Pharmaceuticals Follow-Up

State Departments That Purchase Prescription Drugs Have Not Yet Fully Implemented Recommendations to Further Refine Their Cost Savings Strategies

June 2007 Letter Report 2007-501

CALIFORNIA STATE AUDITOR

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June 12, 2007 2007-501

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

Dear Governor and Legislative Leaders:

This letter report presents the results of a follow-up review the Bureau of State Audits (bureau) conducted concerning the California Public Employees' Retirement System (CalPERS), Department of General Services' (General Services), and the Department of Health Services' (Health Services) efforts to implement selected recommendations from a report the bureau issued in May 2005 titled *Pharmaceuticals: State Departments That Purchase Prescription Drugs Can Further Refine Their Cost Saving Strategies* (2004-033). During the follow-up review we focused on eight key findings related to cost saving strategies used by CalPERS, General Services, and Health Services when purchasing prescription drugs. We found that although some progress has been made, both General Services and Health Services need to do more to fully address the recommendations from our May 2005 report as well as the following earlier reports:

- *Department of Health Services: Its Efforts to Further Reduce Prescription Drug Costs Have Been Hindered by Its Inability to Hire More Pharmacists and Its Lack of Aggressiveness in Pursuing Available Cost-Saving Measures* (issued April 2003, 2002-118)

- *State of California: Its Containment of Drug Costs and Management of Medications for Adult Inmates Continue to Require Significant Improvements* (issued January 2002, 2001-012)

During this follow-up review, we found that General Services expects to generate savings from two new contracts it negotiated for pharmaceutical services; however, it has yet to analyze other saving options. Specifically, General Services has been slow to fully analyze measures to improve its procurement process, such as joining various group purchasing organizations and alliances. Additionally, General Services and the Common Drug Formulary Committee (committee) have not yet reviewed the statewide formulary for patient safety, efficacy, high quality, and best value drugs. We also found that although Health Services has made some progress in reducing its backlog of older disputed rebates, its current backlog has increased significantly. Finally, Health Services has yet to recoup at least $2.5 million resulting from erroneous payments it made to pharmacies we identified in our 2005 audit.

Background

Chapter 938, Statutes of 2004, required the bureau to report to the Legislature on the State's procurement and reimbursement practices as they relate to the purchase of drugs for or by state departments, including, but not limited to, the departments of Mental Health, Corrections and Rehabilitation (Corrections), the Youth Authority, Developmental Services, Health Services, and CalPERS. Specifically, the statutes required the bureau to review a representative sample of the State's procurement and reimbursement of drugs to determine whether it is receiving the best value for the drugs it purchases. The statutes also required the bureau to compare, to the extent possible, the State's

cost (price per unit) to those of other appropriate entities such as the federal government, Canadian government, and private payers. Finally, the bureau was required to determine whether the State's procurement and reimbursement practices resulted in savings from strategies such as negotiated discounts, rebates, and contracts with multistate purchasing organizations, and whether the State's strategies resulted in the lowest possible costs. The bureau examined the purchasing strategies of the three primary departments that contract for prescription drugs—General Services, Health Services, and CalPERS.

Pursuant to the authority granted to the bureau, including the audit standards the bureau operates under, it has been a long-standing administrative practice to require each agency or department we have audited to report to the bureau on its progress in implementing our recommendations at three intervals—60 days, six months, and one year (California Government Code, Title 2, Section 8543, and Government Auditing Standards, paragraph 1.27). Under that same authority, it has also been a long-standing administrative practice of the bureau to conduct follow-up reviews of audits when resources are available and the bureau determines it is prudent to do so.

CalPERS Has Greater Access to Rebate Information for One of Its Contracts

CalPERS entered into a new pharmacy benefit management agreement on July 1, 2006, that allows it to audit the entity's records pertaining to rebates under the agreement. As reported in our 2005 audit report, the previous agreement prohibited CalPERS from having access to the entity's rebate contracts with pharmaceutical manufacturers or distributors. We recommended that CalPERS explore various contract negotiation methods that would allow it to achieve greater disclosure requirements. During our follow-up, we reviewed the current contract and verified that it contains the language that will enable CalPERS to verify that it is receiving all of the rebates related to this contract to which it is entitled. CalPERS has indicated that it anticipates performing an audit of its current pharmacy benefit manager during fiscal year 2007–08.

General Services Has Negotiated Two New Contracts for Pharmaceutical Services From Which It Expects to Generate Savings

In a January 2002 report, *State of California: Its Containment of Drug Costs and Management of Medications for Adult Inmates Continue to Require Significant Improvements,* the bureau recommended that General Services increase its efforts to

solicit bids from drug manufacturers to obtain more drug prices on contract. General Services negotiates contracts with drug manufacturers so that state agencies can purchase drugs at less-than-wholesale acquisition cost (contract drugs), defined as the standard price a wholesaler pays a manufacturer for drug products not including special deals, such as rebates or discounts. During 2002 General Services had about 850 drugs on contract, but during most of fiscal year 2003–04 had only 665 drugs on contract. General Services stated that because of limited resources, it was focusing on negotiating contracts with manufacturers of high-cost (price per unit) drugs. However, opportunities still existed for General Services to increase the amount of purchases made under contract with drug companies. We recommended that General Services continue its efforts to obtain more drug prices on contract by working with its strategic sourcing contractor to negotiate new and renegotiate existing contracts with certain manufacturers. General Services hired this strategic sourcing contractor to analyze state spending and identify opportunities to generate savings. In May 2005 General Services reported that its strategic sourcing contractor and the contractor's partners were providing support to General Services in its efforts to negotiate and renegotiate contracts with drug manufacturers.

According to General Services, its strategic sourcing contractor assisted it in negotiating two new pharmaceutical contracts for the period of November 2005 to November 2007 that General Services believed would result in significant savings to the State. The first of these two-year contracts is with a pharmacy benefits manager (benefits manager) to provide prescription drugs to parolees for Corrections. The second contract is with a pharmaceuticals prime vendor (prime vendor) to distribute drugs purchased under the State's bulk purchasing program. Our follow-up review of reports summarizing pharmaceutical purchases provided by General Services indicates that the State appears to have achieved savings of $7.8 million during the first 10 months of these two new contracts. Although General Services has yet to verify the accuracy of its savings estimates, the methodology it used to calculate its savings estimates appears reasonable.

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When we compared the discounts of the earlier contracts with the two new pharmaceutical contracts, we found that the State should achieve savings in three ways. First, although the benefits manager sells its prescription drugs to the State at the same price, the new contract guarantees discounts greater than the former contracts. Second, the previous and new prime vendor also sell their prescriptions at the same price, but the new contract guarantees discounts off certain prices that were not formerly discounted. Third, unlike the previous prime vendor contract, the new contract does not require General Services to pay administrative fees

and offers volume discounts. Based on the discounts in the new contracts, it is logical to assume that the State will achieve savings from greater discounts and fewer fees.

Moreover, General Services provided us with monthly savings reports from March to December 2006 related to the pharmaceutical purchases made under these two contracts. According to General Services, it obtains these reports from the strategic sourcing contractor it used to assist it in negotiating these two contracts. The contractor compiles the reports from data provided to General Services by the two new contractors. These reports are lists of all purchases made by state agencies under the two new contracts and include information such as drug names, drug prices, purchased quantities, and accrued savings. The accrued savings included in these reports are calculated by subtracting the costs of goods purchased under the new contract from what the costs of these exact same goods would be, were they purchased under the former contracts. Based on reports from the strategic sourcing contractor, it appears that the State generated $3.7 million in savings by contracting with the new benefits manager and an additional $4.1 million in savings from its prime vendor contract.

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We reviewed the methodology for calculating the accrued savings and believe it is appropriate. However, General Services has not verified the accuracy of the accrued savings. According to General Services it is currently relying on pricing for individual drugs provided by the new benefits manager and prime vendor to calculate savings because it does not have access to First DataBank Inc., a pricing database that could allow it to verify drug prices used in the reports. However, by not performing some type of procedures to verify the accuracy of the information included in these reports, General Services cannot state with assurance that the calculated savings are accurate. Further, because the fees it pays its strategic sourcing contractor that assisted it in negotiating the two pharmaceutical contracts are based on the amount of savings generated under the contracts, by not verifying the accuracy of the reports, General Services cannot be certain that it paid its contractor the appropriate fee. According to General Services, it may seek to obtain access to First DataBank Inc. as part of a larger effort to verify the data included in these reports, but it had not completed the feasibility study report for this project as of April 2007 and it does not know when it will complete the study.

General Services Has Not Yet Analyzed Options for Improving Its Procurement Process

In our January 2002 report, we also recommended that General Services fully analyze measures to improve its procurement process, such as joining various group purchasing organizations and alliances. These organizations negotiate volume discounts with manufacturers and suppliers on behalf of their members, providing members with favorable prices, terms, and conditions. General Services contracted with the Massachusetts Alliance for State Pharmaceutical Buying (alliance) in October 2001 without performing a thorough analysis to determine whether the alliance would be the most effective option for reducing the State's drug costs. In its January 2003 follow-up response to our audit, General Services stated it was conducting a detailed review of the effectiveness of using the alliance. However, as we reported in our May 2005 report, General Services was unable to provide us with the results of its effectiveness review. Additionally, in our 2005 report General Services stated that as resources become available, it intended to solicit bids to contract directly with a group-purchasing organization.

In its one-year response to our 2005 audit, General Services informed us that it planned to send a request for information to large- and medium-size group-purchasing organizations by early January 2007 to gather information to assist it in evaluating the pricing and services available through its current alliance contract. We found that General Services sent a request for information to 13 group-purchasing organizations, and received seven responses by the February 9, 2007, deadline. General Services indicated that it has not yet evaluated the responses; however, it hopes to perform its analysis by the end of June 2007. According to General Services, if its analysis of the responses indicates it may be able to benefit from a different group purchasing relationship, it will release a request for proposal.

General Services and the Committee Have Not Yet Reviewed the Formulary Based on Safe, Effective, High Quality, and Best Value Drugs

In our January 2002 report, we recommended that General Services fully consider and try to mitigate all obstacles that could prevent the successful development of a statewide formulary, such as departments not strictly enforcing such a formulary. A drug formulary is a list of drugs and other information representing the clinical judgment of physicians, pharmacists, and other experts in the diagnosis and treatment of specific conditions. A main purpose of a formulary is to create competition among manufacturers of similar drugs when the clinical uses are roughly equal. However,

the success of a statewide formulary and the State's ability to create enough competition to negotiate lower drug prices for certain products depends on how well state departments adhere to the formulary when they prescribe drugs. Although General Services had developed a statewide formulary, it had not identified the obstacles to enforcing it. General Services had not required departments to adopt a policy requiring strict adherence to the statewide formulary and it was not monitoring departments' adherence to the formulary.

In our 2005 report, we recommended that General Services facilitate the committee and the Pharmacy Advisory Board's development of guidelines, policies, and procedures relating to departments' adherence to the statewide formulary and ensure that departments formalize their plans for compliance. In its one-year response to our report, General Services indicated that at the committee's October 2005 meeting, and the Pharmacy Advisory Board's January 2006 meeting, the formulary was approved. It also stated that now that the statewide formulary has been implemented, General Services and the committee would begin to focus additional resources on the administrative and enforcement concerns raised in our report.

General Services stated that the committee plans to conduct reviews of each therapeutic category to develop a formulary based on four criteria: patient safety, efficacy, high quality, and best value. The committee approved a process for the therapeutic category review at its July 19, 2006, meeting. According to General Services, it is continuing to work with the committee to develop policies and procedures governing the administration and enforcement of the formulary. However, these policies are not yet in place for the major therapeutic categories. General Services stated that it plans to have these policies and procedures in place within the next year. Until General Services and the committee reviews each therapeutic category based on the four criteria and can determine whether departments are purchasing drugs that are not on the formulary, it cannot fully utilize the formulary process to achieve greater savings.

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Moreover, there may be some uncertainty as to whether Corrections will continue to participate in the State's bulk purchasing program, which includes all of the drugs on the State's formulary. If Corrections discontinued its participation, it could affect the committee's ability to effectively review the current therapeutic categories and revise the formulary. As the result of a 2001 class action suit brought against the state of California challenging the quality of medical care in the State's prison system, a federal court order placed the oversight of health care delivery in the prison system under the federal court's control.

On February 14, 2006, the federal court established a receivership and appointed a federal receiver to direct the management of health care delivery in the prisons. The receiver contracted with Maxor National Pharmacy Services Corporation (Maxor) to provide pharmacy management consulting services to implement the receiver's plan to develop a constitutionally adequate pharmacy services delivery system. According to Maxor's monthly progress report for February 2007, it reviewed the State's formulary and identified redundant medications and patient safety risks. From this review, it proposed a new formulary for Corrections, which it presented to a reconstituted Pharmacy and Therapeutics Committee for review and approval.

According to the receiver's March 20, 2007, bi-monthly report to the court, Maxor believes that the formulary committee sometimes made decisions that failed to achieve the maximum fiscal savings Corrections could have realized if it had negotiated separate contracts based on its own clinical pharmaceutical needs. Moreover, according to Maxor, several contracts negotiated by General Services contain unacceptable terms, which assure free access to the formulary with no restrictions on practitioners, despite documented problems with medication management within Corrections. In its report Maxor requested that it be allowed to become the contract negotiator under the purview of the receiver's contracting office for Corrections' pharmaceutical procurements. Accordingly, the federal receiver has recommended to the court that Maxor assume effective control over all Corrections' pharmaceutical purchases.

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It is possible the receiver could decide that Corrections will no longer participate in the formulary committee. Further, should the receiver request a waiver of state law, the court could allow the receiver to remove Corrections from the State's bulk purchasing program. Based on the prime vendor savings reports given to us by General Services, during the period between March 2006 and December 2006, Corrections' purchases through the prime vendor represented 73 percent of all purchases made by departments participating in the bulk purchasing program. Should Corrections no longer participate in the State's bulk purchasing program, the committee may have to change its current approach to review the formulary because Corrections represents the majority of purchases. More specifically, if Corrections is removed from the State's bulk purchasing program, the formulary committee may need to re-establish the State's pharmaceutical needs based on the smaller volumes required by the remaining departments. If that were to happen, it may become beneficial for the State to use Corrections' pharmaceutical purchaser to maintain the same volume of purchases that might allow for greater discounts.

General Services Has Yet to Evaluate Whether Other Departments Are Purchasing Pharmaceuticals Outside of the Bulk Purchasing Program

Although state law requires specific state departments to purchase drugs through General Services, our 2005 audit reported that a survey of various departments indicated they were not always following the law in doing so. Specifically, the California Government Code requires the departments of Corrections, Developmental Services, and Mental Health to participate in General Services' bulk purchasing program. In addition, the California Public Contract Code requires that all state departments purchasing drugs totaling more than $100 must purchase them through General Services. We reported in 2005 that although departments generally purchase most drugs through General Services' contract with its prime vendor, they also purchase drugs through other vendors. We recommended that General Services ask the departments participating in the State's bulk purchasing program to notify General Services of the volume, type, and price of prescription drugs they purchase outside of the program.

In September 2005 General Services modified the Purchasing Authority Manual (PAM) to include a requirement that departments participating in the bulk purchasing program are also required to report information on prescription drugs purchased outside of the State's program. During our follow-up review we found that, although most departments required to submit quarterly reports to General Services that identify the purchases they are making outside the State's bulk purchasing program do so, General Services has not developed a formal process to analyze and use the information included in these reports. In fact, our high level review of these reports identified that not all departments are consistent as to which types of purchases they include on these reports and, at least one department—Corrections—failed to include this information related to its divisions. Some of this variability in reporting may be occurring because the quarterly report template available on General Services' Web site does not include instructions to assist the departments in making decisions as to which items should be reported. According to General Services, it is currently working on creating a database to assist it in analyzing the data included in the quarterly reports and to deal with these inconsistencies.

Although most departments required to submit quarterly reports to General Services that identify the purchases they are making outside the State's bulk purchasing program do so, General Services has not developed a formal process to analyze and use the information included in these reports.

However, as previously discussed, the court appointed receiver has recommended to the federal court that Maxor assume effective control of Corrections' pharmaceutical purchases. Therefore, even though the law requires Corrections to participate in the State's bulk purchasing program, depending on the actions of the receivership,

if Corrections is no longer purchasing drugs through the State's program it would no longer submit the quarterly reports. However, until this occurs, General Services indicated that it will follow up with Corrections to ensure that, in the future, it submits quarterly reports that contain all of Correction's non-state procurement program purchases. Regardless, until General Services addresses the accuracy and completeness problems we observed and develops a process to analyze and use the information it receives in these quarterly reports, it cannot make informed decisions concerning the operation of the bulk purchasing program, nor can it expand the program to include those prescription drugs that best serve the needs of the State's departments.

Health Services Has Not Yet Reconciled All Its Older Rebate Disputes and Its Backlog of Current Disputes Is Growing

In addition to receiving federal rebates, Health Services is required by state law to contract with all drug manufacturers to obtain high-volume discount prices. Each quarter, Health Services sends invoices to drug manufacturers for federal and applicable state supplemental rebates. A manufacturer that does not agree with an invoice can dispute the amount of the rebate due. However, state law requires Health Services and manufacturers to cooperate and make every effort to resolve rebate disputes within 90 days of the manufacturers notifying Health Services of a dispute in the calculation of rebate payments. In our 2003 report, *Department of Health Services: Its Efforts to Further Reduce Prescription Drug Costs Have Been Hindered by Its Inability to Hire More Pharmacists and Its Lack of Aggressiveness in Pursuing Available Cost-Saving Measures,* we found that Health Services' records reflected that it received approximately $216 million less in rebates than the $3.4 billion it actually invoiced manufacturers from January 1991 to September 2001, and that it was just beginning to work with manufacturers to reconcile the 10-year accumulated difference.

As of our 2007 follow-up, Health Services indicates that it had reduced the amount of the disputed rebates from January 1991 to December 2001 to $153 million. However, Health Services states that the total amount of current rebate disputes, those arising from January 2002 to December 2006, stood at approximately $270 million as of January 2007. Health Services explains that it is still unable to resolve new disputes within the mandatory 90-day period, and that, although it has reduced the older backlog of disputed rebates, its current backlog has increased significantly. It believes that this situation stems from problems in retaining the personnel working on resolving those disputed rebates.

Health Services indicates that it had reduced the amount of the disputed rebates from January 1991 to December 2001 to $153 million. However, Health Services states that the total amount of current rebate disputes, those arising from January 2002 to December 2006, stood at approximately $270 million as of January 2007.

For fiscal year 2003–04 Health Services requested and was granted 11 new positions to assist in resolving drug rebate disputes. However, according to Health Services, these 11 positions were for a limited three-year term. Health Services explained that resolving disputed rebates is a complex process that requires at least a six- to 12-month training period, and it indicated that it lost more than half of its limited-term staff to other permanent positions. Thus, for many of these 11 positions, Health Services spent the time to train the staff, but lost them just at the point where they would have become productive. As a result, Health Services requested that these 11 positions be extended through fiscal year 2006–07, which was approved. In addition, in its budget change proposal for fiscal year 2007–08, Health Services is asking to convert half of these limited-term positions to permanent positions to improve its chances of retaining staff. It is also requesting an extension of one more year for the remaining temporary positions as part of its budget for fiscal year 2007–08.

Changes in Federal Regulations May Assist Health Services to Achieve Lower Costs on Generic Drug Purchases

In our 2003 report we recommended that Health Services negotiate state supplemental rebate contracts with manufacturers of generic drugs as the Legislature had directed it to do. According to Health Services' May 2005 response to our recommendation, generic drug manufacturers were not interested in entering into supplemental rebate agreements because the margins of profit are small and they have received negative feedback from the retail community. Instead, Health Services decided to shift from attempting to contract for generic drugs to implementing a new maximum allowable ingredient cost (MAIC), which we describe in the text box. Health Services expected that implementing the new MAIC would result in savings for generic drugs beyond those potential savings that might be achieved through its negotiations with manufacturers of generic drugs.

During our follow-up review, Health Services indicated that it plans to change the way it calculates MAIC for generic drugs by using the average manufacturer price (AMP). However, the change cannot be implemented until certain issues are resolved at the federal level, which Health Services believes most likely will affect the amount it will establish as its MAIC. Health Services plans to use certain pricing information that was unavailable to it in the past, which the federal government plans to publish during late spring 2007. Specifically, the federal Deficit Reduction Act of 2005 (act) requires the federal Centers for Medicare and Medicaid Services (CMS) to publish the AMP. In the past, Health Services did not have access

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to the AMP because it was considered proprietary information and therefore could not be released to the public. According to Health Services, it believes that using the AMP as a basis for calculating the MAIC should result in even greater savings in some cases than if it were to use the average wholesale price (AWP) as it originally intended to do. However, the federal Department of Health and Human Services has yet to finalize the federal regulations related to the changes contained in the act, and therefore has not yet published the AMP information. Until the federal government finalizes the regulations and releases the new pricing information, Health Services indicated it cannot perform a formal analysis to determine whether or not they can achieve additional savings by using the AMP as a basis for the MAIC.

Maximum allowable ingredient cost (MAIC)—the price established by Health Services for a generic drug type. Health Services bases the MAIC on the average wholesale price (AWP), which is the mean price paid by a pharmacy to a wholesale drug distributor, including discounts and rebates. AWP is obtained from Health Services' primary price reference source First DataBank Inc., or Redbook or the principal labeler's catalog.

Average manufacturer price (AMP)—the average price paid for such drugs by wholesalers for drugs distributed to the retail pharmacy class of trade. AMP will be published by the federal Centers for Medicare and Medicaid Services on a monthly basis.

Health Services Has Yet to Recoup Funds Resulting From Overpayments to Pharmacies

In our 2005 audit report we identified several instances where Health Services' payments to pharmacies were based on outdated or incorrect pricing information. For example, we found that Health Services did not update its prices to reflect the elimination of the direct pricing method, which was the price listed by Health Services' primary or secondary reference source or the principal labeler's catalog for 11 specified pharmaceutical companies. Health Services also incorrectly calculated drug prices, because it did not apply the appropriate discount to the AWP. Despite state law eliminating the direct pricing method as of December 1, 2002, Health Services continued to use it during fiscal year 2003–04 to reimburse pharmacies. As a result of our findings, we recommended that Health Services do the following:

- Identify prescription drug claims paid using the direct pricing method, determine the appropriate price for these claims, and make the necessary corrections.

- Ensure that the fiscal intermediary's Integrated Testing Unit removes future outdated pricing methods promptly.

- Ensure that its fiscal intermediary's Integrated Testing Unit verifies that, in the future, drug prices in the pricing file are calculated correctly before authorizing their use for processing claims.

In its one-year response to our audit, Health Services indicated that it is working with its fiscal intermediary to complete the corrections. During our follow-up review Health Services provided a correction notice dated February 2007 from its fiscal intermediary—Electronic Data Systems (EDS)—indicating EDS corrected the pricing of the 2,113 drugs that were incorrectly priced as a result of the error. We reviewed 20 of these drugs during our follow-up and found that all had been updated to reflect the appropriate price.

In its one-year response to our 2005 audit, Health Services indicated its total net recoupment will be $2.5 million as a result of a pricing error we identified. However, it has not yet begun the process to recoup the overpayments.

Additionally, in its one-year response to our 2005 audit, Health Services indicated its total net recoupment will be $2.5 million as a result of the pricing error. However, it has not yet begun the process to recoup the overpayments. According to Health Services, EDS identified four additional pricing errors in addition to the errors we identified in our report that require payment correction including rounding errors, delays in updating its formulary files, and data conversion errors. Health Services indicated that it intends to begin the process to concurrently recoup any overpayments related to these errors and the ones we identified. When we asked during our follow-up why it had not yet started the process of identifying overpayments for these new errors through EDS, Health Services stated that the payment of current claims and current pricing corrections and changes receive priority for system processing time. Health Services also stated that this approach ensures that patient access to care is not hindered and that payment errors on current claims do not occur. Therefore, the pricing errors on previously paid claims are given lower priority based on availability of system resources. Health Services plans to determine the dollar impact of the additional pricing errors EDS identified when it runs the programs to identify the overpayments. Although Health Services plans to start the process of identifying overpayments related to these additional errors before July 2007, because other changes to the system could take priority, Health Services was unable to provide us with an expected completion date for recouping these erroneous payments.

Health Services also reported in its one-year response that to ensure that future program errors do not occur, EDS' testing unit developed a testing environment that ensures all changes process successfully by first processing all changes on a test copy of the system prior to their implementation. In this way Health Services expects to limit the types of errors we identified in our 2005 audit.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the letter report.

Respectfully submitted,

ELAINE M. HOWLE
State Auditor

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