

## Audits and Investigations Response to Workgroup Questions December 1, 2008

### Answers to **General** Questions

2. Please have DHCS describe their AB 1629 audit process.

The audit population is first determined from the universe of NF facilities that file a cost report with OSHPD during the rate setting calendar year. From this data, Audits determines which facilities require a rate audit. Facilities with zero Medi-Cal days, facilities that are closed and facilities that have undergone a change of ownership for which the new owner supplies data for less than 6 months are excluded from the audit population. Facilities that need an audit are then assigned to one of the 8 field sections based on location of the audit records. The branch maintains a database of the desk audit or field audit status of each facility's cost reports by calendar year. The field sections are notified of the requirement of a field audit at least every three years. From this point the desk audit or field audit status is determined by the field section based on either the three year requirement put forth in the statute or as a result of high audit risk determined through our scoping process.

Regardless of the type of audit performed a reclassification of data from the cost report to the rate setting categories must be performed for every audit report issued. The cost report does not present the cost data in the same format as required by AB 1629 for the Provider Rate Section to calculate rates. The auditor uses the provider's books of account to break out the costs particular to the Salaries, Benefits, Agency and Other cost categories. This reclassification is done prior to any audit adjustments related to reimbursement guidelines. The auditor must also identify the pass through costs with the exception of Property Tax. The other pass-through costs are not visible on the filed cost report. The auditor will then follow the procedures on the appropriate audit program and review areas of high audit risk. A portion of our scoping procedures is to compare the reported cost by cost component to the cost component benchmark for the previous rate year. Areas that are materially above or below the benchmark would indicate an area of low audit risk. There is a low risk for overpayment in the facilities above the benchmark because that portion of the provider's rate will be capped. There is a low risk for overpayment for facilities significantly below the benchmark due to the peer grouping of the facilities. These facilities have costs lower than their peers and therefore, it would be difficult to detect negative cost errors on their cost reports. Areas of high audit risk, the risk that the provider will be overpaid, are usually determined as facilities whose reported cost component per diem rate are at or near the benchmarks. These providers' costs not only affect the individual facility's rate, but the rates of the population of facilities within the same peer group. Each provider cost report is unique and therefore, each facility's audit procedures and adjustments are unique.

Once the required reclassifications are performed the cost report data is evaluated against reimbursement applicable regulations. The audit is then finalized and the audit report is issued to the provider. The audit data used in the rate setting process is forwarded electronically to the Provider Rate Section.

### **Follow-up Questions**

Please have DHCS provide an estimate of average audit disallowance percentage per provider for the rate years above.

What proportion of audit disallowances relate to salaries, wages, and benefits for direct care staff? Indirect care staff?

What proportion of audit disallowances relate to administration?

What proportion of audit adjustments relate to other categories?

Meaningful data for the questions asked above are not available. Due to the use of the OSHPD report as reported data limits the ability of DHCS to determine "audit disallowances" due to audit exceptions only.

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The auditors must reclassify costs from the general cost center categories into the cost component specific categories as defined in statute. Reclassifications from the reported cost centers into the cost components are not differentiated on the audit report from other types of reclassifications and adjustments. The inherent limitations of using the audit as a medium to convert reported data designed for a flat rate prospective rate methodology into the current rate system causes various problems with data interpretation. This is particularly apparent for reclassifications of the provider's adjustments made on pages 10.2-10.4 of the cost report. It is common practice for the providers to include facility benefits such as workers compensation or health insurance in the Administration cost center. The provider then reclassifies the cost from Administration (a large negative adjustment) to the various cost centers. This type of reclassification is very common and would skew any summary of audit adjustments when in fact it was not an auditor adjustment at, but one made by the provider that the auditor had to break down by cost component. Also, for OSHPD report purposes, Agency Cost is grouped by the providers in the Other category on the cost report. Initially when the auditors reconcile the cost report to the general ledger these costs are placed in the Other Cost Component until reviewed to determine that the cost meets the criteria of Agency. Once a finding of Agency is determined, the auditor reclassifies the cost from Other to Labor. Thus, large increases to the Labor Cost Component are not due to audit exceptions, but instead are merely moving cost around to comply with AB 1629. The Administration Cost Component is particularly problematic. The pass through costs of Liability Insurance, Care Giver Training, License Fee and expense of Quality Assurance Fee paid is included in the Administration Cost Center. The auditors reclassify these costs from the Administration Cost Center to separate lines on the audit report for use in rate setting. Administration will see large decreases by audit adjustment that are not actual decreases in cost, simply a movement of cost to another category of rate setting. To comply with the work group's request, and in order distill the meaningful adjustments from the population of audit data would require a review of each individual audit adjustment by provider. This type of review is not possible in the time frame given.

Review of total cost reductions is also not relevant data review. Financial Audits Branch offers an opinion on a Cost Report. The Cost Report includes costs not used in the rate setting methodology such as all Capital Cost and Facility License Fees. The capital component of the rate setting methodology is calculated based on a Fair Rental Value System Model. Any total cost review will include these capital items which are not applicable to the purpose of the work group. The pass through of Facility License Fee is not based on the cost, but the Facility License Fee established by the California Department of Public Health are included as an add on to the individual facility's rate.

### Answers to **Cost** Questions

10. Provide aggregate annual spending on facility legal fees. What is the range of reimbursement? What controls exist to prevent excessive reimbursement?

Annual spending on facility legal fees is not available. This is not a cost that is identified individually on the audit report or cost report. This is, however, an area that is reviewed extensively by the auditors when a field audit is performed. Legal fees are reviewed for compliance with CMS Pub. 15-1, Sections 2102.1, 2102.2, 2102.3 and 2183. In order for legal fees to be allowable, the cost must be reasonable, necessary, related to patient care and the audit period. The cost must be in compliance with CMS Pub. 15-1, Section 2183 that states:

Legal fees and related costs incurred by a provider are allowable if related to the provider's furnishing of patient care, e.g., legal fees incurred in appeals to the Provider Reimbursement Review Board and, if applicable, further appeals subsequent to a Board decision. However, legal fees and related costs incurred by a provider related to alleged civil fraud or indictment for a criminal act by the provider or its owners, employees, directors, etc., or legal fees for certain anti-union activities (see §2180), are not related to the furnishing of patient care and, therefore, are unallowable provider costs.

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The controls in place to prevent excessive reimbursement of legal fees include the compliance review discussed above, and the 50<sup>th</sup> percentile cap established by law for the Administrative Component of the rate methodology.

11. Provide aggregate annual spending on management fees to corporate offices. What is the range of reimbursement? What controls exist to prevent excessive reimbursement?

Aggregate annual spending on management fees to corporate offices is not available. This type of expense is not captured separately on the audit report or the cost report. AB 1629 did not allocate additional resources to provide for the additional review that is necessary of corporate office expenses, referred to as Home Office Audits. A portion of the corporate offices is reviewed each production year, however, for the majority of management fees and other corporate expenses, the 50<sup>th</sup> percentile cap on the Administration Cost Component is relied upon for cost control.

### **Additional questions asked at the December 1, 2008 meeting.**

- What percentage of the facility audits are currently full-scope audits and desk audits?

Based on the need for a field audit at least once every three years, at least one-third of the facilities that need a Medi-Cal rate will be full scope audits. The remaining two-thirds are evaluated using various analytical scoping procedures to identify facilities that are a high audit risk. If there is time available, high risk facilities will also receive a full scope audit. For the rate setting year 2008-2009, 49% of the audits performed were identified by the audit section as field audits.

- What are the “flaws” that are referenced in the last paragraph of the document that A&I prepared entitled, “How do we know if the audit system is working?”  
AB 1629, as chaptered, contains certain ambiguities and vagueness that has created challenges and additional time demands for A&I from the standpoint of grouping some cost items for audit purposes. A&I believes that concrete definitions and additional clarification in these areas would resolve misunderstandings and alleviate the current volume of correspondence between providers, auditors, policy and appeals.