MAY 14 2004

TO: Wynethea Walker
Acting Director, Audit Liaison Staff
Centers for Medicare & Medicaid Services

FROM: Dennis J. Duquette
Deputy Inspector General
for Audit Services

SUBJECT: Audit of California's Medicaid Selective Provider Contracting Program, July 1, 1998 Through June 30, 2002 (A-09-02-00082)

Attached is an advance copy of our final report on California's Medicaid Selective Provider Contracting Program. We will issue this report to the California Department of Health Services within 5 business days. The audit was performed at the request of the Centers for Medicare & Medicaid Services (CMS). We suggest you share this report with the Center for Medicaid and State Operations and any other components of CMS involved with Medicaid program integrity and provider issues.

In California, a portion of the Medicaid program was operated under a Federal waiver known as the Selective Provider Contracting Program (program). The program allowed the State to contract with selected hospitals to provide inpatient services to Medicaid patients at negotiated rates of reimbursement. The negotiated rates were typically less than hospitals would have received under traditional Medicaid rules. The State used these lower rates to project savings under the waiver. Based on the savings projected, the State made supplemental payments to hospitals requesting additional funding.

For our audit period, July 1, 1998 through June 30, 2002, the State projected program savings of $7 billion (direct savings of $4.8 billion and indirect savings of $2.2 billion) and made supplemental payments of $6.2 billion.

Our audit objectives were to evaluate the reasonableness of the methodologies the State used to project program savings and the adequacy of the State's supporting documentation for its savings projections.

Our audit found that the State's projection methodologies contained errors. As a result, the State's direct and indirect savings were overstated. In addition, the State did not maintain adequate documentation to support its savings projections. Because the savings projections were inaccurate and inadequately documented, the State could not demonstrate the program's cost-effectiveness as required by the waiver.

The State overstated direct savings because its projection methodology included unrelated construction costs and overlooked Medicaid payment limits for inpatient hospital reimbursement. The State overstated indirect savings because its projection methodology included costs that were not the responsibility of managed care plans and understated the payment limits for managed care.

Also, the State used inaccurate cost and utilization data to determine direct savings. These data did not match the program's cost and utilization data reported on the hospitals' audited cost reports.

We recommend that the State:

- develop appropriate projection methodologies to address the concerns raised in this report
- recalculate projected program savings for the 4-year period ended June 30, 2002
- determine whether supplemental payments exceeded recalculated savings and refund the appropriate Federal share
- ensure that adequate documentation is maintained to support savings projections for the 4-year period ended June 30, 2002 and all subsequent periods of the waiver

The State did not concur with our findings and recommendations. It asserted that its projection methodologies were appropriate and claimed that it had adequate documentation to support program savings projections. The State also asserted that the program was cost effective. The complete text of the State's comments to the draft report are included as an appendix to this report.

As our audit results demonstrate, we believe the State's projection methodologies for direct and indirect savings were not accurate or adequately supported. In projecting savings, the State included unrelated costs, overlooked and understated payment limits, and used inaccurate cost and utilization data. Further, the State did not maintain adequate documentation to support its original projections. Until these problems are resolved, the State cannot demonstrate that the program was cost effective.

In other matters, we found that the State did not make the adjustments to inpatient reimbursement for hospitals not included in the program for fiscal year ending 1993, or later, as required by the State plan. However, State officials informed us that they were in the process of making the appropriate adjustments for all payments subject to Medicaid's payment limits and will refund the associated Federal share of any overpayments identified.

If you have any questions or comments about this report, please do not hesitate to call me or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104, or Lori A. Ahlstrand, Regional Inspector General for Audit Services, Region IX, at (415) 437-8360.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Region IX
Office of Audit Services
50 United Nations Plaza
Room 171
San Francisco, CA 94102

MAY 21 2004

Report Number: A-09-02-00082

Mr. Richard R. Bayquen
Chief Deputy Director
California Department of Health Services
1501 Capitol Avenue
P.O. Box 942732, MS 0003
Sacramento, California 94234-7320

Dear Mr. Bayquen:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Audit of California's Medicaid Selective Provider Contracting Program, July 1, 1998 Through June 30, 2002." A copy of the report will be forwarded to the action official noted below for review and any actions deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. 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 reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent the information contained therein is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-09-02-00082 in all correspondence.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Mr. Jeff Flick
Regional Administrator
Centers for Medicare & Medicaid Services, Region IX
4th Floor, 75 Hawthorne Street
San Francisco, California 94105

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF CALIFORNIA'S MEDICAID SELECTIVE PROVIDER CONTRACTING PROGRAM, JULY 1, 1998 THROUGH JUNE 30, 2002

MAY 2004
A-09-02-00082

EXECUTIVE SUMMARY

BACKGROUND

In California, a portion of the Medicaid[1] program was operated under a Federal waiver known as the Selective Provider Contracting Program (program). The program allowed the State to contract with selected hospitals to provide inpatient services to Medicaid patients at negotiated rates of reimbursement. The negotiated rates were typically less than hospitals would have received under traditional Medicaid rules. The State used these lower rates to project savings under the waiver. Based on the savings projected, the State made supplemental payments to hospitals requesting additional funding.

A condition of the waiver required the program to be cost effective, which meant that program savings had to exceed program supplemental payments. For the 4-year period ended June 30, 2002, the State projected savings of $7 billion (direct savings of $4.8 billion and indirect savings of $2.2 billion) and made supplemental payments of $6.2 billion.

OBJECTIVES

The objectives of our audit were to evaluate the reasonableness of the methodologies the State used to project program savings and the adequacy of the State's supporting documentation for its savings projections.

SUMMARY OF FINDINGS

Our audit found that the State's projection methodologies contained errors. As a result, both the State's direct and indirect savings were overstated. In addition, the State did not maintain adequate documentation to support its savings projections. Because the savings projections were inaccurate and inadequately documented, the State could not demonstrate the program's cost effectiveness as required by the waiver.

The State overstated its direct savings because its projection methodology included unrelated construction costs and overlooked Medicaid payment limits for inpatient hospital reimbursement. The State's projection methodology included costs that were not the responsibility of managed care plans and understated the payment limits for managed care.

Also, the State used inaccurate cost and utilization data to determine direct savings. These data did not match the program's cost and utilization data reported on the hospitals' audited cost reports.

[1] In California, Medicaid is referred to as the Medi-Cal program.

RECOMMENDATIONS

We recommend that the State:

- develop appropriate projection methodologies to address the concerns raised in this report
- recalculate projected program savings for the 4-year period ended June 30, 2002
- determine whether supplemental payments exceeded recalculated savings and refund the appropriate Federal share
- ensure that adequate documentation is maintained to support savings projections for the 4-year period ended June 30, 2002 and all subsequent periods of the waiver

STATE COMMENTS

The State did not concur with our findings and recommendations. It asserted that its projection methodologies were appropriate and claimed that it had adequate documentation to support program savings projections. The State also asserted that the program was cost effective.

The State took exception to the $500 million reduction in direct savings included in our draft report. Specifically, it did not agree with the methodology used to recalculate direct savings using updated cost and utilization data. In addition, the State did not believe that a recalculation of savings was required.

The complete text of the State's comments to the draft report are included as an appendix to this report.

OFFICE OF INSPECTOR GENERAL RESPONSE

The State's projection methodologies for direct and indirect savings were not accurate or adequately supported. In projecting savings, the State included unrelated costs, overlooked and understated payment limits, and used inaccurate cost and utilization data. Further, the State did not maintain adequate documentation to support its original projections. Until these problems are resolved, the State cannot demonstrate that the program was cost effective.

Although our methodology was appropriate, we removed the reference to the $500 million reduction to eliminate any confusion. As a result, many of the State's comments are no longer applicable, including comments on the use of trend factors and inflation and payment adjustments. Originally, we provided this amount to show the difference between the State's original projections and what the savings would have been using updated cost and utilization data. The information was provided only to assist the State and the Centers for Medicare & Medicaid Services (CMS) during the waiver renewal process. We are not recommending that the State recalculate savings based on these updated cost and utilization data. Instead, the State

should recalculate its projections after incorporating our recommended adjustments to its methodologies.

We have summarized and addressed the State's comments in more detail in the "Findings and Recommendations" section of this report and, where appropriate, made changes in the report.

OTHER MATTER

The State did not make the adjustments to inpatient reimbursement for hospitals not in the program for fiscal year 1993 or later as required by the State plan. State officials informed us that they were in the process of making the appropriate adjustments for all payments subject to Medicaid's payment limits and will refund the associated Federal share of any overpayments identified.

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INTRODUCTION

BACKGROUND

Medicaid Program

In 1965, the passage of Title XIX of the Social Security Act (the Act) created the Medicaid program, which authorized Federal grants to States to provide medical assistance for people with limited income and resources. Each Medicaid program is administered in accordance with a State plan approved by CMS. States make payments to providers that furnish medical services to Medicaid patients. The Federal Government pays its share of these expenditures to each State according to a prescribed formula.

Medicaid Waiver in California

In California, a portion of the Medicaid program operated under a Federal waiver in accordance with section 1915(b) of the Act. Under the waiver, the State contracted with selected hospitals to provide Medicaid services at negotiated rates. These rates were typically less than the rates that would have been paid under the traditional fee-for-service (FFS) methodology.[2] CMS first approved the waiver for this program in 1982. On February 4, 2003, it approved the waiver for another 2-year period ending December 31, 2004.

CMS approved the State's waiver with the following conditions:

- The overall program must be cost effective, which meant that total payments under the program must be less than payments the State would have made if the waiver did not exist.

- All Federal funds reimbursed to the State under the program must be for allowable Medicaid inpatient services.

Two State organizations administered the program: the California Department of Health Services and the California Medical Assistance Commission. The Department of Health Services was the single State agency with overall responsibility for administering the State Medicaid program, including managing and monitoring all program contracts. The California Medical Assistance Commission was responsible for negotiating all new program contracts and amendments covering rates, terms, and conditions.

For the 4-year period ended June 30, 2002, the State made $14.3 billion in total program payments to approximately 250 contract hospitals. Of this amount, $8.1 billion consisted of contract payments and the remaining $6.2 billion consisted of supplemental payments.

[2] Medicaid's FFS methodology is based on cost reimbursement principles.

Savings Under the Waiver

In its waiver renewal requests, the State reported to CMS that the program would be cost effective because projected supplemental payments would not exceed projected savings. For the 4 years ended June 30, 2002, the State projected total program savings of $7 billion, which included direct savings of $4.8 billion and indirect savings of $2.2 billion.

According to the State, direct savings represented the difference between negotiated payments it made under the program and the traditional FFS payments it would have made to the same hospitals without the waiver. Indirect savings represented the difference between the upper payment limits for Medicaid managed-care plans with and without the waiver.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of our audit were to evaluate the reasonableness of the methodologies the State used to project program savings and the adequacy of its supporting documentation for the savings projections.

Scope and Methodology

The audit was performed at the request of CMS and covered the 4-year period ended June 30, 2002. To accomplish our objectives, we:

- reviewed Federal and State statutes, regulations, and guidance pertaining to the program
- interviewed CMS and State officials
- evaluated the methodologies the State used to project program savings
- examined supporting documentation for the State's savings projections and supplemental payments made under the program

We did not review the allowability of the $6.2 billion in supplemental payments. We also did not review the allowability of the indirect savings, which the State projected to be $2.2 billion for the 4-year period ended June 30, 2002, because its allowability is contingent upon CMS's approval. We limited our review of savings to an evaluation of the methodologies used by the State and the documentation supporting the State's projections.

We performed the audit in accordance with generally accepted government auditing standards. We performed such tests and other auditing procedures considered necessary to meet the objectives. An overall review of the State's internal control structure was not necessary to achieve our objectives.

We conducted our audit fieldwork from June 2002 through May 2003 at State offices in Sacramento and the CMS regional office in San Francisco.

FINDINGS AND RECOMMENDATIONS

The State overstated the direct and indirect savings it reported for the program because of errors in its projection methodologies. In addition, the State did not maintain adequate documentation to support projected savings.

The State overstated its direct savings because it included unrelated construction costs in its projection methodology. The State also did not account for Medicaid payment limits for inpatient hospital reimbursement. The State overstated indirect savings because it included costs that were not the responsibility of managed care plans and understated the payment limits for managed care. Further, in its projection methodologies, the State used inaccurate cost and utilization data, which did not match the information reported on the hospitals' audited cost reports.

Because of these conditions, the State could not demonstrate the program's cost effectiveness as required. Significant reductions to the State's program savings projections would reduce the amount available for supplemental payments.

DIRECT SAVINGS WERE OVERSTATED

The State overstated direct savings of the program when it projected $4.8 billion of direct savings under the program for the 4-year period ended June 30, 2002. To project direct savings, the State determined each contract hospital's estimated benchmark[3] and contract rates for inpatient services. For each contract hospital, the State estimated benchmark and contract costs by multiplying each rate by the estimated number of inpatient days based on paid claims data for the prior State fiscal year. The State estimated each hospital's direct savings as the difference between benchmark and contract costs. The State then combined each hospital's direct savings to calculate total direct savings for the program. Finally, the State added estimated construction payments to total direct savings.

The State also overstated its direct savings projections by adding construction payments for costs that were not related to the program and not accounting for Medicaid payment limits for inpatient hospital reimbursement:

- Unrelated construction costs--The State added estimated construction payments of $290 million, which incorrectly included estimated costs related to managed care. As a result, the State overstated the hospital benchmark rates as well as its projected direct savings. The State did not provide the detailed information necessary to determine the amount of the overstatement.

- Overlooked hospital payment limits--The State did not consider payment limits when estimating the hospitals' benchmark rates. As a result, the State overstated the benchmark rates and its projected direct savings. The State Medicaid plan sets FFS

[3] The State calculated a benchmark rate for each hospital to estimate what the hospital would have been paid on an average daily basis using Medicaid's traditional FFS basis. The rate was based on each hospital's most recently audited cost data. Because current cost data were not available, the State applied a trend factor to the rate in order to estimate costs for the appropriate State fiscal year.

payment limits for inpatient hospital services. The overall impact of this error could not be determined because the State did not provide the necessary information.

INDIRECT SAVINGS WERE OVERSTATED

The State also overstated indirect savings of the program by projecting indirect savings of $2.2 billion for the 4-year period ended June 30, 2002. To project indirect savings, the State multiplied the daily savings amount (estimated benchmark rate less contract rate) by the estimated number of inpatient days for Medicaid managed-care enrollees. The State used the same estimated benchmark and contract rates it used to calculate direct savings.

State officials asserted that lower payment limits for Medicaid managed-care plans were the result of the program. The State contended that if the program had not existed, the payment limits would have been higher, and therefore it claimed the difference as indirect savings attributable to the program.

The State also overstated its indirect savings projections by including costs that were not the responsibility of managed care plans and understating the payment limits for managed care:

- Overstated benchmark rates--In estimating the benchmark rate under managed care, the State included costs that were not allocable to managed care plans absent the waiver, such as construction and medical education. By including these unrelated costs, the State overstated benchmark rates, which resulted in an overstatement of indirect savings.

- Understated payment limits--The State used the average contract rate to represent the average payment limit for managed care plans. However, the State's methodology did not account for FFS payments to hospitals not in the program, which were approximately 10 percent of total payments. By not including these payments in its methodology, the State understated the payment limits and overstated indirect savings.

COST AND UTILIZATION DATA WERE INACCURATE

The State used inaccurate data to calculate both direct and indirect savings. The State used the Financial Audit Tracking System file to estimate the hospitals' benchmark rates. The file's data did not match the data reported on the hospitals' audited cost reports. In some cases, the State incorrectly included costs and inpatient days that were not covered under the program. In other cases, the costs contained in the Financial Audit Tracking System file could not be reconciled with the audited cost reports.

DOCUMENTATION WAS INADEQUATE

The State did not maintain adequate documentation to support its original savings projections. It was unable to provide or reconstruct much of the supporting documentation.

CONCLUSION AND RECOMMENDATIONS

A condition of the waiver required the program to be cost effective, which meant that savings had to exceed supplemental payments. Because the State's projection methodologies contained errors and the State did not maintain adequate supporting documentation, it is unable to demonstrate the program's cost-effectiveness. Therefore, we recommend that the State:

- develop appropriate projection methodologies to address the concerns raised in this report
- recalculate projected program savings for the 4-year period ended June 30, 2002
- determine whether supplemental payments exceeded recalculated savings and refund the appropriate Federal share
- ensure that adequate documentation is maintained to support savings projections for the 4-year period ended June 30, 2002 and all subsequent periods of the waiver

STATE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSES

We summarized and addressed the State's comments relating to the concerns raised in our report as follows: general summary, construction costs, hospital payment limits, indirect savings, cost and utilization data, and documentation. Where appropriate, we made changes in the report to reflect the State's comments. We also included the full text of the State's response to our draft report as an appendix to this report.

General Summary

State Comments

The State did not concur with our findings and recommendations. The State asserted that its projection methodologies were appropriate and claimed that it had adequate documentation to support program savings projections. The State also asserted that the program was cost effective. The State believed that the program achieved substantial net savings, which would eliminate any need to recalculate savings projections.

The State took exception to the $500 million reduction in direct savings we included in our draft report. Specifically, the State did not agree with the methodology we used to recalculate direct savings using updated cost and utilization data. In addition, the State did not believe that a recalculation of savings was required.

Office of Inspector General Response

The State's projection methodologies for direct and indirect savings were not accurate or adequately supported. In projecting savings, the State included unrelated costs, overlooked and understated payment limits, and used inaccurate cost and utilization data. Further, the State did

not maintain adequate documentation to support its original projections. Until these problems are resolved, the State cannot demonstrate that the program was cost effective.

Although our methodology was appropriate, we removed the reference to the $500 million reduction to eliminate any confusion. As a result, many of the State's comments including the use of trend factors and inflation and payment adjustments are no longer applicable. Originally, we provided this amount to show the difference between the State's original projections and what the savings would have been using updated cost and utilization data. The information was provided only to assist the State and CMS during the waiver renewal process. We are not recommending that the State recalculate savings based on this updated cost and utilization data. Instead, the State should recalculate its projections after incorporating our recommended adjustments to its methodologies.

Construction Costs

State Comments

The State contended that all of the $290 million in estimated construction payments were related to FFS and, therefore, should be included in determining the benchmark rates. According to the State, "None of the payments were intended to cover services provided by managed care plans."

Office of Inspector General Response

The State estimated construction payments using total Medicaid utilization, which included both FFS and managed-care inpatient days. However, the State should have included only the portion of construction payments related to FFS. Therefore, only a portion of the $290 million should have been applied to benchmark rates. By including estimated construction payments applicable to managed care days, the State inflated the benchmark rates, which resulted in an overstatement of program savings.

Hospital Payment Limits

State Comments

The State agreed that it did not consider hospital payment limits when determining the benchmark rates. However, the State indicated that including the limits was not appropriate or necessary and would not have had a material impact on direct savings. The State based this conclusion on its estimate for a 4-year period that showed an insignificant amount of overpayments (about $18 million) for hospitals not in the program; its rationale that not all hospitals were subject to, or will exceed, the payment limits; and its assumption that program hospitals were generally more cost effective and less likely to exceed their limits, whereas hospitals not in the program were more likely to exceed their limits. The State also indicated that accurate hospital payment limits would have been difficult, if not impossible, to apply to future periods because of the lack of hospital data.

Office of Inspector General Response

Although State officials contended that the overpayments for program hospitals would be immaterial, they provided no concrete evidence to support this statement. On the contrary, the evidence provided contradicts the State's conclusion. The State identified $18 million in overpayments for hospitals not in the program. However, these hospitals represented only 10 percent of total hospital inpatient reimbursement. Program hospitals represented the remaining 90 percent. Assuming that overpayments to program hospitals were consistent with hospitals not in the program, potential overpayments would be $162 million. This could significantly reduce benchmark rates, resulting in reduced savings.

Indirect Savings

State Comments

The State asserted that its indirect savings methodology was appropriate and disputed our findings. The State indicated that indirect savings represented the difference between what would be paid without the waiver, which was the benchmark rate, and what was used in calculating the managed-care payment limits, which the State contended was only the contract rates. Specifically, the State asserted that construction and medical education costs should be included in the benchmark rates because an average rate was used and a majority of the hospitals do not receive these funds, and that payments to hospitals not in the program should not be included in calculating the managed-care payment limits because these hospitals do not have managed care contracts.

Office of Inspector General Response

The State's projection methodology was not consistent. The benchmark and the contract rates were not compared using the same basis. The benchmark rates were based on cost, whereas the contract rates were based on reimbursement.

To determine what would have been paid, the State used an average benchmark rate in calculating direct savings. However, this average rate included costs that were not the responsibility of managed care plans, such as construction and medical education costs. Because the State did not adjust its methodology to exclude these unrelated costs, the average benchmark rate was inflated and indirect savings were overstated.

Further, the State's projection methodology did not account for all payments because the State incorrectly assumed the average contract rate represented the average payment limit for managed care. However, in our discussions with State officials, we were informed that the payment limit calculations included payments to both program hospitals and hospitals not in the program. As a result, the average payment limit for managed care was understated, which resulted in an overstatement of indirect savings.

Cost and Utilization Data

State Comments

The State contended that the Financial Audit Tracking System file contained the best cost and utilization data available. The State asserted that it had no reason to believe that the Financial Audit Tracking System file was inaccurate. It argued that we did not present a sufficient explanation or identify any specific errors in the State's savings calculation.

Office of Inspector General Response

The State did not provide any information to show that the Financial Audit Tracking System file was accurate. State officials informed us during the audit that the Financial Audit Tracking System file was not designed for the purpose of determining benchmark rates. According to them, it was used as a tracking system for audits of cost reports only. We also reviewed 38 hospital cost reports and found discrepancies in 28 reports between the Financial Audit Tracking System file data and the audited data. For these reasons, we do not believe the Financial Audit Tracking System file was an accurate source document for the State to use in its projections.

Documentation

State Comments

The State asserted that it provided a considerable amount of documentation to us to support program savings, including actual audited cost information, inflation adjustment factors, details on the specific methodology used to calculate the benchmark and direct savings, and the benchmark rates for each State fiscal year.

Office of Inspector General Response

The State could not support the original projections it reported to CMS in its renewal waivers. The State attempted to replicate the detailed support for the reported amounts; however, the State was unable to reconcile these amounts to the original projections.

OTHER MATTER: ADJUSTMENTS TO HOSPITAL REIMBURSEMENT

The State did not make the adjustments to inpatient reimbursement for hospitals not in the program for fiscal year 1993 or later as required by the State plan. State officials informed us that they were in the process of making the appropriate adjustments for all payments subject to Medicaid's payment limits and will refund the associated Federal share of any overpayments identified.

APPENDIX

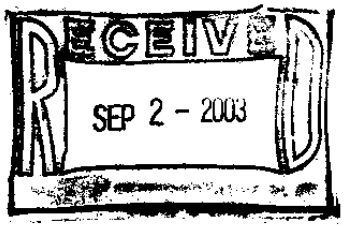
State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services
DIANA M. BONTÁ, R.N., Dr. P.H.
Director

GRAY DAVIS
Governor

August 25, 2003

Ms. Lori A. Ahlstrand
Regional Inspector General
U.S. Department of Health and Human Services
Office of Inspector General
Office of Audit Services
50 United Nations Plaza, Room 171
San Francisco, CA 94102



Dear Ms. Ahlstrand:

The California Department of Health Services (Department) expresses its appreciation to your office for agreeing to consider the Department's general concerns during the finalization of the Office of Inspector General's (OIG's) draft audit report findings. These findings were included in the May 16, 2003, draft audit report, entitled "*Audit of California's Medicaid Selective Provider Contracting Program, July 1, 1998, through June 30, 2002*" (Report Number A-09-02-00082). Furthermore, the Department appreciates the additional time granted by the OIG, which has allowed the Department to review audit workpapers and to prepare its formal response to the draft audit report. This letter constitutes our formal response, which includes a further discussion of our general concerns, as well as specific responses to individual findings.

As previously indicated, the Department is perplexed by several of the conclusions and the overall tone of the draft audit report. The Department is troubled by the overgeneralizations of several of the findings, some of which have been presented in such a way as to constitute allegations of serious violations of federal law. As explained below and within the enclosures, the specific findings do not appear to support such sweeping accusations. Therefore, the Department respectfully requests that this response be fully considered and incorporated in the preparation of the final audit report.

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TELEPHONE: (916) 440-7800 FAX: (916) 440-7805
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California established the Selective Provider Contracting Program (SPCP) in 1982, in order to ensure access to inpatient services for Medi-Cal beneficiaries, while at the same time containing the escalating costs of inpatient services. The first SPCP waiver was approved by the federal government later that same year and has been approved every two years since then. During its 20 years of operation, the SPCP has saved significant state and federal funds -- more than $6.8 billion. These funds would have been spent had the Department continued operating without the SPCP waiver. In order to better use state and federal funds, California sought and obtained this waiver to federal law.

Programs such as the SPCP make the California Medi-Cal program the most economical Medicaid program in the nation for the federal government. With six and one-half million beneficiaries, Medi-Cal provides coverage to more people than any other Medicaid program in the United States, and the program covers among the most optional benefits of any state. Yet, California ranks among the lowest states in the nation in per capita federal spending. California's prudent management of both State and federal tax dollars has generated significant savings to the federal government.

The discussion below represents the Department's concerns. We have organized our response in two parts: (1) General Concerns, which address process issues, such as methodology differences; and (2) Technical Concerns, which relate to specific problems identified within the findings.

From an overall perspective, while the Department disagrees with the OIG's findings, even if they were accepted, the OIG's own workpapers demonstrate that during the audit period under review, the SPCP achieved net savings of $336 million. Thus, the Department demonstrated that the SPCP met all federal cost neutrality standards for the audit period.

GENERAL CONCERNS

(1) **Concerns Regarding the OIG's Methodology.** Overall, the Department disagrees with the methodology used by the OIG during the audit, which consisted of a retrospective reconciliation of projected Program savings to actual savings. The Department's concern is that the OIG's findings and subsequent recommendations were established using this retrospective process.

Based on its findings, the OIG recommends that the State recalculate SPCP savings for the four year period in order to identify any unallowable supplemental payments made in excess of actual savings and to refund the appropriate federal share. This is despite the fact that the savings that were approved by the Centers for Medicare & Medicaid Services (CMS) were known to be "projections" based on the best available information at the time. The projected savings were subject to many discussions and written communications between CMS and the Department

during the waiver renewal and approval process. In the 20 plus year history of the SPCP, CMS has never required a retrospective reconciliation of projected savings to actual savings. Furthermore, during the exit conference, CMS representatives stated that they could only recall one time in the recent history of federal waivers (several hundred) where state budget neutrality estimates were audited and compared to actual expenditures. However, it now appears that the OIG is attempting to impose a new federal requirement and hold the Department accountable for such a reconciliation.

It is also important to note that the OIG's retrospective reconciliation methodology was possible only because the OIG's audit was conducted many years after the hospital's fiscal periods subject to this review. It almost goes without saying that when the direct savings projections were developed by the Department, these audited cost data were unavailable. Therefore, the Department relied upon its collection of two to three year old audited cost information and projected these audited costs based on inflation factors to establish a benchmark for each hospital. The Department believes that this methodology is what the OIG should have evaluated to determine the reasonableness of the State's direct savings projections, as opposed to reconciling to actual audited costs. Nothing in the SPCP waiver approval imposed a requirement for retrospective reconciliation.

Moreover, the imposition of a reconciliation requirement appears to be beyond the original objective of the audit, which was to evaluate both the reasonableness of the Department's methodology used to "project" original program savings, and the adequacy of the Department's supporting documentation for its savings projections. At the time direct savings were projected by the Department, "actual" audited costs and Medi-Cal paid days for the projected period were not known to the State, and it would have been impossible to calculate direct savings based on the retrospective reconciliation process used by the OIG. The Department continues to believe that its methodology using two to three year old hospital audited cost information updated with inflation factors was an appropriate and reasonable method to estimate a hospital's benchmark and associated direct savings. Again, this methodology was accepted by CMS during the waiver renewal process.

(2) **The State's Methodology for Projecting Program Savings**. The draft audit report states direct savings were overstated because the State's methodology for determining benchmark rates *". . . used inaccurate hospital cost and utilization data . . ."*

The above finding relates to the direct and indirect savings projections the Department presented to CMS. The Department disagrees with the OIG's position that the most current audited cost data was not used in projecting direct savings. Apart from the difference in methodologies discussed above, the OIG's recommendation to use more current audited cost data implies that the OIG may not fully understand the hospital's annual cost report submission and auditing

timeframes. This statement may further indicate that the OIG may not realize that the Department did, in fact, use the most current audited cost data available in 1998 when the direct savings estimates were developed. Furthermore, federal law imposes on states a two year claiming limit. To adopt the payment methodology suggested by the OIG would require the Department to violate this claiming limit.

One issue that the OIG identified in relation to this finding is that the Financial Audits Tracking System (FATS) file used by the Department to estimate the hospital's benchmark rates was not accurate. Although the audited cost data used by the Department originated from the FATS file, it was the Department's understanding at the time that the audited cost information in the FATS file represented the most current audited cost information available. The Department had no reason to believe it was inaccurate. During the OIG audit, it was clarified that the FATS file included both "reported" data and "audited" data. Moreover, it was further clarified that the hospital's reported data maintained in the FATS file is only updated when an audit is completed. Thus, the FATS information changes on a continuous basis, which may account for some of the inaccuracies identified by the OIG.

In addition, the OIG did not identify any specific errors in the Department's calculation of any hospital benchmarks used to project direct savings, other than to note that the audit information was derived from the FATS file and the information was considered by the OIG to be inaccurate. Also, the OIG draft audit report and workpapers did not provide any explanation or documentation to support the alleged FATS file inaccuracies, nor did the OIG draft audit report and workpapers identify which data incorrectly included costs and inpatient stays not covered under the waiver. Moreover, the OIG did not explain how the use of the FATS file impacted the Department's projection of direct savings. Although there are likely some errors in the FATS file, the Department believes the errors would not explain the overstated direct savings reported by the OIG. Before the OIG draws such a broad and sweeping conclusion, the Department should be afforded the opportunity to see documentation that leads the OIG to that conclusion.

(3) **Direct Savings vs. Net Savings.** ***Direct Savings:*** In relation to the OIG's finding that the State's methodology for determining hospital's benchmark rates used inaccurate hospital costs and utilization data, the OIG further asserts:

> *". . . projected direct savings would be reduced by approximately $500 million if the State used updated cost and utilization data included on the hospital's most recently audited cost reports."*

The Department disagrees with this finding, in part, due to the methodology used by the OIG. However, in addition to the concerns regarding the methodology, the Department also disagrees with this finding because of technical errors discovered during its review of the OIG workpapers, which are discussed in the later part of this response under Technical Concerns. Moreover, the Department believes that the OIG did not address "net" savings achieved by the State as described below.

Net Savings: Net savings is calculated by determining program savings (Direct and Indirect) less per diem and supplemental payments. Specifically, according to the OIG, the Department reported approximately $836 million in net savings for the four year period under review. These net savings were acknowledged in the OIG workpapers, but for reasons that are unclear, the net savings were not taken into consideration when the OIG recommended that the State:

> *". . . recalculate Program savings for the four-year period ended June 30, 2002 . . . " and ". . . identify any unallowable supplemental payments made in excess of program savings and refund the appropriate federal share . . . "*

The Department disagrees with these recommendations based on the fact that the OIG did not take into consideration the net savings when making their recommendations. Specifically, in accordance with section 1915(b) of the Social Security Act, and the waiver renewal provisions imposed by CMS, the Department must demonstrate that the SPCP is cost-effective. As stated above, according to the OIG, the Department's documentation showed that the SPCP achieved an estimated $836 million in net savings during the four year, thereby demonstrating that the SPCP is cost-effective. Even if the Department accepted the finding that direct savings were overstated by approximately $500 million, the OIG auditors themselves affirm that the Department demonstrated net savings in the amount of $336 million for this four-year period (the Department's $836 million in net savings less the OIG's $500 million in direct savings).

Therefore, regardless of which methodology is used to determine the reasonableness of the Department's projected savings (i.e., the Departments or the OIGs) there were no supplemental payments made in excess of SPCP waiver program savings. Accordingly, there is nothing that would justify the need for the Department to recalculate savings projections for the four year period in order to identify any unallowable payments made in excess of program savings and to refund the appropriate share. While the Department disagrees with the OIG's conclusion, even if the OIG is correct, the SPCP waiver saved $336 million. Thus, the Department demonstrated that the SPCP met all federal cost neutrality standards.

(4) **Documentation for Program Savings.** The OIG draft audit report asserts that:

> *"The State did not maintain adequate documentation to support both its projected direct and indirect Program savings. The State had to reconstruct much of the supporting documentation it provided to us, but encountered difficulties in replicating the documentation to support its original projections."*

The Department disagrees with this finding. The unavailability of personnel who developed the original documentation in 1998, and the resulting difficultly of recreating the supporting documentation does not substantiate this finding.

Specifically, during the audit, the Department provided the OIG with a considerable amount of documentation. This documentation included, but was not limited to, the actual audited (blue cover) cost information, inflation adjustment factors, the specific methodology used to calculate the benchmark and direct savings, and the benchmarks for each State fiscal year.

(5) **Documentation for Supplemental Payments.** Under "Other Matters", the OIG draft audit report findings state that the Department did not have:

> *". . . adequate documentation to support $6.2 billion in supplemental payments made during the 4-year period. Therefore we (OIG) could not determine if (1) the hospitals receiving supplemental payments were eligible, (2) the payments were for allowable Medicaid costs and services. In addition, in some cases, the state was unable to provide a basis for awarding funds to the hospitals."*

At best, these statements are significant over-generalizations and mischaracterize the facts. During the audit, the Department provided the auditors with extensive documentation for the supplemental payments made under the SPCP waiver. To make such a broad statement that documentation is lacking for these supplemental payments is misleading and raises unnecessary and inappropriate concerns. This statement concerning the adequacy of documentation may also indicate that the auditors may not have fully focused on the difference between a reimbursement program, such as the SPCP, and a grant program. Specifically, under a grant program, a "line item" approach is used to track how much money was provided and how the money was used. By contrast, under the SPCP, supplemental payments are available in addition to an eligible hospital's per diem rate -- and such supplemental reimbursement is provided for allowable costs of Medi-Cal services as specified in the waiver.

Furthermore, as recently as June 5, 2003, the OIG auditor staff continued to visit and interview hospitals regarding supplemental payments made through the SPCP waiver. These audit activities were interpreted as an indication that the audit was not yet complete, and yet the draft audit report includes the above findings, which are presented in such a way as to allege serious federal violations. In addition, during the exit conference, OIG audit staff mentioned that their review of the supplemental payment programs would be a totally separate audit. The Department believes any conclusions relative to supplemental payments made under the SPCP and referenced in this OIG audit report would be highly premature. As such, the Department is seriously concerned that a discussion of these supplemental payments and preliminary findings is included in the draft audit report.

TECHNICAL CONCERNS

In addition to the general concerns described above, the Department has identified several technical inaccuracies with respect to the OIG's finding that indicates the direct savings were overstated by $500 million. Specifically, due to the technical concerns discussed below, the Department believes that the direct savings calculated by the OIG and identified as "overstated" should have been estimated at $150 million (using the OIG methodology that the Department disagrees with), instead of $500 million. Please refer to Appendix A for an overview of the Department's findings relative to technical errors and their impact on the $500 million in overstated direct savings calculated by the OIG.

The following represents the Department's review of the OIG's workpapers, which indicate various problems in the OIG's data collection and recalculation of direct savings.

1. **OIG Cost Information.** The OIG used inaccurate hospital audited cost data to recalculate direct savings. Specifically, the OIG workpapers indicate that the OIG based this finding on each contract hospital's actual audited cost. However, the Department found data collection errors or discrepancies in the audited cost data used by the OIG. Specifically, the Department found three hospitals with more audited costs than what was listed in the OIG's workpapers, one of which was significant ($25.7 million for one fiscal year alone). Furthermore, due to time constraints associated with the Department's review of the OIG draft audit report, the Department was unable to review all audit reports referenced in the OIG's analysis. The Department's concern is that similar data collection errors may exist, which could significantly impact the OIG's analysis. For example, if similar data collection errors were made by the OIG in relation to cost report data not verified by the Department, the OIG's estimate of direct savings may be overstated by $155.8 million if the $25.7 million was extrapolated over the remaining costs reports not reviewed by the Department. Please refer to Appendix B for more detail.

2. **Trend Factors.** The Department found two basic errors in the OIG workpapers regarding the application of trend factors used by the OIG to recalculate direct savings: (1) an incorrect application of trend factors that actually reduced the audited costs of certain hospitals; and (2) the OIG was inconsistent in applying the trend factors to various hospitals. The incorrect and inconsistent application of the trend factor to audited costs caused direct savings for several hospitals to be understated by an estimated $48 million. Please refer to Appendix C for more detail.

3. **Inflation Adjustments.** In the draft audit report, the OIG implied that the State did not use updated cost data. However, the OIG auditors themselves used outdated inflation adjustments to recalculate direct savings. Specifically, during the exit conference, the OIG stated that the trend factors originated from the State's benchmark inflation factors provided to the OIG in August 2002. Therefore, the Department found that even the OIG did not use the most current data available for its audit. Instead, the OIG relied upon benchmark inflation or trend factors that

were almost a year old. The Department maintains the position that the methodology used to project direct savings relies on the most current and updated inflation factors available at the time the projections were made. Moreover, if the OIG had done the same, its "overstated" direct savings figure would have been less. Please refer to Appendix D for more detail.

4. **Payment Adjustments.** The OIG used improper payment adjustments to recalculate direct savings. Specifically, the Department disagrees with the OIG's finding relating to third party liability (TPL) and other "payment" adjustments to audited "costs." In California, claims for inpatient services for a Medi-Cal beneficiary may not be submitted for payment until all other payers have been exhausted. Then, when a claim is submitted, the TPL payment is deducted from the Medi-Cal payment and the hospital receives the net amount. Therefore, the TPL reduces the amount that is claimed for federal reimbursement. The Department explained the process of collecting TPL and its relationship to Medi-Cal per diem payments to the OIG, but it appears this explanation was not taken into consideration in developing these workpapers.

   The restoration of these payment adjustments would result in an estimated $139 million in direct savings. In addition, the Department is uncertain as to how the OIG estimated TPL payments. Please refer to Appendix E for more detail.

5. **Updated Cost and Utilization Data.** As stated earlier, the OIG's recommendation that the State should have used more current audited cost data implies the OIG may not fully understand a hospital's annual cost report submission and auditing timeframes. Therefore, please refer to Appendix F for an overview of this process.

6. **Construction Costs not Covered Under the SPCP Waiver.** The OIG indicates that the State added construction costs not covered under the waiver in estimating the hospital's benchmark rates. This issue was discussed in depth with the OIG auditors during the audit. Because no further information was requested by the OIG in December 2002, nor did the OIG staff ask any additional questions relating to these costs, the Department believed that this issue was resolved. However, because this issue is identified as a finding, the Department offers further clarification of its original response. Specifically, the Department previously explained that only the fee-for-service costs for the construction projects attributable to services provided under the SPCP are included in the benchmark, and so the total construction payments should be offset against waiver savings. Therefore, these payments, regardless of how they are computed, are appropriately included under the SPCP waiver calculation. Please refer to Appendix G for more detail.

7. **Peer Group Inpatient Reimbursement Limit.** As one of its five major findings, the draft audit report states that the Department *". . . ignored Medicaid payment limits for inpatient hospital reimbursement . . ."*

   At the exit conference this finding was identified by OIG staff as referring to the peer group inpatient reimbursement limit (PIRL), which is set forth in the California State Plan and is part of the reimbursement calculation for non-SPCP, or non-contracted hospitals. The OIG's finding indicates that the PIRL limitation was not considered when the Department determined the benchmark rates. Although this is true, there are several reasons as to why this would not be appropriate or necessary. A recent estimate of the PIRL calculation indicates that over a four year period, only about $18 million ($9 million Federal Funds) was identified as a potential recovery (before appeals) from non-SPCP contracting hospitals. This is an insignificant recovery relative to the population of non-SPCP hospitals. In addition, the PIRL calculation is an individual hospital limit and there isn't a direct correlation between the SPCP hospitals and the non-SPCP hospitals in order to apply a factor to the benchmark rate. In fact, the SPCP hospitals by virtue of being competitive are historically more cost effective and may not exceed the per discharge limit of their applicable peer group. By contrast, a non-SPCP hospital that is reimbursed costs is more likely to exceed the limit. Therefore, the Department believes that although this finding is true, it is immaterial. Please refer to Appendix H for more detail.

   We would also like to note that the Department and OIG audit staff had an extensive discussion regarding this issue, after which the Department was left with the impression that the auditors were convinced that, although the PIRL adjustment was not applied in the savings calculation, the amounts were insignificant. Now this finding is "bulleted" as one of five major findings in the draft audit report, leaving the reader with the impression that the Department ignored a material issue.

8. **Indirect Savings.** The OIG concluded that the projection of the indirect savings required the same adjustments as the projection for the direct savings. Specifically, the OIG stated that the benchmark rates were overstated and the managed care payment limits were understated. Equally, the Department has the same concerns regarding the OIG's findings due to the technical errors identified in the audit workpapers. In addition, the OIG concluded that the indirect savings should include other considerations for the managed care upper payment limit (UPL), such as (1) the inclusion of construction and medical education costs; and (2) 10 percent of total payments that go to non-SPCP hospitals. Although the managed care UPLs were not a part of this OIG audit, the OIG's conclusions are based on a misunderstanding of how the managed care upper payment limits were calculated during the four year period under audit. As explained in Appendix I, although we agree, the SPCP contracts and managed care plan contracts are concentrated in urban areas and the areas for each overlap. The majority of non-contract hospitals are located in non-urban areas where Medi-Cal does not have managed care contracts.

As such, the managed care UPLs should not include non-contract fee-for-service equivalents in their upper payment limit calculations. The indirect savings are only attributable to the SPCP waiver payments. For these reasons, the Department believes that the OIG conclusion is unfounded.

CONCLUSION

Overall, the Department does not agree with the majority of the draft audit report based on the concerns set forth above. Therefore, the Department believes it is appropriate for the OIG to re-characterize the audit report findings as currently drafted to more accurately reflect the conclusions in relation to the detailed findings. Of most significance is the fact that regardless of the Department's disputes relative to the OIG's findings, the OIG auditors, through their own workpapers, affirm that the Department demonstrated program net savings of at least $336 million for the four year period. This conclusion should eliminate the recommendation that the Department recalculate savings projections for the four year period in order to identify any unallowable payments made in excess of program savings and to refund the appropriate share.

In closing, the Department acknowledges that there is always room for improvement with respect to monitoring and administrating any program, whether it be at a local, state, or federal level. To that end, the Department is willing to consider any reasonable suggestions relative to future program monitoring that may result from this audit. However, it should be noted that the terms and conditions associated with the current SPCP waiver renewal are very different than prior SPCP waiver renewals, in that the terms and conditions are more comprehensive. Specifically, CMS imposed a SPCP waiver UPL in the most recent waiver renewal approval, and as part of this UPL, the Department is required to submit quarterly reports identifying both per diem and supplemental payments made to individual hospitals under the SPCP. Therefore, any suggestions relative to future program monitoring should be considered in association with the current SPCP waiver renewal terms and conditions.

Thank you in advance for your time and consideration. If you have questions, or need additional information, please contact Mr. Benjamin C. Thomas, Chief, Medi-Cal Operations Division, at (916) 552-9115.

Sincerely,

Stan Rosenstein
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Enclosures

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APPENDIX A

Overview of Technical Concerns

The OIG's analysis of available audited costs and payments for State fiscal year's 1998-99 through 2001-02, suggested that the State overstated the direct savings by approximately $500 million, and recommended that the State "identify any unallowable supplemental payments made in excess of savings and refund the appropriate federal share." However, the OIG analysis and subsequent finding failed to mention the "net savings" attributed to the SPCP waiver years under review. "Net savings" represented the sum of direct and indirect (SPCP generated managed care) savings obtained through the SPCP waiver less Medi-Cal contracted (per diem and supplemental) payments. Per the OIG workpapers, for this waiver period, approximately $836 million in "net savings" was reported by the State, yet these savings were not specifically referenced in the OIG draft audit report.

State Response:

Due to the technical issues raised in our letter (and discussed in the following Appendixes), the overstated direct savings calculated by the OIG should have been approximately $150 million (using the OIG methodology that the State disagrees with), instead of $500 million. This figure was calculated as follows:

OIG overstated direct savings estimate		$500,000,000
Errors in the audited cost data	($155,800,000)	
Inconsistent and outdated use of trend factors	($48,000,000)	
Restoration of TPL and other payment Adjustments	($139,000,000)	
Total Deductions to OIG overstated direct Savings		($342,800,000)
Adjusted (and corrected) OIG estimate of overstated direct savings		$157,200,000

To put the OIG's methodology and finding in perspective, total direct savings for the four years under review was $4.8 billion. The $150 million was only 3.2 percent of the total direct savings estimate. Such a relatively small difference can be attributed to a number of factors beyond the control of the State's direct savings methodology. For example, "actual" inflation increases versus the State's "projected" inflation adjustments (which was

not criticized by the OIG and even used for its projections), reductions in the hospital's cost reporting or audit results that resulted in lower than projected audited costs, etc. Despite the explanation, it is important to refer back to the State's position with the reasonableness of the OIG's methodology -- and to understand that the OIG's cost reconciliation methodology was not the same as the methodology used by the State to project direct savings. Therefore, this figure does not represent what is alleged in the OIG draft audit report.

In addition, the recommendation that the State "identify any unallowable supplemental payments made in excess of savings and refund the appropriate federal share," is very misleading, especially when one considers that the OIG workpapers identified approximately $836 million in SPCP "net savings" for the waiver years under review. For reasons that remain unclear, the OIG work papers acknowledged the "$835,977,000" in "net savings," but these "net savings" were not mentioned in the OIG draft audit report. Even if direct savings were different than what was reported by the State, this difference would only reduce "net savings," and the SPCP program would remain cost effective and would not result in inappropriate federal claiming.

APPENDIX B

OIG Cost Information

The OIG workpapers indicated that the OIG based it's finding on each contract hospital's actual audited costs. The workpapers did not identify the source of this audit information, however, it is believed that the information was derived from the (blue cover) audit reports issued by the Department's Audits and Investigations Division.

Additionally, the OIG workpapers did not identify the exact cost centers from the audit report that were presumably used in the determination of each hospital's audited costs and days.

State Response:

The State found data collection errors or discrepancies in the audited cost data used by the OIG. One of these errors was significant in the OIG finding.

Upon receipt of the OIG draft audit report, the audit workpapers and OIG statements indicating that the audited cost information derived from the FATS file were inaccurate, the State obtained copies of the (blue cover) audit report for 156 contract hospitals. Because of time constraints and the availability of the OIG work papers, the State focused only on the fiscal year ending 1999 audit reports listed in the OIG work papers for State fiscal year 1999-00 (approximately two thirds of all audit reports listed for this fiscal year).

The State also analyzed the audit reports for the fiscal year ending in 1999 because these audit reports were readily available and specifically used in the OIG analysis based on the State's review of the OIG workpapers received on June 25, 2003. The State then compared the actual audited cost data contained in each audit report to the audited costs displayed in the OIG workpapers.

The State found three hospitals with more audited costs than what was listed in the OIG workpapers. Two errors were relatively insignificant (less than $22,000) and alone would not have impacted the OIG analysis. However, the third error was significant ($25.7 million), and may explain why the OIG believes that projected direct savings may have been overstated.

The three errors are identified in the following table:

Health Facility Planning Area	*License Number*	*Hospital Name*	*OIG Audited Costs*	*Blue Cover Audited Costs*	*Difference*
811	492	Los Robles Regional Medical Center (FPE 12/31/99)	$3,011,174	$3,013,298	$2,124
921	599	Suburban Medical Center (FPE 8/31/99)	$10,344,862	$10,364,518	$19,656
935	1230	Los Angeles Co. Martin Luther King Medical Center (FPE 6/30/99)	$59,820,067	$85,474,172	$25,654,105
		Total Difference in (Blue Cover) Audited Costs			**$25,675,885**

Unfortunately, the time constraints associated with the State's review of the OIG draft audit report did not allow an opportunity to review all audit reports referenced in the OIG analysis. However, it is possible that similar data collection errors may have been made by the OIG, and therefore, the OIG's estimate of direct savings may be overstated by $155.8 million ($25.7 million/.667 x 4 years). This figure could be even higher if the existence of data collection errors in other audit reports was more frequent and/or the significance of individual errors was larger.

APPENDIX C

Trend Factors

The OIG workpapers indicated that the OIG collected audited cost data on hospitals with varying fiscal year ends. To ensure audited costs were updated and compared with payments for comparable periods, the OIG applied a "trend factor." Because audited cost data is historical, this trend factor should have been a positive adjustment to audited costs for each State fiscal year.

The fiscal year of each hospital and trend factors are found in the OIG workpapers under columns E (labeled "AIFYE") and J (labeled "Trend Factor"), respectively.

State Response:

The State found two basic errors in the OIG workpapers regarding the application of the above trend factors. These errors were:

- The OIG incorrectly applied trend factors that actually reduced the audited costs of certain hospitals, rather than increase the hospital's audited costs (see percentages less than 100% in column J). Because the audited cost data and audit reports were for fiscal periods "prior to" the State fiscal year in each TAB section of the OIG spreadsheet, this was an error. Reducing the hospital's audited costs also understated the direct savings attributed to that hospital.

- The OIG was inconsistent in applying the above trend factor to various hospitals. Because the trend factor was intended to adjust audited costs based on the fiscal year of each SPCP contract hospital, the same trend factor should have been applied to each hospital with the same fiscal year end.

  The State's review of the OIG workpapers indicated that several hospitals with the same fiscal year end had different trend factors applied to their audited costs. For example, Barlow Respiratory ((HFPA 952/License No. 52), Bellflower (HFPA 921/License No. 66), and Brotman Medical Center (HFPA 927/License No. 110) all had a fiscal year ending August 31, 1999 (reference the OIG spreadsheet TAB for fiscal year 1999-00), and the OIG applied trend factors of 98.53%, 103.81% and 98.70%, respectively. Presumably, these three hospitals should have had a trend factor of 103.81% applied to their audited costs (using the OIG inflation adjustments). The inconsistent and incorrect application of the trend factor to audited costs resulted in direct savings for Barlow Respiratory and Brotman Medical Center to be understated. Similar errors were found in the OIG application of the trend factors to other hospitals as well.

The above errors were also found in each State fiscal year of the OIG's analysis. Appendix A provides the estimated fiscal impact of these two error types, combined with the estimated fiscal impact associated with the OIG's use of outdated inflation factors, which is discussed in the following Appendix D.

APPENDIX D

Inflation Adjustments

During the exit conference on June 24, 2003, the OIG audit staff clarified that the trend factors addressed under Appendix C (see column J of the OIG workpapers) originated from the benchmark inflation factors provided to the OIG in August 2002. These inflation factors were established by the State based on monthly updates from the Consumer Price Index (CPI) published by the Bureau of Labor Statistics through June 2002.

State Response:

Under the OIG draft audit report section titled "Objectives, Scope and Methodology," the OIG indicated that it "used the most current data available to calculate direct savings." Also, the OIG analysis (and subsequent recommendation) further suggested that the State should use the most recent data available to project direct savings. Despite making these statements, the State found that even the OIG did not use the most current data available for its audit. Instead, the OIG relied upon benchmark inflation or trend factors that were almost a year old.

Based on the State monthly analysis of the CPI indicators (through May 2003), the current inflation adjustment is slightly higher when compared with the inflation adjustments calculated a year ago. As the State mentioned to the OIG on several occasions, the benchmark inflation factors are updated on a monthly basis, i.e., whenever the Bureau of Labor Statistics publishes new CPI indicators. It is possible that the OIG's delay in issuing its draft audit report contributed to its use of outdated adjustment factors. However, the State could have provided the OIG with more current benchmark inflation or trend factors, but this information was never requested.

The State maintains the position that the methodology used to project direct savings relies on the most current and updated inflation factors available at the time. Moreover, if the OIG had done the same, its overstated direct savings figure would have been less.

The fiscal impact associated with using the most current inflation factors in the OIG's fiscal year 1999-00 direct savings calculation (the first set of OIG workpapers submitted on June 25, 2003), and correcting the OIG errors identified under Trend Factors, was approximately $12.0 million. In effect, direct savings for fiscal year 1999-00 and the four years of the OIG audit should have been approximately $12.0 million and $48.0 million, respectively, higher than what was calculated by the OIG.

APPENDIX E

Payment Adjustments

The OIG workpapers indicated that after the audited costs of each hospital was determined, an adjustment was made to reduce audited costs by the amount of any third party liability (TPL), or other payments. Unfortunately, the OIG workpapers did not disclose the source of these TPL payments, or what was included in the "other payment" category. Nevertheless, these payments and adjustments appeared under columns H ("TPL and other Pmts") and L ("SFY 00 Benchmark Less TPL") of the OIG workpapers.

State Response:

The State disagrees with the above TPL and other "payment" adjustments to audited "costs." The methodology used by the State to calculate direct savings was to compare updated audited "costs," or the hospital's benchmark, to estimate per diem "payments."

In California, claims for inpatient services for a Medi-Cal beneficiary may not be submitted for payment until all other payers have been exhausted. Then when a claim is submitted, the TPL payments are deducted from the Medi-Cal payment and the hospital receives the net amount. Therefore, the TPL reduces the amount that is claimed for Federal match.

However, the TPL varies by beneficiary, by hospital, by year. TPL is not a co-payment that is predictable for any given service or beneficiary. Therefore, It would not be appropriate to reduce the projected benchmark by an amount that is beneficiary specific for a previous period. A hospital may have a large TPL one year and none the next year based on the Medi-Cal beneficiaries that receive services. In other words, for benchmark purposes a reduction for TPL would not be appropriate for projecting the direct savings.

The State explained to the OIG during various discussions the process of collecting TPL and its relationship to Medi-Cal per diem payments, but it appears this explanation was not taken into consideration in developing these workpapers. In addition, the State is uncertain as to how the OIG estimated the TPL for the finding.

Restoring the above payment adjustments in the OIG workpapers would increase direct savings for FY 1999-00 (the first set of OIG workpapers submitted on June 25, 2003) and the four years of the OIG audit by $35.1 million and approximately $139.0 million, respectively.

APPENDIX F

Use of updated cost and utilization data

Under the OIG draft audit report section titled "Direct Savings," the OIG stated that "projected direct savings would be reduced by approximately $500 million if the State used updated cost and utilization data included on the hospital's most recently audited cost reports." Although this statement is vague, the OIG has recommended that the State should rely on more current audited cost data similar to what the OIG used for the audit.

State Response:

The State disagrees with the OIG's position that the most current audited cost data was not used in projecting direct savings. The OIG recommendation to use more current audited cost data implies that the OIG may not fully understand the hospital's annual cost report submission and auditing timeframes. This statement further indicates that the OIG may not realize that the State did, in fact, use the most current audited cost data available when the direct savings estimates were developed. The following should be considered:

- Annual cost reports are due to the Department's Audits and Investigations Division 150 days following the hospital's fiscal year end.
- After each cost report is submitted to the State, it is subject to internal review and tentative settlement (for non-contract hospitals), and typically scheduled for field review months later. The Sate has three years from the submission of the cost report to complete the audit.
- The fieldwork is usually completed several months after the audit is scheduled and the issuance of the (blue cover) audit report can be up to two-three years after the hospital's fiscal year end.
- When the direct savings projections were done, the State used the most current audit data available at the time. Although the audit data did originate from the FATS file, and the OIG has questioned the accuracy. The audited cost information in the FATS file did represent the most current audited cost information available, and, at the time, the State had no reason to believe it was inaccurate.
- Because of the hospital cost report and audit schedule lag time, even the OIG found that the audited cost information was not all available for State fiscal years 1999-00, 2000-01 and 2001-02. As a result, the OIG relied on projections based on what audited cost data was available, which is essentially the methodology used by the State.

It is also important to note that the OIG methodology and retrospective reconciliation process was an option only because the OIG audit was conducted many years after the fiscal periods under review. When the direct savings projections were developed by the State, these audited cost data were unavailable. Therefore, the State collected two to

three year old audited costs information and projected these costs based on inflation factors to establish a benchmark for each hospital. The State believes this is what the OIG should have evaluated to determine the reasonableness of the State's direct savings projections, as opposed to reconciling to actual audited costs.

APPENDIX G

Construction Costs Not Covered by the SPCP Waiver:

The OIG indicates that the State added estimated construction costs of $290 million in estimating the hospital's benchmark rates. However, these construction costs related to both FFS and managed care patients. The state should have excluded the construction costs related to managed care. As a result of not excluding these non-covered costs, the state overstated the hospital benchmark rates and its projected direct savings. The state could not provide the detailed information necessary for us to determine the amount of the overstatement.

State Response:

This issue was discussed in depth with OIG auditors during the audit. The following represents the State's written response, which was provided to the OIG auditor's in December 2002.

The State statute that addresses the SB 1732 program was established in 1988, and the applicable regulations include the methodology for computing the reimbursement under this program. This methodology is dependant on the Disproportionate Share Hospital program methodology for the determination of the Medi-Cal utilization rate. By statute, the SB 1732 utilization rate includes managed care days.

However, this is only a methodology for determining the amount to be paid. The total amount paid under the SPCP waiver is only for services provided under the SPCP waiver. As is the case for payments under any of the supplemental programs, this amount is deducted in total from the SPCP savings. None of the payments are intended to cover services provided by managed care plans. In addition, only the fee-for-service costs for the construction projects attributable to services under the SPCP are included in the benchmark. Therefore, the SB 1732 payments, regardless of how the payments are computed, should be included under waiver calculations. Since no further information was requested by the OIG in December 2002, nor did the OIG staff ask any additional questions relating to these costs, the State believed that this issue was resolved. However, because this issue is identified as a finding, the State offers further clarification of its original response below.

Example:

In the attached Schedule each hospital has applicable Medi-Cal charges, Medi-Cal costs and Medi-Cal payments, depending on the programs for which they are eligible. However, in this example the dollars in each of these categories are SPCP related. In other words, for comparison purposes, all Medi-Cal charges, costs and payments are included regardless of how they are negotiated or calculated. Neither the State nor CMAC, decrease any of these dollars for managed care or any other non-SPCP dollars.

- Medi-Cal charges includes only claims that are billed using the SPCP contract provider number.
- Medi-Cal costs are derived from the submitted or audited cost report for services provided to Medi-Cal fee-for-service beneficiaries. These costs do not include any costs related to providing services to managed care beneficiaries.
- Medi-Cal payments are all payments made to an SPCP contract hospital regardless of how the payments are negotiated or calculated.

Construction Costs Not Covered By The SPCP Waiver
Example Schedule

		Hospital A	Hospital B	Hospital C	Hospital D	Total M/Cal
1	M/Cal Charges	$150	$100	$140	$80	$470
2	M/Cal Costs	$125	$90	$120	$75	$410
	M/Cal Payments					
3	Per Diem Pmts	$80	$85	$100	$70	
4	SB 1255	$15	$0	$10	$0	
5	AB 761	$0	$0	$0	$2	
6	GME	$10	$0	$5	$0	
7	SB 1732	$8	$0	$10	$0	
8	Total M/Cal Payments	$113	$85	$125	$72	$395

APPENDIX H

California State Plan Payment Limits (PIRL)

The OIG indicated in the summary of findings that the State "ignored Medicaid payment limits for hospital inpatient hospital reimbursement." Additionally, the OIG indicated that the California State Plan requires the adjustment to inpatient reimbursement for hospitals not in the program, in the "Other Matters" portion of the draft audit report. During the exit conference there was further clarification that the State did not consider these limits when estimating each hospital's benchmark rate. The OIG further asserts that by not considering these limits, the State overstated the benchmark rate and the resulting projected direct savings. The OIG also states that the overall impact of these payment limits on the calculation of direct savings was not quantifiable.

State Response:

At the exit conference, this finding was identified by OIG staff as referring to the peer group inpatient reimbursement limit (PIRL), which is set forth in the California State Plan and is part of the reimbursement calculation for non-SPCP contracting hospitals. The OIG correctly found that the PIRL limitation is not considered when the CMAC determines the benchmark rates for contract hospitals.

However, there are several reasons as to why the inclusion of this calculation would not be appropriate or necessary, such as the availability of hospital data, or lack thereof, would make it virtually impossible to do an accurate PIRL calculation on a "prospective" basis. These reasons were discussed with the OIG auditors at the time of the audit. The following are additional reasons why the State believes that the inclusion of this calculation would be immaterial.

- A recent estimate of the PIRL calculation indicates that over a 4-year period, only about $18 million ($9 million federal funds) was identified as a potential recovery (before appeals) from non-SPCP contracting hospitals. This is an insignificant recovery relative to the population of non-SPCP hospitals, which is approximately 230 hospitals. Moreover, not all contract hospitals are subject to PIRL – i.e., less than 20 percent of all non-contract hospitals were subject to the PIRL.

- Many hospitals do not exceed their Peer Group limit and so there is no recovery and the hospital is reimbursed its costs, which is the basis for the benchmark. The PIRL limitation should not be confused with a median rate where half of the hospitals would be above the rate. In fact, the rate is established at the 60th percentile for each peer group in California as published in the Federal Register.

- The PIRL calculation is an individual hospital limit. Therefore, there isn't a direct correlation between SPCP hospitals and non-SPCP hospitals in order to apply an adjustment factor to the benchmark rate. It would be necessary to perform the PIRL calculation for each individual hospital for comparison purposes, only to find that the reimbursement to the hospital would have been limited to costs. However, it should be noted the PIRL calculation is retrospective and it would very difficult, if not impossible, to perform the calculation prospectively. This is further compounded by the fact that occasionally, the peer group of a hospital may change from one year to the next, and in essence, if the peer group mix changes, then the resulting calculations could change.

- The SPCP hospitals by virtue of the need to be competitive in negotiations are historically more cost effective and do not exceed the per discharge limit of their applicable peer group. By contrast, a non-SPCP contract hospital that is reimbursed costs is more likely to exceed the limit. The competitive nature of the SPCP has traditionally had an inflation rate that is lower than that of the non-contract hospitals. In the CMAC Annual Report 2001, it was reported that the payments to non-contract hospitals had increased by 5.0% per year on a compound basis compared to 3.6% per year for contract hospitals since the inception of SPCP.

In conclusion, although this finding is true, the State believes it is immaterial. Therefore, the State believes that this broad finding should not be identified in the draft audit report, particularly when it could not be quantified nor even confirmed that there would be a financial consequence.

APPENDIX I

Indirect Savings

Under the OIG draft audit report section titled "Indirect Savings", the OIG stated that the State's methodology in calculating indirect savings were overstated, in part, because: "(1) the benchmark rates were not adjusted to exclude costs that were not the responsibility of managed care plans, and (2) the average payment limit used by the State to project indirect savings was understated."

State Response:

The OIG concluded that the projection of the indirect savings required the same adjustments as the projection for the direct savings. Specifically, the OIG stated that the benchmark rates were overstated and the payment limits were understated.

The overstatement of the benchmark rates was previously discussed under the "Direct Savings" finding. The same comments apply to the projection of the indirect savings. This finding is not supported for either direct or indirect savings. However, under indirect savings, the OIG also states that the benchmark incorrectly included construction and medical education costs that were not the responsibility of the managed care plans. Because the only comparison between the average benchmark and the average contract rate is used to compute the indirect savings projection, it is appropriate to use what would be paid "without the waiver" (the benchmark) and what is used in the managed care upper payment limit calculation (the average contract rate). Because averages are used, it would not be appropriate to make adjustments for either the construction or the medical education costs, as a majority of the hospitals do not even receive these funds.

In addition, the OIG noted that the managed care upper payment limits should include the supplemental payments. This would not be appropriate because the upper payment limits should only include what would be paid without the managed care waivers. The supplemental payments would not exist without the SPCP waiver and would not be paid without either the SPCP or the managed care waivers.

The OIG also indicated that the indirect savings calculation did not consider that 10 percent of total payments to hospitals are not covered under the SPCP waiver. Although that is true, the SPCP contracts and managed care plan contracts are concentrated in urban areas and the areas for each overlap. The majority of non-contract hospitals are located in non-urban areas where Medi-Cal does not have managed care contracts. And so, the managed care upper payments limits should not include non-contract fee-for-service equivalents in their upper payment limit calculations. The indirect savings are only attributable to the SPCP waiver payments.