DEPARTMENT OF FINANCE

EDMUND G. BROWN JR. ▪ GOVERNOR
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Transmitted via e-mail

January 31, 2014

Mr. Toby Douglas, Director
California Department of Health Care Services
1501 Capitol Avenue, Suite 71.6001
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Mr. Douglas:

Final Report—Agreed-Upon Procedures for California's Disproportionate Share Hospital Program

The Department of Finance, Office of State Audits and Evaluations (Finance), has completed the agreed-upon procedures to the six verifications for the State of California's Disproportionate Share Hospital (DSH) Program for Medicaid State plan rate year ending June 30, 2010. The engagement was performed pursuant to an interagency agreement between Finance and the California Department of Health Care Services (DHCS). The engagement also satisfies the Centers for Medicare and Medicaid Services DSH audit and reporting requirements.

The enclosed report is for your information and use. The report will be placed on our website.

We appreciate the assistance and cooperation of the DHCS. If you have any questions regarding this report, please contact Susan Botkin, Manager, or Angie Williams, Supervisor, at (916) 322-2985.

Sincerely,

Original signed by:

Richard R. Sierra, CPA
Chief, Office of State Audits and Evaluations

Enclosure

cc: Mr. John Mendoza, Chief of Safety Net Financing Division, California Department of Health Care Services
Ms. Dinnie Chao, Chief of Disproportionate Share Hospital Financing and Non-Contract Hospital Recoupment Branch, California Department of Health Care Services

AGREED-UPON PROCEDURES

California Disproportionate Share Hospital Program
For the Period July 1, 2009 through June 30, 2010

Source: Centers for Medicare and Medicaid Services

Prepared By:
Office of State Audits and Evaluations
Department of Finance

134260115

January 2014

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INDEPENDENT ACCOUNTANT'S REPORT ON APPLYING AGREED-UPON PROCEDURES

Mr. Toby Douglas, Director
California Department of Health Care Services
1501 Capitol Avenue, Suite 71.6001
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

We have performed the procedures within the Results section of this report, which were agreed to by the California Department of Health Care Services (DHCS), solely to assist DHCS in performing the six verifications for the Medicaid State plan rate year 2009-10 (July 1, 2009 through June 30, 2010), as defined in Title 42, *Code of Federal Regulations* (CFR) Part 455 relating to the Medicaid Program for Disproportionate Share Hospital Payments Final Rule (DSH Rule). DHCS' management is responsible for compliance with those requirements.

This engagement to apply agreed-upon procedures was performed in accordance with attestation standards established by the American Institute of Certified Public Accountants and the standards applicable to attestation engagements contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. The sufficiency of these procedures is solely the responsibility of DHCS. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested, or for any other purpose.

In connection with our engagement, there are certain disclosures required by *Generally Accepted Government Auditing Standards*. Finance is not independent of DHCS, as both are part of the State of California's Executive Branch. As required by various statutes within the California Government Code, Finance performs certain management and accounting functions. These activities impair independence. However, sufficient safeguards exist for readers of this report to rely on the information contained herein.

The agreed-upon procedures and the results are detailed in the Results section. No issues or matters outside the agreed-upon procedures came to our attention that would significantly contradict the subject matter being reported.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on compliance. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of DHCS and the Centers for Medicare and Medicaid Services (CMS), and is not intended to be and should not be used by anyone other than these specified parties. However, this report is a matter of public record and its distribution is not limited.

Original signed by:

Richard R. Sierra, CPA
Chief, Office of State Audits and Evaluations

January 31, 2014

RESULTS

For all six verifications, Finance used the best available data and information provided to us by DHCS and the hospitals.

Finance and DHCS agreed to a materiality limit of 20 percent for reporting exceptions (of the total cost or revenue column from the Draft Summary report provided by DHCS). All 52 hospitals [(21 Designated Public Hospitals (DPHs) and 31 Non-Designated Public Hospitals (NDPHs)] were subjected to the same agreed-upon procedures. In most cases, these procedures were performed without an on-site review of the hospital's records; however, records were provided electronically or mailed directly to our office. In some instances, we felt additional procedures were necessary to rely on the supporting documents provided by some hospitals. For these hospitals, we performed site visits to determine if the data provided was reliable.

The six verifications, corresponding procedures, and results are summarized as follows:

Verification 1

Each hospital that qualifies for a DSH payment in the state is allowed to retain that payment so that the payment is available to offset its uncompensated care costs for furnishing inpatient and outpatient (IP/OP) hospital services during the Medicaid State plan rate year to Medicaid eligible individuals and individuals with no source of third-party coverage for the services, in order to reflect the total amount of claimed DSH expenditures. [Source: Federal Register dated December 19, 2008]

<u>DPH and NDPH Procedures:</u>

1. Obtained and reviewed DSH Program, "Final DSH Eligibility List for SFY 2009-10" from DHCS' website and verified hospitals qualified for DSH funding through one of the following methods:
    a. Medicaid Inpatient Utilization Rate (MIUR) per DHCS' calculated mean and standard deviation.
    b. Low Income Utilization Rate (LIUR).
    c. State Plan and California section 1115 Medicaid demonstration entitled Medi-Cal Hospital/Uninsured Care Demonstration, as amended October 5, 2007.

2. Verified qualifying DSH hospitals were allowed to retain payment and that no redistribution and/or recovery of funds occurred for program year 2009-10.
    a. Obtained letter from DHCS confirming no redistribution or recovery of DSH funds occurred.
    b. Requested a written representation from all NDPHs' management verifying that each hospital received and retained its full DSH payment.

3. Reviewed the Centers for Medicare & Medicaid Services (CMS) approval to exclude private hospitals from DSH Audit and Reporting requirements.
    a. Obtained letter from DHCS confirming all private hospitals returned DSH funding and that they are exempt from DSH Audit and Reporting requirements, contingent on the hospitals' return of their DSH payment for program year 2009-10.
    b. Obtained and reviewed a schedule of 2009-10 DSH funding amounts provided to private hospitals.

Results:

Finance completed the agreed-upon procedures relating to Verification 1 without exception. For Medicaid State plan rate year 2009-10, each hospital that qualified for a DSH payment in California was allowed to retain that payment and no unauthorized redistribution occurred.

Finance verified each hospital qualified for DSH funding as stated in the federal regulations. In total, there were 52 hospitals that qualified and received a total of $1,132,587,655 in federal DSH funds. Of the 52 hospitals, 21 DPHs received $1,123,871,808 in DSH funds and 31 NDPHs received $8,715,847 in DSH funds.

Finance confirmed DHCS received approval from CMS to exclude private hospitals from DSH funding for Medicaid State plan rate year 2009-10. Therefore, our review did not include any private hospitals. Further, we did not include Kingsburg Medical Center (a NDPH) in our review because the hospital closed in 2010 and did not submit a Cost and Revenue Workbook for year 2009-10. Kingsburg did receive a $50,663 DSH payment. Because DHCS was unable to recover that payment, DHCS used funds from its Prudent Reserve fund to redistribute to other qualified hospitals.

Verification 2

DSH payments made to each qualifying hospital comply with the hospital-specific DSH payment limit. For each audited Medicaid State plan rate year, the DSH payments made in that audited Medicaid State plan rate year must be measured against the actual uncompensated care cost in that same audited Medicaid State plan rate year.
[Source: Federal Register dated December 19, 2008]

DPH and NDPH Procedures:

1. Verified "Total Eligible Uncompensated Care Costs" were calculated accurately for each hospital.

2. Compared "Total DSH Payment Received" to "Total Eligible Uncompensated Care Costs" for each hospital.

3. If "Total Eligible Uncompensated Care Costs" were less than the "Total DSH Payment Received", Finance provided a list to DHCS identifying the hospital(s) that received excess DSH payment(s).

Results:

Finance has completed the agreed-upon procedures relating to Verification 2. The following exceptions were noted:

According to the State Plan under Title XIX of the Social Security Act Attachment 4.19-A(F), California is allowed to make payments up to 175 percent of the uncompensated care costs to public hospitals. Finance verified the total eligible uncompensated care costs were calculated accurately. When variances were identified, Finance requested supporting documents, updated the hospitals' P14 or Cost and Revenue Workbooks to reflect the most accurate amounts and provided the information to DHCS.

For DPHs only, California is allowed to "redistribute the Federal DSH funds that are based on the certified public expenditures of DPHs" to qualifying DPHs as stated in the 1115 Waiver (Demonstration). Therefore, instead of reporting results by each DPH, Finance summarized the amount in total. Finance determined that overall (at the state level), the uncompensated care costs ($3,170,463,724) exceeded the California DSH allotment ($2,247,743,618) by $922,720,106.

For the NDPHs, California is not allowed to redistribute the DSH funds as permitted for the DPHs. Therefore, Table 1 below is listed by hospital. Finance identified four hospitals that had DSH payments greater than their total eligible uncompensated care costs (shown as negative variances).

Table 1: Non-Designated Public Hospitals
DSH Payments Compared To Eligible Uncompensated Care Cost

	Hospital Name	Total DSH Payment Received per DHCS	Total Eligible Uncompensated Care Costs (175%) per Our Review	Variance
1	Antelope Valley Hospital Medical Center	$ 4,344,147	$ 20,721,370	$ 16,377,223
2	Bear Valley Community Hospital	8,959	1,817,911	1,808,952
3	Butte County Psychiatric Health Facility	89,923	164,343	74,420
4	Coalinga Regional Medical Center	52,912	1,335,904	1,282,992
5	Colorado River Medical Center	17,545	0	(17,545)
6	Corcoran District Hospital	26,073	0	(26,073)
7	Eastern Plumas Hospital-Portola Campus	27,716	101,506	73,790
8	El Centro Regional Medical Center	1,282,327	12,195,075	10,912,748
9	Fresno County Psychiatric Health Facility	58,919	6,654,573	6,595,654
10	Hazel Hawkins Memorial Hospital	347,038	11,701,910	11,354,872
11	Hi-Desert Medical Center	999,967	5,690,397	4,690,430
12	Jerold Phelps Community Hospital	7,559	1,250,175	1,242,616
13	John C. Fremont Healthcare District	4,230	0	(4,230)
14	Kaweah Delta District Hospital	3,155,581	29,290,469	26,134,888
15	Kern Valley Healthcare District	88,766	1,861,489	1,772,723
16	Lompoc Healthcare District	277,664	3,833,054	3,555,390
17	Mayers Memorial Hospital	90,736	105,196	14,460
18	Modoc Medical Center	18,683	1,469,749	1,451,066
19	Mountains Community Hospital	51,288	764,226	712,938
20	Oak Valley District Hospital	177,556	9,560,610	9,383,054
21	Palo Verde Hospital	44,545	11,388,954	11,344,409
22	Pioneers Memorial Hospital	1,383,436	6,625,322	5,241,886
23	San Luis Obispo Psychiatric Hospital	24,221	5,548,132	5,523,911
24	Santa Barbara Psychiatric Health Facility	49,294	6,369,841	6,320,547
25	Sempervirens Psychiatric Health Facility	32,272	3,165,283	3,133,011
26	Sierra Kings District Hospital	1,765,581	2,762,581	997,000
27	Sierra View District Hospital	1,620,469	15,601,593	13,981,124
28	Southern Inyo Hospital	280	0	(280)
29	Tehachapi Hospital	4,396	2,675,259	2,670,863
30	Trinity Hospital	46,169	563,294	517,125
31	Tulare District Hospital	1,316,513	1,600,827	284,314

Verification 3

Only uncompensated care costs of furnishing IP/OP hospital services to Medicaid eligible individuals and individuals with no third-party coverage for the IP/OP hospital services they received as described in section 1923(g)(1)(A) of the Act are eligible for inclusion in the calculation of the hospital-specific DSH payment limit. [Source: Federal Register dated December 19, 2008]

DPH Procedures:

1. Obtained the Report on the Cost Report Review (Audit Report) from DHCS' website for all hospitals, if available.

2. Obtained the DSH 2009-10 DPH Annual Report draft (DSH DPH Summary), Summary Tab from DHCS to verify the value in the following columns:
    a. Regular IP/OP Medicaid fee-for-service (FFS) Rate Payments
    b. IP/OP Medicaid Managed Care Organization (MCO) Payments
    c. Supplemental/Enhanced IP/OP Medicaid Payments
    d. Total Cost of Care - Medicaid IP/OP Services
    e. Total IP/OP Indigent Care/Self-Pay Revenues
    f. Total Applicable Section 1011 Payments
    g. Total IP/OP Uninsured Cost of Care

3. For the columns listed above, performed the following procedures:
    a. Traced the Audit Report (various schedules) to hospital reported P14 workbook data. If variances were identified, updated the P14 workbook data to reflect amounts supported by hospital provided documents.
    b. Selected a sample of charge categories to test for each hospital.
    c. Traced the sample selected to hospital provided support.
    d. Performed various calculations, footing, and cross footing to verify P14 Workbook data was accurately calculated.
    e. Determined through interviews and reviewing hospital's methodology if only eligible uncompensated care costs were included in the calculation of the hospital-specific DSH payment limit.

Results:

Finance has completed the DPH agreed-upon procedures relating to Verification 3. The following exceptions were noted:

Using the Audit Report, hospitals' P14 workbook, and hospital provided support, Finance performed a variety of agreed-upon procedures on costs and payments reported in the various categories under California's Medicaid program. The results showed only 1 of the 21 DPHs had a material variance.

One DPH, Contra Costa Regional Medical Center, had an audit appeal in progress as of the end of fieldwork. Because the appeal was still pending, we utilized the best available information at the time, which Finance considered the DHCS audit report to be the "best available" for the purpose of our review. This resulted in one column having a material variance out of seven columns reviewed. Refer to Table 2 below.

Table 2: Designated Public Hospital
Illustration of Material Variance between Cost Reported vs. Audited

Hospital		Total IP/OP Uninsured Cost of Care
Contra Costa Regional Medical Center	Amount Reported	$ 78,936,109
	Audited Amount	61,818,489
	Variance Amount	17,117,620
	Variance Percentage	22%

NDPH Procedures:

1. Obtained the Report of the Cost Report Review (Audit Report) from the DHCS' website for all hospitals, if available.

2. Obtained the Annual Financial Disclosure Report submitted to the Office of Statewide Health Planning and Development (OSHPD) for all hospitals, if relevant.

3. Obtained the DSH 2009-10 NDPH Annual Report draft (DSH Summary), Summary Tab from DHCS to verify the value in the following columns:
    a. Regular IP/OP Medicaid Fee For Service (FFS) Rate Payments
    b. IP/OP Medicaid MCO Payments
    c. Supplemental/Enhanced IP/OP Medicaid Payments
    d. Total Cost of Care - Medicaid IP/OP Services
    e. Total IP/OP Indigent Care/Self-Pay Revenues
    f. Total Applicable Section 1011 Payments
    g. Total IP/OP Uninsured Cost of Care

4. For the columns listed above, performed the following procedures:
    a. Selected a sample of charge categories to test for each hospital.
    b. Traced the sample selected to hospital provided support and the Paid Claim Summary Report. Traced to the hospital's Cost Report CMS 2552-96 and Detail Cost Report-Short Doyle provided by the Department of Mental Health, when applicable.
    c. Performed various calculations, footing and cross footing to verify Cost and Revenue Workbook data was accurately calculated.
    d. Determined through interviews and review of hospital's methodology if only eligible uncompensated care costs were included in the calculation of the hospital-specific DSH payment limit.

Results:

Finance has completed the NDPH agreed-upon procedures relating to Verification 3. The following exceptions were noted:

Using the Audit Report, hospitals' Cost and Revenue Workbook, and hospital provided support, Finance performed a variety of agreed-upon procedures on costs and payments reported in the various categories under California's Medicaid program. The results showed 13 of 31 NDPHs had material variances in one or more columns, as shown in Table 3 below.

Table 3: Non-Designated Public Hospitals
Illustration of Material Variances between Payment and Cost Reported vs. Audited [1]

Hospital		Regular IP/OP Medicaid Fee-for-Service Rate Payments	IP/OP Medicaid Managed Care Organzation Payments	Total Cost of Care - Medicaid IP/OP Services	Total IP/OP Indigent Care/Self-Pay Revenues	Total IP/OP Uninsured Cost of Care
Antelope Valley Hospital	Amount Reported	$ 65,291,711	$ 27,989,005	$ 102,387,278	$ 637,084	$ 21,466,537
	Audited Amount	49,644,923	36,337,331	95,966,292	637,084	20,634,817
	Variance Amount	15,646,788	(8,348,326)	6,420,986	-	831,720
	Variance Percentage	24%	(30%)	6%	-	4%
Colorado River Medical Center	Amount Reported	1,558,823	-	3,918,851	11,270	515,502
	Audited Amount	1,488,720	-	2,062,251	13,611	-
	Variance Amount	70,103	-	1,856,600	(2,341)	515,502
	Variance Percentage	4%	-	47%	(21%)	100%
Corcoran District Hospital	Amount Reported	840,626	-	1,957,707	59,295	780,938
	Audited Amount	782,691	-	1,368,083	-	-
	Variance Amount	57,935	-	589,624	59,295	780,938
	Variance Percentage	7%	-	30%	100%	100%
Eastern Plumas Hospital	Amount Reported	681,457	400	1,566,984	163,895	472,276
	Audited Amount	974,746	400	1,571,592	163,895	472,276
	Variance Amount	(293,289)	-	(4,608)	-	-
	Variance Percentage	(43%)	-	0%	-	-
Jerold Phelps Community Hospital	Amount Reported	140,557	-	679,866	2,868	795,857
	Audited Amount	208,531	-	547,623	2,868	795,906
	Variance Amount	(67,974)	-	132,243	-	(49)
	Variance Percentage	(48%)	-	19%	-	0%
John C. Fremont Healthcare District	Amount Reported	155,504	-	-	904,002	233,979
	Audited Amount	-	-	-	-	-
	Variance Amount	155,504	-	-	904,002	233,979
	Variance Percentage	100%	-	-	100%	100%
Mayers Memorial Hospital	Amount Reported	922,039	-	2,136,468	55,295	647,896
	Audited Amount	1,190,987	-	1,479,364	55,295	632,155
	Variance Amount	(268,948)	-	657,104	-	15,741
	Variance Percentage	(29%)	-	31%	-	2%
Oak Valley District Hospital	Amount Reported	1,220,592	1,639,257	6,736,720	421,961	2,257,473
	Audited Amount	1,220,592	1,639,257	8,140,713	421,961	2,014,989
	Variance Amount	-	-	(1,403,993)	-	242,484
	Variance Percentage	-	-	(21%)	-	11%
San Luis Obispo County Psychiatric Health Facility (PHF)	Amount Reported	682,460	-	3,917,463	29,851	-
	Audited Amount	732,210	-	3,917,473	14,902	-
	Variance Amount	(49,750)	-	(10)	14,949	-
	Variance Percentage	(7%)	-	0%	50%	-
Santa Barbara PHF	Amount Reported	1,743,839	-	2,234,615	-	1,917,684
	Audited Amount	507,658	-	2,229,883	-	1,917,684
	Variance Amount	1,236,181	-	4,732	-	-
	Variance Percentage	71%	-	0%	-	-
Sierra Kings District Hospital	Amount Reported	5,704,272	7,090,845	15,275,843	-	1,751,380
	Audited Amount	5,930,682	7,090,845	15,237,489	357,232	1,751,380
	Variance Amount	(226,410)	-	38,354	(357,232)	-
	Variance Percentage	(4%)	-	0%	100%	-
Southern Inyo Hospital	Amount Reported	41,700	-	285,321	-	-
	Audited Amount	25,711	-	285,321	-	-
	Variance Amount	15,989	-	-	-	-
	Variance Percentage	38%	-	-	-	-
Trinity Hospital	Amount Reported	1,160,005	-	2,325,084	180,182	621,185
	Audited Amount	1,171,856	-	1,780,788	180,182	621,553
	Variance Amount	(11,851)	-	544,296	-	(368)
	Variance Percentage	(1%)	-	23%	-	0%

[1] For purposes of presentation, variances of less than 20 percent are shown if a material variance was identified in any column for that hospital.

The NDPH material variances identified above were caused by one or more of the following reasons:

- Lack of supporting documentation or the support provided did not agree to what was reported to DHCS.
- Unallowable charges were included.
- Revenues from patients were not reported that should have been.
- Medi-Cal Settlement amount was not included in the revenue calculation.
- Bad debt amount was not included.

Verification 4

For purposes of the hospital-specific limit calculation, any Medicaid payments (including regular Medicaid fee-for-service rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to a disproportionate share hospital for furnishing IP/OP hospital services to Medicaid eligible individuals, which are in excess of the Medicaid incurred costs of such services, are applied against the uncompensated care costs of furnishing IP/OP hospital services to individuals with no source of third-party coverage for such services. [Source: Federal Register dated December 19, 2008]

DPH and NDPH Procedures:

1. Utilized the results of the agreed-upon procedures applied in Verification 3.

2. Compiled total Medicaid incurred costs from the FFY10 Tab, which contains details of cost and revenue information, in the DSH annual report draft.

3. Compiled total Medicaid payments from FFY10 Tab, which contains details of cost and revenue information, in the DSH annual report draft.

4. Reconciled payments to incurred costs to determine if payments were made in excess of Medicaid incurred costs of IP/OP services to eligible Medicaid individuals:
    a. If there was an excess payment, verified excess was used to offset the Uncompensated Care Costs of individuals with no source of third-party coverage.

Results:

Finance has completed the agreed-upon procedures relating to Verification 4. The results are explained in Verification 3.

Verification 5

Any information and records of all of its IP/OP hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured IP/OP hospital service costs in determining payment adjustments; and any payments made on behalf of the uninsured from payment adjustments, have been separately documented and retained by the state. [Source: Federal Register dated December 19, 2008]

DPH and NDPH Procedures:

1. Utilized the results of the agreed-upon procedures applied in Verification 3.

2. Obtained DHCS' policies and procedures for record retention related to:
    a. Information and records of all IP/OP hospital service costs under the Medicaid program.
    b. Claimed expenditures under the Medicaid program.
    c. Uninsured IP/OP hospital service costs in determining payment adjustments.
    d. Payments made on behalf of the uninsured from payment adjustments.

3. Documented the process in place and determined if DHCS separately documented and retained costs and payments under the Medicaid program and costs incurred and payments received for uninsured individuals.

Results:
Finance has completed the agreed-upon procedures relating to Verification 5. The following exceptions were noted:

We reviewed the documentation retained by DHCS and determined that DHCS separately documents and retains costs and payments relating to uninsured patients and the Medicaid program as required by Verification 5. However, DHCS does not have a written retention policy in place specifically for the DSH program.

Verification 6

The information specified in paragraph (d)(5) of Title 42 Code of Federal Regulations (CFR) Part 455.304 includes a description of the methodology for calculating each hospital's payment limit under section 1923(g)(1) of the Act. Included in the description of the methodology, the audit report must specify how the state defines incurred IP/OP hospital costs for furnishing IP/OP hospital services to Medicaid-eligible individuals and individuals with no source of third-party coverage for the IP/OP hospital services they received. [Source: Federal Register dated December 19, 2008]

DPH and NDPH Procedures:

1. Obtained DHCS' methodology for calculating each hospital's DSH payment limit.

2. Reviewed the DSH limit calculation methodology to determine if the process is compliant with section 1923(g)(1) of the Act.

3. Verified the methodology specifies how the state defines incurred IP/OP hospital costs for furnishing IP/OP hospital services to Medicaid-eligible individuals and individuals with no source of third party coverage for the IP/OP hospital services they received.

Results:

Finance has completed the agreed-upon procedures relating to Verification 6 without exception.

DHCS provided an adequate description of its methodology for calculating each hospital's payment limit under section 1923(g)(1) of the Act. Also, the methodology stated there is no distinction for DPHs and NDPHs in the types of charges that are included for Medicaid-eligible individuals. However, there is a distinction in the definition that DPHs and NDPHs used for "uninsured." DPHs define "uninsured" as individuals without a source of third-party coverage for the services furnished during the year. NDPHs define "uninsured" as individuals without a source of third-party coverage. These definitions are allowable per the federal regulations.