



Department of Health Care Services

Despite the COVID-19 Public Health Emergency,
the Department Can Do More to Address
Chronic Medi-Cal Eligibility Problems

July 2021

REPORT 2020-613





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July 8, 2021
2020-613

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 authorized by state law, my office conducted a state high risk audit of the Department of Health Care Services' (Health Care Services) management of federal funds related to the COVID-19 public health emergency that began in 2020. Health Care Services administers the Medi-Cal program, which received a significant increase in federal support to respond to the emergency. The following report details our conclusion that Health Care Services is not doing enough—notwithstanding the emergency—to resolve eligibility questions about Medi-Cal beneficiaries and avoid federal financial penalties associated with individuals who should not be enrolled in Medi-Cal.

Health Care Services has halted efforts to resolve hundreds of thousands of known Medi-Cal eligibility discrepancies and to complete reviews of counties and resolve problems in their eligibility processes. Although it suspended this work for the public health emergency, in part, because changes in federal and state laws have temporarily changed Medi-Cal qualification criteria, we found that Health Care Services can take some steps now to resolve certain known eligibility issues and to prepare counties for the eligibility decisions they must make when the emergency ends. For example, for beneficiaries with questionable eligibility, Health Care Services should direct counties to research their eligibility and, when allowed, take steps to remove those individuals from Medi-Cal who are no longer eligible. Health Care Services could also advise counties to fix problems in their eligibility processes—problems that the department identified before the emergency but has not followed up on.

Our concerns with eligibility processes within Medi-Cal are long-standing; we identified them in numerous past reviews, and they have already cost California tens of millions of dollars in federal reimbursements. We believe it is critical that Health Care Services take steps now to address this potentially costly high-risk issue.

Respectfully submitted,

A handwritten signature in black ink that reads 'Elaine M. Howle'. The signature is written in a cursive, flowing style.

ELAINE M. HOWLE, CPA
California State Auditor

Selected Abbreviations Used in This Report

CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CMS	Centers for Medicare and Medicaid Services
FMAP	Federal Medical Assistance Percentage
HHS	Health and Human Services Agency

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Summary

Results in Brief

The Department of Health Care Services (Health Care Services) administers the California Medical Assistance Program known as *Medi-Cal*, which primarily serves individuals with limited income. The number of Californians enrolled in Medi-Cal has increased during the COVID-19 public health emergency, in part because the federal government is providing additional funds to states that agree to temporarily provide continuous coverage to beneficiaries validly enrolled during the emergency. Although we describe a number of ways in which Health Care Services has responded appropriately to the emergency, we are concerned that the department has halted its efforts to resolve hundreds of thousands of known Medi-Cal eligibility discrepancies that indicate some beneficiaries may no longer be eligible. Many of these discrepancies existed before the emergency began. The number of beneficiaries with questionable or undetermined eligibility has grown by 22 percent over the last year, yet some portion of these discrepancies can be resolved even under current federal requirements. These problems have already cost California tens of millions of dollars in federal reimbursements, and the risk that California will have to pay future financial penalties continues to grow unabated.

In response to the public health emergency, the federal government focused on protecting people's health and their access to health care. The Families First Coronavirus Response Act (Families First Act) increased the federal government's share of Medi-Cal costs and, in exchange, required Health Care Services to maintain most individuals' enrollment in Medi-Cal by not removing them from the program, except in very limited circumstances. Consequently, with federal authorization to do so, Health Care Services has instructed counties to stop various types of eligibility reviews for individuals enrolled in Medi-Cal. Nonetheless, federal and state laws still allow Health Care Services and counties to remove individuals from Medi-Cal who have temporary eligibility but do not ultimately meet eligibility requirements, or for reasons such as death, moving out of state, or requests from the individuals to be removed.

Health Care Services' halting of eligibility work during the emergency is exacerbating a significant, long-standing problem within Medi-Cal. The department has a history of not adequately dealing with beneficiaries with questionable eligibility. It had to reimburse the federal government more than \$43 million as a result of a 2019 Office of the Inspector General review of its eligibility review practices. Prior to this, in an October 2018 audit, we found that Health Care Services paid at least \$4 billion in Medi-Cal payments for beneficiaries with questionable eligibility because of

Audit Highlights . . .

Our audit of Health Care Services' management of Medi-Cal, which has received increased federal funding during the public health emergency, highlighted the following:

- » *Even with protections for beneficiaries' health in place for the emergency, Health Care Services is allowed to resolve and take action on some eligibility discrepancies.*
- » *Hundreds of thousands of known eligibility discrepancies that indicate some beneficiaries may no longer be eligible for Medi-Cal remain unresolved.*
 - *After Health Care Services halted a pilot program intended to help resolve this longstanding problem, the number of eligibility discrepancies grew by 22 percent during the last year.*
 - *More than 37,000 individuals are eligible for Medi-Cal in county data systems but not in the State's, and likely face obstacles obtaining medical care.*
- » *The list of eligibility discrepancies continues to grow each month Health Care Services delays resolving them, as does the risk that the State will need to reimburse the federal government for improper payments.*
- » *Health Care Services needs to do more, such as providing guidance to counties on the resolution of high-risk eligibility issues and in making Medi-Cal redeterminations.*
- » *Health Care Services applied for and implemented federal waivers to modify the Medi-Cal program to respond to the emergency and effectively communicated these and other changes to its stakeholders.*

discrepancies between the State's and the counties' eligibility data systems. In response to our audit findings and recommendations, Health Care Services started a pilot program in July 2019 to resolve these discrepancies. However, in response to the emergency, Health Care Services suspended the pilot program in March 2020. In only one year since this decision, the number of eligibility discrepancies grew by more than 89,000, or 22 percent, and as of March 2021 the total number of discrepancies exceeded 500,000.

Even with the protections the Families First Act put in place for the public health emergency, federal and state laws allow Health Care Services and counties to resolve certain eligibility issues and take immediate action. For example, individuals meeting certain criteria receive temporary eligibility based on preliminary information from their applications, and Health Care Services flags cases in which counties have not processed the application and made an eligibility determination within two months. However, in March 2021, Health Care Services identified nearly 2,400 such beneficiaries who had had temporary eligibility for more than two months. Even under the Families First Act, Health Care Services and the counties have both the authority and the responsibility during the emergency to finalize these beneficiaries' applications by affirming eligibility or appropriately discontinuing their coverage. Further, more than 37,000 individuals have been identified as eligible for Medi-Cal in one of the county data systems but not in the state data system. Without follow-up on these discrepancies, these individuals will likely face obstacles to obtaining medical care.

In addition to these instances, which Health Care Services and counties can and should resolve immediately, Health Care Services should direct counties to restart follow-up work related to 364,000 beneficiaries that Health Care Services has identified as having questionable eligibility because of an unspecified problem requiring action by the county. Although counties will find that some portion of these beneficiaries do qualify for Medi-Cal, or cannot be removed from Medi-Cal during the public health emergency, some portion of these discrepancies likely represent beneficiaries who do not meet eligibility requirements and should not be enrolled in the program. For these discrepancies, eligibility workers at the county level must perform detailed reviews to determine whether the beneficiaries should continue to receive benefits, should have their benefits removed at the end of the emergency, or should have their benefits removed immediately. Each month that Health Care Services delays this effort, the list of these discrepancies grows larger and the risk that California will have to reimburse the federal government for improper Medi-Cal payments increases.

To begin addressing the backlog of halted eligibility work, Health Care Services is developing guidance for counties to resume certain types of eligibility work before the end of the public health emergency. However, we found that Health Care Services has omitted a consideration of key high-risk eligibility problems from its planning efforts. For example, the department does not currently plan to direct counties to research and, if possible, resolve the 364,000 instances of beneficiaries with questionable eligibility, including cases in which the county attempted to terminate a beneficiary's eligibility. By not including all high-risk eligibility issues in its planning and guidance, Health Care Services may be continuing to make payments for individuals who should not be enrolled in Medi-Cal, even during the pandemic, and it is postponing addressing a growing problem that needs timely resolution.

Health Care Services could do more—even during the public health emergency—to prepare the counties to fulfill their critical role of making accurate and timely Medi-Cal redeterminations once the emergency ends. Numerous past audits have found that the department and the counties had poor and faulty processes for performing this work, and in 2018 Health Care Services developed and started county reviews—termed *focus reviews*—to rectify the problems. Although Health Care Services suspended its focus reviews during the emergency, it had already collected information from 39 counties from 2018 and 2019, which it had largely not acted upon. Those data show weaknesses with the processes of at least 24 of the counties. Health Care Services could have capitalized on that information to better position the counties for the redetermination work they must perform once the emergency is over. Coming out of the emergency, counties will have to perform redeterminations for individuals currently on Medi-Cal, and because Health Care Services has not taken all reasonable steps—such as completing focus reviews it started more than two years ago—to help counties improve the processes they follow, counties will likely rely on the past processes that multiple audits and the focus reviews have found to be problematic. When counties make redetermination decisions late or in error, the State is at risk of owing the federal government for Medi-Cal payments that may be disqualified.

In contrast to the concerns described above, we found other areas where the department has appropriately responded to the demands of the emergency. For example, it actively sought authority, called *waivers*, to modify Medi-Cal operations to be more responsive to the emergency. These waivers are issued or approved by the Centers for Medicare and Medicaid Services, the federal agency responsible for administering the Medicaid program, of which Medi-Cal is a part. Key examples of these waiver-based changes are Medi-Cal allowing telehealth appointments to accommodate for social distancing and streamlining the provider enrollment process to allow interested

health care providers to quickly become authorized to serve Medi-Cal beneficiaries. Lastly, we found that Health Care Services has effectively communicated with counties and medical providers about changes in program requirements stemming from the emergency. Even so, the growing backlog of eligibility redeterminations and discrepancies that Health Care Services and counties must address threatens to overshadow these positive efforts. We believe it is critical that Health Care Services take steps now, before the emergency ends and former eligibility requirements are reinstated, to address this looming—and potentially costly—high-risk issue.

Selected Recommendations

To reduce inappropriate payments to health care providers and ensure that eligible individuals have access to care, Health Care Services should do the following by August 2021:

- Begin monitoring instances of individuals identified as eligible for Medi-Cal in a county data system but not the state data system.
- Instruct counties to resume overdue processing of applications for beneficiaries awaiting final eligibility determinations.
- Expand its planning efforts to address all high-risk eligibility discrepancies.
- Resume monitoring counties' progress in resolving high-risk eligibility discrepancies.

To ensure that it is addressing weaknesses in the counties' processes for making eligibility redeterminations, Health Care Services should do the following:

- Review data collected during the focus reviews it conducted in recent years to identify areas in which further county guidance is needed. By September 2021, advise counties of the improvements they must make to their redetermination processes.
- Resume its focus reviews within four months of the end of the public health emergency.

Agency Comments

Health Care Services responded that it will implement our recommendations. However, it disagreed with the implementation dates noted in the recommendations.

Introduction

Background

The federal Medicaid program, overseen by the Centers for Medicare and Medicaid Services (CMS), provides health care coverage to low-income individuals and families who meet federal and state eligibility requirements. California participates in the federal Medicaid program through its California Medical Assistance Program, known as *Medi-Cal*. The Department of Health Care Services (Health Care Services) is the state agency responsible for administering Medi-Cal. Individuals who receive Medi-Cal benefits are referred to as *beneficiaries*.

The State provides Medi-Cal benefits primarily through a managed care delivery system. Health Care Services contracts with managed care health plans (managed care plans) and pays a monthly premium to provide health care to each Medi-Cal beneficiary covered by a plan. These plans work with medical professionals and groups, known as *providers*, who deliver health care services to beneficiaries. About 80 percent of Medi-Cal beneficiaries are enrolled in managed care plans. Health Care Services has responsibility for overseeing managed care plans, including handling the plans' contracts with the department and overseeing their compliance with the terms of the contracts. The remaining Medi-Cal beneficiaries are enrolled in the fee-for-service program. Under this delivery system, Medi-Cal providers bill Health Care Services directly for approved services they have provided to beneficiaries.

Declarations of a Public Health Emergency and Federal COVID-19 Legislation

In January 2020, the secretary of the federal Health and Human Services Agency (HHS) declared that COVID-19 was a public health emergency and in March 2020, the president declared a national emergency related to COVID-19. The combination of these two declarations authorizes the HHS secretary to temporarily waive or modify certain Medicaid requirements during the declared emergency. In this report, we refer to the period of time covered by these two declarations collectively as the *public health emergency*. The purpose of the authority granted to the HHS secretary under the emergency declarations is to ensure sufficient access to health care for people enrolled in Medicaid and to ease the administrative burden on health care providers during the emergency. CMS exercises this authority through the issuance of *waivers*. The HHS secretary authorizes extensions of the emergency in 90-day intervals, and the current extension is in place through July 2021.

In January 2021, the acting HHS secretary indicated in a letter to governors that the emergency will likely be in place at least through December 31, 2021, but the exact end date is unknown.

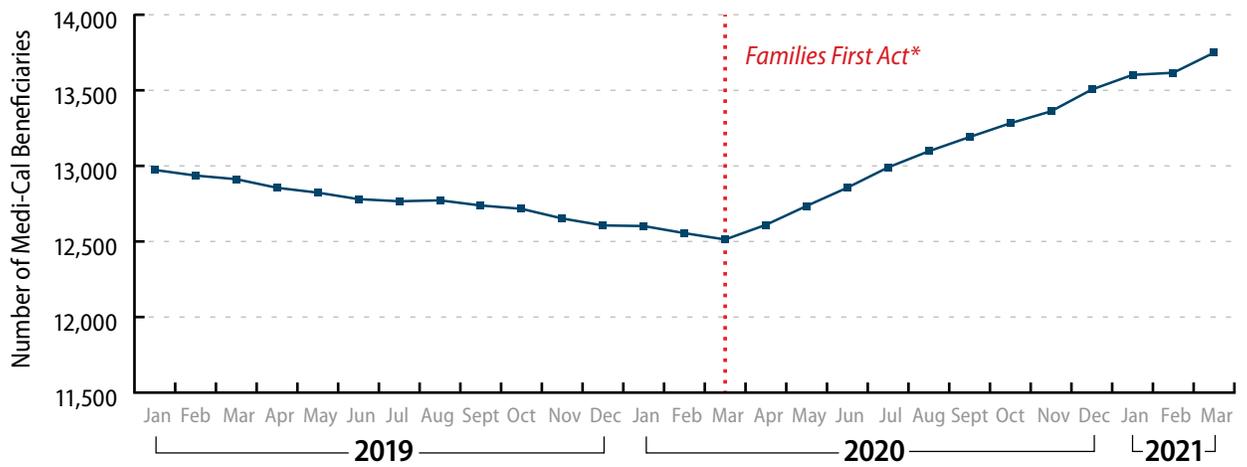
In March 2020, Congress passed two pieces of legislation affecting Medi-Cal: the Families First Coronavirus Response Act (Families First Act) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). The Families First Act generally increased the federal government's share of the payment for Medicaid expenses by 6.2 percent; this share is known as the Federal Medical Assistance Percentage (FMAP). For Medi-Cal, the FMAP increased from 50 percent to 56.2 percent, and the increase will be in place for the duration of the public health emergency. However, as a condition of receiving the increased FMAP, the Families First Act generally requires states to provide continuous coverage to beneficiaries for the duration of the emergency, even when changes to the beneficiaries' status would normally remove their eligibility for Medicaid. The act also prohibits states from making eligibility standards more restrictive than their standards were on January 1, 2020, and it authorizes coverage for COVID-19 testing to uninsured individuals, setting the federal reimbursement rate at 100 percent for these costs. The CARES Act clarifies and adjusts ways that states apply the changes introduced in the Families First Act. For example, the CARES Act added a 30-day grace period beginning in March 2020 to allow states to adjust Medicaid premiums to comply with the Families First Act.

COVID-19 Legislation's Effect on Medi-Cal Enrollment and Costs

Medi-Cal enrollment has increased over the course of the public health emergency. The average number of beneficiaries from January to March 2020, just before the emergency began, was 12.6 million per month. As shown in Figure 1, by March 2021, or about one year into the emergency, the number of beneficiaries had increased to 13.7 million. Two reasons for the increase in beneficiaries stand out: the continuous coverage requirement that the Families First Act established and labor market changes. First, validly enrolled beneficiaries may stay in the Medi-Cal program for the duration of the emergency. Health Care Services may only remove them from Medi-Cal for limited reasons, such as death or moving out of state, or a request from the individual to be removed. Thus, whereas a certain number of beneficiaries would typically be exiting the Medi-Cal program, during the emergency beneficiaries are generally only joining Medi-Cal, and this is causing the number of beneficiaries to steadily increase. Second, more people are becoming eligible for Medi-Cal through labor market changes, such as loss of employment driven by the emergency, which causes them to lose employer-sponsored health care and to need Medi-Cal benefits.

Health Care Services has estimated that for fiscal year 2020–21, Medi-Cal will average a total of 13.6 million beneficiaries. Further, in its May 2021 Medi-Cal local assistance estimate, Health Care Services noted that there is still considerable uncertainty surrounding the magnitude and duration of the COVID-19 impacts on enrollment. It estimated that for fiscal year 2021–22 Medi-Cal will average a total of 14.5 million beneficiaries.

Figure 1
Number of Medi-Cal Beneficiaries From January 2019 Through March 2021
 (in Thousands)

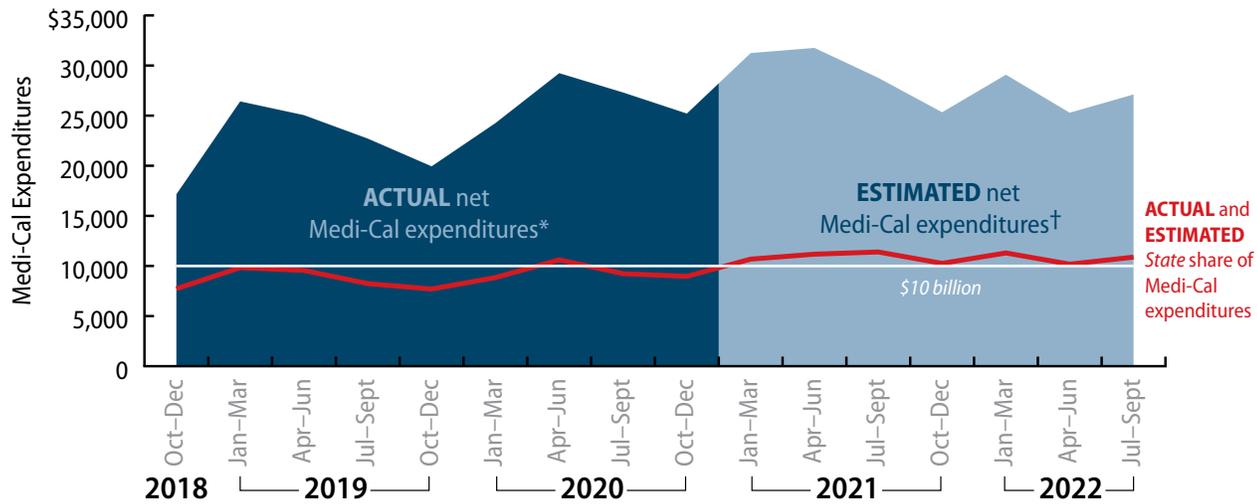


Source: Eligibility data reported on the Health Care Services website and federal law.

* The Families First Act called for 'continuous coverage', which allows validly enrolled beneficiaries to stay in the Medi-Cal program for the duration of the public health emergency.

Due in part to the increase in beneficiaries, total Medi-Cal costs have also risen as a result of COVID-19. Health Care Services reports Medi-Cal expenditures quarterly to CMS, and those total costs increased to an average of \$26.5 billion per quarter in 2020 compared to an average of \$23.5 billion per quarter in 2019. Figure 2 shows total Medi-Cal costs—actual and estimated costs—by quarter from late 2018 through September 2022. As shown in the figure, Health Care Services expects total costs to generally increase, with quarterly costs in July to September 2022 of more than \$27 billion.

Figure 2
Actual and Estimated Medi-Cal Expenditures From October 2018 Through September 2022
(in Millions)



Source: Health Care Services' CMS expenditure reports and November 2020 CMS quarterly grant award report.

* Expenditures include adjustments from the prior quarter and a health program for children.

† Estimated expenditures include those for a health program for children.

The total cost of Medi-Cal has increased and thus, the State's share of Medi-Cal costs has also increased, as indicated in Figure 2. Although state costs were generally less than \$10 billion per quarter in 2019 through early 2020, Health Care Services estimates that these costs will exceed \$10 billion for 2021 and 2022. The department necessarily increased its budget estimate in May 2020 to compensate for the anticipated increase in expenditures, and the Legislature approved an increase in Medi-Cal funding as presented in the May 2020 revision of the Governor's budget.

Reports of Problems With Medi-Cal Eligibility

Historically, Health Care Services has struggled to ensure that Medi-Cal eligibility is determined in a timely and accurate manner. Numerous federal and state reviews of Health Care Services and Medi-Cal have identified weaknesses in how the State determines eligibility, weaknesses that the department has not fully addressed. In our October 2018 report, *Department of Health Care Services: It Paid Billions in Questionable Medi-Cal Premiums and Claims Because It Failed to Follow Up on Eligibility Discrepancies* (2018-603), we found that Health Care Services paid at least \$4 billion in Medi-Cal payments over four years for beneficiaries

with questionable eligibility because of discrepancies between the separate information technology systems that the State and the counties use to store and process beneficiaries' eligibility data. The federal Office of the Inspector General also issued findings similar to ours, and as a result of its review in May 2019, Health Care Services asserts that it has reimbursed the federal government more than \$43 million.

Health Care Services is still working to resolve the recommendations we made in our 2018 report. We made multiple recommendations to the department, including that it implement procedures to ensure the timely resolution of system discrepancies and that it regularly follow up on recurring, unresolved system discrepancies with the responsible counties. In July 2019, Health Care Services implemented a pilot program aimed at reducing the number of discrepancies between state and county eligibility data systems, and it focused on six counties—Alameda, Los Angeles, Orange, Riverside, San Diego, and San Francisco. These six counties are responsible for at least 85 percent of the discrepancies we identified in our 2018 audit report and for 54 percent of all Medi-Cal beneficiaries as of February 2021. At the start of the public health emergency, Health Care Services was operating the pilot program in an effort to reduce the hundreds of thousands of discrepancies that had accumulated, but it suspended the program shortly thereafter. As a result, the number of discrepancies, which was already large, has steadily increased, posing a risk that the State may have to repay CMS for the federal share of Medi-Cal costs for those beneficiaries who have erroneously been granted benefits.

In addition, each year our office reviews Health Care Services to determine whether it meets the federal requirements established for the Medicaid program. Although counties are authorized to make Medi-Cal eligibility decisions, the department retains responsibility for this work being done in a timely and accurate way. In at least the last five reviews, which were conducted between fiscal years 2014–15 and 2018–19, we found that Health Care Services did not ensure that counties were meeting the federal eligibility requirements because counties did not meet the time frames within which they must make eligibility decisions; in addition, the counties sometimes made erroneous decisions. In our 2016 review of federal requirements, for example, the error rate was 10 percent (7 of 69), and in the last published review for 2019, the error rate grew to 36 percent (27 of 75). In 2019 the types of identified errors the counties made included missing applications, missed deadlines, unmet income requirements, and lack of support for the benefits awarded. Because these errors were found in a small, selected sample, the magnitude of the percentage of errors indicates that there are significant numbers of errors across the whole population of Medi-Cal beneficiaries. We could not calculate the dollar

effect, but CMS can require the State to repay the federal share of Medi-Cal costs that are erroneously incurred, and we determined that those costs could be significant. In response to the findings about eligibility, Health Care Services developed a corrective action plan to perform county reviews focusing on eligibility. Health Care Services began performing these focus reviews in 2018. However, to allow counties to prioritize access-to-care issues and concentrate staffing where needed during the public health emergency, the department suspended its focus reviews as of 2020.

The American Rescue Plan Act of 2021

In March 2021, the president signed the American Rescue Plan Act of 2021 (Rescue Act) into law. The Rescue Act provides relief for the continued impacts of COVID-19. Among other provisions, the Rescue Act requires the federal government to cover 100 percent of the costs a state spends for medical assistance for a COVID-19 vaccine and the administration of the vaccine. This report does not address the additional funds or provisions of the Rescue Act.

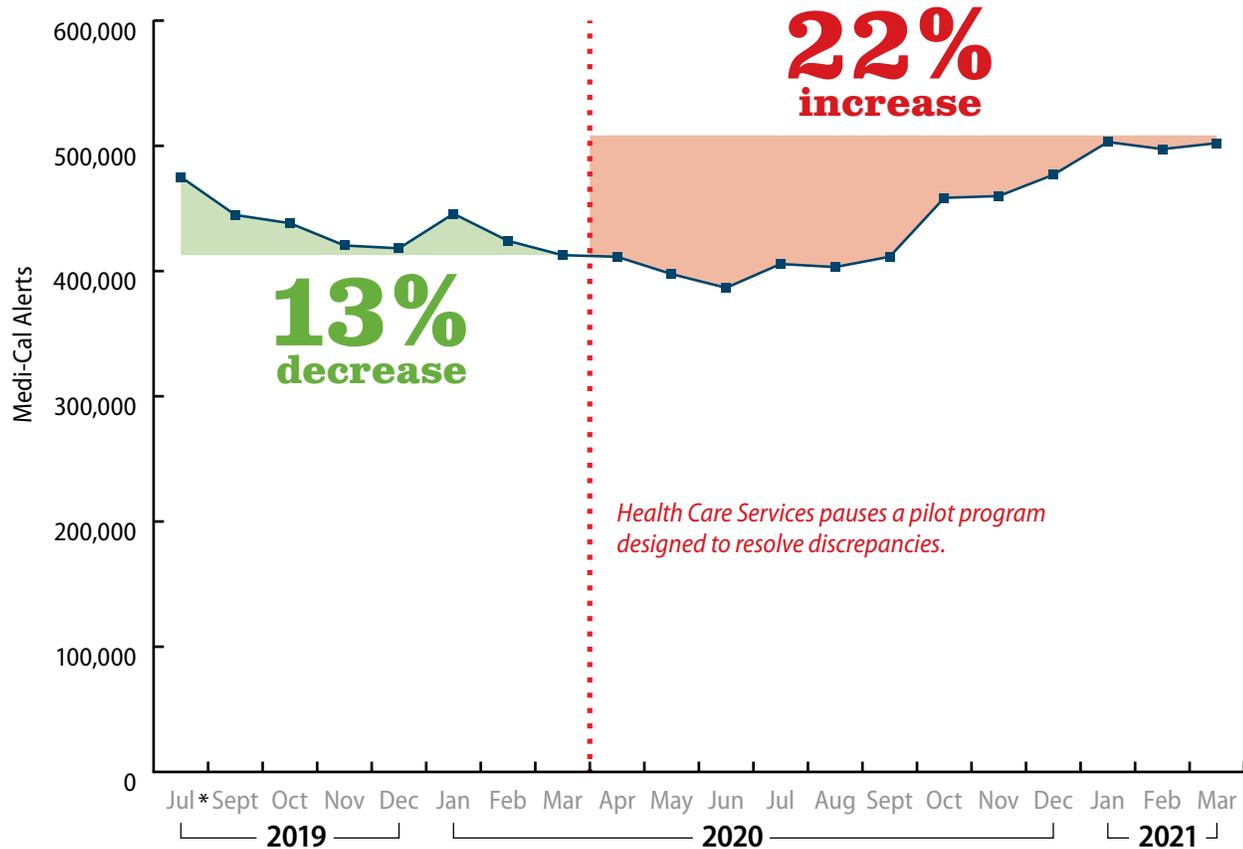
Audit Results

The Large Number of Medi-Cal Beneficiaries With Eligibility Concerns Has Continued to Grow, Increasing the Risk That the State Will Have to Reimburse the Federal Government

Citing the COVID-19 public health emergency, Health Care Services halted its efforts to resolve existing Medi-Cal eligibility discrepancies between state and county data systems in March 2020. As a result, the number of these discrepancies has grown during the emergency, increasing the risk that the State will improperly provide Medi-Cal benefits and may have to reimburse the federal government for a portion of those costs. Although counties are responsible for determining whether individuals are eligible for Medi-Cal, Health Care Services has overall responsibility for Medi-Cal, including statewide oversight of county eligibility determinations. As discussed in the Introduction, Health Care Services established a pilot program to help resolve a long-standing problem with eligibility discrepancies caused by differences in the counties' and the State's data systems. In July 2019, Health Care Services began providing counties involved in the pilot program monthly reports identifying discrepancies for beneficiaries who might not be eligible for Medi-Cal. The reports list alerts for beneficiaries at high risk of being inappropriately enrolled. Between July 2019 and March 2020, Health Care Services and the six counties involved in the pilot program were able to reduce the number of alerts by 62,000, or 13 percent, as shown in Figure 3. However, after Health Care Services paused the pilot program in response to the emergency, the number of alerts grew over the next year by more than 89,000, or 22 percent, and exceeded 500,000 alerts.

Health Care Services indicated that one of the reasons it paused the pilot program was because it believed that the number of people requesting Medi-Cal benefits would increase because of the public health emergency. The department believed that by pausing the requirement for counties to address these alerts, the counties could use staff resources to focus on the anticipated increase in applications. However, as seen in Figure 4, the number of monthly applications only increased initially, and the overall number of new applications for Medi-Cal was actually lower in 2020 than in 2019. Despite this, according to the acting chief of Health Care Services' Policy Development Branch, county eligibility workers still faced significant additional workload resulting from the emergency, such as working with current beneficiaries who were experiencing changes in income that could impact their coverage. Further, in December 2020, the number of COVID-19 cases in California was climbing and the acting state public health officer issued regional stay-at-home orders, which had the potential to increase unemployment and result in an increase in Medi-Cal applications.

Figure 3
Medi-Cal Alerts Increased After Health Care Services Paused Its Program for Resolving Eligibility Discrepancies



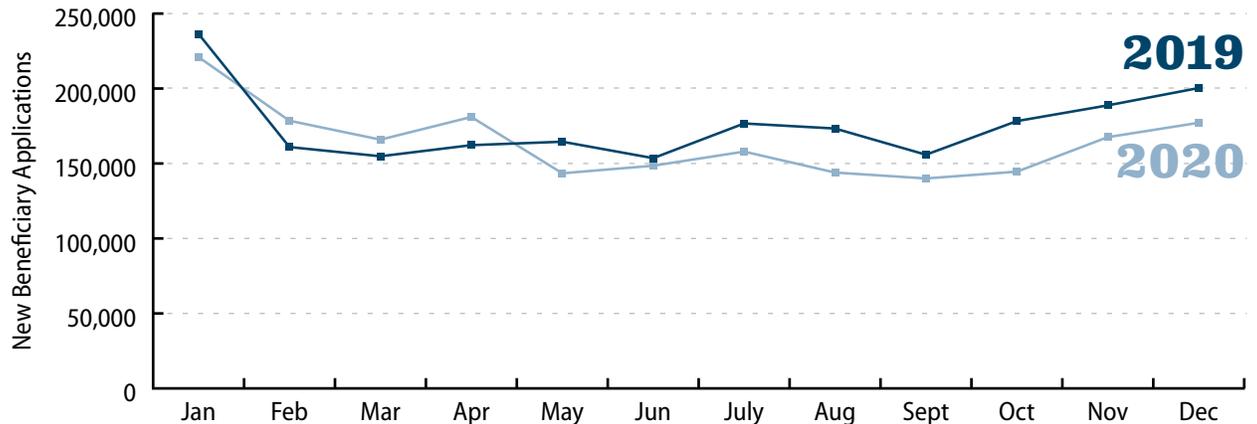
Source: Health Care Services' pilot program reports.

* Health Care Services did not produce a pilot program report for August 2019.

Even so, when applications for Medi-Cal did not subsequently increase and the stay-at-home orders ended, Health Care Services—to its credit—established an emergency workgroup in February 2021 to address certain eligibility issues within Medi-Cal. However, as we discuss in the following section, this emergency workgroup has not yet addressed some of the more critical high-risk alerts originally included in the pilot program.

A second reason that Health Care Services paused the pilot program is that the department and the counties are limited in their authority to resolve some of the alerts during the public health emergency. As discussed in the Introduction, the Families First Act generally requires states to provide continuous coverage to beneficiaries for the duration of the emergency as a condition of receiving additional federal funds. For example, beneficiaries who were enrolled in Medi-Cal when the Families First Act

Figure 4
 The Number of New Beneficiary Applications in Counties in 2020 Was Generally Lower Than in 2019



Source: Health Care Services' enrollment statistics.

was enacted on March 18, 2020, but who needed to have their eligibility redetermined due to a change in circumstance, cannot lose their eligibility until the end of the emergency. Although it was reasonable for Health Care Services to stop monitoring those alerts that could not be resolved during the emergency, Health Care Services and counties could have worked to resolve the many alerts that they still had the authority to correct, as we discuss in the following section.

With an increasing number of unresolved eligibility alerts, the State faces increased risk of improperly providing Medi-Cal benefits and of having to repay the federal government for the federal portion of these payments. We analyzed the monthly pilot program reports and identified more than 173,000 beneficiaries with an unresolved eligibility alert in the 21 months from July 2019 through March 2021. We estimate that the cost is about \$92 million per month in total federal and state dollars for these beneficiaries and \$1.9 billion over the course of the 21-month period.

Although many of the beneficiaries included in this total may ultimately be determined to be eligible, the problem is that Health Care Services also continues to pay the cost of benefits for that portion of this population that may eventually be determined to have been ineligible. As discussed in the Introduction, Health Care Services recently reimbursed the federal government tens of millions of dollars spent on individuals who were not eligible for Medi-Cal and, by halting efforts to resolve known eligibility discrepancies, Health Care Services has increased the risk that the State will have to repay millions more. Additionally, as we discuss in the next section, a smaller number of alerts that are not tracked in

the pilot program identify individuals whom counties determined to be eligible for Medi-Cal but who are not receiving benefits because of a discrepancy in the State's eligibility data system. By not following up on these alerts, Health Care Services risks failing to provide services to these individuals who are potentially eligible during the emergency.

Health Care Services and Counties Are Not Addressing Some Types of Medi-Cal Eligibility Alerts That They Can Address Even During the Public Health Emergency

Health Care Services stopped its efforts to resolve Medi-Cal eligibility alerts although there are steps that it and the counties have both the authority and responsibility to take—even during the public health emergency—to resolve concerns regarding beneficiaries' eligibility for Medi-Cal. Although the department convened an emergency workgroup to start planning how to resume addressing some types of backlogged eligibility determinations, Health Care Services has not directed this workgroup to address many of the high-risk eligibility alerts indicating that a beneficiary may not be eligible for Medi-Cal or that an individual is eligible for Medi-Cal but is not receiving benefits. As discussed in the Introduction, legal requirements stemming from the emergency require the State to maintain, with limited exceptions, continuous Medi-Cal coverage for beneficiaries through the end of the emergency. This requirement limits the authority of Health Care Services and the counties to resolve certain eligibility alerts. However, because federal law requires the State to provide services only to eligible individuals, Health Care Services should direct counties to resolve eligibility alerts when it is allowable.

Although many eligibility alerts cannot be fully resolved until after the public health emergency, Health Care Services and counties can begin resolving some alerts immediately. As shown in Table 1, Health Care Services and counties can immediately resolve alerts for the more than 37,000 individuals identified as eligible for Medi-Cal in the county data systems but not in the state data system, as well as alerts for the nearly 2,400 beneficiaries with temporary eligibility identified through Health Care Services' pilot program. The pilot program reports also identified nearly 364,000 beneficiaries with questionable eligibility because of an unspecified problem requiring action by the county. According to Health Care Services, these alerts include instances where the county attempted to terminate a beneficiary's eligibility but the state system did not reflect the change. Health Care Services can direct the counties to research these alerts and, when allowable, resolve them. However, depending on the underlying cause of the alert, Health Care Services may be required to maintain continuous coverage for these beneficiaries

Health Care Services and counties can immediately resolve alerts for the more than 37,000 individuals identified as eligible for Medi-Cal in the county data systems but not in the state system.

through the end of the emergency. Finally, Table 1 also shows that the department identified alerts for more than 133,000 beneficiaries whose Medi-Cal eligibility must be redetermined; however, if the beneficiary is not eligible, Health Care Services again may not terminate their coverage until after the end of the emergency.

Table 1
Health Care Services Can Take Steps Toward Resolving Eligibility Alerts

ELIGIBILITY ISSUE	DESCRIPTION	WHAT IMMEDIATE ACTIONS ARE COUNTIES ALLOWED TO TAKE?	NUMBER OF INDIVIDUALS WITH ALERTS AS OF MARCH 2021
ABLE TO RESOLVE IMMEDIATELY			
<i>No Coverage for Eligible Individuals</i>	County system indicated that the individual is eligible for Medi-Cal, but this is not reflected in Health Care Services' system.	Research and resolve the alert; start coverage for eligible beneficiaries.	37,247*
<i>Temporary Eligibility</i>	Individual has been eligible for coverage through accelerated enrollment for more than two months, but the application process has not been completed.	Finalize eligibility determination; discontinue coverage for ineligible beneficiaries.	2,384
MAY BE ABLE TO RESOLVE IMMEDIATELY			
<i>Questionable Eligibility</i>	Individual's eligibility is questionable because of an unspecified problem requiring action by the county.	Research cause of eligibility alert; if allowable, resolve the alert and discontinue coverage for ineligible beneficiaries.	363,679
ABLE TO RESOLVE AFTER PUBLIC HEALTH EMERGENCY			
<i>Redetermination Required</i>	Individual who was previously determined eligible for coverage is transitioning out of one benefit program and into another.	Perform redeterminations; track cases where coverage should be discontinued after the end of the public health emergency.	133,373

Source: Analysis of Health Care Services' Medi-Cal Eligibility data, federal and state laws, and executive orders.

* We excluded beneficiaries with alerts showing they were not eligible in the state system under a certain county but for whom we identified eligibility through a different county.

Some individuals eligible for Medi-Cal services are not identified as eligible in the state data system, and they may face obstacles accessing care. Table 1 shows Health Care Services identified more than 37,000 individuals with these alerts. Although Health Care Services sends alerts for these cases to the counties to resolve, it does not monitor whether the counties are correcting the issues that caused the alert. In fact, using Health Care Services' eligibility information, we determined that nearly 29,000 of the 37,000 individuals had repeated system alerts between September 2020 and March 2021 indicating that counties were not resolving these alerts. Although some of these individuals may be deceased, may have moved out of state, or may have a separate active case, other individuals could have trouble obtaining care

Health Care Services had identified alerts for nearly 2,400 beneficiaries who had had temporary eligibility through accelerated enrollment for more than two months but who did not have a final eligibility determination.

because providers use the state system to determine eligibility. When we followed up with Health Care Services' chief of the Medi-Cal Eligibility Division's Program Review Branch about these alerts, he stated that Health Care Services plans to begin monitoring counties' progress in resolving these eligibility alerts by August 2021.

Counties can also immediately address alerts related to beneficiaries with temporary eligibility. Accelerated enrollment provides temporary eligibility to an individual meeting certain criteria based on preliminary information from the application. The counties typically expect to process the completed application and make a final eligibility determination within two months. Health Care Services creates an eligibility alert if this determination is not completed on time. However, the department stopped monitoring these alerts when it paused its pilot program in March 2020. As Table 1 shows, as of March 2021, Health Care Services had identified alerts for nearly 2,400 beneficiaries who had had temporary eligibility through accelerated enrollment for more than two months but who did not have a final eligibility determination. Further, about 1,300 of these 2,400 beneficiaries had overdue eligibility determinations since at least the beginning of the pilot program in July 2019. Medi-Cal coverage for these 1,300 beneficiaries for the duration of the pilot program represents a total estimated cost of \$15 million. Because beneficiaries flagged with this alert have not received a determination, Health Care Services and the counties have both the authority and responsibility during the emergency to either finalize their eligibility or, if they do not meet eligibility requirements, to discontinue their coverage. Health Care Services plans to resume monitoring these alerts by August 2021 as well.

In addition to these eligibility issues, Health Care Services identified 133,000 beneficiaries with eligibility alerts that require a formal review of eligibility; these beneficiaries need a redetermination. Although federal law allows the department to delay processing Medi-Cal redeterminations during the public health emergency, Health Care Services has authorized counties to continue their efforts to determine eligibility as long as they delay actions that would remove certain individuals from coverage. For example, individuals who were validly enrolled in Medi-Cal during the emergency, but who later would have become ineligible due to changing circumstances, may not be removed from coverage until the end of the public health emergency. These efforts could include performing the research needed to determine whether the individual's Medi-Cal coverage should continue or be terminated at the end of the emergency. However, there are challenges to counties performing this work in their eligibility data systems during the emergency. For instance, when a county evaluates a beneficiary's eligibility, the redetermination could initiate automated processes

in the system that ultimately render the beneficiary ineligible. This could violate the requirement to maintain beneficiaries' continuous coverage through the end of the emergency. To ensure that beneficiaries are not inappropriately discontinued and to allow counties to prioritize access to care, Health Care Services instructed counties to stop processing eligibility changes, including redeterminations and some annual renewals, through the end of the emergency, for beneficiaries who may lose coverage. However, Health Care Services is working with counties to resolve this limitation and allow the counties to perform eligibility work for current beneficiaries now.

To help counties resume addressing eligibility determinations, Health Care Services established a workgroup in February 2021 to plan for activities during and after the end of the public health emergency (emergency workgroup). Its efforts include working to modify some of the functions within the counties' eligibility data systems so that counties do not inadvertently remove beneficiaries from Medi-Cal coverage when reevaluating their eligibility. This will allow counties to resume redetermination work before the end of the emergency. Once the emergency ends, counties will remove beneficiaries who qualified for continuous coverage under federal law but who are no longer eligible.

The emergency workgroup is developing guidance on actions that counties are allowed to take during the public health emergency. Although the emergency workgroup is focused on resuming various types of eligibility determination work and associated eligibility alerts before the end of the emergency, the guidance it is developing does not include all of the high-risk eligibility alerts that it should. For example, the guidance will instruct counties to resume processing cases for beneficiaries who have transitioned out of Supplemental Security Income benefits and require a redetermination of their Medi-Cal eligibility. These cases were also included in the pilot program. However, the emergency workgroup's guidance will not include direction on resolving other cases and alerts that were included in the pilot program. One major omission is the 364,000 beneficiaries with questionable eligibility who require action by the county. We followed up with Health Care Services staff members to understand why they had not included all of the alerts from the pilot program in its emergency workgroup discussions and guidance. They stated that the emergency workgroup was focused on resuming normal operations and helping counties address the backlog of case processing, such as processing cases involving changes in beneficiaries' circumstances and tracking cases that will require discontinuation of Medi-Cal coverage after the emergency ends. They also stated that they might include guidance related to resolving high-risk alerts at a later point. However, federal law requires that states provide coverage only to

Guidance from Health Care Services' emergency workgroup excludes direction on resolving the questionable eligibility of 364,000 beneficiaries.

If beneficiaries are ineligible, Health Care Services may have to reimburse the federal government for the federal share of the premiums.

eligible individuals, and these alerts indicate beneficiaries who are at high risk of being inappropriately enrolled and who represent a significant cost to the State. Without providing guidance to the counties to help them research and, when allowable, resolve these high-risk eligibility alerts, Health Care Services may continue to pay Medi-Cal premiums for people who are not eligible. In fact, the estimated monthly cost for these 364,000 beneficiaries is \$195 million. Further, if beneficiaries are ineligible, Health Care Services may have to reimburse the federal government for the federal share of the premiums, which based on data provided to us by Health Care Services, we estimate to be 68 percent.

Health Care Services Could Do More to Help Counties Prepare for the Many Eligibility Redeterminations They Will Need to Perform After the Public Health Emergency Has Ended

Health Care Services could do more—even during the public health emergency—to prepare the counties to fulfill their critical role in making accurate and timely Medi-Cal redeterminations when the emergency is over. Past audits have repeatedly found that the department and the counties have faulty processes for performing this work, and in 2018 Health Care Services started its reviews—known as *focus reviews*—to rectify those faulty processes. Coming out of the emergency, counties will have to resume performing the redeterminations that were delayed during the emergency. Because Health Care Services has not taken all reasonable steps to help counties improve the processes they follow, counties will likely rely on past processes, which were found to be problematic. When counties make redetermination decisions late or in error, the State is at risk of owing the federal government for the federal share of Medi-Cal costs that the State should not have approved.

In response to audit findings dating back at least five fiscal years, Health Care Services committed to reviewing counties' performance in making eligibility redeterminations by conducting focus reviews, issuing reports on the findings, and overseeing corrective action plans. Although Health Care Services performed focus reviews in 2018 and 2019, as Table 2 shows, it made little progress with reporting its findings and overseeing corrective action plans in either of those years because it only reported on three of the 21 focus reviews it performed in 2018, and it reported on none of the 18 focus reviews it performed in 2019. Understandably, Health Care Services could not conduct focus reviews in 2020 during the public health emergency. In addition, according to the chief of the Program Review Branch, based on the Governor's executive order early in the emergency, Health Care Services did not require counties to report on progress toward completing their corrective action plans.

Table 2
Health Care Services Performed Focus Reviews of Counties but Has Not Issued Reports or Followed Up on That Work

YEAR	FOCUS REVIEWS PERFORMED	FOCUS REVIEW REPORTS COMPLETED	CORRECTIVE ACTION PLANS COUNTIES HAVE DEVELOPED
2018	21	3	2
2019	18	0	0
2020	0	0	0

Source: Summary data from Health Care Services.

Further, with regard to its review efforts in 2018 and 2019, Health Care Services had the information from the focus reviews it performed but it did not finalize its analysis and provide reports to the counties. The chief of the Program Review Branch stated that the division had to prioritize other work over the focus reviews, such as developing new audit plans and approaches to significantly redesign its federal audits in response to changes in requirements. In addition, the chief stated that the counties' response to the wildland fires in 2018 and 2019 hampered the Eligibility Division's ability to complete focus reviews, as the fires limited county employees' ability to get to work and increased the amount of support county staff had to provide to Medi-Cal applicants. For example, the chief stated that counties' due diligence in conducting eligibility reviews includes helping beneficiaries locate documentation verifying eligibility. Because many beneficiaries had no access to the physical documents they needed during the fires, county staff members were responsible for helping them identify alternate forms of verification. For the reasons the chief shared, the division did not complete the focus reviews it started in 2018 and 2019 before the public health emergency began. As a result, the weaknesses Health Care Services identified in the counties' redetermination processes during the focus reviews may have gone unaddressed.

However, over this past year, Health Care Services could have capitalized on the information it had already collected and developed from the focus reviews it performed in 2018 and 2019 to better position the counties for the redetermination work they must do once the public health emergency is over. For 2018 and 2019 combined, Health Care Services indicated it performed 39 focus reviews and it identified concerns with at least 24 counties—more than half of the counties it reviewed. The department's records show it identified trends in the types of errors that were contributing to delays in processing redeterminations, and it isolated areas in its policies where guidance was needed for counties to address inaccurate redetermination decisions. In one county it reviewed, Health Care Services found that most of the eligibility

Health Care Services did not notify counties of known weaknesses risking that counties will continue to make redetermination errors.

redeterminations were not processed in an accurate or timely way. The department also found that although comments attached to some eligibility renewal cases indicated that the county conducted the renewals, the county had failed to maintain documents that supported those renewals, as it should have. Further, the department found that the county had not verified all required data elements before renewing the eligibility. Even with restrictions in place on performing focus reviews, we believe Health Care Services could have notified the counties of the weaknesses it had identified based on the information it had already collected. However, Health Care Services did not take this step. As a result, the risk of counties continuing to make eligibility redetermination-related errors after the emergency is still present. When Health Care Services provides Medi-Cal benefits to individuals who are ineligible to receive them, the State risks owing the federal government for the federal share of Medi-Cal costs.

The chief of the Program Review Branch indicated that Health Care Services could alert counties to common themes it identified to heighten the counties' awareness of those issues as they prepare to exit the public health emergency. He noted that there are trends in the information gathered from the focus reviews and that these trends align with prior audit findings related to the counties' eligibility redetermination work. However, the timing of Health Care Services' planned notification to the counties is of concern to us. The Eligibility Division has not yet developed this guidance, and the chief of the Program Review Branch said Health Care Services could do so and send it to the counties in conjunction with other correspondence it planned to send at the end of the emergency. We think this is too late for counties to have sufficient time to review the Eligibility Division's assessments and take appropriate actions because the counties will be starting their redeterminations and will face difficulties if they have to stop to assess and modify their processes then.

A further concern about timing is that Health Care Services plans to restart its focus reviews too far in the future. According to the chief of the Medi-Cal Eligibility Division (eligibility chief), the division plans on restarting focus reviews a year after the end of the public health emergency, likely in January 2023. We disagree with this strategy. According to the eligibility chief, Health Care Services believes it needs to allow counties time to address the backlog of redeterminations that accumulated during the emergency. However, as we describe in the Introduction, the counties have a long-standing history of not conducting redeterminations in accordance with requirements, and the focus reviews are part of the State's corrective action plan to address those issues; if Health Care Services does not correct the procedural issues underlying these redetermination errors, the counties will likely continue

to make those same errors when they restart their eligibility redeterminations. The chief of the Program Review Branch indicated he was not opposed to the concept of restarting the focus reviews earlier than the beginning of 2023, but he cited staffing concerns that might affect the division's ability to meet a faster time frame—specifically, the impact on staffing availability caused by various annual and triennial federal audits and by uncertainty as to whether requests for additional staffing will be approved. We note that these audits, such as the Federal Compliance Audit of the State of California, which analyzes selected transactions and accounts maintained by Health Care Services, are conducted every year, and the audits do not relieve Health Care Services of its responsibility to effectively govern Medi-Cal.

Recommendations

To reduce inappropriate payments made to medical providers and ensure eligible individuals' access to care, Health Care Services should do the following by August 2021:

- Begin monitoring statewide alerts related to individuals identified as eligible for Medi-Cal in a county eligibility data system but not identified as eligible in the state eligibility system.
- Instruct counties to resume processing overdue determinations for individuals who have received temporary eligibility and make a determination on each applicant's Medi-Cal eligibility.
- Expand its workgroup planning efforts to address all high-risk eligibility alerts included in the pilot program.
- Resume monitoring pilot program counties' progress in resolving high-risk eligibility alerts.

To ensure that it is addressing weaknesses in the counties' processes for making eligibility redeterminations, Health Care Services should do the following:

- Review data collected during the focus reviews it conducted in 2018 and 2019 to identify areas in policy for which further county guidance is needed and, by September 1, 2021, share a written summary of the identified concerns with all counties.
- Resume county monitoring via focus reviews within four months of the end of the public health emergency.

Other Areas Reviewed

In addition to the concerns we describe in the Audit Results, we reviewed the waivers CMS issued in response to the public health emergency, Health Care Services' communications related to COVID-19 program changes, and the ability of Medi-Cal to meet the resource demands of those enrolled in the program. Our review of these areas did not result in recommendations.

Health Care Services Has Actively Sought and Adopted Waivers in Response to the Public Health Emergency

CMS has suspended a number of Medicaid requirements in response to the COVID-19 public health emergency. Using its authority in law to waive certain Medicaid requirements, CMS issues various types of waivers, including three in response to the emergency: blanket, emergency, and demonstration waivers. Table 3 summarizes the different purposes associated with the three waiver types and provides examples of current COVID-19-related waivers. Blanket and emergency waivers require declarations of a public health emergency by both the president of the United States and the HHS secretary. The blanket waiver type differs from the emergency waiver in that CMS initiates the blanket waiver when it recognizes a broad-based need that many states have for their Medicaid programs, whereas a state may request an emergency waiver for needs specific to its Medicaid program. Additionally, blanket waivers take effect without a requirement for states to notify CMS or make a request. Waivers last for varying lengths of time; for COVID-19, the blanket and emergency waiver types will remain in effect until the HHS secretary declares an end to the emergency. Further, CMS made its blanket waivers and the emergency waivers it granted to Health Care Services retroactive to March 1, 2020. Demonstration waivers do not require a public health emergency, and Health Care Services requests this waiver type based on the specific needs of the Medi-Cal program. The demonstration waivers CMS granted to Health Care Services specifically to help the department respond to the emergency will remain in effect for time frames that may have begun as early as March 1, 2020, depending on the details and goals outlined in the waivers themselves, and that will expire no later than 60 days after the end of the emergency. For example, CMS approved Health Care Services' waiver request for a COVID-19 testing program in schools that Medi-Cal will reimburse through its fee-for-service program for a period beginning on February 1, 2021, through 60 days after the termination of the emergency.

Table 3
Three Types of Waivers CMS Issued to Address the COVID-19 Public Health Emergency

WAIVER TYPE	HOW AUTHORIZED	WAIVER'S PURPOSE	EXAMPLE OF COVID-19- RELATED WAIVER
<i>Blanket</i>	CMS initiates and issues the waiver.	<ul style="list-style-type: none"> To temporarily ease or eliminate impediments to beneficiaries' access to care during an emergency. To address a broad, recognized need affecting many states and programs. 	States may reimburse providers for telehealth services, which are services providers render remotely to beneficiaries through video, audio, or other electronic communications.
<i>Emergency</i>	Health Care Services requests approval from CMS.	<ul style="list-style-type: none"> To temporarily ease or eliminate impediments to beneficiaries' access to care during an emergency. To address a need specific to the requesting state's Medicaid program. 	Health Care Services may allow Medi-Cal providers to render services in mobile testing sites, temporary shelters, or other temporary locations.
<i>Demonstration</i>	Health Care Services requests approval from CMS.	<ul style="list-style-type: none"> To implement experimental, pilot, or demonstration projects. To address goals and objectives specific to the requesting state's Medicaid program. 	Health Care Services may implement a demonstration project for Medi-Cal to provide COVID-19 testing of children in schools through the State's fee-for-service system.

Source: The Social Security Act, CMS blanket waivers, and waivers CMS granted to Health Care Services.

The waivers that Health Care Services has implemented have made Medi-Cal more responsive to the public health emergency. In March 2020, in an effort to streamline its processes, CMS notified Health Care Services that it had issued a list of blanket waivers for Medicaid. These blanket waivers granted modifications to Medi-Cal that Health Care Services adopted to improve beneficiaries' access to care during the emergency. For example, to make it easier for beneficiaries to access care at a time when states issued stay-at-home orders and social-distancing requirements to slow the spread of COVID-19, CMS issued a blanket waiver allowing more providers to offer telehealth services. Since Health Care Services generally adopted the blanket waivers CMS issued, we found that Health Care Services implemented all of the blanket waivers that it reasonably could have adopted.

Similarly, the emergency waivers that Health Care Services requested have also allowed Medi-Cal to adapt and better serve beneficiaries during the emergency. The waivers touch on many aspects of the Medi-Cal system, including provider requirements, service usage, and eligibility. For example, CMS approved an emergency waiver at Health Care Services' request to allow the department to suspend certain provider enrollment requirements, such as application fees or in-state licensure requirements during the emergency. Health Care Services' proposal was to streamline the process for enrolling providers in order to facilitate greater beneficiary access to care, among other advantages.

Health Care Services made many of its emergency waiver requests early in the public health emergency—most in March and April 2020—and many have been approved. In total, Health Care Services requested 13 emergency waivers, as shown in Table 4, and CMS approved 10 of those requests. As an example of a request that is still pending, Health Care Services asked for an extension of the federal deadlines for submitting cost reports for Medi-Cal by six months, with no late penalties, so that providers would have time to file the appropriate documents. According to Health Care Services' request, many providers told their staff members to work remotely or reassigned staff to emergency response activities, which could cause delays in meeting reporting timelines. Health Care Services does not expect CMS to approve any of the remaining three emergency waivers, and the issues these waivers were intended to address no longer apply. For example, the period covered by the cost report extension request has already passed.

Table 4
Health Care Services Has Requested Many Emergency and Demonstration Waivers and Some Are Still Pending

WAIVER TYPE*	REQUESTED	APPROVED	PENDING	CLOSED†
<i>Emergency</i>	13	10	2	1
<i>Demonstration</i>	24	15	9	0

Source: Health Care Services' letters requesting waivers and CMS's letters approving waivers dated from March 16, 2020, through March 1, 2021.

* If Health Care Services requested a waiver multiple times, we only counted the type associated with the most recent request.

† Health Care Services has closed this waiver request and is no longer seeking approval.

Health Care Services has also requested demonstration waivers to address specific opportunities in the Medi-Cal program for combating COVID-19. Demonstration waivers differ from blanket waivers and emergency waivers in that they allow Health Care Services to model or test approaches for services it believes would promote Medi-Cal's goals. During the public health emergency, Health Care Services requested 24 demonstration waivers. For example, it requested a waiver to implement a demonstration project for Medi-Cal to provide COVID-19 testing of children in schools through its fee-for-service program. Health Care Services stated in its request that the purpose of the waiver was to standardize how the tests are delivered in schools and eliminate inconsistent reimbursement rates among providers; CMS approved the waiver. However, of the 24 COVID-19 related demonstration waivers that Health Care Services requested, CMS has not yet approved or denied nine of them. Of the nine demonstration

requests still pending, seven were originally submitted on or before April 2020. For example, CMS has not yet approved a March 2020 request to recognize any COVID-19 testing and related treatment of a Medi-Cal beneficiary outside of an emergency room setting as constituting “emergency services” or services for an “emergency medical condition” for purposes of various Medicaid requirements. According to the deputy director who oversees the Benefits and Eligibility Division, this waiver is important because of the fiscal implications for the State. For example, this waiver would require managed care plans to provide COVID-19 treatment coverage without prior authorization, including treatment from out-of-network providers.

Health Care Services Has Effectively Communicated With Its Stakeholders About COVID-19-Related Program Changes

Health Care Services has effectively communicated changes in program requirements stemming from the public health emergency to counties and medical providers. To do so, it has leveraged its existing communication channels through news bulletins, informational letters, its provider manual, and periodic meetings to make guidance available for counties and medical providers. For example, Health Care Services has issued news bulletins monthly to county staff to ensure that they are aware of changes in Medi-Cal eligibility requirements. It has also provided policy guidance to county staff members and medical providers through informational letters. Health Care Services maintains a *Medi-Cal Provider Manual* as a source of guidance to medical providers on how to provide services through Medi-Cal. We found that the department is keeping this manual updated regularly with information about the emergency. Further, through its routine meetings with county staff, medical providers, and representatives from various health care-related associations, Health Care Services has communicated information about Medi-Cal program changes. For example, the department has held weekly meetings with medical providers from its managed care networks to discuss implementing the COVID-19 vaccine guidance and to share updates about revised guidance on COVID-19 antibody testing.

Health Care Services has ensured that its communications are accurate and are provided to relevant parties promptly. It has processes for creating and publishing guidance for medical providers and counties, and it has developed flowcharts for developing and approving these communications. For instance, the department developed a publication handbook to assist staff with preparing communications to medical providers about topics such as current news and policy changes affecting Medi-Cal providers. The handbook lists the various communication types that staff can choose

from and their recommended uses; it also lists the steps for staff to follow in reviewing and approving the content of communications for publication. Separately, when preparing some types of communications for counties, Health Care Services has built into its process the opportunity for the counties and related stakeholder groups to review the communications in draft form and provide comments to the department. We reviewed five communications specific to issues about the COVID-19 public health emergency, and we found that Health Care Services followed its relevant processes and performed required reviews before publication.

Further, we found that Health Care Services promptly published guidance concerning key changes in policy. For two publications we reviewed, the department released those publications within five working days of the triggering events—the first event being an executive order the Governor issued and the second being a waiver that granted flexibility to the Medi-Cal program. We reviewed a third publication the department released and noted that it took 22 working days for publication. This time frame was reasonable because Health Care Services developed the publication and approved it in collaboration with county staff, and doing so required time for all parties to perform their review. In fact, the department's publication protocols require that both county staff and other stakeholders have 14 working days to review and approve the draft text.

Health Care Services has also taken reasonable steps to communicate to the public on new Medicaid coverage for COVID-19. Through its COVID-19 Uninsured Group program (Uninsured Group), the department implemented an option introduced under the Families First Act to provide Medicaid coverage to uninsured individuals. The program covers COVID-19 testing at no cost to the individual, even if the individual is not otherwise eligible for Medicaid. Through its website, Health Care Services provides information about coverage and an application for the Uninsured Group. The department issued a news flash via email communicating the eligibility change and containing instructions for providers to register members of the public for the Uninsured Group when those individuals seek medical treatment. The department also communicated eligibility changes to the public through its Consumer-Focused Stakeholder Workgroup (Consumer Workgroup). Health Care Services meets with health care stakeholders monthly through this workgroup to discuss public messaging and to communicate eligibility and enrollment information, including information about the Uninsured Group. Health Care Services describes the Consumer Workgroup stakeholders as advocates from the consumer protection community, representatives of provider associations, and experts in health care. Because the goal of these stakeholders includes communicating eligibility information to the public through

various avenues, such as education, counseling, advocacy, and other services, this stakeholder-based approach that Health Care Services follows extends the reach of its communications.

Health Care Services Determined That Medi-Cal Had Adequate Resources to Serve Higher Enrollments

Although the number of beneficiaries enrolled in Medi-Cal increased during the public health emergency, Health Care Services' data indicate that there have been adequate resources within the system to serve the additional beneficiaries. The number of Medi-Cal beneficiaries increased steadily during the emergency, and Medi-Cal is now serving about one million more beneficiaries per month as of March 2021 compared to March 2020. Overall, the majority of beneficiaries—84 percent—are served through managed care plans as opposed to the fee-for-service program and this proportion has stayed consistent despite the emergency. As the number of beneficiaries in Medi-Cal increases during the emergency, it is important that the managed care plans have adequate resources to serve them.

Health Care Services annually assesses the Medi-Cal managed care plans to determine whether they meet resource requirements. Federal regulations require the department to annually certify to CMS that those care plans meet certain standards. CMS did not suspend the certification requirement for the public health emergency. The last certification Health Care Services submitted to CMS is dated December 2020 and it covered managed care plans with annual contracts from July 2020 through July 2021 and January 2021 through January 2022. For contracts during these periods, Health Care Services has certified to CMS that it had not identified significant changes or deficiencies in its managed care plans that would affect the ability of beneficiaries to obtain all medically necessary services. Health Care Services bases its certification to CMS on a variety of measures, including physician-to-member ratios and time and distance standards for beneficiaries to access care. Health Care Services established the time and distance standards in accordance with federal and state laws based on population density for specific provider types. Given that the time frames the certification covered coincided with the emergency and the continuous coverage requirement that the Families First Act imposes, Health Care Services essentially certified to CMS that the managed care plans could handle the increased number of beneficiaries and the resulting increase in demand for health care.

Although the certification is assurance to CMS that Medi-Cal managed care plans can serve enrollees, Health Care Services' data show that the demand for care has not kept pace with the numbers

of beneficiaries. The department continuously tracks these data through two reports: one on service *utilization*—a term that refers to how much beneficiaries use health care services—and another on complaints. Health Care Services' internal reports show that beneficiaries' overall usage of services, such as emergency room or outpatient visits, has not increased during the emergency. Further, Health Care Services monitors complaints, which include accessibility grievances. Grievances filed can indicate when beneficiaries are not able to get medical appointments or are otherwise not satisfied with their managed care plan. The most recent grievance data show that grievances have not increased during the emergency, further indicating that COVID-19 has not significantly reduced the Medi-Cal system's ability to meet beneficiaries' needs.

Finally, in the context of the public health emergency, it is important to confirm that Medi-Cal has the capacity to serve its beneficiaries, and the certification helps impart confidence that it does. However, the certification does not mean that weaknesses in certain segments of Medi-Cal have been resolved. For example, in our August 2019 report, *Department of Health Care Services: It Has Not Ensured That Medi-Cal Beneficiaries in Some Rural Counties Have Reasonable Access to Care* (2018-122), we found that in certain rural counties using a specific managed care model, the time and distances beneficiaries had to travel were too long and that the quality of the care they received was lower than in other areas of the State. These weaknesses have not been fully resolved.

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

Respectfully submitted,



ELAINE M. HOWLE, CPA
California State Auditor

July 8, 2021

Appendix

Scope and Methodology

State law authorizes the California State Auditor to establish a program to audit and issue reports with recommendations to improve any state agency or statewide issue that our office identifies as being at high risk for the potential of waste, fraud, abuse, and mismanagement or as having major challenges associated with its economy, efficiency, or effectiveness. In January 2020, we issued our latest assessment of high-risk issues that the State and selected agencies face. In August 2020, we added the State’s management of federal COVID-19-related funding to that assessment as a high-risk statewide issue because of the significant amount of money the State has received, the rapid nature of the allocation, and the urgent need for the funding. Health Care Services is responsible for managing a portion of the federal COVID-19-related funds. The table lists the objectives we developed for our review and the methods we used to address them.

Audit Objectives and the Methods Used to Address Them

AUDIT OBJECTIVE	METHOD
<p>1 Identify and summarize the program and funding changes to Medi-Cal that occurred in response to COVID-19.</p>	<ul style="list-style-type: none"> • Identified provisions of the Families First Act and CARES Act that have altered how Health Care Services administers Medi-Cal and how the laws have changed beneficiaries’ care. • Determined what additional federal funding the Families First Act and the CARES Act have authorized for Medi-Cal during the public health emergency. • For Health Care Services’ quarterly estimate of Medi-Cal costs and projected costs, we performed the following: <ul style="list-style-type: none"> - Interviewed key officials about processes Health Care Services’ staff members follow and documents they prepare for an estimate. - Assessed Health Care Services’ assumptions and methods for preparing the quarterly estimates from January 1, 2020, through December 31, 2020. - Determined whether the assumptions are reasonable and if Health Care Services’ methods are sound. Determined the impact of the estimates. - Determined the amount of funding that Health Care Services received from January 1, 2020, through December 31, 2020, in increased federal FMAP for Medi-Cal because of the COVID-19 emergency. • Determined how much Health Care Services expected to receive through the end of the current federal fiscal year—September 30, 2021. • Assessed the impact on the state budget of COVID-19 and related legislation on the Medi-Cal program for fiscal year 2020–21.

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AUDIT OBJECTIVE	METHOD
<p>2 Determine whether Health Care Services has maximized possible policy and requirement changes for the Medi-Cal program in response to COVID-19.</p> <ul style="list-style-type: none"> Assess whether it has taken advantage of available COVID-19 blanket waivers and why Health Care Services may not have opted in to blanket waivers the State is eligible to access. Summarize which waivers it has requested to modify program requirements, which requests CMS has approved, which are still pending, and the effects of these waivers. 	<ul style="list-style-type: none"> Reviewed relevant portions of the Social Security Act and reviewed federal declarations of emergency. Interviewed key Health Care Services' officials to understand the processes staff follow to develop waivers, to track submittal to CMS, and to track CMS's resulting decisions. Identified changes to Medi-Cal that are available to Health Care Services through waivers CMS has granted. Assessed whether Medi-Cal has adopted all blanket waivers it reasonably could have adopted. Determined the function of the emergency waivers (both blanket waivers and requested waivers) and the flexibility afforded to Health Care Services through those waivers. Identified emergency waivers that are COVID-19-related and that are awaiting federal approval or that Health Care Services is developing, and the expected outcomes if those waivers are approved. Determined the function of demonstration waivers and the flexibility afforded to Health Care Services through those waivers. Identified any demonstration waivers that are COVID-19-related and are awaiting federal approval or that Health Care Services is developing, and the expected outcomes if those waivers are approved.
<p>3 Assess the steps Health Care Services has taken to communicate Medi-Cal program and funding changes to affected parties. Determine whether Health Care Services' communication is reasonable and appropriate in the emergency COVID-19 environment.</p>	<ul style="list-style-type: none"> Interviewed key Health Care Services' officials about the various types of communications the department has with counties, providers, and beneficiaries as well as the processes the department follows to draft, review, approve, and release those communications. Assessed various types of communications to determine how quickly Health Care Services produced those communications following events that affected how Medi-Cal must be administered.
<p>4 Determine whether Health Care Services is monitoring counties and ensuring that they are effectively implementing the COVID-19 Medi-Cal changes they are responsible to implement. Also determine whether Health Care Services has prepared for any risks that relaxed program safeguards may present. Additionally, evaluate Health Care Services' and counties' efforts to resolve eligibility data discrepancies.</p>	<ul style="list-style-type: none"> Interviewed key officials within Health Care Services about monitoring that the department typically performs and what it suspended or scaled back because of the public health emergency. Also interviewed key officials about Health Care Services' plans to reinstate monitoring at the appropriate time in the future. Reviewed CMS guidance and waivers for information about oversight the department should perform or alter because of the public health emergency. Interviewed key officials within Health Care Services about how the department assesses resources and plans for adequate resource levels. Reviewed relevant resource reports that Health Care Services submitted to CMS about Medi-Cal to determine whether the department was reporting adequate or inadequate resources during the public health emergency. Obtained Health Care Services' eligibility data and calculated various statistics, including the following: <ul style="list-style-type: none"> Trends in the number of monthly alerts. Estimated monetary impact of eligibility alerts. Evaluated the steps Health Care Services is taking to help counties correct eligibility discrepancies.

Source: Audit work papers.

Assessment of Data Reliability

The U.S. Government Accountability Office, whose standards we are statutorily obligated to follow, requires us to assess the sufficiency and appropriateness of computer-processed information we use to support our findings, conclusions, or recommendations. In performing this audit, we relied on Health Care Services' eligibility data to calculate various statistics related to eligibility alerts. To evaluate these data, we reviewed existing information about the data, interviewed staff members knowledgeable about the data, and performed electronic testing of the data. As a result of this testing, we found the data were sufficiently reliable for our audit purposes.



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



GAVIN NEWSOM
GOVERNOR

June 18, 2021

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

DRAFT AUDIT REPORT RESPONSE

Dear Ms. Howle:

The California Department of Health Care Services (DHCS) is submitting the enclosed response to the California State Auditor's (CSA) draft audit report titled, "Despite the COVID-19 Public Health Emergency, the Department Can Do More to Address Chronic Medi-Cal Eligibility Problems." CSA issued six recommendations for DHCS.

DHCS agrees with all CSA's recommendations except for recommendation six of which DHCS partially agrees with the recommendation. DHCS has prepared corrective action plans to implement.

DHCS appreciates the work performed by CSA and the opportunity to respond to the draft audit report. If you have any other questions, please contact Internal Audits at (916) 215-8604.

Sincerely,

Will Lightbourne
Director

Enclosure

cc: See Next Page

Ms. Howle
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June 18, 2021

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Department of Health Care Services

Audit: Despite the COVID-19 Public Health Emergency, the Department Can Do More to Address Chronic Medi-Cal Eligibility Problems

Audit Entity: California State Auditor

Report Number: 2020-613 (21-10)

Response Type: Draft Report Response

Finding 1: The Large Number of Medi-Cal Beneficiaries with Eligibility Concerns Has Continued to Grow, Increasing the Risk That the State Will Have to Reimburse the Federal Government.

Recommendation 1

Begin monitoring state-wide alerts related to individuals identified as eligible for Medi-Cal in a county eligibility data system but not eligible in the state eligibility system.

Agreement: Agrees with Recommendation

Implementation: Will Implement.

Estimated Implementation Date: 12/31/2022

①

Implementation Plan:

The Department of Health Care Services (DHCS) is working to incorporate Medi-Cal Eligibility Database Systems (MEDS) Alert number 6016, an alert which indicates eligibility in the Statewide Automated Welfare Systems (SAWS) but not in MEDS, into the MEDS Alert Pilot (MAP) reports DHCS sends to counties on a regular basis. MAP consists of the largest counties in the state; therefore, MAP is sufficient to begin initial monitoring of the alert through the pilot. DHCS will incorporate alert number 6016 into a permanent, statewide MEDS Alert monitoring process as part of the California Advancing and Innovating Medi-Cal (CalAIM) county oversight and monitoring proposal no later than December 31, 2022.

Finding 2: DHCS and Counties Are Not Addressing Some Of The Types Of Medi-Cal Eligibility Alerts That They Can Even During A Public Health Emergency.

Recommendation 2

Instruct counties to resume processing overdue determinations for individuals who have received temporary eligibility and make a determination on each applicant's Medi-Cal eligibility.

Agreement: Agrees with Recommendation

Implementation: Fully Implemented.

②

Estimated Implementation Date: 8/14/2020

Implementation Plan:

On August 14, 2020, DHCS released Medi-Cal Eligibility Division Letter (MEDIL) 20-26 (section J) which notifies counties it is allowable to terminate eligibility for individuals enrolled in an Accelerated Enrollment program who fail to provide requested information.

Link to MEDIL 20-26:

<https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I20-26.pdf>

Finding 3: DHCS Could Do More to Prepare Counties for Exiting the Public Health Emergency (PHE).

Recommendation 3

Expand its workgroup planning efforts to address all high-risk eligibility alerts included in the pilot program.

Agreement: Agrees with Recommendation

Implementation: Will Implement

Estimated Implementation Date: 10/31/2021

Implementation Plan:

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DHCS will ensure PHE lift workgroup planning efforts incorporate resolution of system discrepancies as a component of the activities counties will perform once the PHE is lifted.

Recommendation 4

Resume monitoring pilot program counties' progress in resolving high-risk eligibility alerts.

Agreement: Agrees with Recommendation

Implementation: Will Implement

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Estimated Implementation Date: 1/31/2023

Implementation Plan:

DHCS plans to resume all pilot program related activities, including resolution of high-risk eligibility alerts, as of the implementation date.

Recommendation 5

Review data collected during the focus reviews it conducted in 2018 and 2019 to identify areas in policy for which further county guidance is needed and, by September 1, 2021, share a written summary of the identified concerns with all counties.

Agreement: Agrees with Recommendation

Implementation: Will Implement

Estimated Implementation Date: 9/30/2021

Implementation Plan:

DHCS will analyze the data collected from focus reviews between 2018 and 2019 and share common trends with counties as of the implementation date.

Recommendation 6

Resume county monitoring via focus reviews within four months of the end of the public health emergency.

Agreement: Partially Agrees with Recommendation

Implementation: Will Implement

Estimated Implementation Date: 1/31/2023

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Implementation Plan:

DHCS will resume focused reviews in January 2023, due to the level of effort needed at the county level in the 12 months preceding the end of the PHE, to ensure all PHE-related activities are completed timely.

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Comments

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

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

We are concerned with the length of time Health Care Services indicates it will take to implement our recommendation. As we state on page 14, as of March 2021, there were 37,000 individuals determined to be eligible for Medi-Cal in the county eligibility system but who show as ineligible in the state eligibility system. As a result, these Californians will have trouble accessing medical care available to them through Medi-Cal. Although Health Care Services indicates it will begin monitoring alerts associated with the largest counties in the State, Health Care Services does not plan on monitoring the resolution of alerts from all counties until December 2022. Health Care Services' mission is to provide Californians with access to health care and this prolonged implementation date does not demonstrate the appropriate level of urgency necessary to resolve the problem we identified.

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Health Care Services' claim that it has already fully implemented our recommendation is not correct. While the department notified counties that it is allowable to take action on cases with temporary eligibility, the department did not explicitly instruct counties to process these cases. In fact, the department instructed counties to suspend processing reports, which include alerts for temporary eligibility. As we state on page 16, there are nearly 2,400 individuals as of March 2021 who had had temporary eligibility through accelerated enrollment for more than two months but who did not have a final eligibility determination. We also point out that 1,300 of these 2,400 individuals had overdue eligibility determinations since at least July 2019. Therefore, this continues to be an unresolved problem and Health Care Services should provide clear instruction to counties to resume processing these overdue determinations.

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Although Health Care Services agreed to include the resolution of system discrepancies in its workgroup planning efforts, we are concerned by its statement that counties will perform this work once the public health emergency is lifted. As we describe on page 14, there are system discrepancies that can be resolved immediately. Rather than instructing counties to perform this work after the end of the emergency, we believe Health Care Services should instruct counties to resolve these discrepancies and their

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associated alerts as soon as they have the capacity to do so. Doing so would better communicate to counties the urgency with which they should be approaching the resolution of these problems.

- ④ Health Care Services does not plan to monitor counties' progress in resolving high-risk eligibility alerts until January 2023—17 months later than our recommendation of August 2021. As we discuss on pages 14 and 15 and show in Table 1, there are alerts that counties can and should be resolving now. Therefore, Health Care Services should resume monitoring the pilot program alerts, and to the extent that counties are unable to reduce the number of alerts, Health Care Services should understand the reasons why. Not resuming this monitoring communicates to counties that Health Care Services does not prioritize resolving eligibility discrepancies. Timely resolution of these problems is critical because these problems could ultimately cost the State millions of dollars in federal reimbursements.
- ⑤ We continue to disagree with Health Care Services' implementation date of January 2023. On page 20 we describe the department's plan for reinstating its focus reviews one year after the public health emergency ends. We also describe in the Introduction on pages 9 and 10 that counties have a long history of not conducting redeterminations according to federal guidelines and that the focus reviews are the department's corrective action plan to address these deficiencies. However, by not reinstating the focus reviews until one year after the end of the public health emergency, Health Care Services is allowing counties to use deficient processes to address the backlog of redeterminations they will need to process once the emergency ends. This plan does not demonstrate an appropriate level of urgency necessary to resolve these problems in a timely manner.