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

Washington, D.C. 20201

June 22, 2010

TO: Marilyn Tavenner
Acting Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services

FROM: /George M. Reeb/
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of Medicaid Disproportionate Share Hospital Payment Distribution (A-07-09-04150)

The attached final report provides the results of our review of the distribution of Medicaid disproportionate share hospital payments.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the Office of Inspector General (OIG) post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Robert A. Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Robert.Vito@oig.hhs.gov. Please refer to report number A-07-09-04150 in all correspondence.

Attachment

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENT DISTRIBUTION

Daniel R. Levinson
Inspector General

June 2010
A-07-09-04150

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Medicaid Disproportionate Share Hospital Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Omnibus Budget Reconciliation Act (OBRA) of 1981 established the Medicaid Disproportionate Share Hospital (DSH) program. The Medicaid DSH program was established in response to findings that public hospitals and teaching hospitals, which serve a large Medicaid and low-income population, are particularly dependent on Medicaid reimbursement, have high levels of uncompensated care costs, and therefore need additional financial support to continue providing care to the needy. (Uncompensated care costs are the sum of costs incurred to provide services to Medicaid and uninsured patients less payments received for those patients.)

The DSH program requires State Medicaid agencies (State agency) to make special payments, known as DSH payments, to hospitals that serve unusually large numbers of low-income and/or uninsured patients. The Federal Government reimburses State agencies for a percentage of their DSH payments. In 1997, State agencies were allotted approximately $11.7 billion for DSH payments; in 2007, the State agencies were allotted approximately $10.6 billion.

Disproportionate Share Hospital Payment Eligibility

For a hospital to receive DSH payments, the State agency must classify the hospital as DSH. Section 1923 of the Act states that State agencies must make DSH payments to certain hospitals that meet specified requirements and thus are deemed DSH. Specifically, a hospital is deemed DSH, and a State agency must make DSH payments to it, if the hospital's Medicaid inpatient utilization rate (MIUR) is at least one standard deviation greater than the average for all hospitals participating in Medicaid or if its low-income utilization exceeds 25 percent. (A hospital's MIUR, expressed as a percentage, is the number of inpatient days attributable to patients who were Medicaid-eligible divided by the total of the hospital's inpatient days in a particular year.) In addition, section 1923 of the Act allows State agencies to designate additional hospitals in their State plans as DSH provided that such hospitals each have an MIUR of not less than 1 percent.

Disproportionate Share Hospital Payment Restrictions

Since the inception of the DSH program in 1981, Congress has enacted four key pieces of legislation that have restricted State agencies' flexibility in the ways they allocate DSH payments:

- The OBRA of 1987 requires State agencies to deem certain hospitals as Medicaid DSH providers. This legislation also outlines payment methodologies.

- The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 limit DSH payments by establishing State DSH allotments. The State DSH allotments are annual limits on Federal matching funds available for payments made by each State agency to qualifying hospitals.

- The OBRA of 1993 further limits DSH payments by imposing hospital-specific DSH limits on Medicaid payments to hospitals' uncompensated care costs. (The hospital-specific DSH limit is no more than 100 percent of each hospital's uncompensated care costs. In this report, we refer to the hospital-specific DSH limit simply as the DSH limit.) In addition, the OBRA of 1993 imposes a minimum MIUR of 1 percent for hospitals to be eligible to receive DSH payments.

- The Balanced Budget Act of 1997 limits DSH payments to Institutions for Mental Disease (IMD) by creating an IMD DSH limit. The IMD DSH limit restricts the portion of DSH payments a State agency can allocate to IMDs, or other mental health facilities, as a group within that particular State.

We classified hospitals within seven selected States according to four hospital categories: State-owned IMDs, other State-owned hospitals, local public hospitals, and private hospitals.

OBJECTIVE

Our objective was to determine the proportion of uncompensated care costs incurred by State-owned IMDs, other State-owned hospitals, local public hospitals, and private hospitals that were reimbursed by seven selected State agencies' DSH payments.

SUMMARY OF FINDINGS

During Federal fiscal years 2003 through 2007, most of the seven selected State agencies reimbursed State-owned IMDs and other State-owned hospitals the highest proportion of the hospitals' uncompensated care costs.

In comparing DSH payments between hospital categories, we found that:

- three of the seven State agencies reimbursed State-owned IMDs the highest proportion of uncompensated care costs,

- three of the seven State agencies reimbursed other State-owned hospitals the highest proportion of uncompensated care costs, and

- one of the seven State agencies reimbursed private hospitals the highest proportion of uncompensated care costs.

In analyzing the relationship between the DSH payments and uncompensated care costs for all of the hospitals classified as DSH in the seven selected States, we found that, in the aggregate:

- State-owned IMDs received DSH payments averaging 92 percent of their uncompensated care costs,

- other State-owned hospitals received DSH payments averaging 95 percent of their uncompensated care costs,

- local public hospitals received DSH payments averaging 69 percent of their uncompensated care costs, and

- private hospitals received DSH payments averaging 38 percent of their uncompensated care costs.

RECOMMENDATION

We recommend that CMS evaluate how DSH payments are distributed among hospital categories and consider requesting congressional legislation to assure a more even distribution of payments based on uncompensated care costs.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS concurred with our recommendation but noted that recent congressional action may affect DSH payments. CMS stated that it would reevaluate the need to request additional legislative authority to assure a more even distribution of payments based on uncompensated care costs. CMS's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Disproportionate Share Hospital Program

The Omnibus Budget Reconciliation Act (OBRA) of 1981 established the Medicaid Disproportionate Share Hospital (DSH) program. The Medicaid DSH program was established in response to findings that public hospitals and teaching hospitals, which serve a large Medicaid and low-income population, are particularly dependent on Medicaid reimbursement, have high levels of uncompensated care costs,[1] and therefore need additional financial support to continue providing care to the needy.

The DSH program requires State Medicaid agencies (State agency) to make special payments, known as DSH payments, to hospitals that serve unusually large numbers of low-income and/or uninsured patients. The Federal Government reimburses State agencies for a percentage of their DSH payments. In 1997, State agencies were allotted approximately $11.7 billion for DSH payments; in 2007, the State agencies were allotted approximately $10.6 billion.

Disproportionate Share Hospital Payment Eligibility

For a hospital to receive DSH payments, the State agency must classify the hospital as DSH. Section 1923 of the Act states that State agencies must make DSH payments to certain hospitals that meet certain requirements and thus are deemed DSH. Specifically, a hospital is deemed DSH, and a State agency must make DSH payments to it, if the hospital's Medicaid inpatient utilization rate (MIUR) is at least one standard deviation greater than the average for all hospitals participating in Medicaid or if its low-income utilization exceeds 25 percent.[2] In addition, section 1923 of the Act allows State agencies to designate additional hospitals in their State plans as DSH provided that such hospitals each have an MIUR of not less than 1 percent.

[1] Uncompensated care costs are the sum of costs incurred to provide services to Medicaid and uninsured patients less payments received for those patients.

[2] A hospital's MIUR, expressed as a percentage, is the number of inpatient days attributable to patients who were Medicaid-eligible divided by the total of the hospital's inpatient days in a particular year.

Disproportionate Share Hospital Payment Restrictions

Since the inception of the DSH program in 1981, Congress has enacted four key pieces of legislation that have restricted State agencies' flexibility in the ways they allocate DSH payments:

- The OBRA of 1987 requires State agencies to deem certain hospitals as Medicaid DSH providers. This legislation also outlines payment methodologies.

- The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 limit DSH payments by establishing State DSH allotments. The State DSH allotments are annual limits on Federal matching funds available for payments made by each State agency to qualifying hospitals.

- The OBRA of 1993 further limits DSH payments by imposing hospital-specific DSH limits[3] on Medicaid payments to hospitals' uncompensated care costs. In addition, the OBRA of 1993 imposes a minimum MIUR of 1 percent for hospitals to be eligible to receive DSH payments.

- The Balanced Budget Act (BBA) of 1997 limits DSH payments to Institutions for Mental Disease (IMD) by creating an IMD DSH limit. The IMD DSH limit restricts the portion of DSH payments a State agency can allocate to IMDs, or other mental health facilities, as a group within that particular State.[4]

Disproportionate Share Hospital Payment Allocations

Within the restrictions set by legislation, each State agency has broad flexibility to allocate DSH payments to DSH-eligible hospitals. Section 1923(c) of the Act provides the methods for State agencies to calculate DSH payments.

We classified hospitals within seven selected States according to four hospital categories: State-owned IMDs, other State-owned hospitals, local public hospitals, and private hospitals.

[3] The hospital-specific DSH limit is no more than 100 percent of each hospital's uncompensated care costs. In this report, we refer to the hospital-specific DSH limit simply as the DSH limit. The Benefits Improvement and Protection Act (BIPA) of 2000 increased the DSH limit for all qualifying public hospitals to 175 percent of a hospital's uncompensated care costs for a period of 2 years beginning in State fiscal year (FY) 2003.

[4] The BBA of 1997 defines an IMD as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services." See section 1905(i) of the Act. For the State agencies we reviewed, the majority of IMDs that received DSH payments were State-owned IMDs.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine the proportion of uncompensated care costs incurred by State-owned IMDs, other State-owned hospitals, local public hospitals, and private hospitals that were reimbursed by seven selected State agencies' DSH payments.

Scope

We reviewed the DSH payments at the State agencies in seven States: Kansas, Louisiana, Missouri, New Jersey, New York, North Carolina, and Texas, for Federal FYs 2003 through 2007. During this period, the seven State agencies claimed a total of $37,735,708,315 ($21,252,302,016 Federal share) in DSH payments.

We did not perform a detailed review of each State agency's internal controls, because our objectives did not require us to do so. We limited our internal control review to obtaining an understanding of the State agencies' policies and procedures used to claim DSH expenditures.

We performed fieldwork at the State agencies in Jefferson City, Missouri; Albany, New York; and Trenton, New Jersey. For the remaining four State agencies reviewed, we analyzed the DSH data in our Kansas City, Missouri, regional office.

Methodology

To accomplish our objective, we did the following:

- We reviewed the OBRA of 1981, the OBRA of 1987, Medicaid Voluntary and Provider-Specific Tax Amendments of 1991, the OBRA of 1993, and the BBA of 1997.

- We reviewed other applicable Federal and State requirements.

- We judgmentally selected seven State agencies based on DSH payments and IMD DSH limits.

- We reviewed each selected State agency's policies and procedures concerning their administration of their DSH programs.

- We obtained DSH payment amounts, uncompensated care costs, and MIUR data from the seven selected State agencies for FYs 2003 through 2007; however, we did not verify the accuracy of this information. We used these data in our calculations and analysis.

- We classified the hospitals receiving DSH payments into hospital categories based on hospital ownership as defined by Federal regulations: private-owned, State-owned, and non-State owned. To analyze the DSH payments to State-owned hospitals, we further classified the hospital ownership of State-owned hospitals by State-owned IMDs and

other State-owned hospitals. We changed non-State owned to local public to clarify the hospital type for local, county, and city hospitals.

- We analyzed the seven selected State agencies' DSH payment information by hospital category, that is, State-owned IMD, other State-owned hospitals, local public hospitals, and private hospitals. Specifically, we determined:

    - the proportion of the DSH payments relative to uncompensated care costs, by hospital category, for each of the seven selected States and

    - the proportion of Medicaid patients (relative to total patient population) for each hospital category in the seven selected States.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATION

During FYs 2003 through 2007, most of the seven selected State agencies reimbursed State-owned IMDs and other State-owned hospitals the highest proportion of the hospitals' uncompensated care costs.

In comparing DSH payments between hospital categories, we found that:

- three of the seven State agencies reimbursed State-owned IMDs the highest proportion of uncompensated care costs,

- three of the seven State agencies reimbursed other State-owned hospitals the highest proportion of uncompensated care costs, and

- one of the seven State agencies reimbursed private hospitals the highest proportion of uncompensated care costs.

In analyzing the relationship between the DSH payments and uncompensated care costs for all of the hospitals classified as DSH in the seven selected States, we found that, in the aggregate:

- State-owned IMDs received DSH payments averaging 92 percent of their uncompensated care costs,

- other State-owned hospitals received DSH payments averaging 95 percent of their uncompensated care costs,

- local public hospitals received DSH payments averaging 69 percent of their uncompensated care costs, and

- private hospitals received DSH payments averaging 38 percent of their uncompensated care costs.

STATE-OWNED FACILITIES RECEIVED REIMBURSEMENT FOR A HIGHER PROPORTION OF UNCOMPENSATED CARE COSTS

During FYs 2003 through 2007, most of the seven selected State agencies reimbursed State-owned IMDs and other State-owned hospitals the highest proportion of the hospitals' uncompensated care costs. Six of the seven selected State agencies reimbursed a higher percentage of uncompensated care costs through DSH payments to State-owned IMDs and other State-owned hospitals. These six State agencies generally reimbursed lower percentages of uncompensated care costs through DSH payments to local public hospitals and private hospitals. In comparing DSH payments between hospital categories for the seven State agencies reviewed, we found that three of the seven State agencies paid State-owned IMDs the highest proportion of uncompensated care costs, three of the seven State agencies paid other State-owned hospitals the highest proportion of uncompensated care costs, and one of the seven State agencies paid private hospitals the highest proportion of uncompensated care costs.

In the aggregate, State-owned IMDs received DSH payments averaging 92 percent of their uncompensated care costs and other State-owned hospitals received DSH payments averaging 95 percent of their uncompensated care costs, while local public hospitals received DSH payments averaging 69 percent of their uncompensated care costs and private hospitals received DSH payments averaging 38 percent of their uncompensated care costs.

Table 1 shows the hospital count and the DSH payments by hospital category for each of the seven selected State agencies. Table 2 shows the uncompensated care costs, along with the percentage of uncompensated care costs reimbursed through DSH payments for each of the seven selected State agencies.

Table 1:[5] Disproportionate Share Hospital Count and Disproportionate Share Hospital Payment by Hospital Category for State Fiscal Years 2003 Through 2007[6]

State	State-Owned IMDs' Hospital Count	State-Owned IMDs—Total DSH Payments	Other State-Owned Hospitals' Count	Other State-Owned Hospitals—Total DSH Payments	Local Public Hospitals' Count	Local Public Hospitals—Total DSH Payments	Private Hospitals' Count	Private Hospitals—Total DSH Payments
Kansas	3	$102,643,420	N/A[7]	N/A	37	$96,713,094	22	$67,765,902
Louisiana[8]	4	391,418,769	11	2,837,872,179	44	311,896,253	63	89,172,049
Missouri	8	1,086,124,874	3	85,155,602	35	163,267,232	93	1,599,667,735
New Jersey	6	1,716,155,044	N/A	N/A	9	1,356,918,783	93	2,891,287,410
New York	26	2,941,905,067	5	1,068,106,947	22	6,544,813,763	189	3,837,590,718
North Carolina	4	698,337,343	1	184,704,754	42	1,116,412,509	63	75,401,241
Texas	10	1,392,998,960	4	1,159,692,737	85	3,014,652,655	115	1,650,356,001
Totals	**61**	**$8,329,583,477**	**24**	**$5,335,532,219**	**274**	**$12,604,674,289**	**638**	**$10,211,241,056**

[5] In Tables 1 and 2, the DSH payments and uncompensated care costs include both Federal and State share. Some of the selected State agencies report DSH payments on a State FY basis, but the State DSH allotments are on a Federal FY basis (and, moreover, include only the Federal share). Therefore, a comparison between the DSH payment and the DSH allotment would not be accurate.

[6] In Tables 1 and 2, the information for the Louisiana, New Jersey, and New York State agencies is based on FY DSH payments rather than on State FY DSH payments.

[7] "N/A" (not applicable) signifies that that State agency did not receive DSH payments for that particular category of hospital.

[8] The Louisiana State agency was unable to provide the 2007 uncompensated care costs. Therefore, the information provided for Louisiana in Tables 1 and 2 includes only FYs 2003 through 2006 data.

Table 2: Disproportionate Share Hospital Payments as a Percentage of the Disproportionate Share Hospital Limit by Hospital Category for State Fiscal Years 2003 Through 2007

State	State-Owned IMDs' UCC[9]	State-Owned IMDs—Total DSH Payments As Percent of UCC	Other State-Owned Hospitals' UCC	Other State-Owned Hospitals—Total DSH Payments As Percent of UCC[10]	Local Public Hospitals' UCC	Local Public Hospitals—Total DSH Payments As Percent of UCC	Private Hospitals' UCC	Private Hospitals—Total DSH Payments As Percent of UCC
Kansas	$220,972,700	46%	N/A	N/A	$155,656,258	62%	$78,127,395	87%
Louisiana	452,966,342	86%	$3,012,350,572	94%	383,512,941	81%	444,500,998	20%
Missouri	1,086,124,874	100%	101,050,960	84%	183,409,693	89%	1,814,224,549	88%
New Jersey	1,836,317,167	93%	N/A	N/A	1,744,783,963	78%	7,332,210,477	39%
New York	3,023,366,500	97%	1,421,581,596	75%	8,672,692,878	75%	12,497,567,436	31%
North Carolina	946,846,317	74%	153,978,924	120%	1,375,713,124	81%	1,376,345,617	5%
Texas	1,449,833,687	96%	921,804,888	126%	5,783,740,245	52%	3,548,767,698	47%
Totals	**$9,016,427,587**	**92%**	**$5,610,766,940**	**95%**	**$18,299,509,102**	**69%**	**$27,091,744,170**	**38%**

Tables 1 and 2 show the results of the flexibility that section 1923(c) of the Act affords to State agencies for DSH payments. For example:

- The North Carolina State agency paid its 4 State-owned IMDs $698 million in DSH payments (74 percent of the DSH limit for all State-owned IMDs in North Carolina), while over the same time period it paid 63 private hospitals in North Carolina $75 million (5 percent of the DSH limit for all private hospitals in North Carolina). Thus, State-owned IMDs had approximately $249 million in uncompensated care costs not reimbursed by DSH payments, while private hospitals in North Carolina had approximately $1.3 billion in uncompensated care costs not reimbursed by DSH payments.

- The Louisiana State agency paid its 11 other State-owned hospitals $2.8 billion in DSH payments (94 percent of the DSH limit for all other State-owned hospitals in Louisiana), while during the same time period it paid 63 private hospitals in Louisiana $89 million (20 percent of the DSH limit for all private hospitals in Louisiana). Thus, other State-owned hospitals had approximately $174 million in uncompensated care costs not reimbursed by DSH payments, while private hospitals in Louisiana had approximately $355 million in uncompensated care costs not reimbursed by DSH payments.

[9] Uncompensated care costs.

[10] The BIPA of 2000 increased the DSH payment limit for all qualifying public hospitals to 175 percent of a hospital's uncompensated care costs for 2 years beginning in State FY 2003.

CONCLUSION

Despite the restrictions set by legislation, States retain considerable flexibility in apportioning DSH payments between hospital categories. This has resulted in wide variations in the distribution of DSH payments from State to State. As a result, the proportion of uncompensated care costs covered by DSH payments varies widely between State-owned IMDs, other State-owned hospitals, local public hospitals, and private hospitals. Generally, among the States we reviewed, a greater proportion of uncompensated care costs are covered by DSH payments to State-owned IMDs and other State-owned hospitals than are covered by DSH payments to local public hospitals and private hospitals.

RECOMMENDATION

We recommend that CMS evaluate how DSH payments are distributed among hospital categories and consider requesting congressional legislation to assure a more even distribution of payments based on uncompensated care costs.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS concurred with our recommendation but noted that recent congressional action may affect DSH payments. CMS stated that it would reevaluate the need to request additional legislative authority to assure a more even distribution of payments based on uncompensated care costs. CMS's comments are included in their entirety as the Appendix.

OTHER MATTER

With respect to Medicaid inpatient utilization, during FYs 2003 through 2007, the seven selected State agencies made DSH payments to State-owned IMDs, which generally served a lower proportion of Medicaid-eligible patients (as measured by the facilities' MIURs) than other State-owned hospitals, local public hospitals, and private hospitals. Out of the seven State agencies reviewed, we found that three of the seven State agencies served a larger percentage of Medicaid-eligible patients in other State-owned hospitals than they served in any of the other three hospital categories, three of the seven State agencies served a larger percentage of Medicaid-eligible patients in local public hospitals than they served in any of the other three hospital categories, and one of the seven State agencies served a larger percentage of Medicaid-eligible patients in private hospitals than they served in any of the other three hospital categories.

For all seven selected State agencies, the State-owned IMDs had the lowest MIURs of the four hospital categories. The overall average MIUR for the seven selected State agencies was 11 percent for the State-owned IMDs; by contrast, the overall average MIURs for the other State-owned hospitals, local public hospitals, and private hospitals were 29, 34, and 24 percent, respectively.

IMDs generally care for a lower proportion of Medicaid patients, and thus have lower MIURs, because section 1905 of the Act prohibits Medicaid reimbursement for the cost of inpatient

services when they are provided to persons aged 22 through 64 who are patients of IMDs.[11] Even though most patients at IMDs are not eligible for Medicaid, many IMDs qualify for DSH payments because the Act allows a State agency to designate a hospital as DSH if the hospital's MIUR is not less than 1 percent. IMD patients aged 22 through 64 cannot be included in the "total Medicaid days" portion of the MIUR calculation. However, for those IMD patients aged 22 through 64 who are uninsured, the costs can be and are included in the uncompensated care calculation, which increases the hospital-specific DSH limit and thus increases the allowable DSH payment.

Congress imposed DSH payment limits on IMDs as part of the BBA of 1997. Six of the seven States we reviewed complied with these IMD limits.[12] Despite this compliance, the seven selected State agencies made DSH payments that, as a proportion of uncompensated care costs, were generally higher to State-owned IMDs than were the DSH payments to other hospital categories, even though the State-owned IMDs generally had the lowest MIURs of any of the four hospital categories. Because DSH payments are meant to cover the uncompensated care costs of both Medicaid and uninsured patients, the seven selected State agencies were able to obtain Federal matching funds through DSH payments that indirectly covered costs of services provided to patients in IMDs—costs for which Medicaid cannot pay directly.

Table 3 shows the average MIURs, by hospital category, for the seven selected State agencies.

Table 3: Average Medicaid Inpatient Utilization Rates for Fiscal Years 2003 Through 2007

	State-Owned IMD	Other State-Owned Hospitals	Local Public Hospitals	Private Hospitals
Kansas	16%	N/A	25%	26%
Louisiana	9%	36%	18%	27%
Missouri	5%	29%	11%	18%
New Jersey	8%	N/A	28%	15%
New York	14%	27%	57%	29%
North Carolina	5%	30%	21%	18%
Texas	12%	22%	34%	26%
Average[13]	11%	29%	34%	24%

[11] In some circumstances, the exclusion also applies to individuals who are aged 21.

[12] We are reviewing the seventh State agency in a separate audit to determine whether that State complied with the IMD limits.

[13] We calculated the overall average MIUR using the total Medicaid days divided by the total bed days, by hospital category. Therefore, the overall average for each hospital category cannot be correctly calculated by totaling the average MIUR for each State agency and dividing by seven.

APPENDIX

APPENDIX: CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: APR 30 2010

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner
Acting Administrator and Chief Operating Officer

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Medicaid Disproportionate Share Hospital (DSH) Payment Distribution" (A-07-09-04150)

Thank you for the opportunity to review and comment on the subject draft report. This report was initiated by the OIG to determine the proportion of uncompensated care costs incurred by State-owned Institutions for Mental Diseases (IMD), other State-owned hospitals, local public hospitals, and private hospitals that were reimbursed by seven selected State agencies' Disproportionate Share Hospital (DSH) payments. The report found that uncompensated care costs were reimbursed, in the aggregate, at 92 percent in State-owned IMDs, 95 percent in other State-owned hospitals, 69 percent in local public hospitals, and 38 percent in private hospitals.

The draft report recommends that the Centers for Medicare & Medicaid Services (CMS) evaluate how DSH payments are distributed among hospital categories and consider requesting Congressional legislation to assure a more even distribution of payments based on uncompensated care costs.

The CMS concurs with the recommendation, but notes that recent Congressional action may affect this issue. Congress recently enacted legislation affecting DSH payments that relates to the above recommendation. Section 2551 of the Patient Protection and Affordable Care Act, as modified by Section 1203 of the Health Care and Education Reconciliation Act of 2010, provides for a reduction in DSH payments starting in 2014 and directs the Secretary to develop a methodology that imposes the largest DSH payment reductions on States that do not target DSH payments toward hospitals with the highest volume of Medicaid and uncompensated care.

Such a methodology may adversely affect States that have payment methodologies that reimburse a larger percentage of uncompensated care costs for private hospitals. These private hospitals may have a lower overall volume of Medicaid and uncompensated care than State hospitals and State institutions for mental diseases. Such a methodology would probably not affect States that reimburse a larger percentage of uncompensated care costs for State-owned IMDs, other State-owned hospitals, or local private hospitals. These facilities tend to have higher levels of uncompensated care and, with the exception of IMDs, higher levels of Medicaid utilization than private hospitals. Further, after the implementation of this new methodology,

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CMS will reevaluate the need to request additional legislative authority to assure a more even distribution of payments based on uncompensated care costs.

We appreciate the efforts that went into this report and look forward to working with the OIG on this and other issues.