DEC - 4 2007

TO: Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of California's Medicaid Management Information System Expenditures for the Period July 1, 2003, Through June 30, 2005 (A-09-06-00032)

Attached is an advance copy of our final report on California's Medicaid management information system (MMIS) expenditures. We will issue this report to the California Department of Health Care Services (the State agency) within 5 business days.

An MMIS is a system of software and hardware used to process Medicaid claims and manage information about Medicaid beneficiaries and services. Section 1903(a) of the Social Security Act authorizes Federal reimbursement for the operation of an MMIS at an enhanced rate of 75 percent. The Centers for Medicare & Medicaid Services (CMS) "State Medicaid Manual" identifies the specific types of MMIS costs that are allowable for Federal reimbursement. For such costs to be allowable at the enhanced rate of 75 percent, they must be related to the operations of the MMIS for ongoing automated processing of claims, payments, and reports.

In California, the State agency administers the Medicaid program with Federal oversight from CMS. California's MMIS processes both Medicaid and non-Medicaid claims. Non-Medicaid claims include those for other Federal programs and State-only programs, as well as claims for medical services that Medicaid does not cover. Federal regulations require that MMIS costs be equitably allocated to all benefiting programs.

Our objective was to determine whether the State agency's claims for MMIS costs were (1) allowable and equitably allocated and (2) claimed at the correct Federal reimbursement rate. Our audit period covered the 2-year period July 1, 2003, though June 30, 2005, when the State agency claimed $345,805,475 ($254,542,811 Federal share) as MMIS costs for reimbursement under the Medicaid program.

Of the $183,179,805 (Federal share) of MMIS costs that we reviewed, $180,906,594 was allowable. The remaining $2,273,211 consisted of $2,009,782 of unallowable costs that were not

equitably allocated to all benefiting programs, were not related to the Medicaid program, or were claimed twice and $263,429 of postage, administrative, and subcontract costs claimed at the incorrect reimbursement rate. The State agency improperly claimed these costs for Federal reimbursement because it did not have adequate internal controls and procedures to ensure that MMIS costs claimed were allowable, equitably allocated to all benefiting programs, and claimed at the correct reimbursement rate.

We recommend that the State agency:

- refund $2,273,211 to the Federal Government;

- strengthen internal controls and procedures to ensure that MMIS costs claimed for Federal reimbursement are allowable, equitably allocated to all benefiting programs, and claimed at the correct Federal reimbursement rate; and

- review MMIS costs claimed for Federal reimbursement after June 30, 2005, to ensure that the costs claimed were allowable, equitably allocated to all benefiting programs, and claimed at the correct Federal reimbursement rate.

In written comments on the draft report, the State agency partially disagreed with our finding that it did not equitably allocate costs to other benefiting programs. However, the State agency agreed with our other findings related to unallowable costs and costs claimed at the incorrect reimbursement rate. Regarding our recommendations, the State agency agreed to refund $2,273,211 of the $5,557,010 of unallowable costs identified in our draft report. The State agency commented that it is committed to strengthening internal controls and procedures and that it had already reviewed costs claimed for Federal reimbursement after our audit period in light of our findings.

Based on our evaluation of the State agency's comments and our review of additional information that the State agency provided, we revised our report to reflect a refund amount of $2,273,211.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov or Lori A. Ahlstrand, Regional Inspector General for Audit Services, Region IX, at (415) 437-8360 or through e-mail at Lori.Ahlstrand@oig.hhs.gov. Please refer to report number A-09-06-00032.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Region IX
Office of Audit Services
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

DEC - 7 2007

Report Number: A-09-06-00032

Ms. Sandra Shewry
Director
California Department of Health Care Services
P.O. Box 997413
Sacramento, California 95899-7413

Dear Ms. Shewry:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of California's Medicaid Management Information System Expenditures for the Period July 1, 2003, Through June 30, 2005." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, within 10 business days after the final report is issued, it will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Thomas Lenahan, Audit Manager, at (323) 261-7218, extension 604, or through e-mail at Thomas.Lenahan@oig.hhs.gov. Please refer to report number A-09-06-00032 in all correspondence.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Linda Minamoto
Associate Regional Administrator
Division of Medicaid and Children's Health, Region IX
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
90 – 7th Street, Suite 5-300
San Francisco, California 94103-6707

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF CALIFORNIA'S MEDICAID MANAGEMENT INFORMATION SYSTEM EXPENDITURES FOR THE PERIOD JULY 1, 2003, THROUGH JUNE 30, 2005

Daniel R. Levinson
Inspector General

December 2007
A-09-06-00032

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

A Medicaid management information system (MMIS) is a system of software and hardware used to process Medicaid claims and manage information about Medicaid beneficiaries and services. Section 1903(a) of the Social Security Act authorizes Federal reimbursement for the operation of an MMIS at an enhanced rate of 75 percent. The Centers for Medicare & Medicaid Services (CMS) "State Medicaid Manual" identifies the specific types of MMIS costs that are allowable for Federal reimbursement. For such costs to be allowable at the enhanced rate of 75 percent, they must be related to the operations of the MMIS for ongoing automated processing of claims, payments, and reports.

In California, the Department of Health Care Services (the State agency) administers the Medicaid program with Federal oversight from CMS. California's MMIS processes both Medicaid and non-Medicaid claims. Non-Medicaid claims include those for other Federal programs and State-only programs, such as the Genetically Handicapped Persons Program. Non-Medicaid claims also include those for medical services that Medicaid does not cover, such as abortions. Federal regulations require that MMIS costs be equitably allocated to all benefiting programs.

The State agency contracts with a fiscal agent, Electronic Data Systems, to process claims through the MMIS. During the 2-year period July 1, 2003, through June 30, 2005, the State agency claimed $345,805,475 ($254,542,811 Federal share) as MMIS costs for reimbursement under the Medicaid program. We limited our review to $251,023,302 ($183,179,805 Federal share) of the total costs claimed. We did not review invoices that Electronic Data Systems submitted on behalf of the Systems Group ($56,167,305) and Provider Relations ($38,614,868).

OBJECTIVE

Our objective was to determine whether the State agency's claims for MMIS costs were (1) allowable and equitably allocated and (2) claimed at the correct Federal reimbursement rate.

SUMMARY OF FINDINGS

Of the $183,179,805 (Federal share) of MMIS costs that we reviewed, $180,906,594 was allowable. The remaining $2,273,211 consisted of:

- $2,009,782 of unallowable costs that were not equitably allocated to all benefiting programs, were not related to the Medicaid program, or were claimed twice and

- $263,429 of postage, administrative, and subcontract costs claimed at an incorrect reimbursement rate.

The State agency improperly claimed these costs for Federal reimbursement because it did not have adequate internal controls and procedures to ensure that MMIS costs claimed were

allowable, equitably allocated to all benefiting programs, and claimed at the correct reimbursement rate.

RECOMMENDATIONS

We recommend that the State agency:

- refund $2,273,211 to the Federal Government;

- strengthen internal controls and procedures to ensure that MMIS costs claimed for Federal reimbursement are allowable, equitably allocated to all benefiting programs, and claimed at the correct Federal reimbursement rate; and

- review MMIS costs claimed for Federal reimbursement after June 30, 2005, to ensure that the costs claimed were allowable, equitably allocated to all benefiting programs, and claimed at the correct Federal reimbursement rate.

STATE AGENCY'S COMMENTS

In written comments on the draft report (included in their entirety in the Appendix), the State agency partially disagreed with our finding that it did not equitably allocate costs to other benefiting programs. It stated that it considers certain programs that we identified as non-Medicaid programs to be solely Medicaid expenditures, which are "justifiably claimable under Title XIX." However, the State agency agreed with our other findings related to unallowable costs and costs claimed at an incorrect reimbursement rate.

Regarding our recommendations, the State agency agreed to refund $2,273,211 of the $5,557,010 of unallowable costs identified in our draft report. The State agency commented that it is committed to strengthening internal controls and procedures to ensure that MMIS costs claimed for Federal reimbursement are allowable, equitably allocated, and claimed at the correct reimbursement rate. The State agency also commented that it had already reviewed costs claimed for Federal reimbursement after our audit period in light of our findings.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

Based on our evaluation of the State agency's comments and our review of additional information that the State agency provided, we revised our report to reflect a refund amount of $2,273,211. The State agency was able to demonstrate that the remaining $3,283,799 was allowable and that the allocation methodologies used were acceptable.

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INTRODUCTION

BACKGROUND

Medicaid Program

Congress established Medicaid as a jointly funded Federal and State program that provides medical assistance and long-term care to low-income people who qualify under Title XIX of the Social Security Act (the Act). Within a broad legal framework, each State designs and administers its own Medicaid program. Each State operates under a plan approved by the Centers for Medicare & Medicaid Services (CMS) for compliance with Federal laws and regulations. States report Medicaid expenditures for medical assistance and administrative costs to CMS on the "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program," Form CMS-64 (CMS-64). The standard Federal reimbursement rate for Medicaid administrative expenditures is 50 percent.

Medicaid Management Information System

Section 1903(r)(1) of the Act states that, to receive Federal funding for use of automated data systems in administration of the Medicaid program, the State must have a mechanized claims processing and information retrieval system. The CMS "State Medicaid Manual," Chapter 11, section 11100, states that, for Medicaid purposes, the mechanized system is the Medicaid management information system (MMIS). An MMIS is a system of software and hardware used to process Medicaid claims and manage information about Medicaid beneficiaries and services. The system may be operated by either a State agency or a fiscal agent, which is a private contractor hired by the State.

Section 1903(a) of the Act authorizes a 90-percent Federal reimbursement rate for design, development, or installation of an MMIS and a 75-percent rate for operation of an MMIS. The CMS "State Medicaid Manual" identifies the specific types of MMIS costs that are allowable for Federal reimbursement. For such costs to be allowable at the enhanced rate of 75 percent, they must be related to the operations of the MMIS for ongoing automated processing of claims, payments, and reports.

California Medicaid Management Information System

In California, the Department of Health Care Services (the State agency) administers the Medicaid program with Federal oversight from CMS.[1] California's MMIS processes both Medicaid and non-Medicaid claims. Non-Medicaid claims include those for other Federal programs and State-only programs, such as the Genetically Handicapped Persons Program. Non-Medicaid claims also include those for medical services that Medicaid does not cover, such

[1]During the time of our audit, the State agency was known as the Department of Health Services. In California, Medicaid is referred to as the Medi-Cal program.

as abortions. Federal regulations require that MMIS costs be equitably allocated to all benefiting programs.[2]

The State agency contracted with a fiscal agent, Electronic Data Systems (EDS), to process claims through the MMIS. The State agency signed a 4-year, $644-million contract with EDS to operate the MMIS and provide fiscal agent services from July 1, 2003, through June 30, 2007. Under the contract, EDS submitted as many as 40 invoices each month to the State agency for operation of the MMIS. Some of the invoices were for processing providers' claims for services under various medical assistance programs. The costs for processing these claims were allocated to the respective programs based on the number of claims related to each program. The costs for other activities, such as printing, provider relations, telephone support, maintenance, and systems modifications, were generally charged to the Medicaid program.

During the 2-year period July 1, 2003, through June 30, 2005, the State agency claimed $345,805,475 ($254,542,811 Federal share) as MMIS costs for reimbursement under the Medicaid program. During this period, the MMIS processed over 450 million Medicaid and non-Medicaid claims (an average of over 19 million claims per month).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency's claims for MMIS costs were (1) allowable and equitably allocated and (2) claimed at the correct Federal reimbursement rate.

Scope

We limited our review to $251,023,302 ($183,179,805 Federal share) of the total MMIS costs claimed during the 2-year period July 1, 2003, through June 30, 2005. We did not review invoices that EDS submitted on behalf of the Systems Group ($56,167,305) and Provider Relations ($38,614,868).

We did not perform a detailed review of the State agency's internal controls. We limited our review to obtaining an understanding of the procedures used to (1) receive, review, and process EDS claims for reimbursement and (2) calculate and claim the Federal share for MMIS expenditures.

The State agency submitted to CMS an EDS timestudy to support costs of personnel working in selected functions. At the time of our audit, CMS was in the process of reviewing the timestudy. Therefore, we did not review it.

During our audit, we conducted fieldwork at the State agency and EDS offices in Sacramento, California.

[2] 2 CFR part 225, Office of Management and Budget Circular (OMB) A-87, "Cost Principles for State, Local and Indian Tribal Governments."

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations and CMS guidance;
- reviewed the State agency's policies, procedures, and cost reimbursement guidance for ensuring that MMIS costs were allowable, equitably allocated, and claimed at the correct Federal reimbursement rate;
- reviewed the State agency's contract with EDS;
- compared amounts claimed by the State agency on the CMS-64 with supporting spreadsheets and invoices for the period July 1, 2003, through June 30, 2005;
- traced amounts on the supporting spreadsheets to EDS invoices; and
- applied an alternate methodology for allocating costs based on the number of claims processed, as reported by the MMIS, for each benefiting program.[3]

We performed our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Of the $183,179,805 (Federal share) of MMIS costs that we reviewed, $180,906,594 was allowable. The remaining $2,273,211 consisted of:

- $2,009,782 of unallowable costs that were not equitably allocated to all benefiting programs, were not related to the Medicaid program, or were claimed twice and
- $263,429 of postage, administrative, and subcontract costs claimed at an incorrect reimbursement rate.

The State agency improperly claimed these costs for Federal reimbursement because it did not have adequate internal controls and procedures to ensure that MMIS costs claimed were allowable, equitably allocated to all benefiting programs, and claimed at the correct reimbursement rate.

UNALLOWABLE COSTS

The State agency claimed $2,009,782 (Federal share) of MMIS costs that were not allowable under Federal regulations. The unallowable costs consisted of $1,934,999 that was not equitably

[3]This methodology incorporated the differing costs involved in processing the two types of claims, i.e., paper claims that were input manually and electronic claims. We also took into account that the State agency deducted 0.02 percent from the claims before filing them.

allocated to other benefiting programs, $56,558 that was not related to the Medicaid program, and $18,225 that was claimed twice.

Costs Not Equitably Allocated to All Benefiting Programs

OMB Circular A-87, Attachment A, section C.3.a, states: "A cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received." In addition, section C.1.e states that costs must "Be consistent with policies, regulations, and procedures that apply uniformly to both Federal awards and other activities of the governmental unit."

The State agency claimed $1,934,999 (Federal share) in costs under Medicaid that should have been allocated to other benefiting programs. An example of unallocated costs was the Field Office Automation Group, which processed "Treatment Authorization Requests" for other programs that used the MMIS. The State agency did not allocate the costs of these services among all programs in accordance with the relative benefits received; instead, it claimed them as Medicaid-only expenses.

The State agency deducted 0.02 percent before claiming these costs under Medicaid. A State agency staff member told us that the deduction had been developed by personnel who were no longer with the agency and that the State agency was unable to locate documentation to explain how the percentage had been calculated or why it was being deducted from the Medicaid claim.

We determined allowable costs using the methodology described on page 3. We compared our result with the amount the State agency calculated based on a new methodology. Based on this new methodology, $1,934,999 claimed under Medicaid should have been allocated to other benefiting programs.

Costs Not Related to the Medicaid Program

OMB Circular A-87, Attachment A, section C.3.a., states that for costs to be allocable to a Federal award, the goods or services must be ". . . chargeable or assignable to such cost objective in accordance with relative benefits received."

The State agency claimed $56,558 (Federal share) for costs of printing manuals for programs that were not related to Medicaid. These costs were for State-only programs. The overclaim occurred because the State agency did not have adequate controls to prevent including these costs on the Medicaid claim.

Costs Claimed Twice

OMB Circular A-87, Attachment A, section C.1.a, states that, to be allowable under Federal awards, a cost must "Be necessary and reasonable for proper and efficient performance and administration of Federal awards."

The State agency claimed $18,225 (Federal share) twice. The overclaim occurred because EDS made errors in determining the amounts to be claimed for computer equipment on 16 invoices submitted to the State agency. When these errors were discovered, the State agency directed EDS to correct its claiming procedures. However, the State agency did not make an adjustment for the $18,225 on the CMS-64.

COSTS CLAIMED AT AN INCORRECT REIMBURSEMENT RATE

OMB Circular A-87, Attachment A, section C.1.a, states that, to be allowable, a cost must "Be necessary and reasonable for proper and efficient performance and administration of Federal awards."

The State agency claimed $263,429 (Federal share) of allowable MMIS costs at an incorrect Federal reimbursement rate. These costs consisted of:

- postage costs claimed at the 75-percent rate that should have been claimed at the 50-percent rate, resulting in an overclaim of $156,243;

- administrative salary and space costs claimed at the 75-percent rate that should have been claimed at the 50-percent rate, resulting in an overclaim of $61,001; and

- subcontract costs claimed at the 90-percent rate that should have been claimed at the 75-percent rate, resulting in an overclaim of $46,185.

The overclaims occurred because EDS incorrectly classified these costs on invoices that it submitted to the State agency. In addition, the State agency did not have adequate controls to ensure that costs were claimed at the correct rate.

Postage Costs

The CMS "State Medicaid Manual," Chapter 11, section 11276.8, states: ". . . all postage costs associated with the operation of an MMIS are matched at the 50 percent rate." The State agency incorrectly claimed postage costs at the 75-percent rate, resulting in an overclaim of $156,243 (Federal share).

Administrative Salary and Space Costs

The CMS "State Medicaid Manual," Chapter 11, provides for various levels of Federal funding depending on the relationship of the activity to the MMIS:

- Section 11276.2 provides 90 percent for costs directly attributable to the design, development, installation, and enhancement of claims processing.

- Section 11276.3 provides 75 percent for direct costs directly attributable to the Medicaid program for ongoing automated processing of claims.

- Section 11276.1 provides 50 percent for other functions, even if performed by the same unit or individuals.

The State agency incorrectly claimed administrative salary and space costs as MMIS costs at the 75-percent rate, resulting in an overclaim of $61,001 (Federal share). According to the State agency, these costs were for salaries and for space occupied by EDS accounting and purchasing staff who were not involved with the development or operation of the MMIS. The costs also included EDS personnel in the print center, publications, and distribution units. EDS recorded the costs in a "catch-all" cost center because they did not fit in a cost center directly related to MMIS operations. These costs were allowable under Medicaid but should have been claimed at the 50-percent rate.

Subcontract Costs

The CMS "State Medicaid Manual," Chapter 11, section 11276.2, states: "[Federal reimbursement] at 90 percent is available for costs directly attributable to . . . the design, development, installation, and enhancement" of the MMIS. Section 11276.3(A) states: "[Federal reimbursement] at 75 percent is available for direct costs directly attributable to the Medicaid program for ongoing automated processing of claims, payments, and reports. Included [is] . . . maintenance of software and documentation . . . ."

The State agency claimed certain subcontract costs at the 90-percent rate, resulting in an overclaim of $46,185 (Federal share). The costs were on invoices prepared by EDS for work identified as "on-going operational support" and claimed by EDS at the 75-percent rate. In some cases, the State agency subsequently annotated the EDS invoices to indicate that they were eligible at the 90-percent rate. According to the invoices, these costs were not directly attributable to the design, development, installation, or enhancement of the MMIS and should have been claimed at the 75-percent rate.

RECOMMENDATIONS

We recommend that the State agency:

- refund $2,273,211 to the Federal Government;

- strengthen internal controls and procedures to ensure that MMIS costs claimed for Federal reimbursement are allowable, equitably allocated to all benefiting programs, and claimed at the correct Federal reimbursement rate; and

- review MMIS costs claimed for Federal reimbursement after June 30, 2005, to ensure that the costs claimed were allowable, equitably allocated to all benefiting programs, and claimed at the correct Federal reimbursement rate.

STATE AGENCY'S COMMENTS

In written comments on the draft report (included in their entirety in the Appendix), the State agency partially disagreed with our finding that it did not equitably allocate costs to other benefiting programs. It stated that it considers certain programs that we identified as non-Medicaid programs to be solely Medicaid expenditures, which are "justifiably claimable under Title XIX." However, the State agency agreed with our other findings related to unallowable costs and costs claimed at an incorrect reimbursement rate.

Regarding our recommendations, the State agency agreed to refund $2,273,211 of the $5,557,010 of unallowable costs identified in our draft report. The State agency commented that it is committed to strengthening internal controls and procedures to ensure that MMIS costs claimed for Federal reimbursement are allowable, equitably allocated, and claimed at the correct reimbursement rate. The State agency also commented that it had already reviewed costs claimed for Federal reimbursement after our audit period in light of our findings.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

Based on our evaluation of the State agency's comments and our review of additional information that the State agency provided, we revised our report to reflect a refund amount of $2,273,211. The State agency was able to demonstrate that the remaining $3,283,799 was allowable and that the allocation methodologies used were acceptable.

APPENDIX

State of California—Health and Human Services Agency
Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

MAY 31 2007

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Inspector General
50 United Nations Plaza, Room 171
San Francisco, CA 94102

Dear Ms. Ahlstrand:

The California Department of Health Services (CDHS) has prepared its response to the Office of Inspector General's (OIG) draft report entitled "Review of California's Medicaid Management Information System Expenditures for the Period July 1, 2003, Through June 30, 2005" (report number A-09-06-00032). The CDHS appreciates the work performed by the OIG and the opportunity to respond to the draft report.

Please contact Stan Rosenstein, Deputy Director, Medical Care Services, at (916) 440-7800 if you have any questions.

Sincerely,

Sandra Shewry
Director

cc: See next page

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MAY 3 1 2007

cc: Stan Rosenstein
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California Department of Health Services Response to the Office of Inspector General's Draft Report

"Review of California's Medicaid Management Information System Expenditures for the Period July 1, 2003 through June 30, 2005"

On April 20, 2007, the California Department of Health Services (CDHS) received your second draft report entitled "Review of California's Medicaid Management Information System (CA-MMIS) Expenditures for the Period July 1, 2003, through June 30, 2005". In response, CDHS submits written comments expressing our views concerning the validity of the facts and reasonableness of the findings and recommendations and the status of any action taken or contemplated on the recommendations.

Before we address each finding and recommendation from this second draft audit report, we wish to express that CDHS disagrees with the Office of Inspector General (OIG) statement in the report indicating that "we [OIG] performed our review from January through September 2006" (9 months). CDHS concurs that OIG ended its fieldwork in September 2006. However, based on our records of responses to OIG's requests for information for review, OIG actually conducted its fieldwork over a two and one-half year period from September 2004 to May 2007. The OIG Exit Conference was held on May 3, 2007, and subsequent to the Exit the OIG conducted additional field work, the results of which are not included in this second draft report.

Finding #1:
The State agency improperly claimed these costs [$5,557,010] (see Exhibit #1) for Federal reimbursement because it did not have adequate internal controls and procedures to ensure that MMIS costs claimed were allowable, equitably allocated to all benefiting programs, and claimed at the correct reimbursement rate. (Second Draft Report Page 3)

Response:
CDHS partially disagrees with this finding. As discussed below, the State agrees that $2,273,211 rather than $5,557,010 was improperly claimed. While the State acknowledges that it misallocated a small percentage of Federal Financial Participation (FFP) due primarily to isolated errors, this report validates that the State accurately claimed FFP for the vast majority of CA-MMIS expenditures. The State claimed 99 percent correctly ($248.5 million / $251 million). The CDHS is committed to maintaining and improving its internal controls and procedures to ensure accurate federal claiming. To this end, CDHS continuously evaluates its internal controls and policies and updates its desk procedures for invoice review and contract oversight on an annual basis, or whenever a significant change (policy, federal, state or court mandate or due to best business practice, etc.) occurs. Given the limited number of errors the OIG identified during its extensive review of all $251 million of claims, it validates that CDHS has implemented adequate internal controls and

California Department of Health Services Response to the Office of Inspector General's Draft Report

"Review of California's Medicaid Management Information System Expenditures for the Period July 1, 2003 through June 30, 2005"

procedures ensuring that MMIS costs claimed were allowable, equitably allocated to all benefiting programs, and claimed at the correct reimbursement.

Finding #2:
The State agency claimed $5,218,798 (Federal share) (see Exhibit #1) in costs under Medicaid that should have been allocated to other benefiting programs. (Second Draft Report Page 4)

Response:
CDHS partially disagrees with this finding. $3,283,799 was claimed correctly because the State considers certain programs identified by the OIG as non-Medicaid programs to instead be solely Medicaid program expenditures that are justifiably claimable under Title 19. The OIG allocated costs for MMIS expenditures to various health programs based on the percentage of all Adjudicated Claim Lines (ACL) associated with each health program. However, from the State's perspective, the OIG incorrectly identified certain ACLs as non-Medicaid when those ACLs are actually Medicaid claims. Additionally, the OIG incorrectly applied a percentage of 100 percent Medicaid invoices to non-Medicaid programs based on this ACL allocation methodology. The basis of the State's disagreement with $3,283,799 of the OIG's findings is detailed as follows:

a. **ACL Expenditures – $300,387**
The OIG identified $300,387 in Medi-Cal Adjudicated Claim Line (ACL) expenditures as Non-Medicaid program expenditures (see Exhibit #3 column D).

The Aid Codes associated with these $300,387 in ACL expenditures were reviewed by the Center for Medicare & Medicaid Services (CMS) apart from this OIG review and determined to be appropriately assigned to the Medicaid Program pursuant to the Social Security Act and United States Code. Therefore, CDHS disagrees with this $300,387 portion of the OIG finding.

b. **Non-Medicaid Allocation Methodology – $324,104**
The OIG developed a proxy methodology to allocate a percentage of each MMIS invoice to non-Medicaid programs. This proxy methodology was essentially based on its percentage of non-Medicaid ACLs to total ACLs.

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The OIG allocated $324,104 as non-Medicaid costs for State Children's Health Insurance Program Presumption Eligibility (SCHIP PE) and Healthy Families Enhanced category expenditures, which are appropriately claimable under Medicaid (see Exhibit #2 column F).

Including these Medicaid claims as non-Medicaid resulted in the OIG overstating the percentage of non-Medicaid costs applied to MMIS invoices.

c. **Non-Medicaid Costs Allocated to Medicaid-Only Expenditures – $600,202**

The OIG applied non-Medicaid cost of $52,788 for Health Access Program (HAP) Cards for Medicaid-Only beneficiaries and $5,263 for Family PACT. These costs relate only to the Medicaid Family PACT (F-PACT) program. Therefore, none of these costs should be allocated to State-Only Programs.

However, following the Exit Conference on May 3, 2007, the State determined that a very small percentage of Beneficiary Identification Cards (BIC) were issued to non-Medicaid programs. Therefore, the State will reimburse $26,960 and continue to separate the non-Medicaid BIC expenditures on an ongoing basis.

The OIG determined that the Field Office Automation Group (FOAG) processes Treatment Authorization Requests (TARs) for all programs that use the CA-MMIS. Although currently all TARS are restricted to Medicaid-Only benefits, during the period of this review County Medical Services Program (CMSP) TARS were also being reviewed by the Medi-Cal Field Offices. Therefore, the State agrees to refund $217,564, to reflect the CMSP share of FOAG costs incurred during this time period as determined by using the ACL proxy allocation methodology. This allocation is equivalent to 0.84 percent of all FOAG expenditures.

In summary, CDHS believes the OIG ACL percentage methodology should not be used to allocate F-PACT or HAP card costs nor current TAR costs.

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Health Access Program (see Exhibit #1)	$ 52,788
BIC (see Exhibit #6)	(26,960)
Family PACT (see Exhibit #2 Column G)	5,263
Treatment Authorization Requests (see Exhibit #2 Column G)	786,675
TARs Allocated to CMSP Program (see Exhibit #5)	(217,564)
Total Medi-Cal Only Cost per CDHS	$ 600,202

d. Double Allocation of Non-Medicaid Cost – $2,059,106
The OIG applied a duplicate ACL Percentage Allocation of $2,059,106 to non-Medicaid programs, since invoiced expenditures were already included by a direct cost allocation.

The OIG states in the report that System Group (SG) invoices of $61,504,172 were not reviewed. The OIG applied an allocation of non-Medicaid SG costs of $1,432,091 based on its proxy ACL allocation methodology to each invoice. By not reviewing the SG invoices, the OIG did not recognize that the State had already assigned $2,439,870 to State-Only Programs using a project tracking system that identifies the Program for each project.

Additionally, the OIG reviewed Cost Reimbursement (CR) invoices of $34,643,462 and applied an allocation of non-Medicaid CR costs of $627,015 based on its proxy ACL allocation methodology. The OIG did not recognize that the State had already assigned $946,860, to State-Only funded programs.

System Group Invoices (see Exhibit 2 column E)	$ 1,432,091
Cost Reimbursement Invoices (see Exhibit 2 column E)	627,015
Total Double Allocation of Non-Medicaid Cost	$ 2,059,106

Finding #3:
The State agency claimed $56,558 (Federal share) in costs of printing manuals for programs that were not related to Medicaid. (Second Draft Report Page 4)

Response:
CDHS agrees with the $56,558 finding to directly assign the California Children Services (CCS) mailing cost. CDHS performs a monthly review of the Job Costing system to ensure the appropriate programs are charged.

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Finding #4:
The State agency claimed $18,225 (Federal share) twice. (Second Draft Report Page 4)

Response:
CDHS agrees with the $18,225 finding. CDHS has modified its desk procedures for reviewing adjusting entries to include an additional level of management review.

Finding #5:
The State agency incorrectly claimed postage costs at the 75 percent rate that should have been claimed at the 50 percent rate, resulting in an overclaim of $156,243 (Federal share). (Second Draft Report Page 5)

Response:
CDHS agrees with the $156,243 finding. The clerical errors noted in the OIG review were related to the claiming of FFP for the Cost Reimbursement Invoices. After OIG informed CDHS staff of the errors, CDHS modified its Invoicing System for Cost Reimbursement. Each expenditure type was compared to the State Medicaid Manual to determine the correct FFP. The desk procedures were revised to ensure correct claiming. Therefore, if the program is a State Only Program, no FFP is being claimed. If the allowability of enhanced FFP is questionable, 50 percent FFP is being claimed. Hence, CDHS is in compliance with the State Medicaid Manual (SMM).

Finding #6:
The State agency incorrectly claimed administrative salary and space costs as MMIS costs at the 75 percent rate that should have been claimed at the 50 percent rate, resulting in an overclaim of $61,001 (Federal share). (Second Draft Report Page 5)

Response:
CDHS agrees with the $61,001 finding. The clerical errors noted in the OIG review were related to the claiming of FFP for the Cost Reimbursement Invoices. After OIG informed CDHS staff of the errors, CDHS modified its Invoicing System for Cost Reimbursement. Each expenditure type was compared to the State Medicaid Manual to determine the correct FFP. The desk procedures were revised to ensure correct claiming. If the Program is a State Only Program, no FFP is being claimed. If the allowability of enhanced FFP is questionable, 50 percent FFP is being claimed. Hence, CDHS is in compliance with the SMM.

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Finding #7:
The State agency claimed certain subcontract costs at the 90 percent rate that should have been claimed at the 75 percent rate, resulting in an overclaim of $46,185 (Federal share). (Second Draft Report Page 6)

Response:
CDHS agrees with the $46,185 finding. The clerical errors noted in the OIG review were related to the claiming of FFP for the Cost Reimbursement Invoices. After OIG informed CDHS staff of the errors, CDHS modified its Invoicing System for Cost Reimbursement. Each expenditure type was compared to the State Medicaid Manual to determine the correct FFP. The desk procedures were revised to insure correct claiming. If the program is a State Only Program, no FFP is being claimed. If the allowability of enhanced FFP is questionable, 50 percent FFP is being claimed. Hence, CDHS is in compliance with the SMM.

OIG Observation $632,415[1]
The State agency claimed $632,415 (Federal share) of personnel costs that were not adequately supported. These costs were based on a timestudy that CMS had not approved, as required by OMB Circular A-87. Since we [OIG] consider the total personnel costs claimed to be allowable under Medicaid, the $632,415 is the difference between applying the standard Medicaid administrative rate of 50 percent and the enhanced rate of 75 percent to personnel costs reported for operation of the MMIS. Without an approved timestudy, we [OIG] are unable to express an opinion on the allowability of the $632,415. (Second Draft Report Page 7)

Response:
CDHS disagrees. The State submitted its 2004 Time Study to CMS and, based on discussions with CMS, received approval to continue to claim FFP based on that study pending further guidance from CMS. CDHS is actively working with CMS to develop a modified time study or alternative methodology.

Recommendation #1:
We recommend that the State agency refund $5,557,010 to the Federal Government. (Second Draft Report Page 7)

[1]**Office of Inspector General (OIG) Note:** This finding has been removed from the final report.

California Department of Health Services Response to the Office of Inspector General's Draft Report

"Review of California's Medicaid Management Information System Expenditures for the Period July 1, 2003 through June 30, 2005"

Response:
CDHS partially agrees with this recommendation.

The CDHS is committed to maintaining and improving its internal controls and procedures to ensure accurate federal claiming. To this end, CDHS continuously evaluates its internal controls and policies and updates its desk procedures for invoice review and contract oversight on an annual basis, or whenever a significant change (policy, federal, state or court mandate or due to best business practice, etc.) occurs. Given the limited number of errors the OIG identified during its extensive review of all $251 million of claims, it validates that CDHS has implemented adequate internal controls and procedures.

In consideration of our disagreement of certain findings, CHDS agrees to refund an appropriate amount of $2,273,211 based on our analysis.

Recommendation #2:
We recommend that the State agency strengthen internal controls and procedures to ensure that MMIS costs claimed for Federal reimbursement are allowable, equitably allocated to all benefiting programs, and claimed at the correct Federal reimbursement rate. (Second Draft Report Page 7)

Response:
CDHS is committed to strengthening internal controls and procedures to ensure that MMIS costs claimed for Federal reimbursement are allowable, equitably allocated to all benefiting programs, and claimed at the correct Federal reimbursement rate.

Recommendation #3:
We recommend that the State agency review MMIS costs claimed for Federal reimbursement after June 30, 2005, to ensure that the costs claimed were allowable, equitably allocated to all benefiting programs, and claimed at the correct Federal reimbursement rate. (Second Draft Report Page 7)

Response:
CDHS has reviewed previously claimed amounts in light of these findings.

CDHS is continuously improving its controls to ensure the reasonableness and accuracy of all MMIS invoices and the appropriate allocation of FFP. Examples include:

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1. CDHS annually updates and revises its invoice review desk procedure manuals and updates these procedures more frequently whenever significant changes to the Medi-Cal program occur.
2. In 2005 CDHS added an independent auditor to systematically review every aspect of the CDHS oversight of MMIS fiscal intermediary contractor expenditures.
3. CDHS implemented a revised cost reimbursement report. This report specifically tracks the allocation of FFP based on supporting documentation, which can now be reconciled to the State Medicaid Manual.
4. For several years, CDHS has issued to CMS a quarterly report identifying all CMS-approved MMIS expenditures claimed at 90 percent FFP. This report identifies the approved budgeted amounts and the reconciled actual payments as reflected on the CMS-64 federal quarterly reporting database. Additionally, since March 2005, CDHS began reconciling all invoices paid to the Medi-Cal fiscal intermediary to the CMS-64 to ensure the invoices were paid at the correct amount and that the State had correctly claimed FFP.
5. The CDHS currently allocates a portion of all Medi-Cal fiscal intermediary (FI) operations costs based on the percentage of non-Medicaid adjudicated claim lines (ACLs) to all ACLs. The CDHS will now apply this percentage allocation to all Medi-Cal fiscal intermediary invoices that include non-Medicaid program costs. This percentage allocation will only be applied to invoices where the non-Medicaid portion of expenditures are not readily identifiable but for this proxy percentage allocation. As previously stated, a number of Medi-Cal FI invoices already include a direct allocation of expenditures to non-Medicaid programs using a project tracking system.

Recommendation #4:[2]
We recommend that the State agency work with CMS to obtain approval of the timestudy for personnel costs and determine the allowability of $632,415 that was not adequately supported. (Second Draft Report Page 7)

Response:
CDHS has been actively working with CMS regarding implementation of a modified time study or alternative methodology and will continue to do so until we mutually agree on the best methodology to apply prospectively. In the interim, CMS has allowed the State to continue claiming federal reimbursement based on the State's 2004 Time Study.

[2]**OIG Note**: This recommendation has been removed from the final report.

Exhibit #1

California Department of Health Services
OIG Review of CA-MMIS
FY 2003-04 and FY 2004-05

Summary of OIG Findings for CA-MMIS

Costs Not Equitably Allocated to All Benefiting Programs				
Allocated Other CA-MMIS cost				
OIG Overclaimed (Note #1)		$ 4,991,871		
State Credit		(62,926)		
Total Over-Claim Finding			$ 4,928,945	
Adjudicated Claim Lines Direct Processing				
CHDP As Claimed	$ 640,738			
Medi-Cal As Claimed	8,726,308			
Total As Claimed on B-A invoice		9,367,046		
Claims Allowed per OIG review (Note #2)		(8,672,192)		
Total B-A Invoice Finding			694,854	
Health Access Program Finding			52,788	
Sales Tax Finding			(457,789)	
			$ 5,218,798	Finding #2
Cost Not Related to Medicaid Program Finding			56,558	Finding #3
Costs Claimed Twice Finding			18,225	Finding #4
Costs Claimed at an Incorrect Reimbursement Rate Finding				
Postage Claims Finding			156,243	Finding #5
Administrative Salary and Space Finding			61,001	Finding #6
Sub-contractor Costs Finding			46,185	Finding #7
Total Finding			$ 5,557,010	Finding #1

Notes:
#1. See Exhibit 2 column C for the breakdown by invoice groups.
#2. See Exhibit 3 column C for the breakdown by invoice groups.

Exhibit #2

California Department of Health Services
OIG Review of CA-MMIS
FY 2003-04 and FY 2004-05

Allocation of Cost based on ACL

A	B	C	D	E	F	G
Invoice Groups	Invoice Amounts Confirmed by OIG	Review Finding Amount by Invoice Group	Estimated ACL Percent based on 75% FFP	Non-Medicaid Cost already Allocated	Incorrect ACL Percentage Applied	Non-Medicaid Costs Allocated to Medi-Cal Only Expenditures
			C / B * 0.75		B * 0.0034	
Appeals	$ 424,172	$ 9,643	3.03%		1,442	
Change Order 1	1,906,636	40,168	2.81%		6,483	
Change Order 2	383,358	7,603	2.64%		1,303	
Change Order 3	6,464,285	167,080	3.45%		21,979	
Change Order 5	2,177,082	48,209	2.95%		7,402	
Cost Reimbursement	32,665,736	627,015	2.56%	627,015		
Cost Savings	8,178,711	182,253	2.97%		27,808	
CRCO2	1,067,700	15,337	1.92%		3,630	
CRCO3	319,124	7,678	3.21%		1,085	
Enhancement	9,244,518	204,292	2.95%		31,431	
F-Pact	647,839	5,263	1.08%			5,263
HF Invoice	3,474,689	-	0.00%			
HIPAA	776,598	22,174	3.81%		2,640	
Inquiry System	23,566,601	537,797	3.04%		80,126	
Other	2,920,506	2,141	0.10%			
R	4,805,205	13,396	0.37%			
Systems Group	61,504,172	1,432,091	3.10%	1,432,091		
Take Over	17,254,716	375,565	2.90%		58,666	
TARS-FOAG	34,643,462	786,675	3.03%			786,675
Taxes	377,966	6,393	2.26%		1,285	
Telephone Service Center	23,183,163	501,097	2.88%		78,823	
Total	**$ 235,986,240**	**$ 4,991,871**		**$ 2,059,106**	**$ 324,104**	**$ 791,938**

Notes:
#1. The 0.34% comprises of 0.33% for SCHIP PE program and 0.01% Healthy Families Enhanced Program. These programs are considered Medi-Cal program (see Exhibit #4).
#2. $217,564 of the TARS-FOAG invoice amount at 75% FFP has been allocated to CMSP (see Exbibit #5).

Exhibit #3

California Department of Health Services
OIG Review of CA-MMIS
FY 2003-04 and FY 2004-05

Missing Claim on B-A Invoices

A	B	C	D
Programs	B-A Invoice Amounts	OIG Idenified as Medicaid	Medi-Cal Claims as Non-Medicaid
		B * 75% FFP	B * 75% FFP
01. CCS	$ 197,770	$ -	$ -
02. GHPP	34,510		
03. ST/CHDP	121,584		
04. EAPC	479,169		
05. CMSP	1,047,404		
06. CHDTP	7,452		
07. AB75/CHDP	285,896		
08. Healthy Families	293,486		
09. BCEDP	484,571		
10. Abortion	239,413		
11. Denied/unknown	150,984		
12. F-PACT	7,313,033	5,484,775	
13. CHDP Medi-Cal	1,135,088	851,316	
15. Medicaid	3,114,802	2,336,101	
16. S-CHIP PE	392,025		294,019
17. HF Enhanced	8,491		6,369
18. CHDP HF	126,025		
Total	$ 15,431,705	$ 8,672,192	**$ 300,387**

California Department of Health Services
OIG Audit of CA-MMIS
FY 2003-04 and FY 2004-05

Exhibit #4

ACL Allocation by Programs

A	B	C	D	E	F	G
Code	Programs	Program Drug ACL	Program General ACL	Total ACL	ACL Percentage	Adjusted ACL Percentage
					(C + D) / E	
1	CCS Claims	126,108	673,577	485,965,143	0.16%	0.16%
2	GHPP Claims	0	133,625	485,965,143	0.03%	0.03%
3	ST/CHDP Claims	0	444,880	485,965,143	0.09%	0.09%
5	EAPC Claims	0	1,579,915	485,965,143	0.33%	0.33%
6	CMSP Claims	292,602	3,776,599	485,965,143	0.84%	0.84%
7	CHDTP Claims	0	27,599	485,965,143	0.01%	0.01%
8	AB75/CHDP	0	1,055,752	485,965,143	0.22%	0.22%
10	BCEDP Claims	0	1,803,694	485,965,143	0.37%	0.37%
11	Abortion Claims	0	888,142	485,965,143	0.18%	0.18%
12	Denied/Unknown	0	559,096	485,965,143	0.12%	0.12%
9	HFAM Claims	271,682	981,178	485,965,143	0.26%	0.26%
16	SCHIP PE	0	1,602,421	485,965,143	0.33%	
17	HF Enhanced	0	31,502	485,965,143	0.01%	
19	CHDP Healthy Families	0	475,866	485,965,143	0.10%	0.10%
Total		690,392	14,033,846	485,965,143	**3.05%**	**2.71%**

Exhibit #5

California Department of Health Services
OIG Audit of CA-MMIS
FY 2003-04 and FY 2004-05

TARS-FOAG Allocation by Non-Medicaid Programs

A	B	C	D	E
TARS-FOAG Invoice Amounts at 75% FFP	Code	Programs	Adjusted ACL Percentage	Allocated TARS-FOAG Amount
				A * D
$ 25,982,597	6	CMSP Claims	0.84%	$ 217,564
Total			**0.84%**	**$ 217,564**

Note: The allocated TARS-FOAG invoice amount at 75% FFP is for CMSP program that is considered as a Non-Medicaid program (see Exhibit #4).

Exhibit #6

California Department of Health Services
OIG Audit of CA-MMIS
FY 2003-04 and FY 2004-05

BIC Cards Allocation by Non-Medicaid Programs

A	B	C	D	E
BIC Cards Invoice Amounts	Code	Programs	Adjusted ACL Percentage	Allocated BIC Cards Invoice Amount
				A * D
$ 2,619,044	1	CCS Claims	0.16%	$ 4,310
2,619,044	2	GHPP Claims	0.03%	720
2,619,044	6	CMSP Claims	0.84%	21,930
Total			**1.03%**	**$ 26,960**

Note: The allocated BIC Cards invoice amounts are for CCS, GHPP, and CMSP programs that are considered as Non-Medicaid programs (see Exhibit #4).