



MAR 16 2006

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

FROM: Daniel R. Levinson *Daniel R. Levinson*
Inspector General

SUBJECT: Audit of Selected States' Medicaid Disproportionate Share Hospital Programs
(A-06-03-00031)

The attached final report consolidates the results of our individual reviews of 10 States' Medicaid disproportionate share hospital (DSH) programs. The Centers for Medicare & Medicaid Services (CMS) requested that we conduct a multistate review of these programs.

Two common objectives of our individual reviews were to determine whether (1) States complied with the hospital-specific DSH limits imposed by section 1923(g) of the Social Security Act (the Act) and (2) hospitals returned any DSH payments to States through intergovernmental transfers of funds.

Section 1923 of the Act, as amended by the Omnibus Budget Reconciliation Act of 1993, requires that States make Medicaid DSH payments to hospitals that serve disproportionate numbers of low-income patients with special needs. Section 1923(g) of the Act limits these payments to a hospital's uncompensated care costs, which are the annual costs incurred to provide services to Medicaid and uninsured patients less payments received for those patients. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) imposed annual reporting and audit requirements for the DSH program beginning in fiscal year 2004.

Nine of the ten States reviewed did not comply with the hospital-specific DSH limits imposed by section 1923(g) of the Act. As a result, DSH payments exceeded the hospital-specific limits by approximately \$1.6 billion (\$902 million Federal share). The \$902 million Federal share included the following:

- Four States made approximately \$679 million in excess DSH payments based primarily on historical costs rather than actual costs. These States did not later adjust the payments using actual costs.
- Eight States made approximately \$223 million in excess DSH payments because they included unallowable costs in their calculations of hospital-specific limits.

As to our second objective, three States required hospitals to return DSH payments totaling approximately \$3.6 billion through intergovernmental transfers. The use of such transfers does not further the intended purpose of the DSH program, which is to cover the uncompensated costs of treating Medicaid and uninsured patients at DSH-eligible hospitals.

We recommend that CMS:

- ensure that the monetary recommendations concerning DSH payments that exceeded the hospital-specific limits have been resolved;
- establish regulations requiring States to (1) implement procedures to ensure that future DSH payments are adjusted to actual incurred costs, (2) incorporate these adjustment procedures into their approved State plans, and (3) include only allowable costs as uncompensated care costs in their DSH calculations; and
- strengthen its review and approval of State plans to ensure consistency with Federal requirements and use the results of audits conducted under MMA as part of its review process.

In its comments on the draft report, CMS agreed with our recommendations but interpreted our first recommendation to apply only prospectively, not as a requirement to seek recovery of the excess DSH payments that we had identified. We maintain that the Federal share of these excess payments should be recouped.

CMS also provided general remarks about intergovernmental transfers. In response to those remarks, we revised our final report as appropriate.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. 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. Please refer to report number A-06-03-00031 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**AUDIT OF SELECTED STATES'
MEDICAID DISPROPORTIONATE
SHARE HOSPITAL PROGRAMS**



**Daniel R. Levinson
Inspector General**

**MARCH 2006
A-06-03-00031**

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:

Office of Audit Services

The Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts management and program evaluations (called inspections) that focus on issues of concern to HHS, Congress, and the public. The findings and recommendations contained in the inspections generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. OEI also oversees State Medicaid Fraud Control Units which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Notices

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

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

OAS FINDINGS AND OPINIONS

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



EXECUTIVE SUMMARY

BACKGROUND

Section 1923 of the Social Security Act (the Act), as amended by the Omnibus Budget Reconciliation Act of 1993, requires that States make Medicaid disproportionate share hospital (DSH) payments to hospitals that serve disproportionate numbers of low-income patients with special needs. Section 1923(g) of the Act limits these payments to a hospital's uncompensated care costs, which are the annual costs incurred to provide services to Medicaid and uninsured patients less payments received for those patients.

States have considerable flexibility in defining their DSH programs under sections 1923(a) and (b) of the Act. Each State prepares a State plan that defines how it will operate its Medicaid program and is required to submit the plan to the Centers for Medicare & Medicaid Services (CMS) for approval.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) imposed annual reporting and audit requirements for the DSH program beginning in fiscal year 2004. States must now submit to CMS an annual, independently certified audit that verifies the amount by which hospitals have reduced their uncompensated care costs as a result of claimed DSH expenditures.

OBJECTIVES

This report consolidates the results of our reviews of Medicaid DSH programs in 10 States: Alabama, California, Illinois, Louisiana, Missouri, North Carolina, Ohio, Texas, Virginia, and Washington. Two common objectives of our individual reviews were to determine whether (1) States complied with the hospital-specific DSH limits imposed by section 1923(g) of the Act and (2) hospitals returned any DSH payments to States through intergovernmental transfers of funds.

SUMMARY OF FINDINGS

Nine of the ten States reviewed did not comply with the hospital-specific DSH limits imposed by section 1923(g) of the Act. As a result, DSH payments exceeded the hospital-specific limits by approximately \$1.6 billion (\$902 million Federal share). The \$902 million Federal share included the following:

- Four States (California, Illinois, Texas, and Washington) made approximately \$679 million in excess DSH payments based primarily on historical costs rather than actual costs. These States did not later adjust the payments using actual costs. The California and Texas State plans did not address adjusting estimated payments to actual costs. However, the Illinois State plan required adjusting estimated DSH payments to actual costs, and the Washington State plan required recoupment of DSH payments if the hospital-specific limit was exceeded.

- Eight States made approximately \$223 million in excess DSH payments because they included unallowable costs in their calculations of hospital-specific limits. Approximately \$151 million (67 percent) of the unallowable costs consisted of costs for institutions for mental diseases and nonhospital services. The remaining approximately \$72 million consisted of various unallowable costs such as bad debts, miscalculations, and other accounting errors.

As to our second objective, three States required hospitals to return DSH payments totaling approximately \$3.6 billion through intergovernmental transfers. The use of such transfers does not further the intended purpose of the DSH program, which is to cover the uncompensated costs of treating Medicaid and uninsured patients at DSH-eligible hospitals.

RECOMMENDATIONS

We recommend that CMS:

- ensure that the monetary recommendations concerning DSH payments that exceeded the hospital-specific limits have been resolved;
- establish regulations requiring States to (1) implement procedures to ensure that future DSH payments are adjusted to actual incurred costs, (2) incorporate these adjustment procedures into their approved State plans, and (3) include only allowable costs as uncompensated care costs in their DSH calculations; and
- strengthen its review and approval of State plans to ensure consistency with Federal requirements and use the results of audits conducted under MMA as part of its review process.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on the draft report, CMS agreed with our recommendations but interpreted our first recommendation to apply only prospectively, not as a requirement to seek recovery of the excess DSH payments that we had identified. We maintain that the Federal share of these excess payments should be recouped.

CMS also provided general remarks about intergovernmental transfers. In response to those remarks, we revised our final report as appropriate.

CMS's comments are included in Appendix B.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Medicaid and the Disproportionate Share Hospital Program	1
National Institutional Reimbursement Team	1
Intergovernmental Transfers	1
Recent Legislation	2
OBJECTIVES, SCOPE, AND METHODOLOGY	2
Objectives	2
Scope.....	2
Methodology	3
FINDINGS AND RECOMMENDATIONS	3
COMPLIANCE WITH HOSPITAL-SPECIFIC LIMITS	4
Federal Requirements	4
Payments Not Adjusted to Actual Costs.....	5
Unallowable Costs Included in Computations.....	6
INTERGOVERNMENTAL TRANSFERS	7
RECOMMENDATIONS	8
CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE	8
APPENDIXES	
A – LIST OF REPORTS	
B – CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS	

INTRODUCTION

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) requested that we conduct a multistate review of compliance with hospital-specific disproportionate share hospital (DSH) payment limits.

Medicaid and the Disproportionate Share Hospital 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 it 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, which is codified in section 1923 of the Social Security Act (the Act). Section 1923 requires State Medicaid agencies to make additional payments to hospitals that serve disproportionate numbers of low-income patients with special needs. The Omnibus Budget Reconciliation Act of 1993 limits these payments to a hospital's uncompensated care costs, which are the annual costs incurred to provide services to Medicaid and uninsured patients, less payments received for those patients. This limit is known as the hospital-specific limit.

States have considerable flexibility in defining their DSH programs under sections 1923(a) and (b) of the 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.

National Institutional Reimbursement Team

In May 2002, CMS established the Medicaid National Institutional Reimbursement Team (NIRT) to perform three functions. First, NIRT reviews and recommends actions on all Medicaid institutional reimbursement methodologies for inpatient hospital and long term care services in each State plan. Second, NIRT provides technical assistance to States on Medicaid institutional reimbursement issues. Third, NIRT directs the development and promulgation of all Medicaid institutional reimbursement regulations and policies.

Intergovernmental Transfers

An intergovernmental transfer is a transfer of funds between a local government and a State government. Pursuant to section 1902(a)(2) of the Act, a State may use local funds for up to 60 percent of the matching funds used to claim Federal Medicaid funding.

Our prior audit work involving upper-payment-limit funding found that public hospitals were required to return millions of dollars of these funds to the State and other entities

through intergovernmental transfers. The upper payment limit is an estimate of the amount that would be paid for Medicaid services under Medicare payment principles. Because of the potential vulnerability of the Medicaid DSH program to these same intergovernmental transfers, we determined the extent to which hospitals returned DSH funds to States or other entities.

Recent Legislation

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) implemented new reporting and audit requirements for the DSH program. For fiscal years beginning in 2004, each State is required to submit to CMS an annual report that identifies each hospital that received DSH payments for the preceding fiscal year and the amount of the DSH payments made to the hospital. CMS may also obtain other information deemed necessary to ensure the appropriateness of DSH payments for the preceding fiscal year.

For fiscal years beginning in 2004, each State is also required to submit to CMS an annual, independently certified audit that verifies the amount by which hospitals have reduced their uncompensated care costs as a result of claimed DSH expenditures. This comprehensive audit is to include verification of payments to hospitals, uncompensated care costs, hospital-specific limits, and adherence to documentation requirements.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

This report consolidates the results of our individual reviews of 10 States' Medicaid DSH programs. Two common objectives of our individual reviews were to determine whether (1) States complied with the hospital-specific DSH limits imposed by section 1923(g) of the Act and (2) hospitals returned any DSH payments to States through intergovernmental transfers of funds.

Scope

Our multistate review included 10 States: Alabama, California, Illinois, Louisiana, Missouri, North Carolina, Ohio, Texas, Virginia, and Washington. In North Carolina, we were unable to determine whether DSH payments were made in accordance with the hospital-specific limits because the State had not made final adjustments to cost reports.

Between June 6, 2001, and October 13, 2004, we issued a total of 19 individual reports to the States and provided the reports to CMS. This consolidated report addresses the most significant findings from our individual reviews. Each review covered a specific period ranging from hospital fiscal year 1996 to State fiscal year 2001. For a list of the reports, the audit periods, and the Internet addresses, see Appendix A.

We limited our review of internal controls to obtaining an understanding of how the States administer their DSH programs.

Methodology

To accomplish our objectives, we:

- reviewed Federal laws, regulations, and guidelines applicable to the Medicaid DSH program;
- reviewed the State plans to gain an understanding of the DSH program in each State;
- where available, obtained from each State the hospital-specific limit for each hospital during the audit period;
- where available, compared the total DSH payments to each hospital with the hospital-specific limit;
- reviewed the data used to calculate the uncompensated care cost element of the hospital-specific limit to determine whether the information was accurate and the costs claimed were allowable; and
- discussed our findings with NIRT officials.

We performed our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Nine of the ten States reviewed did not comply with the hospital-specific DSH limits imposed by section 1923(g) of the Act. As a result, DSH payments exceeded the hospital-specific limits by approximately \$1.6 billion (\$902 million Federal share). The \$902 million Federal share included the following:

- Four States (California, Illinois, Texas, and Washington) made approximately \$679 million in excess DSH payments based primarily on historical costs rather than actual costs. These States did not later adjust the payments using actual costs. The California and Texas State plans did not address adjusting estimated payments to actual costs. However, the Illinois State plan required retroactive adjustments of estimated DSH payments to actual costs, and the Washington State plan required recoupment of DSH payments if the hospital-specific limit was exceeded.
- Eight States made approximately \$223 million in excess DSH payments because they included unallowable costs in their calculations of hospital-specific limits. Approximately \$151 million (67 percent) of the unallowable costs consisted of

costs for institutions for mental diseases (IMDs) and nonhospital services. The remaining approximately \$72 million consisted of various unallowable costs such as bad debts, miscalculations, and other accounting errors.

As to our second objective, three States required hospitals to return DSH payments totaling approximately \$3.6 billion through intergovernmental transfers. The use of such transfers does not further the intended purpose of the DSH program, which is to cover the uncompensated costs of treating Medicaid and uninsured patients at DSH-eligible hospitals.

COMPLIANCE WITH HOSPITAL-SPECIFIC LIMITS

The following table summarizes the DSH payments that exceeded the hospital-specific limits in nine States.

Summary of DSH Payments Exceeding Hospital-Specific Limits

State	Amount in Excess of Hospital-Specific Limits	Federal Share		
		Total	Payments Not Adjusted to Actual Costs	Unallowable Costs
Alabama	\$65,784,887	\$45,763,327		\$45,763,327
California	505,420,012	253,905,137	\$202,644,157	51,260,980
Illinois	291,541,669	145,770,834	144,798,024	972,810
Louisiana	26,652,601	18,664,815		18,664,815
Missouri	62,100,000	37,500,000		37,500,000
Ohio	80,197,000	47,115,000		47,115,000
Texas	511,424,933	319,177,651	319,177,651	
Virginia	21,512,948	11,085,181		11,085,181
Washington	44,300,000	23,300,000	12,700,000	10,600,000
Total	\$1,608,934,050	\$902,281,945	\$679,319,832	\$222,962,113

Federal Requirements

Section 1923(g) of the Act provides that DSH 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.

In an August 17, 1994, letter to State Medicaid agencies, CMS provided guidance regarding implementation of the hospital-specific limits. According to the letter, the limit

is composed, in part, of the Medicaid shortfall, which is the cost of services furnished to Medicaid beneficiaries less the non-DSH Medicaid payments to the hospitals.

An August 16, 2002, CMS letter to State Medicaid agencies again stated that calculations of the Medicaid shortfall must reflect a hospital's cost of providing services to Medicaid patients and the uninsured, net of Medicaid payments (except DSH payments). CMS further stated that Medicaid payments include any supplemental or enhanced (upper-payment-limit) payments to hospitals. Not recognizing these payments would overstate a hospital's shortfall, thus inflating the uncompensated care cost limits.

Section 1923(d)(3) of the 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:

. . . "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 its August 17, 1994, letter, 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

Payments Not Adjusted to Actual Costs

Contrary to Federal requirements, DSH payments in four States exceeded the hospital-specific limits by approximately \$679 million. This noncompliance occurred primarily because the States based estimated payments on historical costs and did not later adjust these payments using actual costs. The historical data dated from 1½ to 8 years before the year in which DSH payments were claimed. In California and Texas, the approved State plans described the calculation methodology based on historical costs but did not address the need for later adjustments of those costs to actual costs. The Illinois State plan required retroactive adjustments, but the State did not make those adjustments. The Washington State plan required recoupment of DSH payments in excess of the hospital-specific limits, but the State did not make those recoupments.

Because the California and Texas State plans did not address the adjustment of estimated DSH payments to actual costs, we recommended that CMS work with the two States to resolve approximately \$202 million and \$319 million, respectively. However, we

recommended recovery of approximately \$145 million in excess funds in Illinois because the State plan called for retroactive adjustments to actual costs. We also recommended recovery of approximately \$13 million in Washington because the State plan required recoupment of DSH payments that exceeded the hospital-specific limits.

Although the Act provides that DSH payments must not exceed the hospital-specific limits, CMS has not established Federal regulations requiring States, in the absence of a State plan provision, to adjust estimated DSH payments to actual costs incurred. We believe that the lack of such a specific Federal requirement contributed to the excess payments in the four States. Formal comments that we received from various States and discussions with State officials support our belief. For example, California stated that a retrospective reconciliation was not a statutory requirement, and Texas asserted that the congressional intent was not to require reconciliation of DSH payments to final costs.

Unallowable Costs Included in Computations

Contrary to Federal requirements, eight States made approximately \$223 million in excess DSH payments because they included unallowable costs in their calculations of hospital-specific limits. Approximately \$151 million (67 percent) of the unallowable costs consisted of IMD costs and nonhospital service costs, as detailed below.

- Ohio inappropriately included IMD residents between the ages of 21 and 65 in calculating the Medicaid inpatient utilization rate. When we excluded these IMD residents from the calculation, seven IMDs that received DSH payments did not have the minimum 1-percent Medicaid inpatient utilization rate. As a result, Ohio made approximately \$47 million in unallowable DSH payments to these facilities. The State plan allowed the inclusion of IMD residents in the Medicaid utilization rate. However, section 1923(b)(2) of the Act, by including only inpatient days for patients “eligible for medical assistance,” and CMS’s August 1994 letter to State Medicaid directors expressly prohibited their inclusion.
- Alabama did not reduce its uncompensated care costs by upper-payment-limit payments (non-DSH Medicaid payments) to hospitals. As a result, Alabama made DSH payments of \$46 million in excess of hospital-specific limits. CMS’s 1994 and 2002 letters, which interpreted section 1923(g) of the Act, require States to reduce uncompensated care costs by non-DSH Medicaid payments in the calculation of hospital-specific limits.
- Contrary to sections 1923(c) and (g) of the Act, Missouri and Virginia included the costs of nonhospital services as part of their hospital-specific limit calculations. Missouri included costs for community mental health centers that resulted in DSH payments of \$36.2 million in excess of the hospital-specific limits. No provision in the State plan allowed Missouri to claim these costs. Virginia included nonhospital physician practice costs

that were incurred by a separate legal entity, not a hospital, which resulted in approximately \$11.1 million in excess DSH payments.

- By including billed charge amounts in its DSH payment calculations, Washington made DSH payments of approximately \$10.4 million in excess of the hospital-specific limits. Pursuant to section 1923(g)(1)(A) of the Act, the hospital-specific limit calculations should be based on costs incurred. Washington also made approximately \$0.2 million of DSH payments to ineligible hospitals. As a result, Washington's DSH payments exceeded the hospital-specific limits by approximately \$10.6 million.

The remaining \$72 million (33 percent) consisted of various unallowable costs such as bad debts, miscalculations, and other accounting errors.

In their responses to our draft reports, States often commented that CMS had not issued regulations or clear guidance on what hospital expenditures could be included in computing DSH payments. For example, Ohio (1) disagreed that its calculation of the Medicaid inpatient utilization rates was inconsistent with the Act and with written CMS policy and (2) did not believe that CMS's August 1994 letter governed agency policy during the review period. As another example, Virginia stated that (1) CMS had never issued regulations interpreting the hospital-specific limits of the DSH statute, (2) neither statute nor regulation defined "hospital services" for purposes of DSH, and (3) CMS's August 1994 letter to State Medicaid directors gave States significant flexibility in determining the costs of services.

INTERGOVERNMENTAL TRANSFERS

Hospitals in three States returned to the States approximately \$3.6 billion in DSH payments through intergovernmental transfers:

- North Carolina required State-owned hospitals and non-State public hospitals to transfer more than \$1.6 billion of the approximately \$1.7 billion in total DSH payments back to the State.
- In California, public entities with DSH-eligible hospitals transferred approximately \$1.4 billion to the State. The Federal Government provided matching funds of approximately \$1.3 billion to California. California then distributed DSH payments of approximately \$2.6 billion (\$2.1 billion to public hospitals and \$0.5 billion to private hospitals). Public hospitals then transferred approximately \$1.4 billion back to the public entities. Private hospitals were not required to return any DSH funds through intergovernmental transfers.
- Alabama required hospitals to transfer approximately \$632 million (86 percent) of the \$738 million in DSH payments back to the State.

The use of intergovernmental transfers does not further the intended purpose of the DSH program, which is to cover the uncompensated costs of treating Medicaid and uninsured patients at DSH-eligible hospitals.

RECOMMENDATIONS

We recommend that CMS:

- ensure that the monetary recommendations concerning DSH payments that exceeded the hospital-specific limits have been resolved;
- establish regulations requiring States to (1) implement procedures to ensure that future DSH payments are adjusted to actual incurred costs, (2) incorporate these adjustment procedures into their approved State plans, and (3) include only allowable costs as uncompensated care costs in their DSH calculations; and
- strengthen its review and approval of State plans to ensure consistency with Federal requirements and use the results of audits conducted under MMA as part of its review process.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its December 21, 2005, comments on the draft report, CMS agreed with our recommendations, but with a qualification. Specifically, although it agreed with our first recommendation, CMS interpreted the recommendation to apply only prospectively, not as a requirement to seek recovery of the excess DSH payments that we had identified. CMS's interpretation is incorrect. In many of our individual reports on States' DSH programs, we recommended that States refund the Federal share of DSH payments that exceeded the hospital-specific limits. We maintain that the Federal share of these payments should be recouped.

CMS also provided general remarks about intergovernmental transfers. In response to those remarks, we revised our final report as appropriate.

CMS's comments are included in Appendix B.

APPENDIXES

LIST OF REPORTS**Alabama**

“Review of Alabama’s Medicaid Disproportionate Share Hospital Program” (A-04-01-02006, issued June 24, 2004).

The audit period was State fiscal years 1999 and 2000.

Internet address: <http://oig.hhs.gov/oas/reports/region4/40102006.pdf>

California

“Audit of California’s Medicaid Inpatient Disproportionate Share Hospital Payments for Los Angeles County Hospitals, State Fiscal Year 1998” (A-09-02-00071, issued May 30, 2003).

The audit period was State fiscal year 1998.

Internet address: <http://oig.hhs.gov/oas/reports/region9/90200071.pdf>

“Audit of California’s Medicaid Inpatient Disproportionate Share Hospital Payment for Kern Medical Center, Bakersfield, California, State Fiscal Year 1998” (A-09-01-00098, issued September 17, 2002).

The audit period was State fiscal year 1998.

Internet address: <http://oig.hhs.gov/oas/reports/region9/90100098.pdf>

“Audit of California’s Medicaid Inpatient Disproportionate Share Hospital Payments for University of California, San Diego Medical Center, State Fiscal Year 1998” (A-09-01-00085, issued September 18, 2002).

The audit period was State fiscal year 1998.

Internet address: <http://oig.hhs.gov/oas/reports/region9/90100085.pdf>

“Audit of California’s Medicaid Inpatient Disproportionate Share Hospital Payments for State Fiscal Year 1998” (A-09-02-00054, issued May 29, 2003).

The audit period was State fiscal year 1998.

Internet address: <http://oig.hhs.gov/oas/reports/region9/90200054.pdf>

Illinois

“Review of Medicaid Disproportionate Share Hospital Payment Limits for University of Illinois – Chicago” (A-05-01-00099, issued October 13, 2004).

The audit period was State fiscal years 1997 through 2000.

Internet address: <http://oig.hhs.gov/oas/reports/region5/50100099.pdf>

“Review of Medicaid Disproportionate Share Hospital Payments to Mount Sinai Hospital of Chicago” (A-05-01-00102, issued October 18, 2004).

The audit period was State fiscal years 1997 through 2000.

Internet address: <http://oig.hhs.gov/oas/reports/region5/50100102.pdf>

“Review of Illinois Medicaid Disproportionate Share Hospital Payments – Illinois Department of Public Aid, Springfield, Illinois” (A-05-01-00059, issued August 25, 2004).

The audit period was State fiscal years 1997 through 2000.

Internet address: <http://oig.hhs.gov/oas/reports/region5/50100059.pdf>

Louisiana

“Audit of the Louisiana Medicaid Disproportionate Share Hospital Program – Louisiana State University Medical Center Hospitals Overseen by the Health Care Services Division” (A-06-00-00026, issued June 11, 2001).

The audit period was State fiscal year 1998.

Internet address: <http://oig.hhs.gov/oas/reports/region6/60000026.pdf>

“Audit of the Louisiana Medicaid Disproportionate Share Hospital Program – Louisiana State University Medical Center – Shreveport, Louisiana” (A-06-00-00058, issued June 6, 2001).

The audit period was State fiscal year 1998.

Internet address: <http://oig.hhs.gov/oas/reports/region6/60000058.pdf>

Missouri

“Review of the Calculation Methodology Utilized for Disproportionate Share Hospital Amounts Claimed Under the Missouri Medicaid Program” (A-07-01-02089, issued May 28, 2002).

The audit period was State fiscal year 1999.

Internet address: <http://oig.hhs.gov/oas/reports/region7/70102089.pdf>

“Review of Disproportionate Share Hospital Costs Claimed by the State of Missouri for Fiscal Year Ended June 30, 1999” (A-07-01-02093, issued August 12, 2002).

The audit period was State fiscal year 1999.

Internet address: <http://oig.hhs.gov/oas/reports/region7/70102093.pdf>

North Carolina

“Review of North Carolina State Medicaid Disproportionate Share Hospital Payments for Fiscal Years 1997 to 2001” (A-04-01-00003, issued April 30, 2004).

The audit period was State fiscal years 1997 through 2001.

Internet address: <http://oig.hhs.gov/oas/reports/region4/40100003.pdf>

Ohio

“Review of Medicaid Disproportionate Share Hospital Payment Limits for St. Vincent Charity Hospital and St. Luke’s Medical Center, Cleveland, Ohio” (A-05-01-00087, issued March 12, 2004).

The audit period was Federal fiscal year 2000.

Internet address: <http://oig.hhs.gov/oas/reports/region5/50100087.pdf>

“Review of Ohio’s Medicaid Disproportionate Share Hospital Payments” (A-05-01-00058, issued June 15, 2004).

The audit period was Federal fiscal year 2000.

Internet address: <http://oig.hhs.gov/oas/reports/region5/50100058.pdf>

Texas

“Audit of Texas Medicaid Inpatient Disproportionate Share Hospital Program for Hospital Fiscal Years 1996 Through 1998” (A-06-01-00041, issued February 19, 2003).

The audit period was hospital fiscal years 1996 through 1998.

Internet address: <http://oig.hhs.gov/oas/reports/region6/60100041.pdf>

Virginia

“Review of Medicaid Disproportionate Share Hospital Payments Made by Virginia’s Department of Medical Assistance Services to the University of Virginia Medical Center for the Fiscal Years Ending June 30, 1997, and June 30, 1998” (A-03-01-00226, issued May 1, 2003).

The audit period was State fiscal years 1997 and 1998.

Internet address: <http://oig.hhs.gov/oas/reports/region3/30100226.pdf>

“Review of Medicaid Disproportionate Share Hospital Payments Made by Virginia’s Department of Medical Assistance Services to the Medical College of Virginia Hospitals for the Fiscal Years Ending June 30, 1997, and June 30, 1998” (A-03-01-00222, issued April 18, 2003).

The audit period was State fiscal years 1997 and 1998.

Internet address: <http://oig.hhs.gov/oas/reports/region3/30100222.pdf>

Washington

“Review of Washington State’s Disproportionate Share Hospital Program” (A-10-01-00001, issued October 22, 2002).

The audit period was State fiscal year 1999.

Internet address: <http://oig.hhs.gov/oas/reports/region10/100100001.pdf>



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

DEC 21 2005

Administrator
Washington, DC 20201

RECEIVED
2005 DEC 22 PM 4:07
OFFICE OF INSPECTOR
GENERAL

TO: Daniel R. Levinson
Inspector General
Office of Inspector General

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

SUBJECT: OIG Draft Report: Report on Selected States' Medicaid Disproportionate Share Hospital Programs (A-06-03-00031)

Thank you for the opportunity to review and comment on the above referenced OIG report. The purpose of this report, completed at the request of the Center for Medicaid and State Operations, was to determine whether 1) States complied with the hospital specific DSH limits imposed by section 1923(g) of the Social Security Act (the Act) and 2) hospitals returned any DSH payments to States through intergovernmental transfers of funds.

General Comment

Office of Inspector General Note: This paragraph has been redacted because the issue referred to by the auditee is no longer included in this report.

The CMS fully recognizes that the statute allows States to share their cost of the Medicaid program with local governments and that intergovernmental transfers (IGTs) that meet the conditions for protection under the Medicaid statute are a permissible source of State funding of Medicaid costs. Section 1903(w) (6) (A) of the Social Security Act (the Act) specifies that the Secretary may not restrict a State's use of funds where such funds are derived from State or local taxes (or funds appropriated to State teaching hospitals) transferred from, or certified by, units of government within a State as the non-Federal share of Medicaid expenditures, regardless of whether the unit of government is also a health care provider. Except as provided in section 1902(a) (2) of the Act, unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under section 1903(w) of the Act.

During the State plan amendment (SPA) review process, CMS discovered that several States were utilizing financing techniques that do not meet the matching requirements of the Federal-State

Page 2 – Daniel R. Levinson

partnership. Specifically, CMS has discovered that several States make claims for Federal matching funds associated with certain Medicaid payments, payments of which the health care providers are not ultimately allowed to retain. Instead, through the “guise” of the intergovernmental transfer (IGT) process, State and/or local governments require the health care provider to forgo and/or return certain Medicaid payments to the State, which effectively shifts the cost of the Medicaid program onto the Federal taxpayer.

The result of such an arrangement is that the health care provider is unable to retain the full Medicaid payment amount to which it was entitled (a payment for which Federal funding was made available based on the full payment), and the State and/or local government may use the funds returned by the health care provider for costs outside the Medicaid program and/or help draw additional Federal dollars for other Medicaid program costs. The net effect of this re-direction of Medicaid payments is that the Federal government bears a greater level of Medicaid program costs, which is inconsistent with the Federal medical assistance percentages specified in the Medicaid statute.

The State practices identified in this report are not considered IGTs, but instead are improper returns of certain Medicaid payments that contradict the matching requirements of the Federal-State partnership.

OIG Recommendations

Ensure that the monetary recommendations concerning DSH payments that exceeded the hospital specific limits have been resolved.

CMS Response

We agree and intend to work fully with all States in order to ensure that Medicaid DSH payments meet the Federal statutory requirements. We interpret this recommendation as a prospective resolution and not a requirement to recoup any Federal payments associated with these findings. As the OIG report points out, the affected States did not always have reconciliation in their State plan and/or required the return of the DSH payment upon receipt of such payment. Moreover, many of the affected States contend CMS guidance was inadequate. In addition, States always have the ability to redistribute DSH payments within their DSH allotments. Also, as fully detailed in response #2, CMS has issued a proposed regulation to ensure compliance with the hospital specific limit. Finally, since August 2003, CMS has been requesting information from States regarding detail on how States are financing their share of the Medicaid program costs under the Medicaid reimbursement SPA review process. This process is fully detailed in response to finding #3.

Page 3 – Daniel R. Levinson

OIG Recommendations

Establish regulations requiring States to (1) implement procedures to ensure that future DSH payments are adjusted to actual incurred costs, (2) incorporate these adjustment procedures into their approved State plans, and (3) include only allowable costs as uncompensated care costs in their DSH calculations.

CMS Response

We agree, and on August 26, 2005, CMS published a Notice of Proposed Rulemaking (NPRM) to implement the new Medicaid DSH payment reporting and auditing provisions of section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003(MMA). Specifically, the NPRM would require States to submit an annual report that identifies each disproportionate share hospital that received a DSH payment under the State's Medicaid program, as well as the total annual DSH payments made to the hospital, the total annual costs incurred for furnishing inpatient and outpatient hospital services provided to Medicaid individuals and the total costs incurred for furnishing those services provided to individuals with no source of third party coverage, and the total amount of uncompensated care costs for furnishing inpatient hospital and outpatient services to Medicaid individuals and to individuals with no source of third party coverage.

Further, the NPRM would require States to have their Medicaid DSH payment programs independently audited and to submit the certified audit annually to the Secretary. The certified independent audit must verify:

- The extent to which hospitals in the State have reduced uncompensated care costs to reflect the total amount of claimed expenditures made under the Federal statutory DSH provisions.
- DSH payments to each hospital comply with the applicable hospital-specific DSH payment limit.
- Only the uncompensated care costs of providing inpatient and outpatient hospital services to Medicaid individuals and uninsured individuals are included in the calculation of the hospital-specific limits.
- The State included all Medicaid payments, including supplemental payments, in the calculation of such hospital-specific limits.
- The State has separately documented and retained a record of all its costs under the Medicaid program, claimed expenditures under the Medicaid program, uninsured costs in determining payment adjustments, and any payments made on behalf of the uninsured from payment adjustments.

OIG Recommendations

Strengthen its review and approval of State plans to ensure consistency with Federal requirements and use the results of audits conducted under MMA as part of its review process.

Page 4 -- Daniel R. Levinson

CMS Response

We agree. Since August 2003, CMS has been requesting information from States regarding detail on how States are financing their share of the Medicaid program costs under the Medicaid reimbursement SPA review process. The questions related to State financing of the Medicaid program are applied consistently and equally to all States under the SPA review process. CMS will not approve new SPA proposals until States have fully explained how they finance their Medicaid programs, including DSH payments, and until such time that States have agreed to terminate any financing practices that contradicts the spirit of the Federal-State partnership.

During the SPA review process, CMS discovered that several States were utilizing financing techniques that do not comport with the matching requirements of the Federal-State partnership. Specifically, CMS has discovered that several States make claims for Federal matching funds associated with certain Medicaid payments, payments of which the health care providers are not ultimately allowed to retain. Instead, through the "guise" of the intergovernmental transfer (IGT) process, State and/or local governments require the health care provider to forgo and/or return certain Medicaid payments to the State, which effectively shifts the cost of the Medicaid program onto the Federal taxpayer.

As of August 30, 2005, CMS has reviewed over 850 Medicaid reimbursement SPAs under the process outlined above. Twenty six (26) States have agreed to terminate one or more financing practices that contradict the matching requirements of the Federal-State partnership, effective with the end of their State fiscal year (SFY) 2005. Through its review in developing this report, the OIG identified three states (North Carolina, California and Alabama) that employed such impermissible financing mechanisms with their Medicaid DSH programs. As a result of the SPA review process mentioned above, all three of these States have agreed to terminate the impermissible financing of their Medicaid DSH programs with the end of their SFY 2005.

In addition, we view the certified independent audit as required by section 1001(d) of the MMA, as an important tool in ensuring compliance with the Federal statutory DSH requirements and will consider the results of such audits during the SPA review process.