

California State Auditor

B U R E A U O F S T A T E A U D I T S

Department of Health Services:

*It Has Not Yet Fully Implemented
Legislation Intended to Improve the
Quality of Care in Skilled Nursing Facilities*



February 2007
2006-035

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CALIFORNIA STATE AUDITOR

ELAINE M. HOWLE
STATE AUDITOR

DOUG CORDINER
CHIEF DEPUTY STATE AUDITOR

February 15, 2007

2006-035

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 required by Chapter 875, Statutes of 2004, the Bureau of State Audits presents its audit report concerning the Department of Health Services' (Health Services) progress in carrying out the provisions of the Skilled Nursing Facility Quality Assurance Fee and the Medi-Cal Long Term Care Reimbursement Act of 2004 (Reimbursement Act). The Reimbursement Act required Health Services to implement a new reimbursement rate system that reimburses each facility that serves Medi-Cal beneficiaries based on its cost.

This report concludes that although Health Services promptly created the reimbursement rate and fee systems, it experienced an eight-month delay in calculating the new reimbursement rates and applying them to claims submitted by facilities. Health Services attributed some of this delay to specific tasks that Health Services had to accomplish before the new rate system could be put into effect. Also, Health Services is required to audit the costs reported by facilities, but has not yet fully met the auditing requirement. The Reimbursement Act also imposed a new fee on each facility to provide a revenue stream that would enhance federal financial participation in the Medi-Cal program. However, Health Services has not reconciled fee receipts to its record of anticipated collections. Conducting a reconciliation would help Health Services promptly identify facilities that are delinquent in the payment of the quality assurance fee (fee) or that may have paid an incorrect amount.

To develop the new reimbursement rate system, Health Services contracted with a consultant as allowed for by the Reimbursement Act. However, when we tried to replicate the reimbursement rate system, neither Health Services nor its consultant were able to provide a complete methodology used to develop the system. Until it can provide such a methodology, we cannot verify that the rates produced by the system are appropriate. In addition, we are concerned about Health Services' continued reliance on contracted services to maintain and update the new reimbursement rate system.

Health Services believes that even though the new reimbursement rate system will produce higher reimbursement rates, the cost of these increases will be offset by the new revenue stream of the fee and will result in a \$176 million savings to the General Fund over three fiscal years, ending with fiscal year 2007-08. However, Health Services' projected savings do not consider \$5.2 million in ongoing costs resulting from the implementation of the Reimbursement Act. Finally, between August 1, 2005, and July 31, 2006, Health Services' contractor responsible for receiving and authorizing payment of facility Medi-Cal claims, authorized over 2,100 duplicate payments totaling in excess of \$3.3 million.

Respectfully submitted,

ELAINE M. HOWLE
State Auditor

BUREAU OF STATE AUDITS

555 Capitol Mall, Suite 300, Sacramento, California 95814 Telephone: (916) 445-0255 Fax: (916) 327-0019 www.bsa.ca.gov

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SUMMARY

Audit Highlights . . .

Our review of the Department of Health Services' (Health Services) progress in implementing the Skilled Nursing Facility Quality Assurance Fee and Medi-Cal Long-Term Care Reimbursement Act (Reimbursement Act) revealed:

- Although Health Services promptly obtained federal approval for the reimbursement rate and fee systems, it was delayed in installing the new rates for Medi-Cal payments.*
- Health Services has not yet met all of the auditing requirements included in the Reimbursement Act, but has recently hired 20 additional auditors to meet the requirement.*
- Health Services has not reconciled the fee payments made by facilities to its record of anticipated collections.*
- Health Services believes the Reimbursement Act will result in General Fund savings. However, the savings projections do not consider \$5.2 million in ongoing costs prompted by the act.*

continued on next page . . .

RESULTS IN BRIEF

Currently, about 1,300 skilled nursing facilities (facilities) in the State provide services to patients covered by the California Medical Assistance Program (Medi-Cal), the State's Medicaid program. Until the passage of the Skilled Nursing Facility Quality Assurance Fee and Medi-Cal Long-Term Care Reimbursement Act (Reimbursement Act) in September 2004, facilities received reimbursements for Medi-Cal services based on a flat rate. The Reimbursement Act required the Department of Health Services (Health Services) to implement a modified reimbursement rate methodology that reimburses each facility based on its costs. In passing the Reimbursement Act, the Legislature intended the cost-based reimbursement rate to expand individuals' access to long-term care, improve the quality of that care, and promote decent wages for facility workers. The Reimbursement Act also imposed a Quality Assurance Fee (fee) on each facility to provide a revenue stream that would enhance federal financial participation in the Medi-Cal program, increase reimbursements to facilities, and support quality improvement efforts in facilities. This audit report discusses Health Services' progress in carrying out the provisions of the Reimbursement Act.

Health Services experienced delays in implementing the requirements outlined in the Reimbursement Act. Under the Reimbursement Act, Health Services must create a reimbursement rate system to calculate facility-specific, cost-based reimbursements as well as a system to calculate the fee rates within specified time frames. Although Health Services promptly created and obtained federal approval for the reimbursement rate and fee systems, it was slow to calculate the new reimbursement rates for each facility and apply the rates to Medi-Cal claims submitted by facilities. This delay caused facilities to receive lower rates during the eight months it took Health Services to calculate the new rate. The cost to Health Services in employee expenses to reprocess those claims using the new rates was \$7,000. However, the delay also had an impact on fee collections because the Reimbursement Act required facilities to pay the fee only after they started receiving the new, higher reimbursement rate.

Health Services did not follow sound contracting practices when it contracted with its consultant to develop a system to calculate rates.

Health Services was not able to provide the methodology underlying the reimbursement rate system. As a result, we could not verify that the system appropriately calculates rates. To make such a verification in a separate public letter, we asked Health Services to provide a complete and accurate methodology of the system within 60 days of this report's publication.

Neither Health Services nor its consultants formally document changes made to final reimbursement rates or to the reimbursement rate system.

Health Services' contractor responsible for receiving and authorizing payment for Medi-Cal claims, authorized over \$3.3 million in duplicate payments to some facilities for the same services.

Health Services and its contractor have begun the process of recouping the duplicate payments.

Health Services has not yet met all the auditing requirements included in the Reimbursement Act, having reviewed only about two-thirds of the State's facilities. When a facility reports costs, Health Services has an obligation to perform an audit to ensure that those costs are reasonable. If an audit reveals a discrepancy, Health Services must make an audit adjustment, which becomes the amount Health Services uses to develop the facility's reimbursement rate. When it does not audit facilities' reported costs, Health Services cannot be certain it is developing accurate rates. In fact, Health Services calculated approximately one-third of all facilities' reimbursement rates using unaudited cost data. Health Services stated that it did not have enough staff to conduct the required audits. To remedy this, the Department of Finance approved Health Services' request for 22 new audit staff. As of January 2007, Health Services had filled 20 of the audit staff positions and plans to fill the remaining positions by the end of fiscal year 2006–07.

Unlike reimbursements, the fee rate all facilities must pay is based on the revenue they report. However, Health Services has not reconciled its fee receipts to its records of anticipated collections. Before it started collecting fee payments, Health Services estimated each facility's annual reported resident days—the total number of days patients reside in a facility—and recorded the estimate in a database. With its fee payment, each facility reports actual resident days for the period and the total fee due. On receiving this information, Health Services records it in the database next to its estimates. However, Health Services had not reviewed these records and as a result it may not have collected all the 2004 fees due, with a shortage estimated to be as much as \$17 million, as of June 2006.

By reviewing its records of fee payments received alongside its estimates, Health Services could have promptly identified delinquent facilities. Instead, it waited several months to follow up on facilities that did not pay their fees. By August 2006, however, Health Services had taken steps to collect fee payments for 2004 by withholding Medi-Cal payments for delinquent facilities that submitted claims for Medi-Cal reimbursements or by blocking license renewals for facilities that were not participating in Medi-Cal.

Conducting a reconciliation would also help Health Services identify facilities that have incorrectly reported resident days. According to its policy, Health Services must investigate reported resident days that vary by more than 5 percent from

its estimate. Health Services cited a lack of sufficient staff as the reason for not reconciling its records. However, although Health Services has known for several years that it would likely require more resources to manage the increased workload, it waited until it drafted the 2006–07 budget change proposal to request additional staff. Since we are unable to determine what collections should have been until facilities report their days and the variances are investigated, we cannot reach a conclusion on the accuracy of Health Services' fee estimate. This highlights the importance of this reconciliation and the need for Health Services to follow up with the 325 facilities that reported significantly more or fewer resident days than anticipated.

Health Services believes that the new reimbursement rate system will result in a substantial savings to the State's General Fund. Specifically, it anticipated that the significant increase in reimbursement rates, as offset by the revenue stream provided by the new fee, will generate a total three-year savings to the General Fund of approximately \$176 million from August 1, 2005, through July 31, 2008, with the amount of savings decreasing in each year. However, when projecting these savings, Health Services did not consider several ongoing costs resulting from the implementation of the Reimbursement Act, such as an estimated \$4.2 million per year for additional employees hired to maintain the new system and \$1 million per year for contract costs. As a result, the projected General Fund savings may decrease even more sharply than expected each year.

To develop the new reimbursement rate system, Health Services contracted with a consultant. Although the Reimbursement Act allows contracting, we are concerned about Health Services' continued reliance on contracted services to maintain and update the new reimbursement rate model. Health Services anticipated taking over rate development but did not specify in the contract with its consultant a date for doing so. According to Health Services, high turnover in its rate development branch has impeded its ability to take over the system. As a result, Health Services continues to require the services of the contracted consultant.

Further, Health Services did not always follow sound contracting practices. The consultant it hired to provide advice and research related to reimbursement rate methodologies was responsible for developing the reimbursement rate system, even though development work was not included in the scope of the contract. Health Services should have included detailed

expectations in the contract for the final product. Additionally, it should have required the consultant to document the process used to build the system. Because it failed to include these details in the contract, Health Services does not have a blueprint of the system, leaving it vulnerable in the event of a system failure and at greater risk should the system fall short of Health Services' needs. In fact, when we attempted to replicate the reimbursement rate system that produced the fiscal year 2005–06 rates, neither Health Services nor its consultant were able to provide a complete methodology used to develop the system. Consequently, we could not verify that the rates produced by the system the consultant developed are appropriate. As a result, we have asked Health Services to develop and test formal, accurate and detailed documentation that includes all of the complexities of the rate development methodology within 60 days of this report's publication. Once we obtain this formalized methodology, we will test the reimbursement rate system to determine if it appropriately develops rates. When complete, we will issue a separate public letter that summarizes the results of our testing.

Neither Health Services nor the two consultants responsible for applying reimbursement rates to Medi-Cal claims and authorizing them for payment and for developing and administering the rate reimbursement system formally document changes made to the final reimbursement rates applied or changes made to the reimbursement rate system, which may leave Health Services vulnerable if such changes are later challenged.

Before the Reimbursement Act sunsets on July 31, 2008, the Legislature plans to review its overall impact. In its review, the Legislature may consider possible federal changes and quality-of-care issues as reported by the licensing division. The 2006–07 federal budget outlines proposed changes to the fee that, if approved, would affect the State's General Fund. These changes involve reducing the amount of the fee states could collect from 6 percent to 3 percent of facilities' total revenue.

The Reimbursement Act also requires that the licensing division prepare two reports that focus on quality improvements in facilities since the implementation of the Reimbursement Act. However, it does not require the licensing division to include information demonstrating the impact of the Reimbursement Act on the General Fund in these reports. Nevertheless,

we believe that including General Fund data in its reports would help the Legislature understand the full impact of the Reimbursement Act.

Finally, the Health Services' contractor responsible for receiving and authorizing payment of facility Medi-Cal claims, authorized paying some facilities more than once. Although this contractor was unaware that it was authorizing duplicate payments, we found more than 2,100 instances of such payments totaling over \$3.3 million since October 2005. Because the scope of this audit included only long-term care Medi-Cal payments for the 2005–06 fiscal year, we were unable to reach a conclusion as to whether the duplicate payments extended beyond the population we examined. Further, we cannot determine the magnitude of duplicate payments that might have been made to recipients that are not subject to the new rates. Health Services is currently investigating this issue and has begun taking corrective action.

RECOMMENDATIONS

To reduce the risk of using flawed data to calculate reimbursement rates, Health Services should conduct all the audits of facilities called for in the Reimbursement Act.

To ensure that it collects the Quality Assurance Fees (fees) it is entitled to, Health Services should take the following steps:

- Promptly initiate collection efforts for facilities that are delinquent in making their fee payments by either offsetting amounts owed against Medi-Cal reimbursements or levying a penalty against facilities that do not participate in Medi-Cal.
- Reconcile the fee payments made by facilities to the estimated payments due and follow-up on all significant variances.

To hold the consultant contracted by Health Services to the intended terms and conditions of the contract to develop and administer the reimbursement rate system, Health Services should take the following steps:

- Amend the contract to clearly describe the scope of work and to include a statement that Health Services will obtain the logic and business rules of the reimbursement rate system

and will receive training in how to use the system, as well as a specific date that Health Services will take over developing reimbursement rates for facilities.

- Include in its 60-day response to this audit report or sooner, formal and detailed documentation that includes all of the complexities of the reimbursement rate development methodology and evidence that the methodology, when used, produces the reimbursement rates Health Services published for fiscal year 2005–06.
- Follow best practices for contracting in the future by including clear language to describe the products or services it expects from the agreement.

To develop a mechanism to formally document changes, Health Services should take the following steps:

- Formalize a rate change process that documents the reason for a rate change and provides a notification of the rate change to its contractor responsible for authorizing payments.
- Formalize a change process that documents and records any changes either it or its contractor responsible for administering the system makes to the reimbursement rate system's programming language.

To ensure that its contract consultant authorizes the disbursement of Medi-Cal funds only to facilities entitled to them, Health Services should take the following steps:

- Further investigate the possibility that duplicate payments were authorized by the contract consultant beyond those we noted to ensure that the magnitude of the problem is identified and corrected. This would include researching all payment types authorized by the contract consultant since at least October 2005.
- Research and identify all the duplicate payments authorized by its contract consultant and recoup those payments.

AGENCY COMMENTS

Health Services generally agreed with our recommendations and has already taken some actions to address them. ■

INTRODUCTION

BACKGROUND

The Department of Health Services (Health Services) administers the California Medical Assistance Program (Medi-Cal), the State's Medicaid program. The Medi-Cal program is funded and administered through a state and federal partnership to benefit low-income people who do not have health insurance, including low-income families with children and persons on Supplemental Security Income who are aged, blind, or disabled.

The Long-Term Care System Development Unit and Long-Term Care Reimbursement Unit within Health Services conduct an annual study to develop the Medi-Cal rates for long-term care providers. That study serves as the basis for Medi-Cal reimbursements of approximately \$3 billion annually for skilled nursing facilities (facilities), intermediate care facilities for the developmentally disabled, hospice care, adult day health care, and home health agency services. The Long-Term Care Reimbursement Unit also conducts research to develop or revise reimbursement methodologies as needed to meet changing policy or program needs.

Approximately 1,300 facilities operate in California. As defined by the Skilled Nursing Facilities Quality Assurance Fee and Medi-Cal Long-Term Care Reimbursement Act (Reimbursement Act), a facility is licensed to provide care to patients who need skilled nursing care on an extended basis, as defined in Section 1250(c) of the Health and Safety Code. Some patients in facilities do not have the resources to pay for their care. For those patients, Medicare, which is a federal health insurance program for people age 65 or older, pays for up to 100 days of approved short-term care. A patient's net assets must fall within established limits to become eligible for coverage by the Medi-Cal program, which paid more than half the costs of care in facilities in 2002.

The Reimbursement Act, Chapter 875, Statutes of 2004, directed Health Services to implement a facility-specific system for setting reimbursement rates, subject to federal approval. The new reimbursement rate system must reflect the actual costs and staffing levels associated with quality care for facility residents and thus is intended to improve the quality of care

and accountability. The new reimbursement rates became effective August 1, 2005, and the Reimbursement Act will sunset July 31, 2008, unless the Legislature amends it.

In addition to the reimbursement rate system, the Reimbursement Act required Health Services to implement the Quality Assurance Fee (fee). Health Services calculates two fee rates, one for facilities with more than 100,000 resident days and the other for facilities with fewer than 100,000 resident days. These rates are based on the net revenue of all facilities subject to the fee. To calculate its fee, each facility multiplies the total number of days that patients were admitted to the facility, called resident days, by its fee rate. According to the Reimbursement Act, the fee serves to provide a revenue stream to enhance federal financial participation in the Medi-Cal program, increase reimbursements to facilities, and support quality improvement efforts in facilities. Health Services and the federal government share responsibility for Medi-Cal reimbursement payments to facilities. Overall, reimbursement rates increased under the Reimbursement Act, leading to increased payments by both the federal government and Health Services. However, the revenue generated from the fee offsets the impact for Health Services' portion of the payments.

The U.S. Department of Health and Human Services, Centers for Medicare and Medical Services (CMS), is the federal agency that provides regulatory oversight of Medi-Cal. CMS must approve any changes to Health Services' reimbursement plan before implementation.

SCOPE AND METHODOLOGY

The Reimbursement Act directs the Bureau of State Audits to review Health Services' new facility-specific reimbursement rate system. Specifically, it requires us to evaluate the progress Health Services has made in implementing the new system for facilities. It also directs us to determine if the new system appropriately reimburses facilities within specified cost categories and to identify the fiscal impact of the new system on the State's General Fund.

To evaluate whether Health Services has fully implemented the Reimbursement Act, we identified the laws, rules, regulations and policies relevant to the new facility-specific reimbursement system. We also reviewed the documents Health Services submitted to obtain federal approval for the new reimbursement

rates. Additionally, we spoke with officials in the Medi-Cal Rate Development Branch within Health Services and the company that Health Services contracted with to develop and implement the changes in the rate formula. Finally, to understand how implementing the system and applying the new rates have affected facilities, we conducted a survey asking them to describe problems or complaints related to the new rate. Of the 40 surveys we sent out, we received 28 responses, all indicating that they had no concerns about the new rates.

To determine if Health Services appropriately calculated the facility-specific reimbursement rates, we reviewed the reimbursement rate calculation system. For the purposes of our testing, we included only those facilities that provide standard skilled nursing services; we did not test the reimbursement rate calculation for the 28 facilities that provide subacute services. We conducted tests of the rate calculation system to determine if Health Services imported data correctly and if the system appropriately manipulated those data. To do this, we attempted to independently calculate the reimbursement rates, using the same cost data Health Services used, and compare the results with Health Services' published rates. To ensure that these rates were properly applied, we compared Health Services' published reimbursement rates to those its contractor, Electronic Data Systems (EDS), applied to Medi-Cal claims submitted by facilities. We repeated a similar process for the fee to establish whether Health Services had appropriately calculated the fee rates. We also examined its plan for collecting unpaid fees and attempted to examine Health Services' reconciliation of fee receipts.

In addition to attempting to test the new reimbursement rate system for proper rate calculation, we reviewed Health Services' reimbursement methodology to ensure that it included the cost components specified in the Reimbursement Act. We also evaluated the controls Health Services has in place to ensure the accuracy of the cost data that facilities submit. Finally, we obtained Health Services fee data and EDS payment systems' data. The U.S. Government Accountability Office, whose standards we follow, requires us to assess the reliability of certain computer-processed data. Based on our testing of Health Services' fee data, we determined it to be sufficiently reliable for the purposes of this audit. EDS' data, however, was of undetermined reliability because the data EDS provided was incomplete. EDS recognized that its system had a programming error that caused it to provide

the bureau only a portion of its data. However, we determined that using EDS' data for the purposes of this audit would not lead to an incorrect or unintentional message.

To evaluate the controls Health Services has for ensuring that data it receives are accurate, we spoke to officials within Health Services' Audits and Investigations Division (audits division). In addition, we obtained an understanding of the requirements and procedures used to audit skilled nursing facilities. To determine if it audited the minimum number of facilities as outlined in the Reimbursement Act, we tested the audits division's audit completion records for compliance. We also conferred with the audits division to obtain an understanding of the changes in its audit procedures, both completed and pending, to meet the requirement of the Reimbursement Act.

To analyze the impact of the Reimbursement Act on the State's General Fund, we used data supplied by Health Services and EDS to recalculate the total amounts it would have paid using the old rate methodology and compared them with the amounts Health Services actually paid using the new reimbursement rates. Additionally, we accounted for the new revenue stream for the General Fund resulting from fee collections. We also calculated other ongoing costs of the new reimbursement system, such as the total number of new employees hired to help maintain the reimbursement rate program, and calculated the total projected annual expense of those ongoing costs.

Finally, we evaluated relevant internal controls and assessed the risk that fraud, illegal acts, or violations of provisions of contracts or grant agreements occurred that could have significantly affected the audit objectives and results. To do this, we reviewed controls Health Services has in place to limit conflicts of interest, payments made to fictitious entities, and misrepresentations of resident or Medi-Cal days. Additionally, we looked into practices Health Services used to award the contract for development of the reimbursement rate system. ■

AUDIT RESULTS

THE DEPARTMENT OF HEALTH SERVICES HAS ONLY PARTIALLY IMPLEMENTED THE SKILLED NURSING FACILITIES QUALITY ASSURANCE FEE AND MEDI-CAL LONG-TERM CARE REIMBURSEMENT ACT

The Skilled Nursing Facility Quality Assurance Fee and Medi-Cal Long-Term Care Reimbursement Act (Reimbursement Act) required the Department of Health Services (Health Services) to establish a new cost-based reimbursement rate system in which each skilled nursing facility (facility) would be reimbursed for the cost of caring for Medi-Cal patients based on a rate specific to that facility. The Reimbursement Act specified a timeline that Health Services had to follow in establishing the new rates and gaining federal approval. Although it met the goals of the timeline, Health Services did not install the new rates to facilities until eight months after the legislated start date of August 1, 2005. As a result, Health Services paid facility claims from August 2005 to April 2006 using the old rates. After it adopted the new rates, Health Services reprocessed all the claims paid during the eight-month period during which facilities had been eligible for the higher rate. The cost to Health Services to reprogram its system and reprocess claims with the new rates was \$7,000.

Before passage of the Reimbursement Act, Health Services was required to conduct comprehensive audits of all facilities once every three years. Under the Reimbursement Act, Health Services must also perform limited-scope audits in the years between the comprehensive audits. Effectively, this requires Health Services' Audits and Investigations Division (audits division) to conduct annually some type of review on every facility's reported costs. However, for the 2005 rate year, the audits division was able to complete only about 66 percent of its audits.

As a result of an audit, Health Services may make an audit adjustment that directly affects a facility's reimbursement rate. A facility that Health Services does not audit, therefore, receives a rate based on information that has not gone through an audit. To make up for possible errors resulting from its use of unaudited cost data, Health Services applies an audit adjustment factor to the costs reported by the unaudited facilities. Health

Services calculates the audit adjustment factor for a facility by comparing that facility's reported and audit-adjusted costs for a previous year. Without a current audit, however, Health Services cannot be sure that it calculates accurate reimbursement rates for all facilities.

In addition to new rates, the Reimbursement Act established the Quality Assurance Fee (fee) to provide a new revenue stream for Health Services. Health Services was required to obtain federal approval of the fee and implement it by August 1, 2004, to initially raise the funds needed to establish the new reimbursement rate system and increase federal financial participation.

Health Services met the established timeline and promptly implemented the fee. However, it does not know if all facilities have paid the full amounts they owe because it has not reconciled its collection records against its own estimates of the fee that facilities should be paying.

Health Services Developed New Reimbursement Rates With the Help of a Contracted Consultant and Uses the Services of Another Contractor to Apply Those Rates

Unlike the previous reimbursement rate methodology, which increased rates through flat rate adjustments, the reimbursement rate methodology that Health Services developed is based on the actual costs each facility incurs. As part of the development

process, Health Services used the services of a consultant, which the Reimbursement Act specifically allowed, to develop the new reimbursement rate system. During our review, we determined that Health Services calculates reimbursement rates using the appropriate cost components, as described in the Reimbursement Act (see the text box).

Health Services uses two contractors to calculate and apply rates for the new reimbursement rate system. First, through one of its contractors, Navigant, Health Services imports into the reimbursement rate system the most recent data that facilities reported to the Office of Statewide Health Planning and Development (Health Planning and Development) for each of the cost components. Typically, the most recent costs available for rate calculation would be

from two years earlier. For example, Health Services' consultant developed its 2005 rates using 2003 cost data. The audits division

Cost Components Specified in the Reimbursement Act

- Direct and indirect labor costs (e.g., salaries and benefits for staff)
- Indirect nonlabor care costs (e.g., laundry and dietary costs)
- Administrative costs (e.g., allowable home office expenses)
- Capital costs (e.g., land and building costs)
- Direct pass-through costs (e.g., property taxes and liability insurance)

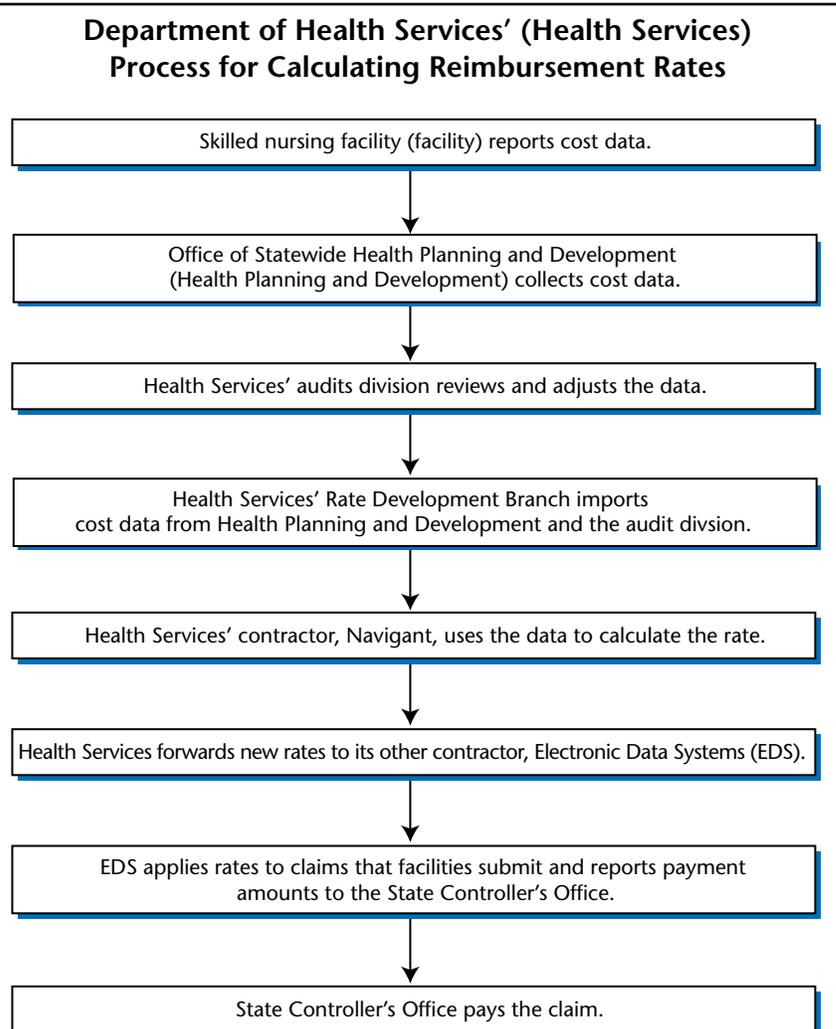
Source: Medi-Cal Long-Term Care Reimbursement Act, California Health and Welfare Institutions Code.

then reviews each facility and its associated cost reports to make any necessary audit adjustments. These audited amounts override the costs reported through Health Planning and Development. Navigant imports the audited numbers into the reimbursement rate system to calculate each facility's rate.

After developing the rates, Health Services forwards them to its second contractor—Electronic Data Systems (EDS), the State's fiscal intermediary. EDS loads the rates into its system and applies them to the Medi-Cal claims each facility submits. It creates a remittance advice detailing each facility's payments and forwards it to the State Controller's Office, which issues payments to the facility for the amount stated on the remittance advice.

Figure 1 summarizes Health Services' process for calculating reimbursement rates.

FIGURE 1



Source: Department of Health Services' Rate Development Branch.

Although Health Services Met the Legislated Deadlines for Obtaining Federal Approval of the New Reimbursement Rate System, It Did Not Promptly Apply the New Rates

Although Health Services received federal approval for the new rate methodology by the date specified in the Reimbursement Act, it did not start installing the new rates into the system until eight months later. Health Services sought approval of an amendment to the Medicaid State Plan for the facility-specific reimbursement rate system effective August 1, 2005, as specified in the Reimbursement Act. Effective February 1, 2005, Health Services submitted its amendment to the Centers for Medicare and Medicaid Services (CMS), describing the rate methodology changes affecting facilities. On September 9, 2005, CMS approved the amendment, to be retroactively effective August 1, 2005.

Although Health Services received federal approval of the new reimbursement rate system in September 2005, it did not implement the new rates until April 2006 because of important tasks it needed to complete first.

Health Services did not implement the newly approved reimbursement rate system until April 2006 because of other important tasks the department needed to complete before it could apply the new rates. For example, between October 2005 and April 2006, the department addressed about 300 individual requests from facilities in which the facilities questioned the new rates that the department had proposed. Also, before the department could apply the new facility-specific rates, it needed to first implement two rate increases for fiscal year 2004–05. Before passage of the Reimbursement Act, facilities did not receive their annual rate increase for fiscal year 2004–05. The Reimbursement Act, however, reinstated that increase and included a provision to increase reimbursements a second time for facilities assessed the fee in fiscal year 2004–05. A third rate increase occurred when Health Services implemented the facility-specific reimbursement rates as described in the Reimbursement Act. As part of implementing the Reimbursement Act, Health Services allowed facilities to review the facility-specific reimbursement rates and request rate reviews. Specifically, in a Medi-Cal update issued in October 2005, Health Services described the process a facility would take to request a rate review. The 300 requests mentioned earlier occurred as part of this rate review process.

When Health Services had completed the rate updates and reviews, it forwarded the new rates to EDS. In April 2006, EDS started applying the new rates. Because all claims that had been submitted as of that date in fiscal year 2005–06 were paid at the old rate, Health Services required EDS to reprocess all claims with dates of service between August 2005 and April 2006 to

ensure that facilities received the new rates. At a cost to the State of about \$7,000, EDS conducted an Erroneous Payment Correction to adjust for the claims that had been submitted and paid between August 2005 and April 2006.

As a result of receiving the new reimbursement rates, facilities that serve Medi-Cal patients received significantly more than they would have under the previous reimbursement rate methodology. Using actual payment data from fiscal year 2005–06, we estimated that facilities received nearly an additional \$289 million for Medi-Cal services rendered. Further, Health Services anticipates that reported costs will continue to increase, resulting in facilities receiving higher reimbursements each year.

Health Services Has Not Completed the Audit Requirements Established in the Reimbursement Act

Before the Reimbursement Act passed, the audits division was responsible for conducting a field audit for each facility at least once every three years. This responsibility became a requirement under the Reimbursement Act, which also mandated the performance of a desk audit every year between field audits, with the objective of each facility receiving some type of review each year. Although not requiring the same depth of review that a field audit does, the desk audit is designed to test the cost components outlined in the Reimbursement Act.

Health Services' audits division stated it was able to audit only about 66 percent of facilities for the 2005 rate year.

Health Services did not complete field or desk audits at all facilities before it developed the 2005 reimbursement rates. The audits division stated that it was able to audit, either through field or desk audits, only about 66 percent of facilities for the 2005 rate year. Consequently, Health Services did not review the 2003 Health Planning and Development data for 34 percent of the State's facilities. Because it failed to fulfill the audit requirement, Health Services had to estimate the costs of the facilities it did not audit. Given that 2003 costs were the basis for the 2005 reimbursement rates, Health Services needed to estimate each unaudited facility's 2003 costs based on the most current audited cost information available, which were 2002 costs. To calculate the rates using these audited data, Health Services applied audit adjustment factors to the 2003 data reported by the facilities not audited in 2003. The audit adjustment factors were created

Hypothetical Example of Audit Adjustment Factor Calculation

2002 audited direct labor cost	\$3,000	= 75 percent adjustment factor
2002 facility-reported direct labor cost	\$4,000	
2003 facility-reported direct labor cost	\$4,500	
Multiply audit adjustment factor from 2002	x 75 percent	
2003 direct labor cost used to develop reimbursement rate	\$3,375	

by dividing the 2002 “as audited” cost by the “as reported” cost (see the text box). Health Services then applied the audit adjustment factors to the unaudited 2003 data the facilities reported to Health Planning and Development.

The audits division stated that it was unable to complete all the audits because it did not have enough staff or time to do so. In a budget change proposal for fiscal year 2006–07, the audits division requested 22 new audit staff positions to meet the increased requirement. As of January 2007, Health Services had filled 20 of the audit staff positions and plans to fill the remaining positions by the end of fiscal year 2006–07. In the meantime, for the 2006–07 audit production year, Health Services anticipates completing approximately 80 percent of the required audits. Until it fills the necessary staff positions, Health Services will struggle to meet the audit requirements of the Reimbursement Act.

It is important that Health Services conduct both field and desk audits, not only because these audits are required by the Reimbursement Act but also because audited costs are used to develop the reimbursement rates. When developing the reimbursement rate system, Health Services determined that the audited cost numbers were more accurate than the unaudited numbers the facilities reported. As a result, any unaudited data used to develop rates could reduce their accuracy.

Health Services’ previous audit-tracking system did not differentiate between field audits and desk audits. As a result, Health Services could not consistently demonstrate its compliance with the requirement to conduct a field audit for each facility at least once every three years and a desk audit every year between field audits. To remedy this, Health Services recently changed its tracking procedure and system to distinguish between the two types of audits, but it has not yet decided what action it will take to identify the facilities that received field audits in fiscal years 2004–05 and 2005–06.

As required by the Reimbursement Act, Health Services developed a desk audit process it will use to audit facilities every year that a field audit is not conducted. This desk audit process is more limited in scope than the field audit process and does not require a site visit. Rather, facilities must submit the necessary records to the audits division for review to ensure that cost components are properly reported in accordance with the Reimbursement Act. However, in our review we noted that the desk audit process used in fiscal years 2004–05 and 2005–06 had removed most audit procedures that test key administrative components used to develop the reimbursement rates. Health Services updated its desk audit process in late 2006, but it is too early to determine if the new process will sufficiently review all cost components defined in the Reimbursement Act.

As Required by the Reimbursement Act, Health Services Established the Quality Assurance Fee

The Reimbursement Act mandated that Health Services develop a methodology to assess and collect fees to provide a revenue stream that would, among other things, increase reimbursements to facilities and enhance federal financial participation in the Medi-Cal program. It required Health Services to obtain approval of the fee rate methodology effective August 1, 2004. Health Services requested CMS approval of its levying of the fee on September 20, 2004, and CMS approved the implementation on June 14, 2005, specifying its effective date as retroactive to August 1, 2004.

Formula for Calculating the Quality Assurance Basic Fee (fee) Rate

$$\frac{\text{Facilities' Aggregate Net Revenue} \times 6 \text{ percent}^*}{\text{Estimated Total Resident Days of All Facilities}}$$

Source: Skilled Nursing Facility Quality Assurance Fee, California Health and Safety Code.

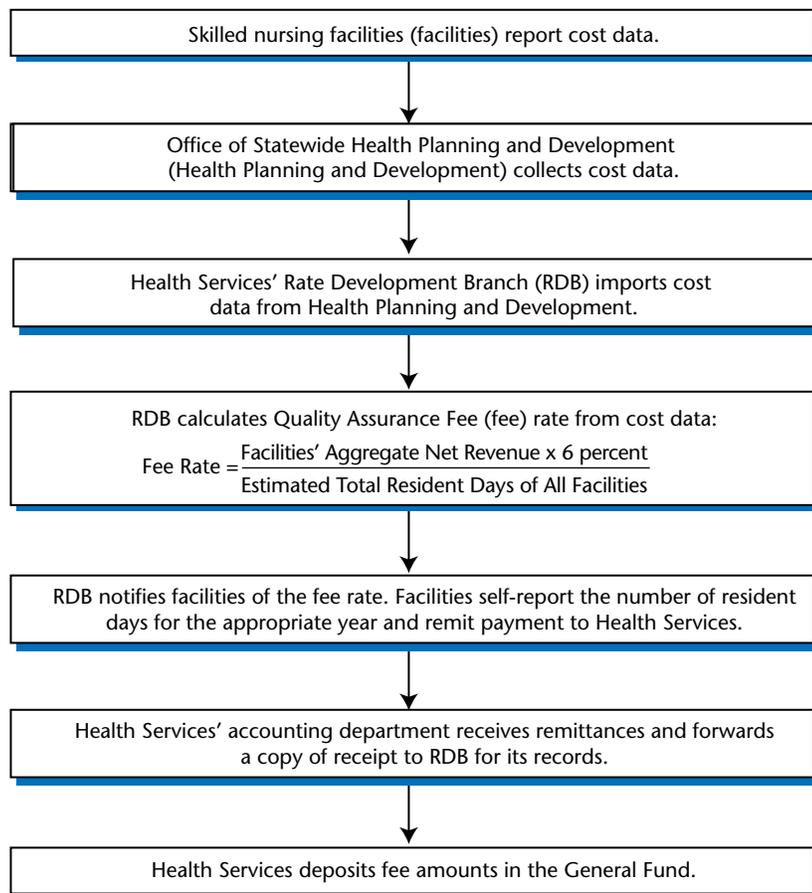
* The first year of the fee, 2004–05, the Reimbursement Act required the Department of Health Services to multiply facilities' net revenue by 3 percent. For all other years, the multiplier is 6 percent.

Although Health Services relied on its consultant, Navigant, to develop the reimbursement rate system and apply the new rates, it developed the system it uses to calculate the fee and track payments received. First, Health Services imports into its fee calculation system the cost data that facilities report to Health Planning and Development, which includes revenue and resident days. Then Health Services calculates a basic fee rate based on the aggregate net revenue of all facilities subject to the fee (see the text box). Health Services adjusts this basic rate to accommodate different-sized facilities, creating one rate for facilities with more than 100,000 resident days and another for facilities with fewer than 100,000 resident days.

After calculating the annual fee rate using the formula provided in the Reimbursement Act, Health Services sends each facility a letter notifying it of its rate. For example, for fiscal year 2005–06, facilities with fewer than 100,000 resident days received a letter specifying their fee rate as \$7.31 per resident day. Each facility is responsible for reporting its total resident days, calculating the total fee it must pay using the fee rate Health Services calculated, and remitting payment to Health Services’ accounting department using the fee remittance document included with the notification letter it received from Health Services. Health Services records the fee payments and deposits them in the State’s General Fund. This process is illustrated in Figure 2.

FIGURE 2

Department of Health Services’ (Health Services) Process for Calculating and Collecting Quality Assurance Fees



Source: Department of Health Services’ Rate Development Branch.

Health Services Has Recently Made Progress in Collecting Fee Payments Owed

When we began our review in June 2006, it appeared that Health Services may not yet have collected as much as \$17 million in fees estimated as being due from facilities in fiscal year 2004–05. When Health Services develops the annual fee rate, it also develops estimates of what it will collect. The estimates are based on resident days reported in Health Planning and Development data from a prior year multiplied by the fee rate. Health Services uses these estimates to help ensure it collects the proper amount of fees from facilities. In addition, these estimates provide Health Services with potential collection data.

Health Services has recently made progress in collecting fees. The Reimbursement Act states that if a facility fails to pay all or part of the fee within 60 days of the date the payment is due, Health Services may deduct the unpaid assessment and interest owed from any Medi-Cal reimbursement payments owed to the facility until the full amount is recovered. Because the Reimbursement Act also allowed facilities to postpone fee payments until they received the higher reimbursement rates, the latest date on which facilities could make fee payments for the fiscal year 2004–05 fee without being considered delinquent was in June 2006—60 days after EDS applied the new rates to facility claims for reimbursement. If a facility that is delinquent in paying its fee does not participate in Medi-Cal, Health Services can refuse to renew the facility's license until it pays the fee. Additionally, Health Services is allowed to assess a penalty of up to 50 percent of the unpaid fee amount to any facility that does not participate in Medi-Cal and fails to pay the fee. This option has not been used by Health Services. However, if facilities that do not participate in Medi-Cal knew that they could be charged such a substantial penalty, they might be motivated to pay the fee when due. At the time of our initial review, 88 facilities had not paid their fees for fiscal year 2004–05; and although Health Services had sent notices to delinquent facilities indicating that payments were due March 30, 2006, it did not start withholding Medi-Cal payments until August 2006.

In June 2006, Health Services had not yet collected fiscal year 2004–05 fee payments from 88 facilities. By November 2006, only 13 facilities still had not paid.

As of July 2006, Health Services stated that only 23 facilities still owed the fee. Of the 23 facilities, 11 participated in Medi-Cal and 12 were private facilities. Therefore, Health Services was able to withhold Medi-Cal payments from 11 of the nonpaying facilities. In June 2006, Health Services had issued final notices to these facilities, stating that if they did not pay, it would start

withholding Medi-Cal payments. According to Health Services, in August 2006, it began withholding Medi-Cal payments for some of the delinquent facilities. According to a discussion we had with Health Services, as of November 2006, it had collected payments from nine of the 11 facilities and is still pursuing payment from the remaining two. Health Services appears to be appropriately addressing collection efforts for these remaining facilities.

As we mentioned earlier, for private pay facilities, the Reimbursement Act allows Health Services to assess a penalty or deny license renewal, which occurs annually, until the facility meets its fee obligation. To ensure that the delinquent facilities' license renewals are denied until they pay the fees they owe, beginning in June 2006, Health Services initiated a process to withhold license renewals for the 12 private facilities that had not paid. As of November 2006, Health Services had collected unpaid fees for fiscal year 2004–05 from one of the 12 private facilities. This is a first step in Health Services' collection of approximately \$559,000 in fiscal year 2004–05 fees that have not been paid by private facilities.

The Reimbursement Act provides Health Services with another tool to encourage facilities that do not participate in Medi-Cal to pay delinquent fees. Specifically, Health Services may assess a penalty of up to 50 percent of the owed amount. For example, one facility that owes \$82,000 in unpaid fees could incur a penalty of an additional \$41,000. To date, Health Services has not exercised this option. However, given that Health Services is limited in its ability to promptly enforce collections from these private facilities, it is losing revenue by not using all means available to encourage facilities to pay promptly.

Health Services Did Not Reconcile Fee Payments It Received to Its Estimates

To ensure that it collects the correct fees and prevents fraud, Health Services established a control that should enable it to test the reasonableness of the total resident days that each facility reports when paying its fee. The control calls for Health Services to follow up with any facility that reports total resident days on its fee remittance document that differs from the number that facility reported in a prior year by more than 5 percent. Based on Health Planning and Development data from a previous year, Health Services estimates total resident days for each facility. When a facility remits a fee payment, it reports the actual number of resident days it used to calculate the total due. Once

Although it established a control to ensure that it collects the correct fees and prevents fraud, Health Services has never used the control to assess the reasonableness of resident days facilities reported.

a facility remits payment, Health Services records the actual resident days and fee amount in the database alongside the estimated information, to allow for reconciliation.

Health Services' policy is to investigate variances of plus or minus 5 percent between the estimated and actual payments. However, it has never reconciled its records to identify and research discrepancies. During our review, we determined that fees remitted for fiscal year 2004–05 by 325 of the 983 (33 percent) facilities required to pay differed from Health Services' estimates by more than 5 percent. In one case, a facility remitted just under \$91,000, although Health Services anticipated receiving more than \$250,000. According to Health Services, it has not had enough staff to reconcile its records; however, it has known for several years that it would need staff to manage the new reimbursement rate program. Until it conducts such reconciliations and investigates variances that exceed the control it established, Health Services will not know whether it has collected the entire fee for the year or identified facilities that may be fraudulently under reporting total resident days to avoid paying the fee. The department reported that in October 2006 it added an individual to its team who will, among other duties, conduct these reconciliations and follow up on variances.

ONGOING COSTS LIMIT THE SAVINGS THE STATE WILL REALIZE FROM THE NEW REIMBURSEMENT RATE METHODOLOGY

In passing the Reimbursement Act, the Legislature intended to reimburse facilities under a new method that would develop facility-specific reimbursement rates based on the unique costs of each facility. Further, the facility-specific rates were to be as high or higher than those under the prior plan so as to improve the care provided to long-term care patients in a way that would not overburden the State's General Fund, through which Health Services pays Medi-Cal reimbursements. The Reimbursement Act also provided a new stream of revenue to Health Services through the Quality Assurance Fee (fee).

Health Services estimated that the Reimbursement Act would initially result in a savings to the General Fund that would decrease over the life of the act. However, the additional costs incurred to implement and maintain the system have been significant. Actual General Fund savings are projected to be nearly \$83 million overall in fiscal year 2005–06, while the facilities' reimbursement rates were at least as high or higher

under the Reimbursement Act methodology than they would have been in its absence. Somewhat offsetting these savings, Health Services incurred additional costs of approximately \$4 million to research alternatives and develop the technology to calculate the new rates, and it continues to rely on a contracted consultant to operate that technology at a cost of about \$1 million per year. In addition, Health Services is in the process of hiring 46 new employees at a cost of \$4.2 million per year to meet the requirements of the Reimbursement Act, including producing reports related to quality of care, prepared by the Licensing and Certification Division (licensing division) and submitted to the Legislature.

The Reimbursement Act also includes provisions designed to expedite approval of Health Services' contract with a consultant to develop the reimbursement rate system. Specifically, the Reimbursement Act granted Health Services an exemption from the Public Contracting Code, allowing it to execute a contract that did not require competitive bidding or the approval of the Department of General Services. However, in the absence of the controls specified in the Public Contracting Code, Health Services did not always follow sound contracting practices. When a state contract will be used to develop a product, such as the reimbursement rate system, one of the basic elements of sound contracting calls for the contract to include a clear description of the work product and the legal requirements of the project. Although the Reimbursement Act defines the cost components to be included in the reimbursement rate system, neither Health Services' contract with the consultant nor the two subsequent contract amendments addressed these cost components.

Other basic elements of sound contracting are statements in the contract specifying that the vendor will be paid only after the deliverable has been accepted and outlining the consultant's liability and responsibility if the product fails. Again, Health Services did not include these key elements in its contract with the consultant, and it subsequently did not receive a document outlining the source code—the business logic used to build the system. To create the 2005 and 2006 reimbursement rates, the consultant developed a calculation system, and it intends to train Health Services' staff in operating the system. Although Health Services has access to the calculation system, it does not have a contract that provides assurance of the consultant's responsibilities if the system should fail. Because it did not follow sound contracting principles, Health Services may not be guaranteed satisfaction with the final product, and

it may not be able to re-create or restore the system if necessary without the help of the consultant. In fact, in our attempt to replicate the methodology used to produce the rates Navigant developed for fiscal year 2005–06, neither Health Services nor Navigant were able to provide us with a complete methodology used to develop the system. As a result, we have asked Health Services to develop and test formal, accurate and detailed documentation that includes all of the complexities of the rate development methodology within 60 days of this report’s publication. Once we obtain this formalized methodology, we will test the reimbursement rate system to determine if it appropriately develops rates. When complete, we will issue a separate public letter that summarizes the results of our testing.

Health Services also does not have a mechanism in place to record changes it makes to its finalized reimbursement rates or changes made to the reimbursement rate system. Because it does not document and track these changes, Health Services runs the risk that if challenged, it would not be able to explain or defend such changes.

Revenues Generated From Quality Assurance Fees Result in General Fund Savings That May Decrease Over Time

The Reimbursement Act protects facilities from receiving lower reimbursements than they would have under the previous methodology because of the new rate calculation methodology. To meet this requirement, Health Services compared rates developed under the new methodology with the rates facilities would have received under the old methodology and adjusted the new rates accordingly. Because the Reimbursement Act required that each facility receive a rate that is at least as high as its old rate, Health Services anticipated that reimbursements to facilities would increase significantly. Similar to reimbursements made under the old system, the federal government continues to match all reimbursements. As a result, the increased burden of higher rates is shared between the state and federal governments. For example, using actual 2005–06 payment data, we estimated that Health Services would have paid \$1.37 billion for its share of Medi-Cal claims under the previous reimbursement methodology. Using the new reimbursement rates, however, we estimate that Health Services will pay about \$1.52 billion for its share of Medi-Cal claims in fiscal year 2005–06. As with the old methodology, these payments are matched by the federal government. Therefore, the amounts just mentioned are only half the amount that the facilities

are expected to receive. Further offsetting the State's higher reimbursement costs was the \$233 million in revenue Health Services estimated it would collect from the fee in fiscal year 2005–06, netting a projected savings based on actual paid claims data of \$83 million compared with costs calculated using the previous methodology.

State law authorizes Health Services to use the revenue generated from the fee to offset reimbursement rate increases in the Medi-Cal program, and Health Services anticipated that the implementation of the fee would result in significant savings for the General Fund in the first several years. Nevertheless, Health Services believes that if the new reimbursement rate methodology were to continue beyond the sunset date for the Reimbursement Act of July 31, 2008, the Medi-Cal payments made under the new reimbursement system would no longer generate a net savings for the State. To confirm this belief, Health Services developed a projection of the impact of the Reimbursement Act on the General Fund, using its historical data as well as data from Health Planning and Development. This projection is shown in the Table. In the projection, Health Services estimates a decrease of \$19 million in General Fund savings from fiscal years 2005–06 to 2006–07. By fiscal year 2007–08, Health Services expects to save nearly \$34 million, a \$28 million decrease from fiscal year 2006–07. Moreover, these projected savings do not reflect a number of additional contract and personnel costs associated with the new reimbursement rate system and requirements of the Reimbursement Act discussed in the following sections.

Health Services Has Incurred Significant Costs Using a Contracted Consultant to Meet the Requirements of the Reimbursement Act

To implement the Reimbursement Act, Health Services' contracting unit reported spending almost \$4 million for consulting contracts and received approval for 46 new positions. Health Services contracted with a consulting firm that eventually developed a system to calculate facility-specific reimbursement rates. Although a provision in the Reimbursement Act permits Health Services to use contracted services to develop and implement the new reimbursement rate, Health Services did not always follow sound contracting practices. For example, Navigant, the consultant contracted to develop the reimbursement rate system, worked under a contract that did not specify either the product Health Services wanted Navigant

By July 2006, Health Services had paid Navigant nearly \$4 million and had agreed to a \$1 million amendment to the consulting contract to continue administration of the reimbursement rate system for fiscal year 2006–07.

to provide or set a date when Health Services would take over administration of the reimbursement rate system. By July 2006, Health Services had paid Navigant nearly \$4 million and had agreed to a \$1 million amendment to the consulting contract to continue administration of the reimbursement rate system for fiscal year 2006–07.

TABLE

**Department of Health Services' Estimate of Savings Resulting
From the New Reimbursement System**

Prior System	Fiscal Rate Years*			
	2004–05	2005–06	2006–07	2007–08
Total reimbursements to facilities	\$2,716,441,596	\$3,038,026,457	\$3,144,357,383	\$3,254,409,892
Federal cost (50 percent)	1,358,220,798	1,519,013,229	1,572,178,692	1,627,204,946
General Fund cost (50 percent)	1,358,220,798	1,519,013,229	1,572,178,692	1,627,204,946
Cost to state	1,358,220,798	1,519,013,229	1,572,178,692	1,627,204,946

New System	Fiscal Rate Years*			
	2004–05	2005–06	2006–07	2007–08
Total reimbursements to facilities	2,956,722,276	3,343,374,258	3,510,542,971	3,703,622,834
Federal cost (50 percent)	1,478,361,138	1,671,687,129	1,755,271,485	1,851,811,417
General Fund cost (50 percent)	1,478,361,138	1,671,687,129	1,755,271,485	1,851,811,417
Quality Assurance Fee estimated collections	116,574,867	233,149,733	244,807,220	258,271,617
Cost to state	1,361,786,271	1,438,537,396	1,510,464,266	1,593,539,800

General Fund Savings	\$ (3,565,473)	\$ 80,475,833	\$ 61,714,426	\$ 33,665,146
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Source: Department of Health Services' (Health Services) Rate Development Branch.

Note: Health Services based these projections on data available to it. The information presented here is unaudited.

* Fiscal rate year is August 1st through July 31st.

To expedite the contracting process, the Reimbursement Act exempts Health Services from typical state contracting requirements such as obtaining bids and approval from the Department of General Services. However, Health Services still had a responsibility to follow sound contracting practices designed to protect the State and its assets.

We are concerned that Health Services' approach to contracting out this work was flawed. Best practices for contracting for a deliverable require a state agency to include certain key elements in the agreement, such as a clearly defined scope of work for the project and specified measures to ensure that the State has a strong contract. In its contract with Navigant, Health Services did not specify what work product it expected from

the consultant. The language spells out only the consulting nature of the contract. For example, the language in the contract states that the consultant will evaluate options for California's long-term care reimbursement methodology, including a review of other state methodologies. However, what Health Services ultimately needed was for Navigant to develop a rate calculation system. To be able to properly manage this task, Health Services should have included clear language describing the specific product it wanted, such as a program or database application that calculates reimbursement rates according to the specifications of the Reimbursement Act.

In addition to using clear language to describe the desired product, the contract should have required Navigant to provide Health Services with detailed technical system documentation of the reimbursement rate system, outlining the logic and business rules used to build the system. Formal documentation of the product and a user guide or training plan would help Health Services learn to effectively use the reimbursement rate system as well as identify the process its programmers would use to rebuild the system, should it become necessary. Health Services stated that although it has asked for a description of the system's logic, it has not yet received it.

In fact, when we tried to replicate the reimbursement rate system methodology used to produce the rates Navigant developed for the 2005–06 fiscal year, neither Health Services nor Navigant were able to provide us with a complete methodology used to develop the system. Because there was no formal system documentation, we worked extensively with both Health Services and Navigant to document the methodology used to compute the new rates. In October 2006, we submitted a document to Health Services and Navigant outlining our attempt to document a reimbursement rate system that would mirror Health Services' system. On October 31, 2006, Health Services and Navigant confirmed to us that, after making some minor changes, the methodology we had documented was correct. However, when we attempted to use the methodology that Health Services and Navigant had asserted was correct to calculate facility reimbursement rates, certain portions of the rate calculations did not entirely reconcile with the rates published by Health Services. Although we resolved some of these discrepancies with Health Services and Navigant, on January 2, 2007, Navigant informed us that some of the methodology it had earlier asserted was correct was, in fact, not correct. As a result, we could not verify that the rates

Neither Health Services nor its consultant were able to provide us with a complete methodology used to develop the reimbursement rate system. As a result, we could not verify that the rates produced by the system are appropriate.

produced by the system Navigant developed are appropriate. However, since rate verification is an important part of this audit, we allowed Health Services up to 60 days from the date of this report to develop and test formal, accurate and detailed documentation that includes all of the complexities of the reimbursement rate development methodology. Once we obtain this formalized methodology, we will test the reimbursement rate system to determine if it appropriately develops rates. When complete, we will issue a separate public letter that summarizes the results of our testing.

Health Services Has No Official Tracking System to Record Rate or System Changes

EDS authorized payment for some Medi-Cal claims in fiscal year 2005–06 using rates that were different than those Health Services had published.

Health Services does not formally document and record changes to its published rates or changes to its reimbursement rate system. As a result of not keeping formal records, it could not provide an overall record of changes it made to its published rates or the basis for changing those rates. Health Services develops rates for facilities and forwards them to EDS. EDS is responsible for entering these rates into its system and applying them to Medi-Cal claims. However, EDS authorized payment for some Medi-Cal claims in fiscal year 2005–06 using rates that were different than those Health Services had published. When asked about changes to the published rates, Health Services stated that most of the changes were probably informally initiated by the facilities after the rates were finalized and acknowledged that it did not have a formal mechanism in place to document these rate changes. However, since Health Services is responsible for developing the rates, it is also responsible for formally tracking any changes made to those rates. Using its current process, if challenged, Health Services may not have all the information it needs to review EDS' records to verify that the rates it uses are accurate.

In addition, neither Health Services nor Navigant, the consultant that developed the reimbursement rate system, have a formal change control process in place to record programming changes Navigant makes or may need to make to the system. Without such a process, Health Services has no way to ensure that any changes Navigant makes to the system are the ones it intended. In addition, without such a process to document all changes made to the system, once it takes over the system's operation, Health Services may not be able to explain or defend how the system computes facility reimbursement rates.

Health Services' Continued Reliance On the Contractor Is Not According to the Original Plan

We are concerned that Health Services has relied too heavily on outside contractors to develop and update the new reimbursement system. The Reimbursement Act anticipated that Health Services would need to hire outside consultants to assist with the development of the new reimbursement system by 2005. However, now that the new system is in place, Health Services' continued reliance on the contractor is questionable. To date, Health Services has not used its staff to administer the new system, even though that has been Health Services' intention from the outset. Originally, Health Services planned to have its staff develop the reimbursement rates for fiscal year 2006–07, but that plan fell through because time was short and staff were not trained to run the database to calculate the rates. In addition, according to Health Services, the branch responsible for developing rates has experienced high turnover. As a result, the five employees in that branch have experience levels ranging from a few months to almost three years with this program. According to Health Services, high turnover has stalled its efforts to take over the reimbursement rate system and internally develop rates.

Health Services has not included in its contract a date when it will take over the reimbursement rate calculation.

Even after Health Services begins calculating the reimbursement rates itself, it anticipates still needing the consultant's help. Health Services has not included in the contract a date when it will take over the reimbursement rate calculations. By extending its contract each year, Health Services incurs annual costs to the State totaling about \$1 million in payments to the contractor. Health Services has recently stated that it plans to calculate the fiscal year 2007–08 reimbursement rates on its own. However, its staff have not yet completed training on the system. As a result, we believe that it is likely Health Services will continue to rely on the consultant during this transition period.

Although Health Services believes it will need to continue renewing the contract until its staff are able to calculate reimbursement rates, we question its delay in taking over implementation of the reimbursement rate system. Health Services obtained approval to hire additional staff to meet the obligations imposed by the Reimbursement Act. Among the additional staff requested were two positions in the Medi-Cal Policy Division (policy division), which is responsible for administering the reimbursement rate and fee systems. One of those positions had been administratively established, and the other was requested and authorized for fiscal year 2006–07.

Health Services was able to fill both positions by November 2006. Because Health Services requested only two people to administer the reimbursement rate and fee systems, it appears to now have the resources necessary to take over the reimbursement rate system.

Besides requesting new positions to administer the new reimbursement rates, Health Services requested new employees in the policy and other divisions. For fiscal year 2006–07, Health Services requested and received funding for 14 positions that had already been administratively established in fiscal year 2005–06 to enhance its policy, administration, and licensing divisions. For example, the licensing division requested funding to continue positions to assist in developing regulations, gathering and analyzing data, and producing mandated reports.

Health Services received authorization for a total of 46 new or newly funded positions to meet the increased workload resulting from the Reimbursement Act.

In addition to obtaining funding for the administratively established positions, Health Services received authorization for 32 positions to augment its policy division, audits division, and office of legal services, for a total of 46 new or newly funded positions. Twenty-two of the new positions were audit staff needed to meet the increased audit requirement in the Reimbursement Act. The policy division received approval for one additional Associate Governmental Program Analyst to help monitor the fee and assist with work related to the facility-specific reimbursement rates. Further, Health Services projects that as the number of required audits has increased, so will the number of audit appeals its office of legal services must hear. To manage the heavier workload, Health Services requested additional attorneys and administrative law judges. Although the 46 positions were approved in October 2005, Health Services had not filled eight positions as of November 2006. The new positions requested would result in increased salary and benefit amounts of approximately \$4.2 million in fiscal year 2006–07, \$1.6 million of which would come from the State’s General Fund. The remaining \$2.6 million would be funded through the Federal and Special Funds.

Other Considerations Will Also Affect the Cost-Effectiveness of the Reimbursement Act

Because the Reimbursement Act sunsets on July 1, 2008, the Legislature will be reviewing its overall impact on the quality of care in facilities and its fiscal impact on the State. According to payment records from EDS, facilities have received significant increases in reimbursement rates. Specifically, according to paid claims data, had Health Services continued using the previous methodology

to calculate reimbursement rates, facilities would have received approximately \$117 per Medi-Cal day in fiscal year 2005–06. With the new reimbursement rate methodology, however, the facilities received approximately \$129 per Medi-Cal day.

Health Services projects decreasing savings for the General Fund in fiscal years 2006–07 and 2007–08. According to actual expenditure amounts from fiscal year 2005–06, these projections appear to be reasonable. However, the General Fund may face even more significant declines in revenue because of possible federal changes. In its 2007 budget, the federal government proposed to systematically reduce quality assurance fees nationwide from 6 percent to 3 percent over the next three years. These fees are designed to increase the amount of federal financial participation in state Medicaid programs; therefore, the proposed reduction would ease the federal government’s burden. Although this reduction could be enacted through changes in federal regulations, the federal government has only started the process of adopting the regulations. If it successfully reduces the fees, the State’s General Fund would receive only half of the revenue expected from the fees.

The federal government recently proposed to systematically reduce the quality assurance fee nationwide from 6 percent to 3 percent over the next three years. If the fees are reduced, the State’s General Fund would receive only half of the revenue expected from the fees.

In passing the Reimbursement Act, the Legislature intended to improve the level of service provided to the residents of skilled nursing facilities. To assess whether such improvement has occurred, the Reimbursement Act requires Health Services to track changes in the quality of care provided by facilities as a result of increased reimbursements. The Reimbursement Act mandates that Health Services issue reports to the Legislature in January 2007 and January 2008. Both reports must focus on elements outlined in the Reimbursement Act, such as the number of state citations issued to facilities, to give the Legislature an idea of what improvements the increased rates produced. Based on this information, Health Services will be in a better position to demonstrate whether there is a correlation between the increased rates and the quality of care. As of November 2006, the licensing division was still gathering the information it plans to include in the report due in January 2007.

The Reimbursement Act, in its outline of the information that the licensing division should include in the reports, did not specify the inclusion of any information related to the effect of the higher reimbursement rates and the new fee revenue on overall General Fund expenditures. Although the Reimbursement Act requested that our audit provide

information regarding the impact of the new reimbursement rates on the General Fund, we can provide only actual General Fund cost information for fiscal year 2005–06. However, the licensing division has the responsibility to report to the Legislature twice more before the Reimbursement Act is scheduled to sunset. According to the Reimbursement Act, the licensing division is to report information that reflects changes in quality of care but not the General Fund costs related to these changes. However, including General Fund cost information in both of the required licensing division reports would show how the new rates are affecting the General Fund. Because the Reimbursement Act is scheduled to sunset in 2008, this information may aid the Legislature in assessing the act’s true costs and benefits.

THE CONTRACTOR HEALTH SERVICES USES TO MAKE MEDI-CAL REIMBURSEMENTS AUTHORIZED PAYING SOME FACILITIES MORE THAN ONCE FOR SKILLED NURSING SERVICES

Between August 1, 2005, and July 31, 2006, EDS erroneously issued more than 2,100 duplicate payments to facilities totaling approximately \$3.3 million.

When we assessed the reliability of data gathered and used by EDS—the firm Health Services contracted with to authorize Medi-Cal payments—we identified more than 2,100 duplicate payments to facilities for claims reflecting dates of service between August 1, 2005, and July 31, 2006, totaling approximately \$3.3 million. Further, we are aware of other potential duplicate payments to facilities, however, due to the complexity of these payments, additional research by EDS is necessary. According to EDS, its examiners followed a flawed procedure that instructed them to override a specific type of suspended claim, resulting in duplicate payment authorizations. Because the scope of this audit focused on long-term care payments made to facilities subject to the new reimbursement rates established in accordance with the Reimbursement Act, we reviewed only claims paid for those facilities. As a result, we cannot conclude on the magnitude of other duplicate payments that might have been made, such as payments made to facilities not subject to the new rates.

Further analysis of the duplicate payments showed that EDS authorized paying some facilities multiple times for the same services provided to the same individual on the same date. In one instance, we found that, over a four-month period, EDS authorized paying one facility three times for the same services rendered to one individual. In this one instance, the State paid more than \$55,000 when it should have paid less than

\$19,000—an overpayment of more than \$36,000. Despite Health Services' assertion that it has controls to ensure that it authorizes the payment for services only once, these controls did not prevent, nor was EDS even aware that it had authorized, these duplicate payments until we asked about them.

After researching a sample of duplicate payments, EDS confirmed that it had inadvertently implemented a flawed procedure its examiners follow when reviewing possible duplicate claims. As a result, EDS examiners inappropriately overrode certain suspended claims and authorized their payment. Even though Health Services reviewed and approved the procedure EDS used in these circumstances, neither EDS nor Health Services could tell us how the flaw in the written procedure was overlooked. Additionally, even though EDS considers its examiners to be the front line of defense against authorizing improper payments, until we brought this matter to its attention, no examiner had questioned the edit criteria that had been in place since October 2005, one year before we began our audit work.

Health Services and EDS have subsequently taken measures to resolve the duplicate payment problem. EDS has implemented a special processing guideline to discontinue overriding suspended claims, updated its procedures, and started to identify all facilities that received duplicate Medi-Cal payments to begin efforts to recoup those funds. In addition, to ensure that facilities did not fraudulently exploit the weakness in EDS' payment authorization process, Health Services is currently investigating this issue.

RECOMMENDATIONS

To reduce the risk of using flawed data to calculate reimbursement rates, Health Services should:

- Conduct all the audits of skilled nursing facilities called for in the Reimbursement Act.
- Identify which audits conducted in fiscal years 2004–05 and 2005–06 were field audits to determine whether it met the field audit requirement of the Reimbursement Act.

To ensure that it collects the Quality Assurance Fees (fees) it is entitled to, Health Services should take the following steps:

- Promptly initiate collection efforts for facilities that are delinquent in making their fee payments by either offsetting amounts owed against Medi-Cal reimbursements or levying a penalty against facilities that do not participate in Medi-Cal.
- Reconcile the fee payments made by facilities to the estimated payments due and follow-up on all significant variances.

To hold the consultant contracted by Health Services to the intended terms and conditions of the contract to develop and administer the reimbursement rate system, Health Services should take the following steps:

- Amend the contract to clearly describe the scope of work and to include a statement that Health Services will obtain the logic and business rules of the reimbursement rate system and a specific date that Health Services will take over developing reimbursement rates for facilities.
- Include in its 60-day response to this audit report or sooner, formal and detailed documentation that includes all of the complexities of the reimbursement rate development methodology and evidence that the methodology, when used, produces the reimbursement rates Health Services published for fiscal year 2005–06.
- Follow best practices for contracting in the future by including clear language to describe the products or services it expects from the agreement.

To reduce its costs and maximize savings to the General Fund, Health Services should take the following actions:

- Continue to learn how to use the database and then train its staff to calculate the rates for fiscal year 2007–08.
- Amend the contract with Navigant to include training Health Services' staff in using the rate calculation database and facilitate staff takeover of managing the annual calculations.

To develop a mechanism to formally document changes, Health Services should take the following steps:

- Formalize a rate change process that documents the reason for a rate change and provides a notification of the rate change to EDS.
- Formalize a change process that documents and records any changes either it or Navigant makes to the reimbursement rate system's programming language.

To provide more complete information to the Legislature on the reimbursement rate and fee systems, Health Services should include information on the savings to the General Fund in the reports its licensing division is required to prepare.

To ensure that its contract consultant authorizes disbursements of Medi-Cal funds only to facilities entitled to them, Health Services should take the following steps:

- Further investigate the possibility that duplicate payments were authorized by the contractor beyond those we noted to ensure that the magnitude of the problem is identified and corrected. This would include researching all payment types authorized by the contractor since at least October 2005.
- Research and identify all the duplicate payments authorized by its contractor and recoup those payments.

We conducted this review 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. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,



ELAINE M. HOWLE
State Auditor

Date: February 15, 2007

Staff: Steven Hendrickson, Audit Principal
Steven A. Cummins, CPA, Audit Principal
Barbara Henderson, CPA
Michelle J. Baur, CISA
Sunny Andrews
Rosa Reyes
Leonard Van Ryn, CISA
Ben Ward

Agency's comments provided as text only.

Department of Health Services
1501 Capitol Avenue, Suite 6001
Sacramento, CA 95899-7413

January 26, 2007

Elaine M. Howle*
State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

The California Department of Health Services (CDHS) has prepared its response to the Bureau of State Audits' (BSA) draft report entitled "Department of Health Services: It Had Not Yet Fully Implemented Legislation Intended to Improve the Quality of Care in Skilled Nursing Facilities." The CDHS appreciates the work performed by the BSA and the opportunity to respond to the draft report.

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

Sincerely,

(Signed by: Tom McCaffery for:)

Sandra Shewry
Director

* California State Auditor's comments appear on page 43.

**Response to the Bureau of State Audits
Draft Audit Report**

**“Department of Health Services: It Has Not Yet Fully Implemented Legislation Intended
to Improve the Quality of Care in Skilled Nursing Facilities”**

To reduce the risk of using flawed data to calculate reimbursement rates, Health Services should:

Recommendation: Conduct all the audits of skilled nursing facilities called for in the Reimbursement Act.

Response: The Department of Health Services (CDHS or Department) agrees that it needs to conduct audits of all free standing skilled nursing facilities receiving Medi-Cal funds for inpatient services. The 19 auditor positions, two audit manager positions and one Management Services Technician position gained in the 2006-2007 budget will be put to use in completing this recommendation. CDHS expects this to be completed during the 2007-2008 production year.

Recommendation: Identify which audits conducted in 2004 and 2005 were field audits to determine whether it met the field audit requirement of the Reimbursement Act.

Response: The CDHS disagrees with this recommendation. We believe that the audit plans in place properly address the requirements of the Reimbursement Act. It is not necessary to look back to the production completed in 2004 which is prior to the enactment of AB 1629. Audits completed in 2005 met the requirements of the Reimbursement Act.

The legislation was signed on September 29, 2004, well into CDHS' audit production cycle for the July 1, 2004 through June 30, 2005 period. During the 2003-2004 production cycle, a combination of field and desk audits were performed in order to complete 66 percent of the level B universe when audit resources were only budgeted to complete half that number of audits. Completing such a dramatic increase in level B audits required that the department accept a greater than normal amount of audit risk when determining the resources to be applied in specific instances. Expanding the number of audits with the then existing resources, would have resulted in less time available per audit and therefore greater risk of higher non-allowable costs being included in the rate calculations.

During the 2004-2005 production cycle the Department focused on the 34 percent of facilities that were not audited in 2003-2004. Detailed levels of scoping and analytical procedures were performed to determine where audit resources would best be used. Reported data were grouped according to cost components (used in the rate setting

process) and compared to the bench marks to determine areas of risk by cost component. Facilities at or near the bench mark for their peer group cost components were candidates for more detailed audits. Facilities with reported costs that were below the hold harmless rate would likely receive a payment rate above their reported costs and as a result, would receive a less detailed audit as a more intensive full scope audit would not impact the rates of these facilities. These audits met the Reimbursement Act requirements that facilities receive an audit once in three years.

In the current fiscal (2006-2007) year, CDHS is evaluating those facilities that were not audited in 2005-2006 and is selecting full scope audits based on audit risk by applying the methods discussed to above. CDHS intends to conduct full scope audits on 33 percent of the skilled nursing Medi-Cal facilities and to perform more limited reviews on an additional 44 percent of this population. The 33 percent of full scope audits performed in the current fiscal year meets the audit requirement of the Reimbursement Act that facilities are to be audited once in every three years. CDHS has also implemented a system to track those facilities where full scope audits have been performed. This tracking system will enable CDHS to ensure that all facilities receive audits as required by the Act.

In the next fiscal year (2007-2008), facilities that did not receive full scope audits in 2004 or in 2005 will receive a full scope audit, bringing the Department into full compliance with the requirements of the Reimbursement Act.

Please note that this recommendation is not reported on page nine.

To ensure that it collects the amount of fees it is entitled to, Health Services should take the following steps:

Recommendation: Promptly initiate collection efforts for facilities that are delinquent in making their fee payments by either offsetting amounts owed against Medi-Cal reimbursements or levying a penalty against facilities that do not participate in Medi-Cal.

Response: The CDHS concurs in general with the finding and is in the process of collecting Quality Assurance Fees (QAF) due for the rate years 2004/05 and 2005/06. Collection efforts include offsetting payments due to the facility, as well as a delay in licensure renewal. For facilities that are not Medi-Cal participants, CDHS feels that it is a more effective approach to recover fees due through the renewal of licensure process. CDHS is in the process of implementing formal, written procedures to assess the penalties within a published time frame. Included in the procedures will also be a time frame that addresses the delay in licensure.

Recommendation: Reconcile the fee payments made by facilities to estimated fee payments due and follow-up on all significant variances.

Response: The CDHS concurs with the finding and reconciliation efforts are currently in process. Staff was hired effective October 2006. As the staff are trained and are competent on the nature of AB1629 and the reconciliation processes are fully in place, they will organize the estimated amounts and actual collections to allow for a reconciliation process. CDHS has targeted its first reconciliation process to be completed by June 2007 for the rate years 2004/05 and 2005/06. Based on this reconciliation process, CDHS will follow-up with additional collection efforts for any unpaid balances that remain.

To hold the consultant contracted by Health Services to the intended terms and conditions of the contract to develop and administer the reimbursement rate system, Health Services should take the following steps:

Recommendation: Amend the contract to clearly describe the scope of work and to include a statement that Health Services will obtain the logic and business rules of the reimbursement rate system and will receive training in how to use the system, as well as a specific date that Health Services will take over developing reimbursement rates for facilities.

Response: The CDHS is in the process of preparing a contract amendment for this contractor that will include in the turnover plan: logic and business rules of the reimbursement rate system and the necessary training to successfully internally operate its own reimbursement rate system consistent with AB 1629. As shared with the BSA during its audit engagement, CDHS is currently in the turnover phase with this contractor and began its training/turnover process in January 2007 to be completed no later than May 2007.

Recommendation: Include in its 60-day response to this audit report or sooner, formal detailed documentation that includes all of the complexities of the reimbursement rate development methodology and evidence that the methodology, when used, produces the reimbursement rates Health Services published for fiscal year 2005-06.

Response: The CDHS will include in its 60-day response to this audit report or sooner, formal detailed documentation that includes all of the complexities of the reimbursement rate development methodology and evidence that the methodology, when used, produces the reimbursement rates Health Services published for fiscal year 2005-06.

Recommendation: Follow best practices for contracting in the future by including clear language to describe the products or services it expects from the agreement.

Response: The CDHS always attempts to follow best business practices in its contracting processes. This contract was entered into on an expedited basis due to AB 1629 being passed as urgency legislation with specific provisions that allowed the Department to enter into a sole source agreement to fulfill the urgency requirements. While this contract was executed on an urgency basis it was subject to the full control agency review/oversight process. The bill was signed into law on September 29, 2004 and to fulfill the Department's obligations of timely obtaining the Federal government approvals and develop rates for the rate year starting August 1, 2005 expedited processes were necessary. Normal State Government contract procurement efforts requires approximately two to three years from the start of a procurement to contract execution. This contract was an expedite contract and due to this ground breaking legislation that moved the Department into new areas, specific language as to final work products could not be fully defined until there had been sufficient experience in this area. Without this expedited process the Department would not have been able to achieve the timely implementation of this legislation. Instead it would have taken up to an additional two years had the "normal" procurement practices been followed. As a result of obtaining the necessary experience, the Department is amending this contract to provide the necessary clarity.

To reduce its costs and maximize savings to the General Fund, Health Services should take the following actions:

Recommendation: Continue to learn how to use the database and then train its staff to calculate the rates for fiscal year 2007-08.

Response: The CDHS concurs with the finding and a series of training sessions have already been started in January 2007 continuing through May 2007, in which the contractor (Navigant Consulting, Inc) will perform theory and practice sessions. Key staff members will be in participation and CDHS intends to produce the rates for the upcoming 2007/08 rate-year using the system that was created by the contractor.

Recommendation: Amend the contract to include training Health Services staff in using the rate calculation database and facilitate staff takeover of managing the annual calculations.

Response: The CDHS is in the process of preparing a contract amendment for this contractor that will include in the turnover plan: logic and business rules of the reimbursement rate system and the necessary training to successfully internally operate its own reimbursement rate system consistent with AB 1629. As shared with the BSA during its audit engagement, CDHS is currently in the turnover phase with this contractor and began its training/turnover process in January 2007 to be completed no later than May 2007.

To develop a mechanism to formally document changes, Health Services should take the following steps:

Recommendation: Formalize a rate change process that documents the reason for a rate change and provides a notification of the rate change to EDS.

Response: The CDHS concurs with the finding in general. An expedited system is in place that utilizes e-mail that also provides a document record; however, the CDHS recognizes the importance of creating a more formal process to provide an audit trail of all rate revisions. Staff is in the process of creating a transmittal sheet for all rate changes that will document the reason for the rate change and management approval.

Recommendation: Formalize a change process that documents and records any changes either it or Navigant makes to the reimbursement rate system's programming language.

Response: The CDHS concurs with the finding and is already in process of developing procedures and a document that identifies procedures to be followed regarding changes in the system's programming language.

To provide more complete information to the Legislature, Health Services should:

Recommendation: Include General Fund information in the reports its licensing division is required to prepare.

Response: The basis of this recommendation is that the legislature needs both cost and benefit information before it can fully assess the impacts of the Skilled Nursing Facilities Quality Assurance Fee and Medi-Cal Long-Term Care Reimbursement Act. In its audit, the BSA is providing cost information, in the form of General Fund impact estimates, for FY 2005-06. There is no requirement; however, that this information be provided in subsequent fiscal years (prior to the Act's sunset in 2008).

The BSA recommends that the reports on the Act's benefits includes cost information. L&C agrees with BSA's finding that both cost and benefit information may be useful to the Legislature. General fund cost information is collected and maintained by other operational aspects other than L&C and may be included as supplemental information. BSA correctly observes that L&C's mandate is to oversee and improve the quality of care in the State's health care facilities. If General Fund impact information is to be provided to the Legislature, it would be prepared by another operational aspect of the Department that more routinely prepares this type of information.

To ensure that its contractor disburses Medi-Cal funds only to facilities entitled to them, Health Services should take the following steps:

Recommendation: Further investigate the possibility that duplicate payments were made by the contractor beyond those identified to ensure that the magnitude of the problem is identified and fixed. This would include researching all payment types made by the contractor for a reasonable period.

Response: The CDHS agrees that duplicate payments were authorized by the contract consultant beyond those noted in the BSA's draft audit report. Electronic Data Systems (EDS) and the CDHS have taken immediate action to resolve the duplicate payment problem by implementing a special processing guideline that discontinues overriding suspended claims. Investigation continues for the identification of all facilities that received duplicate Medi-Cal payment and all means to recoup those funds will be pursued. In addition, CDHS is currently investigating the issue of possible fraudulent billing practices by these facilities.

Recommendation: Research and identify all the duplicate payments made by its contractors and recoup those payments.

Response: A corrective action plan to resolve this problem is underway which includes the running of an Erroneous Payment Correction (EPC) to recoup all duplicate payments made to long-term care facilities. Fiscal Intermediary – Information Technology Management Branch (FI-ITMB) management will be reviewing the priority of this EPC in relation to other existing EPC priorities later this week. The corrective action plan also includes an effort to identify and recoup claims for all other payment types affected by the duplicate payment problem. As the report indicates, the manual processing instructions Electronic Data Systems (EDS) was using that were in error have already been corrected. We expect to have the timeline for completion of all tasks in the corrective action plan more firmly established within the next two weeks.

Additional notes:

Page 4, Last Paragraph

“Unlike reimbursements, the fee rate each facility must pay is based on the revenue it reports.”

Comments:

The fee rate is based on the resident days, not revenue.

Page 1, Second Paragraph

“The Long-Term Care Reimbursement Unit within Health Services...”

Comments:

The CDHS concurs in general, however, the item should read “The Long Term Care System Development Unit and Long Term Care Reimbursement Unit within Health Services...”

Page 2, Last Paragraph

“...Health Services required EDS to reprocess all claims with dates of service between August 2005 and April 2006 to ensure that facilities received the new rates. At a cost to the State of about \$7,000, EDS conducted Erroneous Payment Correction to adjust for the claims that had been submitted and paid between August 2005 and April 2006.”

Comments:

The CDHS concurs in general, however, it should be noted that due to inquiries from the facilities fee paying the fee (an unforeseen circumstance), a delay in installing rates into the payment processing system occurred. CDHS exercised good stewardship of State resources by being responsive to questions/concerns raised by the impacted stakeholders. In noting the cost of the delay, had rates been loaded prematurely into the payment processing system, or without concern to provider questions, the additional costs could have been far greater due to potential litigation and/or legal challenges.

COMMENTS

California State Auditor's Comments on the Response From the Department of Health Services

To provide clarity and perspective, we are commenting on the response to our audit report from the Department of Health Services (Health Services). The numbers correspond with the number we have placed in Health Services' response.

- As stated on page 15, before passage of the Reimbursement Act, Health Services conducted a field audit for each skilled nursing facility (facility) once every three years. To meet the requirement for the Reimbursement Act, Health Services must continue to complete a field audit for each facility once every three years and also complete a desk audit in the years in between. We recommend that Health Services look back to the audits completed in fiscal years 2004–05 and 2005–06 so that at the end of the fiscal year 2006–07, it will know which facilities had not received a field audit within the three years from fiscal years 2004–05 through 2006–07 and adjust its audit plan accordingly.
- We are not questioning Health Services' need to expedite by using a sole source contract to develop its reimbursement rate system. However, as stated on page 25, we do question why the contract lacked even the most basic elements, such as a clear description of the work product and legal requirements of the project.
- As indicated on page 34, we made this recommendation to Health Services, not the licensing division.

cc: Members of the Legislature
Office of the Lieutenant Governor
Milton Marks Commission on California State
Government Organization and Economy
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press