DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

August 25, 2004

Report Number: A-05-01-00059

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." 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.

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Please refer to report number A-05-01-00059 in all correspondence.

Sincerely,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Ms. Cheryl Harris
Associate Regional Administrator
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Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

REVIEW OF ILLINOIS MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

ILLINOIS DEPARTMENT OF PUBLIC AID SPRINGFIELD, ILLINOIS

August 2004
A-05-01-00059

Office of Inspector General

http://oig.hhs.gov

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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 HHS/OIG/OAS. Authorized officials of 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 limited 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 from those patients. This limit is known as the hospital-specific limit.

States receive allotments of DSH funds as set forth by Federal statute. Only a discrete part of a State's allotment may be used for DSH payments to institutions for mental disease (IMD) facilities or other mental health facilities. In order to qualify for DSH funding, hospitals must have a Medicaid inpatient utilization rate of not less than one percent.

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 acute care hospitals and IMD facilities. For the State fiscal year ended June 30, 2000, the Illinois DSH allotment for IMD facilities was distributed among 10 State-owned IMD facilities accredited as psychiatric hospitals.

OBJECTIVES

The objectives of our audit were to determine whether (1) DSH payments to hospitals were calculated in accordance with the approved State plan and the hospital-specific limit requirements of section 1923(g) of the Social Security Act and (2) State-owned IMD facilities were qualified to receive DSH payments.

SUMMARY OF FINDINGS

Regarding our first objective, since the DSH funds paid by the State to acute care hospitals were combined with regular Medicaid payments through the use of enhanced per diem rates, we relied on selective testing to assess whether the payments were made in accordance with the approved State plan. Although our testing confirmed that the State generally followed the State plan in making the per diem payments, the State did not make retroactive adjustments as required by the State plan for limiting the DSH payments to the hospital-specific limits. From our audits of two acute care hospitals, we found that the procedures used by the State did not prevent significant DSH overpayments. The results of our audits of the University of Illinois at Chicago Hospital and Mount Sinai Hospital of Chicago are reported separately under report numbers A-05-01-00099 and A-05-01-00102, respectively.

Regarding our second objective, the Alton IMD facility (1 of 10 State-owned IMD facilities that received DSH payments) did not qualify for DSH payments because it did not have the minimum 1-percent Medicaid inpatient utilization rate required by section 1923(d)(3) of the Social Security Act and by the State plan. For State fiscal year 2000, the State paid the facility DSH funds totaling $1,945,620 (Federal share of $972,810). The State had not established procedures to ensure that IMD facilities met the 1-percent rate requirement. The State believed that the 22- to 64-year-old patient age group, who would otherwise be Medicaid-eligible during a given admission period, should be included toward attaining the 1-percent rate threshold, even though the services provided to this group are not covered by the Medicaid program. The State contended that many of the 22-to 64-year-old residents at these IMD facilities were Medicaid-eligible and that the inclusion of this group of individuals within the numerator of the fraction easily resulted in DSH eligibility for each of the10 State-owned IMD facilities.

RECOMMENDATIONS

We recommend that the State:

- refund $972,810 to the Federal Government

- develop a process to evaluate the ongoing compliance of IMD facilities with the 1-percent Medicaid inpatient utilization rate requirement to ensure that future DSH payments are distributed only to qualified facilities

STATE COMMENTS

Illinois disagreed with our finding and recommendations. The State stated that it objected to "operational definitions" that it contended were applied in our audit to exclude data from the Medicaid inpatient utilization rate calculation. The State believed that additional inpatient days for individuals who were under 21 years of age or 65 years of age or older should be included in the calculation for the Alton IMD facility. The State also believed that all Medicaid patient days, including days for patients who are over 21 but less than 65 years of age, should be included.

OFFICE OF INSPECTOR GENERAL RESPONSE

Concerning inpatient days for individuals who were under 21 years of age or 65 years of age or older, our finding was revised from our draft report to reflect the results of a further analysis of the Alton IMD facility's Medicaid inpatient utilization. With regard to inpatient days for patients who were over 21 but less than 65 years of age, we continue to believe that the rate calculation should not include these days. The Departmental Appeals Board specifically supported this interpretation of section 1923(b)(2) and CMS policy in New York State Department of Health, DAB No. 1867 (2003).

We summarized the State's comments and our response in the report. We also included the State's comments in their entirely as an appendix.

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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 Illinois Department of Public Aid administers the Medicaid program in Illinois.

The Omnibus Budget Reconciliation Act of 1981 established the DSH program, which is currently 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 limited 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. In order to qualify for DSH funding, hospitals must have a Medicaid inpatient utilization rate of not less than one percent.

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. Only a discrete part of a State's allotment may be used to make DSH payments to institutions for mental disease (IMD) facilities or other mental health facilities.[1] 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 Acute Care Hospitals

Qualified acute care hospitals in Illinois receive DSH funding through an add-on to their per diem payments for individual regular Medicaid inpatient hospital admissions. DSH payment rates are determined by the State and are, for the most part, calculated using a complex system of tiered rates that generally increase as the Medicaid utilization increases. These payments are not calculated on the basis of the uncompensated care costs incurred by the acute care hospitals.

Illinois IMD Facilities

The State distributes the DSH allotment available for IMD facilities on the basis of each facility's estimated number of Medicaid utilization days. For State fiscal year 2000, this

[1] The Balanced Budget Act of 1997 limited the amount of the Federal DSH allotment that a State could distribute to IMD facilities. Annual State limits were phased-in over several years. Beginning with Federal fiscal year 2003, no more than 33 percent of a State's Federal DSH allotment could be distributed to IMD facilities or other mental health facilities.

distribution was made to 10 State-owned IMD facilities that were accredited as psychiatric hospitals.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of our audit were to determine whether (1) DSH payments to hospitals were calculated in accordance with the approved State plan and the hospital-specific limit requirements of section 1923(g) of the Social Security Act and (2) State-owned IMD facilities were qualified to receive DSH payments.

Scope

Our review of the hospital-specific limits for two acute care hospitals covered the 4-year period of State fiscal year 1997 through 2000. Our review to assess whether DSH payments were calculated in accordance with the approved State plan, and whether IMD facilities were qualified to receive DSH payments, covered DSH funding in State fiscal year 2000. Our review of management controls was limited to discussions with State officials and was intended to facilitate an understanding of the Illinois DSH program and the general procedures utilized to ensure compliance with Federal and State requirements.

Methodology

To accomplish the objectives, we relied on selective testing to assess whether DSH payments to acute care hospitals were made in accordance with the State plan and Federal requirements. Selective testing of the accuracy of the State's hospital per diem rate calculations was necessary because the State combined the DSH funds with regular Medicaid payments through the use of enhanced per diem rates. We further verified that IMD facilities received DSH payments in accordance with the DSH payment methodology of the State plan and confirmed that these payments did not exceed the calculated DSH limits for State-owned IMD facilities.

In order to determine whether the hospital-specific limits were exceeded for two acute care hospitals, we compared total Medicaid inpatient and outpatient costs and charity care costs to total Medicaid inpatient, outpatient, and DSH payments for State fiscal years 1997 through 2000.

For State fiscal year 2000, we also computed the Medicaid inpatient utilization rate for each of the 10 State-owned IMD facilities to determine whether the facilities met the 1-percent threshold necessary to qualify for DSH payments. We further verified that the State distributed DSH payments to IMD facilities in accordance with the State plan and confirmed that these payments did not exceed the hospital-specific limits for State-owned IMD facilities.

Fieldwork was completed at the State offices in Springfield, Illinois and at two acute care hospitals in Chicago, Illinois. Our audit was conducted in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

ACUTE CARE HOSPITALS

Regarding our first objective, although our testing confirmed that the State generally followed the State plan in making DSH payments to acute care hospitals, the State did not make retroactive adjustments as required by the State plan for limiting the DSH payments to the hospital-specific limits. From our review of two acute care hospitals, we found that the procedures used by the State did not prevent significant DSH overpayments. The results of our reviews of the University of Illinois at Chicago Hospital and Mount Sinai Hospital of Chicago are reported separately under report numbers A-05-01-00099 and A-05-01-00102, respectively.

IMD FACILITIES

Regarding our second objective, the Alton IMD facility did not have the minimum 1-percent Medicaid inpatient utilization rate required for DSH program participation. As a result, the facility did not qualify for the $1.9 million (Federal share about $970,000) in DSH payments that it received for State fiscal year 2000. The facility received the payments to which it was not entitled because the State had not established procedures to ensure that IMD facilities qualified for DSH funding.

Federal Requirements and CMS Policy

Section 1923(d)(3) of the Social Security Act requires hospitals to have a Medicaid inpatient utilization rate of not less than one percent to qualify for DSH funding. Section 1923(b)(2) defines the Medicaid inpatient utilization rate by stating, in part:

> . . . "medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this title in a period . . . and the denominator of which is the total number of the hospital's inpatient days in that period . . . .

In a letter to State Medicaid directors dated August 17, 1994, CMS provided further clarification of the requirement in section 1923(b)(2) by stating:

> It is important to note that the numerator of the MUR [Medicaid utilization rate] formula does <u>not</u> include days attributable to Medicaid patients between 21 and 65 years of age in Institutions for Mental Disease (IMDs). These patients are not eligible for Medical Assistance under the State plan for the days in which they are inpatients of IMDs and may not be counted as Medicaid days in computing the Medicaid utilization rate . . . .

State Plan Requirements

The Illinois State plan, Attachment 4.19-A, section (VI)(C)(7)(f)(v) states, in part, that:

> . . . Hospitals that qualify for DSH payment adjustments under this Section shall not be eligible for DSH payment adjustments if the hospital's Medicaid inpatient utilization rate . . . is less than one percent . . . .

The State plan, Attachment 4.19-A, section (VI)(C)(8)(e), defines "Medicaid inpatient utilization rate" as:

> . . . a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12-month period to patients who, for such days, were eligible for Medicaid under Title XIX . . . and the denominator of which is the total number of the hospital's inpatient days in that same period . . . .

Medicaid Inpatient Utilization Not Met by Alton IMD Facility

During State fiscal year 2000, only 435 days[2] of a total 58,846 inpatient days at the Alton IMD facility were days that qualified for the calculation of the "Medicaid inpatient utilization rate" as defined by section 1923(b)(2) of the Social Security Act and by the State plan. Since these days represented only about three-quarters of one percent of the total inpatient utilization, the Alton IMD facility did not meet the minimum 1-percent requirement and was not eligible for the DSH funding that it received.

For the State fiscal year 2000, the State inappropriately paid $1,945,620 in DSH funds to the Alton IMD facility. The Federal share of the payments was $972,810.

IMD Facility	Total Inpatient Days	Medicaid Inpatient Utilization Days	Medicaid Inpatient Utilization Rate	DSH Funding	Federal Share
Alton	58,846	435	0.74%	$ 1,945,620	$ 972,810

Appropriate Procedures Not Established by State

State officials informed us that they believed CMS's policy regarding the Medicaid inpatient utilization rate (as stated in the August 1994 letter) had no authoritative basis. The State contended that the 22- to 64-year-old patient age group, who would otherwise be Medicaid-eligible during a given admission period, should be included toward attaining the 1-percent rate threshold, even though the services provided to this group are not covered by the Medicaid program. Consistent with this position, the State did not implement procedures to ensure

[2] The number of days was revised from 586 days shown in our draft report.

compliance with the 1-percent requirement. The State indicated that many of the 22- to 64-year-old residents at these IMD facilities were Medicaid-eligible, and that the inclusion of this group of individuals within the numerator of the fraction easily resulted in DSH eligibility for each of the10 State-owned IMD facilities. We observed that all 10 facilities would meet the 1-percent Medicaid inpatient utilization rate requirement if this group were included.

RECOMMENDATIONS

We recommend that the State:

- refund $972,810 to the Federal Government

- develop a process to evaluate the ongoing compliance of IMD facilities with the 1-percent Medicaid inpatient utilization rate requirement to ensure that future DSH payments are distributed only to qualified facilities

STATE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In responding to our draft report[3], the State disagreed with our finding and recommendations. The State said that while it did not dispute the fact that one percent is the minimum necessary Medicaid inpatient utilization rate, it objected to the "operational definitions" that it contended were applied by the Office of Inspector General to exclude data from the utilization rate calculation. The State's comments addressed two areas: (1) the status of the claim and (2) the age of the patient. We have attached the State's comments in their entirety as an appendix and have included specific parts of these comments, and our response, as follows:

State Comments – Status of the Claim

The State believed that additional inpatient days for individuals who were under 21 years of age or 65 years of age or older should be included in the calculation of the Alton IMD facility's Medicaid inpatient utilization rate. We initially showed in our draft report that 586 of the facility's 58,846 inpatient days for State fiscal year 2000 represented Medicaid inpatient utilization. (The 586 days had been claimed by the Alton facility, and paid, under Medicaid.) The State contended that all Medicaid days, paid or unpaid, claimed or unclaimed, should be included in the calculation of the utilization rate. According to the State, an additional 40 inpatient days were claimed and paid subsequent to our analysis, and an additional 865 inpatient days remained "unclaimed" but were eligible. The State therefore concluded that 1,491 days, 626 (586 + 40) "claimed" days plus 865 "unclaimed" days, qualified as Medicaid inpatient utilization. On this basis, the State asserted that the Medicaid inpatient utilization rate was 2.53 percent (1,491 divided by 58,846).

[3] In the draft report, we identified three IMD facilities as not meeting the 1-percent Medicaid inpatient utilization rate requirement. Based on additional information provided by the State in response to our draft report, we concluded that two of the three facilities met the requirement, but that the Alton IMD facility did not. We revised our finding accordingly.

Office of Inspector General Response

Our finding was revised from our draft report to reflect the results of a further analysis that we made of the Alton facility's Medicaid utilization in response to the State's comments. We determined that 366 of the 626 "claimed" days did not qualify as Medicaid inpatient utilization because the days were attributable to an individual who was 21 years of age at the time of admission to the facility. The 366 inpatient days had been claimed and paid in error under Medicaid.[4] We also determined that 690 of the 865 "unclaimed" days had not been claimed by the facility because the patients resided in units at the facility that were not certified for Medicaid program participation (non-certified units). Since these 690 "unclaimed" inpatient days did not qualify for Medicaid payment, we do not believe that these days should be counted in the Medicaid inpatient utilization rate computation. We were unable to determine why the Alton facility had not claimed the remaining 175 days (865 less 690). Although time limits for filing claims for these days have now expired, we nonetheless included them in our recalculation. Our recalculation includes 435 Medicaid inpatient days (260 of which had been claimed under Medicaid and 175 of which had not been claimed under Medicaid).

State Comments – Age of the Patient

The State expressed its position that all Medicaid patient days, including days for patients who are over 21 but less than 65 years of age, should be included in the calculation of the Medicaid inpatient utilization rate. Illinois indicated that the CMS interpretation in the letter to State Medicaid directors, dated August 17, 1994, was subsequently rejected in the Medicare context. The State said that various court decisions affirmed that the term "eligible for medical assistance under a State plan" should be read to include those who are otherwise eligible to receive Medicaid reimbursement, even if the specific services they are receiving are not reimbursable services. The State said that CMS announced compliance with these court decisions in a ruling dated February 27, 1997 (Ruling 97-2). According to the State, it is simply not reasonable to conclude that Medicare should calculate a Medicaid inpatient utilization rate using a different methodology than that used for Medicaid.

Office of Inspector General Response

Consistent with section 1923(b)(2) of the Social Security Act, and in accordance with CMS policy stated in the August 1994 letter, we continue to believe that the Medicaid inpatient utilization rate calculation should not include days attributable to Medicaid patients between 21 and 65 years of age. The Departmental Appeals Board specifically supported this interpretation in New York State Department of Health, DAB No. 1867 (2003).

In that case, the Board held that Ruling 97-2 applied only to the calculation of Medicare DSH payment adjustments and not to Medicaid DSH payment adjustments. Therefore, the 22- to 64-year-old population could not be included in the Medicaid inpatient utilization rate calculation.

[4] A person who enters an IMD after turning 21 years old and before turning 65 is not eligible for Medicaid, until the person turns 65. However, 21-year-old residents of an IMD who were eligible for Medicaid and residing in an IMD the month they turned 21 may continue to be eligible through the month they turn 22. Eligibility for a 21-year-old ends when he or she is discharged from the IMD, or when he or she turns 22, whichever happens first.

The Board stated that "not only are IMDs ineligible to be reimbursed for the cost of inpatient hospital services to patients ages 22 through 64, but such patients are themselves ineligible for Medicaid by virtue of their institutional status." The Board therefore concluded that New York improperly included in the numerator of its Medicaid utilization rate inpatient days attributable to IMD patients ages 22 through 64 since these patients could not be eligible for Medicaid as long as their status remained that of IMD patients. The Board looked to the August 1994 letter as the applicable CMS policy.

APPENDIX

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

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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-05-01-00059*

Dear Mr. Swanson:

I want to thank you for the opportunity to review the draft reports of the 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-05-01-00059, Review of Medicaid Disproportionate Share Program.* The stated objectives of the audit are whether DSH payments to hospitals were calculated in accordance with the approved State Plan and the requirements of the *Omnibus Budget Reconciliation Act of 1993* (*OBRA*) and whether State-owned institutions for mental disease (IMDs) were qualified to receive DSH payments.

As a result of its review, the OIG concluded that three of ten State-owned IMDs had received DSH payments for which they were not eligible. At the center of the review is the provision in federal statute that for a hospital to be eligible for DSH payments, the facility must have a Medicaid inpatient utilization rate (MIUR) of "not less than one percent" (42 *U.S.C.* 1396r-4[d][3]). Because the Medicaid inpatient utilization rate (MIUR), as recalculated by the OIG, was below that minimum, the OIG's draft report recommends that the IDPA:

- Refund $3,506,862, the federal share on approximately $7 million in DSH payments made to the three IMDs.
- Develop a process to evaluate ongoing compliance with the one percent MIUR requirement.

While the IDPA does not dispute the fact that one percent is the minimum necessary MIUR, it objects to the operational definitions applied by the OIG to exclude data from the calculation of the MIUR. As a result, the IDPA strongly disagrees with the resulting conclusions and recommendations reported by the OIG.

The OIG applied two criteria to exclude data from the calculation—only one of which was described in the report—the status of the claim with respect to claiming and the age of the Medicaid eligible patient.

Status of the claim.

First, the OIG ignored data provided by the IDPA that would have resulted in a calculated MIUR in excess of one percent for each of the three IMDs in question. Although the report provides no explanation or rationale for the exclusion of these Medicaid patient days, the IDPA was informed,

orally, that they would include only "paid" days to determine if the one percent threshold was met—counting as "paid" only those patient days that had been submitted for federal claiming on or before January 24, 2002 (column [c] of the table below).

Medicaid inpatient utilization rate for three Illinois State-operated institutions for mental diseases using only Medicaid patient days attributable to individuals under 21 years of age or 65 years of age or older

(a)	(b)	(c)	(d)	(e)	(f)	(g)
		Medicaid patient days*				
		Claimed				Medicaid inpatient utilization rate
Facility	Total patient days	As of 01/24/02	Subsequent to 01/24/02	Unclaimed	Total	
Alton	58,846	586	40	865	1,491	2.53%
Chicago Reed	70,503	381	316	102	799	1.13%
Madden	49,130	346	89	62	497	1.01%

*Medicaid patient days in this tabulation include only those for individuals were under 21 years of age or 65 years or age or older.

It is the position of the State that all Medicaid patient days, paid or unpaid, claimed or unclaimed, may be included in the calculation of the MIUR. The interpretation by the OIG is inconsistent with Section 1923(b)(2) of the *Social Security Act* (42 *U.S.C.* 1396r-4[b][2]), which specifies the MIUR as:

> ". . . a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days **attributable to patients who (for such days) were eligible for medical assistance** under a State plan approved under this title in a period, and the denominator of which is the total number of the hospital's inpatient days in that period." (Emphasis added.)

Nowhere in federal law does it specify that only paid patient days are to be included. In fact, to the contrary, in a letter to officials of the State of Kansas, the CMS agreed with the position taken by the State that the relevant days to be counted for the MIUR were not those days

> ". . . paid by the Medicaid Program but rather that these days relate to individuals who were eligible for medical assistance under the Kansas State Plan at the time they were in [the IMD].
>
> "The Health Care Financing Administration agrees with the State's interpretation of the Medicaid inpatient utilization rate as defined in Section 1923(b)(2) of the Social Security Act." (Letter from Thomas W. Lenz, Associate Regional Administrator for Medicaid and State Operations to Janet Schalansky of Kansas Medicaid, dated December 15, 1999.)

On that basis, the CMS allowed Kansas to claim for DSH payments to the facility. Additionally, the CMS has approved Medicaid State plans that include this methodology for calculating the MIUR at IMDs.

A subsequent analysis of paid claim information by the IDPA shows that some of the claims that were unclaimed at the time of the OIG's fieldwork have subsequently been claimed (column [d] in the table above). Column (e) displays, by facility, paid Medicaid patient days that were not submitted in a claim for federal financial participation.

The table above provides a recalculated MIUR for each facility based only upon patient days attributable to Medicaid eligible individuals under 21 years of age or 65 years of age or older. (Detailed documentation of the age and Medicaid eligibility for the patients is enclosed with this response.)

Age of the patient.

The OIG has taken the position that because State expenditures for their otherwise reimbursable behavioral health services provided to patients who are over 21 but less than 65 years of age are not eligible for federal financial participation if the patient is resident in an IMD, those patient days should not be included in the calculation of the MIUR.

It is the position of the State that all Medicaid patient days, without regard to the age of the Medicaid-eligible individual, may be included in the calculation of the MIUR. CMS guidance on this issue has, over time, been inconsistent, but recent precedent and communication from the CMS support inclusion of these patients in the calculation.

Soon after Section 1923(d) of the *Social Security Act* was enacted CMS declared that patients over 21 but less than 65 years of age who are resident in an IMD should not be included in the numerator of the MIUR calculation. The reasons for this initial position are unclear but it appears to be related to a similar position taken with regard to identical language in the Medicare DSH calculation. The OIG relies upon this statement of policy (communicated to the States in a letter from Sally K. Richardson, dated August 17, 1994) as a basis for its recommendation.

This 1994 interpretation was subsequently rejected in the Medicare context. Various court decisions affirmed that the term "eligible for medical assistance under a State plan" should be read to include those who are otherwise eligible to receive Medicaid reimbursement, even if the specific services they are receiving are not reimbursable services. The CMS announced compliance with these court decisions in a ruling dated February 27, 1997.

The language used in Medicaid DSH statute is parallel to the Medicare language addressed by the courts. The objectives of the DSH calculations in both programs are identical and serve the same purpose—identification of hospitals that care for a high percentage of patients that are not able to pay for their own services. The burden placed on hospitals to care for these individuals is the same, regardless of the methods used to determine hospitals' eligibility for DSH payments under Medicare and Medicaid. The OIG's interpretation and subsequent recommendation, however, implies that this burden is somehow different across programs. It is simply not reasonable to conclude that Medicare should calculate a MIUR using a different methodology than that used for Medicaid.

Communications with various CMS regional offices confirm that the revised Medicare interpretation applies also to the Medicaid calculation.

> "According to the DSH folks in [CMS] Central Office: 'HCFA has always stated that as long as the patient is eligible for Medicaid under a State plan (regardless of the available coverage) these patients should be counted as Medicaid.'" (E-mail correspondence from CMS representative Billy Farrell to Debbie Gough of Louisiana Medicaid, dated May 11, 1999.)

This communication clearly recognizes that the eligibility of the individual for Medicaid is independent of the eligibility of a given service for federal financial participation (*i.e.*, a Medicaid covered service) and that "these patients should be counted as Medicaid."

The IDPA calculation of the MIUR is based on its current understanding of Medicaid eligibility and Medicaid countable patient days. The table below presents MIUR (and the relevant supporting data) computed using this understanding of the policy for each of the three facilities in question. The three IMD hospitals in Illinois cited by the OIG are, in fact, eligible and qualify for the DSH payments made due to their disproportionate share of low-income residents for whom they provide care. The goal of the DSH payments is to provide financial relief and not to penalize those institutions providing care to the disadvantaged.

Medicaid inpatient utilization rate for three Illinois State-operated institutions for mental diseases using all Medicaid patient days

Facility	Total patient days	Medicaid patient days			Medicaid inpatient utilization rate
		Age of patient			
		Under 21 or 65 or older	Over 21 but under 65	Total	
Alton	58,846	1,491	5,909	7,400	12.58%
Chicago Reed	70,503	799	12,861	13,660	19.38%
Madden	49,130	497	11,837	12,334	25.10%

IDPA does not accept the OIG's findings and conclusions. After considering all of the data provided to OIG during its fieldwork, it is clear that the three IMDs identified by the OIG do, in fact, meet the one percent threshold for DSH payment eligibility. Even after removing the days for Medicaid eligible patients who were 21 through 64 years of age (an interpretation with which the IDPA disagrees), the three IMDs meet the one percent threshold.

Sincerely,

Barry S. Maram
Director