

## California Department of Health Care Services

It Should Improve Its Administration and Oversight of  
School-Based Medi-Cal Programs

Report 2014-130

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August 20, 2015

2014-130

The Governor of California  
President pro Tempore of the Senate  
Speaker of the Assembly  
State Capitol  
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the California State Auditor presents this audit report concerning the School-Based Medi-Cal Administrative Activities program (administrative activities program) and the Local Educational Agency Medi-Cal Billing Option Program (billing option program) administered by the California Department of Health Care Services (Health Care Services). This report concludes that while the *reasonableness test criteria* process that Health Care Services used to review reimbursement claims for the administrative activities program from October 2013 through October 2014 was reasonable and not inconsistent with federal requirements, Health Care Services approved fewer than 10 percent of the claims submitted under this process. The entities with which Health Care Services contracts to review reimbursement claims—local educational consortia and local governmental agencies—added little value during this review process; they approved and forwarded to Health Care Services claims that did not comply with the *reasonableness test criteria* benchmarks and other limits. Furthermore, Health Care Services is behind in its required reviews of local educational consortia and local governmental agencies, which increases the risk that these entities are not performing the administrative tasks for which they are responsible. Health Care Services also does not effectively oversee the contracts between the local educational consortia or local governmental agencies and the claiming units.

Furthermore, Health Care Services missed an opportunity to cut costs through the implementation of a single statewide quarterly time survey when it implemented the random moment time survey methodology. We estimate that the administrative activities program could save as much as \$1.3 million annually in coding costs alone if Health Care Services conducted a single statewide quarterly time survey. However, if Health Care Services implemented its own single statewide quarterly survey and took over responsibility for overseeing the administrative activities program, thus eliminating the need to use the local educational consortia and local governmental agencies for these purposes, it would result in significant savings to the administrative activities program.

In addition, Health Care Services could increase federal funding by an estimated \$10.2 million annually if more claiming units participated in the program and could have increased federal reimbursements by about \$4.6 million from February 2009 through June 2015 if it increased the reimbursement rate for translation activities to the rate allowed by federal law. Finally, Health Care Services has not complied with state law requiring the adoption of regulations for its administrative activities program and has failed to issue a required annual report for its billing option program.

Respectfully submitted,



ELAINE M. HOWLE, CPA  
State Auditor

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## Summary

### Results in Brief

Medicaid is a jointly funded federal-state health insurance program for low-income and needy individuals. The California Department of Health Care Services (Health Care Services) is the single state agency responsible for administering the State's Medicaid program, called *Medi-Cal*. Health Care Services provides Medi-Cal services in school settings through school-based Medi-Cal programs, which provide direct medical services through its Local Educational Agency Medi-Cal Billing Option Program (billing option program) and which perform program-related administrative activities through its School-Based Medi-Cal Administrative Activities program (administrative activities program). Through this latter program, Health Care Services allows claiming units to file claims for federal reimbursement for 50 percent of the cost for certain types of administrative activities.<sup>1</sup>

We found that the *reasonableness test criteria* review process that Health Care Services used to review claims for the administrative activities program from October 2013 through October 2014 was reasonable and not inconsistent with federal requirements. Health Care Services implemented the reasonableness test criteria review process in response to findings from a federal financial management review completed in 2013. The Centers for Medicare and Medicaid Services (CMS), part of the U.S. Department of Health and Human Services, found weaknesses so severe at two California claiming units that it began deferring, or withholding, reimbursements to most claiming units in the State, and it directed Health Care Services to implement a reasonableness review process to assess whether the deferred claims were allowable. Health Care Services developed benchmark percentages and other limits to assess claims under the reasonableness test criteria review process. Recognizing that claiming units varied in nature and size, Health Care Services allowed claiming units to exceed these benchmark percentages and limits if they submitted adequate justification explaining the overages.

However, Health Care Services' reasonableness test criteria review process failed to result in the approval of many deferred claims. Specifically, Health Care Services approved fewer than 10 percent of the claims that claiming units submitted under this process. Despite the low number of approved claims, we believe that this process would have maximized federal reimbursement to claiming units if Health Care Services had accurately communicated and

<sup>1</sup> According to CMS, a *claiming unit* is typically a school district or a program within a district. California has claiming units that are as diverse as county offices of education, special education local plan areas, local school districts, community colleges, and Healthy Start programs.

### Audit Highlights . . .

*Our review of the California Department of Health Care Services' (Health Care Services) administration of the School-Based Medi-Cal Administrative Activities program (administrative activities program) and the Local Educational Agency Medi-Cal Billing Option Program (billing option program) revealed the following:*

- » *The reasonableness test criteria review process that Health Care Services used for the administrative activities program claims from October 2013 through October 2014 was reasonable, but failed to result in the approval of many deferred claims.*
  - *Fewer than 10 percent of the claims that claiming units submitted under this process were approved.*
  - *Local educational consortia and local governmental agencies approved and forwarded claims to Health Care Services that did not comply with the process's requirements.*
- » *Health Care Services lacks adequate oversight of local educational consortia and local governmental agencies.*
  - *It is behind in required reviews.*
  - *Weaknesses exist in the contracts between these two types of entities and their claiming units.*
- » *The administrative activities program could save as much as \$1.3 million annually in coding costs alone if Health Care Services conducted a single statewide quarterly time survey.*
- » *Health Care Services has not maximized the participation of claiming units in the administrative activities program—the State could increase federal funding by an estimated \$10.2 million annually.*

- » *Health Care Services did not increase the reimbursement rate for translation activities to the rate allowed by federal law, failing to claim an estimated \$4.6 million in federal funding.*
- » *Health Care Services did not adopt regulations for its administrative activities program as required by state law.*
- » *It failed to issue to the Legislature a required annual report for the billing option program.*

applied the reasonableness test criteria and the claiming units had complied with CMS-approved requirements of that process. In addition, although Health Care Services has a process that allows claiming units to appeal the decisions and actions that local educational consortia and local governmental agencies take, the appeals process does not allow claiming units to directly appeal Health Care Services' decisions and actions.<sup>2</sup> We also believe that the local educational consortia and local governmental agencies have added little value during this review process. These entities contract with Health Care Services to review administrative activities program claims that claiming units submit and, if the claims meet the established criteria, they forward the claims to Health Care Services for final review and payment. However, we found that these entities approved and forwarded to Health Care Services claims that did not comply with the reasonableness test criteria benchmarks and other limits.

Furthermore, Health Care Services continues to ineffectively oversee these local educational consortia and local governmental agencies, which increases the risk that they are not performing the oversight and administrative tasks for which they are responsible. For example, it is behind in its reviews of these entities, which are required at least once every three years. Other states, such as Illinois and Michigan, use a risk-based approach to select participants to review. For example, Michigan considers factors such as the dollar amount of claims filed, previous audit findings, and staff turnover when selecting participants for review. We believe if Health Care Services used such a strategy, it could better focus its efforts on those participants with a relatively higher likelihood of material findings.

We also identified weaknesses in the contracts between the local educational consortia or local governmental agencies and their claiming units that effective Health Care Services' oversight should have prevented. For instance, the contracts issued by the Los Angeles County Office of Education (Los Angeles County) allow its claiming units to inappropriately bill the federal government for "participation fees" that are based on costs that Health Care Services has already claimed. Federal requirements prohibit such duplicate billing. In addition, some contracts between local educational consortia or local governmental agencies and their

<sup>2</sup> Health Care Services contracts with two types of entities to help it administer the administrative activities program. A *local educational consortium* is one of the 11 service regions of the California County Superintendents Educational Services Association. Each consortium is led by a county education office within the region. A *local governmental agency* is an agency of either a county or a chartered city, or a Native American Indian tribe, tribal organization, or subgroup of a Native American Indian tribe or tribal organization. The *California School-Based Medi-Cal Administrative Activities Manual* requires claiming units to contract with one of these two types of entities to participate in the administrative activities program.



claiming units contain provisions whereby the local educational consortia or local governmental agencies retain a percentage of the approved reimbursement amounts as payment. We believe such payment provisions may create an unnecessary incentive for local educational consortia and local governmental agencies to approve otherwise unallowable claims to increase their revenues.

Health Care Services also missed an opportunity to implement a single statewide quarterly time survey when it implemented the random moment time survey methodology. Instead, local educational consortia, local governmental agencies, and the Los Angeles Unified School District conduct nine time surveys each quarter. The increased costs associated with conducting nine surveys rather than a single statewide survey are neither necessary nor efficient. We estimate that the administrative activities program could save as much as \$1.3 million annually in coding costs alone if Health Care Services conducted a single statewide quarterly time survey. We identified other states (Illinois and Texas) that have implemented a single statewide survey and simultaneously removed intermediaries similar to local educational consortia and local governmental agencies from the administration of their programs. Additionally, because Health Care Services issued interim payments to local educational consortia and local governmental agencies and not individual claiming units, some claiming units may not receive promptly the full interim payment to which they are entitled under the settlement agreement with CMS. We believe that if Health Care Services implemented its own single statewide quarterly survey and took over responsibility for overseeing the administrative activities program, thus eliminating the need to use the local educational consortia and local governmental agencies for these purposes, it would result in significant savings to the administrative activities program.

In addition, Health Care Services could further maximize federal funds for the administrative activities program both by increasing program participation and by allowing claiming units to claim reimbursement for translation activities at the 75 percent reimbursement rate that federal law has allowed since 2009. We estimate that Health Care Services could increase yearly reimbursements by \$10.2 million if more entities participated in the program. Also, translation activities include assisting a student or parent in accessing or understanding the Medi-Cal application process or treatments that Medi-Cal covers. Health Care Services was unaware that translation activities were authorized by federal law to be reimbursed at a higher rate. Health Care Services could have increased federal reimbursements by about \$4.6 million from February 2009 through June 2015 if it had raised the reimbursement rate for translation activities from 50 percent to 75 percent.

Further, Health Care Services failed to comply with four subdivisions of a section of state law requiring that it adopt regulations for its administrative activities program despite the fact that these statutory requirements have been in effect for more than 15 years. Health Care Services' failure to comply with state law regarding the adoption of these regulations limits the public's ability to participate fully in developing the rules governing this program. In addition, we believe that stakeholders could construe that Health Care Services' policies are *underground regulations* that have not been adopted in compliance with California's Administrative Procedure Act (APA), which could make them unenforceable and could lead to interrupted reimbursement payments to claiming units.

Finally, Health Care Services has not filed a required annual report for the billing option program, thus failing to provide the Legislature and other stakeholders with timely and relevant information regarding program successes and barriers. We believe that these legislative reports present information useful to stakeholders and that reporting similar information for the administrative activities program is important.

## **Recommendations**

### ***Legislature***

The Legislature should amend state law to allow claiming units to submit reimbursement claims directly to Health Care Services.

In addition, the Legislature should enact legislation that requires Health Care Services to prepare reports annually for the administrative activities program similar to the annual report that state law requires for the billing option program.

### ***Health Care Services***

To ensure that it provides claiming units with reasonable opportunities to address concerns with department decisions or actions, Health Care Services should begin crafting within three months regulations to establish and implement a formal appeals process that allows claiming units to appeal Health Care Services' decisions and inform all stakeholders, including claiming units, of the existence of this appeals process.

Until the Legislature implements our recommendation to allow claiming units to submit claims directly to Health Care Services, Health Care Services should immediately take steps to improve its

oversight of local educational consortia and local governmental agencies to ensure that they sufficiently meet their responsibilities and meet the terms of their contracts.

Health Care Services should also take steps to minimize the risk that claiming units could include unallowable costs when calculating their reimbursement claims. For example, Health Care Services should encourage Los Angeles County to revise its contracts with its claiming units to make it clear that claiming units cannot include Health Care Services' participation fee as part of their claims.

Health Care Services should implement a single statewide quarterly random moment time survey and implement as soon as reasonably possible a plan to take over responsibility for conducting the surveys and performing related activities.

Health Care Services should explore opportunities to expedite interim payments to ensure that each claiming unit receives the interim payment to which it is entitled.

Within six months, Health Care Services should take the following actions:

- Revise the reimbursement rates so that claiming units can receive the 75 percent reimbursement rate for translation activities that federal law allows.
- Determine the extent to which claiming units can claim the unreimbursed difference between the 50 percent and 75 percent reimbursement rate for translation activities performed in past years and inform claiming units of the findings.

If the Legislature implements our recommendation to allow claiming units to submit claims directly to Health Care Services, Health Care Services should develop and implement its own outreach functions to ensure that nonparticipating claiming units understand the benefits and consider participating in the administrative activities program.

Health Care Services should immediately develop and adopt the regulations as required by four subdivisions of a section of the California Welfare and Institutions Code in accordance with California's APA.

Health Care Services should issue its statutorily required reports on the billing option program in a timely manner.

**Agency Comments**

Although Health Care Services agrees with most of our recommendations, it disagrees with a few. However, for certain recommendations that it disagrees with, Health Care Services describes steps it will take to at least partially address many of the issues we identified.

# Introduction

## Background

Medicaid is a jointly funded, federal-state health insurance program for low-income and needy individuals. It covers children; the aged, blind, or disabled; and other individuals who are eligible to receive federally assisted income maintenance payments. The Centers for Medicare and Medicaid Services (CMS), part of the U.S. Department of Health and Human Services, administers the Medicaid program at the federal level. According to CMS, the school setting provides a unique opportunity to enroll eligible children in Medicaid and to assist children who are already enrolled in Medicaid to access the benefits available to them.

Federal law requires states to identify a single state agency to administer the Medicaid program. While many organizations are involved in administering the Medicaid program in California, which is called *Medi-Cal*, the California Department of Health Care Services (Health Care Services) is the single state agency responsible. To assist eligible children in their school settings, Health Care Services uses separate organizational structures to operate two school-based programs: the School-Based Medi-Cal Administrative Activities program (administrative activities program) and the Local Educational Agency Medi-Cal Billing Option Program (billing option program). For the administrative activities program, Health Care Services contracts with local educational consortia and local governmental agencies to perform many functions, such as contracting with claiming units, coordinating and submitting Medi-Cal administrative activities reimbursement claims that claiming units file, and overseeing claiming unit activities.<sup>3,4</sup> State law currently requires each claiming unit participating in the administrative activities program to submit reimbursement claims through either its local educational consortium or its local governmental agency. Claiming units can contract with the local educational consortium or local governmental agency in whose jurisdiction they reside. Figure 1 on the following page shows California's 11 local educational consortia and the eight local governmental agencies that were participating in the administrative activities program as of January 2015.

<sup>3</sup> A *local educational consortium* is one of the 11 service regions of the California County Superintendents Educational Services Association. Each consortium is led by a county education office within the region. A *local governmental agency* is an agency of either a county or chartered city, or a Native American Indian tribe, tribal organization, or subgroup of a Native American Indian tribe or tribal organization.

<sup>4</sup> According to CMS, a *claiming unit* is typically a school district or program within a district. California has claiming units that are as diverse as county offices of education, special education local plan areas, local school districts, community colleges, and Healthy Start programs.

**Figure 1**  
Geographic Areas Served by Local Educational Consortia and Local Governmental Agencies Participating in the School-Based Medi-Cal Administrative Activities Program as of January 2015



Sources: The California Department of Health Care Services and the California County Superintendents Educational Services Association.

Through the administrative activities program, Health Care Services allows claiming units to file claims for federal reimbursement for 50 percent of the cost for certain types of administrative activities related to Medi-Cal that are eligible for reimbursement. See the text box for a list of the allowable types of administrative activities. To be reimbursed for the time that the claiming units' staff spend performing administrative activities, federal requirements require documentation such as personnel activities reports that account for all time spent or substitute systems such as time studies that use sampling methods. Types of time studies include worker log and random moment time surveys, both of which we describe in more detail later. Claiming units then submit completed reimbursement claims to their local educational consortium or local governmental agency for review and approval.

After approving these claims, the local educational consortium or local governmental agency prepares and submits a summary invoice to Health Care Services, which performs a final review of the claims. If Health Care Services approves the claims, it includes them as part of a quarterly Medicaid expenditure report, which it submits to CMS at the end of each federal quarter. Health Care Services also schedules the claims for payment via the California State Controller's Office (state controller) and draws the federal funds for payment. If Health Care Services does not approve a claim, it requests a revised claim from the local educational consortium or local governmental agency that forwarded it.

Local educational agencies may also claim federal reimbursement under the billing option program for up to 50 percent of the cost of certain types of direct medical services, or health-related services provided in school settings, to students eligible for Medi-Cal. See the

### Medi-Cal Administrative Activities in the School Setting That Are Eligible for Federal Reimbursement

Under federal and state laws, activities necessary for the efficient administration of Medi-Cal are reimbursable. Federal and state policies specify that the following Medi-Cal administrative activities are eligible for reimbursement in a school setting:

- Medi-Cal outreach.
- Facilitating the applications for Medi-Cal.
- Referral, coordination, and monitoring of Medi-Cal services.
- Arranging transportation to support Medi-Cal services.
- Translation of documents related to Medi-Cal services.
- Program planning, policy development, and interagency coordination related to Medi-Cal services.
- Medi-Cal claims administration, coordination, and training.

Sources: Title 42, United States Code, Section 1396b; Title 42, Code of Federal Regulations, Section 433.15; U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services' *Medicaid School-Based Administrative Claiming Guide* (2003); California Welfare and Institutions Code, Section 14132.47; and California Department of Health Care Services' *California School-Based Medi-Cal Administrative Activities Manual* (June 2014).

Note: An additional category of reimbursable activities exists that includes the following: general administration, completing the Medi-Cal administrative activities time survey form, and paid time off. Costs in this category are to be reallocated across other activities on a pro rata basis.

### Medical Services Under the Local Educational Agency Medi-Cal Billing Option Program That Are Eligible for Federal Reimbursement

State law and California's Medicaid State Plan identify the following direct services as allowable and reimbursable through the Local Educational Agency Medi-Cal Billing Option Program:

- Health and mental health evaluations and education.
- Physical therapy.
- Occupational therapy.
- Speech pathology and audiology services.
- Physician services.
- Mental health and counseling services.
- Nursing services.
- School health aide services.
- Medical transportation.

Sources: California Welfare and Institutions Code, Section 14132.06, and California's Medicaid State Plan.

text box for a summary of the allowable types of direct services that are eligible for reimbursement under the billing option program. However, if a Medi-Cal-eligible student needs any medically necessary services, Medicaid's early and periodic screening, diagnostic, and treatment (EPSDT) services provisions require states to provide those services, whether or not the services are covered under the state plan. Medicaid's EPSDT provisions state that covered services include any necessary health care, diagnostic services, treatments, or other measures described in federal law to correct or ameliorate defects and physical and mental illnesses and conditions discovered through screening.

Unlike the administrative activities program, local educational agencies participating in the billing option program do not file reimbursement claims with local educational consortia or local government agencies; instead, they file claims using the traditional Medi-Cal fee-for-service system through Health Care Services' fiscal intermediary, Xerox State Healthcare (Xerox). Health Care Services contracts with Xerox to perform services such as reviewing and then approving or denying provider claims. After local educational agencies send their claims to Xerox, it reviews and

approves or denies the claims for payment. If Xerox approves the claims, it submits payment files to the state controller for the issuance of warrants to providers. According to the chief of Health Care Services' Medi-Cal Administrative Claiming Section, Xerox submits a report of paid claims to Health Care Services' accounting department, which then prepares the quarterly Medicaid expenditure report to obtain reimbursement from the federal government.

### A Federal Financial Management Review Triggered Changes to the Administrative Activities Program

In 2012 CMS completed its fieldwork on a financial management review of expenditures for Health Care Services' administrative activities program, leading to changes in how claims for the administrative activities programs are reviewed and in the type of time studies used in the State. At the time of the CMS review, Health Care Services required claiming units to use a time study methodology known as *worker log*. Using the worker log, claiming unit staff tracked the amounts of time they spent during five consecutive workdays each quarter on different types of activities—both related and unrelated to the administrative activities program. Claiming units applied the time survey results from this week to the entire quarter to calculate their administrative activities claims.



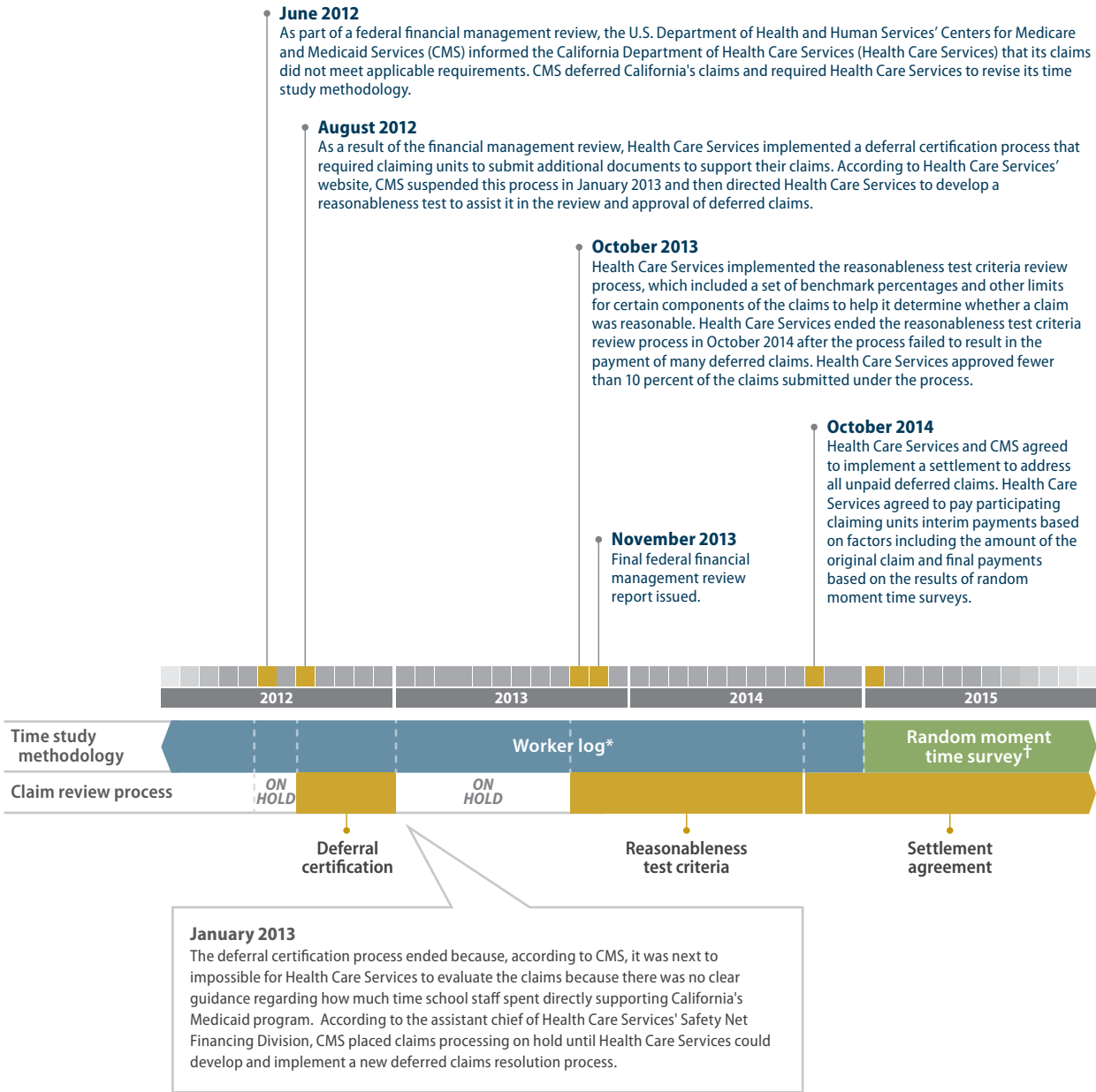
In November 2013 CMS issued its final report based on the results of its financial management review. However, from its review of the reimbursement claims paid to three California claiming units, CMS made decisions and issued directives to Health Care Services even before it issued the final report. For instance, in June 2012 CMS required Health Care Services to revise its time study methodology to comply with federal requirements. Also in June 2012, CMS began deferring the payment of reimbursement claims pertaining to administrative activities performed as far back as fiscal year 2009–10.

In its review, CMS found that two out of the three claiming units it reviewed submitted claims for reimbursement that did not comply with federal requirements. CMS found that staff at both the Turlock Unified School District and the Tulare County Office of Education–Special Services were directed to perform activities during the survey period that were outside their normal job duties to maximize federal reimbursement. CMS concluded that these additional activities resulted in an overallocation of claiming unit costs to the Medicaid program.

CMS also reported that neither Health Care Services nor the respective local educational consortium or local governmental agency for each of the two claiming units questioned the reimbursement claims because their oversight reviews did not include an assessment of the reasonableness of the claims' information. One CMS finding noted that the State lacked appropriate internal controls to ensure compliance with federal requirements. CMS also found that instead of providing consistent oversight and monitoring guidance to claiming units, local educational consortia, and local governmental agencies, Health Care Services allowed the latter two entities to either establish their own standards or perform a very cursory review of the claiming units' claims. Consequently, CMS stated that Health Care Services must implement a *reasonableness review* of reimbursement claims to ensure that the time studies and invoices were reasonable and allocable, and that Health Care Services must implement internal controls to ensure compliance with federal regulations and guidelines.<sup>5</sup> Figure 2 on the following page summarizes the evolution of the time study methodologies and claims review processes that Health Care Services has used for the administrative activities program. We describe Health Care Services' efforts to resolve deferred claims using the deferral certification and reasonableness test criteria review process in the Appendix. We describe Health Care Services' efforts to resolve deferred claims under the terms of its settlement agreement with CMS in the next section.

<sup>5</sup> According to federal regulations, a cost is allocable to a particular federal award if, among other things, the goods or services involved are chargeable or assignable to that federal award in accordance with benefits received.

**Figure 2**  
**California Department of Health Care Services' Time Study Methodologies and Claim Review Processes for the School-Based Medi-Cal Administrative Activities Program**



Sources: Documents obtained from and interviews held with staff of Health Care Services and interviews held with staff of CMS.

\* Health Care Services used its worker log time study methodology for more than a decade until replacing it with a new time study methodology—the random moment time survey—in January 2015.

† According to Health Care Services' June 2014 *California School-Based Medi-Cal Administrative Activities Manual*, the random moment time survey methodology polls selected staff from the claiming unit individually to determine what they were doing at randomly selected minutes during the quarter being surveyed, and then it totals the results to identify the proportion of time spent on allowable administrative activities for the entire population of time survey participants.

### Health Care Services Agreed to Resolve Deferred Claims by Making Interim and Final Reimbursement Payments to Claiming Units

When the reasonableness test criteria review process failed to result in the payment of many of the deferred claims, Health Care Services and CMS entered into an agreement in October 2014 to implement a third process. Under the terms of the settlement agreement, Health Care Services would make initial interim reimbursement payments to claiming units, followed later by final payments, all of which would resolve the deferred claims. Figure 3 on the following page summarizes the payment terms of the settlement agreement. Health Care Services could make interim payments ranging from 25 percent to 100 percent of the claim amounts depending on the size of the reimbursement claim and the fiscal year that the claiming unit provided the services. For those claiming units no longer participating in the administrative activities program, Health Care Services would calculate a single amount as payment in full based on a percentage of the original deferred claim ranging from 35 percent to 100 percent depending on the size of the deferred invoice. As of July 2015 Health Care Services was making interim payments to local educational consortia and local governmental agencies for their claiming units.

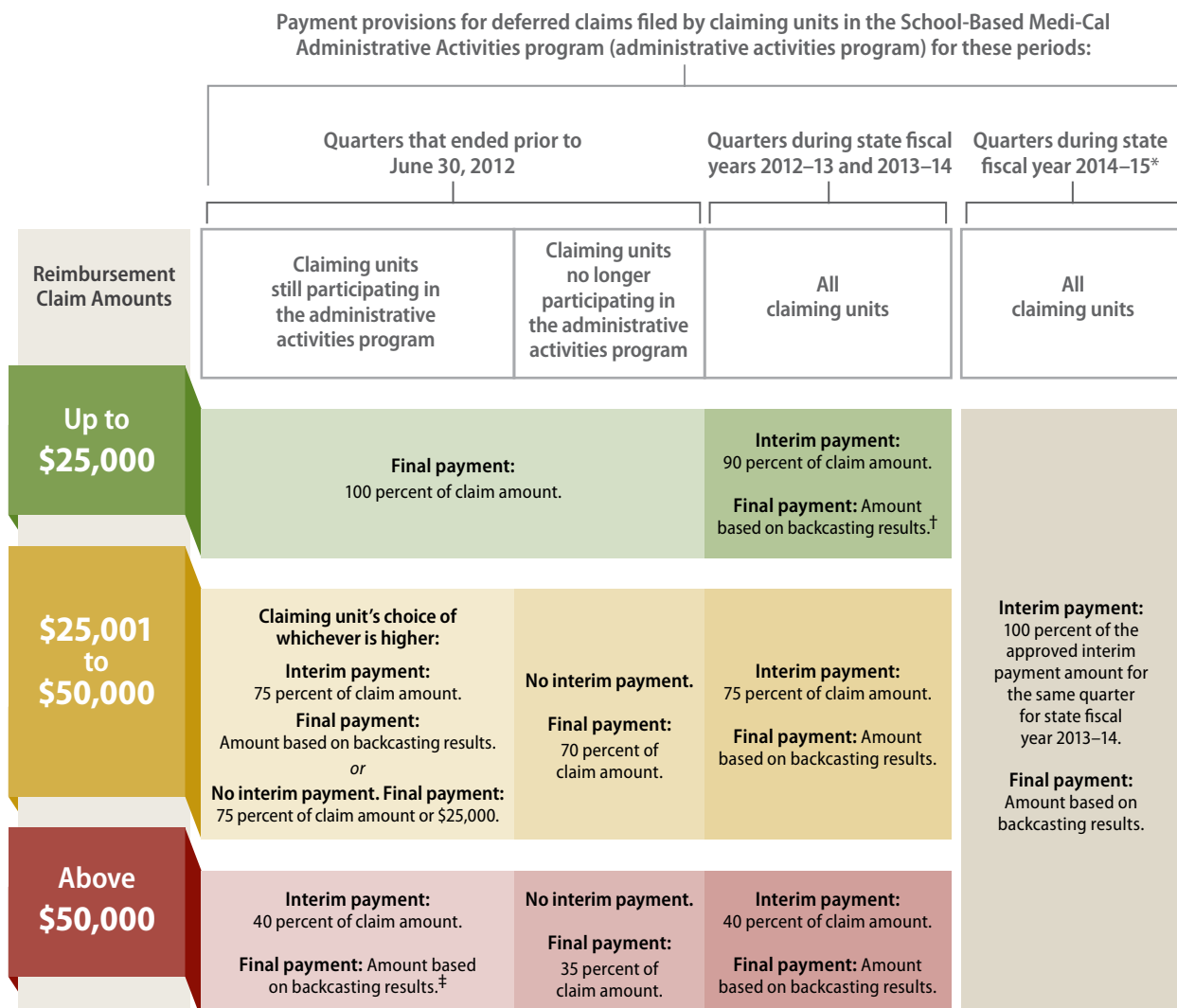
Under the terms of the settlement agreement, Health Care Services is to calculate the final payments and pay the unpaid balances of the remaining claims through a process it and CMS call *backcasting*, which relies on the results of the new time study methodology that Health Care Services implemented in January 2015. According to Health Care Services' June 2015 proposed backcasting methodology, CMS requires Health Care Services to collect data from the results of four quarterly surveys conducted under the new random moment time survey methodology that we discuss later in this report.<sup>6</sup> The methodology states that these data will be used to determine the final reimbursement amount for all deferred claims. Local educational consortia and local governmental agencies will calculate an average of the administrative activities percentages for each quarter. The results will be combined and averaged to produce a single set of summary percentages for each *administrative unit* for each quarter, after which an overall average will be calculated for each administrative unit from the four quarters of data.<sup>7</sup> This final set of summary percentages will replace the worker log summary percentages in all claims subject to backcasting. Per the methodology, a final claim amount

<sup>6</sup> The four quarters used for backcasting may not be consecutive. According to the June 2015 proposed backcasting methodology, data for backcasting can come from four of the five quarters from January 2015 through March 2016. The proposed methodology states that if Health Care Services determines that the data from January through March 2015 are not comparable to the data from the following three quarters, then data from January through March 2016 can be used in their place.

<sup>7</sup> Health Care Services' June 2015 proposed backcasting plan describes an *administrative unit* as one of the eight survey entities that generate random moments in California, not including the Los Angeles Unified School District, which conducts its own quarterly time survey.

will be determined based on the survey results for all claims subject to backcasting and compared to the interim payments made. If the comparison results in a balance due to the claiming unit, Health Care Services will issue the payment. If the comparison results in a balance due to Health Care Services, the claiming unit will issue payment through their local educational consortium or local governmental agency to Health Care Services.

**Figure 3**  
**Payment Provisions of the October 2014 Settlement Agreement Between the Centers for Medicare and Medicaid Services and the California Department of Health Care Services**



Sources: October 2014 letter from the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) to the California Department of Health Care Services (Health Care Services) regarding the settlement agreement, Health Care Services' January 2015 letter to claiming units about implementation of the random moment time survey, and Health Care Services' April 2015 backcasting methodology.

\* Health Care Services used this process only for the two quarters from July 1, 2014, through December 31, 2014. Health Care Services started using random moment time surveys beginning January 1, 2015.

† *Backcasting* is a process that takes time survey percentages computed from the average of results from the first several quarters of the new time surveys and applies the percentages to the deferred claims.

‡ CMS had a single exception to this provision; it would approve an interim payment of 25 percent of the claim amount for the Turlock Unified School District (Turlock Unified) and then backcast to calculate its final payment. The reduced percentage is based on the results of CMS's review of Turlock Unified's claims and the revised invoices that Turlock Unified submitted to Health Care Services.

Claiming units may not receive some final payments to resolve deferred claims until 2019. Health Care Services' June 2015 proposed backcasting methodology states that local educational consortia and local governmental agencies will submit recalculated claims for deferred claims greater than \$25,000 according to the following schedule:

- State fiscal years 2009–10 and 2010–11 by June 30, 2017
- State fiscal years 2011–12 and 2012–13 by December 31, 2017
- State fiscal years 2013–14 and 2014–15 by June 30, 2018

The proposed backcasting methodology also states that the reconciliation of all deferred claims must be completed by April 1, 2019, and that any deferred claims not finalized by Health Care Services by June 2019 will be forfeited.

### Scope and Methodology

The Joint Legislative Audit Committee (audit committee) directed the California State Auditor to audit the administrative activities and billing option programs. Table 1 lists the audit committee's objectives and the methods we used to address them.

**Table 1**  
**Audit Objectives and the Methods Used to Address Them**

AUDIT OBJECTIVE	METHOD
1 Review and evaluate the laws, rules, and regulations significant to the audit objectives.	<ul style="list-style-type: none"> <li>• We reviewed relevant federal and state laws and regulations, as well as other relevant requirements applicable to the administration by the California Department of Health Care Services (Health Care Services) of Medicaid claims filed for school-based Medi-Cal, which includes the School-Based Medi-Cal Administrative Activities program (administrative activities program) and the Local Educational Agency Medi-Cal Billing Option Program (billing option program).</li> <li>• We interviewed key staff at the Centers for Medicare and Medicaid Services (CMS), part of the U.S. Department of Health and Human Services, and key staff at Health Care Services.</li> <li>• We examined California's Administrative Procedure Act and relevant information from the Office of Administrative Law for requirements applicable to state agencies when adopting regulations.</li> </ul>
2 Research the oversight and administrative structure of similar Medicaid programs in other states. To the extent possible, identify best practices for the administration of these programs.	<p>To identify states with similar school-based Medicaid programs, we gathered data about all 50 states such as the following information: the number of kindergarten through 12<sup>th</sup> grade students, the number of local educational agencies, state spending on Medicaid and education, and the status of Medicaid expansion. We selected nine states based on these data, and we reviewed general information about each state's school-based Medicaid program. From those states, we selected three—Illinois, Michigan, and Texas—that were comparable to California in terms of the number of local educational agencies and the current or former structures of their school-based Medicaid programs.</p> <p>For purposes of this report, we identified practices used by other states that we believe could enhance California's school-based Medicaid programs. To identify these practices, we gathered documentation and interviewed staff at the Illinois, Michigan, and Texas Medicaid agencies as well as staff at California local educational consortia and local governmental agencies.</p>

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AUDIT OBJECTIVE	METHOD
<p>3 Compare California's structure, including the use of local educational consortia and local governmental agencies, to the structures implemented by other states. To the extent possible, determine how California's program structure compares to those of other states in the areas of cost-effectiveness, transparency of fiscal reporting, the extent to which state reporting requirements allow for tracking of student outcomes, clarity and effectiveness of program communication, stakeholder engagement processes, and the potential for conflicts of interest.</p>	<p>To identify the structure of California's administrative activities and billing option programs, we reviewed documentation and interviewed key staff members at Health Care Services.</p> <p>We then reviewed documentation and interviewed staff from the Illinois, Michigan, and Texas Medicaid agencies to determine how their administrative activities programs compare to California's program in terms of cost-effectiveness, transparency of fiscal reporting, the extent to which state reporting requirements allow for tracking student outcomes, clarity and effectiveness of program communication, stakeholder engagement, and the potential for conflicts of interest.</p>
<p>4 Determine whether Health Care Services maximizes the amount of federal funding available to California under the administrative activities and billing option programs. For increases in federal reimbursement rates since 2010, determine how Health Care Services distributed increased funding between state and local agencies.</p>	<p>We defined the verb <i>maximize</i> in this context as "to ensure that California receives the maximum amount of federal Medicaid funding allowed under federal and state laws and regulations." Therefore, we focused our audit work on these three Health Care Services' activities:</p> <ul style="list-style-type: none"> <li>• Efforts to ensure that the amounts claimed by claiming units participating in the administrative activities program are at the maximum allowable rate.</li> <li>• Efforts to increase the number of claiming units participating in the two programs.</li> <li>• Whether Health Care Services reimbursed local educational agencies participating in the billing option program for the maximum percentage of federal financial participation allowed under federal law or regulations during periods of increased reimbursement rates.</li> </ul> <p>To determine whether Health Care Services ensured that claiming units participating in the administrative activities program claimed reimbursement of federal financial participation at the maximum allowable percentage, we identified the maximum reimbursement rates for each activity the federal government allows and compared those to reimbursement rates that Health Care Services allowed. We then estimated the potential loss of reimbursements because of Health Care Services' use of percentages that were lower than those the federal government allows.</p> <p>To determine whether Health Care Services exerted sufficient efforts to increase the number of claiming units participating in the administrative activities program, we interviewed department staff members to identify the extent to which Health Care Services performed outreach to nonparticipating claiming units and the extent to which Health Care Services held local educational consortia and local governmental agencies responsible for performing contractually obligated outreach. We also estimated the potential loss in federal reimbursements from nonparticipating claiming units.</p> <p>To determine whether Health Care Services accurately reimbursed local educational agencies participating in the billing option program when reimbursement rates increased, we identified sources and amounts of federal rate increases. We then verified that Health Care Services reimbursed local educational agencies based on these increased rates by reviewing reimbursement data.</p>
<p>5 Related to Health Care Services' reasonableness test criteria review process:</p> <p>a. Review the design of the reasonableness test criteria review process and determine whether the benchmarks for reimbursements are reasonable given the wide range of sizes and types of local educational agencies statewide. To the extent possible, determine whether reimbursement criteria are consistently applied across all local educational agencies and whether there are areas where the criteria are more restrictive than federal guidelines.</p>	<ul style="list-style-type: none"> <li>• We interviewed Health Care Services' staff to determine how Health Care Services developed the reimbursement process that uses the reasonableness test criteria, which was in effect from October 2013 through October 2014, and we reviewed documents related to the process.</li> <li>• We compared the reasonableness test criteria with applicable federal guidance.</li> <li>• We examined a selection of reimbursement claims subject to the reasonableness test criteria to determine whether Health Care Services applied the criteria correctly and consistently.</li> </ul>

AUDIT OBJECTIVE	METHOD
<p>b. Review a selection of claims subject to the reasonableness test criteria to determine whether Health Care Services has effective fiscal and administrative controls over the reimbursement process to ensure that local educational agencies receive consistent, appropriate, and timely reimbursements. To the extent possible, determine whether the process for reimbursements is consistently applied across all local educational agencies.</p>	<ul style="list-style-type: none"> <li>• We judgmentally selected 10 quarterly claims subject to the reasonableness test criteria, taking into account amounts claimed, relative size of the claiming unit, and the geographic location of the claiming units filing the claim. The claim amounts ranged from \$1,856 to nearly \$400,000.</li> <li>• Using the reasonableness test criteria's fiscal and administrative controls that Health Care Services provided, we examined each claim to determine whether Health Care Services adhered to these controls for the reimbursement process.</li> <li>• We identified and reviewed an additional 10 claims that local educational consortia or local governmental agencies approved and forwarded to Health Care Services that did not contain required justifications to determine whether it was a frequent occurrence.</li> </ul>
<p>c. To the extent possible, determine whether Health Care Services' direction to local educational consortia and local governmental agencies about the reasonableness test criteria review process maximizes federal reimbursements and whether the criteria used in determining allowable staff costs is reasonable and consistent with allowable federal guidelines.</p>	<p>To determine whether the reasonableness test criteria maximized federal reimbursements and were reasonable and consistent with federal guidelines, we interviewed staff from CMS and Health Care Services, and we reviewed relevant documentation for the reasonableness test criteria—including policy letters, guidance materials, and CMS's approval of the process that used the reasonableness test criteria—and federal regulations and requirements, such as the Office of Management and Budget Circular A-87.</p>
<p>d. Determine whether Health Care Services has clearly communicated the criteria for approving or rejecting a reimbursement claim to local educational agencies and whether it has an adequate appeals process for denied claims under the reasonableness test criteria review process.</p>	<ul style="list-style-type: none"> <li>• To determine whether Health Care Services clearly communicated reasonableness test criteria for approving or rejecting reimbursement claims, we examined for clarity and completeness the written instructions that Health Care Services provided to program participants.</li> <li>• To determine whether Health Care Services had an adequate appeals process for claims denied under the reasonableness test criteria, we interviewed Health Care Services' staff and reviewed applicable policies.</li> </ul>
<p>e. Determine the approval rate of reimbursement claims by local educational consortium or local governmental agency by region and statewide.</p>	<p>Using Health Care Services' claims database, we calculated the approval rates of reimbursement claims statewide and for each local educational consortium and local governmental agency.</p>
<p>6 Determine what Health Care Services has done to comply with the administrative and reporting requirements of Welfare and Institutions Code, Section 14115.8(f), and to the extent possible, determine whether a reasonable process is in place for local educational agencies to be compensated for withheld reimbursements.</p>	<p>To assess Health Care Services' compliance with the administrative and reporting requirements in Section 14115.8(f) of the Welfare and Institutions Code, which apply only to the billing option program, we did the following:</p> <ul style="list-style-type: none"> <li>• Verified that reports were submitted as required.</li> <li>• Compared the contents of the most recent final report to the 11 report elements required by law.</li> <li>• Judgmentally selected five elements to determine whether Health Care Services reported each one reasonably and accurately. We concluded that it did.</li> </ul> <p>To determine whether a reasonable process existed for claiming units to be compensated for withheld reimbursements, we examined communication between Health Care Services and CMS regarding the deferral resolution methodologies Health Care Services used through June 2015.</p>

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AUDIT OBJECTIVE	METHOD
<p>7 Review and assess any other issues that are significant to the structure of the administrative activities and billing option programs and Health Care Services' implementation of the reasonableness test criteria review process.</p>	<p>Because Health Care Services replaced the reimbursement process that used reasonableness test criteria with another process in October 2014, we interviewed staff at CMS and Health Care Services, and we reviewed relevant documents to examine the replacement process.</p> <p>At the beginning of our audit, we received several stakeholder concerns about Health Care Services' administration of the random moment time surveys. Many concerns fell into two categories: lack of new contracts between the local educational consortia or the local governmental agencies and their claiming units, and claiming units' inability to provide in a timely manner the participation lists to the local educational consortia or the local governmental agencies. Our discussions with local educational consortia and local governmental agencies did not disclose any problems with contracts or participant lists that were serious enough to prevent the claiming units from participating in the first random moment time survey quarter, which Health Care Services implemented January 2015 through March 2015.</p>

Sources: California State Auditor's analysis of the Joint Legislative Audit Committee's audit request 2014-130, our planning documents, and our analysis of information and documentation identified in the column titled *Method*.

### Assessment of Data Reliability

In performing this audit, we relied on various electronic data files extracted from the information systems listed in Table 2. The U.S. Government Accountability Office, whose standards we are statutorily required to follow, requires us to assess the sufficiency and appropriateness of computer-processed information that we use to support findings, conclusions, or recommendations. Table 2 describes the analyses we conducted using data from these information systems, our methodology for testing them, and the limitations we identified in the data. Although we recognize that these limitations may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations.



**Table 2**  
**Methods Used to Assess Data Reliability**

INFORMATION SYSTEM	PURPOSE	METHOD AND RESULT	CONCLUSION
<p>California Department of Health Care Services (Health Care Services)</p> <p>The Administrative Claiming Local and School Services Branch's Medi-Cal Administrative Activities Invoice Database (invoice database)</p> <p>Data as of February 2015 for the period from July 2008 through June 2014</p>	<p>To select claims for in-depth testing and to calculate estimates based on claim statistics.</p>	<ul style="list-style-type: none"> <li>• We performed data-set verification procedures and electronic testing of key data elements and found no significant issues.</li> <li>• To test the accuracy of the data, we randomly selected 29 claims and verified that key data elements matched source documentation and did not identify any significant issues.</li> <li>• To test the completeness of the data, we haphazardly selected 29 other claims and traced them from source documentation back to the invoice database. We found the database to be complete.</li> </ul>	<p>Sufficiently reliable for the purposes of this audit.</p>
<p>California Department of Education (Education)</p> <p>California Longitudinal Pupil Achievement Data System (achievement data system)</p> <p>Enrollment data for academic year 2011–12</p>	<p>To determine the universe of California local educational agencies and their enrollments for estimating lost reimbursement amounts due to nonparticipation in the School-Based Medi-Cal Administrative Activities program. We created a ratio of enrollment in nonparticipating local educational agencies to enrollment in participating local educational agencies to aid in the creation of this estimate.</p>	<p>We did not perform data reliability testing for the enrollment data within the achievement data system because source documents are located throughout the State, making such testing cost-prohibitive.</p>	<p>Undetermined reliability for the purposes of this audit. Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations.</p>
<p>Health Care Services</p> <p>Management Information System/Decision Support System (MIS/DSS)</p> <p>Service invoice payment data for September 2011</p>	<p>To determine whether the Local Educational Agency Medi-Cal Billing Option Program received increased federal reimbursements during the time the American Recovery and Reinvestment Act was in effect.</p>	<p>We did not perform data reliability testing for the MIS/DSS because we used these data only to confirm the accuracy of other evidence. Additionally, this database is a mix of paperless and paper claims, and any source documents are located at local educational agencies throughout the State, making such testing cost-prohibitive.</p>	<p>Undetermined reliability for the purposes of this audit. Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings and conclusions.</p>
<p>Health Care Services</p> <p>School-Based Medi-Cal Administrative Activities Interim Claiming and Reasonableness Test Criteria Tracker Database</p> <p>Data for tracking claims processed using the reasonableness test criteria</p> <p>Claims received under the reasonableness test criteria review process for the period from July 2009 through June 2013</p>	<p>To determine the number and dollar value of claims received and approved using the reasonableness test criteria for each local educational consortium and local governmental agency.</p>	<p>To test the accuracy of the data, we randomly selected 29 claims and attempted to verify that key data elements matched another data set that we had previously determined was sufficiently reliable for our purposes. After testing 14 claims, we found four material exceptions. Based on this information, we discontinued our data reliability testing for these data.</p>	<p>Not sufficiently reliable for the purposes of this audit. Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings and conclusions.</p>

Sources: California State Auditor's analysis of various documents, interviews, and data obtained from Health Care Services, and our analysis of data obtained from Education.

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# Chapter 1

## THE FAILURE OF THE REASONABLENESS TEST CRITERIA REVIEW PROCESS TO RESOLVE DEFERRED CLAIMS HELPED EXPOSE FLAWS IN THE ADMINISTRATION OF THE SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES PROGRAM

### Chapter Summary

The California Department of Health Care Services (Health Care Services) implemented the claims review process involving reasonableness test criteria in response to a financial management review that the federal Centers for Medicare and Medicaid Services (CMS) conducted on California's School-Based Medi-Cal Administrative Activities program (administrative activities program). We believe that this claims review process was reasonable and would have maximized federal reimbursements to the claiming units if Health Care Services had accurately communicated and applied the criteria and if claiming units had complied with the process's CMS-approved requirements.<sup>8</sup> However, as executed, this process failed to result in Health Care Services' approval of many deferred claims. In addition, local educational consortia and local governmental agencies approved and forwarded claims that Health Care Services did not approve as complying with the process's requirements.<sup>9</sup> Therefore, we believe that local educational consortia and local governmental agencies provided little value during this process. In addition, Health Care Services has no formal appeals process available for claiming units wishing to directly appeal its decisions to not approve reimbursement claims filed under the process.

Furthermore, Health Care Services does not effectively oversee the local educational consortia and local governmental agencies with which it contracts to perform key administrative and oversight functions for the administrative activities program. For example, Health Care Services' lack of oversight prevents it from detecting unallowable provisions in the contracts between local educational consortia or local governmental agencies and their claiming units.

<sup>8</sup> According to CMS, a *claiming unit* is typically a school district or a program within a district. California has claiming units that are as diverse as county offices of education, special education local plan areas, local school districts, community colleges, and Healthy Start programs.

<sup>9</sup> A *local educational consortium* is one of the 11 service regions of the California County Superintendents Educational Services Association. Each consortium is led by a county education office within the region. A *local governmental agency* is an agency of either a county or a chartered city or is a Native American Indian tribe, tribal organization, or subgroup of a Native American Indian tribe or tribal organization.

### **Health Care Services' Claims Review Process Involving Reasonableness Test Criteria Failed to Result in the Payment of Many Deferred Claims**

Health Care Services' reasonableness test criteria review process for the administrative activities program failed to result in the approval of many deferred claims. As shown in Table 3, Health Care Services approved fewer than 10 percent of the reimbursement claims that claiming units submitted during the nearly one-year period under this process, and it did not review all of the claims it received before the reasonable test criteria process was cancelled. Consequently, claiming units received very few federal reimbursements through this process. Despite the low number of approved reimbursement claims, we believe that this process would have maximized federal reimbursements to claiming units if Health Care Services had accurately communicated and applied the criteria and if the claiming units had complied with the process's CMS-approved requirements.

*CMS instructed Health Care Services to implement a reasonableness review to ensure that claims and time studies were reasonable and that proper time coding was used.*

As described in the Introduction, Health Care Services' implementation of the reasonableness test criteria flowed out of a recommendation from CMS's financial management review. CMS instructed Health Care Services to implement a reasonableness review to ensure that claims and time studies were reasonable and that proper time coding was used. Using the Kern County Office of Education (Kern County) methodology as a model, CMS recommended that Health Care Services develop its reasonableness test criteria based on authorized job classifications, claiming data, and vendor fee limits. The Kern County methodology was chosen because CMS did not have to defer payments for reimbursement claims for the Santa Barbara County Education Office—Special Education Division (Santa Barbara), which submitted its claims through the four-county local educational consortium led by Kern County. During its financial management review, CMS had reviewed the time survey results for one of Santa Barbara's quarterly claims and interviewed time study participants and representatives from Kern County, and it determined that the time survey results for the individual participants were reasonable given their job responsibilities and that Kern County had performed a thorough review of the claim including assessing the reasonableness of both the time study results and other direct charges reported on the claim. Based on this review, CMS validated that all claimed costs for Santa Barbara for fiscal year 2010–11 met federal requirements

**Table 3**  
**Approval Rates for Reimbursement Claims Submitted Under the Reasonableness Test Criteria Review Process, Which Was in Place From October 28, 2013, Through October 7, 2014**

NAME OF LOCAL ENTITY	NUMBER OF CLAIMS SUBMITTED	NUMBER OF CLAIMS APPROVED FOR PAYMENT	DOLLAR AMOUNT OF CLAIMS SUBMITTED	DOLLAR AMOUNT OF CLAIMS APPROVED FOR PAYMENT	PERCENTAGE OF CLAIMS APPROVED FOR PAYMENT
<b>Local educational consortium</b>					
Region 1—Sonoma County Office of Education	398	47	\$4,826,640	\$487,407	12%
Region 2—Glenn County Office of Education	819	59	12,789,217	489,209	7
Region 3—Sutter County Superintendent of Schools Office	454	25	7,047,614	383,621	6
Region 4—Contra Costa County Office of Education	374	32	11,824,724	456,785	9
Region 5—Santa Cruz County Office of Education	375	4	8,076,815	23,594	1
Region 6—Stanislaus County Office of Education	371	35	15,584,529	1,023,172	9
Region 7—Madera County Office of Education	344	2	7,287,915	1,469	1
Region 8—Kern County Office of Education	479	248	19,473,125	14,318,871	52
Region 9—Orange County Department of Education	230	0	14,757,048	0	0
Region 10—San Bernardino County Superintendent of Schools	90	15	4,565,015	275,334	17
Region 11—Los Angeles County Office of Education	600	6	52,882,691	49,460	1
<b>Subtotals</b>	<b>4,534</b>	<b>473</b>	<b>\$159,115,333</b>	<b>\$17,508,922</b>	<b>10.4%</b>
<b>Local governmental agency*</b>					
Alameda County Health Care Services Agency	16	0	\$1,778,586	\$0	0%
Fresno County Auditor-Controller/Treasurer-Tax Collector	38	1	3,192,733	196,829	3
Imperial County Public Health Department	89	2	1,454,778	973	2
Inyo County Health and Human Services	11	0	30,126	0	0
Kern County Department of Public Health	24	15	370,819	205,339	63
Riverside County Fiscal Services—Community Health Agency	23	0	3,237,305	0	0
Sacramento County Health and Human Services	12	0	1,074,974	0	0
San Bernardino County Department of Aging and Adult Services	90	9	9,818,555	281,267	10
San Diego County Health and Human Services Agency	44	0	1,452,198	0	0
City and County of San Francisco Department of Public Health	1	0	92,227	0	0
San Luis Obispo County Public Health Department	19	0	1,682,324	0	0
Santa Clara County Finance/Public Health	50	0	2,026,787	0	0
Solano County Health and Social Services Department	12	0	249,221	0	0
Tulare County Health and Human Services Agency	295	4	8,771,469	891,021	1
City of Pasadena Public Health Department	1	0	268,460	0	0
<b>Subtotals</b>	<b>725</b>	<b>31</b>	<b>\$35,500,562</b>	<b>\$1,575,429</b>	<b>4.3%</b>
<b>Statewide totals</b>	<b>5,259</b>	<b>504</b>	<b>\$194,615,895</b>	<b>\$19,084,351</b>	<b>9.6%</b>

Sources: The School-Based Medi-Cal Administrative Activities Interim Claiming and Reasonableness Test Criteria Tracker database, and the California Department of Health Care Services' (Health Care Services) and local governmental agency consortium's websites. See the *Methods Used to Assess Data Reliability* section in the Introduction to the report regarding the electronic data used in the table.

Note: This table shows the number of claims that Health Care Services received and approved under the reasonableness test criteria. However, Health Care Services did not review an unknown number of claims before it discontinued the process.

\* These local governmental agencies serviced claiming units in their respective regions when the latter submitted the listed claims.

***Health Care Services recognized that each local educational agency represents a unique set of circumstances, and it set up an exception component to the reasonableness test criteria, which CMS approved.***

and it concluded that Santa Barbara was administering the time study and completing claims in accordance with the approved school-based administrative claiming guide.<sup>10</sup>

Furthermore, according to its documentation, when developing the reasonableness test criteria, Health Care Services consulted with CMS to develop statewide standards for each type of administrative activity. For example, Health Care Services developed limits on the overall percentage of time that each claiming unit's time survey participants spent on administrative activities in relation to their total work time that could be included in claims for federal reimbursement. Health Care Services also limited the number of administrative staff that could participate in the time survey and the amount of external vendor fees that could be included in reimbursement claims. See Table 4 for a summary of the reasonableness test criteria.

Health Care Services recognized that each local educational agency is unique and represents a unique set of circumstances, and it set up an exception component to the reasonableness test criteria, which CMS approved as part of the process. Under the new process, Health Care Services would allow claiming units to exceed or otherwise not comply with the benchmark percentages, limits, or authorized time survey participants if the claiming units submitted an adequate justification why exceeding the criteria was reasonable and necessary for the proper and efficient administration of the Medi-Cal program. Health Care Services also developed and posted on its website several example justifications to help local educational agencies prepare their own. For instance, Health Care Services used one of these examples to illustrate an adequate justification for a fictitious school district whose time study participants spent 4.63 percent of their overall time on initial Medi-Cal outreach (which exceeded the 4 percent limit for this activity). In the example, the fictitious school district successfully justified exceeding the limit for this administrative activity by explaining that a high percentage (68 percent) of its large student population is eligible for Medi-Cal and its community service workers serve a vital role in connecting these students with programs and services related to Medi-Cal. Because community service workers perform a heavy volume of daily work related to Medi-Cal, a substantial portion of their time would therefore be reasonably allotted to reimbursable Medi-Cal outreach activities.

<sup>10</sup> The school-based administrative claiming guide refers to CMS's 2003 *Medicaid School-Based Administrative Claiming Guide* (guide). The purpose of the guide is to inform schools, state Medicaid agencies, and other interested parties on the appropriate methods for claiming federal reimbursement for the costs of Medicaid administrative activities performed in the school setting.

**Table 4**  
**California Department of Health Care Services’ Reasonableness Test Criteria**

The California Department of Health Care Services (Health Care Services) required claiming units to take the following actions to obtain approval of deferred claims under the reasonableness test criteria review process for the School-Based Medi-Cal Administrative Activities program:

- Remove all unauthorized job classifications from the time study.
- Limit clerical and administrative positions to no more than 20 percent of the total number of nonclerical and nonadministrative time study participants.
- Limit vendor fees to 15 percent of the total amount of the claim (after the application of other reasonableness test criteria).
- Apply the following percentage limits to the overall time survey results (which indicate the percentage of time that participants spent on various administrative activities during the survey period) for each billable administrative activity:

ADMINISTRATIVE ACTIVITY	LIMIT
Medi-Cal outreach	4%
Facilitating Medi-Cal applications	2
Referral, coordination, and monitoring of Medi-Cal services	8
Arranging transportation to support Medi-Cal services	3
Translation of documents related to Medi-Cal services	3
Program planning, policy development, and interagency coordination related to Medi-Cal services	3
Medi-Cal claims administration, coordination, and training	4/7*
General administration, completing the time survey form, and paid time off†	10/7*

Sources: Health Care Services’ Policy and Procedure Letter 13-012, its *California School-Based Medi-Cal Administrative Activities Manual*, and interviews with Health Care Services’ staff.

Note: If a claim is not in compliance with the above limits (with the exception of the limits related to vendor fees), claiming units could submit a written justification to Health Care Services explaining the reasons for the noncompliance.

\* For fiscal year 2012–13 and later, Health Care Services increased the limit on Medi-Cal claims administration, coordination, and training from 4 percent to 7 percent, and decreased the limit on general administration, completing the time survey form, and paid time off from 10 percent to 7 percent.

† General administration, completing the Medi-Cal administrative activities time survey form, and paid time off are allocated to other activities.

The reasonableness test criteria that Health Care Services developed were not inconsistent with federal requirements. Federal requirements specify that all costs submitted for reimbursement must be “necessary and reasonable for the proper and efficient performance and administration of federal awards.” As we mentioned earlier, CMS required Health Care Services to implement a reasonableness review process. CMS also approved the benchmarks and other criteria that Health Care Services established for this process. Given that CMS directed Health Care Services to develop and implement a reasonable process for reviewing reimbursement claims, that Health Care Services created

the reasonableness test criteria using Kern County's methodology as a starting point as CMS recommended, and that CMS approved the criteria that Health Care Services proposed, we believe that the reasonableness test criteria including the benchmark percentages and other limits it established were in themselves reasonable.

Health Care Services used a checklist to log compliance with the benchmark percentages and other criteria to document its review of claims that claiming units submitted under the process. Health Care Services also reviewed the documentation that claiming units included in their claims to ensure that no staff positions were reporting an unreasonable amount of time spent on Medi-Cal administrative activities in relation to time spent on their other responsibilities. As explained in Table 1 on page 17, we reviewed 10 reimbursement claims to determine whether Health Care Services had effective fiscal and administrative controls over the reasonableness test criteria review process to ensure that local educational agencies received consistent, appropriate, and timely reimbursements. We also determined whether the process for reimbursements was consistently applied across all local educational agencies. Health Care Services approved only three of the 10 claims. Of those three, one complied with the benchmarks and other criteria, and Health Care Services concluded that another included an acceptable justification for exceeding various benchmarks. Health Care Services acted leniently in approving the third claim because, although it concluded that two of the three justifications for noncompliance with various benchmarks were not reasonable, it approved the claim anyway, citing the claiming unit's small size of the time survey participant pool and the minimal degree of the overages. Health Care Services did not approve the other seven claims because they exceeded the benchmarks or included unauthorized positions in their time studies without adequate justifications, included excessive vendor fees, did not include adequate supporting documentation, or the individual positions reported unreasonable amounts of time spent on Medi-Cal administrative activities. Based on our review of these seven claims, we believe that Health Care Services' decision not to approve them was reasonable.

***In reviewing 10 reimbursement claims, we found that Health Care Services' controls over the reasonableness test criteria review process were insufficient to ensure consistent, appropriate, and timely federal reimbursements.***

However, in reviewing the 10 claims, we found that Health Care Services' controls over the reasonableness test criteria review process were insufficient to ensure consistent, appropriate, and timely federal reimbursements. Health Care Services issued a policy and procedure letter in October 2013 to notify stakeholders of the new reasonableness test criteria, in which it specified the benchmarks and other criteria with which claiming units had to comply. However, we found that this letter included inaccurate benchmarks related to two administrative categories. As shown in Table 4 on page 25, Health Care Services increased the time limit



on Medi-Cal claims for administration, coordination, and training from 4 percent to 7 percent, and decreased the time limit on general administration, completing the time survey form, and paid time off from 10 percent to 7 percent for all claims related to fiscal year 2012–13 and later. Health Care Services' chief of its Medi-Cal Administrative Claiming Section (section chief) told us that the changes were due to revisions made to its *California School-Based Medi-Cal Administrative Activities Manual* (manual) between fiscal years 2011–12 and 2012–13 to move time spent completing the time survey from one activity category to another. However, she stated that she did not have any documentation showing that Health Care Services relayed this change in criteria to the local educational consortia, local governmental agencies, or local educational agencies. Neither the initial 2013 policy and procedure letter sent to stakeholders nor another letter describing the reasonableness test criteria that was updated in April 2014 included the updated benchmarks for these two categories. Consequently, some claiming units may have believed that their claims complied with the reasonable test criteria only to have Health Care Services conditionally deny their claims because Health Care Services was using the revised benchmarks and the claiming units were not. We also found that three of the 10 checklists that we reviewed did not contain the right benchmarks for these two categories of activities based on the period of the claim. Although Health Care Services' use of the wrong benchmarks did not result in improper decisions for these three claims, it is conceivable that it may have made improper decisions to approve or not approve other claims because its claim reviewers were using the wrong benchmarks for these two activity categories. Because Health Care Services did not accurately communicate the reasonableness test criteria to stakeholders and because it sometimes used incorrect criteria when reviewing claims, we believe it contributed to the failure of the reasonableness test criteria process to result in the payment of many deferred claims.

### **Health Care Services Has Offered Claiming Units No Formal Opportunity to Appeal Its Decisions to Deny Reimbursement Claims**

Health Care Services has had no processes in place that allow claiming units to directly appeal its decisions to not approve claims submitted under the reasonableness test criteria review process. Health Care Services' manual allows local educational consortia and local governmental agencies to request that Health Care Services reconsider such decisions. However, neither state law nor Health Care Services' manual identifies claiming units as entities that can directly appeal Health Care Services' decisions. According to the chief of the Safety Net Financing Division, local educational

*Health Care Services did not accurately communicate the reasonableness test criteria to stakeholders, and it sometimes used incorrect criteria when reviewing claims.*

*Health Care Services' formal appeals process allows claiming units to appeal actions or decisions that local educational consortia or local governmental agencies make but not decisions that Health Care Services makes.*

consortia or local governmental agencies can appeal Health Care Services' actions or decisions, such as denying claims, on behalf of their claiming units.

Health Care Services has a formal appeals process that allows claiming units to appeal actions or decisions that local educational consortia or local governmental agencies make but not decisions that Health Care Services makes. In April 2014 Health Care Services issued a policy and procedure letter that established a formal process for local educational agencies to appeal actions or decisions that local educational consortia or local governmental agencies made. This letter instructed local educational agencies on how to file a request for appeal to Health Care Services within six months of an unresolved or disputed decision or action.

According to the policy, Health Care Services would then generally provide a written decision to all parties within 90 days. According to the assistant chief of the Safety Net Financing Division (assistant division chief), no claiming units have ever used this formal appeals process. We believe that Health Care Services should revise its appeals process to allow claiming units to directly appeal its decisions since these decisions likely have more of a financial impact on the claiming units than on the local educational consortia and local governmental agencies that represent them.

#### **Local Entities Added Little Value When They Reviewed Claims Using Reasonableness Test Criteria**

We observed that local educational consortia and local governmental agencies appeared to add little value during the reasonableness test criteria review process. In its policy and procedure letter initiating that process, Health Care Services instructed local educational consortia and local governmental agencies to "review and forward" reimbursement claims to it. We asked Health Care Services to clarify for us what this instruction meant, and the assistant division chief told us it expected those entities to reject claims that failed to meet the reasonableness test criteria and that did not contain adequate justification for noncompliance. In addition, staff at the claiming units' local educational consortium or local governmental agency signed a statement on each reimbursement claim certifying that the information provided was true and correct, was based on actual expenditures of the claiming unit, was necessary for federal matching funds according to federal regulations, and was for allowable administrative activities. Despite these factors, it does not appear that these entities properly reviewed claims submissions because many of these claims did not conform to the reasonableness test criteria.

Although Health Care Services did not review all claims it received while the reasonableness test criteria review process was in effect, for the claims it did review, it conditionally denied more than two and a half claims for each one it approved. During our review of 10 claims described earlier, we noted instances where local educational consortia or local governmental agencies approved claims that did not comply with the reasonableness test criteria benchmarks or other criteria and that did not contain adequate justifications. To determine whether these were isolated occurrences, we examined additional claims at Health Care Services. We identified an additional 10 claims that local educational consortia or local governmental agencies approved and forwarded to Health Care Services that did not contain required justifications. Further, before the implementation of the reasonableness test criteria review process, CMS found in its financial management review that instead of providing consistent oversight and monitoring guidance to claiming units, local educational consortia and local governmental agencies either established their own standards or performed a very cursory review of the claiming units' submissions. In general, our findings mirrored the results of CMS's review.

When we questioned Health Care Services about why it did not take adverse action against local educational consortia and local governmental agencies when they continued to forward unallowable claims, the assistant division chief told us that the reasonableness test criteria review process was new for all parties and that it was working collaboratively with the local educational consortia and local governmental agencies to ensure that they understood the process and that it viewed this as an educational opportunity rather than a punitive one.

### **Health Care Services Has Not Effectively Overseen Local Educational Consortia and Local Governmental Agencies in the Past**

Health Care Services has an established record of failing to monitor local educational consortia and local governmental agencies. Federal requirements charge Health Care Services, as California's single state agency responsible for Medicaid, with supervising and administering the administrative activities program. As our Introduction notes, Health Care Services contracts with local educational consortia and local governmental agencies to perform key administrative and oversight functions for the administrative activities program, which in turn contract with the claiming units. The responsibilities of the local educational consortia and local governmental agencies include training claiming unit staff, overseeing the time survey process, and reviewing and submitting reimbursement claims to Health Care Services on

*For the claims Health Care Services reviewed while the reasonableness test criteria review process was in effect, it conditionally denied more than two and a half claims for each one it approved.*

behalf of participating claiming units. Health Care Services' policy requires it to monitor every local educational consortium and local governmental agency at least once every three years.

Reports citing oversight concerns include an audit that the California State Auditor released in August 2005. In that audit report titled *Department of Health Services: Participation in the School-Based Medi-Cal Administrative Activities Program Has Increased, but School Districts Are Still Losing Millions Each Year in Federal Reimbursements* (report number 2004-125), we noted that Health Care Services did not conduct a sufficient number of site visits to local educational consortia and local governmental agencies. We concluded that this lack of oversight meant that Health Care Services was unable to ensure that local educational consortia and local governmental agencies were properly administering the administrative activities program.

More recently, the annual federal compliance reports that we issued covering the state fiscal years ending in June 2012, 2013, and 2014 all pointed out that Health Care Services had not conducted site or desk reviews of local educational consortia and local governmental agencies within the required time frame. These reports, required by state law, assess the State's compliance with federal laws and regulations. In fiscal year 2011–12, Health Care Services did not perform site or desk reviews on seven of the 28 local educational consortia and local governmental agencies participating in the administrative activities program. Health Care Services attributed this backlog to a ban on discretionary travel instituted in 2011, but it stated that it would complete the reviews by June 30, 2013. However, the following year, the number of reviews it failed to conduct increased from seven to nine. Health Care Services again attributed the cause to the 2011 travel restrictions, plus the CMS financial management review and the development of the new claiming plan. Health Care Services stated this time that it anticipated completing the overdue site visits or desk reviews by June 30, 2014. Nevertheless, by the end of fiscal year 2013–14, the number of reviews it had failed to conduct had grown to 15, and Health Care Services offered no explanation in its response to this report other than to say that it was reviewing site visit requirements and expected to begin site visits in spring 2015. However, according to the section chief, Health Care Services now plans to commence site visits in August 2015. This lack of adequate monitoring increases the risk that local educational consortia and local governmental agencies are not performing the oversight and administrative tasks for which they are responsible.

***Lack of adequate monitoring by Health Care Services increases the risk that local educational consortia and local governmental agencies are not performing the oversight and administrative tasks for which they are responsible.***

Because of its continued inability to conduct desk or site reviews with reasonable frequency, we believe Health Care Services could monitor program participants more cost-effectively if it were to

employ a risk-based approach as do other states we reviewed for this audit. Health Care Services' process for reviewing local educational consortia and local governmental agencies consists of a detailed review of the documentation to support two fiscal years' worth of invoices for two claiming units once every three years. More specifically, Health Care Services is supposed to review each entity at least once every three years regardless of other factors.

In contrast to Health Care Services' attempt to monitor local educational consortia and local governmental agencies according to a set schedule, the Medicaid agencies for Illinois and Michigan use a risk-based approach and consider various risk factors when selecting and scheduling program participants for review. For example, Michigan considers risk factors that include the dollar amount of claims, the existence of previous audit findings, and turnover of key claiming unit staff. Using a risk-based approach to select and review participants helps these states focus their limited monitoring resources on those participants that are most likely to have problems or that are most likely to have findings with the biggest impact on the program. We believe that if Health Care Services used a risk-based strategy to select and review participants, it would, similarly, be better able to focus its resources on monitoring the riskier participants with which it contracts.

### **Health Care Services Continues to Ineffectively Oversee the Medi-Cal Administrative Activities Program**

Despite the findings and recommendations cited in prior audits and Health Care Services' repeated assurances that it would address the audits' findings, certain weaknesses in its oversight of local educational consortia and local governmental agencies remain. These flaws reduce the likelihood that claimed costs will be reasonable and necessary, and that they will therefore qualify for federal reimbursement. For instance, the contract issued by one local educational consortium with about 80 claiming units participating in the administrative activities program, including the State's largest claiming unit—the Los Angeles Unified School District (LA Unified)—could inappropriately allow those claiming units to claim costs that Health Care Services has already claimed. Federal regulations generally allow California entities to receive federal reimbursement of up to 50 percent of the costs they incur for the administrative activities program. Health Care Services claims federal reimbursement for 50 percent of the costs for its administration of the administrative activities program. It then passes on the other 50 percent of its costs to the local educational consortia and local governmental agencies in the form of a participation fee. Because Health Care Services already claimed reimbursement from the federal government for 50 percent of its

*We believe that if Health Care Services used a risk-based strategy to select and review participants, it would be better able to focus its resources on monitoring the riskier participants with which it contracts.*

costs, other entities are prohibited from including Health Care Services' participation fee as part of their own claim for federal reimbursement. Otherwise, the federal government could end up paying more than 50 percent of Health Care Services' costs.

Nevertheless, the Los Angeles County Office of Education (Los Angeles County) passes on Health Care Services' participation fee to its claiming units. According to the terms of the contract between Los Angeles County and its claiming units, claiming units are allowed to include the participation fee as part of the costs in their reimbursement claims. As a result of these contract provisions, LA Unified submitted at least one claim that included unallowable charges. Presumably many of the invoices that Los Angeles County has submitted on behalf of its claiming units contain similar unallowable charges. According to its manager of business advisory services, Los Angeles County was not aware that Health Care Services claims federal reimbursement for its costs. In addition, he stated that Los Angeles County will review its records to identify invoices that contained Health Care Services' participation fee and refund any unallowable charges as appropriate.

***Contracts between local educational consortia and local governmental agencies and their claiming units contain problematic provisions, in part, because Health Care Services does not monitor the contracts and is therefore unaware of any contract weaknesses.***

Contracts between local educational consortia and local governmental agencies and their claiming units contain problematic provisions, in part, because Health Care Services does not monitor the contracts and is unaware of any contract weaknesses. Health Care Services' manual states that Health Care Services expects the language in these contracts to "mirror" the language in the contracts between Health Care Services and the local educational consortia and local governmental agencies. However, Health Care Services does not dictate the terms of or maintain copies of the contracts between local educational consortia or local governmental agencies and their respective claiming units. The assistant division chief stated that Health Care Services includes these contracts as part of the desk or site review process. Nevertheless, the review to which the assistant division chief refers checks only to ensure that the claiming unit is not claiming a fee based on a percentage of the federal reimbursement, that the contract was in effect on the date of the claim, and that the reimbursable administrative activities listed in the contract match what is in the manual. According to an assistant chief counsel for Health Care Services, it would have the ability to dictate the terms of contracts between claiming units and local educational consortia and local governmental agencies if there was a regulation, but there are no regulations on this point. However, as California's single state agency for Medicaid and the administrative activities program administrator, Health Care Services should ensure that all interagency agreements related to Medi-Cal are consistent with federal requirements and that claims are allowable. We further discuss Health Care Services' lack of regulations in Chapter 3.

Another contract weakness relates to the payment provisions contained in contracts between some local educational consortia and local governmental agencies and their claiming units. Federal guidance urges caution when program participants, which would include claiming units, pay for professional services based on percentages of the reimbursement because it may increase the risk of abusive billing practices. Before Health Care Services implemented the random moment time survey methodology, the local educational consortia and local governmental agencies were responsible for ensuring the accuracy and reasonableness of claiming units' reimbursement claims. However, some local educational consortia and local governmental agencies charge claiming units a percentage of their reimbursement. As such, the higher the approved reimbursement amount, the more the local educational consortium or local governmental agency could retain as payment.

Such payment provisions unnecessarily increase the risk that these local educational consortia and local governmental agencies might approve otherwise unallowable reimbursement claims to increase the revenue they earn from claiming units. Furthermore, local educational consortia and the local governmental agencies do not bear the primary financial risk associated with reimbursements that are subsequently disallowed based on audits or other reviews; instead, the claiming units do. Claiming units are financially responsible for paying back federal reimbursements that audits or similar reviews identify as unallowable, not the local educational consortia and local governmental agencies. It is currently unclear whether local educational consortia or local governmental agencies would have to return administrative fees to claiming units that were contingent on reimbursements that were subsequently disallowed.

We noted a similar concern associated with the random moment time survey. According to the section chief, local educational consortia elected to use in-house staff to code the time survey responses as opposed to hiring a third-party vendor. According to Health Care Services' documentation, as of April 2015 eight of the 11 local educational consortia charge their claiming units administrative fees based upon a percentage of their reimbursements. The decisions the coders make can directly affect the amount of compensation that the local educational consortium will receive, and this increases the risk that they will improperly code time survey responses as reimbursable activities. In fact, stakeholders raised similar concerns that if local educational consortia and local governmental agencies code survey responses, prepare invoices, and monitor claiming units, it may result in conflicts of interest. In contrast, California's local governmental agency consortium (all but San Diego County), Illinois, Michigan, and Texas all hired vendors to code their time survey responses

***Claiming units are financially responsible for paying back federal reimbursements that audits or similar reviews identify as unallowable, not the local educational consortia and local government agencies.***

that are not paid based on a percentage of their reimbursement. Because the vendors' compensation is not tied to the amount of the reimbursement, they have no financial incentive to code more survey responses as reimbursable activities.

Health Care Services could ensure that the contracts with claiming units for the administrative activities program are appropriate and consistent with state and federal requirements by contracting directly with claiming units using a standardized contract. The Medicaid agencies in both Illinois and Texas contract directly with claiming units that wish to claim federal reimbursements for their respective administrative activities programs. Contracting directly with the school districts helps ensure that the districts have consistent contract language to follow to avoid unallowable costs. In fact, the Texas Medicaid agency publishes a standard contract for its administrative activities program online and it directs claiming units to download, print, sign, and submit the contract. Because this contract is standardized—that is, claiming units have no ability to modify its terms—the Texas Medicaid agency can ensure that these contracts are consistent and comply with applicable federal and state requirements. Similarly, Health Care Services publishes a standardized contract for the Local Educational Agency Medi-Cal Billing Option Program (billing option program) on its website to help ensure compliance with state and federal requirements. Local educational agencies must sign this contract if they intend to participate in the billing option program.

***The lack of fiscal transparency of the costs and revenues of local educational consortia and local governmental agencies is another area where Health Care Services' oversight falls short.***

The lack of fiscal transparency of the costs and revenues of local educational consortia and local governmental agencies is another area where Health Care Services' oversight falls short. Not only do federal regulations require that claiming units claim only those costs that are reasonable and necessary for the proper and efficient administration of the program, but those regulations also prohibit program participants from earning a profit from administering the administrative activities program. Health Care Services allows local educational consortia and local governmental agencies to charge claiming units an administrative fee to help cover the costs they incur to administer the program. Depending on the local educational consortium or local governmental agency, this fee may be a percentage of the claiming unit's reimbursement, a portion of the actual costs of the local educational consortium or local governmental agency, a per-participant fee, or a fee based on the claiming unit's student enrollment. Health Care Services does not require local educational consortia and local governmental agencies to report how much they collect in administrative fees from claiming units. Because it does not collect this information, Health Care Services cannot determine if the local educational consortia or local governmental agencies are collecting administrative fees in excess of their costs, which would result in an inappropriate profit



and an unnecessary financial expense for claiming units. Further, because it does not track or report this financial information, Health Care Services cannot ensure that these administrative fees are reasonable and necessary and therefore allowable as federal regulations require. Finally, this lack of fiscal transparency prevents Health Care Services from determining if claiming units are paying an excessive portion of their reimbursements to their respective local educational consortia or local governmental agencies.

Other states' administrative activities programs provide greater fiscal transparency. Claiming units in both Illinois and Texas submit claims directly to the state, and the states withhold 4 percent and 5 percent of the reimbursement, respectively, to defray the cost of administering the program. Illinois and Texas have no intermediate parties such as local educational consortia or local governmental agencies and their claiming units can easily determine how much of their reimbursement they will retain without needing additional fiscal reporting. In addition, the Michigan Medicaid agency publishes annually a document on its website that shows the cost of its statewide random moment time study and claim calculation process, including vendor fees for its administrative activities program. The document also shows each intermediate school district's share of the cost.<sup>11</sup> Health Care Services could enhance the fiscal transparency of its administrative activities program by adopting and then adapting these other states' practices for use in California.

We were also asked to compare the extent to which other states' and California's reporting requirements allow for tracking student outcomes. However, it does not appear that state Medicaid programs are tracking this information. For example, the director of cost reporting, time study, and data support services at the Texas Medicaid agency is not aware of any requirement that the Medicaid agency track or report student outcomes. Similarly, a public service administrator from the Illinois Medicaid agency stated that it does not track any student outcome information other than Medicaid enrollment. Health Care Services' section chief also informed us that she is not aware of any requirement to track student outcomes and that Health Care Services does not currently do so.

***Because Health Care Services does not track administrative fees claiming units pay, it cannot ensure that these administrative fees are reasonable and necessary and therefore allowable as federal regulations require.***

<sup>11</sup> According to a school-based services auditor in Michigan, intermediate school districts are regional educational services agencies that help local school districts with programs and services that are best done regionally. They provide state-mandated functions like pupil accounting and special education monitoring and compliance.

## Recommendations

To ensure that Health Care Services provides claiming units with reasonable opportunities to address concerns with its decisions or actions, it should take the following actions within three months:

- Begin preparing regulations to establish and implement a formal appeals process that allows claiming units to directly appeal Health Care Services' decisions.
- Inform all stakeholders, including claiming units, of the existence of this appeals process.

Until the Legislature implements our recommendation in Chapter 2, Health Care Services should immediately resolve weaknesses in its oversight of local educational consortia and local governmental agencies to ensure that these entities sufficiently meet their responsibilities under the administrative activities program and meet the terms of their contracts with Health Care Services. Actions to take include the following:

- Update its site review and desk review procedures to include the following steps:
  - A risk-based approach to selecting entities for review.
  - Verification that local educational consortia and local governmental agencies are adequately meeting the oversight and administrative responsibilities described in their contracts with Health Care Services.
  - Verification that contracts between local educational consortia or local governmental agencies and their claiming units do not include provisions that could result in disallowed costs, such as allowing Health Care Services' participation fee to be included in the claim calculations.
  - Examination of local educational consortia and local governmental agencies' records to ensure that:
    - Costs they claim for federal reimbursement are necessary and reasonable.
    - The entities are not inappropriately earning a profit based on the fees they collect from claiming units.
    - The coding performed by local educational consortia that charge claiming units a percentage of their federal reimbursement is reasonably accurate.

- Complete the oversight reviews for at least three high-risk local educational consortia or local governmental agencies by December 31, 2015, and post the results to its website.
- Complete the oversight reviews for any remaining high-risk local educational consortia or local governmental agencies by June 30, 2016, and post the results to its website.

To minimize the risk that claiming units could include unallowable costs when calculating their reimbursement claims, Health Care Services should take the following actions immediately:

- Encourage Los Angeles County to revise its contracts with its claiming units to make it clear that claiming units cannot include Health Care Services' participation fee as part of their claims.
- For all claims that Los Angeles County received and reviewed under its current contracts with its claiming units, Health Care Services should do the following:
  - Determine whether claiming units included Health Care Services' participation fee as part of the claim.
  - For those paid claims that included the participation fee, identify the inappropriate amount paid and take appropriate action to resolve the improper payment including, if necessary, obtaining a refund from the claiming unit.
  - For those submitted claims that have not yet been paid, instruct Los Angeles County to reject the claims and direct claiming units to revise the claims to omit Health Care Services' participation fee.
- Remind all local educational consortia and local governmental agencies that contracts with their claiming units should prohibit claiming units from seeking federal reimbursement of Health Care Services' participation fee.

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## Chapter 2

### IMPLEMENTING A SINGLE STATEWIDE TIME SURVEY WOULD BE MORE COST-EFFECTIVE THAN THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES' CURRENT APPROACH TO ESTIMATING MEDICAL ADMINISTRATIVE TIME

#### Chapter Summary

When it implemented the random moment time survey methodology, the California Department of Health Care Services (Health Care Services) missed an opportunity to implement a statewide quarterly time survey for the School-Based Medi-Cal Administrative Activities program (administrative activities program). Random moment time surveys are used to estimate the portion of time that participating staff spend on reimbursable administrative activities during a given quarter. Health Care Services could have implemented a single statewide survey but did not. Instead, local educational consortia, local governmental agencies, and the Los Angeles Unified School District (LA Unified) conduct nine different time surveys each quarter.<sup>12,13</sup>

As discussed in the Introduction, state law currently requires claiming units to submit claims through either a local educational consortium or local governmental agency.<sup>14</sup> However, a single statewide time survey could render the local educational consortia and local governmental agencies' involvement in the administrative activities program unnecessary. We identified two states—Illinois and Texas—that each implemented a single statewide survey and no longer include consortia of school districts in their programs. The costs associated with implementing and conducting nine surveys rather than a single statewide survey are considerable and are neither necessary nor efficient. Health Care Services did not implement the single survey itself because it did not believe it had the time to acquire the necessary software. Also, Health Care Services did not require local educational consortia and local governmental agencies to minimize the cost and administrative burdens associated with the surveys. By switching to a single statewide survey,

<sup>12</sup> A *local educational consortium* is one of the 11 service regions of the California County Superintendent Educational Services Association. Each consortium is led by a county education office within the region.

<sup>13</sup> A *local governmental agency* is an agency of either a county or a chartered city, or a Native American Indian tribe, tribal organization, or subgroup of a Native American Indian tribe or tribal organization.

<sup>14</sup> According to the federal Centers for Medicare and Medicaid Services (CMS), a *claiming unit* is typically a school district or a program within a district. California has claiming units that are as diverse as county offices of education, special education local plan areas, local school districts, community colleges, and Healthy Start programs.

Health Care Services could reduce the number of survey notifications per quarter to only 5,522 rather than the 49,698 under the current nine-survey structure. Having fewer survey responses would result in lower administrative costs to review survey responses and to ask clarifying questions. Finally, because of the process that Health Care Services used to issue interim payments, some claiming units may not receive the full interim payments to which they are entitled under the settlement agreement with CMS.

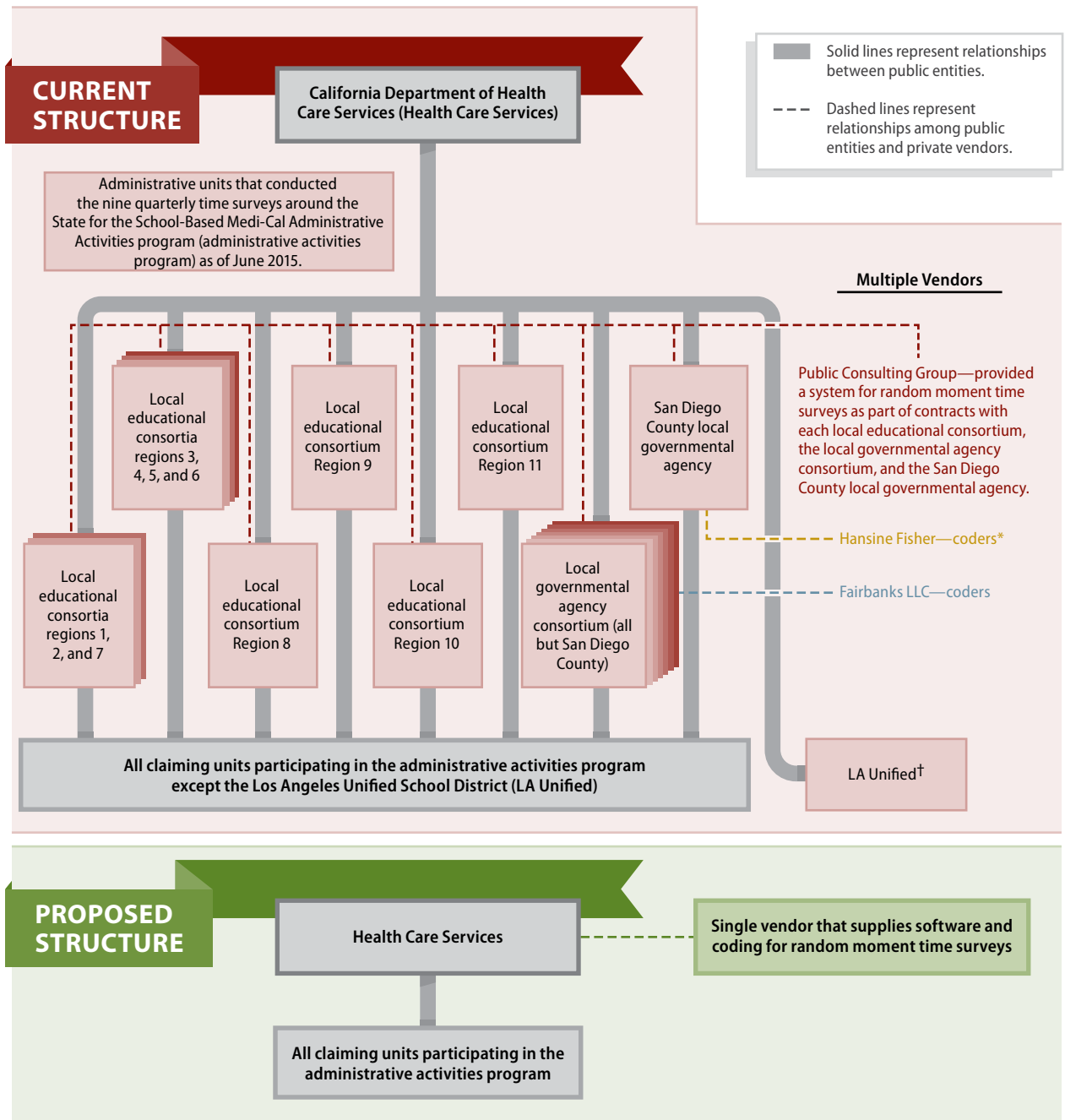
### **Health Care Services Could Reduce California's Medicaid Program Costs by Conducting One Statewide Survey**

When Health Care Services implemented the random moment time survey methodology for its administrative activities program, it missed an opportunity to implement a single statewide quarterly time survey. Random moment time surveys are used to estimate the portion of time that participating staff spend on reimbursable administrative activities during a given quarter. Health Care Services' use of a single quarterly time survey throughout the State would have minimized costs for *claiming units*—the school districts or local educational programs that claim reimbursements for participating in the administrative activities program—and for the federal government. Federal regulations require that all costs claimed and submitted to the federal government for federal programs be necessary and reasonable for the program's efficient operation. Because Health Care Services had the opportunity to implement a single statewide quarterly time survey that could have saved money for stakeholders, the costs and effort associated with implementing nine different quarterly time surveys by local educational consortia, local governmental agencies, and LA Unified are neither necessary nor efficient.

Moreover, Health Care Services delegated the responsibility for implementing the random moment time survey methodology to the local educational consortia and local governmental agencies. Although CMS approved Health Care Services' implementation of the new time survey methodology, according to a CMS representative, it was not involved in the decision to have separate time surveys in multiple geographic regions around the State. When they kicked off the new methodology in January 2015, the local educational consortia and local governmental agencies conducted separate quarterly time surveys covering different geographic regions, plus the preexisting one conducted by LA Unified. Health Care Services refers to the nine entities that generate the random moments for these quarterly time surveys as *administrative units*. Figure 4 summarizes the entities involved in issuing the nine quarterly surveys and proposes a more streamlined alternative structure.

***Although CMS approved Health Care Services' implementation of the new time survey methodology, it was not involved in the decision to have separate time surveys in multiple geographic regions around the State.***

**Figure 4**  
California’s Current Time Survey Structure for the School-Based Medi-Cal Administrative Activities Program and a Proposed Revision to That Structure



Sources: Documents obtained from staff of Health Care Services and from the websites of Health Care Services and LA Unified.

\* According to Health Care Services’ documentation, all local educational consortia use their own in-house staff for coding survey responses. Local governmental agencies use vendors for coding survey responses. Coding categorizes the activity a time survey participant performed during a randomly selected moment and determines whether that activity is reimbursable by the administrative activities program.

† In October 2010 the Centers for Medicare and Medicaid Services approved LA Unified’s plan to perform its own time surveys. This district submits its reimbursement claims to Health Care Services through the Region 11 local educational consortium.

Local educational consortia and local governmental agencies implemented more than one quarterly time survey. According to the chief of Health Care Services' School-Based Administrative Activities Unit (section chief), Health Care Services did not impose any requirements on these entities when they were forming administrative units to conduct random moment time surveys. The local educational consortia and the local governmental agencies each issued a single request for proposals to identify a vendor to help them implement the new methodology; they each selected the same vendor, but they did not each decide to conduct a single quarterly time survey. The San Diego County local governmental agency conducts its own quarterly time survey, while the remaining seven local governmental agencies formed a consortium to conduct a single quarterly time survey for their claiming units. Four local educational consortia banded together to conduct a single quarterly time survey of their claiming units while three other local educational consortia banded together to conduct a single quarterly time survey of their claiming units. The remaining four local educational consortia each conduct their own individual quarterly time surveys. As a result, the local educational consortia and local governmental agencies conduct a total of eight quarterly time surveys among them.

By conducting nine separate time surveys each quarter, when LA Unified is included, rather than a single statewide quarterly time survey, participants in the administrative activities program expend nine times the effort and incur corresponding additional costs to complete, code, and assure the quality of the time survey responses. If Health Care Services implemented a single statewide quarterly time survey, it could reduce the administrative activities program's cost by avoiding these duplicative tasks. Although the costs and effort to set up a quarterly time survey—such as assembling and submitting roster reports and participant pools and identifying the total pool of time study moments available to survey—would be similar for one quarterly time survey as it is for nine, the costs and effort to complete, code, and assure the quality of the survey responses would decrease significantly if Health Care Services conducted that single survey. Each time survey requires a minimum number of survey responses to achieve a statistically valid result; this minimum number increases as the number of potential survey respondents increases. However, statistical calculations show that once each pool of time survey participants reaches a certain size—roughly 270 full-time employees—no additional survey responses are necessary to achieve a statistically valid estimate, no matter how many more employees are added to the pool. For instance, rather than issuing 49,698 survey moments as required under the current structure using nine administrative units, Health Care Services could conduct a single statewide quarterly survey requiring just 5,522 survey moments.

***Health Care Services could conduct a single statewide quarterly survey requiring just 5,522 survey moments, rather than issuing 49,698 survey moments as required under the current survey structure.***



In addition, the local educational consortia or local governmental agencies must review and code each of the assigned moments to indicate whether the activity the employee reported is reimbursable by the federal government under the administrative activities program. Health Care Services requires at minimum two primary coders to review each completed survey and assign an activity code and a senior coder to ensure that the primary coders correctly coded the survey and to resolve any discrepancies. We estimate that the administrative activities program could save as much as \$1.3 million annually in coding costs alone if Health Care Services conducted a single statewide quarterly time survey. These savings would be shared equally by claiming units and the federal government.

Program costs and effort would also be saved during the multi-step quality assurance process that local educational consortia, local governmental agencies, and Health Care Services must perform as described in the June 2014 *California School-Based Medi-Cal Administrative Activities Manual* (manual).<sup>15</sup> Health Care Services requires local educational consortia and local governmental agencies to review a minimum of 10 percent of all coded survey responses each quarter to ensure that survey participants respond completely, that responses are properly coded, and that the senior coder or survey administrator corrects all coding errors. In addition, it requires local educational consortia and local governmental agencies to review a minimum of 10 percent of the clarifying questions that the coders asked to ensure that the coders did not ask leading questions.<sup>16</sup> Health Care Services further requires local educational consortia and local governmental agencies to prepare summary reports of their quality assurance reviews and retain them in an audit file to be made available to Health Care Services or CMS. Finally, Health Care Services requires each local educational consortium and local governmental agency to submit its quarterly quality assurance reviews to Health Care Services. For its part, to ensure that the quality assurance process is applied statewide with consistency, Health Care Services is required to randomly select a minimum 10 percent sample of each quarter's coded responses and clarifying questions and validate the sample. The validation process must consist of reviewing the survey responses, the assigned codes, and the clarifying questions to determine whether the code accurately reflects the activities performed, whether the activities performed were necessary for proper administration of the program, that no direct medical services were included within an administrative activity code, and

***To ensure quality assurance statewide, Health Care Services is required to randomly select a minimum 10 percent sample of each quarter's coded responses and clarifying questions and validate the sample.***

<sup>15</sup> The implementation plan for LA Unified's random moment time survey describes a different quality assurance process than the one mentioned in the manual. Therefore, the calculations described in this paragraph exclude LA Unified.

<sup>16</sup> A leading question is one that is phrased in such a manner as to suggest a desired answer.

*Implementing a single statewide quarterly time survey would save money and also render local educational consortia and local governmental agencies unnecessary for the administrative activities program.*

that coders did not ask leading questions. Based on the extent of the activities that Health Care Services includes as part of the quality assurance process, it seems reasonable to us that the administrative activities program would save a significant amount of money and effort if local educational consortia, local governmental agencies, and Health Care Services performed quarterly quality assurance reviews on a sample of 10 percent of the responses from a single statewide quarterly time survey rather than a sample of 10 percent of the responses from eight surveys.

### **Other States Conduct Statewide Random Moment Time Surveys and Communicate Directly With Claiming Units**

Not only would a single statewide quarterly time survey save money, but implementing that time survey would also render local educational consortia and local governmental agencies unnecessary for the administrative activities program. State law currently requires claiming units to submit administrative claims to a local educational consortium or a local governmental agency. When reviewing the organizational structure of other states' administrative activities programs, we identified two states that have implemented a single statewide quarterly time survey since 2007. According to the U.S. Department of Education, Illinois had 1,075 school districts during the 2011–12 school year, which is comparable to California's 1,187 school districts. Illinois transitioned its time study methodology from a worker log to a statewide random moment time survey in 2009 in order to simplify its Medicaid claiming process, reduce local educational agency staff time in completing claims, and increase the reliability of the claims.

Before implementing its single survey, Illinois had allowed school districts to compile their reimbursement claims independently or through cooperative arrangements between multiple school districts, and some individual and cooperating groups of local educational agencies entered into agreements with billing agents or consultants to assist them with the claim filing process. For example, the Peoria, Illinois consortium submitted administrative claims to the state on behalf of hundreds of school districts.

According to a public service administrator at the Illinois Department of Healthcare and Family Services, the consortium was responsible for training member districts on completing their time surveys, and it received reimbursement from the state and distributed it to member districts. When the state implemented its statewide quarterly random moment time survey, this practice stopped. According to the public service administrator, Illinois operates its program now with five state agency staff. In addition,

the program uses a vendor to help administer its quarterly surveys and code the survey responses, and it charges claiming units 4 percent of their claim amounts to help cover its costs.

Similarly, Texas replaced its worker log time study methodology with a statewide quarterly time survey in 2007. According to the U.S. Department of Education, Texas had 1,262 school districts during the 2011–12 school year. A rate analyst with the Texas Health and Human Services Commission told us that under the worker log methodology, school districts had the option to participate in the administrative claiming program as a stand-alone district or as part of a consortium. When Texas transitioned its time study methodology from a worker log to a random moment time survey, it did not include the consortium option in its administrative claiming program. The rate analyst explained that the single statewide quarterly time survey negated the need for such consortia and was more cost-effective and simpler to oversee. According to the director of cost reporting, time study, and data support services, Texas operates its program with eight state agency staff and uses a vendor to help administer its quarterly surveys and code the survey responses. Texas withholds a maximum of 5 percent of claiming units' federal reimbursements to help cover its costs.

On the other hand, a third state we examined—Michigan—employs a structure similar to California's for its administrative claiming program. According to the U.S. Department of Education, Michigan had 869 school districts during the 2011–12 school year. Michigan's regional educational services agencies, known as *intermediate school districts*, submit reimbursement claims that include administrative costs from multiple local school districts. However, Michigan conducts a single statewide quarterly time survey to calculate the claim amounts for these agencies. Michigan charges intermediate school districts for the costs of three staff, uses a vendor to help administer its quarterly time surveys and code the survey responses, and allocates the actual costs of its program to the intermediate school districts and other education institutions proportionately based on student counts.

Health Care Services delegated implementation of the new survey methodology to the local educational consortia and the local governmental agencies and did not retain this responsibility itself because it did not believe that it had the time to acquire the necessary software. According to the assistant chief of its Safety Net Financing Division (assistant division chief), Health Care Services originally explored the possibility of developing custom software for statewide use rather than purchasing licensing software from a vendor. The assistant division chief also indicated that Health Care Services rejected this idea because it was attempting to comply with a CMS-imposed timeline for implementing the new methodology

***Health Care Services delegated implementation of the new survey methodology to the local educational consortia and the local governmental agencies because it did not believe that it had the time to acquire the necessary software.***

and that the length of the state procurement process did not allow Health Care Services to comply with that timeline. She added that Health Care Services delegated responsibility to procure a random moment time survey system to the local educational consortia and the local governmental agencies because it wanted claiming units to get reimbursed quickly for their deferred claims. However, CMS appears to have been flexible regarding timelines. According to one of its representatives, the role CMS had in relation to the implementation date of the new methodology was to consider Health Care Services' proposals and to work with Health Care Services on implementing the new methodology because CMS required all administrative activities costs from July 2012 forward to be based on the new methodology. He also stated that as of February 2015, CMS has approved every extension request Health Care Services made regarding implementation of the new methodology. Regardless of the difference of opinion, now that it has begun paying deferred claims to claiming units, Health Care Services has the opportunity to reevaluate its decision to delegate responsibility for the surveys to the local educational consortia and local governmental agencies.

In addition to Texas' use of a statewide random moment time survey and its use of a standard contract for claiming units to print, sign, and submit (mentioned in Chapter 1), we observed another practice Texas' Medicaid agency uses that California could adopt to help to ensure the clarity and effectiveness of administrative activities program communication. Texas' Medicaid agency posts on its website a *frequently asked questions*, or FAQ, document that answers questions claiming units ask during training sessions or submit to the agency by phone or email. This nine-page FAQ answers general questions—for instance, those pertaining to eligibility requirements to participate in the program—and more specific ones—such as those pertaining to training requirements and filing reimbursement claims. Texas updates the FAQ as needed; the document was last updated in January 2015. In contrast, Health Care Services has posted various FAQs to its website based on questions asked during annual administrative activities program training sessions going back to 2007. However, these documents have not been updated since 2012 and do not adequately reflect current policy and therefore would be of little value to claiming units with policy questions.

### **The Structure of the Administrative Activities Program May Prevent Some Claiming Units From Receiving the Full Amount of Interim Payments**

The administrative activities program's use of local educational consortia and local governmental agencies also affects Health Care Services' ability to promptly make the full amount of interim

payments to some claiming units in accordance with the settlement agreement with CMS. Because Health Care Services issues interim payments to local educational consortia and local governmental agencies and not to individual claiming units, it appears that some claiming units will not promptly receive their full interim payment amounts as described in the settlement agreement. As discussed in the Introduction, the terms of the settlement agreement authorized Health Care Services to make interim payments based on a percentage of the original amounts of the deferred reimbursement claims. These interim payments were intended to provide claiming units a portion of the funds for their deferred claims before Health Care Services fully resolved these claims, which Health Care Services estimates could be as late as 2019.

However, Health Care Services' payments to local educational consortia and local governmental agencies were not always large enough to cover the interim payments owed to some claiming units because of previous overpayments made to other claiming units. Further, as of August 2015, it was not clear how Health Care Services would ensure that each claiming unit would receive the amount to which it is entitled under the settlement agreement. For example, the Sacramento City, Folsom Cordova, and San Juan unified school districts submitted reimbursement claims through the Sacramento County local governmental agency. Health Care Services previously paid these same claiming units for certain reimbursement claims that CMS subsequently deferred. As such, Health Care Services considered those reimbursement amounts to be overpayments. As part of the process to resolve the deferred claims, these three claiming units are entitled to receive interim payments under the terms of the settlement agreement. However, for the claims considered in June 2015, the overpayments to other claiming units within the Sacramento County local governmental agency were larger than the interim payment amount owed to the San Juan Unified School District. As a result, the district did not receive the more than \$76,000 to which it was entitled under the settlement agreement.

Similarly, it appears that some claiming units in the Los Angeles County local educational consortium did not receive their full interim payments. Health Care Services paid the consortium only \$55,000 to cover more than \$2 million in interim payments owed to some claiming units because other claiming units within the consortium had overpayments that totaled more than their interim payments. According to the section chief, Health Care Services is working to resolve this issue. Although Health Care Services should eventually resolve all deferred claims as described in the settlement agreement, it may be as late as 2019 before this process is complete.

*Because of the process Health Care Services used to issue interim payments, it appears that some claiming units will not promptly receive their full interim payments.*

## **Recommendations**

To streamline the organizational structure of the administrative activities program and to improve the program's cost-effectiveness, the Legislature and Health Care Services should implement the following recommendations, thus allowing California to eliminate the need for local educational consortia and local governmental agencies to participate in the program.

### ***Legislature***

To streamline the organizational structure of Health Care Services' administrative activities program and to improve the program's cost-effectiveness, the Legislature should amend state law to allow claiming units to submit reimbursement claims directly to Health Care Services.

### ***Health Care Services***

To streamline the organizational structure of its administrative activities program and to improve the program's cost-effectiveness, Health Care Services should take the following actions to implement a single statewide quarterly random moment time survey:

- Develop and implement a plan to take over responsibility for conducting quarterly time surveys and performing related activities as soon as reasonably possible.
- Develop and issue a request for proposals to identify a responsible vendor to assist in implementing a statewide quarterly random moment time survey.
- Draft revisions to regulations as appropriate and to applicable documents, including the manual, oversight strategies and plans, and policy and procedure letters.

In addition to our earlier recommendation related to streamlining, Health Care Services should take the following actions:

- To the extent that local educational consortia and local governmental agencies are no longer involved in the administrative activities program, Health Care Services should develop and issue a standard contract for claiming units to sign to participate in the program.

- To improve the clarity and effectiveness of program communication, Health Care Services should develop and implement feedback mechanisms, such as organized, up-to-date FAQs, through which it can communicate results of relevant inquiries to other stakeholders, including claiming units.
- To better ensure that some claiming units do not unfairly disadvantage other claiming units in the receipt of interim payments, Health Care Services should explore opportunities to expedite consistent, timely, and fair interim payments to those claiming units with no overpayments. Health Care Services should involve representatives of local educational consortia, local governmental agencies, and claiming units in these efforts and communicate the results to interested stakeholders.

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## Chapter 3

### OTHER SHORTCOMINGS EXIST IN THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES' ADMINISTRATION OF SCHOOL-BASED MEDICAL PROGRAMS

#### Chapter Summary

The California Department of Health Care Services (Health Care Services) has displayed certain weaknesses in its administration of school-based Medi-Cal programs, which consists of the School-Based Medi-Cal Administrative Activities program (administrative activities program) and the Local Educational Agency Medi-Cal Billing Option Program (billing option program). For instance, Health Care Services has not maximized the participation of claiming units in the administrative activities program.<sup>17</sup> We estimate that 275, or 27 percent, of the 1,004 local educational agencies did not participate in the administrative activities program during fiscal year 2011–12, resulting in a loss to the State of an estimated \$10.2 million in federal reimbursements. In addition, Health Care Services delegated responsibility for maximizing claiming unit participation to local educational consortia and local governmental agencies, but it did not adequately oversee their efforts.<sup>18</sup> Health Care Services also did not maximize federal reimbursement for the administrative activities program by failing to authorize claiming units to claim reimbursement for translation activities at a 75 percent rate as federal law currently allows rather than the 50 percent rate it previously allowed. Because the claiming units used the lower rate, we estimate that they failed to claim \$4.6 million in federal funding from February 2009 through June 2015.

We also observed that as of August 2015, Health Care Services had not yet adopted required regulations despite state laws in effect for more than 15 years to do so. Health Care Services' failure to adopt regulations for its administrative activities program limits the public's ability to participate fully in developing the rules governing it. In addition, we believe that stakeholders could construe

<sup>17</sup> According to the federal Centers for Medicare and Medicaid Services (CMS), a *claiming unit* is typically a school district or a program within a district. California has claiming units that are as diverse as county offices of education, special education local plan areas, local school districts, community colleges, and Healthy Start programs.

<sup>18</sup> A *local educational consortium* is one of the 11 service regions of the California County Superintendents Educational Services Association. Each consortium is led by a county education office within the region. A *local governmental agency* is an agency of either a county or chartered city, or a Native American Indian tribe, tribal organization, or subgroup of a Native American Indian tribe or tribal organization.

Health Care Services' policies as *underground regulations*, which could make them unenforceable under California's Administrative Procedure Act (APA), and thus could potentially interrupt reimbursement payments to claiming units.

Finally, Health Care Services has not filed a required annual report for the billing option program with the Legislature since February 2013. By not filing the report annually as required, Health Care Services has failed to provide the Legislature and other stakeholders with timely and relevant information, including program successes and barriers.

### **Health Care Services Has Not Maximized Federal Reimbursements for its Administrative Activities Program**

Health Care Services has not maximized federal reimbursements applicable to the administrative activities program. For instance, we observed that even though the number of claiming units participating in the administrative activities program increased since we last identified this as a concern, Health Care Services still has not adequately maximized claiming units' participation. In our August 2005 audit report titled *Department of Health Services: Participation in the School-Based Medi-Cal Administrative Activities Program Has Increased, but School Districts Are Still Losing Millions Each Year in Federal Reimbursements* (report number 2004-125), we pointed out that 679, or 65 percent, of local educational agencies were not participating, costing California \$52.7 million in lost reimbursements. Based on our current examination of information from Health Care Services and the California Department of Education, we estimate that 275, or 27 percent, of the 1,004 local educational agencies still were not participating in the administrative activities program during fiscal year 2011–12.<sup>19</sup> We estimate that these 275 claiming units missed out on claiming \$10.2 million in federal reimbursements for that same fiscal year. Furthermore, based on Health Care Services' claiming data and participant lists that local educational consortia and local governmental agencies filed, approximately 145 claiming units that filed claims in fiscal year 2011–12 did not participate in the random moment time study in the third quarter of fiscal year 2014–15, resulting in less federal funding to the State.

***During fiscal year 2011–12, we estimate that 275 local educational agencies were not participating in the administrative activities program; these claiming units missed out on claiming an estimated \$10.2 million in federal reimbursements.***

We believe that as the single state agency designated by state law to administer Medicaid in California, Health Care Services should ensure that claiming units participate in the administrative

<sup>19</sup> We selected fiscal year 2011–12 to calculate our estimate because it was the latest complete year outside the two-year window that CMS gives Health Care Services to submit reimbursement claims.

activities program to the greatest extent reasonably possible. One way to obtain this assurance is to conduct outreach activities to nonparticipating claiming units to encourage them to participate. The administrative activities program staff in other states—including those in Illinois and Texas—informed us that they perform outreach at the state agency level to encourage participation in their programs. For instance, the Medicaid administering agency within Texas—the Health and Human Services Commission—partners with the Texas Education Agency to distribute messages at least yearly containing outreach materials to promote the administrative activities program to all school districts in Texas.

Under the current structure of California’s administrative activities program, Health Care Services has delegated outreach responsibility to the local educational consortia and local governmental agencies. However, Health Care Services does not gather any information to assess the results of these entities’ outreach efforts, such as the number and names of nonparticipating claiming units that could participate in the administrative activities program. Health Care Services’ chief of the Medi-Cal Administrative Claiming Section (section chief) stated that Health Care Services could determine which claiming units have participated in the past and have since dropped out, but it has no way to identify those claiming units that have never participated. Additionally, the assistant division chief of the Safety Net Financing Division (assistant division chief) stated that Health Care Services will be looking for ways to bring back claiming units that have dropped out and will discuss how to expand the program to other claiming units in the future. Without knowing the total number of nonparticipating claiming units that could participate in the administrative activities program and who they are, Health Care Services cannot assess whether the local educational consortia and local governmental agencies are performing adequate outreach to nonparticipating claiming units on the department’s behalf and encouraging these units to participate in the program.

Health Care Services also has not maximized the federal reimbursement amount available for one type of activity allowed in a school-based setting. For the six fiscal years from 2009–10 through 2014–15, Health Care Services allowed claiming units to claim a 50 percent federal reimbursement rate for translation services, one of the allowable activities, when the maximum reimbursement rate was actually 75 percent. Activities covered by translation include assisting a student or parent in accessing or understanding California’s Medicaid program (Medi-Cal) application process or treatments that Medi-Cal covers.

***Without knowing the total number of nonparticipating claiming units that could participate in the administrative activities program and who they are, Health Care Services cannot assess whether the local educational consortia and local governmental agencies are performing adequate outreach to nonparticipating claiming units.***

*Health Care Services has allowed California claiming units to claim only a 50 percent reimbursement rate for translation, resulting in the loss of an estimated \$4.6 million in federal funding from February 2009 through June 2015.*

Federal law allows claiming units to be reimbursed for a portion of the costs they incur for providing different types of administrative activities, and it specifies the reimbursement rates. Federal law generally authorizes a reimbursement of up to 50 percent of costs, but for translation services federal law authorizes reimbursement of up to 75 percent. We also observed that guidance issued by other states for their administrative activities programs, including Georgia, New Mexico, and Texas, all allowed their claiming units to claim the 75 percent reimbursement rate for translation. Health Care Services, however, has allowed California claiming units to claim only a 50 percent reimbursement rate for translation, resulting in the loss of an estimated \$4.6 million in federal funding from February 2009 through June 2015. This loss caused claiming units to unnecessarily use other funding sources to cover the costs of translation services within the administrative activities program.

Health Care Services did not allow claiming units to claim the higher reimbursement rate for translation because the section chief was unaware that translation services were authorized by federal law to be reimbursed at a higher rate. However, a July 2010 CMS letter addressed to the directors of Medicaid state agencies (such as Health Care Services) expressly allows claiming units to use a 75 percent reimbursement rate for translation services under a federal law. The letter also says that states can claim the increased rate for allowable expenditures dating back to February 2009, the effective date of the federal law. However, Health Care Services took no action to increase the reimbursement rate for translation services from 50 percent to 75 percent even after telling CMS in October 2013 that it was aware of the increased rate. Once she became aware of the July 2010 CMS letter, the assistant division chief confirmed that Health Care Services found nothing to prevent the claiming of translation activities at 75 percent and that the department will contact CMS to discuss the increased rate.

### **Health Care Services Did Not Adopt Regulations That State Law Requires**

Health Care Services' failure to comply with state law regarding the adoption of regulations for its administrative activities program limits the public's ability to participate fully in developing the rules governing it. Four subdivisions of Section 14132.47 of the California Welfare and Institutions Code require Health Care Services to adopt regulations for the administrative activities program. For example, one of these subdivisions requires Health Care Services to consult with local educational consortia and local governmental agencies to adopt regulations regarding the submission and payment of administrative activities claims and to deny any claim from a participating local educational consortium

or a local governmental agency if it determines that the claim is not supported in accordance with criteria established pursuant to this law and implementing regulations.

Although these statutory requirements have been in effect for more than 15 years, as of August 2015, Health Care Services had not yet adopted the regulations as called for. According to the section chief, Health Care Services did not adopt these regulations because it believed that its manual and policy and procedure letters provided the necessary guidance to stakeholders. We observed that the 2014 edition of this manual is a 151-page document consisting of 11 sections and eight appendices, collectively governing how program participants are to develop, submit, process, and receive reimbursement claims. For instance, to receive reimbursement, claiming units must limit flat-fee vendor reimbursements to 15 percent of the total amount claimed during a given fiscal year and must not include direct costs related to teachers. If claiming units fail to comply with these requirements, their local educational consortium, local governmental agency, or Health Care Services can reject their claims. Policy and procedure letters serve to update or augment the manual with specific policies, and they impose similar requirements on program participants. Over the years, Health Care Services has issued a number of policy and procedure letters related to the administrative activities program, covering topics such as establishing an appeals process and issuing a policy governing the use of electronic signatures.

Nevertheless, by not adopting regulations, Health Care Services limits the opportunities available to claiming units and to the public to participate in the regulatory process. The APA defines a *regulation* as any rule of general application adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure. The APA requires state agencies to submit proposed regulations through a process that allows public comment and review by the Office of Administrative Law (office). According to the office, which administers the APA, the State designed the requirements of the APA to provide the public with a meaningful opportunity to participate in the adoption of state regulations and to ensure that regulations are clear, necessary, and legally valid. One way the APA provides meaningful opportunities to participate in the adoption of regulations is the minimum 45-day public comment period. After an agency publishes and issues the notice of proposed rulemaking, the public has the opportunity to submit written, faxed, or emailed comments to the agency regarding the proposed rules; the public may participate in any public hearing on the proposal; and the public may review the adopting agency's written summary of its responses to the submitted comments.

***By not adopting regulations, Health Care Services limits the opportunities available to claiming units and to the public to participate in the regulatory process.***

***By using and enforcing its manual and its policy and procedure letters rather than adopting them as regulations, Health Care Services could increase the risk of an interruption to future federal reimbursement payments to claiming units.***

As a result, not developing regulations means claiming units, which have demonstrated in the past their willingness to identify concerns when Health Care Services implemented changes to the administrative activities program, may not have their voices heard. For instance, when it implemented the random moment time survey methodology discussed in Chapter 2, claiming units voiced concerns, including that Health Care Services' manual and website were incomplete and that Health Care Services provided inaccurate and inadequate training. While Health Care Services does hold stakeholder meetings, state law does not require written responses to questions that local educational agencies raise during those meetings, unlike what the APA would require in the adoption of regulations.

Furthermore, if a state agency issues a requirement that meets the definition of the term *regulation* without following the APA when it is required to do so, this requirement is called an *underground regulation*. State law allows anyone to file a petition with the office to determine whether a state agency's policies containing such requirements are underground regulations. The office also stated that state agencies are prohibited from enforcing underground regulations. Because Health Care Services issued policies rather than adopting regulations that local educational consortia, local governmental agencies, and claiming units must follow as part of the administrative activities program, we believe that stakeholders—including any member of the public—could construe the manual and the policy and procedure letters as underground regulations. By using and enforcing its manual and its policy and procedure letters rather than adopting them as regulations in accordance with the APA, Health Care Services may also risk interrupting the flow of federal reimbursement funds to claiming units. If someone were to successfully challenge the manual and the policy and procedure letters as underground regulations, Health Care Services, the local educational consortia, and the local governmental agencies might be unable to use or enforce the claim reimbursement provisions included in them. The inability to use or enforce these provisions could increase the risk of an interruption to future reimbursement payments to claiming units.

Finally, although state law exempts certain policies from the APA's requirements, we do not believe Health Care Services should seek such statutory exemptions for the administrative activities program. For instance, Health Care Services may implement state law related to Medi-Cal's electronic medical records through provider bulletins or similar instructions without taking regulatory action; however, exempting Health Care Services from complying with the APA's provisions related to the administrative activities program could impede the ability of claiming units to participate to the extent envisioned under the APA when Health Care Services develops administrative activities requirements with which they

must comply. As we previously discussed, the APA allows all claiming units to participate in the regulatory process if they wish. We believe denying claiming units this opportunity increases the likelihood of misinterpretations and inconsistent application of administrative activities program requirements.

### **Health Care Services' Lack of Required Annual Reports Limits the Transparency of the Billing Option Program**

Although its most recently submitted version of an annual report for the billing option program contained all elements the law requires, Health Care Services last filed a report that was due in 2012 with the Legislature in February 2013—and has not filed another since then. State law requires Health Care Services to file an annual report with the Legislature about the billing option program. Table 5 on the following page shows the 11 elements that state law requires Health Care Services to include as part of that report. For the 2012 report covering the 14 months from April 2011 through May 2012, which is the most recent report that it filed, Health Care Services included all 11 required elements. For instance, the report identified Medicaid reimbursement revenues for California and other states for two fiscal years and discussed program successes, including increases in federal reimbursements. Health Care Services mentions that Medi-Cal reimbursements for the billing option program more than doubled from \$63.6 million in fiscal year 2005–06 to \$130.4 million in fiscal year 2009–10.

According to Health Care Services, this increase is due in part to its efforts to allow local educational agencies to correct previous errors in claims that caused them to be incorrectly paid or denied as well as increased federal funding due to the federal American Recovery and Reinvestment Act of 2009 (recovery act). In addition to these factors, adding more services increases the Medi-Cal reimbursement. According to the assistant division chief, Health Care Services reviews new guidance issued by CMS and any changes to California's Welfare and Institutions Code for additional services that could be claimed under the billing option program. She also stated that Health Care Services identifies new services for reimbursement through a process that stakeholders initiate. The assistant division chief told us that stakeholders first notify Health Care Services of medical services they believe should be reimbursable. Next, Health Care Services begins a vetting process through which it examines other states to determine if the service is reimbursed elsewhere in the country, identifies a reasonable reimbursement rate for the service, and assesses how prevalent the need is for the particular service. Health Care Services then submits a state plan amendment, if needed, to CMS for approval to add the

*Health Care Services is required to file an annual report with the Legislature about the billing option program—it filed a report in February 2013 and has not filed another since then.*

new service into the allowed reimbursable services. Some changes merely represent a new delivery method of currently approved services and thus do not require a state plan amendment.

**Table 5**  
**Annual Report Elements Required by the State for the Local Educational Agency Medi-Cal Billing Option Program**

1	An annual comparison of school-based Medicaid systems in other states.
2	A state-by-state comparison of school-based Medicaid total and per eligible child claims as well as federal revenues for the most recent two years for which data are available.
3	A summary of the California Department of Health Care Services' (Health Care Services) activities that contributed toward narrowing the gap between California's federal fund recovery per eligible student and that of the top three states in the report.
4	An explanation of how each activity in item (3) contributed toward narrowing the gap between California's federal fund recovery per eligible student and that of the top three states in the report.
5	A listing of all school-based services, activities, and providers approved for reimbursement by the Centers for Medicare and Medicaid Services (CMS) in other state plans that are not yet approved for reimbursement in California's state plan.
6	The service unit rates for all services, activities, and providers identified in item (5).
7	The official recommendations made to Health Care Services by the California Department of Education; representatives of urban, rural, large, and small school districts; county offices of education; the local educational consortia; local educational agencies; staff from Region IX of CMS; experts from the fields of both health and education; and state legislative staff.
8	The actions taken by Health Care Services for each recommendation identified in item (7).
9	A one-year timetable for state plan amendments and other actions necessary to obtain reimbursement for those items listed in item (5).
10	Identification of any barriers to local educational agency reimbursement, including those specified by the entities in item (7), that federal requirements have not imposed.
11	A description of the actions that have been and will be taken to remove the barriers identified in item (10).

Source: Section 14115.8(f) of the California Welfare and Institutions Code.

We found that Health Care Services received higher reimbursements for the billing option program because of temporary rate increases the recovery act allowed. The recovery act increased the federal reimbursement percentages for Medicaid services from 50 percent to as much as 61.6 percent from October 2008 through June 2011.<sup>20</sup> See the text box for the recovery act's

<sup>20</sup> The recovery act provided increased reimbursement rates for the billing option program; it did not provide increased reimbursement rates for the administrative activities program.



increased reimbursement rates and the periods to which they applied. Health Care Services passed on to the local educational agencies the higher reimbursements that occurred under the recovery act.

Although its most recently issued report contains the 11 required elements and describes its successes and barriers related to the billing option program, Health Care Services has not filed an annual report since February 2013, about two and a half years ago. Based on past practice, the two annual reports expected in 2013 and 2014 would have covered the roughly two-year period from April 2012 through May 2014. By not filing the required billing option program reports annually, Health Care Services unnecessarily restricts transparency by depriving the Legislature, the general public, and other stakeholders of the billing option program prompt access to program information. For example, in the report covering April 2011 through May 2012, Health Care Services mentions setting up a meeting with CMS in 2012 to discuss adding new services. However, Health Care Services presented this plan about two and a half years ago and it has still not filed a new report to disclose what, if any, progress has occurred related to these new services.

The section chief attributed the delay in issuing the report covering April 2012 through May 2013 to turnover among the executive staff that review the report and slow responses from other states for the portion of the report that requires comparisons to other states' Medicaid agencies. The chief of Health Care Services' Safety Net Financing Division told us in June 2015 that Health Care Services plans to release shortly the report covering the 14 months from April 2012 through May 2013, and then it will issue a single report covering the two years from April 2013 through May 2015 by December 2015. As of August 2015 Health Care Services had not yet posted the report covering the period through May 2013 to its website.

Although Health Care Services has not recently issued its required annual report for the billing option program, such a report presents information useful to stakeholders. We believe that providing similar information for the administrative activities program would also be useful. The statutory requirement for the annual report compels Health Care Services to examine routinely its billing option program for ways to improve the program and to file periodically the results of its examination in a report to the Legislature. The legislative report provides a retrospective look at program successes and barriers, and it identifies anticipated future issues and ways to

**Medicaid Reimbursement Rates Under the American Recovery and Reinvestment Act of 2009**

The American Recovery and Reinvestment Act of 2009 increased the federal reimbursement rates for the Local Educational Agency Medi-Cal Billing Option Program from 50 percent to the following percentages from October 2008 through June 2011:

From October 1, 2008, through December 31, 2010	61.59%
From January 1, 2011, through March 31, 2011	58.77%
From April 1, 2011, through June 30, 2011	56.88%

Sources: American Recovery and Reinvestment Act of 2009, the *Federal Register*, and a California Department of Health Care Services' Policy and Procedure Letter (PPL 11-001).

address them. Writing a periodic report that the public can access forces Health Care Services to document and describe those areas where the program requires improvement. The annual requirement, when followed, provides the Legislature and stakeholders with timely access to information on potential program problems or upcoming changes. Health Care Services indicated that it does not prepare a similar annual report for the administrative activities program because the law does not presently require it to do so.

## **Recommendations**

### ***Legislature***

To help improve and maximize the benefits of the administrative activities program, as well as to provide enhanced transparency to stakeholders, the Legislature should enact legislation as soon as possible that requires Health Care Services to prepare a report annually for the administrative activities program similar to the annual report state law requires for the billing option program.

### ***Health Care Services***

To better maximize federal reimbursements for the administrative activities program, Health Care Services should complete the following actions within six months:

- Develop and implement a method to oversee and track the outreach efforts that local educational consortia and local governmental agencies use for ensuring that nonparticipating claiming units understand the benefits and consider participating in the administrative activities program.
- Revise reimbursement rates to authorize claiming units to claim the 75 percent reimbursement rate for translation activities as federal law allows.
- Determine the extent to which claiming units can claim the unreimbursed difference between the 50 percent and 75 percent reimbursement rates for translation activities for past years and inform claiming units of the findings.

Should the Legislature implement our recommendation in Chapter 2 to allow claiming units to submit reimbursement claims directly to it, Health Care Services should develop and implement its own outreach functions to ensure that claiming units that do not currently participate understand the benefits and consider participating in the administrative activities program.

To provide the public with the ability to participate fully in developing the rules governing the administrative activities program, Health Care Services should, in accordance with the APA, immediately develop and adopt the regulations cited in the four subdivisions of Section 14132.47 of the California Welfare and Institutions Code.

To ensure that it provides stakeholders with timely access to information regarding the billing option program, Health Care Services should do the following:

- Issue the required annual report covering April 2012 to May 2013 immediately.
- Issue the required annual report covering April 2013 to May 2015 by December 2015 as promised.
- Issue all future annual reports in a timely manner.

We conducted this audit under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives specified in the Scope and Methodology section of the report. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,



ELAINE M. HOWLE, CPA  
State Auditor

Date: August 20, 2015

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## Appendix

### HISTORY OF RECENT CHANGES TO THE CLAIMING PROCESS FOR THE SCHOOL-BASED MEDICAL ADMINISTRATIVE ACTIVITIES PROGRAM

As we mention in the Introduction, the Centers for Medicare and Medicaid Services (CMS) required the California Department of Health Care Services (Health Care Services) to implement a reasonableness review of claims for which CMS had deferred payment as a result of its financial management review. In August 2012, Health Care Services implemented a *deferral certification* process as its reasonableness review. The deferral certification process required claiming units to submit additional documentation to support reimbursement for deferred invoices.<sup>21</sup> Once CMS approved the supporting documentation, the claims would be reimbursed. However, CMS suspended the deferral certification process in January 2013—five months after it started—when the process did not result in Health Care Services approving deferred claims for payment. CMS directed California to develop a reasonableness test to assist in the review and approval of the submissions for deferral certification.

As its second attempt to address CMS's concerns about claims, in October 2013 Health Care Services implemented a review process using *reasonableness test criteria*, which were benchmark percentages and other limits that Health Care Services established and that claiming units had to meet if they were to receive approval for their reimbursement claims. For instance, Health Care Services limited the proportion of reimbursable time that a claiming unit could spend facilitating Medi-Cal applications to 2 percent of the claiming unit's total work time. In addition, Health Care Services' guidance stated that because each claiming unit is unique and represents a unique set of circumstances, Health Care Services would allow them to provide justifications for their claims that fell outside of the requirements imposed by the reasonableness test criteria.

However, the reasonableness test criteria process also failed to result in the payment of many of the deferred claims. Of the approximately 5,300 reasonableness test criteria claims that Health Care Services' data show were submitted as of February 2015, Health Care Services approved only 504 (fewer than 10 percent).

<sup>21</sup> According to CMS, a *claiming unit* is typically a school district, or program within a district. California has claiming units that are as diverse as county offices of education, special education local plan areas, local school districts, community colleges, and Healthy Start programs.

Another CMS finding pointed out that Health Care Services' claiming plan did not comply with federal requirements.<sup>22</sup> CMS reported that the claiming plan allowed improper coding of certain staff time as 100 percent reimbursable, resulting in inflated claimed amounts, and therefore the plan did not comply with federal regulations and requirements. CMS recommended that Health Care Services amend its claiming plan to fix this issue. Health Care Services agreed and stated it would implement a new time study methodology, the random moment time survey, as part of the revisions to its claiming plan.

According to Health Care Services' June 2014 *California School-Based Medi-Cal Administrative Activities Manual* (manual), the random moment time survey methodology polls selected staff from the claiming unit individually to determine what they were doing at randomly selected minutes during the quarter being surveyed, and then it totals the results to identify the proportion of time spent on allowable administrative activities for the entire population of time survey participants. Local educational consortia and local governmental agencies then use this information to calculate the total Medi-Cal reimbursement amount for claiming units in their respective jurisdictions.<sup>23</sup> Claiming units that participate in the time study must identify staff that regularly spend their time performing administrative activities and assign them to one of two participant pools: one for staff that perform direct medical services and administrative activities and one for staff that perform only administrative activities. Claiming units must update this information quarterly in the random moment time survey system. Health Care Services refers to the eight entities that perform quarterly time surveys and the Los Angeles Unified School District (LA Unified) as *administrative units*. Before the beginning of the survey quarter, each administrative unit must certify to Health Care Services a comprehensive list of all claiming unit staff eligible to participate in the time survey. Time study software at each administrative unit generates and issues 2,761 random moment time surveys to participants in each of the two pools each

<sup>22</sup> According to the chief of Health Care Services' Medi-Cal Administrative Claiming Section, CMS's usage of the term *claiming plan* appears to mean the manual. The manual describes how claiming units can obtain federal reimbursement under the School-Based Medi-Cal Administrative Activities program (administrative activities program). Health Care Services publishes this manual periodically.

<sup>23</sup> Health Care Services contracts with two types of entities to help it administer the administrative activities program. A *local educational consortium* is one of the 11 service regions of the California County Superintendents Educational Services Association. Each consortium is led by a county education office within the region. A *local governmental agency* is an agency of either a county or a chartered city or is a Native American Indian tribe, tribal organization, or subgroup of a Native American Indian tribe or tribal organization. State law requires claiming units to contract with one of these two types of entities to participate in the administrative activities program.

quarter, or a total of 5,522 random moments per quarter per time survey for each administrative unit. We refer to the surveys for both participant pools collectively as the *quarterly time survey*.

Local educational consortia, local governmental agencies, or their vendors send email messages to the selected staff members from the participant pools notifying them that they have been selected to participate in a survey and informing them of the date and minute for their survey. Each random moment survey asks the participant to answer three specific questions: “What were you doing? Who were you with? Why were you performing this activity?” After receiving survey responses, the local educational consortia, local governmental agencies, or their vendors code—interpret—the answers to the three questions to conclude whether the task was related to Medi-Cal and reimbursable. Using the quarterly survey results and other information, claiming units prepare detailed claims, certify their accuracy, and submit them to their local educational consortium or local governmental agency. The local educational consortia and local governmental agencies then prepare summary claims based on each claiming unit’s detailed claim. The local educational consortia and local governmental agencies submit the summary claims to Health Care Services, which compiles expenditure data from the summary claims into the State’s expenditures report for federal reimbursement.

Local educational consortia and local governmental agencies first used the new time study methodology during the quarter from January 2015 through March 2015. As described in Chapter 2, when Health Care Services began using the methodology, the local educational consortia and local governmental agencies conducted eight separate quarterly surveys covering different geographic regions of the State, along with the preexisting survey conducted by LA Unified. Local educational consortia performed six of the eight quarterly surveys while local governmental agencies performed the remaining two. LA Unified continued to perform its own random moment time survey, the use of which CMS had approved previously in 2010.

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August 2015



JENNIFER KENT  
Director

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



EDMUND G. BROWN JR.  
Governor

AUG 05 2015

Ms. Elaine M. Howle\*  
California State Auditor  
621 Capitol Mall, Suite 1200  
Sacramento, CA 95814

Dear Ms. Howle:

The California Department of Health Care Services (DHCS) hereby provides response to the draft findings of the California State Auditor's (CSA) report entitled, *California Department of Health Care Services: It Should Improve Its Administration and Oversight of School-Based Medi-Cal Programs*. The CSA conducted this audit and issued eight (8) findings and twenty-one (21) recommendations.

DHCS agrees with fifteen (15) of the recommendations and has prepared corrective action plans to implement them. DHCS appreciates the work performed by CSA and the opportunity to respond to the findings. If you have any questions, please contact Ms. Sarah Hollister, Audit Coordinator, at (916) 650-0298.

Sincerely,

A handwritten signature in black ink that reads "Jennifer Kent".

Jennifer Kent  
Director

## **Department of Health Care Services Response to CSA Draft Report Entitled, *California Department of Health Care Services: It Should Improve Its Administration and Oversight of School-Based Medi-Cal Programs***

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**Finding A: DHCS should ensure that it provides claiming units with reasonable opportunities to address concerns with department decisions or actions and should take the following actions within three (3) months.**

**Recommendation A1:** Begin preparing regulations to establish and implement a formal appeals process that allows claiming units to directly appeal Health Care Services' decisions.

① **DHCS Response:** DHCS disagrees with the recommendation.

DHCS does not contract with the LEAs directly. LEAs contract with their local LEC or LGA and DHCS contracts with the LEC/LGAs. Therefore, any disputes with DHCS directives must first be addressed at the LEC/LGA level before the issue can be elevated to DHCS. If there is no resolution between the LEA and LEC/LGA, the appeal can be directed to DHCS to work with both the LEA and the LEC/LGA to resolve.

DHCS currently has a formal appeals process that has been distributed to all program stakeholders and posted to the SMAA web page that specifically addresses appeals.

**Recommendation A2:** Inform all stakeholders, including claiming units, of the existence of this appeals process.

① **DHCS Response:** DHCS disagrees with the recommendation

As stated in the previous response, DHCS does not contract with the LEAs directly and all disputes must first be addressed at the LEC/LGA level before the issue can be elevated to DHCS. Policy and Procedure Letter (PPL) 14-006 was issued on April 4, 2014 that outlines the appeal process (this is posted on the SMAA website).

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**Finding B: Until the Legislature implements the recommendation in Chapter 2, Health Care Services should ensure that local educational consortia and local governmental agencies sufficiently meet their responsibilities under the administrative activities program and meet the terms of their contracts with Health Care Services by immediately resolving weaknesses in its oversight of these entities.**

**Recommendation B1:** Update its site and desk review procedures to include the following steps:

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- (A) A risk based approach to selecting entities for review.
- (B) Verification that local educational consortia and local governmental agencies are adequately meeting the oversight and administrative responsibilities described in their contracts with DHCS.
- (C) Verification that contracts between local educational consortia or local governmental agencies and their claiming units do not include provisions that could result in disallowed costs, such as allowing the inclusion of Health Care Services' participation fee in the claim calculations.
- (D) An examination of local educational consortia and local governmental agencies' records to ensure that:
  - Costs they claim for federal reimbursement are necessary and reasonable.
  - The entities are not inappropriately earning a profit based on fees they collect from claiming units.
  - Close scrutiny of the coding performed by local educational consortia that charge claiming units a percentage of their federal reimbursement.

**DHCS Response:**

DHCS agrees with the recommendation.

- (A) DHCS will work with our audit staff in Audits and Investigation to review current risk-based practices to develop an approach for selecting entities for review.
- (B) DHCS will review the LEC/LGA contracts to determine the oversight and administrative responsibilities and verify these activities are being accomplished.
- (C) Review of the LEA/LEC/LGA contracts is part of the current oversight reviews and DHCS will ensure that they do not include provisions for unallowed costs.
- (D) As part of the oversight review, DHCS will:
  - Verify compliance with 42 CFR 433.15 (b)(7) ensuring all costs are necessary and reasonable.
  - Meet with our Audits and Investigations Division to research the activities necessary to identify inappropriately charged fees.
  - Utilize the real-time access to RMTS to view all coding to ensure that all activities are coded accurately.

Estimated completion date to research, develop and implement the above is March 2016.

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**Recommendation B2:** Complete the oversight reviews for at least three high-risk local educational consortia or local governmental agencies by December 31, 2015, and post the results to its website.

**DHCS Response:** DHCS agrees with the recommendation.

DHCS will work with audit staff in Audits and Investigations to review current risk-based practices and to develop an approach for selecting entities for review.

Since the new methodology for identifying high-risk LEC/LGAs is not yet in place, DHCS will select at least three high – risk LEC/LGAs based on the departments experience in reviewing claims during the Reasonable Test Criteria (RTC) process.

The results of the oversight reviews will supplement the research to create, and implement the over-all risk-based oversight review. In addition, DHCS will look into posting oversight reviews to its website.

Estimated completion date of December 31, 2015.

**Recommendation B3:** Complete the oversight reviews for any remaining high-risk local educational consortia or local governmental agencies by June 30, 2016, and post the results to its website.

**DHCS Response:** DHCS agrees with the recommendation.

DHCS will work with audit staff in Audits and Investigations to review current risk-based practices and to develop an approach for selecting entities for review. Once the research into best practices for a risk-based site review process has been developed, DHCS will use this criterion to identify high risk LECs/LGAs and set a site review schedule based on that criterion. DHCS will start the oversight review for the top remaining LECs/LGAs by September 2016.

Estimated completion date to establish a risk-based site review schedule is April 2016. DHCS will look into posting oversight reviews to its website.

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**Finding C: DHCS should minimize the risk that claiming units could include unallowable costs when calculating their reimbursement claims.**

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**Recommendation C1:** Encourage Los Angeles County to revise its contracts with its claiming units to make it clear that claiming units cannot include DHCS' participation fee as part of their claims.

**DHCS Response:** DHCS agrees with the recommendation.

DHCS will review the language in LACOE's contract, if it is found that the language allows for the claiming of the participation fee, DHCS will require LACOE to revise its contract. DHCS will also review and ensure that all LEC/LGAs, as needed, revise their contracts so that the DHCS participation fees are not included as part of their LEA claims. To allow for contract revisions, review, submission to local boards for approval and signature, the estimated completion date is June 30, 2016.

**Recommendation C2:** For all claims that Los Angeles County received and reviewed under its current contracts with its claiming units: Determine whether claiming units included DHCS' participation fee as part of the claim.

For those paid claims that included participation fee, identify the amount of the inappropriate amount paid and take appropriate action to resolve the improper payment including, if necessary, obtaining a refund from the claiming unit.

For those submitted claims that have not yet been paid, instruct Los Angeles County to reject the claims and direct claiming units to revise the claims to omit DHCS' participation fee.

**DHCS Response:** DHCS agrees with the recommendation.

DHCS will conduct a site visit with LACOE as first priority. As part of the audit file, a schedule details all other costs claimed on the LEA invoice. DHCS will ensure that any participation fees will not be listed as part of the invoice. For any paid claims that include a participation fee, DHCS will take appropriate action to recoup those funds. For those submitted claims that have not yet been paid, DHCS will instruct Los Angeles County to reject the claims and direct claiming units to revise the claims to omit DHCS' participation fee. To allow schools to return from summer break and allow for the necessary personnel to be available for interviews, DHCS will initiate an entrance letter to LACOE by mid-August 2015 for a site visit in September 2015.

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**Recommendation C3:** Remind all local educational consortia and local governmental agencies that contracts with their claiming units should prohibit claiming units from seeking federal reimbursement of DHCS' participation fee.

**DHCS Response:** DHCS agrees with the recommendation.

DHCS will re-issue PPL 97-20 by September 30, 2015 reminding all LEC/LGAs of this requirement.

**Finding D: To streamline the organizational structure of its administrative program and to improve the program's cost effectiveness, DHCS should take the following actions to implement a single statewide quarterly random moment time survey.**

**Recommendation D1:** Develop and implement a plan to take over responsibility for conducting quarterly time surveys and performing related activities as soon as reasonably possible.

② **DHCS Response:** DHCS disagrees with the recommendation.

DHCS will review the implications and cost effectiveness of taking over the responsibility of conducting quarterly time surveys, and related activities. DHCS will reach out to other states that utilize a single statewide time survey to determine the scope of service involved with this methodology and identify a set of best practices for possible implementation in California.

**Recommendation D2:** Develop and issue a request for proposals to identify a responsible vendor to assist in implementing a statewide quarterly random moment survey.

② **DHCS Response:** DHCS disagrees with the recommendation.

DHCS will reach out to other states that administer a statewide Random Moment Time Study (RMTS) methodology in order to identify a set of best practices for the development and implementation of a statewide RMTS in California, and determine the number and type of resources necessary to administer the program at a statewide level. Once that review is complete, the Department will make a determination of the practicality of a statewide RMTS implementation.

If it can be determined that an increased efficiency and cost savings will result from a statewide RMTS methodology with

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respect to achieving the overall objectives of the SMAA program, DHCS will reach out to gather stakeholder input in order to develop a Request for Proposal (RFP) to contract with a vendor to implement a statewide quarterly random moment time survey.

**Recommendation D3:** Draft revisions to regulations as appropriate and to applicable documents, including the California School Based Medi-Cal Administrative Activities Manual, oversight strategies and plans, and policy and procedures letters.

**DHCS Response:** DHCS agrees with the recommendation.

DHCS staff is currently working on drafting regulations for the SMAA program. Estimated time to submit regulations for the SMAA program is June 30, 2017.

③

**Recommendation D4:** To the extent that local educational consortia and local governmental agencies are no longer involved in the administrative activities program, Health Care Services should develop and issue a standard contract for claiming units to sign to participate in the program.

**DHCS Response:** DHCS disagrees with the recommendation.

④

DHCS currently has standard contracts with the LEC/LGAs. Should DHCS determine the necessity of eliminating the LEC/LGAs from the SMAA program, DHCS will continue to use standard contracts for all claiming units contracting with DHCS. Contracting directly with the LEAs would be dependent upon elimination of LEC/LGAs and the timeframe needed to transition duties to the claiming units.

**Recommendation D5:** To improve the clarity and effectiveness of program communication, DHCS should develop and implement feedback mechanisms, such as organized, up – to – date FAQs, through which it can communicate results of relevant inquiries to other stakeholders, including claiming units.

**DHCS Response:** DHCS agrees with the recommendation.

DHCS will begin to review emails, notes, meeting comments/agendas to update current FAQs and establish a separate FAQ link on the SMAA home page. This will entail reaching out to stakeholders for issues to address and publish.

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Anticipated publication will be March 2016.

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**Finding E: To better maximize the federal reimbursements for the administrative activities program, DHCS should complete the following actions within six (6) months.**

**Recommendation E1:** Develop and implement a method to oversee and track the outreach efforts used by local educational consortia and local governmental agencies for ensuring that nonparticipating claiming units understand the benefits and consider participating in the administrative activities program.

**DHCS Response:** DHCS agrees with the recommendation.

DHCS will work with its stakeholders to develop a standard training tool and presentation to be used by LEC/LGAs to reach out to non-participating schools. DHCS will work with stakeholders to create a tracking tool for LEC/LGAs to use to monitor outreach activities.

Anticipated implementation is March 30, 2016.

**Recommendation E2:** Revise reimbursement rates to authorize claiming units to claim the 75 percent reimbursement rate for translation activities as allowed by federal law.

**DHCS Response:** DHCS agrees with the recommendation

DHCS is working with CMS to establish a process to claim translation services at the enhanced rate of 75 percent.

Estimated completion date is December 31, 2015.

**Recommendation E3:** Determine the extent to which claiming units can claim the unreimbursed difference between the 50 percent and 75 percent reimbursement rate for translation activities for past years and inform claiming units of the results.

**DHCS Response:** DHCS agrees with the recommendation.

DHCS is currently working with CMS to incorporate the increased reimbursement for translation services and will ask if retroactive claiming will be allowed.

Estimated completion date is December 31, 2015.

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**Finding F: DHCS should provide the public with the ability to participate fully in developing the rules governing the administrative activities program.**

**Recommendation F1:** DHCS should, in accordance with the APA, immediately develop and adopt the regulations cited in the four subdivisions of Section 14132.47 of the California Welfare and Institutions Code.

**DHCS Response:** DHCS agrees with the recommendation.

DHCS staff is currently working on drafting regulations for the SMAA program. DHCS meets regularly with our stakeholders and will engage them in the regulatory development process. The public will have time to comment during the public comment period required by the APA.

Estimated time to submit regulations for the SMAA program is June 30, 2017.

③

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**Finding G: DHCS should provide stakeholders with timely access to information regarding the billing option program.**

**Recommendation G1:** Issue the required annual report covering April 2012 to May 2013 immediately.

**DHCS Response:** DHCS agrees with the recommendation.

DHCS is working to issue the April 2012 to May 2013 annual report by the end of 2015.

⑤

**Recommendation G2:** Issue the required annual report covering April 2013 to May 2015 by December 2015 as promised.

**DHCS Response:** DHCS agrees with the recommendation.

DHCS is working to issue the April 2013 to May 2015 annual report by December 31, 2015.

**Recommendation G3:** Issue all future annual reports in a timely manner.

**DHCS Response:** DHCS agrees with the recommendation.

DHCS will work to issue reports timely.

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**Finding H: The structure of the Administrative Activities Program may prevent some Claiming Units from receiving the full amount of interim payments**

**Recommendation H1:** To better ensure that some claiming units do not unfairly disadvantage other claiming units in the receipt of interim payments, Health Care Services should explore opportunities to expedite consistent, timely, and fair interim payments to those claiming units with no overpayments. Health Care Services should involve representatives of local educational consortia, local governmental agencies, and claiming units in these efforts and communicate the results to interested stakeholders.

⑥

**DHCS Response:** DHCS disagrees with the recommendation.

DHCS issued interim settlement payments to all claiming units based on the net difference between the deferred paid claims (amount owed to the state) and the deferred placeholder claims (amount owed to the LEAs). Any money owed to the state by the LEAs through the application of the CMS settlement to previously paid claims was netted against any money owed to the LEA through all unpaid deferred placeholder claims. In order to expedite the payment process, a single payment was issued to each LEC or LGA based on the total amount that was due to the LEAs within the LEC/LGA service regions. Had this process not been implemented, DHCS would have had to issue individual checks for over 800 claiming units, accounting for eight quarters of deferred claims. If an LEA continues to have a net negative balance after all claims are netted, the LEC/LGA is responsible for recouping those funds before they can issue payment to the LEAs with a net positive balance.

Currently there are 34 claiming units with a net negative balance representing approximately \$2.7 million.

DHCS is drafting a guidance letter to assist the LEC/LGAs with finalizing the settlement payment process. This letter will be issued by August 14, 2015.

## Comments

### CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

To provide clarity and perspective, we are commenting on the California Department of Health Care Services' (Health Care Services) response to our audit. The numbers below correspond to the numbers we have placed in the margin of Health Care Services' response.

Health Care Services' disagreement with our recommendations regarding its appeals process is perplexing. Although it does not contract directly with claiming units, Health Care Services is the single state agency responsible for administering Medicaid in California, including the School-Based Medi-Cal Administrative Activities program (administrative activities program), and therefore it should strive to ensure that claiming units achieve success under this program. We mention on pages 27 and 28 that Health Care Services' process allows claiming units to appeal actions or decisions that local educational consortia and local governmental agencies make and, according to the chief of the Safety Net Financing Division (division chief), the local educational consortia or local governmental agencies can appeal Health Care Services' actions or decisions on behalf of their claiming units. Health Care Services' use of an appeals process that allows claiming units to appeal decisions to only their local educational consortium or local governmental agency, and that forces claiming units to rely on these entities to appeal those decisions to Health Care Services on their behalf is unnecessarily convoluted. As we also mention on page 28, that, according to the assistant chief of Health Care Services' Safety Net Financing Division, no claiming units have ever used the appeals process. The apparent failure of this appeals process for claiming units, which has been in place since April 2014, is clear. We, therefore, stand by our recommendations.

Despite its disagreement with these recommendations, Health Care Services states that it will review the implications and cost-effectiveness of implementing a single statewide random moment time survey and performing related activities. We look forward to reviewing the results of these efforts when Health Care Services submits status reports to us at 60 days, six months, and one year following the issuance of our report. Further, we are confident that once Health Care Services completes its analysis, it will agree that implementing a statewide quarterly time survey will result in a significant savings for claiming units and simplify the oversight of the administrative activities program.

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- ③ In its response, Health Care Services did not explain why it needs until June 30, 2017, “to submit regulations” (presumably to the Office of Administrative Law), about 22 months after the issuance of our report. As we describe on page 56, because Health Care Services’ policies and manuals could be construed as underground regulations, it could increase the risk of an interruption to future reimbursement payments to claiming units. We look forward to reviewing Health Care Services’ explanation of why it will need so much time when it submits status reports to us at 60 days, six months, and one year following the issuance of our report.
- ④ Although Health Care Services disagrees with our recommendation regarding developing a standard contract for claiming units, its additional statements indicate otherwise. Health Care Services acknowledges that it will continue to use standard contracts for all local educational consortia and local governmental agencies with which it contracts and that contracting directly with local educational agencies is dependent upon elimination of local educational consortia and local governmental agencies and the time frame needed to transition duties to claiming units. These statements are in line with our recommendation.
- ⑤ Although we appreciate its agreement with our recommendation, it is unclear why Health Care Services may need until the end of 2015 to issue the required annual report for the Local Educational Agency Medi-Cal Billing Option Program covering April 2012 through May 2013 (the 2013 report). Health Care Services’ response indicates that it will issue the 2013 report at some point during the four months from the end of August 2015 through the end of December 2015. We state on page 59 of our report, the division chief told us in June 2015 that Health Care Services plans to release the 2013 report shortly. In an email dated June 9, 2015, the division chief indicated that his team was revising the report to show updated information and stated that he believed that Health Care Services would be able to finalize and post the 2013 report in the next couple of weeks.
- ⑥ Despite its disagreement with our recommendation, additional statements Health Care Services makes in its response indicate its apparent commitment to ensuring that claiming units receive the full amount of their interim payments. We look forward to reviewing the status of Health Care Services’ efforts in achieving this goal, including updates on the number of claiming units that have not received the full amount of their interim payments, when it submits status reports to us at 60 days, six months, and one year following the issuance of our report.