



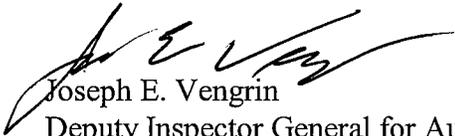
DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

DEC 21 2006

TO: Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: 
Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Additional Reimbursement for Distinct-Part Nursing Facilities of Public Hospitals in California (A-09-05-00050)

Attached is an advance copy of our final report on additional reimbursement for distinct-part nursing facilities of public hospitals in California. We will issue this report to the California Department of Health Services (the State agency) within 5 business days. The Centers for Medicare & Medicaid Services requested this audit.

A distinct-part nursing facility (facility) is part of a hospital and is certified to provide skilled nursing services. The facility must be physically distinguishable from the hospital and fiscally separate for cost reporting purposes.

In California, the State agency administers the Medicaid program and pays facilities a per diem rate for skilled nursing services provided to Medicaid residents. An eligible facility may receive additional reimbursement for the Federal share of certified public expenditures in excess of the per diem payments. To determine the certified public expenditures, the State plan amendment requires that a facility report quarterly the amount of eligible costs, which are the lesser of actual costs or the State agency's projected costs for that facility.

For the audit period (August 1, 2002, through July 31, 2004), the Federal Government provided approximately \$59 million in additional reimbursement to the State agency for participating facilities. For our review, we selected the three facilities that received the largest amount of additional reimbursement, totaling \$51 million: Laguna Honda Hospital (Laguna Honda), San Mateo Medical Center (San Mateo), and Edgemoor Geriatric Hospital (Edgemoor). During our review, we determined that San Mateo had not properly calculated additional reimbursement amounts for the period August 1, 2004, through January 31, 2005. Therefore, we expanded our audit period for San Mateo to include this period.

Our objectives were to determine, for the selected facilities, whether the State agency (1) properly established eligibility for additional reimbursement and (2) claimed additional reimbursement amounts in accordance with State and Federal requirements.

The State agency properly established eligibility for additional reimbursement for the selected facilities. However, the State agency did not claim additional reimbursement amounts for San Mateo and Edgemoor in accordance with State and Federal requirements. Specifically:

- San Mateo was overpaid \$3,050,232 because it significantly overstated its estimated quarterly costs per patient day and then used the projected costs, which appeared to be lower than the estimated costs, to calculate additional reimbursement amounts. If San Mateo had correctly estimated its quarterly costs and reconciled the estimated costs with actual costs, it would have determined that the quarterly costs were lower than the projected costs.
- Edgemoor was overpaid \$559,035 because it overstated the number of paid Medicaid days that it used to calculate additional reimbursement amounts. Also, Edgemoor overstated the historical routine costs that the State agency used to calculate projected costs. By overstating the number of Medicaid days and the historical routine costs, Edgemoor overstated its certified public expenditures eligible for additional reimbursement.

The errors occurred because the State agency did not provide adequate instructions to the facilities to properly calculate the certified public expenditures used to support additional reimbursement amounts. Also, the State agency did not have adequate monitoring procedures to ensure that the facilities properly calculated their reported Medicaid days and expenditures. The improper calculations resulted in an overpayment of \$3,609,267 (Federal share), including \$2,691,957 in the audit period and \$917,310 in the extended audit period.

We recommend that the State agency:

- refund \$3,609,267 to the Federal Government,
- review additional reimbursement amounts paid to the selected facilities subsequent to our audit period and refund any overpayments,
- provide adequate instructions to all facilities to ensure that the certified public expenditures used to support additional reimbursement amounts are properly calculated, and
- strengthen monitoring procedures to ensure that all facilities' reported Medicaid days and expenditures are properly calculated.

In its comments on our draft report, the State agency disagreed with our finding and recommended disallowance related to the overstatement of San Mateo's estimated quarterly

costs. However, it agreed with the remaining findings and recommendations. After carefully evaluating the State agency's comments, we continue to recommend that the State agency refund the entire recommended amount of \$3,609,267 to the Federal Government.

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 through e-mail at George.Reeb@oig.hhs.gov or Lori A. Ahlstrand, Regional Inspector General for Audit Services, Region IX, at (415) 437-8360 or through e-mail at Lori.Ahlstrand@oig.hhs.gov. Please refer to report number A-09-05-00050.

Attachment



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

DEC 27 2006

Report Number: A-09-05-00050

Ms. Sandra Shewry
Director
California Department of Health Services
P.O. Box 997413, MS 4000
Sacramento, California 95899-7413

Dear Ms. Shewry:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Additional Reimbursement for Distinct-Part Nursing Facilities of Public Hospitals in California" for the period August 1, 2002, through July 31, 2004. A copy of this report will be forwarded to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. 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 the public to the extent the information 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-09-05-00050 in all correspondence.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori A. Ahlstrand".

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

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

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF
ADDITIONAL REIMBURSEMENT
FOR DISTINCT-PART NURSING
FACILITIES OF PUBLIC
HOSPITALS IN CALIFORNIA**



Daniel R. Levinson
Inspector General

December 2006
A-09-05-00050

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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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

A distinct-part nursing facility (facility) is part of a hospital and is certified to provide skilled nursing services. The facility must be physically distinguishable from the hospital and fiscally separate for cost reporting purposes.

In California, the Department of Health Services (the State agency) administers the Medicaid program and pays facilities a per diem rate for skilled nursing services provided to Medicaid residents. An eligible facility may receive additional reimbursement for the Federal share of certified public expenditures in excess of the per diem payments.

Pursuant to the State plan amendment approved by the Centers for Medicare & Medicaid Services (CMS):

- To be eligible for additional reimbursement, a facility must (1) provide skilled nursing services to Medicaid residents; (2) be a distinct part of an acute care hospital; and (3) be owned or operated by a county, city, or health care district.
- Certified public expenditures submitted for additional reimbursement must be allowable under State and Federal requirements.

To determine the certified public expenditures used to support additional reimbursement, the State plan amendment requires that a facility report quarterly the amount of eligible costs, which are the lesser of actual costs or the State agency's projected costs for that facility. State instructions allow the facility to report estimated quarterly costs instead of actual costs.

Federal regulations (42 CFR § 433.51) authorize the use of public funds as the State's share in claiming Federal financial participation. Contributing public agencies must certify the public funds as representing expenditures eligible for Federal financial participation.

For the audit period (August 1, 2002, through July 31, 2004), the Federal Government provided approximately \$59 million in additional reimbursement to the State agency for participating facilities. For our review, we selected the three facilities that received the largest amount of additional reimbursement, totaling \$51 million: Laguna Honda Hospital (Laguna Honda), San Mateo Medical Center (San Mateo), and Edgemoor Geriatric Hospital (Edgemoor). During our review, we determined that San Mateo had not properly calculated additional reimbursement amounts for the period August 1, 2004, through January 31, 2005. Therefore, we expanded our audit period for San Mateo to include this period.

CMS requested this audit.

OBJECTIVES

Our objectives were to determine, for the selected facilities, whether the State agency (1) properly established eligibility for additional reimbursement and (2) claimed additional reimbursement amounts in accordance with State and Federal requirements.

SUMMARY OF FINDINGS

The State agency properly established eligibility for additional reimbursement for the selected facilities. However, the State agency did not claim additional reimbursement amounts for San Mateo and Edgemoor in accordance with State and Federal requirements. Specifically:

- San Mateo was overpaid \$3,050,232 because it significantly overstated its estimated quarterly costs per patient day and then used the projected costs, which appeared to be lower than the estimated costs, to calculate additional reimbursement amounts. If San Mateo had correctly estimated its quarterly costs and reconciled the estimated costs with actual costs, it would have determined that the quarterly costs were lower than the projected costs.
- Edgemoor was overpaid \$559,035 because it overstated the number of paid Medicaid days that it used to calculate additional reimbursement amounts. Also, Edgemoor overstated the historical routine costs that the State agency used to calculate projected costs. By overstating the number of Medicaid days and the historical routine costs, Edgemoor overstated its certified public expenditures eligible for additional reimbursement.

The errors occurred because the State agency did not provide adequate instructions to the facilities to properly calculate the certified public expenditures used to support additional reimbursement amounts. Also, the State agency did not have adequate monitoring procedures to ensure that the facilities properly calculated their reported Medicaid days and expenditures. The improper calculations resulted in an overpayment of \$3,609,267 (Federal share), including \$2,691,957 in the audit period and \$917,310 in the extended audit period.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$3,609,267 to the Federal Government,
- review additional reimbursement amounts paid to the selected facilities subsequent to our audit period and refund any overpayments,
- provide adequate instructions to all facilities to ensure that the certified public expenditures used to support additional reimbursement amounts are properly calculated, and

- strengthen monitoring procedures to ensure that all facilities' reported Medicaid days and expenditures are properly calculated.

STATE AGENCY'S COMMENTS

In its written comments on our draft report, the State agency disagreed with our finding related to the overstatement of San Mateo's estimated quarterly costs. Specifically, the State agency maintained that it correctly used projected costs, not actual costs, in its claim for additional reimbursement. However, the State agency agreed that Edgemoor overstated Medicaid days and routine costs. The State agency also agreed that it lacked adequate instructions and monitoring procedures.

The State agency agreed to refund \$559,035 of our total recommended refund of \$3,609,267 and agreed with the remaining three recommendations. The full text of the State agency's comments is included as Appendix F.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

The State agency should recalculate San Mateo's additional reimbursement amount using actual costs. Because San Mateo's actual costs were lower than projected costs, San Mateo should have used actual costs as the limit for additional reimbursement. The State agency should refund the entire recommended amount of \$3,609,267 to the Federal Government.

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INTRODUCTION

BACKGROUND

A distinct-part nursing facility (facility) is part of a hospital and is certified to provide skilled nursing services. The facility must be physically distinguishable from the hospital and fiscally separate for cost reporting purposes.

In California, the Medicaid program pays a facility a per diem rate for skilled nursing services provided to Medicaid residents. An eligible facility may receive additional reimbursement for the Federal share of certified public expenditures in excess of the per diem payments.

The Centers for Medicare & Medicaid Services (CMS) requested this audit.

Medicaid Program

Enacted in 1965, Medicaid is a combined Federal-State entitlement program that provides health care and long term care for certain individuals and families with low incomes and limited resources. Within a broad legal framework, each State designs and administers its own Medicaid program, including determining how much to pay for each service. Each State operates under a plan approved by CMS for compliance with Federal laws and regulations. The Federal Government established a financing formula to calculate the Federal share of medical assistance expenditures under each State's Medicaid program.

In California, the Department of Health Services (the State agency) administers the Medicaid program.

Certified Public Expenditures

Federal regulations (42 CFR § 433.51) authorize the use of public funds as the State's share in claiming Federal financial participation if the public funds are (1) appropriated directly to the State or local Medicaid agency, (2) transferred from other public agencies to the State or local agency and under its administrative control, or (3) certified by the contributing public agency as representing expenditures eligible for Federal financial participation. Also, the public funds must not be Federal funds unless Federal law authorizes their use to match other Federal funds.

California's Distinct-Part Nursing Facility Additional Reimbursement Program

The State agency submitted a State plan amendment, Transmittal Number (TN) 01-022, to CMS for the public hospital distinct-part nursing facility additional reimbursement program. CMS approved the amendment, which went into effect August 1, 2001. During the audit period (August 1, 2002, through July 31, 2004), the Federal Government provided approximately \$59 million in additional reimbursement to the State agency for participating facilities.

Eligibility and Certified Public Expenditure Requirements

The State plan amendment allows eligible facilities to receive additional reimbursement. To be eligible, a facility must (1) provide skilled nursing services to Medicaid residents; (2) be a distinct part of an acute care hospital; and (3) be owned or operated by a county, city, or health care district.

To determine the certified public expenditures used to support additional reimbursement, the State plan amendment requires that the facility report quarterly the amount of eligible costs, which are the lesser of actual costs or the State agency's projected costs for that facility. The total annual reimbursement may not exceed the State agency's projected costs.

Additional Reimbursement Calculation

Annually, the State agency sends each eligible facility a participation letter, a quarterly claim and certification form, program instructions, and a copy of the applicable regulations. The quarterly claim and certification form is preprinted with the projected cost per patient day (projected cost) and the per diem rate. To calculate the projected cost, the State agency uses the facility's historical routine costs and makes adjustments to reflect current costs.¹ The State agency sets the per diem rate for each facility based on the median projected cost from eligible facilities.²

To determine additional reimbursement amounts, the facility estimates its quarterly cost per patient day (estimated quarterly cost) and determines the number of paid Medicaid days.³ The facility compares the estimated quarterly cost with the projected cost and uses the lesser of the two as the limit for additional reimbursement. The difference between the limit and the per diem rate represents the cost per patient day eligible for additional reimbursement. This difference is multiplied by the number of paid Medicaid days in the quarter to determine the expenditures for the program. The facility then certifies the expenditures as allowable costs for Federal financial participation and submits the form to the State agency for reimbursement. Based on the certification form, the facility receives additional reimbursement equal to the Federal share of the certified public expenditures.

¹Routine costs are the costs associated with routine services, including regular room, dietary, and nursing services; minor medical and surgical supplies; and the use of equipment and facilities for which a separate charge is not customarily made.

²A facility whose projected costs are equal to or greater than the median projected cost receives a per diem rate equal to the median projected cost. A facility whose projected costs are less than the median projected cost receives a per diem rate equal to its projected costs.

³The quarterly costs are based on actual direct costs and estimated indirect costs. Because an actual indirect cost rate is not available until the end of the year, the facility uses the indirect cost rate from the prior year to estimate its quarterly indirect costs.

The additional reimbursement is calculated as follows:

$$\left(\begin{array}{l} \text{Lesser of estimated quarterly} \\ \text{cost per patient day or} \\ \text{projected cost per patient day} \end{array} - \begin{array}{l} \text{Per diem} \\ \text{rate} \end{array} \right) \times \begin{array}{l} \text{Number of paid} \\ \text{Medicaid days} \end{array} = \begin{array}{l} \text{Certified public} \\ \text{expenditures} \end{array}$$
$$\begin{array}{l} \text{Certified public} \\ \text{expenditures} \end{array} \times \begin{array}{l} \text{Federal financial} \\ \text{participation rate} \end{array} = \begin{array}{l} \text{Additional} \\ \text{reimbursement} \end{array}$$

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine, for the selected facilities, whether the State agency (1) properly established eligibility for additional reimbursement and (2) claimed additional reimbursement amounts in accordance with State and Federal requirements.

Scope

We reviewed the State agency's methodology for calculating the certified public expenditures used to support additional reimbursement amounts for rate year 2002 (August 1, 2002, through July 31, 2003) and rate year 2003 (August 1, 2003, through July 31, 2004).⁴

Twelve facilities participated in the program in rate year 2002, and 10 participated in rate year 2003. We selected three facilities that participated in both rate years for our review: Laguna Honda Hospital (Laguna Honda), San Mateo Medical Center (San Mateo), and Edgemoor Geriatric Hospital (Edgemoor). These facilities received approximately \$51 million, or 86 percent of the total additional reimbursement for the audit period.

During our review, we determined that San Mateo had not properly calculated additional reimbursement amounts for the period August 1, 2004, through January 31, 2005. Therefore, we expanded our scope for San Mateo to include this period.

We did not review the overall internal controls of the State agency or the selected facilities. However, we gained an understanding of the State agency's internal controls related to establishing eligibility and calculating additional reimbursement amounts. In addition, we did not audit San Mateo's actual cost per patient day of \$394 from the cost report for rate year 2003. We conducted our fieldwork at the State agency's office in Sacramento, California, and at the offices of Laguna Honda in San Francisco, California, San Mateo in San Mateo, California, and Edgemoor in Santee, California.

⁴The State agency develops a per diem rate for each facility annually. The rate is in effect from August 1 to July 31 of the following year. For example, the State agency refers to the period August 1, 2002, through July 31, 2003, as rate year 2002.

Methodology

To accomplish our objectives, we:

- reviewed applicable State and Federal laws and regulations and the State plan amendment;
- interviewed officials from CMS, the State agency, and the selected facilities;
- reviewed the State agency's documents, including program instructions and claim processing procedures;
- analyzed the State agency's methodology for calculating the certified public expenditures used to support additional reimbursement amounts;
- determined the eligibility of the selected facilities to participate in the program;
- reviewed the State agency's calculation of the projected costs for the selected facilities;
- reviewed the facilities' quarterly claim and certification forms and the appropriate supporting documents;
- reviewed the additional reimbursement amounts paid to the facilities and the amounts that the State agency claimed on its CMS-64 reports;
- analyzed the methodology that the facilities used to determine estimated quarterly costs and the number of paid Medicaid days;
- determined the accuracy of the facilities' estimated quarterly costs and compared them with the filed or audited cost reports, if available;
- determined the accuracy of the facilities' Medicaid days claimed and compared them with the State agency's payment records; and
- reviewed certified days and expenditures that San Mateo submitted for the extended audit period.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The State agency properly established eligibility for additional reimbursement for the selected facilities. However, the State agency did not claim additional reimbursement amounts for San Mateo and Edgemoor in accordance with State and Federal requirements.⁵ Specifically:

⁵We found no material errors in Laguna Honda's calculations of additional reimbursement amounts.

- San Mateo was overpaid \$3,050,232 because it significantly overstated its estimated quarterly costs per patient day and then used the projected costs, which appeared to be lower than the estimated costs, to calculate additional reimbursement amounts. If San Mateo had correctly estimated its quarterly costs and reconciled the estimated costs with actual costs, it would have determined that the quarterly costs were lower than the projected costs.
- Edgemoor was overpaid \$559,035 because it overstated the number of paid Medicaid days that it used to calculate additional reimbursement amounts. Also, Edgemoor overstated the historical routine costs that the State agency used to calculate projected costs. By overstating the number of Medicaid days and the historical routine costs, Edgemoor overstated its certified public expenditures eligible for additional reimbursement.

The errors occurred because the State agency did not provide adequate instructions to the facilities to properly calculate the certified public expenditures used to support additional reimbursement amounts. Also, the State agency did not have adequate monitoring procedures to ensure that the facilities properly calculated their reported Medicaid days and expenditures. The improper calculations resulted in an overpayment of \$3,609,267 (Federal share), including \$2,691,957 in the audit period and \$917,310 in the extended audit period.

STATE AND FEDERAL REQUIREMENTS

To determine the certified public expenditures used to support additional reimbursement, the State plan amendment requires that a facility report quarterly the amount of the eligible costs, which are the lesser of actual costs or the State agency's projected costs for that facility. Because the State plan requires the use of actual costs, if a facility uses estimated data in determining quarterly costs, it should reconcile the estimated costs with actual costs at the end of the year when those data become available.

Federal regulations (42 CFR § 433.51) authorize the use of public funds as the State's share in claiming Federal financial participation. Contributing public agencies must certify the public funds as representing expenditures eligible for Federal financial participation.

SAN MATEO'S OVERSTATED QUARTERLY COSTS

For rate year 2002, San Mateo correctly calculated its certified public expenditures. However, for rate year 2003 and the extended audit period, San Mateo significantly overstated the estimated quarterly costs that it used to calculate certified public expenditures and failed to reconcile the estimated quarterly costs to actual costs at the end of the year. The overstated costs resulted in an overpayment of \$3,050,232, including \$2,132,922 in rate year 2003 and \$917,310 in the extended audit period.

Rate Year 2003

Pursuant to the State plan amendment, a facility must use the lesser of actual costs or projected costs to determine certified public expenditures. State instructions allow the facility to report estimated quarterly costs instead of actual costs.

As permitted by State instructions, San Mateo reported estimated quarterly costs instead of actual costs in rate year 2003. However, San Mateo significantly overstated its estimated quarterly costs by incorrectly estimating the indirect costs and incorrectly calculating the average direct cost per patient day. As noted in Appendix A, San Mateo's estimated costs per patient day ranged from \$502.81 to \$674.42 in the four quarters of rate year 2003. San Mateo compared these estimated costs with the projected cost of \$466.30 to determine the lesser of the two. Because the projected cost was lower than the estimated quarterly costs, San Mateo used the projected cost to calculate certified public expenditures eligible for additional reimbursement. San Mateo also failed to reconcile the estimated quarterly costs to actual costs at the end of the year, which would have corrected the error.

We compared the estimated quarterly costs with the actual cost per patient day (\$394.79) that San Mateo included in its annual cost report and found that San Mateo had overstated its estimated costs by 46 percent for the first quarter, 71 percent for the second quarter, 57 percent for the third quarter, and 27 percent for the fourth quarter. San Mateo overstated its estimated costs because it incorrectly calculated its indirect and direct costs:

- For indirect costs, San Mateo applied the 2002 average indirect cost per patient day to rate year 2003. The 2002 information was based on a 94-bed facility; however, the number of beds almost quadrupled to 375 in rate year 2003.⁶ This significant increase in beds resulted in a significant increase in patient days, which decreased the average indirect cost per patient day.
- For direct costs, San Mateo divided all direct costs by only paid Medicaid days to determine the average direct cost per patient day. San Mateo should have divided all direct costs by all patient days, including both Medicaid and non-Medicaid days, for which it provided services in the quarter.

By overstating its estimated quarterly costs, San Mateo incorrectly used the State agency's projected costs instead of actual (estimated) costs as the limit to calculate certified public expenditures. As a result, San Mateo was overpaid \$2,132,922 for rate year 2003. We did not recalculate San Mateo's quarterly costs because we used the reported actual costs for the year, as required by the State plan, to determine the overpayments.

Rate Year 2004—Extended Audit Period

Appendixes B and C detail the calculations for the first two quarters of rate year 2004. San Mateo continued to calculate its direct costs incorrectly and thus overstated its certified public expenditures eligible for additional reimbursement. Specifically, the facility used Medicaid days

⁶Effective August 1, 2003, San Mateo took over another nursing facility and increased the number of facility beds from 94 to 375.

paid in each quarter to calculate its direct cost per patient day. San Mateo should have divided all direct costs by all patient days, including both Medicaid and non-Medicaid days, for which it provided services in the quarter. Furthermore, the facility made a mathematical error when calculating estimated quarterly costs for the second quarter. As a result, San Mateo was overpaid a total of \$917,310 for the first two quarters of rate year 2004 (\$506,308 for the first quarter and \$411,002 for the second quarter).

EDGEMOOR'S OVERSTATED MEDICAID DAYS AND HISTORICAL ROUTINE COSTS

Edgemoor overstated its Medicaid days and historical routine costs used to calculate certified public expenditures. By overstating the number of Medicaid days and the historical routine costs, Edgemoor overstated its certified public expenditures eligible for additional reimbursement. The State plan amendment specifies that the total annual reimbursement may not exceed the State agency's projected costs. The overstated Medicaid days and costs resulted in an overpayment of \$559,035 for rate years 2002 and 2003.

Rate Year 2002—Medicaid Days Overstated

As shown in Appendix D, Edgemoor overstated the number of paid Medicaid days and thus overstated its certified public expenditures eligible for additional reimbursement. The overstatement caused the total payments to exceed the State agency's projected costs. By comparing the number of paid Medicaid days that Edgemoor reported on its quarterly claims with the State agency's payment record, we found that Edgemoor had overstated the number of days by 5,408. As a result, Edgemoor was overpaid \$376,347 for rate year 2002. Edgemoor officials could not explain the difference.

Rate Year 2003—Historical Routine Costs Overstated

As shown in Appendix E, Edgemoor overstated the historical routine costs that the State agency used to calculate the projected cost for rate year 2003. The overstatement occurred because Edgemoor included ancillary costs associated with physician services that were reimbursed separately. Pursuant to the State plan amendment, ancillary costs that are billed and reimbursed separately should not be included in the routine costs. Because Edgemoor overstated routine costs, the State agency overstated the projected cost used to calculate certified public expenditures. As a result, Edgemoor was overpaid \$182,688 for rate year 2003. State agency officials agreed that Edgemoor should not have included ancillary costs associated with physician services in the routine costs and recalculated the projected cost.

LACK OF ADEQUATE INSTRUCTIONS AND MONITORING PROCEDURES

The overstatements occurred because the State agency did not (1) provide adequate instructions to the facilities to properly calculate certified public expenditures or (2) have adequate procedures to monitor the facilities' claims, supporting documentation, and calculations. Officials at all three facilities informed us that the State agency's instructions did not clearly indicate how to estimate quarterly costs. During our audit, the State agency proposed changes in

its instructions for cost calculations used to determine additional reimbursement amounts. Also, the State agency did not have adequate monitoring procedures to ensure that the facilities properly calculated their reported Medicaid days and expenditures. The State agency's monitoring procedures for the quarterly claim and certification forms were not sufficient to determine the validity of the data.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$3,609,267 to the Federal Government,
- review additional reimbursement amounts paid to the selected facilities subsequent to our audit period and refund any overpayments,
- provide adequate instructions to all facilities to ensure that the certified public expenditures used to support additional reimbursement amounts are properly calculated, and
- strengthen monitoring procedures to ensure that all facilities' reported Medicaid days and expenditures are properly calculated.

STATE AGENCY'S COMMENTS

In its written comments on our draft report, the State agency disagreed with our finding related to the overstatement of San Mateo's estimated quarterly costs. However, the State agency agreed that Edgemoor overstated Medicaid days and routine costs. The State agency also agreed that it lacked adequate instructions and monitoring procedures. Finally, the State agency agreed to refund \$559,035 of our total recommended refund of \$3,609,267 and agreed with the remaining three recommendations. The full text of the State agency's comments is included as Appendix F.

Regarding our finding related to the overstatement of San Mateo's estimated quarterly costs, the State agency maintained that it correctly used projected costs, not actual costs, in its claim for additional reimbursement. The State agency asserted that the State plan amendment does not require the use of actual costs and allows the use of projected costs as the upper limit for claiming additional reimbursement amounts. In addition, the State agency noted that projected costs are actual audited costs from a previous year, adjusted to reflect trend data, and that those costs are the basis for the calculation of reimbursement rates. Finally, the State agency indicated that State plan amendment TN 03-025 entitled San Mateo to be reimbursed up to projected costs.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

The State agency should recalculate San Mateo's additional reimbursement amount using actual costs. The State plan amendment, Attachment 4-19D, section VIII(B)(4), states: "The provider shall report to the Department [State agency], on a quarterly basis, the amount of the eligible costs that are the lesser of actual costs or the Department's projected costs for that facility." Because San Mateo's actual costs were lower than projected costs, San Mateo should have used

actual costs as the limit for additional reimbursement. Further, the CMS-approved State plan amendment TN 03-025 applies only to the Medicaid per diem rate and did not entitle San Mateo to be reimbursed up to projected costs for the public hospital distinct-part nursing facility additional reimbursement program. The State agency should refund the entire recommended amount of \$3,609,267 to the Federal Government.

APPENDIXES

**CALCULATION OF SAN MATEO'S ADDITIONAL REIMBURSEMENT AMOUNT
FOR RATE YEAR 2003**

	Description of Calculation	(A) Per State Agency	(B) Per Audit	(C) Difference
1	Projected cost per patient day for the quarter claimed (provided by the State agency)	\$466.30	\$466.30	\$0
2	Estimated quarterly cost per patient day during the quarter claimed (calculated by facility) ¹	\$502.81	\$394.79	\$108.02
3	Allowable cost per patient day incurred by the facility during the quarter claimed (the lesser of line 1 or line 2)	\$466.30	\$394.79	\$71.51
4	Medicaid per diem rate paid to the facility during the year (provided by the State agency)	\$236.82	\$236.82	\$0
5	Cost per patient day eligible for additional reimbursement (subtract line 4 from line 3)	\$229.48	\$157.97	\$71.51
6	Actual patient days reimbursed by Medicaid during the year (provided by facility)	56,680	56,680	0
7	Certified public expenditures eligible for additional reimbursement (multiply line 5 by line 6)	\$13,006,926	\$8,953,740	\$4,053,186
8	Additional reimbursement amount overpaid (multiply column C, line 7, by the Federal medical assistance percentage [FMAP]) ²		\$2,132,922	

¹San Mateo estimated quarterly costs per patient day ranging from \$502.81 to \$674.42 in the four quarters of rate year 2003. For this analysis, we used San Mateo's lowest estimated quarterly cost in column A. Because San Mateo's estimated quarterly costs were significantly overstated, we obtained San Mateo's actual cost per patient day of \$394.79 as reported by San Mateo in its annual cost report for the year ended June 30, 2004, and used that amount in column B.

²The FMAP was 52.95 percent for the first 11 months of rate year 2003. For July 2004, the FMAP was 50 percent.

**CALCULATION OF SAN MATEO'S ADDITIONAL REIMBURSEMENT AMOUNT
FOR THE FIRST QUARTER OF RATE YEAR 2004
(AUGUST 1 – OCTOBER 31, 2004)**

	Description of Calculation	(A) Per State Agency	(B) Per Audit	(C) Difference
1	Projected cost per patient day for the quarter claimed (provided by the State agency)	\$466.30	\$466.30	\$0
2	Estimated quarterly cost per patient day during the quarter claimed (calculated by facility)	\$495.61	\$412.36	\$83.25
3	Allowable cost per patient day incurred by the facility during the quarter claimed (the lesser of line 1 or line 2)	\$466.30	\$412.36	\$53.94
4	Medicaid per diem rate paid to the facility during the year (provided by the State agency)	\$236.82	\$236.82	\$0
5	Cost per patient day eligible for additional reimbursement (subtract line 4 from line 3)	\$229.48	\$175.54	\$53.94
6	Actual patient days reimbursed by Medicaid during the year (provided by facility)	18,773	18,773	0
7	Certified public expenditures eligible for additional reimbursement (multiply line 5 by line 6)	\$4,308,028	\$3,295,412	\$1,012,616
8	Additional reimbursement amount overpaid (multiply column C, line 7, by the FMAP of 50 percent)		\$506,308	

**CALCULATION OF SAN MATEO'S ADDITIONAL REIMBURSEMENT AMOUNT
FOR THE SECOND QUARTER OF RATE YEAR 2004
(NOVEMBER 1, 2004 – JANUARY 31, 2005)**

	Description of Calculation	(A) Per State Agency	(B) Per Audit	(C) Difference
1	Projected cost per patient day for the quarter claimed (provided by the State agency)	\$466.30	\$466.30	\$0
2	Estimated quarterly cost per patient day during the quarter claimed (calculated by facility)	\$403.43	\$413.92	\$10.49
3	Allowable cost per patient day incurred by the facility during the quarter claimed (the lesser of line 1 or line 2)	\$403.43	\$413.92	\$10.49
4	Medicaid per diem rate paid to the facility during the year (provided by the State agency)	\$236.82	\$236.82	\$0
5	Cost per patient day eligible for additional reimbursement (subtract line 4 from line 3)	\$166.61	\$177.10	\$10.49
6	Actual patient days reimbursed by Medicaid during the year (provided by facility)	28,161	28,161	0
7	Certified public expenditures eligible for additional reimbursement (multiply line 5 by line 6)	\$5,809,318 ¹	\$4,987,313	\$822,005
8	Additional reimbursement amount overpaid (multiply column C, line 7, by the FMAP of 50 percent)		\$411,002	

¹San Mateo reported \$5,809,318. However, the calculation results in \$4,691,904.

**CALCULATION OF EDGEMOOR'S ADDITIONAL REIMBURSEMENT AMOUNT
FOR RATE YEAR 2002**

	Description of Calculation	(A) Per State Agency	(B) Per Audit	(C) Difference
1	Projected cost per patient day for the quarter claimed (provided by the State agency)	\$362.82	\$362.82	\$0
2	Estimated quarterly cost per patient day during the quarter claimed (calculated by facility) ¹	\$423.81	\$423.81	\$0
3	Allowable cost per patient day incurred by the facility during the quarter claimed (the lesser of line 1 or line 2)	\$362.82	\$362.82	\$0
4	Medicaid per diem rate paid to the facility during the year (provided by the State agency)	\$236.38	\$236.38	\$0
5	Cost per patient day eligible for additional reimbursement (subtract line 4 from line 3)	\$126.44	\$126.44	\$0
6	Actual patient days reimbursed by Medicaid during the year (provided by facility)	63,062	57,654	5,408
7	Certified public expenditures eligible for additional reimbursement (multiply line 5 by line 6)	\$7,973,559	\$7,289,772	\$683,787
8	Additional reimbursement amount overpaid (multiply column C, line 7, by the FMAP) ²		\$376,347	

¹Edgemoor reported estimated quarterly costs that ranged from \$423.81 to \$451.57 in rate year 2002. Because the amount did not affect this calculation, we used the lower amount.

²The FMAP was 50 percent for the first 6 months of rate year 2002 and 54.35 percent for the last 6 months.

**CALCULATION OF EDGEMOOR'S ADDITIONAL REIMBURSEMENT AMOUNT
FOR RATE YEAR 2003**

	Description of Calculation	(A) Per State Agency	(B) Per Audit	(C) Difference
1	Projected cost per patient day for the quarter claimed (provided by the State agency) ¹	\$392.24	\$386.35	\$5.89
2	Estimated quarterly cost per patient day during the quarter claimed (calculated by facility) ²	\$402.11	\$402.11	\$0
3	Allowable cost per patient day incurred by the facility during the quarter claimed (the lesser of line 1 or line 2)	\$392.24	\$386.35	\$5.89
4	Medicaid per diem rate paid to the facility during the year (provided by the State agency)	\$236.82	\$236.82	\$0
5	Cost per patient day eligible for additional reimbursement (subtract line 4 from line 3)	\$155.42	\$149.53	\$5.89
6	Actual patient days reimbursed by Medicaid during the year (provided by facility)	57,446	57,446	0
7	Certified public expenditures eligible for additional reimbursement (multiply line 5 by line 6)	8,934,719 ³	\$8,589,900	\$344,819
8	Additional reimbursement amount overpaid (multiply column C, line 7, by the FMAP) ⁴		\$182,688	

¹Edgemoor overstated its historical routine costs that the State used to calculate the projected costs for rate year 2003. The State's recalculated projected costs amounted to \$386.35 per patient day.

²Edgemoor reported estimated quarterly costs that ranged from \$402.11 to \$490.06 in rate year 2003. Because the amount did not affect this calculation, we used the lower amount.

³Edgemoor reported \$8,934,719. However, the calculation results in \$8,928,257.

⁴The FMAP for rate year 2003 ranged from 50 percent to 54.35 percent.



SANDRA SHEWRY
Director

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



ARNOLD SCHWARZENEGGER
Governor

AUG 14 2006

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

Dear Ms. Ahlstrand:

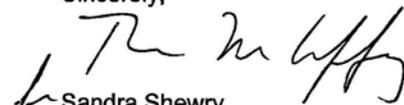
DRAFT REPORT #A-09-05-00050

The California Department of Health Services (CDHS) has prepared its response to the Office of Inspector General's draft report entitled, "Review of Additional Reimbursement for Distinct-Part Nursing Facilities of Public Hospitals in California," issued June 22, 2006. The objective of the review was to determine whether the facilities were eligible to receive payments and to review the Certified Public Expenditures methodology used by the State to determine the payment amounts.

The CDHS appreciates the opportunity to respond to the draft report.

Should you have any questions, please feel free to contact Mr. Stan Rosenstein, Deputy Director, Medical Care Services, at (916) 440-7800.

Sincerely,


for Sandra Shewry
Director

cc: Mr. Jeff Flick
Regional Administrator, Region IX
Centers for Medicare & Medicaid Services
75 Hawthorne Street
San Francisco, CA 94105

Ms. Lori Ahlstrand
Page 2

cc: Ms. Mary Cody, C.P.A.
Audit Coordinator
Audits & Investigations
California Department of Health Services
1500 Capitol Avenue, MS 2001
P.O. Box 997413
Sacramento, CA 95899

Mr. Tom McCaffrey
Chief Deputy Director, Health Care Programs
California Department of Health Services
1501 Capitol Avenue, MS 0004
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Sacramento, CA 95899-7413

Mr. Stan Rosenstein
Deputy Director, Medical Services
California Department of Health Services
1501 Capitol Avenue, MS 4000
P.O. Box 997413
Sacramento, CA 95899-7413

Mr. Tim Matsumoto
Chief, Provider Rate Section
California Department of Health Services
1501 Capitol Avenue, MS 4612
P.O. Box 99717
Sacramento, CA 95899-7417

California Department of Health Services
Medi-Cal Policy Division

Response to OIG's Audit of the Distinct-Part Nursing Facilities of Public Hospital Supplemental Reimbursement Program

The California Department of Health Services (CDHS) is responding to the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services draft report on the Review of Additional Reimbursement for Distinct-Part Nursing Facilities (DP/NF) of Public Hospitals in California. This draft report highlights findings on the following:

- 1) the State did not use actual costs to claim Federal reimbursement
- 2) San Mateo County overstated its quarterly costs and claimed this overstatement
- 3) Edgemoor in San Diego County overstated its Medicaid days and routine costs and claimed the overstatement, and
- 4) that there is a lack of instructions and monitoring procedures for the program.

OIG Findings 1: The State did not use actual costs to claim Federal reimbursement.

The CDHS disagrees with this finding. The State Plan Amendment (SPA) for this program does not require the State to use actual costs to claim Federal reimbursement. This SPA allows CDHS to use projected costs for the claiming of additional federal reimbursement and only requires that the projected costs be the upper limit for claiming. Also, projected costs are actual audited costs from a previous year, which are trended forward and is the basis for the calculation of reimbursement rates and is used to establish the additional federal reimbursement under this DP/NF supplemental payment program.

OIG Findings 2: San Mateo County overstated its quarterly costs and claimed this overstatement.

The CDHS disagrees with this finding. As approved in the DP/NF rate setting SPA 03-025, projected costs established in SPA 03-025 were used to determine the calculation of the payments in the DP/NF supplemental program. Based on the approved provisions of this SPA, it is CDHS's interpretation that San Mateo is entitled to be reimbursed up to the projected costs in accordance with the DP/NF, Medi-Cal Long Term Care Rates SPA 03-025.

OIG Findings 3: Edgemoor in San Diego County overstated its Medicaid days and routine costs and claimed the overstatement.

The CDHS and Edgemoor concur with this finding. The CDHS and Edgemoor have corrected this error by recalculating the supplemental reimbursement for this facility and CDHS has recovered \$559,035 in an overpayment of Federal share from Edgemoor for rate year 2002 and 2003.

California Department of Health Services
Medi-Cal Policy Division

OIG Findings 4: There is a lack of instructions and monitoring procedures for the program.

The CDHS concurs with the finding regarding the lack of instructions for this program. The CDHS has created new forms to clarify the error on the reporting forms to eliminate the language confusion in reporting of "days of service" and "days of payment". The CDHS is addressing these administrative issues by revising the instructions to the facilities in completing the documentation needed to support the supplemental reimbursement amounts. [See attached revised DP/NF instructions and claim & certification forms]

The CDHS agrees with the finding regarding the lack of a monitoring procedure for this program. To ensure Medicaid days are properly accounted for, CDHS will utilize a Surveillance Utilization Review System (SURS) that will report paid Medicaid days. The information from SURS will then be compared to the number of days claimed by a facility to verify the accuracy of the claim. To ensure expenditures are properly calculated, CDHS will require facilities to supply more detailed information that will link the costs reported on the claim with accounting records of the facility.

The following is in response to the OIG's recommendations for the DP/NF supplemental program:

OIG Recommendation 1: State to refund \$3,609,267 to the federal Government.

The State agrees with the recommendation to seek recovery of \$559,035 of the \$3,609,267 in an overpayment of Federal share from Edgemoor for rate year 2002 and 2003. The Edgemoor facility has refunded this amount to CDHS and CDHS is in the process of refunding the \$559,035 to CMS.

However, the State disagrees with the recommendation to seek recovery of \$3,050,232 amount in an overpayment of Federal share from San Mateo for quarters in rate year 2003 and 2004, per our response to OIG Finding 2 on the previous page.

OIG recommendation 2: State to review additional reimbursement amounts paid to the selected facilities subsequent to our audit period and refund any overpayment.

The State agrees with the recommendation to review additional reimbursed amounts paid to the selected facilities subsequent to the audit. CDHS will implement the recommendation beginning January 1, 2007.

OIG recommendation 3: State to provide adequate instructions to all facilities to ensure that the certified public expenditures used to support additional reimbursement amount are properly calculated.

The States agrees with the recommendation to provide adequate instructions to all facilities. CDHS revised the forms to provide clarity in identifying the date elements required in completing the forms. CDHS implemented this revision in August 2005.

California Department of Health Services
Medi-Cal Policy Division

OIG recommendation 4: State to strengthen monitoring procedures to ensure that all facilities' reported Medicaid days and expenditures are properly calculated.

The State agrees with the recommendation regarding the lack of monitoring procedures. To ensure Medicaid days are properly accounted for, CDHS will utilize a Surveillance Utilization Review System (SURS) that will report paid Medicaid days. The information from SURS will then be compared to the number of days claimed by a facility to verify the accuracy of the claim. To ensure expenditures are properly calculated, CDHS will require facilities to supply more detailed information that will link the costs reported on the claim with accounting records of the facility. CDHS will implement this process by January 1, 2007.

Enclosures:

- Exhibit A: DP/NF Claim & Certification Form (Revised)
- Exhibit B: DP/NF Claim & Certification Form Instructions (Revised)

Exhibit A

DISTINCT PART/NURSING FACILITY (DP/NF) SUPPLEMENTAL PAYMENT PROGRAM CLAIM AND CERTIFICATION FORM
REVISED
2005-2006

The instructions to complete this form are attached. Completion of the form is only necessary if you have a qualified facility and wish to participate in the program.

1. Name of Facility		2. County or Other Agency Name	
3. Medi-Cal Provider No.		4. Facility Phone No. ()	
5. Facility Street Address		6. City & State	7. Zip Code
8. Mailing Address (if different)		9. City & State	10. Zip Code
11. Administrator or Contact Person		12. Administrator or Contact Person Phone No. ()	
13. Claim for Quarterly Period		<input type="checkbox"/> 8/01/05----10/31/05 <input type="checkbox"/> 11/01/05----1/31/06 <input type="checkbox"/> 2/01/06----4/30/06 <input type="checkbox"/> 5/01/06----7/31/06	

Claim calculation steps:

1. Projected cost per patient day for the quarter claimed from the study used to set the Medi-Cal rates.	\$ _____
2. Estimated cost per patient day that the service is incurred by the facility during the quarter claimed. <i>(Please refer to the Instructions defining "Routine Costs", do not include any "Ancillary Costs", and refer to the example.)</i>	\$ _____
3. Allowable cost per patient day incurred by the facility during the quarter claimed. (No. 1 or No. 2, whichever is less).	\$ _____
4. Medi-Cal Distinct Part/Nursing Facility median rate paid during the quarter claimed.	\$ 299.80 _____
5. Allowable cost per patient day subject to supplemental reimbursement (No. 3 less No. 4).	\$ _____
6. Paid patient days reimbursed by Medi-Cal during the quarter claimed. Note instructions. <i>(Please refer to the Instructions defining "Paid Patient Days" and refer to the example.)</i>	_____
7. Allowable cost per patient day multiplied by Medi-Cal patient days is subject to supplemental reimbursement (No. 5 multiplied by No. 6). The Federal Financial Participation share of this amount is based upon the Federal Medicaid Assistance Percentage in effect on the date of service. <i>(Please refer to the Instructions defining "Date of Service".)</i>	\$ _____

Certification:

1. For the purposes of this claim and certification, "facility" is a distinct part of an acute care hospital providing skilled nursing services and is owned and operated by a county, city, city and county, or health care district as specified in Welfare and Institutions Code section 14105.27.
2. The information on the accompanying claim form is true and correct, based on expenditures for skilled nursing services for the period covered by the claim, in accordance with Welfare and Institutions Code section 14105.27. The facility will maintain documentation supporting these expenditures pursuant to section 14105.27, subdivisions (e)(2) and (e)(4). This documentation must include all fiscal records normally required in the performance of Medi-Cal field audits.
3. The facility's costs of skilled nursing services rendered to Medi-Cal beneficiaries during the period of the accompanying claim exceeds the amount of total payment received for those services based on the Median Rate.
4. The public funds expended for services provided have been expended as necessary for federal financial participation pursuant to the requirements of Section 1903(w) of the Social Security Act and 42 C.F.R § 433.50 *et seq.* for allowable costs.
5. The expenditures claimed have not previously been, nor will they be, claimed at any other time as claims to receive federal participation funds under Medicaid or any other program.
6. The facility acknowledges that the information is to be used for filing of a claim with the Federal government for federal funds and understands that misrepresentation of information constitutes violation of federal and state law.
7. The facility acknowledges that all funds expended pursuant to Welfare and Institutions Code section 14105.27 are subject to review and audit by the Department (see § 14105.27, subd. (i)).
8. The facility understands that the Department must deny payment of any claim submitted under Welfare and Institutions Code section 14105.27 if it determines that the certification is not adequately supported for purposes of federal financial participation.

I, the undersigned, state: That as an administrator, officer or other individual duly authorized in a resolution by the governing board as having authority to sign on behalf of the facility, I am authorized and designated to make this certification for and on behalf of _____ (name of facility), that the certification documents attached hereto are true to my knowledge. I declare that the certification information is true and correct. I understand that the making of false statements or the filing of false or fraudulent claims is punishable under Welfare and Institutions Code sections 14107, 14107.11, and other applicable provisions of law.

SIGNED: _____

PRINT NAME: _____

TITLE: _____

DATED: _____

In order to expedite payment consideration, the above certification and completed claim form must be mailed to the following address within ninety days after the end of the quarter.

Ms. Marie Taketa
 Department of Health Services
 Rate Development Branch
 Rate Analysis Unit
 1501 Capitol Avenue, Ste. 71.4001
 MSC 4612
 P.O. Box 997417
 Sacramento, CA 95899-7417

Note: Questions regarding this certification should be submitted in writing to the address listed above or e-mailed to the following: mtaketa@dhs.ca.gov.

Exhibit B

**DISTINCT PART/NURSING FACILITY (DP/NF) SUPPLEMENTAL
PAYMENT PROGRAM CLAIM AND CERTIFICATION FORM
INSTRUCTIONS
REVISED**

The DP/NF Supplemental Payment Program, effective August 1, 2001, provides for the federal share of Medi-Cal DP/NF uncompensated care costs up to a maximum limit. (Your facility is not required to participate.)

The U.S. Department of Human Services, Office of Inspector General (OIG) has conducted an audit of the DP/NF Supplemental Payment Program and has asked that additional clarification be made to both the claim form instructions and the DP/NF Supplemental Payment Program Claim and Certification Form. Please pay attention to some important changes or clarifications in ***bold italics***.

Please complete the attached claim and certification form for each quarter according to the instructions below. Note that the Department of Health Services (Department) provides two elements of information from the audited facility cost report used to set the Medi-Cal rates for the rate year (Claim calculation steps 1 and 4). A new Program Claim and Certification Form will be mailed to the facility annually.

Definitions of Terms Used:

Ancillary Costs – Ancillary costs are services in a hospital or SNF that includes laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including post-anesthesia and post operative recovery rooms), and therapy services (physical, speech, occupational). Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge.

Routine Costs - Routine costs are inpatient routine services in a hospital or SNF generally are those services included by the provider in a daily service charge – sometimes referred to as the “room and board” charge. Routine services are composed of two components: (1) general routine services, and (2) special care units (SCU’s), including coronary care units (CCU’s) and intensive care units (ICU’s). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

Date of Service – Centers for Medicare & Medicaid Services (CMS) clarified that for any Certified Public Expenditure program, both the Federal Medicaid Assistance Percentage (FMAP) and two-year federal claiming limit must be determined by the date the Medicaid expenditure was actually incurred. Therefore, the amount of the supplemental payment under the DP/NF Supplemental Payment Program must be calculated at the FMAP in effect during the quarter, or portion of the quarter, for which the facility incurred the cost included in the quarterly claim. (Refer to Claim Calculation Step No. 7.) Please refer to the letter dated January 30, 2004 from Mr. Brennan, Chief of the Rate Development Branch.

Paid Patient Days – The number of SNF Days paid and noted on a facility’s Medi-Cal Remittance Advice (RA). These paid days listed on the Medi-Cal RA are to be used for the specific quarter being captured by the DP/NF Supplemental Payment Program Claim and Certification Form.

Facility Information (No. 1 through No. 13):

1. **Name of Facility** – Include the name of your facility or the name that your facility uses as the primary business name.
2. **County or Other Agency Name** – Enter the County or other Agency title.
3. **Medi-Cal Provider No.** – Enter your nine digit alpha-numeric Medi-Cal provider number (three alphas, five numerics, one alpha).
4. **Facility Phone No.** – Enter the main facility phone number. This will serve as a secondary phone number in the event that the designated facility contact person cannot be reached.
- 5, 6, and 7. **(Facility Street Address, City and State, and Zip Code)** – Enter the actual physical address of the facility.
- 8, 9, and 10. **(Mailing Address, City and State, and Zip Code)** – Enter the mailing address of the facility, if different than the street address.
11. **Administrator or Contact Person** – Enter the name of the person to be contacted in the event the Department has questions concerning your claim and/or supporting documentation that may be required.
12. **Administrator or Contact Person Phone No.** – Enter the phone number where the administrator or contact person can be reached.
13. **Claim for Quarterly Period** – Enter the quarterly period to which this claim applies.

Claim calculation steps (No. 1 through No. 7):

Line 1: The projected cost per patient day is calculated by the Department and is already supplied on the line of the DP/NF Supplemental Payment Program Claim and Certification Form. This information is provided to each facility and is effective for each quarter until superseded by later notification from the Department.

Line 2: Enter the estimated cost per patient day that the service is incurred by the DP/NF as determined by the hospital administration from facility records. *(Please refer to the definitions for both “Routine Costs” and “Ancillary Costs”. DO NOT include Ancillary Costs in the facility’s estimated cost per patient day as stated in the Department letter dated March 29, 2002.)*

To determine Estimated Cost Per Patient Day follow these steps in the provided example:

(Quarter: August 1, 2005-October 31, 2005)

		August 2005	September 2005	October 2005	Quarterly Totals
Step 1	Direct Cost – Relevant Cost Centers (SNF Portion)	\$663,588	\$656,135	\$642,758	\$1,962,481
Step 2	Indirect Costs (Percentage of Direct Costs)	\$575,663	\$596,197	\$557,593	\$1,729,453
Step 3	Total Costs (add together Steps 1 and 2)	\$1,239,251	\$1,252,332	\$1,200,351	\$3,691,934
Step 4	Total Days (SNF Patient Days)	2,253	2,196	2,143	6,592
Step 5	Cost Per Patient Day (Divide Step 3 by Step 4)	\$550.04	\$570.28	\$560.13	<u>\$560.06</u>
Step 6	Enter bold and underlined amount to Line 2 of the DP/NF Supplemental Payment Program Claim and Certification Form				

Line 3: Indicate the lesser of Line 1 or Line 2 to determine allowable Medi-Cal certification program cost per patient day.

Line 4: The Medi-Cal DP/NF median rate for the rate year is entered by the Department.

Line 5: Subtract Line 4 from Line 3 to determine the cost per patient day that is to be subject to supplemental reimbursement.

Line 6: For this quarter, enter the total Medi-Cal DP/NF ***paid patient days*** regardless of the dates of service that were reimbursed by Medi-Cal during the quarter covered by this claim form. Such reimbursement may not have been made for services rendered prior to August 1, 2001, which is the effective date of the supplemental reimbursement program. *(Please refer to the definition of "Paid Patient Days".)*

To determine the Paid Patient Days follow these steps in the provided example:

(Quarter: August 1, 2005-October 31, 2005)

		Medi-Cal Remittance Advice (RA) Date	RA Number	Days Paid
Step 1	List all RA days paid from Medi-Cal Remittance Advices (See items a through f)			
		a. 8/7/2005	0542471	55
		b. 8/21/2005	0546712	125
		c. 9/3/2005	0546733	35
		d. 9/26/2005	0552211	200
		e. 10/5/2005	0552222	150
		f. 10/18/2005	0552261	14
Step 2	Paid Patient Days – Add the "Days Paid" Column together to get a total			<u>579</u>
Step 3	Enter bold and underlined amount to Line 6 of the DP/NF Supplemental Payment Program Claim and Certification Form			

Line 7. Multiply line 5 times Line 6 to obtain the amount that will be claimed for Federal Financial Participation (FFP). The supplemental reimbursement paid to the DP/NF depends upon the FFP percentage rate (Federal Medicaid Assistance Percentage or FMAP) in effect on the **date of service**. *(Please refer to the definition of "Date of Service".)*

Certification:

An authorized person must certify to the truth of the claim. Such person may be an administrator, officer or other person duly authorized by the governing board as having authority to sign on behalf of the facility.