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Report to the Ranking Member, Committee on Finance, U.S. Senate

November 2009

MEDICAID

Ongoing Federal Oversight of Payments to Offset Uncompensated Hospital Care Costs Is Warranted

GAO-10-69

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Highlights

Highlights of GAO-10-69, a report to the Ranking Member, Committee on Finance, U.S. Senate

Why GAO Did This Study

In addition to standard Medicaid payments, hospitals receive supplemental payments for uncompensated costs of care provided to uninsured and Medicaid patients. These supplemental payments are referred to as disproportionate share hospital (DSH) payments. Hospitals may also receive non-DSH supplemental payments. In fiscal year 2006, DSH payments totaled about $17 billion and non-DSH supplemental payments exceeded $6 billion. Hospitals' DSH payments are limited to their uncompensated care costs, that is, their costs for covered care less Medicaid and other payments. Concerns have been raised about the accuracy of DSH payment limits, particularly as states may estimate limits using data that are not audited or up to date. GAO was asked to examine (1) how state DSH payments in 2006 compared to DSH payment limits, and (2) certain aspects of states' calculations of 2006 DSH payment limits. In selected states, GAO analyzed state Medicaid payment data and interviewed officials from the states and from the Centers for Medicare & Medicaid Services (CMS), the federal agency that oversees Medicaid.

What GAO Recommends

GAO recommends that CMS ensure that states account for all Medicaid payments, including non-DSH supplemental payments, when calculating DSH payment limits. CMS agreed with GAO's recommendation.

View GAO-10-69 or key components.
For more information, contact Katherine Iritani at (202) 512-7114 or iritanik@gao.gov.

What GAO Found

In four states selected on the basis of their large supplemental payments, state-reported DSH payments varied widely as a percentage of the hospital-specific DSH payment limits that the states calculated. DSH payments to 682 hospitals in California, Michigan, New York, and Texas ranged from less than 1 percent to more than 169 percent of DSH payment limits. GAO identified a small number of hospitals in three states—California, New York, and Texas—that received DSH payments in excess of their hospital-specific DSH payment limits, and officials from these states reported that they had taken or plan to take actions to correct the excess payments. The four states paid government-operated hospitals a relatively high proportion of their estimated DSH payment limits, with state-operated psychiatric hospitals called institutions for mental diseases receiving the largest relative payments in three states.

In examining the four states' calculations of 2006 DSH payment limits, GAO found that two of the four states' hospital-specific DSH limits for 2006 were not calculated appropriately; that is, the states did not take into account all Medicaid payments the hospitals received. Specifically, when estimating hospital uncompensated care costs for the purpose of calculating their 2006 DSH payment limits, for 91 hospitals in California and 88 hospitals in Texas the states did not, as required, take into account the non-DSH supplemental Medicaid payments the hospitals had received. In addition, in light of a series of reports from the Department of Health and Human Services' Office of Inspector General that found that a number of states had used data that did not accurately represent hospitals' costs, GAO examined whether the four states used updated data for calculating DSH payment limits, and had their state-calculated DSH payment limits or the data used to calculate them independently audited. GAO found that none of the four states (1) consistently updated 2006 hospital DSH payment limits and (2) subjected hospital DSH payment limits to an independent audit. However, California, Michigan, and New York had processes to update their DSH payment limits to reflect actual costs and used data from sources subject to an audit for some hospitals. Under a final rule that CMS issued in December 2008, during the course of GAO's review, all states will be required to use actual cost data for hospital-specific DSH payment limits and have their DSH payment limits independently audited. Although the 2008 final rule set a December 2009 deadline for states to report to CMS the results of their independent audits of 2005 and 2006 DSH payments, there will be a transition period before the agency will take any action on such reports. California's experience indicates that implementing the requirements of CMS's 2008 final rule could have a substantial effect on hospital-specific DSH payment limits in the future. In 2006, the state reduced DSH payment limits for 22 hospitals by over 49 percent after applying a methodology based on audited and updated data.

Contents

Tables

Figures

Abbreviations

CMS	Centers for Medicare & Medicaid Services
DSH	disproportionate share hospital
FMAP	federal medical assistance percentage
HHS	U.S. Department of Health & Human Services
IMD	institution for mental diseases
MMA	Medicare Prescription Drug, Improvement, and Modernization Act
OIG	Office of Inspector General
UPL	upper payment limit

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Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

November 20, 2009

The Honorable Charles E. Grassley
Ranking Member
Committee on Finance
United States Senate

Dear Senator Grassley:

Medicaid, a program that finances health care for certain low-income individuals, is a significant source of funding for hospitals, which receive billions of dollars both in standard Medicaid payments related to specific services for Medicaid patients and in Medicaid supplemental payments.[1] The federal government and the states share in the cost of Medicaid, with the federal government matching at least 50 percent of state expenditures for Medicaid services and administration. In 2003, we designated Medicaid as a high-risk program, in part because of state financing arrangements in which states made large, inappropriate supplemental payments to government providers.[2] A large component of Medicaid supplemental payments is disproportionate share hospital (DSH) payments, which are designed to help offset hospitals' uncompensated costs for serving Medicaid and uninsured low-income individuals. Many state Medicaid programs have also established other supplemental payments, which are also funded in part with federal dollars, to supplement standard Medicaid payments and help offset the costs of care provided to individuals covered by Medicaid. For example, over the years many states have used the flexibility under Medicaid's upper payment limit (UPL) to make supplemental payments to hospitals and other providers that were separate from and in addition to standard Medicaid payments and DSH supplemental payments. For purposes of this report, we refer to these other Medicaid supplemental payments as non-DSH supplemental payments. In May 2008, we reported that states made at least $23 billion in Medicaid DSH and non-DSH supplemental payments during fiscal year

[1]Medicaid supplemental payments are payments separate from and in addition to those made at states' standard Medicaid rates.

[2]GAO, *High-Risk Series: An Update*, GAO-09-271 (Washington, D.C.: Jan. 22, 2009).

2006—nearly three-quarters as DSH payments—but that the exact amount was unknown because states did not report all their payments.[3]

Congress has taken certain actions to help ensure the integrity of Medicaid DSH payments. For example, in 1991, Congress limited overall federal expenditures for DSH payments and established DSH allotments for states, which are annual limits on federal matching funds available for payments made by each state to qualifying hospitals.[4] In 1993, Congress created a hospital DSH payment limit capping the amount of DSH payments a state may pay to an individual hospital.[5] As a result, under federal law, a hospital's DSH payments may not exceed a hospital's uncompensated care costs; that is, the costs incurred in furnishing hospital services during the year to Medicaid patients and the uninsured, net of Medicaid payments made to the hospital and of payments made by uninsured patients for those services.[6]

In response to continuing concerns about the integrity of DSH payments, Congress and the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees the Medicaid program, took additional steps in the late 1990s and early to mid-2000s to ensure the appropriateness of states' DSH payments to hospitals.

- In 1997, Congress created a second type of DSH payment limit, which restricted the total amount of DSH payments a state could make to institutions for mental diseases (IMD) or other mental health facilities as a group.[7]

[3]GAO, *Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments*, GAO-08-614 (Washington, D.C.: May 30, 2008). The American Recovery and Reinvestment Act of 2009 increased the amount of federal DSH funding available to individual states for fiscal years 2009 and 2010 by $456 million, according to Congressional Budget Office estimates. Pub. L. No. 111-5, Div. B, § 5002, 123 Stat. 115, 502-3 (2009) (codified at 42 U.S.C. § 1396r-4(f)(3)).

[4]Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Pub. L. No. 102-234, § 3, 105 Stat. 1793, 1799-1803 (1991) (codified, as amended, at 42 U.S.C. § 1396r-4(f)).

[5]Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13621, 107 Stat. 312, 629-632 (1993) (codified, as amended, at 42 U.S.C. § 1396r-4(g)).

[6]42 U.S.C. § 1396r-4(g).

[7]Balanced Budget Act of 1997, Pub. L. No 105-33, § 4721, 111 Stat. 251, 511-514 (1997) (codified, as amended, at 42 U.S.C. § 1396r-4(h)).

- In 2002, CMS clarified in a letter to state Medicaid directors[8] that states must account for non-DSH Medicaid supplemental payments when estimating uncompensated care costs; that is, non-DSH supplemental payments must be considered Medicaid payments for the purpose of estimating uncompensated care costs and calculating the associated hospital DSH payment limits.[9]

- In 2003, Congress mandated improved accountability for DSH payments under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), by providing that the Secretary of HHS require, beginning in federal fiscal year 2004, states to submit annual, independent certified audits of their DSH programs and annually report information on their DSH programs. Required report information includes the hospitals that received DSH payments, the amount of DSH payments they received, and other information the Secretary determines is necessary to ensure the appropriateness of states' DSH payments.[10] In 2005, CMS issued a proposed rule in response to these DSH auditing and reporting requirements.[11] As discussed later in this report, CMS did not finalize this rule until December 2008, during the course of this review.[12]

Concerns about state DSH programs and CMS's oversight and accountability for DSH and non-DSH supplemental payments have continued. In 2006, HHS's Office of Inspector General (OIG) published a summary of findings from prior reviews of 10 states' DSH payments. The

[8]CMS provides guidance to states about Medicaid program requirements in several ways, including through a published *State Medicaid Manual*, standard letters issued to all state Medicaid directors, and technical guidance manuals on particular topics.

[9]See Centers for Medicare & Medicaid Services. Letter to State Medicaid Directors (Aug. 16, 2002).

[10]Pub. L. No. 108-173, § 1001(d), 117 Stat. 2066, 2430-2431 (2003) (codified, as amended, at 42 U.S.C. § 1395r-4(j)). In 1997, Congress had previously required that states provide an annual report to the Secretary of Health and Human Services describing DSH payments made to each hospital. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4721, 11 Stat. 251, 511-514 (1997) (codified, as amended, at 42 U.S.C. § 1396r-4(a)(2)). However, according to CMS officials, reporting on DSH payments was inconsistent among the states.

[11]*Medicaid Program: Disproportionate Share Hospital Payments*, 70 Fed. Reg. 50,262 (Aug. 26, 2005).

[12]*Medicaid Program: Disproportionate Share Hospital Payments*, 73 Fed. Reg. 77,904 (Dec. 19, 2008). Because this rule was not finalized until 2008, we did not consider the related provisions of the MMA or this rule as requirements for the 2006 payments that we reviewed.

HHS OIG found that one state's DSH payment limits and associated DSH payments were not accurate because the state did not account for non-DSH supplemental payments. They also found the states that used historical cost and payment data to estimate hospitals' uncompensated care costs would have significantly lowered their DSH payments and payment limits if they had updated the limits with actual cost data once they became available. In our May 2008 report, we reported additional concerns about CMS's ability to oversee state DSH programs given the lack of information it collected on states' Medicaid supplemental payments. We found that CMS did not require states to report hospital-specific data, such as data on the DSH and non-DSH supplemental payments made to each hospital. Such data are needed to ensure that (1) states account for non-DSH supplemental payments when calculating hospital uncompensated care costs and associated DSH payment limits and (2) DSH payments to individual hospitals do not exceed these limits.[13]

This report responds to your request for information on how states' DSH payments to individual hospitals and categories of hospitals compare to hospital DSH payment limits and on state methods for estimating uncompensated care costs.[14] For selected states, this report examines the following.

1. How 2006 DSH payments to individual hospitals and categories of hospitals compare to 2006 hospital DSH payment limits.

2. Certain aspects of states' methods for estimating uncompensated care costs for the purpose of calculating hospitals' 2006 DSH payment limits.

To determine how DSH payments to hospitals and categories of hospitals compared to hospital DSH payment limits in selected states, we obtained state-reported DSH payments for state and federal fiscal year 2006 and state-calculated DSH payment limits for fiscal year 2006 for all hospitals,[15]

[13]In addition, we found that state reporting of non-DSH supplemental payments to CMS was incomplete, in that not all states were reporting their payments to CMS.

[14]For purposes of this report, we categorized hospitals by operating organization (government or private), by hospital type (children's, general, and IMD), and by combinations of operating organization and hospital type.

[15]In this report, we refer to the hospital DSH payment limits that were calculated by the states and reported to us as state-calculated DSH payment limits.

including IMDs, that received a DSH payment.[16] We obtained this information for four selected states—California, Michigan, New York, and Texas—which were included in our May 2008 report on Medicaid supplemental payments. These states represented those that reported making the largest total amount of DSH and non-DSH supplemental payments in 2005. Although Massachusetts was included in our May 2008 report, we excluded the state from this review because it did not make DSH payments in 2006.[17] For the four states selected for this review, we examined DSH payments as a percentage of hospital DSH payment limits and determined whether these payments exceeded the limits.[18] We also obtained information from a CMS database that allowed us to categorize hospitals by operating organization (government or private) and hospital type (children's, general, or IMD) and performed additional comparisons between payments and hospital-specific limits across different hospital categories.[19] Because of past concerns about DSH payments to state-operated IMDs, we identified total DSH payments made to IMDs in each state and compared the federal share of these payments to each state's IMD DSH payment limit for federal fiscal year 2006 as published in the *Federal Register*.[20] We also compared Medicaid and DSH payments to these hospitals to state data on each hospital's total operating costs. We reviewed relevant Medicaid laws, regulations, and policy documents and

[16]We obtained both state and federal fiscal year data because facility-specific DSH payment limits are applied for the state fiscal year and federal IMD payment limits are applied for the federal fiscal year.

[17]Under the authority of an approved Medicaid section 1115 demonstration, Massachusetts does not make DSH payments to hospitals for fiscal years 2006 through 2011.

[18]We included as DSH payments all payments that a state counted against its 2006 hospital DSH payment limits. Before state fiscal year 2006, private hospitals in California received a substantial amount in DSH payments, but beginning in state fiscal year 2006, the state converted nearly all of these payments to non-DSH supplemental payments, referred to as "DSH replacement" payments. Our analysis includes a total of $160 in DSH payments that California made to 96 private hospitals, but does not include the more than $464 million in DSH replacement payments the state made to these hospitals as non-DSH supplemental payments. For the purpose of this analysis, we considered the $464 million as non-DSH supplemental payments.

[19]To calculate DSH payments as a percentage of state-calculated DSH limits for a category of hospitals, we divided the sum of the DSH payments made to all hospitals in the category by the sum of these hospitals' DSH payment limits.

[20]*Medicaid Program: Fiscal Year Disproportionate Share Hospital Allotments and Disproportionate Share Hospital Institutions for Mental Disease Limits*, 72 Fed. Reg. 73,831 (Dec. 28, 2007).

discussed with CMS officials the federal requirements on DSH payment limits for individual hospitals and for IMDs as a group.

We examined two aspects of selected states' methods for calculating DSH payment limits: (1) the extent to which states accounted for non-DSH supplemental payments, as required, when estimating uncompensated care costs for the purpose of calculating 2006 hospital DSH payment limits, and (2) the extent to which states updated hospital DSH payment limits with actual cost data for 2006 when they became available and had their state-calculated hospital DSH payment limits and the data used to calculate them independently audited. To assess these aspects of state hospital DSH payment limit calculations, we reviewed documentation of state methods in state Medicaid plans and state policy guidance provided by state officials. We reviewed relevant federal Medicaid policy documents and discussed related CMS policies with CMS officials. We also obtained and reviewed the data and calculations states used to estimate uncompensated care costs for state fiscal year 2006. We discussed state methods and data with state officials and reviewed documentation needed to determine the extent to which states updated 2006 DSH payment limits with 2006 cost and payment data, when they became available, and had their payment limits independently audited. In addition, we determined the extent to which the data sources states used to calculate DSH payment limits were subject to independent audit, for example by a public accounting firm or a state auditing agency.

Beyond these two aspects of state methods for estimating hospital uncompensated care costs, we did not examine the states' methods for estimating uncompensated care costs. In addition, we did not independently test data used by states to estimate uncompensated care costs for the purpose of calculating DSH payment limits. That is, we did not audit states' data sources or determine the extent to which they accurately captured costs and payments related to inpatient and outpatient services to Medicaid enrollees or low-income uninsured individuals. We requested that the states review the data they reported to us and confirm that they were complete and accurate. We also checked for missing data and inconsistencies in the data. We determined that the state data on 2006 DSH payments and 2006 state-calculated hospital DSH payment limits were sufficiently reliable for the purposes of comparing state-reported DSH payments to state-calculated DSH payment limits. The information we obtained from the four states cannot be generalized to all states.

We conducted this performance audit from June 2008 through October 2009 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 objectives.

Background

Title XIX of the Social Security Act established Medicaid as a federal-state partnership that finances health care for certain low-income individuals, including children, families, the aged, and the disabled.[21] In 2008, Medicaid provided health coverage for over 62 million individuals. Within broad federal requirements, each state operates and administers its Medicaid program in accordance with a CMS-approved state Medicaid plan. These plans detail the populations served, the services covered (such as physician services, nursing home care, and inpatient hospital care), and the methods used to calculate payments to providers. Qualified health care providers are paid for rendering covered services to Medicaid beneficiaries.[22] The federal government matches state Medicaid expenditures for services according to a state's federal medical assistance percentage (FMAP). The FMAP is based on a statutory formula under which the federal share of a state's Medicaid expenditures for services may range from 50 to 83 percent.[23]

All state Medicaid programs make supplemental payments—that is, payments that are separate from and in addition to those made at a state's standard payment rates—to certain providers. For the purposes of this

[21]Medicaid programs are administered by the 50 states, the District of Columbia, Puerto Rico, and 4 U.S. territories.

[22]In order to receive reimbursement for services, providers must have a valid Medicaid provider agreement in place with the state.

[23]States with lower per capita incomes receive a higher FMAP. 42 U.S.C. §§ 1396b(a)(1), 1396d(b). For the period covered in this review, the federal government reimbursed California and New York at 50 percent, Michigan at 57 percent, and Texas at 62 percent of state expenditures for Medicaid services. States also may be eligible for an increased FMAP under the American Recovery and Reinvestment Act of 2009 for 27 months from October 1, 2008, through December 31, 2010, but this increased FMAP does not apply to DSH payments. Pub. L. No. 111-5, Div. B, § 5001, 123 Stat. 115, 496-502 (2009) (codified at 42 U.S.C. § 1396d note).

report, we classified supplemental payments into two general categories: DSH and non-DSH.

- **DSH payments**. Under federal law, states are required to make DSH payments to hospitals that serve a disproportionate share of low-income individuals.[24] Congress established DSH payments to hospitals in 1981 when changes were made to the methods states could use to determine Medicaid hospital payment rates, in response to concerns about the effects those changes could have on hospitals serving large numbers of Medicaid and low-income individuals.[25]

- **Non-DSH payments**. Most states also make non-DSH supplemental payments to providers, though unlike DSH payments, these payments are not required. In reviewing the purposes of the non-DSH supplemental payment programs in five states, we reported in May 2008 that in some cases, the states' reported purposes for their non-DSH programs were similar to those of DSH programs in that they provided supplemental payments to hospitals serving Medicaid, indigent, or uninsured individuals, or a combination of these groups. Non-DSH supplemental payments include those made under Medicaid's UPL.[26] Federal Medicaid regulations define the UPL as a ceiling on federal matching of Medicaid

[24]In establishing hospital payment rates, states must take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs. 42 U.S.C. § 1396a(a)(13)(A)(iv). States are required to make DSH payments to DSH hospitals, which are defined as any hospital that has a Medicaid inpatient utilization rate of at least 1 percent and meets additional criteria, such as (i) has a Medicaid inpatient utilization rate of at least one standard deviation greater than the average rate for other Medicaid-participating hospitals in the state or (ii) has a low-income utilization rate of more than 25 percent. 42 U.S.C. §§ 1396r-4(b), (d)(3). Some states operate HHS-approved 1115 Medicaid demonstrations under which the state does not make DSH payments directly to hospitals. For example, Tennessee and Hawaii incorporate a portion of their DSH funding into payments to managed care organizations and all of Massachusetts's DSH funds are used to support a special fund for safety net health care providers.

[25]Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2173, 95 Stat. 357, 808-809 (1981) (codified, as amended, at 42 U.S.C. § 1396a(a)(13)). Congress has since created and modified requirements for the DSH program at various times. For example, in 1987, Congress further formalized the DSH program by establishing criteria for the program including (i) requiring states to submit state plan amendments authorizing DSH payments, and (ii) providing a definition for DSH hospitals. Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4112, 101 Stat. 1330 (1987) (codified, as amended, at 42 U.S.C. 1396a note).

[26]Some states also make non-DSH supplemental payments under Medicaid demonstrations authorized under section 1115 of the Social Security Act.

expenditures.[27] This ceiling is based on what Medicare—the federal health care program for seniors aged 65 and older and some disabled individuals—would pay for comparable services. States' standard payment rates for providers are, in practice, often less than the UPL, and states have established programs to make non-DSH supplemental payments to providers that are above standard Medicaid payments but below the UPL.

Much attention has been focused on Medicaid supplemental payments, in part because of their growth and size and also because of concerns that we and others have raised. From 1994 through 2007, we issued reports on various inappropriate payment arrangements whereby states received federal matching funds by making large, often temporary, supplemental payments to certain government providers.[28] In May 2008, we found that CMS's Medicaid expenditure reports showed that between October 2005 and September 2006 states made approximately $17 billion and $6 billion in DSH and non-DSH supplemental payments, respectively, but states did not report all non-DSH payments.

Under federal Medicaid law, states must restrict DSH payments made to an individual hospital to a hospital's annual uncompensated care costs for hospital services provided to Medicaid and uninsured patients.[29] Specifically, uncompensated care costs are defined as those incurred in furnishing inpatient and outpatient services by the hospital to individuals who either are eligible for Medicaid or have no health insurance (or other source of third-party coverage), net of any Medicaid payments and payments by uninsured patients. Hospitals collect cost information by inpatient, outpatient, and other types of services as well as information on the amount of services provided to Medicaid, uninsured, and other patient populations. States then combine the cost information with information on

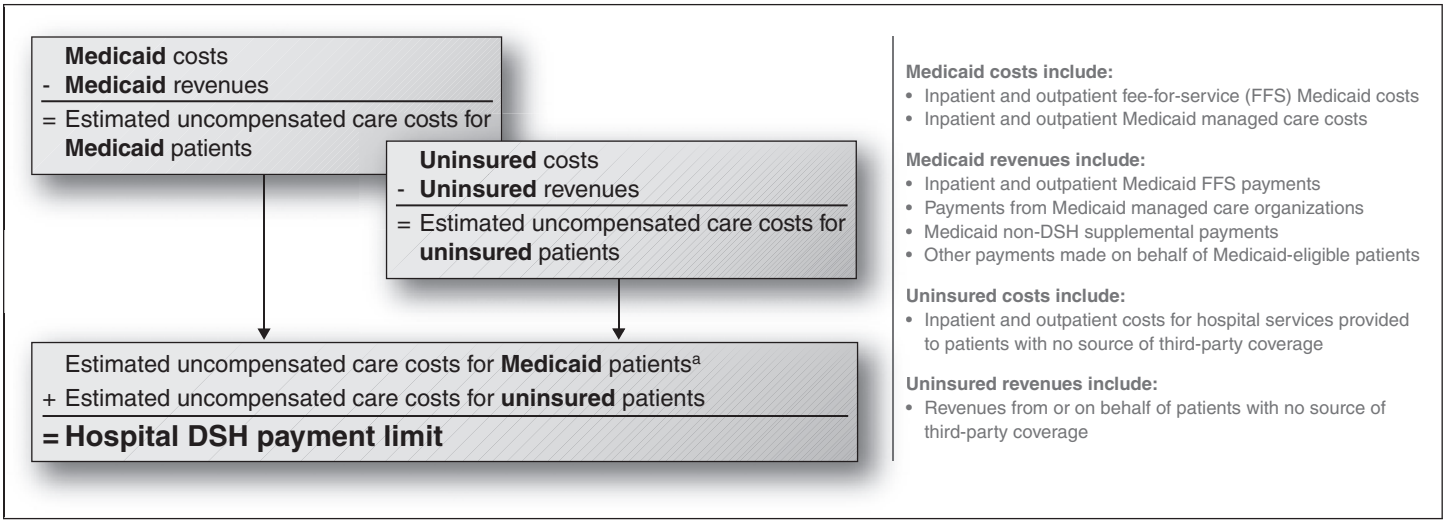
[27]Separate UPLs exist for inpatient services provided by hospitals, nursing facilities, and intermediate care facilities for the mentally retarded, and outpatient and clinic services provided by hospitals and clinics. These UPLs are applied on an aggregate basis to three categories of providers: local-government-owned or -operated facilities, state-government-owned or -operated facilities, and privately owned and operated facilities. See 42 C.F.R. §§ 447.272, 447.321.

[28]A list of related GAO products can be found at the end of this report.

[29]42 U.S.C. § 1396r-4(g). There is an exception to this requirement. Congress authorized certain public hospitals in California to receive DSH payments up to 175 percent of their uncompensated care costs associated with Medicaid and uninsured patients. Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113, App. F, § 607, 113 Stat. 1501, 1501A-396 (1999) (codified, as amended, at 42 U.S.C. § 1396r-4 note).

the amount of services provided to Medicaid and uninsured patients to estimate the costs related to providing hospital services to these patients. For example, when estimating inpatient costs for Medicaid patients, a state may multiply the average cost of a day of inpatient care by the number of days of inpatient care provided to Medicaid patients. Generally, to determine the uncompensated care costs for Medicaid patients, states subtract Medicaid payments from the hospital's estimated Medicaid costs.[30] Through this process, states calculate hospital DSH payment limits. The methods and data sources used to determine uncompensated care costs for the purpose of calculating DSH payment limits may vary by state. Figure 1 illustrates the basic components of the hospital DSH payment limits as identified by CMS.

Figure 1: Basic Components for Calculating Hospital DSH Payment Limits



Source: GAO analysis of CMS information.

[a]Hospital-specific DSH limit calculations must account for situations where Medicaid revenues exceed Medicaid costs. When calculating a hospital's DSH payment limit, a state must account for such a Medicaid surplus by subtracting it from the hospital's uncompensated care costs for uninsured patients.

[30]Payments received from or on behalf of Medicaid patients, such as out-of-pocket payments and Medicare payments for patients who are eligible for both Medicaid and Medicare, are also subtracted from estimated Medicaid costs.

Since the early 1990s, a variety of legislative actions have been taken at the federal level to control federal spending and improve accountability of DSH payments, including the 1993 hospital DSH payment limits and the 1997 payment limit for IMDs as a group (see table 1). Within these requirements states have broad flexibility in how they distribute their DSH funding among DSH-eligible hospitals.

Table 1: Examples of Congressional Actions to Control DSH Spending and Improve Accountability of DSH Payments, 1990 through 2003

Congressional action	Condition
In 1991, Congress limited overall federal expenditures for DSH and established allotments limiting federal DSH funds to individual states.[a]	Rapid growth in DSH expenditures, from just under $1 billion in 1990 to almost $17 billion in 1992.
In 1993, Congress set a limit on DSH payments to individual hospitals equivalent to a hospital's uncompensated care costs.[b]	Inappropriate payment arrangements through which some states made unusually large DSH payments to government hospitals, which then returned the bulk of the payments to the state.
In 1997, Congress limited the total amount of DSH payments states could make to IMDs or other mental health facilities.[c]	A large share of DSH payments were paid to state-operated psychiatric hospitals, where they were used to pay for services not covered by Medicaid or were returned to the state treasuries.
In 1997, Congress required that states provide an annual report to the Secretary of HHS describing DSH payments made to each hospital.[d] In 2003, Congress provided that the Secretary was to require states to submit annual DSH reports and independent certified audits of DSH payments.[e]	Lack of information on state DSH programs, including the hospitals receiving DSH payments and the amount of DSH payments received.

Source: GAO.

[a]Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Pub. L. No. 102-234, § 3, 105 Stat. 1793, 1799-1803 (1991) (codified, as amended, at 42 U.S.C. § 1396r-4(f)). Congress capped total annual federal DSH payments at 12 percent of total Medicaid expenditures, excluding administrative costs. Out of this amount, each state was to receive its federal allotment based on a formula, which generally was capped at 12 percent of the state's total Medicaid expenditures for the federal fiscal year.

[b]Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13621, 107 Stat. 312, 629-632 (1993) (codified, as amended, at 42 U.S.C. § 1396r-4(g)).

[c]Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4721, 111 Stat. 251, 511-514 (1997) (codified, as amended, at 42 U.S.C. § 1396r-4(h)).

[d]Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4721(c) 111 Stat. 251, 514 (1997) (codified, as amended, at 42 U.S.C. § 1396r-4(a)(2)).

[e]Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1001(d), 117 Stat. 2066, 2430-2431 (2003) (codified, as amended, at 42 U.S.C. § 1395r-4(j)). In 2005, CMS issued a proposed rule to implement the statutory auditing and reporting requirements and a final rule implementing these requirements was published in December 2008, during the course of this review.

Despite these actions, concerns have continued regarding state DSH programs, particularly about the accuracy of states' calculation of hospital-specific DSH payment limits and the extent to which CMS ensures federal requirements are followed. During the early 2000s, the HHS OIG reported significant overpayments to hospitals resulting from states not using accurate methods or data for estimating hospitals' uncompensated care costs for the purpose of calculating DSH payment limits. Specifically, in a series of reports issued between 2001 and 2004, the OIG found that (1) one state did not account for non-DSH supplemental payments when calculating DSH payment limits, and (2) some states calculated DSH payment limits using historical data that were not updated, even when cost data from the relevant payment year were available.[31] The OIG found that if states had updated hospital DSH payment limits with cost and payment data for the year the payments were made, the states' hospital DSH payment limits and DSH payments would have been significantly lower.[32] The OIG stated that the lack of specific federal requirements contributed to excess DSH payments, and recommended that CMS issue regulations requiring states ensure that DSH payments are updated to reflect actual incurred costs. In response to the OIG report, CMS indicated that when it finalized its 2005 proposed DSH rule, which addressed the auditing and reporting requirements in the MMA, it would require states to ensure that DSH payment limits are updated to reflect cost and payment data for the payment year. In addition, our May 2008 report found that five states making large supplemental payments had multiple supplemental payment programs from which they made payments and that payments were concentrated on a small proportion of providers. We also found that some providers received substantial payments from more than one program, and that CMS was not collecting the facility-specific information needed to ensure that states' payments were not exceeding the hospital-specific DSH limits. We recommended that CMS expedite issuance of a final rule in response to the auditing and reporting requirements in the MMA. The

[31]The HHS OIG review of 10 states' DSH programs resulted in 19 reports issued between 2001 and 2004 and culminated in a 2006 summary report. HHS OIG, *Audit of Selected States' Medicaid Disproportionate Share Hospital Programs*, A-06-03-00031(Washington D.C.: March 2006). The OIG based its analyses of updating DSH payment limits on federal statutory language stating that hospital DSH payment limits must be based on "costs incurred during the year of providing hospital services."

[32]The OIG found that by not accounting for non-DSH supplemental payments when calculating DSH payment limits, one state made DSH payments exceeding hospital DSH payment limits by $46 million. The OIG also found that by not updating historical data used to estimate uncompensated care costs with actual costs, four states made DSH payments exceeding hospital DSH payment limits by about $679 million.

agency issued the final rule in December 2008, during the course of this review.

DSH Payments Varied Widely Relative to State-Calculated Hospital DSH Payment Limits, with Relatively Higher Payments Made to Government-Operated Hospitals

In the four states we reviewed, state DSH payments varied widely relative to the state-calculated DSH payment limits. The four states paid government-operated hospitals a relatively high proportion of their state-calculated DSH limits. State-operated IMDs received the largest relative payments in three states.

Four States' 2006 DSH Payments Ranged Widely as a Percentage of State-Calculated Hospital DSH Payment Limits

When we compared 2006 DSH payments to the 2006 hospital DSH payment limits calculated by the four selected states—California, Michigan, New York, and Texas—we found that, for the 682 hospitals that received DSH payments in these states, DSH payments varied widely relative to state-calculated DSH payment limits. Hospitals' DSH payments ranged from less than 1 percent to more than 169 percent of state-calculated DSH payment limits. Three states—California, New York, and Texas—made DSH payments to a small number of hospitals that exceeded the 2006 DSH payment limits.[33] Specifically, 5 of 147 hospitals in California, 1 of 226 hospitals in New York, and 9 of 182 hospitals in Texas received payments in 2006 that exceeded their state-calculated DSH payment limits. However, officials from these states reported that they had taken or planned to take the following actions to correct the excess payments:

- Officials from California and New York reported that, as of September 2009, they had not completed the reconciliation processes they have in place for certain DSH hospitals, including those that we identified as

[33]During our review, we also found issues related to compliance with federal DSH requirements that were outside the scope of this review. We discussed these issues with CMS officials. See appendix II for a summary of these issues.

receiving payments exceeding limits.[34] They indicated that once their 2006 DSH payment limits were finalized as part of this process, DSH payment limits would be based on actual incurred costs for 2006, and that they would reduce DSH payments as necessary to correct for excess payments.

- Texas officials reported that they had identified and addressed the excess payments we identified. They provided documentation indicating that the state had reduced 2007 DSH payments to eight of the nine hospitals overpaid in state fiscal year 2006 by an amount equal to the total excess payments made to the hospitals in 2006.[35]

The dollar amount of 2006 DSH payments to individual hospitals also varied widely, ranging from 1 cent to more than $395 million. (See table 2.) California reported both the lowest and the highest DSH payment amounts: the state made a total of only $160 in DSH payments to 96 private hospitals and paid $2 billion in DSH payments to 51 government hospitals.[36] Before state fiscal year 2006, private hospitals in California received a substantial amount in DSH payments, but beginning in state

[34]DSH payment amounts and state-calculated DSH payment limits for 22 hospitals in California, including those for the several California hospitals that received DSH payments in excess of the state-calculated DSH payment limits, 18 hospitals in Michigan, and 203 hospitals in New York, were determined using historical cost data. Each of these states had processes in place to update the payment limits for these hospitals, and make adjustments to the associated payments, once actual cost data for the payment year becomes available. At the time of our review, this reconciliation process had not occurred.

[35]Texas officials were unable to reduce the 2007 DSH payment to the ninth hospital because it was not eligible to receive DSH payments in state fiscal year 2007.

[36]California distributes a pro-rata share of the $160 pool to private hospitals that qualify for DSH payments. In California, some private hospitals received as little as 1 cent in DSH payments.

fiscal year 2006, the state converted these payments to non-DSH supplemental payments, referred to as "DSH replacement" payments.[37]

Table 2: Number of Hospitals That Received a DSH Payment, Range of DSH Payments as a Percentage of State-Calculated Hospital DSH Payment Limits, and Range of DSH Payment Amounts by State, State Fiscal Year 2006

		DSH payments as a percentage of state-calculated DSH limits			DSH payment amounts		
State	Number of hospitals	Low	Median	High	Low	Median	High
California[a]	147	<1%	<1%	169%[b]	$<1	$2	$395,712,888
Michigan	127	<1	12	100	42	652,960	57,229,935
New York	226	<1	44	101[c]	301	1,682,330	82,470,289
Texas	182	8	39	106[d]	23,924	1,134,613	186,877,453

Source: GAO analysis of state-reported data on DSH payments and state-calculated DSH payment limits.

[a]Our analysis of California included DSH payments totaling $160 paid to 96 private hospitals. The DSH payment amounts to these private hospitals ranged from 1 cent to $14.53. The relatively small size of these DSH payments skewed the median DSH payment for the state. When the DSH payments to the private hospitals were excluded from our analysis, the median DSH payment as a percentage of state-calculated DSH limits was 10 percent and the median DSH payment was $1.1 million.

[b]DSH payments made to five hospitals in California exceeded the hospitals' DSH payment limits. According to California officials, under the state's process for updating payment limits based on historical data to actual cost data once they become available, any identified overpayment would be corrected.

[c]DSH payments made to one hospital in New York exceeded the hospital's DSH payment limit. According to New York officials, under the state's process for updating payment limits based on historical data to actual cost data once they become available, any identified overpayment would be corrected.

[d]DSH payments made to nine hospitals in Texas exceeded the hospitals' DSH payment limits. Texas officials reported that they made adjustments to the state's 2007 DSH payments that addressed overpayments made to these hospitals in 2006. We did not include any 2007 payment adjustments in this analysis of 2006 DSH payments.

[37]Although California replaced DSH payments to private hospitals with non-DSH supplemental payments in state fiscal year 2006, according to state officials, the state used the same methodology to calculate the payment amounts for individual hospitals as it had used when the payments were considered DSH payments. Further, as we reported in our May 2008 report, California stated that the purpose of DSH replacement payments was to provide supplemental reimbursement to private hospitals that serve a disproportionate share of Medicaid, indigent, and uninsured patients; and officials indicated to us that the payments may be used to offset the costs of care to uninsured patients. According to CMS officials, however, because these payments are now considered non-DSH supplemental payments, they can only be used for Medicaid patients and services. Because of the potential that California's DSH replacement payments are being used by hospitals for non-Medicaid purposes, we referred this issue to the HHS OIG in July 2009 for follow-up.

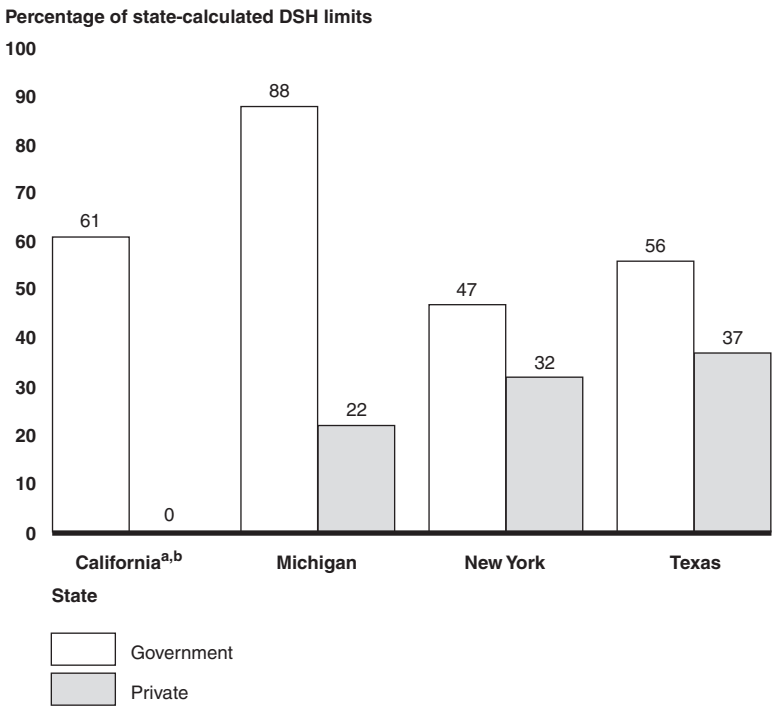
Four States Paid Government-Operated Hospitals a Relatively High Proportion of Their State-Calculated Hospital DSH Payment Limits, with State-Operated IMDs Receiving the Largest Relative Payments in Three States

DSH Payments by Operating Organization

When categorized by operating organization, government-operated hospitals received higher DSH payments, relative to their state-calculated DSH payment limits, than privately-operated hospitals.[38] As shown in figure 2, DSH payments to government-operated hospitals as a percentage of the hospital DSH payment limits ranged from 47 percent in New York to 88 percent in Michigan. For privately-operated hospitals, this percentage ranged from less than 1 percent in California to 37 percent in Texas. (See table 5 in app. III for detailed information on our comparison of DSH payments to state-calculated DSH limits by operating organization.)

[38]Our analysis of DSH payments as a percentage of state-calculated DSH payment limits was done in the aggregate: for each hospital category, we divided the sum of the hospitals' DSH payments by the sum of their state-calculated DSH payment limits.

Figure 2: DSH Payments as a Percentage of State-Calculated DSH Payment Limits, by State and Operating Organization, State Fiscal Year 2006



Source: GAO analysis of state-reported data on DSH payments and state-calculated DSH payment limits.

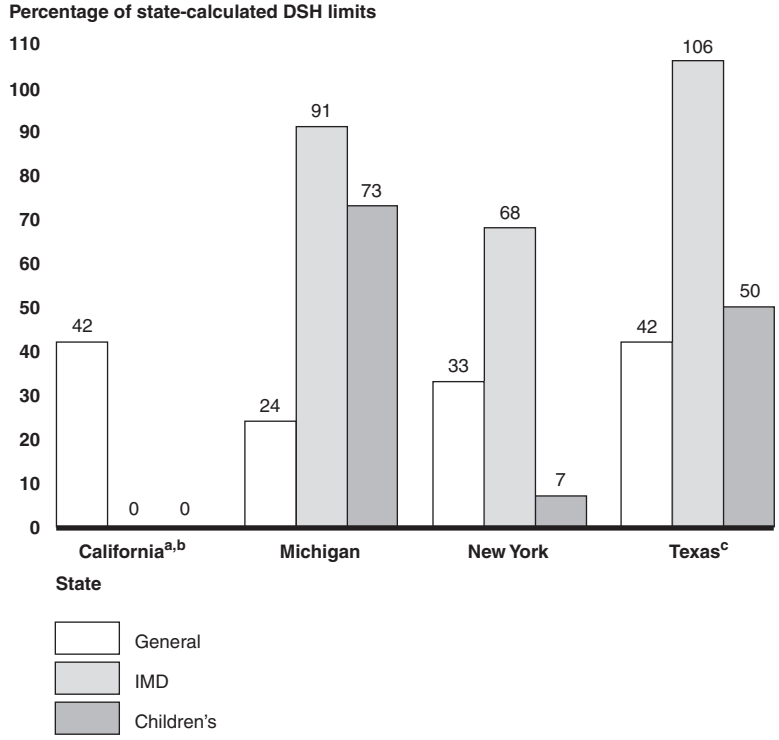
[a]For government-operated hospitals in California, state-calculated DSH payment limits were equal to 175 percent of uncompensated costs associated with Medicaid and uninsured patients.

[b]Our analysis of California included DSH payments totaling $160 paid to 96 private hospitals. The DSH payment amounts to these private hospitals ranged from 1 cent to $14.53. As a result, DSH payments to private hospitals in California were less than 1 percent of these hospitals' DSH payment limits.

DSH Payments by Hospital Type

When grouped by hospital type, in three of the four states—Michigan, New York, and Texas—IMDs received larger DSH payments, measured as a percentage of state-calculated DSH payment limits, than general hospitals and children's hospitals. DSH payments to IMDs as a percentage of their state-calculated DSH payments limits were 91 percent in Michigan, 68 percent in New York, and 106 percent in Texas (see fig. 3). California did not make significant DSH payments to IMDs: of the state's nearly $2.1 billion in DSH payments for state fiscal year 2006, about $164,000 was paid to IMDs. (See table 6 in app. III for detailed information on our comparison of DSH payments to state-calculated DSH limits by hospital type.)

Figure 3: DSH Payments as a Percentage of State-Calculated DSH Payment Limits by State and Hospital Type, State Fiscal Year 2006



Source: GAO analysis of state-reported data on DSH payments and state-calculated DSH payment limits.

[a]For government-operated hospitals in California, state-calculated DSH payment limits were equal to 175 percent of uncompensated costs associated with Medicaid and uninsured patients.

[b]Our analysis of California included DSH payments totaling $160 paid to 96 private hospitals—10 IMDs, 79 general hospitals, and 7 children's hospitals. The payment amounts for these private hospitals ranged from 1 cent to $14.53. As a result, DSH payments as a percentage of DSH payment limits for IMDs and children's hospitals were less than 1 percent for California.

[c]DSH payments made to nine IMDs in Texas exceeded the hospitals' DSH payment limits. Texas officials reported that they made adjustments to the state's 2007 DSH payments that addressed overpayments made to these hospitals in 2006. We did not include any 2007 payment adjustments in this analysis of 2006 DSH payments.

Considering both operating organization and hospital type, in the same three states—Michigan, New York, and Texas—state-government-operated IMDs received the largest DSH payments relative to their state-calculated DSH payment limits.[39] (See tables 7, 8, and 9 in app. III for detailed

[39]California DSH payments to IMDs totaled about $164,000 for state fiscal year 2006, and no DSH payments were made to state-operated IMDs.

information on our comparison of DSH payments to state-calculated DSH limits by the combination of operating organization and hospital type.)

DSH Payments to IMDs

When we compared each state's total DSH payments made to IMDs to the federal limit on the amount that each state can pay to IMDs as a group, we found that three of the four states paid IMDs at or near the federal limit. In Michigan, New York, and Texas, IMDs as a group were paid 97, 100, and 100 percent of the 2006 IMD limits published in the *Federal Register*.[40] California has an IMD limit significantly lower than the other three states, and its payments to IMDs were 11 percent of the IMD limit for the state. (See table 3.) Officials from the remaining three states told us that they annually allocate the maximum amount of DSH funds allowed to state-operated IMDs.[41]

Table 3: Comparison of Federal Share of DSH Payments to IMDs to IMD Payment Limits for Federal Fiscal Year 2006, by State

(Dollars in millions)

State	DSH payments to IMDs (federal share)	IMD payment limit (federal share)[a]	Payments as a percentage of IMD payment limit
California	$0.1	$0.7[b]	11%
Michigan	80.3	82.4	97
New York	302.5	302.5	100
Texas	174.1	174.1	100

Source: GAO analysis of state-reported data on DSH payments and 2006 federal IMD DSH payment limits.

[a]DSH payments that can be made to IMDs are limited to the lesser of total DSH payments made to IMDs and other mental health facilities in 1995 or 33 percent of the federal share of DSH payments made to IMDs and other mental health facilities out of the state's 1995 DSH allotment. As a result, this limit may be lower than the sum of state-calculated hospital DSH payment limits for individual IMDs.

[b]California's IMD DSH limit is relatively low because it is based on the state's IMD DSH expenditures in federal fiscal year 1995, which represented less than 1 percent of DSH payments made that year.

[40]CMS calculates and publishes each state's federal fiscal year IMD DSH limit annually. Each state's IMD limit is presented as the total amount of DSH payments allowed (federal and state share), and as the maximum federal payments allowed. See 72 Fed. Reg. 73,831 (Dec. 28, 2007) for final IMD limits for federal fiscal year 2006.

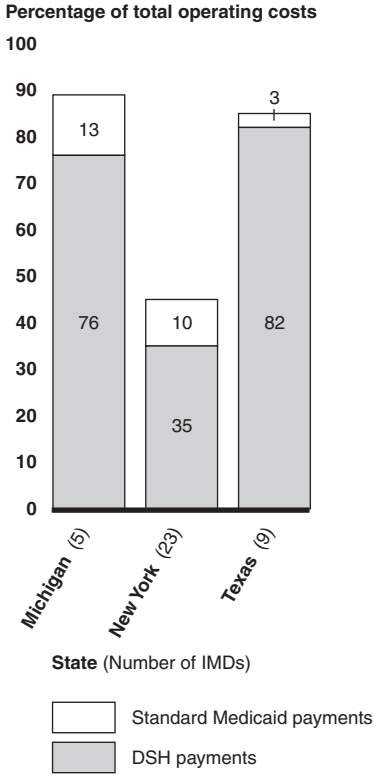
[41]Within the IMD payment limit and the hospital DSH payment limit, states have broad flexibility in how they distribute their DSH allotment (total amount of federal DSH funding allowed) among DSH-eligible hospitals.

In the three states that made DSH payments to state-operated IMDs—Michigan, New York, and Texas—2006 Medicaid payments (considering both DSH payments and standard Medicaid payments) also covered a significant share of the total 2006 costs of operating these hospitals, and for two state-operated IMDs in different states, total Medicaid payments exceeded total operating costs.[42] Total operating costs are all direct and indirect costs incurred in operating a hospital, including costs of providing medical care to patients, general management, building maintenance, and personnel. In Michigan, 88 percent of the state's operating costs for 5 IMDs were covered by Medicaid; in New York, 45 percent of the state's operating costs for 23 IMDs were covered by Medicaid; and in Texas, 85 percent of the state's operating costs for 9 IMDs were covered by Medicaid. In each case, DSH payments constituted the bulk of Medicaid payments to the IMDs (see fig. 4). In Michigan, Medicaid payments exceeded total operating costs for 1 of the 5 IMDs by a total of $2.1 million, 6 percent of the facility's operating costs. Based on data provided during the course of our review, 2006 Medicaid payments exceeded total 2006 operating costs for 1 of the 9 Texas IMDs by $1.8 million, 3 percent of the facility's operating costs.[43]

[42]DSH and standard Medicaid payments exceeding total operating costs could be a result of overstated uncompensated care costs, DSH payments being in excess of DSH payment limits, or other factors. We did not determine the specific reasons that Medicaid payments exceeded total costs for these two facilities.

[43]Texas officials provided revised 2006 operating cost data as part of their technical review of a draft of this report. Although we did not assess their reliability, these revised data indicate that Medicaid payments represented 99.6 percent, rather than 103 percent, of this facility's 2006 operating costs.

Figure 4: Three States' Standard Medicaid and Medicaid DSH Payments to Government-Operated IMDs as a Percentage of the Hospitals' Total Operating Costs, State Fiscal Year 2006



Source: GAO analysis of state-reported data on DSH payments, standard Medicaid payments and operating costs.

Not All Reviewed States Accounted for Non-DSH Supplemental Payments, Consistently Updated DSH Payment Limits, or Subjected DSH Payment Limits to Independent Audits

Although states are required to account for non-DSH supplemental payments when estimating hospital uncompensated care costs, two of the four reviewed states did not consistently do so when calculating their 2006 hospital DSH payment limits. In examining whether the reviewed states used methods to ensure that their 2006 DSH payment limits accurately reflected hospitals' costs, we found that none of the four reviewed states consistently updated 2006 hospital DSH payment limits and subjected hospital DSH payment limits to an independent audit. Although states were not required to take these steps in 2006, they will be required to do so in the future under CMS's rule, which was finalized in December 2008.

Contrary to Federal Requirements, Two States Did Not Account for Medicaid Non-DSH Supplemental Payments, Thus Overestimating Uncompensated Care Costs

Two of the four states we reviewed, California and Texas, did not adhere to the federal requirement that states include non-DSH supplemental payments as Medicaid payments when estimating hospital uncompensated care costs for purposes of setting DSH payment limits. By not accounting for non-DSH supplemental payments, both California and Texas overestimated uncompensated care costs and the associated DSH payment limits for a number of hospitals. This resulted in DSH payments in excess of the correctly calculated hospital DSH payment limits for some hospitals in Texas.

- California included some, but not all, non-DSH supplemental payments as Medicaid payments when estimating hospitals' uncompensated care costs. Specifically, the state did not include $22.4 million in non-DSH supplemental payments paid to 91 hospitals in its estimates of the hospitals' Medicaid revenues and did not offset these revenues against the hospitals' incurred Medicaid and uninsured costs. By not accounting for these payments, the estimated uncompensated care costs and the associated DSH payment limits for these hospitals were overstated by about 1 percent. However, because most California hospitals received DSH payments that were less than their state-calculated DSH payment limits, we estimate that correcting for this adjustment would not have resulted in any hospitals receiving DSH payments in excess of their limits.
- Texas did not account for any of the $883.4 million in non-DSH supplemental payments paid to 88 of the state's 182 DSH hospitals in its estimates of hospitals' uncompensated care costs. Texas officials told us that they did not account for any non-DSH supplemental payments

because they first make DSH payments and then limit non-DSH supplemental payments to a hospital's remaining uncompensated care costs. Our analysis indicates that this methodology was not always followed. After accounting for non-DSH supplemental payments, we estimated that Texas's 2006 DSH payments to 12 hospitals exceeded DSH payment limits by $1.3 million ($769,038 in federal funds).

Reviewed States Did Not Consistently Update DSH Payment Limits or Subject Limits to Independent Audits; CMS's 2008 DSH Rule Requires All States to Do So in the Future

Not all of the reviewed states had processes to update 2006 DSH payment limits for all hospitals with actual 2006 cost and payment data when they become available. Only one of the reviewed states had a process to update DSH payment limits for all hospitals with actual 2006 cost and payment data when they become available. Two states had processes for some hospitals and one state did not have a process for any of its hospitals. For 203 DSH hospitals in New York, the state made interim payments to hospitals based on hospitals' uncompensated care cost data from 2000 and 2004. For the remaining 23 hospitals, uncompensated care costs were from 2004. For all 226 hospitals, the state has a process to finalize its payment limits once data on uncompensated care costs from 2006 are available, and then compare 2006 DSH payments to the finalized limits and make DSH payment adjustments as necessary. For 22 of the 147 hospitals in California, the state initially estimated 2006 uncompensated care costs using 2004 and 2005 data; and for 18 of the 127 hospitals in Michigan, the state initially estimated 2006 uncompensated care costs using 2003 and 2004 data. According to state officials, for these hospitals each state will update their estimates once 2006 data become available.[44] For other hospitals, however, states did not have processes to update DSH payment limits. For the remaining 125 hospitals in California and 109 hospitals in Michigan, and all 182 hospitals in Texas, cost data from earlier years were trended forward to estimate 2006 uncompensated care costs when calculating 2006 DSH payment limits, but the limits were not updated when actual 2006 data became available.[45]

[44]Officials from California and New York reported that they expect to have final 2006 DSH limits calculated by the end of 2009. Michigan officials reported that final 2006 DSH limits would by calculated by the end of 2012.

[45]Specifically, California's calculations of 2006 hospital DSH payment limits for 125 of its 147 hospitals were based on 2003 and 2004 data, Michigan's calculations for 109 of its 127 hospitals were based on 2003 and 2004 data, and Texas's calculations for all 182 of its hospitals were based on 2004 data.

None of the four states we reviewed had their 2006 hospital DSH payment limit calculations independently audited. When estimating hospitals' uncompensated care costs for purposes of calculating 2006 DSH payment limits, however, the states sometimes used data sources that were subject to audit, but they did not do so consistently for all hospitals or all data, as shown in the following examples.[46]

- In California, for the 22 government-operated hospitals that received 99 percent of the state's DSH payments, the state auditor conducted an audit of hospital cost reports, which provide Medicaid fee-for-service inpatient cost data. Other cost and payment data for the 22 hospitals were from sources not subject to audit. For the remaining 125 hospitals in California, the state used an audited data source for Medicaid fee-for-service payment data, but cost and other payment data were from sources that were not subject to audit.

- For all 127 hospitals in Michigan, the state used an audited data source for Medicaid fee-for-service cost and payment data, but other cost and payment data were from sources that were not subject to audit.

- New York requires 203 government- and privately-operated hospitals to submit state cost reports that are ultimately certified by an independent auditor. For the remaining 23 hospitals in New York, the state used some data sources that were not subject to audit.

- For all 182 hospitals in Texas, the information the state used to convert hospital charges to hospital costs came from an audited data source,[47] but hospital charge and payment data were from annual state surveys that were not subject to audit.[48]

[46]In our review, we determined whether the various data sources states used were subject to independent audit, either before or after the data were used to estimate uncompensated care costs.

[47]To convert hospital charges to hospital costs, Texas used the cost-to-charge ratio from each hospital's Medicare cost report. This ratio represents a hospital's total costs compared to total charges. The Medicare cost reports are audited by contractors hired by the federal government to pay hospitals for caring for Medicare beneficiaries.

[48]To calculate hospital DSH payment limits, Texas obtains Medicaid charge and payment data from annual surveys of the state contractor that processes Medicaid fee-for-service claims and from the managed care organizations that pay hospitals for services provided to Medicaid managed care patients. These entities are subject to audit, which typically includes testing their data. However, the data provided by these entities in response to the state's surveys, which are used to calculate DSH payment limits, are not independently audited.

Data sources used by the states that were not subject to audit included self-reported hospital cost and payment data for Medicaid and uninsured patients obtained through annual hospital surveys and data from state-developed Medicaid forms designed to capture cost and payment data for Medicaid managed care and uninsured patients. See table 4 for the audit status of the sources of data states used to calculate 2006 hospital DSH payment limits.

Table 4: Audit Status of the Sources of Data Used by States in Calculating 2006 DSH Payment Limits, by State

	Type of cost and payment data		
State	Medicaid fee-for-service	Medicaid managed care	Uninsured
California	◒	◒	◒
Michigan	●	○	○
New York	◒	●	◒
Texas	◒	◒	◒

Source: GAO analysis of information from California, Michigan, New York, and Texas.

Legend:

● All data sources are independently audited

◒ Some data sources are independently audited

○ No data sources are independently audited

Although states were not required by CMS to either update DSH payment limits with actual cost and payment data or have DSH payment limit calculations independently audited in 2006, CMS will require all states to do so in the future. Specifically, in December 2008, during the course of this review, CMS finalized a DSH rule that requires updating and independent auditing of DSH limits and payments for all DSH hospitals in all states.[49] The 2008 DSH rule required that states have their DSH programs independently audited and certified to verify that

[49]73 Fed. Reg. 77,904 (Dec. 19, 2008). In this report, we use the term 2008 DSH rule to refer to this final rule. The rule implements requirements to improve the accountability over DSH payments as imposed under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. No. 108-173, § 1001(d), 117 Stat. 2066, 2430-2431 (2003) (codified, as amended, at 42 U.S.C. § 1395r-4(j)).

- each eligible hospital is allowed to retain DSH payments so that these payments are available to offset uncompensated care costs in order to reflect the total amount of claimed DSH expenditures;
- DSH payments to each hospital comply with the hospital's DSH payment limit based on measuring DSH payments to each hospital during the payment year against the hospital's actual uncompensated care costs for the same year;[50]
- only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to Medicaid-eligible and uninsured individuals are included in the calculation of the hospital DSH payment limits;
- the state included all Medicaid payments, including non-DSH supplemental payments, in the calculation of hospital DSH payment limits;[51]
- the state has documented and retained a record of Medicaid inpatient and outpatient service costs, Medicaid expenditures, uninsured inpatient and outpatient service costs, and payments made by or on behalf of the uninsured; and
- records must include a description of the methodology for calculating each hospital's DSH payment limit, including the definition of incurred costs.

Although the 2008 DSH rule set a December 2009 deadline for states' 2005 and 2006 DSH audits and reports, CMS provided states a transition period—through payment year 2010. According to CMS, the transition period was created due to concerns from states regarding budget cycles, planning complications, and the economic downturn. The transition period is intended to ensure states are not adversely affected

[50]In the preamble to the rule, CMS recognized that states may need to estimate DSH payments and DSH payment limits for an upcoming year. States must ensure, however, that using estimates does not result in DSH payments that exceed a hospital's incurred uncompensated care costs by revising methodologies or providing for the reconciliation of prospective DSH payments. See 77 Fed. Reg. at 77,944. According to CMS officials, the payment year can vary by state. While it typically corresponds with a state's fiscal year, the payment year may also follow the federal fiscal year or another time period established by the state, according to CMS officials.

[51]This provision reiterates a CMS 2002 policy which clarified that non-DSH supplemental payments are Medicaid payments and must be accounted for when calculating hospital DSH payment limits.

retrospectively by the availability of new data resulting from the new requirements, as well as to give states time to develop and refine their reporting and auditing processes. According to CMS, any findings of noncompliance with hospital DSH payment limits resulting from state reports for payment years 2005 through 2010 will not be acted upon by CMS, though these findings may be used to question the calculation of hospitals' DSH payment limits for 2011 and years thereafter.

California's experience indicates that states' implementation of requirements of the 2008 DSH rule to update and audit hospital DSH payment limit calculations could have a substantial effect on states' estimates of uncompensated care costs and associated hospital DSH payment limits. In 2006, California began using a new methodology to estimate uncompensated care costs for calculating DSH payment limits for 22 public hospitals that received 99 percent of the state's DSH payments. Under this new methodology, the state uses cost data from sources that are audited and also updates the DSH payment limits when actual cost and payment data for the DSH payment year become available. Using this new methodology, California's 2006 DSH payment limits for these hospitals were over 49 percent lower than what they would have been using the state's previous method, which used self-reported hospital data from 2003 and 2004.[52]

Conclusions

Since the early 1990s, Medicaid's DSH program has grown significantly and at times has been used by some states to inappropriately generate federal Medicaid matching funds. Over the years, Congress has taken steps to ensure the integrity of the program by establishing new requirements, including hospital DSH payment limits that cap a hospital's DSH payments to its uncompensated care costs. However, we found that for 2006, two states did not account for non-DSH supplemental payments when calculating hospital DSH payment limits, as required. We also found variation in the extent to which states took measures to ensure the accuracy of their hospital DSH payment limit calculations.

[52]We were able to make this assessment because California continued to calculate uncompensated care costs for all DSH-eligible hospitals, including the 22 for which the state now uses data from audited cost reports, under the prior methodology. Although Michigan has instituted a similar methodology for 18 of its 127 hospitals, we could not assess the effect of this change because we did not have estimates for these 18 hospitals using the previous methodology.

CMS has an important role in ensuring that states adhere to federal DSH requirements, and issuance of the 2008 DSH rule is a positive step toward improved federal oversight of the tens of billions of dollars paid annually in Medicaid supplemental payments. The state DSH reports and audit reports required under federal law should provide information that CMS needs to ensure states' compliance with and enforcement of DSH requirements, such as ensuring that states account for non-DSH supplemental payments when calculating DSH payment limits. The effect of the 2008 DSH rule will depend, however, upon the extent to which CMS uses the information reported by states to identify and correct problems in state DSH programs. Ongoing federal oversight is warranted to ensure that states are following federal requirements and taking corrective actions, as needed.

Recommendations for Executive Action

In light of our findings from selected states that existing DSH requirements are not always followed, we recommend that CMS ensure that states account for all Medicaid payments, including non-DSH supplemental payments, when calculating DSH payment limits.

Agency and External Comments and Our Evaluation

We provided a draft of this report to HHS for comment. Responding for HHS, CMS agreed with our recommendation. The full text of CMS's comments is reprinted in appendix IV.

CMS provided clarifications and comments, which we incorporated as appropriate. In particular, CMS correctly noted that we referred to the DSH audit and reporting final rule published in December 2008, and that we did not consider this rule or the related provisions of the MMA as requirements for the 2006 payment data that we reviewed. CMS also suggested additional language describing the time frames for transitioning and implementing the final rule, which we considered and incorporated as appropriate.

We also provided a draft of this report to California, Michigan, New York, and Texas for technical review. California and Michigan had no comments; New York concurred with our findings; and Texas provided the following comments related to three findings in the draft report.

- First, in response to our finding that Texas did not account for all non-DSH supplemental payments, Texas officials noted that the state was taking corrective action by updating its DSH payment methodology to limit the amount of DSH and non-DSH supplemental payments to hospital DSH payment limits.

- Second, in light of our finding that combined DSH and standard Medicaid payments to one state-operated IMD in Texas exceeded the facility's operating costs in 2006, the state provided revised 2006 operating cost data. Based on these revised data, total Medicaid payments to the IMD would have represented 99.6 percent, rather than 103 percent, of this facility's operating costs. We did not assess the reliability of the revised data, but noted its effect in the final report.

- Third, Texas asserted that we underreported the extent to which the Medicaid cost and payment data the state used in calculating DSH hospital payment limits came from sources that were subject to audit. Texas uses a contractor to process the state's Medicaid fee-for-service claims and relies on managed care organizations to pay hospitals for services provided to Medicaid managed care patients. To calculate DSH payments, Texas obtains Medicaid cost and payment data by surveying the fee-for-service contractor and the manage care organizations. These entities are subject to audit, which typically includes testing their data. However, the reliability of the data provided by these entities in response to the state's surveys are not independently verified. Therefore, we continue to report that some Medicaid fee-for-service and managed care data are from sources not subject to an independent audit.

Texas also provided technical views that we considered and incorporated as appropriate.

As arranged with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days after its issuance date. At that time, we will send copies of this report to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, the State Medicaid Directors of California, Michigan, New York, and Texas, and other interested parties. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff members have any questions, please contact me at (202) 512-7114 or iritanik@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report are listed in appendix V.

Sincerely yours,

Katherine M. Iritani
Acting Director, Health Care

Appendix I: Objectives, Scope, and Methodology

To review states' Medicaid disproportionate share hospital (DSH) payments, we examined DSH payments and DSH payment limits in four selected states: California, Michigan, New York, and Texas. These states were four of the five states included in our May 2008 report on supplemental payments that states made to Medicaid providers.[1] The five states represented those that reported making the largest total amount of DSH and non-DSH supplemental payments in 2005.[2] For this review, we interviewed state officials in each of the four states and collected information on each hospital that received a DSH payment for state fiscal year 2006, including DSH payments received, non-DSH supplemental payments received, standard Medicaid payments received, and state-calculated DSH payment limits.[3] We also obtained information on the data sources used in state calculations of DSH payment limits, including information on whether the data sources were subject to audit.

Comparison of DSH Payments to 2006 DSH Payment Limits

Using state-provided data on DSH payments and hospital DSH payment limits for state fiscal year 2006, we calculated for each hospital its DSH payment as a percentage of its state-calculated DSH payment limit. We identified hospitals whose DSH payments exceeded the state-calculated DSH payment limits. We also examined DSH payments as a percentage of hospital DSH payment limits across hospital categories: operating organization (private or government), hospital type (general, institutions for mental diseases (IMD), or children's) and combinations of operating organization and hospital type.[4] We also compared state DSH payments to

[1]GAO, *Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments*, GAO-08-614 (Washington, D.C.: May 30, 2008).

[2]The fifth state in our May 2008 report, Massachusetts, was excluded in this report because under the authority of an approved Medicaid section 1115 demonstration the state does not make DSH payments to hospitals for fiscal years 2006 through 2011.

[3]Hospital DSH payment limits are applied on a state fiscal year basis.

[4]We determined hospital operating organization and hospital types from a database of providers maintained by CMS that contains provider-reported information on each facility. We classified hospitals operated by proprietary or nonprofit organizations as private and hospitals operated by governmental entities—such as counties, states, or hospital districts—as government. For hospital type, we considered psychiatric hospitals, called institutions for mental diseases (IMD), and children's hospitals as separate hospital types, and classified all other hospital types—including short-term, long-term, critical access, and rehabilitation hospitals—as general hospitals. We classified four IMDs for children in New York as IMDs because the federal aggregate limit on DSH payments to IMDs includes IMDs for children. To calculate DSH payments as a percentage of state-calculated DSH limits for a category of hospitals, we divided the sum of the DSH payments made to all hospitals in the category by the sum of these hospitals' DSH payment limits.

IMDs to each state's IMD limit for federal fiscal year 2006 published in the *Federal Register*.[5] For this analysis we obtained from states the DSH payments they made for federal fiscal year 2006. In addition, because of past concerns with DSH payments to state-operated IMDs, we compared the total Medicaid payments (including DSH payments and standard Medicaid payments) made to state-operated IMDs to the operating costs of these hospitals, which we obtained from the states.

Review of Methods Used by States to Estimate Uncompensated Care Costs for the Purpose of Establishing Hospital DSH Payment Limits

We examined two aspects of the four states' methods for calculating DSH payment limits: (1) the extent to which selected states accounted for non-DSH supplemental payments, as required since 2002, and (2) the extent to which selected states updated hospital DSH payment limits with actual cost data for 2006 when they became available, and had their state-calculated hospital DSH payment limits or the data used to calculate them independently audited.

To determine the extent to which selected states accounted for non-DSH supplemental payments, as required since 2002, we interviewed state officials on the methods and data they used to estimate uncompensated care costs. We reviewed documentation of state methods in state Medicaid plans, administrative manuals, and internal policy guidance provided by state officials. We obtained information from state officials as to whether and how they account for non-DSH supplemental payments when estimating hospital uncompensated care costs. We also analyzed states' data and calculations to determine whether non-DSH supplemental payments were accounted for as required.

To determine the extent to which selected states updated hospital DSH payment limits with actual cost data for 2006 when they became available, and state-calculated hospital DSH payment limits were independently audited, we reviewed documentation of state methods in state Medicaid plans and state policy guidance provided by state officials. We reviewed relevant federal Medicaid policy documents and discussed related CMS

[5]Each year, CMS calculates and publishes each state's federal fiscal year IMD DSH limit. CMS published preliminary 2006 IMD limits in October 2006, and published the final IMD limits in December 2007. Each state's IMD limit is presented as the total amount of DSH payments allowed (federal and state share), and as the maximum federal payments allowed. See 71 Fed. Reg. 58,398 (Oct. 3, 2006) for preliminary IMD limits for federal fiscal year 2006, and 72 Fed. Reg. 73,831 (Dec. 28, 2007) for final IMD limits for federal fiscal year 2006. There was no difference between the preliminary and final IMD limits for the four states we examined.

policies with CMS officials. We also interviewed officials and examined state data and calculations. In addition, when hospital DSH payment limit calculations were not independently audited, we determined the extent to which the data sources states used to calculate these limits were subject to audit, for example by a public accounting firm or a state auditing agency.

Beyond these two aspects of state methods for estimating hospital uncompensated care costs, we did not examine the states' methods for estimating uncompensated care costs. In addition, we did not independently test the reliability of the data used by states to estimate uncompensated care costs. That is, we did not audit states' data sources or determine the extent to which they accurately captured costs and payments related to services to Medicaid enrollees or low-income uninsured individuals. We requested that the states review the data they reported to us and confirm that they were complete and represented 2006 hospital DSH payments and hospital DSH payment limits. We also checked for missing data and inconsistencies in the data. We determined that the states' data were sufficiently reliable for the purposes of comparing state-reported DSH payments to the state-calculated DSH payment limits and for assessing the extent to which states' methods for estimating uncompensated care costs accounted for Medicaid non-DSH supplemental payments. The information we obtained from the four states cannot be generalized to all states.

We conducted this performance audit from June 2008 through October 2009 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 objectives.

Appendix II: Issues Related to Disproportionate Share Hospital Payments in Two States

During the course of our review, we identified two issues related to compliance with federal requirements regarding disproportionate share hospital (DSH) payments. These issues were outside the scope of our review, as they dealt with hospitals' eligibility to receive DSH payments. We discussed these cases with CMS officials so that they could review them and take appropriate corrective actions. Specifically, we found the following.

- We found that Michigan made $34 million in DSH payments to a state-operated institution for mental diseases (IMD) for state fiscal year 2006, even though the IMD was not eligible to receive DSH payments because the IMD was not an enrolled and participating Medicaid provider. CMS officials confirmed that under federal law and regulations, all health care providers must be enrolled and certified to participate in Medicaid before they can receive Medicaid payments, including DSH payments.

- We identified one privately operated IMD in Texas that received a DSH payment despite having no uncompensated care costs. After making $46,000 in DSH payments to the IMD, the state realized the facility did not have uncompensated care costs and discontinued payments. The state did not recoup the payments, however, because according to state officials the payments were made in good faith that the hospital had uncompensated care costs.

We also identified a third issue that was resolved during the course of our review. Specifically, Michigan used a method for calculating DSH payment limits that did not always account for all Medicaid payments when calculating DSH payment limits. In 2006, we found that for nine hospitals, which had an outpatient surplus—payments for outpatient services that exceeded outpatient costs—the state chose to use only the uncompensated costs for inpatient services to calculate 2006 hospital DSH payment limits. By ignoring outpatient surpluses, the state overstated the hospitals' uncompensated care costs by $7.5 million, and the state made DSH payments exceeding these costs by $7.0 million. In July 2009, however, the state terminated this practice, effective for state fiscal year 2009. Officials stated that they changed their methods as a result of clarification provided in CMS's 2008 DSH rule.

Appendix III: Comparison of Disproportionate Share Hospital Payments to Payment Limits by Categories of Hospitals

This appendix provides the results of our analysis of state fiscal year 2006 disproportionate share hospital (DSH) payments, state-calculated DSH payment limits, and uncompensated care for each state we reviewed—California, Michigan, New York, and Texas. In each of the four states, for hospitals categorized by operating organization and hospital type, we calculated (1) DSH payments as a percentage of state-calculated DSH payment limits, (2) DSH payments as a percentage of total state DSH funding, and (3) uncompensated care provided as a percentage of total uncompensated care provided in each state.

- Table 5 provides information on DSH payments as a percentage of state-calculated DSH payment limits by operating organization (government or private) and state.
- Table 6 provides information on DSH payments as a percentage of state-calculated DSH payment limits by hospital type (general, institution for mental diseases (IMD), or children's)[1] and state.
- Table 7 provides information on DSH payments as a percentage of state-calculated DSH payment limits by state and by combinations of operating organization and hospital type.
- Table 8 provides information on uncompensated care costs as a share of total uncompensated care costs and DSH payments as a share of total DSH payments by state and by combinations of operating organization and hospital type.
- Table 9 provides information on DSH payments, non-DSH supplemental payments, and total supplemental payments by state and by combinations of operating organization and hospital type.

[1]We classified IMDs for children as IMDs because the federal aggregate limit on payments to IMDs includes IMDs for children.

Table 5: Number of Hospitals and DSH Payments as a Percentage of State-Calculated DSH Payment Limits by Operating Organization and State, State Fiscal Year 2006

(Dollars in millions)

State	Operating organization	Number of hospitals	Total DSH payments	Total state-calculated DSH payment limits	DSH payments as a percentage of DSH payment limits[a,b]
California[c]	Government	51	$2,065	$3,397	61%
	Private	96	<1	1,978	<1
Michigan	Government	23	197	225	88
	Private	104	243	1,119	22
New York	Government	49	1,103	2,333	47
	Private	177	774	2,446	32
Texas	Government	86	1,105	1,980	56
	Private	96	444	1,200	37

Source: GAO analysis of state-reported data on DSH payments and state-calculated DSH payment limits.

[a]DSH payments as a percentage of state-calculated DSH payment limits is in the aggregate (i.e., sum of payments divided by sum of state-calculated limits).

[b]For government-operated hospitals in California, state-calculated DSH payment limits were equal to 175 percent of uncompensated care costs associated with Medicaid and uninsured patients.

[c]Our analysis of California included DSH payments totaling $160 paid to 96 private hospitals—10 IMDs, 79 general hospitals, and 7 children's hospitals. The payment amounts for these private hospitals ranged from 1 cent to $14.53. The 96 private hospitals were eligible to receive a DSH payment.

Table 6: Number of Hospitals and DSH Payments as a Percentage of State-Calculated DSH Payment Limits by Hospital Type and State, State Fiscal Year 2006

(Dollars in millions)

State	Hospital type	Number of hospitals	Total DSH payments	Total state-calculated DSH payment limits	DSH payments as a percentage of limits[a,b]
California[c]	IMD	14	$<1	$50	<1%
	General	126	2,065	4,970	42
	Children's	7	<1	355	<1
Michigan	IMD	5	142	155	91
	General	121	281	1,166	24
	Children's	1	17	23	73
New York	IMD[d]	23	605	894	68
	General	202	1,272	3,881	33
	Children's[d]	1	<1	5	7
Texas	IMD	16	319	301	106[e]
	General	159	1,158	2,734	42
	Children's	7	72	144	50

Source: GAO analysis of state-reported data on DSH payments and state-calculated DSH payment limits.

[a]DSH payments as a percentage of state-calculated DSH payment limits is in the aggregate (i.e., sum of payments divided by sum of state-calculated limits).

[b]For government-operated hospitals in California, state-calculated DSH payment limits were equal to 175 percent of uncompensated care costs associated with Medicaid and uninsured patients.

[c]Our analysis of California included DSH payments totaling $160 paid to 96 private hospitals—10 IMDs, 79 general hospitals, and 7 children's hospitals. The payment amounts for these private hospitals ranged from 1 cent to $14.53. The 96 private hospitals were eligible to receive a DSH payment.

[d]We classified four IMDs for children in New York as IMDs because the federal aggregate limit on payments to IMDs included IMDs for children.

[e]DSH payments made to nine hospitals in Texas exceeded the hospitals' DSH payment limits. Texas officials reported that they made adjustments to the state's 2007 DSH payments that addressed overpayments made to these hospitals in 2006. We did not include any 2007 payment adjustments in this analysis of 2006 DSH payments.

Table 7: DSH Payments, State-Calculated DSH Payment Limits, and DSH Payments as a Percentage of Limits Grouped by State, Operating Organization, and Type of Hospital, State Fiscal Year 2006

(Dollars in millions)

State	Operating organization	Hospital type	Number of hospitals	Total DSH payments	Total state-calculated DSH payment limits	DSH payments as a percentage of limits[a,b]
California[c]	Government	IMD	4	$<1	$18	1%
	Government	General	47	2,065	3,379	61
	Private	IMD	10	<1	32	<1
	Private	General	79	<1	1,591	<1
	Private	Children's	7	<1	355	<1
Michigan	Government	IMD	5	142	155	91
	Government	General	18	55	70	79
	Private	General	103	226	1,096	21
	Private	Children's	1	17	23	73
New York	Government	IMD[d]	23	605	894	68
	Government	General	26	498	1,440	35
	Private	General	176	774	2,441	32
	Private	Children's[d]	1	<1	5	7
Texas	Government	IMD	9	313	295	106[e]
	Government	General	77	792	1,685	47
	Private	IMD	7	5	7	80
	Private	General	82	366	1,049	35
	Private	Children's	7	72	144	50

Source: GAO analysis of state-reported data on DSH payments and state-calculated DSH payment limits.

[a]DSH payments as a percentage of state-calculated DSH payment limits is in the aggregate (i.e., sum of payments divided by sum of state-calculated limits).

[b]For government-operated hospitals in California, state-calculated DSH payment limits were equal to 175 percent of uncompensated care costs associated with Medicaid and uninsured patients.

[c]Our analysis of California included DSH payments totaling $160 paid to 96 private hospitals, The payment amounts for these private hospitals ranged from 1 cent to $14.53. The 96 private hospitals were eligible to receive a DSH payment.

[d]We classified four IMDs for children in New York as IMDs because the federal aggregate limit on payments to IMDs included IMDs for children.

[e]DSH payments made to nine hospitals in Texas exceeded the hospitals' DSH payment limits. Texas officials reported that they made adjustments to the state's 2007 DSH payments that addressed overpayments made to these hospitals in 2006. We did not include any 2007 payment adjustments in this analysis of 2006 DSH payments.

Table 8: Hospitals' Share of Total Uncompensated Care Costs, Hospitals' Share of Total DSH Payments, and Total DSH Payments by State, Operating Organization, and Hospital Type, State Fiscal Year 2006

(Dollars in millions)

State	Operating organization	Hospital type	Number of hospitals	Share of total uncompensated care costs[a]	Share of total DSH payments	Total DSH payments
California[b]	Government	IMD	4	<1%	<1%	$<1
	Government	General	47	50	100	2,065
	Private	IMD	10	<1	<1	<1
	Private	General	79	40	<1	<1
	Private	Children's	7	9	<1	<1
Michigan	Government	IMD	5	12	32	142
	Government	General	18	5	13	55
	Private	General	103	82	52	226
	Private	Children's	1	2	4	17
New York	Government	IMD[c]	23	19	32	605
	Government	General	26	30	27	498
	Private	General	176	51	41	774
	Private	Children's[c]	1	<1	<1	<1
Texas	Government	IMD	9	9	20	313
	Government	General	77	53	51	792
	Private	IMD	7	<1	<1	5
	Private	General	82	33	24	366
	Private	Children's	7	5	5	72
All four states	Government	IMD	41	10	18	1,060
	Government	General	168	39	58	3,410
	Private	IMD	17	<1	<1	5
	Private	General	440	47	23	1,366
	Private	Children's	16	4	2	89

Source: GAO analysis of state-reported data on DSH payments and state-calculated uncompensated care costs.

[a]We used state-calculated uncompensated care costs for this analysis, including for the 49 government hospitals in California that were eligible to receive DSH payments up to 175 percent of uncompensated care costs.

[b]Our analysis of California included DSH payments totaling $160 paid to 96 private hospitals. The payment amounts for these private hospitals ranged from 1 cent to $14.53. The 96 private hospitals were eligible to receive a DSH payment.

[c]We classified four IMDs for children in New York as IMDs because the federal aggregate limit on payments to IMDs included IMDs for children.

Table 9: DSH Payments, Non-DSH Supplemental Payments, and Total Supplemental Payments by State, Operating Organization, and Hospital Type, State Fiscal Year 2006

(Dollars in millions)

State	Operating organization	Hospital type	Number of hospitals	DSH payments	Non- DSH supplemental payments	Total DSH and non-DSH supplemental payments[a]
California[b]	Government	IMD	4	$<1	$0	$<1
	Government	General	47	2,065	1,216	3,281
	Private	IMD	10	<1	0	<1
	Private	General	79	<1	122	122
	Private	Children's	7	<1	82	82
Michigan	Government	IMD	5	142	0	142
	Government	General	18	55	77	131
	Private	General	103	226	470	696
	Private	Children's	1	17	54	71
New York	Government	IMD[c]	23	605	0	605
	Government	General	26	498	0	498
	Private	General	176	774	0	774
	Private	Children's[c]	1	<1	0	<1
Texas	Government	IMD	9	313	0	313
	Government	General	77	792	773	1,565
	Private	IMD	7	5	0	5
	Private	General	82	366	79	445
	Private	Children's	7	72	32	104
All four states	Government	IMD	41	1,060	0	1,060
	Government	General	168	3,410	2,067	5,476
	Private	IMD	17	5	0	5
	Private	General	440	1,366	671	2,038
	Private	Children's	16	89	168	257

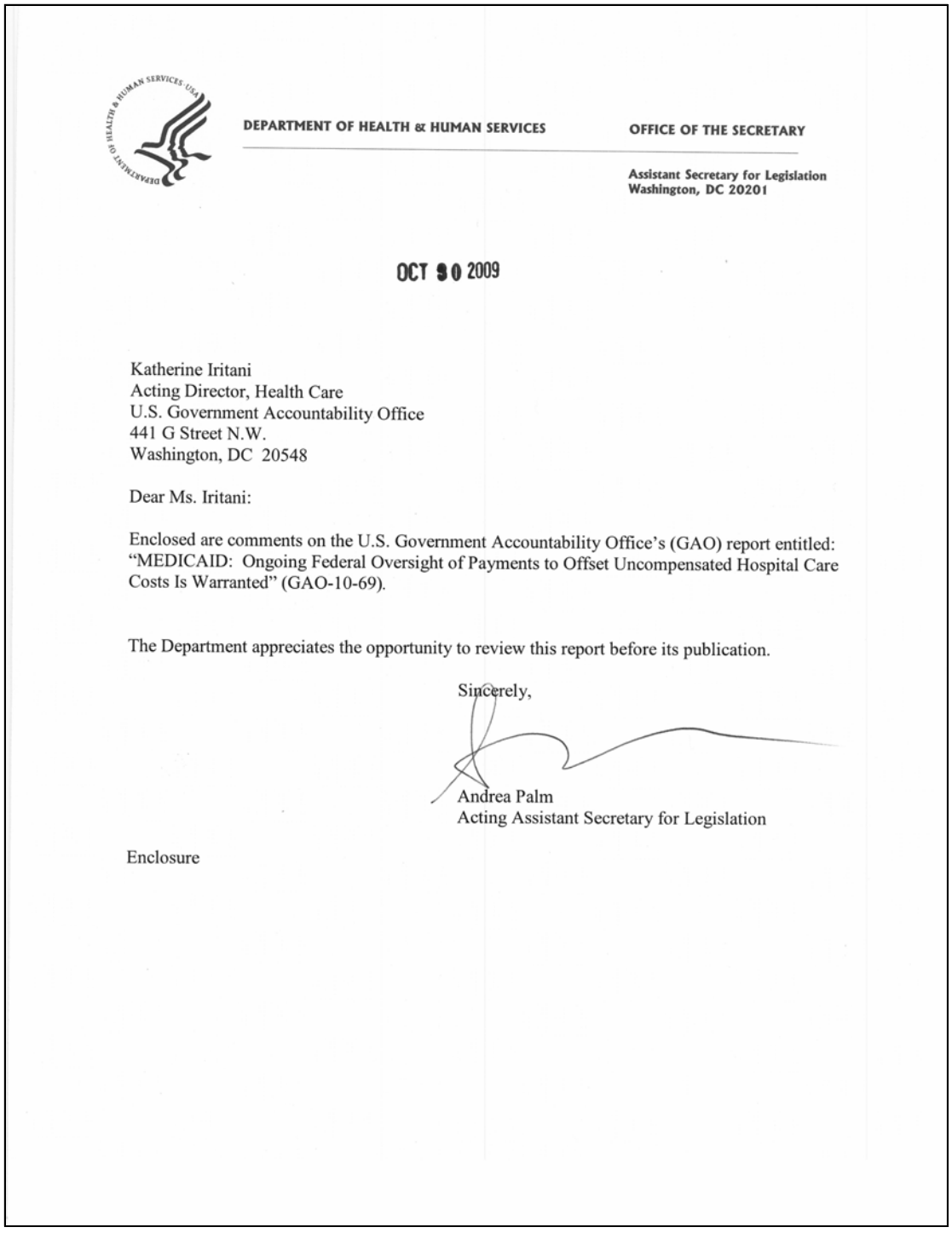
Source: GAO analysis of state-reported data on DSH payments and non-DSH supplemental payments.

[a]DSH and non-DSH supplemental payments may not sum to total because of rounding.

[b]Our analysis of California includes DSH payments totaling $160 paid to 96 private hospitals. The payment amounts for these private hospitals ranged from 1 cent to $14.53. The 96 private hospitals were eligible to receive a DSH payment.

[c]We classified four IMDs for children in New York as IMDs because the federal aggregate limit on payments to IMDs included IMDs for children.

Appendix IV: Comments from the Department of Health & Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES — OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

OCT 30 2009

Katherine Iritani
Acting Director, Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

Dear Ms. Iritani:

Enclosed are comments on the U.S. Government Accountability Office's (GAO) report entitled: "MEDICAID: Ongoing Federal Oversight of Payments to Offset Uncompensated Hospital Care Costs Is Warranted" (GAO-10-69).

The Department appreciates the opportunity to review this report before its publication.

Sincerely,

Andrea Palm
Acting Assistant Secretary for Legislation

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: OCT 30 2009

TO: Andrea Palm
Acting Assistant Secretary for Legislation
Office of the Secretary

FROM: Charlene Frizzera
Charlene Frizzera
Acting Administrator

SUBJECT: Government Accountability Office (GAO) Draft Report "MEDICAID: Ongoing Federal Oversight of Payments to Offset Uncompensated Hospital Care Costs is Warranted" (GAO-10-69)

We appreciate the opportunity to review and comment on the above referenced draft report. The draft report is in response to a request for information from Senator Charles Grassley on how States' disproportionate share hospital (DSH) payments to individual hospitals and categories of hospitals compare to hospital DSH payment limits and on State methods for estimating uncompensated care costs.

In four States selected on the basis of their large supplemental payments, GAO examined the ways in which 2006 DSH payments to individual hospitals and categories of hospitals compare to 2006 DSH payment limits, and also examined certain aspects of States' methods for estimating uncompensated care costs for the purpose of calculating hospitals' 2006 DSH payment limits. The GAO found in the selected States that—

- DSH payments in 2006 varied widely as a percentage of the State-calculated hospital-specific DSH payment limits;
- States paid government-operated hospitals a relatively high proportion of their State-calculated hospital-specific DSH limits
- Two States overestimated their uncompensated care costs because they did not account for Medicaid non-DSH supplemental payments; and
- States did not consistently update or independently audit DSH payment limits.

The draft report concludes that ongoing Federal oversight is warranted to ensure that States are following Federal requirements and taking corrective actions as needed.

The report references the DSH audit and reporting final rule published in December 2008. This final rule implements section 1001 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and, requires independent auditing of DSH limits and payments for all DSH hospitals in all States. We note that in the draft report, because of the

timing of the final rule, the GAO did not consider this rule or the related provisions of the MMA as requirements for the 2006 payments that the GAO reviewed. The Centers for Medicare & Medicaid Services (CMS) agrees that this final rule is "a positive step toward improved Federal oversight"[1] of Medicaid supplemental payments. In regard to implementation timeframes, the draft report acknowledges that "Although States were not required by CMS to either update DSH payment limits with actual cost and payment data or have DSH payment limit calculations independently audited in 2006, CMS will require all States to do so in the future."[2] The draft report also says, "Although the 2008 DSH rule set a December 2009 deadline for States' 2005 and 2006 DSH audits and reports, CMS provided States with a transition period – through payment year 2010 – before the agency will take any action on the reports."[3] We believe this language should be revised for clarity and propose that the following explanatory information be included in the body of the report:

> "In light of States' concerns regarding budget cycles, planning complications, and the economic downturn, CMS has determined that it will apply a flexible enforcement strategy designed to ensure that States have sufficient time to properly implement the new requirements without undue hardship. Thus, CMS will not find a State to be out of compliance with the DSH reporting and auditing requirements for the initial (2005 and 2006) Medicaid State plan rate years until December 31, 2010. Pursuant to the provisions of the regulation, independent audits must begin with Medicaid State plan year 2005, and must be completed no later than September 30, 2009, for the State plan rate years 2005 and 2006. Audits and reports for State plan rate years 2005 and 2006 are due to CMS on or before December 31, 2009. In the final rule, CMS provided a transition period to allow States time for developing and refining reporting and auditing techniques. During the transition period, States must complete the independent audits and submit the required reports in accordance with the provisions of the regulation. However, findings of State reports and audits for Medicaid State plan years 2005-2010 will not be given weight, except to the extent that the findings draw into question the reasonableness of State uncompensated care cost estimates used for calculations of prospective DSH payments for Medicaid State plan year 2011 and thereafter."

In addition, Figure 1: Basic Components for Calculating Hospital DSH Payment Limits, should clarify that the hospital-specific DSH limit calculation must account for situations where Medicaid revenues exceed Medicaid costs. Current Federal law expressly demands the offset of all payments under Title XIX (other than DSH payments) when determining hospital-specific DSH limits. This includes revenue received that is in excess of cost. Medicaid inpatient and outpatient hospital revenues received by hospitals in excess of Medicaid inpatient and outpatient hospital costs must also be offset against the eligible uncompensated inpatient and outpatient hospital costs associated with individuals with no source of third party coverage for the inpatient/ outpatient hospital services that they received.

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[1] GAO, *MEDICAID: Ongoing Federal Oversight of Payments to Offset Uncompensated Hospital Care Costs is Warranted*, GAO-10-069 (Washington D.C.: September, 2009). Page 27.
[2] Ibid, Page 25.
[3] Ibid, Page 26.

GAO Recommendation

GAO recommends that CMS ensure that States account for all Medicaid payments, including non-DSH supplemental payments, when calculating DSH payment limits.

CMS Response

The CMS agrees with the recommendation and finds it consistent with ongoing efforts by the Agency to ensure a more efficient and economic Medicaid program. The final DSH audit and reporting rule set forth data elements necessary to comply with the requirements of section 1923(j) of the Social Security Act (the Act) related to auditing and reporting of DSH payments under State Medicaid programs. As the draft report notes, the final DSH audit and reporting rule provides CMS with tools needed to assess States' compliance with hospital-specific DSH limits at section 1923(g) of the Act, and to take action as needed. Since the final rule was published, CMS—

- Has provided question and answer technical assistance to States, provider groups, and the accountant community;
- Has conducted national conference calls outlining the rule requirements and the implementation processes;
- Has participated in State-specific calls regarding the requirements; and
- Is preparing to post on our policy website a list of frequently asked questions.

The CMS will continue to work with States and their partners to ensure universal understanding of the DSH audit and reporting requirements.

The draft report states that the effect of the rule will depend on the extent to which CMS uses the information reported by States to identify and correct problems in State DSH programs. CMS reminds the GAO that we are bound by the final rule which requires that, during the transition period, a State's failure to complete the audits and required reporting by the specified deadlines would put Federal financial participation (FFP) for that State's DSH expenditures at risk. After the transition period, FFP will not be available for expenditures for DSH payments that are found in the audit to exceed the hospital-specific eligible uncompensated care cost limit.

We thank the GAO staff for their work in this important area of Medicaid DSH hospital-specific limits and payments to providers, and look forward to working with the GAO on this and other issues.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Katherine M. Iritani, (202) 512-7114 or Iritanik@gao.gov

Acknowledgments

In addition to the contact name above, James C. Cosgrove, Director; Catina Bradley, Assistant Director; Susannah Bloch; Tim Bushfield; Helen Desaulniers; Aaron Holling; Tom Moscovitch; Perry Parsons; and Hemi Tewarson made key contributions to this report.

Related GAO Products

High-Risk Series: An Update. GAO-09-271. Washington, D.C.: January 22, 2009.

Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments. GAO-08-614. Washington D.C.: May 30, 2008.

Medicaid Financing: Long-Standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight. GAO-08-650T. Washington D.C.: April 3, 2008.

Medicaid Financing: Long-Standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight. GAO-08-255T. Washington D.C.: November 1, 2007.

Medicaid Financing: Federal Oversight Initiative is Consistent with Medicaid Payment Principles but Needs Greater Transparency. GAO-07-214. Washington D.C.: March 30, 2007.

Medicaid Financial Management: Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts. GAO-06-705. Washington D.C.: June 22, 2006.

Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight. GAO-05-748. Washington D.C.: June 28, 2005.

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