



SEP 17 2002

TO: Thomas Scully
Administrator
Centers for Medicare & Medicaid Services

FROM: Janet Rehnquist *Janet Rehnquist*
Inspector General

SUBJECT: Audit of California's Medicaid Inpatient Disproportionate Share Hospital
Payment for Kern Medical Center, Bakersfield, California, State Fiscal Year 1998
(A-09-01-00098)

This memorandum is to alert you to the issuance of the subject audit report within 5 business days from the date of this memorandum. A copy of the report is attached. The review was conducted at the request of the Centers for Medicare & Medicaid Services (CMS) as part of a multi-state initiative focusing on Medicaid disproportionate share hospital (DSH) payments made under section 1923 of the Social Security Act (the Act), as amended.

The objective of our review was to verify that state fiscal year (SFY) 1998 DSH payments to Kern Medical Center (KMC) did not exceed the hospital specific limit (the limit) as mandated by the Omnibus Budget Reconciliation Act of 1993.

Our audit showed that the California Department of Health Services (the state) made DSH payments to KMC that exceeded the limit by \$38,714,784 (\$19,446,435 federal share) for SFY 1998. Payment in excess of the limit occurred primarily because the limit for KMC determined by the state did not comply with federal statutes and regulations and CMS implementing guidance.

The overstatement of the KMC limit consisted of the following items:

- using projected amounts instead of actual incurred expenses and payments;
- not limiting total operating expenses to amounts that would be allowable under Medicare cost principles;
- including bad debts as an additional operating expense; and
- double counting charges for the Short Doyle program and including charges for services provided to inmates and Kern County employees.

We recommended the state:

- refund to the Federal Government \$14,165,950 representing the federal share of the KMC overpayment associated with the findings for Medicare cost principles, bad debts, Short Doyle program, and Kern County employees.
- work with CMS to address and resolve the \$5,280,485 representing the federal share of the KMC payment in excess of the limit associated with the findings for actual incurred expenses and payments and services provided to inmates. The state plan was silent on these issues. Nevertheless, we believe that the state plan's silence did not invalidate the intent of section 1923 of the Act or its implementing guidance.
- provide written instructions to KMC to correctly report charges in the annual hospital disclosure report upon which the state relied for the limit calculation.

In a subsequent report on the California DSH program, we will include recommendations pertaining to the deficiencies in the California Medicaid state plan and state procedures for determining the limit identified in the report.

The state generally disagreed with the findings presented in our draft report, except for bad debts and charges for the Medicaid Short Doyle program and services provided to Kern County employees. In addition, the state disagreed with the recommendation to refund the federal share of the KMC overpayment primarily because the state claimed that the approved state plan met federal statutory and regulatory requirements.

Where appropriate, we have made changes in the report to reflect the state's comments. However, some of the challenges to our findings and recommendations raised by the state in its comments were inconsistent with federal statutory or regulatory requirements or other CMS-issued program and state-specific guidance. We summarized the state's comments and included the Office of Inspector General's response to those comments in a separate section of the attached copy of the report. We have also appended the state's comments, in their entirety, to the report.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for Centers for Medicare and Medicaid Audits, at (410) 786-7104 or Lori Ahlstrand, Regional Inspector General for Audit Services, Region IX, (415) 437-8360.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**AUDIT OF CALIFORNIA'S MEDICAID
INPATIENT DISPROPORTIONATE
SHARE HOSPITAL PAYMENT FOR
KERN MEDICAL CENTER,
BAKERSFIELD, CALIFORNIA, STATE
FISCAL YEAR 1998**



**JANET REHNQUIST
INSPECTOR GENERAL**

**SEPTEMBER
A-09-01-00098**

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at <http://oig.hhs.gov/>

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services' (OAS) reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

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





Region IX
Office of Audit Services
50 United Nations Plaza
San Francisco, CA 94102

SEP 24 2002

CIN: A-09-01-00098

Stan Rosenstein
Assistant Deputy Director
California Department of Health Services
714 P Street, Room 1253
Sacramento, CA 95814

Dear Mr. Rosenstein:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, "Audit of California's Medicaid Inpatient Disproportionate Share Hospital Payment for Kern Medical Center, Bakersfield, California, State Fiscal Year 1998." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

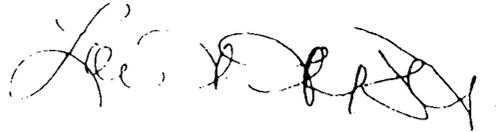
Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231) OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

Page 2 – Stan Rosenstein

To facilitate identification, please refer to Common Identification Number A-09-01-00098 in all correspondence relating to this report.

Sincerely yours.

A handwritten signature in black ink, appearing to read "Lori A. Ahlstrand". The signature is fluid and cursive, with the first name "Lori" being the most prominent.

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:

Elizabeth Abbott
Regional Administrator
Centers for Medicare and Medicaid
Region IX
75 Hawthorne Street, Suite 408
San Francisco, CA 94105

cc: w/Enclosure

Maria Faer, MPH, DrPH, Director of Clinical Policy & Legislation, UCOP
Stephanie Burke, Director, Audit & Management Advisory Services, UDSD
Elizabeth Abbott, Regional Administrator, CMS, Region IX

EXECUTIVE SUMMARY

BACKGROUND

In 1965, the Congress established the Medicaid¹ program as a jointly funded federal and state program providing medical assistance to qualified low-income people. The Omnibus Budget Reconciliation Act (OBRA) of 1981 established the disproportionate share hospital (DSH) program by adding section 1923 to the Social Security Act (the Act). Section 1923 required state Medicaid agencies to make additional payments to hospitals serving disproportionate numbers of low-income patients with special needs. The OBRA 1993 amended section 1923 of the Act to limit DSH hospital payments to the amount of incurred uncompensated care costs (UCC). The UCC was limited to the costs of medical services provided to Medicaid and uninsured patients less payments received for those patients excluding Medicaid DSH payments. For state fiscal years (SFY) effective on or after July 1, 1997, payments to all hospitals were limited to 100 percent of UCC with a special provision that allowed payments up to 175 percent of UCC to those public hospitals qualifying as “high DSH” hospitals in the state of California.²

OBJECTIVE

Our objective was to verify that SFY 1998 DSH payments to Kern Medical Center (KMC) did not exceed the hospital specific limit (the limit) as mandated by OBRA 1993.

SUMMARY OF FINDINGS

Our audit showed that the California Department of Health Services (the state) made DSH payments to KMC that exceeded the limit for SFY 1998. The KMC limit determined by the state did not comply with federal statutes and Centers for Medicare & Medicaid Services (CMS) requirements and implementing guidance. The limit determined by the state, based on projected data, was \$84,145,551 and the state made DSH payments to KMC for that amount for SFY 1998. The limit based on our audit results, however, was \$45,430,767. As a result, KMC received a payment of \$38,714,784 (\$19,446,435 federal share) in excess of the limit based on our audit.

The overstatement of the KMC limit consisted of the following items:

- \$8,585,373 for not calculating the limit using actual incurred expenses and payments;
- \$26,533,060 for not limiting total operating expenses to amounts that were allowable under Medicare cost principles;

¹ In the state of California, Medicaid is referred to as the Medi-Cal program. In this report, we use the term “Medicaid” to refer to the Medi-Cal program.

² For SFYs beginning after September 30, 2002, the DSH payment limit will be raised from 100 to 175 percent of UCC for public hospitals in all states for a 2-year period. The hospital specific limit was modified by section 701(c) of the Medicare, Medicaid, and State Child Health Insurance Program Benefits Improvement and Protection Act of 2000.

- \$670,658 for including bad debts as an additional operating expense; and
- \$2,925,693 for double counting charges for the Short Doyle³ program (\$637,987) and including charges for services provided to inmates (\$1,927,240) and county employees (\$360,466).

State law required that if any DSH payment exceeded the limit as determined by an audit or a federal disallowance, the state should recoup the amount of the payment that exceeded the limit. The state plan also required recoupment of amounts that exceeded the limit.

RECOMMENDATIONS

We recommended the state:

- refund to the Federal Government \$14,165,950 representing the federal share of the KMC overpayment associated with the findings for Medicare cost principles, bad debts, Short Doyle program, and Kern County employees.
- work with CMS to address and resolve the \$5,280,485 representing the federal share of the KMC payment in excess of the limit associated with the findings for actual incurred expenses and payments and services provided to inmates. The state plan was silent on these issues. Nevertheless, we believe that the state plan's silence did not invalidate the intent of section 1923 of the Act or its implementing guidance.
- provide written instructions to KMC to report charges for the Short Doyle program in the appropriate category of the annual hospital disclosure report.
- provide written instructions to KMC to exclude charges for Kern County employees from the county indigent patient category of the annual hospital disclosure report.

In a subsequent report on the California Medicaid inpatient DSH program, we will include recommendations pertaining to the California Medicaid state plan and state processes for determining the limit identified in this report.

SYNOPSIS OF STATE RESPONSE

In response to our draft report, the state generally disagreed with the findings, except for bad debts and charges for the Medicaid Short Doyle program and services provided to county

³ The Short Doyle program provides reimbursement for a broad range of mental health services and a limited range of services for treatment of substance abuse. These mental health services are provided by the county or through a contract with the county.

employees. In addition, the state disagreed with the recommendation to refund the federal share of the KMC overpayment primarily because the state asserted that the approved state plan met federal statutory and regulatory requirements.

Where appropriate, we made changes in the report to reflect the state's comments. However, some of the challenges to our findings and recommendations raised by the state in its comments were inconsistent with federal statutory or regulatory requirements or other program guidance. The state's comments and the OIG's responses to those comments are summarized in the report. Also, the state's comments, in their entirety, are included as an APPENDIX to this report.

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INTRODUCTION

BACKGROUND

In 1965, the Congress established the Medicaid¹ program as a jointly funded federal and state program providing medical assistance to qualified low-income people. At the federal level, the program is administered by the Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration, an agency of the Department of Health and Human Services. Within the broad legal framework, each state designs and administers its Medicaid program and is required to submit state Medicaid plan amendments for CMS approval.

FEDERAL STATUTES

The Omnibus Budget Reconciliation Act (OBRA) of 1981 established the disproportionate share hospital (DSH) program by adding section 1923 to the Social Security Act (the Act). Section 1923 required state Medicaid agencies to make additional payments to hospitals serving disproportionate numbers of low-income patients with special needs and allowed the states considerable flexibility to establish their DSH program.

The OBRA 1993 established additional inpatient DSH parameters by amending section 1923 of the Act to limit DSH payments to a hospital's incurred uncompensated care costs (UCC). The UCC was limited to costs of medical services provided to Medicaid and uninsured patients less payments received for those patients excluding Medicaid DSH payments.

For state fiscal years (SFY) effective on or after July 1, 1997, payments to hospitals were limited to 100 percent of UCC with a special provision that allowed payments up to 175 percent of UCC to those public hospitals qualifying as "high DSH" hospitals in the state of California.² In general, to qualify as a high DSH hospital, the hospital must have a Medicaid inpatient utilization rate that exceeds, by at least one standard deviation, the mean utilization rate of hospitals receiving Medicaid payments.

CALIFORNIA MEDICAID INPATIENT DSH PROGRAM

The California Department of Health Services (the state) administered the Medicaid inpatient DSH program using data collected from several different sources. The sources included annual reports submitted by hospitals to the Office of Statewide Health Planning and Development (OSHPD), hospital surveys, and paid claims files for Medicaid and county health plans.

¹ In the state of California, Medicaid is referred to as the Medi-Cal program. In this report, we used the term "Medicaid" to refer to the Medi-Cal program.

² For SFYs beginning after September 30, 2002, the DSH payment limit will be raised from 100 to 175 percent of UCC for public hospitals in all states for a 2-year period. The hospital specific limit was modified by section 701(c) of the Medicare, Medicaid, and State Child Health Insurance Program Benefits Improvement and Protection Act of 2000.

California hospitals were required to file with OSHPD annual standardized reports (OSHPD report) and other health care related data. The OSHPD collected and analyzed data from health care facilities licensed in California and acted as a clearinghouse for information on health care costs, quality, and access.

Hospital Specific Limit Methodology

To identify those hospitals eligible for DSH, the state calculated the Medicaid and low-income inpatient utilization rates for all hospitals. The state used data collected from annual OSHPD reports, surveys from eligible hospitals, and paid claims files to calculate the hospital specific limit (the limit). Data used in these calculations were approximately 1½ to 3 years old.

The state's methodology determined estimates of each hospital's current year operating expenses and payments from uninsured patients by using historical operating expenses and payments from uninsured patients that were projected up to 3 years based on the Medicare Hospital Market Basket Index. The state calculated the UCC as the pro rata share of the projected total hospital expenses related to the Medicaid, county indigent, and uninsured patients less Medicaid payments and projected payments for uninsured patients.

The State's formula for the UCC:

$$\left(\begin{array}{l} \text{Projected Total} \\ \text{Hospital Expenses} \end{array} \times \begin{array}{l} \text{Patient} \\ \text{Mix} \\ \text{Ratio}^* \end{array} \right) + \begin{array}{l} \text{Demo} \\ \text{Project} \\ \text{Expenses}^{**} \end{array} - \begin{array}{l} \text{Medicaid and Projected} \\ \text{Uninsured Payments} \end{array} = \text{UCC}$$

** Patient Mix Ratio = Total Charges for Medicaid, County Indigent, and Uninsured Patients / Total Charges for All Patients*

*** Demo (Demonstration) Project Expenses = Additional expense applicable only to Los Angeles County Hospitals*

In accordance with the Act, the state determined the limit for non-high DSH hospitals as 100 percent of the UCC. For high DSH hospitals, the limit was 175 percent of the UCC. Consequently, for every dollar of UCC, the limit for a high DSH hospital is equivalent to \$1.75. APPENDIX A shows the data elements, data source, and methodology used by the state in the 1998 UCC calculation.

The state determined the DSH payment for the year based on the type of hospital (e.g., teaching, children's, acute psychiatric), the low-income number, and 80 percent of the annualized Medicaid inpatient days for the prior calendar year. The DSH payment was adjusted based on the California Medicaid state plan (state plan) requirements. One of the adjustments was to ensure that the payment did not exceed the limit.

Distribution of DSH Payments for SFY 1998

The following table shows the SFY 1998 state distribution of DSH payments for public and private hospital categories:

Hospital Categories	No. of Hospitals	Total DSH Payments
Public		
Non-high DSH	24	\$ 106,794,087
High DSH (Excludes Los Angeles County Hospitals)	18	961,695,970
Los Angeles County Hospitals ³	6	996,511,518
Private – Non-high DSH	74	549,157,752
Total	122	\$2,614,159,327

KERN MEDICAL CENTER LIMIT AND PAYMENT

The Kern Medical Center (KMC) is a 222-bed general acute care county hospital with 6 licensed teaching programs supporting approximately 120 medical students and clinical residents. The KMC is owned and operated by Kern County. The Chief Executive Officer of KMC reports directly to the Kern County Board of Supervisors.

For SFY 1998, the state determined the limit for KMC as \$84,145,551 and the state made DSH payments to KMC for that amount. Of the \$84,145,551, the non-federal share was \$41,341,066 and the federal share was \$42,804,485. The federal share was based on federal financial participation (FFP) rates of 50.23 percent and 51.23 percent. The state designated KMC as a high DSH public hospital with a limit of 175 percent of its UCC for SFY 1998. Accordingly, for every dollar of UCC, KMC received \$1.75 in DSH payments.

RECOUPMENT OF OVERPAYMENTS

State law and the state plan included provisions to recover, withhold, or recoup overpayments.

Section 14105.98(r)(1) of the California Welfare and Institutions Code stated:

Any hospital that has received payments under this section...shall be liable for any audit exception or federal disallowance only with respect to the payments made to that hospital. The department shall recoup from a hospital the amount of any audit exception or federal disallowance in the manner authorized by applicable laws and regulations.

³ Los Angeles County hospitals are also high DSH.

Furthermore, section 14105.98(r)(2) stated:

...if any payment adjustment that has been paid...exceeds the OBRA 1993 payment limitation for the particular hospital, the department shall withhold or recoup the payment adjustment amount that exceeds the limitation.

Additionally, the state plan specified, "If any payment adjustment that has been paid...exceeds the hospital specific limitations...the Department shall withhold or recoup the payment adjustment amount that exceeds the limitation."

OBJECTIVE, SCOPE, AND METHODOLOGY

Our objective was to verify that SFY 1998 DSH payments to KMC did not exceed the limit as mandated by OBRA 1993. The audit was performed in accordance with generally accepted government auditing standards. Accordingly, we performed such tests and other auditing procedures as necessary to meet the objective of our review. An overall review of KMC's internal control structure was not necessary to achieve our objective.

To accomplish our objective, we analyzed data elements used by the state in the calculation of KMC's limit to determine compliance with applicable federal Medicaid statutes, Code of Federal Regulations (CFR), and CMS guidance pertaining to the DSH program. Our review focused on the determination of the limit for inpatient DSH payments.

We reviewed federal Medicaid statutes, CFRs, CMS guidance, California Welfare and Institutions Code, and state plan provisions pertaining to the DSH program. We interviewed CMS Region IX, state, and KMC officials and obtained copies of pertinent documentation. We reconciled KMC's fiscal year 1998 OSHPD report to its accounting records. We also performed limited testing of KMC charges for different payer groups.

The state's methodology, as shown in APPENDIX A, used data from different time periods (i.e. hospital fiscal year and calendar year). Our review applied the state's methodology using actual 1998 data obtained from subsequent limit calculations, state payment schedules, and KMC's Medicare cost report. Our review of the state-provided Medicaid revenue amounts was limited to Medicaid billing policy and provider numbers and did not include transaction testing of the data processing systems used to identify and aggregate the Medicaid revenues.

Our fieldwork was performed at the state's office in Sacramento, California during the period February through August 2001 and at KMC offices in Bakersfield, California during the period June through November 2001. From March 2002 to June 2002, in response to the state's comments on our December 2001 draft report, we performed additional fieldwork with the state's office in Sacramento, California.

FINDINGS AND RECOMMENDATIONS

Our audit showed that the state made DSH payments to KMC that exceeded the limit by \$38,714,784 for SFY 1998. The KMC limit determined by the state did not comply with federal statutes and CMS requirements and implementing guidance. The limit determined by the state, based on projected data, was \$84,145,551. The state made DSH payments to KMC for the full amount of the state determined limit for SFY 1998. The limit based on our audit results, however, was \$45,430,767. As a result, KMC received a payment of \$38,714,784 (\$19,446,435 federal share) in excess of the limit based on our audit.

The following summary identifies the issues and the amount of overstatement. *The issues are presented in the order that they would appear in the state's SFY 1998 methodology for UCC, shown on APPENDIX A, rather than descending dollar order. A summary of the operative parts of the formula starts with total operating expenses multiplied by the patient mix ratio (charges for Medicaid, county indigent, and uninsured patients divided by the hospital's charges for all patients) and ends with reducing those expenses by payments made for Medicaid and uninsured patients. The result is the hospital specific UCC. Because KMC was a designated high DSH hospital, the state calculated its limit at 175 percent of its UCC. As a result, KMC's state determined limit was overstated by \$1.75 for every dollar that its UCC was overstated.*

An explanation for each issue follows the summary table below:

Summary	<u>Adjustment (Decrease)</u>
State Determined Limit	\$ 84,145,551
<u>Overstatement Issues</u>	
• Actual Incurred Expenses and Payments (See page 6.)	(8,585,373)
• Medicare Cost Principles (See page 6.)	(26,533,060)
• Bad Debts (See page 7.)	(670,658)
• Patient Mix Ratio (See pages 8 and 9.)	<u>(2,925,693)</u>
Adjusted limit based on our audit	<u><u>\$45,430,767</u></u>

APPENDICES B and C show, by data element, each adjustment used in our recalculation of the KMC limit.

State law required that if any DSH payment exceeded the limit as determined by an audit or a federal disallowance, the state should recoup the amount that exceeded the limit.

ACTUAL INCURRED EXPENSES AND PAYMENTS

The state determined limit was overstated by \$8,585,373 because the state did not calculate the limit using incurred expenses and payments as required by section 1923 of the Act.

Consistent with the state plan, the state applied a trend factor to historical expenses and uninsured payments to determine the limit for the year of the DSH payment. Section 1923(g)(1)(A) of the Act required that DSH payments not exceed the:

...**costs incurred during the year of furnishing hospital services** (as determined by the Secretary and **net of payments** under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) **for services provided during the year**. [Emphasis added]

The state plan did not require a recalculation using incurred costs and payment data after the data became available.

The state estimated the limit for SFY 1998 as \$84,145,551. Our calculation of the limit uses the state methodology as shown in APPENDIX B substituting 1998 actual incurred costs and payments in place of projected historical costs and payments. The KMC limit calculated⁴ using actual data was \$75,560,178, a reduction of \$8,585,373.

MEDICARE COST PRINCIPLES

The state determined limit was overstated by \$26,533,060 because the state used total hospital operating expenses that exceeded the amounts that were allowable under Medicare principles of cost reimbursement.

The state plan required the state to calculate the limit using total operating expenses obtained from KMC's OSHPD report. However, total operating expenses on that report included costs (e.g., unused space and gift, flower, and coffee shops costs) that were not allowable under Medicare cost principles.

Total operating expenses used in calculating the limit, based on 1998 cost data, were \$103,193,661. In our calculation of the limit, we determined that total hospital operating expenses were \$85,397,753. This amount included total operating expenses of \$71,369,586⁵ as

⁴ We used the limit calculated with actual incurred expenses and payments as the basis for recalculation of the limit for subsequent issues presented in this report.

⁵ KMC Medicare Cost Report for fiscal year ending June 30, 1998, Worksheet B, Part I, row 95, column 27.

reported on KMC's finalized Medicare Cost Report for fiscal year 1998 to which we added \$5,045,602⁶ for Medicare allowable graduate medical education (GME) costs and \$8,982,565⁷ of costs for professional medical services.⁸

Although professional medical services costs were not included in the reimbursable cost category of KMC's Medicare Cost Report, they may be reimbursed as physician services under the Medicare Part B program, per section 1887(a)(1)(A) of the Act. In addition, as a county hospital in California, KMC was permitted to employ physicians, making costs associated with professional medical services provided by those employed physicians a recognizable hospital cost. Therefore, we included these professional medical services costs in the calculation of the limit. At APPENDIX D, we show descriptive adjustments needed to bring total hospital operating expenses per KMC's SFY 1998 OSHPD report into agreement with the 1998 Medicare Cost Report.

In a letter dated August 17, 1994, the CMS Director of the Medicaid Bureau provided guidance to State Medicaid Directors that stated:

...in defining 'costs of services' under this provision [section 1923(g)], HCFA would permit the State to use the definition of allowable costs in its State plan, or any other definition, as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement.

The effect of including costs that exceeded the amount allowable under Medicare cost principles was an overstatement of the limit by \$26,533,060. Using Medicare cost principles, we reduced total operating expenses by \$17,795,908. See APPENDIX C for the detailed limit calculation.

BAD DEBTS

The state determined limit was overstated by \$670,658 because bad debts were included as an additional operating expense in the limit calculation. The amounts used for bad debts in the limit calculation were obtained from "Provision for Bad Debts." A provision for bad debts is not a cost.

Consistent with the state plan, the state added bad debts, obtained from "Provision for Bad Debts" as shown on KMC's OSHPD report, to total operating expenses. However, by adding bad debts to total operating expenses, the expenses related to providing the services were counted at least twice – once in total operating expenses as costs incurred in the production of the service and a second time as bad debts.

⁶ KMC Medicare Cost Report for fiscal year ending June 30, 1998, Worksheet E-3, Part IV, row 3.

⁷ KMC Medicare Cost Report for fiscal year ending June 30, 1998, Worksheet A-8-2, row 101, column 4 (less \$5,382,782 in costs that were not for professional medical services).

⁸ Professional medical services consist of those services that are personally rendered for an individual patient by a physician and contribute to the diagnosis or treatment of that patient. Costs associated with these services constitute the professional component of provider-based physician costs.

Federal regulations established that bad debts should not be added to total operating expenses. Title 42, CFR section 413.80(c) stated:

Bad debts...represent reductions in revenue. The failure to collect charges for services furnished does not add to the cost of providing the services. Such costs have already been incurred in the production of the services.

The effect of including bad debts was an overstatement of the limit by \$670,658. To eliminate the duplicate expenses, we reduced bad debts from \$479,209 to zero. See APPENDIX C for the detailed limit calculation.

PATIENT MIX RATIO

The state determined limit was overstated by \$2,925,693 because the patient mix ratio was overstated. The overstatement was due to double counting charges for the Short Doyle⁹ program and including ineligible charges for services provided to inmates and county employees. As a result, the patient mix ratio was overstated by almost 2 percent.

The overstatement in the limit for each category of charges follows:

<u>Category</u>	<u>Overstatement</u>
Short Doyle Program	\$ 637,987
Inmates	1,927,240
County Employees	360,466
Total Overstatement	<u>\$2,925,693</u>

A discussion of each category follows.

SHORT DOYLE PROGRAM

The state determined limit was overstated by \$637,987 due to double counted charges for the Short Doyle program. The double counting occurred because KMC incorrectly reported these charges. As a result, the patient mix ratio was overstated by almost one half of 1 percent.

The KMC included charges of \$702,538 for the Short Doyle program in the OSHPD report category for Medicaid inpatient/outpatient charges, instead of the category for third-party payer as indicated in the OSHPD reporting instructions. The state plan did not include the third-party payer category in the limit calculation. Although the state acknowledged that its reporting instructions for Short Doyle program charges were ambiguous, KMC's execution of those

⁹ The Short Doyle program provides reimbursement for a board range of mental health services and a limited range of services for treatment of substance abuse. These mental health services are provided by the county or through a contract with the county.

instructions brought about the incorrect reporting of those charges in the Medicaid inpatient/outpatient category on the OSHPD report.

Consistent with the state plan, the state separately added charges for the Short Doyle program to Medicaid inpatient/outpatient charges. This resulted in double counting Short Doyle program charges because KMC included these charges in the OSHPD category for Medicaid inpatient/outpatient charges.

The effect of KMC's reporting Short Doyle program charges in an inappropriate category was an overstatement of the limit by \$637,987. We reduced Medicaid inpatient/outpatient charges by \$702,538 to eliminate the duplicate charges for the Short Doyle program. See APPENDIX C for the detailed limit calculation.

SERVICES PROVIDED TO INMATES

The state determined limit was overstated by \$1,927,240 because the state included ineligible charges for services provided to inmates. By including ineligible charges for services provided to inmates, KMC's patient mix ratio was overstated by more than 1 and one quarter percent.

The KMC included charges of \$2,122,239 for services provided to inmates in the category for county indigent inpatient/outpatient charges on the OSHPD report. The state used the OSHPD reported county indigent inpatient/outpatient charges in the calculation of the patient mix ratio.

The state plan did not address charges for services provided to inmates. However, in a case involving another state, CMS determined that the costs of providing inpatient services to inmates were unallowable because inmates were wards of the state (or other subdivisions of government) and, as such, they had a source of third-party coverage, which prevented costs for services to those inmates from being considered in the DSH limit calculation.

The effect of including the ineligible charges for inmate services was an overstatement of the limit by \$1,927,240. To exclude the ineligible charges for services provided to inmates, we reduced the county indigent program charges by \$2,122,239. See APPENDIX C and its footnote 4 for the detailed limit calculation.

SERVICES PROVIDED TO COUNTY EMPLOYEES

The state determined limit was overstated by \$360,466 because KMC included charges for employment-related services (e.g., pre-employment physicals and immunizations against exposure) provided to Kern County employees. By including charges for services provided to Kern County employees, KMC's patient mix ratio was overstated by one quarter of 1 percent.

The KMC included \$396,938 of charges for employment-related services for county employees in the category for county indigent inpatient/outpatient charges on the OSHPD report. Consistent with the state plan, the state used the OSHPD reported county indigent inpatient/outpatient charges in the calculation of the patient mix ratio.

Those charges described in the OSHPD instructions were "...for patients covered under [California's] Welfare and Institution (W&I) Code section 17000." This section required every county to:

...relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident...when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions.

Employment-related services for county employees are an inherent element of county operations and are the responsibility of county government. By classifying employment-related charges for county employees as indigent care and including them in the county indigent category on the OSHPD report, KMC overstated the county indigent charges that the state relied on when it calculated KMC's limit.

The effect of including charges for employment-related services provided to county employees in the county indigent patient category was an overstatement of the limit by \$360,466. To exclude the charges for employment-related services provided to county employees, we reduced the county indigent program charges by \$396,938. See APPENDIX C and its footnote 4 for the detailed limit calculation.

CONCLUSION AND RECOMMENDATIONS

For SFY 1998, the state made DSH payments totaling \$84,145,551 to KMC. We determined that the state paid KMC \$38,714,784 (\$19,446,435 federal share) in excess of the limit based on our audit – \$45,430,767. This occurred, in part, because KMC incorrectly reported charges for the Short Doyle program and Kern County employees in the annual OSHPD report.

We recommended the state:

- refund to the Federal Government \$14,165,950 representing the federal share of the KMC overpayment (\$28,202,171 x 50.23 percent)¹⁰ associated with the findings for Medicare cost principles, bad debts, Short Doyle program, and services provided to Kern County employees.
- work with CMS to address and resolve the \$5,280,485 representing the federal share of the KMC payment in excess of the limit (\$10,512,613 x 50.23 percent) associated with the findings for actual incurred expenses and payments and services provided to inmates. The state plan was silent on these issues. Nevertheless, we believe that the state plan's silence did not invalidate the intent of section 1923 of the Act or its implementing guidance.

¹⁰ The federal share of the DSH payments made in SFY 1998 was based on FFP rates of 50.23 percent and 51.23 percent. We used the lower of the two FFP rates to calculate the federal share.

- provide written instructions to KMC to report charges for the Short Doyle program in the appropriate category of the OSHPD report; and
- provide written instructions to KMC to exclude charges for Kern County employees from the county indigent patient category of the OSHPD report.

In a subsequent report on the California Medicaid inpatient DSH program, we will include recommendations pertaining to the California Medicaid state plan and state processes for determining the limit.

AUDITEE’S COMMENTS AND OIG’S RESPONSE

The state generally disagreed with the findings presented in our draft report, except for bad debts and charges for the Medicaid Short Doyle program, and services provided to Kern County employees. Where appropriate, we made changes in the report to reflect the state’s comments. However, some of the challenges to our findings and recommendations raised by the state in its comments were inconsistent with federal statutory or regulatory requirements or other program guidance. Below we summarized the state’s comments and included the OIG’s response to those comments. APPENDIX E contains the state’s comments in their entirety.

The state grouped the findings into two categories: (i) state plan deficiencies and (ii) hospital data discrepancies. In addition to addressing these findings, the state raised other issues: timing and response to recommendations.

The state related the findings of actual incurred expenses and payments, Medicare cost principles and bad debts to deficiencies in a CMS approved state plan. The state commented that the audit should not have included disallowances for state plan deficiencies because the draft audit report did not include recommendations pertaining to state plan provisions for determining the limit. As noted in the draft report, we will include recommendations pertaining to the California Medicaid state plan and state processes for determining the limit in a subsequent report on the California Medicaid inpatient DSH program.

The state related the findings for the patient mix ratio to hospital data discrepancies. The state acknowledged that KMC’s OSHPD reporting errors may have caused an overstatement of the limit and could have resulted in an overpayment to KMC.

STATE PLAN DEFICIENCIES

STATUTORY AND REGULATORY COMPLIANCE

State's Comments

The state claimed that its approved state plan satisfied OBRA 1993 and Medicaid statutory and regulatory requirements for the following issues identified in our report:

- Actual incurred expenses and payments,
- Medicare cost principles, and
- Bad debts.

OIG's Response

Contrary to the state's claim, the results of our audit clearly demonstrated that costs determined in accordance with the state plan methodology did not meet federal statutory and regulatory requirements or CMS-issued program and state-specific guidance.

*As to the use of actual costs and payments for services provided, the methodology in the state plan used projections (i.e., historical amounts adjusted for trend factors) to estimate the current year unreimbursed costs and payments. Section 1923(g)(1)(A) of the Act explicitly states, "**A payment adjustment [DSH payment] during a fiscal year shall not ... exceeds the costs incurred during the year of furnishing hospital service....**" [Emphasis added] We believe the state plan, which was silent on the use of incurred costs, did not invalidate the statutory requirement that DSH payment adjustments for the year not exceed UCC.*

As to the use of Medicare cost principles, the methodology in the state plan was silent. In our opinion, the state plan being silent on the use of Medicare cost principles did not invalidate CMS's OBRA 1993 implementing guidance, issued August 17, 1994, that limited costs of services to those amounts that did not exceed the principles of Medicare cost reimbursement.

As for bad debts, the state plan called for its inclusion as an addition to total operating expenses in the limit calculation. However, federal regulation at 42 CFR 413.80(c) stated that the failure to collect charges for services furnished (i.e., bad debts) does not add to the cost of providing the services since those costs have already been incurred in the production of the services. Therefore, the state plan methodology did not comply with federal regulation.

ACTUAL INCURRED EXPENSES AND PAYMENTS

State's Comments

The state claimed that the OBRA 1993 statute provided that the costs incurred are as determined by the Secretary and the statutory requirement was satisfied by CMS approving the state plan on behalf of the Secretary. The state also claimed that the California DSH program is a prospective

system analogous to the Medicare prospective payment system and, as a result, payment amounts are regarded as actual. The state added that payments on the basis of actual data could not be fully determined within the 2-year federal claim filing time limit required by federal regulations (45 CFR sections 95.1 – 95.34).

OIG's Response

As mentioned above, section 1923(g)(1)(A) of the Act explicitly requires the use of incurred costs, net of payments, for the year in which hospital services were rendered. In our opinion, the state plan, which was silent on the use of incurred costs, did not nullify the statutory requirement that DSH payment adjustments for the year not exceed UCC.

The state's claim that its DSH program is analogous to the Medicare prospective payment system is in direct conflict with guidance issued to the state by CMS. In a letter, dated May 8, 1996, granting specific approval to the California state plan amendment implementing the OBRA 1993 hospital specific DSH limits requirement, CMS Region IX advised the state that while the state's methodology for calculating and applying the payment limit applies to prospective periods and is based on estimates, those amounts are not final in the same sense as payments are for the prospective payment system.

As to the federal claim filing limit, we believe that the state had ample opportunity to use amounts for the calculation of KMC's limit that were derived from the year in which the hospital services were furnished. Well within the required 2-year filing period following the quarter in which expenditures were made, the state had access to several reports (e.g., Medicaid Cost Report, OSHPD annual hospital report) submitted by KMC to the state that would have more closely reflected incurred costs and payments for the year in which services were rendered.

MEDICARE COST PRINCIPLES

State's Comments

The state claimed that the August 17, 1994 guidance issued by CMS to State Medicaid Directors, upon which the OIG relied, has limited authority because CMS failed to issue corresponding federal rules to its guidance. They also stated that federal law does not require any particular methodology for determining costs and payments.

OIG's Response

*The August 17, 1994 CMS guidance declared intent was "... to provide the States with HCFA's **interpretation of the key provisions of the new law.**" [Emphasis added] A key CMS interpretation was to define allowable costs of services that granted the state flexibility up to a maximum standard - Medicare cost principles.*

In a subsequent letter, dated May 8, 1996, granting specific approval to the California state plan amendment implementing the OBRA 1993 hospital specific DSH limits requirement, CMS

Region IX advised the state that cost estimates used by the state were subject to future adjustment based upon reconciliation to Medicare principles of cost reimbursement. In that letter, CMS stated:

*As with other Medicaid provisions utilizing estimates in program administration, these **estimates are subject to future adjustment**, or reconciliation, should they later prove to have been established in excess of the limits. Such adjustments are based upon reconciliation to Medicare principles of cost reimbursement. **Costs determined may not exceed amounts that would be allowable under Medicare**, following cost report settlement. [Emphasis added]*

GME Costs

State's Comments

The state claimed that the portion of GME costs related to patient care may be included as an allowable cost. The state commented that the intent of the state plan is to include costs of health care provided by interns. The state also noted that it has initiated a review of the limit calculation to ensure that GME costs are included and will amend the state plan as necessary.

OIG's Response

In response to the state's comments, we included \$5,045,602 of Medicare allowable GME costs in the calculation of the DSH limit. As required by section 1923(g), we also included offsetting Medicaid GME revenues¹¹ to determine the UCC.

The state plan was silent on the inclusion of Medicaid GME revenues as well as GME costs. Accordingly, the state did not include Medicaid GME revenues when it calculated KMC's SFY 1998 DSH limit.

Provider-Based Physician Costs – Provider Component

State's Comments

The state claimed that the OIG significantly understated KMC's costs by excluding the costs of hospital administrative and quality of care functions performed by the medical director and physician chairpersons. The state maintains that these costs should be included in hospital total operating expenses used to calculate the DSH limit.

OIG's Response

Costs of hospital administrative and quality of care functions performed by the medical director and physician chairpersons are classified under Medicare cost principles as the provider

¹¹ At the request of the state, certain Medicaid revenues are not revealed/shown individually.

component of provider-based physician costs. As such, they are allowable under Medicare cost principles only to the extent the hospital provides up-to-date physician time studies to support the amounts it claims on its Medicare Cost Report. Section 1887(a)(2)(A) of the Act states:

For purposes of cost reimbursement, the Secretary shall recognize as reasonable cost...only that portion of the cost...apportioned on the basis of the amount of time actually spent by such physician rendering such services.

The KMC did not claim provider component costs on its 1998 Medicare Cost Report because, according to KMC officials, these costs were not supported by the up-to-date physician time studies required by Medicare and, as such, they did not qualify for reimbursement, partial or otherwise. The KMC chose not to seek reimbursement for provider component costs and, by its own admission, lacked the necessary documentation to support their allowance.

BAD DEBTS

State's Comments

The state agrees that bad debts are counted twice in the current state plan methodology. The state has initiated a review of the bad debts and claimed that the state plan will be amended to eliminate double counting of bad debts in the future. However, the state disagreed with any disallowance since the approved state plan required the addition of bad debts in the limit calculation.

OIG's Response

Although the state is planning to take corrective action for what it readily acknowledged to be double counting of costs associated with the addition of bad debts to hospital total operating expenses, it claimed that a disallowance for the amount should not be taken because payment was made under the approved state plan. We disagree for two reasons. First, the amounts used for bad debts were obtained from "Provision for Bad Debts" shown on the KMC's OSHPD report. The KMC provision for bad debts was not a cost or expense and should not have been included as a cost in KMC's limit calculation. Secondly, KMC was effectively compensated twice for the costs associated with bad debts since it received payment from the state in an amount equal to its state determined hospital specific limit – a limit calculated, in part, by adding bad debt to total operating expenses.

Federal regulation at 42 CFR 413.80(c) stated that the failure to collect charges for services furnished (i.e., bad debt) does not add to the cost of providing the services since those costs have already been incurred in the production of the services. Bad debts, as used in the limit calculation and reported under "Provision for Bad Debts" on the OSHPD report, were not a recognized cost. Although the state plan called for the inclusion of bad debts in the DSH limit calculation, it is unreasonable for the Federal Government to pay twice for the same costs or pay for an amount that was not a cost. Furthermore, we believe that CMS never intended to approve state plan provisions that allowed payment for the same costs twice or for amounts that did not constitute costs in the first place.

HOSPITAL DATA DISCREPANCIES

PATIENT MIX RATIO – SHORT DOYLE PROGRAM

State's Comments

The state acknowledged that the KMC reporting procedure generated double counting of charges for Medicaid Short Doyle services. The double counting caused the overstatement of the OBRA limit and resulting overpayment for this issue.

OIG's Response

The state generally agreed with our finding.

PATIENT MIX RATIO – SERVICES PROVIDED TO INMATES

State's Comments

The state claimed that the costs of services provided to Medicaid eligible inmates are allowed in the DSH limit calculation as exceptions to the federal regulation on which our finding relied for their disallowance. The state added that the cost of care to inmates who are not Medicaid eligible are also includable, to the extent those inmates satisfy the appropriate indigent and uninsured criteria.

OIG's Response

The state correctly noted the existence of an exception to the federal regulations we originally cited to support the exclusion of inmate costs from the DSH limit calculation. Nevertheless, costs associated with services provided to inmates are not allowable when calculating the hospital specific DSH limit. In a letter dated October 3, 2000, CMS denied a proposed plan amendment, submitted by another state, that would have provided DSH payments covering costs for inpatient services to inmates on the basis that inmates were not uninsured because they were wards of the state and, as such, the state had an obligation to provide for the inmates well-being (i.e., food, shelter, health care). The amounts paid by the state, or any subdivision of government, for inmate care are considered third-party payments. Because inmates have a source of third-party coverage, the state cannot make DSH payments to cover their costs. Although the state plan was silent on the inclusion of inmate costs, it clearly excluded third-party costs.

Even though CMS may not have distributed its guidance to every state, we believe CMS never intended to approve a state plan that allowed payment for third-party amounts that were properly the obligation of the state or a subdivision of government (e.g., counties). We defer to CMS to resolve this issue with the state.

PATIENT MIX RATIO – SERVICES PROVIDED TO COUNTY EMPLOYEES

State's Comments

The state acknowledged that KMC reporting procedures misclassified charges for employment-related services provided to Kern County employees as uninsured patients, resulting in an overstatement of the KMC OBRA 1993 limit and DSH payments in excess of that limit.

OIG's Response

The state generally agreed with our finding.

RECOMMENDATIONS

REFUND

State's Comments

Although the state did not dispute that an overpayment occurred, the state rejected the recommendation to refund the federal share of the KMC overpayment because the state claimed (i) the recommendation exceeds the scope of our audit authority and (ii) the approved state plan meets all federal statutory and regulatory requirements.

OIG's Response

We disagree with the state's claim that the recommendation to refund the federal share of the KMC overpayment exceeded the scope of our authority. The Inspector General Act of 1978, as amended, established the Office of Inspector General, Department of Health and Human Services and authorizes the conduct and supervision of audits and investigations relating to the programs and operations of the Department. Section 6(a)(2) of that Act further authorizes the Inspector General to:

... make such investigations and reports relating to the administration of the programs and operations...as are, in the judgment of the Inspector General, necessary or desirable....

Contrary to the state's second claim, the results of our audit clearly demonstrated that costs determined in accordance with the state plan methodology did not meet federal statutory and regulatory requirements.

PROVIDE WRITTEN INSTRUCTIONS TO KMC

State's Comments

The state responded that OSHPD is responsible for the Annual Financial Disclosure Report. The state will forward a copy of the audit report to OSHPD and request that OSHPD review the reporting instructions for the Annual Financial Disclosure Report and provide the state with recommendations to clarify the reporting issues identified.

OIG's Response

The proposed state review is welcome as long as it results in the timely implementation of our recommendation.

OTHER MATTERS

LITIGATION SETTLEMENT

On January 10, 2002, California announced a \$350 million tentative Medicaid settlement for litigation initiated in 1990 over low hospital reimbursement rates. The terms of the settlement stipulated that the payments be shared equally by the state and Federal Government. Although the Federal Government was not a party to the tentative settlement, the state had requested, in a letter dated March 22, 2001, that CMS confirm:

- ◆ FFP will be provided for the \$350 million in retroactive payments,
- ◆ the 30 percent rate increase is consistent with the state plan, and
- ◆ either (a) the retroactive payments will not be counted toward a hospital's OBRA 1993 limit or (b) the retroactive payment can be allocated to past years so that the OBRA 1993 limit will not be exceeded in any year.

We noted that both options (a) and (b) above benefit the state by eliminating the possibility that, in any year, the retroactive payments could lower the hospital specific limit and could result in overpayment.

On May 7, 2002, the state informed us that it planned to pay \$175 million, the state's share of the retroactive settlement, to the administrator of the settlement. After making the payment, the state planned to file a claim with CMS for the federal share. Although the state did not know the exact number of hospitals that will receive payments, the number may exceed 400.

The impact of the settlement on the results of this audit cannot be determined at this time.

APPENDICES

SFY 1998 STATE METHODOLOGY FOR UCC

DATA ELEMENTSSOURCE**Section I: Medicaid and Uninsured Expenses****Projected Total Hospital Expenses:**

Total Operating Expenses (TOE)-----	FY 1995 OSHPD L0820001 ¹
Add: Bad Debts -----	FY 1995 OSHPD L1242025
Subtract: CRRP ² Costs FY 1995 -----	1997/1998 Hospital Survey
Subtotal	
Multiply by: Trend factor -----	Medicare Market Basket Index for FY 1996/1997/1998
Subtotal: Projected Adjusted Hospital Operating Expenses	
Add: Estimated CRRP Costs -----	1997/1998 Hospital Survey
Subtract: Estimated Medicaid Administrative Activities (MAA)-----	1997/1998 Hospital Survey

Projected Total Hospital Expenses**Patient Mix Ratio:**

Medicaid In/Outpatient Charges -----	FY 1995 OSHPD (L1241505 + L1241507)
<i>Add Charges for:</i>	
Managed Care and County Health Plans -----	CY 1995 OSHPD Confidential Discharge and County paid claims files
Short Doyle Program -----	CY 1995 Medicaid Short Doyle paid claims file
County Indigent Program In/Outpatient -----	FY 1995 OSHPD (L1241509 + L1241511)
Uninsured In/Outpatient-----	FY 1995 OSHPD (L1241517 + L1241519)
Subtotal: Medicaid, County Indigent, and Uninsured Charges	
Divide by: Total In/Outpatient Charges -----	FY 1995 OSHPD L1241525

Patient Mix Ratio

Projected Total Hospital Expenses x Patient Mix Ratio =
Medicaid and Uninsured Expenses

Add: Demonstration Project Expenses ----- Terms and conditions of demonstration project

Total Medicaid and Uninsured Expenses**Section II: Medicaid and Uninsured Revenues**

Medicaid In/Outpatient Revenues -----	CY 1996 Medicaid paid claims files and Medicaid managed care data
<i>Add Revenues for:</i>	
Estimated FY 1997/1998 CRRP -----	1997/1998 Hospital Survey
Emergency Services/Supplemental Payments (SB 1255) -----	CMAC ³ negotiated amount for FY 1997/1998
Estimated FY 1997/1998 Targeted Case Management -----	1997/1998 Hospital Survey
Uninsured Cash Payments -----	FY 1995 OSHPD (L1246017 + L1246019) multiplied by trend factor
Demonstration Project Revenues -----	Terms and conditions of demonstration project

Total Medicaid and Uninsured Revenues**Section III: Uncompensated Care Costs (UCC) [Section I Less Section II]**

¹ OSHPD L0820001 refers to Page 8, Row 200, Column 01 of the hospital annual disclosure report provided by OSHPD.

² CRRP refers to the Medicaid Construction Renovation and Replacement Program.

³ CMAC refers to the California Medical Assistance Commission.

**COMPARISON OF PROJECTED AND ACTUAL DATA FOR KMC
SFY 1998**

<u>DATA ELEMENTS</u>	<u>STATE DETERMINED LIMIT¹</u>	<u>AUDIT ADJUSTMENT BASED ON ACTUAL²</u>
Section I: Medicaid and Uninsured Expenses		
Projected Total Hospital Expenses:		
Total Operating Expenses (TOE) -----	\$ 103,728,877	\$ 103,193,661
Add: Bad Debts -----	6,967,117	479,209
Subtract: CRRP Costs FY 1995 -----	None	In TOE
Subtotal -----	110,695,994	103,672,870
Multiply by: Trend factor -----	1.0905795	N/A
Subtotal: Projected Adjusted Hospital Operating Expenses -----	120,722,782	103,672,870
Add: Estimated CRRP Costs -----	1,626,225	In TOE
Subtract: Estimated Medicaid Administrative Activities -----	500,000	500,000
Projected Total Hospital Expenses -----	121,849,007	103,172,870
Patient Mix Ratio:		
Medicaid In/Outpatient Charges -----	91,691,626	66,672,929
<i>Add Charges for:</i>		
Managed Care and County Health Plans -----	388,718	19,827,927
Short Doyle Program -----	1,978,743	1,974,490
County Indigent Program In/Outpatient -----	14,887,213	40,631,818
Uninsured In/Outpatient-----	22,536,410	1,729,902
Subtotal: Medicaid, County Indigent, and Uninsured Charges -----	131,482,710	130,837,066
Divide by: Total In/Outpatient Charges -----	158,930,823	163,603,534
Patient Mix Ratio -----	0.8272952182³	0.7997202889³
<i>Projected Total Hospital Expenses x Patient Mix Ratio =</i>		
Medicaid and Uninsured Expenses -----	100,805,101	82,509,437
Add: Demonstration Project Expenses -----	None	None
Total Medicaid and Uninsured Expenses -----	100,805,101	82,509,437
Section II: Medicaid and Uninsured Revenues		
Medicaid In/Outpatient Revenues & Supplemental Payments ⁴ -----	47,467,235	37,277,147
<i>Add Revenues for:</i>		
Uninsured Cash Payments -----	5,254,693	2,055,046
Demonstration Project Revenues -----	None	None
Total Medicaid and Uninsured Revenues -----	52,721,929³	39,332,193
Section III: Uncompensated Care Costs (Section I Less Section II)	48,083,172	43,177,244
Section IV: High DSH Limit (Section III Multiplied by 1.75)	\$ 84,145,551	\$ 75,560,178³

Overstatement based on actual: \$84,145,551 (State limit) - \$75,560,177 (limit based on actual) = \$8,585,373

¹ Based on projected data.

² Based on actual 1998 data.

³ Slight difference due to rounding.

⁴ Supplemental Medicaid payments are confidential and, therefore, are not separately reported here.

**ADJUSTED LIMIT FOR KMC
SFY 1998**

<u>DATA ELEMENTS</u>	<u>AUDIT ADJUSTMENT BASED ON ACTUAL¹</u>	<u>PAGE²</u>	<u>ADDITIONAL ADJUSTMENTS (DECREASE)</u>	<u>ADJUSTED LIMIT</u>
Section I: Medicaid and Uninsured Expenses				
Projected Total Hospital Expenses:				
Total Operating Expenses (TOE) -----	\$103,193,661	6	(\$17,795,908)	\$85,397,753 ³
Add: Bad Debts -----	479,209	7	(479,209)	0
Subtract: CRRP Costs FY 1995 -----	In TOE			In TOE
Subtotal -----	103,672,870			85,397,753
Multiply by: Trend factor -----	N/A			N/A
Subtotal: Projected Adjusted Hospital Operating Expenses --	103,672,870			85,397,753
Add: Estimated CRRP Costs -----	In TOE			In TOE
Subtract: Estimated Medicaid Administrative Activities-----	500,000			500,000
Projected Total Hospital Expenses -----	103,172,870			84,897,753
Patient Mix Ratio:				
Medicaid In/Outpatient Charges -----	66,672,929	8	(702,538)	65,970,391
<i>Add Charges for:</i>				
Managed Care and County Health Plans -----	19,827,927			19,827,927
Short Doyle Program -----	1,974,490			1,974,490
County Indigent Program In/Outpatient -----	40,631,818	9	(2,519,177) ⁴	38,112,641
Uninsured In/Outpatient-----	1,729,902			1,729,902
Subtotal: Medicaid, County, and Uninsured Charges -----	130,837,066			127,615,351
Divide by: Total In/Outpatient Charges -----	163,603,534			163,603,534
Patient Mix Ratio -----	0.7997202889⁵			0.7800280798⁵
<i>Projected Total Hospital Expenses x Patient Mix Ratio =</i>				
Medicaid and Uninsured Expenses -----	82,509,437			66,222,631
Add: Demonstration Project Expenses -----	None			None
Total Medicaid and Uninsured Expenses -----	82,509,437			66,222,631
Section II: Medicaid and Uninsured Revenues				
Medicaid In/Outpatient Revenues & Supplemental Payments	37,277,147			38,207,147 ⁶
<i>Add Revenues for:</i>				
Uninsured Cash Payments -----	2,055,046			2,055,046
Demonstration Project Revenues -----	None			None
Total Medicaid and Uninsured Revenues -----	39,332,193			40,262,193
Section III: Uncompensated Care Costs (Section I Less II)	43,177,244			25,960,438
Section IV: High DSH Limit (Section III Multiplied by 1.75)	\$75,560,178⁵			\$45,430,767

Overstatement of the Limit: \$84,145,551 (State limit) – \$45,430,767 (limit based on audit results) = \$38,714,784

¹ The actual data is from APPENDIX B and explained on page 6.

² These adjustments are explained on the referenced page.

³ See Appendix D, footnote 3, for detail calculation of Total Operating Expenses allowable under Medicare Principles of Cost Reimbursement.

⁴ The \$2,519,177 consists of \$2,122,239 for inmate services and \$396,938 for services provided to county employees.

⁵ Slight difference due to rounding.

⁶ Includes additional adjustments to Medicaid revenues/payments.

APPENDIX D

**SUMMARY OF MEDICARE ADJUSTMENTS TO OSHPD EXPENSES
SFY 1998**

In this table, we show descriptive adjustments that were needed to bring total hospital operating expenses per KMC's SFY 1998 OSHPD report into agreement with the 1998 Medicare Cost Report.

MEDICARE

Allowable Cost Per Medicare Cost Report		\$71,369,586
Add: Provider-Based Physician Costs (Professional Component) ¹	8,982,565	
Graduate Medical Education ²	5,045,602	14,028,167
Cost Allowable Under Medicare Principles of Cost Reimbursement		\$85,397,753³

OSHPD TOTAL EXPENSES

Total Operating Expenses	103,193,661	
Add: Non-Operating Expense	2,652,904	
Total Expenses (carried over from OSHPD to Medicare Cost Report)		\$105,846,565

Medicare Cost Report Adjustments (Decrease)

Medicare Audit Adjustment (Worksheet A, line 101, column 6)		(17,061,339)
Interns and Residents Cost and Post Step Down Adjustment (Worksheet B-1, line 95, column 26)		(7,010,118)
Non-reimbursable Cost Centers:		
Other Non-Reimbursables	(8,363,996)	
Unused Space	(1,763,765)	
Research	(197,891)	
Gift, Flower, and Coffee Shop	(80,046)	
Total Non-Reimbursable Cost Centers		(10,405,698)

SUBTOTAL

Add: Immaterial Difference		176
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ALLOWABLE COST PER MEDICARE COST REPORT

\$71,369,586

¹ KMC Medicare Cost Report for fiscal year ending June 30, 1998, Worksheet A-8-2, row 101, column 4 (less \$5,382,782 in costs that were not for professional medical services).

² KMC Medicare Cost Report for fiscal year ending June 30, 1998, Worksheet E-3, Part IV, row 3.

³ We used this amount as the total operating expenses in Appendix C.

APPENDIX E

STATE OF CALIFORNIA RESPONSE TO OIG DRAFT KMC DSH REPORT
(PLUS ENCLOSURES)

(28 pages)



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



DIANA M. BONTÁ, R.N., Dr. P.H.
Director

GRAY DAVIS
Governor

April 4, 2002

Ms. Lori A. Ahlstrand
Regional Inspector General
for Audit Services
Region IX
Office of Inspector General
50 United Nations Plaza, Room 171
San Francisco, CA 94102

Dear Ms. Ahlstrand:

This letter is to inform you of amendments to the Department of Health Services' responses regarding the recent audits of the University of California, San Diego Medical Center (CIN: A-09-01-00085) and Kern Medical Center (CIN: A-09-01-00098) performed by the Office of Inspector General (OIG) on behalf of the Centers for Medicare and Medicaid Services. The OIG auditors contacted the Disproportionate Share Hospital (DSH) Unit to confirm that Graduate Medical Education (GME) revenues discussed in the Department responses were applicable during the State Fiscal Year (SFY) 1997-98 DSH program.

Historical review of the formula used to calculate the Omnibus Budget Reconciliation Act (OBRA) of 1993 hospital specific limit (the OBRA 1993 limit) revealed that the GME revenue factor was added to the formula beginning in SFY 1998-99. Thus, the GME revenue factor was not applicable to the SFY 1997-98 OBRA 1993 limit calculation; the first GME payments were made in 1998. Amended responses in which the reference to GME revenues has been appropriately edited are enclosed. Individual corrected pages with the edits are also enclosed for your convenience.

This amendment is a technical correction. Whether or not a GME payment was made in SFY 1997-98 does not affect the validity of the Department's argument that GME costs related to patient care may properly be included in the limit formula. Further, this technical correction does not change the fact that the SFY 1997-98 DSH OBRA 1993 limit and payment amount calculations were made in compliance with applicable provisions of the State Plan.



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(916) 654-0391

Internet Address: www.dhs.ca.gov

Ms. Lori A. Ahlstrand

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April 4, 2002

The Department appreciates the fact that the OIG auditors called this discrepancy to our attention and looks forward to continued efforts to resolve the audit issues with the federal government. If you have questions or need additional information, please contact me at (916) 654-0391.

Sincerely,



Stan Rosenstein
Assistant Deputy Director
Medical Care Services

Enclosures

cc: See Next Page



Ms. Lori A. Ahlstrand
Page 3
April 4, 2002

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CALIFORNIA DEPARTMENT OF HEALTH SERVICES

Response to the Department of Health and Human Services
Office of the Inspector General's
"Audit of California's Medicaid Inpatient Disproportionate Share Hospital
Payment of Kern Medical Center
State Fiscal Year 1998 - CIN: A-09-01-00098"

The Draft Audit Report¹ alleges that the California Department of Health Services (Department) overstated the State Fiscal Year (SFY) 1997-98 Kern Medical Center (KMC) Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) hospital specific limit (the limit). The auditors alleged that the Department's failure to comply with federal statutes and Centers for Medicare & Medicaid Services (CMS) requirements contributed to the KMC limit being overstated. The Draft Audit Report alleges that the Department overpaid KMC for the SFY 1997-93 Disproportionate Share Hospital (DSH) payment adjustment year.

The Department's response addresses the following major topics:

- I. Deficiencies in the California Medicaid State Plan (State Plan)
- II. Data Discrepancies
- III. Timing of Issuance of Final Findings and Recommendations
- IV. Response to Recommendations

SUMMARY OF DEPARTMENT'S RESPONSE

I. DEFICIENCIES IN THE CALIFORNIA MEDICAID STATE PLAN

The Department contests all of the proposed findings pertaining to the first category of deficiencies. The Draft Audit Report states that the Department made payments to KMC for the full amount of the State Plan determined limit, not in excess of it.

¹ Please note that the Emergency Services/Supplemental Payments (SB 1255), like all Medicaid contract payments under the State's Selective Provider Contracting Program, are confidential. Appendix B, *SFY 1997-98 Comparison of Projected and Actual Data for KMC* lists the SB 1255 revenues in Section II: *Medicaid and Uninsured Revenues*. Because the Draft Audit Report will become public record, the Department requests that the SB 1255 revenues not be separately identified in Section II. We recommend that the SB 1255 revenues be subsumed in the total for Medicaid In/Outpatient Revenues.

The Draft Audit Report does not make any findings concluding that the Department varied from the CMS-approved State Plan for the 1997-98 DSH payment adjustment year. The proposed audit findings, which are related to State Plan deficiencies include:

- A. Actual Incurred Expenses and Payments
- B. Medicare Cost Principles
- C. Bad Debt

The Department implemented the 1997-98 DSH program applying a valid State Plan carrying the approval of CMS. The Draft Audit Report should not include disallowances related to the alleged discrepancies in the State Plan.

II. DATA DISCREPANCIES

The Department acknowledges that data discrepancies may have caused an overstatement of the limit. The KMC Annual Financial Disclosure Report for SFY 1997-98, submitted to the Office of Statewide Health Planning and Development (OSHPD), and used by the Department in the OBRA 1993 limit calculation may have contributed to the data discrepancies.²

The audit findings related to these data discrepancies include:

- A. Patient Mix Ratio
 - 1. Short/Doyle Program
 - 2. Services Provided to Inmates
- B. Services Provided to County Employees

The Department further is aware that the auditors assert that the overstated limit resulted in an overpayment to KMC. Each of the potential data discrepancies is addressed in detail below.

III. TIMING OF FINAL FINDINGS AND RECOMMENDATIONS

The Department requests that all decisions regarding the hospital reporting errors and the related recommendations be postponed pending the determination of findings pertaining to possible offsets and the resulting total amounts to be refunded, as well as the final resolution of the alleged discrepancies in the California Medicaid State Plan.

² The KMC response (Enclosure 2) provides additional detailed comments on this topic.

IV. RESPONSE TO RECOMMENDATIONS

The Department presents, below, a separate response to the auditors' recommendations, which subsume the Department's responses to the proposed audit findings, as applicable.

DETAILED RESPONSE

ALLEGED DEFICIENCIES IN THE CALIFORNIA STATE PLAN

The Department contests all findings regarding deficiencies in the California State Plan. The **Objective** section of the **Executive Summary** stated that the "objective was to verify that the [KMC] did not exceed the hospital specific limit for SFY 1998." In the **Summary of Findings** section, the **Executive Summary** affirmed that "the State made DSH payments to KMC for the full amount of the State determined limit for SFY 1998." Clearly, the Draft Audit Report satisfied its stated objective and verified that KMC did not exceed the hospital specific limit as determined pursuant to the State Plan. Further, the Draft Audit Report did not identify any areas in which the Department varied from execution of the CMS-approved State Plan. Based upon this finding alone, there should be no disallowance in these areas.

However, the Draft Audit Report goes beyond the stated objective and audit authority by addressing State Plan compliance issues. Questions of whether the State Plan complies with federal law are reserved to the authority of the Secretary of the Department of Health and Human Services. The process for disapproval of State Plan materials includes formal notice and hearing procedures. (See, generally, 42 C.F.R. Part 430.)

Not only is the California Medicaid State Plan approved by CMS, it complies in all respects with federal Medicaid requirements; State Plan provisions related to the DSH program are within the scope of flexibility granted by Congress to the states to determine DSH payments. Accordingly, the Department contests the basis for the alleged deficiencies in the State Plan. The Department's position regarding each of the alleged deficiencies in the State Plan is discussed below.

Any corrective action that would be required following a final determination of State Plan noncompliance would be prospective only. Prior to such a final determination, payments made in accordance with the State Plan are allowable Medicaid expenditures. Thus, the recoupment recommended in the Draft Audit Report would be inappropriate, because the payments made to KMC are not "overpayments" under the approved State Plan.³

³ *Ibid.*

A. Actual Incurred Expenses and Payments

1 Use of Actual Data Is Not A Statutory Requirement

The language in Section 1923(g)(1)(A) of the Social Security Act that establishes the DSH Limit does not support the auditors' premise that the DSH program requires use of actual costs. OBRA 1987 amended the DSH program to require state Medicaid agencies to make additional payments to hospitals serving disproportionate numbers of low-income patients with special needs. Congress enacted DSH program specifications using general language that provides states the flexibility to adopt procedures and a methodology to implement a program tailored to each state's health care delivery system. Had Congress wished to tie the Medicaid program to Medicare cost principles, it could have done so explicitly in the language of Section 1923(g). The auditors' use of the term "actual" does not reflect a specified meaning in the context of the federal DSH requirements.

Further, the OBRA 1993 limit statute provides that the costs incurred are "as determined by the Secretary." California's State Plan methodology was in fact approved by CMS on behalf of the Secretary, and it follows that the costs determined in accordance with that approved methodology satisfy the statutory requirement.

2 CMS Approved California's State Plan Methodology

The Draft Audit Report portrays the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) limit determinations under the approved State Plan methodology as "estimates," suggesting that the methodology is incomplete. The California Disproportionate Share Hospital (DSH) program is a *prospective* system, under which DSH program eligibility, payment amounts and hospital-specific payment limits are determined at the start of the SFY. One analogy to the California approach is the Medicare prospective payment system (PPS), which establishes Medicare payment rates based on a complex rate setting methodology. PPS payments are never characterized as "estimates," even though they are derived from data pertaining to previous periods without any effort towards reconciliation with "actual" data. PPS payments are considered the "actual" payment amounts.

DHS expressly designed the prospective approach for administration of DSH program payments to assure timely and predictable funding levels for those financially distressed hospitals that are the core of California's safety net for low-income patients with special needs. DHS developed detailed limit determination methodology consistent with the overall prospective structure of the DSH program. The DSH program uses the most current actual

hospital cost and revenue data available in eligibility and payment determinations, including OBRA 1993 limits. OBRA 1993 limits calculated according to the State Plan methodology are the "actual" determinations. No retrospective reconciliation is warranted.

Federal law does not require any particular methodology for determining costs and payments with respect to the DSH program. The Department is not aware of any federal regulation on this topic. The methodology employed by California, since the requirement was enacted (in 1993), is set forth in detail in the State Plan, which has had federal approval for many years. That methodology applies definitions of costs and payments consistent with generally accepted accounting principles. As explained above, that methodology is based on projections based on actual data for prior periods on file at OSHPD and from other sources; there is no provision for reconciling the projections to later determined "actual" numbers. (See California State Plan, Attachment 4.19-A, Increase in Medicaid Payment Amounts for California Disproportionate Providers, section J, "OBRA 1993 Hospital-Specific Limitations," pages 29N to 29gg.)

Finally, as noted above, CMS disapproval of State Plan materials requires the administrative process included in 42 C.F.R. Part 430.

3. Conflicts with Federal Claiming Time Limits

On November 16, 2001, CMS informed the State of Virginia of a DSH disallowance regarding claims that were more than two years old. CMS based the disallowance on federal regulations (45 C.F.R. §§ 95.1-95.34) that require filing of claims within two years of the calendar quarter in which the expenditures were made. The interpretation that led to this disallowance establishes a direct conflict with the auditors' finding suggesting that OBRA 1993 limit calculations must use actual data; hence, payments on this basis could not be fully determined in the federal claiming limit.

Based on experience in other programs, a retrospective reconciliation to actual costs would take several years to complete, as demonstrated to the auditors during their efforts to calculate the OBRA limit based on SFY 1997-98 actual data. During the 2001 OIG audit, three years after the SFY 1997-98 DSH program year, all of the "actual" data required for the retrospective calculation was not available. Thus, the Department questions whether a retrospective limit calculation would jeopardize the Department's ability to process all appropriate claims. We question whether any increased claims that were indicated by the application of the "actual" calculations could be submitted, given the two-year rule.

4. Audit Report "Actual" Calculation

The OIG Auditors requested that the Department provide actual data for the retrospective analysis presented in the Draft Audit Report. It is important to note, related to the "Conflicts with Federal Claiming Time Limits" discussed above, that some of the actual data requested by the OIG Auditors was not available. The Department does not currently have reporting mechanisms to collect these data elements for the DSH calculation, because they are not required by the State Plan.

It is also significant to note that the "actual" determination methodology employed in the Draft Auditor Report relies in part on the determination methodology defined in the Department's State Plan. Specifically, calculation of the limit requires derivation of the *Patient Mix Ratio* to establish the *Total Medicaid and Uninsured Revenues*, which is derived through the State Plan methodology - which does not use "actual."

B. Medicare Cost Principles

1 The August 17, 1994, Letter Is Not a Controlling Document

The Draft Audit Report cites a HCFA⁴ letter dated August 17, 1994, to support the proposition that Medicaid cost principles are required in the fiscal administration of the DSH Program. However, the auditors refer to the letter as having "provided guidance to State Medicaid Directors." Recognizing the limited authority of the guidance provided in its letter, HCFA stated that it was considering the issuance of corresponding federal rules. However, such regulations have never been issued, and, thus, the guidance that the audit relies on was not forthcoming.

2. Graduate Medical Education Costs are Costs of Care

The Draft Audit Report failed to provide any detail regarding specific amounts disallowed as operating expenses. In a schedule provided separately, upon the Department's request, the auditors identified \$7,010,118 as "Intern and Resident Cost and Post Step Down Adjustment" as operating expenses that the auditors disallowed. The portion of this total that constitutes Graduate Medical Education (GME) costs is unclear.⁵

⁴ The federal Health Care Financing Administration (HCFA) is now known as the Centers for Medicare and Medicaid Services (CMS).

⁵ The KMC response provides additional detailed comments on this topic.

The auditors contend that federal rules require the exclusion of educational activities from hospital operating expenses. However, the Department believes that GME costs may properly be included in the limit formula – those costs related to patient care. During internship, the student physician provides patient care. The intent of the approved State Plan is to include cost of health care provided by interns.

The Department has initiated a review of the components of the OBRA 1993 formulas where GME expenses are included to ensure that amounts are properly included. The Department will submit an amendment to the State Plan, as necessary, to ensure that GME costs are properly incorporated in the hospital cost elements of the limit calculation.

3. CMS Approved California's State Plan

As discussed above, we believe federal law does not require any particular methodology for determining costs, and we are not aware of any federal regulation on this topic. The methodology employed by California, since the requirement was enacted (in OBRA 1993), is described in the State Plan, which has had federal approval for many years.

The fact that CMS approved the State Plan several years after issuing its 1994 guidance indicates that CMS recognized the importance of the flexibility with which Congress set forth the DSH Program limits in OBRA 1993. CMS chose to allow California to exercise the flexibility necessary to ensure that California safety net hospitals would be able to continue to provide support to low-income patients with special needs.

C. Bad Debt

The methodology that California has employed, since the requirement was enacted (in OBRA 1993), is described in the State Plan. The Department agrees that bad debt is counted twice in the current State Plan methodology.⁶ However, as noted above, the audit finding exceeds the stated objective of the audit. The auditors have not identified any variance from the approved State Plan methodology regarding calculation of total operating expenses; therefore no disallowances should be taken.

Nevertheless, the Department has initiated a review of the "Bad Debt" component of the OBRA 1993 formulas. The State Plan will be amended to eliminate double counting of bad debt in the future.

⁶ The KMC response (Enclosure 2) provides additional detailed comments on this topic.

II. DATA DISCREPANCIES

The Department acknowledges that some of the findings associated with data discrepancies may have caused an overstatement of the KMC OBRA 1993 limit for SFY 1997-98, and thus, could have resulted in an overpayment to KMC.⁷ However, the Department disagrees with the manner in which the Draft Audit Report determined the amounts at issue.

A. Patient Mix Ratio⁸

1. Short/Doyle Program

Hospital implementation of OSHPD guidance for reporting Managed Care patient data in the hospital's Annual Financial Disclosure Report generated double counting of Short/Doyle Mental Health data when the hospital's data was used in conjunction with the Short/Doyle Program data, as specified in the State Plan.

2. Services Provided to Inmates

The Department disputes the disallowance of cost of care to inmates to the extent that cost of care provided to indigent and Medicaid eligible inmates is allowed in the limit calculation. The OIG Auditors disallowed, as a reporting error, all inmate expenses on the basis that inmates are barred from Medicaid patient care services. However, the HCFA Medicaid Regional Memorandum No. 98-4 (published January 27, 1998) described exceptions to prohibition of federal financial participation (FFP) regarding inmates. In the "Policy Application" section of the memorandum, HCFA specifically addressed inmates (as item 6 of the examples of when FFP is available) stating that, "Inmates who become inpatients of a hospital, nursing facility, juvenile psychiatric facility or intermediate care facility for the mentally retarded (Note: subject to meeting other requirements of the Medicaid program)." Thus, the auditor's conclusion, based on the premise that inmates in medical facilities are not Medicaid eligible, is not correct.

Further, cost of care to inmates who are not Medicaid eligible are properly included in the OBRA 1993 limit calculation to the extent that the inmates satisfy the appropriate indigent and uninsured criteria. There is no basis to treat these indigent patients differently from other indigent patients.

⁷ *Ibid.*

⁸ *Ibid.*

B. Services Provided to County Employees

KMC reporting procedures misclassified county employees as uninsured patients. The associated patient costs were included in the expense component of the OBRA 1993 limit calculation.

III. TIMING OF FINAL FINDINGS AND RECOMMENDATIONS

The auditors omitted recommendations pertaining to the deficiencies in the State Plan, indicating that those recommendations would be included in a separate report. However, the auditors included disallowance amounts related to the alleged State Plan deficiencies in their recommendations. It is difficult for the Department to respond to the proposed disallowances regarding the KMC payment amounts that pertain to the alleged State Plan deficiencies prior to reviewing the auditors' recommendations regarding them. The Department requests that decisions regarding the findings related to the State Plan and the related recommendations be postponed pending the determination of findings pertaining to the discrepancies in the California Medicaid State Plan.

Additionally, as stated above, the Department requests that all decisions regarding the hospital reporting errors and the related recommendations be postponed pending the determination of findings pertaining to possible offsets and the resulting total amounts to be refunded.

IV. RESPONSE TO RECOMMENDATIONS

Prior to the detailed discussion of the recommendations, it is important to note that the Draft Audit Report significantly understates KMC's costs by excluding the cost of hospital administrative and quality of care functions performed by the medical director and physician chair persons.⁹ These costs should be included in the hospital total operating expenses, which will offset the final determination of the findings and recommendations.

A. Refund to the Federal Government \$22,088,531 representing the Federal share of the KMC overpayment (\$43,974,779 X 50.23 percent, the Federal financial participation percentage)

The Department rejects this recommendation. The recommendation exceeds the scope of the audit authority.

1. As noted earlier, the Department determined that the proposed audit findings fit two basic categories. The Department feels that it is imperative to consider

⁹ *Ibid.*

these categories in the discussion regarding the Draft Audit Report recommendations. The first category, alleged State Plan deficiencies, includes the first three findings representing \$41,222,965 of the \$43,974,779 disallowance addressed in this recommendation.

Because the auditors did not include any recommendations pertaining to the alleged State Plan deficiencies, it seems inappropriate to include amounts related to those findings in any recommendation for repayment. In addition, as noted above, the Department of Health and Human Services must implement the appropriate review and hearing process to disapprove State Plan material before such recommendations regarding State Plan deficiencies can be implemented.

Further, with the exception of the bad debt change the State will process, we believe that California's current SPA meets all federal statutory and regulatory requirements, is valid, and is necessary for the proper administration of the Medicaid program.

2. The Department does not dispute the finding that KMC reporting errors would have resulted in an overpayment. However, the Department disagrees with the audit methodology used to determine the amounts at issue. There are many outstanding issues regarding this OIG audit when taken as a whole. The auditors have issued partial reports pertaining to their audit of two specific California hospitals while continuing to develop an over-all report regarding the State's DSH program. The Department requests that the federal government postpone any disallowance pending the outcome of the audit in its entirety.

B. Provide written instructions to KMC to report charges for the Short Doyle program in the appropriate category on the OSHPD report.

Under state law, OSHPD is responsible for the Annual Financial Disclosure Report. The Department will forward a copy of the audit report to OSHPD and request that OSHPD review the reporting instructions for the Annual Financial Disclosure Report and provide the Department with recommendations to clarify the reporting issues identified in the Draft Audit Report.

C. Provide written instructions to KMC to exclude allowances for insured patients from the category for county employees from the county indigent patient category of the OSHPD report.

The Department will address this item in the same manner specified in the response to Draft Audit Report recommendation II above.

CONCLUSIONS

In conclusion, the Department wishes to emphasize the following points regarding the OIG Audit of KMC:

The Department contests the first three proposed audit findings, which the Draft Audit Report identifies as discrepancies in the State Plan. Our responses can be summarized as follows:

The auditors did not include findings suggesting that the Department deviated from the approved State Plan. The Department properly implemented the appropriate State Plan provisions for FFY 1998.

- The issues raised by the findings relating to discrepancies in the State Plan represent compliance issues that are outside the scope of an audit.

California's State Plan is valid and meets all federal statutory and regulatory requirements.

- The Department disputes the unsubstantiated Draft Audit Report findings regarding use of actual costs and application of Medicare Cost Principles on their merits. Federal law or regulations do not support these findings.
 - The Draft Audit Report's focus on use of actual costs would force the Department to change to a retrospective reconciliation process. A requirement to undertake a retrospective reconciliation to actual costs would require a major overhaul of the DSH program currently operating in California. Most significantly, disapproval of the current methodology would require the State to abandon its present focus on making timely payments based on that methodology. Based on experience in other programs, a retrospective reconciliation process would take years to complete. Last, a retrospective approach would be inconsistent with the requirements of federal regulations.
 - The auditors should include adjustments that favor KMC.
- 2 The Draft Audit Report recommendations to return funds include proposed disallowances regarding the alleged State Plan deficiencies. Given the overlapping

issues, the Department requests that the auditors and CMS postpone decisions regarding the findings and recommendations until all relevant reports can be reviewed and addressed together. The Department reserves the right to discuss these issues further in response to subsequent reports.

DEPARTMENT OF HEALTH SERVICES

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February 28, 2002

Ms. Lori A. Ahlstrand
Regional Inspector General
For Audit Services
Region IX Office of Inspector General
50 United Nations Plaza, Room 171
San Francisco, CA 94102

Dear Ms. Ahlstrand:

Enclosed, please find "Enclosure 2" for the Department of Health Services' response to the federal Department of Health and Human Services' Office of the Inspector General draft report, entitled "Audit of California's Medicaid Inpatient Disproportionate Share Hospital Payment of Kern Medical Center (KMC), State Fiscal Year 1998." The enclosed replaces the draft version of "Enclosure 2" sent to you with our response.

Thank you.



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<http://www.consumerenergycenter.org/flex/index.html>

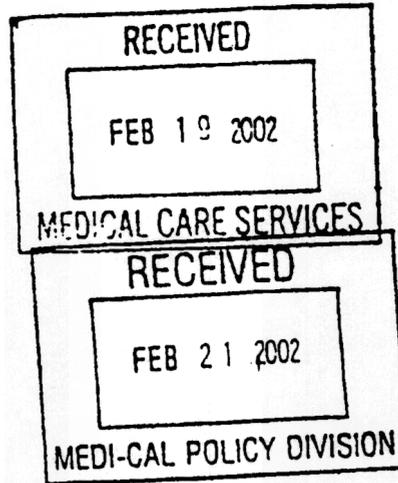


Adusto

AFFILIATED WITH UNIVERSITY OF CALIFORNIA SCHOOLS
MEDICINE AT LOS ANGELES, SAN DIEGO, AND IRVINE

February 14, 2002

Mr. Stan Rosenstein
Assistant Deputy Director
Medical Care Services
California Department of Health Services
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Dear Mr. Rosenstein:

This responds to the Office of Inspector General ("OIG") draft report transmitted December 17, 2001, entitled "Audit of California's Medicaid Inpatient Disproportionate Share Hospital Payment For Kern Medical Center, Bakersfield, California, State Fiscal Year 1998." The County of Kern and Kern Medical Center appreciate this opportunity to comment on the draft report.

The draft report concludes that more than one half of Kern Medical Center's disproportionate share hospital ("DSH") payments for the year should be recouped, even though the payments were made in accordance with California's approved Medicaid State Plan. This assertion is stunning, not only because of its magnitude, but because the OIG proposes to apply a new and different DSH methodology retroactively to reach this result. The new methodology purportedly addresses "deficiencies in the California Medicaid State Plan and State procedures", which will be the subject of a future OIG report on the California DSH program that has not yet been issued. Inherent in the new methodology are several adjustments that have yet to be explained by the OIG. For example, inexplicably, the OIG does not consider the Medical Director's salary to be a hospital cost. The costs of the hospital's interns and residents were similarly disregarded.

The draft report assumes that California's approved Medicaid State Plan methodology for determining the hospital-specific limits for DSH payments, as required by the Omnibus Budget Reconciliation Act of 1993 ("OBRA 1993"; Soc. Sec. Act §1923(g); 42 U.S.C. §1396r-4(g)), violates federal law. Kern Medical Center, as all disproportionate share hospitals in the State, has relied for years on the federally approved State Plan methodology for determining and applying the OBRA 1993 limits. Given this legitimate reliance, and the precarious financial situation of these safety net hospitals, the State should steadfastly oppose the OIG's attempt to enforce a new and different plan retrospectively.

The recommendations made in the draft report, if implemented, would make it financially infeasible to continue operations at Kern Medical Center, and would likely result in the closure of the hospital. As you know, Kern Medical Center has been recognized as a disproportionate share hospital since the inception of the Medicaid DSH program. The hospital's low-income utilization rate, a federally defined measure of services provided to Medicaid and other indigent individuals, consistently exceeds 80 percent. Kern Medical Center also meets the federal definition of a high DSH facility (Social Security Act § 1923(g)(2)(B)). The hospital provides health care services to people in need without regard to source of payment or ability to pay. The financial realities simply cannot be reconciled with the draft report's assumptions and conclusions regarding the appropriateness of the DSH payments made to Kern Medical Center.

L. Kern Medical Center Is Entitled to Payments Made Under the Approved Medicaid State Plan

A. DSH Payments Were Consistent with the State Plan

The draft report sets forth the objective of the audit "to verify that DSH payments to Kern Medical Center (KMC) did not exceed the hospital specific limit (the limit) for SFY 1998." The appropriate measure of whether or not the payments complied with the OBRA 1993 limit is a comparison of the hospital's DSH payments to that limit which was determined pursuant to the approved Medicaid State Plan. The auditors reviewed the State's calculation of Kern Medical Center's limit made pursuant to the State Plan for the fiscal year ending June 30, 1998, and identified no audit issues regarding the State's execution of the State Plan calculations.

However, the auditors subsequently applied a vastly different methodology that they developed in the course of the audit. Based on this alternative methodology, the audit determined an "overpayment" was made, and recommended that the amount at issue be recouped from the hospital.

The development and application of a methodology that is different from that contained in the approved Medicaid State Plan goes beyond the scope of the OIG's audit authority with respect to overpayment determinations. Apparently, the focus of the draft report is California's approved Medicaid State Plan, which the audit found "did not comply with Federal statutes and Centers for Medicare & Medicaid Services requirements." (Draft Report, pp. i, 5.) We note, however, that the OIG is not charged with making State Plan compliance determinations. Such determinations are made by the CMS Administrator on behalf of the Secretary of the Department of Health and Human Services, and only after a notice and hearing process. (Soc. Sec. Act §1904; 42 C.F.R. §430.60 et seq.)

Further, any corrective action that would be required following such a final determination would be prospective only. Prior to a final determination of noncompliance, payments made in accordance with the State Plan are allowable Medicaid expenditures. Thus, the recoupment recommended in the draft audit is inappropriate, because the payments made to Kern Medical Center are not "overpayments" under the approved Medicaid State Plan.

Contrary to the assumptions made in the draft report, California's Medicaid State Plan complies in all respects with federal Medicaid requirements, and is within the scope of

flexibility granted by Congress to states to determine DSH payments. As detailed below, we strongly disagree with the interpretation of federal DSH limit requirements that is reflected in the draft report. California correctly determined and applied the OBRA 1993 limit to Kern Medical Center, and we therefore dispute the findings of the draft report.

B. The OBRA 1993 Statute Does Not Require Retrospective Adjustments.

California's approved State Plan sets forth a detailed methodology that specifies the calculations and data sources for determining the OBRA 1993 limit. The calculations utilize the most recently available, actual cost and payment data to determine hospital OBRA 1993 limits prior to the start of the applicable state fiscal year. The limits are applied prospectively in conjunction with the prospective determinations of hospitals' maximum DSH payment amounts for the year.

The draft report found the approved Medicaid State Plan deficient because it "did not require a recalculation using actual incurred costs and payment data after the data became available." According to the auditors, such recalculation is "required by section 1923(g)(1)(A) of the Act." The draft report further stated that the recalculation was to be "in accordance with Medicare cost principles." (Draft Report, pp. 6-7.)

We take issue with the draft report's liberal use of the term "actual cost" as though that term were contained in the OBRA 1993 limit statute and ascribed any specific legal meaning, or even contemplated by Congress. None of the alleged requirements asserted in the draft report are supported by the statutory language. Section 1923(g)(1)(A) of the Social Security Act establishes the DSH limit as follows:

IN GENERAL.—A payment adjustment during a fiscal year shall not be considered to be consistent with subsection (c) with respect to a hospital if the payment adjustment exceeds the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year. For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government within a State shall not be considered to be a source of third party payment.

Although it would have been simple to do so, Congress did not choose to adopt Medicare cost principles for purposes of the DSH limit. By declining to adopt the restrictive and intricate Medicare cost rules in this context, Congress granted states the flexibility to determine the DSH limits, similar to other aspects of the Medicaid program, such as rate setting (see Social Security Act section 1902(a)(13)(A)). Section 1923(g) sets a hospital specific limit for DSH payments, but does not require DSH payments to be based either on Medicare cost principles or any other retrospective cost determination. Doing so would result in a single, national DSH

payment methodology, and effectively eviscerate any flexibility for states in regard to their DSH programs. Such a result is contrary to the basic structure of the Medicaid program and congressional intent.

Moreover, the purported guidance contained in CMS' August 17, 1994 letter, cited by the draft report, does not represent law or current policy. As an initial matter, the "guidance" was not promulgated in accordance with the rulemaking requirements of the federal Administrative Procedures Act (5 U.S.C. §551 et seq.). Although the Medicaid director acknowledges in that letter that regulations regarding the DSH limit would be required, the rulemaking process was never initiated. On the contrary, the CMS' subsequent approval of the California State Plan and the state plans of other states suggests that the views expressed in the letter were rejected in favor of state flexibility. Under the Medicaid statute, the State properly relied on the approval of its State Plan as the basis for receiving federal matching funds (see Social Security Act section 1903(a)). At best, the letter represents an agency interpretation that has been superseded by CMS' subsequent approval of California's State Plan. It also should be noted that nothing in CMS' letter indicates that states would be required to undertake retrospective cost settlements.

C. The Prospectively Determined OBRA 1993 Limits Under the Approved State Plan Are Valid Determinations Under Federal Medicaid Law.

In general, California's Medicaid DSH program is administered on a prospective basis. Hospital eligibility and payment determinations are based on data that existed prior to the beginning of the particular state fiscal year (commencing July 1) during which DSH payment adjustments would be applied. The data used are *actual* expenses and revenues that are the most recent and complete annual hospital data available at the time of the determination. This data is maintained by the California Office of Statewide Health Planning and Development ("OSHPD").

Consistent with the structure of the DSH program, under the State Plan, the OBRA 1993 DSH limits are computed and applied prospectively to ensure predictability. Hospital expenses for Medicaid and uninsured patients are generally derived from the hospital's prior year OSHPD actual cost data as reported by hospitals, trended forward through the particular state fiscal year. Such expenses are then offset by amounts representing Medicaid revenues and uninsured cash payments to arrive at Medicaid and uninsured uncompensated costs, which form the basis for the hospital's DSH limit. Because the fundamental structure of this methodology is to make reasonable, prospective determinations of the DSH limits based on actual costs and revenues from prior periods, the State Plan appropriately does not provide for retrospective adjustments. Thus, the draft report mischaracterizes the State Plan OBRA 1993 limit calculations as "estimates," when they are in fact actual determinations that are applied to appropriately limit the hospital's DSH payments for the particular year.

The policy rationale for the State's method is similar to that of the various prospective payment system ("PPS") methodologies under Medicare. The prospective nature of California's DSH program is designed to assure predictable levels of funding, on a timely basis, for the State's safety net hospitals. By avoiding payment delays and disruptions to current operations that would result from retrospective recoupments, this approach is consistent with the federal Medicaid law that requires DSH payments to "take into account ... the situation of

hospitals which serve a disproportionate number of low-income patients with special needs." Indeed, the use and application of currently available actual data for prior periods by states to structure their DSH programs were expressly contemplated by Congress (see OBRA 1987, Report of the Committee on the Budget, H.R. Rep. No. 391, 100th Cong., 1st Sess., p. 526). A retrospective settlement made on a completely different basis from the original methodology would be extremely disruptive and counter-productive to the purposes of the DSH program.

Further, the OBRA 1993 limit statute provides that the costs incurred are "as determined by the Secretary." California's State Plan methodology was in fact approved by CMS on behalf of the Secretary, and it follows that the costs determined in accordance with that approved methodology satisfy the statutory requirement. California is entitled to rely on its approved Medicaid State Plan as the basis for its receipt and retention of federal financial participation, and it follows that disproportionate share hospitals in the State are entitled to the payments properly made thereunder.

II. The Audit's Alternative Methodology Understates Uncompensated Costs.

A. The Total Operating Expenses Used Under the State Plan Are Appropriate and Consistent With the OBRA 1993 Limit Requirement

The alternative OBRA 1993 methodology proposed in the draft audit, in addition to being contrary to the approved Medicaid State Plan and unsupported by federal law, does not fully reflect the financial circumstances of California's disproportionate share hospitals. This is because, unlike the approved Medicaid State Plan methodology, the alternative methodology does not consider all of the costs necessarily incurred for the continued operation of these special facilities.

A major adjustment contained in the draft report was based on a determination of uncompensated costs attributable to Medicaid and uninsured patients that was derived from Kern Medical Center's Medicare cost report. Specifically, the draft report largely determines costs from an operating expense amount identified from the hospital's audited Medicare cost report for fiscal year 1998, worksheet B, part I, column 27, line 95. As discussed below, this amount vastly understates the full extent of Kern Medical Center's operating expenses. Total operating expenses are more accurately reflected on the hospital's financial disclosure reports filed with the California OSHPD, and the hospital's audited financial statements. Nothing in section 1923 requires Medicare costs to be the basis for determining uncompensated care costs.

The draft report references section 1886(a)(4) of the Social Security Act in its interpretation of hospital operating costs for purposes of determining the OBRA 1993 limit. As an initial matter, this particular statutory reference is misplaced, because it pertains to a narrow scope of inpatient costs that is subject to the Medicare rate of increase limitations (TEFRA 1982) and the establishment of the Medicare prospective payment system rates. For example, this limited definition does not include capital costs, hospital-based physician costs, and intern and resident costs, all of which have long been recognized as legitimate hospital costs.

The purpose of the Medicaid DSH payment requirement is to assure the continued viability of financially distressed hospitals. Specifically, Congress intended that:

payment rates at a minimum meet the needs of those facilities which, because they do not discriminate in admissions against patients based on source of payment or on ability to pay, serve a large number of Medicaid-eligible and uninsured patients who other providers view as financially undesirable. These "disproportionate share" hospitals are an essential element of the Nation's health care delivery system, and the Federal and State governments, through the Medicaid program, have an obligation to assure that payment levels assist these facilities in surviving the financial consequences of competition in the health care market place.

(OBRA 1987, Report of the Committee on the Budget, H.R. Rep. No. 391, 100th Cong., 1st Sess., p. 524.)

The costs reflected in the OSHPD reports are actual costs incurred by hospitals. These costs, when largely unreimbursed, place disproportionate share hospitals in financial peril, whether or not the costs are reflected in the Medicare cost reports. Such hospitals are at a particular financial disadvantage because very few of their patients are able to pay the hospital charges for services rendered. Notwithstanding the OBRA 1993 limit, Congress intended to continue the protection for disproportionate share hospitals against perpetual financial losses by permitting relief for all of their otherwise uncompensated costs associated with low-income and uninsured patients.

A substantial amount of the hospital's costs that were not considered by the auditors relates to provider-based physicians, interns and residents. Although the draft report purports to include the hospital's costs for physician services, it does not include all of these costs. Kern Medical Center incurs these costs to ensure access to physician services for Medicaid beneficiaries and other indigent patients. Further, Kern Medical Center serves as a teaching hospital, and necessarily incurs additional overhead and staffing costs in providing services to Medi-Cal and uninsured patients. All of these costs are typical and appropriate for safety net hospitals across the nation serving large, indigent populations. Other examples of necessary and typical hospital costs that apparently were disregarded are the costs of the hospital's medical director, as well as the costs for the physician department chairpersons to perform hospital administrative and quality of care review functions. The draft report erroneously omits these legitimate hospital costs when recasting the DSH limit calculations.

Moreover, by limiting the scope of the costs to only a portion of the hospital's costs, the audit results in a mismatching of costs and revenues in the determination of "uncompensated costs." This is because, consistent with established standard business practices, the hospital's patient charges are intended to address *all* of the hospital's operating expenses. The little patient revenue that disproportionate share hospitals such as Kern Medical Center are able to receive toward patient charges, however, are appropriately applied against all of the hospital's operating expenses. There is no legal basis or accounting principle to support the

notion that the hospital must apply its patient revenues first toward the narrow scope of costs identified in the draft report. If all of the hospital's Medicaid and uninsured patient revenues are to be applied in the OBRA 1993 limit calculation to determine uncompensated costs, since the patient revenues serve as compensation for all costs it is only appropriate that all of the hospital's operating costs be included to achieve a balanced comparison of revenues to costs. Failure to do so results in an erroneously low uncompensated cost amount.

B. County Incarcerated Patients Who Are Uninsured Are Appropriately Regarded As Uninsured Patients

The draft audit determined that the costs of County-sponsored incarcerated patients should be excluded from the DSH limit calculation, citing 42 C.F.R. section 435.1008(a)(1) as the legal basis for this position.

Kern Medical Center disagrees with this exclusion, because the audit's reliance on section 435.1008 is misplaced. This regulatory proscription relates to federal financial participation in expenditures for *Medicaid services* rendered to individuals determined eligible for Medicaid (42 C.F.R. §435.1000). The DSH program does *not* confer Medicaid eligibility on the uninsured individuals whose service costs are included in the OBRA 1993 uncompensated cost calculation, nor does the DSH payments received by Kern Medical Center transform uninsured patient services into Medicaid covered services. Therefore, the fact that incarcerated individuals generally are not eligible to receive Medicaid covered services under the cited regulation is irrelevant. These patients are no different from other uninsured individuals who do not meet federal Medicaid eligibility criteria. We are unaware of any contrary position taken by the State on this issue, notwithstanding the suggestion made in the draft report.

The County of Kern and all other counties in the State are required by State law to arrange for the care of their county prisoners, and the costs of such care must be charged against the particular county. (Cal. Penal Code §4011 et seq.; Cal. Gov. Code §29602.) In instances which a prisoner or other responsible party is found financially able to pay for the prisoner's care, or the prisoner has private medical insurance, these statutes authorize counties to pursue reimbursement from the prisoner or third party. Kern Medical Center, as a County operated entity, is therefore charged with providing services for those inmate patients having no other source of coverage, i.e., private insurance, third party payor or state and federally funded health care programs. For purposes of this calculation these patients are indigent, and it is appropriate for the cost of their care incurred by Kern Medical Center to be considered in the DSH limit. The State Plan methodology correctly takes into account the cost of care rendered to these patients when determining the OBRA 1993 limit.

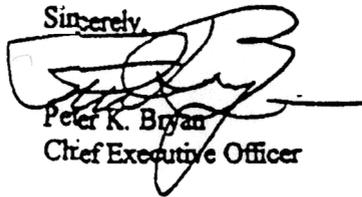
C. Underreported Costs

Kern Medical Center reaffirms our position that Short Doyle charges on the OSHPD Report were reported consistent with instructions provided by OSHPD. To the extent that any recoupment were to be initiated with respect to this issue, Kern Medical Center reserves the right to provide evidence of any underreporting of costs that would counterbalance the adjustment at issue.

* * * *

We appreciate this opportunity to comment on the OIG's draft audit. We cannot overemphasize how critical DSH payments have been for the survival of this hospital and other core safety net hospitals throughout the State. The costs that are taken into account by the approved Medicaid State Plan methodology are actual costs incurred by safety net hospitals, and such hospitals should be able to rely on payments made in accordance with the State Plan. We believe that the State Plan is consistent in all respects with federal law and congressional intent.

If you have any questions regarding our comments, or desire additional information, please call me at 661-326-2102.

Sincerely,

Peter K. Bryan
Chief Executive Officer

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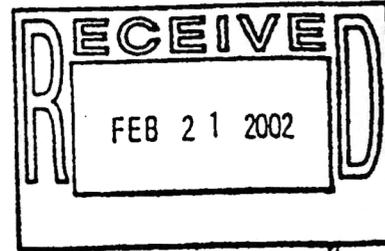
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February 15, 2002

Ms. Lori A. Ahlstrand
Regional Inspector General
for Audit Services
Region IX Office of Inspector General
50 United Nations Plaza, Room 171
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Dear Ms. Ahlstrand:

On behalf of the California Department of Health Services (DHS), thank you for the opportunity to review the federal Department of Health and Human Services' Office of the Inspector General (OIG) draft report, entitled "Audit of California's Medicaid Inpatient Disproportionate Share Hospital Payment of Kern Medical Center (KMC), State Fiscal Year 1998." Enclosure 1 contains our detailed comments to the Draft Audit Report.¹

DHS shares the OIG's strong commitment to ensuring that Medi-Cal operates with the highest level of program integrity. That is why California will continue to ensure that Medi-Cal funds are spent only under appropriate federal authority. In fact, the Governor has continually focused on combating Medi-Cal fraud in an effort that is already reaping significant savings for both the federal government and California.

However, some aspects of the Draft Audit Report are not fully accurate and several key facts have not been considered. In particular, the following points, in addition to others set forth in the enclosure, should be highlighted in the report to improve its quality and completeness.

- An analysis of California's Disproportionate Share Hospital Program spending clearly indicates that all spending is conducted with the long-standing approval of the Health Care Financing Administration.² DHS properly implemented the appropriate State Plan provisions for State Fiscal Year (SFY) 1997-1998.
- The "overpayment" determination in the Draft Audit Report is misleading because it was based on a modified methodology created and applied by OIG staff retroactively to SFY 1997-1998. Given that this modified methodology

¹ KMC submitted to the Department a response to the Draft Audit Report. A copy of KMC's response is included as Enclosure 2 and is incorporated into the Department's response (to the extent that it is not inconsistent).

² The federal Health Care Financing Administration (HCFA) is now known as the Centers for Medicare & Medicaid Services (CMS).



differed substantially from the HCFA approved State Plan, it is not clear how it is relevant.

- The findings of the Draft Audit Report regarding the use of Medicare cost principles and several other accounting procedures are not required by federal law and regulations. In fact, the federal government has not issued regulations on several items that the OIG asserts are definitive requirements.

To amplify on the second bullet, we note that the Draft Audit Report portrays the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) limit determinations under the approved State Plan methodology as "estimates," suggesting that the methodology is incomplete. The California Disproportionate Share Hospital (DSH) program is a *prospective* system, under which DSH program eligibility, payment amounts and hospital-specific payment limits are determined at the start of the SFY. One analogy to the California approach is the Medicare prospective payment system (PPS), which establishes Medicare payment rates based on a complex rate setting methodology. PPS payments are never characterized as "estimates," even though they are derived from data pertaining to previous periods without any effort towards reconciliation with "actual" data. PPS payments are considered the "actual" payment amounts.

DHS expressly designed the prospective approach for administration of DSH program payments to assure timely and predictable funding levels for those financially distressed hospitals that are the core of California's safety net for low-income patients with special needs. DHS developed detailed limit determination methodology consistent with the overall prospective structure of the DSH program. The DSH program uses the most current actual hospital cost and revenue data available in eligibility and payment determinations, including OBRA 1993 limits. OBRA 1993 limits calculated according to the State Plan methodology are the "actual" determinations. No retrospective reconciliation is warranted.

DHS values the long-standing relationship with the OIG, and the successful work done to ensure the proper and appropriate use of Medi-Cal dollars. However, based on the above concerns and others discussed in the enclosures, DHS is forced to contest the key findings and recommendations. More importantly, not only would implementation of the OIG's recommendations be contrary to long-standing federal approval of California's procedures, but implementation would also cause significant harm to California's hospitals without any improvement in program integrity.

Ms. Lori A. Ahlstrand
Page 3

DHS looks forward to resolving these issues with the federal government. If you have questions or need additional information, please contact Mr. Stan Rosenstein, Assistant Deputy Director, at (916) 654-0391.

Sincerely,

A handwritten signature in black ink, appearing to read 'Stan Rosenstein', written in a cursive style.

Stan Rosenstein
Assistant Deputy Director
Medical Care Services

Enclosures

cc: See Next Page

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