decision, we estimate that, were this system used more broadly by other States, it would result in \$10 billion in additional Medicaid costs nation-wide per year.
- o The State has already decreased its payments to its counties based on the anticipated increase in Federal payment for these claims. As a result, the counties are lobbying strongly for the approval of these claims. The \$315 million claim we deferred in October was for Los Angeles County, which was the first to submit a claim under the new system. County officials have told us that they will have to impose severe budget reductions if the claim is not approved.
- o California is actively notifying members of Congress regarding their situation. They are indicating that the billing is legal and that they 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. See point #2 on page 2 of attached memo.) Congressional staff are inclined to side with California at this time. However, they are holding judgement until we let them know our position. The sooner this can happen, the better off we will be.

SYSTEMIC PROBLEMS in MAC -- There are three fundamental problems with the MAC system design.

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

- o The time alleged to be Medicaid claimable is never directly associated with specific Medicaid eligibles, but is imputed to Medicaid eligibles based on the gross percentage of eligibles served by an agency. Our observations indicated that this often resulted in an inaccurate and inflated attribution of costs to Medicaid.
- o The system lacks the capability to distinguish between uncompensated costs and costs which have already been paid by Federal and other sources; therefore, double payment may occur.

ERRONEOUS CLAIMS PRODUCED -- Most of the claims produced by the MAC system are not legitimate Medicaid administrative costs.

- o The largest portion of the claims, to date, appear to represent the overhead costs of providing outpatient hospital or clinic services for which Medicaid payment has already been made as a medical service payment. The State's assertion that the rates paid to providers did not cover costs is contradicted in other State documents and, even if true, does not legitimize an additional payment outside the provider payment system. Moreover, this appears to be a mechanism to increase Federal payments to public hospitals without making similar payments to private providers.
- o Significant portions of the claims represent activities with tangential or no connection to the Medicaid program. These include such things as adult protective services, juvenile corrections, and even child care.
- o A former employee of the State MAC office has contacted the Inspector General and requested it investigate allegations of fraud and abuse in the MAC.

PROBLEM RESOLUTION -- We can find no means to provide retroactive relief to California with regard to the erroneous claims generated by the MAC system. Medicaid law does not permit the types of retroactive changes to a State Medicaid plan needed to resolve California's problem. However, prospectively, a number of solutions are available:

- o The State could increase its payments to clinics and hospitals to recover any uncompensated costs. Unlike the MAC system, this approach would not result in dual payment for overhead costs of providing medical services. However, increasing rates for public providers would result in demands from private providers which the State would find difficult to meet. California is currently in State court defending its continued use of outpatient clinic rates established in 1985.

- o The State could bill for targeted case management for those specific Medicaid eligibles who require assistance in accessing and coordinating medical, educational, and social services. However, billing for these services is more complex than administrative claiming and it would not yield the level of revenue claimed under MAC.
- o The State could restructure its system to isolate claimable administrative activities. However, the bona fide claim resulting from such restructuring would be a small fraction of the inflated MAC claim.

CONCLUSION -- Based on our examination of the MAC system and the claims it has generated for Federal Medicaid matching payments, we intend to do the following:

1. The \$315 million in claims presently deferred (from the quarter ending June 1994) will be disallowed and subsequent claims will be disallowed until such time as California's system is proven capable of generating valid claims for administrative costs.
2. We will offer assistance to the State to develop a valid administrative claiming system and mechanisms to obtain Medicaid service match for activities which are claimable only on that basis.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the General Counsel
Health Care Financing Division

DEC 14 1994

Room 800 East High Rise
6328 Security Boulevard
Baltimore, MD 21207

SUBJECT TO ATTORNEY/CLIENT AND WORK PRODUCT
PRIVILEGES -- DO NOT DISCLOSE

MEMORANDUM

TO : Sally Richardson
Director, Medicaid Bureau

FROM : Donna Eden
Attorney, Office of the General Counsel

SUBJECT: Proposed response to California's reply to deferral of
Medicaid Administrative Claiming (MAC) system claims

Your staff and I have reviewed California's response, dated December 2, 1994, to the deferral of Medicaid claims based on the MAC system. The response makes no new arguments nor does it address a number of the concerns raised by the deferral letter. You may therefore wish to prepare a formal disallowance letter for all claims based on the MAC system. A rough outline of the arguments to support such a disallowance and to defend the subsequent litigation are outlined below, beginning with possible brief replies to California's response. The various elements which could be considered in crafting a settlement are also identified. As we have previously discussed, the options for retroactive relief are far more limited than the options for prospective relief.

California's Response

For the quarter ending June 30, 1994, California submitted a claim which included \$315,233,267 (Federal Share) for prior period expenditures for administrative expenses based on information collected through the MAC system. This system, which was described in more detail in earlier memos, purports to identify administrative expenses incurred by county providers of Medicaid services in performing certain functions related to the administration of the Medicaid plan--outreach, health education, eligibility and case management. The claim was deferred based on issues and concerns identified from review of the MAC system materials, which were first received by central office at the end of the summer of 1991, and a site visit to review implementation of the MAC system in Los Angeles County (IAC).

California's response to the deferral letter is organized around ten points. Each of the State's arguments, and the outline of a proposed HCFA response, is given below.

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1. HCFA has ignored the state's discretion to claim costs administratively.

Section 1903(a)(7) gives authority to determine what administrative costs are "necessary and proper for the general administration of the State plan" to the Secretary, not the State. The State does not have the discretion to segregate certain portions of the Medicaid service cost to claim as Medicaid administration.

HCFA regulations and manuals require administrative costs to be documented, able to be audited, and able to be segregated from costs properly charged to other programs. The MAC system is unable to make this segregation accurately.

2. HCFA Staff actively participated in and implicitly approved the MAC system.

One branch of the Region IX staff was in fact very helpful in providing technical assistance to the group developing the MAC time study system and the MAC manual. That staff, however, was not asked to approve the entire MAC system, nor does it have the authority to do so even if asked. (See, in Chronology of Medicaid Administrative Claiming prepared by Region IX, various letters from Region IX to the State clearly indicating that approvals of specific allocation methodologies relate only to those methodologies, and that actual payment of claims is contingent on actual costs claimed by the state being allowable under prevailing cost principles, program regulations and law.)

The first formal request for approval of the MAC system was not made until October, 1994, two years after initial implementation of MAC in some counties, and three months after the \$315,000,000 in MAC claims were submitted to HCFA. The Cost Allocation Plan (CAP) approval which California alleges shows approval of MAC, actually refers only to proposed use of targeted case management and other specific changes.

3. California has historically underclaimed federal Medicaid dollars and absorbed health care costs locally.

This point, if true, is irrelevant. HCFA can only pay for those claims which meet the statutory standard for payment: FMAP for claims for medical assistance and administrative costs "necessary and proper, etc." It has no authority to increase a claim one quarter to make up for previously underclaimed amounts which were not covered by the State plan in the previous quarters.

Were
any
"narrow"
approval
means?

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4. California's unique demographics require a higher level of administrative support services to Medicaid beneficiaries/ therefore MAC costs are unlikely to be duplicated in other states.

California has failed to link its demographics to specific additional costs of providing Medicaid services to its unusual population. If the State wants to provide additional case management services to particular groups, Congress established payment for targeted case management as a service. CA has not submitted state plan amendment(s) required to implement this option.

Even though California appears to be arguing that additional payment is needed to compensate for additional costs incurred in delivery of services to non-English speaking persons from minority cultures, they do not limit the increases to these clients, but claim them for the English speaking, non-immigrant Medicaid beneficiaries as well.

Also, as to the special problems encountered by the Roybal Clinic (see, affidavit of Irene Recendez, Director of Nursing at Roybal Comprehensive Health Center, Los Angeles County, Tab F of the California response), the manager of the clinic told the site visit team proudly that all the non-physician staff is bi-lingual in English and Spanish because the clinic is targeted to the Spanish population.

5. The deferred claim includes administrative case management and other activities which are clearly allowable.

There may well be some truth in this statement. However, the amount appears to be a very small fraction of the total claim. The difficulty in claiming this amount is that the MAC system is unable to accurately identify and account for these allowable costs. Other documentation would be necessary. Given the poor state of documentation in LA, it may not be readily available.

6. County clinic administrative activity is necessary to facilitate access and effective utilization of services for special needs Medi-Cal beneficiaries and should not be included in rates.

- A. The administrative activities coded by county clinic employees are not "standard medical protocol."

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Some of the activities indeed may not be standard. The MAC system does not accurately identify and account for these activities. Neither the services provided nor the persons served appear on the MAC claim. The accounting for percentage of Medicaid patients varies from gross estimates to actual counts. Since CA has no targeted case management amendments, other than for the developmentally disabled, there is no basis for paying for these additional services directly. The present time study system confuses services such as referral to other Medicaid providers, which is clearly allowable as an administrative cost if not performed as part of clinical encounter, with arranging baby sitting or housing, which are clearly not allowable.

B. The clinic activities performed by nurses, social workers, and pharmacists were properly coded and claimed as Medi-Cal administrative activities.

There is no definitive evidence to support or refute this assertion. The very limited site visit observations do not support this statement, but these visits were not intended to be a statistically valid sample of MAC units. The provider sites and personnel were selected by county staff, not by the federal team. In any case, the MAC claiming sheets clearly indicate that MAC is seeking reimbursement of a Medicaid share of all uncompensated costs of operating these providers.

C. The administrative activities coded by county clinic employees should not be reimbursed through the clinic rate.

This statement contradicts a fundamental requirement of the Medicaid provider agreement. 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.

The State argues that county clinic rates should not include administrative functions related to management of unique needs of the Medi-Cal population. The county hospitals and clinics provide care almost exclusively to low income, indigent and uninsured patients who have problems with language, educational, cultural and socio-economic barriers to understanding the health care system and health care issues. This population requires more extensive counseling and guidance by medical staff than the

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average population. Consequently, the State believes that case management is necessary to providing appropriate medical care.

The State agrees that to require it to roll all administrative activities provided in the county outpatient clinics into the direct service rate would force an inappropriate mixing of two entirely different reimbursement systems. However, the State's "MAC Manual, A Handbook for Local Jurisdictions", appears to do just that. It accumulates provider operating costs and compares them to revenues received from Medi-Cal, Medicare, commercial insurers, grant programs, and patient fees. The Manual instructions describe the offsetting of revenues received against operating costs as if funding for the subject clinics was based on cost reimbursement principles rather than on a rate setting methodology established in the State Medicaid plan.

The MAC Manual's cost reimbursement procedures are based on the accumulation of all provider costs in four cost pools, and the offset of these costs by revenues accumulated in four revenue pools. Costs attributable to staff who were time studied are charged directly to MAC in proportion to the time spent on MAC claimable activities. Costs attributable to all other aspects of the provider's operation--travel, training and costs of staff not time studied, including supervisory personnel--are then distributed proportionately to MAC. Revenues are then applied to the cost pools.

Review of the cost and revenue segments of the MAC claiming process demonstrates that the MAC program, in essence, claims unreimbursed program costs as MAC administrative costs. The State, in its December 2 letter, notes that it is not required to reimburse direct service providers, including county health facilities, for their actual costs of providing services. Yet the State is asking HCFA to reimburse "unreimbursed" program costs as administrative costs through the MAC claim. Through the MAC system, the State is attempting to have Medicaid reimburse public providers on a cost reimbursement basis, in clear violation of the requirement that Medicaid provider must accept, as payment in full, the rates paid by the agency.

7. Public health education, outreach, and coordination activities are allowable Medicaid expenditures.

HCFA agrees that some of these costs may be legitimate Medicaid administrative costs. Public health education campaigns, for example, would not be allowable if directed toward an entire population, such as all elderly persons or all seventh graders, but would be allowable if explicitly directed toward

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informing Medicaid eligible persons about a health issue and assisting them to access the Medicaid program.

8. MAC codes and time studying are valid.

Enough of the individual MAC codes include both allowable and unallowable activities within the same code, such as Code 8, which includes allowable translation and unallowable child care services, to render the entire system invalid. The 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 included by the CPT4 as clinical activities, such as obtaining case histories, educating patients, providing referrals to specialists, consulting with other clinicians and service providers, and counseling patients. The codes also fail to distinguish between activities related to administration of the provider facilities--supervision, training, personnel--and administration of the Medicaid program--facilitating eligibility determinations, organizing programs or services required to meet federal Medicaid standards.

9. Medicaid administration may entail referrals to other state and federal programs; there is no duplicate claiming for activities.

The first part of this statement concerning referrals is certainly true and not disputed insofar as the referrals are for services provided under the State Plan. We believe medical referrals from one service provider to another are included in the fee or rate for that service. The second part of this statement is not supported by the observations of the site visit teams or limited review provided by the Office of Inspector General of LAC contract activities.

10. Backcasting is an approvable method of claiming.¹

No. Neither HCFA nor the DAB has approved the use of backcasting. The DAB has said, in three different cases, that backcasting could be approvable, if properly done under certain circumstances. The DAB has never approved use of backcasting in an actual case.

¹"Backcasting" is the use of data, such as a time study, from one quarter to establish a claim for a previous quarter, on the theory that the activities performed and population served have not changed from one quarter to the next.

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HCFA's Position

HCFA's position is developing around two main themes: 1) California's claim is not for administrative case management costs, but the uncompensated costs of operating county direct service providers; such costs may not be paid as administrative costs by the Medicaid program and 2) California's position that it needs additional funds in order to continue providing services to Medicaid beneficiaries directly contradicts the position the State took in two recent cases that the rates for outpatient services are adequate.

1. The costs claimed by the MAC system are not bona fide costs of administering the Medicaid state plan and therefore should not be matched by the Medicaid program at the 50% administrative cost matching rate; they are the uncompensated costs of operating county direct service providers.

The Medicaid program's obligation to pay matching funds on any claim is limited to the statutory authority to pay a percentage of either medical assistance costs or administrative costs, as these terms are defined in statute, regulation and manual. To the extent that the MAC system seeks payment for uncompensated costs of operating county-run providers, it is seeking payments that Medicaid has no obligation or authority to pay.

- A. The Medicaid statute requires or permits payment only for specified expenses. The MAC claims do not fit any of these areas.

(1). Medical Assistance.

Medical assistance is defined in § 1905(a) 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). The federal government has no authority to set state rates; the rate setting method or methods must be set out in the State plan, and federal officials have no authority to retroactively approve rate changes.

Social services are not claimable for matching as medical assistance except:

--where expressly provided as a service under a waiver program for functionally disabled elderly or developmentally disabled under §§ 1929 and 1930;

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--where identified as targeted case management service under § 1915(g), to be provided to a specific population and paid as if medical assistance. This option requires a state plan amendment, and cannot be approved retroactively.

(ii). Administrative Expenses

Section 1903(a)(2) identifies the following as costs to be matched by the federal government at various rates:

--compensation and training of skilled professional medical personnel of the State agency or other public agency*;

--nurse aide training programs*;

--preadmission screening programs*;

--design, development and installation of mechanized claims processing and information systems;

--operation of claims payment system;

--utilization and quality control systems*;

--drug use review systems*;

--immigration status verification systems;

--family planning services and supplies;

--fraud control programs*; and

--other costs of administration*.

Statutory language for items marked with an asterisk includes the phrase: "(as found necessary by the Secretary for the proper and efficient administration of the State plan)." This language indicates that the Secretary, not the individual states, is to determine which claims are to be matched.

B. The MAC claims do not follow the guidance issued by HCFA on payment for administrative expenses:

(i). Regulations on general administrative expenses.

42 CFR 431, Parts 431 through 434 give specific HCFA guidance on general administration, personnel administration, fiscal administration, and contracts. 45 CFR Part 74,

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Administration of Grants, provides guidance for all HHS grant programs, including Medicaid. These regulations include:

--prohibition against double billing of the federal government for the same items or services at 43 CFR 74.53(a).

--requirement that accounting systems used to determine overhead and make appropriate cost allocations among various programs must be able to be audited. 45 CFR Subpart K.

--requirement for accurate reporting and claiming. 45 CFR Subpart I.

--requirement that grant funds be expended for purpose of grant, and not for ineligible persons or unapproved services or functions. 45 CFR Subpart O.

(ii). Targeted case management guidance

HCFA has issued a proposed regulation permitting claiming of case management as a service which can be claimed for FFP. The final regulation will further clarify what is allowable as targeted case management. HCFA received numerous comments on the proposed regulation, many of which questioned the distinction between what should be claimed as targeted case management and what could be claimed as administrative case management. HCFA will be able to clarify this issue in responding to the comments, but will not be able to limit or redefine administrative case management through this regulation.

The DAB has taken a very expansive view of what can be claimed as administrative case management in West Virginia Department of Health & Human Resources, DAB No. 1217 (1992) and Maryland Dep't of Health and Mental Hygiene, DAB Preliminary Analysis (1989). A new, separate regulation defining administrative case management is the only effective way to overturn or modify their interpretation.

(iii). Administrative case management instructions

The difficulty of distinguishing targeted case management from administrative case management, currently articulated at section 4302.2(g) of the State Medicaid Manual, needs further clarification, given the DAB's interpretation of administrative case management. An all-States letter has already been drafted on this subject.

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(iv). EPSDT

The MAC system justifies inclusion of any activity that can be described as intensive informing or health education. These activities are indeed required and reimbursed under EPSDT for eligible children, but are not required for the adult population. They are also not allowable if they are provided to an ineligible population, such as illegal aliens or inmates of public institutions.

C. The statute does not permit payment under MAC or any other system for duplicate claims, claims for ineligible, or claims for services which are not allowable services:

The MAC system alleges that it removes all other federal and state revenues. The site visits and OIG initial audit identified numerous areas where federal and state revenues were not offset properly. They also identified several areas where the federal government appears to have been billed twice for the same service.

The MAC system does not require accurate counting of the number of Medicaid eligibles served by individual programs. It gives counties and programs the option to use actual numbers of persons served, numbers from previous time periods, or various approximations of the Medicaid eligible population. The site visit teams found a wide range in the accuracy of these approximations.

The MAC system permits counties to submit claims related to services provided to inmates of detention facilities who are awaiting final court placement. Section 1905(a)(25)(A) prohibits payment of medical assistance costs to Medicaid eligibles who are inmates of public institutions, except medical institutions.

D. Miscellaneous claims made under MAC which should not be paid without further scrutiny now and which would require further refinement if system were to be approved:

(i). Disproportionate hospital share payments.

MAC accounting does not address the portion of disproportionate hospital share payments received by outpatient clinics of hospitals. This issue should be investigated further.

(ii). Capitation payment services.

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San Mateo County has all Medicaid recipients in a managed care program. Primary physicians receive a monthly capitation payment for coordinating all care provided to enrollees. Yet, San Mateo public health nurses and other county personnel are also claiming MAC costs for providing "administrative case management" to precisely the same population. San Mateo personnel argue that they are providing different services: outreach to persons who are eligible but not yet enrolled, which may be properly claimed, and education to ensure that eligibles have access to needed services, which appears to be an activity for which the managed care plan is responsible.

- (iii). Inclusion of all supervisory personnel in MAC administrative cost pool, with proportionate share charged to MAC.
- (iv). Drug utilization review counseling program.

The cost of providing the drug utilization review and counseling program, required by § 1927(g), is charged to MAC at county facilities. Private pharmacists do not get additional fees for DUR counseling; the drug dispensing fee is considered to cover all required services.

- 2. The State's position that MAC funds are essential to keep county providers in operation directly contradicts the position taken in a recent court case, Orthopaedic Hospital v. Kizer.

California hospitals challenged the adequacy and legitimacy of the Medi-Cal hospital outpatient service rates in two cases, consolidated into Orthopaedic Hospital, et al. v. Kizer, Central District of California, October 8, 1992. It is undisputed that the current Medi-Cal outpatient rates were set in 1981, and increased by only 2% in 1985. With seven minor exceptions, the rates have not changed since. Moreover, the rates paid to outpatient clinics of hospitals are essentially the same rates paid to physicians for performing the same services in an office setting, with the exception of rates paid to hospitals in LAC. Outpatient rates for LAC hospitals are negotiated separately. They also haven't been increased since the early 1980's.

After reviewing the rate-making records, the court found that the State had not considered the federally mandated factors of efficiency, economy, and quality of care in adopting almost all of the Medi-Cal payment rates for hospital outpatient services. It ordered the State to conduct a full rate setting hearing, which the State did on December 16, 1992. On April 18,

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1994, the State Department of Health Services issued its final administrative decision in which it concluded:

Based upon the Rate Study, public comments submitted, and the addendum to the Rate Study, the Department has determined that there is no basis for changing existing Medi-Cal reimbursement for hospital outpatient services, based upon a consideration of efficiency, economy, quality of care, and access. Therefore, the Department hereby readopts Medi-Cal reimbursement levels for hospital outpatient services currently set forth in Medi-Cal regulations.

We believe that the position taken in the rate setting hearing concerning the adequacy of the hospital outpatient rates directly contradicts the State's claim for additional administrative payments to those same hospital outpatient providers and to other county providers whose rates are based on the outpatient rates.

- A. The rates include administrative and overhead costs as well as direct physician's services.

The early California rate studies were conducted in the middle and late 1960's as part of relative value scale studies by simply asking physicians and hospitals what they charged for specific procedures. There was no separate inquiry for administrative charges. Indeed, one adjustment to the 1969 study was made expressly to account for "increases in the costs of nurses and other support staff." This indicates that non-physician staffing costs were included within the rates.

- B. MAC would permit payment of additional amounts to public providers without a parallel increase in payments to private providers for the same service.

The State is attempting to use the administrative cost claiming process to provide additional funding to public providers rather than raising their outpatient or clinic rates. These rates have not been increased since the early 1980's and have not kept pace with inflation of medical costs over the last 10 years. Testimony provided in conjunction with the rate hearing in 1993 indicated that while Medi-Cal costs per visit increased 74 percent from 1982 to 1992, the rates per visit have not increased. Medi-Cal rates have gone from covering 75 percent of costs of outpatient departments in 1982 to 41 percent in 1992,

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private payments per visit have increased from \$120 to \$369, while Medi-Cal payments have essentially remained constant at \$83 per visit; Medicare rates increased from \$135 to \$229.³ Comparison of rates paid by different payors for the same services, however, is only one possible measure of the overall adequacy of rates.

The State does not wish to raise its outpatient or clinic rates because of the large expenditures that would be required if these rate increases applied to both public and private providers. Admission of the inadequacy of the rates would moreover obligate the State to make retroactive corrective payments to outpatient providers dating from either 1982 or 1985. Since retroactive relief cannot be claimed against the Medicaid program as a federal program, California would have to bear the burden of these payments by itself.

- C. If a portion of the California population does have special needs requiring case management, California should amend its State Plan to adopt the Targeted Case Management option or devise another methodology to reimburse providers for demonstrated additional costs of treating these beneficiaries.

The program which grew into MAC started as a simple targeted case management program to permit counties to claim the costs of targeted case management as medical assistance, under the provisions of § 1915(g). California abandoned this approach when it decided that the MAC approach offered the possibility of far greater income without the need for a State Plan amendment, identification of the target populations, or identification of dates of service and other burdensome accounting and documentation requirements. Nonetheless, the site visit teams observed that many of the populations served by county staff who were time studying for MAC would be appropriate candidates for targeted case management. These included groups of frail elderly, tuberculosis patients, certain groups of mentally ill persons, and groups with specific chronic diseases such as hypertension and diabetes. We note that this approach also would ensure that beneficiaries actually receive bona fide case management services. Under MAC, no additional services are provided to beneficiaries.

³Testimony on Rate Study by the California Department of Health Services, provided by Henry W. Zaretsky, consulting health economist, December 16, 1993.

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Alternatively, the State might adjust its payment rates for public providers. This may be accomplished through a modification of its State plan if the State could justify the need for increasing the rates of public outpatient providers (and the amount of that increase), over those rates used to reimburse private providers.

Settlement Options

You also asked for possible settlement options on this claim. Prospectively, we can encourage California to a) increase its outpatient rates and b) pursue use of targeted case management options to permit claiming of case management expenses for groups with special needs. Both options could increase federal matching revenue substantially. Both options require state plan amendments and may only take effect prospectively.

Retroactively, there is no sound basis for paying the current claim. The evidence to date indicates that the MAC system is so seriously flawed in both design and application that it should not be used as the basis for Medicaid administrative claiming. Some counties may well have separate documentation to support at least a small portion of their retrospective claims. They should be encouraged to submit this documentation as soon as possible. Other counties, including LAC, will not have such documentation and thus will not be able to support their existing claims.

Furthermore, we believe there is no basis for approving any of California's claim based on backcasting. Instead, we recommend letting the DAB decide whether this case presents the circumstances appropriate for use of backcasting.

Please call me at (410) 965-8859 for further information.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

07-Feb-1995 03:38pm

TO: Jennifer N. Palmieri
TO: John C. Angell

FROM: Carol H. Rasco
 Economic and Domestic Policy

CC: Jeremy D. Benami
CC: Diana M. Fortuna

SUBJECT: California and Medicaid

Leon:

As a follow up to our meeting with Secretary Shalala on the California Medicaid issue I called her this a.m. as she had indicated to you and me that the second IG report (the one in response to the "whistle-blower") would be completed this week. She says she has learned that it will not be completed, possibly not even before the March 2 deadline for giving California a definitive answer on the disallowance. She has asked HCFA to put together a strategy for disallowance to present to us as she feels the IG report will back it once it is out. I have told her we are a bit nervous since there are only three weeks left and that we need to talk strategy long before the midnight hour on March 1.

Please let me know if there is anything further you want me to do other than to check in with her frequently on this matter.

Carol

February 21, 1995

DETERMINED TO BE AN
ADMINISTRATIVE MARKING
INITIALS: By DATE 5/29/2018
2018-0525-S

PRIVILEGED AND CONFIDENTIAL
MEMORANDUM FOR ABNER J. MIKVA

FROM: STEPHEN R. NEUWIRTH

SUBJECT: L.A. MEDICAID CLAIM: SETTLEMENT DISCUSSIONS

QUESTION PRESENTED: If the Administration begins discussions to settle Los Angeles County's pending claim for Medicaid reimbursement, could information exchanged or statements made during those discussions be used as evidence in future litigation?

CONCLUSIONS: Pursuant to Rule 408 of the Federal Rules of Evidence, the fact and content of settlement proposals, or conduct and statements during settlement discussions, would not, as a general matter, be admissible in later judicial proceedings as evidence of the validity of L.A. County's claim or its amount. This rule applies regardless of whether a formal judicial or administrative claim is pending at the time of the settlement discussions.

The HHS General Counsel's Office advises that in an HHS administrative hearing, evidence relating to settlement proposals and discussions similarly would not be admissible as evidence of the validity of L.A.'s claim or its amount. (This is a matter of practice and tradition, since the HHS Departmental Appeals Board is not bound by the Federal Rules of Evidence.)

Documents or statements from settlement proceedings might be admissible in either a judicial or administrative proceeding, however, to establish facts other than the validity of the claim or its amount -- e.g., to negate a contention that a party was not diligent in taking certain action while the negotiations were pending. **In this regard, it is especially important to maintain a distinction between any settlement discussions and the actual decision to deny L.A. County's claim -- that is, the settlement talks should not become a factor in determining whether to deny the claim on the merits -- since evidence concerning the circumstances of the denial might be admissible in future litigation.**

Documents or statements from settlement discussions might also be admissible to impeach the testimony of a witness concerning the witness's knowledge or intentions at the time of the settlement talks. Furthermore, documents and information that are otherwise discoverable in litigation normally remain discoverable even if exchanged during settlement negotiations.

I have been advised that it is not the practice of either the Justice Department or HHS to use written agreements to establish that parties to settlement discussions will not seek to introduce evidence from those discussions in judicial and administrative proceedings. Of course, unless the parties act in good faith, there is little -- other than interest in the long-term relationship with HHS -- to prevent California state or local officials from disclosing to third parties the content of any settlement proposals or discussions.

DISCUSSION

Federal court: Rule 408 of the Federal Rules of Evidence provides that, as a general matter, the proposal, discussion or acceptance of a settlement cannot be introduced in federal court as evidence of the validity or invalidity of a claim or its amount. This general principle applies not only to the fact and substance of settlement proposals, but also to any evidence of "conduct or statements" during settlement negotiations.

Rule 408 makes evidence of settlement proposals and discussions inadmissible even if settlement negotiations took place before any formal claim had been filed. It is only necessary that there have been "an actual dispute" and "at least an apparent difference of view between the parties as to the validity or amount of the claim."¹ In general, a "dispute" will exist when parties disagree on the validity or amount of a claim that may ultimately become the subject of litigation. Thus, for example, a federal district court found that a "dispute" began when several companies took actions that a patent holder considered an infringement of the patent. The Court held that letters from the patent holder to the alleged infringers, in which the patent holder offered to license the patent, constituted settlement proposals that were inadmissible in a proceeding to determine the validity of the patent infringement claim.²

Rule 408 applies not only to settlement offers, but also to settlement agreements. In subsequent litigation between parties to a settlement, acceptance of a settlement offer should not be admissible as evidence of liability.³ This principle extends as well to circumstances where a third party sues one of the parties to the settlement and states a claim arising from a transaction that is the same as or similar to the transaction addressed in the settlement. Weinstein explains that "Rule 408 codifies the general practice of the federal courts in making compromise agreements inadmissible in such circumstances as proof of liability for, or

¹ McCormick, Evidence Vol. 2 § 266, at 194 (4th ed. 1992). See also Weinstein and Berger, Weinstein's Evidence Vol. 2 ¶408[01] at 408-12.

² See Alpex Computer Corp. v. Nintendo Co., 770 F. Supp. 161, 163-64 (S.D.N.Y. 1991). See also Weinstein's Evidence Vol. II ¶ 408[01], at 408-12. But see Big O Tire Dealers v. Goodyear Tire and Rubber Co., 561 F.2d 1365 (10th Cir. 1977), cert. dismissed, 434 U.S. 1052 (1978) (in trademark infringement action, communications between plaintiff and defendant prior to initiation of lawsuit were business communications and not offers to compromise covered by Rule 408).

³ Of course, where a settlement results in an enforcement contract, evidence concerning the settlement offer and its surrounding circumstances can be offered to establish breach of the settlement contract.

invalidity of, the claim or its amount."⁴ As the Second Circuit has observed, "[s]ettlements have always been looked on with favor, and courts have deemed it against public policy to subject a person who has compromised a claim to the hazard of having a settlement proved in a subsequent lawsuit by another person asserting a cause of action arising out of the same transaction."⁵

At the same time, there are several limits on the general exclusionary treatment for evidence of settlement proposals and discussions. Rule 408 itself expressly provides that evidence of settlement negotiations may be used to prove a material fact in issue other than the validity or invalidity of the claim or its amount. Thus, settlement evidence has been admitted to negate a contention that a party failed to exercise due diligence in taking certain action, or to show that the real party in interest had already settled all claims arising from a transaction. Rule 408 also allows evidence of settlement discussions to be admitted to prove the bias or prejudice of a witness -- for example, to impeach a witness's testimony about his knowledge of material facts or his intentions at the time the settlement negotiations occurred.

In addition, if a party acknowledges during settlement negotiations that it is liable for a certain amount, that acknowledgment may be admissible in a later judicial proceeding. The Advisory Committee Note accompanying Rule 408 states that "[t]he policy considerations which underlie the rule do not come into play when the effort is to induce a creditor to settle an admittedly due amount for a lesser sum. Hence, the rule requires that the claim be disputed as to either validity or amount."⁶

Moreover, certain courts have taken a restrictive view of Rule 408: as Weinstein and Berger observe, the Rule "may become irksome when it interferes with the admissibility of evidence that is helpful." In an age discrimination action, for example, the Ninth Circuit held that Rule 408 could not be used to bar evidence concerning the circumstances of the plaintiff's termination. The Court thus upheld the admission of a proposed "settlement agreement and general release" that the defendant employer had presented to the plaintiff at the time of his termination. That proposed agreement, rejected by the plaintiff, had offered \$18,000 in

⁴ Weinstein's Evidence Vol. II ¶408[04] at 408-30-31.

⁵ Hawthorne v. Eckerson Co., 77 F.2d 844, 847 (2d Cir. 1935).

⁶ Weinstein and Berger write that the statement, "All right, I was negligent, so let's talk about damages," would not be admissible because no acknowledgment has been made about the amount of damages due. By contrast, a different type of statement -- "Of course, I owe you the money, but unless you're willing to settle for less, you'll have to sue me for it" -- would be admissible. Weinstein and Berger Vol. II ¶ 408[01] at 408-13.

exchange for the release by plaintiff of all claims against his employer.⁷ In another case, the Ninth Circuit distinguished between "post-termination settlement offers," which are inadmissible as evidence of liability, and "contemporaneous severance pay packages," which are admissible.⁸

Stuart Schiffer, Deputy Assistant Attorney General in the Civil Division, advised that it is not the normal practice of the Justice Department to enter into written agreements setting forth that the parties to settlement discussions will not seek to introduce evidence from those discussions in future litigation proceedings. Stuart noted that Rule 408 already provides such protection.

ADMINISTRATIVE PROCEEDINGS: In the event that HHS formally denies a Medicaid reimbursement claim, the claimant is entitled to challenge that denial in an administrative proceeding before the HHS Departmental Appeals Board.

Darrold Grinstead, of the HHS General Counsel's Office, advised that the Departmental Appeals Board is not bound by the Federal Rules of Evidence. Moreover, there are no written rules otherwise addressing whether evidence relating to settlement discussions can be introduced in proceedings before the Board.

According to Grinstead, however, it is well established, as a matter of practice and tradition, that in actions before the Board, parties cannot introduce evidence of settlement discussions for the purpose of establishing the validity or invalidity of a claim or its amount. Grinstead said that a relatively small community of private firms and state officials participates in settlement discussions with HHS concerning Medicaid claims. He said that these people work with each other regularly and, in practice, do not attempt to introduce into litigation the content of settlement talks.

Grinstead added that it is not the normal practice of HHS to enter into written agreements providing that the parties to settlement discussions will not seek to introduce evidence from those discussions in future judicial or administrative proceedings.

⁷ See Cassino v. Reichold Chemicals, Inc., 817 F.2d 1338, 1343 (9th Cir. 1987), cert. denied, 484 U.S. 1047 (1988).

⁸ See Mundy v. Household Fin. Corp., 885 F.2d 542, 546-47 (9th Cir. 1989).

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