



Department of Health Care Services

It Paid Billions in Questionable Medi-Cal Premiums and Claims Because It Failed to Follow Up on Eligibility Discrepancies

Report 2018-603

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October 30, 2018

2018-603

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

Dear Governor and Legislative Leaders:

This report presents the results of our high risk audit concerning \$4 billion in questionable California Medical Assistance Program (Medi-Cal) payments that the Department of Health Care Services (Health Care Services) made from 2014 through 2017 because it failed to ensure that counties resolved discrepancies between the state and county Medi-Cal eligibility systems. Counties are generally responsible for determining Medi-Cal eligibility and for recording this information in their eligibility systems, which then transmit the beneficiaries' information and Medi-Cal eligibility to the State's eligibility system. Health Care Services uses the information from the State's eligibility system to determine the amount that it pays for Medi-Cal beneficiaries. Although Health Care Services has established a process for notifying counties of beneficiary records that require follow-up, gaps in this process allowed the problems we identified to persist.

Our statewide comparison of Medi-Cal beneficiary eligibility data identified pervasive discrepancies between the state and county systems. Specifically, our analysis of 10.7 million Medi-Cal beneficiary records from December 2017 revealed more than 453,000 beneficiaries marked as eligible in the State's eligibility system although they were not listed as eligible in the counties' eligibility systems for at least three months. Upon examining the data for these beneficiaries from 2014 through 2017, we found that 57 percent of these discrepancies had persisted for more than two years. Many of these discrepancies resulted from Health Care Services failing to ensure that counties had evaluated the Medi-Cal eligibility of beneficiaries transitioning from other programs. One reason counties failed to complete those evaluations promptly was because of the implementation of the federal Patient Protection and Affordable Care Act which created a backlog of Medi-Cal applications and eligibility redeterminations.

In addition to questionable payments, we identified more than 54,000 individuals who were not recorded as eligible for Medi-Cal in Health Care Services' system, even though the counties' records indicated that they were eligible. Because health care providers use Health Care Services' records to authorize care for beneficiaries, eligible individuals may encounter hardship when their eligibility status is not accurately reflected in Health Care Services' records. Further, there may be additional data discrepancies related to people who qualify for Medi-Cal benefits through other entitlement programs.

Respectfully submitted,



ELAINE M. HOWLE, CPA
California State Auditor

Selected Abbreviations Used in This Report

CalHEERS	California Healthcare Eligibility, Enrollment, and Retention System
CalWIN	CalWORKs Information Network
CalWORKs	California Work Opportunity and Responsibility to Kids
LRS	LEADER Replacement System
MEDS	Medi-Cal Eligibility Data System
Medi-Cal	California Medical Assistance Program
SAWS	Statewide Automated Welfare System
SSI/SSP	Supplemental Security Income/State Supplementary Payment

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Summary

Results in Brief

The Department of Health Care Services (Health Care Services) paid at least \$4 billion in questionable California Medical Assistance Program (Medi-Cal) payments from 2014 through 2017 because it failed to ensure that it provided benefits only to eligible beneficiaries. Medi-Cal offers two delivery models for health care services: managed care and fee for service. Health Care Services pays a managed care plan a monthly capitation payment (premium) to provide eligible services for a Medi-Cal beneficiary. More than 80 percent of Medi-Cal beneficiaries were in managed care plans as of January 2018. Under the fee-for-service model, which less than 20 percent of Medi-Cal beneficiaries use, medical providers bill Health Care Services directly for the services they provide to Medi-Cal beneficiaries. Of the \$4 billion in questionable payments, roughly \$3 billion were premiums paid to managed care plans. Of this, about \$700 million of those payments came from state funds. Health Care Services also paid medical providers nearly \$1 billion in questionable fee-for-service claims, a portion of which also came from state funds.¹

The key reason for these questionable payments is that Health Care Services failed to ensure that the counties resolved discrepancies between the state and county Medi-Cal eligibility systems. Counties are generally responsible for determining Medi-Cal eligibility and for recording this information in one of the three data systems—collectively known as the Statewide Automated Welfare System (SAWS)—which then transmit the beneficiaries' information and Medi-Cal eligibility to Health Care Services' Medi-Cal Eligibility Data System (MEDS). Health Care Services uses the information in MEDS to determine the amount that it pays for Medi-Cal beneficiaries. However, instead of actively monitoring identified eligibility discrepancies between the county systems and MEDS and then working with the associated county Medi-Cal office (county office) to ensure that the discrepancies are resolved, Health Care Services relies on county offices to address the discrepancies identified in automated reports from MEDS. However, we found that this process does not always resolve mismatches between state and county systems in a timely manner or at all in many instances.

We performed a statewide comparison of beneficiaries' eligibility in MEDS and SAWS data and found pervasive discrepancies between the systems. As Figure 1 on the following page shows,

¹ Because the data system Health Care Services uses to calculate the State's share of fee-for-service payments does not track this information by beneficiary, it was cost-prohibitive for us to determine the amount of state funds used to pay for these claims.

Audit Highlights . . .

Our audit of Health Care Services' Medi-Cal eligibility system highlighted the following:

» *Health Care Services paid at least \$4 billion in questionable Medi-Cal payments from 2014 through 2017 because it did not ensure that counties resolved eligibility discrepancies between the state and county Medi-Cal eligibility systems in a timely manner.*

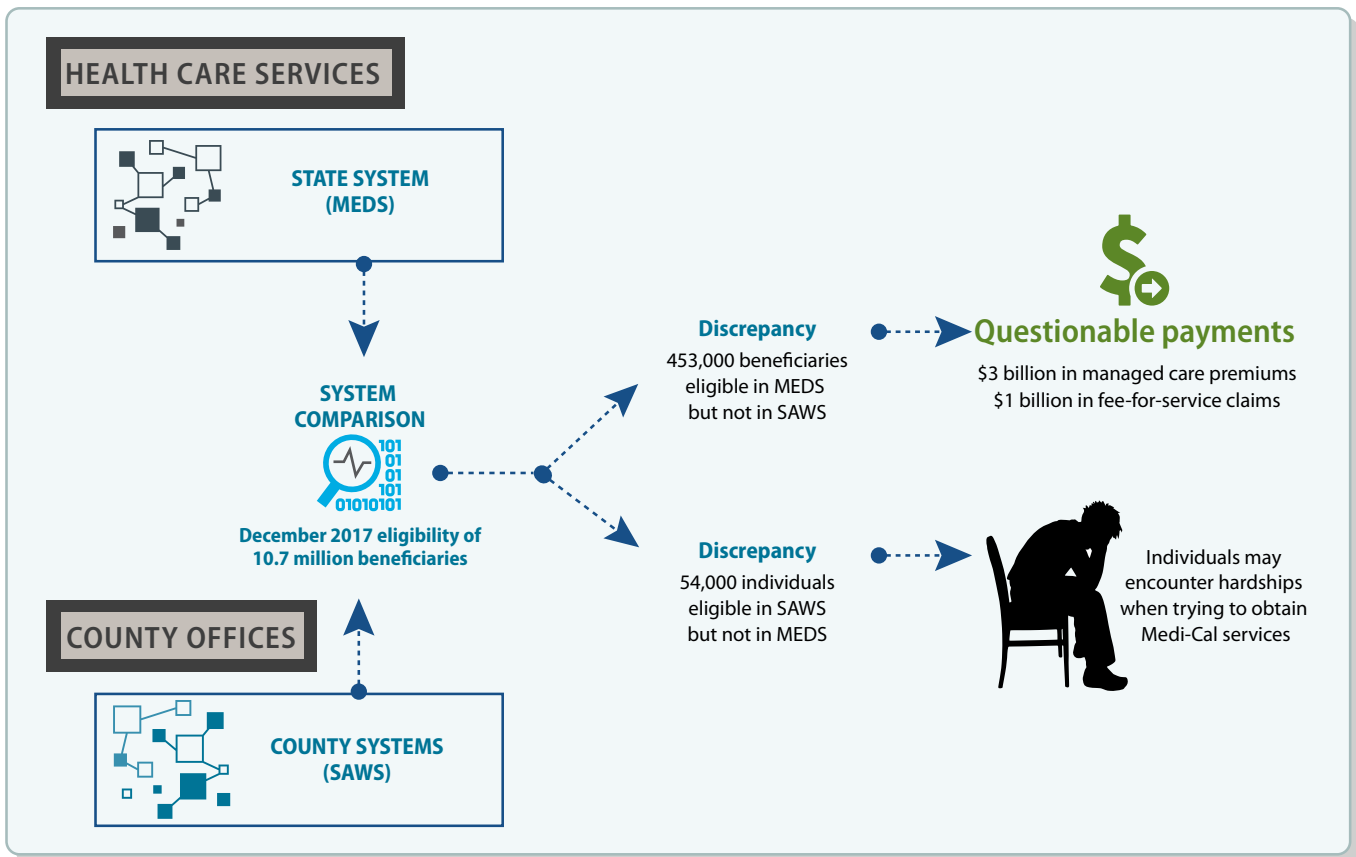
- *We compared Medi-Cal eligibility data in the state and county systems and found pervasive discrepancies. Our analysis of 10.7 million beneficiary records from December 2017 found more than 453,000 were marked as eligible in the state system but not in the county system for at least three months.*
- *We identified an instance in which Health Care Services paid a managed care plan more than \$383,000 for a deceased person who the county had discontinued in its system four years prior.*
- *Nearly 40 percent of the 453,000 discrepancies we identified were related to beneficiaries who had been given temporary eligibility status but whose cases had exceeded the permissible period for resolving their eligibility—many cases had exceeded the permissible period by at least three years.*
- *Because we identified beneficiaries with discrepancies from only one point in time—December 2017—and because we did not examine beneficiaries who were eligible for Medi-Cal through other entitlement programs, the monetary impact of the problem we identified could be greater than \$4 billion.*

continued on next page . . .

» *Health Care Services may be denying benefits to individuals who may be entitled to receive them because discrepancies have not been resolved—we found roughly 54,000 individuals whom counties designated as eligible but were not listed as eligible in the state system.*

our analysis of 10.7 million Medi-Cal beneficiary records from December 2017 revealed more than 453,000 beneficiaries marked as eligible in MEDS although they were not listed as eligible in SAWS for at least three months. Upon examining the data for these beneficiaries from 2014 through 2017, we found that 57 percent of these discrepancies had persisted for more than two years. Because counties are generally responsible for eligibility determinations, SAWS likely contains the most up-to-date eligibility information. Nevertheless, Health Care Services bases payments to managed care plans and fee-for-service providers on information contained in MEDS. It is critical that Health Care Services ensures that MEDS has the most up-to-date information on eligibility because it pays managed care plans a monthly premium for an increasing number of Medi-Cal beneficiaries regardless of whether beneficiaries receive services.

Figure 1
Large Discrepancies Exist Between Health Care Services’ and Counties’ Medi-Cal Eligibility Records



Source: Analysis of the counties’ and Health Care Services’ eligibility data and Health Care Services’ payment data.

For example, we identified one instance in which a member of a beneficiary's household notified Los Angeles County in April 2014 that the beneficiary had died. Although the county discontinued the beneficiary's Medi-Cal eligibility in its system, it did not address—and Health Care Services did not ensure that it resolved—numerous notifications from MEDS indicating the need for further follow-up on this case. As a result, the beneficiary remained active in MEDS. Exacerbating this error further, Health Care Services transitioned this deceased individual from fee for service to a managed care plan for long-term care in November 2014 as part of an effort to increase the use of managed care plans. From then on, the State continued to pay monthly premiums for the deceased beneficiary until August 2018, shortly after our office notified Health Care Services and Los Angeles County of this error. In total, the State paid the managed care plan more than \$383,000 for an individual who Health Care Services should have known was no longer in need of services.

Of the roughly 453,000 discrepancies we identified, 170,000 were related to beneficiaries who had been given temporary Medi-Cal eligibility status but whose cases had exceeded the permissible period for resolving their eligibility. State law provides certain individuals with temporary Medi-Cal eligibility while their counties assess whether they continue to be eligible for Medi-Cal services. For example, when individuals are no longer eligible for certain entitlement programs, such as Supplemental Security Income/State Supplementary Payment, state law requires Health Care Services to ensure uninterrupted medical coverage for those individuals until the counties finish evaluating their Medi-Cal eligibility. To provide this coverage, beneficiaries are assigned temporary Medi-Cal benefits and then Health Care Services notifies the counties that they must assess the beneficiaries' eligibility. Health Care Services typically expects this process of assessing eligibility to take from two months to a year, depending upon why the beneficiary is receiving temporary benefits. However, most of the 170,000 beneficiaries we identified had temporary eligibility status for Medi-Cal for more than one year beyond that time frame, and nearly 20,000 of these beneficiaries had temporary eligibility status for at least three years past the allowable time frame. Because Health Care Services does not actively follow up on counties' efforts to complete these eligibility determinations, it continues to make Medi-Cal payments related to these individuals without knowing whether they are eligible for program benefits.

In our review, we looked at discrepancies existing at a specific point in time—December 2017—and we did not examine beneficiaries who qualified for Medi-Cal through other entitlement programs that depend on MEDS for Medi-Cal eligibility determinations, such

as California Work Opportunity and Responsibility to Kids. Given these limitations, the monetary impact of the problem could be much greater than the \$4 billion we identified.

As Figure 1 indicates, we also found roughly 54,000 individuals whom counties designated as eligible for Medi-Cal but who were not listed as eligible in MEDS. Because health care providers use MEDS to authorize care for beneficiaries, these individuals may have experienced hardships in accessing health care services, as they would have been denied benefits until the system discrepancies were resolved. Health Care Services places highest priority on resolving system errors in which individuals are denied benefits. This may be one reason why we found fewer of these errors than we did errors in which Health Care Services paid for benefits for beneficiaries with uncertain eligibility. Nevertheless, unless Health Care Services takes a more proactive role in resolving data discrepancies between MEDS and SAWS, the State will continue to both deny benefits to potentially eligible individuals and make questionable Medi-Cal payments—a large portion of which will be paid to managed care plans for beneficiaries who may not be receiving services.

Selected Recommendations

To recover inappropriately spent funds, prevent future erroneous payments, and ensure eligible individuals' access to care, Health Care Services should resolve the discrepancies we identified and recover erroneous payments where allowable by June 30, 2019.

To prevent future erroneous payments, Health Care Services should implement procedures by December 31, 2018, to ensure the timely resolution of system discrepancies. These procedures should include Health Care Services regularly following up on recurring, unresolved system discrepancies with the responsible county.

Agency Comments

Health Care Services agreed with our recommendations and indicated that it plans to implement them. However, Health Care Services stated that it could not commit to implementing all of them within our recommended time frames.

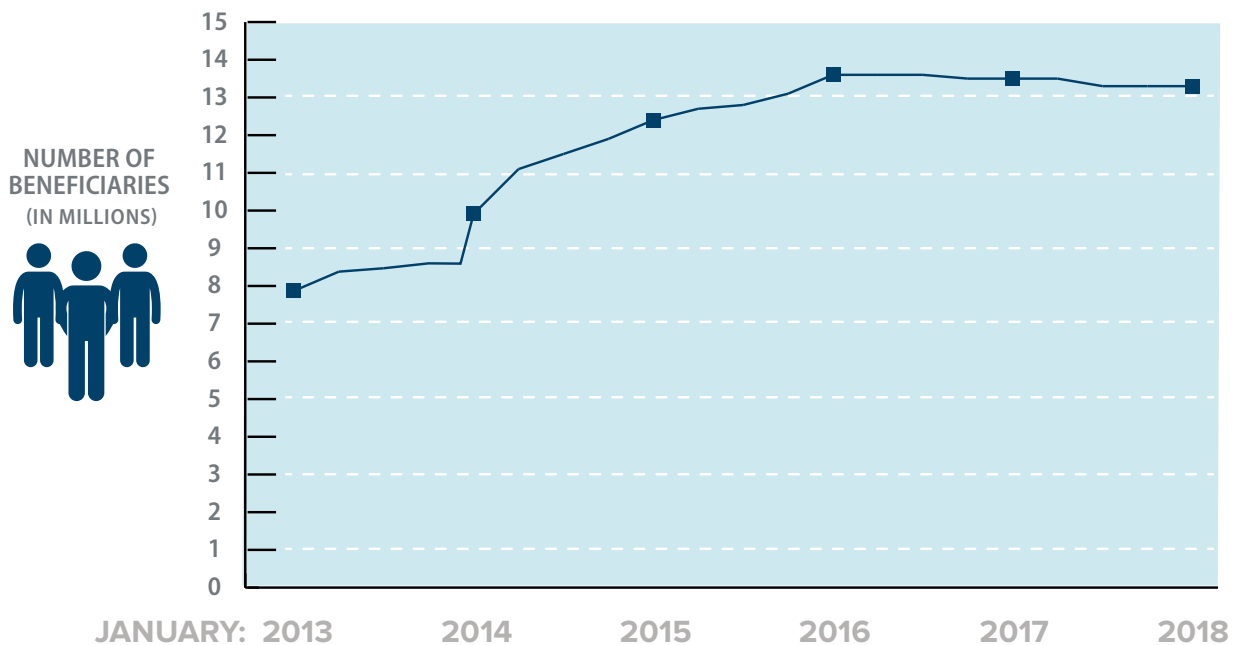
Introduction

Background

The federal Medicaid program provides funds to states to pay for the medical treatment for a variety of groups, including the aged, disabled, and people with low income. The State of California participates in the federal Medicaid program through its California Medical Assistance Program, known as Medi-Cal. Overseen by the Department of Health Care Services (Health Care Services), the program provides a safety net of health care services, such as hospitalization, preventive care, pregnancy services, emergency care, dental care, and mental health and substance abuse treatment. Medi-Cal provides these and other services as the payer of last resort for families with low income.

The transition of children previously covered by the state Healthy Families Program to Medi-Cal in 2013 and the enactment of the federal Patient Protection and Affordable Care Act (Affordable Care Act), which allowed California to expand eligibility to previously ineligible adults in 2014, were largely responsible for the expansion of Medi-Cal shown in Figure 2. As a result of these programs, the number of California residents enrolled in Medi-Cal increased from 8.6 million in December 2013 to 13.3 million in December 2017, a 55 percent increase. Although the number of enrolled beneficiaries stabilized in 2016, the current population of Medi-Cal beneficiaries now represents nearly one-third of the State’s total population and half of the State’s youth.

Figure 2
The Number of Enrolled Medi-Cal Beneficiaries Increased Rapidly but Then Stabilized
 January 2013 Through January 2018

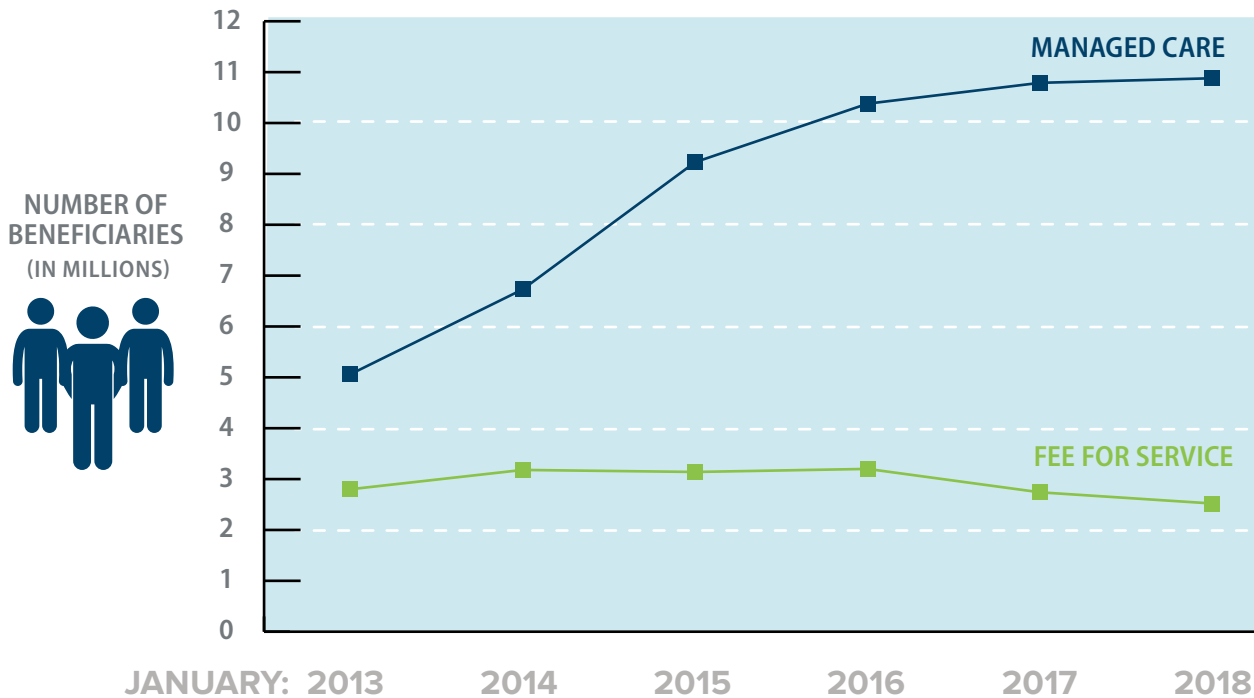


Source: Health Care Services’ Medi-Cal Management Information System/Decision Support System (MIS/DSS) data warehouse and Research and Analytics Studies Division.

Managed Care and Fee-for-Service Models

Medi-Cal benefits come in two forms: fee for service and managed care. Under fee for service, medical providers bill Health Care Services directly for approved services they provide to a Medi-Cal beneficiary. In managed care, Health Care Services pays a managed care plan a monthly capitation payment (premium) to provide eligible services needed for a Medi-Cal beneficiary’s health care. Health Care Services states that managed care is a cost-effective system that emphasizes primary and preventive care. Over the last five years, the number of beneficiaries who are on managed care plans has increased, while the number of beneficiaries in the fee-for-service model has decreased slightly, as Figure 3 shows. The increase in the use of managed care plans is a result of Health Care Services’ focus on shifting patients from fee for service to managed care plans as well as pushing to expand the managed care option to all California counties.

Figure 3
The Number of Beneficiaries in Managed Care Increased While Fee For Service Decreased
January 2013 Through January 2018



Source: Health Care Services’ MIS/DSS data warehouse; reports from Health Care Services and the Center for Medicaid and CHIP Services.

State Spending on Medi-Cal

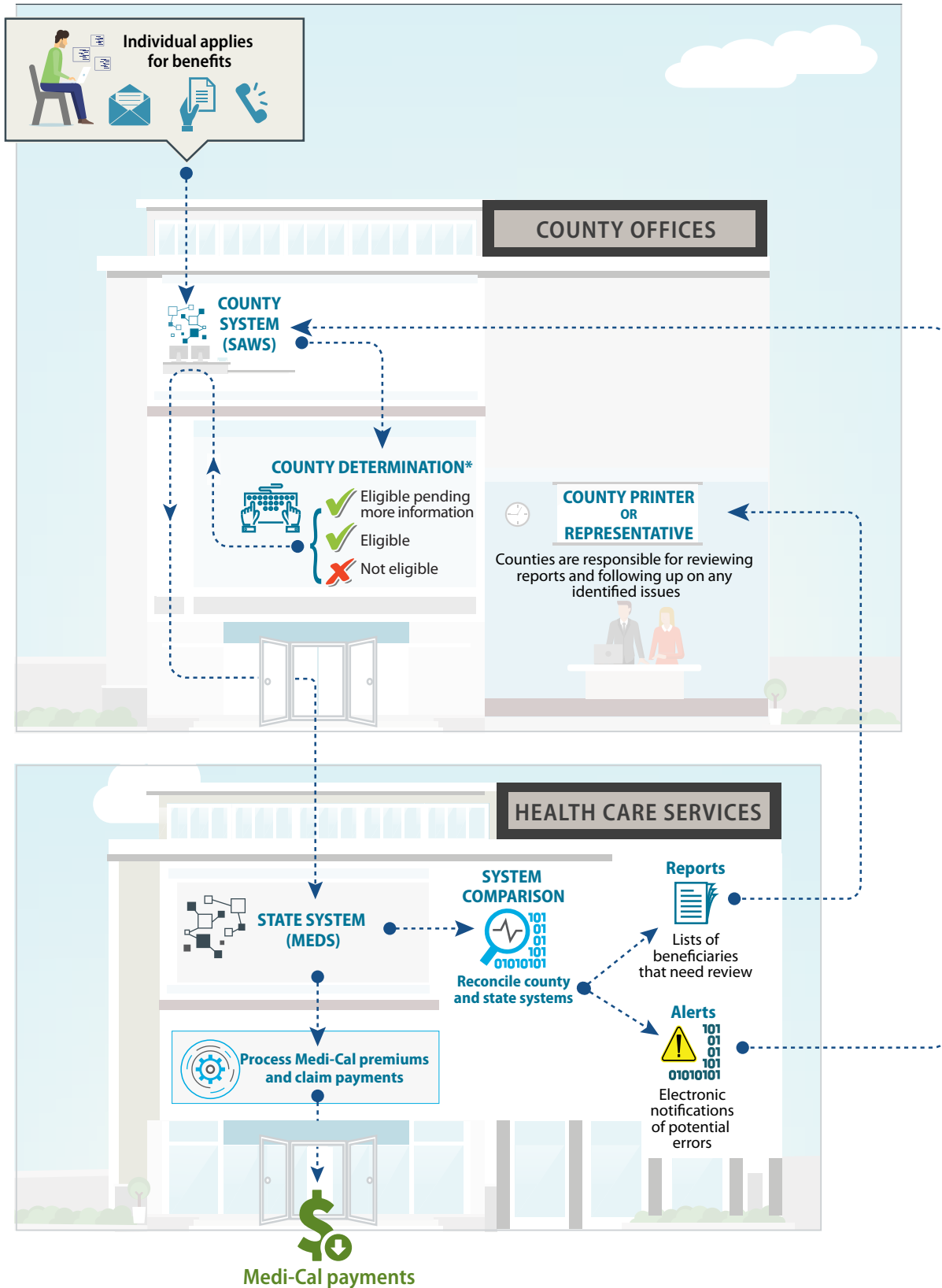
More than \$19 billion of the \$107 billion budget for Medi-Cal in fiscal year 2017–18 came from the State’s General Fund, representing nearly 16 percent of that fund’s total budget. Further, it is likely that the amount California spends on Medi-Cal will increase in the future. The federal government, which pays for the majority of the Medi-Cal program, began reducing the share of funding it provides for newly eligible beneficiaries at the beginning of 2017. The 2017 decrease brought the federal government’s share of the costs of certain health care services for newly eligible Medi-Cal beneficiaries down from 100 percent to 95 percent. This share will further decrease to 90 percent in 2020 and will remain at that level thereafter, driving up the State’s share of the cost. The Legislative Analyst’s Office estimates that by fiscal year 2020–21, the additional cost to the State’s General Fund for newly eligible beneficiaries will be around \$1 billion a year.

Health Care Services and County Medi-Cal Responsibilities

Health Care Services is the single state agency responsible for administering Medi-Cal. State law authorizes the agency to supervise every phase of the administration of health care services and medical assistance for which grants are received from the federal or state government. Although Health Care Services has overall responsibility for Medi-Cal, state law identifies each county’s welfare department as the agency responsible for administering Medi-Cal in its county. Figure 4 on the following page shows that counties perform critical aspects of Medi-Cal, such as processing applications for benefits and determining eligibility. In fiscal year 2017–18, Health Care Services paid counties \$2.3 billion for the local administration of Medi-Cal eligibility.

While counties generally make the Medi-Cal eligibility determination for beneficiaries, in a number of circumstances other entities can assign individuals temporary benefits or make the eligibility determination. For example, state law requires Health Care Services to provide temporary Medi-Cal coverage to children who are enrolled into Medi-Cal by qualified physicians, certain community clinics, or other entities. Additionally, if the federal Social Security Administration determines that an individual is eligible for Supplemental Security Income/State Supplementary Payment (SSI/SSP), the individual is also eligible for Medi-Cal.

Figure 4
Medi-Cal Beneficiary Information Flows Between Counties and Health Care Services



Source: Analysis of Covered California’s website, MEDS, MEDS Network User Manual, and the U.S. Department of Health and Human Services’ Office of the Inspector General’s February 2018 Report A-09-16-02023.

* If an individual applies for Medi-Cal through another entity such as Covered California, the individual’s eligibility may be determined before the information flows into the county’s system, where county workers are responsible for verifying the results of the eligibility determination.

Health Care Services is responsible for providing guidance as well as oversight to the counties on their administration of Medi-Cal. This oversight comes, in part, through automated alerts and reports from Health Care Services to each county as indicated in Figure 4. These notifications flag mismatches between the counties' electronic beneficiary records and those of the State. Each county uses one of three different electronic systems for its beneficiary records, referred to collectively as the Statewide Automated Welfare System (SAWS).

Process for Resolving Inconsistencies Between Health Care Services and the County Systems

As the state entity responsible for overseeing Medi-Cal, Health Care Services has relied on automated alerts and reports sent to the counties to ensure that both counties and the State have accurate information regarding each Medi-Cal beneficiary. Counties receive alerts when an automated process at Health Care Services, which compares information in its Medi-Cal Eligibility Data System (MEDS) to information in SAWS, identifies discrepancies between the systems. In addition to the automated alerts, Health Care Services provides counties with automated reports that summarize all the cases with eligibility discrepancies between the county and state systems. Health Care Services provides guidance to the counties stating that they should use these alerts and reports to resolve the identified eligibility issues. When a discrepancy exists, Health Care Services considers MEDS to be the system of record for a beneficiary's eligibility status, and it makes all payments based on the information in MEDS. Thus, unresolved system mismatches can cause the State to pay for benefits for an individual the county has determined to be ineligible.

Health Care Services' Status as a High-Risk Agency

The California State Auditor's Office (State Auditor) has identified Health Care Services as an agency with high-risk characteristics since September 2013 because of a variety of concerns, including the fact that it has not addressed recommendations related to our concerns with MEDS. In January 2018, we continued to designate Health Care Services as high risk. As part of that assessment, we found 83,000 beneficiaries receiving federal aid for the full scope of Medi-Cal services as of June 2017 whose eligibility was in question because their Social Security numbers had been unverified for more than 12 months—and an additional 10,000 beneficiaries with similar aid in June 2017 who had statuses that likely disqualified them from receiving such aid. In planning this audit, we had intended to

understand the extent and impact of our concern that Health Care Services is not verifying some eligibility qualifications for Medi-Cal beneficiaries, such as a beneficiary's Social Security number.

However, during our initial planning for the audit, we found beneficiaries whose eligibility statuses were inconsistent between the state and county systems. Specifically, we reviewed the eligibility of 60 beneficiaries in Los Angeles, Sacramento, and Stanislaus counties and found that four of the 60 beneficiaries were ineligible according to the county system and yet eligible according to Health Care Services' data. Meanwhile, in February 2018 the U.S. Department of Health and Human Services' Office of the Inspector General (federal Inspector General) issued an audit report that echoed our concerns that Health Care Services had made Medicaid payments on behalf of beneficiaries who did not meet federal and state eligibility requirements. Further, the federal Inspector General revealed that for the time period covered by its review, California did not have the system functionality to retrieve and use certain federal information to determine a beneficiary's eligibility for the full scope of Medicaid services. To avoid duplicating the work of the federal Inspector General, we focused our efforts on the inconsistencies between county and state systems rather than other eligibility problems.

Scope and Methodology

State law authorizes the State Auditor to establish a program to audit and issue reports with recommendations to improve any state agency or statewide issue that the State Auditor identifies as being at high risk for the potential of waste, fraud, abuse, and mismanagement or that has major challenges associated with its economy, efficiency, or effectiveness. State law also authorizes the State Auditor to require state agencies identified as high risk, or as responsible for all or a portion of a statewide issue identified as high risk, to periodically report to the State Auditor on the status of these recommendations for improvement.

In January 2018, the State Auditor issued its latest assessment of high-risk issues that the State and selected agencies face. Because we continue to include Health Care Services as a high-risk agency, we performed this audit of Health Care Services' beneficiary eligibility system. We list the audit objectives we developed and the methods we used to address them in Table 1.

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.	We reviewed relevant laws, rules, regulations, and other background materials.
2 Determine Health Care Services' role and responsibilities related to determining Medi-Cal eligibility.	We interviewed key staff at Health Care Services and at Los Angeles, Sacramento, and Stanislaus counties. We obtained and reviewed internal policies and procedures of these entities to gain an understanding of their role and responsibilities in determining Medi-Cal eligibility.
3 Assess Health Care Services' performance of its responsibilities related to Medi-Cal eligibility by identifying the internal controls established by Health Care Services to prevent fraud, waste, and abuse, and by testing these internal controls using a selection of Medi-Cal beneficiaries.	<ul style="list-style-type: none"> • We interviewed Health Care Services and county staff and reviewed applicable documentation to identify their key internal controls over the Medi-Cal eligibility verification process. • We obtained and reviewed documentation from Health Care Services that shows the criteria that MEDS uses to flag beneficiaries for follow-up. • We reviewed 20 cases at each of the three counties we visited—Los Angeles, Sacramento, and Stanislaus. We selected our cases from a population of beneficiaries whose Social Security numbers were unverified for more than 12 months, a population of beneficiaries without a Social Security number, and a population of potentially ineligible beneficiaries. We identified several instances of data mismatches between the counties' systems and MEDS as of June 2017. • As Appendix B details, we electronically compared Medi-Cal beneficiaries' eligibility information in MEDS to the information in county eligibility systems to identify cases in MEDS that did not match the county records. We focused our comparison on Medi-Cal beneficiary records that had a data mismatch in December 2017. We then used Health Care Services' payment data to identify claims and payments associated with these mismatched cases.

Source: Analysis of the information and documentation identified in the column titled *Method*.

Assessment of Data Reliability

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 our findings, conclusions, and recommendations. In performing this audit, we obtained Health Care Services' and the counties' beneficiary eligibility data. To evaluate these data, we performed electronic testing of the data, reviewed existing information about the data and systems, and interviewed agency officials knowledgeable about the data. We found the data to be sufficiently reliable for determining whom Health Care Services and the counties identified as eligible to receive Medi-Cal benefits. However, we did not evaluate the accuracy of these eligibility determinations.

Additionally, we obtained Health Care Services' Medi-Cal payment data. To evaluate these data, we performed electronic testing of the data, reviewed existing information about the data and systems, and interviewed agency officials knowledgeable about the data. However, we were unable to account for adjustments to the payments because Health Care Services does not track all adjustments at the beneficiary level. Therefore, we found the data to be of undetermined reliability for the purpose of identifying how much Health Care Services paid in Medi-Cal premiums and claims. Although this determination may affect the precision of the dollar amounts we present, there is sufficient evidence in total to support our findings, conclusions, and recommendations.

Audit Results

Health Care Services Made Questionable Payments Amounting to Billions of Dollars and May Have Prevented Some Individuals From Accessing Services

Health Care Services paid at least \$4 billion in questionable Medi-Cal payments from 2014 through 2017 because it failed to ensure that it was providing benefits only to eligible beneficiaries. We performed a statewide comparison of Medi-Cal beneficiary eligibility data and found pervasive discrepancies between the state and county systems. Many of these discrepancies resulted from Health Care Services failing to ensure that counties had evaluated the Medi-Cal eligibility of beneficiaries transitioning from other programs. Some counties may have failed to complete those evaluations promptly because the implementation of the Affordable Care Act created a backlog of Medi-Cal applications and eligibility redeterminations. In addition to questionable payments, we identified more than 54,000 individuals who were not recorded as eligible for Medi-Cal in Health Care Services' system, even though the counties' records indicated that they were eligible. Because health care providers use Health Care Services' records to authorize care for beneficiaries, eligible individuals may encounter hardship when their eligibility status is not accurately reflected in Health Care Services' records. Further, there may be additional data discrepancies related to beneficiaries who qualify for Medi-Cal benefits through other entitlement programs.

Health Care Services Recorded More Than 453,000 Beneficiaries as Eligible for Medi-Cal Although the Counties Had Not Confirmed Their Eligibility

Health Care Services paid at least \$4 billion in Medi-Cal payments for beneficiaries who may have been ineligible for Medi-Cal. Specifically, in reviewing the Medi-Cal beneficiaries in December 2017 and tracing their eligibility status over the previous four years, we found more than 453,000 beneficiaries in Health Care Services' MEDS who were not listed as eligible in SAWS. This problem spanned all three of the county eligibility systems that are part of SAWS and existed in each of the 58 counties, as detailed in Appendix A beginning on page 31.

Table 2 on the following page shows that the \$4 billion in questionable payments associated with these beneficiaries consisted of premiums paid to managed care plans and fee-for-service claims paid to medical providers. Health Care Services paid managed care plans roughly \$3 billion in questionable premiums, of which about \$700 million came from state funds. Health Care Services also paid medical

providers about \$1 billion in questionable fee-for-service claims, a portion of which also came from state funds.² As described in the Introduction, the federal share of Medi-Cal costs is scheduled to decrease over the next few years for some beneficiaries. Consequently, the State's share of Medi-Cal costs for these types of errors will likely increase in the future.

Table 2
Health Care Services Paid More Than \$4 Billion in Questionable Premiums and Claims
January 2014 Through December 2017

SAWS INFORMATION		BENEFICIARY INFORMATION (AS OF DECEMBER 2017)			QUESTIONABLE PAYMENTS (FROM JANUARY 2014 THROUGH DECEMBER 2017)		
COUNTY ELIGIBILITY SYSTEM	NUMBER OF COUNTIES USING THE SYSTEM	ELIGIBLE BENEFICIARIES IN MEDS THAT WE REVIEWED*	BENEFICIARIES WITH QUESTIONABLE ELIGIBILITY	PERCENT	MANAGED CARE PREMIUMS	FEE-FOR-SERVICE CLAIMS	TOTAL
LEADER Replacement System	1	3,134,520	229,248	7%	\$1,532,680,994	\$585,660,939	\$2,118,341,933
CalWORKs Information Network	18	4,475,248	172,968	4	1,226,421,776	294,095,476	1,520,517,252
Consortium IV system	39	3,109,997	51,175	2	304,256,184	102,610,399	406,866,583
Totals	58	10,719,765	453,391	4%	\$3,063,358,954	\$982,366,814	\$4,045,725,768

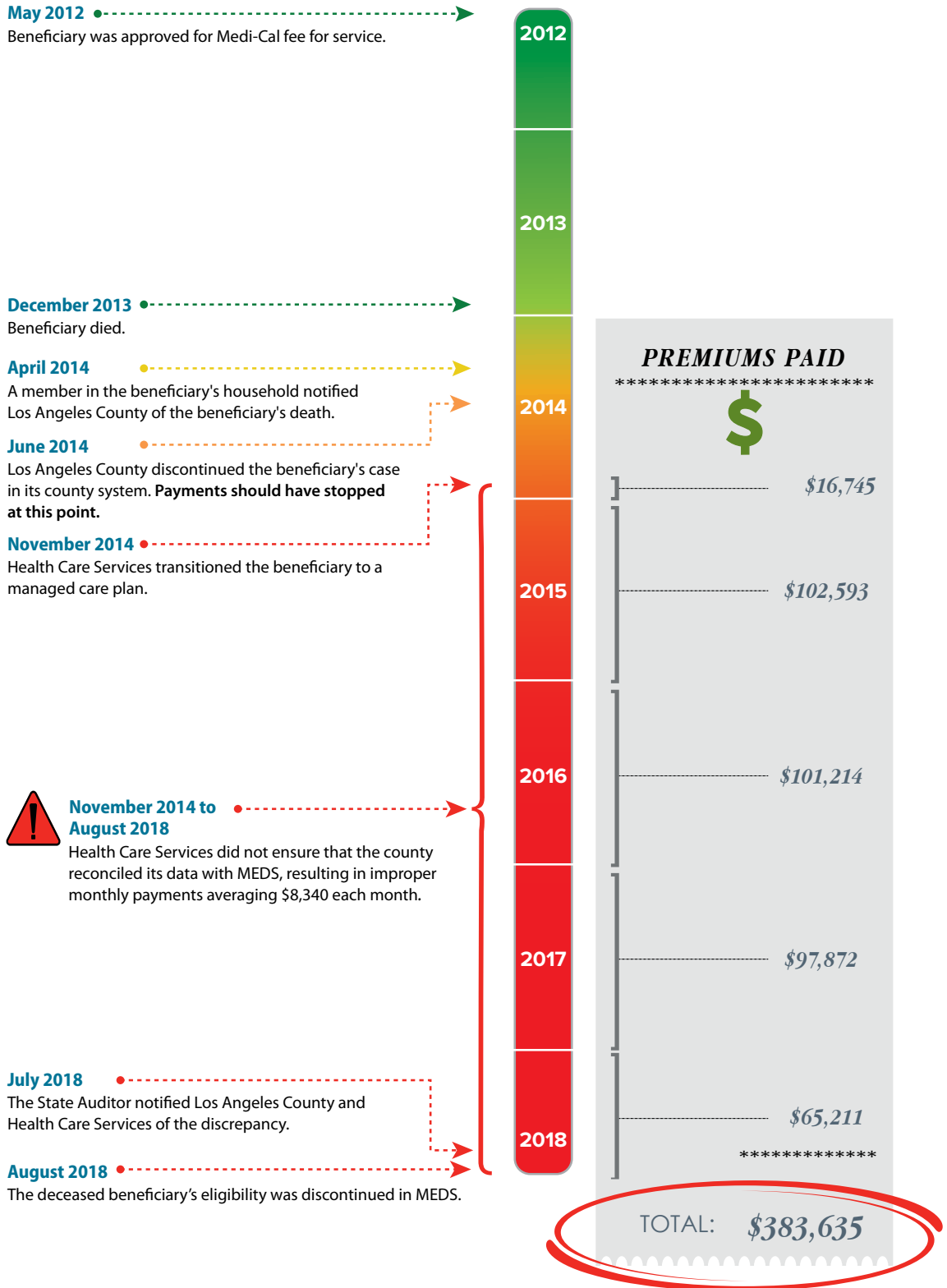
Source: Analysis of the counties' and Health Care Services' eligibility data and Health Care Services' payment data.

* Our review focused on 10.7 million of 13.3 million Medi-Cal beneficiaries who were eligible for Medi-Cal services. The difference in number of beneficiaries is, in part, attributable to our exclusion of beneficiaries who received Medi-Cal services through an associated entitlement program, such as CalWORKS. We describe the population included in our analysis further in Appendix B.

Because the premiums that Health Care Services pays for managed care continue whether the beneficiary uses the services or not, it is critical that Health Care Services works with counties to promptly resolve discrepancies between SAWS and MEDS. Although Health Care Services has a process for notifying counties of discrepancies between the two systems, in our review period it did not ensure that counties resolved these discrepancies. For example, Figure 5 illustrates a case in which an individual from a beneficiary's household notified Los Angeles County in April 2014 that the beneficiary had died. Although the county discontinued the beneficiary's case in its system in June 2014, the case remained active in MEDS. Further, the county did not address—and Health Care Services did not ensure that it resolved—numerous notifications from Health Care Services indicating the need to review this case. Exacerbating this error further, Health Care Services transitioned the deceased beneficiary from

² Because the data system Health Care Services uses to calculate the State's share of fee-for-service payments does not track this information by beneficiary, it was cost-prohibitive for us to determine the amount of state funds used to pay for these claims.

Figure 5
Health Care Services Paid More Than \$383,000 in Erroneous Premiums for a Deceased Beneficiary
From November 2014 Through August 2018



Source: Analysis of Health Care Services' and Los Angeles County's eligibility data, Health Care Services' payment data, and interviews with Health Care Services' and Los Angeles County's staff.

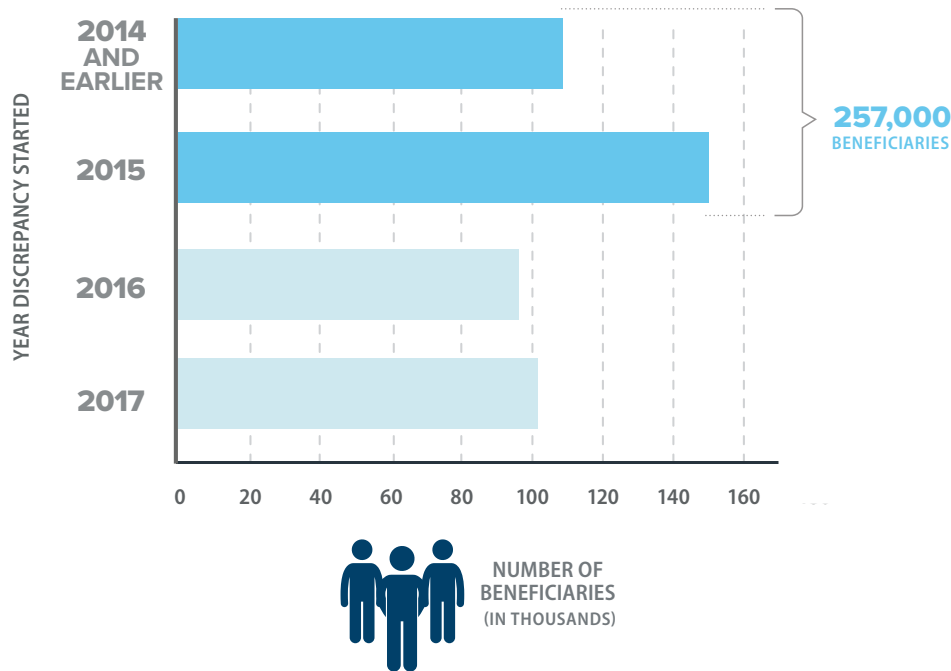
Over half of the discrepancies we identified between the counties' records and those of Health Care Services persisted for more than two years.

fee for service to managed care for long-term care in November 2014 as part of an effort to increase the use of managed care plans. Health Care Services continued to pay a monthly premium for the deceased beneficiary for nearly four years, until shortly after we notified Health Care Services and Los Angeles County of this error. In total, Health Care Services paid the managed care plan more than \$383,000 for a beneficiary whom it should have known was no longer in need of services. Health Care Services' standard contract with managed care plans contains language that would permit the recovery of premiums that the State paid for beneficiaries who are determined to be ineligible for specified reasons. Accordingly, Health Care Services has started the process to recover the funds it paid to the managed care plan after this person had died.

Many of the discrepancies we identified between the counties' records and those of Health Care Services persisted for years. In fact, about 257,000, or 57 percent, of the more than 453,000 beneficiaries we identified had discrepancies that continued for more than two years, as Figure 6 shows. Because county Medi-Cal offices (county offices) are generally responsible for eligibility determinations, SAWS likely contains the most up-to-date eligibility information. Nevertheless, payments to managed care plans and fee-for-service providers are based on information contained in MEDS. As described in the Introduction, in recent years Health Care Services has been expanding the use of managed care, for which it pays a premium whether beneficiaries receive services or not. Consequently, it is critical for Health Care Services to ensure that MEDS has the most up-to-date information on eligibility.

Although the average fee-for-service payments associated with the identified discrepancies cost less than the average amount paid for managed care premiums, discrepancies related to fee-for-service claims can represent significant costs. In one case, Health Care Services paid roughly \$1 million in fee-for-service claims for a beneficiary in Los Angeles County between June 2016 and December 2017 even though the county system showed that she was no longer eligible for services. The beneficiary's case notes from July 2016 indicate that the county was aware of a discrepancy between the county's system and MEDS, which showed her as eligible. Los Angeles County subsequently reviewed the case and confirmed that she was not eligible for Medi-Cal. Although Health Care Services had identified this discrepancy, it did not ensure that the county promptly addressed its notifications to review the case and continued to pay these fee-for-service claims. Without prompt resolution of identified discrepancies, Health Care Services cannot ensure that MEDS has the most up-to-date information on eligibility and consequently it may pay for costly services for which a beneficiary is ineligible.

Figure 6
Approximately 257,000 Beneficiaries Had Records With Discrepancies Lasting More Than Two Years
January 2014 Through December 2017



Source: Analysis of the counties' and Health Care Services' eligibility data.

Counties Did Not Always Determine Whether Beneficiaries With Temporary Medi-Cal Eligibility Were Actually Eligible for Medi-Cal

We identified 170,000 beneficiaries who, as of December 2017, had temporary Medi-Cal eligibility statuses that were past the permissible period for resolution. Under certain circumstances, state law provides people with temporary Medi-Cal eligibility while their county assesses whether they continue to be eligible for Medi-Cal services. For example, when a person is discontinued from SSI/SSP programs for exceeding income and property requirements, Health Care Services may not discontinue his or her coverage until the county makes a determination that he or she is no longer eligible for Medi-Cal benefits. Other circumstances in which state law directs Health Care Services to provide temporary Medi-Cal coverage include when children are enrolled into Medi-Cal by qualified hospitals, physicians, and certain community clinics or other entities. To provide this coverage, a person is assigned temporary Medi-Cal benefits, and then automated notifications and reports are sent to the county indicating that they must assess the person's eligibility. Once a county office completes the eligibility determination process, the county office either authorizes or discontinues the Medi-Cal eligibility.

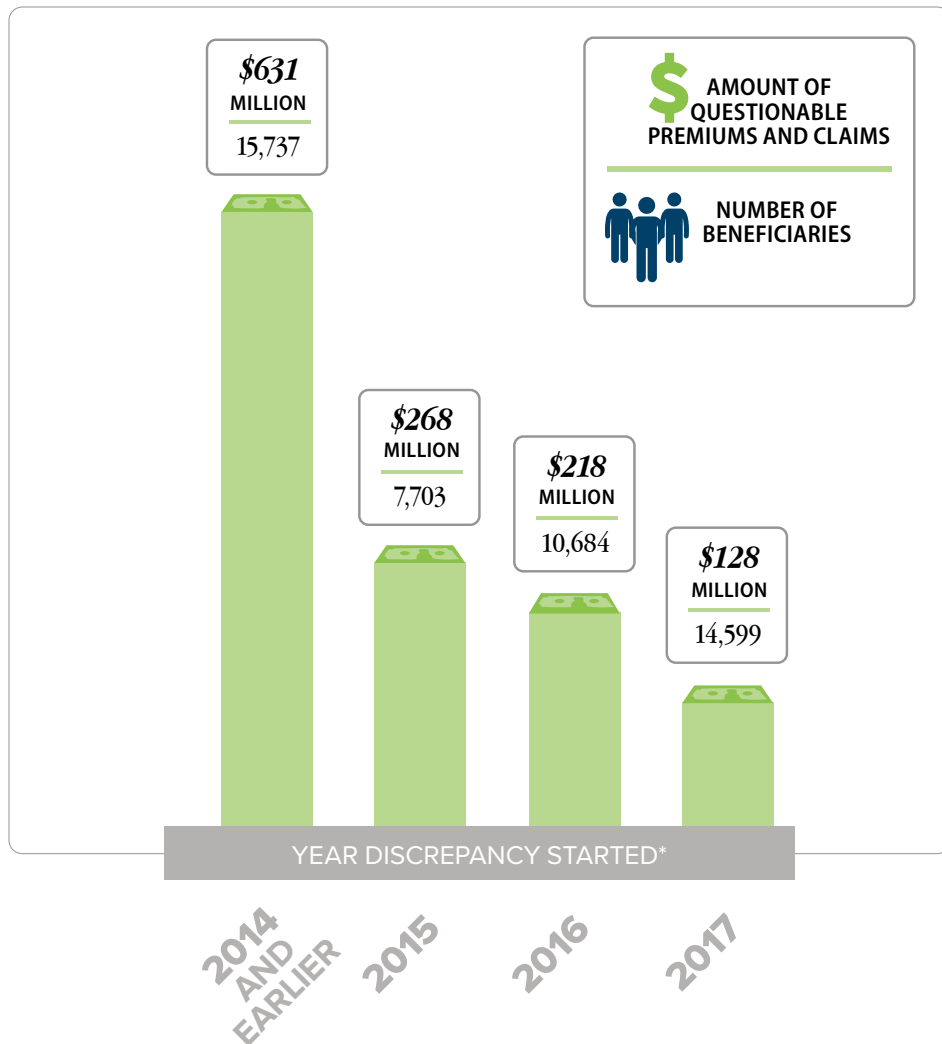
Health Care Services expects counties to complete a typical eligibility determination process within two months to a year, depending upon why the beneficiary is receiving temporary benefits. However, for the cases we reviewed, all of the counties in the State failed to complete this determination for at least some temporary Medi-Cal beneficiaries—and Health Care Services did not ensure that the counties determined their eligibility. While some of the individuals we identified will ultimately qualify for Medi-Cal, Health Care Services' failure to ensure that the counties promptly determined whether these individuals were qualified for Medi-Cal benefits creates an unnecessary risk that premium and claim payments will be made on behalf of people who do not qualify.

Although Health Care Services asserted that it is able to recover some improper payments, it may be unable to recover past payments for beneficiaries with temporary eligibility who are later determined to be ineligible because state and federal law generally guarantees this coverage for them. For example, state and federal law typically requires counties to first notify beneficiaries of any changes to their eligibility status before the counties can stop the beneficiaries' Medi-Cal benefits. However, if counties do not perform timely determinations of eligibility and then send these notices to temporary beneficiaries who do not qualify for Medi-Cal, Health Care Services may be unable to recover payments for them.

Most of the 170,000 beneficiaries we identified had temporary eligibility for Medi-Cal for more than one year beyond the allowable time frame.

Most of the 170,000 beneficiaries we identified had temporary eligibility for Medi-Cal for more than one year beyond the allowable time frame. In fact, more than 20,000 of these beneficiaries were at least three years past that time frame. The most prevalent temporary eligibility statuses were related to cases in which an individual was terminated from SSI/SSP but received temporary Medi-Cal benefits until the counties redetermined the individual's eligibility. Health Care Services expects counties to determine the Medi-Cal eligibility of a beneficiary transitioning out of SSI/SSP within three months. However, we found almost 50,000 beneficiaries who still had temporary Medi-Cal eligibility status four months or more after transitioning out of SSI/SSP, and on average counties had not reassessed the eligibility of these nearly 50,000 beneficiaries for more than two years. Further, Figure 7 shows that Health Care Services made payments totaling \$631 million for nearly 16,000 beneficiaries whose temporary eligibility status extended for more than three years past the allowable time frame. Because Health Care Services made these payments for beneficiaries who might not have qualified for Medi-Cal, we consider these payments to be questionable. In total, Health Care Services made \$1.2 billion in questionable payments for these beneficiaries.

Figure 7
 Health Care Services Paid More Than \$600 Million for Beneficiaries Who Were Transitioning From SSI/SSP
 for More Than Three Years
 January 2014 Through December 2017



Source: Analysis of the counties' and Health Care Services' eligibility data and of Health Care Services' payment data.

* Pursuant to the holding of *Craig v. Bontá*, beneficiaries losing SSI/SSP-based Medi-Cal for any reason other than death or incarceration must be reevaluated for eligibility before their benefits are discontinued. Health Care Services expects this process to take up to three months. Therefore, we consider beneficiaries as having eligibility discrepancies starting in the fourth month of temporary eligibility.

Beneficiaries who remain on a temporary eligibility status may accumulate significant costs to the State. Although Health Care Services paid an average of about \$12,000 for each of the 170,000 temporary Medi-Cal beneficiaries with discrepancies that we identified, in one example, Health Care Services paid

Health Care Services paid more than \$6 million in claims for a beneficiary transitioning from SSI/SSP whose county had not determined eligibility for two and a half years.

more than \$6 million in claims for a beneficiary transitioning from SSI/SSP whose county had not determined eligibility for two and a half years. According to Los Angeles County, it did not complete its evaluation of this beneficiary's eligibility within the mandated time frame for beneficiaries transitioning from SSI/SSP because of worker oversight and issues with Health Care Services' exception reports, which Health Care Services transmits to a county printer each month. Los Angeles County explained that this method of communication proves difficult because of recurring equipment malfunction and the cumbersome distribution of the paper referrals to the appropriate personnel. The county completed its determination in September 2018 and concluded that the beneficiary was eligible for Medi-Cal services at that time. However, the county's determination did not assess whether the beneficiary would have been eligible during the two and a half years when Health Care Services paid \$6 million for those services.

Although Health Care Services has a process for notifying counties of these temporary Medi-Cal beneficiaries, counties may not input the beneficiaries into their county systems. Specifically, Health Care Services provides counties with exception reports that counties can use to track beneficiaries with temporary Medi-Cal eligibility and the number of months the beneficiary has received temporary eligibility. However, there are limitations to these reports and Health Care Services did not follow up to ensure that counties resolved these cases, as we discuss later. Further, if counties do not use these reports properly, they may not create records for these temporary Medi-Cal beneficiaries in SAWS. Because payments to managed care plans and fee-for-service providers are based on information contained in MEDS rather than SAWS, Health Care Services may continue to make payments for these beneficiaries even though counties have not evaluated their eligibility.

Changes in Federal Law and System Issues Contributed to the Unresolved Discrepancies

The three counties we visited—Los Angeles, Sacramento, and Stanislaus—reported that some of the discrepancies resulted from the increase in their workload due to the implementation of the Affordable Care Act in 2014. All three counties stated that the number of Medi-Cal applications increased well above their historical averages after the Affordable Care Act became effective. Although Health Care Services noted that the counties' workloads started to stabilize by the end of 2016, it said that as of August 2018, counties were still working to resolve issues and exceptions created during the initial implementation of the act in 2014. According to Los Angeles County, because its eligibility processes are back to normal, it plans to start reviewing past cases.

Further contributing to the increased workload, the three counties noted that they experienced system difficulties related to the implementation of Covered California's and Health Care Services' California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) in 2014 and 2015. As part of its implementation of the Affordable Care Act, the State required counties to rely upon CalHEERS to determine the appropriate levels of Medi-Cal eligibility for some applicants. The counties asserted that system issues with CalHEERS hindered their ability to maintain accurate eligibility records during the system's implementation. Although the State developed an interim process in late 2014 to address some system issues, these issues prevented counties from performing basic tasks in CalHEERS, such as denying or discontinuing certain cases, because the system did not initially include this functionality. Health Care Services noted that in 2014 and 2015, CalHEERS required significant system modifications to accommodate policy changes and to interface with the counties' systems. Although some of these system modifications introduced new functionality, others altered existing functionalities that required counties to create manual processes. When we discussed the topic of CalHEERS' system issues with Health Care Services, it explained that CalHEERS has become more reliable and stable since 2014. Nevertheless, the discrepancies we found persisted until at least December 2017. As we discuss later, Health Care Services has started implementing a new process that it believes will reduce these kinds of discrepancies. However, if counties are unable to resolve discrepancies between the county systems and the State's system, Health Care Services may continue to incur questionable costs.

Finally, we found that one of the county systems had a system error that prevented it from reporting when certain beneficiaries were not eligible for Medi-Cal. Specifically, CalWORKs Information Network (CalWIN) sometimes continued to identify beneficiaries as eligible for Medi-Cal even though the counties had discontinued or denied the beneficiaries' eligibility. When we brought this to CalWIN's attention, its representatives explained that issues with the way CalWIN interacts with CalHEERS created this system error. In total, Health Care Services paid more than \$14 million in Medi-Cal premiums and claims from January 2014 through December 2017 for beneficiaries affected by this system error in December 2017. CalWIN plans to resolve the issue as part of a system update in February 2019; however, until then, this issue may continue to affect all 18 counties that use that system.

If counties are unable to resolve discrepancies between the county systems and the State's system, Health Care Services may continue to incur questionable costs.

In total, we identified more than 54,000 individuals in December 2017 who had been eligible for Medi-Cal at least three months, according to the counties' records, but Health Care Services' records did not show them as eligible.

Individuals May Have Been Inappropriately Denied Services

Because of unresolved discrepancies between Health Care Services and county records, some individuals may have been inappropriately denied Medi-Cal benefits. For example, Los Angeles County recorded one individual as being eligible for benefits beginning in May 2016, but Health Care Services' records did not show that individual as eligible. The county's case notes indicated that its system and MEDS had a conflict with the individual's identification numbers, an error that causes a barrier to receiving care. According to Health Care Services, MEDS shows that this individual was later recorded as eligible for Medi-Cal in January 2018. However, this discrepancy lasted for more than a year and the individual could have encountered barriers to care during that time. In total, we identified more than 54,000 individuals in December 2017 who had been eligible for Medi-Cal at least three months, according to the counties' records, but Health Care Services' records did not show them as eligible. Some of these discrepancies may be attributable to timing issues where counties retroactively corrected the individuals' eligibility records.³ However, these individuals could have experienced a barrier to medical care during the period when their records showed them as ineligible.

Although eligible individuals can ultimately obtain the Medi-Cal services to which they are entitled, these types of discrepancies in Health Care Services' records conflict with the department's mission. Specifically, Health Care Services states that its mission is to provide Californians with access to health care. With certain exceptions, state law gives the county of residence the responsibility for determining eligibility and providing ongoing case management; however, health care providers use Health Care Services' records to authorize care. Therefore, providers may deny individuals medical services until the discrepancy is resolved or may bill individuals directly for those services even though the county has approved them for Medi-Cal. Los Angeles County explained that for an individual to resolve this type of error, he or she would have to contact the county, which would then make arrangements for updating MEDS. When Health Care Services and the counties leave these Medi-Cal eligibility discrepancies unresolved, individuals may encounter hurdles to obtain the services to which they are entitled.

³ Because we received the counties' data after the date that we received MEDS data from Health Care Services, some of the counties' recent changes giving an individual retroactive eligibility may not have existed in the MEDS data we reviewed.

There Could Be Additional Data Discrepancies in MEDS That Were Not Included in Our Review

The State uses MEDS to store eligibility information for all Medi-Cal beneficiaries, including those who receive Medi-Cal through other entitlement programs. For example, MEDS houses the Medi-Cal eligibility information for CalWORKs because CalWORKs recipients may also qualify for Medi-Cal benefits. MEDS also includes eligibility information for beneficiaries who qualify for Medi-Cal benefits based on their CalFresh eligibility. Until July 2017, California had a federal waiver to grant certain CalFresh participants Medi-Cal benefits without the need for an application or a determination for 12 months. Because payments to managed care plans and fee-for-service providers are based on information contained in MEDS, inaccurate eligibility information in MEDS could generate inappropriate Medi-Cal payments for these beneficiaries. However, we did not determine whether discrepancies existed for these beneficiaries because the scope of our audit excluded beneficiaries who are eligible for Medi-Cal through other entitlement programs. Many of the 2.6 million beneficiaries we excluded from our analysis received Medi-Cal through entitlement programs that are not under the oversight authority of Health Care Services. The text box lists some of the programs that we excluded from our review. Additionally, because of the amount of data needing review, we limited our analysis to beneficiaries with eligibility discrepancies in Medi-Cal as of December 2017. As further described in Appendix B beginning on page 33, our analysis and calculation of payments included only discrepancies that persisted for at least three months. Consequently, our estimates of questionable payments are conservative and the actual amount of questionable Medi-Cal premiums and claims paid by Health Care Services is likely greater than the \$4 billion we identified.

Some Programs That We Excluded From Our Review

- CalWORKs
- CalFresh
- SSI/SSP
- Foster Care
- Adoption Assistance

Source: Analysis of the counties' and Health Care Services' eligibility data.

Health Care Services Failed to Ensure That Counties Corrected Data Discrepancies

Although Health Care Services has established a process for notifying counties of beneficiary records that require follow-up, gaps in this process allowed the problems we identified to persist. Specifically, Health Care Services uses MEDS to identify temporary beneficiary records that require further follow-up and beneficiary records that have been discontinued in MEDS but are still eligible in SAWS. Health Care Services sends the results of this process to the counties in two ways: through MEDS alerts and exception reports. Health Care Services provides the SAWS administrators

with MEDS alerts data files that the administrators enter into their respective systems to notify county workers of discrepancies by flagging cases. Exception reports, on the other hand, exist outside of the county systems and list beneficiaries who the counties need to review.

Although MEDS alerts are important, counties may not resolve all discrepancies if they only address the cases flagged by these alerts in their systems. For example, Stanislaus County eligibility workers do not typically continue to work on cases related to beneficiaries who have been discontinued in the county system, so they are unlikely to open these cases and thus encounter MEDS alerts for these beneficiaries. They also do not encounter MEDS alerts for beneficiaries who do not have a case in the county system to flag. Therefore, the exception reports that Health Care Services generates are a critical tool for counties to use in resolving the problems we identified.

In spite of the importance of exception reports in resolving costly eligibility problems, Health Care Services provides the reports to some counties in a format that limits their usefulness and that does not ensure that all counties receive or use the reports. For example, Health Care Services stated that it does not send the exception report containing temporary beneficiaries to four counties. Further, 26 counties receive Health Care Services' exception reports containing temporary beneficiaries in printed form only, as they are transmitted

to a printer at the county office. Los Angeles County, which accounts for 52 percent of the questionable payments we identified, stated that it takes roughly two weeks to manually process the voluminous monthly exception reports that Health Care Services sends to its printer. Beneficiaries listed in paper reports such as the one Figure 8 depicts cannot be sorted, filtered, or easily compared to earlier reports to enable workers to prioritize or monitor the timely resolution of eligibility issues. Health Care Services asserts that it transmits the rest of the exception reports containing temporary beneficiaries to the counties electronically, but the electronic files are simply text versions of the printed reports and are subject to the same limitations unless the counties process them further. Figure 9 shows an example of an exception report that Health Care Services sends to some counties.

Figure 8
An Example of a Printed Exception Report



Source: Los Angeles County photo of one exception report received via a county printer on August 28, 2018.

Figure 9
 Exception Reports Are Not User-Friendly

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      E E R E P O R T S T O F O L L O W
1 RS-MED331-R100 STATE OF CALIFORNIA RUN DATE: 06/26/2018
  RENEWAL MONTH: 07/2018 DEPARTMENT OF HEALTH SERVICES PAGE 1
      EXCEPTION ELIGIBLES TRACKING REPORTS
      RECIPIENT LIST

ORGANIZATION: COUNTY NAME
DISTRICT-WORKER: -
REPORT CATEGORY: XXX-CWD-CNTY

TOTAL
MONTHS CASE OR CLIENT NAME COUNTY-ID CIN BIRTHDATE
-----
013 DOE, JANE XX-XX-XXXXXXX-X-XX XXXXXXXXXX 01/1/1900
004 DOE, JANE XX-XX-XXXXXXX-X-XX XXXXXXXXXX 01/1/1900
002 DOE, JANE XX-XX-XXXXXXX-X-XX XXXXXXXXXX 01/1/1900

TOTAL NUMBER OF XXX-CWD-CNTY RECIPIENTS = 3
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1-RS-MED331-R100 STATE OF CALIFORNIA RUN DATE: 06/26/2018
  RENEWAL MONTH: 07/2018 DEPARTMENT OF HEALTH SERVICES PAGE 1
      EXCEPTION ELIGIBLES TRACKING REPORTS
      RECIPIENT LIST

ORGANIZATION: COUNTY NAME
DISTRICT-WORKER: -
REPORT CATEGORY: XXX-CWD-MEDS

TOTAL
MONTHS CASE OR CLIENT NAME COUNTY-ID CIN BIRTHDATE
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013 DOE, JANE XX-XX-XXXXXXX-X-XX XXXXXXXXXX 01/1/1900
013 DOE, JOHN XX-XX-XXXXXXX-X-XX XXXXXXXXXX 01/1/1900
013 DOE, JOHN XX-XX-XXXXXXX-X-XX XXXXXXXXXX 01/1/1900
013 DOE, JANE XX-XX-XXXXXXX-X-XX XXXXXXXXXX 01/1/1900
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Source: A redacted Health Care Services exception report.

When we followed up with Sacramento County, it asserted that it does not receive or use either the report containing temporary beneficiaries or the report containing beneficiaries with eligibility discrepancies. The county began using the data file containing MEDS alerts to generate its own tracking spreadsheet in 2018. Similarly, Stanislaus County does not use either of these reports. Until Health Care Services provides more useful reports to the counties to help them identify and prioritize the cases that require further review, the problems that we identified could continue to go unresolved.

In addition to identifying beneficiaries needing follow-up, Health Care Services has provided the counties guidance on how to prioritize alerts. However, this guidance has deemphasized the need to correct some eligibility errors and instead focused on ensuring beneficiaries' access to care as its highest priority. For example, Health Care Services categorized errors related to beneficiaries who are in MEDS but not in the counties' systems as the lowest priority—equivalent to notifications related to beneficiary zip code changes. Health Care Services describes notifications in this category as informational and requiring some review. When we followed up with Health Care Services about this prioritization, it explained that it is reconsidering how counties should prioritize notifications and that it anticipated updating its guidance in October 2018.

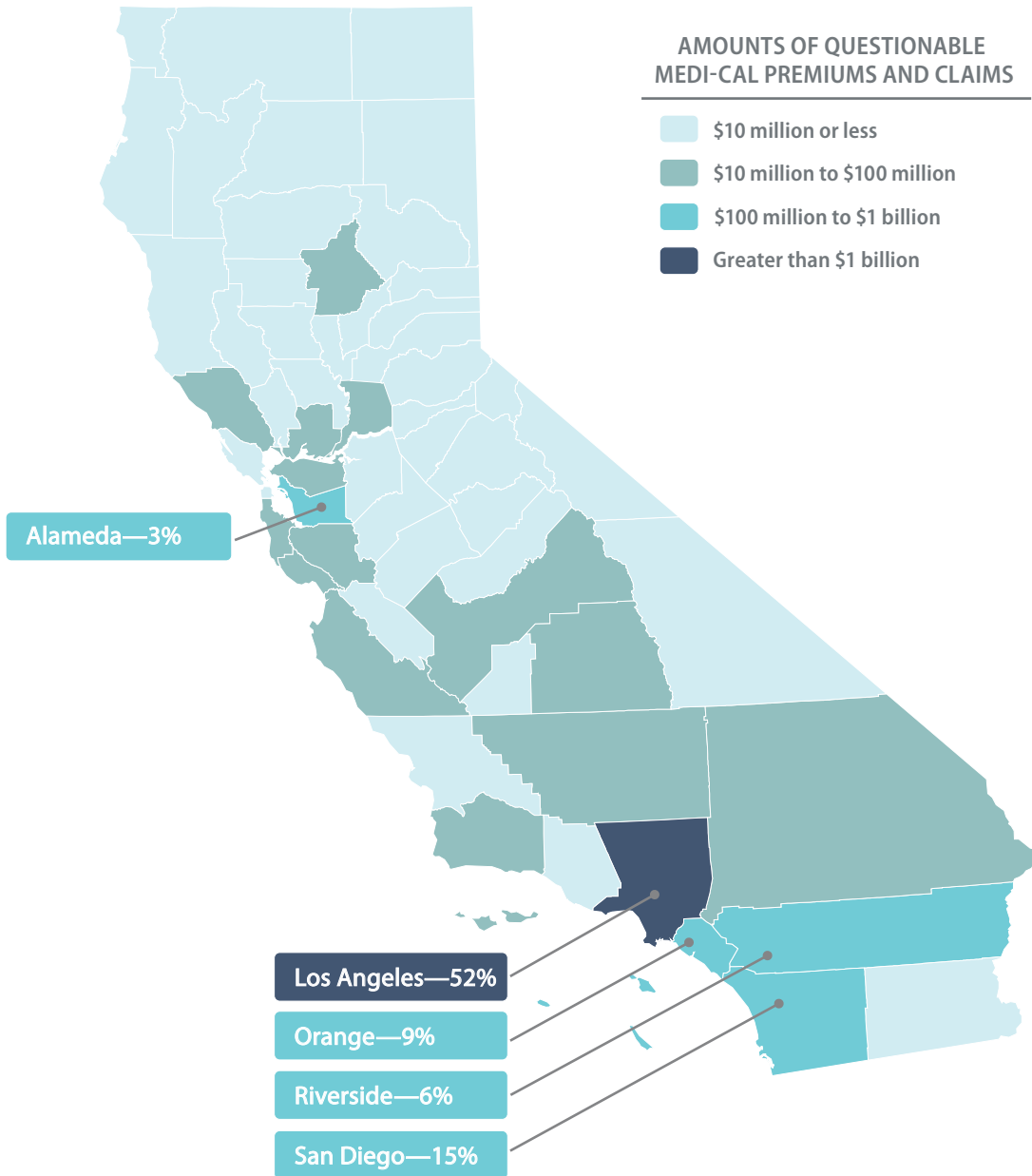
Health Care Services paid counties \$2.3 billion for the local administration of Medi-Cal eligibility in fiscal year 2017–18; however, despite this funding, it has not used its authority to ensure that the counties resolve discrepancies in a timely manner.

Further, Health Care Services paid counties \$2.3 billion for the local administration of Medi-Cal eligibility in fiscal year 2017–18; however, despite this funding, it has not used its authority to ensure that the counties resolve discrepancies in a timely manner. State law establishes county performance standards that, for example, require counties to resolve MEDS alerts affecting eligibility within approximately two months. However, Health Care Services took no action to identify which counties were out of compliance with these standards from 2014 through 2017. According to the standards, if Health Care Services finds that a county does not meet the stated time frame among other requirements, the county must submit a corrective action plan for approval. If Health Care Services finds that a county is not meeting improvement benchmarks specified in its corrective action plan and the county received a cost-of-doing-business increase from the State in that year, Health Care Services has the authority to sanction the county by reducing the funding that the county receives to administer Medi-Cal. After the county has made sufficient improvement, Health Care Services can restore the funding to the county. However, Health Care Services suspended the program it used to measure compliance with the county performance standards in February 2014 because of the difficulties that counties faced during the initial implementation of the Affordable Care Act. As such,

no counties submitted corrective action plans during our audit period. Health Care Services said that it is exploring whether it will sanction counties that do not remedy known discrepancies, and if they do, the process through which it would implement these sanctions. However, Health Care Services stated that it does not anticipate that it would start implementing sanctions until counties have the time to meet performance standards and submit corrective action plans if necessary.

Health Care Services finalized a plan in September 2018 to implement a new quality control process to monitor eligibility discrepancies and temporary beneficiaries. Portions of the plan were piloted in August 2018 and Health Care Services anticipates that it will implement the final portion of the plan in December 2018. This program will focus on, among other things, MEDS alerts that directly affect eligibility, beneficiaries with eligibility discrepancies, and beneficiaries with temporary eligibility that has persisted for more than 90 days. In pursuing these changes, we determined that Health Care Services could efficiently reduce the number and cost of eligibility discrepancies by focusing its efforts on the counties that pose the highest risk. For example, Figure 10 on the following page shows that 85 percent of the questionable payments we identified were attributed to just five counties: Alameda, Los Angeles, Orange, Riverside, and San Diego. If Health Care Services focused its initial efforts on these counties, it could address most of the questionable payments we identified.

Figure 10
Five Counties Were Associated With 85 Percent of the Questionable Premiums and Claims Paid By
Health Care Services
January 2014 Through December 2017



Source: Analysis of the counties' and Health Care Services' eligibility data, and Health Care Services' payment data.

Recommendations

To ensure that Health Care Services adequately monitors the counties' resolution of system discrepancies, the Legislature should require Health Care Services to report publicly on counties' compliance with the performance standards set forth in state law, as well as Health Care Services' actions taken in response to counties not complying with the standards.

To recover inappropriately spent funds, prevent future erroneous payments, and ensure eligible individuals' access to care, Health Care Services should resolve the discrepancies we identified and recover erroneous payments where allowable by June 30, 2019.

To prevent future erroneous payments, Health Care Services should do the following by December 31, 2018:

- Implement procedures to ensure the timely resolution of system discrepancies. These procedures should include Health Care Services regularly following up on recurring, unresolved system discrepancies with the responsible county.
- Establish procedures that define when it will use its authority as defined in state law to sanction unresponsive counties that do not remedy known discrepancies.

To assist counties in addressing discrepancies, Health Care Services should do the following by December 31, 2018:

- Find a cost-effective method to provide its exception reports in an electronic format readable by common database and spreadsheet software products that would allow users to sort and filter the data readily.
- Reevaluate and update its guidance to the counties related to prioritizing MEDS alerts.

We conducted this audit under the authority vested in the California State Auditor by Government Code 8543 et seq. 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
California State Auditor

Date: October 30, 2018

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For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at 916.445.0255.

Appendix A

HEALTH CARE SERVICES' PAYMENTS FOR BENEFICIARIES WITH QUESTIONABLE ELIGIBILITY BY COUNTY

Health Care Services paid at least \$4 billion in questionable Medi-Cal premiums and claims from January 2014 through December 2017 because it failed to ensure that it was providing benefits only to eligible beneficiaries. As the Audit Results discusses and Table A shows, we found more than 453,000 beneficiaries with eligibility discrepancies in Health Care Services' eligibility system when compared to the three systems counties use to track beneficiaries—CalWIN, Consortium IV system (C-IV), and the LEADER Replacement System (LRS). Further, our analysis identified questionable payments in all 58 counties and across both managed care and fee for service.

Table A
Health Care Services' Questionable Payments by County
January 2014 Through December 2017

COUNTY	COUNTY ELIGIBILITY SYSTEM	NUMBER OF BENEFICIARIES WITH QUESTIONABLE ELIGIBILITY	QUESTIONABLE PAYMENTS			PERCENTAGE OF TOTAL QUESTIONABLE PAYMENTS
			MANAGED CARE PREMIUMS	FEE-FOR-SERVICE CLAIMS	TOTAL	
Alameda	CalWIN	16,576	\$102,076,949	\$39,202,592	\$141,279,541	3.5%
Alpine	C-IV	18	111,776	3,198	114,974	0.0
Amador	C-IV	17	150,769	91,505	242,274	0.0
Butte	C-IV	1,269	8,674,341	1,885,072	10,559,413	0.3
Calaveras	C-IV	311	2,429,671	899,317	3,328,988	0.1
Colusa	C-IV	36	87,892	20,999	108,891	0.0
Contra Costa	CalWIN	7,920	49,935,252	33,879,863	83,815,115	2.1
Del Norte	C-IV	211	1,577,960	140,628	1,718,588	0.0
El Dorado	C-IV	105	616,193	87,021	703,214	0.0
Fresno	CalWIN	5,297	18,709,439	5,568,238	24,277,677	0.6
Glenn	C-IV	40	294,679	45,276	339,955	0.0
Humboldt	C-IV	79	318,614	231,436	550,050	0.0
Imperial	C-IV	550	3,353,730	710,360	4,064,090	0.1
Inyo	C-IV	16	43,300	181,053	224,353	0.0
Kern	C-IV	2,357	10,421,757	2,854,656	13,276,413	0.3
Kings	C-IV	163	779,034	327,911	1,106,945	0.0
Lake	C-IV	463	3,273,444	855,301	4,128,745	0.1
Lassen	C-IV	69	387,951	58,094	446,045	0.0

continued on next page...

COUNTY	COUNTY ELIGIBILITY SYSTEM	NUMBER OF BENEFICIARIES WITH QUESTIONABLE ELIGIBILITY	QUESTIONABLE PAYMENTS			PERCENTAGE OF TOTAL QUESTIONABLE PAYMENTS
			MANAGED CARE PREMIUMS	FEE-FOR-SERVICE CLAIMS	TOTAL	
Los Angeles	LRS	229,248	\$1,532,680,994	\$585,660,939	\$2,118,341,933	52.4%
Madera	C-IV	119	864,046	1,989,151	2,853,197	0.1
Marin	C-IV	827	8,859,327	627,725	9,487,052	0.2
Mariposa	C-IV	67	299,716	285,105	584,821	0.0
Mendocino	C-IV	748	3,748,953	2,149,447	5,898,400	0.1
Merced	C-IV	86	341,869	152,196	494,065	0.0
Modoc	C-IV	20	47,371	16,239	63,610	0.0
Mono	C-IV	112	504,847	399,282	904,129	0.0
Monterey	C-IV	2,563	18,387,622	3,430,382	21,818,004	0.5
Napa	C-IV	595	6,741,645	3,225,622	9,967,267	0.2
Nevada	C-IV	396	1,311,998	407,463	1,719,461	0.0
Orange	CalWIN	34,891	323,964,900	34,352,740	358,317,640	8.9
Placer	CalWIN	1,393	7,298,676	1,648,104	8,946,780	0.2
Plumas	C-IV	162	660,807	121,101	781,908	0.0
Riverside	C-IV	29,018	180,213,715	60,838,585	241,052,300	6.0
Sacramento	CalWIN	11,251	68,144,496	9,930,744	78,075,240	1.9
San Benito	C-IV	495	1,536,023	1,210,685	2,746,708	0.1
San Bernardino	C-IV	5,907	27,007,104	13,326,250	40,333,354	1.0
San Diego	CalWIN	70,080	474,787,181	130,309,308	605,096,489	15.0
San Francisco	CalWIN	366	1,377,952	1,496,221	2,874,173	0.1
San Joaquin	C-IV	1,747	6,954,016	985,090	7,939,106	0.2
San Luis Obispo	CalWIN	982	5,244,684	1,614,122	6,858,806	0.2
San Mateo	CalWIN	4,015	38,392,429	2,351,471	40,743,900	1.0
Santa Barbara	CalWIN	3,507	21,179,178	3,601,565	24,780,743	0.6
Santa Clara	CalWIN	3,931	32,825,284	8,542,892	41,368,176	1.0
Santa Cruz	CalWIN	1,240	9,838,597	5,370,235	15,208,832	0.4
Shasta	C-IV	70	420,248	1,960,819	2,381,067	0.1
Sierra	C-IV	24	122,038	24,143	146,181	0.0
Siskiyou	C-IV	400	2,047,409	570,499	2,617,908	0.1
Solano	CalWIN	3,784	36,185,927	3,590,391	39,776,318	1.0
Sonoma	CalWIN	2,009	8,882,768	4,753,208	13,635,976	0.3
Stanislaus	C-IV	768	4,558,082	1,247,585	5,805,667	0.1
Sutter	C-IV	555	3,193,302	312,170	3,505,472	0.1
Tehama	C-IV	65	171,574	35,906	207,480	0.0
Trinity	C-IV	33	161,649	76,513	238,162	0.0
Tulare	CalWIN	4,016	15,727,846	5,214,699	20,942,545	0.5
Tuolumne	C-IV	49	256,429	80,509	336,938	0.0
Ventura	CalWIN	901	5,596,056	1,954,286	7,550,342	0.2
Yolo	CalWIN	809	6,254,162	714,797	6,968,959	0.2
Yuba	C-IV	645	3,325,283	746,105	4,071,388	0.1
Totals*		453,391	\$3,063,358,954	\$982,366,814	\$4,045,725,768	100%

Source: Analysis of the counties' and Health Care Services' eligibility data, and Health Care Services' payment data.

* The percentage of total questionable payments does not total 100 percent due to rounding.

Appendix B

METHODOLOGY AND LIMITATIONS OF OUR REVIEW OF MEDI-CAL ELIGIBILITY DATA

To identify Medi-Cal beneficiaries with eligibility discrepancies between the State's and counties' data, we obtained Health Care Services' MEDS files covering the period from January 2014 through December 2017. We also obtained Medi-Cal eligibility data from the three county systems—CalWIN, LRS, and C-IV—for the same period. We then identified the beneficiaries whose eligibility status in the county systems was inconsistent with the MEDS records as of December 2017. Because of the volume of data related to Medi-Cal eligibility, we focused our review on a portion of the population that had eligibility discrepancies in December 2017. Specifically, we reviewed the history of eligibility for this population and limited our analysis to beneficiaries with discrepancies for consecutive months starting in December 2017 and going as far back as January 2014. To allow a reasonable time for Health Care Services and the counties to resolve the discrepancies, we excluded beneficiary records with eligibility discrepancies lasting for less than three months. Figure B on the following page depicts these and other beneficiaries who we did not include in our analysis—including beneficiaries who received Medi-Cal eligibility based on their eligibility for other entitlement programs, such as CalWORKs.

To calculate managed care premiums and fee-for-service claims associated with the beneficiaries whose eligibility was inconsistent between MEDS and the counties' systems, we obtained Health Care Services' Medi-Cal payment information. We then calculated the total amount Health Care Services paid for beneficiaries with eligibility discrepancies between the systems in December 2017 and in prior consecutive months. Because health care providers may continue submitting fee-for-service claims after the date of service, we included claims that were processed from January 2014 through February 2018. Although Health Care Services may have adjusted some payments, it was cost-prohibitive for us to calculate all of these adjustments because Health Care Services does not maintain all adjustment records for individual beneficiaries. Further, as noted above, our analysis did not include beneficiaries who qualify for Medi-Cal based on their enrollment in other entitlement programs; thus, our calculations do not include payments for these beneficiaries. Because our analysis focuses on a portion of the population that had discrepancies in December 2017, we have the most complete payment data for that month. For example, as Figure B describes in scenario 4, we did not include beneficiaries who only had discrepancies before our December 2017 starting point. Thus, additional discrepancies likely exist outside of the portion of the population that we reviewed. The total questionable

October 2018



JENNIFER KENT
Director

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



EDMUND G. BROWN JR.
Governor

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 responses to the draft findings of the California State Auditor's (CSA) report entitled, *Department of Health Care Services: It Paid Billions in Questionable Medi-Cal Premiums and Claims Because It Failed to Follow Up on Eligibility Discrepancies*. The CSA conducted this audit and issued four findings and five recommendations.

DHCS agrees with the findings and the recommendations and has prepared corrective action plans to implement them. DHCS appreciates the work performed by the CSA and the opportunity to respond to the findings. If you have any questions, please contact Ms. Nicole Jacot, External Audit Manager, at (916) 713-8812.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jennifer Kent'.

Jennifer Kent
Director

Director's Office
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Internet address: <http://www.dhcs.ca.gov>

* California State Auditor's comments appear on page 41.

Department of Health Care Services'
Responses to the California State Auditor Report Entitled: Department of Health
Care Services: It Paid Billions in Questionable Medi-Cal Premiums and Claims
Because It Failed to Follow Up on Eligibility Discrepancies
Report Number: 2018-603 (18-08)

- Finding #1:** Health Care Services made questionable payments amounting to billions of dollars and may have prevented some beneficiaries from accessing services.
- Recommendation #1:** To recover inappropriately spent funds, prevent future erroneous payments, and ensure eligible individuals' access to care, Health Care Services should resolve the discrepancies identified and recover erroneous payments where allowable by June 30, 2019.
- DHCS Agreement:** Fully Agrees with Finding
- Response:** The Department of Health Care Services (DHCS) agrees to review the discrepant records identified in the course of this audit. Due to the volume of records, DHCS cannot commit to resolving all discrepancies and recovering associated erroneous payments by June 2019, but does commit to demonstrating reasonable progress by this date.
- ①
- Implementation Status:** Fully Implemented:
Implementation Date:
 Not Fully Implemented:
Estimated Implementation Date: October 2019
 Will Not Implement
- Substantiation:** Attached (Fully Implemented)
 Not Applicable (Not Fully Implemented or Will Not Implement)
-

Finding #2: Although Health Care Services has established a process for notifying counties of beneficiary records that require follow-up, gaps in this process allowed the problems identified to persist.

Recommendation #2: To prevent future erroneous payments, Health Care Services should do the following by December 31, 2018:

Implement procedures to ensure the timely resolution of system discrepancies. These procedures should include Health Care Services regularly following up on recurring,

Department of Health Care Services'
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unresolved system discrepancies with the responsible county.

DHCS Agreement: Fully Agrees with Finding

Response: DHCS is in the process of implementing a quality control process that will identify system discrepancies. DHCS will work collaboratively with counties to ensure that these discrepancies are resolved in a timely manner.

Implementation Status: Fully Implemented:
Implementation Date:
 Not Fully Implemented:
Estimated Implementation Date: Winter 2018.
 Will Not Implement

Substantiation: Attached (Fully Implemented)
 Not Applicable (Not Fully Implemented or Will Not Implement)

Recommendation #3: To prevent future erroneous payments, Health Care Services should do the following by December 31, 2018:

Establish procedures that define when it will use its authority as defined in state law to sanction unresponsive counties that do not remedy known discrepancies.

DHCS Agreement: Fully Agrees with Finding

Response: DHCS will establish procedures that include administrative remedies to address county performance in resolving known system discrepancies, including corrective action plans and potential sanctions, as allowed under state law, for counties that are not making reasonable progress. DHCS cannot commit to implement such procedures by December 31, 2018, but does commit to having procedures established by July 1, 2019. This delay is needed as the department continues our work with the counties regarding their overall performance and establishing metrics by which to hold them accountable. These efforts include conducting onsite visits to all of the county offices which requires extensive

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Department of Health Care Services'
Responses to the California State Auditor Report Entitled: Department of Health
Care Services: It Paid Billions in Questionable Medi-Cal Premiums and Claims
Because It Failed to Follow Up on Eligibility Discrepancies
Report Number: 2018-603 (18-08)

coordination, time and needed follow-up as well as vetting the required procedures with counties.

Implementation Status: Fully Implemented:
Implementation Date:
 Not Fully Implemented:
Estimated Implementation Date: July 1, 2019.
 Will Not Implement

Substantiation: Attached (Fully Implemented)
 Not Applicable (Not Fully Implemented or Will Not Implement)

Finding #3: Health Care Services provides reports to some counties in a format that limits their usefulness and does not ensure that all counties received or used the reports.

Recommendation #4: To assist counties in addressing discrepancies, Health Care Services should do the following by December 31, 2018:

Find a cost-effective method to provide its exception reports in an electronic format readable by common database and spreadsheet software products that would allow users to sort and filter the data readily.

DHCS Agreement: Fully Agrees with Finding

Response: DHCS will pursue a multi-pronged approach to address this finding. DHCS will stop sending printed exception eligible reports to the counties and will work with our partners to ensure that the data is provided in an electronic format consumable and workable at the county level with a target phased completion by end of current fiscal year 18-19.

③

Implementation Status: Fully Implemented:
Implementation Date:
 Not Fully Implemented:
Estimated Implementation Date: June 2019
 Will Not Implement

Substantiation: Attached (Fully Implemented)

**Department of Health Care Services'
Responses to the California State Auditor Report Entitled: Department of Health
Care Services: It Paid Billions in Questionable Medi-Cal Premiums and Claims
Because It Failed to Follow Up on Eligibility Discrepancies
Report Number: 2018-603 (18-08)**

Not Applicable (Not Fully Implemented or Will Not Implement)

Finding #4: Health Care Services has provided the counties guidance on how to prioritize alerts. However, this guidance has deemphasized the need to correct some eligibility errors and instead focus on ensuring beneficiaries' access to care, as its highest priority.

Recommendation #5: To assist counties in addressing discrepancies, Health Care Services should do the following by December 31, 2018:

Reevaluate and update its guidance to the counties related to prioritizing Medi-Cal Eligibility Data System (MEDS) alerts.

DHCS Agreement: Fully Agrees with Finding

Response: DHCS cannot commit to issuing counties new MEDS alerts guidance by December 31, 2018. DHCS commits to issuing updated guidance to counties on how to prioritize MEDS alerts by April 30, 2019. The April 30, 2019 target implementation date provides DHCS with the time needed to work with external partners to identify all critical alerts that impact eligibility processing and to provide counties with updated policy and procedural guidance as a result of these efforts.

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Implementation Status: Fully Implemented:
Implementation Date:
 Not Fully Implemented:
Estimated Implementation Date: April 30, 2019.
 Will Not Implement

Substantiation: Attached (Fully Implemented)
 Not Applicable (Not Fully Implemented or Will Not Implement)

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Comments

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

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

We acknowledge that Health Care Services needs to review a large number of discrepancies we identified during the audit. However, because it will continue to make questionable payments and may prevent some individuals from accessing services until it resolves these discrepancies, we encourage Health Care Services to complete this work as close to our recommended date as possible. We look forward to Health Care Services' 60-day and six-month responses to the audit, which should detail its progress in resolving these discrepancies.

①

Health Care Services should not need to delay implementing this recommendation until it conducts on-site visits at all county offices and while it works with counties regarding their overall performance. Instead of waiting to complete these activities, Health Care Services should incentivize counties to correct known discrepancies and prevent future erroneous payments by establishing procedures by December 31, 2018, that define when it will sanction unresponsive counties.

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By setting a target completion date of June 30, 2019, Health Care Services is not prioritizing this recommendation. As we explain on page 24, exception reports are a critical tool to help counties resolve system discrepancies and prevent questionable payments. In addition, Health Care Services asserted that it already transmits exception reports to many counties electronically, thus it should be able to convert existing reports into a more useful electronic format and provide them to the counties by December 31, 2018.

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As we state on page 26, Health Care Services' current guidance deemphasizes the need for counties to correct some eligibility errors. In addition, Health Care Services previously stated that it anticipated updating its guidance regarding MEDS alerts priorities by October 2018. Therefore, Health Care Services should be able to update its guidance to the counties by December 31, 2018.

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