DEPARTMENT OF FINANCE

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Transmitted via e-mail

December 18, 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, 2011. 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. This report will be placed on our website.

We appreciate the assistance and cooperation of DHCS. If you have any questions regarding this report, please contact Susan Botkin, Manager, or Fabiola Torres, 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, 2010 through June 30, 2011

Source: Centers for Medicare and Medicaid Services

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

144260075

December 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 enumerated in 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 2010-11 (July 1, 2010 through June 30, 2011), as defined in Title 42, *Code of Federal Regulations* (CFR) Part 455 relating to the Medicaid Program for Disproportionate Share Hospital (DSH) Payments Final Rule (DSH Rule). DHCS' management is responsible for compliance with those requirements.

The agreed-upon procedures engagement was conducted 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 Government Auditing Standards. Finance and DHCS are both 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. Under Government Auditing Standards, performance of these activities creates an organizational impairment with respect to independence. However, Finance has developed and implemented sufficient safeguards to mitigate the organizational impairment so reliance can be placed on the work performed.

For Verifications 2, 3, and 4, DHCS and Finance agreed to 10 percent (of the total cost or revenue columns from the DSH 2010-11 Designated Public Hospital [DPH] and Non-Designated Public Hospital [NDPH] Annual Report Draft Summary [DSH DPH and NDPH Summary Reports] provided by DHCS) as the materiality limit for reporting identified variances. That is, if the total verified cost or revenue amount varied by 10 percent or greater when compared to the amount reported in the DSH DPH and NDPH Summary Reports, it was considered material. Adjustments were made to the DSH DPH and NDPH Summary Reports for any material and immaterial variances found. However, immaterial variances were not reported.

The procedures and associated findings are presented in the Results section.

We were not engaged to and did not conduct an audit, the objective of which would be the expression of an opinion on the six verifications for the Medicaid State plan rate year 2010-11. 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

December 1, 2014

The procedures and associated findings are as follows:

Verification 1

Designated Public Hospital (DPH) and Non-Designated Public Hospital (NDPH) Procedures:

1. Obtain the "Final Disproportionate Share Hospital (DSH) Eligibility List for State Fiscal Year (SFY) 2010-11" from the Department of Health Care Services (DHCS) website and verify that each hospital qualifies for DSH funding by ensuring they either met the Medicaid Utilization Rate (MUR) or Low Income Utilization Rate (LIUR) requirement, or as specified in the State Plan and California section 1115 Medicaid demonstration, entitled, Medi-Cal Hospital/Uninsured Care Demonstration, as amended dated October 5, 2007.

   Finding: No exceptions were found as a result of applying the procedure.

NDPH Procedures:

2. Verify that each qualifying DSH hospital was allowed to retain payment and that no redistribution and/or recovery of funds occurred for program year 2010-11 by performing the following procedures:

   A. Compare written representation from management of each NDPH regarding receipt and retention of full DSH payment to the letter from DHCS confirming: only qualified hospitals received DSH funding and were allowed to retain their payment; overpayments of DSH funds, if any, were recouped and redistributed to qualifying hospitals; and no recovery of DSH funds occurred. Determine if any NDPH written representation differs from the DHCS letter.

   Finding: All NDPH written representations received matched the DSH payment confirmation letter from DHCS except for the following:

   - Corcoran District Hospital did not provide a written representation because it has closed operations.
   - Tulare District Hospital stated they were not allowed to retain their full interim DSH payment for Medicaid State plan rate year 2010-11 due to a DSH overpayment which was determined after the DSH payments for all hospitals were finalized. DHCS confirmed the overpayment was recouped and redistributed to other qualified hospitals.

   B. From the schedule of DSH Program 2010-11 Final DSH Payments provided to eligible NDPH hospitals, determine that all hospitals received DSH funding.

   Finding: No exceptions were found as a result of applying the procedure.

C. For all NDPH hospitals that received DSH funding, identify those hospitals that are closed or did not provide hospital specific cost and revenue data for fiscal year 2010-11 and will be excluded from Verifications 2, 3, and 4 agreed-upon procedures (AUPs).

Finding: All NDPHs that received DSH funding provided hospital specific cost and revenue data for fiscal year 2010-11 except:

- Corcoran District Hospital did not provide hospital specific cost and revenue data because it has closed operations.
- John C. Fremont Hospital opted not to provide hospital specific cost and revenue data.

These two hospitals were excluded from Verifications 2, 3, and 4 AUPs.

Private Hospitals:

3. Compare private hospitals listed on the schedule of DSH Program 2010-11 Final DSH Payments to the letter from DHCS confirming all private hospitals returned DSH payment, to determine that the private hospitals are excluded from DSH Audit and Reporting requirements.

   Finding: No exceptions were found as a result of applying the procedure.

Verification 2

DPH and NDPH Procedure:

1. Using the results of Verifications 3 and 4 procedures, compare column "Total DSH Payment Received" to column "Total Eligible Uncompensated Care Costs" (UCC) in the DSH DPH and NDPH Summary reports for each hospital and quantify the number of hospitals, if any, with excess DSH Payments.

   Finding: No exceptions were identified for the comparison of Verifications 3 and 4 procedure results to the DSH DPH Summary report.

   For the comparison of Verifications 3 and 4 procedure results to the DSH NDPH Summary report, one hospital was identified with an excess DSH payment.

Verification 3

DPH Procedures:

1. Using the results of Verification 4, DPH Procedures 1A, 1B, and 1C, compare the Medi-Cal Fee-for-Service (FFS) Inpatient Costs as presented in the DSH 2010-11 DPH Annual Report Draft Summary (DSH DPH Summary) to the sum of *Medi-Cal Costs Inpatient Total Costs* reported in P14 Schedule 1, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 – 3/31/11, and 4/1/11 – 6/30/11).

   Finding: No material exceptions were found as a result of applying the procedure.

2. Using the results of Verification 4, DPH Procedures 1A, 1B, and 1C, compare the Medicare/Medi-Cal Crossover Inpatient Costs as presented in DSH DPH Summary to the sum of *Medi-Medi Crossover Inpatient Costs for Claims Not Included in the Medi-Cal Payment Calculation Total Costs* reported in P14 Schedule 1, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10–12/31/10, 1/1/11–3/31/11, and 4/1/11–6/30/11).

   Finding: No material exceptions were found as a result of applying the procedure.

3. Using the results of Verification 4, DPH Procedures 1A, 1B, and 1C, compare the Medicare/Medi-Cal Crossover Outpatient Costs as presented in DSH DPH Summary to the sum of *Medi-Medi Crossover Outpatient Costs for Claims Not Included in the Assembly Bill (AB) 915 Payment Calculation Total Costs* reported in P14 Schedule 1, for all fiscal periods (7/1/10 –10/31/10, 11/1/10–12/31/10, 1/1/11–3/31/11, and 4/1/11–6/30/11).

   Finding: No material exceptions were found as a result of applying the procedure.

4. Verify the Medi-Cal Managed Care Inpatient Costs as presented in DSH DPH Summary, are supported by hospital records by performing the following procedures:

   A. Trace all *Medi-Cal Managed Care Inpatient Days* reported in P14 Schedule 1, for all fiscal periods (7/1/10–10/31/10, 11/1/10–12/31/10, 1/1/11–3/31/11, and 4/1/11–6/30/11), to hospital provided support. If variance noted, record days to agree with supporting documentation for all cost centers.

   Finding: No material exceptions were found as a result of applying the procedure.

   B. Trace *Subtotal Ancillary Charges* for *Medi-Cal Managed Care Inpatient Charges* reported in P14 Schedule 1, for all fiscal periods (7/1/10–10/31/10, 11/1/10–12/31/10, 1/1/11–3/31/11, and 4/1/11–6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

   Finding: No material exceptions were found as a result of applying the procedure.

5. Verify the Medi-Cal Managed Care Outpatient Costs as presented in DSH DPH Summary, are supported by hospital records by tracing *Subtotal Ancillary Charges* for *Medi-Cal Managed Care Outpatient Charges* reported in P14 Schedule 1, for all fiscal periods (7/1/10–10/31/10, 11/1/10–12/31/10, 1/1/11–3/31/11, and 4/1/11–6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

   Finding: No material exceptions were found as a result of applying the procedure.

6. Verify the Medi-Cal Psychiatric (Psych) Inpatient Costs, as presented in DSH DPH Summary, are supported by hospital records by performing the following procedures:

   A. Trace all *Medi-Cal Psych Inpatient Days* reported in P14 Schedule 1, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record days to agree with supporting documentation for all cost centers.

   Finding: No exceptions were found as a result of applying the procedure.

B. Trace *Subtotal Ancillary Charges* for *Medi-Cal Psych Inpatient Charges* reported in P14 Schedule 1, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

Finding: No exceptions were found as a result of applying the procedure.

7. Verify the Medi-Cal Psych Outpatient Costs (OP) as presented in DSH DPH Summary, are supported by hospital records by tracing *Subtotal Ancillary Charges* for *Medi-Cal Psych Outpatient Charges* reported in P14 Schedule 1, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

   Finding: No exceptions were found as a result of applying the procedure.

8. Verify the Out-Of-State Medicaid Inpatient Costs, as presented in DSH DPH Summary, are supported by hospital records by performing the following procedures:

   A. Trace all *Out-of-State Medicaid Inpatient Days* reported in P14 Schedule 1, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record days to agree with supporting documentation for all cost centers.

   Finding: No material exceptions were found as a result of applying the procedure.

   B. Trace *Subtotal Ancillary Charges* for *Out-of-State Medicaid Inpatient Charges* reported in P14 Schedule 1, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

   Finding: No exceptions were found as a result of applying the procedure.

9. Verify the Out-Of-State Medicaid Outpatient Costs, as presented in DSH DPH Summary, are supported by hospital records by tracing *Subtotal Ancillary Charges* for *Out-of-State Medicaid Outpatient Charges* reported in P14 Schedule 1, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

   Finding: No exceptions were found as a result of applying the procedure.

10. Verify the Another County's Low Income Health Program (LIHP) Patient Medicaid Coverage Expansion (MCE) Inpatient Costs, as presented in DSH DPH Summary, are supported by hospital records by performing the following procedures:

    A. Trace all *Another County's LIHP Patient Inpatient MCE Days* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record days to agree with supporting documentation for all cost centers.

    Finding: No material exceptions were found as a result of applying the procedure.

B. Trace *Subtotal Ancillary Charges* for *Another County's LIHP Patient Inpatient MCE Charges* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

Finding: No material exceptions were found as a result of applying the procedure.

11. Verify the Another County's LIHP Patient MCE Outpatient Costs, as presented in DSH DPH Summary, are supported by hospital records by tracing *Subtotal Ancillary Charges* for *Another County's LIHP Patient Outpatient MCE Charges* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

    Finding: No material exceptions were found as a result of applying the procedure.

12. Verify the Medi-Cal OP Costs (AB 915 Claim), as presented in DSH DPH Summary, are supported by hospital records by tracing *Subtotal Ancillary Charges* for *Medi-Cal OP Charges (AB 915 Claim)* reported in P14 Schedule 1, for all fiscal periods (7/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

    Finding: No material exceptions were found as a result of applying the procedure.

13. Verify the Cost-Based Reimbursement Clinics (CBRC) Medi-Cal OP Costs, as presented in DSH DPH Summary, are supported by hospital records by tracing *Subtotal Ancillary Charges* for *CBRC Medi-Cal OP Charges* reported in P14 Schedule 1, for all fiscal periods (7/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

    Finding: No exceptions were found as a result of applying the procedure.

14. Verify the Medical Services MCE LIHP Inpatient Costs, as presented in DSH DPH Summary, are supported by hospital records by performing the following procedures:

    A. Trace all *Medical Services MCE Inpatient Days* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record days to agree with supporting documentation for all cost centers.

    Finding: No exceptions were found as a result of applying the procedure.

    B. Trace *Subtotal Ancillary Charges* for *Medical Services MCE Inpatient Charges* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

    Finding: No exceptions were found as a result of applying the procedure.

15. Verify the Medical Services MCE LIHP Outpatient Costs, as presented in DSH DPH Summary, are supported by hospital records by tracing *Subtotal Ancillary Charges* for *Medical Services MCE Outpatient Charges* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

    Finding: No exceptions were found as a result of applying the procedure.

16. Verify the Mental Health Services MCE LIHP Inpatient Costs, as presented in DSH DPH Summary, are supported by hospital records by performing the following procedures:

    A. Trace all *Mental Health Services MCE Inpatient Days* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record days to agree with supporting documentation for all cost centers.

    Finding: No exceptions were found as a result of applying the procedure.

    B. Trace *Subtotal Ancillary Charges* for *Mental Health Services MCE Inpatient Charges* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

    Finding: No exceptions were found as a result of applying the procedure.

17. Verify the Mental Health Services MCE LIHP Outpatient Costs, as presented in DSH DPH Summary, are supported by hospital records by tracing *Subtotal Ancillary Charges* for *Mental Health Services MCE Outpatient Charges* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

    Finding: No exceptions were found as a result of applying the procedure.

18. Verify the Services Always Certified Public Expenditure (CPE) Based MCE LIHP Inpatient Costs, as presented in DSH DPH Summary, are supported by hospital records by performing the following procedures:

    A. Trace all *Services Always CPE Based MCE Inpatient Days* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record days to agree with supporting documentation for all cost centers.

    Finding: No material exceptions were found as a result of applying the procedure.

    B. Trace *Subtotal Ancillary Charges* for *Services Always CPE Based MCE Inpatient Charges* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

    Finding: No material exceptions were found as a result of applying the procedure.

19. Verify the Services Always CPE Based MCE LIHP Outpatient Costs, as presented in DSH DPH Summary, are supported by hospital records by tracing *Subtotal Ancillary Charges* for *Services Always CPE Based MCE Outpatient Charges* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

    Finding: No material exceptions were found as a result of applying the procedure.

20. Verify the MCE for State Prisoners County Inpatient Costs, as presented in DSH DPH Summary, are supported by hospital records by performing the following procedures:

    A. Trace all *MCE for State Prisoners Inpatient Days* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record days to agree with supporting documentation for all cost centers.

    Finding: No MCE for State Prisoners Inpatient Days were reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), by the hospitals.

    B. Trace *Subtotal Ancillary Charges* for *MCE for State Prisoners Inpatient Charges* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

    Finding: No Subtotal Ancillary Charges for MCE for State Prisoners Inpatient Charges were reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), by the hospitals.

21. Verify the MCE for County Jail Inmates County Inpatient Costs, as presented in DSH DPH Summary, are supported by hospital records by performing the following procedures:

    A. Trace all *MCE for County Jail Inmates Inpatient Days* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record days to agree with supporting documentation for all cost centers.

    Finding: No exceptions were found as a result of applying the procedure.

    B. Trace *Subtotal Ancillary Charges* for *MCE for County Jail Inmates Inpatient Charges* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

    Finding: No exceptions were found as a result of applying the procedure.

22. Verify the MCE for Prisoners in Another County's Program Inpatient Costs, as presented in DSH DPH Summary, are supported by hospital records by performing the following procedures:

    A. Trace all *MCE for Prisoners Enrolled in Another County's Program Inpatient Days* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record days to agree with supporting documentation for all cost centers.

    Finding: No MCE for Prisoners Enrolled in Another County's Program Inpatient Days were reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), by the hospitals.

    B. Trace *Subtotal Ancillary Charges* for *MCE for Prisoners Enrolled in Another County's Program Inpatient Charges* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

    Finding: No Subtotal Ancillary Charges for MCE for Prisoners Enrolled in Another County's Program Inpatient Charges were reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), by the hospitals.

23. Quantify the number of hospitals with a material variance between the *Total Cost of Care – Medicaid Inpatient (IP)/Outpatient (OP) Services* presented on DSH DPH Summary and the sum of verified amounts from Procedures 1 through 22.

    Finding: Of the 21 DPH hospitals included in this review, 0 (zero) had a material variance between the Total Cost of Care – Medicaid IP/OP Services presented on DSH DPH Summary and the sum of verified amounts from Procedures 1 through 22.

24. Verify the Uninsured Inpatient Costs, as presented in DSH DPH Summary, are supported by hospital records by performing the following procedures:

    A. Trace all *Uninsured Inpatient Days* reported in P14 Schedule 1, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record days to agree with supporting documentation for all cost centers.

    Finding: No material exceptions were found as a result of applying the procedure.

    B. Trace *Subtotal Ancillary Charges* for *Uninsured Inpatient Charges* reported in P14 Schedule 1, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

    Finding: No material exceptions were found as a result of applying the procedure.

25. Verify the Uninsured Outpatient Costs, as presented in DSH DPH Summary, are supported by hospital records by performing the following procedures:

    A. Trace *Subtotal Ancillary Charges* for *Uninsured Outpatient Charges* reported in P14 Schedule 1, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

    Finding: No material exceptions were found as a result of applying the procedure.

    B. Trace *Add Drugs and Supplies to Uninsured* reported in P14 Schedule 2.1, Step 3, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation.

    Finding: No material exceptions were found as a result of applying the procedure.

26. Verify the Coverage Initiative (CI) Inpatient Costs, as presented in DSH DPH Summary, are supported by hospital records by performing the following procedures:

    A. Trace all *CI Inpatient Days* reported in P14 Schedule 1 (July-December), for all fiscal periods (7/1/10 – 8/31/10 and 9/1/10 – 10/31/10), to hospital provided support. If variance noted, record days to agree with supporting documentation for all cost centers.

    Finding: No material exceptions were found as a result of applying the procedure.

    B. Trace *Subtotal Ancillary Charges* for *CI Inpatient Charges* reported in P14 Schedule 1 (July-December), for all fiscal periods (7/1/10 – 8/31/10 and 9/1/10 - 10/31/10), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

    Finding: No exceptions were found as a result of applying the procedure.

27. Verify the CI Outpatient Costs, as presented in DSH DPH Summary, are supported by hospital records by tracing *Subtotal Ancillary Charges* for *CI Outpatient Charges* reported in P14 Schedule 1 (July-December), for all fiscal periods (7/1/10 – 8/31/10 and 9/1/10 - 10/31/10), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

    Finding: No exceptions were found as a result of applying the procedure.

28. Verify the Health Care Coverage Initiative (HCCI) Inpatient Costs as presented in DSH DPH Summary, are supported by hospital records by performing the following procedures:

    A. Trace all *HCCI Inpatient Days* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record days to agree with supporting documentation for all cost centers.

    Finding: No exceptions were found as a result of applying the procedure.

B. Trace *Subtotal Ancillary Charges* for *HCCI Inpatient Charges* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

Finding: No material exceptions were found as a result of applying the procedure.

29. Verify the HCCI Outpatient Costs, as presented in DSH DPH Summary, are supported by hospital records by tracing *Subtotal Ancillary Charges* for *HCCI Outpatient Charges* reported in P14 Schedule 1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

    Finding: No material exceptions were found as a result of applying the procedure.

30. Quantify the number of hospitals with a material variance between the Total IP/OP Uninsured Cost of Care presented on DSH DPH Summary and the sum of verified amounts from Procedures 24 through 29.

    Finding: Of the 21 DPH hospitals included in this review, 0 (zero) had a material variance between the Total IP/OP Uninsured Cost of Care presented on DSH DPH Summary and the sum of verified amounts from Procedures 24 through 29.

<u>NDPH Procedures:</u>

1. Trace the *Hospital Per Diems* and *Cost/Charge Ratios (CCRs)* in the Cost and Revenue Workbook (CRW) Cost Tab Column 1 to the Audited Medicare 2552-10 cost report. If the Audited version is not available, trace the Per Diems and CCRs to the "as filed" Medicare 2552-10 cost report. If variance noted, record Per Diems and CCRs to agree with the cost report.

    Finding: No material exceptions were found as a result of applying the procedure.

2. Verify the Medi-Cal FFS Costs, as presented in DSH 2010-11 NDPH Annual Report Draft Summary (DSH NDPH Summary), are supported by the Paid Claims Summary Report (PCSR) or hospital records by performing the following procedures:

    A. Trace all *Medi-Cal FFS IP Days* reported in the CRW Cost Tab Column 2a to the PCSR Fiscal Year 1 (FY1) IP Detail Tab, Medi-Cal Administrative Days total and Accommodation total. If PCSR is not available, trace to hospital provided support. If variance noted, record days to agree with supporting documentation for all cost centers

    Finding: Material variance was noted in 1 of the 25 NDPHs; we recorded the Medi-Cal FFS IP Days to agree with the PCSR or supporting documentation.

B. Trace *Total Medi-Cal FFS IP/OP Charges* reported in the CRW Cost Tab Column 2a to the PCSR (FY1 IP Detail Tab, Medi-Cal, Abortion (if applicable), and Genetically Handicapped Persons Program (GHPP) (if applicable) Ancillary Service Totals row, Amount Billed column, plus PCSR FY1 OP Summary Tab, Medi-Cal, Abortion (if applicable), and GHPP (if applicable) Total row, Amount Billed column) and hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

Finding: No material exceptions were found as a result of applying the procedure.

3. Verify the Medi-Cal Managed Care Costs, as presented in DSH NDPH Summary, are supported by hospital provided records by performing the following procedures:

   A. Trace all *Medi-Cal Managed Care Days* reported in the CRW Cost Tab Column 3a to hospital provided support. If variance noted, record days to agree with supporting documentation for all cost centers.

   Finding: No material exceptions were found as a result of applying the procedure.

   B. Trace *Total Medi-Cal Managed Care IP/OP Charges* in the CRW Cost Tab Column 3a to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

   Finding: No material exceptions were found as a result of applying the procedure.

4. Verify the Medi-Cal Psych Costs, as presented in DSH NDPH Summary, are supported by the PCSR and hospital provided records by performing the following procedures:

   A. Trace all *Medi-Cal Psych Days* reported in the CRW Cost Tab Column 4a to PCSR FY1 Psych Detail Tab and hospital provided support. If variance noted, record days to agree with supporting documentation for all cost centers.

   Finding: Material variance was noted in 1 of the 25 NDPHs; we recorded the Medi-Cal Psych Days to agree with supporting documentation.

   B. Trace *Total Medi-Cal Psych IP/OP Charges* in the CRW Cost Tab Column 4a to PCSR FY1 Psyc Detail Tab and hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

   Finding: No material exceptions were found as a result of applying the procedure.

   C. Trace *Total Short-Doyle/Medi-Cal Costs* in the CRW Cost Tab Column 8 to Short-Doyle Report. If Short-Doyle Report is not available, trace to hospital provided support. If variance noted, record charges to agree with supporting documentation.

   Finding: No exceptions were found as a result of applying the procedure.

5. Verify the Medi-Cal IP/OP Dual Eligible Costs, as presented in the DSH NDPH Summary, are supported by hospital provided records by performing the following procedures:

   A. Trace all *Dual Eligible Days* reported in the CRW Cost Tab Column 7a to hospital provided support. If variance noted, record days to agree with supporting documentation for all cost centers

   Finding: No material exceptions were found as a result of applying the procedure.

   B. Trace *Total Dual Eligible IP/OP Charges* in the CRW Cost Tab Column 7a to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

   Finding: No exceptions were found as a result of applying the procedure.

6. Quantify the number of hospitals with a material variance between the *Total Cost of Care – Medicaid IP/OP Services* presented on DSH NDPH Summary and the sum of verified amounts from Procedures 2 through 5.

   Finding: Of the 25 NDPH hospitals included in this review, 0 (zero) had a material variance between the Total Cost of Care – Medicaid IP/OP Services presented on DSH NDPH Summary and the sum of verified amounts from Procedures 2 through 5.

7. Verify with the hospital whether their treatment (or definition) of uninsured is consistent with CMS regulation as defined in Title 42, CFR Part 447.295(b). Quantify the number of hospitals whose treatment of uninsured was not consistent with CMS regulation.

   Finding: Of the 25 NDPH hospitals included in this review, 11 did not define uninsured in accordance with CMS final rule, issued on December 19, 2008, when reporting their uninsured charges and payments. These hospitals defined uninsured as those "who have no health insurance (or other source of third party coverage)" (individual-specific). The remaining 14 NDPHs defined uninsured as those "who have no health insurance (or other source of third party coverage) for the specific inpatient hospital or outpatient hospital service furnished by the hospital" (service-specific); which agrees with CMS proposed rule issued on January 18, 2012. The individual-specific definition of uninsured is more restrictive than the service-specific definition, which results in under reporting.

8. Verify the Uninsured IP/OP Costs, as presented in the DSH NDPH Summary, are supported by hospital provided records by performing the following procedures:

   A. Trace all *Uninsured Days* reported in the CRW Cost Tab Column 5a to hospital provided support. If variance noted, record days to agree with supporting documentation for all cost centers

   Finding: No material exceptions were found as a result of applying the procedure.

   B. Trace *Total Uninsured IP/OP Charges* in the CRW Cost Tab Column 5a to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers. Include California Children's Services (CCS), Abortion, and GHPP charges for services provided to uninsured patients, if reported and applicable.

   Finding: No material exceptions were found as a result of applying the procedure.

9. Verify the Section 1011 Uninsured IP/OP Costs, as presented in the DSH NDPH Summary, are supported by hospital provided records by performing the following procedures:

   A. Trace all *Section 1011 Uninsured Days* reported in the CRW Cost Tab Column 6a to hospital provided support. If variance noted, record days to agree with supporting documentation for all cost centers

   Finding: No exceptions were found as a result of applying the procedure.

   B. Trace *Total Section 1011 Uninsured IP/OP Charges* in the CRW Cost Tab Column 6a to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

   Finding: No exceptions were found as a result of applying the procedure.

10. Quantify the number of hospitals with a material variance between the *Total IP/OP – Uninsured Cost of Care* presented on DSH NDPH Summary and the sum of verified amounts from Procedures 7 and 8.

    Finding: Of the 25 NDPH hospitals included in this review, 0 (zero) had a material variance between the Total IP/OP – Uninsured Cost of Care presented on DSH NDPH Summary and the sum of verified amounts from Procedures 7 and 8.

Verification 4

DPH Procedures:

1. Verify the Medi-Cal IP Payment, as presented in DSH DPH Summary, is supported by hospital records by performing the following procedures:

   A. Trace *Medi-Cal FFS, Well Baby, Medicare/Medi-Cal Crossover, Carve Out and Administrative Days* reported in P14 Schedule 1.1, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record days to agree with supporting documentation for all cost centers.

   Finding: No material exceptions were found as a result of applying the procedure.

   B. Trace *Subtotal Ancillary Charges* for all charge columns reported in P14 Schedule 1.1, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record charges to agree with supporting documentation for all cost centers.

   Finding: No material exceptions were found as a result of applying the procedure.

   C. Trace the *Hospital Per Diems and CCRs* reported in P14 Schedule 1 (July-December) to the Audited Medicare cost report. If the Audited Medicare cost report is not available, trace the Per Diems and CCRs to the "as filed" Medicare cost report. For transplant related cost centers, trace CCRs to hospital support. If variance noted, record CCRs to agree with supporting documentation.

   Finding: No material exceptions were found as a result of applying the procedure.

a. If either the DHCS' Report On The Cost Report Review (Audit Report) or "filed" Medi-Cal cost report is provided as an alternative to support the Per Diems and CCRs reported by the hospital, perform the following procedures:
    i. Trace the Per Diems and CCRs to the Medi-Cal cost report provided. If variance noted, record Per Diems and CCRs to agree with supporting documentation for all cost centers.
    ii. Verify with the hospital that data from the filed Medi-Cal cost report is consistent with that from the filed Medicare cost report. If any variations exist between the two cost reports, document the reason(s) provided by the hospital.

Finding: We found 19 of the 21 DPHs did not provide their Medicare cost report to support their Per Diems and CCRs. Instead, these hospitals provided their Medi-Cal cost report as an alternative to support their Per Diems and CCRs. Refer to Table 1 below for reasons provided by the 19 DPHs explaining the variations that exist between their filed Medi-Cal and Medicare cost reports.

Table 1: Variations between the filed Medi-Cal and Medicare Cost Reports for the DPH Listed

	DPH Name	Reason(s) for variation between the filed Medi-Cal cost report and the filed Medicare cost report as provided by the hospital
1	Riverside County Regional Medical Center	Hospital included Intern and Resident costs in the total allowable costs of each affected cost center reported on the filed Medi-Cal cost report, so the costs can be distributed and included for reimbursement. Intern and Resident costs are reimbursed through separate payment programs by Medicare so the costs are excluded from the filed Medicare cost report in order to eliminate double-reimbursement.
2	Alameda County Medical Center	
3	Kern Medical Center	
4	Natividad Medical Center	
5	UC San Francisco Medical Center	
6	Contra Costa Regional Medical Center	Hospital included Intern and Resident costs in the total allowable costs of each affected cost center reported on the filed Medi-Cal cost report, so the costs can be distributed and included for reimbursement. Intern and Resident costs are reimbursed through separate payment programs by Medicare so the costs are excluded from the filed Medicare cost report in order to eliminate double-reimbursement. Costs for Federally Qualified Health Center (FQHC) clinics, which are Medi-Cal certified only, are separated under individual cost centers on the filed Medi-Cal cost report. Associated Physician and/or Non-Physician Practitioner (PNPP) costs, if applicable, are included in this report. FQHC clinic costs are reported collectively under one cost center on the filed Medicare cost report and associated PNPP costs are excluded from this report.
7	San Francisco General Hospital	
8	Los Angeles County (LAC) - Harbor/UCLA Medical Center	The LAC DPHs prepare their P14 workbooks based on the Medi-Cal cost report in accordance with CMS Special Terms and Conditions (amended effective April 3, 2013), titled California Bridge to Reform Demonstration, Attachment F. The LAC DPHs do file a Medicare cost report. However, no information was provided on the variations that exist between the filed Medicare and Medi-Cal cost reports.
9	LAC - Olive View Medical Center	
10	LAC - Rancho Los Amigos	
11	LAC - USC Medical Center (LAC + USC)	
12	San Mateo Medical Center	Costs for FQHC clinics, which are Medi-Cal certified only, are separated under individual cost centers on the filed Medi-Cal cost report. Associated PNPP costs, if applicable, are included in this report. FQHC clinic costs are reported collectively under one cost center on the filed Medicare cost report and associated PNPP costs are excluded from this report.
13	Santa Clara Valley Medical Center	
14	UC Davis Medical Center	Hospital included Intern and Resident costs in the total allowable costs of each affected cost center reported on the filed Medi-Cal cost report, so the costs can be distributed and included for reimbursement. Intern and Resident costs are reimbursed through separate payment programs by Medicare so the costs are excluded from the filed Medicare cost report in order to eliminate double-reimbursement. There is also a Reasonable Compensation Equivalent disallowance on the Medicare cost report.
15	UC Irvine Medical Center	Costs for FQHC clinics, which are Medi-Cal certified only, are separated under individual cost centers on the filed Medi-Cal cost report. Associated PNPP costs, if applicable, are included in this report. FQHC clinic costs are reported collectively under one cost center on the filed Medicare cost report and associated PNPP costs are excluded from this report. The filed Medicare cost report includes an adjustment for medical education payments. The filed Medi-Cal cost report does not require this adjustment.

16	UC San Diego Medical Center	Hospital included Intern and Resident costs in the total allowable costs of each affected cost center reported on the filed Medi-Cal cost report, so the costs can be distributed and included for reimbursement. Intern and Resident costs are reimbursed through separate payment programs by Medicare so the costs are excluded from the filed Medicare cost report in order to eliminate double-reimbursement. The filed Medi-Cal cost report includes organ acquisition costs. The filed Medicare cost report does not include these costs The filed Medicare cost report included admin costs that had been erroneously recorded twice or were recorded incorrectly.
17	UCLA Medical Center Ronald Reagan	Hospital included Intern and Resident costs in the total allowable costs of each affected cost center reported on the filed Medi-Cal cost report, so the costs can be distributed and included for reimbursement. Intern and Resident costs are reimbursed through separate payment programs by Medicare so the costs are excluded from the filed Medicare cost report in order to eliminate double-reimbursement. Days reported in the filed Medi-Cal cost report are adjusted to agree with days reported on the Paid Claims Summary Report.
18	UCLA Santa Monica	
19	Ventura County Medical Center	Costs for FQHC clinics, which are Medi-Cal certified only, are separated under individual cost centers on the filed Medi-Cal cost report. Associated PNPP costs, if applicable, are included in this report. FQHC clinic costs are reported collectively under one cost center on the filed Medicare cost report and associated PNPP costs are excluded from this report. Mental Health Clinics are treated the same.

D. Compare the *Percentage Reduction for State Only Medi-Cal Claims (from Paid Claims Data)* reported in P14 Schedule 2.1, Step 1, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to "FY 1011 SOC% for DOF" document provided by DHCS – Safety Net Financing Division. If variance noted, record percentage to agree with supporting documentation.

Finding: Material variance was noted in 1 of the 21 DPHs; we recorded the Percentage Reduction for State Only Medi-Cal Claims to agree with supporting documentation provided by DHCS – Safety Net Financing Division.

E. Trace *Medi-Cal Share of Cost Charges* reported in P14 Schedule 3.1, Medi-Cal section, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

Finding: No material exceptions were found as a result of applying the procedure.

F. Trace *Estimated Admin Day payments, Estimated Blood Factor payments and Other Estimated Payments* reported in P14 Schedule 3.1, Medi-Cal section, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

Finding: No material exceptions were found as a result of applying the procedure.

G. Trace *Medi-Cal Share of Cost Payments Received* reported in P14 Schedule 3.1, Medi-Cal section, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

Finding: No material exceptions were found as a result of applying the procedure.

2. Compare the Medi-Cal total of the *Amount Paid* column reported in the PCSR, FY1 OP Summary tab to the Medi-Cal OP Payment in the DSH DPH Summary. If variance noted, record payments to agree with the PCSR.

   Finding: No exceptions were found as a result of applying the procedure.

3. Verify the Dual Eligibles Medicare and Medicaid Payments, as presented in DSH DPH Summary, are supported by hospital records by performing the following procedures:

   A. Trace *Estimated Medi-Cal Payments for Cross-Over Claims, Medicare Payments for Cross-Over Claims, and Patient Share of Cost Obligation for Cross-Over Claims* reported in P14 Schedule 3.1, Medi-Cal section, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

   Finding: No material exceptions were found as a result of applying the procedure.

   B. Trace all Medicare/Medi-Cal payments reported in P14 Schedule 3.1, Medicare/Medi-Cal (Medi-Medi) for DSH Calculation section, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support, to determine the *Total Payment for Medi-Medi Claims not included in the Medi-Cal cost calculation and used for determining UCC costs for DSH purposes*. If variance noted, record payments to agree with supporting documentation.

   Finding: No material exceptions were found as a result of applying the procedure.

4. Verify the CBRC (OP Hospital Services), as presented in DSH DPH Summary, is supported by hospital records by tracing *Patient Payments Related to CBRC Hospital Outpatient Services* reported in P14 Schedule 3.1, CBRC State Plan Amendment (SPA) section, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

   Finding: No exceptions were found as a result of applying the procedure.

5. Verify the Medi-Cal Psych Payment, as presented in DSH DPH Summary, is supported by hospital records by performing the following procedures:

   A. Trace *Medi-Cal Psych IP Payment from Mental Health Plan allocated to hospital services* reported in P14 Schedule 3.1, Medi-Cal Psych section, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

   Finding: No material exceptions were found as a result of applying the procedure.

B. Trace *Medi-Cal Psych OP Payment from Mental Health Plan allocated to hospital services* reported in P14 Schedule 3.1, Medi-Cal Psych section, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

Finding: No material exceptions were found as a result of applying the procedure.

C. Trace *Total Computable Supplemental Psych Payments (Mental Health SPA)* reported in P14 Schedule 3.1, Medi-Cal Psych section, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

Finding: No exceptions were found as a result of applying the procedure.

D. Trace *Psych Portion of Hospital Fee* reported in P14 Schedule 3.1, Medi-Cal Psych section, for all fiscal periods (7/1/10 – 10/31/10, and 11/1/10 – 12/31/10), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

Finding: No exceptions were found as a result of applying the procedure.

E. Trace *Medicare, Medi-Cal, and Share of Cost Payments for Cross-Over Claims Included in Psych Medi-Cal calculation* reported in P14 Schedule 3.1, Medi-Cal Psych section, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

Finding: No exceptions were found as a result of applying the procedure.

F. Trace *Patient Payments Related to Medi-Cal Psych IP and OP hospital costs* reported in P14 Schedule 3.1, Medi-Cal Psych section, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

Finding: No exceptions were found as a result of applying the procedure.

6. Verify the Out-of-State Medicaid Payments, as presented in DSH DPH Summary, is supported by hospital records by performing the following procedures:

A. Trace *Out-of-State Medicaid Payments for Hospital Services* reported in P14 Schedule 3.1, Out-of-State Medicaid section, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

Finding: No exceptions were found as a result of applying the procedure.

B. Trace *Patient Payments Related to Out-of-State Medicaid Hospital Costs* reported in P14 Schedule 3.1, Out-of-State Medicaid section, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

Finding: No exceptions were found as a result of applying the procedure.

7. Verify the LIHP Another County's MCE Enrollee (Including Prisoners), as presented in DSH DPH Summary, is supported by hospital records by performing the following procedures:

   A. Trace *Payments received from another County for their MCE enrollees for hospital services* reported in P14 Schedule 3.1, Other County's MCE Enrollee For Hospital Services section, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

   Finding: No exceptions were found as a result of applying the procedure.

   B. Trace *Amounts Certified to an LIHP for inclusion in the LIHP's MCE claim* reported in P14 Schedule 3.1, Other County's MCE Enrollee For Hospital Services section, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

   Finding: No exceptions were found as a result of applying the procedure.

   C. Trace *Payment received from the California Department of Corrections and Rehabilitation (CDCR) or California Prison Health Care Services (CPHCS) for Prisoners enrolled in another County's MCE Program* reported in P14 Schedule 3.1, Other County's MCE Enrollee For Hospital Services section, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

   Finding: No exceptions were found as a result of applying the procedure.

   D. Trace *Patient payments received from another county's MCE enrollees* reported in P14 Schedule 3.1, Other County's MCE Enrollee For Hospital Services section, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

   Finding: No exceptions were found as a result of applying the procedure.

8. Verify the MCE Medi-Cal Services, as presented in DSH DPH Summary, is supported by hospital records by tracing *Patient Payments Related to MCE DSH eligible Hospital Medical Services* reported in P14 Schedule 3.1, MCE section, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

   Finding: No material exceptions were found as a result of applying the procedure.

9. Verify the MCE Mental Health Services, as presented in DSH DPH Summary, is supported by hospital records by tracing *Patient Payments Related to MCE DSH eligible Hospital Mental Health Services* reported in P14 Schedule 3.1, Mental Health Services section, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

   Finding: No exceptions were found as a result of applying the procedure.

10. Verify the MCE Services Always CPE Based, as presented in DSH DPH Summary, is supported by hospital records by performing the following procedures:

    A. Trace *Payments from the State Department of Corrections for services provided at the LIHP's hospital* reported in P14 Schedule 3.1, Services Always CPE Based section, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

    Finding: No Payments from the State Department of Corrections for services provided at the LIHP's hospital were reported in P14 Schedule 3.1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), by the hospitals.

    B. Trace *Prisoner Patient Payments Related to MCE Hospital Medical Services including payments for physician services* reported in P14 Schedule 3.1, Services Always CPE Based section, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

    Finding: No Prisoner Patient Payments Related to MCE Hospital Medical Services including payments for physician services were reported in P14 Schedule 3.1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), by the hospitals.

    C. Trace *Payments from the County or County Corrections Department for services provided at the LIHP's hospital to county jail inmates* reported in P14 Schedule 3.1, Services Always CPE Based section, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

    Finding: No Payments from the County or County Corrections Department for services provided at the LIHP's hospital to county jail inmates were reported in P14 Schedule 3.1, for all fiscal periods (11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), by the hospitals.

11. Quantify the number of hospitals with a material variance between the Regular IP/OP Medicaid FFS Rate Payments presented on DSH DPH Summary and the sum of the verified amounts from Procedures 1 through 10.

    Finding: Of the 21 DPH hospitals included in this review, 1 had a material variance between the Regular IP/OP Medicaid FFS Rate Payments presented on DSH DPH Summary and the verified amounts from Procedures 1 through 10.

12. Verify the IP/OP Medicaid MCO Payments, as presented in DSH DPH Summary, is supported by hospital records by performing the following procedures:

    A. Trace *Medi-Cal Managed Care IP and OP Payments* reported in P14 Schedule 3.1, Medi-Cal Managed Care section, for all fiscal periods (7/1/10 – 9/30/10, 10/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 – 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

    Finding: No material exceptions were found as a result of applying the procedure.

    B. Trace *Supplemental Managed Care Payment Less Physician and Non-Hospital Portion* reported in P14 Schedule 3.1, Medi-Cal Managed Care section, for all fiscal periods (7/1/10 – 9/30/10, 10/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 – 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

    Finding: No material exceptions were found as a result of applying the procedure.

    C. Trace *Seniors and Persons with Disabilities (SPD) Managed Care Payment Less Physician and Non-Hospital Portion* reported in P14 Schedule 3.1, Medi-Cal Managed Care section, for all fiscal periods (7/1/10 – 9/30/10, 10/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 – 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

    Finding: No exceptions were found as a result of applying the procedure.

    D. Trace *Total Hospital Fee Payment–Managed Care Component* reported in P14 Schedule 3.1, Medi-Cal Managed Care section, for all fiscal periods (7/1/10 – 9/30/10, 10/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 – 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

    Finding: No material exceptions were found as a result of applying the procedure.

13. Quantify the number of hospitals with a material variance between the IP/OP Medicaid MCO Payments presented on DSH DPH Summary and the sum of the verified amount from Procedure 12.

    Finding: Of the 21 DPH hospitals included in this review, 0 (zero) had a material variance between the IP/OP Medicaid MCO Payments presented on DSH DPH Summary and the sum of verified amount from Procedure 12.

14. Verify the Senate Bill (SB) 1732 (Construction and Renovation Reimbursement Program) payment, as presented in DSH DPH Summary, is supported by hospital records by tracing *SB 1732 Payments* reported in P14 Schedule 3.1, Affecting Uninsured section, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

    Finding: No exceptions were found as a result of applying the procedure.

15. Quantify the number of hospitals with a material variance between the Supplemental & Enhanced IP/OP Medicaid Payments presented on DSH DPH Summary and the verified amount from Procedure 14 plus the AB 915 OP Payment.

    Finding: Of the 21 DPH hospitals included in this review, 2 had a material variance between the Supplemental & Enhanced IP/OP Medicaid Payments presented on DSH DPH Summary and the sum of the verified amount from Procedure 14 plus the AB 915 OP Payment.

16. Verify the Uninsured Revenues, as presented in DSH DPH Summary, are supported by hospital records by tracing *Patient Payments Related to Uninsured IP and OP Hospital Costs* reported in P14 Schedule 3.1, Affecting Uninsured section, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

    Finding: Material variances were noted in 2 of the 21 DPHs; we recorded the Patient Payments Related to Uninsured IP and OP Hospital Costs to agree with supporting documentation.

17. Calculate CI Revenue based on DHCS' CI calculation methodology (CI and HCCI tab in Data Location file) and compare to *CI Revenue* as presented in DSH DPH Summary. If variance noted, record payments to agree with the calculated amount.

    Finding: Material variance was noted in 1 of the 21 DPHs when we calculated CI Revenue based on DHCS' CI calculation methodology and compared it to CI Revenue as presented in the DSH DPH Summary.

18. Calculate HCCI Revenue based on DHCS' HCCI calculation methodology (CI and HCCI tab in Data Location file) and compare to *HCCI Revenue* as presented in DSH DPH Summary. If variance noted, record payments to agree with the calculated amount.

    Finding: Material variance was noted on 1 of the 21 DPHs when we calculated HCCI Revenue based on DHCS' HCCI calculation methodology and compared it to HCCI Revenue as presented in the DSH DPH Summary.

19. Compare Safety Net Care Pool (SNCP) (Hospital costs claimed), as presented in DSH DPH Summary, to the *FY 1011 SNCP column* in DHCS' FY 1011 DSH and SNCP Claiming bridging document. If variance noted, record payments to agree with supporting documentation.

    Finding: No exceptions were found as a result of applying the procedure.

20. Quantify the number of hospitals with a material variance between the Total IP/OP Indigent Care/Self-Pay Revenues presented on DSH DPH Summary and the sum of verified amounts from Procedures 16 through 19.

    Finding: Of the 21 DPH hospitals included in this review, 4 had a material variance between the Total IP/OP Indigent Care/Self-Pay Revenues presented on DSH DPH Summary and the verified amounts from Procedures 16 through 19.

21. Verify the Total Applicable Section 1011 Payments, as presented in DSH DPH Summary, are supported by hospital records by tracing *Section 1011 Payments* reported in P14 Schedule 3.1, Affecting Uninsured section, for all fiscal periods (7/1/10 – 10/31/10, 11/1/10 – 12/31/10, 1/1/11 - 3/31/11, and 4/1/11 – 6/30/11), to hospital provided support. If variance noted, record payments to agree with supporting documentation.

    Finding: No material exceptions were found as a result of applying the procedure.

22. Quantify the number of hospitals with a material variance between the Total Applicable Section 1011 Payments presented on DSH DPH Summary and the verified amount from Procedure 21.

    Finding: Of the 21 DPH hospitals included in this review, 0 (zero) had a material variance between the Total Applicable Section 1011 Payments presented on DSH DPH Summary and the verified amount from Procedure 21.

<u>NDPH Procedures:</u>

1. Verify the Total Regular IP/OP Medicaid FFS Payments, as presented in DSH NDPH Summary, are supported by hospital records by performing the following procedures:

    A. Trace the *IP/OP Medicaid Payments for Psychiatric Services* in the CRW Revenue Tab Category 1, Row 1a to sum of PCSR FY1 "Psyc Summary" tab for the Medi-Cal total amounts from "Patient Liability", "Other Coverage", and "Amount Paid" columns. If PCSR is not available, trace to hospital provided support. If variance noted, record payments to agree with supporting documentation.

    Finding: No material exceptions were found as a result of applying the procedure.

    B. Trace the *Regular IP/OP Medicaid FFS Payments* in the CRW Revenue Tab Category 1 Row 1b to sum of PCSR, FY1 IP and OP Summary tab for the Medi-Cal, Abortion (if applicable), and GHPP (if applicable) total amounts from "Patient Liability", "Other Coverage", and "Amount Paid" columns and the Cost Settlement from DHCS' Report On The Cost Report Review (Audit Report), "Summary of Findings" page, row 17–"Total Combined Audited Settlement Due Provider" (include even if this amount is a negative number). If Audit Report is not available, trace to hospital provided support. If variance noted, record payments to agree with supporting documentation.

    Finding: Material variances were noted in 5 of the 25 NDPHs; we recorded the Regular IP/OP Medicaid FFS Payments to agree with supporting documentation.

2. Verify the Medicaid Payments from Other States and Non-States IP/OP Medicaid Payments, as presented in the DSH NDPH Summary, is supported by tracing the *Payments for Out-Of-State Medicaid Services* in the CRW Revenue Tab Category 3 to hospital provided support. If variance noted, record payments to agree with supporting documentation.

    Finding: No exceptions were found as a result of applying the procedure.

3. Verify the Medicare Payments for Dual Eligibles, as presented in the DSH NDPH Summary, is supported by tracing the *Payments for Dual Eligibles with both Medicare and Medicaid* in the CRW Revenue Tab Category 5 to hospital provided support, including any Medicare Bad Debts payments from Medicare Cost Report Worksheet E Part A "Adjusted Reimbursable Bad Debts" line 65, and Worksheet E Part B "Adjusted Reimbursable Bad Debts" line 35. For Critical Access Hospitals, use Worksheet E-3 Part V "Adjusted Reimbursable Bad Debts" line 26 and Worksheet E Part B "Adjusted Reimbursable Bad Debts" line 35. If variance noted, record payments to agree with supporting documentation.

   Finding: Material variances were noted in 7 of the 25 NDPHs; we recorded the Payments for Dual Eligibles with both Medicare and Medicaid to agree with supporting documentation.

4. Quantify the number of hospitals with a material variance between the *Regular IP/OP Medicaid FFS Rate Payments* presented on DSH NDPH Summary and the sum of verified amounts from Procedures 1 through 3.

   Finding: Of the 25 NDPH hospitals included in this review, 8 had a material variance between the Regular IP/OP Medicaid FFS Rate Payments presented on DSH NDPH Summary and the sum of verified amounts from Procedures 1 through 3.

5. Verify the IP/OP Medicaid Managed Care Organization (MCO) Payments, as presented in the DSH NDPH Summary, is supported by tracing the *Total IP/OP Medicaid Managed Care Payments* in the CRW Revenue Tab Category 4 to hospital provided support. If variance noted, record payments to agree with supporting documentation.

   Finding: No exceptions were found as a result of applying the procedure.

6. Quantify the number of hospitals with a material variance between the *IP/OP Medicaid MCO Payments* presented on DSH NDPH Summary and the sum of verified amount from Procedure 5.

   Finding: Of the 25 NDPH hospitals included in this review, 0 (zero) had a material variance between the IP/OP Medicaid MCO Payments presented on DSH NDPH Summary and the sum of verified amount from Procedure 5.

7. After recording the *Supplemental/Enhanced IP/OP Medicaid Payments* provided by DHCS for the CRW Revenue Tab Category 2 Row 2a, verify the Supplemental & Enhanced IP/OP Medicaid Payments, as presented in the DSH NDPH Summary, by tracing the *Other Supplemental/Enhanced Payments* in the CRW Revenue Tab Category 2 Row 2b to hospital provided support. If variance noted, record payments to agree with supporting documentation.

   Finding: We recorded the Supplemental/Enhanced IP/OP Medicaid Payments provided by DHCS for the CRW Revenue Tab Category 2 Row 2a and verified against the Supplemental & Enhanced IP/OP Medicaid Payments as presented in the DSH NDPH Summary. Further, no Other Supplemental/Enhanced Payments were reported in the CRW Revenue Tab Category 2 Row 2b by the hospitals; as no payments were reported, there were no payments to trace and agree to hospital support.

8. Quantify the number of hospitals with a material variance between the *Supplemental/Enhanced Medicaid IP/OP Payments* presented on DSH NDPH Summary and the verified amounts from Procedure 7.

   Finding: Of the 25 NDPH hospitals included in this review, 0 (zero) had a material variance between the Supplemental/Enhanced Medicaid IP/OP Payments presented on DSH NDPH Summary and the verified amounts from Procedure 7.

9. Verify the Uninsured IP/OP Revenue, as presented in the DSH NDPH Summary, is supported by tracing the *Total IP/OP Indigent Care/Self-Pay Revenues* in the CRW Revenue Tab Category 6 to hospital provided support. If variance noted, record payments to agree with supporting documentation. Include CCS, Abortion, and GHPP payments for services provided to uninsured patients, if reported and applicable.

   Finding: Material variances were noted in 4 of the 25 NDPHs; we recorded the Total IP/OP Indigent Care/Self-Pay Revenues to agree with supporting documentation.

10. Quantify the number of hospitals with a material variance between the *Uninsured IP/OP Revenue* presented on DSH NDPH Summary and the verified amount from Procedure 9.

    Finding: Of the 25 NDPH hospitals included in this review, 4 had a material variance between the Uninsured IP/OP Revenue presented on DSH NDPH Summary and the verified amount from Procedure 9.

11. Verify the Total Applicable Section 1011 Payments, as presented in the DSH NDPH Summary, is supported by tracing the *Total Applicable Section 1011 Payments* in the CRW Revenue Tab Category 7 to hospital provided support. If variance noted, record payments to agree with supporting documentation.

    Finding: Material variance was noted in 1 of the 25 NDPHs; we recorded the Total Applicable Section 1011 Payments to agree with supporting documentation.

12. Quantify the number of hospitals with a material variance between the *Total Applicable Section 1011 Payments* presented on DSH NDPH Summary and the verified amount from Procedure 11.

    Finding: Of the 25 NDPH hospitals included in this review, 1 had a material variance between the Total Applicable Section 1011 Payments presented on DSH NDPH Summary and the verified amount from Procedure 11.

Verifications 2, 3, and 4

DPH and NDPH Procedure:

1. Finance will provide DHCS with updated DSH 2010-11 DPH Annual Report, FFY11 tab and DSH 2010-11 NDPH Annual Report, Combined tab with cost and revenue data verified in performing the agreed upon procedures listed under Verifications 2, 3, and 4.

   Finding: No exceptions were found as a result of applying the procedure.

Verification 5

DPH and NDPH Procedures:

1. Obtain California's state plan rate year 2010-11 DSH audit protocol (protocol) and compare to requirements defined in Title 42, CFR Part 455.301 and Part 455.304(d)(5). Provide a review of the protocol and descriptions of the information and records of all inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments; and, any payments made on behalf of the uninsured from payment adjustments under section 1923 of the Social Security Act.

   Finding: Except for the instructions on how to report costs and revenues in the Data Collection Tools developed by DHCS, DHCS did not have a protocol in place for state plan rate year 2010-11; thus, a review of the protocol was not performed. However, DHCS was able to provide information and records of all inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments; and, any payments made on behalf of the uninsured from payment adjustments under section 1923 of the Social Security Act, for all but two of the 46 hospitals (21 DPHs and 25 NDPHs). We found that two of the NDPHs did not provide documentation because one hospital has closed operations and the other opted not to provide documentation. Refer to Appendix B, titled Data Collection Tools, for a description of the information and records provided by DHCS.

2. Verify whether DHCS separately documented and retained information and records of all inpatient and outpatient hospital service costs under the Medicaid program; claimed expenditures under the Medicaid program; uninsured inpatient and outpatient hospital service costs in determining payment adjustments; and, any payments made on behalf of the uninsured from payment adjustments.

   Finding: DHCS does separately document and retain cost and payment information and records submitted by the hospitals or compiled by their department. We found that DHCS has a process in place to ensure DPHs and NDPHs participating in the DSH program are retaining detailed support for all amounts reported in their cost and revenue workbook.

Verification 6

DPH and NDPH Procedures:

1. Obtain DHCS' methodology for calculating each hospital's DSH payment limit and compare to requirements in Section 1923(g) (1) of the Social Security Act and Title 42, CFR Part 455.304(d)(6). Provide a description of how DHCS defines incurred inpatient and outpatient hospital costs for Medicaid and uninsured individuals.

   Finding: No exceptions were found for the comparison of DHCS' methodology for calculating each hospital's DSH payment limit to the requirements in Section 1923(g) (1) of the Social Security Act and Title 42, CFR Part 455.304(d)(6). DHCS defines incurred inpatient hospital and outpatient hospital costs for Medicaid and uninsured individuals as follows:

   > "Inpatient hospital services are defined in Title XVIII of the Social Security Act (the Act) [Section 1861] and in the regulations ([Title] 42, CFR [Part] 409.10). Inpatient hospital [services] means the following services furnished to an inpatient of a participating hospital:
   >
   > 1. Bed and board.
   > 2. Nursing services and other related services.
   > 3. Use of hospital.
   > 4. Medical social services.
   > 5. Drugs, biologicals, supplies, appliances, and equipment.
   > 6. Certain other diagnostic or therapeutic services.
   > 7. Medical or surgical services provided by certain interns or residents-in-training.
   > 8. Transportation services, including transport by ambulance.
   >
   > A hospital outpatient is a person who has not been admitted to the hospital as an inpatient and receives services (rather than supplies alone) from the hospital."

2. Identify the allowable costs and payments accepted by DHCS to be included in the calculation of each hospital's DSH payment limit.

   Finding: Table 2 identifies the allowable costs and payments accepted by DHCS to be included in the calculation of each hospital's DSH payment limit.

Table 2: Costs and Payments Included in the Calculation of Each Hospital's DSH Payment Limit

DPH	NDPH
Regular IP and OP Medicaid FFS Rate Payments	
Medi-Cal IP Payments Medi-Cal OP Payments Dual Eligibles Medicare and Medicaid Payments CBRC (OP Hospital Services) Medi-Cal Psych Payments Out-of-State Medicaid Payments LIHP Another County's MCE Enrollee (Including Prisoners) MCE Medi-Cal Services MCE Mental Health Services MCE Services Always CPE Based	Total Regular IP and OP Medicaid FFS Payments Medicaid Payments from Other States and Non-States IP and OP Medicaid Payments Payments for Dual Eligibles
IP and OP Medicaid MCO Payments	
IP and OP Medicaid Managed Care Organization Payments	IP and OP Medicaid Managed Care Organization Payments
Supplemental/Enhanced IP and OP Medicaid Payments	
SB 1732 AB 915 OP Payments	Supplemental & Enhanced IP and OP Medicaid Payments Other Supplemental Payment received by the Hospital
Total Cost of Care – Medicaid IP and OP Services	
Medi-Cal FFS Inpatient Costs Medicare/Medi-Cal Crossover IP Costs for DSH Calculation Medicare/Medi-Cal Crossover OP Costs for DSH Calculation Medi-Cal Managed Care IP Costs Medi-Cal Managed Care OP Costs Medi-Cal Psych IP Costs Medi-Cal Psych OP Costs Out-Of-State Medicaid IP Costs Out-Of-State Medicaid OP Costs Another County's LIHP Patient MCE IP Costs Another County's LIHP Patient MCE OP Costs Medi-Cal OP Costs (AB915 Claim) CBRC Medi-Cal OP Costs Medical Services MCE LIHP IP Costs Medical Services MCE LIHP OP Costs Mental Health Services MCE LIHP IP Costs Mental Health Services MCE LIHP OP Costs Services Always CPE Based MCE LIHP IP Costs Services Always CPE Based MCE LIHP OP Costs MCE for State Prisoners County IP Costs MCE for County Jail Inmates IP Costs MCE for Prisoners in Another County's Program IP Costs	Medi-Cal FFS IP and OP Costs Medi-Cal IP and OP Managed Care Costs Medi-Cal IP and OP Psych Costs Medi-Cal IP and OP Dual Eligible Costs
Total IP and OP Indigent Care/Self-Pay Revenues	
Uninsured IP and OP Revenues CI Revenues HCCI Revenues Safety Net Care Pool (Hospital costs Claimed)	Uninsured IP and OP Revenues
Total Applicable Section 1011 Payments	
Total Applicable Section 1011 Payments	Total Applicable Section 1011 Payments
Total IP and OP Uninsured Cost of Care	
Uninsured IP Costs Uninsured OP Costs CI IP Costs CI OP Costs HCCI IP Costs HCCI OP Costs	Uninsured IP and OP Costs Section 1011 IP and OP Costs

Independence Certification

This Independence Certification is to be included with and attached to the Independent Accountant's Report on the Results of Agreed-Upon Procedures applied to the six verifications as defined in Title 42, *Code of Federal Regulations* (CFR) Part 455 relating to the Medicaid Program for Disproportionate Share Hospital (DSH) Payments Final Rule, issued by the Centers for Medicare & Medicaid Services for Medicaid State plan rate year 2010-11.

The Department of Finance, Office of State Audits and Evaluations (Finance), and the California Department of Health Care Services (DHCS) are both 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. Under Government Auditing Standards, performance of these activities creates an organizational impairment with respect to independence. However, Finance has developed and implemented sufficient safeguards to mitigate the organizational impairment so reliance can be placed on the work performed. Some examples of Finance's independence safeguards include:

- Finance staff do not report to, nor are they supervised by, DHCS.
- Finance staff are required to assess individual independence prior to each engagement. For each assignment, all team members (manager, supervisor, and staff) must sign a Statement of Independence, attesting that there is no known independence impairment.
- Finance conforms to Government Auditing Standards by having external and internal peer reviews performed.
- A significant number of Finance managers, supervisors, and staff are Certified Public Accountants (CPAs). Reports are signed by a CPA in good standing. CPAs are held to a higher standard of ethical conduct and have a stake in maintaining their licenses in good standing.
- There are multiple levels of Finance supervisory review which allows for different perspectives with each level of review, to ensure the work reflects objectivity and an unbiased examination.
- Finance's Quality Advisory Team reviews, develops, facilitates, and communicates independence policies and procedures to all Finance staff to ensure awareness and importance of individual auditor independence.

In addition, Finance and the individual staff on this engagement are completely independent of the DSH hospitals that were subjected to the agreed-upon procedures.

Therefore, Finance certifies that in all matters relating to this engagement, Finance and the individual staff are independent of mind and in appearance as defined in accordance with the applicable *Government Auditing Standards* issued by the Comptroller General of the United States.

Sincerely,

Original signed by:

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

Data Collection Tools

Cost and Revenue Workbook (CRW)

The Department of Health Care Services (DHCS) developed the CRW to obtain actual cost and revenue data from Non-Designated Public Hospitals (NDPH) to meet Centers for Medicare and Medicaid Services' (CMS) regulation and is used to compute each hospital's uncompensated care costs. The primary sources for the CRW are the Audited Medicare 2552-10 cost reports and the data contained in the Paid Claims Summary Report (PCSR), generated from the Medicaid Management Information System (MMIS) and provided by DHCS. When audited cost reports are not available within the timeframe allowed for the reporting and audit submission, as-filed 2552-10 cost reports can be used. The CRW includes a certification statement from the hospital official certifying completeness and accuracy of all reported charges, costs, and payments and that the information was compiled in accordance with CMS and DHCS reporting guidelines. The CRW also contains an instruction sheet and a data sources sheet indicating source documents deemed acceptable by DHCS to support the costs and revenues reported by the hospital.

Interim Hospital Payment Rate Workbook (P14 Workbook)

DHCS developed the P14 workbook to obtain actual cost and revenue data from Designated Public Hospitals (DPH). The P14 contains a briefly summarized instructions sheet which references a separate document titled "Interim Hospital Payment Rate Workbook Instructions" for more detailed instructions. Per the instructions, the P14 provides a simplified way to obtain the costs associated with the various categories of reimbursement under the 1115 Medi-Cal Hospital/Uninsured Care Demonstration (Demonstration) Waiver 11-W-00193/9, the Physician SPA (05-023), and the LA County CBRC SPA. This Workbook is designed for FY 2010-11 and incorporates part of [Demonstration Year 5] DY5 (7/1/10 - 8/31/10), the extension period from the 2005 waiver (9/1/10 - 10/31/10), and DY6, an eight-month period under the 2010 waiver (11/1/10 - 6/30/11).

Paid Claims Summary Report

This report is provided to each hospital by DHCS to be used as a source when preparing and completing their workbooks. DHCS will request the PCSR reports from Xerox (fiscal intermediary). Hospitals can also request a PCSR from Xerox.

NDPH and DPH Disproportionate Share Hospital (DSH) Annual Reports

The NDPH and DPH DSH Annual Reports are populated by DHCS and are used to capture applicable costs and payments for DSH reporting purposes. They contain information from the P14, the CRW, the PCSR, and supplemental payment information provided by DHCS that are not reflected in the P14 or the CRW.