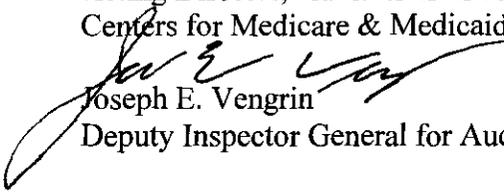




OCT 13 2004

**TO:** Wynethea Walker  
Acting Director, Audit Liaison Staff  
Centers for Medicare & Medicaid Services

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

**SUBJECT:** Review of Illinois Medicaid Disproportionate Share Hospital Payments  
to Mount Sinai Hospital of Chicago (A-05-01-00102)

Attached is an advance copy of our final report on Illinois Medicaid disproportionate share hospital (DSH) payments to Mount Sinai Hospital of Chicago. We will issue this report to the Illinois Medicaid agency within 5 business days. We conducted the audit as part of a multistate initiative requested by the Centers for Medicare & Medicaid Services.

Section 1923 of the Social Security Act, as amended by the Omnibus Budget Reconciliation Act of 1993, requires that States make Medicaid DSH payments to hospitals that serve disproportionate numbers of low-income patients with special needs. The statute limits these payments to a hospital's uncompensated care costs, which are the annual costs incurred to provide services to Medicaid and uninsured patients less payments received for those patients. This limit is known as the hospital-specific limit.

Our objective was to determine whether DSH payments to Mount Sinai Hospital exceeded the hospital-specific limits imposed by section 1923(g) of the Social Security Act. Specifically, we determined whether the Medicaid inpatient, outpatient, and DSH payments made by Illinois to the hospital exceeded the hospital's costs of providing inpatient and outpatient services to Medicaid beneficiaries and uninsured patients (charity care).

The State's DSH payments to Mount Sinai Hospital exceeded the hospital-specific limits. The State paid about \$9 million in excess of the hospital's costs of providing inpatient and outpatient services to Medicaid and uninsured patients during State fiscal years 1997 through 2000. The Federal share of the overpayments is about \$4.5 million.

The excessive payments occurred because the State did not have effective procedures to ensure compliance with the hospital-specific limits or with State plan and State Administrative Code requirements. For example, the State did not use actual cost data to calculate DSH payments. The State also did not compare Medicaid payments (including DSH payments) with the hospital's actual Medicaid and charity care costs and did not adjust DSH payments as required by the State plan's retroactive adjustment provisions.

## **RECOMMENDATIONS**

We recommend that the State:

- refund \$4,516,112 to the Federal Government
- compare annual Medicaid payments (including DSH payments) with the actual cost of providing services to Medicaid and uninsured patients for all hospitals receiving DSH payments and, if applicable, make retroactive adjustments as required by the State plan, including the recovery of any identified overpayments

The State disagreed with our recommendations. The State commented that its State plan methodology for determining compliance with the hospital-specific limits was prospective and that reference in the State plan to retroactive adjustments did not make the methodology retrospective. According to the State, its methodology for determining Medicaid costs for estimating hospital-specific limits was consistent with Medicare payment principles and was the same as that used to ensure compliance with hospital upper payment limits.

The Federal statute that addresses hospital-specific limits refers to costs as “the costs incurred during the year of furnishing hospital services.” Retroactive adjustments in accordance with the State plan would be consistent with the statute’s apparent overall purpose to ensure that payments do not exceed the hospital-specific limits based on costs incurred during the year of furnishing the services. We did not question the State’s methodology for calculating the hospital-specific limits for Mt. Sinai Hospital. Our finding relates to the State’s failure to compare Medicaid payments (including DSH payments) with the hospital’s actual Medicaid and charity care costs and adjust DSH payments as required by the State plan’s retroactive adjustment provisions.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Paul Swanson, Regional Inspector General for Audit Services, Region V, at (312) 353-2618.

Attachment



DEPARTMENT OF HEALTH AND HUMAN SERVICES

REGION V  
105 W ADAMS ST  
CHICAGO ILLINOIS 60603-6201

OFFICE OF  
INSPECTOR GENERAL

OCT 18 2004

Report Number: A-05-01-00102

Mr. Barry S. Maram  
Director  
Illinois Department of Public Aid  
201 South Grand Avenue East  
Springfield, Illinois 62763-0001

Dear Mr. Maram:

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

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

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

Please refer to report number A-05-01-00102 in all correspondence.

Sincerely,

Paul Swanson  
Regional Inspector General  
for Audit Services

Enclosures – as stated

Page 2 – Mr. Barry S. Maram

**Direct Reply to HHS Action Official:**

Ms. Cheryl Harris  
Associate Regional Administrator  
Division of Medicaid and Children's Health  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
233 North Michigan Avenue, Suite 600  
Chicago, Illinois 60601-5519

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF ILLINOIS MEDICAID  
DISPROPORTIONATE SHARE HOSPITAL  
PAYMENTS TO  
MOUNT SINAI HOSPITAL OF CHICAGO**

**ILLINOIS DEPARTMENT OF PUBLIC AID  
SPRINGFIELD, ILLINOIS**



October 2004  
A-05-01-00102

# ***Office of Inspector General***

**<http://oig.hhs.gov>**

---

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## ***Office of Audit Services***

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the department.

## ***Office of Evaluation and Inspections***

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. The OEI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

## ***Office of Investigations***

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

## ***Office of Counsel to the Inspector General***

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

# *Notices*

---

**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
at <http://oig.hhs.gov>

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR part 5.)

## **OAS FINDINGS AND OPINIONS**

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



## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Section 1923 of the Social Security Act, as amended, requires that States make Medicaid disproportionate share hospital (DSH) payments to hospitals that serve disproportionate numbers of low-income patients with special needs. The Omnibus Budget Reconciliation Act of 1993 limits these payments to a hospital's uncompensated care costs, which are the annual costs incurred to provide services to Medicaid and uninsured patients less payments received for those patients. This limit is known as the hospital-specific limit.

States have considerable flexibility in defining their DSH programs under section 1923(a) and (b) of the Social Security Act. Each State prepares a State plan that defines how it will operate its Medicaid program and is required to submit the plan to the Centers for Medicare & Medicaid Services (CMS) for approval. The Illinois Department of Public Aid administers the Illinois Medicaid program and computes and distributes DSH payments to DSH-eligible hospitals, including Mount Sinai Hospital of Chicago.

### **OBJECTIVE**

Our objective was to determine whether DSH payments to Mount Sinai Hospital exceeded the hospital-specific limits imposed by section 1923(g) of the Social Security Act. Specifically, we determined whether the Medicaid inpatient, outpatient, and DSH payments made by Illinois to the hospital exceeded the hospital's costs of providing inpatient and outpatient services to Medicaid beneficiaries and uninsured patients (charity care).

### **SUMMARY OF FINDINGS**

The State's DSH payments to Mount Sinai Hospital exceeded the hospital-specific limits. The State paid about \$9 million in excess of the hospital's costs of providing inpatient and outpatient services to Medicaid and uninsured patients during State fiscal years 1997 through 2000. The Federal share of the overpayments is about \$4.5 million.

These excessive payments occurred because the State did not have effective procedures to ensure compliance with the hospital-specific limits or with State plan and State Administrative Code requirements. For example, the State did not use actual cost data to calculate DSH payments. The State also did not compare Medicaid payments (including DSH payments) with the hospital's actual Medicaid and charity care costs and did not adjust DSH payments as required by the State plan's retroactive adjustment provisions.

### **RECOMMENDATIONS**

We recommend that the State:

- refund \$4,516,112 to the Federal Government

- compare annual Medicaid payments (including DSH payments) with the actual cost of providing services to Medicaid and uninsured patients for all hospitals receiving DSH payments and, if applicable, make retroactive adjustments as required by the State plan, including the recovery of any identified overpayments

## **STATE COMMENTS**

The State disagreed with our recommendations. The State commented that its State plan methodology was prospective and that reference in the State plan to retroactive adjustments did not make the methodology retrospective. According to the State, its methodology for determining Medicaid costs for estimating hospital-specific limits was consistent with Medicare payment principles and was the same as that used to ensure compliance with hospital upper payment limits.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

The Federal statute that addresses hospital-specific limits refers to costs as “the costs incurred during the year of furnishing hospital services.” Retroactive adjustments in accordance with the State plan would be consistent with the statute’s apparent overall purpose to ensure that payments do not exceed the hospital-specific limits based on costs incurred during the year of furnishing the services. We did not question the State’s methodology for calculating the hospital-specific limits for Mount Sinai Hospital. Our finding relates to the State’s failure to compare Medicaid payments (including DSH payments) with the hospital’s actual Medicaid and charity care costs and adjust DSH payments as required by the State plan’s retroactive adjustment provisions.

We summarized the State’s comments in the report and included the comments in their entirety as Appendix B.

# TABLE OF CONTENTS

	<u>Page</u>
<b>INTRODUCTION</b> .....	1
<b>BACKGROUND</b> .....	1
Medicaid and the DSH Program.....	1
Illinois DSH Program for Acute Care Facilities.....	1
State Estimates for Hospital-Specific Limits.....	2
<b>OBJECTIVE, SCOPE, AND METHODOLOGY</b> .....	2
Objective.....	2
Scope .....	2
Methodology.....	3
<b>FINDINGS AND RECOMMENDATIONS</b> .....	3
<b>COMPLIANCE WITH HOSPITAL-SPECIFIC LIMITS</b> .....	3
Limitation on DSH Payments .....	3
Payments in Excess of Hospital-Specific Limits .....	4
Actual Cost Data Not Used.....	4
Retroactive Adjustments Not Made.....	5
Uncompensated Charity Care Charges Inaccurately Reported.....	5
<b>RECOMMENDATIONS</b> .....	5
<b>STATE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE</b> .....	5
<b>APPENDICES</b>	
A – CALCULATION OF HOSPITAL-SPECIFIC LIMITS	
B – STATE COMMENTS	

## INTRODUCTION

### BACKGROUND

#### Medicaid and the DSH Program

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

The Omnibus Budget Reconciliation Act of 1981 established the DSH program, which is codified in section 1923 of the Social Security Act. Section 1923 requires State Medicaid agencies to make additional payments to hospitals that serve disproportionate numbers of low-income patients with special needs. The Omnibus Budget Reconciliation Act of 1993 limits these payments to a hospital's uncompensated care costs, which are the annual costs incurred to provide services to Medicaid and uninsured patients less payments received for those patients. This limit is known as the hospital-specific limit.

States have considerable flexibility in defining their DSH programs under section 1923(a) and (b) of the Social Security Act. States receive allotments of DSH funds as set forth by section 1923. The Federal Government shares in the cost of Medicaid DSH expenditures based on the Federal medical assistance percentage for each State. In Illinois, the Federal medical assistance percentage is 50 percent, and the State's share is 50 percent.

#### Illinois DSH Program for Acute Care Facilities

The Illinois Department of Public Aid administers the Illinois DSH program under provisions of section 1923 of the Social Security Act and 89 Illinois Administrative Code, chapter I, section 148.120. Qualified acute care hospitals, including Mount Sinai Hospital, receive DSH funding as an add-on to their regular per diem payments for individual Medicaid inpatient hospital admissions. The State determines DSH payment rates in accordance with the approved State plan and, for the most part, calculates the rates using a complex system of tiered rates that generally increase as Medicaid inpatient utilization increases. The State does not, however, calculate DSH rates on the basis of the uncompensated care costs incurred by the hospitals.

Annually, the State compiles information for computing hospital-specific limits and compares its computed limits with the budgeted DSH funding. The State incorporates its Medicaid upper-payment-limit calculation methodology into this process.<sup>1</sup>

The Illinois Administrative Code and the State plan implement the hospital-specific DSH limits. Both require adjustments to an individual hospital's DSH payments if the sum of Medicaid

---

<sup>1</sup>The Medicaid upper payment limit is an estimate of the maximum amount that would be paid (excluding DSH payments), in the aggregate, to a group of facilities, such as hospitals, on a statewide basis under Medicare payment principles. It represents a ceiling on Medicaid payments, other than DSH payments, to groups of facilities.

inpatient, outpatient, and DSH payments to the hospital exceeds the costs of providing services to Medicaid beneficiaries and persons without insurance. The State plan provides that if the estimated DSH payments exceed the DSH limit, the State will reduce the hospital's DSH rate so that its DSH payments will equal the DSH limit. The State plan also provides that retroactive adjustments will be made if necessary.

### **State Estimates for Hospital-Specific Limits**

In determining whether budgeted Medicaid payments were in compliance with the hospital-specific limits, Illinois used the following process to estimate a hospital's costs.

- **Medicaid Inpatient Costs.** The State used estimates from its inpatient upper-payment-limit calculation, which was based on each hospital's "costs per discharge" for State fiscal year 1992. The State adjusted the base-year costs per discharge for inflation and case-mix factors and applied the costs to the estimated number of discharges for each hospital.
- **Medicaid Outpatient Costs.** The State used amounts from its outpatient upper-payment-limit calculation. That calculation was based on State fiscal year 1994 Medicaid outpatient charges subject to further adjustment and factoring.
- **Uncompensated Charity Care Costs.** The State used charges reported on each hospital's OBRA 1993 Data Collection Form for the second preceding year as a base year. It then inflated the base-year charges and applied the hospital's cost-to-charge ratio for the third preceding year to arrive at each year's estimated uncompensated charity care costs.

For each hospital, the State compared the total estimated Medicaid inpatient, outpatient, and uncompensated charity care costs with the budgeted Medicaid liability. If the budgeted payments were less than the estimated costs, the State concluded that the hospital-specific limit was not exceeded.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether DSH payments to Mount Sinai Hospital exceeded the hospital-specific limits imposed by section 1923(g) of the Social Security Act. Specifically, we determined whether the Medicaid inpatient, outpatient, and DSH payments made by Illinois to the hospital exceeded the hospital's costs of providing inpatient and outpatient services to Medicaid beneficiaries and uninsured patients (charity care).

### **Scope**

Our audit scope included a comparison of Mount Sinai Hospital's Medicaid inpatient, outpatient, and charity care costs of \$282.5 million with its Medicaid inpatient, outpatient, and DSH

payments of \$291.5 million for the 4-year period covering State fiscal years 1997 through 2000.<sup>2</sup> We did not evaluate the State's or the hospital's internal management controls, nor did we audit the hospital's financial statements or cost reports.

## **Methodology**

To accomplish our objective, we consulted applicable laws, regulations, Medicaid guidelines, and the State plan. We also collected summarized data on Medicaid inpatient costs, Medicaid outpatient costs, and uncompensated charity care costs from Mount Sinai Hospital for State fiscal years 1997 through 2000. In addition, we obtained summarized Medicaid inpatient, outpatient, and DSH payment data from the State for the same period. From the hospital's inpatient and outpatient cost data, we computed a cost-to-charge ratio and applied it to the hospital's uninsured patient charges (charity care) in order to calculate the costs of providing inpatient and outpatient services to uninsured patients (charity care). To determine compliance with the hospital-specific limits, we added Medicaid inpatient costs, Medicaid outpatient costs, and charity care costs and compared the total with total Medicaid inpatient, outpatient, and DSH payments to the hospital.

At the request of State officials, we did not discuss the results of our calculation of Mount Sinai Hospital's hospital-specific limits, or the financial impact of our findings, with hospital officials. We did, however, discuss with them the accuracy of the cost and payment data used in our calculations. They generally agreed that the data were accurate.

We performed fieldwork at Mount Sinai Hospital in Chicago, IL, and at the State offices in Springfield, IL. We conducted the audit in accordance with generally accepted government auditing standards.

## **FINDINGS AND RECOMMENDATIONS**

### **COMPLIANCE WITH HOSPITAL-SPECIFIC LIMITS**

During State fiscal years 1997 through 2000, DSH payments to Mount Sinai Hospital exceeded the hospital-specific limits of section 1923(g) of the Social Security Act. Specifically, the State's Medicaid inpatient, outpatient, and DSH payments to the hospital exceeded the hospital's costs of providing inpatient and outpatient services to Medicaid and uninsured patients by about \$9 million (\$4.5 million Federal share). The excessive payments occurred because the State did not use actual cost data to calculate DSH payments and did not make retroactive adjustments.

#### **Limitation on DSH Payments**

Section 1923(g) of the Social Security Act provides that DSH payments to a hospital may not exceed:

. . . the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either

---

<sup>2</sup>Illinois operates under the State fiscal year that ends on June 30.

are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year.

In an August 1994 letter to State Medicaid agencies, CMS provided guidance regarding implementation of the hospital-specific limits. According to the letter, the limit is composed, in part, of the Medicaid shortfall, which is the cost of services furnished to Medicaid beneficiaries less the non-DSH Medicaid payments made to the hospitals. The letter defined the other part of the limit as the cost of services provided to patients who have no health insurance or source of third-party payment for services provided during the year, less the payments made by these patients.

**Payments in Excess of Hospital-Specific Limits**

The following table summarizes the DSH payments made to Mount Sinai Hospital, the hospital-specific limits, and the resulting payments in excess of the hospital-specific limits for State fiscal years 1997 through 2000. (See Appendix A for details on our calculation of the hospital-specific limit for each year.)

**Overpayment Calculation**

<u>State Fiscal Year</u>	<u>DSH Payments</u>	<u>Hospital- Specific Limit</u>	<u>Overpayments</u>
1997	\$ 6,033,795	\$ 2,584,083	\$ 3,449,712
1998	5,839,042	3,583,983	2,255,059
1999	5,634,130	2,972,330	2,661,800
2000	21,783,205	21,117,552	665,653
<b>Total</b>	<b><u>\$39,290,172</u></b>	<b><u>\$30,257,948</u></b>	<b><u>\$9,032,224</u></b>
<b>Federal Share</b>			<b><u>\$4,516,112</u></b>

These overpayments occurred because the State did not have effective procedures to ensure compliance with the hospital-specific limits or with State plan and State Administrative Code requirements.

**Actual Cost Data Not Used**

The State did not use the hospital’s actual cost data to calculate DSH payments, but instead used a number of estimates in the calculations. For inpatient costs, the State used cost figures from State fiscal year 1992 hospital patient discharges and adjusted these costs for inflation and case-mix factors. The State applied the trended-forward cost figures to the number of estimated hospital discharges for each year from 1997 through 2000. For outpatient costs, the State used State fiscal year 1994 outpatient charges subject to further adjustment and factoring. For uncompensated charity care costs, the State used uncompensated charity care charges reported on the OBRA 1993 Data Collection Form for the second preceding fiscal year (for each year of 1997 through 2000) and inflated these charges by an inflation factor of 8.67 percent for each year. The State then applied the hospital cost report’s cost-to-charge ratio for the third preceding

year (for each year of 1997 through 2000) against these trended-forward charges to arrive at each year's estimated uncompensated charity care costs.

### **Retroactive Adjustments Not Made**

The State did not compare Medicaid payments (including DSH payments) with Mount Sinai Hospital's actual Medicaid and charity care costs and make retroactive adjustments as required by the State plan. The State plan, Attachment 4.19-A, section (VI)(C)(7)(f)(iv) states, in part, that "adjustments to individual hospital's disproportionate share payments shall be made if the sum of Medicaid payments (inpatient, outpatient, and disproportionate share) made to a hospital exceed the costs of providing services to Medicaid clients and persons without insurance . . . if necessary, retroactive adjustments will be made."

### **Uncompensated Charity Care Charges Inaccurately Reported**

Mount Sinai Hospital improperly included uncompensated charges for insured patients (unpaid copayments or third-party obligations) in its calculation of uncompensated charity care charges. We reported this issue in our prior report, "Review of Illinois Medicaid Disproportionate Share Hospital Payments to the University of Illinois at Chicago Hospital" (A-05-01-00099, dated October 13, 2004). In that report, we recommended that the State provide clear guidelines on properly reporting uncompensated charity care charges on the OBRA 1993 Data Collection Form.

## **RECOMMENDATIONS**

We recommend that the State:

- refund \$4,516,112 to the Federal Government
- compare annual Medicaid payments (including DSH payments) with the actual cost of providing services to Medicaid and uninsured patients for all hospitals receiving DSH payments and, if applicable, make retroactive adjustments as required by the State plan, including the recovery of any identified overpayments

## **STATE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

The State disagreed with our findings and recommendations. We have included the State's comments in their entirety as Appendix B. A summary of these comments and our response follow.

### **State Comments**

The State believed that the findings were based, in large part, on a misinterpretation of selective language from the relevant page of the State plan. Within its comments, the State included text from the State plan that had been omitted from our report. The State believed that our approach (use of actual data) differed from the State plan methodology, which, it contended, was a

prospective methodology. According to the State, we appeared to have inappropriately relied on a sentence in this State plan provision that states, “If necessary, retroactive adjustments will be made.” The State said that we seemed to be confusing the term “retroactive” with the term “retrospective”; it stated that the term “retroactive” described a process in which something is made effective to a date prior to enactment, while the term “retrospective” indicated a review, mediation, or reconciliation based on past events. The State indicated that reference in the State plan to retroactive adjustments did not make the methodology retrospective.

### **Office of Inspector General Response**

The Federal statute that addresses the hospital-specific limit refers to costs as “the costs incurred during the year of furnishing hospital services.” Retroactive adjustments in accordance with the State plan would be consistent with the apparent overall purpose of the statute to ensure that payments do not exceed the hospital-specific limits based on costs incurred during the year of furnishing the services. We note that the definition of the term “retroactive” includes “affecting things past.”

### **State Comments**

Illinois stated that Federal regulation did not prescribe the methodology that States were to use in determining the DSH payment limits. It quoted from the August 1994 CMS letter to State Medicaid directors, as follows:

. . . in defining “costs of services” under this provision, [CMS] would permit the State to use the definition of allowable costs in its State plan, or any other definition, as long as the costs determined under such a definition do not exceed the amounts that would be allowable under Medicare principles of cost reimbursement. The Medicare principles are the general upper payment limit under institutional payment under the Medicaid program . . . .

The State indicated that its methodology for determining hospital-specific DSH payment limits, and related compliance with those limits, was a prospective methodology consistent with Medicare payment principles and was the same as that used by Illinois to ensure compliance with hospital upper payment limits (42 CFR §§ 447.272 and 447.321).

### **Office of Inspector General Response**

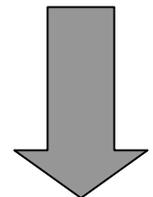
We did not question the methodology that the State used to calculate the hospital-specific limits for Mount Sinai Hospital. Our finding relates to the State’s failure to compare Medicaid payments (including DSH payments) with the hospital’s actual Medicaid and charity care costs and adjust DSH payments as required by the State plan’s retroactive adjustment provisions.

# **APPENDICES**

APPENDIX A

**CALCULATION OF HOSPITAL-SPECIFIC LIMITS**  
**State Fiscal Years 1997 Through 2000**

<u>State Fiscal Year</u>	<u>(A) Total Medicaid Inpatient and Outpatient Costs</u>	<u>(B) Total Medicaid Inpatient and Outpatient Payments (Excluding DSH Payments)</u>	<u>(A)-(B) = (C) Total Medicaid Shortfall</u>	<u>(D) Charity Care Costs</u>	<u>(C)+(D) Hospital- Specific Limit</u>
1997	\$ 51,813,890	\$ 65,275,427	<b>\$(13,461,537)</b>	\$16,045,620	<b>\$ 2,584,083</b>
1998	47,438,972	63,730,669	<b>(16,291,697)</b>	19,875,680	<b>3,583,983</b>
1999	53,096,134	66,711,370	<b>(13,615,236)</b>	16,587,566	<b>2,972,330</b>
2000	<u>60,187,211</u>	<u>56,556,613</u>	<u><b>3,630,598</b></u>	<u>17,486,954</u>	<u><b>21,117,552</b></u>
<b>Total</b>	<u><b>\$212,536,207</b></u>	<u><b>\$252,274,079</b></u>	<u><b>\$(39,737,872)</b></u>	<u><b>\$69,995,820</b></u>	<u><b>\$30,257,948</b></u>



The hospital-specific limit for each year equals the Medicaid shortfall plus charity care costs (the costs of services provided to patients who have no health insurance or source of third-party payment, less any payments made by these patients).



Rod R. Blagojevich, Governor  
Barry S. Maram, Director

## Illinois Department of Public Aid

Prescott E. Bloom Building  
201 South Grand Avenue East  
Springfield, Illinois 62763-0001

Telephone: (217) 782-1200  
TTY: (800) 526-5812

September 4, 2003

Mr. Paul Swanson  
Regional Inspector General for Audit Services  
U. S. Department of Health and Human Services  
233 North Michigan Avenue  
Chicago, Illinois 60601

Re: *OIG Report A-05-01-00102*

Dear Mr. Swanson:

I want to thank you for the opportunity to review the draft reports of several audits of Illinois' disproportionate share hospital (DSH) adjustment payment program recently conducted by your staff. This letter is written in response to *OIG Report A-05-01-00102, Review of Medicaid Disproportionate Share Hospital Payment Limits for Mount Sinai Hospital of Chicago*. The stated objectives of the audit of Mount Sinai Hospital of Chicago (Mt. Sinai) were to verify that Mt. Sinai appropriately reported uncompensated care charges and that its DSH payments were within the DSH limits imposed by the *Omnibus Budget Reconciliation Act of 1993 (OBRA)* for State fiscal years 1997 through 2000.

As a result of the audit, the OIG concluded that the Illinois Department of Public Aid (IDPA) made inappropriate DSH payments to Mt. Sinai for State fiscal years 1997 through 2000. The OIG reached that conclusion by comparing, for each of the review periods, DSH payments made by the IDPA to DSH payment limits that were estimated on a retrospective basis by the OIG. This approach differs from the methodology used by the IDPA, which is (and was during the review period) a prospective methodology, consistent with Illinois' approved Title XIX State plan.

The draft OIG report recommends that the IDPA:

- Refund to the federal government \$4,516,112, the federal share of over \$9 million in DSH payments made to Mt. Sinai that (in the opinion of the OIG) exceeded the hospital-specific limit imposed by *OBRA*.
- Reconcile retrospectively, for all hospitals receiving DSH payments, annual Medicaid (including DSH) payments to the actual cost of providing services to Medicaid beneficiaries and persons without insurance.

The IDPA strongly disagrees with the findings and conclusions put forth by the OIG in this report. They appear to be based upon misinterpretation of selective language from the relevant page (Attachment 4.19-A[VI][C][7][g][iv]) of the Illinois Title XIX State plan (the OIG report does not include the underlined language):

"The adjustments to individual hospital's disproportionate share payments shall be made if the sum of the Medicaid payments (inpatient, outpatient, and disproportionate share) made to a hospital exceed the costs of providing services to Medicaid clients and persons without insurance.

The adjustment to hospitals will be computed by determining a hospital's cost of inpatient and outpatient services furnished to Medicaid patients, less the amount paid to the hospital for inpatient and outpatient services excluding DSH payments made under this State plan. The cost of services provided to patients who have no health insurance or source of third-party payment less any payments made by these patients shall be determined and added to the Medicaid shortfall calculated above. The result shall be compared to the hospital's estimated DSH payments. If the estimated DSH payments exceed the DSH limit (Medicaid shortfall plus cost of uninsured) then the Department will reduce the hospital's DSH rate per day so that their DSH payments will equal the DSH limit. If necessary, retroactive adjustments will be made. [Emphases added.]

Federal regulation does not prescribe the methodology that States are to use in determining the DSH payment limitations under *OBRA*. Guidance was provided in an August 17, 1994, letter to State Medicaid directors from Health Care Financing Administrator Sally Richardson. The letter provided a summary of the new DSH requirements and included a section on determining the cost of services. As shown in the following paragraph, the letter clearly states that the only limit on the definition of allowable costs would be that they not exceed the institutional upper payment limit. The letter stated:

"There are several important considerations that must be made in determining the cost of services under the DSH limit, whether for Medicaid or uninsured individuals. First, the legislative history of this provision makes it clear that States may include both inpatient and outpatient costs in the calculation of the limit. Second, in defining "costs of services" under this provision, HCFA would permit the State to use the definition of allowable costs in its State plan, or any other definition, as long as the costs determined under such a definition do not exceed the amounts that would be allowable under Medicare principles of cost reimbursement. The Medicare principles are the general upper payment limit under institutional payment under the Medicaid program. HCFA believes this interpretation of the term "costs incurred" is reasonable because it provides States with a great deal of flexibility up to a maximum standard that is widely known and used in the determination of hospital costs. [Emphasis added.]

The IDPA's methodology for determining hospital-specific DSH payment limits, and related compliance with those limits, follows these guidelines. It is a prospective methodology, based on estimates, and without subsequent reconciliation to actual costs incurred. The methodology is consistent with Medicare payment principles and is the same as that used by Illinois to assure compliance with the hospital upper payment limits (42 *CFR* 447.272 and 447.321). In that methodology, the estimated Medicaid cost is based upon reported historical (Medicare cost report) data. The estimated cost of serving uninsured individuals is likewise based upon reported (IDPA reporting form) historical charges net of patient payments, reduced to cost by the application of a hospital-specific cost-to-charge ratio. Both sets of cost are trended forward to the rate period using CMS-approved inflators. Projected Medicaid payments are then subtracted from the summed, inflation-adjusted Medicaid and uninsured patient costs to determine the DSH payment limit for each hospital. Projected DSH payments are then compared to the DSH payment limit to determine whether DSH payments described in the State plan are in compliance.

The upper payment limit methodology has been reviewed and approved each year by the Centers for Medicare and Medicaid Services (CMS) through the State plan approval process and the methodology was, in fact, developed with significant guidance and input from individuals at the CMS.

There appears to be no requirement, nor is there reason to presume a requirement, that the *OBRA* DSH limit test must reconcile to actual hospital costs determined on a retrospective basis. CMS policy requires that States assure their compliance with DSH limits on a prospective basis, as a condition for approval of related amendments to their State plans. This analysis must be completed in advance of submitting a State plan for approval. Illinois, in establishing its aggregate and hospital-

specific limits in conjunction with each State plan amendment submittal, follows instructions provided by the CMS in 1994, as well as many years of history in applying, and CMS concurring with, the tests.

The OIG also appears to inappropriately rely on the last sentence included in the language of Illinois' Title XIX State plan provision: "If necessary, retroactive adjustments will be made."

The OIG seems to have confused the term "retroactive" with the term "retrospective." The term retroactive describes a process where something is made effective to a date prior to enactment. The term retrospective, which the OIG appears to be using, indicates a review, mediation or reconciliation based on past events. The reference in the State plan to retroactive adjustments does not make the methodology a retrospective one, as has been concluded by the OIG. The Illinois State plan language provides for retroactive adjustments in the event that an error in computation is found or a hospital's appeal is upheld. In either case, such a determination may not be known until well after the prospective implementation of the DSH payment rates. If such a determination resulted in noncompliance with the *OBRA* DSH limit test, the State plan language allows for retroactive adjustments to DSH rates.

Regardless of these facts, the OIG has concluded that retrospective reconciliation of cost is necessary for purposes of establishing compliance with DSH limits.

The IDPA strongly disagrees with the findings and conclusions presented in the draft OIG report. They are inconsistent with the federal regulations governing the *OBRA* DSH limits and are based upon a misinterpretation of the language in Illinois' approved Title XIX State plan. Lacking audit criteria upon which the draft findings are based, I ask that those findings be removed from, and that the criteria presented in this letter be included in, the final report.

Sincerely,



Barry S. Maram  
Director