DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

APR 30 2003

Report Number: A-04-01-00003

Carmen Hooker Odom, Secretary
North Carolina Department of Health
And Human Services
Adams Building, 101 Blair Drive
Raleigh, North Carolina 27603

Dear Secretary Odom:

Enclosed are two copies of the U. S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services (OAS)' final report entitled *Review of North Carolina State Medicaid Agency Disproportionate Share Hospital Payments for Fiscal Years 1997 to 2001.*

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.

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To facilitate identification, please refer to report number A-04-01-00003 in all correspondence relating to this report. If you have any questions, please contact me or have your staff contact Peter Barbera at (404) 562-7758.

Sincerely,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures – as stated

Direct Reply to HHS Action Official:

Mr. Richard James
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Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

REVIEW OF NORTH CAROLINA STATE MEDICAID AGENCY DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR FISCAL YEARS 1997 TO 2001

JANET REHNQUIST
Inspector General

APRIL 2003
A-04-01-00003

Notices

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OAS FINDINGS AND OPINIONS

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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61 Forsyth Street, S.W., Suite 3T41
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April 30, 2003

Report Number: A-04-01-00003

Carmen Hooker Odom, Secretary
North Carolina Department of Health
and Human Services
Adams Building, 101 Blair Drive
Raleigh, North Carolina 27603

Dear Secretary Odom:

This report presents the results of an Office of Inspector General review of Medicaid disproportionate share hospital (DSH) payments to hospitals and the use of intergovernmental transfers (IGT) in the State of North Carolina.

The objectives of our review were to verify that DSH payments in North Carolina were calculated in accordance with the approved State Plan Amendments (SPA) and to verify that payments to individual hospitals did not exceed the limits imposed by the Omnibus Budget Reconciliation Act (OBRA) of 1993. Our review also included an evaluation of how the North Carolina Medicaid agency's (state agency) use of DSH payments and IGTs impacted the Medicaid program.

We found that during the period from September 1996 through June 2001, the state agency paid a total of $1.7 billion in DSH payments. Of this total, approximately $900 million was paid to non-state public hospitals and approximately $825 million was paid to state-owned hospitals. While we obtained documentation of all DSH payments during the audit period, we focused primarily on the fiscal year (FY) 1997 DSH payments.

EXECUTIVE SUMMARY

The state agency makes its DSH payments to hospitals based on cost estimates. We found that the state agency was broadly within the framework of the SPAs by following this methodology. However, the SPAs state that the estimated payments will be adjusted to actual costs based on completed cost reports. At the time of our review, the state agency had not adjusted the estimated FY 1997 DSH payments to actual costs. As a result, we could not determine if the state agency's DSH payments were made in accordance with OBRA 1993 limits. Consequently, we have no assurance as to the propriety of federal funds expended during the audit period.

The state agency acknowledged that its records might not accurately support the amount of Medicaid payments made to hospitals. As a result, the state agency is in the process of finalizing its settlement of FY 1997 DSH payments. As part of this process they are also trying to determine the actual amount of Medicaid payments hospitals received. Hospital Medicaid payments could have a direct and significant impact on the allowable DSH amounts.

The state agency must devote considerably more research and cost analysis to settle the DSH payment issue and has contracted with a consulting firm to assist in the settlement process. As a result, we cannot conduct a meaningful audit on the reasonableness of the DSH payments until the state agency finalizes and validates its own information. We anticipate conducting a follow-up audit in this area once the state agency completes its final settlement of the DSH payments. Consequently, this report does not contain any financial recommendations. In the interim, we believe the state agency's efforts to resolve this matter should be coordinated with the Centers for Medicare and Medicaid Services (CMS).

We also found that a large majority of the payments to hospitals are transferred back to the state agency via IGTs. For FY's 1996 through 2001, the state agency made DSH payments to non-state public hospitals totaling approximately $900 million of which approximately $826 million ($522 million federal share) was IGT'd back to the state agency and deposited into a trust fund to be used to match future federal draw downs.

For state-owned hospitals, during the same time period, DSH payments totaled approximately $825 million of which approximately $821 million was IGT'd back to the state agency. Upon receipt of the IGT amount, the state agency immediately transferred the federal share (approximately $521 million) to the Department of the State Treasurer where it was deposited into the state's general fund. The state legislature used its discretion to budget these funds.

We are recommending that the state agency:

- continue to work with CMS as well as through its contractor to finalize DSH settlements for applicable periods;

- follow SPA requirements to perform final settlements of DSH payments within 12 months of the completion of non-state public hospital cost reports; and

- establish similar timeliness parameters for the state-owned facilities.

In other matters, we noted that the state agency pays millions of dollars in supplemental payments to public and private hospitals under separate SPAs to cover Medicaid deficits (i.e., Medicaid costs in excess of regular Medicaid payments). The return of almost all of the DSH payments by public hospitals to the state agency raises the question as to whether supplemental payments would be needed if the total DSH payments were retained by the hospitals. We also believe the transfer of DSH funds allowed the state to use federal funds for matching of other federal funds, which in our opinion seriously counters the intended use of DSH funds.

In a written response to our draft report, the state agency acknowledged that several significant problems relating to DSH payments had surfaced. Efforts are being made to correct the problems and to settle the 1997 cost reports. The state agency is in the process of reorganizing in an effort to assure the integrity of financial information and operations. The state agency's complete response is included as an attachment.

INTRODUCTION

BACKGROUND

In 1965, Medicaid was established as a jointly funded federal and state program providing medical assistance to qualified low-income people. At the federal level, the CMS, an agency within the Department of Health and Human Services, administers the program. Within a broad legal framework, each state designs and administers its own Medicaid program. Each state prepares a state plan that defines how the state will operate its Medicaid program and is required to submit the plan for CMS approval.

The OBRA 1981 established the DSH program by adding Section 1923 to the Social Security Act (the Act). Section 1923 required state agencies to make additional payments to hospitals serving disproportionate numbers of low-income patients with special needs. States had considerable flexibility to define DSH hospitals under Sections 1923(a) and (b).

The OBRA 1993 established additional DSH parameters by amending Section 1923 of the Act to limit DSH payments to a hospital's incurred uncompensated care costs. Under Section 1923(g) of the Act, the uncompensated care costs was limited to costs of medical services provided to Medicaid and uninsured patients less payments received for those patients excluding Medicaid DSH payments. The specific language contained in the Act, as amended, is as follows:

> *. . . Section 1923 . . .*
> *(g) Limit on Amount of Payment to Hospital.--*
> *(1) Amount of adjustment subject to uncompensated costs.--*
> *(A) IN GENERAL.---A payment adjustment during a fiscal year shall not be considered to be consistent with* [these regulations] *. . . with respect to a hospital if the payment adjustment exceeds 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. . . .*

For those states that do not have regular legislative sessions scheduled in 1994, the DSH limit provision applies to FYs beginning after January 1, 1995. The law provided special treatment for certain "High Disproportionate Share Hospitals," for the state fiscal year (SFY) that began before January 1, 1995. During this period, the limit on the DSH payment adjustment such a hospital could receive is 200 percent of the general limit.

North Carolina DSH Program

In North Carolina, DSH payments were made to public hospitals based on unreimbursed/ uninsured patient charges. Also, DSH payments were paid to state mental facilities based on interim cost report data and uninsured patient days.

The North Carolina Department of Health and Human Services is the state agency responsible for administering the DSH program. The state agency developed a method of identifying hospitals that qualified for the DSH program and formulas to reimburse them for the costs of treating uninsured patients. This methodology is presented in an approved state plan.

For non-state owned public hospitals, SPA 97-07 provides that an additional one-time DSH payment shall be paid to qualified public hospitals to cover their unreimbursed charges (to be converted to unreimbursed costs) for inpatient and outpatient services provided to uninsured patients during the specific FY. The state agency calculated a hospital specific limit (cap) derived from unreimbursed/uninsured patient charges based on the hospital's FY ended in the prior calendar year. The charges were converted to costs in order to compute the cap. The cap was trended forward for inflation to the coming SFY to arrive at an adjusted cap.

State-owned mental hospitals' and public hospitals' DSH payments are determined for the coming SFY at 100 percent of the respective caps as long as the state's DSH allotment is not exceeded. Per the SPA 94-33 which covers state hospitals (Institutions of Mental Diseases (IMD) and the University of North Carolina), the payments will not exceed the hospitals' costs of providing inpatient and outpatient services to Medicaid and uninsured patients less all payments received. The plan specifies that the hospital patient bed day counts for the month immediately prior to the month that payments are made should be used for estimating payments.

To assure compliance with Section 1923 (g) of the Act, total DSH payments made to each hospital are to be cost settled, and appropriate adjustments made to assure that the hospital's net aggregate DSH payments do not exceed the hospital's net costs of providing services to Medicaid and uninsured patients. For non-state public hospitals, the plan provides that payments shall be adjusted within 12 months based on the completed cost reports. No additional payments shall be made in connection with the cost settlement. For state-owned hospitals, the plan does not specify when the cost settlement is to occur. Large DSH payments made to state-owned hospitals starting in 1991 through 2001 have never been cost settled.

OBJECTIVES, SCOPE AND METHODOLOGY

The objectives of our review were to verify that DSH payments in North Carolina were calculated in accordance with the approved state plan and to verify that payments to individual hospitals did not exceed the hospital specific limits imposed by OBRA 1993. We also evaluated how the state agency's use of DSH payments and IGTs impacted the Medicaid program. Our analysis covered DSH payments made to all public hospitals from September 1996 through June 2001.

To accomplish our objectives, we held discussions with CMS regional staff to determine its role pertaining to North Carolina's Medicaid DSH program. We conducted a review at the state agency, interviewed key personnel, and reviewed applicable records supporting the calculations of Medicaid DSH payments and IGTs. We also obtained schedules of DSH payments made to hospitals during the audit period.

We reviewed federal laws, regulations, and guidelines; state statutes and budgets; and applicable SPAs.

We contacted the State Auditor's Office and obtained copies of pertinent working papers. We visited the state agency's audit section and obtained copies of audits and cost reports prepared by Myers and Stauffer (certified public accountants contracted by the state agency to perform settlements of Medicaid cost reports) or Blue Cross Blue Shield for state IMDs for years these reports were available.

We made site visits at one state-owned IMD hospital, and two non-state public acute care hospitals. The DSH payments to these hospitals comprised 25 percent of the total DSH payments for that year. We also traced the dollars that were transferred between the state agency and these three hospitals during FY 1997.

Our review was conducted in accordance with generally accepted government auditing standards. We performed fieldwork at the state agency and a state-owned IMD hospital in Raleigh, North Carolina and at non-state public hospitals in Charlotte and Greenville, North Carolina.

RESULTS OF REVIEW

The state agency makes its DSH payments to hospitals based on cost estimates. We found that the state agency was broadly within the framework of the SPAs by following this methodology. However, the SPAs state that the estimated payments will be adjusted to actual costs based on completed cost reports. At the time of our review, estimated payments had not been adjusted to actual costs. As a result, we could not determine if the state agency's DSH payments were made in accordance with OBRA 1993 limits. Consequently, we have no assurance as to the propriety of federal funds expended during the audit period.

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The state agency acknowledged that its records might not accurately report the amount of Medicaid payments made to hospitals. As a result, the state agency is in the process of finalizing its settlement of FY 1997 DSH payments. As part of this process they are also trying to determine the actual amount of Medicaid payments hospitals have received. Hospital Medicaid payments could have a direct and significant impact on the allowable DSH amount.

The state agency has contracted with a consulting firm to assist in the settlement process. We anticipate conducting a follow-up audit in this area once the state agency completes its final settlement of the DSH payments. Consequently, this final report does not contain any financial recommendations. In the interim, we believe the state agency's efforts to resolve this matter should be coordinated with CMS.

We also found that a large majority of the payments to hospitals were transferred back to the state agency via IGTs. For FY 1996 through 2001, the state agency made DSH payments to non-state public hospitals totaling approximately $900 million of which approximately $826 million ($522 million federal share) was IGT'd back to the state agency and deposited into a trust fund to be used to match future federal draw downs.

For state-owned hospitals, during the same time period, DSH payments totaled approximately $825 million of which approximately $821 million was IGT'd back to the state agency. Upon receipt of the IGT amount, the state agency immediately transferred the federal share (approximately $521 million) to the Department of the State Treasurer where it was deposited into the state's general fund. The state legislature used its discretion to budget these funds.

In other matters, we noted that the state agency pays supplemental payments to public and private hospitals under separate SPAs to cover Medicaid deficits (i.e., Medicaid costs in excess of regular Medicaid payments). The return of almost all of the DSH payments by public hospitals to the state agency raises the question as to whether supplemental payments would be needed if the total DSH payments were retained by the hospitals. We believe the return of DSH payments to the state agency contradicts the purpose of assisting these hospitals.

The following sections provide more details on the results of our review.

COMPLIANCE WITH THE STATE PLAN AMENDMENTS

We found that the state agency was broadly within the framework of the SPAs in making its DSH payments to hospitals based on estimates. The state agency has two SPAs that relate to DSH payments. The SPA 97-07 applies to non-state public hospitals. According to SPA 97-07, DSH payments for non-state public hospitals are to be paid based on estimated, unreimbursed, uninsured patient charges that are converted to costs. The SPA 94-33 that applies to state-owned hospitals provides that DSH payments are to be calculated using estimated costs of uninsured patient days. For both non-state public and state-owned hospitals, the estimates are to be based on cost figures from cost reports prior to the period to which the DSH payments relate.

The state agency followed the SPA in calculating DSH payments for non-state public hospitals. The state agency obtained estimated hospital charges for services to uninsured patients and patients whose services were paid for by other state or local government sources (charity care). These estimated charges were increased for inflation (around 3 percent) and then converted to costs by a Medicaid cost-to-charge ratio using the Medicaid cost report figures for the prior year.

The state generally followed the SPA in making its initial DSH estimates for the state-owned public hospitals. The estimates were based on the costs of uninsured patient days. The per diem figures used by the state agency were estimated using the costs from the cost report for the period prior to the period in which the DSH payments were made (i.e., the FY 1995 cost reports). This was in accordance with the SPA.

The state agency deviated slightly from the SPA in that it estimated the uninsured patient days based on a 6-month period that preceded the period in which the DSH payments were to be made. The SPA states that the estimates should be based on the patient days for the month prior to the month in which the DSH payments are made.

In addition to providing for estimation methodology, both of the SPAs (one for non-state public hospitals and the other for state-owned hospitals) provide that the estimates will be adjusted, or cost settled, based on the completed cost reports for the period of the payment. The SPA 97-07 for non-state public hospitals provided that the settlement was to occur within 12 months after the cost reports were completed. Moreover, per SPA 97-07, if the hospital has been underpaid, no additional DSH payment is to be made. The SPA 94-33 for state-owned hospitals did not stipulate when the cost settlement was to occur; however, it provides for an "appropriate adjustment" when cost settled. The state agency has not complied with the final settlement provision of either of the applicable SPAs. This matter is further discussed below.

Final Settlement of DSH Payments is Not Being Performed

Contrary to the SPAs, the state agency did not perform final settlement of the estimated DSH payments made to hospitals. As a result, there is no assurance that the DSH payments are accurate, or whether the federal contributions to these payments were appropriate.

We attempted to determine if the DSH payments were made in accordance with OBRA l993 limits by analyzing the state agency's supporting documentation. For the most part, we relied on the same estimated and preliminary data utilized by the state agency in making the DSH payments. We also obtained some data from hospitals we visited, but could not obtain final data for all the components of the DSH calculation. The available data indicated that the state agency had made overpayments to some hospitals.

The state agency responded by providing new information, which indicated that some of the hospitals were underpaid rather than overpaid. However, similar to our calculations, the state agency's response was not based on final data. The state agency has been unable to provide

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complete and accurate data to finalize the estimated DSH payments made in FY 1997. As the state agency devoted more time to this matter, emerging issues regarding the state agency's records were disclosed. The state agency later acknowledged that its records might not accurately support the amount of Medicaid payments made to hospitals. Because Medicaid hospital payments have a direct effect on hospital DSH payments and the state agency's records significantly understated the totals for Medicaid hospital payments, the DSH payments to these hospitals could be significantly overstated.

The state agency contracted with a consulting firm to assist in the settlement process and is in the process of finalizing its FY 1997 DSH payments, including determining the actual amount of Medicaid payments hospitals have received. As a result, the state agency must devote considerably more research and cost analysis before a final accounting of DSH payments can be made.

Our review showed that the state agency was not in compliance with its SPA, and had not acted timely to protect the federal interest in the DSH payments. Considering the difficulty we encountered in obtaining reliable data, we are concerned about the federal interest in these payments. We cannot conduct a meaningful audit on the reasonableness of the DSH payments until the state agency finalizes and validates its own information. As a result, we will conduct a follow-up audit in this area once the state agency completes its final settlement of the DSH payments. Consequently this report does not contain any financial recommendations. In the interim, we believe the state agency's efforts to resolve this matter should be coordinated with the CMS.

Intergovernmental Transfers

During the period from September 1996 through June 2001, the state agency made Medicaid DSH payments totaling approximately $1.7 billion of which approximately $1.6 billion was IGT'd back to the state agency. For non-state public hospitals, the DSH funds IGT'd back to the state agency were used to provide the state's share of future DSH payments and supplemental payments. For state-owned hospitals, the federal share of the IGT'd funds was transferred to the Department of the State Treasurer where it was deposited into the state's general fund to be used at the state legislature's discretion.

Of the approximate $1.7 billion in DSH payments noted above, about $900 million was paid to non-state public hospitals and approximately $826 million of this was IGT'd back to the state agency. The federal share of the IGT amount was approximately $522 million and was deposited into a trust fund at the state agency. The state agency's match for the DSH payments to public hospitals and supplemental payments came from this trust fund where prior years' returned IGTs had been deposited. This process of using the federal share of IGT'd funds to provide the state agency's share of payments has been in place for at least 6 years. By using this process, the state agency effectively increased the actual federal share of the Medicaid DSH and supplemental payments beyond the federal medical assistance percentage.

In addition, we found that the 0 to 10 percent of DSH payments retained by the non-state hospitals was the only part of the total DSH payments ever recorded on the hospitals' accounting records. The hospitals have an escrow agreement with an agent who receives the DSH and supplemental payments and IGTs approximately 90 to 100 percent of the DSH payments back to the state agency. The fact that only the small portion of the DSH payments retained appears on the hospitals' records indicates that the DSH payments are being used to maximize the state agency's share of federal funds and not to actually assist the hospitals.

Approximately $821 million (almost 100 percent) of the $825 million in DSH payments to state-owned hospitals was IGT'd back to the state agency. Upon receipt of the IGT amount, the state agency immediately transferred the federal share (approximately $521 million) to the Department of the State Treasurer where it was deposited into the state's general fund. The state legislature used its discretion to budget these funds. All of the DSH payments to state-owned hospitals were reflected on the accounting records.

CONCLUSIONS AND RECOMMENDATIONS

The state agency estimated DSH payments in accordance with the SPAs; however, did not perform final cost settlements on a timely basis as required in the approved state plan. As a result, there is no assurance that the DSH payments made to the hospitals were accurate.

Because of emerging issues on this matter, which the state agency is in the process of attempting to resolve, our report does not contain any financial recommendations. To determine the extent of any DSH overpayments will require extensive cost analysis by the state agency. As a result, we will conduct a follow-up audit in this area once all the necessary information is available. In the interim, we believe the state agency's efforts to resolve this matter should be coordinated with CMS.

We also believe that the manner in which the state agency uses IGTs to return DSH payments to the state agency contradicts the purpose for which the DSH funding was provided. Our findings on the use of IGTs as well as the use of supplemental payments will be reported to CMS to demonstrate how states are using federal funds to draw down additional federal funds with the apparent purpose of only maximizing federal reimbursement.

We recommend that the state agency:

- continue to work with CMS as well as through its contractor to finalize and cost settle DSH payments for the applicable periods;
- follow SPA requirements to perform final settlements of DSH payments within 12 months of the completion of non-state public hospital cost reports; and
- establish similar timeliness parameters for the state-owned facilities.

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OTHER MATTERS

During our review, another matter came to our attention regarding supplemental payments. The state agency made supplemental payments to non-state public and private hospitals for Medicaid inpatient and outpatient deficits. During our audit period, over $1 billion was paid to these hospitals for Medicaid deficits. Hospitals kept 100 percent of these supplemental payments. If public hospitals had not IGT'd back to the state agency approximately $826 million of the $900 million DSH payments they received, there would have been no need for supplemental payments to the public hospitals.

Auditee's Comments

The state agency acknowledged that several significant problems relating to DSH payments have surfaced. The 1997 cost settlements have not been performed, but efforts are being made to finalize the settlements through a nationally recognized independent firm. At the conclusion of their work, appropriate fiscal adjustments will be made. The state agency is in the process of reorganizing in such a way as to build in additional checks and balances to assure the integrity of the financial information and operations.

Sincerely,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosure

North Carolina Department of Health and Human Services
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Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

April 25, 2003

Transmitted by fax:
404-562-7795

Reference: CIN: A-04-01-00003

Mr. Charles J. Curtis
Regional Inspector General for Audit Services, Region IV
Office of Inspector General - Office of Audit Services
Room 3T41, Atlanta Federal Center
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

Dear Mr. Curtis:

We have received your April 4, 2003 letter and revised draft report entitled, *Review of North Carolina State Medicaid Agency Disproportionate Share Hospital Payments for Fiscal Years 1997 to 2001.* We apologize that the report was temporarily lost and certainly appreciate the time extension granted to provide our response.

The OIG report is correct in that several significant problems relating to Disproportionate Share Hospital (DSH) payments have surfaced as a result of this audit and internal management reviews. As pointed out in the audit report, cost settlements have not been performed for 1997 forward. Senior Department management was unaware of these delays. It is certainly embarrassing to have such a lengthy delay in such an important matter. The NC DHHS is currently working on the 1997 DSH settlements through the nationally recognized independent firms, Myers & Stauffer and Tucker Alan. Unfortunately, even that effort has been delayed by the errors in reports provided by our MMIS contractor and hospital cost reports. Corrected numbers have been sent to Myers & Stauffer who should be finalizing their settlement numbers very soon. At the conclusion of their work, appropriate fiscal adjustments will be made. It is our goal to get all of the cost reports settled as soon as practicable.

As an additional note, we are in the process of reorganizing the Division of Medical Assistance in such a way as to build in additional checks and balances to assure the integrity of the financial information and operations. NC DHHS is re-directing additional resources to achieve this goal.

We recognize that we cannot instantly change such a large complex system but we have started the process by conducting a business review and redefining working relationships including segregation of duties to ensure that we have an efficient and well-managed Medicaid system. We have also recruited and hired two specialized auditors that will be working full-time in the Division of Medical Assistance and reporting to the DHHS Office of the Internal Auditor. Before we complete our reorganization process, we anticipate reviewing basically all of the functions within the Division of Medical Assistance and making appropriate changes.

We appreciate the opportunity to provide additional information in regards to this audit. If additional clarification is needed, please contact Dan Stewart at 919-715-4791.

Sincerely,

Carmen Hooker Odom

Carmen Hooker Odom

CHO:ds

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ACKNOWLEDGMENTS

This report was prepared under the direction of Charles J. Curtis, Regional Inspector General for Audit Services, Region IV. Other principal Office of Audit Services staff who contributed include:

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For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.

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