JUN 24 2004

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

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

SUBJECT: Review of Alabama's Medicaid Disproportionate Share Hospital Program (A-04-01-02006)

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

Section 1923 of the Social Security Act, as amended 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. The statute 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 Medicaid upper payment limit is an estimate of the maximum amount that would be paid to a group of facilities, such as hospitals, on a statewide basis under Medicare payment principles. Our prior work in Alabama and other States found that some public providers returned upper-payment-limit funds to States through intergovernmental transfers. States have relied on these funding transfers to augment Federal reimbursement without having to increase Medicaid services.

Our objectives were to determine whether (1) hospitals returned any DSH payments to the State via intergovernmental transfers and (2) the State was in compliance with the hospital-specific DSH payment limits imposed by section 1923(g) of the Social Security Act.

The results of our review are summarized below:

- During fiscal years 1999 and 2000, acute care hospitals transferred about $632 million, or 86 percent, of the $738 million in statewide DSH payments back to the State via intergovernmental transfers. Through a managed care arrangement operated pursuant to a State plan waiver, the State made DSH payments primarily to publicly owned hospitals because these hospitals could return the funds to the State. As a result, private hospitals were likely not reimbursed for all of their uncompensated care costs.

- The State did not comply with the hospital-specific DSH payment limits mandated by section 1923(g). Based on the State's 2002 survey data, we found that the State did not

reduce hospitals' uncompensated care costs by the $391 million in Medicaid enhanced payments subject to the Medicare upper payment limit. The State also did not require hospitals participating in the managed care arrangement to compute uncompensated care costs annually. State officials believed that the approved State plan waiver exempted the State from the hospital-specific DSH limits. As a result, DSH payments for hospitals participating in the managed care arrangement exceeded those limits by about $66 million ($46 million Federal share) in fiscal years 1999 and 2000. This amount represents an overpayment.

Our recommended financial adjustment is based partly on unaudited data from the State's 2002 survey of uncompensated care costs and partly on audited data for six of the hospitals included in the survey. We note that the audited uncompensated care costs for the six hospitals were lower than the costs found in the survey, indicating that the survey figures for other hospitals may be overstated. If so, our recommended financial adjustment is likely understated.

We recommend that the State:

- calculate DSH limits to include an offset for all Medicaid enhanced payments received by hospitals and calculate uncompensated care costs annually

- refund $45,763,327 to the Federal Government

- establish controls to ensure the reasonableness and allowability of future uncompensated care costs

In commenting on our draft report, the State disagreed with our findings. The State noted that its 2002 survey of uncompensated care costs showed no DSH overpayments. The State also said that because it did not make DSH payments directly to hospitals, it was not subject to the hospital-specific limits imposed by the Omnibus Budget Reconciliation Act of 1993.

We revised our report, where appropriate, based on the State's comments. However, we believe that our findings and recommendations are still valid.

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 Charles J. Curtis, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

JUN 30 2004

Report Number: A-04-01-02006

Ms. Carol Herrmann
Medicaid Director
Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36103-5624

Dear Ms. Herrmann:

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

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports are made available to members of the press and the general public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-04-01-02006 in all correspondence.

Sincerely,

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

Enclosure

Direct Reply to HHS Action Official:

Mr. Renard L. Murray
Associate Regional Administrator
Division of Medicaid and State Operations, Region IV
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF ALABAMA'S MEDICAID DISPROPORTIONATE SHARE HOSPITAL PROGRAM

JUNE 2004
A-04-01-02006

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:

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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 information contained therein 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 awarding agency will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Medicaid Disproportionate Share Hospital Program

Section 1923 of the Social Security Act, as amended, requires that States make Medicaid disproportionate share hospital (DSH) payments to hospitals that serve disproportionate numbers of low-income patients with special needs. The Omnibus Budget Reconciliation Act of 1993 limited 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.

To operate a DSH program, a State must submit a State plan amendment to the Centers for Medicare & Medicaid Services (CMS) for approval. On October 1, 1995, Alabama began making DSH payments via a managed care arrangement authorized by State plan amendment 95-14. A year later, this arrangement began operating pursuant to a State plan waiver under sections 1915(b)(1) and (4) of the Social Security Act. The State made DSH payments to eight prepaid health plans, which distributed the funds to participating hospitals through capitation and other payments arrived at via negotiations between the prepaid plans and the hospitals.

Intergovernmental Transfers

An intergovernmental transfer is a transfer of funds between a local government and a State government. According to section 1902(a)(2) of the Social Security Act, a State may fund up to 60 percent of its State matching payments with local funds.

Our prior work found that Alabama and other States used intergovernmental transfers in conjunction with Medicaid enhanced payments allowed by Federal upper-payment-limit regulations. The upper payment limit is an estimate of the maximum amount that would be paid to a group of facilities, such as hospitals, on a statewide basis under Medicare payment principles. States have relied on intergovernmental transfers to augment Federal reimbursement without having to increase Medicaid services.

OBJECTIVES

Our objectives were to determine whether (1) hospitals returned any DSH payments to the State via intergovernmental transfers and (2) the State was in compliance with the hospital-specific DSH payment limits imposed by section 1923(g) of the Social Security Act.

SUMMARY OF FINDINGS

Intergovernmental Transfers

During fiscal years 1999 and 2000, acute care hospitals transferred about $632 million, or 86 percent, of the approximately $738 million in statewide DSH payments back to the State via intergovernmental transfers. Through its managed care arrangement, the State made DSH payments primarily to publicly owned hospitals because these hospitals could return the funds to the State. As a result, private hospitals were likely not reimbursed for all of their uncompensated care costs.

Compliance With Hospital-Specific DSH Limits

The State did not comply with the hospital-specific limits of section 1923(g) of the Social Security Act. Based on the State's 2002 hospital survey, we found that the State did not reduce uncompensated care costs by the $391 million in Medicaid enhanced payments subject to the Medicare upper payment limit. The State also did not require hospitals participating in the managed care arrangement to compute uncompensated care costs annually, as suggested by section 1923(g).

These problems occurred because State officials believed that the approved State plan waiver exempted the State from the hospital-specific DSH limits. As a result, DSH payments for hospitals participating in the managed care arrangement exceeded those limits by about $66 million ($46 million Federal share) in fiscal years 1999 and 2000. This amount represents an overpayment.

Other Matter

Our recommended financial adjustment is based partly on unaudited data from the State's 2002 survey of uncompensated care costs and partly on audited data for six of the hospitals included in the survey. We note that the audited uncompensated care costs for the six hospitals were lower than the costs found in the survey, indicating that the survey figures for other hospitals may be overstated. If so, our recommended financial adjustment is likely understated.

RECOMMENDATIONS

We recommend that the State*:*

- calculate DSH limits to include an offset for all Medicaid enhanced payments received by hospitals and calculate uncompensated care costs annually
- refund $45,763,327 to the Federal Government
- establish controls to ensure the reasonableness and allowability of future uncompensated care costs

STATE'S COMMENTS

The State disagreed with our findings, asserting that its 2002 survey of uncompensated care costs showed no DSH overpayments. The State also said that because it did not make DSH payments directly to hospitals, it was not subject to the hospital-specific limits imposed by the Omnibus Budget Reconciliation Act of 1993.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We revised our report, where appropriate, based on the State's comments. However, we believe that our findings and recommendations are still valid. The State offered no new information to make us reconsider our position that its DSH payments were subject to section 1923. CMS supports our position.

We summarized the State's comments and our response in the report. We also included the State's comments in their entirety as Appendix C.

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INTRODUCTION

BACKGROUND

Medicaid and the DSH Program

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

The Omnibus Budget Reconciliation Act of 1981 established the DSH program, which is currently codified in section 1923 of the Social Security Act. Section 1923 requires State Medicaid agencies to make additional payments to hospitals that serve disproportionate numbers of low-income patients with special needs. The Omnibus Budget Reconciliation Act of 1993 limited 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 program under sections 1923(a) and (b) of the Social Security Act. States receive allotments of DSH funds as set forth by section 1923. The Federal Government shares in the cost of Medicaid DSH expenditures based on the Federal medical assistance percentage for each State.

Alabama DSH Program

Section 1923(i) of the Social Security Act requires that DSH payments be made directly to hospitals; however, it allows an exception for States that had managed care payment arrangements in effect as of July 1, 1997. This exception applied to Alabama. On October 1, 1995, Alabama began paying hospitals via a managed care arrangement known as the Partnership Hospital Program, which was authorized by State plan amendment 95-14. A year later, this arrangement began operating pursuant to a State plan waiver under sections 1915(b)(1) and (4) of the Social Security Act. Through the managed care arrangement, the State made DSH payments to eight prepaid plans, which distributed the funds to member hospitals through capitation payments and other payments arrived at via negotiations between the prepaid plans and the hospitals.

Intergovernmental Transfers

An intergovernmental transfer is a transfer of funds between a local government and a State government. According to section 1902(a)(2) of the Social Security Act, a State may fund up to 60 percent of its State matching payments with local funds.

Our prior work found that Alabama and other States used intergovernmental transfers in conjunction with Medicaid enhanced payments made under Federal upper-payment-limit

regulations. The upper payment limit is an estimate of the maximum amount that would be paid to a group of facilities, such as hospitals, on a statewide basis under Medicare payment principles. States have relied on intergovernmental transfers to augment Federal reimbursement without having to increase Medicaid services.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether (1) hospitals returned any DSH payments to the State via intergovernmental transfers and (2) the State was in compliance with the hospital-specific DSH payment limits imposed by section 1923(g) of the Social Security Act.

Scope

Our audit covered the period October 1, 1998 through September 30, 2000.

To determine if hospitals returned any DSH payments to the State via intergovernmental transfers, we reviewed the $738 million in DSH payments to all hospitals statewide, which the State reported on Form HCFA 64.[1]

Our review of the State's compliance with hospital-specific DSH payment limits was limited to the hospitals participating in the managed care arrangement and excluded Mobile County hospitals, which received DSH payments directly from the State. The participating hospitals received $666 million of the total $738 million in DSH payments for the State. For these hospitals, we calculated DSH payments in excess of hospital-specific limits by comparing their aggregate uncompensated care costs with the $666 million in DSH payments made by the State to the prepaid plans.

To support this calculation, we visited six hospitals and tested their calculations of uncompensated care costs. The six hospitals had the highest uncompensated care costs in the State and accounted for approximately 43 percent of acute care hospitals' total uncompensated care costs according to the State's 2002 survey. One hospital, which was publicly owned, received DSH payments directly from the State. The five other hospitals received funds from the prepaid plans. Four of the five were publicly owned, and one was privately owned.

We relied primarily on substantive testing and did not require an understanding of internal controls, either at the State or the individual hospitals.

Methodology

To accomplish our objectives, we met with regional CMS staff, discussed their role, and reviewed their records on Alabama's Medicaid program. At the State Medicaid agency,

[1] CMS was formerly known as HCFA, or the Health Care Financing Administration.

we interviewed key personnel and reviewed records supporting DSH payment calculations.

At the six hospitals, we reviewed the reasonableness of uncompensated care costs. At the time of our audit, the State had not conducted an uncompensated care cost survey since 1996, and that survey was based on fiscal year 1994 hospital data. Instead of testing the reasonableness of these older data, we asked the six hospitals to compute their uncompensated care costs for our audit period. We reviewed the methodology and costs in support of the hospitals' uncompensated care cost data and made audit adjustments as necessary to determine the amount we considered reasonable and allowable. (See Appendix B for our results.) We then compared the hospitals' adjusted uncompensated care costs with the DSH payments received (whether from the prepaid plans or the State) to determine if the hospitals received excessive DSH payments.

We conducted our review in accordance with generally accepted government auditing standards. We performed fieldwork at the State agency in Montgomery, AL, and at six hospitals in the State. Upon receipt of the State agency's comments on our draft report, we conducted additional analyses and made additional inquiries of the State agency.

FINDINGS AND RECOMMENDATIONS

USE OF INTERGOVERNMENTAL TRANSFERS

During fiscal years 1999 and 2000, the State received about $632 million via intergovernmental transfers from prepaid plan members and nonmembers. As explained below, we believe this $632 million represented a return of DSH payments.

During fiscal years 1999 and 2000, the State made and reported on Form HCFA 64 $738 million in DSH payments. The $738 million was comprised of about $666 million paid to prepaid plans and about $72 million paid directly to hospitals not participating in the prepaid plans. Subsequently, the prepaid plans made what the State characterized as "Essential Provider Supplement" (EPS) payments to member hospitals. The State contends that these EPS payments were not DSH payments; however, the payments appeared to serve the same purpose. As explained below, we conclude that the EPS payments were actually DSH payments.

The EPS payments to member hospitals were arrived at through negotiations between the prepaid plans and the member hospitals. According to a contract between a prepaid plan and a hospital, EPS payments were to compensate a hospital that, among other things, "serves a disproportionate share of Medicaid patients." Furthermore, as shown in Table 1, total EPS payments were almost equal to the total State DSH payments to the prepaid plans.

Table 1: Comparison of DSH and EPS Payments (Prepaid Plan Member Hospitals Only)

	Fiscal Year 1999	Fiscal Year 2000	Total
DSH payments from State to prepaid plans	$348,676,597	$317,899,823	$666,576,420
EPS payments from prepaid plans to hospitals	349,184,320	317,156,399	666,340,719
Difference	**$ (507,723)**	**$ 743,424**	**$ 235,701**
Percentage difference	**-0.15%**	**0.23%**	**0.04%**

For the 2 fiscal years combined, the difference between DSH payments and EPS payments was four-hundredths of a percent. Additionally, EPS payments to the four publicly owned prepaid plan hospitals reviewed were the source of funds transferred back to the State. Therefore, we believe that the EPS payments were actually a transfer of DSH funds from the prepaid plans to the member hospitals.

Table 2 demonstrates that publicly owned hospitals received the large majority of EPS payments during fiscal years 2000 and 1999.

Table 2: EPS Payments to Public Versus Private Hospitals

	Fiscal Year 1999		Fiscal Year 2000	
	Amount	**Percentage**	**Amount**	**Percentage**
Public hospitals	$324,626,185	93%	$296,741,597	94%
Private hospitals	24,558,135	7%	20,414,802	6%
Total	**$349,184,320**	**100%**	**$317,156,399**	**100%**

Thus, through the State's managed care arrangement, DSH/EPS payments were disproportionately directed to publicly owned hospitals because those hospitals were able to return the funds to the State via intergovernmental transfers. According to State officials, they had no written agreement with hospitals as to the percentage returned.

Although private hospitals accounted for 40 percent of the total statewide uncompensated care in fiscal year 1994,[2] they received only 7 percent and 6 percent of the DSH funds in fiscal years 1999 and 2000, respectively. As a result, private hospitals were likely not reimbursed for all of their uncompensated care costs.

[2] As explained under "DSH Payments in Excess of Hospital-Specific Limits," DSH payments in 1999 and 2000 were based on 1994 uncompensated care costs.

COMPLIANCE WITH HOSPITAL-SPECIFIC DSH LIMITS

By analyzing the aggregate DSH payments from the State to the prepaid plans, we found that the State was not in compliance with the hospital-specific DSH payment limits of section 1923(g) of the Social Security Act.

Limitation on DSH Payments

Section 1923(g) provided that the 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 August 1994, CMS provided guidance to State Medicaid agencies regarding implementation of the hospital-specific limits. According to the guidance, the limit is composed, in part, of the Medicaid shortfall, which is the cost of services furnished to Medicaid beneficiaries less the amount of non-DSH Medicaid payments made to the hospitals.

In August 2002, CMS clarified the policy, specifying that States must consider Medicaid enhanced payments when computing the cost of uncompensated care. CMS 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). CMS further stated that Medicaid payments include any supplemental or enhanced upper-payment-limit payments made to hospitals. Not recognizing these payments would overstate a hospital's shortfall, thus inflating the uncompensated care cost limits.

DSH Payments in Excess of Hospital-Specific Limits

Statewide DSH payments to prepaid plans for hospitals participating in the managed care arrangement exceeded the hospital-specific limits. Using figures from the State's 2002 survey of uncompensated care costs, we determined that the $666 million in DSH payments for these hospitals exceeded their aggregate hospital-specific limits by about $66 million ($46 million Federal share) in fiscal years 1999 and 2000. Appendix A includes our detailed computations.

The State made these DSH payments based on a survey of uncompensated care costs conducted in 1996 using fiscal year 1994 data. Initially, we used this information to assess the reasonableness of DSH payments because the State relied on it and it was the only information available. Our calculations indicated that the State had made DSH overpayments of about $239 million, which we reported in our draft report.

In commenting on our draft report, State officials informed us that in 2002, at the request of CMS, they performed a new survey that was based primarily on fiscal year 2000 hospital data with some fiscal year 1999 data. We then incorporated the new survey information into our calculations. (See Appendix A.) However, for the six hospitals we reviewed, we used the actual uncompensated care costs, adjusted to correct calculation errors, as identified in Appendix B. Our analysis in Appendix A still indicated that the State made DSH overpayments, although to a lesser extent.

DSH Payments Not Offset by Enhanced Payments and Uncompensated Care Costs Not Computed Annually

Statewide DSH payments exceeded the hospital-specific limits because the State did not offset DSH payments by enhanced payments and did not compute the costs of uncompensated care annually. The CMS guidance offered in 1994 and 2002 clearly provides that a hospital's DSH payments may not exceed its annual incurred costs for furnishing services to Medicaid and uninsured patients less payments received for those patients and that Medicaid payments include enhanced payments. Therefore, enhanced payments should have been considered in determining uncompensated care costs and DSH payments. In addition, as suggested by section 1923(g), the State should have required hospitals to compute uncompensated care costs annually.

In fiscal year 1994, the State made enhanced payments of about $1.8 million to hospitals under the upper-payment-limit regulations. These payments gradually escalated to about $135 million in fiscal year 1999 and $256 million in fiscal year 2000. During fiscal years 1999 and 2000, the State did not consider enhanced payments when determining the amount of DSH payments. The State's 2002 survey did include an offset of the enhanced payments that hospitals retained but excluded payments that hospitals returned to the State via intergovernmental transfers. Our determination that $666 million in DSH payments to prepaid plans exceeded hospital-specific limits by $66 million ($46 million Federal share) reflects an offset of all enhanced payments.

The results of our review of six hospitals were in line with our statewide observation. The hospitals did not offset all enhanced payments in calculating their uncompensated care costs; as a result, DSH payments exceeded unreimbursed costs. See Appendix B for details.

During our review, State officials said that because of their approved State plan waiver (known as the Bachus amendment), the State was no longer subject to the hospital-specific DSH limits. Consequently, until the CMS request in 2002, the State had not required uncompensated care computations from hospitals participating in the managed care arrangement since October 1, 1996, the effective date of the waiver. Moreover, as previously noted, the State maintained that EPS payments were not DSH payments and therefore were not subject to the hospital-specific DSH limits.

Despite the waiver and the State's perspective on EPS payments, the terms of the waiver did not exempt the State from the hospital-specific limits of section 1923(g) of the Social

Security Act. Also, the general waiver authority that the State relied on, section 1915 of the Act, does not authorize the waiver of DSH requirements. Moreover, according to a May 29, 2002 letter from the Director for Medicaid and State Operations, CMS, to the Commissioner, Alabama Medicaid Agency, the State was subject to the hospital-specific DSH limits. The letter stated, "we do not believe that the Bachus amendment exempts the State from the OBRA-93 [Omnibus Budget Reconciliation Act of 1993] hospital specific DSH limits . . . ."

OTHER MATTER

Our recommended financial adjustment is based partly on unaudited data from the State's 2002 survey of uncompensated care costs and partly on audited data for six of the hospitals included in the survey. We note that the audited uncompensated care costs for the six hospitals were lower than the costs found in the survey, indicating that the survey figures for other hospitals may be overstated. If so, our recommended financial adjustment is likely understated.

RECOMMENDATIONS

We recommend that the State:

- calculate DSH limits to include an offset for all Medicaid enhanced payments received by hospitals and calculate uncompensated care costs annually
- refund $45,763,327 to the Federal Government
- establish controls to ensure the reasonableness and allowability of future uncompensated care costs

STATE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

Asserting that the draft report conclusions were based on errors, assumptions, faulty calculations, and positions that CMS had directly contradicted, the State requested that we withdraw the report. We have revised our results to reflect a lower DSH overpayment amount, but respectfully disagree with the State's comments and believe that our findings are sound.

The State's comments on the main issues, as well as our response, are summarized below. Appendix C includes the full text of the State's comments.

State Comments on Uncompensated Care Survey Data

State officials objected to our use of the 1994 survey data, noting that the State conducted an uncompensated care survey at CMS's request in February 2002. They said that they provided the results of that survey to CMS in April 2002 and informed us of the more recent survey in January 2003.

According to the State, the 2002 survey demonstrated that total DSH payments to prepaid health plans were below the statewide hospital-specific limits imposed by the Omnibus Budget Reconciliation Act of 1993.

Office of Inspector General Response

The State's more recent uncompensated care survey was not available to us while we were conducting our fieldwork or preparing our draft report. We incorporated the more recent survey into our review and adjusted our results accordingly.

Our analysis of the 2002 survey data still indicated that the State made overpayments. We found that during our 2-year audit period, payments exceeded the hospital-specific limits by about $66 million ($46 million Federal share).

State Comments on Essential Provider Supplement Payments

The State disagreed with our assertion that EPS payments were actually DSH payments. The State noted our reference to a prepaid plan/provider contract, which stated that one basis for the payments was to provide funds to a provider that served a disproportionate share of Medicaid patients. The State said that we failed to note six other reasons, as cited in the contract, for classifying a provider as "essential" and eligible for the payments. According to the State, the contract granted prepaid plans the discretion—without any oversight from Alabama—to make EPS payments, and the fact that the aggregate amount of these payments was almost equal to the capitated add-on payments to the prepaid plans did not transform EPS payments into DSH payments.

Office of Inspector General Response

The six other reasons that the State cited help to define who may receive EPS payments, but they do not address the nature of the payments, which is what is in question. The May 29, 2002 CMS letter to the State included the following statements:

> We find it hard to understand the State's contention that it does not make DSH payments under the PHP [prepaid health plan] program.
>
> In addition, we do not believe that the Bachus amendment exempts the State from the OBRA-93 hospital specific DSH limits . . . the Bachus amendment simply exempts the State from the direct payment requirement of section 1923(I) and not the OBRA-93 hospital specific DSH limits contained in section 1923(g).

Moreover, a June 13, 2002 letter from the Secretary to the Honorable Spencer T. Bachus provides that:

> . . . the PHP as implemented circumvented the OBRA-93 hospital specific disproportionate share hospital (DSH) limits. This allowed the State to make all of the State's public and private hospitals' DSH payments to the PHP, and the

PHP then paid all of the DSH payments to the public hospitals. The public hospitals received DSH payments in excess of the OBRA-93 individual hospital limits for those hospitals.

Although the State discounted the fact that EPS payments were almost equal to payments to the prepaid plans, we believe that it is more than coincidence that the two cash flows totaling approximately $666 million varied by less than four-hundredths of a percent over fiscal years 1999 and 2000.

State Comments on Hospital-Specific Limits

The State asserted that it was not subject to the hospital-specific limits imposed by the Omnibus Budget Reconciliation Act of 1993 because it did not make DSH payments directly to hospitals and because it had a managed care payment arrangement. The State also cited a June 13, 2002 letter from the Secretary in which the Secretary acknowledged that the hospital-specific DSH limits did not apply to the State: "[The PHP] allowed the State to make all of the State's public and private hospitals' DSH payments to the PHP."

Office of Inspector General Response

We continue to believe that the State was subject to the hospital-specific DSH limits. CMS's May 29, 2002 letter states, "We believe the OBRA-93 hospital specific limits apply . . . ." Additionally, we believe that the full context of the Secretary's letter offers a different perspective from that cited in the State's response. The letter states, "Let me be clear as to why we could no longer renew the PHP waiver. Among our reasons was that the PHP as implemented circumvented the OBRA-93 hospital specific disproportionate share hospital (DSH) limits. This allowed the State to make all of the State's . . . DSH payments to the PHP . . . ." Further, the letter states, "Thus, the waiver is not consistent with the OBRA-93 hospital specific DSH limits . . . ."

We believe that CMS and the Secretary clearly intended that the State remain subject to the hospital-specific DSH limits despite the State's managed care waiver. We disagree that the Secretary's letter condones the State's practice.

State Comments on Intergovernmental Transfers

The State took exception to our objective to determine if hospitals returned any DSH payments via intergovernmental transfers. The State cited a CMS letter to the Commissioner of the Alabama Medicaid Agency: "[w]e have never questioned Alabama's ability to impose IGTs [intergovernmental transfers] on its hospitals nor the use of those IGTs received by the State as a source of the State share." The State believed that we had no basis to examine this issue.

Office of Inspector General Response

We have not questioned the State's use of intergovernmental transfers. As part of our mission to improve the efficiency of the Department's programs, we are gathering

information on intergovernmental transfers in a number of States and may report our observations to CMS separately.

APPENDICES

APPENDIX A

COMPARISON OF UNCOMPENSATED CARE COSTS WITH DSH PAYMENTS FOR HOSPITALS PARTICIPATING IN ALABAMA'S MANAGED CARE ARRANGEMENT

	Fiscal Year UU1999	Fiscal Year 2000	Total
Aggregate FY 2000 statewide uncompensated care costs (before enhanced payment offset) for all hospitals statewide	$544,164,060	$544,164,060	$1,088,328,120
Less: Uncompensated care costs for non-PHP and non-DSH-eligible hospitals	(75,626,083)	(75,626,083)	(151,252,166)
Aggregate uncompensated care costs for all PHP hospitals	468,537,977	468,537,977	937,075,954
Less: Submitted FY 2000 uncompensated care costs (before enhanced payment offset) for tested PHP hospitals	(185,327,282)	(185,327,282)	(370,654,564)
Plus: Audited FY 2000 uncompensated care costs (before enhanced payment offset) for tested PHP hospitals	178,812,205	178,812,205	357,624,410
Adjusted uncompensated care costs (before enhanced payment offset) for all PHP hospitals	462,022,900	462,022,900	924,045,800
Less: Aggregate enhanced payments for all PHP hospitals	(114,419,214)	(208,835,053)	(323,254,267)
Net uncompensated care costs (aggregate hospital-specific limits) for all PHP hospitals	347,603,686	253,187,847	600,791,533
Total DSH payments for all PHP hospitals	348,676,597	317,899,823	666,576,420
DSH payments in excess of hospital-specific limits	(1,072,911)	(64,711,976)	(65,784,887)
Federal share percentage	69.27%	69.57%	N/A
Federal share	**$ (743,205)**	**$ (45,020,122)**	**$ 45,763,327)**

AUDIT EXCEPTIONS TO SIX ALABAMA HOSPITALS' CALCULATIONS OF UNCOMPENSATED CARE COSTS

The following provides a hospital-by-hospital summary of audit exceptions we noted when testing the hospitals' calculations of uncompensated care costs. Criteria citations may be found at the end of this appendix.

HOSPITAL A

Hospital A's submitted total of uncompensated care costs was $25,354,930. Our audit tests revealed differences that brought the audited total down to $6,251,649.

Not offsetting 100% of enhanced payments	$(9,379,550)	(1)
Including Medicaid secondary days (i.e., patients with insurance)	(32,408)	(2)
Including insured patients and using financial estimates for bad debts	(5,501,150)	(2)
Not offsetting prepaid plan capitation premium	(4,190,173)	(1)
Total impact of revisions	**$(19,103,281)**	

HOSPITAL B

Hospital B's submitted total of uncompensated care costs was $32,006,185. Our audit tests revealed differences that brought the audited total down to $28,442,892.

Using Medicare vs. overall cost per day calculation			$(3,207,469)	(3)
Not offsetting enhanced payments			(2,440,475)	(1)
Using unsupported outpatient vs. overall cost-to-charge ratio			(1,029,024)	(3)
Using estimated vs. actual bad debts	$570,959	(2)		
Offsetting county funds against bad debts	4,577,679	(4)		
Including insured patients in bad debts	(937,416)	(2)		
Total bad debts related			4,211,222	
Including nonreimbursable costs			(908,489)	(5)
Not offsetting prepaid plan capitation premium			(189,058)	(1)
Total impact of revisions			**$(3,563,293)**	

HOSPITAL C

Hospital C's submitted total of uncompensated care costs was $17,315,995. Our audit tests revealed only one difference, resulting in an audited total of $8,647,146. The hospital offset a portion of enhanced payments, but did not offset the portion of enhanced payments that it was required to return to the State. The gross amount should have been offset (1). The difference between gross enhanced payments and the amount offset by the hospital was $8,668,849, the amount of our adjustment.

HOSPITAL D

Hospital D's submitted total of uncompensated care costs was $25,266,968. Our audit tests revealed differences that eliminated the uncompensated care costs.

Including insured patients	$ (936,894)	(2)
Not offsetting prepaid plan capitation premium	(2,003,390)	(1)
Not offsetting enhanced payments	(22,326,684)	(1)
Total impact of revisions	**$(25,266,968)**	

The actual enhanced payments for Hospital D were $24,354,719; however, we offset only an amount sufficient to bring the uncompensated care costs to zero.

HOSPITAL E

Hospital E's submitted total of uncompensated care costs was $37,982,092. Our audit tests revealed differences that brought the audited total down to $33,310,996.

Duplicating Medicaid days	$(3,924,079)	(2)
Not including intern and resident costs	2,042,087	(2)
Offsetting net EPS payments (hospital was not required to offset these because they were DSH payments)	2,081,177	(6)
Offsetting only net enhanced payments retained (see Hospital C exception for enhanced payments)	(5,018,768)	(1)
Making mechanical errors in hospital calculation	148,487	(2)
Total impact of revisions	**$(4,671,096)**	

HOSPITAL F

Hospital F did not calculate its uncompensated care costs. Rather, it submitted information and had us calculate the costs. We calculated a figure of $79,407,297, which represented the hospital's submitted figure. We then performed audit tests, which brought the audited total down to $54,465,482.

Not offsetting enhanced payments	$(18,882,762)	(1)
Not offsetting prepaid plan capitation premium and maternity lump-sum payments	(3,247,728)	(1)
Overstating allowable cost per day	(1,092,976)	(2)
Using various data discrepancies	(1,718,349)	(2)
Total impact of revisions	**$(24,941,815)**	

CRITERIA CITATIONS

(1) Section 1923(g) of the Social Security Act states that uncompensated care costs for uninsured and Medicaid patients must be "net of payments under this title, other than under this section, and by uninsured patients. . . ." Thus, State enhanced payments to cover a hospital's cost of caring for Medicaid patients must be used to reduce uncompensated care costs. Also, other payments made by prepaid plans to cover Medicaid services should be used to reduce uncompensated care costs (other than EPS payments, which are equivalent to DSH payments).

(2) Section 1923(g) of the Social Security Act also provides that DSH payments are intended to cover "the cost incurred during the year of furnishing hospital services (as determined by the Secretary) . . . 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" (emphasis added). Thus, by definition, costs for patients with insurance should not be counted as uncompensated care costs. Also, the cost should be calculated as accurately as possible, using actual writeoffs of revenues rather than financial statement estimates because such estimates are not verifiable to a detail.

(3) Per section 1923 of the Social Security Act, DSH payments are intended to cover costs related to Medicaid and uninsured patients. Costs should be computed as accurately as possible and must be supported. The use of a cost per day unique to Medicare patients might not accurately reflect the cost per day to Medicaid and uninsured patients. Thus, we used overall cost per day. Also, in one instance, the provider used an unsupported outpatient cost-to-charge ratio to compute outpatient costs for Medicaid and uninsured patients.

(4) Section 1923(g) of the Act specifically provides that "payments made to a hospital for services provided to indigent patients made by a State or local government within a State shall not be considered a source of third party payment."

(5) Section 1923(g) provides that DSH payments are to cover "the cost incurred during the year of furnishing hospital services (as determined by the Secretary) . . . ." In this case, a hospital included nonreimbursable costs in its uncompensated care costs. These costs should be excluded under the "as determined by the Secretary" part of the DSH limitation.

(6) Section 1923(g) requires that the cost for DSH payments be "net of payments under this title, other than under this section, and by uninsured patients . . . ." Under this definition, DSH payments themselves (i.e., payments under "this section") do not have to be used to reduce uncompensated care costs. This provider reduced its uncompensated care costs by the amount of EPS payments that it was allowed to retain. However, EPS payments are equivalent to DSH payments.

BOB RILEY
Governor

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MIKE LEWIS
Acting Commissioner

February 25, 2003

Mr. Charles J. Curtis
Regional Inspector General for Audit Services,
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Re: OIG Report "Review of Alabama Medicaid Agency Disproportionate Share Hospital Payments for State Fiscal Years 1999 and 2000." Report Number: A-04-01-02006.

Dear Mr. Curtis:

Rather than respond comprehensively, I am writing to highlight some of the errors in the Health and Human Service's Office of Inspector General's ("OIG") draft report released on January 24, 2003, report number A-04-01-02006 (the "Report"). The Report alleges that because Alabama Medicaid did not include enhanced payments to hospitals in its uncompensated care figures, Alabama "did not comply with OBRA 93 hospital specific DSH payment limitations." Report at 1. OIG's allegations are incorrect. They are based on: (i) OIG's unexplained failure to utilize the most recent data, (ii) flatly incorrect assumptions, (iii) misleading and selective quotations of relevant documents, and (iv) an analysis that is contrary to the facts and applicable law. Further, OIG's analysis directly contradicts statements and positions taken on the issues by CMS and Secretary Thompson.

The Report states that in determining the amount of uncompensated care Alabama hospitals provided, OIG "used the figures from the FY 1994 calculation as a starting point because, with the exception of the five PHP hospitals that we tested, these were the most current calculations." Report at 8. This statement is inaccurate. Alabama conducted an uncompensated care survey, at CMS's request, as recently as February 2002, eight years after the data utilized by OIG was obtained through a similar survey. Alabama provided CMS with the complete results of that survey in April of 2002, almost nine months before OIG published this draft Report. Further, OIG was reminded by Alabama that the survey had been done and of the existence of the more current data in early January 2003, three weeks before the draft Report was released.
The uncompensated care survey conducted in 2002 at CMS's request demonstrates that, even when enhanced payments are included in the calculation, as OIG believes is appropriate, the statewide total of any DSH-like payments made by Alabama to the PHPs are below the statewide aggregate OBRA 93 hospital-specific DSH limits. In fact, after CMS received the results of the survey CMS agreed with this conclusion, stating, "[w]e would agree that your recent uncompensated care survey

would resolve the questions we have about possible duplicate payments for the single annual time period covered by the uncompensated care survey if certain issues are clarified." May 29, 2002 letter from Dennis Smith to Mike Lewis.

OIG's analysis also is premised on the erroneous assertion that essential provider supplement (EPS) payments are actually DSH payments made by the PHPs to the hospitals. OIG asserts that EPS payments are DSH payments subject to OBRA 93 hospital specific DSH limits because the PHP-provider contract OIG reviewed provides that one basis for the EPS payments is to provide funds to "a provider that (i) serves a disproportionate share of Medicaid patients . . ." OIG fails, however, to note that the very paragraph the Report quotes actually provides six other reasons a PHP may classify a provider as "essential" and eligible for EPS payments. The complete contractual provision reads:

> (a) In the PHP's discharge of its contractual obligations to Medicaid, and its obligations of care to the Medicaid Eligibles, the parties acknowledge that certain providers are more essential to the PHP than others ("Essential Providers"). The PHP, at its discretion, may denominate as an Essential Provider a provider that: (i) serves a disproportionate share of Medicaid patients, (ii) serves a rural or isolated area that cannot be reasonable served by other providers, (iii) provides a necessary, unique, sophisticated or technical level of services not available at all, or in sufficient or appropriate levels from other providers, (iv) provides substantial amounts of uncompensated care, (v) requires support because it is a necessary or integral part of the District's healthcare delivery system, (vi) serves as regional referral centers, or (vii) has other characteristics which make them essential to the mission and purpose of the PHP.

Thus, the contract actually demonstrates that EPS payments are not disguised DSH payments, but may be made for a variety of purposes without regard to whether a hospital serves a disproportionate number of Medicaid patients. For example, tertiary treatment centers and rural facilities incur high "stand-by" costs for some services. Yet, it is critical that tertiary treatment centers and rural hospitals remain viable so that Medicaid beneficiaries and others have adequate access to services. Accordingly, the PHP-provider contract grants PHPs the discretion -- without any oversight whatsoever from Alabama Medicaid -- to make EPS payments, ensuring that needed hospital services remain available.

OIG also makes the circular argument that EPS payments are DSH payments because the aggregate amount of EPS payments a PHP makes to its member hospitals is almost equal to the capitated add-on payments that Alabama makes to the PHPs. While this may be the case, it does not transform

EPS payments into DSH payments. The PHPs cannot pay hospitals more for Medicaid services than they receive from Alabama Medicaid, thus it is no surprise that the two payments are almost equal in amount.

Additionally, the Report is based on incorrect assumptions regarding the requirements imposed by OBRA 93. OBRA 93 makes explicit that hospital specific DSH limits are imposed only on payments by states to individual hospitals. See Section 1923(g) of the Social Security Act. OIG conceded, however, that Alabama "made DSH payments to Prepaid Health Plans (PHP) using a capitation amount per enrollee per month," Report at 2, and not to any individual hospitals. Because Alabama did not make DSH payments to hospitals, it was not subject to the hospital specific limits imposed by OBRA 93.

The Report notes that "Section 1923 (i) of the Act requires DSH payments to be made directly to hospitals (and not through a managed care organization); however, the same section of the Act provides an exception [i.e., the Bachus amendment] for states that had a managed care payment arrangement in effect as of July 1, 1997, an exception that applies to Alabama." Report at 3. As recently as last June, Secretary Thompson acknowledged that the OBRA 93 hospital specific DSH limits do not apply to Alabama: "[The PHP] allowed the State to make all of the State's public and private hospitals' DSH payments to the PHP," allowing Alabama to avoid the hospital specific limits imposed by OBRA 93. June 13, 2002 letter from Secretary Thompson to Representative Bachus.

Finally, Alabama objects to the OIG's decision to examine whether "any of the DSH payments were being returned to the state via intergovernmental transfers (IGT)." Report at 1. Acknowledging the legality of funding the state's share with IGT's, CMS recently stated that "[w]e have never questioned Alabama's ability to impose IGTs on its hospitals nor the use of those IGT received by the State as a source of the State share." May 16, 2002 letter from Dennis Smith to Mike Lewis. Consequently, there is no basis for OIG to examine the issue.

Further, the OIG concludes that "the state received federal funds without actually incurring any expenditure," as a result of the IGTs. Report at 12. This conclusion is based on the assumption that the IGTs the hospitals made were comprised of federal dollars (i.e., "DSH funds") rather than state dollars or other hospital revenues. In contrast, CMS has stated "Federal funds, once received by the hospital, are fungible." Medicaid Program; Modification of the Medicaid Upper Payment limit for Non-State Government-Owned or Operated Hospitals, 67 Fed. Reg. 2605 (2002) *codified at* 42 C.F.R. pt. 447. CMS also has stated that it "does not have the authority to prescribe how facilities are to use the Medicaid payments they receive from state Medicaid agencies." OIG Report "Review of Medicaid Enhanced Payments to Hospitals and the Use of Intergovernmental Transfers in North Carolina" (A-04-00-00140) Appendix B at 2.

Even a cursory review of the OIG's Report demonstrates that its conclusions are based on egregious errors, unsupported and inaccurate assumptions, faulty calculations, misleading quotations and positions that have been directly contradicted by CMS. Accordingly, Alabama requests that OIG withdraw this Report. Alabama reserves all its legal rights and remedies in the event OIG fails to withdraw the Report.

Please call me if you wish to discuss any aspect of this response.

Sincerely,

Mike Lewis
Commissioner

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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