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

November 2012

MEDICAID

More Transparency of and Accountability for Supplemental Payments Are Needed

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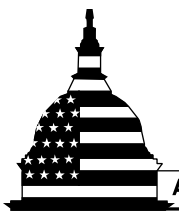

G A O

Accountability * Integrity * Reliability

GAO-13-48

November 2012

MEDICAID

More Transparency of and Accountability for Supplemental Payments Are Needed

GAO Accountability * Integrity * Reliability

Highlights

Highlights of GAO-13-48, a report to the Committee on Finance, U.S. Senate

Why GAO Did This Study

In 2011, states reported making $43 billion in Medicaid supplemental payments—payments above regular payments for Medicaid services—to certain providers, mainly hospitals. The federal government shares in the cost of these payments. By law, states make certain supplemental payments, known as DSH payments, for uncompensated care costs experienced by hospitals serving large numbers of low-income and Medicaid patients. States also make other supplemental payments—referred to here as non-DSH payments—to hospitals and other providers who, for example, serve high-cost Medicaid beneficiaries. Past GAO reports have found gaps in federal oversight of these high-risk payments: a lack of information on the providers receiving them, inaccurate payment calculation methods, and a lack of assurances the payments were used for Medicaid purposes. CMS has required states to submit annual audits and reports on DSH payments since 2010. GAO was asked to review federal oversight of supplemental payments and examined (1) how information in DSH audits and reports facilitates CMS's oversight of DSH payments, and (2) the extent to which similar information exists for non-DSH payments. GAO analyzed 2010 DSH audits and reports and interviewed CMS officials.

What GAO Recommends

Congress should consider requiring the Administrator of CMS to improve transparency of and accountability for non-DSH supplemental payments by requiring facility-specific payment reporting and annual audits, among other steps.

View GAO-13-48. For more information, contact Katherine Iritani at (202) 512-7114 or iritanik@gao.gov.

What GAO Found

The recently implemented annual audits and reports for states' disproportionate share hospital (DSH) payments could improve oversight by the Centers for Medicare & Medicaid Services (CMS)—the federal agency that oversees Medicaid—by illuminating needed changes. States are required to submit audits and reports to CMS as a condition for receiving federal funds for their DSH payments. The first set of DSH audits was submitted by states in 2010 and covers states' 2007 DSH payments. The audits give CMS information on how well states are complying with six DSH requirements, including whether payments are limited to hospitals' uncompensated care costs and are accurately calculated. Under a transition period, CMS will not act on audit findings until the 2014 audits are complete; however, findings from GAO's analysis of the 2010 DSH audits show that 44 states will likely need to make changes to their DSH payments to come into compliance. For example,

- 41 states made DSH payments to 717 hospitals that exceeded the individual hospitals' uncompensated care costs as calculated by the auditors, and
- 9 states did not accurately calculate the uncompensated care costs of 206 hospitals in those states for purposes of making DSH payments.

The DSH reports can also improve oversight because they provide hospital-specific information that CMS can use to better align capped federal DSH funds with hospitals' uncompensated care costs. Federal law reduces national DSH funding beginning in fiscal year 2014, and requires CMS to implement a method for corresponding reductions in each state's DSH funding. GAO analysis of DSH reports shows that some states' DSH payments are not proportionally targeted to hospitals with the highest uncompensated care.

CMS lacks similar information for overseeing non-DSH payments; available information suggests that better reporting and audits of non-DSH payments could improve CMS's ability to oversee them. Reporting of non-DSH payments that states make to individual hospitals and other providers relative to the providers' Medicaid costs could improve the transparency of these payments. Audits could improve accountability by providing information on how non-DSH payments are calculated and the extent to which payments to individual providers are consistent with the Medicaid payment principles of economy and efficiency. GAO analysis of the limited hospital-specific information available found that 39 states made non-DSH payments to 505 DSH hospitals that, along with their regular Medicaid payments, exceeded those hospitals' total costs of providing Medicaid care by a total of about $2.7 billion. Although regular and non-DSH Medicaid payments are not required to be limited to a provider's costs of delivering Medicaid services, payments that greatly exceed these costs raise questions, for example, as to whether payments are being used for Medicaid. As of November 2012, CMS has no plans to require states to report provider-specific non-DSH payments, clarify permissible methods for calculating non-DSH payments, and require annual independent audits of states' non-DSH payments, because in its view legislation was crucial to implementing similar DSH requirements.

In reviewing a draft of this report, the Department of Health and Human Services agreed with GAO about the need to improve reporting and oversight of non-DSH payments and noted some efforts under way to do so.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
CPA	Certified Public Accountant
DSH	Disproportionate Share Hospital
FMAP	federal medical assistance percentage
HHS	Department of Health and Human Services
MACPAC	Medicaid and CHIP Payment and Access Commission
OIG	Office of Inspector General
PPACA	Patient Protection and Affordable Care Act
UPL	Upper Payment Limit

GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

November 26, 2012

The Honorable Max Baucus
Chairman
The Honorable Orrin Hatch
Ranking Member
Committee on Finance
United States Senate

In 2011, Medicaid—the joint federal-state program that finances health care for certain low-income individuals—cost an estimated $410 billion.[1] States pay qualified health care providers for covered services provided to Medicaid beneficiaries and obtain federal matching funds for the federal share of these payments.[2] In addition to these regular payments, which are generally based on claims submitted by the providers for services rendered, states also make and obtain federal matching funds for supplemental payments to certain providers—particularly hospitals—to help offset remaining costs of care for Medicaid patients,[3] as well as, in some cases, the costs they incur to treat uninsured patients. Unlike regular Medicaid payments, supplemental payments typically are not made on the basis of claims submitted for services rendered. Rather, they generally consist of large lump sum payments made on a monthly, quarterly, or yearly basis. Supplemental payments are a significant and growing component of Medicaid spending. Some states have made relatively large supplemental payments to relatively small numbers of providers, and the total amount of supplemental payments has

[1]Medicaid provided health coverage for an estimated 55 million low-income individuals, including children, families, and aged or disabled individuals in 2011.

The 2011 cost figure represents combined federal and state Medicaid expenditures for provider services in fiscal year 2011 and does not include expenditures for administration. Centers for Medicare & Medicaid Services' Office of the Actuary, *2011 Actuarial Report on the Financing Outlook for Medicaid* (Washington, D.C.: March 2012).

[2]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. States with lower per capita income receive a higher FMAP. 42 U.S.C. §§ 1396b(a)(1), 1396d(b).

[3]States' regular Medicaid payments are not required to fully cover the costs of providing Medicaid services.

increased.[4] In fiscal year 2011, states reported spending at least $43 billion on supplemental payments, up from $32 billion in fiscal year 2010 and at least $23 billion in fiscal year 2006.[5] These amounts were likely understated, because reporting of supplemental payments was incomplete. We and others have raised concerns about the need for improved transparency regarding the size of the payments and who receives them, as well as the need for improved accountability regarding how the funds are related to Medicaid services.[6] Since 2003, we have designated Medicaid a high-risk program due to concern about its size, growth, and fiscal oversight, including federal oversight of supplemental payments.[7]

The Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), is responsible for overseeing state Medicaid programs at the federal level. These responsibilities include reviewing and approving state Medicaid plans, which include states' methodologies for determining provider payments. CMS responsibilities also include ensuring that state Medicaid payments are consistent with federal requirements, including the requirements that payments to providers must be consistent with efficiency, economy, and quality of care and must be sufficient to enlist enough providers that care and services are available at least to the extent that they are available to the general population in the area.[8] To fulfill these responsibilities, CMS

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

[5]GAO, *Medicaid: States Reported Billions More in Supplemental Payments in Recent Years*, GAO-12-694 (Washington, D.C.: July 2012).

[6]A list of related GAO products can be found at the end of this report. Also see, for example, HHS, Office of the Inspector General, *Audit of Oregon's Medicaid Upper Payment Limits for Non-State Government Nursing Facilities for State Fiscal Years 2002 and 2003*, A-09-03-00055 (Washington, D.C.: 2005); HHS, Office of the Inspector General, *Adequacy of Tennessee's Medicaid Payments to Nashville Metropolitan Bordeaux Hospital, Long-Term-Care Unit*, A-04-03-03023 (Washington, D.C.: 2005); and HHS, Office of the Inspector General, *Adequacy of Washington State's Medicaid Payments to Newport Community Hospital, Long-Term-Care Unit*, A-10-04-00001 (Washington, D.C.: 2005).

[7]GAO, *High-Risk Series: An Update*, GAO-11-278 (Washington, D.C.: February 2011).

[8]42 U.S.C § 1396a(a)(30)(A).

needs to have relevant, reliable, and timely information available for management decision making and external reporting purposes.[9]

A large component of Medicaid supplemental payments is disproportionate share hospital (DSH) payments. Under federal Medicaid law, states are required to make DSH payments to certain hospitals. These payments are designed to help offset these hospitals' uncompensated care costs for serving Medicaid and uninsured low-income individuals.[10] Congress and CMS have taken several actions over the past two decades—including setting limits, or caps, on DSH spending at the state level—to help ensure the transparency and accountability of these payments and enable more-informed oversight. In addition to establishing annual state DSH allotments, which limit the amount of federal matching funds each state is permitted to receive for DSH payments, federal law also limits the amount of DSH payments states may make to an individual hospital to an amount equal to or less than the hospital's annual uncompensated care costs.[11] In 2003, Congress mandated improved accountability for DSH payments under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, by providing that the Secretary of Health and Human Services require states to submit annual independent certified audits and annual reports on their DSH payments.[12] In 2008, CMS issued a final rule to implement the 2003

[9]*Standards for Internal Control in the Federal Government* states that agencies are responsible for determining through monitoring that relevant, reliable, and timely information is available for management decision making and external reporting purposes. In addition, agencies are responsible for continually examining and improving internal controls to provide reasonable assurance that the objectives of the agency, such as compliance with applicable laws and regulations, are being achieved. GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

[10]See 42 U.S.C. §§ 1396a(13)(A), 1396r-4. Uncompensated care costs are the costs incurred in providing services during the year to Medicaid and uninsured patients minus any payments made to the hospital for Medicaid and uninsured patients for those services. 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 larger numbers of Medicaid and uninsured low-income individuals.

[11]42 U.S.C. § 1396r-4(g)(1).

[12]Pub. L. No. 108-173, § 1001(d), 117 Stat. 2066, 2430-2431 (2003) (adding section 1923(j) to the Social Security Act) (codified, as amended, at 42 U.S.C. § 1395r-4(j)).

DSH audit and report requirement.[13] The 2008 final rule laid out key audit and reporting requirements, including the requirement that states include in their annual DSH reports facility-specific information on the costs of serving Medicaid and uninsured patients and payments received from or on behalf of these patients. The first sets of DSH audits and reports, covering payments made in 2005 through 2007, were submitted to CMS in December 2010.

In addition to DSH payments, many states also make another type of Medicaid supplemental payment—referred to here as non-DSH supplemental payments—to providers. Unlike DSH payments, states are not required under federal law to make non-DSH payments,[14] and non-DSH payments do not have a specified statutory or regulatory purpose.[15] Non-DSH payments are made not only to hospitals but also to other providers, such as nursing homes and physician groups that, for example, serve high-cost Medicaid beneficiaries. Since the 1980s, some states have made non-DSH payments to certain hospitals and providers if the state's regular Medicaid payments did not reach the upper payment limit (UPL) for federal matching.[16] The UPL is based on what Medicare—the federal health program that covers individuals aged 65 and over, individuals with end-stage renal disease, and certain disabled individuals—would pay for comparable services.[17] The UPL is the upper

[13]Medicaid Program; Disproportionate Share Hospital Payments, 73 Fed. Reg. 77904 (Dec. 19, 2008) (codified at 42 C.F.R. Parts 447 and 455); Medicaid Program; Disproportionate Share Hospital Payments; Correcting Amendment, 74 Fed. Reg. 18656 (Apr. 24, 2009). CMS subsequently issued a notice of proposed rulemaking to revise certain provisions of this rule. Medicaid Program; Disproportionate Share Hospital Payments—Uninsured Definition, 77 Fed. Reg. 2500 (Jan. 18, 2012).

[14]In this report, we use the terms non-DSH payments and non-DSH supplemental payments interchangeably.

[15]We found in our 2008 study of five states that some states indicated that one purpose may be similar to that for DSH payments in that non-DSH payments are made to hospitals serving a large number of Medicaid patients. See GAO-08-614.

[16]Sometimes non-DSH payments are referred to as UPL payments.

[17]The UPL is not a facility-specific limit, but is instead applied on an aggregate basis to three categories of providers: local (nonstate) government-owned or local (nonstate) government-operated facilities, state-government-owned or state-government-operated facilities, and privately owned and operated facilities. Separate UPLs exist for inpatient services provided by hospitals, nursing facilities, and intermediate care facilities for individuals with intellectual disabilities, and outpatient services provided by hospitals and clinics. See 42 C.F.R. §§ 447.272, 447.321 (2011).

bound on what the federal government will pay as its share of the Medicaid payments for different classes of covered services, and it often exceeds regular Medicaid payments for services. On the basis of the gap between the UPL and regular Medicaid payments, states can make non-DSH supplemental payments to selected providers for different classes of services.[18] These non-DSH payments, which are in addition to regular Medicaid payments made to providers, but within the UPL, are not subject to the same type of overall state spending limits or facility-specific limits that DSH payments are. In particular, non-DSH supplemental payments are not limited to an individual provider's cost of providing Medicaid services.

In recent years, states have reported increasing amounts of non-DSH payments.[19] In 2012, CMS's Office of the Actuary reported that recent increases in Medicaid spending for hospital services were due in part to large non-DSH payments to hospitals in 2010.[20] In contrast to recent years, when DSH payments exceeded non-DSH payments, in fiscal year 2011 non-DSH payments exceeded DSH payments, with non-DSH payments totaling nearly $26 billion, compared to over $17 billion for DSH payments.

You asked for information about federal oversight of supplemental payments, including whether recent audits of DSH payments are facilitating oversight of these payments. For this report, we determined (1) how the information collected from DSH audits and reports can facilitate CMS's oversight of DSH payments and (2) the extent to which similar information exists to facilitate CMS's oversight of non-DSH supplemental payments.

[18]DSH payments are not included in calculating the gap between the UPL and regular Medicaid payments.

[19]At the same time, we have reported that many states have reduced regular Medicaid payment rates in response to budgetary pressures. GAO, *Increased Medicaid Funds Aided Enrollment Growth, and Most States Reported Taking Steps to Sustain Their Programs*, GAO-11-58 (Washington, D.C.: Oct. 8, 2010).

[20]Researchers with CMS's Office of the Actuary compared health care spending growth for calendar years 2009 and 2010. They found that overall Medicaid spending growth slowed from 8.9 percent in 2009 to 7.2 percent in 2010, whereas Medicaid spending increases for hospital services grew from 10.4 percent in 2009 to 11.2 percent in 2010. Anne B. Martin et al., "Growth in U.S. Health Spending Remained Slow in 2010; Health Share of Gross Domestic Product Was Unchanged from 2009," *Health Affairs*, vol. 31, no. 1 (2012).

To determine how the information collected from DSH audits and reports can facilitate CMS's oversight of DSH payments, we reviewed relevant federal laws, regulations, and guidance and analyzed states' 2010 DSH audits and reports for payments made in 2007, the most recent year available at the time of our review.[21] A total of 49 states submitted DSH audits and reports covering about 3,000 DSH hospitals.[22] We analyzed auditors' assessments of states' compliance with key audit requirements and analyzed hospitals' DSH payments and uncompensated care costs from the DSH reports to examine the extent to which state DSH payments are aligned with hospitals' uncompensated care costs. Our analysis of the DSH audits did not evaluate the quality of the audits or the process that the independent auditors followed to produce the DSH audits. To ensure that the data submitted by the states were sufficiently reliable for our analyses, we reviewed auditors' findings in each state's DSH audit, reviewed DSH reports for incomplete and erroneous entries, and discussed these findings with CMS officials. We determined that the DSH audits and reports were sufficiently reliable for the purposes of this report, and we accounted for any limitations in these data during our analyses. We also conducted interviews with CMS officials.

To determine the extent to which information similar to that which exists for DSH payments also exists to facilitate CMS's oversight of non-DSH supplemental payments, we reviewed relevant federal laws, regulations, and guidance; analyzed data on non-DSH supplemental payments and Medicaid payments and costs that were reported for DSH hospitals in

[21]In this report, we use the term state to refer to the 50 states and the District of Columbia. We do not include Puerto Rico or four U.S. territories—American Samoa, Guam, the Northern Mariana Islands, and the U.S. Virgin Islands.

[22]Massachusetts and Tennessee did not make DSH payments in 2007 and did not submit DSH audits or reports. Some states operate HHS-approved Section 1115 Medicaid demonstrations under which the state does not make DSH payments directly to hospitals. For example, Tennessee incorporated DSH funding into payments to managed care organizations, and all of Massachusetts's DSH funds were used to support a special fund for safety-net health care providers.

For the purpose of this report, we refer to hospitals that receive DSH payments as DSH hospitals.

states' 2010 DSH reports; and conducted interviews with CMS officials.[23] More details on our methodology can be found in appendix I.

We conducted this performance audit from December 2011 through November 2012 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

The two types of supplemental payments—DSH and non-DSH—had very different origins and have different requirements. Federal law requires states to make DSH payments to certain eligible hospitals.[24] States are required to report these payments separately from their regular Medicaid payments in their quarterly expenditure reports, which they submit to CMS to obtain federal matching funds. The separate reporting for DSH payments has allowed CMS to monitor these payments. In the early 1990s, following a period of rapid growth in DSH payments and reports of states establishing complex financing arrangements involving these payments that, in effect, resulted in the diversion and use of federal funds for non-Medicaid purposes, Congress set the limits, or caps, on DSH spending at the state and facility levels. In contrast to DSH payments, the amount of non-DSH payments a state may make has no firm dollar limit. Instead, the UPL, under which non-DSH payments are made, fluctuates because it is based on the amount of Medicaid services provided, a state's regular Medicaid payment rate for the services, and the rates that Medicare would pay for comparable services,[25] factors that may fluctuate

[23]DSH hospitals include any hospital that has a Medicaid inpatient utilization rate of at least 1 percent, and, with the exception of children's hospitals and certain hospitals that do not offer nonemergency obstetric services, at least two obstetricians who have staff privileges at the hospital and have agreed to provide obstetric services. 42 U.S.C. §§ 1396r-4(d).

[24]Federal law requires states to make DSH payments to eligible hospitals that have a Medicaid inpatient utilization rate of at least one standard deviation above the mean rate for hospitals receiving Medicaid payments in the state and to eligible hospitals that have a low-income utilization rate that exceeds 25 percent. 42 U.S.C. § 1396r-4(b).

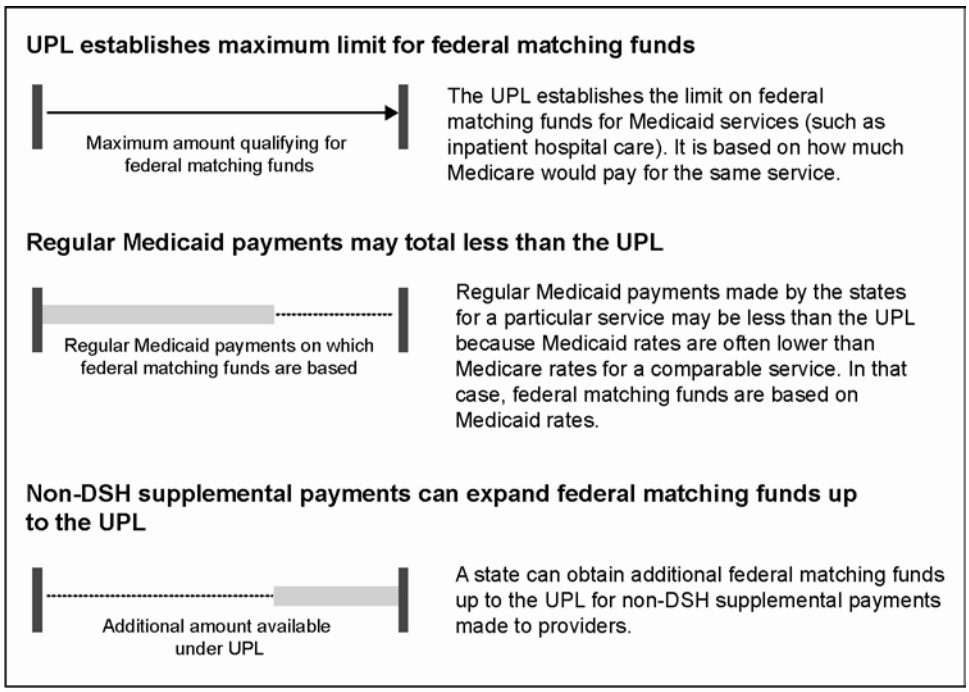
[25]See 42 C.F.R. §§ 447.272, 447.321 (2011). Medicare payment rates are typically higher than state Medicaid payment rates.

over time. In this way, the UPL does not operate as a firm dollar limit on non-DSH supplemental payments in the same way state DSH allotments serve to cap DSH payments. States began making non-DSH payments to target additional payments to certain providers. Under federal Medicaid regulations, states may make such payments, with approval from CMS through the state plan approval process, as long as regular and non-DSH supplemental payments to a class of providers do not exceed the respective UPL.[26] The UPL is not applied to individual providers; instead it is applied to all providers within specified ownership classes. As a result, states have discretion in how they distribute non-DSH supplemental payments to individual providers. We and the HHS Office of Inspector General (OIG) have reported that some states concentrated these payments to a small number of providers and there was no assurance that they were used for Medicaid purposes.[27] (See fig. 1 for a description of how states make non-DSH supplemental payments in addition to regular Medicaid payments under the Medicaid UPL provisions.)

[26]Separate UPLs exist for inpatient services provided by hospitals, nursing facilities, and intermediate care facilities for individuals with intellectual disabilities, and outpatient services provided by hospitals and clinics. These UPLs are applied on an aggregate basis to three categories of providers: local (nonstate) government-owned or local (nonstate) government-operated facilities, state-government-owned or state-government-operated facilities, and privately owned and operated facilities. See 42 C.F.R. §§ 447.272, 447.321 (2011). Although there are several UPLs, in this report we use the term UPL to encompass all UPLs.

[27]GAO, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*, GAO-04-228 (Washington, D.C.: Feb. 2004), and HHS, Office of the Inspector General, A-09-03-00055, A-04-03-03023, and A-10-04-00001.

Figure 1: Overview of How States Make Non-Disproportionate Share Hospital (DSH) Supplemental Payments in Addition to Regular Medicaid Payments under Medicaid's Upper Payment Limit (UPL)



Source: GAO.

Notes: The UPL applies to regular Medicaid payments and non-DSH supplemental payments and does not include DSH payments. DSH payments are made for services provided to Medicaid and uninsured patients and have separate payment limits.

We have previously reported concerns about a lack of reliable information regarding DSH payments and concerns about the accuracy of states' calculations of these payments. In May 2008, we reported that CMS was not collecting the facility-specific information needed to oversee the integrity of the DSH payments.[28] We recommended that CMS expedite issuance of a final rule implementing the 2003 statute requiring states to complete annual independent audits of DSH payments and annual state reports on DSH payments made to individual hospitals. As mentioned above, CMS issued this rule in December 2008. In our November 2009 report, we found DSH payments that were not based on accurate

[28]GAO-08-614.

estimates of individual hospitals' DSH payment limits.[29] In particular, two of the four states we reviewed did not adhere to the federal requirement that states include all Medicaid payments, including non-DSH supplemental payments, when estimating hospitals' DSH payment limits.[30] In these cases, payments were being made to reimburse hospitals for uncompensated care costs without considering other Medicaid payments the providers had received, resulting in overpayments. At that time, CMS indicated that its 2008 final rule would better ensure that states account for all Medicaid payments. The 2008 final rule included instructions for states to use to ensure that their methodology for calculating DSH payments was consistent with federal law. As mentioned earlier, the first sets of DSH audits and reports, covering payments made in 2005 through 2007, were submitted to CMS in December 2010. CMS gave states a transition period during which the agency would not take action against states on the basis of findings of noncompliance with federal DSH requirements identified in the audits and reports. Beginning in 2014, after the transition period has ended,[31] CMS may use audit findings to recover federal funds for payments that did not comply with federal DSH audit requirements; however, states will have the option to seek approval from CMS to redistribute the federal funding in question to other hospitals that are qualified to receive DSH payments.

Over the past decade, we have also raised concerns related to the oversight of non-DSH payments. In 2004, we reported a need for more-complete CMS review of non-DSH supplemental payment arrangements to ensure that payments were for Medicaid purposes.[32] Although CMS increased the scrutiny of states' requests for approval of non-DSH supplemental payments through the state plan amendment approval process, in 2008 we reported that not all supplemental payments had

[29]GAO, *Medicaid: Ongoing Federal Oversight of Payments to Offset Uncompensated Hospital Care Costs Is Warranted*, GAO-10-69 (Washington, D.C.: Nov. 20, 2009).

[30]All Medicaid payments, including non-DSH supplemental payments, count against a hospital's DSH cap, reducing the total DSH payments a hospital may receive. See 42 U.S.C. § 1396r-4(g).

[31]Audits for payments made in 2011 will be completed and submitted by December 31, 2014. The delay in the submission of audits and reports allows for any lag in the availability of actual hospital cost and payment data.

[32]GAO-04-228.

been reviewed through this process.[33] We also have reported on a need for guidance to states regarding appropriately estimating the UPL, and a need for improved transparency for non-DSH payments, which are often large and made to small numbers of providers, through facility-specific reporting of these payments. For example, we reported in February 2004 and May 2008 that CMS lacked comprehensive information on how states were allocating non-DSH payments to providers.[34] We also found in 2004 that CMS did not issue guidance to states on the methods used to calculate the amounts of their non-DSH payments. In a sample of six states, we found widely varying and potentially inaccurate methods for calculating the UPL, which is the basis for the amount of non-DSH supplemental payments states may make. Inaccurate methods could result in overestimates of the UPL and excessive claims for federal matching funds. To address these concerns, we recommended that CMS require facility-specific reporting of non-DSH payments and establish uniform guidance on the acceptable methods for calculating the amount of non-DSH payments. As of November 2012, facility-specific reporting requirements had not been established, and uniform guidance had not been issued.[35]

[33]GAO-08-614.

[34]GAO-04-228 and GAO-08-614.

[35]In conjunction with a final rule CMS issued in 2007 that created facility-specific limits on non-DSH payments for governmental providers, the agency established methods and data sources for states to use to calculate these payment limits; however, a federal district court vacated the rule in 2008, and CMS formally rescinded the rule in 2010. See *Alameda County Medical Center, et al. v. Leavitt*, *et al.*, no. 1:08-00422 (D.D.C. filed Mar. 11, 2008).

DSH Audits and Reports Provide Information That Can Improve Federal Oversight by Illuminating Needed Changes to DSH Payments

The DSH audits can help improve oversight of states' DSH payments by providing CMS with information on state compliance with federal DSH requirements, and information from recent audits shows that most states may need to take corrective actions by 2014. The 2010 DSH reports provide CMS with information that can be used, for example, to better align DSH payments with hospitals' uncompensated care costs as required by recent federal law.

Audits Provide CMS with Enhanced Information for Overseeing States' Compliance with Key DSH Requirements and Show That Most States May Need to Take Corrective Actions

The annual independent audits of state DSH payments provide information that CMS can use to improve its oversight of the extent of states' compliance with six key DSH requirements (see table 1 for a summary of the six DSH audit requirements). According to CMS officials, DSH audits provide more transparency about state DSH payments than previously existed, which can help the agency to better oversee these payments. CMS officials said that in the past the agency relied on states' assurances and HHS OIG investigations to ensure that DSH payments were being made appropriately. CMS officials told us that the 2003 DSH audit mandate provides the first strong statutory requirement for states reporting information about their DSH payments. Additionally, a provision in the statute authorizes CMS to withhold federal matching funds for DSH payments for states that do not submit their DSH audits and reports on time. CMS withheld four states' federal matching funds for DSH payments in 2011, totaling about $92 million, because the states did not submit audits and reports as required. After the states submitted DSH audits and reports, CMS provided the states with the withheld federal matching funds.

Table 1: Disproportionate Share Hospital (DSH) Audit Requirements Established by 2008 Final Rule

DSH audit requirement	Description
DSH payments do not exceed hospitals' uncompensated care costs	DSH payments made to each hospital are limited to the uncompensated care costs calculated by the auditors using acceptable data sources and methods established by the Centers for Medicare & Medicaid Services (CMS) in the 2008 final rule.[a]
Hospital uncompensated care costs are accurately calculated	Only the cost of inpatient and outpatient services provided to Medicaid and uninsured patients can be included in the calculation of hospitals' uncompensated care costs. The inclusion of ineligible costs, such as physician costs, would inflate a hospital's uncompensated care costs, which could result in a DSH overpayment.[b]
Any Medicaid payment surpluses are applied against the uncompensated care costs of uninsured patients when calculating hospitals' total uncompensated care costs	States' procedures for calculating hospitals' uncompensated care costs must ensure that all Medicaid surpluses, that is, payments that are in excess of Medicaid costs for providing hospital services to Medicaid patients, are used to offset the uncompensated care costs of uninsured patients.[c] If hospitals did not account for all Medicaid payment surpluses, the amount of their uncompensated care costs would be inflated, which could result in a DSH overpayment.
Qualified hospitals are allowed to retain their DSH payments	Hospitals must meet certain federal qualifications to be eligible to receive DSH payments, and payments must be retained by the hospital and be available to offset uncompensated care costs.[d] In addition, auditors must ensure that DSH payments made to each hospital are not returned to the state and used for other purposes.
State has records of all payments and expenditures related to Medicaid and uninsured patients	States must document and retain all information and records of payments and expenditures related to hospital services provided to Medicaid and uninsured patients.
State has documented its methodologies for determining hospitals' uncompensated care costs	States must have documentation describing their methods for calculating hospital-specific uncompensated care costs, including the state's definition of incurred costs for Medicaid and uninsured patients.

Source: GAO summary of regulations.

Notes: Regulatory information is from Disproportionate Share Hospital Payments, Final Rule 73 Fed. Reg. 77904 (Dec. 19, 2008) (codified at 42 C.F.R. Parts 447 and 455).

[a]The 2008 final rule prescribed specific methodologies by which states are to calculate costs for the purpose of determining hospital-specific DSH limits. In some cases, these methodologies may differ from actual state practices for calculating hospital-specific DSH limits and payments in 2007, and could account for certain hospitals receiving DSH payments in excess of the limits calculated using the 2008 final rule methodologies.

[b]The 2008 final rule specifically excludes physician costs from the definition of "hospital services" that is used to determine hospital-specific DSH limits; however, some states have historically included the cost of physician services in such calculations. Additionally, in January 2012 CMS issued a proposed rule to revise the definition of eligible uninsured costs used to calculate uncompensated care costs and reiterated CMS's past position that costs associated with bad debt, including unpaid coinsurance and deductibles, as well as cost of services provided to individuals who are inmates in a public institution or are otherwise involuntarily held in secure custody as result of criminal charges, cannot be included in the calculation of hospital uncompensated care costs. Under the proposed rule, the costs of services provided to individuals whose health insurance coverage has been exhausted or did not cover the specific service provided would be considered uninsured costs when calculating uncompensated care costs. The rule also proposes that the costs of services provided to American Indians / Alaska Natives who have Indian Health Service and tribal health program coverage would be considered uninsured if the Indian Health Service or tribal health program coverage did not provide the services or authorize coverage for the services. Under the 2008 final rule, the costs of services provided to American Indians / Alaska Natives who had Indian Health Service or tribal health program coverage and to individuals whose health insurance coverage had been exhausted or did not cover the specific service provided were not considered eligible uninsured costs. The new definition of uninsured costs will be effective for DSH audits and reports that cover DSH payments made in 2011, which states will submit to CMS in 2014. The proposed rule also states that the

definition of uninsured costs may affect the calculation of uncompensated care costs for some hospitals, depending upon the method utilized by the hospital or state in calculating uncompensated care costs prior to the effective date of a final rule. Hospitals affected by this change should have higher uncompensated care costs, according to the proposed rule. As of November 2012, this rule had not been finalized. See 77 Fed. Reg. 2500 (Jan. 18, 2012).

[c]In our November 2009 report, we identified a state that omitted Medicaid surpluses when calculating the uncompensated care costs for some of its hospitals, resulting in DSH payments in excess of the hospitals' actual uncompensated care costs. The state terminated this practice during the course of that review. See GAO-10-69. According to a CMS official, this requirement is intended to address such practices by ensuring that states do not omit Medicaid surpluses when calculating the uncompensated care costs. However, the official added that the requirement is not an authorization for states to make regular or non-DSH supplemental Medicaid payments for uninsured individuals or other non-Medicaid purposes.

[d]In order for a hospital to qualify as a DSH hospital, it must have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under the state plan. Children's hospitals and certain hospitals that do not offer nonemergency obstetric services are exempt from this requirement. In addition, the hospital must have a Medicaid inpatient utilization rate of at least 1 percent. 42 U.S.C. § 1396r-4(d).

Our analysis of findings from the 2010 DSH audits illustrates the types of changes that states may need to make to their DSH payments by 2014 to avoid potential loss of federal funds or having to redistribute payments in the future.[36] For example, we found that 44 of 49 states making DSH payments in 2007, and hence submitting audits in 2010, made payments to at least one hospital that did not comply with one or more of the six DSH audit requirements. Specifically, in 21 of these 44 states, DSH payments to at least 30 percent of the hospitals did not comply with one or more of the requirements. States were directed to use findings from audits completed during the transition period to make any necessary changes, beginning with payments made in 2011.[37] Action in response to noncompliance begins with audits of the 2011 DSH payments, which must be submitted to CMS in 2014. At that time, states found to be noncompliant with DSH audit requirements may be subject to loss of federal funds or may be required to redistribute any excess DSH payments to other DSH hospitals. As a result, these states may need to

[36]Under the 2008 final rule, the independent auditors may be the state audit agency or any other Certified Public Accountant (CPA) firm that operates independently from either the Medicaid agency or the hospitals being audited. States may not use non-CPA firms, fiscal intermediaries, or independent certification programs currently in place to audit uncompensated care costs, nor expand audits of hospital financial statements to obtain audit certification of the hospital-specific DSH limits. Of the 49 2010 DSH audits, 36 were performed by two national CPA firms, and the remaining 13 audits were performed by state audit agencies and other CPA firms.

[37]The transition period applies to 2010 through 2013 DSH audits, which provide auditors' findings on DSH payments made from 2005 through 2010.

take corrective actions by 2014, when the transition period ends, to resolve any ongoing noncompliance.

Our analysis of the 2010 audits of the 2007 DSH payments showed the following:

- Forty-one states made DSH payments to 717 hospitals in 2007 that exceeded the hospitals' uncompensated care costs, as calculated by independent auditors using data sources and methods that CMS established in the 2008 final rule. The number of hospitals that received excess payments ranged from 1 each in Arkansas, the District of Columbia, Hawaii, Oregon, and Vermont to 114 in Missouri.

- Nine states did not accurately calculate uncompensated care costs for 206 hospitals because they included ineligible costs. Examples of ineligible costs, as described by the 2008 final rule, included those for nonhospital services that are not allowed, such as physician services, and those for services provided to patients whose third-party insurance had either been exhausted or did not cover the specific service.[38]

[38]In January 2012, CMS issued a proposed rule to revise the definition of eligible uninsured costs used to calculate uncompensated care costs, and reiterated CMS's past position that costs associated with bad debt, including unpaid coinsurance and deductibles, as well as cost of services provided to individuals who are inmates in a public institution or are otherwise involuntarily held in secure custody as result of criminal charges, cannot be included in the calculation of hospital uncompensated care costs. Under the proposed rule, the costs of services provided to individuals whose health insurance coverage has been exhausted or did not cover the specific service provided would be considered uninsured costs when calculating uncompensated care costs. The rule also proposes that the costs of services provided to American Indians / Alaska Natives who have Indian Health Service and tribal health program coverage would be considered uninsured if the Indian Health Service or tribal health program coverage did not provide the services or authorize coverage for the services. Under the 2008 final rule, the costs of services provided to American Indians / Alaska Natives who had Indian Health Service or tribal health program coverage and to individuals whose health insurance coverage had been exhausted or did not cover the specific service provided were not considered eligible uninsured costs. The new definition of uninsured costs will be effective for DSH audits and reports that cover DSH payments made in 2011, which states will submit to CMS in 2014. The proposed rule also states that the definition of uninsured costs may affect the calculation of uncompensated care costs for some hospitals, depending upon the method utilized by the hospital or state in calculating uncompensated care costs prior to the effective date of a final rule. Hospitals affected by this change should have higher uncompensated care costs, according to the proposed rule. As of November 2012, this rule had not been finalized.

- Fifteen states made DSH payments to a total of 58 hospitals that either did not retain their DSH payments or were not qualified to receive them. Auditors found that 18 of these hospitals did not retain their DSH payments, while the remaining 40 hospitals were not qualified because these hospitals did not meet the federal requirements to receive DSH payments. For example, some of these hospitals did not meet the requirement of having a Medicaid inpatient volume of at least 1 percent of their total workload.

Table 2 summarizes the number of hospitals for which states' DSH payments complied or did not comply with audit requirements, and appendix II provides similar information by state. In addition, the table includes information on the extent to which auditors could not determine compliance with DSH audit requirements because of data reliability or documentation issues.

Table 2: Summary of the 2010 Disproportionate Share Hospital (DSH) Audit Findings for 49 States, by DSH Audit Requirement

DSH audit requirements	Compliance with requirement		Noncompliance with requirement		Compliance with requirement could not be determined	
	Number of hospitals	As percentage of total hospitals[a]	Number of hospitals	As percentage of total hospitals[a]	Number of hospitals	As percentage of total hospitals[a]
DSH payments do not exceed hospital uncompensated care costs	2,008	68.0%	717	24.3%	228	7.7%
Uncompensated care costs are accurately calculated	1,752	59.3	206[b]	7.0	995	33.7
Any Medicaid surplus is applied against uninsured uncompensated care costs	1,851[c]	62.7	18	0.6	1,084	36.7
Qualified hospitals are allowed to retain their DSH payments	2,638	89.3	58[d]	2.0	257	8.7
State has records of all payments and expenditures related to Medicaid and uninsured patients	2,470	83.6	106	3.6	377	12.8
State documented its method for calculating uncompensated costs	2,679	90.7	261	8.8	13	0.4

Source: GAO analysis of Centers for Medicare & Medicaid Services data.

Notes: Data are from 2010 DSH audits of 2007 DSH payments. Percentages of hospitals in each compliance category may not add to 100 percent due to rounding.

[a]Percentages are based on GAO analysis of 2010 DSH audits of 2007 DSH payments to 2,953 DSH hospitals. We analyzed independent auditor findings on states' compliance with each of the six requirements and identified the number of hospitals for which there was a determination of compliance or noncompliance, or compliance could not be determined. A total of 3,104 hospitals were included in the 2011 DSH audits. We excluded 151 hospitals from our analysis, including those that were closed, did not receive a DSH payment, or were duplicates.

[b]For 83 of these 206 hospitals, auditors found noncompliance on the basis of reviewing only a limited number of hospitals in five states. Thus compliance with respect to the remaining hospitals that were not reviewed by the auditors could not be determined for these states.

[c]For hospitals that did not have a Medicaid surplus, we categorized the DSH payments as being in compliance.

[d]DSH payments to 18 of these hospitals were categorized as noncompliant because the hospitals did not retain their DSH payments, while the DSH payments to the remaining 40 hospitals were categorized as noncompliant because the hospitals were not qualified to receive DSH payments.

DSH Reports Provide Information That Can Help CMS Align States' DSH Allotments with Uncompensated Care Costs

The annual DSH reports provide information CMS can use to better align the states' federal DSH allotments with their levels of uncompensated care, as required by the Patient Protection and Affordable Care Act (PPACA). This act reduces national DSH funding beginning in fiscal year 2014 and requires that CMS implement a method for making corresponding reductions in state DSH allotments on the basis of how states have distributed their DSH payments.[39] Although states have broad flexibility in determining which hospitals receive DSH payments and the amount that each hospital receives, PPACA directs CMS to make the largest reductions in DSH allotments for states that do not target their DSH payments to (1) hospitals with high volumes of Medicaid inpatients and (2) hospitals that have high levels of uncompensated care.[40] CMS has identified the annual DSH reports as a key source of information for analyzing the relationship between DSH payments and uncompensated care and assessing potential new methods for establishing state DSH allotments. States are required to provide 17 pieces of information for each DSH hospital on their annual DSH reports, such as Medicaid and low-income inpatient utilization rates, total Medicaid and uninsured inpatient and outpatient payments and costs, and DSH payments made to each hospital. (See app. III for a description of all 17 data elements states are required to include in DSH reports.)

CMS can use the information from the DSH reports to identify the extent to which states are targeting their DSH payments to hospitals with high levels of uncompensated care. For example, our analysis of the 2010 DSH reports showed that in 30 of 42 states,[41] the hospitals that received

[39]Under PPACA, total national DSH funding will be reduced by a total of about $18 billion from fiscal years 2014 to 2020. Pub. L. No. 111-148, §§ 2551, 10201(e), 124 Stat. 119, 312, 920 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1203, 124 Stat. 1029, 1053 (Mar. 30, 2010) (amending section 1923(f) of the Social Security Act, as codified at 42 U.S.C. § 1396r-4(f)).

[40]Although states are required to make DSH payments to hospitals treating large numbers of Medicaid or low-income patients, states may also make DSH payments to other hospitals as long as at least 1 percent of their patients are Medicaid patients and, with certain exceptions, the hospitals have at least two obstetricians who have staff privileges and have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under the state plan. 42 U.S.C. § 1396r-4(d).

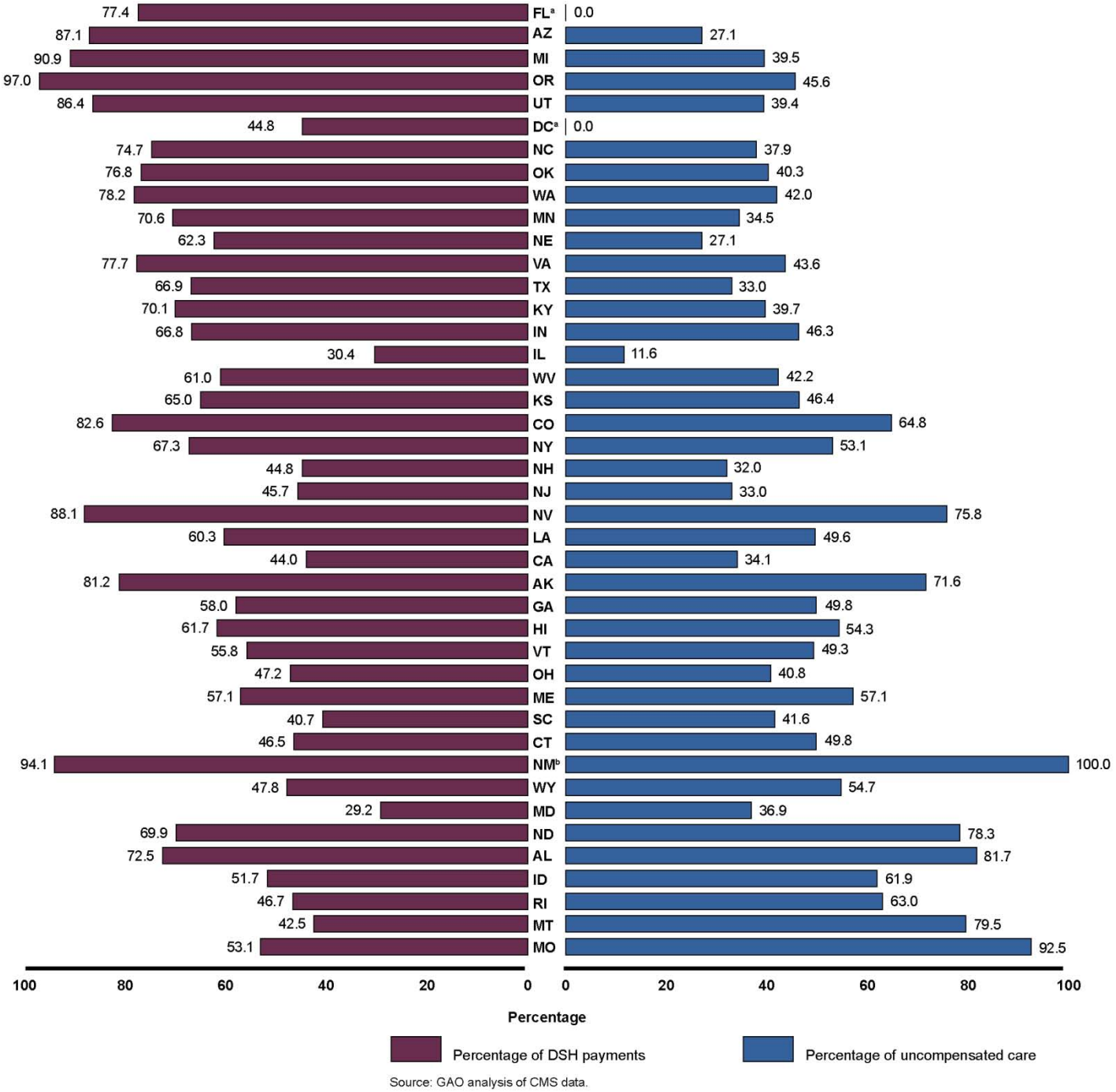
[41]Massachusetts and Tennessee did not make DSH payments in 2007 and did not submit DSH reports. The DSH reports in seven additional states (Arkansas, Delaware, Iowa, Mississippi, Pennsylvania, South Dakota, and Wisconsin) did not include the necessary data to analyze DSH payments and uncompensated care.

the largest share of the state's DSH payments did not provide the largest share of the state's total uncompensated care.[42] (See fig. 2, which shows the share of DSH payments received and the share of uncompensated care provided by the 10 percent of total DSH hospitals in each state that received the largest DSH payments.) In 11 states the 10 percent of the hospitals receiving the largest DSH payments provided a larger share of the state's total uncompensated care and received a smaller share of the state's total DSH payments.[43] (See app. IV for additional information about the share of DSH payments and uncompensated care for the 10 percent of DSH hospitals that received the largest DSH payments in the state and the 90 percent of DSH hospitals that received the smallest DSH payments in each state.)

[42]For the purposes of this report, we consider the hospitals receiving the largest DSH payments in each state to be the 10 percent of total DSH hospitals in the state that received the largest DSH payments. When calculating the number of DSH hospitals representing 10 percent, we rounded up to the nearest whole number.

[43]In the remaining state, Maine, the share of DSH payments and uncompensated care cost were equal for the 10 percent of the hospitals receiving the largest DSH payments.

Figure 2: Share of Disproportionate Share Hospital (DSH) Payments Received and Share of Uncompensated Care Provided by the 10 Percent of DSH Hospitals Receiving the Largest DSH Payments in 2007, Ranked by Difference between Share of DSH Payments and Share of Uncompensated Care



Source: GAO analysis of CMS data.

Notes: For the purpose of this report, we consider the hospitals receiving the largest DSH payments in each state to be the 10 percent of total DSH hospitals in the state that received the largest DSH payments. When calculating the number of DSH hospitals representing 10 percent, we rounded up to the nearest whole number. Massachusetts and Tennessee did not make DSH payments in 2007 and did not submit DSH reports. Some states operate HHS-approved Section 1115 Medicaid demonstrations under which the state does not make DSH payments directly to hospitals. For example, Tennessee incorporated 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. The DSH reports for Arkansas, Delaware, Iowa, Mississippi, Pennsylvania, South Dakota, and Wisconsin did not include the necessary data to analyze DSH payments and uncompensated care. In analyzing uncompensated care in California, we did not adjust for public hospitals authorized by law to receive DSH payments of up to 175 percent of their uncompensated care.

[a]In the District of Columbia and Florida, the 10 percent of total DSH hospitals in the state that received the largest DSH payments did not in the aggregate have uncompensated care costs. Rather, in these states the hospitals receiving the largest DSH payments in the aggregate had a surplus—that is, total regular and non-DSH payments exceeded total costs for Medicaid and uninsured patients. The surplus results in the hospitals' share of total state uncompensated care being a negative percentage. For example, in Florida, a $13 million surplus (a positive number) divided by the state's total uncompensated care of $506 million (a negative number) results in negative 2.6 percent. However, we do not show negative percentages on this figure, but instead report the hospital's share of the state's total uncompensated care as 0 percent.

[b]In New Mexico, the 90 percent of total DSH hospitals in the state that together received the smallest DSH payments did not have uncompensated care costs.

Information on Non-DSH Payments Does Not Exist to the Same Extent as for DSH Payments, and Available Reports Suggest That Such Information Could Enhance Oversight

Information similar to that required for DSH supplemental payments, such as information on facility-specific payments and on state compliance with federal requirements, does not exist to the same extent for non-DSH supplemental payments. However, the limited information that is available on non-DSH payments to DSH hospitals demonstrates the potential need for similar reports and audits of non-DSH payments to enhance CMS's ability to oversee non-DSH payments.

Facility-Specific Payment Information and Independent Audits Do Not Exist to the Same Extent for Non-DSH Payments That They Do for DSH Payments

Information specific to individual facilities is not available for non-DSH payments to the same extent that it is for DSH payments, since non-DSH payments are not subject to the same reporting and audit requirements. While some limited information about non-DSH payments made to DSH hospitals can be found in the annual DSH reports that states must submit, information about non-DSH payments made to hospitals that are not eligible to receive DSH payments—or other health care facilities, such as nursing homes—does not exist at the facility level. In addition, some information on non-DSH payments is available in the quarterly expenditure reports that states submit to CMS to obtain the federal

matching funds for Medicaid payments made. These reports include the state's non-DSH payments aggregated by the facility's ownership type—local-government-owned or local-government-operated, state-government-owned or state-government-operated, or privately owned or operated—and by some categories of service, such as inpatient and outpatient hospital services,[44] but do not include facility-specific payments.[45] (See table 3 for information states are required to provide to CMS for DSH payments, in comparison with that required for non-DSH payments.)

Table 3: Information That States Are Required to Provide to the Centers for Medicare & Medicaid Services on Medicaid Disproportionate Share Hospital (DSH) and Non-DSH Supplemental Payments Made to Hospitals, by Source of Information

Source	Information	Required for DSH payments	Required for non-DSH payments
Annual DSH reports	Supplemental Medicaid payments made, by facility	Yes	Partial[a]
Quarterly state expenditure reports	Payments made, by category of service	Yes	Partial[b]
Quarterly state expenditure reports	Payments made, by provider ownership type	No	Yes
Annual DSH audits	Independent audits of compliance with federal requirements	Yes	No

Source: GAO.

[a]Only available for hospitals that receive DSH payments and are included in states' annual DSH reports.

[b]Only available for some categories of service, such as inpatient and outpatient hospital services, but not others, such as mental health services or clinic services.

Without information on allocations of non-DSH payments to individual providers, CMS and others are unable to identify or assess total Medicaid funding received by individual providers and how Medicaid payments relate to providers' Medicaid costs. The targeting of non-DSH supplemental payments to certain providers may be necessary and

[44]Starting with the first quarter of fiscal year 2010, CMS began requiring states to report non-DSH payments for six categories of service: inpatient hospital services, outpatient hospital services, nursing facility services, physician and surgical services, other practitioners' services, and intermediate care facility services.

[45]We recently reported—using available information in quarterly expenditure reports—that facilities receiving non-DSH payments, other than DSH hospitals, received at least $1.6 billion in non-DSH supplemental payments in fiscal year 2010. The exact amount of non-DSH supplemental payments for these other facilities was unknown because state reporting was incomplete. See GAO-12-694.

appropriate to ensure, for example, that those providers serving larger numbers of Medicaid beneficiaries are appropriately compensated for their costs of serving those beneficiaries. However, without information on the providers to which payments are targeted, assessments of whether those payments are affecting beneficiary access to care and are not excessive in view of providers' costs are not possible. For example, the Medicaid and CHIP Payment and Access Commission (MACPAC), the commission created by Congress to study Medicaid payment and access, reported in March 2012 on the data limitations at the federal level regarding non-DSH payments, which it refers to as "UPL payments." MACPAC noted that these payments can be an important source of revenue for certain providers. However, because these payments are not necessarily associated with specific services or enrollees and are not reported at the provider level, it is difficult for state and federal policymakers to compare total Medicaid payments across providers and enrollment groups and to evaluate the effect of these lump-sum payments on payment methods and delivery models.[46]

Oversight of non-DSH payments is also constrained by the lack of audited information on non-DSH payments. Unlike DSH payments, states' non-DSH payments are not subject to annual independent audits or standard requirements regarding the methods and data sources for calculating payment amounts. CMS and others have limited information regarding the reliability of the methods and data used to calculate payments, and the consistency of the payments with Medicaid payment principles. We and others have reported on aspects of selected states' non-DSH payments and raised varied concerns regarding whether some states' payments were used for Medicaid purposes and were consistent with economy and efficiency—key Medicaid principles. For example, our prior work in selected states has found that some states were making non-DSH payments that were vastly higher than the payments the facilities

[46]MACPAC noted that without provider-specific information, it is not possible to identify how much Medicaid actually spends on specific services and populations or to make meaningful intra- or cross-state comparisons of payment amounts or methods; determine the ultimate disposition of federal funds that are provided to states for their Medicaid programs (i.e., which providers receive supplemental payments and in what amounts); or assess fully the extent to which payment policies affect efficiency, quality, and access to appropriate services. Furthermore, the effect of policies intended to promote certain outcomes through payment rates (e.g., pay for performance) may be muted by providers' ability to access supplemental payments. See Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP* (Washington, D.C.: 2012).

would have received under regular Medicaid payment rates and were not retained by the providers for Medicaid purposes.[47] We have also reported that non-DSH payments were made for similar purposes as DSH payments, and that selected states had used widely varying and inaccurate methods for calculating their non-DSH payment amounts.[48] Similarly, the HHS OIG has reported for selected states that large non-DSH supplemental payments were made to certain providers that were returned to the state, not accurately calculated, and did not improve the quality of care provided to Medicaid beneficiaries.[49] These reports have generally been focused on a small number of states—five or fewer—and have covered a limited time frame. Although CMS established an oversight initiative in 2003 to closely review state payment arrangements before approving them, not all existing payment arrangements had been reviewed.

In 2004, we made recommendations to improve the oversight of these payments, including recommending that CMS establish uniform guidance for states that would set acceptable methods for calculating the amount of non-DSH supplemental payments and adopt requirements for facility-specific reporting of non-DSH payments. At the time, CMS generally agreed with our recommendations, stating that it would issue guidance on the characteristics and principles underlying acceptable methods, and that it would also consider improvements in reporting requirements for non-DSH payments.[50] However, as of November 2012, requirements implementing these recommendations had not been established. CMS officials said that they do not have plans to make changes to the oversight of non-DSH payments that would institute requirements similar to those for DSH payments, such as requiring annual facility-specific reporting of non-DSH payment information, clarifying permissible methods for calculating non-DSH payment amounts, and requiring annual independent audits of state non-DSH payment calculations. Officials stated that they were able to implement the DSH payment requirements—which encountered objections from states, hospitals, and

[47]GAO-04-228.

[48]GAO-08-614 and GAO-04-228.

[49]For example, see HHS, Office of the Inspector General, A-09-03-00055, A-04-03-03023, and A-10-04-00001.

[50]GAO-04-228.

others—because they were required by law to do so, and that legislation would be needed for CMS to establish similar requirements for non-DSH payments.

Available Information Suggests That Reports and Audits for Non-DSH Supplemental Payments Could Improve CMS's Ability to Oversee These Payments

The hospital-specific information on non-DSH payments that is available from DSH reports illustrates the potential utility of having such information for enhancing oversight. Using this information, CMS can determine the extent to which non-DSH payments are targeted to a small number of providers, are related to those providers' Medicaid workload, and resulted in total Medicaid payments (regular Medicaid and non-DSH supplemental payments) that exceeded an individual provider's costs of providing Medicaid services. This type of analysis can point to circumstances where a state's payments to individual hospitals may warrant further scrutiny, to ensure the payments were made for Medicaid purposes and were consistent with Medicaid payment principles.

In reviewing states' 2010 DSH reports, we found that a small proportion of DSH hospitals in each state received a large proportion of total non-DSH supplemental payments made to DSH hospitals and that payments were not always aligned with hospitals' uncompensated Medicaid costs.[51] Across the 43 states that reported making non-DSH payments in their DSH reports,[52] over $5.1 billion of the $7.6 billion in total non-DSH payments made to DSH hospitals went to the 10 percent of DSH

[51]For our analysis, uncompensated Medicaid costs are the expenses incurred in providing Medicaid-covered services to Medicaid beneficiaries minus regular Medicaid payments the hospitals received. In conjunction with CMS's 2008 final rule on DSH audits and reports, CMS also issued a DSH audit and reporting protocol to provide guidance and direction on how the audits were to be conducted, including methodology and data sources to be used in calculating hospitals' payments and costs. The protocol requires that information in the DSH reports about DSH hospitals' Medicaid payments and costs come from existing cost-reporting tools and documents, such as the Medicaid Management Information System, the approved state Medicaid plan, the Medicare 2552-96 hospital cost report, and audited hospital financial statements or other auditable hospital accounting records.

[52]Eight states were excluded from our analysis of non-DSH supplemental payments. Of these eight states, two states (Massachusetts and Tennessee) did not make DSH payments in 2007 and did not submit DSH reports. Five states (Delaware, Maine, North Dakota, Vermont, and Wisconsin) did not report non-DSH supplemental payments in their DSH reports or did not make non-DSH supplemental payments in 2007. One state, South Dakota, was excluded from our analysis because we could not determine the reliability of its data.

hospitals in each state that received the largest non-DSH payments.[53] The proportion of non-DSH payments made to a small number of DSH hospitals was not always aligned with the hospitals' uncompensated Medicaid costs, that is, total costs of Medicaid services provided to Medicaid beneficiaries minus total regular Medicaid payments received by the hospitals. For example, in 6 of 13 states, the 10 percent of DSH hospitals with the largest non-DSH payments received 90 percent or more of the non-DSH payments made to DSH hospitals, while their shares of total uncompensated Medicaid costs in the state were less than 35 percent. The allocation of non-DSH payments to hospitals in this way raises questions about how the payments relate to the provision of Medicaid services and the purposes for which these payments are made. (See app. V for more information about the percentage and dollar amount of non-DSH payments made to, and the percentage of uncompensated Medicaid costs for, DSH hospitals in each state.)

The 2010 DSH reports also demonstrate how having more-detailed information on states' non-DSH payments can improve CMS's oversight for these payments, which have no facility-specific payment limits and for which states have flexibility in how they are distributed to providers. The 2010 DSH reports suggest that states' total regular Medicaid and non-DSH payments in some cases significantly exceeded the Medicaid costs experienced by the providers receiving those payments.[54] Of the 43 states that reported making non-DSH payments in their DSH reports, we found that in 39 states at least one hospital received total regular Medicaid and non-DSH supplemental payments in excess of Medicaid

[53]When calculating the number of DSH hospitals representing the 10 percent that received the largest share of non-DSH payments, we rounded up hospitals' non-DSH payments to the nearest whole number.

[54]In their annual DSH reports, states are required to report three categories of Medicaid payments that hospitals may have received: fee-for-service payments, managed care organization payments, and non-DSH supplemental payments. For the purpose of our report, we combined the fee-for-service payment and managed care organization payment amounts and refer to them as total regular Medicaid payments. States are also required to report the total Medicaid payments for each hospital, that is, the sum of the three categories of Medicaid payments hospitals may have received. For the 2010 reports, however, in some states this total also included other payments, such as payments a hospital received from another state Medicaid program and payments received from Medicare for Medicaid individuals who were eligible for both Medicaid and Medicare.

costs.[55] On the basis of the hospital-specific information in these 39 states' 2010 DSH reports, a total of 505 DSH hospitals received total regular Medicaid and non-DSH payments in excess of Medicaid costs.[56] These hospitals' payments exceeded costs by a total of about $2.7 billion. For these hospitals, non-DSH payments were a significant factor in Medicaid payments exceeding Medicaid costs.

- Of the 505 hospitals, 310 received a non-DSH payment that, when added to the regular Medicaid payments the hospital received, resulted in total Medicaid payments exceeding Medicaid costs by about $1.9 billion. For example, one hospital received almost $320 million in non-DSH payments, which when combined with $331 million in regular Medicaid payments exceeded the $410 million in costs experienced by the hospital in providing Medicaid services by about $241 million.

- The remaining 195 hospitals received regular Medicaid payments that exceeded Medicaid costs before they received a non-DSH payment, and total payments exceeded costs by about $900 million. For example, one hospital received almost $62 million in non-DSH payments even though regular Medicaid payments made to the hospital exceeded its costs of providing Medicaid services by over $52 million.

(See fig. 3 and app. VII for the number and percentage of DSH hospitals in each state that received a non-DSH payment and for which their regular Medicaid and non-DSH payments exceeded Medicaid costs and the amounts by which payments exceeded costs.)

[55]The remaining four states (Connecticut, the District of Columbia, Hawaii, and Nebraska) did not have any hospitals that received total regular Medicaid and non-DSH payments in excess of Medicaid costs.

[56]For purposes of this report, the term Medicaid costs refers to expenses incurred in providing Medicaid-covered services to Medicaid beneficiaries.

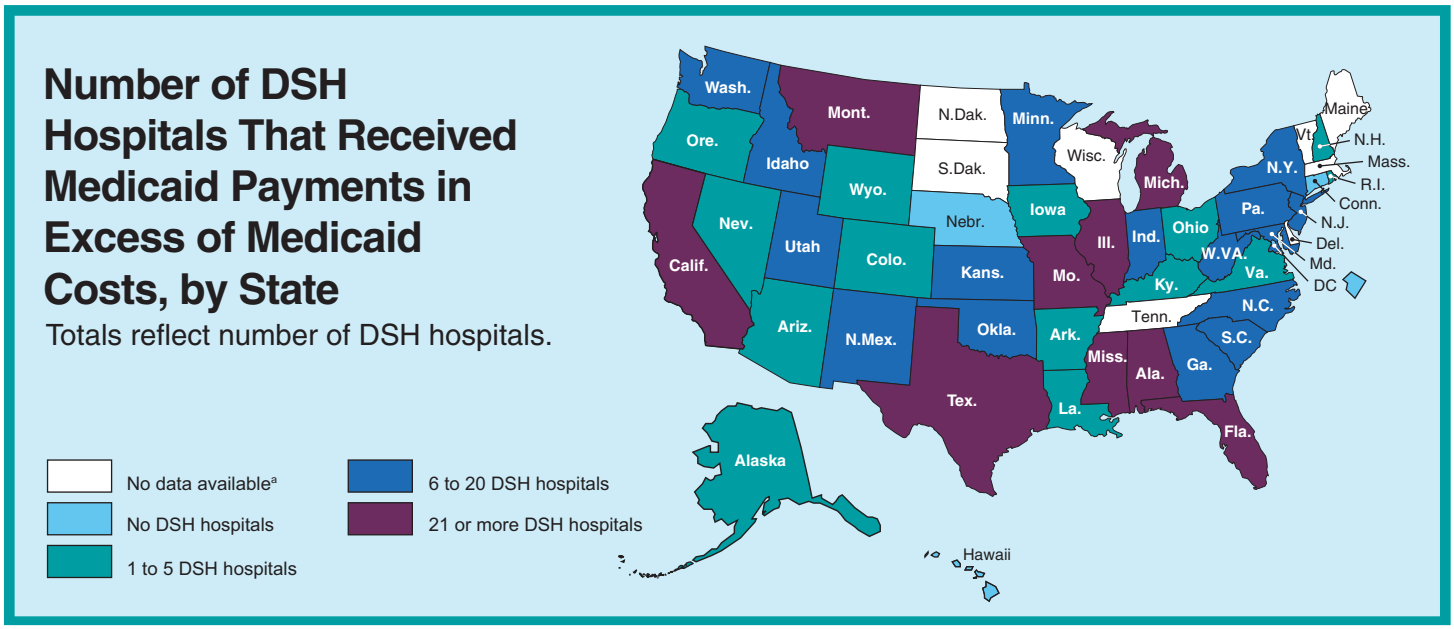
Another 200 hospitals did not receive a non-DSH payment, but their regular Medicaid payments exceeded Medicaid costs. For these hospitals, as well as the 505 hospitals that received total regular Medicaid and non-DSH payments in excess of Medicaid costs, we also analyzed their DSH payments and uncompensated care costs. (See app. VI for the results of this analysis.)

Interactive graphic

Figure 3: Number and Percentage of Disproportionate Share Hospital (DSH) Hospitals That Received Regular Medicaid and Non-DSH Supplemental Payments in Excess of Medicaid Costs, and Amounts by Which Payments Exceeded Costs, by State

Hospitals | Percentages | Dollars

Move mouse over the above categories to view the number of hospitals with Medicaid payments exceeding Medicaid costs, the percentage of hospitals with Medicaid payments exceeding Medicaid costs, or the dollar amounts by which Medicaid payments exceeded Medicaid costs.



Source: GAO analysis of Centers for Medicare & Medicaid Services data.

Notes: Data are from 2010 DSH reports of 2007 DSH payments. Total Medicaid payments are regular Medicaid and non-DSH supplemental payments. Total Medicaid costs are the expenses incurred in providing Medicaid-covered services to Medicaid beneficiaries.

[a]Massachusetts and Tennessee did not make DSH payments in 2007 and did not submit DSH reports. Delaware, Maine, North Dakota, South Dakota, Vermont, and Wisconsin did not report the necessary information to analyze Medicaid payments and costs.

Print instructions | To print expanded information, see appendix VII.

Regular and non-DSH Medicaid payments are not limited to providers' costs of delivering Medicaid services; however, as Medicaid payments, they are intended to pay for Medicaid-covered services provided to Medicaid beneficiaries. As a result, Medicaid payments that greatly exceed Medicaid costs raise questions about the purpose of the payments, including how they relate to Medicaid services, whether they are consistent with economy and efficiency, and whether they contribute to beneficiaries' access to quality care. For example, recent research suggests that Medicaid supplemental payments were a key factor that resulted in overall profits for government-owned and government-operated hospitals reviewed.[57] Hospital-specific information can be helpful to CMS and others for understanding, at the provider level, the relationship of supplemental payments to both regular Medicaid payments and Medicaid costs, which currently cannot be assessed given available information. According to CMS officials, since 2003, CMS typically has assessed the appropriateness of supplemental payment arrangements when a state proposes implementing a new payment arrangement or makes changes to established programs. In reviewing proposals, CMS reviews how the payments are calculated and the purposes for which they are made. We have found, however, that some states have reported broad purposes for their non-DSH supplemental payments and that CMS has not reviewed all payment arrangements.[58] States' payment methods and payment arrangements can be complex and challenging to assess, and doing so can require significant time and resources.

[57]Researchers examined the financial performance of 150 hospitals that they identified as providing a large share of care to low-income, uninsured, and Medicaid populations. The study examined hospitals' finances during 2003 to 2007 and compared the financial performance of government-owned and government-operated hospitals, nonprofit hospitals, and private for-profit hospitals. Researchers found that government-owned and government-operated hospitals had positive operating margins (profits) in part because of supplemental Medicaid payments. In contrast, nonprofit and private for-profit hospitals had negative operating margins. Nancy M. Kane et al., "Strained Local and State Government Finances among Current Realities That Threaten Public Hospitals' Profitability," *Health Affairs*, vol. 31, no. 8 (2012).

[58]See GAO-08-614.

Conclusions

Medicaid is a large and growing program and is vital to tens of millions of vulnerable individuals, who rely on it for their health care. To understand the complex program and make decisions on how best to oversee it, decision makers at the federal level need reliable and accurate information on how program resources are allocated and spent. Supplemental payments are a significant and growing component of Medicaid spending, and non-DSH supplemental payments appear to be a contributor to this growth.

For more than two decades, concerns have been raised about the lack of transparency and accountability in CMS's oversight of both DSH and non-DSH supplemental payments. For example, information has been lacking on the distribution of supplemental payments, the relationship of supplemental payments to regular Medicaid payments and to the level of services provided, and the purposes for which supplemental payments are made. The annual DSH reports that states are now submitting to CMS, and the annual independent audits of states' compliance with key federal DSH audit requirements, including calculations of DSH payment limits, are important steps toward improving transparency and accountability for Medicaid DSH payments. They should help improve the allocation of these payments to qualified hospitals in future years. Similar information is lacking, however, for non-DSH payments. Moreover, the limited information available on non-DSH payments shows that a large share of these payments are paid to a small number of hospitals, and that when these payments are combined with regular Medicaid payments, hundreds of hospitals may be receiving Medicaid payments well in excess of their actual costs of providing Medicaid services. Such excessive payments raise concerns, including whether such payments are consistent with the requirement that provider payments be economical and efficient. These concerns highlight the need for clear guidelines regarding the calculation of non-DSH payment amounts.

We believe our longstanding concerns regarding the need for improved transparency and accountability for supplemental payments are still valid. In 2004, to better ensure the fiscal integrity of Medicaid, we made recommendations to CMS to address concerns about transparency for large non-DSH payments and about widely varying and inaccurate state calculations of non-DSH payment amounts. However, as of November 2012, CMS had not established facility-specific reporting requirements or clarified permissible methods for calculating non-DSH payment amounts. In addition, states' non-DSH payments are not subject to annual independent audits. Given the size and growth of non-DSH payments, which now exceed DSH payments in total amounts, there is an urgent

need for improvements in the transparency of and accountability for non-DSH supplemental payments. Accordingly, we are raising these issues to the Congress as a new matter for its consideration.

Matter for Congressional Consideration

To improve transparency of and accountability for Medicaid non-DSH supplemental payments, we suggest that Congress consider requiring the Administrator of CMS to (1) improve state reporting of non-DSH supplemental payments, including requiring annual reporting of payments made to individual facilities and other information that the agency determines is necessary to oversee non-DSH supplemental payments; (2) clarify permissible methods for calculating non-DSH supplemental payments; and (3) require states to submit an annual independent certified audit verifying state compliance with permissible methods for calculating non-DSH supplemental payments.

Agency Comments

We provided a draft of this report to HHS for comment. In its written comments, HHS agreed that improved reporting and oversight of non-DSH supplemental payments was needed. HHS noted that some efforts were under way to do so, including a comprehensive review of state supplemental payment methodologies to ensure that payments are compliant with Medicaid statute and federal regulation. HHS also noted that work was under way to evaluate and improve the implementation of Medicaid DSH certified audits and reports. HHS's letter is reprinted in appendix VIII.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, 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 IX.

Katherine M. Iritani
Director, Health Care

Appendix I: Scope and Methodology

This appendix describes in detail our work to determine how the information collected from disproportionate share hospital (DSH) audits and reports facilitates the Centers for Medicare & Medicaid Services' (CMS) oversight of DSH supplemental payments and the extent to which similar information exists for overseeing non-DSH supplemental payments. We obtained from CMS information from 49 states' 2010 DSH audits and reports for payments made in 2007, the most-recent year available at the time of our review.[1] We did not evaluate the quality of the DSH audits or the audit processes the independent auditors used. We also did not independently verify the accuracy of the DSH report data. We checked the audit and report data for obvious errors and omissions and interviewed CMS officials to resolve any identified discrepancies. In reviewing the audit data, we also removed from our analysis hospitals that were closed, were out-of-state (not located in the state for which the audit was conducted), and had no reported DSH payments (either $0 was reported or no information was provided), as well as hospitals that appeared twice, which was the case in only one state's audit. In reviewing the DSH report data, we removed hospitals with incomplete information or for which independent auditors had raised questions about data reliability or the hospital's qualifications for receiving a DSH payment. The number of hospitals removed for each type of analysis differed because each analysis was based on a review of different information in the DSH reports. We did not remove hospitals for which auditors had noted that information provided by states and hospitals could not be confirmed. On the basis of this review, we determined that the DSH audits and reports were sufficiently reliable for the purposes of this report, and we accounted for any limitations in these data during our analyses. We also reviewed applicable laws and regulations.

[1]In this report, we use the term state to refer to the 50 states and the District of Columbia. Massachusetts and Tennessee did not make DSH payments in 2007 and did not submit DSH audits or reports. Some states operate HHS-approved Section 1115 Medicaid demonstrations under which the state does not make DSH payments directly to hospitals. For example, Tennessee incorporated DSH funding into payments to managed care organizations, and all of Massachusetts's DSH funds were used to support a special fund for safety-net health care providers.

Analysis of DSH Audits and Reports for Oversight of DSH Payments

To determine how the information collected from DSH audits facilitates CMS's oversight of DSH payments, we analyzed the DSH audits for the 49 states that submitted them to determine the extent of states' compliance with the six audit requirements established by the 2008 final rule: (1) DSH payments do not exceed hospitals' uncompensated care costs; (2) hospital uncompensated care costs are accurately calculated; (3) any Medicaid payment surpluses are applied against the uncompensated care costs of uninsured patients; (4) qualifying hospitals are allowed to retain the DSH payments that they receive; (5) the state has records of all payments and expenditures related to Medicaid and uninsured patients; and (6) the state has documented its methods for calculating uncompensated care costs. Each audit documented independent auditors' findings regarding the extent to which states' DSH payments complied with these six requirements. We analyzed the audit findings, and for each state we determined the extent of compliance with the audit requirements by identifying the number of hospitals (1) whose DSH payments complied with the audit requirement; (2) whose DSH payments did not comply with the audit requirement; and (3) for which compliance of their DSH payments with the audit requirement could not be determined. Specifically, we determined the number of hospitals whose DSH payments complied with the audit requirements on the basis of the number of hospitals cited by auditors as compliant, or calculated the number on the basis of the number of hospitals auditors identified as noncompliant or whose compliance could not be determined. We determined the number of hospitals whose DSH payments did not comply with audit requirements on the basis of the number of hospitals cited by auditors as noncompliant, or calculated the number on the basis of the number of hospitals auditors identified as compliant or whose compliance could not be determined. The number of hospitals for which compliance of their DSH payments could not be determined was based on findings that explicitly identified hospitals whose compliance with the audit requirements could not be determined by auditors because, for example, documentation was not provided or the documentation provided was not sufficient for auditors to determine the level of compliance. We also calculated the number of hospitals for which compliance of their DSH payments could not be determined on the basis of the number of hospitals that auditors did not identify as being compliant or noncompliant. For this analysis, we removed 151 hospitals of the 3,104 hospitals included in the 2010 DSH audits. As a result, our analysis reflects findings from the remaining 2,953 hospitals.

To determine how the information collected from DSH reports facilitates CMS's oversight of DSH payments, we analyzed hospital-specific information from the 2010 DSH reports for 49 states to determine the extent to which DSH payments were targeted to hospitals with high levels of uncompensated care.[2] Of these states, 7 states did not report the necessary data to analyze DSH payments and uncompensated care.[3] We removed all 351 hospitals in these states. In addition, in the remaining 42 states, we removed 876 hospitals for which data were missing or were deemed by us to be unreliable, so our analysis is based on 1,877 hospitals in 42 states. The hospital-specific information in the reports includes payments received for Medicaid and uninsured patients, non-DSH supplemental payments, and the costs of care for Medicaid and uninsured patients.[4] In conducting our analysis, we reviewed DSH payments made to DSH hospitals and the uncompensated care they provided to Medicaid and uninsured patients as a proxy for the amount of uncompensated care each hospital provided. We calculated the percentage of DSH payments made to, and uncompensated care provided by, the 10 percent of DSH hospitals that received the largest DSH payments in the state and the remaining 90 percent of DSH hospitals in each state.

[2]Massachusetts and Tennessee did not make DSH payments in 2007 and did not submit DSH audits and reports. Some states operate HHS-approved Section 1115 Medicaid demonstrations under which the state does not make DSH payments directly to hospitals. For example, Tennessee incorporated DSH funding into payments to managed care organizations, and all of Massachusetts's DSH funds were used to support a special fund for safety-net health care providers.

[3]The 7 states that did not report the necessary data to analyze DSH payments and uncompensated care were Arkansas, Delaware, Iowa, Mississippi, Pennsylvania, South Dakota, and Wisconsin.

[4]According to CMS's general DSH audit and reporting protocol, information in DSH reports about payments and costs comes from existing cost-reporting tools and documents, such as the Medicaid Management Information System, approved state Medicaid plans, the Medicare 2552-96 hospital cost report, and audited hospital financial statements or other auditable hospital accounting records.

Analysis of DSH Reports for Oversight of Non-DSH Supplemental Payments

To determine the extent to which similar information exists to facilitate CMS's oversight of non-DSH supplemental payments, we analyzed the information states submitted in their 2010 DSH reports for DSH payments made in 2007, which includes hospital-specific information on non-DSH payments made to DSH hospitals. Of the 49 states that submitted a 2010 DSH report, 6 states were excluded from our analysis of non-DSH supplemental payments because they did not report non-DSH supplemental payments in their DSH reports, or did not make non-DSH supplemental payments in 2007, or the reliability of their data could not be determined.[5] We removed all 105 hospitals in these states. In addition, in the remaining 43 states, we removed 330 hospitals for which data were missing or payments were not made, so our analysis is based on 2,669 hospitals in 43 states. Using the information from these states' DSH reports, we did the following:

- Analyzed non-DSH payment information and Medicaid uncompensated care costs to identify the extent to which non-DSH payments were aligned with hospitals' uncompensated Medicaid costs in each state. Specifically, we reviewed the non-DSH payments and Medicaid uncompensated care costs for these hospitals and calculated the percentage of non-DSH payments and Medicaid uncompensated care costs for the 10 percent of DSH hospitals that received the largest non-DSH payments in each state and for the remaining 90 percent of DSH hospitals in each state.

- Analyzed the total regular Medicaid and non-DSH supplemental payments and total Medicaid costs to identify the number and percentage of DSH hospitals with combined regular Medicaid and non-DSH supplemental payments in excess of Medicaid costs, as well as the dollar amount by which Medicaid payments exceeded Medicaid costs, for DSH hospitals that received a non-DSH supplemental

[5]The 5 states that did not report non-DSH supplemental payments in their DSH reports or did not make non-DSH supplemental payments in 2007 were Delaware, Maine, North Dakota, Vermont, and Wisconsin. One state, South Dakota, was excluded from our analysis because we could not determine the reliability of its data.

payment.[6] Specifically, we reviewed regular Medicaid and non-DSH payments made to these hospitals and the costs associated with treating Medicaid beneficiaries. We calculated the number and percentage of DSH hospitals in each state that both received combined regular Medicaid and non-DSH payments in excess of Medicaid costs and received a non-DSH payment. For these hospitals, we also calculated the amounts by which combined regular Medicaid and non-DSH payments exceeded Medicaid costs and determined whether regular Medicaid payments alone exceeded Medicaid costs or whether regular Medicaid payments, when combined with non-DSH payments, exceeded Medicaid costs.

We conducted this performance audit from December 2011 through November 2012 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.

[6]In their annual DSH reports, states are required to report three categories of Medicaid payments that hospitals may have received: fee-for-service payments, managed care organization payments, and non-DSH supplemental payments. For the purpose of our report, we combined the fee-for-service payment and managed care organization payment amounts and refer to them as total regular Medicaid payments. States are also required to report the total Medicaid payments for each hospital, that is, the sum of the three categories of Medicaid payments hospitals may have received. For the 2010 reports, however, in some states this total also included other payments, such as payments a hospital received from another state Medicaid program and payments received from Medicare for Medicaid individuals who were eligible for both Medicaid and Medicare.

Appendix II: Extent of Compliance with DSH Audit Requirements in 2010 DSH Audits

In 2003, Congress mandated improved accountability for disproportionate share hospital (DSH) payments under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, by providing that the Secretary of Health and Human Services require states to submit annual independent certified audits and annual reports on their DSH payments.[1] In 2008, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to implement the 2003 DSH audit and report requirement.[2] The 2008 final rule laid out key audit and reporting requirements. The first sets of DSH audits and reports, covering payments made in 2005 through 2007, were submitted to CMS in December 2010. Action in response to noncompliance begins with audits of the 2011 DSH payments, which must be submitted to CMS in 2014. At that time, states found to be noncompliant with DSH audit requirements may be subject to loss of federal funds or may be required to redistribute any excess DSH payments to other DSH hospitals. As a result, these states may need to take corrective actions by 2014, when the transition period ends, to resolve any ongoing noncompliance.

Tables 4 and 5 present more-detailed information on the results of our analysis of the 2010 DSH audits of the 2007 DSH payments on the extent of states' compliance with each of the six DSH audit requirements. These requirements include

- DSH payments do not exceed hospitals' uncompensated care costs,
- hospital uncompensated care costs are accurately calculated,
- any Medicaid payment surpluses are applied against the uncompensated care costs of uninsured patients,
- qualified hospitals are allowed to retain the DSH payments that they receive,

[1]Pub. L. No. 108-173, § 1001(d), 117 Stat. 2066, 2430-2431 (2003) (adding section 1923(j) to the Social Security Act) (codified, as amended, at 42 U.S.C. § 1395r-4(j)).

[2]Medicaid Program; Disproportionate Share Hospital Payments, 73 Fed. Reg. 77904 (Dec. 19, 2008) (codified at 42 C.F.R. Parts 447 and 455; Medicaid Program; Disproportionate Share Hospital Payments; Correcting Amendment, 74 Fed. Reg. 18656 (Apr. 24, 2009). CMS subsequently issued a notice of proposed rulemaking to revise certain provisions of this rule. Medicaid Program; Disproportionate Share Hospital Payments—Uninsured Definition, 77 Fed. Reg. 2500 (Jan. 18, 2012).

- the state has records of all payments and expenditures related to Medicaid and uninsured patients, and
- the state has documented its methods for calculating uncompensated care costs.

Table 4: Extent of Compliance with Federal DSH Audit Requirements, by State, Audit Requirement, and Number of Hospitals as Reported in 2010 Disproportionate Share Hospital (DSH) Audits (part 1)

		DSH payments do not exceed hospital uncompensated care costs			Hospital uncompensated care costs are accurately calculated			Any Medicaid surplus is applied against uninsured uncompensated care costs		
State	Total number of hospitals	Met	Not met	Could not be verified	Met	Not met	Could not be verified	Met	Not met	Could not be verified
Alabama	**98**	49	49	0	15	6[a]	77	0	0	98[b]
Alaska	**4**	4	0	0	3	0	1	4	0	0
Arizona	**40**	40	0	0	40	0	0	40	0	0
Arkansas	**4**	3	1	0	4	0	0	0	0	4[b]
California	**141**	124	17	0	1	0	140	0	0	141
Colorado	**47**	0	0	47	0	0	47	0	0	47
Connecticut	**35**	0	0	35	0	0	35	0	0	35
Delaware	**1**	1	0	0	1	0	0	1	0	0
District of Columbia	**10**	5	1	4	6	0	4	6	0	4
Florida	**63**	44	19	0	63	0	0	63	0	0
Georgia	**109**	83	26	0	109	0	0	109	0	0
Hawaii	**15**	14	1	0	15	0	0	15	0	0
Idaho	**35**	30	5	0	35	0	0	35	0	0
Illinois	**42**	9	32	1	41	0	1	41	0	1
Indiana	**66**	51	15	0	66	0	0	66	0	0
Iowa	**12**	9	3	0	0	0	12	0	0	12
Kansas	**45**	23	22	0	42	0	3	45	0	0
Kentucky	**108**	82	26	0	105	0	3	108	0	0
Louisiana	**118**	55	63	0	116	0	2	118	0	0
Maine	**2**	2	0	0	2	0	0	2	0	0
Maryland	**20**	14	6	0	20	0	0	20	0	0
Michigan	**130**	102	28	0	18	27[a]	85	0	0	130[b]
Minnesota	**106**	39	0	67	0	0	106	38	0	68
Mississippi	**58**	29	29	0	0	12[a]	46	0	0	58[b]
Missouri	**144**	30	114	0	144	0	0	144	0	0
Montana	**50**	25	25	0	41	0	9	28	0	22
Nebraska	**28**	24	4	0	26	0	2	28	0	0
Nevada	**12**	9	3[c]	0	11	0	1	12	0	0
New Hampshire	**29**	11	15[c]	3	29	0	0	29	0	0
New Jersey	**88**	72	16	0	88	0	0	88	0	0

		DSH payments do not exceed hospital uncompensated care costs			Hospital uncompensated care costs are accurately calculated			Any Medicaid surplus is applied against uninsured uncompensated care costs		
State	**Total number of hospitals**	**Met**	**Not met**	**Could not be verified**	**Met**	**Not met**	**Could not be verified**	**Met**	**Not met**	**Could not be verified**
New Mexico	**23**	9	14	0	23	0	0	23	0	0
New York	**222**	167	32	23	171	28	23	222	0	0
North Carolina	**110**	103	7	0	110	0	0	110	0	0
North Dakota	**7**	4	3	0	4	0	3	7	0	0
Ohio	**176**	168	8	0	176	0	0	176	0	0
Oklahoma	**65**	50	6	9	0	65	0	49	3	13
Oregon	**9**	8	1	0	9	0	0	9	0	0
Pennsylvania	**176**	164	12	0	0	10	166	0	1	175
Rhode Island	**14**	10	4	0	14	0	0	14	0	0
South Carolina	**61**	40	19[c]	2	58	0	3	58	0	3
South Dakota	**20**	16	4[c]	0	0	20	0	0	0	20
Texas	**181**	125	39[c]	17	0	22[a]	159	0	0	181[b]
Utah	**34**	21	13	0	34	0	0	34	0	0
Vermont	**14**	0	1[d]	13	0	0	14	0	14	0
Virginia	**21**	19	2	0	21	0	0	21	0	0
Washington	**72**	52	13[c]	7	3	16[a]	53	0	0	72[b]
West Virginia	**57**	40	17	0	57	0	0	57	0	0
Wisconsin	**26**	26	0	0	26	0	0	26	0	0
Wyoming	**5**	3	2	0	5	0	0	5	0	0
Total	**2,953**[d]	**2,008**	**717**	**228**	**1,752**	**206**	**995**	**1,851**	**18**	**1,084**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data.

Notes: Data are from 2010 DSH audits of the 2007 DSH payments. Massachusetts and Tennessee did not make DSH payments in 2007 and did not submit DSH audits. We analyzed the audit findings, and for each state we determined the extent of compliance with the audit requirements by identifying the number of hospitals (1) whose DSH payments complied with the audit requirement—categorized as "Met"; (2) whose DSH payments did not comply with the audit requirement—categorized as "Not met"; and (3) for which compliance of their DSH payments with the audit requirement could not be determined—categorized as "Could not be verified." DSH payments made between 2005 and 2010 are subject to a transition period during which CMS would not take action against states based on findings of noncompliance with federal DSH requirements identified in the audits.

[a]In these states, the number of hospitals with payments found noncompliant was based on auditors' review of a case study of hospitals.

[b]The DSH audit findings of these states' compliance with this requirement noted that because the Medicaid State Plans of these states were silent about the inclusion of all Medicaid payments (i.e., out-of-state, dual eligible, and supplemental payments) in the calculation of hospitals' uncompensated care costs, not all Medicaid payment surpluses were applied against the uninsured uncompensated care costs. As a result, we could not determine the specific number of hospitals whose DSH payments were compliant or noncompliant with this requirement.

[c]Of the number of hospitals in each of these states whose DSH payments exceeded the hospitals' uncompensated care costs, the following numbers of hospitals in each state were not qualified to receive DSH payments and thus exceeded their uncompensated care costs by default: one in Nevada, two in New Hampshire, one in South Carolina, four in South Dakota, three in Texas, one in Vermont, and one in Washington.

[d]The total number of hospitals represents the number of hospitals whose DSH payments we reviewed. This number is less than the total number of hospitals included in submitted DSH audits because we removed from our analysis hospitals that were closed prior to 2007, were out-of-state (not located in the state for which the audit was conducted), had no reported DSH payments (either $0 was reported or no information was provided), and appeared twice in a DSH audit.

Table 5: Extent of Compliance with Federal DSH Audit Requirements, by State, Audit Requirement, and Number of Hospitals as Reported in 2010 Disproportionate Share Hospital (DSH) Audits (part 2)

		Qualified hospitals are allowed to retain their DSH payments			State has records of all payments and expenditures related to Medicaid and uninsured patients			State documented its method for calculating uncompensated costs		
State	Total number of hospitals	Met	Not met	Could not be verified	Met	Not met	Could not be verified	Met	Not met	Could not be verified
Alabama	**98**	66	3[a]	29	64	34	0	98	0	0
Alaska	**4**	4	0	0	4	0	0	4	0	0
Arizona	**40**	40	0	0	40	0	0	40	0	0
Arkansas	**4**	4	0	0	4	0	0	4	0	0
California	**141**	141	0	0	141	0	0	141	0	0
Colorado	**47**	0	11[a]	36	0	0	47	47	0	0
Connecticut	**35**	0	0	35	0	0	35	35	0	0
Delaware	**1**	1	0	0	1	0	0	1	0	0
District of Columbia	**10**	6	0	4	10	0	0	10	0	0
Florida	**63**	63	0	0	63	0	0	63	0	0
Georgia	**109**	109	0	0	109	0	0	109	0	0
Hawaii	**15**	15	0	0	15	0	0	15	0	0
Idaho	**35**	32	0	3	35	0	0	35	0	0
Illinois	**42**	42	0	0	41	0	1	41	0	1
Indiana	**66**	66	0	0	66	0	0	66	0	0
Iowa	**12**	0	0	12	0	0	12	0	0	12
Kansas	**45**	45	0	0	45	0	0	45	0	0
Kentucky	**108**	108	0	0	108	0	0	108	0	0
Louisiana	**118**	118	0	0	118	0	0	118	0	0
Maine	**2**	2	0	0	0	2	0	2	0	0
Maryland	**20**	20	0	0	20	0	0	20	0	0
Michigan	**130**	126	2[a]	2	130	0	0	130	0	0
Minnesota	**106**	38	0	68	0	45	61	101	5	0
Mississippi	**58**	58	0	0	56	2	0	58	0	0
Missouri	**144**	144	0	0	144	0	0	144	0	0
Montana	**50**	39	0	11	50	0	0	50	0	0
Nebraska	**28**	28	0	0	28	0	0	28	0	0
Nevada	**12**	11	1[a]	0	12	0	0	12	0	0
New Hampshire	**29**	24	2[a]	3	29	0	0	29	0	0
New Jersey	**88**	70	18	0	88	0	0	88	0	0
New Mexico	**23**	23	0	0	23	0	0	23	0	0

State	Total number of hospitals	Qualified hospitals are allowed to retain their DSH payments			State has records of all payments and expenditures related to Medicaid and uninsured patients			State documented its method for calculating uncompensated costs		
		Met	Not met	Could not be verified	Met	Not met	Could not be verified	Met	Not met	Could not be verified
New York	**222**	194	5[a]	23	100	23	99	0	222	0
North Carolina	**110**	110	0	0	110	0	0	110	0	0
North Dakota	**7**	5	0	2	7	0	0	7	0	0
Ohio	**176**	176	0	0	176	0	0	176	0	0
Oklahoma	**65**	52	4[a]	9	0	0	65	65	0	0
Oregon	**9**	7	1[a]	1	9	0	0	9	0	0
Pennsylvania	**176**	176	0	0	176	0	0	176	0	0
Rhode Island	**14**	14	0	0	14	0	0	14	0	0
South Carolina	**61**	58	1[a]	2	61	0	0	61	0	0
South Dakota	**20**	14	4[a]	2	0	0	20	0	20	0
Texas	**181**	170	3[a]	8	164	0	17	181	0	0
Utah	**34**	34	0	0	34	0	0	34	0	0
Vermont	**14**	13	1[a]	0	0	0	14	0	14	0
Virginia	**21**	20	1[a]	0	21	0	0	21	0	0
Washington	**72**	64	1[a]	7	66	0	6	72	0	0
West Virginia	**57**	57	0	0	57	0	0	57	0	0
Wisconsin	**26**	26	0	0	26	0	0	26	0	0
Wyoming	**5**	5	0	0	5	0	0	5	0	0
Total	**2,953**[b]	**2,638**	**58**[c]	**257**	**2,470**	**106**	**377**	**2,679**	**261**	**13**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data.

Notes: Data are from 2010 DSH audits of the 2007 DSH payments. Massachusetts and Tennessee did not make DSH payments in 2007 and did not submit DSH audits. We analyzed the audit findings, and for each state we determined the extent of compliance with the audit requirements by identifying the number of hospitals (1) whose DSH payments complied with the audit requirement—categorized as "Met"; (2) whose DSH payments did not comply with the audit requirement—categorized as "Not met"; and (3) for which compliance of their DSH payments with the audit requirement could not be determined—categorized as "Could not be verified." DSH payments made between 2005 and 2010 are subject to a transition period during which CMS would not take action against states based on findings of noncompliance with federal DSH requirements identified in the audits.

[a]DSH payments to these hospitals were categorized as noncompliant because the hospitals were not qualified to receive DSH payments.

[b]The total number of hospitals represents the number of hospitals whose DSH payments we reviewed. This number is less than the total number of hospitals included in submitted DSH audits because we removed from our analysis hospitals that were closed prior to 2007, were out-of-state (not located in the state for which the audit was conducted), had no reported DSH payments (either $0 was reported or no information was provided), and appeared twice in a DSH audit.

[c]DSH payments to 18 of these hospitals were categorized as noncompliant because the hospitals did not retain their DSH payments, while DSH payments to the remaining 40 hospitals were categorized as noncompliant because the hospitals were not qualified to receive DSH payments.

Appendix III: Overview of the 17 Data Elements on DSH Reports

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 directed the Secretary of Health and Human Services to require states to submit annual independent certified audits and annual reports on their disproportionate share hospital (DSH) payments.[1] Congress stipulated that the annual DSH reports identify each hospital that received a DSH payment in the prior fiscal year, the amount of the DSH payment, and such other information that the Secretary determines is necessary to ensure the appropriateness of state DSH payments. In 2008, the final rule implementing the 2003 DSH audit and report requirements identified the following 17 pieces of information in table 6 that states are required to include on their annual DSH reports for each DSH hospital.[2]

[1]Pub. L. No. 108-173, § 1001(d), 117 Stat. 2066, 2430-2431 (2003) (adding section 1923(j) to the Social Security Act) (codified, as amended, at 42 U.S.C. § 1395r-4(j)).

[2]Medicaid Program; Disproportionate Share Hospital Payments, 73 Fed. Reg. 77904 (Dec. 19, 2008) (codified at 42 C.F.R. § 447.299(c)); Medicaid Program; Disproportionate Share Hospital Payments; Correcting Amendment, 74 Fed. Reg. 18656 (Apr. 24, 2009).

Table 6: Data Elements on Disproportionate Share Hospital (DSH) Reports

Data element	Description
1. Hospital name	The name of the hospitals that received DSH payments from the state, identifying facilities that are institutes for mental disease and facilities that are located out of state.
2. State-estimated hospital-specific DSH limit	The estimate of eligible uncompensated care for the hospital receiving a DSH payment for the year under audit based on the state's methodology for determining such limit.
3. Medicaid inpatient utilization rate	The hospital's Medicaid inpatient utilization rate as defined by federal law, unless the state uses alternative qualification criteria described in element (5) of this table.
4. Low-income utilization rate	The hospital's low-income utilization rate as defined by federal law, unless the state uses alternative qualification criteria described in element (5) of this table.
5. State-defined DSH qualification criteria	If the state uses an alternate broader DSH qualification methodology as authorized by federal law, it must provide the value of the statistic and the methodology used to determine that statistic.
6. Inpatient and outpatient Medicaid fee-for-service rate payments	The total annual amount of Medicaid fee-for-service payments made to the hospital for inpatient and outpatient services furnished to Medicaid-eligible individuals, but excluding DSH payments or non-DSH supplemental payments.
7. Inpatient and outpatient Medicaid managed care organization payments	The total annual amount paid to the hospital by Medicaid managed care organizations for inpatient hospital and outpatient hospital services furnished to Medicaid-eligible individuals.
8. Non-DSH supplemental inpatient and outpatient Medicaid payments	The total annual amount of non-DSH supplemental Medicaid payments made to the hospital under the state plan. These amounts do not include DSH payments, regular Medicaid fee-for-service rate payments, and Medicaid managed care organization payments.
9. Total Medicaid inpatient and outpatient payments	Sum of inpatient and outpatient Medicaid fee-for-service, managed care organization, and non-DSH supplemental payments (sum of elements (6), (7), and (8) in this table).
10. Total cost of care—Medicaid inpatient and outpatient services	The total annual costs incurred by each hospital for providing inpatient and outpatient hospital services to Medicaid-eligible individuals.
11. Total Medicaid uncompensated care cost	The total amount of uncompensated care for providing Medicaid inpatient and outpatient services. That is, total cost of inpatient and outpatient Medicaid services minus total Medicaid inpatient and outpatient payments (element (10) minus element (9) in this table). The uncompensated care costs of providing Medicaid physician services cannot be included in this amount.
12. Uninsured inpatient and outpatient payments	Total annual payments received by the hospital by or on behalf of individuals with no source of third-party coverage for inpatient and outpatient hospital services they receive. This amount does not include payments made by a state or units of local government for services furnished to indigent patients.
13. Total applicable Section 1011 payments[a]	Federal Section 1011 payments for uncompensated inpatient and outpatient hospital services provided to Section 1011-eligible aliens with no source of third-party coverage for the inpatient and outpatient hospital services they receive.

Data element	Description
14. Total inpatient and outpatient uninsured cost of care	The total costs incurred for furnishing inpatient and outpatient hospital services to individuals with no source of third-party coverage for the hospital services they receive.
15. Total inpatient and outpatient uninsured uncompensated cost of care	Total annual amount of uncompensated inpatient and outpatient care for furnishing inpatient hospital and outpatient hospital services to individuals with no source of third-party coverage for the hospital services they receive. The amount should be the result of the total inpatient and outpatient cost of providing hospital services to these individuals minus total payments received by or on behalf of these individuals (element (14) minus the sum of elements (12) and (13) in this table). The uncompensated care costs of providing physician services cannot be included. The uninsured uncompensated amount also cannot include unpaid copays or deductibles for individuals with third-party coverage for the hospital services they receive or any other unreimbursed costs associated with hospital services provided to individuals with those services in their third-party coverage benefit package. Moreover, the uncompensated care costs also cannot include bad debt or payer discounts related to services furnished to individuals who have health insurance or other third-party payer.
16. Total annual uncompensated care cost	The total annual uncompensated care cost equals the total cost of care for furnishing inpatient hospital and outpatient hospital services to Medicaid-eligible individuals and to individuals with no source of third-party coverage for the hospital services they receive less the sum of regular Medicaid fee-for-service rate payments, Medicaid managed care organization payments, non-DSH supplemental payments, uninsured payments, and Section 1011 payments for inpatient and outpatient hospital services (the sum of elements (9), (12), and (13) subtracted from the sum of elements (10) and (14) in this table).
17. Total DSH payments received	The total amount of DSH payments made to the hospital during the Medicaid plan year.

Source: GAO summary of regulations.

Notes: The source regulations are Medicaid Program; Disproportionate Share Hospital Payments, 73 Fed. Reg. 77904 (Dec. 19, 2008) (codified at 42 C.F.R. § 447.299(c)); Medicaid Program; Disproportionate Share Hospital Payments; Correcting Amendment, 74 Fed. Reg. 18656 (Apr. 24, 2009).

[a]Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provided $250 million per year for fiscal years 2005 to 2008 for payments to eligible providers for emergency health services provided to undocumented aliens and other specified aliens. Pub. L. No. 108-173, § 1011, 117 Stat. 2066, 2432-2435 (2003).

Appendix IV: Percentage of DSH Payments and Uncompensated Care for DSH Hospitals in 2010 DSH Reports

Table 7 presents the number of hospitals and the proportion of disproportionate share hospital (DSH) payments and uncompensated care attributable to the 10 percent of DSH hospitals that received the largest DSH payments in the state and to the 90 percent of DSH hospitals that received the smallest DSH payments in each state, based on states' 2010 DSH reports of 2007 payments.

Table 7: Number of Hospitals, Percentage of Disproportionate Share Hospital (DSH) Payments, and Percentage of Uncompensated Care for the 10 Percent of DSH Hospitals Receiving the Largest DSH Payments and the 90 Percent Receiving the Smallest DSH Payments, by State

	The 10 percent of DSH hospitals with largest DSH payments			The 90 percent of DSH hospitals with smallest DSH payments		
State	Number of hospitals	Percentage of DSH payments	Percentage of uncompensated care[a]	Number of hospitals	Percentage of DSH payments	Percentage of uncompensated care[a]
Alabama	6	72.5%	81.7%	48	27.5%	18.3%
Alaska	1	81.2	71.6	1	18.8	28.4
Arizona	4	87.1	27.1	33	12.9	72.9
California[b]	9	44.0	34.1	77	56.0	65.9
Colorado	2	82.6	64.8	10	17.4	35.2
Connecticut	4	46.5	49.8	31	53.5	50.2
District of Columbia	1	44.8	(2.5)[c]	4	55.2	102.5[c]
Florida	6	77.4	(2.6)[c]	48	22.6	102.6[c]
Georgia	10	58.0	49.8	88	42.0	50.2
Hawaii	1	61.7	54.3	8	38.3	45.7
Idaho	3	51.7	61.9	27	48.3	38.1
Illinois	1	30.4	11.6	5	69.6	88.4
Indiana	6	66.8	46.3	50	33.2	53.7
Kansas	3	65.0	46.4	25	35.0	53.6
Kentucky	7	70.1	39.7	57	29.9	60.3
Louisiana	9	60.3	49.6	77	39.7	50.4
Maine	1	57.1	57.1	1	42.9	42.9
Maryland	2	29.2	36.9	16	70.8	63.1
Michigan	1	90.9	39.5	1	9.1	60.5
Minnesota	5	70.6	34.5	40	29.4	65.5
Missouri	10	53.1	92.5	90	46.9	7.5
Montana	3	42.5	79.5	20	57.5	20.5
Nebraska	2	62.3	27.1	18	37.7	72.9
Nevada	1	88.1	75.8	9	11.9	24.2
New Hampshire	3	44.8	32.0	22	55.2	68.0
New Jersey	5	45.7	33.0	45	54.3	67.0
New Mexico	1	94.1	128.5[d]	8	5.9	(28.5)[d]
New York	19	67.3	53.1	168	32.7	46.9
North Carolina	10	74.7	37.9	87	25.3	62.1
North Dakota	1	69.9	78.3	2	30.1	21.7
Ohio	18	47.2	40.8	157	52.8	59.2

State	The 10 percent of DSH hospitals with largest DSH payments			The 90 percent of DSH hospitals with smallest DSH payments		
	Number of hospitals	Percentage of DSH payments	Percentage of uncompensated care[a]	Number of hospitals	Percentage of DSH payments	Percentage of uncompensated care[a]
Oklahoma	5	76.8	40.3	43	23.2	59.7
Oregon	1	97.0	45.6	5	3.0	54.4
Rhode Island	2	46.7	63.0	10	53.3	37.0
South Carolina	6	40.7	41.6	52	59.3	58.4
Texas	15	66.9	33.0	130	33.1	67.0
Utah	4	86.4	39.4	27	13.6	60.6
Vermont	2	55.8	49.3	12	44.2	50.7
Virginia	2	77.7	43.6	12	22.3	56.4
Washington	7	78.2	42.0	56	21.8	58.0
West Virginia	6	61.0	42.2	49	39.0	57.8
Wyoming	1	47.8	54.7	2	52.2	45.3

Source: GAO analysis of Centers for Medicare & Medicaid Services data.

Notes: Data are from 2010 DSH reports of 2007 DSH payments. For the purpose of this report, we consider the hospitals receiving the largest DSH payments in each state to be the 10 percent of total DSH hospitals in the state that received the largest DSH payments. When calculating the number of DSH hospitals representing 10 percent, we rounded up to the nearest whole number. Massachusetts and Tennessee did not make DSH payments in 2007 and did not submit DSH reports. Arkansas, Delaware, Iowa, Mississippi, Pennsylvania, South Dakota, and Wisconsin did not report the necessary data to analyze DSH payments and uncompensated care.

[a]Figures in parentheses represent a negative number.

[b]In analyzing uncompensated care costs in California, we did not adjust for public hospitals authorized to receive DSH payments of up to 175 percent of their uncompensated care.

[c]In the District of Columbia and Florida, the 10 percent of total DSH hospitals in the state that received the largest DSH payments did not in the aggregate have uncompensated care costs. Rather, 1 hospital in the District of Columbia and 6 hospitals in Florida in the aggregate had surpluses because payments exceeded uncompensated care costs. Their surpluses reduced the overall uncompensated care costs for DSH hospitals in their states and therefore contributed a negative amount to overall uncompensated care costs. For example, in Florida the 6 hospitals had a $13 million surplus, which reduced the overall uncompensated care costs for DSH hospitals in the state from $519 million to $506 million. These hospitals contributed negative 2.6 percent to overall uncompensated care costs for DSH hospitals in the state. In contrast, the 90 percent of total DSH hospitals (48 hospitals) in the state that received the smallest DSH payments provided $519 million in uncompensated care costs, or 102.6 percent of the $506 million in total uncompensated care costs in the state.

[d]In New Mexico, the 90 percent of total DSH hospitals in the state that received the smallest DSH payments did not in the aggregate have uncompensated care costs. Rather, these eight hospitals in the aggregate had a surplus because payments exceeded uncompensated care costs. Their surplus reduced the overall uncompensated care costs for DSH hospitals in the state and therefore contributed a negative amount to overall uncompensated care costs. The hospital with the largest DSH payment in New Mexico had a greater amount of uncompensated care costs than all hospitals' combined uncompensated care costs and therefore contributed more than 100 percent of overall uncompensated care costs.

Appendix V: DSH Hospitals' Non-DSH Payments and Medicaid Uncompensated Care Costs in 2010 DSH Reports

Table 8 presents information about the number of hospitals and the percentage of non-disproportionate share hospital (DSH) supplemental payments and Medicaid uncompensated care costs attributable to the 10 percent of DSH hospitals that received the largest non-DSH payments in the state and the 90 percent of DSH hospitals that received the smallest non-DSH payments in each state, based on states' 2010 DSH reports of 2007 DSH payments.

Table 8: Number of Hospitals, Percentage of Non-Disproportionate Share Hospital (DSH) Supplemental Payments, and Percentage of Medicaid Uncompensated Care Costs for the 10 Percent of DSH Hospitals Receiving the Largest Non-DSH Payments and the 90 Percent of DSH Hospitals Receiving the Smallest Non-DSH Supplemental Payments, by State

	The 10 percent of DSH hospitals with largest non-DSH payments			The 90 percent of DSH hospitals with smallest non-DSH payments		
State	Number of hospitals	Percentage of non-DSH payments received[a]	Percentage of Medicaid uncompensated costs[a]	Number of hospitals	Percentage of non-DSH payments received[a]	Percentage of Medicaid uncompensated costs[a]
Alabama	7	78.8%	46.1%	57	21.2%	53.9%
Alaska	1	100.0	9.2	3	0.0	90.8
Arizona	5	72.5	35.3	38	27.5	64.7
Arkansas	1	93.9	74.1	3	6.1	25.9
California	15	52.0	39.2	128	48.0	60.8
Colorado	4	68.9	33.6	28	31.1	66.4
Connecticut	4	90.0	8.4	31	10.0	91.6
District of Columbia	1	(22.3)[b]	0.4	7	122.3[b]	99.6
Florida	7	76.4	35.8	54	23.6	64.2
Georgia	11	60.5	48.8	98	39.5	51.2
Hawaii	1	64.6	55.1	8	35.4	44.9
Idaho	4	62.1	9.0	27	37.9	91.0
Illinois	4	34.1	25.1	35	65.9	74.9
Indiana	7	57.5	41.5	59	42.5	58.5
Iowa	1	78.4	62.7	9	21.6	37.3
Kansas	5	80.9	63.9	40	19.1	36.1
Kentucky	11	99.8	56.4	97	0.2	43.6
Louisiana	12	100.0	15.3	106	0.0	84.7
Maryland	2	71.3	(250.0)[c]	18	28.7	350.0[c]
Michigan	13	62.7	46.5	113	37.3	53.5
Minnesota	5	80.1	43.9	40	19.9	56.1
Mississippi	6	50.0	22.7	50	50.0	77.3
Missouri	15	67.4	65.7	128	32.6	34.3
Montana	4	55.6	65.2	35	44.4	34.8
Nebraska	3	100.0	36.6	24	0.0	63.4
Nevada	2	97.9	73.7	9	2.1	26.3
New Hampshire	3	135.1[d]	16.4	26	(35.1)[d]	83.6
New Jersey	9	63.0	33.9	81	37.0	66.1
New Mexico	3	77.1	192.1[e]	20	22.9	(92.1)[e]
New York	19	72.6	29.3	170	27.4	70.7

	The 10 percent of DSH hospitals with largest non-DSH payments			The 90 percent of DSH hospitals with smallest non-DSH payments		
State	Number of hospitals	Percentage of non-DSH payments received[a]	Percentage of Medicaid uncompensated costs[a]	Number of hospitals	Percentage of non-DSH payments received[a]	Percentage of Medicaid uncompensated costs[a]
North Carolina	11	59.6	51.6	99	40.4	48.4
Ohio	18	98.8	34.2	158	1.2	65.8
Oklahoma	6	83.3	45.2	46	16.7	54.8
Oregon	1	104.1[d]	61.8	8	(4.1)[d]	38.2
Pennsylvania	19	82.7	34.2	169	17.3	65.8
Rhode Island	2	322.9[d]	9.1	11	(222.9)[d]	90.9
South Carolina	6	46.5	41.8	54	53.5	58.2
Texas	17	85.3	53.5	144	14.7	46.5
Utah	4	98.4	446.6[e]	29	1.6	(346.6)[e]
Virginia	2	81.3	35.3	13	18.7	64.7
Washington	7	121.3[d]	41.8	56	(21.3)[d]	58.2
West Virginia	6	72.2	62.1	51	27.8	37.9
Wyoming	1	85.5	72.1	4	14.5	27.9

Source: GAO analysis of Centers for Medicare & Medicaid Services data.

Notes: Data are from 2010 DSH reports of 2007 DSH payments. For the purpose of this report, we consider the hospitals receiving the largest non-DSH supplemental payments in each state to be the 10 percent of total DSH hospitals in the state that received the largest non-DSH supplemental payments. When calculating the number of DSH hospitals representing 10 percent, we rounded up to the nearest whole number. Massachusetts and Tennessee did not make DSH payments in 2007 and did not submit DSH reports. Delaware, Maine, North Dakota, Vermont, and Wisconsin did not report non-DSH supplemental payments or did not make non-DSH supplemental payments in 2007. One state, South Dakota, was excluded from our analysis because we could not determine the reliability of its data. For our analysis, uncompensated Medicaid costs are the expenses incurred in providing Medicaid-covered services to Medicaid beneficiaries minus regular Medicaid payments the hospitals received.

[a]Figures in parentheses represent a negative number.

[b]Because of adjustments for non-DSH payments made, there were no aggregate non-DSH supplemental payments for the District of Columbia in 2007.

[c]Maryland did not have uncompensated Medicaid costs for all hospitals. For all hospitals in the state, payments exceeded costs by about $7.8 million, while for two hospitals in the top 10 percent costs exceeded payments by about $19.5 million. When calculating the two hospitals' share of the state's uncompensated Medicaid costs, the statewide surplus is treated as a negative uncompensated Medicaid cost. As a result, the two hospitals' share appears as a negative number.

[d]In New Hampshire, Oregon, Rhode Island, and Washington, the 90 percent of total DSH hospitals that received the smallest non-DSH supplemental payments include hospitals with payment adjustments that reduced non-DSH payments already made. This resulted in an overall reduction in non-DSH supplemental payments for this group of hospitals.

[e]In New Mexico and Utah, the aggregate uncompensated Medicaid costs of the top 10 percent of hospitals in each state were greater than the state's overall uncompensated Medicaid costs, resulting in these hospitals having more than 100 percent of the state's uncompensated Medicaid costs. The statewide uncompensated Medicaid costs are lower than those of the top 10 percent of hospitals, because some hospitals in the state had a Medicaid surplus, which reduces the uncompensated Medicaid costs of other hospitals when calculating the statewide total.

Appendix VI: DSH Payments and Uncompensated Care Costs for Selected DSH Hospitals in 2010 DSH Reports

This appendix provides the results of our analysis of total regular Medicaid, disproportionate share hospital (DSH), and non-DSH supplemental payments in states' 2010 DSH reports compared to hospitals' total cost of care for Medicaid and uninsured patients for certain hospitals. We conducted this analysis to illustrate the extent to which DSH reports can provide the Centers for Medicare & Medicaid Services (CMS) with information about how supplemental payments, in particular non-DSH supplemental payments, relate to regular Medicaid payments, DSH payments, and the costs of providing care to Medicaid and uninsured patients. Our analysis is based on the 2010 DSH reports of 2007 DSH payments, which were subject to a transition period, during which CMS would not take action against states based on findings of noncompliance with federal DSH requirements. During the transition period, states are directed to use findings from DSH audits and reports to make any necessary changes in their DSH payments. Actions in response to noncompliance begin with payments made in 2011, which must be submitted to CMS in 2014. We identified 705 DSH hospitals that received total regular Medicaid and non-DSH supplemental payments in excess of Medicaid costs.[1] For these hospitals, we compared DSH payments to uncompensated care costs—the costs incurred in providing

[1]Of these 705 DSH hospitals, 505 received both regular Medicaid and non-DSH payments, and 200 received only regular Medicaid payments.

These findings are based on CMS's definition of eligible uninsured costs under the 2008 final rule that was in place for the 2010 audits. In January 2012, however, CMS published a proposed regulation to clarify which individuals are considered uninsured for the purposes of calculating hospitals' uncompensated care costs. The rule proposes that the costs of services provided to individuals whose health insurance coverage has been exhausted or did not cover the specific service provided would be considered uninsured costs when calculating uncompensated care costs. Under the 2008 final rule, these costs were not considered eligible uninsured costs. The new definition of eligible uninsured costs may affect the calculation of hospitals' uncompensated care costs and determinations of whether DSH payments exceed hospitals' uncompensated care costs. See 77 Fed. Reg. 2500 (Jan. 18, 2012).

In their annual DSH reports, states are required to report three categories of Medicaid payments that hospitals may have received: fee-for-service payments, managed care organization payments, and non-DSH supplemental payments. For the purpose of our report, we combined the fee-for-service payment and managed care organization payment amounts and refer to them as total regular Medicaid payments. States are also required to report the total Medicaid payments for each hospital, that is, the sum of the three categories of Medicaid payments hospitals may have received. For the 2010 reports, however, in some states this total also included other payments, such as payments a hospital received from another state Medicaid program and payments received from Medicare for Medicaid individuals who were eligible for both Medicaid and Medicare.

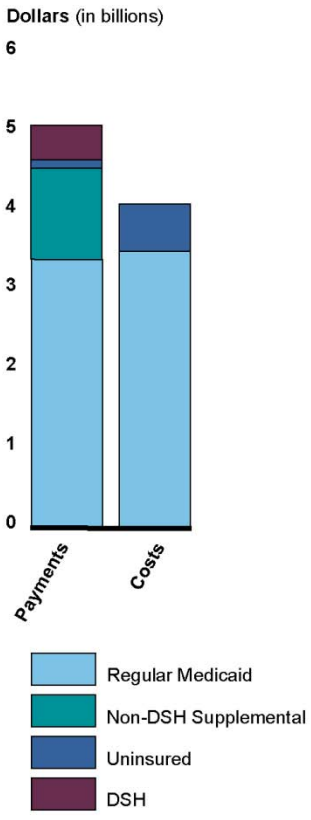
services during the year to Medicaid and uninsured patients minus any regular Medicaid, non-DSH supplemental, and uninsured patient payments made to the hospital for those services. When we compared DSH payments to uncompensated care costs for these hospitals, we found that 255 of the hospitals received DSH payments in excess of uncompensated care costs.[2] Of the 255 hospitals, 118 did not have uncompensated care costs—that is, total regular Medicaid, non-DSH payments, and uninsured patient payments exceeded total costs for Medicaid and uninsured patients—and should not have received a DSH payment, while the remaining 137 hospitals had uncompensated care costs but received DSH payments in excess of these costs.

For the 118 hospitals that did not have uncompensated care costs and, therefore, did not warrant receiving a DSH payment, total payments exceeded total costs of care by about $1 billion. We found that total payments were about $5.1 billion,[3] while these hospitals' Medicaid and uninsured care costs were about $4.1 billion. (See fig. 4 and table 9 for these payments and costs.)

[2]Of the remaining 450 hospitals, 212 did not have DSH payments in excess of uncompensated care costs, and 238 did not report the data necessary to analyze DSH payments and uncompensated care costs.

[3]The payments consisted of the following: over $3.4 billion of regular Medicaid payments, nearly $1.2 billion of non-DSH supplemental payments, and about $439 million of DSH payments. Total payments also include about $107 million in payments made by or on behalf of uninsured patients.

Figure 4: Medicaid and Uninsured Patient Payments and Costs for Disproportionate Share Hospital (DSH) Hospitals That Did Not Have Uncompensated Care Costs



Source: GAO analysis of CMS data.

Note: Totals for 118 hospitals that had no uncompensated care costs and for which regular Medicaid and non-DSH supplemental payments exceeded Medicaid costs.

Table 9: Medicaid and Uninsured Patient Payments and Costs for Disproportionate Share Hospital (DSH) Hospitals That Had No Uncompensated Care Costs and Received a DSH Payment, by State

		Costs (dollars in thousands)			Payments (dollars in thousands)					
State	Number of DSH hospitals	Total Medicaid costs of care	Total uninsured costs of care	Total costs	Total regular Medicaid payments	Total non-DSH supple-mental payments[a]	Total uninsured patient payments	Total DSH payments received	Total payments	Amount by which payments exceed costs
Alabama	12	$206,133	$47,304	**$253,437**	$323,626	$80,361	$6,284	$41,293	**$451,564**	$198,126
California[b]	7	287,490	54,063	**341,553**	323,669	80,029	12,570	<1	**416,268**	74,715
District of Columbia	1	144,590	4,649	**149,239**	150,428	0	609	24,583	**175,620**	26,381
Florida	6	479,144	193,057	**672,201**	394,642	349,704	29,334	98,697	**872,376**	200,175
Idaho	1	194	50	**244**	174	91	2	17	**284**	40
Indiana	1	2,522	26	**2,548**	2,865	0	1	298	**3,163**	614
Kentucky	3	6,242	674	**6,916**	7,227	105	326	434	**8,092**	1,176
Maryland	4	177,370	24,404	**201,774**	204,468	3,203	1,044	13,803	**222,517**	20,743
Minnesota	1	1,378	566	**1,944**	1,768	33	694	48	**2,543**	599
Missouri	31	1,408,130	175,489	**1,583,619**	1,123,949	563,885	25,454	163,612	**1,876,900**	293,281
Montana	6	8,241	2,076	**10,317**	8,356	1,901	815	1,432	**12,503**	2,186
New Hampshire	1	6,204	60	**6,264**	6,468	68	1	2,284	**8,821**	2,557
New Mexico	6	28,735	14,557	**43,292**	40,460	15,746	3,225	702	**60,133**	16,842
New York	5	125,661	13,526	**139,187**	156,817	1,191	1,515	19,220	**178,743**	39,557
North Carolina	2	5,116	389	**5,505**	6,283	303	138	1	**6,725**	1,220
Ohio	4	4,954	713	**5,667**	6,509	0	125	1,522	**8,156**	2,489
Oklahoma	1	16,511	547	**17,058**	19,456	45	1,575	309	**21,430**[c]	4,372
Rhode Island	1	1,535	596	**2,131**	2,134	(302)	2,239	2,648	**6,718**	4,587
South Carolina	2	31,058	7,272	**38,330**	32,662	4,447	2,922	5,458	**45,489**	7,159
Texas	10	517,775	44,310	**562,085**	526,283	50,221	12,579	61,060	**655,554**[c]	93,468
Utah	7	35,464	9,922	**45,386**	47,060	0	3,117	313	**50,392**[c]	5,006
Washington	2	3,376	132	**3,508**	4,197	(59)	28	231	**4,403**[c]	894
West Virginia	3	22,044	3,424	**25,468**	25,446	382	2,044	1,413	**29,284**	3,816
Wyoming	1	1,653	769	**2,422**	1,292	812	339	14	**2,456**	34
Total	**118**	**$3,521,520**	**$598,574**	**$4,120,094**	**$3,416,236**	**$1,152,163**	**$106,980**	**$439,388**	**$5,120,134**	**$1,000,040**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data.

Notes: Data are from 2010 DSH reports of 2007 DSH payments. Payment and cost amounts may not sum to totals because of rounding.

[a]Figures in parentheses represent a negative number.

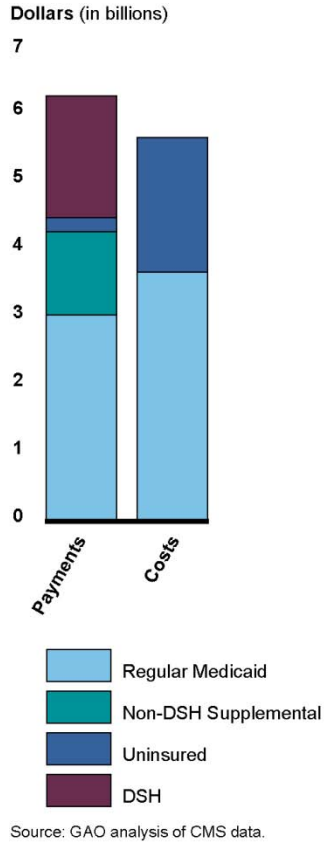
[b]California also had two public hospitals that did not have uncompensated care costs and received a DSH payment. Since these hospitals were eligible to receive DSH payments up to 175 percent of their uncompensated care costs, we removed them from our analysis.

[c]In Oklahoma, Texas, Utah, and Washington state, total payments do not equal the sum of total regular Medicaid payments, non-DSH supplemental payments, uninsured patient payments, and DSH payments because in these states the total payments column includes other payments that were not separately reported in these states' DSH reports. Specifically, in Oklahoma and Texas, CMS officials said that these other payments were Medicare payments for Medicaid individuals that are eligible for both Medicaid and Medicare. In Utah, these payments were adjustments made to Medicaid payments received. In Washington state, these other payments were payments received from another state Medicaid program.

For the 137 hospitals that had uncompensated care costs but received a DSH payment in excess of those costs, total payments exceeded total costs of care by about $664 million. We found that total payments were about $6.3 billion,[1] while Medicaid and uninsured care costs were about $5.7 billion. (See fig. 5 and table 10 for these payments and costs.)

[1]The payments consisted of the following: nearly $3.1 billion of regular Medicaid payments, over $1.2 billion of non-DSH supplemental payments, and almost $1.8 billion of DSH payments. Total payments also include about $205 million in payments made by or on behalf of uninsured patients.

Figure 5: Medicaid and Uninsured Patient Payments and Costs for Disproportionate Share Hospital (DSH) Hospitals That Had Uncompensated Care Costs



Source: GAO analysis of CMS data.

Note: Totals for 137 hospitals that had uncompensated care costs and for which regular Medicaid and non-DSH supplemental payments exceeded Medicaid costs.

Table 10: Medicaid and Uninsured Patient Payments and Costs for Disproportionate Share Hospital (DSH) Hospitals That Had Uncompensated Care Costs and Received a DSH Payment in Excess of These Costs, by State

		Costs (dollars in thousands)			Payments (dollars in thousands)					
State	Number of hospitals	Total Medicaid costs of care	Total uninsured costs of care	Total costs	Total regular Medicaid payments	Total non-DSH supple-mental payments	Total uninsured patient payments	Total DSH payments received	Total payments	Amount by which payments exceed costs
Alabama	9	$249,062	$99,163	**$348,225**	$231,517	$41,319	$5,918	$140,781	**$419,534**	$71,309
Colorado	2	74,102	42,146	**116,248**	50,978	41,341	0	47,871	**140,190**	23,942
Florida	6	145,745	136,327	**282,072**	139,277	97,289	36,865	23,320	**296,751**	14,679
Georgia	9	58,443	15,475	**73,918**	59,630	1,797	3,288	13,047	**77,763**	3,845
Illinois	2	136	7,938	**8,074**	181	0	66	19,259	**19,506**	11,432
Indiana	5	130,736	131,393	**262,129**	90,903	44,682	5,210	144,354	**285,148**	23,019
Kansas	2	6,533	1,101	**7,634**	6,344	286	234	1,374	**8,238**	604
Kentucky	1	5,836	1,138	**6,974**	6,797	0	0	329	**7,126**	153
Louisiana	7	212,447	118,919	**331,366**	215,095	5,062	3,632	158,226	**382,015**	50,649
Missouri	39	656,970	349,330	**1,006,300**	531,967	199,098	35,527	390,702	**1,157,293**	150,993
Montana	4	1,139	968	**2,107**	1,138	392	398	395	**2,323**	215
Nevada	1	369	455	**824**	345	255	32	418	**1,058**[a]	234
New Jersey	3	130,844	87,550	**218,394**	118,602	34,665	1,938	86,398	**241,603**	23,208
New York	12	398,218	42,942	**441,160**	418,510	957	5,005	37,657	**462,129**	20,969
North Carolina	1	27,297	4,944	**32,241**	24,904	3,632	631	4,635	**33,802**	1,560
Ohio	2	44,564	5,708	**50,272**	47,397	0	312	4,650	**52,359**	2,087
Rhode Island	1	38,198	3,408	**41,606**	37,033	1,726	140	7,848	**46,746**	5,140
South Carolina	8	140,998	49,455	**190,453**	119,627	25,790	4,520	57,983	**207,920**	17,466
Texas	14	1,138,527	817,206	**1,955,733**	746,220	691,512	91,620	612,229	**2,181,744**[a]	226,011
Utah	1	1,236	334	**1,570**	1,329	0	206	372	**1,907**	337
Virginia	1	110,779	49,312	**160,091**	97,968	31,565	6,504	21,749	**161,887**[a]	1,795
Washington	3	112,464	14,392	**126,856**	108,406	5,670	3,045	19,605	**138,963**[a]	12,106
West Virginia	4	6,665	2,347	**9,012**	7,076	235	222	3,628	**11,161**	2,149
Total	**137**	**$3,691,309**	**$1,981,950**	**$5,673,259**	**$3,061,242**	**$1,227,270**	**$205,309**	**$1,796,832**	**$6,337,164**	**$663,905**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data.

Notes: Data are from 2010 DSH reports of 2007 DSH payments. Payment and cost amounts may not sum to totals because of rounding.

[a]In Nevada, Texas, Virginia, and Washington state, total payments do not equal the sum of total regular Medicaid payments, non-DSH supplemental payments, uninsured patient payments, and DSH payments because in these states the total payments column includes other payments that were not separately reported in these states' DSH reports. Specifically, for Texas, CMS officials said that these other payments were Medicare payments for Medicaid individuals that are eligible for both Medicaid and Medicare. In Nevada, Virginia, and Washington state, these other payments were payments received from another state Medicaid program.

Appendix VII: DSH Hospitals with Medicaid Payments in Excess of Medicaid Costs in 2010 DSH Reports

Regular and non-disproportionate share hospital (DSH) Medicaid payments are not limited to providers' costs of delivering Medicaid services; however, as Medicaid payments they are intended to pay for Medicaid-covered services provided to Medicaid beneficiaries and must be consistent with efficiency, economy, and quality of care. Table 11 presents information from interactive figure 3 on the number and percentage of DSH hospitals in each state that received total regular Medicaid and non-DSH supplemental payments in excess of Medicaid costs and the amounts by which payments exceeded costs for DSH hospitals that received non-DSH supplemental payments.

Table 11: Number and Percentage of Disproportionate Share Hospital (DSH) Hospitals That Received Non-DSH Supplemental and Regular Medicaid Payments in Excess of Medicaid Costs and Amount by Which Payments Exceeded Costs, by State

State	Number of DSH hospitals	Percentage of DSH hospitals	Dollar amount by which regular Medicaid and non-DSH supplemental payments exceeded Medicaid costs
Alabama	22	34%	$204,012,498
Alaska	1	25	182,708
Arizona	1	2	134,246
Arkansas	1	25	2,917,316
California	23	16	148,499,802
Colorado	2	6	18,216,205
Connecticut	0	0	0
District of Columbia	0	0	0
Florida	37	61	625,694,383
Georgia	17	16	1,693,135
Hawaii	0	0	0
Idaho	10	32	561,101
Illinois	29	74	262,185,810
Indiana	9	14	5,994,186
Iowa	4	40	3,412,828
Kansas	7	16	4,291,691
Kentucky	5	5	18,314,308
Louisiana	2	2	4,372,258
Maryland	6	30	53,652,164
Michigan	25	20	34,774,182
Minnesota	9	20	15,700,509
Mississippi	30	54	53,338,361
Missouri	101	71	424,467,105
Montana	23	59	5,598,006
Nebraska	0	0	0
Nevada	1	9	239,852
New Hampshire	1	3	331,755
New Jersey	9	10	37,682,503
New Mexico	15	65	119,893,213
New York	11	6	45,332,681

State	Number of DSH hospitals	Percentage of DSH hospitals	Dollar amount by which regular Medicaid and non-DSH supplemental payments exceeded Medicaid costs
North Carolina	8	7	3,387,059
Ohio	2	1	16,128,593
Oklahoma	11	21	27,891,507
Oregon	1	11	25,926
Pennsylvania	6	3	9,375,010
Rhode Island	1	8	560,581
South Carolina	13	22	11,905,483
Texas	35	22	496,527,209
Utah	6	18	45,025,319
Virginia	2	13	34,006,273
Washington	9	14	6,182,632
West Virginia	8	14	5,081,405
Wyoming	2	40	539,407
Total	**505**	**19%**	**$2,748,129,210**

Source: GAO analysis of Centers for Medicare & Medicaid Services data.

Notes: Data are from 2010 DSH reports of 2007 DSH payments. Massachusetts and Tennessee did not make DSH payments in 2007 and did not submit DSH reports. Delaware, Maine, North Dakota, South Dakota, Vermont, and Wisconsin did not report the necessary information to analyze Medicaid payments and costs.

Appendix VIII: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

NOV 6 20

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

Dear Ms. Iritani:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "MEDICAID: More Transparency of and Accountability for Supplemental Payments Is Needed" (GAO-13-48).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICAID: MORE TRANSPARENCY OF AND ACCOUNTABILITY FOR SUPPLEMENTAL PAYMENTS IN NEEDED" (GAO-13-48)

The Department appreciates the opportunity to review and comment on the Government Accountability Office Draft Report entitled: *"MEDICAID: More Transparency of and Accountability for Supplemental Payments is Needed" (GAO-13-48)*. The purpose of the report is to consider the Centers for Medicare & Medicaid Services (CMS) oversight of hospital supplemental payments. The report highlights that both disproportionate share hospital (DSH) and non-DSH supplemental payments are a significant and growing component of Medicaid spending and includes background and summary information regarding the recently implemented regulations that require annual audits and reports for states' DSH payments. The report concludes that there is an urgent need for improvements in the transparency of and accountability for non-DSH supplemental payments that are similar to the steps taken to address DSH payments and raises these issues to Congress for its consideration.

HHS agrees with GAO about the need to improve reporting and oversight of non-DSH supplemental payments and would like to share some of the work underway.

It is important to note that any supplemental payment that is newly proposed or modified under a state plan amendment (SPA) is subject to CMS' oversight through its SPA review and approval process. This requires that the state respond to detailed questions regarding how the state will finance its share of the payment. Supplemental payment proposals will not be approved until CMS has determined that the state is securing appropriate non-federal funding to finance its share of its Medicaid program. In addition, for any supplemental payment proposal, a state must demonstrate that the aggregate payment amount will be within the state's applicable upper payment limit (UPL). The UPL requires that a total Medicaid payment (which includes base rate payments and any supplemental payments) cannot exceed a reasonable estimate of what Medicare would pay for similar services.

In order to ensure a consistent policy across states and over the years, and to evaluate the need for further guidance and oversight, we are undertaking a comprehensive review of all approved SPAs to scrutinize supplemental payment methodologies. As part of this activity, we are identifying any states that are failing to report supplemental payments through the Medicaid Budget and Expenditure System (MBES) as required, and taking necessary steps to ensure compliance with the requirement and address methodologies that are not compliant with the Medicaid statute and federal regulation. This analysis will assist us in determining the need for more guidance or definition of formulas, data sources, validation, and updates of UPL demonstrations and payments.

Finally, we also want to note the work we are doing to evaluate and improve our work with respect to the Medicaid DSH certified audits and reports. In fiscal year 2011, CMS began an in-depth review of a select number of states and hospitals in different regions of the country in an attempt to obtain a nationwide representation of audit implementation. We have continued this work in fiscal years 2012 and 2013. This effort is intended to produce a greater understanding of how states, hospitals and auditors completed the DSH audits and reports. CMS is compiling the information it learns and will be issuing further national guidance to ensure proper implementation of the audit and reporting requirements.

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Appendix IX: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Tim Bushfield, Assistant Director; Helen Desaulniers; Carolyn Fitzgerald; Sandra George; Peter Mangano; Roseanne Price; and Said Sariolghalam made key contributions to this report.

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