



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

OCT 24 2006

Washington, D.C. 20201

TO: Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson *Daniel R. Levinson*
Inspector General

SUBJECT: Audit of California's Section 1115 Medicaid Demonstration Project Extension
for Los Angeles County (A-09-04-00038)

The attached final report presents the results of our audit of California's section 1115 Medicaid demonstration project extension for Los Angeles County (the County). Under section 1115 of the Social Security Act, the Secretary of the Department of Health and Human Services may waive compliance with certain requirements of Medicaid law to enable States to carry out demonstration projects and receive Federal funds.

In January 2001, the Centers for Medicare & Medicaid Services (CMS) entered into an agreement with California to extend the County demonstration project for 5 years. The purpose of the extension was to provide Federal financial support ". . . to continue to assist the County in restructuring its health care delivery system to ensure its long-term viability and reduce the County's reliance on Federal demonstration revenue."

CMS provided Federal funding for the project extension through three components: Ambulatory Service Costs (Ambulatory), Supplemental Project Pool (Supplemental), and Administrative Costs. Ambulatory funding was based on the County's certified public expenditures for providing outpatient clinic services to the indigent. Supplemental funding was based on the State's disbursements to the County. Administrative Cost funding was based on actual expenditures. For the 4-year period ended June 30, 2004, the State claimed approximately \$1.6 billion in Ambulatory and Supplemental expenditures and approximately \$47.1 million in Administrative Cost expenditures.

CMS requested that we evaluate the State's compliance with the project extension agreement. We agreed to focus our review on Ambulatory and Supplemental funding.

Our objective was to determine, for State fiscal years 2001 through 2004, whether the State followed the requirements of the project extension agreement when claiming Federal Ambulatory and Supplemental funds and adequately supported the costs claimed.

The State followed the requirements of the project extension agreement when claiming Federal Ambulatory and Supplemental funds and adequately supported the costs claimed for outpatient clinic services under both components. We noted, however, that the County could not identify approximately \$549.8 million (approximately \$285.2 million Federal share) in claimed Supplemental expenditures with specific costs incurred.

The project extension agreement did not require that claimed Supplemental expenditures be based on costs incurred by the County or State for specific services, supplies, or equipment. According to the project extension proposal, the purpose of the Supplemental funding was to offset any disproportionate share hospital payments lost as a result of reduced inpatient hospital utilization under the waiver. The project extension agreement allowed the State to claim as Supplemental expenditures amounts that the State disbursed to the County if the County (1) provided the non-Federal share of the disbursements and (2) certified annually to providing at least 450,000 outpatient clinic visits to indigent and Medicaid patients.

An agreement for a federally funded project should contain an accountability requirement to ensure that Federal funds are spent in accordance with the purposes of the project. Without such a requirement, there was no assurance that the County used the approximately \$549.8 million in Supplemental funding for the intended purposes. County documentation indicated that Supplemental disbursements had contributed to a reserve fund of approximately \$306.4 million accumulated by the County Department of Health Services.

Given our finding that the County placed a significant portion of Federal funds in a reserve account, we recommend that CMS, in future demonstration project agreements with California and the County, deny or limit such use of Federal funds. We also recommend that if CMS approves future section 1115 agreements, it require documentation by the State and County for claimed expenditures.

In its written comments on the draft report, CMS agreed with our recommendations.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov. Please refer to report number A-09-04-00038 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**AUDIT OF CALIFORNIA'S
SECTION 1115 MEDICAID
DEMONSTRATION PROJECT
EXTENSION FOR LOS ANGELES
COUNTY**



Daniel R. Levinson
Inspector General

October 2006
A-09-04-00038

Office of Inspector General

<http://oig.hhs.gov>

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OAS FINDINGS AND OPINIONS

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



EXECUTIVE SUMMARY

BACKGROUND

Section 1115 of the Social Security Act (the Act) provides the Secretary of the Department of Health and Human Services with broad authority to authorize demonstration projects to assist in promoting the objectives of the Medicaid program. Under section 1115, the Secretary may waive compliance with any of the requirements of section 1902 of the Act to enable States to carry out these projects and receive Federal funds.

In January 2001, the Centers for Medicare & Medicaid Services (CMS) entered into an agreement with California to extend the Los Angeles County (the County) Medicaid demonstration project for 5 years. The purpose of the extension was to provide Federal financial support “. . . to continue to assist the County in restructuring its health care delivery system to ensure its long-term viability and reduce the County’s reliance on Federal demonstration revenue.”

CMS provided Federal funding for the project extension through three components: Ambulatory Service Costs (Ambulatory), Supplemental Project Pool (Supplemental), and Administrative Costs. Ambulatory funding was based on the County’s certified public expenditures for providing outpatient clinic services to the indigent. Supplemental funding was based on the State’s disbursements to the County. Administrative Cost funding was based on actual expenditures. For the 4-year period ended June 30, 2004, the State claimed approximately \$1.6 billion in Ambulatory and Supplemental expenditures and approximately \$47.1 million in Administrative Cost expenditures.

CMS requested that we evaluate the State’s compliance with the project extension agreement. We agreed to focus our review on Ambulatory and Supplemental funding.

OBJECTIVE

Our objective was to determine, for State fiscal years 2001 through 2004, whether the State followed the requirements of the project extension agreement when claiming Federal Ambulatory and Supplemental funds and adequately supported the costs claimed.

SUMMARY OF FINDINGS

The State followed the requirements of the project extension agreement when claiming Federal Ambulatory and Supplemental funds and adequately supported the costs claimed for outpatient clinic services under both components. We noted, however, that the County could not identify approximately \$549.8 million (approximately \$285.2 million Federal share) in claimed Supplemental expenditures with specific costs incurred.

The project extension agreement did not require that claimed Supplemental expenditures be based on costs incurred by the County or State for specific services, supplies, or equipment. According to the project extension proposal, the purpose of the Supplemental funding was to offset any disproportionate share hospital payments lost as a result of reduced inpatient hospital

utilization under the waiver. The project extension agreement allowed the State to claim as Supplemental expenditures amounts that the State disbursed to the County if the County (1) provided the non-Federal share of the disbursements and (2) certified annually to providing at least 450,000 outpatient clinic visits to indigent and Medicaid patients.

An agreement for a federally funded project should contain an accountability requirement to ensure that Federal funds are spent in accordance with the purposes of the project. Without such a requirement, there was no assurance that the County used the approximately \$549.8 million in Supplemental funding for the intended purposes. County documentation indicated that Supplemental disbursements had contributed to a reserve fund of approximately \$306.4 million accumulated by the County Department of Health Services.

RECOMMENDATIONS

Given our finding that the County placed a significant portion of Federal funds in a reserve account, we recommend that CMS, in future demonstration project agreements with California and the County, deny or limit such use of Federal funds. We also recommend that if CMS approves future section 1115 agreements, it require documentation by the State and County for claimed expenditures.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In its written comments on the draft report, CMS agreed with our recommendations. The complete text of CMS's comments is included as Appendix D.

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INTRODUCTION

BACKGROUND

Section 1115 of the Social Security Act (the Act) provides the Secretary of the Department of Health and Human Services with broad authority to authorize demonstration projects to assist in promoting the objectives of the Medicaid program. Under section 1115, the Secretary may waive compliance with any of the requirements of section 1902 of the Act to enable States to carry out these projects and receive Federal funds.

The projects, generally approved for 5 years, allow States the flexibility to expand eligibility and provide additional services that may not be otherwise allowed under the Medicaid program. The projects are required to be budget neutral.

Los Angeles County Medicaid Demonstration Project

The Centers for Medicare & Medicaid Services (CMS) approved California's section 1115 Medicaid demonstration project for Los Angeles County (the County) for an initial term of 5 years ended June 30, 2000. The project provided approximately \$1.2 billion of Federal funds to stabilize the County health care delivery system and assist in restructuring the system to rely less on emergency room care and more on primary and outpatient care.

All existing legal requirements of the Medicaid program applied except those expressly waived or identified as not applicable in the project award letter. The project award letter waived the requirement that the project be implemented statewide and provided Federal funds.

Demonstration Project Extension

In January 2001, CMS entered into an agreement with California to extend the demonstration project for an additional 5 years. CMS extended the project ". . . to continue to assist the County in restructuring its health care delivery system to ensure its long-term viability and reduce the County's reliance on Federal demonstration revenue."

According to the project extension agreement, CMS would provide funds to the State at the applicable Federal medical assistance percentage for three project extension components: Ambulatory Service Costs (Ambulatory), Supplemental Project Pool (Supplemental), and Administrative Costs. The agreement limited Federal funding for the Ambulatory and Supplemental components to a total of \$900 million over the term of the project extension. This limitation was structured as a 5-year phaseout with annual upper limits. The agreement required the State to submit all claims for Federal funds to CMS within 2 years of the calendar quarter in which the expenditures were made.

- Ambulatory funding would reimburse the County's certified public expenditures for providing outpatient clinic services to indigent patients. The certified public expenditures represented those expenditures not reimbursed by Medicaid or other third parties, excluding State and County subsidies. The State reported the County's certified public

expenditures as project extension expenditures and claimed Federal funds based on the date the services were rendered.

- Supplemental funding, according to the project extension proposal, would reimburse the County for disproportionate share hospital (DSH) payments that were lost as a result of reduced inpatient hospital utilization under the waiver. The State disbursed this funding, which consisted of both Federal and non-Federal funds, in amounts requested by the County if the County provided the non-Federal share and certified to rendering at least 450,000 visits annually to indigent and Medicaid patients in designated outpatient clinics. The State reported the disbursements as project extension expenditures and claimed Federal funds when it made the disbursements. The County provided the non-Federal share to the State through intergovernmental transfers (IGT).
- Administrative Cost funding would reimburse the County for actual expenditures to administer the project extension.

CMS, which is responsible for monitoring and evaluating Medicaid demonstration projects, requested that we evaluate the State's compliance with the project extension agreement. We agreed to focus our review on Ambulatory and Supplemental funding.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine, for State fiscal years (FY) 2001 through 2004, whether the State followed the requirements of the project extension agreement when claiming Federal Ambulatory and Supplemental funds and adequately supported the costs claimed.

Scope

We reviewed State FYs 2001 through 2004.¹ For that period, the State claimed approximately \$1.6 billion in Ambulatory and Supplemental expenditures.²

We performed tests and other auditing procedures as necessary to meet the objective of our review. An overall review of the State and County internal control structures was not necessary to achieve our objective. We did not evaluate the County's achievement of project extension goals, nor did we review the budget neutrality of the project extension.

We conducted fieldwork at the County Department of Health Services, selected County health clinics, and the State Department of Health Services in Sacramento, California. We also met with CMS region IX officials in San Francisco and Sacramento and held teleconferences with CMS headquarters officials.

¹CMS requested that we review State FY 2003 (July 1, 2002, through June 30, 2003). However, when we began the audit, expenditures for State FY 2003 were not finalized. For a more comprehensive review, we added the finalized expenditures for State FYs 2001 and 2002 and the nonfinalized expenditures for State FY 2004.

²For the same period, the State claimed approximately \$47.1 million in Administrative Cost expenditures.

Methodology

To accomplish our objective, we:

- reviewed the project extension agreement and the related “Operational Protocol” and “Accounting Procedures” documents;
- interviewed CMS headquarters and region IX staff and State and County personnel;
- analyzed documentation pertaining to the (1) State’s and County’s processes for claiming Federal Ambulatory and Supplemental funds, (2) State’s disbursements of Federal funds to the County, (3) County’s use of Federal funds, and (4) State’s reporting of expenditures to CMS;
- reviewed the adequacy of the State’s and County’s processes for documenting and claiming Ambulatory expenditures through substantive testing of judgmentally selected transactions supporting expenditures claimed by the State in State FY 2003; and
- reviewed supporting documentation for Supplemental expenditures claimed by the State in State FYs 2001 through 2004.

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

FINDINGS AND RECOMMENDATIONS

The State followed the requirements of the project extension agreement when claiming Federal Ambulatory and Supplemental funds and adequately supported the costs claimed for outpatient clinic services under both components. We noted, however, that the County could not identify approximately \$549.8 million (approximately \$285.2 million Federal share) in claimed Supplemental expenditures with specific costs incurred.³

The project extension agreement did not require that claimed Supplemental expenditures be based on costs incurred by the County or State for specific services, supplies, or equipment. According to the project extension proposal, the purpose of Supplemental funding was to offset any DSH payments lost as a result of reduced inpatient hospital utilization under the waiver. The project extension agreement allowed the State to claim as Supplemental expenditures amounts that the State disbursed to the County if the County (1) provided the non-Federal share of the disbursements and (2) certified annually to providing at least 450,000 outpatient clinic visits to indigent and Medicaid patients.

An agreement for a federally funded project should contain an accountability requirement to ensure that Federal funds are spent in accordance with the purposes of the project. Without such a

³State expenditures of approximately \$348.9 million (approximately \$179.1 million Federal share) for State FYs 2001 and 2002 are final. At the completion of our fieldwork, State expenditures of approximately \$200.9 million (approximately \$106.1 million Federal share) for State FYs 2003 and 2004 were subject to change up to the 2-year claiming limitation specified in the project extension agreement.

requirement, there was no assurance that the County used the approximately \$549.8 million in Supplemental funding for the purposes intended by the project extension agreement. Documentation provided by County officials indicated that Supplemental disbursements had contributed to a reserve fund of approximately \$306.4 million accumulated by the County Department of Health Services.

PROJECT EXTENSION REQUIREMENTS

Attachment A, section 1(b), of the project extension agreement allowed the State to claim Ambulatory costs for indigent patients as expenditures eligible for Federal funding. To receive the Federal funds, the County was required to certify public expenditures for providing medical services to indigent patients. Federal regulations (42 CFR § 433.51) allow a local public agency to certify its public expenditures and submit them to the State to receive Federal funds.

Attachment A, section 1(c), of the project extension agreement allowed the State to claim Supplemental disbursements to the County as expenditures eligible for Federal funding. Exhibit IV of the project extension proposal stated that the amount of the Supplemental expenditures would include the amount of DSH funds lost as a result of reduced inpatient hospital utilization under the waiver. To receive the Supplemental disbursements, the County was required to (1) request amounts to be disbursed; (2) provide the non-Federal share of the disbursements; and (3) certify that at least 450,000 visits were rendered annually to indigent and Medicaid patients in designated outpatient clinics. The project extension agreement did not require that Supplemental disbursements be identified with specific costs incurred for services, supplies, or equipment.

AMBULATORY AND SUPPLEMENTAL EXPENDITURES

Through the first 4 years of the project extension, the State claimed approximately \$783.2 million in Ambulatory expenditures and approximately \$791.2 million in Supplemental expenditures. (See Appendix A for a summary of these expenditures by State FY.)

Ambulatory Expenditures Identified With Costs

For the Ambulatory component, the State claimed approximately \$783.2 million based on County-certified public expenditures for services, supplies, and equipment used in providing medical care to the indigent in outpatient facilities. (See Appendix B for a diagram showing the flow of funds and certified public expenditures for the Ambulatory component.)

Supplemental Expenditures Not Identified With Costs

For the Supplemental component, the State claimed approximately \$791.2 million based on disbursements it made to the County, not specific costs incurred. We identified approximately \$241.4 million in County-certified public expenditures for medical care to the indigent that the State did not claim for Federal reimbursement under the Ambulatory component. The County could not identify the approximately \$549.8 million remaining with specific costs incurred.

The County initiated the State disbursements by requesting the amounts to be disbursed, providing the non-Federal share of the disbursements through IGTs, and certifying to rendering at least 450,000 visits annually to indigent and Medicaid patients in designated outpatient clinics. (The certified visits were reimbursed by the Ambulatory component of the project extension or the regular Medicaid program.) After receiving the disbursements, the County allocated amounts equal to the IGTs to its General Fund and the remaining amounts to departmental units of the County Department of Health Services and Department of Mental Health. (See Appendix C for a diagram showing the flow of funds for the Supplemental component.)

County officials informed us that they were unable to identify the specific use of the disbursements allocated to the General Fund and departmental units. County officials also stated: “The available federal funds . . . helped us maintain our current service levels and helped build a reserve (Designation Fund), which the County will draw upon to delay potential future service reductions.” County documentation showed that the Department of Health Services had accumulated a balance of approximately \$306.4 million in the Designation Fund for State FYs 2001 through 2004.⁴ The following table shows the annual increases in the fund:

Annual Increases in the Designation Fund
(in millions)

<u>State FY</u>	<u>Increase</u>
2001	\$55.9
2002	48.7
2003	18.0
2004	<u>183.8</u>
Total	\$306.4

RECOMMENDATIONS

Given our finding that the County placed a significant portion of Federal funds in a reserve account, we recommend that CMS, in future demonstration project agreements with California and the County, deny or limit such use of Federal funds. We also recommend that if CMS approves future section 1115 agreements, it require documentation by the State and County for claimed expenditures.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In its written comments on the draft report, CMS agreed with our recommendations. CMS stated that future section 1115 demonstration project agreements with California would contain specific

⁴In addition to accumulating approximately \$306.4 million during the first 4 years of the project extension, the County accumulated a surplus of approximately \$262.3 million during the initial 5-year term of the project. At the end of State FY 2004, the balance of the Designation Fund was approximately \$568.7 million.

terms and conditions that require financial controls and documentation related to the funding and disbursement of expenditures. CMS pointed out that it had recently approved a section 1115 project agreement with California that replaced questionable financing mechanisms with documented permissible funding sources and an accountable and transparent financing system. CMS also detailed several financial safeguards included in the agreement.

The complete text of CMS's comments is included as Appendix D.

APPENDIXES

**SUMMARY OF AMBULATORY AND SUPPLEMENTAL EXPENDITURES
BY STATE FISCAL YEAR**
(in millions)

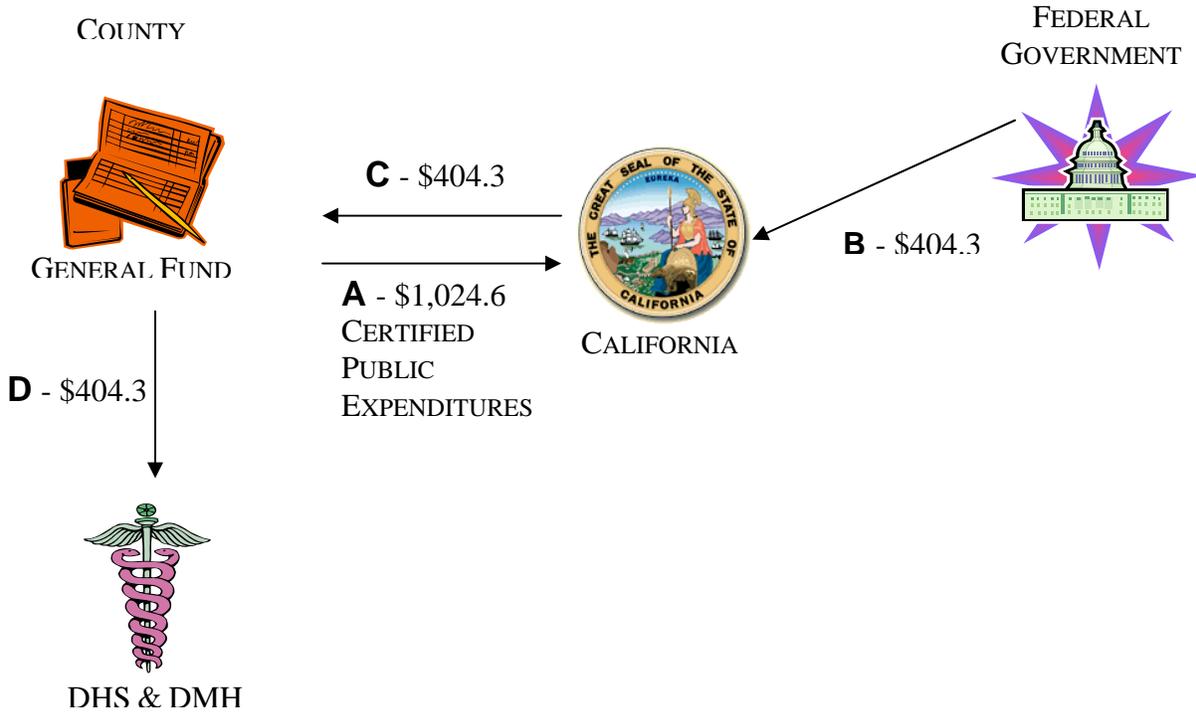
<u>Expenditures</u>	<u>State Fiscal Year (FY)</u>				<u>Total</u>
	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>	
By component:					
Ambulatory	\$247.0	\$240.3	\$162.9	\$133.0	\$783.2
Supplemental	<u>233.6</u>	<u>239.7</u>	<u>204.6</u>	<u>113.3</u>	<u>791.2</u>
Total (A)	\$480.6	\$480.0	\$367.5	\$246.3	\$1,574.4
Certified public					
Claimed ¹	\$247.0	\$240.3	\$162.9	\$133.0	\$783.2
Unclaimed ²	<u>63.2</u>	<u>61.2</u>	<u>62.9</u>	<u>54.1</u>	<u>241.4</u>
Total (B)	\$310.2	\$301.5	\$225.8	\$187.1	\$1,024.6
Claimed amount not identified with specific costs [(A) – (B)]	\$170.4	\$178.5	\$141.7	\$59.2	\$549.8

¹The State claimed these amounts under the Ambulatory component.

²These amounts were costs that the State did not claim under the Ambulatory component. We offset these unclaimed amounts against Supplemental amounts not identified with specific costs incurred.

**AMBULATORY COMPONENT:
FLOW OF FUNDS AND CERTIFIED PUBLIC EXPENDITURES**

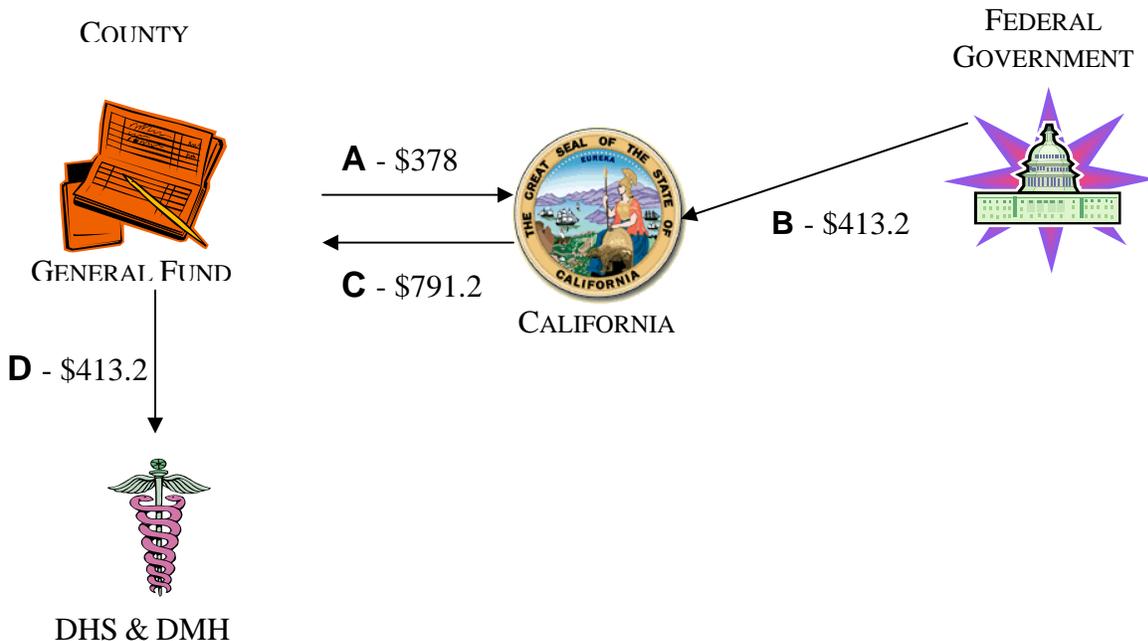
State FYs 2001–2004
(in millions)



- A** The Los Angeles County (the County) Department of Health Services (DHS) certified that DHS and the Department of Mental Health (DMH) made expenditures of \$1,024.6 million for outpatient clinic services to indigent patients. California claimed \$783.2 million of the certified amounts as project extension expenditures eligible for Federal reimbursement.
- B** The Federal Government provided matching funds to the State at the applicable Federal medical assistance percentage (FMAP) rate.
- C** The State made payments to DHS, and the County deposited the payments in its General Fund.
- D** The County allocated funds to departmental units of DHS and DMH.

**SUPPLEMENTAL COMPONENT:
FLOW OF FUNDS**

State FYs 2001–2004
(in millions)



- A** The County transferred funds from its General Fund to the State through intergovernmental transfers. These transfers were used as the State’s share.
- B** The Federal Government provided matching funds to the State at the applicable FMAP rate.
- C** The State made payments to DHS and claimed the payments as project extension expenditures eligible for Federal reimbursement. The County deposited the payments in its General Fund.
- D** The County allocated a portion of the funds to departmental units of DHS and DMH.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

RECEIVED
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GENERAL*Administrator*
Washington, DC 20201

DATE: AUG 24 2006

TO: Daniel R. Levinson
Inspector General

FROM: Mark B. McClellan, M.D., Ph.D. *MM*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Audit of California's Section 1115 Medicaid Demonstration Project Extension for Los Angeles County" (A-09-04-00038)

Thank you for the opportunity to review and comment on the above OIG Draft report. We note that you conducted this report in response to our request and greatly appreciate your activities in this area. Moreover, we note that the specific demonstration that you reviewed has since been closed out and is no longer operational. Please be assured that subsequent Section 1115 demonstrations in California will contain specific terms and conditions that require financial controls and documentation related to the funding and disbursement of demonstration expenditures.

Most recently, the Centers for Medicare & Medicaid Services (CMS) has approved a California Hospital/Uninsured Section 1115 Waiver (11-W-00193/9) which moved many of the State's governmentally operated hospitals from a payment structure dependent on supplemental payments funded by intergovernmental transfers (IGTs) and under which providers did not fully retain payments to one which bases payments to such providers on documented Medicaid and uninsured costs and is funded by certified public expenditures (CPEs). With the implementation of this demonstration, California has replaced previous questionable financing mechanisms with documented permissible funding sources and an accountable and transparent financing system.

OIG Recommendation:

OIG recommends that if CMS approves a future section 1115 demonstration for California and LA County, that CMS deny or limit the State's ability to retain Federal funds in a reserve account and require documentation for claimed expenditures.

CMS Response:

We concur with the recommendations presented to CMS by OIG. Please note that the Los Angeles county demonstration has terminated prior to the release of the OIG report.

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The current demonstration in California has been implemented and includes the following financial safeguards.

- This demonstration creates a platform for Medicaid reform in the State by creating a Safety Net Care Pool out of which the state can make payments to providers for medical care services provided to the uninsured and also requires the State to expand healthcare coverage to the uninsured to fully access the pool. This pool provides the traditional safety net hospitals (23 governmentally operated facilities) with a source of revenue tied directly to their actual incurred costs for providing services to uninsured through the use of CPEs and documented cost reports.
- The demonstration also addresses the financing of the non-Federal share of Medicaid payments that were based on IGTs. The State will convert funding of base Medicaid rates, disproportionate share hospital (DSH) payments and Safety Net Care Pool payments to CPEs. The amounts eligible for certification will be determined using a CMS approved State Medicaid cost report (Medi-Cal 2552-96) derived from the Medicare/Medicaid 2552-96 cost report. The State is precluded through the demonstration terms and conditions of making any payments above cost to governmentally-operated providers; Medicaid, DSH and pool payments will all be based on the actual costs of services delivered by these providers.
- Payments to 23 governmentally-operated hospitals will be based on, and limited to, Medicaid cost as determined by the approved Medi-Cal 2552-96 Cost Report. The State will now fund all Medicaid base and DSH payments to these hospitals using CPEs.
- The creation of a Safety Net Care Pool which potentially makes available to the State \$766 million per year for five years (total of \$3,830,000,000) in Federal financial participation for the reimbursement of costs of providing medical care services to the uninsured or creating an insurance product targeted to the uninsured. Of this \$766 million, the availability of \$180 million will be contingent upon the State meeting specified Federal goals in each of the five years. The first two years of contingent money are tied to goals associated with the expansion of managed care to the aged, blind, and disabled population. The last three years of contingent Federal funding are tied to goals for expansion of healthcare coverage to currently uninsured individuals. We believe these represent significant program improvements with regard to both cost containment and new coverage for uninsured Californians.
- Safety Net Care Pool funds may be accessed only by the State, counties, or cities and designated governmentally operated providers for uncompensated costs of medical care services provided to uninsured individuals. The use of CPEs by any of these entities must

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be based on cost reimbursement with cost identified using reporting tools agreed on by both CMS and the State.

- The State must have (and must demonstrate to CMS, as requested) permissible sources for the non-Federal share of payments from the Safety Net Care Pool, which sources can include CPEs from government operated entities. Sources of non-Federal funding shall not include provider taxes or donations impermissible under section 1903(w), IGTs from

Safety Net Care Pool providers, or Federal funds received from other Federal programs (unless expressly authorized by Federal statute to be used for matching purposes).

- During the term of the demonstration, the State may not impose a provider tax, fee or assessment on inpatient hospitals, outpatient, or physician services that will be used as the non-Federal portion of any Title XIX payment.

Thus, we believe that the currently approved demonstration responds directly to the OIG recommendations.

We again thank you for the opportunity to comment on this draft report.