DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

MAY 30 2003

TO: Thomas Scully
Administrator
Centers for Medicare and Medicaid Services

FROM: Dennis J. Duquette
Acting Principal Deputy Inspector General

SUBJECT: Audit of California's Medicaid Inpatient Disproportionate Share Hospital Payments for Los Angeles County Hospitals, State Fiscal Year 1998 (A-09-02-00071)

This memorandum is to alert you to the issuance of the subject audit report within 5 business days from the date of this memorandum. A copy of the report is attached. The audit was conducted at the request of the Centers for Medicare and Medicaid Services (CMS) as part of a multi-state initiative focusing on Medicaid disproportionate share hospital (DSH) payments made under section 1923 of the Social Security Act (the Act), as amended. The objective of our audit was to verify that state fiscal year (SFY) 1998 DSH payments to the Los Angeles County (LAC) hospitals did not exceed the hospital specific limit (the limit) as imposed by the Omnibus Budget Reconciliation Act (OBRA) of 1993.

Our audit showed that the California Department of Health Services (the state) made DSH payments to four of the six LAC hospitals that exceeded their SFY 1998 limits. The limits as determined by the state did not comply with the apparent purpose of OBRA 1993 and CMS requirements and implementing guidance. Excess DSH payments totaling over $195 million ($98 million federal share) were made because the state overstated the limits. The limits were overstated because the state:

- used projected amounts instead of actual incurred costs and payments for the year in which hospital services were rendered,
- did not limit total operating expenses to amounts that would be allowable under Medicare cost principles, and
- inappropriately included bad debts as an additional operating expense.

We recommended the state work with CMS to address and resolve more than $98 million representing the federal share of DSH payments in excess of the limits for four LAC hospitals. In a subsequent report on the California Medicaid Inpatient DSH program, we will include information and recommendations pertaining to state processes for determining the limit. We will also include other matters pertaining to the California Medicaid state plan.

Except for the finding on bad debts, the state disagreed with the findings based on its interpretation of OBRA 1993 and CMS's implementing guidance for OBRA 1993. Regarding our recommendation, the state indicated a willingness to work with the Federal Government on the issues related to the findings. The state agreed that bad debts were counted twice in the current state plan methodology and stated that it will amend the state plan to eliminate any double counting of bad debts in the future.

Where appropriate, we made changes in the report to reflect the state's comments. However, some of the state's comments to our findings were inconsistent with federal statutory or regulatory requirements or other program guidance. We summarized the state's comments and included the Office of Inspector General's response to those comments in a separate section of the report. We also included the state's detailed comments to our draft report as an appendix to the report.

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

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

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

June 5, 2003

Report Number: A-09-02-00071

Mr. Stan Rosenstein
Assistant Deputy Director
Medical Care Services
California Department of Health Services
714 P Street, Room 1253
Sacramento, California 95814

Dear Mr. Rosenstein:

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

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

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR part 5.) As such, within 10 business days after the final report is issued, it will be posted on the Internet at http://oig.hhs.gov/.

To facilitate identification, please refer to report number A-09-02-00071 in all correspondence relating to this report.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:

H. Stephen Deering
Acting Regional Administrator
Centers for Medicare and Medicaid Services
Region IX
75 Hawthorne Street, Suite 408
San Francisco, California 94105

cc: w/Enclosure

H. Stephen Deering, Acting Regional Administrator, CMS, Region IX

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF CALIFORNIA'S MEDICAID INPATIENT DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR LOS ANGELES COUNTY HOSPITALS STATE FISCAL YEAR 1998

JANET REHNQUIST
Inspector General

May 2003
A-09-02-00071

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

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

OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

In 1965, the Congress established the Medicaid[1] program as a jointly funded federal and state program providing medical assistance to qualified low-income people. The Omnibus Budget Reconciliation Act (OBRA) of 1981 established the disproportionate share hospital (DSH) program by adding section 1923 to the Social Security Act (the Act). Section 1923 required state Medicaid agencies to make additional payments to hospitals serving disproportionate numbers of low-income patients with special needs. The OBRA 1993 amended section 1923 of the Act to limit DSH payments to the amount of incurred uncompensated care costs (UCC).

The UCC was limited to the costs of medical services provided to Medicaid and uninsured patients less payments received for those patients excluding Medicaid DSH payments. For state fiscal years (SFY) effective on or after July 1, 1997, payments to all hospitals were limited to 100 percent of UCC with a special provision that allowed payments up to 175 percent of UCC to those public hospitals qualifying as "high DSH" in the state of California.[2] The county of Los Angeles owned and operated six hospitals that were designated as high DSH for SFY 1998.

OBJECTIVE

Our objective was to verify that SFY 1998 DSH payments to the six Los Angeles County (LAC) hospitals did not exceed the hospital specific limits (the limits) as imposed by OBRA 1993.

SUMMARY OF FINDINGS

Our audit showed that the California Department of Health Services (the state) made DSH payments to four of the six LAC hospitals that exceeded their SFY 1998 limits. The limits as determined by the state did not comply with the apparent purpose of OBRA 1993 and the Centers for Medicare and Medicaid Services (CMS) requirements and implementing guidance. Excess DSH payments totaling over $195 million ($98 million federal share) were made because the state overstated the limits. The limits were overstated because the state:

- used projected amounts instead of actual incurred costs and payments for the year in which hospital services were rendered,
- did not limit total operating expenses to amounts that would be allowable under Medicare cost principles, and

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

[2] For SFYs beginning after September 30, 2002, the DSH payment limit was raised from 100 to 175 percent of UCC for public hospitals in all states, except California, for a 2-year period. For California, the 175 percent DSH limit for public hospitals would continue for an indefinite time period.

- inappropriately included bad debts as an additional operating expense.

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

RECOMMENDATION

We recommend the state work with CMS to address and resolve more than $98 million representing the federal share of DSH payments in excess of the limits for four LAC hospitals.

In a subsequent report on the California Medicaid Inpatient DSH program, we will include information and recommendations pertaining to state processes for determining the limit. We will also include other matters pertaining to the California Medicaid state plan.

SYNOPSIS OF STATE'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

Except for the finding on bad debts, the state disagreed with the findings based on its interpretation of OBRA 1993 and CMS's implementing guidance for OBRA 1993. Regarding our recommendation, the state indicated a willingness to work with the Federal Government on the issues related to the findings. The state agreed bad debts were counted twice in the current state plan methodology and it would amend the state plan to eliminate any double counting of bad debts in the future.

Where appropriate, we made changes in the report to reflect the state's comments. However, some of the state's comments to our findings were inconsistent with federal statutory or regulatory requirements or other program guidance. We summarized the state's comments and included the Office of Inspector General's response to those comments in a separate section of the report. We also included the state's detailed comments to our draft report as an appendix to this report.

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INTRODUCTION

BACKGROUND

In 1965, the Congress established the Medicaid[1] program as a jointly funded federal and state program providing medical assistance to qualified low-income people. At the federal level, the program is administered by the Centers for Medicare and Medicaid Services (CMS), an agency of the Department of Health and Human Services (HHS). Within the broad legal framework, each state designs and administers its Medicaid program and is required to submit state Medicaid plan amendments for CMS approval.

FEDERAL STATUTES

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

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

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

CALIFORNIA MEDICAID INPATIENT DSH PROGRAM

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

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

[2] For SFYs beginning after September 30, 2002, the DSH payment limit was raised from 100 to 175 percent of UCC for public hospitals in all states, except California, for a 2-year period. For California, the 175 percent DSH limit for public hospitals would continue for an indefinite time period.

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

Funding Through Intergovernmental Transfers

Both public and private hospitals were eligible to receive DSH funds but only public entities were required to finance the nonfederal share of DSH funds through an intergovernmental transfer (IGT) to the state. Public entities consisted of counties, cities, University of California, local health care districts, local health authorities, or any other political subdivision of the state of California. The state collected the mandatory IGT funds from public entities for deposit into the "Medi-Cal Inpatient Payment Adjustment Fund." The state distributed federal matching funds and the nonfederal share as DSH payments to both public and private hospitals. For a diagram of the SFY 1998 funding of the DSH program and payment distribution, see APPENDIX A.

Hospital Specific Limit Methodology

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

The state's methodology estimated each hospital's current year operating costs and payments from uninsured patients by using historical operating costs and payments from uninsured patients that were projected up to 3 years based on the Medicare hospital market basket index. As illustrated in Figure 1, the state calculated the UCC as the unreimbursed costs related to providing services to Medicaid, county indigent, and uninsured patients plus demonstration project expenses, if applicable, net of Medicaid payments and projected payments for services rendered to uninsured patients. Costs related to Medicaid, county indigent, and uninsured patients were calculated as the pro rata share of projected total hospital expenses.

For Los Angeles County (LAC) hospitals only, the state's UCC formula included additional demonstration project expenses. These expenses, LAC's share of IGTs used to fund the nonfederal share for federal matching of DSH payments to private hospitals, were included through a Medicaid demonstration project waiver that began in SFY 1995. See the **COUNTY OF LOS ANGELES DEMONSTRATION PROJECT** section for more discussion.

Figure 1: ***The State's SFY 1998 Formula for the UCC***

$$\left(\text{Projected Total Hospital Expenses} \times \text{Patient Mix Ratio*}\right) + \text{Demonstration Project Expenses **} - \text{Medicaid and Projected Uninsured Payments} = \text{UCC}$$

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

*** Demonstration Project Expenses = Additional expense applicable only to LAC Hospitals*

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

The state determined the DSH base payments for the year based on the type of hospital (e.g., teaching hospital, children's hospital, acute psychiatric hospital), the low-income number,[3] and 80 percent of the annualized Medicaid inpatient days for the prior calendar year (CY). In addition to the DSH base payments, one or more supplemental DSH payments were made according to the California Medicaid state plan (state plan). The DSH payments were adjusted based on the state plan requirements. One of the adjustments was to ensure that payments did not exceed the limit.

DISTRIBUTION OF SFY 1998 DSH PAYMENTS

For SFY 1998, the state made DSH payments totaling over $2.61 billion. Of the total DSH payments, the federal share was over $1.33 billion and the nonfederal share was over $1.28 billion. The federal share was based on federal financial participation (FFP) rates of 50.23 percent and 51.23 percent. The following table shows the SFY 1998 state distribution of DSH payments for public and private hospital categories.

Table 1: *Distribution of SFY 1998 DSH Payments*

Hospital Categories	No. of Hospitals	Total DSH Payments	Percent of Total
Public			
Non-high DSH	24	$ 106,794,087	4 %
High DSH (Excludes LAC Hospitals)	18	961,695,970	37
LAC Hospitals[4]	**6**	**996,511,518**	**38**
Subtotal for Public	48	2,065,001,575	79
Private – Non-high DSH	74	549,157,752	21
Total	122	$2,614,159,327	100 %

COUNTY OF LOS ANGELES DEMONSTRATION PROJECT

In February 1996, the state applied under section 1115 of the Act for a Medicaid demonstration project for the county of Los Angeles (the waiver). The Secretary of HHS approved the waiver in April 1996 for a 5-year period beginning with SFY 1995. The purpose of the waiver was to

[3] The low-income number was defined as the percentage of Medicaid revenues to total revenues, plus the percentage of the hospital's charges for charity care to total hospital charges, rounded down to the nearest whole number.

[4] The LAC hospitals were designated high DSH.

help financially stabilize LAC's public health care system and assist in the process of restructuring the health care delivery system to rely more on primary and outpatient care. The waiver expanded the type of expenditures that qualify for federal matching funds under Medicaid.

One of the significant provisions of the waiver related to the calculation of the DSH limit for LAC hospitals. This provision allowed the state to recognize, as an additional DSH Medicaid/uninsured expense, LAC's share of IGTs used to fund the nonfederal share for federal matching of DSH payments to private hospitals. This amount was referred to as demonstration project expenses in the state's UCC formula. In January 2001, the state received approval for an additional 5-year extension to the waiver. Notably, the provision for the additional DSH Medicaid/uninsured expense was not included.

Other key provisions in the waiver that expanded the type of expenditures that qualify for federal matching funds under Medicaid included:

- administrative costs for project administration,

- costs incurred for outpatient services to the indigent provided at county-operated and contract clinics for primary and mental health care, and

- payments from the Supplemental Project Pool of up to $125 million for each SFY from 1996 through 2000, if LAC rendered at least 450,000 outpatient clinic visits annually to Medicaid and indigent patients.

Los Angeles County Hospitals

The county of Los Angeles owned and operated six hospitals that were designated as high DSH for SFY 1998. They were LAC+USC Healthcare Network, Martin Luther King/Drew Medical Center, Harbor/UCLA Medical Center, Olive View/UCLA Medical Center, Rancho Los Amigos National Rehabilitation Center, and High Desert Hospital.

Recoupment of Overpayments

State laws and the state plan included provisions to recover, withhold, or recoup overpayments. Section 14105.98(r)(1) of the California Welfare and Institutions Code stated:

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

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

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

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

LITIGATION SETTLEMENT

On January 10, 2002, the state of California announced a tentative agreement with California hospitals to settle litigation initiated in 1990 over low Medicaid reimbursement rates. The terms of the settlement stipulated that the payments be shared equally by the state and the Federal Government. The state paid $175 million, its share of the settlement, to the administrator of the settlement. The impact of the settlement on the results of this audit cannot be determined at this time. For further discussion of the litigation settlement, see APPENDIX C.

OBJECTIVE, SCOPE, AND METHODOLOGY

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

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

The state's methodology, as shown in APPENDIX B, used data from different time periods (i.e., hospital fiscal year (FY) versus CY). Our review applied the state's methodology using 1998 data obtained from the state's limit calculations, state provided demonstration expenses, and state payment schedules. We also used Medicare cost report data obtained from CMS.

Our adjustments to the limits were based on data provided by the state and CMS. We did not verify the state and CMS provided data to hospital records for completeness or accuracy. Our review of Medicaid revenues provided by the state was limited to Medicaid billing policy and provider numbers and did not include transaction testing of the data processing systems used to identify and aggregate Medicaid revenues.

We used the LAC hospitals' Medicare Cost Reports, as filed by the hospitals and finalized by CMS's fiscal intermediary review, to identify the amounts for cost report adjustments and

non-reimbursable cost centers. We contacted each LAC hospital and the LAC Department of Health Services to obtain a general understanding of the types of hospital activities reported in selected non-reimbursable cost centers on the LAC hospitals' Medicare Cost Reports.

We obtained written confirmations from public hospitals to determine the amount of funds transferred to public entities after receipt of DSH payments. On the confirmations, six LAC hospitals stated they shared an account with the county government. They also stated that accounting records were used to separate hospital financial activity from county activity.

Our review of federal Medicaid statutes, CFRs, CMS guidance, California Welfare and Institutions Code, and the state plan was limited to the DSH program. We interviewed CMS Headquarters and CMS Region IX staff as well as state personnel and, when available, obtained copies of pertinent documentation.

Our fieldwork was performed during the period March 2002 through July 2002 and included visits to the state's office in Sacramento, California. In response to the state's comments on our September 2002 draft report we performed additional fieldwork with the state, CMS, and CMS's fiscal intermediary during the period January 2003 through April 2003.

FINDINGS AND RECOMMENDATION

Our audit showed that the state made DSH payments to four of the six[5] LAC hospitals that exceeded their limits for SFY 1998. The limits as determined by the state did not comply with the apparent purpose of OBRA 1993 and CMS requirements and implementing guidance. APPENDIX D provides a summary of excess DSH payments made by the state and the recommended amounts to resolve with CMS. The excess DSH payments resulted from overstated limits. The overstatement of the limits occurred because the state:

- used projected amounts instead of actual incurred costs and payments for the year in which the hospital services were rendered,
- did not limit total operating expenses to amounts that would be allowable under Medicare cost principles, and
- inappropriately included bad debts as an additional operating expense.

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

[5] Martin Luther King/Drew Medical Center and High Desert Hospital were not paid in excess of their limits.

EXCESS DSH PAYMENTS TO FOUR LAC HOSPITALS

The state made excess DSH payments totaling $195,480,873 ($98,190,042 federal share[6]) to four LAC hospitals. The excess payments resulted from overstated limits. The limits as determined by the state did not comply with federal statutes and CMS's implementing guidance. APPENDIX E provides a summary of limits and excess DSH payments by hospital. The limits were overstated due to the issues discussed below.

ACTUAL INCURRED COSTS AND PAYMENTS

The state overstated the limits by using projections (i.e., historical amounts adjusted for trend factors) instead of actual incurred costs and payments in its methodology to estimate the UCC. Federal statute required the use of incurred costs, net of payments, for the year in which the hospital services were rendered. The CMS also advised the state on the use of estimates in the calculation of the limit.

The state substantially overstated the UCC for the four LAC hospitals by only using projected amounts in its calculation instead of incurred 1998 amounts. The overstatement of the UCC was partially due to the state's omission of Medicaid Emergency Services and Supplemental Payments (SB 1255). The overstatement was further increased when the state applied the high DSH percentage of 175 to the UCC.

Statutory Requirement

Section 1923(g)(1)(A) of the Act stated that DSH payments not exceed the:

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

CMS Guidance

In a letter dated January 10, 1995, the CMS Director of the Medicaid Bureau provided guidance to State Medicaid Directors in response to questions regarding the DSH provisions contained in OBRA 1993. The CMS stated that it is important to note that states have flexibility in developing the methods and standards described in its state plan to specify whether it will use estimated amounts of revenues pertaining to uninsured services, or will make retroactive settlements based on recalculations of actual revenues received for uninsured services. It should be noted that this flexibility applied to uninsured revenues and not expenses.

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

CMS Region IX's Approval of State Plan Amendment

In a May 8, 1996 letter that granted specific approval to the state plan amendment implementing OBRA 1993, CMS Region IX advised the state regarding the use of estimates. In this letter, CMS stated that while the state's methodology for calculating and applying the OBRA 1993 payment limits applied to prospective periods and was based on estimates, those amounts were not final in the same sense as payments for diagnosis-related group rates used in the Medicare prospective payment system.

Use of Projected Versus Incurred Amounts

The state's methodology used a prospective application of historical cost and payment estimates (i.e., projected 1½ to 3 years of historical amounts) to determine the limit for the year of the DSH payment. The state's methodology also used data from different time periods (i.e., hospital FY and CY). See APPENDIX B for the time periods of each data element.

By only using projected amounts in its calculation instead of incurred 1998 amounts, the state substantially overstated total expenses of four LAC hospitals and significantly understated the hospitals' total revenues for a total overstatement of four LAC hospitals' UCC by more than $699 million. The understatement to revenues was due, in large part, to the state's omission of over $433 million in revenues for SB 1255. The state increased the LAC hospitals' UCC by 175 percent to arrive at the hospitals' limits. The effect of using projected amounts instead of incurred 1998 amounts resulted in significant overstatements of the limits totaling more than $1.2 billion ($699 million x 175 percent).

The state had access to several reports (e.g., Medicaid Cost Report, OSHPD Hospital Annual Disclosure Report) submitted by hospitals directly to the state that would have more closely reflected incurred costs and payments for the year in which services were rendered. The Medicaid Cost Reports were due 5 months after the end of the reporting period. The OSHPD Hospital Annual Disclosure Reports were due 4 months after hospital year-end.

Using the state's methodology as described in APPENDIX B, we adjusted the limit by replacing projected costs and payments with 1998 incurred costs and payments.[7] APPENDIX F shows the adjustment for this issue made to the limit for the four LAC hospitals whose DSH payments exceeded their limits for SFY 1998.

MEDICARE COST PRINCIPLES

The state overstated the limits by using total hospital expenses that exceeded amounts allowable under Medicare principles of cost reimbursement. In defining allowable costs of services under the DSH limit provision, CMS granted states considerable flexibility up to a maximum standard – Medicare cost principles. Additionally, CMS advised the state that estimates were subject to future adjustments based on reconciliation to Medicare cost principles.

[7] We used the limit adjusted for actual incurred costs and payments as the base amount for further adjustments made to the limit for subsequent issues (i.e., Medicare and bad debts issues).

CMS Guidance

In a letter dated August 17, 1994, the CMS Director of the Medicaid Bureau provided guidance to State Medicaid Directors regarding OBRA 1993. The stated purpose of the guidance was "…to provide the States with HCFA's interpretation of the key provisions of the new law." The CMS letter stated:

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

CMS Region IX's Approval of State Plan Amendment

In a subsequent letter, dated May 8, 1996, granting specific approval to the state plan amendment implementing the OBRA 1993 hospital specific DSH limit requirement, CMS Region IX advised the state that cost estimates used by the state were subject to future adjustment based upon reconciliation to Medicare principles of cost reimbursement. In that letter, CMS stated:

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

Use of Medicare Cost Principles

The state's methodology relied on total operating expenses from the OSHPD reports in the calculation of the limit. However, total operating expenses in that report included costs that were not allowable under Medicare cost principles, such as non-reimbursable cost centers (e.g., idle/vacant space, research, gift and flower shop).

We adjusted the limits by using total hospital operating expenses based on Medicare principles of cost reimbursement. These amounts included total operating expenses[8] as reported in the hospitals' FY 1998 Medicare Cost Reports. We added graduate medical education (GME) costs[9] allowable under Medicare, costs for physicians' assistants[10] and non-physician anesthetists,[11] and

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[8] Per the hospital's Medicare Cost Report Worksheet B, Part 1, Line 95, Column 27.

[9] Per the hospital's Medicare Cost Report Worksheet B, Part 1, Line 95, Column 22 and Column 23.

[10] Per the hospital's Medicare Cost Report Worksheet A-8, Line 34, Column 2.

[11] Per the hospital's Medicare Cost Report Worksheet A-8, Line 33, Column 2.

costs for professional medical services,[12] if applicable. Although professional medical service costs were not included in the reimbursable cost category, county hospitals in California are permitted to employ physicians to deliver patient care. APPENDIX F shows the adjustment for this issue made to the limit for the four hospitals whose DSH payments exceeded their limits for SFY 1998.

BAD DEBTS

The state overstated the limits by including bad debts as an additional operating expense. The state's methodology called for the inclusion of bad debts in the limit calculation. The amount used for bad debts in the limit calculation was obtained from "Provision for Bad Debts" as shown on the OSHPD report. However, a provision for bad debts is not a cost or an expense and should not have been included as a cost in the limit calculation.

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

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

Although the state's methodology called for the inclusion of bad debts in the limit calculation, it is unreasonable for the Federal Government to pay twice for the same costs or pay for an amount that was not a cost. Paying twice for the same costs occurred if a hospital's DSH payment exceeded its limit after the reduction for bad debts. Furthermore, we believe that CMS never intended to approve state plan provisions that allowed payment for the same costs twice or for amounts that did not constitute costs in the first place.

We adjusted the hospitals' limits by reducing bad debts to zero. APPENDIX F shows the adjustment for this issue made to the limit for the four hospitals whose DSH payments exceeded their limits for SFY 1998.

CONCLUSION

We used the state's methodology as described in APPENDIX B and adjusted the limits for the six LAC hospitals by (i) replacing projected amounts with 1998 incurred costs and payments, (ii) limiting total operating expenses to amounts allowable under Medicare cost principles, and (iii) reducing bad debts to zero. Based on these adjustments, we determined that the four LAC hospitals received excess DSH payments totaling over $195 million ($98 million federal share) due to overstatements of their limits. APPENDIX D shows a summary of the payments in excess of the limit for each hospital.

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[12] Professional medical services consist of those services that are personally rendered for an individual patient by a physician and contribute to the diagnosis or treatment of that patient. Costs associated with these services constitute the professional component of provider-based physician costs (Medicare Cost Report Worksheet A-8-2, Line 101, Column 4).

Although the state had flexibility in using estimates specifically for uninsured revenues, CMS Region IX's approval of the state plan did not permit the state to exclude or ignore revenues in the calculation of the LAC hospitals' limits. The omission of SB 1255 payments in the limit calculations contributed to the overstatement of the limits. Additionally, CMS Region IX advised the state that while the state's methodology for calculating and applying the payment limit applied to prospective periods and was based on estimates, those amounts were not final in the same sense as payments for diagnosis-related group rates used in the Medicare prospective payment system.

RECOMMENDATION

We recommend the state work with CMS to address and resolve the $98,190,042 representing the federal share of the DSH payments in excess of the limits for four LAC hospitals.

In a subsequent report on the California Medicaid Inpatient DSH program, we will include other information and recommendations pertaining to state processes for determining the limit. We will also include other matters pertaining to the California Medicaid state plan.

STATE'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

Except for the finding on bad debts, the state disagreed with the findings based on its interpretation of OBRA 1993 and CMS's implementing guidance for OBRA 1993. Regarding our recommendation, the state indicated a willingness to work with the Federal Government on the issues related to the findings. The state agreed bad debts were counted twice in the current state plan methodology and it would amend the state plan to eliminate any double counting of bad debts in the future.

Where appropriate, we made changes in the report to reflect the state's comments. However, some of the state's comments to our findings were inconsistent with statutory and regulatory requirements, CMS guidance, or other data presented in the report. We summarized and addressed the substantive comments made by the state in this section of the report. We also included the state's detailed comments to our draft report, Enclosure 1, as APPENDIX G.

In summarizing the state's comments, we grouped them into two categories: (i) predominant comments and (ii) comments referenced to specific findings.

PREDOMINANT COMMENTS

In the first category, the state made predominant comments pertaining to (i) the scope and authority of the Office of Inspector General's (OIG) audit, and (ii) the interpretation of OBRA 1993 and CMS guidance.

SCOPE AND AUTHORITY OF OIG'S AUDIT

State's Comments

The state claimed that (i) the audit went beyond the stated objective by addressing state plan compliance issues and (ii) any question of whether the state plan complied with federal law was reserved for the authority of the HHS Secretary.

OIG's Response

The audit did not go beyond its stated objective. The objective of the audit was to review the DSH program to verify that the SFY 1998 DSH program payments made to individual hospitals did not exceed the hospital specific limit as imposed by OBRA 1993. The audit achieved this objective.

Further, OIG did not exceed its authority in conducting the audit. The Inspector General Act of 1978 (IG Act), as amended, authorizes the Inspector General of HHS to conduct and supervise audits and investigations relating to the programs and operations of the Department. Section 6(a)(2) of the IG Act specifically authorizes the Inspector General to:

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

INTERPRETATION OF OBRA 1993 AND CMS GUIDANCE

State's Comments

The state claimed that the state plan provisions for the computation of OBRA 1993 limits complied in all respects with federal Medicaid requirements.

The state asserted that the state plan provisions related to the DSH program are within the scope of flexibility granted by Congress to the states to determine DSH payments. The state also asserted the Federal Government fostered state flexibility to respond to DSH issues by not setting forth uniform DSH standards. In addition, the state declared that neither the federal statute nor regulations required any particular methodology for determining costs and payments for purposes of OBRA 1993.

The state alleged "…the OIG seeks to mandate its own DSH methodology…" and "The OIG cannot now substitute its own rules…." The state added "The OIG's assertion that estimated DSH payments must be reconciled using actual data is without foundation and contradicts California's approved state plan."

The state asserted that because its DSH methodology was approved by CMS, on behalf of the Secretary, costs determined in accordance with the approved methodology fully satisfied the

OBRA 1993 requirements. At the same time, the state also asserted that CMS's May 1996 approval letter "…does not constitute any component of the approved State Plan."

OIG's Response

Contrary to the state's claim, the results of our audit demonstrated that hospital limits determined in accordance with the state plan methodology were not consistent with the apparent purpose of section 1923 of the Act, regulatory requirements, or CMS issued program and state specific guidance. As noted in our report, the state did not comply with the statutory requirement to use incurred costs, the regulatory requirement to exclude bad debts, and the CMS guidance to limit costs to Medicare cost principles.

We disagree with the state's assertion that Congress granted the states flexibility with respect to the determination of the hospital specific limit. The state's response did not address the apparent purpose of section 1923, which was that DSH payments do not exceed the hospital specific limit. The state also ignored CMS guidance relating to the use of Medicare cost principles in determining the hospital specific limit.

We disagree with the state's claim that OIG mandated its own methodology by substituting its own rules and that these rules were without foundation in law. We used the state's own methodology and substituted state provided data in place of the data the state originally used in its limit calculations. The state data we used was for the year in which the services were rendered. As cited in our report, we consistently used the following federal statute and CMS guidance in our audit of the state's DSH program:

- Section 1923(g)(1)(A) of the Act required the use of incurred costs, net of payments, for the year in which the hospital services were rendered.

- CMS's August 1994 and January 1995 guidance that implemented OBRA 1993 included limiting (i) costs to those amounts that did not exceed the Medicare principles of cost reimbursement and (ii) the use of estimated revenues to uninsured services, respectively.

- CMS's May 1996 letter granted specific approval of the California state plan amendment that implemented the OBRA 1993 hospital specific DSH limit, and included guidance on future adjustments or reconciliation of estimates to Medicare cost principles.

We disagree with the state's assertion that CMS's May 1996 approval letter was not part of the approved state plan. This approval letter was issued specifically for the California state plan amendment and was consistent with CMS's August 1994 and January 1995 guidance on implementing OBRA 1993. Furthermore, this approval letter provided notice that cost estimates used in the state's DSH methodology "…are subject to future adjustment, or reconciliation, should they later prove to have been established in excess of the limits."

COMMENTS REFERENCED TO SPECIFIC FINDINGS

The second category of state comments is grouped by specific findings: (i) incurred costs, (ii) Medicare cost principles, (iii) bad debts, and (iv) conclusion and recommendation.

INCURRED COSTS – USE OF OR RECONCILIATION TO INCURRED COSTS

State's Comments

The state claimed that retrospective reconciliation was not a statutory requirement. The state pointed out that the California state plan methodology for determining DSH eligibility, limit, and payment amounts was administered entirely on a prospective basis and that CMS was fully familiar with the structure and prospective aspects of its DSH program.

Also, the state claimed that the prospective payment system was designed to allow hospitals to rely on the certainty of DSH payments without concern for possible recoupment. The state asserted "Indeed, it is particularly important for disproportionate share hospitals to have certainty with respect to the amount of their DSH payments, as such hospitals are often significantly reliant on DSH payments in order to survive, and do not have the resources to withstand a retroactive recoupment."

OIG's Response

Although the statute did not explicitly require retrospective reconciliation of DSH payments to the limit, the statute limited those payments to incurred costs, net of payments, for the year in which hospital services were rendered. Furthermore, CMS recognized the need for reconciliation by notifying the state in the May 1996 approval letter that estimates used in its DSH methodology "…are subject to **future adjustment**, or **reconciliation**, should they later prove to have been established in excess of the limits." [Emphasis added]

As to the state's claim that its prospective payment system was designed to ensure payment certainty, CMS advised the state in the approval letter that while its methodology was based on estimates, these estimates were not final. As to the state's assertion that DSH hospitals did not have sufficient resources to withstand retroactive recoupment, data provided by public DSH hospitals, as noted in our report, contradicted the state's assertion. The state paid 48 public hospitals over $2 billion (including FFP) in DSH payments for SFY 1998. Of the 48 public hospitals, 44 confirmed that they transferred over $1.4 billion to their public entities after receipt of those DSH payments.[13]

The state did not address the omission of more than $433 million[14] of SB 1255 payments in the SFY 1998 limit calculations for four LAC hospitals. The OBRA 1993 and the state plan

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[13] Page 2 of this report provides a description of the state's funding through IGTs. APPENDIX A provides a diagram of DSH funding and payment distributions for IGTs.

[14] Our draft report identified $521 million of SB 1255 payments for five LAC hospitals. In this report, we identified four hospitals with DSH payments that exceeded the adjusted limits.

required the state to use SB 1255 payments to offset costs in calculating the UCC. Significant overstatements of the limits occurred because the state did not use incurred costs, net of payments, for the year in which services were rendered.

INCURRED COSTS – AUDIT METHODOLOGY

State's Comments

The state claimed that the audit applied a vastly different methodology than the state plan methodology. The state added that the audit compared DSH payments to a different "estimate" of costs that has no support in law and did not use "actual" data. Furthermore, the state claimed that while the audit methodology substituted more recent estimates than the estimates used by state plan methodology, the audit also used estimates.

OIG's Response

We disagree with the state's claim that we used a vastly different methodology. We used the California state plan methodology and substituted 1998 incurred amounts and managed care organizations' survey data applicable to 1998 obtained from the state. The managed care survey data requested by the state consisted of managed care inpatient and outpatient payments for 1998. We did not apply a trend factor to the 1998 data because our data was from the year the services were rendered as required by statute. We used data that was used by the state in its calculation of DSH limits for a subsequent year.

INCURRED COSTS – IMPLEMENTATION

State's Comments

The state asserted that retrospective reconciliation to actual data for the year of the hospital services would take several years to complete and would have been operationally impossible to implement. The state also asserted that alternative data sources cited in the audit report were not available to the state since the hospital reports were filed after the year of the hospital services.

OIG's Response

We disagree with the state's assertion that it would have been operationally impossible to use incurred costs and payments and would have taken several years to complete. Contrary to the state's claim, the state plan required a retrospective reconciliation of estimates to actual data for the SB 1255 program. If the actual supplemental payment amount was not finalized, the state plan required the use of an estimate[15] and the application of an adjustment in the following year's limit calculation. The adjustment was made to recognize the difference between the estimated and actual payment when "…the amount of the additional S.B. 1255 revenue…would have caused the hospital to surpass its OBRA 1993 limit for any such prior year…."[16] Since the state

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[15] Refer to the state plan, Attachment 4.19-A, section J.4.c.(4)(b), page 29X.

[16] Refer to the state plan, Attachment 4.19-A, section J.4.c.(4)(f)(iii), page 29aa.

plan required adjustments for supplemental payments to recognize the difference between estimated and actual amounts, the state plan demonstrated that it was not operationally impossible to implement a retrospective reconciliation process. For SFY 1998, the state paid more than $908 million in SB 1255 program payments to 62 disproportionate share hospitals.

As to the state's assertion that data sources were not available, the state had access to several reports (e.g., Medicaid Cost Report, OSHPD Hospital Annual Disclosure Reports) submitted by hospitals to the state that would have more accurately reflected incurred costs and payments for the year in which services were rendered. As noted in our report, Medicaid Cost Reports were due 5 months after the end of the reporting period. The OSHPD Hospital Annual Disclosure Reports were due 4 months after year-end. Accordingly, we believe the state had an opportunity to use more recent data for the calculation of the limits.

MEDICARE COST PRINCIPLES – APPLICABILITY

State's Comments

The state claimed that federal law and regulations did not require the use of Medicare cost principles. Specifically, the state claimed, "…nothing in section 1923 of the Act requires Medicare costs to be the basis for determining uncompensated care costs." The state also claimed that the August 1994 CMS letter that implemented OBRA 1993 and was issued to all State Medicaid Directors did not constitute definitive guidance relative to the application of Medicare cost principles.

OIG's Response

We disagree with the state's claim that federal law and regulations did not require the use of Medicare cost principles. Under the authority granted by OBRA 1993, the HHS Secretary defined "costs of services" as amounts that do not exceed those costs allowable under Medicare principles of cost reimbursement. As cited in our report, section 1923(g)(1)(A) of the Act provided the Secretary with the authority to determine the costs to be used for the hospital specific limit. The cited statutory language "…costs incurred during the year of furnishing hospital services (as determined by the Secretary…)…" permitted the Secretary to determine the appropriate basis for UCC. The Secretary, through CMS's Director of the Medicaid Bureau, issued guidance on August 17, 1994 to all State Medicaid Directors that limited cost of services to Medicare principles of cost reimbursement.

The CMS provided the state with additional guidance in a state plan approval letter issued in May 1996. In that letter, CMS approved the state plan amendment that implemented OBRA 1993 hospital specific DSH limits. The approval letter reaffirmed the application of Medicare principles of cost reimbursement. Specifically, CMS notified California that cost estimates used in its DSH methodology are:

> "…subject to future adjustment, or reconciliation, should they later prove to have been established in excess of the limits. Such adjustments are based upon

reconciliation to Medicare cost principles of cost reimbursement. Costs determined may not exceed amounts that would be allowable under Medicare…."

MEDICARE COST PRINCIPLES – ADJUSTMENTS TO MEDICARE ALLOWABLE COSTS

State's Comments

The state claimed that OIG auditors used Medicare cost report figures that reflected numerous adjustments that were made because of how Medicare pays for services, not because these costs were not incurred by the hospital in furnishing uncompensated care. Some of the examples the state cited were:

- **GME Costs:** The state claimed that the audit disregarded costs of interns and residents as well as related overhead costs from Medicare allowable costs and recognized only the Medicare "aggregate approved amount" for GME reimbursement.

- **Provider-Based Physician Costs:** The state claimed that the audit excluded costs of delivering provider-based physician services. The state also claimed that there was no reason to exclude such costs for provider-based physicians for the LAC hospitals and that these costs were actually incurred in furnishing health care services.

- **Physician Assistants and Non-Physician Anesthetists:** The state claimed that the audit disregarded costs for physician assistants and non-physician anesthetists. The state maintained that these costs were incurred by the hospitals in providing patient care services and should be included in the hospital costs.

OIG's Response

In response to the state's comments, we made adjustments as noted below to Medicare allowable costs in the calculation of the DSH limits.

- **GME Costs:** The state correctly noted that we used the GME reimbursement amount instead of Medicare allowable GME costs in the limit calculations. To correct for our inadvertent use of GME reimbursement amounts, we have adjusted the limit calculations to include Medicare allowable GME costs. These adjustments resulted in a net increase of over $33 million in total Medicare allowable costs for the four LAC hospitals.

- **Provider-Based Physician Costs:** We disagree with the state's claim that we excluded provider-based physician costs. As noted in our report, we added those costs in the calculation of the limit. Specifically, over $79 million in provider-based physician costs was added to Medicare allowable costs for the four LAC hospitals.

- **Physician Assistants and Non-Physician Anesthetists:** The state correctly noted that we did not include physician assistants and non-physician anesthetists' costs as Medicare allowable costs in the limit calculations. To correct our inadvertent omission, we have

adjusted the limit calculations to include those costs. These adjustments resulted in an increase of over $8 million in total Medicare allowable costs for the four LAC hospitals.

BAD DEBTS

State's Comments

The state agreed bad debts were counted twice in the current state plan methodology. The state claimed that it will amend the state plan to eliminate any double counting of bad debts in the future.

OIG's Response

Although the state claimed that it would take corrective action to amend the state plan to eliminate the double counting of bad debts for the future, the state should work with CMS to resolve any overpayments due to bad debts for SFY 1998. We believe that CMS never intended to approve state plan provisions that allowed payment for the same costs twice or for amounts that did not constitute costs in the first place.

CONCLUSION AND RECOMMENDATION

State's Comments

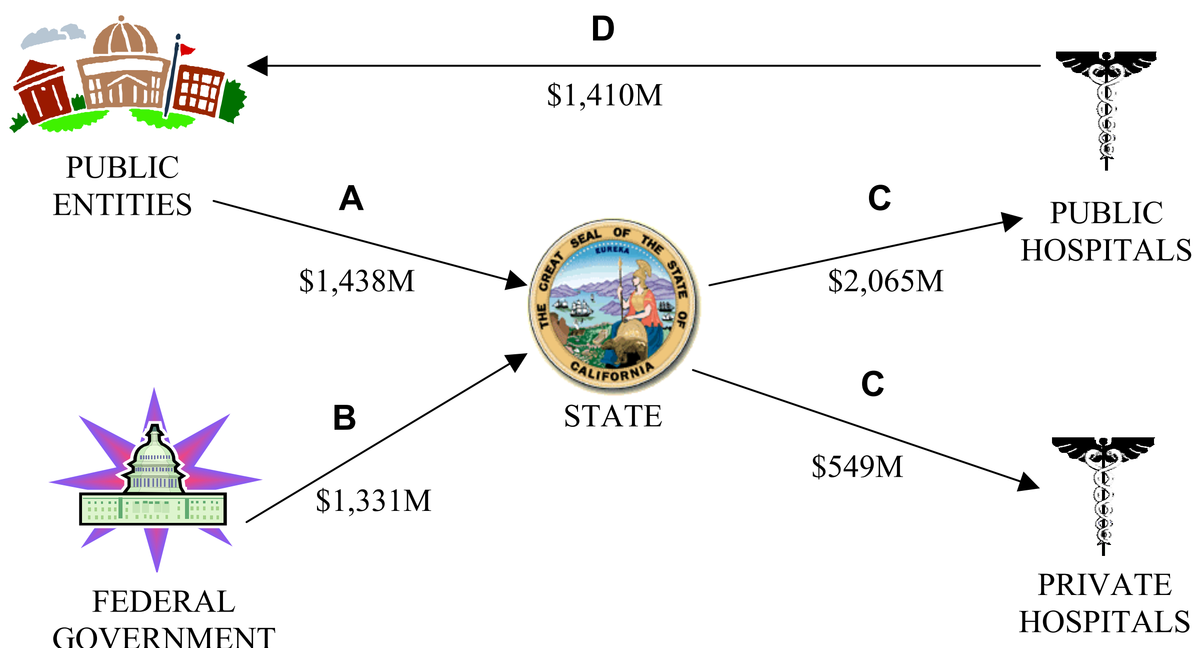
The state claimed that it "…is forced to contest the key findings and recommendations." The state also claimed that it "…looks forward to resolving these issues with the federal government."

OIG's Response

We addressed the state's comments to the "key findings" in the OIG's response sections above. We support the state's willingness to work with the Federal Government on the issues associated with the key findings and recommendation.

APPENDICES

SFY 1998
DSH FUNDING DIAGRAM AND PAYMENT DISTRIBUTION



	DESCRIPTION OF FUNDING DIAGRAM AND PAYMENT DISTRIBUTION	NO. OF HOSPITALS	AMOUNT (IN MILLIONS)
A	Public entities with DSH eligible hospitals transferred funds to the state through IGTs.	48	$1,438
B	The Federal Government provided matching funds for hospitals that received DSH payments.	122	$1,331
C	The state distributed a total of $2,614 million as DSH payments to:		
	Private hospitals	74	$ 549
	Public hospitals	48	$2,065
D	Public hospitals transferred funds after receipt of DSH payments to public entities. These public entities provided IGT funds to the state.	44	$1,410

APPENDIX B

SFY 1998
STATE METHODOLOGY FOR UCC

DATA ELEMENTS	SOURCE
Section I: Medicaid and Uninsured Expenses	
Projected Total Hospital Expenses:	
Total Operating Expenses (TOE)	FY 1995 OSHPD L0820001[1]
Add: Bad Debts	FY 1995 OSHPD L1242025
Subtract: CRRP[2] Costs FY 1995	1997/1998 hospital survey
Subtotal	
Multiply by: Trend factor	Medicare market basket index for FY 1996/1997/1998
Subtotal: Projected Adjusted Hospital Operating Expenses	
Add: Estimated CRRP Costs	1997/1998 hospital survey
Subtract: Estimated Medicaid Administrative Activities (MAA)	1997/1998 hospital survey
Projected Total Hospital Expenses	
Patient Mix Ratio:	
Medicaid In/Outpatient Charges	FY 1995 OSHPD (L1241505 + L1241507)
Add Charges for:	
Managed Care and County Health Plans	CY 1995 OSHPD Confidential Discharge Data files and county paid claims files
Short Doyle Program	CY 1995 Medicaid Short Doyle paid claims file
County Indigent Program In/Outpatient	FY 1995 OSHPD (L1241509 + L1241511)
Uninsured In/Outpatient	FY 1995 OSHPD (L1241517 + L1241519)
Subtotal: Medicaid, County Indigent, and Uninsured Charges	
Divide by: Total In/Outpatient Charges	FY 1995 OSHPD L1241525
Patient Mix Ratio	
Projected Total Hospital Expenses x Patient Mix Ratio = Medicaid and Uninsured Expenses	
Add: Demonstration Project Expenses	Terms and conditions of demonstration project
Total Medicaid and Uninsured Expenses	
Section II: Medicaid and Uninsured Revenues	
Medicaid In/Outpatient Revenues	CY 1996 Medicaid paid claims files and Medicaid managed care data
Add Revenues for:	
Estimated FY 1997/1998 CRRP	1997/1998 hospital survey
Emergency Services/Supplemental Payments (SB 1255)	CMAC[3] negotiated amount for FY 1997/1998
Estimated FY 1997/1998 Targeted Case Management	1997/1998 hospital survey
Uninsured Cash Payments	FY 1995 OSHPD (L1246017 + L1246019) multiplied by trend factor
Demonstration Project Revenues	Terms and conditions of demonstration project
Total Medicaid and Uninsured Revenues	
Section III: Uncompensated Care Costs (UCC) [Section I Less Section II]	

[1] OSHPD L0820001 refers to Page 8, Row 200, Column 01 of the OSHPD Hospital Annual Disclosure Report.

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

[3] CMAC refers to the California Medical Assistance Commission.

APPENDIX C

LITIGATION SETTLEMENT

On January 10, 2002, the state of California announced a $350 million tentative Medicaid settlement for litigation initiated in 1990 over low hospital reimbursement rates. The terms of the settlement stipulated that the payments be shared equally by the state and the Federal Government. According to the state's announcement, the settlement was contingent on CMS agreeing to pay its share of the settlement and a Medicaid rate increase.

In a March 22, 2001 letter, the state informed CMS of the tentative settlement and requested an advisory opinion on the availability of FFP (in particular concerning the treatment of retroactive payments for purposes of hospital specific payment limits for disproportionate share payments).

On January 8, 2002, the United States District Court for the Central District of California (the Court) issued to HHS an "order to show cause" for its failure to provide the opinion requested by the state in the March 22, 2001 letter. On February 11, 2002, HHS responded to the Court's order and submitted that HHS had demonstrated good cause to dismiss the order. No further orders had been issued as a result of a February 25, 2002 hearing with the Court.

The state has now paid $175 million, the state's share of the retroactive settlement, to the administrator of the settlement. The state has also filed an expenditure report with CMS, claiming FFP for the entire $350 million contemplated by the settlement, but the expenditure report noted that the state had only paid $175 million. The state's claim was deferred by CMS on December 24, 2002 and remained under review at the time of this report.

The state has also increased rates prospectively for Medicaid outpatient hospital services in accordance with the settlement agreement, but these increases were consistent with its approved state plan and did not require CMS approval.

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

SFY 1998
SUMMARY OF EXCESS DSH PAYMENTS AND RECOMMENDED AMOUNTS

HOSPITAL	EXCESS DSH PAYMENTS (From APPENDIX E)	RECOMMENDED AMOUNTS[1]
LAC+USC Healthcare Network	$85,552,331	$42,972,936
Harbor/UCLA Medical Center	60,138,591	30,207,614
Olive View/UCLA Medical Center	44,542,369	22,373,632
Rancho Los Amigos National Rehabilitation Center	5,247,582	2,635,860
TOTAL	$195,480,873	$98,190,042

[1] The recommended amounts represent the federal share of excess DSH payments based on an FFP rate of 50.23 percent. We recommend the state work with CMS to resolve these amounts.

SFY 1998
SUMMARY OF LIMITS AND EXCESS DSH PAYMENTS

HOSPITAL	(a) STATE DETERMINED LIMIT	(b) TOTAL ADJUSTMENTS (From Appendix F)	(c) ADJUSTED LIMIT (a) – (b)	(d) TOTAL DSH PAYMENTS	EXCESS DSH PAYMENTS (d) – (c)
LAC+USC Healthcare Network	$1,212,190,326	$875,420,961	$336,769,365	$422,321,696	$85,552,331
Harbor/UCLA Medical Center	437,559,412	315,656,157	121,903,255	182,041,846	60,138,591
Olive View/UCLA Medical Center	316,762,902	231,775,030	84,987,872	129,530,241	44,542,369
Rancho Los Amigos National Rehabilitation Center	230,860,627	134,081,105	96,779,522	102,027,104	5,247,582

SFY 1998
SUMMARY OF LIMIT ADJUSTMENTS BY ISSUE

HOSPITAL	INCURRED	MEDICARE	BAD DEBTS	TOTAL ADJUSTMENTS
LAC+USC Healthcare Network	$697,550,679	$168,316,894	$9,553,388	$875,420,961
Harbor/UCLA Medical Center	234,013,926	55,515,814	26,126,417	315,656,157
Olive View/UCLA Medical Center	180,127,837	49,709,289	1,937,904	231,775,030
Rancho Los Amigos National Rehabilitation Center	112,099,743	12,818,207	9,163,155	134,081,105

APPENDIX G

CALIFORNIA'S RESPONSE TO OIG DRAFT REPORT ON AUDIT OF CALIFORNIA'S MEDICAID INPATIENT DSH PAYMENTS FOR LOS ANGELES COUNTY HOSPITALS, SFY 1998

(Transmittal Letter Plus Enclosure 1)
(26 Pages)

The state's response consisted of 10 exhibits and 3 enclosures. The exhibits included federal and state issued documents such as federal statutes, CMS guidance, and excerpts from the California state plan. The enclosures included comments from the state, the county, and a hospital association. The state advised that the enclosures were incorporated into the state's response to the extent that they were not inconsistent with the state's comments in Enclosure 1 (i.e., the California Department of Health Services' detailed comments to the draft audit report). Due to the voluminous amount of material in the state's response and the proprietary nature of hospital data, we included only the state's detailed comments to our draft report (i.e., Enclosure 1) and transmittal letter.

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

California Department of Health Services

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

GRAY DAVIS
Governor

December 2, 2002

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

Dear Ms. Ahlstrand

On behalf of the California Department of Health Services (CDHS), thank you for the opportunity to review the Federal Department of Health and Human Services', Office of Inspector General (OIG) draft report, "Audit of California's Medicaid Inpatient Disproportionate Share Hospital Payments for Los Angeles County Hospitals, State Fiscal Year 1998." Enclosure 1 contains our detailed comments to the Draft Audit Report.[1]

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

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

California's State Plan provisions for the computation of the OBRA 1993[2] limits comply with Federal law.

The current prospective OBRA 1993 methodology is proper--especially in light of the fact that its application has never caused Federal Financial Participation (FFP) for the Disproportionate Share Hospital (DSH) program as a whole to be greater than it would

[1] CAPH and Los Angeles County submitted to CDHS responses to the Draft Audit Report. A copy of these responses are included as enclosures and are incorporated into CDHS's response (to the extent that they are not inconsistent).
[2] The Omnibus Budget Reconciliation Act of 1993.

have been if the methodology urged by the OIG were applied. The OIG's methodology would result in slightly different payments to the DSH hospitals (both more and less), but would not affect total FFP.

An analysis of California's DSH Program spending clearly indicates that all spending is conducted with the long-standing approval of the Health Care Financing Administration (HCFA).[3] The Department properly implemented the appropriate California Medicaid State Plan (State Plan) provisions for State Fiscal Year (SFY) 1997-98 (with a few minor exceptions[4]).

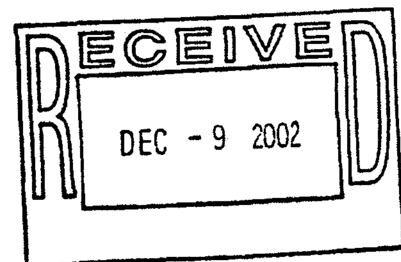
- The "overpayment" determination in the Draft Audit Report seems misleading because it was based on a modified methodology created and applied by OIG staff retroactively to SFY 1997-98. Given that this modified methodology differed substantially from the HCFA approved State Plan, it is not entirely clear how it is relevant.

  The findings of the Draft Audit Report regarding the use of Medicare cost principles and various reimbursement rules are not required by Federal law and regulations. In fact, the Federal government has never issued regulations on several items that the OIG asserts are definitive requirements.

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

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

Sincerely,



Stan Rosentein
Assistant Deputy Director
Medical Care Services

Enclosures
cc: See Next Page

[3] The federal Health Care Financing Administration (HCFA) is now known as the Centers for Medicare & Medicaid Services (CMS). Reference to "CMS" with respect to events prior to the name change should be read to refer to "HCFA."
[4] CDHS has conceded an improper double counting of bad debt

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CIN: A-09-02-00071
12/02/2002

ENCLOSURES

1 Department of Health Services
2 California Association of Public Hospitals and Health Systems
3 Los Angeles County

Response to CIN: A-09-02-00071
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C. section J, "OBRA 1993 Hospital-Specific Limitations," pages 29N to 29gg
D. DSH Structure approved by CMS in 1991
E. CMS Letter, dated May 1996
F. HCFA Letters, dated August 1994 and January 1995
G. CMS Letter, dated January 1995
H. CMS approval letter and State Plan 00-012, dated November 2002
I. Worksheet A-8-2 of the Medicare Cost Report
J. 65 Fed. Reg. 47054, 47102 (August 1, 2000).

CALIFORNIA DEPARTMENT OF HEALTH SERVICES

Response to the Department of Health and Human Services Office of the Inspector General's "Audit of California's Medicaid Inpatient Disproportionate Share Hospital Payments for Los Angeles County Hospitals, State Fiscal Year 1998 - CIN: A-09-02-00071"

INTRODUCTION

This document constitutes the California Department of Health Services' (Department) response to the Draft Audit Report, dated September 2002 (No. A-09-02-00071), for the Los Angeles County (LAC) hospitals.

In the discussion of the OIG Auditors findings and recommendations, the Department's response makes the following key points:

- California's State Plan provisions for the computation of the OBRA 1993[1] limits comply with Federal law.[2]

  The current prospective OBRA 1993 methodology is proper--especially in light of the fact that its application has never caused Federal Financial Participation (FFP) for the Disproportionate Share Hospital (DSH) program as a whole to be greater than it would have been if the methodology urged by the OIG were applied. The OIG's methodology would result in slightly different payments to the DSH hospitals (both more and less), but would not affect total FFP.

- An analysis of California's DSH Program spending clearly indicates that all spending is conducted with the long-standing approval of the Health Care Financing Administration (HCFA).[3] The Department properly implemented the appropriate California Medicaid State Plan (State Plan) provisions for State Fiscal Year (SFY) 1997-98 (with a few minor exceptions described below).

  The "overpayment" determination in the Draft Audit Report seems misleading because it was based on a modified methodology created and applied by OIG staff retroactively to SFY 1997-98. Given that this modified methodology differed substantially from the HCFA approved State Plan, it is not entirely clear how it is relevant.

  The findings of the Draft Audit Report regarding the use of Medicare cost principles and various reimbursement rules are not required by Federal law and regulations. In fact, the Federal government has never issued regulations on several items that the OIG asserts are definitive requirements.

[1] The Omnibus Budget Reconciliation Act of 1993.
[2] CDHS has conceded an improper double counting of bad debt.
[3] The federal Health Care Financing Administration (HCFA) is now known as the Centers for Medicare & Medicaid Services (CMS). Reference to "CMS" with respect to events prior to the name change should be read to refer to "HCFA."

DISCUSSION OF ALLEGED HOSPITAL OVERPAYMENTS

The Department questions all of the findings, to the extent that they are based on allegations that the California State Plan violates Section 1923 of the Social Security Act (the Act) as added by OBRA 1993 and related Federal guidance. The Objective section of the Executive Summary stated that the objective of the audit was to verify that payments made to the Six Los Angeles County (LAC) hospitals did not exceed the hospital specific limit. In the "Excess DSH Payments to Five LAC Hospitals" section, the Executive Summary states that "the State made excess DSH payments totaling over $283 million because the limits determined by the State were overstated." The Draft Audit Report also recommends that the State refund the overpayments associated with the findings for Medicare cost principles and bad debts. The State disagrees with those findings.

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

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

Specific issues raised by the OIG

1 THE OIG'S ASSERTION THAT ESTIMATED DSH PAYMENTS MUST BE RECONCILED USING ACTUAL DATA IS WITHOUT FOUNDATION AND CONTRADICTS CALIFORNIA'S APPROVED STATE PLAN.

   The OIG recommends that the Department work with CMS to address and resolve the $142,626,773 representing the Federal share of payments in excess of the limits ($283,947,389 x 50.23 percent) associated with the finding on actual incurred costs and payments. The OIG concluded that the State Plan was silent on this issue, but asserted that the State Plan's silence* did not invalidate the intent of section 1923 of the Act or its implementing guidance.

   The Department accepts this recommendation as it pertains to working with CMS to address issues relating to actual incurred expenses. As set forth in detail below, the Department has presented credible arguments that the State

*Auditor's Note: For the indicated item, the state's comments refer to a description used in the draft report that has been deleted in the final report.

used its best efforts to identify appropriate data for hospital-specific OBRA limit calculations pursuant to the approved State Plan and as allowed by Federal Law. As a result, disallowance's pertaining to findings regarding actual incurred expenses are not warranted.

a. RETROSPECTIVE RECONCILIATION IS NOT A STATUTORY REQUIREMENT.

The Draft Audit Report found that the OBRA 1993 limits determined and applied pursuant to the approved State Plan "did not comply" with Federal requirements. The auditors base this finding on the State Plan's "silence" as to the use of reconciliation to "incurred costs and payments." The finding, however, assumes that such reconciliation is required under any controlling statute or regulation.

Neither the Federal statute nor regulations require any particular methodology for determining costs and payments for purposes of OBRA 1993. Indeed, the language in Section 1923(g)(1)(A) of the Act (*attached as Exhibit A*) that establishes the OBRA 1993 limit does not support the auditors' premise that the State must recalculate and retroactively adjust DSH program payments using the "actual" year's numbers after they become available. Nothing in the Act prohibits the use of a reasonable estimate, as California uses.

OBRA 1987 amended the Federal DSH program statute to require state Medicaid agencies to make additional payments to hospitals serving disproportionate numbers of low-income patients with special needs. Congress enacted DSH program specifications using general language that provides states the flexibility to adopt procedures and a methodology to implement a program tailored to each state's health care delivery system. Had Congress wished to tie the Medicaid program to a retrospective reconciliation process, it could have done so explicitly in the language of Section 1923(g) as added by OBRA 1993.

The State's prospective approach for determining and applying the OBRA 1993 limits is well within the scope of flexibility accorded to states under the Medicaid DSH statutes. The use and application of currently available actual data from prior periods by states to structure their DSH programs were expressly contemplated by Congress (see OBRA 1987, Report of the Committee on the Budget, H.R. Rep. No. 391, 100th Cong., 1st Sess., p. 526, *attached as Exhibit B.*). CMS obviously interprets the Medicaid statute to permit states to use prior year data, without reconciliation, for purposes of DSH eligibility and payment determinations. These determinations, however, are inherently integrated with respect to the calculation and application of the OBRA 1993 limits. For example, a hospital's qualification for the 175% high DSH limit is based on its low-

income or Medicaid utilization rates, both of which are determined under California's State Plan using prior year, unreconciled data.

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

b. CALIFORNIA'S OBRA 1993 METHODOLOGY IS CONSISTANT WITH THE CMS-APPROVED STATE PLAN.

The OBRA 1993 limit methodology employed by California, is set forth in detail in the State Plan, which has had Federal approval for many years. As permitted by the flexibility allowed by Federal law, that methodology applies definitions of costs and payments consistent with generally accepted accounting principles. Further, that methodology is based on projections based on actual data for prior periods on file at the Office of Statewide Health Planning and Development (OSHPD) and from other sources; there is no provision for reconciling the projections to later determined "actual" numbers. (See California State Plan, Attachment 4.19-A, Increase in Medicaid Payment Amounts for California Disproportionate Providers, section J, "OBRA 1993 Hospital-Specific Limitations," pages 29N to 29gg, *attached as Exhibit C.*)

California's State Plan methodology for determining DSH eligibility and payment amounts, as approved by CMS, is administered entirely on a prospective basis. The DSH determinations are based on the most complete and recent data that existed prior to the beginning of the particular SFY (commencing July 1) during which DSH payment adjustments would be applied.

CMS is fully familiar with the structure and prospective aspects of California's DSH program. When the prospective structure was initially developed and presented to CMS for approval in 1991 (*attached as Exhibit D*), CMS required the State to fully explain its approach. CMS ultimately accepted the present methodology under which the determinations, based on prior year data available at the beginning of a particular fiscal year, are considered final and applied prospectively with respect to that year.

The DSH program computes and applies OBRA 1993 DSH limits prospectively to ensure certainty and predictability. The calculations utilize the most recently available, actual cost and payment data to determine hospital OBRA 1993 limits prior to the start of the applicable SFY. These

data sources in general are the same as those used in determining DSH eligibility and payment amounts. Because the fundamental structure of this methodology is to make reasonable, prospective determinations of the DSH limits based on actual costs and revenues from prior periods, the State Plan appropriately does not provide for retrospective adjustments.

Although the Draft Audit Report characterizes the State Plan OBRA 1993 limit calculations as "estimates," these "estimates" are in fact based upon actual determinations from prior years that are applied to appropriately limit the hospital's DSH payments for the particular year, consistent with Federal law.

As with the Medicare Prospective Payment System (PPS), California's DSH program is designed to provide hospitals with certainty, so that the hospitals can rely on the amount of DSH payments they will receive (without concern about possible recoupments). Indeed, it is particularly important for disproportionate share hospitals to have certainty with respect to the amount of their DSH payments, as such hospitals are often significantly reliant on DSH payments in order to survive, and do not have the resources to withstand a retroactive recoupment. Thus, at least to the same extent that the prospective nature of Medicare PPS requires that outlier payments be determined prospectively and not be subject to retroactive reconciliation, the prospective nature of California's DSH program requires that the OBRA 1993 limits on DSH payments be determined prospectively and not subject to retroactive reconciliation.

c. THE STATE PLAN IS THE CONTROLLING DOCUMENT WITH REGARD TO MEDICAID OPERATIONS.

The OIG report references the CMS May 1996 letter (*attached as Exhibit E*) that accompanied the approval of the State's OBRA 1993 limit State Plan amendment, and treats it as determinative as to requirement for future reconciliation to "actual." This letter does not constitute any component of the approved State Plan.

The Department is not aware of any mechanism or precedent under which CMS may condition a State Plan on elements contained in an external document (such as the May 1996 letter, *Exhibit E*). This is particularly true when the Medicaid statute expressly authorizes CMS to withhold its approval of a State Plan amendment until it incorporates all elements necessary to conform with Medicaid requirements.

At most, the letter expresses CMS' intent to subsequently require modifications to the State Plan as further statutory and regulatory provisions are issued. For more than five years (prior to the current OIG audit

process), nothing further was heard from CMS regarding any such deficiency in the State Plan methodology. If CMS had intended the language of the May 1996 letter (*Exhibit E*) to be part of the State Plan, then CMS should have required that language to be incorporated into the State Plan.

d. IN THE DRAFT AUDIT REPORT, THE OIG SEEKS TO MANDATE ITS OWN DSH METHODOLOGY, EVEN THOUGH CMS HAS CONSISTENTLY FOSTERED STATE FLEXIBILITY IN DETERMINING PAYMENTS.

DSH is an extremely complex program. In recognition of this complexity, and recognizing the state-federal partnership that is the foundation of Medicaid, HCFA issued two letters, one in August 1994 and in January 1995 (*attached as Exhibit F*) to promote state flexibility. The Federal government has not published uniform standards regarding DSH; indeed, a review of Federal guidance on this matter clearly shows that the Federal government has appropriately fostered state flexibility to respond to DSH issues by not setting forth uniform DSH standards. The OIG cannot now substitute its own rules, let alone apply those rules retrospectively.

There is no reason to assume that Congress intended to treat the determination of Medicaid and low-income patient uncompensated care costs differently than other DSH program elements that are within the scope of state flexibility. A retrospective determination of DSH limits based on entirely different data as are used to determine the core DSH program elements would create program inconsistencies, and would be extremely disruptive and counter-productive to the purposes of the DSH program.

CMS consistently has recognized states' flexibility in structuring their DSH programs to comply with the various Federal requirements. The August 17, 1994 letter acknowledges that states may use prior, unreconciled data to determine hospital compliance with the 1% Medicaid utilization threshold for DSH eligibility, so long as states match the period to which the data pertained to the same period from which data were used to determine general DSH eligibility. This acknowledgment is directly contrary to the OIG's position that the August 1994 letter requires retrospective settlement of the limits to year of service data. Further, no mention is made in the letter of any settlement requirement. In fact, the letter concludes by expressly permitting the use of "estimates" to demonstrate compliance with the OBRA 1993 limit.

Notably, it was also Congress' expectation that CMS would issue OBRA 1993 limit guidance to states through the rulemaking process. As late as 2000, Congress recognized that CMS had not yet done so. In the Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000

("BIPA 2000"), Congress requires the Secretary to implement "accountability standards" to ensure that Medicaid DSH payments are used to reimburse states and hospitals "for providing uncompensated health care to low-income patients" (Section 701(e) of BIPA 2000). This recent congressional action also contradicts the OIG's assumption that there are DSH standards to support its recommendations and confirms that Congress does not recognize the August 1994 letter as establishing such standards.

The Draft Audit Report also refers to a January 1995 letter (attached as *Exhibit G*) from CMS to the State Medicaid Directors Association. In that letter, CMS continues to recognize states' need for flexibility in determining and applying the OBRA 1993 limits. Two of CMS' responses to questions posed by the Association confirm that states may "estimate" the limit based on best available data to avoid the "tedious task" of conducting retroactive settlements.

The OIG narrowly construes one of the responses as allowing such estimates only for determining Medicaid and uninsured patient revenues. This narrow construction is unreasonable, because, while the question was posed in the context of the revenues, the broader inquiry was whether states could avoid having to make "continued recalculations" based on subsequent data. CMS supported the use of estimated revenues to facilitate state flexibility, which would be meaningful only if states also were permitted to determine costs in a similar manner.

In the August 1995 letter, CMS reaffirms its approval of prior year data in response to a follow-up question, stating that any base year may be designated for determining DSH payments, so long as all relevant data pertaining to the selected year is used to determine the DSH payment amounts. This is also contrary to the approach taken by the OIG in the audit, which would require the State to determine the OBRA 1993 limits in isolation from other key components of the DSH program, under a different set of data from different periods, to be applied retrospectively versus prospectively.

e. THE OIG'S SUGGESTION ON HOW TO RECONCILE DSH PAYMENTS IS OPERATIONALLY IMPOSSIBLE FOR CALIFORNIA TO IMPLEMENT.

Based on experience in other programs, a retrospective reconciliation to data for the actual year at issue would take several years to complete, as demonstrated to the auditors during their efforts to calculate the OBRA limit based on SFY 1997-98 "actual" data. During the 2001 OIG audit, three years after the SFY 1997-98 DSH program year, all of the "actual" data required for the retrospective calculation still was not available.

The Federal claiming limit, (45 C.F.R. §§ 95.1-95.34) likely raises another difficulty. On November 16, 2001, CMS informed the State of Virginia of a DSH disallowance regarding claims that were more than two years old. CMS based the disallowance on Federal regulations that require filing of claims within two years of the calendar quarter in which the expenditures were made.

The interpretation that led to this disallowance establishes a direct conflict with the auditors' finding suggesting that OBRA 1993 limit calculations must use actual data. Any new claims that were indicated by the reconciliation to "actual" likely could not be made within the two-year Federal claiming limit. Thus, the Department questions whether a retrospective limit calculation would jeopardize the Department's ability to process all appropriate claims.

f. THE ABILITY TO RECONCILE DSH PAYMENTS TO ACTUAL DATA IS SO INHERENTLY LIMITED THAT EVEN THE OIG'S METHODOLOGY FAILS TO COMPLETELY USE DATA FROM SFY 1997-98.

Although the Draft Audit Report states the auditors had "applied the State's methodology" to arrive at its overpayment findings, the auditors in fact applied a vastly different methodology that apparently was developed in the course of the 18-month, statewide audit. The OIG auditors are comparing DSH payments to a different "estimate" of costs, one that has no support in law, and one that does not itself use "actual" data.

The Draft Audit Report criticizes the State's use of data from various sources and time periods, and asserts that other reports "would have more closely reflected incurred costs and payments for the year in which services were rendered." The State questions this assertion for several reasons. First, the data reports suggested by the auditors were not available for purposes of the State's prospective DSH program since they were not even filed until after the year at issue concluded. The reports for the period at issue are typically not audited until years after they are filed, and even then they are almost always subject to appeal, which may take many years to resolve. All of these factors render the use of these data sources directly contrary to the structure and purpose of a prospective system, which is designed to ensure predictable funding for financially distressed safety net hospitals.

Second, the State Plan methodology consistently applies the specified data sources and time periods to which they relate with respect to all aspects of California's DSH program, not just the OBRA 1993 limit determinations. For example, the OSHPD report for a hospital that is used to determine its DSH status is the same report that is used to determine the hospital's compliance with the minimum 1 percent Medicaid utilization requirement. It

makes sense, therefore, to use the same report for purposes of the OBRA 1993 limit determination. The paid Medicaid inpatient days from the prior calendar year claims data also is used as a proxy for the coming fiscal year to determine a hospital's base DSH payment. It is only reasonable to use this same data to determine Medicaid payments in the OBRA 1993 limit determination. California's State Plan methodology, contrary to that which was applied by the OIG, is internally consistent.

The methodology used in the Draft Audit Report intending to reconcile the OBRA limit determined by the Department methodology to "actual" data substitutes different estimates in the model than the Department developed to determine hospital-specific OBRA limit based on the most complete and current data available at the time the prospective determinations were made. While the OIG's estimates are more recent than the estimates used by the Department, the OIG also used estimates. At the time of the audit, the Department still did not have final actual data.

2. IN THE DRAFT AUDIT REPORT, THE OIG HAS ASSERTED THAT MEDICARE COST PRINCIPLES MUST BE USED TO DETERMINE THE OBRA 1993 LIMITS.

On the basis of this assertion, the OIG has included amounts associated with the application of Medicare cost principles in the overpayment amount of $142,626,773, which the OIG recommend that the Department work with CMS to address and resolve.[4]

The department believes that this recommendation exceeds the scope of the audit. As set forth in detail below, the DSH payments represent proper expenditures under the approved State Plan and the OIG's findings, based on a methodology that is different from that contained in the State Plan, are not grounds for disallowance.

a. THE OIG ANALYSIS IS CONTRARY TO THE CMS-APPROVED STATE PLAN. ALL OF CALIFORNIA'S PAYMENTS ARE CONSISTENT WITH THE CMS-APPROVED STATE PLAN.

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

[4] The OIG Draft Audit Report only provided an aggregate refund amount that addressed overpayment amounts related to both Medicare cost principles and bad debt. The Department estimated these figures based on data provided in the Draft Audit Report Appendices.

In 2000, CMS Region IX approved State Plan Amendment 00-012 (*attached as Exhibit H*) that implemented broad and significant modifications to the State Plan. The November 3, 2000, CMS approval letter did not indicate any concern with the State's accounting methodology. The State was unaware that there was a problem because nothing signaled a problem. If CMS had raised a question or concern, the State would have addressed the issue with CMS, but no question was raised. CMS chose to allow California to exercise the flexibility necessary to ensure that California safety net hospitals would be able to continue to provide support to low-income patients with special needs.

The Draft Audit Report cites the May 8, 1996, CMS letter (*Exhibit E*) approving the California State Plan implementing the OBRA 1993 hospital-specific limit as additional guidance regarding the application of Medicare cost principles. As noted above, the OIG has not cited authority under which commentary in an external document is incorporated into, or becomes an amendment to the approved State Plan provisions. The Department is not aware that such authority exists.

b. THE OIG'S ANALYSIS IS CONTRARY TO THE PURPOSE OF OBRA 1993 LIMIT STATUTE AS MANIFESTED BY CONGRESSIONAL INTENT.

The OIG's recommended modifications to California's State Plan methodology do not fully reflect the financial circumstances of California's disproportionate share hospitals, and is contrary to the Federal Medicaid DSH requirement. This is because, unlike the approved Medicaid State Plan methodology, the OIG's methodology does not consider all of the costs necessarily incurred for the continued operation of these special facilities, and goes beyond what is federally required.

Each of the five LAC hospitals included in the Draft Audit Report have indicated that the total operating expenses figure used by the OIG auditors originated from the respective hospital's Medicare cost report. However, that figure reflects numerous adjustments that are made because of how Medicare pays for services, not because of any finding that these costs were not incurred by the hospital in furnishing uncompensated care. The Draft Audit Report's application of "Medicare cost principles" appears to be a confusing amalgamation of Medicare cost reporting, payment and coverage rules. The mixed application of these various rules result in an illogical and internally inconsistent audit approach, and defeats the true purpose of the DSH program.

For example, the Medicare cost report provides for the removal of the salaries and benefits for interns and residents, as well as related overhead costs, from the Medicare allowable costs. These costs are removed

because Medicare payment rules provide that hospitals are reimbursed for medical education costs through the Graduate Medical Education ("GME") and Indirect Medical Education adjustments, and not on the basis of allowable costs. While the OIG auditors purport to have made an adjustment to recognize the hospital's GME costs, the auditors' methodology for calculating actual medical education costs appears to be problematic. This is because the auditors decided in this instance to disregard Medicare reasonable cost principles in favor of Medicare payment rules to arrive at a reduced amount. Specifically, the auditors would only recognize the "aggregate approved amount" for GME, which is based on the hospital's per-resident costs from 1985. In light of the Draft Audit Report's statement that the OBRA 1993 limit must be based on current year costs, it is not clear why the OIG auditors would remove the hospital's actual current year costs and substitute an amount based on costs incurred thirteen years prior to the cost reporting period.

Another example involves the expenses the hospital incurred in delivering the services of provider-based physicians. The provider-based physician costs taken from Worksheet A-8-2 of the Medicare cost report (*attached as Exhibit I*) were included in the OIG's determination of expenses with respect to the audit reports for the University of California San Diego Medical Center and Kern Medical Center. There is no reason to exclude such costs from the determination of the facility's costs for the five LAC DSH hospitals, as provider-based physician costs are costs actually incurred in furnishing health care services. These costs are reimbursable through the Medicare Program, but are paid by the carrier and not through the cost report.

There are other examples of hospital costs that are not taken into account in the Draft Audit Report. These are specifically identified in the comments submitted by the individual hospitals, which are attached.

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

> "...payment rates at a minimum meet the needs of those facilities which, because they do not discriminate in admissions against patients based on source of payment or on ability to pay, serve a large number of Medicaid-eligible and uninsured patients who other providers view as financially undesirable. These "disproportionate share" hospitals are an essential element of the Nation's health care delivery system, and the Federal and State governments, through the Medicaid program, have an obligation to assure that payment levels assist these facilities in surviving the financial consequences of competition in the health care market place." (OBRA 1987, Report

of the Committee on the Budget, H.R. Rep. No. 391, 100th Cong., 1st Sess., p. 524, attached as *Exhibit B.*)

The costs reflected in the OSHPD reports that are used in California's State Plan OBRA 1993 limit methodology are actual costs incurred by hospitals. These costs, when largely unreimbursed, place disproportionate share hospitals in financial peril, whether or not the costs are reflected in the Medicare cost reports. Such hospitals are at a particular financial disadvantage because very few of their patients are able to pay the hospital charges for services rendered.

Nothing in the language of the OBRA 1993 limit would indicate that Congress intended anything other than to continue the protection for disproportionate share hospitals against perpetual financial losses by permitting relief for all of their otherwise uncompensated costs associated with low-income and uninsured patients. This is based on the fact that nothing in section 1923 of the Act requires Medicare costs to be the basis for determining uncompensated care costs. Although it would have been simple to do so, Congress did not choose to adopt Medicare cost principles for purposes of the OBRA 1993 limit. Moreover, since the OBRA 1993 limit was enacted, Congress twice has addressed the topic of uncompensated care costs incurred by DSH facilities. In each instance, Congress makes no mention that its concern was limited only to Medicare costs. In fact, in the context of Medicare (not Medicaid) DSH payments, as discussed below, Congress rejected the existing Medicare cost data in favor of developing new data that are more reflective of the non-Medicare uncompensated care costs incurred by DSH facilities.

c. DESPITE THE OIG'S ASSERTIONS, CONGRESS AND CMS HAVE ALREADY RECOGNIZED THAT MEDICARE COST REPORT DATA IS NOT A SUFFICIENT REPRESENTATION OF UNCOMPENSATED CARE COSTS.

The OIG assumes that data from hospitals' Medicare cost reports are sufficient for determining uncompensated care costs associated with Medicaid and uninsured patients. However, both Congress and CMS have previously concluded that this is not the case. Agreeing with Congress and CMS, California has used the most complete information possible in its DSH calculations.

In the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA 1999"), Congress considered potential amendments to the Medicare DSH payment formula. In order to develop a revised formula, Congress recognized the need to collect additional data from those ordinarily collected in the Medicare cost reports. Specifically, the Secretary was required to collect "data on the costs incurred by the hospital for

providing inpatient and outpatient hospital services for which the hospital is not compensated, including non-Medicare bad debt, charity care and charges for Medicaid and indigent care." (Section 112(b) of BBRA 1999.) The data are to be collected as part of hospitals' cost reports for cost reporting periods beginning on or after October 1, 2001.

If the data for determining uncompensated care costs already existed within the Medicare cost report, the above legislation enacted by Congress would have been unnecessary.

CMS is in agreement with Congress that the necessary data for determining uncompensated care costs is not available:

> "[T]he non-Medicare data that would be collected have never before been collected and reviewed....The data would have to be determined to be accurate and usable, and corrected if necessary....
>
> "One of the difficulties in collecting uncompensated care and non-Medicare bad debt data is defining exactly the types of data being sought, particularly when there are no existing cost reporting guidelines to follow. We will be working closely with the hospital industry to identify and collect these data." (65 Fed. Reg. 47054, 47102 (August 1, 2000). *(attached as Exhibit J)*

California's State Plan methodology was specifically designed to use the most complete data available that are reflective of hospitals' costs incurred in serving Medicaid and uninsured patients. The State should not be required to retroactively modify its State Plan methodology to use data that has been rejected by Congress and CMS as unusable for purposes of determining uncompensated care costs.

Section 1923(g) provides that "the costs incurred" during the year must be determined. Section 1923(g) does not refer to Medicare reimbursement principles, and does not refer to "reasonable costs," but refers only to "incurred costs."

The term "reasonable costs" is a very specific term under the Medicare and Medicaid Acts. It is defined by Congress in 42 U.S.C. § 1395x(v)(1)(A) as the "cost actually incurred, excluding therefrom any part of incurred cost found costs determined to be unnecessary in the efficient delivery of needed health services." "Reasonable costs" is much narrower than "incurred costs," as many costs actually incurred by a hospital are not reasonable costs as defined in the statute and the Medicare regulations. Rather, reasonable costs are only a subset of incurred costs.

In addition to being clear from the language in § 1923(g), it is very reasonable that Congress would not have intended Medicare cost reimbursement principles be used in determining incurred costs of treating Medicaid and low income patients. The Medicare reasonable cost principles are not designed for the purpose of determining a hospital's total actual expenses of treating Medicare patients. Rather, the Medicare reimbursement principles are designed as a payment system, to determine the amount that should be paid for furnishing services to Medicare patients.

Various policy determinations are incorporated into the Medicare cost reimbursement rules that have little to do with determining the costs incurred by a hospital, but represent the Medicare program's policy concerning the amount of reimbursement that the program wishes to pay for services.

The use of Medicare principles to determine the OBRA 1993 limit is particularly ironic as the Medicare cost reimbursement principles now have almost no role in the Medicare program. Rather, providers (with limited exceptions) are no longer reimbursed under Medicare reimbursement principles. Since 1983, hospitals have been reimbursed for their inpatient operating costs under the Medicare prospective payment system, not under Medicare reasonable cost principles. Prospective payment methodologies have now been implemented for inpatient hospital capital-related costs, hospital outpatient service, skilled nursing facility services, home health agency services, and inpatient hospital rehabilitation services. It would be particularly anomalous for such principles to be resurrected under the Medicaid program to reduce reimbursement of DSH hospitals when they have virtually been abandoned by the Medicare program.

In conclusion, the Draft Report would require states to compute the OBRA 1993 limit using Medicare cost reimbursement principles even though:

- The governing statute does not require the use of Medicare cost reimbursement principles.
- Medicare cost reimbursement principles recognize only a portion of the incurred costs required to be included in a hospital's uncompensated costs for purposes of determining the OBRA 1993 limit.
- Medicare cost reimbursement principles are designed as a payment system to determine how much to pay hospitals, not as a system for determining incurred costs.

- The Medicare cost reimbursement principles are no longer used by CMS for purposes of determining hospital reimbursement, except in a very limited number of situations.

- The Medicare cost reports are inherently unreliable since they are no longer important to hospital reimbursement.

The Draft Report's recommendation that Medicare cost principles be used is clearly unsupportable and should be reconsidered by the OIG.

d. THE AUGUST 1994 CMS LETTER DOES NOT CONSTITUTE DEFINITIVE GUIDANCE RELATIVE TO THE APPLICATION OF MEDICARE COST PRINCIPLES.

The Draft Audit Report cites a CMS letter dated August 17, 1994, to support the proposition that reconciliation to Medicare costs are required in the fiscal administration of the DSH program. However, the auditors refer to the letter as having "provided guidance to state Medicaid Directors." Recognizing the limited authority of the guidance provided in its letter, HCFA stated that it was considering the issuance of corresponding Federal rules. Such regulations have never been issued, and thus the "guidance" that the Audit relies on has never been adopted.

The State believes that the August 1994 letter ultimately required states to develop their own standards, and the states, with very little lead time before the OBRA 1993 limits became effective, have done so. The resulting diversity of methodologies cannot be consistently assessed in accordance with a single standard. In the absence of regulations, and, in the context of state flexibility, it is not appropriate for the OIG to fill the void retrospectively with ad hoc segments of a different methodology.

What cannot be derived from the August 1994 letter is a single method as to how states are to apply "Medicare cost principles" for purposes of the OBRA 1993 limits. It cannot be as simple, as the Draft Audit Report suggests, as substituting a single data element from a particular column and line of the Medicare cost report for that otherwise called for in a complex, state-specific methodology. The effect of doing so would be unpredictable from state to state.

The State also notes that the August 1994 letter, upon which the Draft Audit Report relies heavily to support its application of Medicare allowable costs, states that Medicare principles of cost reimbursement constitute the general Medicaid upper payment limit for institutional services. As reaffirmed by CMS recently, such upper payment limits are based on a "reasonable estimate" of what Medicare would *pay* for comparable services. Notably,

states may make these upper payment limit estimates under various payment methods used by Medicare, not just reasonable costs.

e. OIG'S INCONSISTENT APPROACH TO DSH FINDINGS.

There appears to be some inconsistency in the OIG's approach to determining state compliance with the OBRA 1993 limit. The OIG is conducting similar audits of states with respect to their implementation of the OBRA 1993 limits. Audit reports for two states, Louisiana and Missouri, have been issued. The State believes the OIG has applied different audit standards with respect to those states than it has been applying for the audits in California.

Those audits appeared to focus on each state's execution of the OBRA 1993 limits under their respective State Plans. It is not apparent from any of those reports that the OIG reviewed whether the limits that were computed by the states complied with a consistent definition of "Medicare allowable costs." Specifically, with respect to Missouri, which computes the OBRA 1993 limits based on prior year data trended to the current year, the OIG applied "the same methodology used by the State in calculating DSH costs, including such factors as inflation and growth escalations...."

Those other audits did not appear to apply a cap on hospitals' allowable costs based on what is reported in the Medicare costs reports. For example, the OIG did not take issue with the Missouri State Plan methodology, which derived uncompensated care costs from a combination of estimated payments and charges for services. The OIG appeared to have found that aspects of hospital costs recognized under Louisiana's State Plan methodology should be based on Medicaid, rather than Medicare, cost report data.

3. IN THE DRAFT AUDIT REPORT, THE OIG HAS ASSERTED THAT THE STATE PLAN METHODOLOGY DOUBLE COUNTS BAD DEBT.

On the basis of this assertion, the OIG has included amounts associated with the double counting of bad debt in the overpayment amount of $142,626,773, which the OIG recommend that the Department work with CMS to address and resolve.[5]

The Department agrees that bad debt is counted twice in the current State Plan methodology. The methodology that California has employed, since the

[5] The OIG Draft Audit Report only provided an aggregate refund amount that addressed overpayment amounts related to both Medicare cost principles and bad debt. The Department estimated these figures based on data provided in the Draft Audit Report Appendices.

requirement was enacted (in OBRA 1993), is described in the State Plan. However, as noted above, the audit finding exceeds the stated objective of the audit. The auditors have not identified any variance from the approved State Plan methodology regarding calculation of total operating expenses; therefore, no disallowances should be taken. Nevertheless, the Department has reviewed the "Bad Debt" component of the OBRA 1993 formulas. The State Plan will be amended to eliminate any double counting of bad debt in the future.

The provision for bad debt was included as an explicit element of hospital costs under California's methodology, which was duly approved by CMS. As noted above, to retroactively reverse this approval, as recommended by the OIG, is not appropriate. There was a reason that this provision was included. It should be noted that Congress has expressly identified bad debt as a cost under the Medicare program. In a 1997 amendment to the Medicare definition of reasonable costs, Congress expressly refers to "the amount of bad debts otherwise treated as allowable costs...." (Section 1861(v)(1)(T) of the Social Security Act). More recently, as cited in the discussion above, Congress in 2000 directed the Secretary to collect "data on the costs incurred by the [DSH] hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated, including non-Medicare bad debt...." Clearly, this would explain why these costs were originally included in the State Plan methodology. Nevertheless, the costs should not be counted twice.

CONCLUSIONS

In conclusion, the Department wishes to emphasize the following points regarding the OIG Audit of the California DSH program:

1 The OIG concluded that the OBRA 1993 limit determined in accordance with the State Plan "did not comply" with Federal requirements. Other than in the case of the data reporting errors, all of the OIG's findings are premised on modifications from the approved State Plan methodology. The issues raised by the OIG in this audit are not isolated with respect to a particular hospital or fiscal year, but, rather, relate to the fundamental structure of California's DSH program as implemented under the State Plan. As discussed above, the Department believes there remains a lack of clear and uniform approach for determining the OBRA 1993 limits to support the OIG's recommended State Plan modifications. This factor, too, should weigh heavily in favor of resolving these issues on a prospective basis at the national level.

   Our responses can be summarized as follows:

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

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

- The Department disputes the Draft Audit Report findings regarding use of actual costs and application of Medicare cost principles on their merits. Neither Federal law nor Federal regulations support these findings.

  The Draft Audit Report's focus on use of actual costs would force the Department to change to a retrospective reconciliation process. A requirement to undertake a retrospective reconciliation to data for the actual year at issue would require a major overhaul of the DSH program currently operating in California. Most significantly, disapproval of the current methodology would require the State to abandon its present focus on making expeditious payments using that methodology. Based on experience in other programs and the auditors experience in this audit process, a retrospective reconciliation process would take years to complete. Finally, a retrospective approach could be inconsistent with the purpose of the Federal law .

2. Return of the Federal share of hospital-specific overpayments is not warranted. The State did not exceed the DSH Program total amount and should be afforded the opportunity to recover and redistribute the overpayment amounts to appropriate DSH eligible hospitals for SFY 1997-98.

3. Payments made in accordance with a State Plan are eligible for FFP (see Section 1903(a) of the Act), and, therefore, should not be considered overpayments. The Draft Audit Report did not identify any areas in which the Department varied from execution of the CMS-approved State Plan. Based upon this finding, the DSH payments represent proper Medicaid expenditures under the approved State Plan, and no disallowance is warranted.

   Any corrective action that would be required following a final determination of State Plan noncompliance should be prospective only. Prior to such a final determination payments made in accordance with the State Plan are allowable Medicaid expenditures. Thus, the recoupment recommended in the Draft Audit Report would be inappropriate, because the payments made to the 5 LAC DSH hospitals are not "overpayments" under the approved State Plan.

   If CMS concludes that the State Plan is inconsistent with law, the only appropriate remedy would be prospective, after notice and opportunity for hearing under section 1904 of the Act. To characterize the issues raised in the audit as disallowance issues would be to do what courts have regarded as legally, as well as practically, problematic. As noted by the Court of Appeals for the Seventh Circuit:

"The Secretary might not object to a nonconforming plan when it was first submitted but might wait till the state requested reimbursement under the plan and then disallow the request....[I]t is not at all clear that having made an initial determination of plan conformity the Secretary could in effect reverse it, despite the absence of any changed circumstances, when he later received requests for reimbursement from the state for expenditures made in strict conformity with the approved plan. The statute and regulations do not appear to authorize such an about-face, and the principles of estoppel, even if narrowly construed when asserted against the government,....would weigh heavily against permitting it." (*State of Illinois v. Schweiker*, 707 F. 2d 273, 278 (7th Cir. 1983).)