DEPARTMENT OF FINANCE

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Transmitted via e-mail

December 15, 2015

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

Dear Ms. Kent:

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, 2012. 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 Department of Health Care Services
Disproportionate Share Hospital Program
For the Period July 1, 2011 through June 30, 2012

Source: Centers for Medicare and Medicaid Services

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

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December 2015

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Final reports are available on our website at http://www.dof.ca.gov

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INDEPENDENT ACCOUNTANT'S REPORT ON APPLYING AGREED-UPON PROCEDURES

Ms. Jennifer Kent, 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 2011-12 (July 1, 2011 through June 30, 2012), 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 (GAS), 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.

The Department of Finance, Office of State Audits and Evaluations (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 GAS, 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.

DHCS and Finance agreed to materiality guidelines for reporting identified variances (findings). Findings were considered reportable for Verifications 2, 3, and 4, if variances noted were 10 percent or greater of the total cost or revenue columns from the DSH 2011-12 Designated Public Hospital (DPH) and Non-Designated Public Hospital (NDPH) Annual Report Draft Summary (DSH DPH and NDPH Summary Reports) provided by DHCS. That is, if the total verified cost or revenue amount varied by 10 percent or greater when compared to the amount reported in the hospital's P14 or Cost and Revenue Workbook, 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 agreed-upon procedures and associated findings are detailed in the Results section.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the six verifications for the Medicaid State plan rate year 2011-12. 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, 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, 2015

The procedures and associated findings are as follows:

Verification 1

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

1. Obtain the "Final Disproportionate Share Hospital (DSH) Eligibility List for [State Fiscal Year] SFY 2011-12" 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, titled, Medi-Cal Hospital/Uninsured Care Demonstration, as amended 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 2011-12 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.
   - The following five hospitals stated they were not allowed to retain their full interim DSH payment for Medicaid State plan rate year 2011-12 due to a DSH overpayment which was determined after the DSH payments for all hospitals were finalized. DHCS confirmed the overpayments were recouped and redistributed to other qualified hospitals.

     - Butte County Mental Health PHF
     - Coalinga Regional Medical Center
     - Mayers Memorial Hospital
     - Oak Valley District Hospital
     - Sierra Kings District Hospital

B. From the schedule of DSH Program 2011-12 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 2011-12 and will be excluded from Verifications 2, 3, and 4 Agreed-Upon Procedures (AUPs).

Finding: Of the NDPHs that received DSH funding Corcoran District Hospital has closed operations. John C. Fremont Hospital did not 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 2011-12 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 Procedures:

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: For the comparison of Verification 3 and 4 procedure results to the DSH DPH Summary Report, no excess DSH payment was identified.

   For the comparison of Verification 3 and 4 procedure results to the DSH NDPH Summary Report, three hospitals were identified with an excess DSH payment.

2. Verify with DHCS whether funds have been repaid by hospitals whose fiscal year 2010-11 DSH payment exceeded its individual UCC limit and whether any returned funds were redistributed to DSH eligible hospitals.

   Finding: Subsequent to the issuance of the FY 2010-11 DSH AUP Report, DHCS and Trinity Hospital worked together to identify errors in the hospital's reported amounts which resulted in a revision to the hospital's cost and revenue workbook. Based on the adjustments made, there was no repayment of DSH funds needed and therefore, no redistribution of funds was required.

Verification 3

DPH Procedures

1. Verify the Medi-Cal Managed Care Inpatient Costs are supported by hospital records by performing the following procedures:

   A. Trace all *Medi-Cal Managed Care Inpatient Days* reported in P14 Schedule 1, 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 Managed Care Inpatient Charges* reported in P14 Schedule 1, 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.

2. Verify the Medi-Cal Managed Care Outpatient Costs are supported by hospital records by tracing *Subtotal Ancillary Charges* for *Medi-Cal Managed Care Outpatient Charges* reported in P14 Schedule 1, 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.

3. Verify the Medi-Cal Psychiatric (Psych) Inpatient Costs are supported by hospital records by performing the following procedures:

   A. Trace all *Medi-Cal Psych Inpatient Days* reported in P14 Schedule 1, 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, 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 Outpatient Costs are supported by hospital records by tracing *Subtotal Ancillary Charges* for *Medi-Cal Psych Outpatient Charges* reported in P14 Schedule 1, 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 Out-Of-State Medicaid Inpatient Costs are supported by hospital records by performing the following procedures:

   A. Trace all *Out-of-State Medicaid Inpatient Days* reported in P14 Schedule 1, 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 *Out-of-State Medicaid Inpatient Charges* reported in P14 Schedule 1, 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 Out-Of-State Medicaid Outpatient Costs are supported by hospital records by tracing *Subtotal Ancillary Charges* for *Out-of-State Medicaid Outpatient Charges* reported in P14 Schedule 1, 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.

7. Verify the Another County's Low Income Health Program (LIHP) Patient Medicaid Coverage Expansion (MCE) Inpatient Costs 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, 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 *Another County's LIHP Patient Inpatient MCE Charges* reported in P14 Schedule 1, 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 Another County's LIHP Patient MCE Outpatient Costs are supported by hospital records by tracing *Subtotal Ancillary Charges* for *Another County's LIHP Patient Outpatient MCE Charges* reported in P14 Schedule 1, 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 MCE Inpatient Costs are supported by hospital records by performing the following procedures:

   A. Trace all *MCE Medical Inpatient Days* reported in P14 Schedule 1, 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 Medical Inpatient Charges* reported in P14 Schedule 1, 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.

10. Verify the MCE Outpatient Costs are supported by hospital records by tracing *Subtotal Ancillary Charges* for *MCE Medical Outpatient Charges* reported in P14 Schedule 1, 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 MCE Medical Federally Qualified Health Center (FQHC) Costs are supported by hospital records by tracing *Subtotal Ancillary Charges* for *MCE Medical FQHC Charges* reported in P14 Schedule 1, 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.

12. Verify the Mental Health MCE Inpatient Costs are supported by hospital records by performing the following procedures:

    A. Trace all *Mental Health MCE Inpatient Days* reported in P14 Schedule 1, 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 MCE Inpatient Charges* reported in P14 Schedule 1, 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 Mental Health MCE Outpatient Costs are supported by hospital records by tracing *Subtotal Ancillary Charges* for *Mental Health MCE Outpatient Charges* reported in P14 Schedule 1, 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 Services Always Certified Public Expenditure (CPE) Based MCE Inpatient Costs 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, 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 *Services Always CPE Based MCE Inpatient Charges* reported in P14 Schedule 1, 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 Services Always CPE Based MCE Outpatient Costs are supported by hospital records by tracing *Subtotal Ancillary Charges* for *Services Always CPE Based MCE Outpatient Charges* reported in P14 Schedule 1, 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 MCE for State Prisoners Inpatient Costs are supported by hospital records by performing the following procedures:

A. Trace all *MCE for State Prisoners Inpatient Days* reported in P14 Schedule 1, 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 State Prisoners Inpatient Charges* reported in P14 Schedule 1, 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.

17. Verify the MCE for County Jail Inmates Inpatient Costs 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, 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, 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 MCE for Prisoners in Another County's Program Inpatient Costs 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, 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 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, 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 by the hospitals.

19. Verify the Medi-Cal Outpatient (OP) Costs (AB 915 Claim) are supported by hospital records by tracing *Subtotal Ancillary Charges* for *Medi-Cal OP Charges (AB 915 Claim)* reported in P14 Schedule 1, 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 Cost-Based Reimbursement Clinics (CBRC) Medi-Cal OP Costs are supported by hospital records by tracing *Subtotal Ancillary Charges* for *CBRC Medi-Cal OP Charges* reported in P14 Schedule 1, 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.

21. Quantify the number of hospitals with a material variance between the reported amounts in the P14 and the sum of verified amounts from Procedures 1 through 20 and the amounts in Instructions to Practitioner step 7. The material variances pertain to the *Total Cost of Care – Medicaid Inpatient (IP)/Outpatient (OP) Services* column in the updated DSH DPH Summary.

    Finding: Of the 21 DPH hospitals included in this review, 1 had a material variance between the reported amounts in the P14 and the sum of verified amounts from Procedures 1 through 20 and the amounts in Instructions to Practitioner step 7 (Total Cost of Care – Medicaid IP/OP Services).

22. Verify the Uninsured Inpatient Costs are supported by hospital records by performing the following procedures:

    A. Trace all *Uninsured Inpatient Days* reported in P14 Schedule 1, 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, 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.

23. Verify the Uninsured Outpatient Costs are supported by hospital records by performing the following procedures:

    A. Trace *Subtotal Ancillary Charges* for *Uninsured Outpatient Charges* reported in P14 Schedule 1, 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, 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.

24. Verify the Health Care Coverage Initiative (HCCI) Inpatient Costs are supported by hospital records by performing the following procedures:

    A. Trace all *HCCI Inpatient Days* reported in P14 Schedule 1, 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, 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.

25. Verify the HCCI Outpatient Costs are supported by hospital records by tracing *Subtotal Ancillary Charges* for *HCCI Outpatient Charges* reported in P14 Schedule 1, 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.

26. Verify the HCCI FQHC Costs are supported by hospital records by tracing *Subtotal Ancillary Charges* for *HCCI FQHC Charges* reported in P14 Schedule 1, 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. Quantify the number of hospitals with a material variance between the reported amounts in the P14 and the sum of verified amounts from Procedures 22 through 26. The material variances pertain to the *Total IP/OP Uninsured Cost of Care* column in the updated DSH DPH Summary.

    Finding: Of the 21 DPH hospitals included in this review, 0 (zero) had a material variance between the reported amounts in the P14 and the sum of verified amounts from Procedures 22 through 26 (Total IP/OP Uninsured Cost of Care).

NDPH Procedures

1. Verify the Hospital Per Diems and Cost-to-Charge Ratios (CCRs) in the Cost and Revenue Workbook (CRW) Cost Tab Column 1 are supported by tracing all Hospital Per Diems and CCRs 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 supporting documentation.

   Finding: Material variance was noted in 2 of the 27 NDPHs; we recorded Per Diems and CCRs to agree with supporting documentation.

2. Verify the Medi-Cal Fee-for-Service (FFS) IP and OP Costs 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: No material exceptions were found as a result of applying the procedure.

   B. Trace *Total Medi-Cal FFS IP/OP Charges* reported in the CRW Cost Tab Column 2a and 2c to the PCSR (FY1 IP Detail Tab, Medi-Cal, Abortion (if applicable), and Genetically Handicapped Persons Program (GHPP) (if applicable) Ancillary Service Totals rows, Amount Billed column, and 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 to inpatient charges.

   Material variance was noted in 1 of the 27 NDPHs for outpatient charges; we recorded the Medi-Cal FFS OP Charges to agree with supporting documentation.

3. Verify the Medi-Cal IP and OP Managed Care Costs 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 IP and OP Psych Costs are supported by the PCSR, hospital provided records, or other identified reports 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: No exceptions were found as a result of applying the procedure.

   B. Trace *Total Medi-Cal Psych IP/OP Charges* in the CRW Cost Tab Column 4a to PCSR FY1 Psych 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 material exceptions were found as a result of applying the procedure.

5. Verify the Medi-Cal IP/OP Dual Eligible Costs 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 material exceptions were found as a result of applying the procedure.

6. Quantify the number of hospitals with a material variance between the reported amounts in the CRW and the sum of verified amounts from Procedures 1 through 5. The material variances pertain to the *Total Cost of Care – Medicaid IP/OP Services* column in the updated DSH NDPH Summary.

   Finding: Of the 27 NDPH hospitals included in this review, 0 (zero) had a material variance between the Total Cost of Care – Medicaid IP/OP Services presented in the CRW and the sum of verified amounts from Procedures 1 through 5.

7. Verify the Uninsured IP and OP Costs are supported by hospital provided records or other identified reports 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.

C. Trace *Total Uninsured IP and OP Costs applicable to Psychiatric Health Facilities* in the CRW Cost Tab Column 9 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 material exceptions were found as a result of applying the procedure.

8. Verify the Section 1011 Uninsured IP and OP Costs 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 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.

9. Quantify the number of hospitals with a material variance between the reported amounts in the CRW and the sum of verified amounts from Procedures 7 and 8. The material variances pertain to the *Total IP/OP Uninsured Cost of Care* column in the updated DSH NDPH Summary.

Finding: Of the 27 NDPH hospitals included in this review, 2 had a material variance between the Total IP/OP Uninsured Cost of Care presented in the CRW and the sum of verified amounts from Procedures 7 and 8.

Verification 4

DPH Procedures

1. Verify the Medi-Cal IP Payment is supported by hospital records or other identified reports by performing the following procedures:

A. Trace *Medi-Cal FFS, Well Baby, Medicare/Medi-Cal Crossover, Carve Out, Administrative and Medicare/Medi-Cal Crossover for DSH Calculation Days* reported in P14 Schedule 1.1 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 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 to the Audited Medicare cost report. If the Audited Medicare cost report is not available, traced 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 Per Diems and CCRs to agree with supporting documentation.

Finding: All 21 DPHs included in this review did not provide their Medicare cost report to support their Per Diems and CCRs; therefore, the alternative procedures were performed.

a. If either the 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.

    ***Finding*:** Of the 21 DPHs included in this review, 8 had variances; we recorded Per Diems and CCRs to agree with supporting documentation.

    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*:** See Appendix C for reasons provided by the hospitals.

D. Compare the *Percentage Reduction for State Only Medi-Cal Claims (from Paid Claims Data)* reported in P14 Schedule 2.1, Step 1, to "FY 1112 SOC% for DOF" document provided by DHCS – Safety Net Financing Division. If variance noted, record percentage to agree with supporting documentation.

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

E. Trace *Medi-Cal Share of Cost Charges* reported in P14 Schedule 3.1, Medi-Cal section, 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, 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, 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. Verify the Dual Eligibles Medicare and Medicaid Payments 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, 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, 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: Material variance was noted in 1 of the 21 DPHs; we recorded all Medicare/Medi-Cal payments to agree with supporting documentation.

3. Verify the CBRC (OP Hospital Services) 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, 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.

4. Verify the Medi-Cal Psych Payment 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, 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, 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, to hospital provided support. If variance noted, record payments to agree with supporting documentation.

   Finding: No Total Computable Supplemental Psych Payments were reported in P14 Schedule 3.1 by the hospitals.

D. 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, 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 *Patient Payments Related to Medi-Cal Psych IP and OP hospital costs* reported in P14 Schedule 3.1, Medi-Cal Psych section, 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 Out-of-State Medicaid Payments are 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, 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 *Patient Payments Related to Out-of-State Medicaid Hospital Costs* reported in P14 Schedule 3.1, Out-of-State Medicaid section, 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 LIHP Another County's MCE Enrollee (Including Prisoners) 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, 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 *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, to hospital provided support. If variance noted, record payments to agree with supporting documentation.

   Finding: None of the 21 DPH hospitals reported Amounts Certified to an LIHP for inclusion in the LIHP's MCE claim; therefore the procedure was not performed.

   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, to hospital provided support. If variance noted, record payments to agree with supporting documentation.

Finding: None of the 21 DPH hospitals reported Payment received from the CDCR or CPHCS for Prisoners enrolled in another County's MCE Program; therefore the procedure was not performed.

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, 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.

7. Verify the County Rate Based MCE Program Hospital Medical (Not Cost Reimbursed) for hospitals that elect rate based payments is supported by hospital records by performing the following procedures:

   A. Trace *Patient Payments Related to MCE DSH eligible Hospital Medical Services* reported in P14 Schedule 3.1, MCE section, to hospital provided support. If variance noted, record payments to agree with supporting documentation.

   Finding: None of the 21 DPH hospitals elected rate based payments; therefore the procedure was not performed.

   B. Trace *Rate Based Payments from LIHP MCE Plan for DSH eligible Hospital Medical Services* reported in P14 Schedule 3.1, MCE section, to hospital provided support. If variance noted, record payments to agree with supporting documentation.

   Finding: None of the 21 DPH hospitals elected rate based payments; therefore the procedure was not performed.

8. Quantify the number of hospitals with a material variance between the reported amounts in the P14 and the sum of the verified amounts from Procedures 1 through 7. The material variances pertain to the *Regular IP/OP Medicaid FFS Rate Payments* column in the updated DSH DPH Summary.

   Finding: Of the 21 DPH hospitals included in this review, 1 had a material variance between the reported amounts in the P14 and the sum of verified amounts from Procedures 1 through 7 (Regular IP/OP Medicaid FFS Rate Payments).

9. Verify the IP/OP Medicaid Managed Care Organization (MCO) Payments are 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 each fiscal period (7/1/11 – 9/30/11 and 10/1/11 – 6/30/12) to hospital provided support. If variance noted, record payments to agree with supporting documentation.

   Finding: Material variance was noted in 1 of the 21 DPHs; we recorded Medi-Cal Managed Care IP and OP Payments to agree with supporting documentation.

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

Finding: Material variance was noted in 1 of the 21 DPHs; we recorded SPD Managed Care Payment Less Physician and Non-Hospital Portion to agree with supporting documentation.

D. Trace *Total Hospital Fee Payment – Managed Care Component* reported in P14 Schedule 3.1, Medi-Cal Managed Care section, for each fiscal period (7/1/11 – 9/30/11 and 10/1/11 – 6/30/12) 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. Quantify the number of hospitals with a material variance between the reported amounts in the P14 and the sum of the verified amount from Procedure 9. The material variances pertain to the *IP/OP Medicaid MCO Payments* column in the updated DSH DPH Summary.

    Finding: Of the 21 DPH hospitals included in this review, 2 had a material variance between the reported amounts in the P14 and the sum of verified amounts from Procedure 9 (IP/OP Medicaid MCO Payments).

11. Verify the Senate Bill (SB) 1732 Construction and Renovation Reimbursement Program (CRRP) payment is supported by hospital records by tracing *SB 1732 Payments* reported in P14 Schedule 3.1, Affecting Uninsured section, 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.

12. Quantify the number of hospitals with a material variance between the reported amounts in the P14 and the verified amount from Procedure 11 plus the AB 915 OP Payment. The material variances pertain to the *Supplemental & Enhanced IP/OP Medicaid Payments* column in the updated DSH DPH Summary.

    Finding: Of the 21 DPH hospitals included in this review, 0 (zero) had a material variance between the reported amounts in the P14 and the verified amount from Procedure 11 plus the AB 915 OP Payment (Supplemental & Enhanced IP/OP Medicaid Payments).

13. Verify the Uninsured Revenues 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, 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.

14. Recalculate *HCCI Revenue* based on DHCS' HCCI calculation methodology (HCCI tab in Data Location file) and record in the HCCI Revenue column in the updated DSH DPH Summary.

    Finding: No updates were required as a result of applying the procedure.

15. Quantify the number of hospitals with a material variance between the reported amounts in the P14 and the sum of verified amounts from Procedures 13 and 14. The material variances pertain to the *Total IP/OP Indigent Care/Self-Pay Revenues* column in the updated DSH DPH Summary.

    Finding: Of the 21 DPH hospitals included in this review, 0 (zero) had a material variance between the reported amounts in the P14 and the sum of verified amounts from Procedures 13 and 14 (Total IP/OP Indigent Care/Self-Pay Revenues).

16. Verify the Total Applicable Section 1011 Payments are supported by hospital records by tracing *Section 1011 Payments* reported in P14 Schedule 3.1, Affecting Uninsured section, 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.

17. Quantify the number of hospitals with a material variance between the reported amounts in the P14 and the verified amount from Procedure 16. The material variances pertain to the *Total Applicable Section 1011 Payments* column in the updated DSH DPH Summary.

    Finding: Of the 21 DPH hospitals included in this review, 0 (zero) had a material variance between the reported amounts in the P14 and the verified amount from Procedure 16 (Total Applicable Section 1011 Payments).

<u>NDPH Procedures</u>

1. Verify the Total Regular IP/OP Medicaid FFS Payments are supported by hospital records or other identified reports 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 "Psych 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, Rows 1b(1) and 1b(2) to PCSR, FY1 IP Summary and OP Summary tabs for the Medi-Cal, Abortion (if applicable), and GHPP (if applicable) total amounts from "Patient Liability", "Other Coverage", and "Amount Paid" columns. For inpatient payments, include the Cost Settlement from DHCS on the 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 2 of the 27 NDPHs for inpatient payments; we recorded the Regular IP Medicaid FFS Payments to agree with supporting documentation.

No material exceptions were found as a result of applying the procedure to outpatient payments.

2. Verify the Medicaid Payments from Other States and Non-States IP/OP Medicaid Payments are 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 material exceptions were found as a result of applying the procedure.

3. Verify the Medicare Payments for Dual Eligibles are supported by hospital records by tracing the *Payments for Dual Eligibles with both Medicare and Medicaid* in the CRW Revenue Tab Category 5 to hospital provided support. Payments should include 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 3 of the 27 NDPHs; we recorded the Medicare Payments for Dual Eligibles to agree with supporting documentation.

4. Quantify the number of hospitals with a material variance between the reported amounts on the CRW and the sum of verified amounts from Procedures 1 through 3. The material variances pertain to the *Regular IP/OP Medicaid FFS Rate Payments* column in the updated DSH NDPH Summary.

   Finding: Of the 27 NDPH hospitals included in this review, 5 had a material variance between the Regular IP/OP Medicaid FFS Rate Payments presented in the CRW and the sum of verified amounts from Procedures 1 through 3.

5. Verify the IP/OP Medicaid MCO Payments are 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 reported amounts in the CRW and the verified amount from Procedure 5. The material variances pertain to the *IP/OP Medicaid MCO Payments* column in the updated DSH NDPH Summary.

   Finding: Of the 27 NDPH hospitals included in this review, 0 (zero) had a material variance between the IP/OP Medicaid MCO Payments presented in the CRW and the verified amount from Procedure 5.

7. Verify the Total IP/OP Indigent Care/Self-Pay Revenues are supported by hospital records 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 3 of the 27 NDPHs; we recorded the Total IP/OP Indigent Care/Self-Pay Revenues to agree with supporting documentation.

8. Quantify the number of hospitals with a material variance between the reported amounts in the CRW and the verified amount from Procedure 7. The material variances pertain to the *Total IP/OP Indigent Care/Self-Pay Revenues* column in the updated DSH NDPH Summary.

   Finding: Of the 27 NDPH hospitals included in this review, 3 had a material variance between the Total IP/OP Indigent Care/Self-Pay Revenues presented in the CRW and the verified amount from Procedure 7.

9. Verify the Total Applicable Section 1011 Payments are supported by hospital records 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 27 NDPHs; we recorded the Total Applicable Section 1011 Payments to agree with supporting documentation.

10. Quantify the number of hospitals with a material variance between the reported amounts in the CRW and the verified amount from Procedure 9. The material variances pertain to the *Total Applicable Section 1011 Payments* column in the updated DSH NDPH Summary.

    Finding: Of the 27 NDPH hospitals included in this review, 1 had a material variance between the Total Applicable Section 1011 Payments presented in the CRW and the verified amount from Procedure 9.

Verification 5

DPH and NDPH Procedure:

1. Obtain California's state plan rate year 2011-12 DSH audit protocol (protocol) and compare to requirements defined in Title 42, *Code of Federal Regulations* (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: DHCS developed a "DSH Audit and Reporting Protocol for State Plan Rate Year 2011-12" (protocol) for use by DSH hospitals. This protocol was to be used in conjunction with the hospital's cost and revenue workbook, which include additional instructions, source documents, and categories of costs and revenues that are part of the protocol. The protocol includes general instructions, data sources, and identifies cost reports and hospital records to determine costs and revenues eligible for inclusion in developing the hospital specific

DSH limit. Further, per the protocol, hospitals are responsible for maintaining their own supporting documents and records related to all information reported in their cost and revenue workbook. DHCS and the hospitals were 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 50 hospitals (21 DPHs and 29 NDPHs). 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 D, 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 maintains a record retention policy that establishes the retention period for files maintained by the state and hospitals. Further, the policy also identifies the particular records that are required to be maintained by the state. DHCS does separately document and retain cost and payment information and records submitted by the hospitals or compiled by their department. 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 Procedure:

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

Table 1: Costs and Payments Included in the Calculation of Each Hospital's DSH Payment Limit

DPH	NDPH
Regular Inpatient (IP) and Outpatient (OP) Medicaid FFS Rate Payments	
Medi-Cal IP Payments Medi-Cal OP Payments Dual Eligibles Medicare and Medicaid Payments Medicare/Medi-Cal Crossover Payments CBRC (OP Hospital Services) Medi-Cal Psych Payments Out-of-State Medicaid Payments LIHP Another County's MCE Enrollee (Including Prisoners) County Rate Based MCE Program Hospital Medical (Not Cost Reimbursed) MCE Medi-Cal Services MCE Mental Health Services MCE Services Always CPE Based	IP and OP Medicaid Payments for Psychiatric Services (including Short-Doyle/Medi-Cal) Regular IP Medicaid FFS Payments Regular OP Medicaid FFS Payments Medicaid Payments from Other States and Non-State IP and OP Medicaid Payments Payments for Dual Eligibles
IP and OP Medicaid Managed Care Organization (MCO) Payments	
IP and OP Medicaid MCO Payments	IP and OP Medicaid MCO Payments
Supplemental and Enhanced IP and OP Medicaid Payments	
SB 1732 CRRP Outpatient DSH Payments AB 915 OP Payments	Supplemental and Enhanced IP and OP Medicaid Payments
Total Cost of Care for Medicaid IP and OP Services	
Medi-Cal FFS IP Costs Medicare/Medi-Cal Crossover IP Costs Medicare/Medi-Cal Crossover OP Costs 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 MCE IP Costs MCE OP Costs MCE Medical FQHC Costs Mental Health MCE IP Costs Mental Health MCE OP Costs Services Always CPE Based MCE IP Costs Services Always CPE Based MCE OP Costs MCE for State Prisoners IP Costs MCE for County Jail Inmates IP Costs MCE for Prisoners in Another County's Program IP Costs Medi-Cal OP Costs (AB915 Claim) CBRC Medi-Cal OP Costs	Medi-Cal IP FFS Costs Medi-Cal OP FFS Costs Medi-Cal IP and OP Managed Care Costs Medi-Cal IP and OP Psych Costs and Medi-Cal Short-Doyle Costs Medi-Cal IP and OP Dual Eligible Costs
Total IP and OP Indigent Care/Self-Pay Revenues	
Uninsured Revenues HCCI Revenues Safety Net Care Pool (SNCP) (Hospital costs Claimed)	Total IP and OP Indigent Care/Self-Pay 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 HCCI IP Costs HCCI OP Costs HCCI FQHC Costs	Uninsured IP and OP Costs Uninsured IP and OP Costs applicable to Psychiatric Health Facilities 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 state plan rate year 2011-12.

Though the Department of Finance (Finance) and the Department of Health Care Services (DHCS) are both part of the State of California's Executive Branch, Finance provides objective audits by establishing and maintaining appropriate safeguards to mitigate organizational impairment of independence so reliance can be placed on its reports. Some examples of Finance's independence safeguards include:

- Finance staff does not report to, nor are they supervised by, DHCS.
- Finance staff is 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 in attitude and appearance 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 generally accepted government auditing standards.

Original signed by:

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

APPENDIX B

Instructions to Practitioner

1. The following seven columns from the Disproportionate Share Hospital (DSH) Annual Report provided by the Department of Health Care Services (DHCS) will be included in the engagement:

    - Regular Inpatient (IP)/ Outpatient (OP) Medicaid FFS Rate Payments
    - IP/OP Medicaid Managed Care Organization Payments
    - Supplemental/Enhanced IP/OP Medicaid Payments
    - Total Cost of Care – Medicaid IP/OP Services
    - Total IP/OP Indigent Care/Self Pay Revenues
    - Total Applicable Section 1011 Payments
    - Total IP/OP Uninsured Cost of Care

2. Finance will provide DHCS with updated DSH 2011-12 Designated Public Hospital (DPH) Annual Report, FFY12 tab and DSH 2011-12 Non-Designated Public Hospital (NDPH) Annual Report, ReportY1 and ReportY2 tabs with cost and revenue data verified in performing the agreed upon procedures listed under Verifications 2, 3, and 4.

3. Finance will provide DHCS with a summarized report of the results of the Agreed-Upon Procedures (AUPs) performed to verify the six verifications.

4. Apply the AUPs only to Cost and Revenue Workbooks, P14 Workbooks, complete DSH Annual Reports, and Safety Net Care Pool (SNCP) support provided by DHCS on or before July 31, 2015.

5. The amount reported in the Medi-Cal OP Payment column in the DSH DPH Annual Report, FFY12 tab will be taken from each hospital's PCSR, FY1 OP Summary tab, Medi-Cal total of the Amount Paid column.

6. The amount reported in the SNCP (Hospital costs Claimed) column in DSH DPH Annual Report, FFY12 tab for each hospital will be taken from DHCS' FY 1112 DSH and SNCP Claiming bridging document.

7. The amounts reported in the Medi-Cal Fee-for-Service IP Costs, Medicare/Medi-Cal Crossover IP Costs, and Medicare/Medi-Cal Crossover OP Costs columns in the DSH DPH Annual Report, FFY12 tab for each hospital will be taken from the Total Costs row in the P14 Schedule 1.

8. The amount reported in the Supplemental/Enhanced IP/OP Medicaid Payments column in DSH NDPH Annual Report, ReportY1 and ReportY2 tabs for each hospital will be taken from internal records provided by DHCS.

9. The amount reported in the OP DSH Payments column in DSH DPH Annual Report, FFY12 tab for each hospital will be taken from internal records provided by DHCS.

10. The amounts reported in the Medicaid Coverage Expansion (MCE) Payments (Cost Based) for Medical, Mental Health Services and MCE Payments (CPE Based) for Services Always, State Prisoner, County Jail Prisoner columns in the DSH DPH Annual Report, FFY12 tab for each hospital will be taken from the Total Costs row in the P14 Schedule 1.

11. The amount reported in the MCE Medical Federally Qualified Health Center Payments column in the DSH DPH Annual Report, FFY12 tab for each hospital will be taken from the Total Costs row in the P14 Schedule 1, if the hospital elected rate based payments. If the hospital did not elect rate based payments, record zero.

Variations between the filed Medi-Cal and Medicare Cost Reports For the Designated Public Hospitals 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	Arrowhead 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	Riverside County Regional Medical Center	
4	San Joaquin General Hospital	
5	Kern Medical Center	
6	Natividad Medical Center	
7	UC Davis Medical Center	
8	UC San Francisco Medical Center	
9	San Francisco General Hospital	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.
10	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 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. Physician reimbursement for secondary insurances is done through Medicare rather than the subsidiaries. Therefore, the allocation rate differs since Medi-Cal does not make this payment for Part A beneficiaries.
11	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.
12	Santa Clara Valley Medical Center	

13	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 provided the following reasons as some of the major variations between the filed Medi-Cal and Medicare cost reports: Hospital excluded Graduate Medical Education (GME) costs on the filed Medicare cost report. CMS has established reimbursement limits for GME costs under the Medicare program. GME costs include the direct cost for interns and residents, teaching physicians, plus allocated overhead costs. The fully allocated costs are removed from the cost report via the step down process; the GME costs are not included in the per diem and cost-to-charge ratios (CCRs). GME costs are included on the Medi-Cal cost report; the fully allocated GME costs are included in the per diem and CCRs. Physician costs are subjected to a reasonable cost equivalent (RCE) limit by specialty that is established by CMS. On the Medicare cost report, the cost amount for physician compensation that is in excess of the RCE limit is disallowed. The RCE limit does not apply to costs of physician compensation by providers which are paid under Inpatient Prospective Payment System or as GME costs. As a result, these costs are added back through adjustments to expenses (Worksheet A-8). Physicians' GME costs are reported to GME cost centers and subjected to the "Other" specialty RCE limit. On the Medi-Cal cost report, the amounts in excess of the RCE limit are disallowed and not included in the per diems or CCRs. Further, the GME costs are reported to the "where-worked" cost center rather than the GME cost center and are subjected to the physician's specialty RCE limit rather than the "Other" limit. Pension bond expense, which is based on Medicare regulations, can be amortized on an accelerated schedule versus the standard fifteen years on the filed Medicare cost report. Pension bond expense is amortized using the standard amortization schedule on the filed Medi-Cal cost report.
14	LAC - Olive View Medical Center	
15	LAC - Rancho Los Amigos	
16	LAC - USC Medical Center (LAC + USC)	
17	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. .
18	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
19	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.
20	UCLA Santa Monica	Days reported in the filed Medi-Cal cost report are adjusted to agree with days reported on the Paid Claims Summary Report.
21	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.

APPENDIX D

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) regulations 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 2011-12.

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.

Summary Report – Overall Assessment of the Six Verifications

Verification 1
Each hospital that qualifies for a Disproportionate Share Hospital (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]

Overall Verification 1 Results

We prepared an overall assessment for Verification 1 based on the results of the procedures to note whether the Department of Health Care Services' (DHCS) procedures satisfy the federal regulation in section 1923 of the Social Security Act (Act).

Findings: All 50 hospitals (21 Designated Public Hospitals [DPHs] and 29 Non-Designated Public Hospitals [NDPHs]) that received DSH payments during Medicaid State plan rate year 2011-12, qualified for a DSH payment by meeting either 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, titled, Medi-Cal Hospital/Uninsured Care Demonstration, as amended October 5, 2007.

Further, specific to NDPHs, hospitals that qualified were allowed to retain their full DSH payment.

Of the 29 NDPHs, 27 provided hospital specific cost and revenue data to support that the payment was available to offset its uncompensated care costs for furnishing 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. The other two NDPH hospitals were excluded from Verifications 2, 3, and 4 agreed-upon procedures.

DHCS confirmed all private hospitals who received DSH payments returned their DSH payment and are excluded from the DSH Audit and Reporting requirements.

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]

Overall Verification 2 Results

We prepared an overall assessment for Verification 2 based on the results of the procedures to note whether DHCS' procedures satisfy the federal regulation in section 1923 of the Act and identify any hospitals that exceeded their hospital-specific DSH payment limit.

Findings: We compared the total DSH payment received by all hospitals to the uncompensated care costs (UCC) calculated by DHCS' annual report used to capture applicable costs and payments for DSH reporting purposes and calculated the hospitals' DSH limit. DSH payments made to all 21 DPHs did not exceed the hospital-specific DSH payment limit. However, DSH payments made to 3 of 27 NDPHs exceeded the hospital-specific DSH payment limit.

The DSH overpayments noted for Eastern Plumas Health Care and Trinity Hospital were significantly impacted by the reporting of reimbursable bad debts in the *Payments for Dual Eligibles with both Medicare and Medicaid*. Finance recorded the payments for dual eligibles as instructed in the AUP (Verification 4, NDPH Procedure number 3).

The DSH overpayment noted for Pioneers Memorial Hospital was caused by the recording of per diems, cost-to-charge ratios, and additional Medi-Cal Fee-for-Service (FFS) IP charges to agree with hospital provided support. These changes reduced the hospital's originally reported Medi-Cal FFS IP costs and uninsured costs.

Further, DHCS determined no repayment and redistribution of funds was needed for the hospital whose fiscal year 2010-11 DSH payment exceeded its individual UCC limit. Per DHCS, subsequent to the issuance of the FY 2010-11 DSH AUP Report, DHCS and Trinity Hospital worked together to identify errors in the hospital's reported amounts which resulted in a revision to the hospital's cost and revenue workbook. Based on the adjustments made, there was no repayment of DSH funds needed and therefore, no redistribution of funds was required.

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]

Overall Verification 3 Results

We prepared an overall assessment for Verification 3 based on the results of the procedures to note whether DHCS' procedures satisfy the federal regulation in section 1923 of the Act.

Findings: All 48 hospitals (21 DPHs and 27 NDPHs) reviewed provided documentary support for their uncompensated care costs for Medicaid eligible individuals and individuals with no third-party coverage for IP/OP hospital services they received. Material variances were noted between reported uncompensated care costs and hospital provided support documentation.

Further, of the 27 NDPHs 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 16 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 Centers for Medicare and Medicaid Services (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.

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]

Overall Verification 4 Results

We prepared an overall assessment for Verification 4 based on the results of the procedures to note whether DHCS' procedures satisfy the federal regulation in section 1923 of the Act.

Findings: All 48 hospitals (21 DPHs and 27 NDPHs) reviewed and DHCS were able to provide documentary support for any Medicaid payments (including regular Medicaid FFS rate payments, supplemental/enhanced Medicaid payments, and Medicaid managed care organization payments) made to the hospital for furnishing IP/OP hospital services to Medicaid eligible individuals, which are in excess of the Medicaid incurred costs of such services. Further, we verified these Medicaid payments were applied against the uncompensated care costs of furnishing IP/OP hospital services to individuals with no source of third-party coverage for such services. Material variances were noted between reported Medicaid payments and hospital provided support documentation.

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]

Overall Verification 5 Results

We prepared an overall assessment for Verification 5 based on the results of the procedures to note whether DHCS' procedures satisfy the federal regulation in section 1923 of the Act.

Findings: DHCS developed a "DSH Audit and Reporting Protocol for State Plan Rate Year 2011-12" (protocol) for use by DSH hospitals. This protocol was to be used in conjunction with the hospital's CRW and P14 workbook, which include additional instructions, source documents, and categories of costs and revenues that are part of the protocol. The protocol includes general instructions, data sources, and identifies cost reports and hospital records to determine costs and revenues eligible for inclusion in developing the hospital specific DSH limit. Further, per the protocol, hospitals are responsible for maintaining their own supporting documents and records related to all information reported in their cost and revenue workbook. DHCS and the hospitals were 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 50 hospitals (21 DPHs and 29 NDPHs). Two of the NDPHs did not provide documentation because one hospital has closed operations and the other opted not to provide documentation.

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]

Overall Verification 6 Results

We prepared an overall assessment for Verification 6 based on the results of the procedures to note whether DHCS' procedures satisfy the federal regulation in section 1923 of the Act.

Findings: DHCS has a methodology for calculating each hospital's DSH payment limit as required in Section 1923(g)(1) of the Social Security Act and Title 42, CFR Part 455.304(d)(6). We also identified the allowable costs and payments used by the state to calculate each hospital's DSH payment limit. 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."