

**Memorandum**

Date DEC 27 2001
From Janet Rehnquist *Janet Rehnquist*
Inspector General
Subject Reviews Indicate That an Increase in Medicaid Disproportionate Share Hospital Payments to 175 Percent of Uncompensated Care Cost May Not Be Warranted (A-06-01-00069)
To Thomas Scully
Administrator
Centers for Medicare & Medicaid Services

Attached are two copies of our final audit report entitled, "Reviews Indicate That an Increase in Medicaid Disproportionate Share Hospital Payments to 175 Percent of Uncompensated Care Cost May Not Be Warranted." Our reviews of uncompensated care costs (UCC) at selected States and other related reviews indicate that legislation to increase disproportionate share hospital (DSH) reimbursement from 100 percent to 175 percent of UCC may not be warranted or should at least be studied further before being implemented. The objective of our review was to determine whether the results from our reviews of UCC claimed by hospitals at selected States and our review of enhanced payments and intergovernmental transfers (IGT) in three States would support the need for increased DSH reimbursements.

Based on current audit results in Alabama, North Carolina, Illinois, and Louisiana, we believe that DSH payments presently are not always being retained and used by the public hospitals and the DSH funds received are not always calculated correctly. We, therefore, are concerned that raising the limit to 175 percent may only result in more DSH funds not actually going to public hospitals, not retained by public hospitals, or in DSH payments being made that are not correct.

We are conducting additional audits of DSH costs in other States to determine if unallowable costs are being claimed on a nationwide basis. In addition, our audit of the DSH programs in other States will include reviews of public hospitals' use of IGTs to transfer DSH payments back to the State Medicaid agencies. Our preliminary work, however, shows that States are reimbursing hospitals in excess of the DSH limits. We will report the results of these reviews to the Centers for Medicare & Medicaid Services (CMS) as we complete our work.

Therefore, based on our audit results and the preliminary issues being developed in our ongoing nationwide review, we recommended that CMS seek legislation to at least delay, if not repeal, the implementation of the increase in the DSH limit from 100 to 175 percent of UCC until the need for and use of DSH funds for actual direct care of uninsured patients can be sufficiently reviewed. If the DSH limit is increased to 175 percent, we would encourage CMS to consider seeking legislative reform to ensure that DSH funds remain at the hospitals

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to provide care to vulnerable populations, rather than being returned to the States through IGTs. We believe that any Medicaid payment returned by a provider to the State should be treated as a credit applicable to the Medicaid program. We also recommended that CMS perform any other studies or reviews of the DSH program, which it deems appropriate, to evaluate the reasonableness of DSH reimbursement. We would be pleased to assist CMS in any such efforts.

In response to our draft report, CMS agreed with our recommendations and will take our recommendations regarding the DSH legislation into consideration. The CMS also intends to develop regulations that will outline the accountability standards that States must address when making DSH expenditures. The CMS also stated that they looked forward to our assistance with these regulations.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you should have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-06-01-00069 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEWS INDICATE THAT AN
INCREASE IN MEDICAID
DISPROPORTIONATE SHARE
HOSPITAL PAYMENTS TO 175 PERCENT
OF UNCOMPENSATED CARE COST
MAY NOT BE WARRANTED**



**JANET REHNQUIST
Inspector General**

**DECEMBER 2001
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Subject Reviews Indicate That an Increase in Medicaid Disproportionate Share Hospital Payments to 175 Percent of Uncompensated Care Cost May Not Be Warranted (A-06-01-00069)
To Thomas Scully
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Centers for Medicare & Medicaid Services

This final audit report presents how the results of our reviews of uncompensated care costs (UCC) at selected States and other related reviews indicate that legislation to increase disproportionate share hospital (DSH) reimbursement from 100 percent to 175 percent of UCC may not be warranted or should be at least studied further before being implemented. This legislation was enacted--along with changes to the Medicaid upper payment limit (UPL) regulations--to account for special circumstances facing public hospitals. The objective of our review was to determine whether the results from our reviews of UCC claimed by hospitals at selected States and our review of enhanced payments and intergovernmental transfers (IGT) in three States would support the need for increased DSH reimbursements.

The Medicare, Medicaid, and State Child Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA 2000) was enacted during December 2000. Section 701(c) of BIPA 2000 modified the DSH payment limit applicable to public hospitals. Currently, hospitals in all States except California may receive DSH payments up to 100 percent of UCC (public hospitals in California may receive DSH payments up to 175 percent of UCC).

The BIPA 2000 required that public hospitals in all States beginning on the first day of the State fiscal year (FY) that begins after September 30, 2002 will have a new 175 percent limit for DSH, and the higher limit would continue for a span of 2 years. The Centers for Medicare & Medicaid Services (CMS) estimates that raising the DSH limit will increase Federal spending by a total of \$380 million during Federal FYs 2003 through 2005. The intent of this legislation was to increase the DSH cap so that public hospitals could address anticipated funding shortfalls resulting from action taken by CMS to close the loophole in the Medicaid UPL regulations that allowed States to make enhanced payments to public hospitals. We agree that public safety net hospitals face special circumstances and play a critical role in providing care to vulnerable populations. However, based on current audit results, we believe that DSH payments presently are not always being retained and used by the public hospitals and the DSH funds received are not always correctly calculated. We,

therefore, are concerned that raising the limit to 175 percent may only result in more DSH funds either not actually going to public hospitals, not retained by public hospitals, or in DSH payments being made that are not correct.

Our work has shown that the States' use of the Medicaid UPL has impacted the need and retention of DSH funds by these same types of public safety net providers. During our audits of enhanced payments to public providers in Alabama, North Carolina, and Illinois, we found that public hospitals in two States (Alabama and North Carolina) had been using IGTs to return 86 percent to 90 percent of the DSH payments to the State Medicaid agencies. Once returned, the States used the funds for any purpose deemed appropriate. By increasing the DSH cap to 175 percent of UCC, these States would be able to obtain increased Federal Medicaid funds by requiring public hospitals to return an even larger amount of the DSH payments through an IGT. We believe that the return of these funds contradicts the stated purpose of assisting these types of hospitals. In Illinois, we found that public hospital providers in Cook County did not receive DSH payments. Rather, enhanced payments were meeting the total funding needs for the county hospitals so DSH funds were not allocated to the county but redistributed to other hospitals within the State.

In addition to our DSH related work in the 3 States noted above, basically involving how DSH was used as part of State financial mechanisms, we conducted 2 separate reviews of the DSH payments made by the State of Louisiana to 10 hospitals affiliated with the Louisiana State University Medical Center (LSUMC). One of the 10 hospitals maintained its own accounting records and prepared its own Medicare and Medicaid cost reports and UCC schedules and was, therefore, reviewed separately. The Health Care Services Division (HCSD) of the LSUMC oversaw the other nine hospitals.

In our review of the single hospital, we found that: (1) DSH payments for State FY 1998 exceeded the total claimed UCC for that hospital by approximately \$5.1 million and (2) UCC reported by the same hospital was understated by about \$0.7 million. During the course of our second audit, we found that: (1) DSH payments for State FY 1998 exceeded total UCC reported by the nine hospitals overseen by HCSD by about \$10 million and (2) UCC reported by two of those nine hospitals were overstated by about \$12 million for the same time period. In addition, we set aside about \$4 million in overhead costs at one of these two facilities because we were unable to determine the reasonableness of the methodology used to calculate these costs.

We believe that the type of audit results shown in Alabama, North Carolina, Illinois, and Louisiana raise concerns regarding the basis and process currently used to make DSH payments. We are conducting additional audits of DSH costs similar to our Louisiana work in other States to determine if unallowable costs are being claimed on a nationwide basis. In addition, our audit of the DSH programs in other States will include reviews of public hospitals' use of IGTs to transfer DSH payments back to the State Medicaid agencies. Our preliminary work, however, shows that States are reimbursing hospitals in excess of the

DSH limits similar to the audit results we had in Louisiana. We will report the results of these reviews to CMS as we complete our work.

However, based on our audit results and our preliminary issues being developed in our ongoing nationwide review, we believe that the legislation that increases the DSH limit should be reviewed further. The CMS needs more information to evaluate whether UCC currently being claimed by hospitals is fully supported and meets the DSH program requirements. Our ongoing reviews, when completed, should assist CMS in evaluating whether an increase in DSH reimbursements is warranted. We also believe that until States discontinue their financing mechanisms which are aimed more at maximizing Federal revenues rather than ensuring public hospitals receive all the funds they are entitled to, it will be difficult to fully assess DSH payments. However, it does appear, based on information obtained to date, that public hospitals should be receiving adequate reimbursement to provide services to Medicaid beneficiaries and uninsured patients if the hospitals (1) retained 100 percent of the State and Federal share of the enhanced Medicaid payments up to the aggregate limit and (2) received and retained 100 percent of the State and Federal share of the allowable DSH payments. While further study is needed, we believe this combination of Medicaid payments (both enhanced and DSH payments) at the 100 percent levels should be sufficient reimbursement for public hospitals. Therefore, we recommended that CMS seek legislation to at least delay, if not repeal, the implementation of the increase in the DSH limit from 100 to 175 percent of UCC until the need for and use of DSH funds for actual direct care of uninsured patients can be sufficiently reviewed. If the DSH limit is increased to 175 percent, we would encourage CMS to consider seeking legislative reform to ensure that DSH funds remain at the hospitals to provide care to vulnerable populations, rather than being returned to the States through IGTs. We believe that any Medicaid payment returned by a provider to the State should be treated as a credit applicable to the Medicaid program. We also recommended that CMS perform any other studies or reviews of the DSH program which it deems appropriate to evaluate the reasonableness of DSH reimbursement. We would be pleased to assist CMS in any such efforts.

In a memorandum dated October 25, 2001, CMS responded to our draft report. The CMS agreed with our recommendations and will take the recommendations regarding the DSH legislation into consideration. The CMS also intends to develop regulations that will outline the accountability standards that States must address when making DSH expenditures. The CMS also stated that they looked forward to our assistance with these regulations. The full text of CMS's comments is included as an **APPENDIX** to this report.

INTRODUCTION

Background

The DSH program originated with the Omnibus Budget Reconciliation Act (OBRA) of 1981, which required State Medicaid agencies to make additional payments to hospitals serving a disproportionately large number of low-income patients. States had considerable flexibility to define DSH hospitals under sections 1923(a) and (b) of the Social Security Act (the Act).

Subsequent legislation established DSH parameters. Section 13621 of OBRA 1993 amended section 1923 of the Act to limit DSH payments. For State FYs beginning between July 1, 1994 and January 1, 1995, payments to public hospitals were limited to 100 percent of UCC with a special provision that allowed payments of up to 200 percent of UCC to those public hospitals qualifying as high DSH hospitals. For State FYs beginning after January 1, 1995, payments to all hospitals were limited to 100 percent of UCC except public hospitals in California, which could receive up to 175 percent of UCC.

The BIPA 2000 allowed for an increase in the amount of DSH payments that public hospitals might receive for the cost of uncompensated care furnished to low-income individuals. The bill raised the current limit of 100 percent of UCC to 175 percent for public hospitals entitled to DSH payments, beginning on the first day of the first State FY that begins after September 30, 2002, and ends on the last day of the succeeding State FY. The President signed the bill on December 22, 2000. The CMS estimates that raising the DSH limit will increase Federal spending by a total of \$380 million during Federal FYs 2003 through 2005. The BIPA 2000 also contained a provision that requires CMS to implement accountability standards to ensure that DSH payments are used to reimburse States and hospitals that are eligible for such payments and are otherwise made in accordance with Medicaid statutory requirements.

Objective, Scope, and Methodology

The objective of our review was to determine whether the results from our reviews of UCC claimed by hospitals at selected States and our review of enhanced payments and IGTs in three States would support the need for increased DSH reimbursements. We accomplished our objective by reviewing pertinent legislation and other documentation regarding the DSH program, audit reports from our enhanced payment reviews, and our work on hospital-specific DSH costs. These reviews were conducted in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The BIPA 2000 provides for the DSH cap to be raised from 100 percent of UCC to 175 percent for public hospitals in all States beginning on the first day of the State FY that begins after September 30, 2002, and ends on the last day of the succeeding State FY. Currently, public hospitals in California may receive DSH payments up to 175 percent of UCC. While the 175 percent limit for California would continue for an indefinite time period, the increase for all other States would be for 2 years. The CMS estimates that raising the DSH limit will increase Federal spending by a total of \$380 million during Federal FYs 2003 through 2005. The change made to increase the DSH cap was, in part, an attempt to address anticipated funding shortfalls resulting from CMS's action to close the loophole in the Medicaid UPL regulations that allowed States to make excessive enhanced payments to public providers. We agree that public safety net hospitals face special circumstances and play a critical role in providing care to vulnerable populations. However, based on current audit results, we believe that DSH payments presently are not always being retained and used by the public hospitals and the DSH funds received are not always correctly calculated. We, therefore, are concerned that raising the limit to 175 percent may only result in more DSH funds either not actually going to public hospitals, not retained by public hospitals, or in DSH payments being made that are not correct.

The States' use of the Medicaid UPL also impacted the need and retention of DSH funds by these same types of public safety net providers. In preparing for the increase in the DSH cap, we believe that CMS needs to consider the issues that have been identified during our reviews of enhanced Medicaid payments and IGTs, as well as issues raised during our audit of hospital-specific DSH costs in Louisiana.

Disproportionate Share Hospital Payments at the State or County Level

During the course of our audit work involving Medicaid enhanced payments and IGTs in Alabama, North Carolina, and Illinois, we found that public hospitals were returning a significant portion of the DSH payments to the State Medicaid agency:

Alabama: We found that the State appeared to be using enhanced payments to replace a portion of the DSH payments hospitals received, thus leaving more disposable funds at the State level. State officials acknowledged that in FY 1994, the year prior to the first full year of enhanced payments, facilities returned 68 percent of the DSH payments to the State through IGTs. With the implementation of Medicaid enhanced payments, this increased to 86 percent by FY 1996. The facilities retained less of their DSH payments. During our audit period of October 1, 1996 through July 31, 2000, Alabama hospital providers received an average of \$389 million per year in DSH payments. During this period, we estimated that the providers returned about \$335 million of these annual payments to the State.

North Carolina: We found that the State developed a mechanism to receive additional Federal Medicaid funds without committing its share of required matching funds. This was done by using previous DSH payments, 90 percent (\$145 million in FY 1999) of which was returned to the State from public hospitals, as the source of the State match for supplemental payments, thus effectively reducing the State's share. The State initially received about 63 percent in Federal matching dollars when it made DSH payments to public hospitals and reported them as program expenses, even though 90 percent of these payments were returned to the State and transferred into a trust fund. Then, when supplemental payments and additional DSH payments were made, the State used transfers from this trust fund as the State match to draw down additional Federal funds. This had the effect of matching Federal funds with Federal funds thereby increasing the overall Federal share.

Illinois: We found that because the needs of public hospitals in Cook County were being met through Medicaid enhanced payments, the State Medicaid agency did not allocate DSH funds to Cook County hospitals. Instead, the DSH funds were distributed to other hospitals within the State. For Federal FY 1999, the total DSH allotment for Illinois was \$199 million.

Audit of Louisiana Hospital-Specific DSH Payments

In a fourth State, Louisiana, we conducted 2 separate reviews of the DSH payments made by the State of Louisiana to 10 hospitals affiliated with LSUMC. One of the 10 hospitals maintains its own accounting records and prepared its own Medicare and Medicaid cost reports and UCC schedules and was, therefore, reviewed separately. The HCSD of LSUMC oversaw the other nine hospitals. The State of Louisiana agreed with the findings detailed below.

In our review of the single hospital, we found that: (1) DSH payments for State FY 1998 exceeded the total claimed UCC for that hospital by approximately \$5.1 million and (2) UCC reported by the same hospital was understated by about \$0.7 million. The understated UCC included errors such as understated private insurance cost reduction adjustment, understated physician supplemental salary cost reduction adjustment, understated non-physician anesthetist cost reduction adjustment, overstated Medicare cost reduction adjustment, and overstated provider-based physician cost reduction adjustment.

During the course of our second audit, we found that: (1) DSH payments for State FY 1998 exceeded total UCC reported by the nine hospitals overseen by HCSD by about \$10 million and (2) UCC reported by two of those nine hospitals was overstated by about \$12 million for the same time period. The overstated UCC included errors such as overstated bond interest, understated commercial insurance cost reduction adjustments, understated private payer cost reduction adjustments, and unsupported costs. In addition, we set aside about \$4 million in overhead costs at one of these two facilities because we were unable to determine the reasonableness of the methodology used to calculate these costs.

We were unable to determine if DSH payments were returned to the State by these hospitals. We were told by a State official that if a given hospital's total revenue exceeded the State appropriations for that hospital, the excess would be returned. However, it was not identified as being from a specific revenue source such as DSH payments. We are also conducting audits of the DSH programs in other States including reviews over public hospitals' use of IGTs to transfer DSH payments back to the State Medicaid agencies and will report the results of these reviews as we complete our work.

Ongoing Nationwide Review

At CMS's request, we initiated a nationwide review of hospital-specific DSH payments. The objectives of this audit are to (1) review the States' DSH programs and verify DSH payments made during our audit period were calculated and distributed in accordance with the approved State plan and (2) verify that payments made to the individual hospitals within the State did not exceed the hospital-specific limit as mandated by OBRA 1993. The States included in this nationwide review are Virginia, North Carolina, Alabama, Ohio, Illinois, Texas, Missouri, California, and Washington.

Several major issues have surfaced to date. Preliminary audit results show there is a general lack of consistency, among the States, with regard to information included in the approved State plans. For example, we found that some State plans are very detailed in the information provided regarding the State's Medicaid DSH program and the calculation of the hospital-specific DSH limit, while others provide very little information on the same issue.

Our preliminary audit work also indicates inconsistencies among the States as to what costs can be included in the calculation of UCC. For example, we found that several States included the cost of providing medical services to prisoners in their calculation of UCC where other States did not. We understand it is current CMS policy to not allow the inclusion of the cost of medical services provided to prisoners in a State's calculation of UCC. However, our preliminary audit work has shown at least one State with an approved State Plan Amendment that allows for the inclusion of the cost of providing care to prisoners in the State's calculation of its UCC. We are also concerned about the practice of including the cost of providing care to residents of an institution for mental diseases (IMD), particularly those residents between the ages of 21 and 64, in the calculation of UCC. While we realize that it is CMS's current policy to allow the inclusion of residents of IMDs in a State's calculation of UCC, we believe this population should not be included for DSH payment purposes. We are also concerned that some of the States under review may not be abiding by the IMD limitation in section 1923(h) of the Act.

Another issue that affects most States in our review is the lack of reconciliation of DSH payments back to actual costs of providing medical care to the indigent. We found that some hospital-specific limits are based on data between 1 and 4 years old that was trended forward with no reconciliation by the States to actual costs to determine if these trended amounts remain accurate. Our preliminary results show that in at least one State, DSH payments are being made to ineligible hospitals and also payments were exceeding the hospital specific limits by significant dollar amounts.

We are planning to issue individual reports to the States and will provide those reports to CMS as the reviews are completed. At the completion of all the individual State audits, we will issue a summary report to CMS that will consolidate the results of our DSH reviews and include recommendations to address the problems identified.

CONCLUSIONS AND RECOMMENDATIONS

Based on our recently completed audit work, we found that while the public hospital providers served a large number of Medicaid beneficiaries and uninsured patients, the hospitals either (1) did not receive Medicaid DSH payments from the State or (2) returned the majority of the Medicaid DSH payments to the State through IGTs. It appears, for these providers, that States have used enhanced payments generated through the Medicaid UPL provisions in place of DSH payments even though Medicaid DSH payments were designed to help hospitals that provide care to a large number of Medicaid beneficiaries and uninsured patients. In other audits, we found that excess DSH payments and unallowable costs were being claimed by public hospitals.

Based on these results and our preliminary findings being developed in our ongoing nationwide review, we believe that the legislation that increases the DSH limit should be delayed, if not repealed. The CMS needs more information to evaluate whether UCC currently being claimed by hospitals is fully supported and meets the DSH program requirements. Our ongoing reviews, when completed, should assist CMS in evaluating whether an increase in DSH reimbursements is warranted. Based on information obtained to date, it appears that public hospitals should receive adequate reimbursement to provide services to Medicaid beneficiaries and uninsured patients if the hospitals (1) retained 100 percent of the State and Federal shares of the enhanced Medicaid payments up to the aggregate limit and (2) received and retained 100 percent of the State and Federal shares of the allowable DSH payments. While further study is needed, we believe this combination of Medicaid payments (both enhanced and DSH payments) at the 100 percent levels should be sufficient reimbursement for public hospitals. Therefore, we recommended that CMS seek legislation to at least delay, if not repeal, the implementation of the increase in the DSH limit from 100 to 175 percent of UCC until the need for and use of DSH funds for actual direct care of uninsured patients can be sufficiently reviewed. If the DSH limit is increased to 175 percent, as part of CMS's implementation of the DSH payment accountability standards required through BIPA 2000, CMS should consider seeking legislative reform to

ensure that DSH funds remain at the hospitals to provide care to vulnerable populations, rather than being returned to the States through IGTs. We believe that any Medicaid payment returned by a provider to the State should be treated as a credit applicable to the Medicaid program. We also recommended that CMS perform any other studies or reviews of the DSH program which it deems appropriate to evaluate the reasonableness of DSH reimbursement. We would be pleased to assist CMS in any such efforts.

CMS's Comments

The CMS Administrator responded to our draft report in a memorandum dated October 25, 2001. The CMS agreed with our recommendations and will take the recommendations regarding the DSH legislation into consideration. The CMS also intends to develop regulations that will outline the accountability standards that States must address when making DSH expenditures. The CMS also stated that they looked forward to our assistance with these regulations. The full text of CMS's comments is included as an **APPENDIX** to this report.



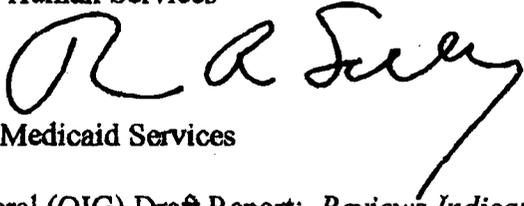
DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Service

Administrator
Washington, DC 20201

DATE: OCT 25 2001

TO: Janet Rehnquist
Inspector General
Department of Health & Human Services

FROM: Thomas A. Scully 
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: *Reviews Indicate That an Increase in Medicaid Disproportionate Share Hospital Payments to 175 Percent of Uncompensated Care Cost May Not Be Warranted*, (A-06-01-00069)

Thank you for the opportunity to comment on the OIG draft report regarding Medicaid disproportionate share hospital (DSH) payments. The information you have provided in the related draft report is very useful to us as we develop new Medicaid payment policies. We look forward to receiving the final reports regarding the results of your ongoing reviews.

The OIG recommended that the Centers for Medicare & Medicaid Services (CMS) should seek legislation that will at least delay, if not repeal, the implementation of the increase in the DSH limits for public hospitals from 100 to 175 percent of the uncompensated care cost limits. This will allow for sufficient review of the need for—and use of—the DSH funds for actual direct care of uninsured patients. If the DSH limit is increased to 175 percent, as part of CMS's implementation of the DSH payment accountability standards required through the Benefits Improvement and Protection Act of 2000 (BIPA), CMS should consider seeking legislative reform to ensure that DSH funds remain at the hospitals to provide care to vulnerable populations rather than being returned to the states through intergovernmental transfers. The OIG believes that any Medicaid payment returned by a provider to the state should be treated as a credit applicable to the Medicaid program. The OIG also recommends that CMS perform any other studies or reviews of the DSH program, which it deems appropriate, to evaluate the reasonableness of DSH reimbursement.

The CMS agrees with the OIG's recommendations. We will take your recommendations regarding the DSH legislation into consideration. The CMS also intends to develop regulations that will outline the accountability standards that states must address when making DSH expenditures. We look forward to your assistance with these regulations.