# Memorandum

Date AUG 12 2002

From Janet Rehnquist
Inspector General

Subject Review of Disproportionate Share Hospital Costs Claimed by the State of Missouri for Fiscal Year Ended June 30, 1999 (A-07-01-02093)

To Thomas Scully
Administrator
Centers for Medicare & Medicaid Services

This memorandum alerts you to the issuance within 5 business days of the final audit report to the Missouri Division of Medical Services entitled, *Review of Disproportionate Share Hospital Costs Claimed by the State of Missouri for Fiscal Year Ended June 30, 1999.* A copy of the report is attached. The review was conducted at the request of the Centers for Medicare & Medicaid Services as part of a multi-state review of Medicaid disproportionate share (DSH) payments. The objectives of the review were to verify that the DSH amounts claimed were consistent with the state plan, and that amounts computed and claimed for individual hospitals did not exceed uncompensated care costs as mandated by the Omnibus Budget Reconciliation Act (OBRA) of 1993.

Our audit showed that DSH amounts claimed were overstated because the state included non-hospital (community mental health center) costs in their DSH calculations. As a result, the uncompensated care cost ceiling specified in OBRA of 1993 was exceeded by $37.5 million federal financial participation (FFP). Of the $37.5 million FFP, $1.3 million was attributable to calculation errors that were questioned as part of a separate audit report (A-07-01-02089). The remaining $36.2 million is covered by this report.

We recommended that the state refund to the Federal Government excessive 1999 DSH payments totaling $36.2 million in FFP; identify and refund similar excessive claims from subsequent years; and implement procedures and controls to prevent similar types of DSH claims in future periods.

The state agency did not concur with our findings and recommendations. Their contention was the costs are provided for in the Medicaid state plan. We continue to believe that non-hospital costs should not be included as part of the DSH computation. We addressed specific issues of the state's comments in the body of our report, and included the complete text of the state's comments as an Appendix to the report.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for Centers for Medicare and Medicaid Audits, at (410) 786-7104 or James P. Aasmundstad, Regional Inspector General for Audit Services, Region VII, at (816) 426-3591.

Attachment

Department of Health and Human Services

# OFFICE OF INSPECTOR GENERAL

# REVIEW OF DISPROPORTIONATE SHARE HOSPITAL COSTS CLAIMED BY THE STATE OF MISSOURI FOR FISCAL YEAR ENDED JUNE 30, 1999

JANET REHNQUIST
INSPECTOR GENERAL

AUGUST 2002
A-07-01-02093

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

AUG 16 2002

CIN: A-07-01-02093

Mr. Gregory Vadner
Director
Missouri Department of Social Services
Division of Medical Services
P.O. Box 6500
Jefferson City, Missouri 65102-6500

Dear Mr. Vadner:

This report provides the results of our review of disproportionate share hospital (DSH) amounts claimed under the Missouri Medicaid program. The objectives of the review were to verify that the State's DSH amounts claimed were consistent with the provisions of the approved State plan and that amounts computed and claimed for individual hospitals did not exceed uncompensated care costs as mandated by the Omnibus Budget Reconciliation Act (OBRA) of 1993. The review covered DSH amounts computed and claimed for the State Fiscal Year (SFY) ended June 30, 1999.

Our review showed that Fiscal Year 1999 DSH amounts were overstated because the Department of Mental Health included non-hospital (community mental health center [CMHC]) costs in their DSH calculations. As a result, DSH calculations for the hospitals exceeded the uncompensated care cost ceiling specified in OBRA of 1993 by $37.5 million Federal financial participation (FFP). Of the $37.5 million, $1.3 million was attributable to calculation errors that were questioned as part of a separate audit report (A-07-01-02089). The remaining $36.2 million ($37.5 million minus $1.3 million) is covered by this report.

We recommended that the State refund to the Federal Government excessive 1999 DSH payments totaling $36.2 million in FFP; identify and refund similar excessive claims from subsequent years; and implement procedures and controls to prevent similar types of DSH claims in future periods.

## 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 program is administered by the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS). Within a broad legal framework, each State designs and administers its own Medicaid program and is required to submit State Medicaid plan amendments for CMS approval. In Missouri, the State Department of Social Services, Division of Medical Services is the single State agency responsible for the administration of the approved Medicaid State plan.

The 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 DSH programs.

The OBRA of 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. Under section 1923(g) of the Act, the uncompensated care costs were limited to costs of medical services provided to Medicaid and uninsured patients less payments received for those patients excluding Medicaid DSH payments. Section 1923(g)(1) states:

> "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…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 SFYs beginning between July 1, 1994 and January 1, 1995, payments to public hospitals were limited to 100 percent of uncompensated care costs with a special provision that allowed payments up to 200 percent to those public hospitals qualifying as high DSH hospitals. For SFYs beginning on or after January 1, 1995, payments to all hospitals were limited to 100 percent of uncompensated care costs.

According to the approved Missouri Medicaid State plan (State plan), uncompensated care cost is defined as:

> "Inpatient days estimated to be reimbursed by Missouri Medicaid multiplied by the Medicaid inpatient rate PLUS base year Medicaid outpatient payments divided by eighty percent (80%) LESS base year general plan payments PLUS base year charity care and bad debts charges multiplied by the base year cost-to-charge ratio."

The Missouri DSH payment and uncompensated care cost for a hospital for any given year was based on the 4th prior year cost report, trended for hospital market basket and anticipated growth indices. For example, the State's 1999 DSH payments (the year under review) were based on 1995 Medicare/Medicaid cost reports.

**Objective, Scope, and Methodology**

Our audit was performed in accordance with generally accepted government auditing standards, and covered SFY 1999 DSH amounts. For SFY ending June 30, 1999, Missouri reported $671 million ($406 million FFP) of DSH expenditures for 147 hospitals.

The objectives of the audit were to verify that the State's DSH amounts were consistent with the provisions of the approved State plan and that amounts claimed for individual hospitals did not exceed uncompensated care costs as mandated by OBRA of 1993.

To accomplish the objectives, we reviewed the State Division of Medical Service's (State agency) policies and procedures for calculating uncompensated care costs. We reviewed Federal Medicaid statutes, Code of Federal Regulations, CMS guidance, and the State plan pertaining to the DSH program. We selected three hospitals for which DSH amounts for 1999 totaled about $100 million, collectively. The $100 million is approximately 16 percent of the total Missouri DSH amounts claimed. We performed an on-site review of the books and records at each of the three hospitals to ascertain whether uncompensated care costs were supported and accurately calculated and reported.

We reviewed books and records at the State Department of Mental Health, Division of Comprehensive Psychiatric Services to the extent necessary to verify supporting documentation for certain DSH amounts claimed on behalf of State mental hospitals. Our review at the Department of Mental Health included all CMHC costs included in the computation of uncompensated care costs. We did not trace payments of DSH monies from the State agency to the respective hospitals.

Our internal control review included interviewing State agency, Department of Mental Health, and hospital officials to the extent necessary to obtain an understanding of the internal controls relevant to the calculation of the DSH amounts claimed.

Fieldwork was performed at the State agency, the Department of Mental Health, and three hospitals. Additional field work was performed in March 2002 after receipt of the State agency's response to the draft report.

## FINDINGS AND RECOMMENDATIONS

Our audit showed that DSH amounts claimed for hospitals were overstated because the State claimed non-hospital (CMHC and other) costs resulting in an overstatement of uncompensated care costs. The overstatement totaled $37.5 million FFP and included $1.3 million attributable to a calculation error that was addressed in a separate audit report (A-07-01-02089). The remaining $36.2 million ($37.5 million minus $1.3 million) is covered by this report. We recommended the State refund the net excessive amount claimed; identify and refund similar amounts claimed in subsequent years; and implement procedures and controls to prevent similar types of DSH claims in future periods.

### Non-Hospital Costs Claimed as Uncompensated Care Costs

Amounts claimed for DSH expenditures included $37.5 million FFP for CMHC and other services that represented costs of the Department of Mental Health and not uncompensated care costs of the State mental hospitals. The claimed amounts included Departmental expenditures for (1) services purchased from 22 privately owned and operated CMHCs, (2) the cost of operating six State-run CMHCs, and (3) the costs of State personnel performing supported community living functions. These claimed amounts represented a variety of services provided to CMHC clients including total case management and community psychiatric rehabilitation. Supported community living costs generally represented costs of State personnel that monitor and otherwise assist the mentally ill that live independently in the community.

These costs represented the majority of the uncompensated care costs reported by one of the hospitals we reviewed. Hospital officials could not provide any support for this amount, stating that the Department of Mental Health told the hospital what amount to report each year. Hospital officials believed the amount represented local area CMHC costs. Officials indicated these costs were not recorded on the hospital's official accounting records and were not for hospital services provided to patients of the hospital. The hospital's Medicare/Medicaid cost report classified these amounts as a "Nonreimbursable Cost Center."

**The State Plan**

In addition, claiming $37.5 million of CMHC and supported community living costs as uncompensated care costs was not provided for in the approved State plan. The State plan provided a detailed description of the procedures and methodologies involved in determining what institutions receive DSH monies; what costs are included; how payments are computed; and the type of costs that can be included in uncompensated care costs. The plan covered both inpatient and outpatient hospital costs. However, there were no provisions in the plan that would allow claiming CMHC and supported community living costs as uncompensated care costs of the mental hospitals.

**Recommendations**

We recommended the State:

(1) Refund to the Federal Government excessive 1999 DSH payments totaling $36.2 million in FFP.

(2) Identify and refund similar excessive claims from subsequent years.

(3) Implement procedures and controls to prevent similar types of DSH claims in future periods.

**State Agency Comments**

The State agency did not agree with the recommendations in the report. The following paragraphs outline their position and our response. We have included the complete text of the State agency's comments as an Appendix to this report.

**State Agency Comment:**

"C. The CMHC Costs Were Claimed In Accordance With the Approved State Plan

Following the budgetary and administrative separation of the CMHCs from the State psychiatric hospitals, the hospitals removed the costs associated with outpatient care from their cost reports. Once these costs were removed, there was no mechanism to make DSH payments for the uncompensated outpatient care provided by the CMHCs, even though these costs continued to be borne by DMH, which also operates the state psychiatric hospitals. When it was realized that, as providers of outpatient hospital services, the CMHCs were eligible for DSH payments to the same extent as the inpatient hospitals previously had been, the inpatient hospitals' cost reports were amended to include the cost of the uncompensated outpatient care

provided by the CMHCs beginning in SFY 93. The change to the cost reports was made after consultation with the hospitals' Medicare intermediary."

**Office of Inspector General (OIG) Response:**

Our report included the section for the State Plan to make the point that the claiming of millions of dollars should not be a matter of interpretation of the provisions or adjustment of cost reports. Rather, it should be specifically provided for in the methodology included in the approved State plan.

Regardless of the interpretation one places on the provisions of the State Plan, the methodology of adding non-hospital costs to the cost report for purposes of computing the DSH amount claimed was inconsistent with the DSH statute, which stated that:

> "A payment adjustment during a fiscal year shall not be considered to be consistent with…respect to a hospital if the payment adjustment exceeds *the costs incurred* during the year of furnishing hospital services…*by the hospital* to individuals who either are eligible for medical assistance under the State plan or have no health insurance…." (*emphasis added.*)

Furthermore, while the amounts were added to the Medicare cost report, they were added as a "non-reimbursable cost center." As such, they were not a reimbursable cost for Medicare and the intermediary would not have been concerned as to the appropriateness of the cost (or the entry) beyond that. The act of entering CMHC costs on the Medicare cost report and getting the intermediary to accept them as a "non-reimbursable cost center" does not meet the statutory requirement that the costs be incurred by the hospital.

**State Agency Comment:**

> "D. The Draft Audit Finding That The CMHC Costs are for 'Non-Hospital' Services Is Not Supported By The Centers for Medicare and Medicaid Services (CMS) Regulations…

Section 1923(g) provides that DSH payments may cover the cost of 'hospital services' to Medicaid patients and the uninsured. CMS has never defined the term 'hospital services' in Section 1923(g) by regulation, and in the only guidance it has provided on the subject-a Medicaid Director letter in August 1994-it allowed that Congress intended to cover outpatient as well as inpatient costs and that the states were afforded considerable flexibility in defining the 'costs' of those services."

**OIG Response:**

The State agency comment focuses substantively on the services provided by the CMHCs. However, the nature of the services provided by the CMHCs was not the issue addressed by the report. The comment, for the most part, did not address the central issue of the report, that CMHC costs were inappropriately reported on the hospital cost report.

The State agency indicated in its comments that the hospital and CMHCs were separate entities, and they are correct. The hospitals and the CMHCs are not contractually obligated to each other. Yet the State agency argued that it was appropriate for the hospital to assume the CMHC's expenses on its books for reporting purposes and hence, for purposes of computing the DSH amount due. The eligibility of the costs incurred by the CMHCs for DSH payments should stand on the eligibility of the CMHCs on their own, as entities separate and apart from the hospitals.

**State Agency Comment:**

"E. The Amount of the Alleged Overpayment is Overstated.

In any case, the amount of the alleged overpayment is overstated. In SFY 99, the state psychiatric hospitals had $203,881,603 in Medicaid shortfall and uninsured costs, $62,792,058 of which is attributable to services provided by the CMHCs. (These figures are from the state's work papers and have not been adjusted to reflect the $1.3 million calculation error). The alleged overpayment in FFP is calculated as if the entirety of the CMHC costs had been included in the state's DSH payments in SFY 99. However, the state had state share sufficient to make only $196,668,170 in DSH payments to state psychiatric hospitals in that year. Thus, the state did not claim $7,213,433 of costs and only $55,578,625 of CMHC costs were included in the total DSH payment. Therefore, the alleged overpayment is overstated by $4,377,111, which is equal to the FFP for the $7.2 million in costs that the audit assumes were included in the state's DSH payments in that year, but were not. The state has the documentation to demonstrate that $7,213,433 in costs were excluded from the DSH payment to the state psychiatric hospitals in SFY 99."

**OIG Response:**

Our questioned dollar amount was computed using the same methodology used by the State in calculating DSH costs, including such factors as inflation and growth escalations, and the institution for mental disease cap reductions.

However, in reviewing our computed amounts, we discovered we had inadvertently omitted one step, the application of the cost-to-charge ratios. Based on our recalculations, which included the cost-to-charge computations, we reduced the questioned amount from $39 million to $37.5 million FFP. The recommendation in the report has been changed to coincide with the corrected amount.

We also noted that the data and schedules submitted by the State to support the figures in their comments were for the year prior to our review (SFY 1998), not the period covered by our review (SFY 1999).

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Final determinations as to the actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the 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, Office of Audit Services reports are made available to members of the public to the extent information contained therein is not subject to exemptions of the Act (see 45 CFR part 5). As such, within 10 business days after the final report is issued, it will be posted on the world-wide-web at http://oig.hhs.gov.

To facilitate identification, please refer to Common Identification Number A-07-01-02093 in all correspondence relating to this report.

Sincerely,

James P. Aasmundstad
Regional Inspector General
for Audit Services

**Direct Reply to HHS Action Official:**

Mr. Joe Tilghman
Regional Administrator
Centers for Medicare & Medicaid Services
Room 235, Federal Building
601 E. 12th Street
Kansas City, Missouri 64106

# APPENDIX

BOB HOLDEN
GOVERNOR

MISSOURI
DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
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RELAY MISSOURI
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February 22, 2002

James P. Aasmundstad
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services
601 East 12th Street, Room 284A
Kansas City, MO 64106

Sent via facsimile

Dear Mr. Aamundstad:

The Department of Social Services (DSS), Division of Medical Services, has reviewed the Department of Health and Human Services draft report dated January 29, 2002 regarding the disproportionate share (DSH) payments for state fiscal year (SFY) ended June 30, 1999.

DSS disagrees that SFY 99 DSH payments were overstated. As explained below, the Community Mental Health Centers (CMHCs) are providing outpatient hospital services whose costs are appropriately reimbursed in the state's DSH payments to state psychiatric hospitals.

Section 1902(a)(13) of the Social Security Act directs states in setting hospital reimbursement rates to "take into account (in a manner consistent with Section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs." Section 1923(g) of the Act provides that such DSH adjustments must not "exceed[ ] the costs incurred during the year of furnishing hospital services . . . by the hospital to individuals who either are eligible for medical assistance under the state plan or have no health insurance." State Medicaid directors were informed by letter dated August 17, 1994 that "States may include both inpatient and outpatient costs in the calculation of the limit."

In Missouri, the CMHCs provide the outpatient hospital services for the state's psychiatric hospitals and also perform entry and exit functions for inpatient hospital

services. Because they are providing "hospital services" within the meaning of the state plan and Section 1923(g), the costs of providing services to Medicaid patients and the uninsured are properly included in the DSH calculation for the state psychiatric hospitals.

A. History of the CMHCs in Missouri

Prior to 1985, six of the state's psychiatric hospitals provided the full spectrum of inpatient and outpatient hospital services. These services were provided either at the hospitals themselves, at clinics located adjacent to the hospitals, or at clinics located off-site.

Beginning in 1984, the state General Assembly began to redesignate the outpatient departments of the hospitals and the adjacent clinics as state-operated CMHCs, and to redirect funds previously allocated to the inpatient hospitals to the CMHCs. Thereafter, the Department of Mental Health (DMH), which operates the State psychiatric hospitals, contracted with the CMHCs for provision of outpatient services. The CMHCs function as a comprehensive service delivery system integrated by cooperative agreements with the inpatient hospitals.

Initially, six CMHCs that had previously been part of the inpatient hospitals were state-operated. These CMHCs are now privately-operated, as are an additional 20 CMHCs that were previously either off-site clinics of the inpatient facilities or community health clinics.

The services provided by all the CMHCs include *the same services* that were previously provided by the outpatient departments and clinics of the inpatient facilities. Moreover, the inpatient hospitals have ceased to provide ambulatory psychiatric services and DMH now relies exclusively on the CMHCs for the provision of these services.

B. Integration of the CMHCs and the State Psychiatric Hospitals

Missouri law defines a community mental health center as an entity "through which comprehensive mental health services are provided to individuals residing in a certain service area", Missouri Revised Statute § 205.975(2). The term "comprehensive mental health services" is, in turn, defined as:

> [I]npatient services, outpatient services, day care and other partial hospitalization services, emergency services, diagnostic and treatment services, liaison and follow-up services, consultation and education services, rehabilitation services, prevention services, screening services, follow-up care

> services, transitional living services, alcoholism and alcohol abuse prevention and treatment services, and drug addiction and drug abuse prevention and treatment services.

Missouri Revised Statute § 205.975(3).

Not only do the CMHCs provide the full-range of outpatient psychiatric services, but they also serve as the point of entry to and exit from the State's six psychiatric hospitals. Whereas a patient seeking psychiatric treatment–inpatient or outpatient–would formerly have gone directly to the inpatient hospital and been evaluated there for treatment and admission, patients served by the DMH now go to the CMHC in their catchment area (except for court-ordered admissions and emergencies).

Each CMHC is appointed as an Administrative Agent of DMH and has entered into a Cooperative Inpatient Agreement with a psychiatric hospital that governs the allocation of services between the two entities. Enclosed are copies of the scope of work for entities designated as Administrative Agents and a copy of a sample Cooperative Inpatient Agreement (Enclosure 1). As Administrative Agents, the CMHCs are responsible for:

- pre-admission screening and evaluation;
- referring patients to an inpatient facility after considering all appropriate community alternatives;
- providing a 24-hour-a-day crisis response system for all individuals who do not meet the criteria for acute inpatient care;
- participating in discharge and conditional release planning, and providing case management services, for individuals who are returning from an inpatient facility and who are eligible for services from the division.

Before the separation of the CMHCs and the inpatient hospitals, each of the above duties was performed by the outpatient department of the inpatient psychiatric facility. The Cooperative Inpatient Agreement also imposes obligations on the inpatient facility. The inpatient facility must:

- notify the CMHC of all admissions for their mental health service area within 24 hours;
- notify the CMHC prior to patient discharge or referral to a supported community living arrangement;

- provide the CMHC with all client information necessary to implement a discharge plan;

- offer medical staff membership and hospital privileges for admission and care to appropriately credentialed physicians employed by the CMHC.

Finally, the Agreement imposes an obligation on the inpatient facility and the CMHC to communicate regularly regarding the implementation of the Agreement, in order to ensure quality service delivery.

Thus, the CMHCs not only provide the outpatient services on behalf of the state's psychiatric hospitals, but also participate in the admission and discharge of patients requiring inpatient hospitalization.

C. The CMHC Costs Were Claimed In Accordance With the Approved State Plan

Following the budgetary and administrative separation of the CMHCs from the State psychiatric hospitals, the hospitals removed the costs associated with outpatient care from their cost reports. Once these costs were removed, there was no mechanism to make DSH payments for the uncompensated outpatient care provided by the CMHCs, even though these costs continued to be borne by DMH, which also operates the state psychiatric hospitals. When it was realized that, as providers of outpatient hospital services, the CMHCs were eligible for DSH payments to the same extent as the inpatient hospitals previously had been, the inpatient hospitals' cost reports were amended to include the costs of the uncompensated outpatient care provided by the CMHCs beginning in SFY 93.[1] The change to the cost reports was made after consultation with the hospitals' Medicare intermediary.

Under the approved state plan in effect in SFY 99 (the year at issue in the audit), the state psychiatric facilities qualified as "first tier ten percent Add-on disproportionate share hospitals." As such, the hospitals were eligible for a "safety net adjustment" equal to the

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[1] In computing the value of the claim for the costs of uncompensated outpatient services provided by the CMHCs, the Department of Mental Health excluded the cost of educational and employment services, and also excluded services that are not outpatient hospital services, such as transitional living services and alcohol and drug abuse prevention and treatment services. It also excluded any cost reimbursed under other Medicaid-covered programs (*e.g.*, Physician, Clinic, Community Psychiatric Rehabilitation, Comprehensive Substance Abuse and Rehabilitation, Targeted Case Management) and costs funded by other federal programs and funds.

shortfall in the costs of serving Medicaid patients and the costs of serving the uninsured. Allowable costs are "those related to covered Medicaid services defined as allowable in 42 CFR Chapter IV, part 413." Charity care is that resulting "from a providers policy to provide health care services free of charge or a reduction in charges because of the indigence or medical indigence of the patient." *See* the state plan amendment (SPA) pages from SPA 98-04, effective April 1, 1998 and SPA 98-13, effective September 10, 1998. (Enclosure 2).

The state has interpreted these provisions of its state plan to include the Medicaid shortfall and charity care costs of outpatient hospital services provided by DMH, the operator of the state psychiatric inpatient hospitals, through its contracts with the CMHCs. The services paid for are all allowable costs under 42 CFR part 413. The state's interpretation of its own state plan is entitled to deference because it is reasonable in light of the language of the plan as a whole and the applicable federal requirements. *See* California Dept. of Health Servs., DAB No. 1474 (1994); *see also* Missouri Dept. of Social Servs., DAB No. 1412 (1993); Arkansas Dept. of Human Servs., DAB No. 1328 (1992); Missouri Dept. of Social Servs., DAB No. 1189 (1990); Kansas Dept. of Social and Rehabilitation Servs., DAB No. 1026 (1989); South Dakota Dept. of Social Servs., DAB No. 934 (1988).

D. The Draft Audit Finding That The CMHC Costs Are For "Non-Hospital" Services Is Not Supported By The Centers for Medicare and Medicaid Services (CMS) Regulations.

The draft audit report finds that SFY 99 DSH payments were overstated by $36.2 million in federal financial participation because the CMHC costs are "non-hospital" costs. That finding is not supported by statute or regulation.

Section 1923(g) provides that DSH payments may cover the cost of "hospital services" to Medicaid patients and the uninsured. CMS has never defined the term "hospital services" in Section 1923(g) by regulation, and in the only guidance it has provided on the subject–a Medicaid Director letter in August 1994–it allowed that Congress intended to cover outpatient as well as inpatient costs and that the states were afforded considerable flexibility in defining the "costs" of those services.

CMS regulations do define both "inpatient hospital services" and "outpatient hospital services" at 42 C.F.R. § 440.10 and 440.20. Outpatient hospital services are defined as "preventive, diagnostic, therapeutic, rehabilitative, or palliative services" that are furnished (1) to outpatients, (2) by or under the direction of a physician or dentist, and (3) "by"–not "in"–an institution that is licensed or formally approved as a hospital by an

officially designated authority for State standard setting, and which meets the requirements for participation in Medicare as a hospital.

The outpatient services provided by the CMHCs meet this definition of outpatient hospital services. Missouri's six inpatient psychiatric hospitals previously provided these services directly. DMH now contracts with the CMHCs to provide these services in their role as Administrative Agents and through the mechanism of the Cooperative Inpatient Agreements. Inpatient hospitals typically contract for a variety of services, including radiology, pharmacy, anesthesiology, and laboratory. Just like these other services, the outpatient services provided through DMH's contracts with the CMHCs constitute "hospital services" for the purpose of determining the availability of DSH reimbursement.

The inclusion of costs of state personnel performing supported community living functions in the DSH payments to the state psychiatric hospitals is also appropriate. The costs claimed are for the staff responsible for reviewing and overseeing the performance of the CMHCs, which includes monitoring of the clients served by the CMHCs who are living in the community. These personnel are employees of [or paid by] the hospitals, and the quality assurance service they provide for the outpatient services provided by the CMHCs is appropriately considered a "hospital service" payable under the DSH program.

CMS has never defined "hospital services" to exclude services that *could* be provided and billed by a hospital, but that are instead provided by a separate entity that is contractually and clinically integrated with the hospital. Nor would such an approach be consistent with the agency's own practice. Elsewhere in its regulations, CMS permits "provider-based" entities to be treated as part of a hospital for purposes of Medicare reimbursement even though they are not licensed as a hospital, *see* 42 C.F.R. 413.65. CMS also treats "contracted services" as services of the contracting hospital, *see* 42 C.F.R. 282.12(e). Because DMH owns and operates the inpatient psychiatric hospitals, the outpatient hospital services that the CMHCs provide pursuant to contract with DMH may likewise be considered "hospital services" for DSH purposes.

Consistent with those regulations, and in light of the flexibility accorded states to define the costs of hospital services, and the deference owed to Missouri's interpretation of its State plan as including CMHC costs, the finding of the draft audit that Missouri's DSH payments were overstated is in error should be withdrawn.

E. The Amount of the Alleged Overpayment is Overstated.

In any case, the amount of the alleged overpayment is overstated. In SFY 99, the state psychiatric hospitals had $203,881,603 in Medicaid shortfall and uninsured costs, $62,792,058 of which is attributable to services provided by the CMHCs. (These figures

are from the state's workpapers and have not been adjusted to reflect the $1.3 million calculation error). The alleged overpayment in FFP is calculated as if the entirety of the CMHC costs had been included in the state's DSH payments in SFY 99. However, the state had state share sufficient to make only $196,668,170 in DSH payments to the state psychiatric hospitals in that year. Thus, the state did not claim $7,213,433 of costs and only$55,578,625 of CMHC costs were included in the total DSH payment. Therefore, the alleged overpayment is overstated by $4,377,111, which is equal to the FFP for the $7.2 million in costs that the audit assumes were included in the state's DSH payments in that year, but were not. The state has the documentation to demonstrate that $7,213,433 in costs were excluded from the DSH payment to the state psychiatric hospitals in SFY 99.

F. Audit A-07-01-02089:

*The final paragraph of the State agency's response has been omitted here because it pertained to another audit report.*

Please feel free to contact me at 573-751-6922 if you have additional questions.

Sincerely,

Gregory A. Vadner
Director

GAV:dmw

Enclosures