DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

OCT 22 2002

TO: Thomas Scully
Administrator
Centers for Medicare and Medicaid Services

FROM: for Janet Rehnquist
Inspector General

SUBJECT: Review of Washington State's Disproportionate Share Hospital Program (A-10-01-00001)

This memorandum is to alert you to the issuance of the subject audit report within 5 business days from the date of this memorandum. A copy of the report is attached. The review was conducted at the request of the Centers for Medicare and Medicaid Services (CMS) as part of a multi-state initiative focusing on Medicaid disproportionate share hospital (DSH) payments made under section 1923 of the Social Security Act, as amended. The objectives of our review were to verify that state fiscal year (SFY) 1999 DSH payments made by the Washington State Department of Social and Health Services, Medical Assistance Administration (state) did not exceed hospital-specific limits (limits) and were calculated in accordance with the approved state plan.

Our audit showed that for some hospitals, the state made DSH payments in excess of the limits and that were not in accordance with the state plan. Specifically, we found that in SFY 1999 the state:

- paid $43.9 million in excess of hospital-specific limits to hospitals eligible for the DSH programs,
- paid $0.4 million to six hospitals not eligible for some DSH programs, and
- allocated DSH funds to hospitals using methods that were not in accordance with the approved state plan.

We recommended that the state:

- refund to the Federal Government $23.1 million representing the federal share of $43.9 million in DSH overpayments for SFY 1999,

- refund to the Federal Government the $0.2 million representing the federal share of $0.4 million of DSH funds paid to ineligible hospitals, and

- allocate DSH funds in accordance with the state plan.

Also, we made recommendations in this report that are intended to help strengthen the state's management controls.

In a written response to our draft report, state officials generally concurred with two of the three findings. Where appropriate, we made changes in the report to reflect the state's comments. A copy of the state's formal response is included as APPENDIX B to our report. However, attachments to the state's response are not included but are available upon request. According to its response, the state is reviewing all of the DSH programs and will be submitting amendments to make administrative clarifications and update the DSH programs.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for the Centers for Medicare and Medicaid Audits, at (410) 786-7104 or Lori Ahlstrand, Regional Inspector General for Audit Services, Region IX, at (415) 437-8360.

Attachment

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

REVIEW OF WASHINGTON STATE'S DISPROPORTIONATE SHARE HOSPITAL PROGRAM

JANET REHNQUIST
Inspector General

OCTOBER 2002
A-10-01-00001

DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

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

OCT 25 2002

Common Identification Number: A-10-01-00001

Mr. Thomas W. Bedell
Deputy Assistant Secretary
Medical Assistance Administration
Department of Social and Health Services
P.O. Box 45500
Olympia, Washington 98504-5500

Dear Mr. Bedell:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, "Review of Washington State's Disproportionate Share Hospital Program." A copy of this report will be forwarded to the action official noted below for her 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, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR part 5.)

To facilitate identification, please refer to Common Identification Number A-10-01-00001 in all correspondence relating to this report.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures - as stated

Directly Reply to HHS Action Official:

Linda Ruiz, Regional Administrator
Centers for Medicare & Medicaid Services, Region X
2201 Sixth Avenue
Mailstop: RX-40
Seattle, Washington, 98121

cc: w/ Enclosure

Linda Ruiz, Regional Administrator, CMS, Region X
Alan McMullen, Hospital Reimbursement Control Audit Manager, Medical Assistance Administration, Department of Social and Health Services

EXECUTIVE SUMMARY

BACKGROUND

In 1965, the Congress established the Medicaid program as a jointly funded federal and state program providing medical assistance to qualified low-income people. The Omnibus Budget Reconciliation Act (OBRA) of 1981 established the disproportionate share hospital (DSH) program by adding section 1923 to the Social Security Act (the Act). Section 1923 required state Medicaid agencies to make additional payments to hospitals serving disproportionate numbers of low-income patients with special needs. The OBRA 1993 amended section 1923 of the Act to limit DSH hospital payments to the amount of incurred uncompensated care costs (UCC). The UCC was limited to the costs of medical services provided to Medicaid and uninsured patients less payments received for those patients excluding Medicaid DSH payments.

OBJECTIVES

Our objectives were to verify that state fiscal year (SFY) 1999 DSH payments made by Washington state's Department of Social and Health Services, Medical Assistance Administration (state) did not exceed hospital-specific limits as mandated by OBRA 1993 (limits) and were calculated in accordance with the approved state plan.

RESULTS OF AUDIT

We found that for some hospitals, the state made DSH payments in excess of the limits and that were not in accordance with the state plan. Specifically, we found that in SFY 1999 the state:

- paid $43.9 million ($23.1 million federal share) in excess of hospital-specific limits to hospitals eligible for the DSH programs,
- paid $0.4 million ($0.2 million federal share) to six hospitals not eligible for some DSH programs, and
- allocated DSH funds to hospitals using methods that were not in accordance with the approved state plan.

RECOMMENDATIONS

We recommended that the state:

- refund to the Federal Government $23.1 million representing the federal share of $43.9 million in DSH overpayments for SFY 1999,

- refund to the Federal Government the $0.2 million representing the federal share of $0.4 million of DSH funds paid to ineligible hospitals, and

- allocate DSH funds in accordance with the state plan.

Also, we made recommendations in this report that are intended to help strengthen the state's management controls.

In a written response to our draft report, state officials generally concurred with two of the three findings. Where appropriate, we made changes to the report to reflect the state's comments. A copy of the state's formal response is included as APPENDIX B to this report. However, attachments to the state's response are not included but are available upon request. According to its response, the state is reviewing all of the DSH programs and will be submitting amendments to make administrative clarifications and update the DSH programs.

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INTRODUCTION

BACKGROUND

In 1965, the Congress established the Medicaid program as a jointly funded federal and state program providing medical assistance to qualified low-income people. At the federal level, the program is administered by the Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration, an agency of the Department of Health and Human Services. Within guidelines established by federal statutes, each state designs and administers its Medicaid program and is required to submit state Medicaid plan amendments for CMS approval.

Federal Statutes

The Omnibus Budget Reconciliation Act (OBRA) of 1981 established the DSH program by adding section 1923 to the Social Security Act (the Act). Section 1923 required state Medicaid agencies to make additional payments to hospitals serving disproportionate numbers of low-income patients with special needs and allowed the states considerable flexibility to establish their disproportionate share hospital (DSH) programs.

The OBRA 1993 established additional inpatient DSH parameters by amending section 1923 of the Act to limit DSH payments to a hospital's incurred uncompensated care costs (UCC). The UCC was limited to costs of medical services provided to Medicaid and uninsured patients less payments received for those patients excluding Medicaid DSH payments.

State DSH Programs

The state had nine separate DSH programs:

Low-Income DSH
Medically Indigent DSH
General Assistance Unemployable DSH
Small Rural Hospital Assistance Program DSH
Teaching Hospital Assistance Program DSH
State Teaching Hospital Financing Program DSH
County Teaching Hospital Financing Program DSH
Public Hospital District DSH
State Psychiatric Hospital DSH

For an explanation of each DSH program's purpose and eligibility requirements, see APPENDIX A.

Hospital Eligibility. According to the state plan, a hospital must have met the Medicaid inpatient utilization rate (MIUR) of 1 percent to be eligible for any DSH program. The

MIUR, as defined in section 1923(b)(2) of the Act, was equal to the hospital's number of inpatient days attributable to patients eligible for medical assistance under an approved state plan divided by the total number of the hospital's inpatient days in that period. In addition, a hospital must have met the specific eligibility requirements for each DSH program.

Hospital-Specific DSH Limit. According to the state plan, amounts paid under the DSH programs to hospitals should not exceed 100 percent of costs. Costs were defined as cost of hospital services to Medicaid and uninsured patients less any payments for Medicaid or the uninsured. The state calculated the limits on a prospective basis by using actual data from prior years and adjusted the data forward using Standard & Poor's health care cost inflation factors.

The state's formula for the hospital-specific DSH limit:

Projected Cost of Services to Medicaid and Uninsured Patients	−	Projected Medicaid Payments and Payments for the Uninsured	=	**DSH Limit**

According to the state plan, the state was required to monitor hospital payments monthly to determine whether limits were exceeded. If a hospital reached its limit, payments should have stopped. If a hospital exceeded its limit, the state should have recouped the excess DSH payments.

DSH Payments for SFY 1999. Of the nine DSH programs, the DSH payments were calculated by the:

- state for six programs (Low-Income DSH, Medically Indigent DSH, General Assistance Unemployable DSH, Teaching Hospital Assistance Program DSH, State Teaching Hospital Financing Program DSH, County Teaching Hospital Financing Program DSH);

- Washington State Hospital Association for two programs (Small Rural Hospital Assistance Program DSH, Public Hospital District DSH); and

- state's Mental Health Division for one program (State Psychiatric Hospital DSH).

Payment methods for each DSH program were described in the state plan. For seven of the DSH programs, payments were based on formulas. For two of the DSH programs, payments were based on claims processed.

For SFY 1999, $345.9 million in DSH funds ($181.6 million federal share) was awarded to 106 hospitals: 45 public hospitals received $305.8 million and 61 non-public hospitals received $40.1 million.

OBJECTIVES, SCOPE, AND METHODOLOGY

We performed our audit in accordance with generally accepted government auditing standards issued by the Comptroller General. The objectives were to verify that SFY 1999 (July 1, 1998 – June 30, 1999) DSH payments made by the state did not exceed the hospital-specific limits imposed by OBRA 1993 and were calculated in accordance with the approved state plan.

As part of this audit, we judgmentally selected Harborview Medical Center (Harborview) and Western State Hospital (Western) for hospital-specific reviews. These two hospitals received 47 percent of the total DSH payments to hospitals in Washington state for SFY 1999.

To accomplish our objectives, we:

- reviewed federal statutes, Code of Federal Regulations, CMS guidance, and the state plan pertaining to the DSH programs;
- interviewed CMS and state officials;
- interviewed Harborview and Western officials; and
- examined state DSH limit and payment worksheets for SFY 1999.

To determine whether hospital DSH payments exceeded the limits, we obtained actual SFY 1999 billed charges and payment data from the state's Medicaid Management Information System (MMIS). Our assessment of the state's MMIS was limited to evaluating the opinions expressed by the Washington State Auditor's Office in its Single Audit Report for the SFY ended June 30, 1999. We also obtained actual calendar year (CY) 1999 charity, bad debts, and managed care billed charges as reported by the hospitals. In addition, we compared actual DSH payments to amounts reported to CMS for federal fiscal year (FFY) 1999.

We reviewed the internal controls associated with the state's DSH programs to the extent considered necessary to accomplish our objectives. We reviewed how the state: (1) determined hospital eligibility, (2) calculated the DSH payments, and (3) calculated the limits. In addition, we reviewed supporting documents for amounts used to compute the limits at two hospitals.

Our field work was performed at the state office in Olympia, Washington from March to September 2001. Additional information was provided by the state through November 2001. We also conducted field work at Harborview in Seattle, Washington from June to August 2001. From May to July 2002, we reviewed additional data provided in the state's response to our draft report.

FINDINGS AND RECOMMENDATIONS

In SFY 1999, the state paid DSH funds to hospitals that were: (1) in excess of the limits for SFY 1999 in the amount of $43.9 million, (2) ineligible to participate in the DSH programs in the amount of $0.4 million, and (3) not allocated in accordance with the state plan.

DSH PAYMENTS AND LIMITS

The state paid DSH funds to 33 hospitals in excess of the limits for SFY 1999 in the amount of $43.9 million ($23.1 million federal share). This overpayment occurred because the state did not reconcile DSH payments to actual costs ($24.2 million overpayment) and used billed charge amounts for some costs ($19.7 million overpayment). Also, the state included unallowable bad debt amounts in its limit calculations. However, the state could not provide adequate documentation to determine the unallowable amount of the $213 million reported by hospitals as bad debts. Federal law and the state plan required that DSH payments not exceed the cost of the services during the year.

Actual Costs

The state did not reconcile DSH payments to the hospital-specific limits (incurred costs) during SFY 1999. State officials believed that they were required only to reconcile DSH payments to the projected limits for each hospital. Section 1923(g)(1)(A) of the Act required that DSH payments should not exceed costs incurred by a hospital during the year that services were furnished to individuals who were either eligible for medical assistance under the state plan or had no health insurance. The state plan under Attachment 4.19-A Part I (B) (#15) required that DSH payments to hospitals should not exceed 100 percent of costs. We computed the limits based on actual SFY 1999 data and found that a total of 26 hospitals had overpayments amounting to $24.2 million.

Also, we found that the state included billed charge amounts for bad debts, charity, and managed care in its limit calculations for each hospital. According to section 1923(g)(1)(A) of the Act and the state plan, the hospital limit calculations should be based on costs incurred, not billed charges. The state was unable to provide its rationale for using billed charges instead of actual costs incurred. As a result of using billed charges, the state paid 33 hospitals approximately $19.7 million over its limits.

Bad Debts

The state included unallowable bad debt amounts in its limit calculations. Bad debts reported by hospitals included costs for both insured and uninsured patients. Costs for insured patients were not allowed under section 1923 of the Act and the state plan. Also, bad debts included a cost-sharing amount for indigent patients that was included already in the hospital's limit calculation. For the 1999 limit calculations, the hospitals reported $213 million of bad debts to the state.

Hospitals were required to submit a DSH application to the state that included bad debt amounts on a calendar year basis. However, the state did not provide instructions on what hospitals should include as bad debt amounts on the DSH application. Amounts for both insured and uninsured patients were included in bad debts.

The state's Medically Indigent program required that an indigent patient had the responsibility for paying a portion of hospital services. At one hospital, the cost-sharing amount was $2,000, known as the spend-down amount. A hospital official stated that most medically indigent patients could not pay the spend-down amount; therefore, this amount was reported as bad debts to the state. The state included these bad debts in the limit calculations although the costs for the medically indigent patients were included already as billed charges.

Recommendations

We recommended that the state:

1. Refund to the Federal Government $23.1 million representing the federal share of $43.9 million in DSH overpayments for SFY 1999.

2. Work with CMS to address and resolve the issue of reconciling DSH payments to limit calculations using actual costs for each hospital.

3. Work with CMS to determine the portion of the $213 million allowable for bad debts and refund to the Federal Government the federal share of any overpayments.

4. Provide written instructions to hospitals on what should be included as bad debts and charity on the DSH application as it applies to the insured and cost-sharing amounts.

State's Comments and OIG's Response

The state officials concurred with $42.6 million in DSH overpayments out of $50.1 million cited in our draft report. They disagreed with $7.5 million in DSH overpayments because:

- state payments for the Medically Indigent and General Assistance Unemployable programs should not have been included as an offset to costs,

- managed care payments were overstated,

- Medically Indigent DSH and General Assistance Unemployable DSH payments by hospital were overstated.

Concerning the issue of bad debts, state officials said that they considered the impact of insured patients on hospital reported bad debts and charity by reducing UCC 2.1 percent.[1] Also, the state noted that the patient cost sharing would have had a minimal effect on Harborview hospital's DSH limit.

We generally concurred with the state's revised DSH overpayment of $42.6 million in SFY 1999. However, we reviewed new data and the state's rationale for recomputing the limits and determined the overpayments to be $43.9 million. The difference of $1.3 million was due to oversights made by the state in recalculating the overpayments.

We acknowledge that the state considered in its estimated UCC the impact of insured patients on hospital reported bad debt and charity amounts. However, we believe that instead of estimating amounts for bad debt and charity, hospitals should be required to report the bad debt and charity amounts that meet CMS criteria. Therefore, the state should provide clear written instructions to hospitals on which bad debt and charity amounts should be reported on the DSH application.

Also, we disagreed with the state that patient cost sharing, which is included in bad debt and charity amounts, may have minimal effects. Cost sharing is different for each hospital. For Harborview hospital, the state noted that the impact of patient cost sharing had little impact on DSH because the hospital was below its DSH limit. However, for those hospitals that are close to or over their DSH limits, the cost sharing may result in an overpayment of DSH funds. Cost sharing amounts should be excluded from the DSH calculations.

ELIGIBILITY OF HOSPITALS

The state made DSH payments to hospitals that were not eligible for some DSH programs. This occurred because the state did not review hospital eligibility for all DSH programs on an annual basis. According to the state plan, a hospital should have received DSH payments if it met the MIUR requirement of 1 percent and any specific requirements for the various DSH programs.[2] In SFY 1999, we found that six hospitals not eligible for some DSH programs received $0.4 million ($0.2 million federal share) in DSH funds.

[1] If we had reduced bad debts and charity amounts by the 2.1 percent used by the state, the overpayments would have increased by $0.8 million.

[2] Specific eligibility requirements for each DSH program are described in APPENDIX A.

Payment amounts to ineligible hospitals were made in the following programs:

DSH Program	Reasons for Ineligibility	Ineligible Hospitals[3]	Payment Amounts[4]
Public Hospital District DSH	Did not meet the MIUR requirement of 1 percent.	1	$318,684
Small Rural Hospital Assistance Program DSH	Did not meet the MIUR requirement of 1 percent or did not meet the non-student population requirement of 13,000.	4	$93,892
Medically Indigent DSH	Did not meet the MIUR requirement of 1 percent or did not meet the low-income utilization rate requirement of 1 percent.	3	$9,908
General Assistance Unemployable DSH	Did not meet the low-income utilization rate requirement of 1 percent.	3	$3,784

Recommendations

We recommended that the state:

1. Refund to the Federal Government the $0.2 million representing the federal share of $0.4 million of DSH funds paid to ineligible hospitals.

2. Develop procedures to ensure only hospitals eligible for DSH programs receive DSH payments.

State's Comments and OIG's Response

The state did not concur with this finding. The state claimed that amounts for hospitals over its DSH limit should be deducted from amounts questioned for ineligible hospitals. Also, the state claimed that SFY 1999 data should be used to determine eligibility. When SFY 1999 data is used, four out of six hospitals are eligible for DSH programs.

We agreed with the state's rationale and reduced the amounts for ineligible hospitals to reflect the amounts reported as overpayments. We have made changes in this finding to reflect these adjustments.

We do not agree with the state's rationale to use SFY 1999 data to determine hospital eligibility that same fiscal year. The state's methodology was to use prior years data to determine hospital eligibility for the upcoming year. Therefore, our review of CYs 1997 and 1998 data is relevant for determining hospital eligibility in SFY 1999. As a result, we identified six ineligible hospitals.

[3] Six hospitals were ineligible for DSH funds. This column does not total six because some hospitals inappropriately received funds from more than one DSH program.
[4] These amounts have been revised to exclude amounts already questioned as overpayments to the various hospitals in these DSH programs.

ALLOCATION OF DSH FUNDS

The state and the Washington State Hospital Association did not follow the state plan in allocating funds in the following DSH programs:

- Low-Income DSH program - the state allocated a specific amount to two hospitals instead of applying the allocation formula equally to all eligible hospitals.

- State Teaching and County Teaching Hospital Finance DSH programs - the state allocated an incorrect percentage of funds to the two eligible hospitals.

- Public Hospital District DSH program - the Washington State Hospital Association used a threshold amount to eliminate 11 eligible hospitals from receiving DSH funds.

Low-Income DSH Program

In the Low-Income DSH program, the state made payments to two hospitals instead of applying the allocation formula equally to all eligible hospitals as required by the state plan. The state legislature appropriated $32 million for the Low-Income DSH program in SFY 1999. Of the $32 million, the state made payments of $16 million to Harborview and $2.1 million to the University of Washington Medical Center (University). The remaining hospitals received the balance of $13.9 million.

The state plan specified that hospitals that were deemed eligible should have received Low-Income DSH payments. The state plan also described the process for allocating these payments to individual hospitals. If the state had allocated Low-Income DSH funds in accordance with the state plan, Harborview would have received $6.9 million, the University would have received $2.9 million, and other eligible hospitals would have received $22.2 million.

Hospital	DSH Amount Received (in millions)	Allocation Amount per State Plan (in millions)	Difference (reduction) (in millions)
Harborview	$16.0	$ 6.9	($9.1)
University	$ 2.1	$ 2.9	$0.8
26 Remaining Hospitals	$13.9	$22.2	$8.3
Totals	**$32.0**	**$32.0**	**$0.0**

State Teaching and County Teaching Hospital Finance DSH Programs

In the State Teaching and County Teaching Hospital Finance DSH programs, the state allocated an incorrect percentage of funds to the two eligible hospitals. The state legislature appropriated $66.6 million for these DSH programs in SFY 1999. The University was the only hospital eligible for the State Teaching Hospital Finance DSH program. Harborview was the only hospital eligible for the County Teaching Hospital Finance DSH program.

According to the state plan, hospitals deemed eligible under the State Teaching and County Teaching Hospital Finance DSH programs should have received 70 percent and 30 percent, respectively, of the appropriated amount. Therefore, 70 percent of the appropriated amount, or $46.6 million, should have been allocated to the University for the State Teaching Hospital Finance DSH program. The remaining 30 percent, or $20.0 million, should have been allocated to Harborview for the County Teaching Hospital Finance DSH program. However, we found that of the $66.6 million appropriated for these programs in SFY 1999, $24.3 million (36 percent) was allocated to the University and $42.3 million (64 percent) was allocated to Harborview.

Hospital	DSH Amount Received (in millions)	Allocation Amount per State Plan (in millions)	Difference (reduction) (in millions)
University	$24.3	$46.6	$22.3
Harborview	$42.3	$20.0	($22.3)

Public Hospital District DSH Program

In the Public Hospital District DSH program, the Washington State Hospital Association used a threshold amount to eliminate 11 eligible hospitals from receiving DSH funds. The use of a threshold amount to determine eligibility for Public Hospital District DSH funds was not in accordance with the state plan. The state awarded $60.9 million for the Public Hospital District DSH program in SFY 1999.

In describing the allocation methodology for Public Hospital District DSH funds, the state plan specified that each hospital that applied and was deemed eligible should receive a payment. The Public Hospital District DSH payments were based on each hospital's limit less amounts calculated for the Medically Indigent DSH, General Assistance Unemployable DSH, Low-Income DSH, and Small Rural Hospital Assistance Program DSH programs. The difference was the remaining limit available for each hospital. In SFY 1999, the Washington State Hospital Association imposed a threshold of $265,000 for each hospital to qualify for this program. Therefore, only hospitals with a remaining limit that exceeded $265,000 received a Public Hospital District DSH payment.

In SFY 1999, 29 hospitals received Public Hospital District DSH funds. If the Washington State Hospital Association had not implemented the threshold amount, an additional 11 hospitals would have received a DSH payment. The 29 hospitals would have received a lesser amount. By imposing a threshold amount, 11 hospitals did not receive Public Hospital District DSH funds totaling $1.3 million.

Description	No. of Hospitals	DSH Amount Received (in millions)	Allocation Amount per State Plan (in millions)	Difference (reduction) (in millions)
Hospitals Funded in SFY 1999	29	$60.9	$59.6	($1.3)
Hospitals Eligible but Denied Funding	11	$0.0	$1.3	$1.3
Total Eligible Hospitals	**40**	**$60.9**	**$60.9**	**$0.0**

Neither the state nor the Washington State Hospital Association could explain their rationale for using the threshold amount. State officials informed us that the SFY 2002 Public Hospital District DSH allocation formula no longer uses a threshold amount in the payment calculations.

Recommendation

We recommended that the state and the Washington State Hospital Association allocate DSH funds for the Low-Income DSH, State Teaching Hospital Finance DSH, County Teaching Hospital Finance DSH, and Public Hospital District DSH programs in accordance with the state plan.

State's Comments and OIG's Response

State officials provided explanations for their allocation of DSH funds. Also, the state noted that it is currently reviewing all of the DSH programs and will be submitting amendments to update and make administrative clarifications.

Although the state provided explanations for its allocations in the Low-Income DSH program, State Teaching and County Teaching Hospital Finance DSH programs, and the Public Hospital District DSH program, the allocations were not in accordance with the state plan.

APPENDICES

Description of DSH Programs

DSH Program (Amount Awarded)	Purpose	Program Specific Requirements
Low-Income Disproportionate Share Hospital ($32 million)	To provide additional monies to hospitals that serve a disproportionate number of low-income Medicaid patients.	a. Hospital's Medicaid inpatient utilization rate is at least one standard deviation above mean Medicaid inpatient utilization rate of hospitals receiving Medicaid payments in the state or the hospital's low-income utilization rate exceeds 25 percent; and, b. Hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals entitled to Medicaid services.
Medically Indigent Disproportionate Share Hospital ($26.4 million)	To qualify the Medically Indigent program expenditures for federal match monies.	a. Hospital is an in-state or border area hospital; and, b. Hospital provides services to low-income, Medically Indigent patients (low-income individuals who are not eligible for any health care coverage and who are encountering an emergency medical condition); and, c. Hospital has a low-income utilization rate of 1 percent or more; and, d. Hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals entitled to Medicaid services.
General Assistance Unemployable Disproportionate Share Hospital ($17.2 million)	To qualify the General Assistance Unemployable program expenditures for federal match monies.	a. Hospital is an in-state or border area hospital; and, b. Hospital provides services to low-income, General Assistance Unemployable patients (low-income individuals who are not eligible for any health coverage and who are encountering a medical condition); and, c. Hospital has a low-income utilization rate of 1 percent or more; and, d. Hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals entitled to Medicaid services.
Small Rural Hospital Assistance Program Disproportionate Share Hospital ($8.4 million)	To qualify needy small rural public hospitals for federal match monies.	a. Hospital is an in-state hospital; and, b. Hospital provides at least 1 percent of its services to low-income patients in rural areas of the state; and, c. Hospital is a small, rural hospital, defined as a hospital with fewer than 75 licensed beds and located in a city or town with a non-student population of 13,000 or less; and, d. Hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals entitled to Medicaid services.
Teaching Hospital Assistance Program Disproportionate Share Hospital ($25 million)	To qualify the University of Washington Medical Center and Harborview Medical Center for DSH program.	a. Hospital must have a Medicaid low-income utilization of 20 percent or above; and, b. Hospital must be a Washington State University hospital; and, c. Hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals entitled to Medicaid services.

DSH Program (Amount Awarded)	Purpose	Program Specific Requirements
State Teaching Hospital Financing Program Disproportionate Share Hospital ($24.2 million)	To provide funds for the Washington state Medicaid program.	a. Hospital provides at least 20 percent of its services to low-income patients; and, b. Hospital is a Washington state-owned university hospital (excluding border area hospitals); and, c. Hospital provides a major medical teaching program, defined as a hospital with more than 100 residents or interns; and, d. Hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals entitled to Medicaid services.
County Teaching Hospital Financing Program Disproportionate Share Hospital ($42.3 million)	To provide funds for the Washington state Medicaid program.	a. Hospital provides at least 25 percent of its services to low-income patients; and, b. Hospital is a county hospital in Washington state (excluding border area hospitals); and, c. Hospital provides a major medical teaching program; and, d. Hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals entitled to Medicaid services.
Public Hospital District Disproportionate Share Hospital ($60.9 million)	To qualify public hospital districts for federal match monies.	a. Hospital provides at least 1 percent of its services to low-income patients; and, b. Hospital is a Public District Hospital in Washington state (as of June 15, 1997, border area public hospitals are included); and, c. Hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals entitled to Medicaid services.
State Psychiatric Hospital Disproportionate Share Hospital ($109.3 million)	To qualify Western State Hospital and Eastern State Hospital for DSH.	a. Hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean state Medicaid inpatient utilization rate of hospitals receiving Medicaid payments in the state; or, b. Hospital's low-income utilization rate exceeds 25 percent.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

May 14, 2002

Lori A. Ahlstrand
Regional Inspector General for Adult Services
Region IX
Office Of Audit Services
50 United Nations Plaza, Room 171
San Francisco, CA 94102

Dear Ms. Ahlstrand:

We have enclosed our comments and corrections from our review and verification of the draft document "Review of Washington State's Disproportionate Share Hospital Program," dated February 2002 for State Fiscal Year (SFY) July 1, 1998, through June 30, 1999.

Overall, we found your review of the program and your recommendations to be helpful for future considerations. We have already started work on some of your recommendations to improve the program.

Sincerely,

Tom Bedell, Deputy Assistant Secretary
Medical Assistance Administration
Department of Social and Health Services
PO Box 5510
Olympia, WA 98504-5510

Enclosures

cc: Linda Ruiz, Regional Administrator
Centers for Medicare & Medicaid Services, Region X

Janet Tursich, Audit Manager, Region X

Department of Social and Health Services
Medical Assistance Administration
State of Washington

COMMENTS AND OBSERVATIONS TO THE OFFICE OF INSPECTOR GENERAL'S REVIEW OF THE WASHINGTON STATE DISPROPORTIONATE SHARE HOSPITAL PROGRAM

May 2002

EXECUTIVE SUMMARY

BACKGROUND

In February 2002 the Office of Inspector General (OIG) completed their review of the Washington State Disproportionate Share Hospital (DSH) Program for the period July 1, 1998 Through June 30, 1999.

The Washington State Department of Social and Health Services (DSHS), Medical Assistance Administration (MAA) on February 27, 2002 received a copy of the draft findings for our review and comment prior to it being made final.

OBJECTIVES

Our objective in reviewing the OIG document is to corroborate with the Auditors to verify that their findings are accurate and to use the findings and recommendations to improve our methods and standards for administrating the program.

HIGHLIGHTS OF THE WASHINGTON STATE REVIEW

Some oversights were found in the OIG findings that need to be corrected. The detail information will be found within this document. The changes we recommend include:

- The Auditors included the state as a third party payor for services provided by hospitals to patients that were classified as indigent.
- The Auditors offset the cost for services with payments that were covered by the DSH program for Medically Indigent (MI) and General Assistance Unemployable (GAU) clients. Using those payments to offset costs, when they were not included to begin with, over estimated federal share.
- For the hospitals that were found to be over their CAPS and had non-qualifying DSH payments, the auditors did not net the disallowed amount from the amount over the caps.
- Some of the data used by the Auditors contained errors. New data from the Department of Health was used in place of the bad data, proving that Mark Reed, Lincoln, Whidbey and Garfield hospitals were eligible for DSH payments.
- Auditors adjusted the hospital Medicaid Managed Care charges to estimate payments. MAA calculated the ratio of payments to charges to the fee-for-service claims and applied the same

payments ratios to the managed care charges. When a proper payment ratio is applied to the managed care services, the individual hospital CAPS increase.

- The Auditors applied payments for the federal fiscal year (ending September 30, 1999) to the state fiscal year (ending June 30, 1999) for the MI and GAU DSH payments. Due to the time lag, it is not possible to accurately assign the actual MI and GAU payment by hospital for 1999. Therefore, an adjustment factor has been applied to the Auditors MI and GAU DSH payments.

SUMMARY OF AMOUNTS OVER CAPS

After adjusting for the MI & GAU payments, the duplicate offsets, and improperly disallowed hospitals; the amount over the CAP and disallowed hospitals changes from $27,046,038 to $22,832,159:

	CAP	DISALLOWED	TOTAL	FEDERAL MATCH*
OIG Audit	*$50,140,882*	*$1,375,380*	*$51,516,262*	*$27, 046,038*
Corrected	*$42,594,199*	*$ 895,627*	*$43,489,826*	*$22,832,159*
Difference	**$ 7,546,683**	**$ 479,753**	**$ 8,026,436**	**$ 4,213,879**

(attachment EC1)

SUMMARY OF CHANGES TO THE OIG AUDIT

FROM OIG SPREADSHEET B

MI & GAU PAYMENT OFFSETS

Section 1923(g)(1)(A) states: "...payments made to a hospital for services provided to indigent patients made by a State or unit of local government within a State shall not be considered to be a source of third party payment." ***(attachment 1)***

The Medically Indigent program and the General Assistance Unemployable program payments that are not covered by the DSH programs should not be offset against the costs for the services. Both State programs use the same indigency criteria as is used to define Medicaid eligibility (WAC 388-503-0505). ***(attachment 2)***

The improperly included MI and GAU payments were taken from the Auditors Attachment B. ***(attachment 3)***

The Auditors offset state only payments against state only programs (less payments attributed to MI & GAU payments). This is an error made by MAA and MAA requested that the Auditors correct. ***(attachment 3, columns Q and S)***

DOUBLE COUNTING AMOUNTS OVER CAPS AND DISALLOWED HOSPITALS

The Auditors did not adjust the amounts hospitals were over their CAPS for the amounts related to hospitals that were disallowed. For example, Island Hospital and Samaritan were not eligible for rural DSH. However, The Auditors did not adjust the amounts from the amounts over the CAP. This oversight was consistently applied throughout the review.

HOSPITALS CALLED INELIGIBLE THAT ARE ELIGIBLE

Whidbey General and Lincoln Hospital were considered ineligible for MI DSH and GAU DSH as the hospitals did not appear to meet the one-percent LIUR test. The Auditors used actual data that contained reporting errors. When correct data from the Department of Health was used both hospitals met the one-percent LIUR test. Lincoln had a LIUR of 7.5 percent and Whidbey General 8.0 percent. ***(attachment 4)***

The DSH payments for Mark Reed Hospital and Garfield were disallowed, as the hospitals appeared not to meet the one-percent Medicaid day test. Thirteen of Mark Reed's 98 days were Medicaid eligible (crossover days from MAA records). The hospital's actual Medicaid eligible percentage was over 13 percent for 1999. Four of Garfield's 75 days were Medicaid eligible (crossover days from MAA records). The hospital's actual Medicaid eligible percentage was over five percent for 1999. ***(attachment 5)***

MISCALCULATION OF MEDICAID MANAGED CARE COST

The Auditors adjusted the hospital Medicaid Managed Care charges to estimate payments. The Auditors applied a hospital ratio of costs to charges to the charges **(attachment 6, Column L for RCC and Column T for calculation of Managed Care payments).** This ratio was applied to determine the costs of the services and the payments thus eliminating the unreimbursed Medicaid Managed Care costs.

MAA currently estimates the payments for the Managed Care portions based on what is paid for fee-for-services claims. MAA calculated the ratio of payments to charges to the fee-for-service claims and applied the same payments ratios to the Managed Care charges **(see Auditors Excel worksheet Tab A-UCC: formula should be (Column P + Column R) / (Column G + Column I) multiplied by Column K (Managed Care charges)).** When a proper payment ratio is applied to the Managed Care services, the individual hospital CAPS increase.

CORRECTION OF MI AND GAU DSH PAYMENTS.

The Auditors applied payments for the federal fiscal year (ending September 30, 1999) to the state fiscal year (ending June 30, 1999) for the MI and GAU DSH payments. Due to the time lag, it is not possible to accurately assign the actual MI and GAU payment by hospital for 1999. The Auditors assigned DSH payments to hospitals that exceeded the total MI and GAU DSH actually claimed for the state fiscal year. **(attachment 6)**

SUMMARY OF THE DIFFERENCES IS AS FOLLOWS

To correct for the overstatements, and understatements, of MI and GAU DSH payments, the MI and GAU DSH payments in Column L through Column N of the summary page **(attachment ES1)** were adjusted by the percentages in the below table. These corrections significantly impact the proposed OIG disallowances.

	CLAIMED HCFA 64	OIG TAB A – UCC	PERCENT
MI DSH (Column AE)	$21,912,573	$26,424,210	82.9%
GAU DSH (Column AF)	$16,978,423	$16,571,891	102.5%
MI & GAU Mental Health DSH (see Summary Column P)	$ 1,339,397	$ 1,503,583	89.1%

OBSERVATIONS IN RELATION TO THE OIG REPORT

BAD DEBTS - FROM THE BOTTOM OF PAGE 4 AND TOP OF PAGE 5

OIG COMMENT:

The state included unallowable bad debt amounts in its limit calculations. Bad debts reported by hospitals included costs for both insured and uninsured patients. Costs for insured patients were not allowed under section 1923 of the Act and the State Plan. Also, bad debts included a cost-sharing amount for indigent patients that were included already in hospital's limit calculation. For the 1999 limit calculations, the hospitals reported $213 million of bad debts to the state.

Hospitals were required to submit a DSH application to the State that included bad debt amounts on a calendar year basis. However, the State did not provide instructions on what hospitals should include as bad debt amounts on the DSH application. Amounts for both insured and uninsured patients were included in bad debts. The State officials considered all bad debts eligible for the limits even though amounts for insured were not allowed.

MAA REVIEW FINDING:

The Medical Assistance Administration (MAA), State of Washington, considered the impact of the insured on hospital reported Bad Debt and Charity. The uncompensated care costs are reduced to 97.872% based on early studies of the proportions of third party coverage for state programs. Over the years, including SFY 1999, MAA consistently reduced all hospital reported Bad Debt and Charity to 97.872% of the reported costs.

MAA will continue to update hospital-reporting forms. We are in the process of reviewing the DSH applications and will update and revise the reporting instructions as appropriate.

HARBORVIEW REPORTING OF $2,000 COST SHARING FROM THE TOP OF PAGE 5

OIG COMMENT:

The State's Medically Indigent program required that an indigent patient had the responsibility for paying a portion of hospital services. At one hospital, the cost-sharing amount was $2,000, known as the spend-down amount. A hospital official stated that most medically indigent patients could not pay the spend-down amount; therefore, this amount was reported as bad debts to the State. The State included these bad debts in the limit calculations although the costs for medically indigent patients were included already as billed charges.

MAA REVIEW FINDING:

Harborview was under its DSH CAP in 1999. To the extent that a hospital may have included patient cost sharing in its Charity category, the excess DSH CAP ($2,996,205) would more than offset the $2,000 one-time cost sharing requirement classified as Charity. Not every case

has a $2,000 cost sharing and for Harborview to exceed its CAP nearly 100% of the sample 1,712 MI cases, identified in 1999, would have to have the $2,000 cost sharing. When the $2,000 charges are reduced to cost, the impact is $1,486 (RCC .743) ***(attachment 7)***

LOW-INCOME DSH PROGRAM FROM THE TOP OF PAGE 7

OIG COMMENT:

In the Low-Income DSH program, the State made payments to two hospitals instead of applying the allocation formula equally to all eligible hospitals as required by the state Plan. The State legislature appropriated $32 million for the Low-Income DSH program in SFY 1999. Of the $32 million, the State made payments of $16 million to Harborview and $2.1 million to the University of Washington Medical Center (the University). The remaining hospitals received the balance of $13.9 million.

The State Plan specified that hospitals that were deemed eligible should have received Low-Income DSH payments. The State Plan also described the process for allocating these payments to individual hospitals. If the State had allocated Low-income DSH funds in accordance with the State Plan, Harborview would have received $6.9 million, the University would have received $2.9 million and other eligible hospitals would have received $22.2 million.

(Note: A table of the above was also in the OIG report)

MAA REVIEW FINDING:

In the fall of 1991, Washington State and CMS settled with hospitals after a successful Boren lawsuit was brought by the hospitals. Included in the settlement, University Medical Center and Harborview Medical Center were to receive fixed Low Income DSH payments of $16 million and $2.1 million. The settlement was for seven years. At the end of the seven years, the University Low Income DSH payment was incorporated into the standard methodology. However, the Washington State Legislature continued to direct that Harborview continue to be viable. This proviso is still in the Legislative appropriations. As a result, Harborview continues to receive $16 million in Low Income DSH. ***(attachment 8)***

STATE AND COUNTY TEACHING HOSPITAL FINANCE PROGRAMS FROM THE TOP OF PAGE 7

OIG COMMENT:

In the State-Teaching and County-Teaching Hospital Finance DSH Programs, the State allocated an incorrect percentage of funds to the two eligible hospitals. The State Legislature appropriated $66.6 million for these DSH Programs in SFY 1999. The University of Washington Medical Center (University) was the only hospital eligible for the State-Teaching Hospital Finance DSH Program. Harborview Medical Center (Harborview) was the only hospital eligible for the County-Teaching Hospital Finance DSH Program.

According to the State Plan, hospitals deemed eligible under the State-Teaching and County-Teaching Hospital Finance DSH Programs should have received 70 percent and 30 percent, respectfully, of the appropriated amount. Therefore, 70 percent of the appropriated amount, or $46.6 million, should have been allocated to the University for the State-Teaching Hospital Finance DSH Program. The remaining 30 percent, or $20.0 million, should have been allocated to Harborview for the County-Teaching Hospital Finance DSH Program. However we found that of the $66.6 million appropriated for these programs in SFY 1999, $24.3 million (36 percent) was allocated to the University and $42.3 million (64 percent) was allocated to Harborview.

MAA REVIEW FINDING:

In 1999, the Legislature appropriated $70,808,816 in funding for the State and County Teaching Financing DSH programs. In 1999, MAA calculated the DSH CAP for University to be $40,356,876 and Harborview to be $66,551,902. There was insufficient CAP space to assign 70 percent of the DSH to University. To stay within the respective DSH CAPs, Harborview was assigned $42,317,218 and University $24,234,684. In essence, University capped out and Harborview was allocated the remaining pool dollars.

PUBLIC HOSPITAL DISTRICT DSH PROGRAM FROM THE TOP OF PAGE 8

OIG COMMENT:

In the Public Hospital District DSH Program, the Association used a threshold amount to eliminate 11 eligible hospitals from receiving DSH funds. The use of a threshold amount to determine eligibility for Public Hospital District DSH funds was not in accordance with the State Plan. The State awarded $60.9 million for the Public Hospital District DSH Program in SFY 1999.

In describing the allocation methodology for Public Hospital District DSH funds, the State Plan specified that each hospital that applied and was deemed eligible would have received a payment. The Public Hospital District DSH payments were based on each hospital's limit less amounts calculated for the Medically Indigent DSH, General Assistance Unemployable DSH, Low-Income DSH, and Small Rural Hospital Assistance Program DSH Programs. The difference was the remaining limit available for each hospital. In SFY 1999, the Association imposed a threshold of $265,000 for each hospital to qualify for this program. Therefore, only hospitals with a remaining limit that exceeded $265,000 received a Public Hospital District DSH payment.

In SFY 1999, 29 hospitals received Public Hospital District DSH funds. If the Association had not implemented the threshold amount, an additional 11 hospitals would have received a DSH payment. The 29 hospitals would have received a lesser amount. By imposing a threshold amount, 11 hospitals did not receive Public Hospital District DSH funds totaling $1.3 million.

Neither the State nor the Association could explain their rationale for using the threshold amount. State officials informed us that the SFY 2002 Public Hospital District DSH allocation formula no longer uses a threshold amount in the payment calculations.

MAA REVIEW FINDING:

There are 40 District hospitals and several of the hospitals are very small. In 1999, Columbia Basin and North Valley used all of their DSH CAPs for the small rural DSH program and were not eligible for the Public District DSH program.

Hospitals participating in the Public Hospital DSH program returned approximately 89 percent of the payments through intergovernmental transfers. A preliminary eligibility threshold was established at $265,000 (remaining DSH CAP) to make the program administratively manageable.

It should be noted that no eligible hospital was denied a payment. All eligible hospitals could have requested to be in the pool and would have been included. MAA received no requests, from hospitals not included the original calculations, to be included in 1999 or any other year.

ADDITIONAL NOTES ON DSH

MAA is currently reviewing all of the DSH programs and will be submitting amendments to make administrative clarifications and update the DSH programs.