

**Department of Health and Human Services
Centers for Medicare & Medicaid Services**

**Medicaid Integrity Program
California Comprehensive Program Integrity Review
Final Report
January 2011**

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the California Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the California Department of Health Care Services (DHCS). The review team met with the Medicaid Fraud Control Unit (MFCU) at the offices of DHCS.

This review focused on the activities of the DHCS Office of Audits and Investigations (A&I), which is primarily responsible for Medicaid program integrity oversight. This report describes nine effective practices, eight regulatory compliance issues, and four vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help California improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of California's Medicaid Program

The DHCS administers the California Medicaid program, Medi-Cal, within the State. The program services are delivered through a combination of fee-for-service (FFS) and three models of managed care health plans: Two-Plan, County Organized Health Systems, and Geographic Managed Care. As of June 2008, the Medi-Cal program served 6,797,600 recipients. The State had 105,614 providers participating in FFS and 94,608 providers participating in physical health managed care plans. Medicaid expenditures for Federal fiscal year (FFY) 2008 totaled \$38,586,119,797. The Federal medical assistance percentage was 50 percent in FFY 2008.

Program Integrity Section

The A&I has lead responsibility for ensuring the fiscal integrity of the health programs administered by DHCS. The A&I is divided into three operational branches: Financial Audits Branch (FAB), Investigations Branch (IB) and Medical Review Branch (MRB). The FAB ensures, through financial audits, that payments made to institutional providers are valid, reasonable, and in accordance with laws, regulations, and program intent. The Code of Federal Regulations mandates that the State has the ability to investigate allegations of recipient fraud and abuse. California has designated the IB as the agency responsible for investigating allegations of recipient fraud and abuse of the Medi-Cal program. The MRB is responsible for performing federally mandated post-payment utilization reviews of non-institutional providers. In addition to the three main operational branches, A&I has two support units: Internal Audits (IA) and Administrative Support (AS). The IA unit is an independent organization housed within A&I that is charged with department-wide internal audit responsibilities. The AS unit is responsible for providing oversight and coordination of all A&I administrative functions.

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Although some program integrity responsibilities have been delegated to other State agencies and contractors through agreements, the ultimate responsibility for program integrity lies with the single State agency, DHCS.

The table below presents the total number of preliminary and full investigations, administrative sanctions, identified overpayments, and average amount identified per case review in the past four State fiscal years (SFYs) as a result of program integrity activities.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Number of State Administrative Actions or Sanctions (Approximation)	Amount of Overpayments Identified by State Agency	Average Amount Identified per Case Review
2005	780	76	661	\$83,424,337	\$33,968
2006	656	100	695	\$116,779,997	\$56,171
2007	584	99	655	\$65,292,413	\$23,063
2008	439	119	682	\$71,186,758	\$26,220

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.

**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.

Methodology of the Review

In advance of the onsite visit, the review team requested that California complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as provider enrollment/disclosures, program integrity, managed care, and the MFCU. A five-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of March 9, 2009, the MIG review team visited the offices of DHCS A&I. The team conducted interviews with numerous State officials¹, as well as with staff from the managed care contractors, a fiscal agent, and the MFCU. In order to determine whether managed care plans were complying with the contract provisions and Federal regulations relating to program integrity, the MIG team reviewed the State's managed care organization (MCO) contracts. The team also conducted sampling of provider enrollment applications, case files, selected claims, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused not only on the activities of the DHCS A&I, but also considered the work of other State agencies and contractors responsible for a range of program integrity functions, including provider enrollment and provider training. California operates both a stand-alone Children's Health Insurance Program (CHIP) and a Title XIX expansion program. The portion of the State's CHIP operating as a Medicaid expansion program was included in this review because the program operates under the same billing and provider enrollment policies as

¹Department of Mental Health, Denti-Cal, Long Term Care Division, Alcohol and Drug Program, Department of Developmental Services, Department of Social Services, and Department of Aging

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California's Title XIX program. The same findings, vulnerabilities, and effective practices discussed in relation to the Medicaid program also apply to the Medicaid portion of CHIP.

Unless otherwise noted, DHCS A&I provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that DHCS A&I provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted five practices that demonstrate its commitment to program integrity. These practices include a standardized fraud and abuse reporting form, provider meetings with DHCS A&I officials, multi-faceted provider education, an anti-fraud task force, and restrictions on pharmaceutical claims.

Standardized fraud and abuse reporting form

Managed care entities, sister State agencies, waiver programs, and fraud and abuse hotline staff are required to use DHCS' standardized form MC-609 for reporting suspected fraud and abuse. Use of the form provides a consistent and efficient method for tracking and identification of cases.

Provider meetings with DHCS A&I officials

In addition to the required provider appeal rights, DHCS A&I provides the opportunity for providers to meet and confer with appropriate department officials regarding payment withhold notice letters. This process has proven effective in enabling DHCS to gather additional information, conduct provider education, and negotiate corrective action plans.

Multi-faceted provider education

The DHCS staff attended a "Train the Trainer" workshop presented by the Medicaid Integrity Institute (MII) giving State staff the tools and resources to develop their own training programs. The MII provided this training onsite in California. The DHCS utilized this opportunity to develop a training packet regarding provider documentation and has presented this to several provider groups, with the most recent training event occurring with the California Medical Board in February 2009. In addition, DHCS has a mandatory training for MCOs that includes sharing best practice information, provision of technical assistance, training by the MFCU, and presentations on fraud and abuse by DHCS A&I. The DHCS noticed an increase in referrals following the workshops as compliance officers became better educated on fraud and abuse issues and were retrained on the referral process.

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Anti-Fraud Task Force

The California single State agency, all sister State agencies who receive Medicaid monies, and the MFCU have formed an Anti-Fraud Task Force. The Anti-Fraud Task Force is chaired by the director of A&I and meets bi-monthly to discuss current cases being investigated, trends in fraud and abuse, and other “hot topic” issues. The DHCS and the MFCU provide cross-training on various anti-fraud education topics.

Restrictions on pharmaceutical claims

All Medi-Cal pharmacy claims are required to have a valid prescribing provider license number. The license number is vetted against the State’s Suspended and Ineligible List that is maintained by the Office of Legal Services (OLS). If a prescribing license number matches a license number on the Suspended and Ineligible List, the claim will deny and no payment will be made. This allows the State to restrict prescribing providers, even if that provider is not billing the program for a service.

Additionally, the MIG review team identified four practices that are particularly noteworthy. The MIG recognizes the State’s payment error studies, State statutes enhancing program integrity efforts in provider enrollment, enhanced provider enrollment procedures, and innovative program safeguards in the Alcohol and Drug Program (ADP) as further evidence of the State’s program strengths.

Medi-Cal payment error studies

The State has developed a Medicaid Payment Error Study to identify provider types at greatest risk for payment errors. These data runs have resulted in special focused reviews of pharmacies and adult day health centers. The State also conducts weekly random audits on various provider claims. Based on the results, the State develops new fraud control strategies and determines how best to deploy limited Medi-Cal anti-fraud resources.

State statutes enhancing integrity efforts in provider enrollment

California has enacted legislation that provides DHCS with additional leverage in enhancing the integrity of Medi-Cal’s provider enrollment system. The legislation provides for a moratorium on the enrollment of providers in certain service categories, and a three year debarment from applying to Medi-Cal for failing to disclose required information during application. New provider applicants and re-applicants are placed on provisional provider status for 12 months or may apply for preferred provisional provider status which lasts for 18 months. The preferred provisional provider status requires the provider to meet certain criteria and involves a less extensive screening due to the higher requirements.

Enhanced provider enrollment procedures

California has implemented enrollment procedures that better identify and more thoroughly screen possible high-risk providers. The Provider Enrollment Division developed a check sheet which is used by analysts when reviewing applications for enrollment, changes in business activity, or changes in service address. The first section of the check sheet must be completed for all providers. If during the review an applicant is deemed to be high-risk, the processing analyst proceeds to the high-risk

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portion of the check sheet which is a more in-depth analysis of the applicant and his business activity. If during the in-depth high-risk review process serious risk factors are found related to an applicant for enrollment, the applicant is referred to A&I for a site visit prior to enrollment.

Innovative program safeguards in the Alcohol and Drug Program

The ADP, a sister State agency, has implemented enhanced certification activities for providers. The ADP is the certification body for addiction professionals in California. As part of the certification process, ADP requires that providers receive training on documentation and potential fraud and abuse issues prior to receiving certification to practice in California. In addition, ADP requires reapplication and recertification if a provider moves its operations to another county. This process allows ADP to track providers who may relocate or move from one county plan to another to avoid detection or scrutiny.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations regarding enrollment of excluded providers, methods for identifying, investigating and referring fraud cases, verification of receipt of billed services, required disclosures, and reporting requirements.

The State does not enforce prepaid inpatient health plan (PIHP) contracts that require individuals debarred, suspended, or excluded by Federal agencies not to be enrolled.

Under the regulation at 42 CFR § 438.610, an MCO, primary care case manager (PCCM), PIHP, or prepaid ambulatory health plan (PAHP) may not have a relationship with a director, officer, partner, an employee, consultant, a person with a 5 percent or more ownership interest, or a contractor for items or services that are material to the managed care entity's obligations to the State who has been debarred, suspended, or excluded, or who is an affiliate of a person who is debarred, suspended, or excluded. If the State Medicaid agency learns that the MCO, PCCM, PIHP, or PAHP has a relationship with such a debarred, suspended, or excluded person, or a person who is an affiliate of a person who is debarred, suspended, or excluded, the State Medicaid agency must notify the Secretary. The State may continue the contract with the MCO, PCCM, PIHP, or PAHP, unless the Secretary instructs the State Medicaid agency to terminate the contract; and the State may not renew or extend the contract with the MCO, PCCM, PIHP, or PAHP, unless the Secretary provides the State and Congress with compelling reasons for continuing the contract.

The Los Angeles (LA) County Department of Mental Health reported current enrollment of one mental health provider on the Federal exclusion list and two mental health providers on the State exclusion list. While the State's PIHP contracts require compliance with 42 CFR § 438.610, LA County has not complied with the regulations and the State has not enforced the regulations.

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Recommendations: Verify LA County's information and immediately remove debarred providers from the Medi-Cal program. Increase State oversight of PIHPs to ensure compliance with 42 CFR § 438.610.

The State does not have methods for the identification, investigation, and referral of suspected fraud cases from sister agencies and waiver programs.

The regulation at 42 CFR § 455.13 requires a State Medicaid agency to have methods and criteria for identifying suspected fraud cases and investigating those cases, and to have procedures for referring suspected cases of fraud to law enforcement officials.

In-Home Support Services (IHSS) and Home and Community-Based Services (HCBS) waiver programs have primary responsibility for detecting fraud and abuse while the State agency maintains general oversight of program integrity functions. However, these sister agencies are not contractually required to report suspected fraud and abuse to the single State agency and as a result, DHCS is unable to refer suspected cases of fraud to the MFCU or any other applicable law enforcement agency.

Recommendations: Revise contracts to require reporting of suspected fraud and abuse cases to the State agency. Develop and implement policies and procedures for identifying, investigating and tracking potential provider fraud cases from agencies outside of DHCS. Develop and implement a policy and procedure for referring cases of suspected fraud to appropriate law enforcement.

California's waiver programs and sister State agencies do not verify with recipients whether services billed by providers were received.

Under 42 CFR § 455.20, the agency must have a method for verifying with recipients whether services billed by providers were received. The MRB sends out requests for recipient verification of services in the course of investigating cases of provider fraud and the IB conducts recipient interviews in the course of investigations. However, the IHSS program, and vendors at the Regional Centers (RCs) do not routinely conduct recipient verification of services. Although the State is conducting quality assurance services in some of these programs, this is insufficient to meet the requirement.

Recommendation: Require waiver programs and sister State agencies to conduct verification of services and provide oversight to ensure that all contractors are in compliance with 42 CFR § 455.20.

The State does not capture all required ownership, control, and relationship information in its FFS operations from providers, and from the survey agency and fiscal agents.

Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity

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has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

Although the State Medicaid agency collects required disclosures from providers who enroll using the State Medi-Cal enrollment form, this information is not being captured for vendors enrolled in the RCs under the HCBS waiver program and providers enrolled in the IHSS program.

The State survey agency, Licensing and Certification, does not promptly report disclosure information to the State agency as required by the regulation. Based on the State's response to the review guide such reporting was not being done and provider enrollment staff indicated that Licensing and Certification staff only report "actionable" information.

The State does not obtain full ownership and control information as part of its procurement of contracts with the fiscal agents. Key staff disclosures are obtained, but information on the Board of Directors is not requested.

Recommendations: Ensure that provider enrollment forms used to enroll vendors in the RCs under the HCBS waiver program and IHSS program request all required information. Develop a cooperative agreement with the State survey agency to routinely report disclosure information under 42 CFR § 455.104(b)(1). Revise procedures in the contract procurement process to ensure that information is disclosed by all appropriate parties.

The State does not require disclosure of business transactions upon request in its FFS operations.

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or U.S. Department of Health & Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors. California's disclosure statement packet, used for FFS providers, requires the disclosure of information upon request related to business transactions at the time of application. However, the provider agreement between the State and the provider does not contain specific language related to this regulation. In addition, disclosure information is not required for vendors enrolled at the RCs in the HCBS waiver program and the IHSS program.

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Recommendations: Review and modify the enrollment packages and contracts to incorporate the appropriate business transaction language. Ensure that all programs receiving Federal Medicaid monies are capturing the appropriate disclosure required by 42 CFR § 455.105(b).

The State does not capture required criminal conviction information in its FFS operations.

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify the HHS Office of Inspector General (HHS-OIG) whenever such disclosures are made. Pursuant to 42 CFR § 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

California's Disclosure Statement requests criminal conviction information related to Federal health care programs "within 10 years of the date of this statement," not since the inception of those programs as required by regulation. The State agency indicated that disclosure information is forwarded to OLS, who, subsequently, forwards the information to the appropriate local branch of HHS-OIG. Sister State agencies having primary responsibility for program integrity oversight are not forwarding criminal conviction information to DHCS.

Recommendations: Revise the Disclosure Statement to capture information required by 42 CFR § 455.106. Develop and implement a procedure to obtain relevant information from sister State agencies and refer that information to HHS-OIG as required.

The State does not report to HHS-OIG adverse actions it takes on FFS provider applications.

The regulation at 42 CFR § 1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. The DHCS is not reporting to HHS-OIG when the State denies enrollment to a provider, or disenrolls a provider, or when a provider voluntarily disenrolls to avoid a formal sanction.

Recommendation: Develop and implement policies and procedures to report to HHS-OIG adverse actions taken against provider enrollment applications and actions taken to limit the ability of providers to participate in the Medicaid program.

The State does not report to HHS-OIG local convictions of crimes against Medicaid.

Under the regulation at 42 CFR § 1002.230, the State Medicaid agency must provide notice to HHS-OIG within specified timeframes, unless the MFCU has already provided such notice, when an individual has been convicted of a criminal offense related to the delivery of health care items or services under the Medicaid program. If the State agency was involved in the investigation or prosecution, the State agency must provide notice to HHS-OIG within 15 days after conviction, and if the State agency was not involved in the investigation or prosecution, the State agency must provide notice to HHS-OIG within 15 days after learning about the conviction.

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The OLS reports criminal convictions to HHS-OIG when it is aware of such convictions. However, OLS may not always learn of such convictions from the MFCU and is not aware if the MFCU has reported the convictions to the HHS-OIG. The Memorandum of Understanding (MOU) between DHCS and the MFCU does not address who is responsible for the reporting.

Recommendations: Institute policies and procedures that address reporting criminal convictions to HHS-OIG pursuant to 42 CFR § 1002.230. Modify the MOU with the MFCU to ensure the State's compliance with reporting criminal convictions to HHS-OIG.

Vulnerabilities

The review team identified four areas of vulnerability in California's program integrity practices regarding capture and reporting of disclosure information, reporting requirements, oversight of managed care programs, and utilization of fraud subject matter experts.

Not capturing ownership, control, and relationship information from providers and managing employees in the MCOs, PIHPs and PAHPs.

The DHCS contracts with MCOs, PIHPs, and PAHPs to deliver medical, dental, and mental health services. Based on review of provider enrollment and credentialing packets of these eight managed care entities, the MIG review team found no evidence that any of the entities required disclosure of ownership, control, and relationship information from individual providers, agents or managing employees of these organizations.

Recommendation: Modify the MCO, PIHP and PAHP contracts to require disclosure of ownership and control, and relationship from each of the entities' providers, including agents and managing employees.

Not reporting to HHS-OIG adverse actions taken on managed care provider applications.

The regulation at 42 CFR §1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. The State Medicaid agency does not require its MCOs to inform them when the MCOs have denied enrollment or credentialing of a provider due to program integrity concerns, and the State is therefore unable to make the required report to the HHS-OIG.

Recommendation: Require MCOs to report all denials of enrollment or credentialing or terminations of providers based on program integrity concerns to DHCS.

Not providing sufficient oversight of MCO program integrity activities.

The managed care regulation at 42 CFR § 438.608 requires that MCOs and PIHPs have specific administrative and management procedures designed to guard against fraud and abuse, which must include written policies, procedures, and standards of conduct regarding the MCO's or PIHP's commitment to compliance; the designation of a compliance officer; training and education for all employees; effective lines of communication; enforcement of standards through

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well-publicized disciplinary guidelines; internal monitoring and auditing; and prompt response to detected offenses and corrective action.

The State's oversight over the actual delivery of managed care services is weak or non-existent in some areas. The State's MCO contracts do not require the MCOs to send out explanations of medical benefits nor to verify with recipients if services were received. While the State does collect some managed care encounter data, it is not capitalizing on the opportunity to perform data analysis or utilization reviews to identify instances of fraud, waste and abuse based on the data. Also, not all MCOs are submitting encounter data to the State. This lack of oversight of the delivery of services leaves the State susceptible to fraud, waste and abuse committed by the MCOs themselves, especially in the area of underutilization.

During onsite interviews with two MCOs, MCO staff stated that they were not aware of what fraud and abuse activities were contractually delegated to them by the State. Interviews with multiple MCOs and sister agencies revealed that not all of the MCOs and sister agencies have policies and procedures in place to address fraud and abuse. Interviews with DHCS indicated that while the State does receive copies of the individual compliance plans, it is unclear what type of attention is given to the plans and if any follow up is performed, if necessary.

Recommendations: Modify MCO contracts to require verification of receipt of services furnished by providers. Develop and implement policies and procedures to verify compliance with the fraud and abuse requirements of the MCO contracts.

Not effectively communicating and referring to the MFCU.

The DHCS screens suspected fraud cases for referral to the MFCU. As part of this process, DHCS reviews complaints and conducts a preliminary investigation to determine if there is some evidence of suspected fraud. At times, the breadth, depth and timeliness of the DHCS preliminary investigation may compromise future investigations conducted by the MFCU. In interviews with OLS, the department indicated referrals of suspected fraud are received from A&I staff. However, OLS indicated that A&I staff may be using the term fraud in an incorrect legal sense. At times, A&I has decided that such cases should be handled administratively by the State as opposed to being referred to the MFCU. This decision raises some concern as to whether DHCS is in compliance with 42 CFR § 455.15(a) and 455.21, which require the agency to refer a provider to the MFCU whenever suspected fraud is discovered. In turn, the MFCU, as the fraud subject matter expert, has responsibility for attempting to substantiate those allegations.

Recommendations: Coordinate with the MFCU early in the DHCS investigative process by providing the MFCU with detailed information regarding matters in which the DHCS believes suspected fraud may exist in order to ensure compliance with 42 CFR 455.15(a) and 455.21(a)(1). Refer to the CMS recommended standard for determining whether a case should be referred to a MFCU. This information is contained in the document "Best Practices for Medicaid PI Units Interactions with MFCU" published on September 30, 2008 for guidance regarding the point in the investigative process at which the agency should refer matters to the MFCU.

CONCLUSION

The State of California applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. These effective practices include:

- a standardized suspected fraud and abuse reporting form,
- provider meetings with DHCS A& I officials,
- multi-faceted provider education,
- an Anti-Fraud Task Force,
- restrictions on pharmaceutical claims,
- Medi-Cal payment error studies,
- State statutes enhancing fraud and abuse efforts,
- enhanced provider enrollment procedures, and
- innovative program safeguards by sister State agencies

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of eight areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, four areas of vulnerability were identified. The CMS encourages DHCS to closely examine each area of vulnerability that was identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require DHCS to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of California will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If California has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of California on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.