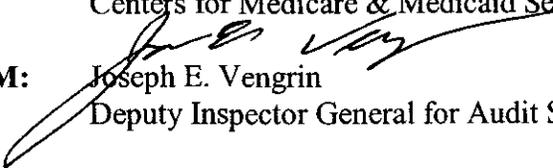




JUN 15 2004

**TO:** Mark B. McClellan, M.D., Ph.D.  
Administrator  
Centers for Medicare & Medicaid Services

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

**SUBJECT:** Review of Ohio's Medicaid Disproportionate Share Hospital Payments  
(A-05-01-00058)

Attached is an advance copy of our final report on Ohio's Medicaid disproportionate share hospital (DSH) payments. We will issue this report to the Ohio Medicaid agency within 5 business days. We conducted the audit as part of a multistate initiative requested by the Centers for Medicare & Medicaid Services (CMS).

Section 1923 of the Social Security Act, as amended, requires that States make Medicaid DSH payments to hospitals that serve disproportionate numbers of low-income patients with special needs. States receive allotments of DSH funds as set forth by Federal statute. During Federal fiscal year 2000, Ohio made DSH payments totaling more than \$618 million to about 190 hospitals and institutions for mental diseases (IMD) and fully expended its Federal DSH allotment of \$363 million.

Our objectives were to (1) verify that DSH limits and payments were calculated in accordance with program requirements of section 1923 and the Ohio State plan and (2) confirm consistency between the State plan and Federal DSH requirements. We attained these objectives through a review of Ohio's DSH program oversight and a facility-specific review of program compliance at Northwest Psychiatric Hospital.

Ohio's oversight and administration of DSH limits and payments were exemplary. Facility-specific DSH limits were calculated in compliance with requirements imposed by section 1923 and the State plan. Furthermore, DSH payments were calculated, distributed, and supported consistent with the State plan.

The State plan was in compliance with Federal requirements and CMS policies, with the exception of the method for calculating the Medicaid inpatient utilization rate for IMDs. Ohio's calculation method, while technically in compliance with the State plan, was inconsistent with section 1923(b)(2) of the Social Security Act and CMS policy. Contrary to CMS policy, Ohio included the 22- to 64-year-old patient age group in the Medicaid inpatient utilization rate calculation for its eight State-owned IMDs. This problem originated in 1997 when CMS approved a State plan amendment that removed the exclusion of this patient group from calculations for IMDs, but retained a general reference to individuals "eligible for medical

assistance.” Based on its interpretation that the 22- to 64-year-old age group was to be included in the calculation, Ohio made approximately \$80 million in DSH payments (\$47 million Federal share) to seven IMDs that did not meet Medicaid inpatient utilization rate requirements.

We recommend that Ohio:

- revise its State plan to exclude the 22- to 64-year-old age group in calculating the Medicaid IMD inpatient utilization rate for future DSH reporting periods
- refund the \$47 million Federal share of payments made to seven State-owned IMDs that did not meet Medicaid inpatient utilization rate requirements

Ohio did not agree that its calculation of the Medicaid inpatient utilization rate for State-owned IMDs was inconsistent with section 1923(b)(2) of the Social Security Act and with written CMS policy. Ohio believed that its calculations, which included days attributable to otherwise Medicaid-eligible 22- to 64-year-old IMD inpatients, were appropriate based on established legal precedent, CMS statements and rulings, and CMS approval of State plan amendments that specifically included those days.

Although we concluded that Ohio’s method of calculating the Medicaid inpatient utilization rate was technically in compliance with its State plan, we believe that the calculations were inconsistent with section 1923(b)(2) of the Social Security Act and with CMS policy stated in an August 1994 letter to the State Medicaid directors. The Departmental Appeals Board specifically supported this interpretation of section 1923(b)(2) and the August 1994 letter in New York State Department of Health, DAB No. 1867 (2003).

Contrary to Ohio’s position, the State plan amendment did not address the inclusion of the 22- to 64-year-old age group in the calculation of the utilization rates. By retaining the reference to those “eligible for medical assistance,” we believe that the amendment simply incorporated the Federal definition of those groups that were eligible.

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 Paul Swanson, Regional Inspector General for Audit Services, Region V, at (312) 353-2618.

Attachment



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF AUDIT SERVICES  
233 NORTH MICHIGAN AVENUE  
CHICAGO, ILLINOIS 60601

REGION V  
OFFICE OF  
INSPECTOR GENERAL

JUN 17 2004

Report Number: A-05-01-00058

Mr. Kenneth B. Marshall  
Chief Inspector  
Office of the Chief Inspector  
Ohio Department of Job & Family Services  
30 East Broad Street  
Columbus, Ohio 43215

Dear Mr. Marshall:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Ohio's Medicaid Disproportionate Share Hospital Payments." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. 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 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-05-01-00058 in all correspondence.

Sincerely,

A handwritten signature in cursive script that reads "Paul Swanson".

Paul Swanson  
Regional Inspector General  
for Audit Services

Enclosures – as stated

Page 2 – Mr. Kenneth B. Marshall

**Direct Reply to HHS Action Official:**

Ms. Cheryl Harris  
Associate Regional Administrator  
Division of Medicaid and Children's Health  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
233 North Michigan Avenue, Suite 600  
Chicago, Illinois 60601-5519

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF OHIO'S MEDICAID  
DISPROPORTIONATE SHARE  
HOSPITAL PAYMENTS**



**JUNE 2004  
A-05-01-00058**

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Section 1923 of the Social Security Act, as amended, requires that States make Medicaid disproportionate share hospital (DSH) payments to hospitals that serve disproportionate numbers of low-income patients with special needs. States receive allotments of DSH funds as set forth by Federal statute. During Federal fiscal year 2000, Ohio made DSH payments totaling more than \$618 million to about 190 hospitals and institutions for mental diseases (IMD) and fully expended its Federal DSH allotment of \$363 million.

### **OBJECTIVES**

Our objectives were to (1) verify that DSH limits and payments were calculated in accordance with program requirements of section 1923 and the Ohio State plan and (2) confirm consistency between the State plan and Federal DSH requirements. We attained these objectives through a review of Ohio's DSH program oversight and a facility-specific review of program compliance at Northwest Psychiatric Hospital.

### **SUMMARY OF FINDINGS**

Ohio's oversight and administration of DSH limits and payments were exemplary. Facility-specific DSH limits were calculated in compliance with requirements imposed by section 1923 and the State plan. Furthermore, DSH payments were calculated, distributed, and supported consistent with the State plan.

The State plan was in compliance with Federal requirements and Centers for Medicare & Medicaid Services (CMS) policies, with the exception of the method for calculating the Medicaid inpatient utilization rate for IMDs. Ohio's calculation method, while technically in compliance with the State plan, was inconsistent with section 1923(b)(2) of the Social Security Act and CMS policy. Contrary to CMS policy, Ohio included the 22- to 64-year-old patient age group in the Medicaid inpatient utilization rate calculation for its eight State-owned IMDs. This problem originated in 1997 when CMS approved a State plan amendment that removed the exclusion of this patient group from calculations for IMDs, but retained a general reference to individuals "eligible for medical assistance." Based on its interpretation that the 22- to 64-year-old age group was to be included in the calculation, Ohio made approximately \$80 million in DSH payments (\$47 million Federal share) to seven IMDs that did not meet Medicaid inpatient utilization rate requirements.

### **RECOMMENDATIONS**

We recommend that Ohio:

- revise its State plan to exclude the 22- to 64-year-old age group in calculating the Medicaid IMD inpatient utilization rate for future DSH reporting periods

- refund the \$47 million Federal share of payments made to seven State-owned IMDs that did not meet Medicaid inpatient utilization rate requirements

## **STATE COMMENTS**

Ohio did not agree that its calculation of the Medicaid inpatient utilization rate for State-owned IMDs was inconsistent with section 1923(b)(2) of the Social Security Act and with written CMS policy. Ohio believed that its calculations, which included days attributable to otherwise Medicaid-eligible 22- to 64-year-old IMD inpatients, were appropriate based on established legal precedent, CMS statements and rulings, and CMS approval of State plan amendments that specifically included those days. Ohio's comments are presented in their entirety as an appendix.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

Although we concluded that Ohio's method of calculating the Medicaid inpatient utilization rate was technically in compliance with its State plan, we believe that the calculations were inconsistent with section 1923(b)(2) of the Social Security Act and with CMS policy stated in an August 1994 letter to the State Medicaid directors. The Departmental Appeals Board specifically supported this interpretation of section 1923(b)(2) and the August 1994 letter in New York State Department of Health, DAB No. 1867 (2003).

Contrary to Ohio's position, the State plan amendment did not address the inclusion of the 22- to 64-year-old age group in the calculation of the utilization rates. By retaining the reference to those "eligible for medical assistance," we believe that the amendment simply incorporated the Federal definition of those groups that were eligible.

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## INTRODUCTION

### BACKGROUND

#### Medicaid and the DSH Program

Medicaid is a jointly funded Federal and State program that provides medical assistance to qualified low-income people. At the Federal level, CMS administers the program. Within a broad legal framework, each State designs and administers its own Medicaid program. Each State prepares a State plan that defines how the State will operate its Medicaid program and is required to submit the plan for CMS approval.

The Omnibus Budget Reconciliation Act of 1981 established the DSH program by adding section 1923 to the Social Security Act. Section 1923 requires State Medicaid agencies to make additional payments to hospitals that serve disproportionate numbers of low-income patients with special needs. States have considerable flexibility in defining their DSH programs under sections 1923(a) and (b) of the Social Security Act.

States receive allotments of DSH funds as set forth by section 1923. The Federal Government shares in the cost of Medicaid DSH expenditures based on the Federal medical assistance percentage for each State.

#### Ohio DSH Program

The Ohio Department of Job and Family Services administers the State's Medicaid program. The Ohio DSH program, established in 1989 and referred to as the Hospital Care Assurance Program, provides funds to qualified facilities to help offset the costs incurred in providing services to a disproportionate share of the indigent population. The program is primarily funded at the State level through a tax assessed on participating general hospitals. The State's assessment revenues are combined with Federal funding to make payments to qualified facilities.

For the review period, the hospital-specific DSH limit included the net Medicaid shortfall plus the reported uncompensated care costs for uninsured persons, based on the hospital cost reporting periods ended during State fiscal year 1999. The DSH limit calculations were based on reported actual charge and cost data that were not trended or otherwise adjusted.

During Federal fiscal year 2000, Ohio made DSH payments totaling more than \$618 million to about 190 hospitals and IMDs and fully expended its Federal DSH allotment of \$363 million. The Federal medical assistance percentage was 58.67 percent. Ohio's aggregate hospital-specific DSH limits exceeded the year's total available DSH funding by over \$200 million. As a result, some hospitals were not paid their DSH limits.

## **Northwest Psychiatric Hospital**

We selected Northwest Psychiatric Hospital, located in Toledo, OH, for further analysis. This hospital was one of eight State-owned IMDs to receive DSH payments during the review period and one of three facilities to receive payments totaling 100 percent of their DSH limits as calculated by Ohio.

### **OBJECTIVES, SCOPE, AND METHODOLOGY**

#### **Objectives**

Our objectives were to (1) verify that DSH limits and payments were calculated in accordance with program requirements of section 1923 and the Ohio State plan and (2) confirm consistency between the State plan and Federal DSH requirements.

#### **Scope and Methodology**

Our review covered DSH funding in Federal fiscal year 2000. We conducted a review of the overall State program administration and a facility-specific review of program compliance at Northwest Psychiatric Hospital. The overall State review included:

- an assessment of DSH limit and payment calculation methods to ensure that these amounts were calculated and distributed consistent with the State plan and Federal DSH spending limitations and requirements
- an evaluation of the State plan to ensure consistency and compliance with Federal program requirements
- a reconciliation of the DSH payments with supporting State accounting records and voucher documentation to confirm that the payments were disbursed to the participating hospitals and did not exceed the State-calculated hospital-specific DSH limits

We evaluated Northwest Psychiatric Hospital to verify that the facility:

- met applicable State and Federal DSH program qualification requirements
- appropriately reported uncompensated care charge and cost information
- received appropriate program payment as capped by the calculated facility-specific DSH limit

We selected this hospital for review because it received the highest amount of DSH payments among the State-operated IMDs that were funded at 100 percent of their State-calculated facility-specific limits.

Our review of internal controls was limited to obtaining an understanding of Ohio's procedures to ensure compliance with State and Federal program requirements. We did not test internal controls.

We performed fieldwork at the Ohio Department of Job & Family Services and the Ohio Department of Mental Health offices in Columbus, OH. We conducted the audit in accordance with generally accepted government auditing standards.

## **FINDINGS AND RECOMMENDATIONS**

### **OHIO'S OVERSIGHT OF DSH LIMITS AND PAYMENTS**

Ohio's oversight and administration of DSH limits and payments were exemplary.

- Facility-specific DSH limits were calculated in compliance with requirements imposed by section 1923 and the State plan.
- DSH payments were calculated, distributed, and supported consistent with the State plan.

Ohio's program oversight included annual reviews of hospital-specific cost data, cost report verifications, and hospital education seminars designed to encourage provider compliance with reporting requirements. During Federal fiscal year 2000, Ohio performed data reviews of uncompensated care costs for about 30 sampled hospitals to confirm that:

- the cost of uncompensated care was appropriately compiled and reported
- services were provided by the hospital and were medically necessary
- services were provided to eligible individuals
- selected facilities were in overall compliance with requirements

This oversight process included the recovery and redistribution of DSH overpayments to other qualifying hospitals and corrective action plans to remedy deficiencies at the hospitals. During this same period, Ohio selected 30 additional hospitals for review and verification of cost report data. Those hospitals with significant variances in cost reporting data for different years were required to verify the accuracy of their reported data and explain the reasons for the variances.

Ohio also held annual educational seminars for participating hospitals. The seminars were designed to improve the hospitals' understanding of, and compliance with, reporting requirements of Ohio's Hospital Care Assurance Program.

## STATE PLAN CONSISTENCY WITH FEDERAL REQUIREMENTS

The State plan was in compliance with Federal requirements and CMS policies, with the exception of the Medicaid inpatient utilization rate calculation for IMDs. Ohio's calculation method, while technically in compliance with the State plan, was inconsistent with section 1923(b)(2) of the Social Security Act and with CMS policy. Contrary to CMS policy, Ohio included the 22- to 64-year-old patient age group in the Medicaid inpatient utilization rate calculation for its eight State-owned IMDs.

This problem originated in 1997 when CMS approved a State plan amendment that removed a reference to the exclusion of the 22- to 64-year-old patient age group from the definition of the "Medicaid inpatient utilization rate." However, this amendment retained a general reference to individuals "eligible for medical assistance." After this change, Ohio considered the 22- to 64-year-old age group as meeting the definition of "eligible for medical assistance" and therefore began including this group in the inpatient utilization rate calculation for its eight State-owned IMDs. Based on its interpretation that the 22- to 64-year-old age group was to be included in the calculation, Ohio made approximately \$80 million in DSH payments (\$47 million Federal share) to seven IMDs that did not meet Medicaid inpatient utilization rate requirements.

### Federal Requirements and CMS Policy

Section 13621 of the Omnibus Budget Reconciliation Act of 1993 amended section 1923 of the Social Security Act to limit DSH payments. The limitation provided that payments to a hospital may not exceed:

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

Section 1923(d)(3) of the Social Security Act requires hospitals to have a Medicaid inpatient utilization rate of not less than 1 percent to qualify for DSH funding. Section 1923(b)(2) defines the Medicaid inpatient utilization rate by stating, in part:

. . . "medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this title in a period . . . and the denominator of which is the total number of the hospital's inpatient days in that period . . . .

In a letter to State Medicaid directors dated August 17, 1994, CMS provided further clarification of the requirement in section 1923(b)(2) by stating:

It is important to note that the numerator of the MUR [Medicaid utilization rate] formula does not include days attributable to Medicaid patients between 21 and 65 years of age in Institutions for Mental Disease (IMDs). These patients are not eligible for Medical Assistance under the State plan for the days in which they are inpatients of IMD's and may not be counted as Medicaid days in computing the Medicaid utilization rate . . . .

### **Medicaid Utilization Requirements Not Met**

Seven of the eight State-owned IMDs (including Northwest Psychiatric Hospital) did not have the minimum 1-percent Medicaid inpatient utilization rate required for DSH program participation. The primary reason for this was that, contrary to CMS written policy, Ohio included the 22- to 64-year-old patient age group in the Medicaid inpatient utilization rate calculations for its eight State-owned IMDs. Using this method, the Medicaid inpatient utilization rates for these facilities easily met the 1-percent requirement, with rates ranging between about 7 and 18 percent. Had Ohio complied with CMS policy and excluded this age group from its calculations, seven of the eight IMDs would not have qualified for DSH participation. For example, our recalculation found that Northwest Psychiatric Hospital had a Medicaid inpatient utilization rate of about 0.5 percent. For the single IMD that would have qualified for DSH participation, we calculated a Medicaid inpatient utilization rate of about 1.03 percent.

### **Revised State Plan Amendment**

CMS approved a State plan amendment in 1997 that changed the definition of "Medicaid inpatient utilization rate." Prior to the amendment, the State had specifically excluded the patient group from the calculation for IMDs as follows:

"Medicaid inpatient utilization rate" means for each psychiatric hospital the ratio of the hospital's number of inpatient days attributable to patients who were eligible for medical assistance and are age twenty-one and under or sixty-five and older divided by the hospital's total inpatient days as described in paragraph (A)(1) of this rule . . . .

The amendment modified the definition by removing the phrase "and are age twenty-one and under or sixty-five and older." No language was added.

Although CMS approved Ohio's revised definition, we conclude that the definition was not in compliance with the Social Security Act or CMS written policy.

### **Inappropriate Payments to Ineligible IMDs**

Ohio made approximately \$80 million in DSH payments (\$47 million Federal share) to seven State-owned IMDs that did not meet Medicaid inpatient utilization rate requirements.

## RECOMMENDATIONS

We recommend that Ohio:

- revise its State plan to exclude the 22- to 64-year-old age group in calculating the Medicaid IMD inpatient utilization rate for future DSH reporting periods
- refund the \$47 million Federal share of payments made to seven State-owned IMDs that did not meet Medicaid inpatient utilization rate requirements

## STATE COMMENTS

Ohio disagreed that its calculation of the Medicaid inpatient utilization rates for State-owned IMDs was inconsistent with section 1923(b)(2) of the Social Security Act and with written CMS policy. Ohio contended that its calculations, which included the days attributable to what it maintained were otherwise Medicaid-eligible 22- to 64-year-old IMD inpatients, were appropriate based on established legal precedent, CMS statements and rulings, and CMS approval of the Ohio State plan that specifically included these days. Ohio did not believe that the letter from CMS to the Medicaid State directors, dated August 17, 1994, was governing agency policy during the review period.

Ohio noted that for DSH payments that apply to the Medicare program, CMS issued Ruling 97-2 in 1997 that interpreted the phrase “eligible for assistance under the State plan” to include “all patient hospital days of service for patients who were eligible for assistance on that day for medical assistance under a State Medicaid plan . . . whether or not the hospital received payment for those inpatient hospital services.” Ohio believed that the same reasoning should apply to DSH payments with respect to Medicaid and concluded that section 1923(b)(2) should be interpreted to include the days attributable to patients meeting the Medicaid eligibility standard, even if Medicaid did not pay for the services because of the IMD exclusion.

Ohio indicated that it modified its State plan after Ruling 97-2 to specifically include the days in question and noted that CMS approved the initial modification to the plan and subsequent amendments. Ohio stated that all payments were made in accordance with the approved State plan and that all payments (including the Federal share) were appropriate. Ohio did not believe that the State plan should be revised.

We have included Ohio’s comments in their entirety as an appendix.

## OFFICE OF INSPECTOR GENERAL RESPONSE

Although we concluded that Ohio’s method of calculating the Medicaid inpatient utilization rate was technically in compliance with the State plan, we continue to believe that the utilization rate calculations were inconsistent with section 1923(b)(2) of the Social Security Act and with CMS policy stated in the August 1994 letter. The Departmental Appeals Board specifically supported this interpretation of section 1923(b)(2) and the August 1994 letter in New York State Department of Health, DAB No. 1867 (2003).

In that case, the Board held that Ruling 97-2 applied only to the calculation of Medicare DSH payment adjustments and not to Medicaid DSH payment adjustments. Therefore, the 22- to 64-year-old population could not be included in the Medicaid inpatient utilization rate calculation. The Board stated that “not only are IMDs ineligible to be reimbursed for the cost of inpatient hospital services to patients ages 22 through 64, but such patients are themselves ineligible for Medicaid by virtue of their institutional status.” The Board therefore concluded that New York improperly included in the numerator of its Medicaid utilization rate inpatient days attributable to IMD patients ages 22 through 64 since these patients could not be eligible for Medicaid as long as their status remained that of IMD patients. The Board looked to the August 1994 letter as the applicable CMS policy.

Contrary to Ohio’s position, the State plan amendment that was submitted after Ruling 97-2 did not address the inclusion of the 22- to 64-year-old age group in the calculation of the utilization rates. By retaining the reference to those “eligible for medical assistance,” we believe that the amendment simply incorporated the Federal definition of those groups that were eligible.

Bob Taft  
Governor



Tom Hayes  
Director

30 East Broad Street • Columbus, Ohio 43215  
[www.state.oh.us/odjfs](http://www.state.oh.us/odjfs)

July 11, 2003

Mr. Paul Swanson  
Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office of Audit Services  
233 North Michigan Avenue  
Chicago, Illinois 60601

Dear Mr. Swanson:

This letter is being sent in response to your letter dated June 13, 2003, and the draft report entitled, "Review of Ohio's Medicaid Disproportionate Share Hospital Program", audit report number A-05-01-00058. Thank you for the opportunity to respond.

ODJFS was pleased to learn that the result of the review found that the oversight and administration of the Federal Fiscal Year 2000 Disproportionate Share Hospital (DSH) Program by ODJFS was exemplary and no exceptions were identified in relation to program management. However, the review found ODJFS's calculation of the Medicaid inpatient utilization rate as it applies to IMDs to be out of compliance with Federal requirements and CMS policies. As a result, the draft report recommended that ODJFS: (1) revise the state plan to exclude the 22 to 64 year old age group for purposes of calculating the Medicaid inpatient utilization rate for future DSH reporting periods; and (2) work with CMS to address and resolve \$47 million representing the federal share of payments made to seven state-owned IMD facilities that did not meet the Medicaid inpatient utilization rate requirements.

ODJFS contends days provided to the 22 to 64 year old age group are appropriate to include in the numerator of the Medicaid utilization rate and based on CMS statements and approval of Ohio's state plan for 2000 and plans for prior years which included those days, ODJFS contends that it was in compliance with federal requirements and CMS policies for the 2000 program. We disagree that the August 17, 1994, letter from CMS to State Medicaid directors was the governing agency policy during the time period covered by the draft audit. In 1997, after repeated litigation all of which held against HCFA, the agency issued Ruling 97-2 which stated that, for purposes of the Medicare DSH calculation, it would interpret the phrase "eligible for assistance under the state plan" to include "all patient hospital days of service for patients who were eligible for assistance on that day for medical assistance under a State Medicaid plan . . . , whether or not the hospital received payment for those inpatient hospital services." Applying that same reasoning to Medicaid DSH, the days attributable to "patients who . . . were eligible for medical assistance under a State plan" in Section 1923(b)(2) must also be interpreted to mean days attributable to patients who meet the Medicaid standard of eligibility, even if the services were not paid for by Medicaid (because of the IMD exclusion). After the issuance of Ruling 97-2, we amended our state plan to include these days, and the plan was approved. It is our understanding that other

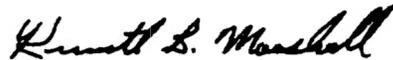
States were also informed that HCFA had acquiesced in this interpretation after the issuance of Ruling 97-2. Moreover, in light of the several cases in which HCFA was unable to defend its prior interpretation of the Medicare DSH provisions using almost identical language, we do not believe that the interpretation set forth in the August 1994 letter is sustainable. See *Jewish Hospital, Inc. v. Secretary of Health and Human Services*, 19 F.3d 270, 274 (6th Cir. 1994); *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996), *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996).

That HCFA Ruling 97-2 effectively negated the position taken in the August 17, 1994, letter is confirmed by the fact that the agency repeatedly approved our plan amendments specifically including days attributable to the 22 to 64 population in the Medicaid utilization rate calculation. Having made all payments in accordance with our approved state plan, we do not agree that there is any question that the payments made were proper, and the amount claimed as federal financial participation was appropriate. Nor do we believe it necessary to revise Ohio Medicaid State Plan in any manner.

Again, thank you for the opportunity to respond to the draft report. Please note that the department reserves the right to make these, and other arguments not set forth herein, if this matter is not resolved to the satisfaction of the department.

Please contact Dick Starks, Office of the Chief Inspector, at 614-466-3015, if you have any questions or comments.

Sincerely,



Kenneth B. Marshall  
Chief Inspector  
Office of the Chief Inspector