DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

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Region 1
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AUG 21 2006

Report Number A-01-05-00007

Ms. Brenda M. Harvey
Commissioner
Department of Human Services
221 State Street
State House Station # 11
Augusta, Maine 04403

Dear Ms. Harvey:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) report entitled "Review of the Maine Claims Management System." A copy of this report will be forwarded to the HHS action official noted on the next page for review and any action deemed necessary.

The HHS action official will make final determination regarding actions taken on all matters in this report. We request that you respond to the HHS action 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.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-01-05-00007 in all correspondence.

Sincerely yours,

Michael J. Armstrong

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Ms. Charlotte S. Yeh
Regional Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
John F. Kennedy Federal Building, Room 2325
Boston, Massachusetts 02203

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE MAINE CLAIMS MANAGEMENT SYSTEM

Daniel R. Levinson
Inspector General

August 2006
A-01-05-00007

Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

BACKGROUND

The Social Security Act requires that State agencies operate an automated data processing system, known as a Medicaid Management Information System (MMIS), to administer State plans for Medicaid and other Federal entitlement programs. Guidelines from the Centers for Medicare & Medicaid Services (CMS) require specific MMIS functionality to ensure effective controls in claims processing and payment. These functions include processing claims adjustments, ensuring that reimbursements to providers are prompt and correct, and automatically suspending all erroneous transactions until corrections are made. An MMIS must also have the capability to process claims for beneficiaries who are dually eligible for both the Medicaid and Medicare programs. To avoid duplicate payments for the same service, the MMIS must verify each claim against historical submissions. MMIS reporting controls must include the ability to identify third party liability and over-utilization of Medicaid services. An MMIS with effective controls has proven to be an important tool in improving a State's management of its Medicaid program.

Because of recent significant changes in the Medicaid program, the Maine Department of Health & Human Services, Office of MaineCare Services (the State agency) retired its legacy MMIS system on January 21, 2005, and placed the Maine Claims Management System (MECMS) into operation as the exclusive processor of Medicaid claims. The State agency reported approximately $2.3 billion as net Medicaid expenditures for calendar year 2005.[1]

OBJECTIVE

Our objective was to determine whether the State agency had effective controls to ensure that claims processed and adjudicated through MECMS from January 21, 2005, through December 31, 2005, were in compliance with Medicaid requirements.

SUMMARY OF FINDINGS

The State agency did not establish effective controls to ensure that Medicaid claims were processed correctly and paid appropriately and that all claim-related expenditures were reported accurately for Federal reimbursement. For example, insufficient edits resulted in a suspended inventory that reached 540,000 claims, and incorrect programming logic caused MECMS to use the wrong information to process some claims. As a result, we have less than reasonable assurance that certain net Medicaid expenditures reported by the State agency for calendar year 2005 are in accordance with Medicaid requirements. MECMS's lack of claims processing and reporting controls and functions was the result of inadequate resources, testing, and oversight.

We acknowledge that the State agency has taken additional oversight responsibility for MECMS and has initiated a corrective action plan that includes hiring external consultants, fixing

[1] We determined that approximately $2 billion ($1.3 billion Federal share) of the $2.3 billion relate to Medicaid claims that have been or will be processed by MECMS. This amount includes approximately $729 million in various types of interim payments that have been or will be reconciled to Medicaid claims processed by MECMS.

MECMS software, replacing hardware, initiating a process of reconciling interim payments, and reorganizing staff and management. Nevertheless, further effort is needed.

RECOMMENDATIONS

We recommend that the State agency:

- reprocess all claims processed through MECMS, after CMS certifies the system, to ensure that the claims were accurately reimbursed and that claims histories were correctly established;
- continue to reconcile interim payments using reprocessed claims;
- maintain documentation to support reprocessed claims and reconciled interim payments;
- ensure that system modifications and enhancements are properly documented;
- continue to ensure that all claims processing and reporting controls and functions are implemented in MECMS and are in compliance with Federal regulations;
- ensure that the MECMS reporting controls adequately identify overpayments related to third party liability and over-utilization of services for calendar year 2005 and thereafter;
- ensure that all overpayments are reported within 60 days of discovery in accordance with Federal regulations; and
- submit quarterly data from its Medicaid Statistical Information System to CMS in compliance with Federal requirements after all the claims have been reprocessed.

STATE AGENCY'S COMMENTS

The State agency generally concurred with our recommendations and identified its progress in implementing MECMS corrective actions. The State agency did not agree with our recommendation to reprocess all claims processed through MECMS after CMS certifies the system. Instead, the State agency intends to rely on findings from its quality assurance process to determine the scope of any reprocessing efforts. It stated that it would engage in an aggressive reprocessing effort if quality assurance findings dictated that result. The State agency maintained that its current hardware capacity is not sufficient to reprocess all claims. It also asserted that current error rates or the prevalence of software deficiencies might not warrant the excess burden on the production environment.

The State agency’s comments are included as an appendix.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We believe the State agency's proposal for relying on the quality assurance process to determine the scope of its reprocessing efforts may not be sufficient because of the prevalence of MECMS's control weaknesses that we identified. We also believe that the State agency will not be able to fully ensure the accuracy of its claims history, payments to providers, and requests for Federal reimbursement unless it reprocesses all claims after CMS certifies the system. Therefore, we stand by our recommendation that the State agency reprocess all claims processed through MECMS to ensure that the claims were accurately reimbursed and that claims histories were correctly established.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

The Medicaid Program

Enacted in 1965, Medicaid is a combined Federal-State entitlement program that provides health care and long-term care for certain individuals and families with low incomes and limited resources. Within a broad legal framework, each State designs and administers its Medicaid program in accordance with a State plan approved by the Centers for Medicare and Medicaid Services (CMS), which is responsible for the program at the Federal level.

Automated Data Processing

The Social Security Act requires that State agencies operate an automated data processing system, known as a Medicaid Management Information System (MMIS), to administer State plans for Medicaid and other Federal entitlement programs. CMS guidelines require specific MMIS functionality to ensure effective controls in claims processing and payment. These functions include processing claims adjustments, ensuring that reimbursements to providers are prompt and correct, and automatically suspending all erroneous transactions until corrections are made. Further, an MMIS must have the capability to process claims for beneficiaries who are dually eligible for the Medicaid and Medicare programs. To avoid duplicate payments for the same service, the MMIS must verify each claim against historical submissions. MMIS reporting controls must include the ability to identify third-party liability and over-utilization of Medicaid services. An MMIS with effective controls has proven to be an important tool in improving a State's management of its Medicaid program.

The Office of MaineCare Services

The Department of Health and Human Services, Office of MaineCare Services (the State agency) administers the Medicaid program in Maine. The State agency's mission is to coordinate programs and benefits and to provide the accountability necessary to determine that programs are administered in an effective and efficient manner. The State agency completes a quarterly Medicaid expenditure report to receive reimbursement for the Federal share of Medicaid expenses.

In 1978, Maine implemented its MMIS to process and report Medicaid claims. Although this system supported the minimal operating and financial reporting needs of the State agency, it lacked the flexibility and functionality to support the growing requirements of the Medicaid program. Changes in managed care, block grants, and new Federal/State regulations created an increasingly complex environment for Medicaid claims processing.

To address these changes, the State agency contracted with Client Network Services, Inc. (CNSI) in August 2001 to develop a replacement for its existing MMIS. CNSI provides information technology solutions for government and commercial enterprises. According to a State official, CNSI had never before implemented a system of this magnitude.

On January 21, 2005, the State agency retired its legacy MMIS and placed its new system, called the Maine Claims Management System (MECMS), into operation as the exclusive processor of Medicaid claims. The State agency reported approximately $2.3 billion as net Medicaid expenditures for calendar year 2005.[1]

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency had effective controls to ensure that claims processed and adjudicated through MECMS from January 21 through December 31, 2005, were in compliance with Medicaid requirements.

Scope

We reviewed the controls that the State agency used for processing and reporting claims through MECMS. We were not able to analyze MECMS claims history because the State agency was unable to provide this data before the end of our fieldwork. As a result, we were unable to quantify a dollar impact resulting from any control weaknesses. We conducted our fieldwork in Augusta, Maine, from October 2005 through February 2006.

Methodology

To accomplish our objective, we:

- researched applicable Medicaid laws and requirements;
- reviewed the State agency's Advance Planning Document, amendments, CMS funding approval letters, limited records of the decision to place MECMS into operation, and available State-published documents;
- analyzed CMS's Quarterly Medicaid Statement of Expenditures reports for calendar year 2005;
- interviewed officials from CMS, the State agency, and subcontractors regarding the implementation of MECMS;
- reviewed the State agency's processes for submitting claims, making interim payments to providers, reporting expenditures, and claiming reimbursement from the Federal government;

[1] We determined that approximately $2 billion ($1.3 billion Federal share) of the $2.3 billion relate to Medicaid claims that have been or will be processed by MECMS. This amount includes approximately $729 million in various types of interim payments that have been or will be reconciled to Medicaid claims processed by MECMS.

- analyzed vendors' contracts to determine additional MECMS-related costs that the State agency had incurred;

- evaluated MECMS reporting capabilities for third-party liability and over-utilization of Medicaid services; and

- performed limited testing to determine if MECMS had made duplicate claims payments to providers.

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

FINDINGS AND RECOMMENDATIONS

The State agency did not establish effective controls to ensure that Medicaid claims were processed correctly and paid appropriately and that all claim-related expenditures were reported accurately for Federal reimbursement. For example, insufficient edits resulted in a suspended inventory that reached 540,000 claims, and incorrect programming logic caused MECMS to use the wrong information to process some claims. As a result, we have less than reasonable assurance that certain net Medicaid expenditures reported by the State agency for calendar year 2005 are in accordance with Medicaid requirements. MECMS's lack of claims processing and reporting controls and functions was the result of inadequate resources, testing, and oversight.

CLAIMS PROCESSING CONTROLS AND FUNCTIONS

Federal Requirements

Section 11115 of the CMS "State Medicaid Manual" identifies the following among the objectives for an MMIS and its enhancements:

- more accurate and timely claims processing,

- improved operational control and audit trails,

- capability to handle increases in claims volume,

- reduction of system audit exceptions,

- reduced time to pay providers, and

- compatibility with Medicare claims processing and information retrieval systems for the processing of Medicare claims.

Ineffective Claims Processing Controls and Functions

Claims processing controls and functions focus on adjudication to ensure accurate and timely claims payments to providers. MECMS's claims processing controls and functions did not meet the Federal requirements listed above. We identified the following deficiencies:

- Insufficient edits resulted in a significant suspended claims inventory (as high as 540,000 at one time), a backlog of new claims, duplicate payments, and erroneously denied payments to providers. For example, a claim was paid four times when three of the payments should have been denied as duplicates. In other instances, edits did not identify the correct service limits allowed and denied claims incorrectly.

- Incorrect programming logic resulted in the system selecting the wrong information to process claims. For example, in some instances MECMS decision-making processes chose the incorrect rates, co-payments, and fund allocation amounts.

- Insufficient hardware capacity limited providers' ability to submit claims in a timely and cost-effective manner. Providers had to create multiple claims input files and submit them over an extended period of time because MECMS could only accept two megabytes of data input per submission.

- Controls over edit routines were inadequate. For example, change controls over edits lacked proper documentation and authorizations for software modifications. In addition, edits could be easily overridden to force claims through the system for payment.

- An inability to process claims adjustments resulted in inaccurate claims payments reported for Federal reimbursement. As a result, the State agency had a significant volume of unprocessed claims adjustments awaiting payment correction.

- Incompatible interfaces with the Medicare system prevented the processing of electronic crossover claims for dual-eligible beneficiaries. For example, the file format for MECMS did not match the Medicare system.

REPORTING CONTROLS

Federal Requirements

Section 11115 of the CMS "State Medicaid Manual" identifies the following among the objectives for an MMIS and its enhancements:

- reduced program and administrative costs through more effective claims processing, utilization control, and third-party liability pursuit, and

- improved capability to support Federal reporting requirements.

Federal regulations (42 CFR § 433.312) require that a State agency "must refund the Federal share of overpayments . . . whether or not the State has recovered the overpayment from the provider." In addition, Federal regulations (42 CFR § 433.316) specify that the State must provide this refund to the Federal government within 60 days of the discovery of the overpayment.

Section 4753 of the Balanced Budget Act of 1997 requires each State to submit claims data to CMS in a format consistent with the Medicaid Statistical Information System.

Ineffective Reporting Controls

Reporting controls focus on postpayment reviews of claims to ensure accurate reporting of Medicaid expenditures and accurate reimbursement of the Federal share. MECMS's reporting controls were inadequate to meet the Federal requirements listed above. The reporting functionalities were still not in place more than a year after MECMS's implementation. We determined that:

- MECMS lacked the required reporting capacity to identify overpayments involving third-party liability and over-utilization of Medicaid services. For example, MECMS was unable to perform basic functions such as tracking letters, invoices, and payment postings received from third parties.

- MECMS lacked the required reporting capacity to comply with a Federal law requiring the State agency to provide Medicaid Statistical Information System files to CMS.

- MECMS lacked the required reporting capacity to adequately quantify overpayments. MECMS contained several types of overpayments, including claims paid using the wrong rates, duplicate payments, and interim payments and claims payments made for the same time period. Although the State agency was aware that overpayments had occurred, they could not quantify these overpayments because of a lack of reporting functionalities in MECMS.

EFFECTS OF INSUFFICIENT CONTROLS

As a result of MECMS's insufficient claims processing and reporting controls and functions, we have less than reasonable assurance that certain net Medicaid expenditures reported by the State agency for calendar year 2005 are in accordance with Medicaid requirements. These expenditures include approximately $430 million in interim payments made to providers to maintain their financial stability. Since these interim payments were made outside of the claims processing function of MECMS, they may duplicate subsequently processed MECMS claims.

Furthermore, the lack of adequate reporting controls provides no assurance that MECMS identifies overpayments pertaining to third-party liability and over-utilization of Medicaid services. We also have less than reasonable assurance that the State agency recovered these and

other types of overpayments in MECMS or refunded the Federal share within the 60-day period required by Medicaid regulations.

INADEQUATE RESOURCES, TESTING, AND OVERSIGHT

MECMS's lack of adequate claims processing and reporting controls and functions was the result of inadequate resources, testing, and oversight. Specifically, we noted that:

- CNSI did not provide adequate resources to complete the project according to its contractual schedule commitment. For example, CNSI transferred key senior staff from MECMS development to other projects.

- CNSI and the State agency did not perform sufficient testing to demonstrate MECMS's ability to correctly process claims. For example, the State agency could not provide the results of integration testing to demonstrate that MECMS's major design elements met functional, performance, and reliability requirements.

- The State agency did not provide adequate management oversight of MECMS's development. Many of MECMS's operation problems resulted from poor system documentation, inadequate hardware, insufficient staffing, and poor communication.

CORRECTIVE ACTIONS TAKEN

We acknowledge that the State agency has taken additional oversight responsibility for MECMS and has initiated a corrective action plan that includes:

- hiring external consultants to manage projects and to identify major deficiencies,

- fixing MECMS software to include required functions,

- stabilizing MECMS (e.g., reducing suspended claims inventory),

- replacing hardware with equipment that has a higher processing capacity,

- initiating a process of reconciling interim payments, and

- reorganizing staff and management.

Nevertheless, further effort is needed.

RECOMMENDATIONS

We recommend that the State agency:

- reprocess all claims processed through MECMS, after CMS certifies the system, to ensure that the claims were accurately reimbursed and that claims histories were correctly established;

- continue to reconcile interim payments using reprocessed claims;

- maintain documentation to support reprocessed claims and reconciled interim payments;

- ensure that system modifications and enhancements are properly documented;

- continue to ensure that all claims processing and reporting controls and functions are implemented in MECMS and are in compliance with Federal regulations;

- ensure that the MECMS reporting controls adequately identify overpayments related to third-party liability and over-utilization of services for calendar year 2005 and thereafter;

- ensure that all overpayments are reported within 60 days of discovery in accordance with Federal regulations; and

- submit quarterly data from its Medicaid Statistical Information System to CMS in compliance with Federal requirements after all the claims have been reprocessed.

STATE AGENCY'S COMMENTS

In its August 1, 2006, comments on our draft report, the State agency generally concurred with our recommendations and identified its progress in implementing corrective actions. The State agency did not agree with our recommendation to reprocess all claims processed through MECMS after CMS certifies the system. Instead, the State agency intends to rely on findings from its quality assurance process to determine the scope of its reprocessing efforts. Specifically, it proposed using the quality assurance process to sample and test MECMS's claims processing and reporting controls and functions and ensure that they are in compliance with Federal regulations. It also stated that it would engage in an aggressive reprocessing effort if quality assurance findings dictated that result. The State agency maintained that its current hardware capacity is not sufficient to reprocess all claims and that the excess burden on the production environment might not be warranted by current error rates or the prevalence of software deficiencies.

The State agency's comments are included as an appendix.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We believe the State agency's proposal for relying on the quality assurance process to determine the scope of its reprocessing efforts may not be sufficient because of the prevalence of MECMS's control weaknesses that we identified. We also believe that the State agency will not be able to fully ensure the accuracy of its claims history, payments to providers, and requests for Federal reimbursement unless it reprocesses all claims after CMS certifies the system. Therefore, we stand by our recommendation that the State agency reprocess all claims processed through MECMS to ensure that the claims were accurately reimbursed and that claims histories were correctly established.

APPENDIX

John Elias Baldacci
Governor

Maine Department of Health and Human Services

Commissioner's Office

221 State Street
#11 State House Station
Augusta, ME 04333-0011

Brenda M. Harvey
Commissioner

August 1, 2006

US Department of Health and Human Services
Office of the Inspector General, Office of Audit Services
JFK Federal Building, Government Center, Room 2425
Boston, MA 02203

RE: MECMS Audit Report: A-01-05-00007

Dear Michael Armstrong:

The State appreciates the opportunity to respond to the above mentioned Audit Report. For the most part, the State agrees with the recommendations and has already implemented a number of processes to ensure future compliance.

Since July 2005, DHHS and OIT have worked in cooperation to focus on claims payments and this process continues. Corrective actions have been identified, prioritized, and are in process to implement. The necessary additional functionality is being prioritized and a schedule for implementation is being developed. The Department has taken measures intended to improve the functionality and performance of the Maine Claims Management System and bring the system to completion.

In June 2005, the Department installed a new management team at MaineCare, including a new Acting Director of OMS and a new Chief Information Officer dedicated full-time to the MECMS project. A few months later, the Department added to the management team a MECMS Project Director. In this same timeframe, the Department acquired additional consulting resources from Deloitte Consulting and XWave, to assist in project management, flaw diagnosis and remediation planning. The Department also added substantial staff resources to the project.

Shortly after arrival of the new management team, more rigorous protocols were instituted to the edit change control process. Management reorganized the Change Control Board to ensure appropriate, strategic prioritization of CCFs. The Claims Resolution Unit was similarly reorganized and new strategies for identifying and resolving payment errors and systemic defects were put in place.

As a result, functionality of the MECMS system has dramatically improved since the audit period. The weekly adjudication rate has improved from 55% in July, 2005, to 89.5% in June, 2006. The suspended claim backlog, which had peaked at 560,000 unresolved claims, has dropped to just over 176,000 claims. The functionality and reliability of the system continually improves as the Department identifies and patches flaws.

The Department has implemented an aggressive schedule for completing the system, repairing lingering malfunctions and implementing essential subsystems, such as adjustments, HIPAA compliance, crossover claims, SURS, and third party liability. Beginning July 2006, the Department will deploy a series of major version upgrades every 60-90 days, bringing MECMS closer to final completion.

The version upgrade schedule coincides with adoption of a full-scale end-to-end testing process designed to ensure that every change is tested exhaustively for quality assurance, both to ensure that the modifications perform as intended and to make sure that they don't generate unintended malfunctions elsewhere in the system.

Ongoing, DHHS is working with its contractors to improve system documentation and to keep it current as new modifications and functionality is implemented.

Additionally, quality assurance of claims payments and permission matrixes is ongoing. DHHS will use QA in a planned effort to sample, test, and ensure that all claims processing and reporting controls and functions are implemented and in compliance with federal regulations. A certain percentage of each claims type will be tested; based on the results of the tests, further action will be taken by the State.

The recommendation to reprocess all claims would have a substantial adverse impact on the system's capacity to maintain the current volume of fresh claims in the production environment. The hardware processing capacity is more than adequate to handle our current claims volume, but not sufficient to absorb a load that would double or triple the throughput, given that by the date of anticipated certification, the volume will include nearly 2 ½ years of claims. Acting on your recommendation would likely require segregation of the "old" claims from the fresh claims processing and could take several years to finish within the existing environment. It's not clear that taxing the production environment is warranted by current error rates or the prevalence of software deficiencies. Clearly some parts of the system have experienced more inaccuracies than others. In other cases, we believe that AQ testing will show that previous errors have been corrected and for the particular types of claims affected by the defect, application of a patch has resolved the error and resulted in accurate payment from that point forward. DHHS intends to use the AQ findings to determine the scope of our reprocessing efforts, both with respect to the type and number of claims recycled, and will engage in an aggressive reprocessing effort if the quality assurance findings dictate that result.

As for interim payments and their recovery, 49% of outstanding interims have been recovered to date and the State has agreements with providers for another 17% already in place. The State is working to recover all interim payment balances by the end of fiscal year 2007. As money is returned to the State, the federal share is returned. The original interim payments as well as the repayments and recoveries are well documented, and the State of Maine continues to work with CMS in Boston on these efforts.

Finally, the State intends that the data from the state's Medicaid Statistical Information System will be submitted to CMS to cover all claims beginning in August, 2006.

Sincerely,

Brenda Harvey

Brenda M. Harvey
Commissioner

BMH/klv

cc: Rebecca Wyke, Commissioner, Dept. of Administrative and Financial Services
Ed Karass, State Controller, Dept. of Administrative and Financial Services
Richard B. Thompson, Chief Information Officer, Dept. of Administrative and Financial Services
Kirsten LC Figueroa, Deputy Commissioner of Finance, Dept. of Health and Human Services
John Michael Hall, Deputy Commissioner. Office of MaineCare Services
Nancy Macirowski, Assistant Attorney General