



APR 1 2009

Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106-3499

Report Number: A-03-08-00203

Theodore Dallas
Executive Deputy Secretary
Department of Public Welfare
Health and Welfare Building, Room 234
Harrisburg, Pennsylvania 17105-2675

Dear Mr. Dallas:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Pennsylvania's Determination of Medicaid Disproportionate Share Hospital Eligibility for the State-Operated Institutions for Mental Diseases." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, OIG reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. Accordingly, this report will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Robert Baiocco, Audit Manager, at (215) 861-4486 or through e-mail at Robert.Baiocco@oig.hhs.gov. Please refer to report number A-03-08-00203 in all correspondence.

Sincerely,

A handwritten signature in black ink, appearing to read "Stephen Virbitsky".

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF PENNSYLVANIA'S
DETERMINATION OF MEDICAID
DISPROPORTIONATE SHARE
HOSPITAL ELIGIBILITY FOR THE
STATE-OPERATED
INSTITUTIONS FOR MENTAL
DISEASES**



Daniel R. Levinson
Inspector General

April 2009
A-03-08-00203

Office of Inspector General

<http://oig.hhs.gov>

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

Office of Audit Services

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

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

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

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. The Pennsylvania Department of Public Welfare (the State agency) administers Pennsylvania's Medicaid program.

Section 1902 of the Act requires State Medicaid programs to “. . . take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs” when determining payment rates for inpatient hospital care. This requirement is referred to as the Medicaid disproportionate share hospital (DSH) payment adjustment. Medicaid DSH payments are made to those hospitals that provide services to a disproportionate number of low-income and uninsured patients.

Institutions for Mental Diseases (IMD) may be eligible for DSH payments to recoup the unreimbursed costs of providing inpatient care to patients who are either Medicaid eligible or uninsured. Section 1923(d)(3) of the Act and Attachment 4.19-A of the approved State plan require that IMDs have a Medicaid inpatient utilization rate (MIUR) of not less than 1 percent to be deemed a Medicaid DSH. IMDs that have an MIUR of at least 1 percent are eligible for DSH payments. Medicaid days associated with unallowable inpatients cannot be included in the MIUR calculation. Section 1905(a) of the Act defines unallowable IMD patients as residents under age 65, except for inpatient psychiatric services provided to individuals under the age of 21. CMS further clarified that individuals who are inmates of correctional facilities are also unallowable. In addition, the State plan requires State-operated IMDs to have a low-income utilization rate (LIUR) in excess of 25 percent to be eligible for a DSH payment.

OBJECTIVE

Our objective was to determine whether the State agency complied with the State plan and Federal requirements in determining whether State-operated IMDs were eligible for Medicaid DSH payments.

SUMMARY OF FINDINGS

The State agency did not fully comply with the State plan and Federal requirements in determining whether State-operated IMDs were eligible for Medicaid DSH payments in State fiscal year (FY) 2008–09. The State agency included in its calculations of the MIUR percentage some inpatient days related to unallowable age groups and inmates held in the IMDs by the State's criminal justice system. Also, the State agency did not compute an LIUR.

Our correction of the errors in the MIUR calculation did not cause the MIUR to fall below the 1 percent minimum allowable DSH eligibility threshold at any facility. Our calculation of the LIUR showed that none of the IMDs fell below the 25 percent minimum allowable DSH eligibility threshold at any facility. Thus, the eight State-operated IMDs were eligible for DSH payments for State FY 2008–09. However, we are concerned that the State may in the future overstate the MIUR or the LIUR and, consequently, incorrectly classify one or more IMDs as DSH eligible.

RECOMMENDATION

We recommend the State agency amend its State plan to comply with Federal requirements concerning the exclusion of unallowable inpatient days and costs from its MIUR and LIUR calculations.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency said that it believes its current MIUR methodology meets Federal requirement and needs no further modifications. The State agency said that the State plan does not require a LIUR calculation, but it provided a LIUR calculation for data collected during State FY 2006–07 and agreed to calculate the LIUR in the future. The State agency said that Medicaid beneficiaries between 22 and 64 qualify as “low income/indigent” patients in the calculation of DSH eligibility and agreed to work with CMS regarding incarcerated individuals. The State agency also called to our attention a technical issue with the patient payment income data used in our report. The State agency’s comments are presented in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

We revised Appendix A to clarify patient payment income as noted by the State agency. However, nothing in the State agency’s comments has given us cause to modify our recommendation.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Medicaid Disproportionate Share Hospital Program.....	1
Institutions for Mental Diseases.....	1
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective	2
Scope.....	2
Methodology	3
FINDINGS AND RECOMMENDATION	3
FEDERAL REQUIREMENTS AND GUIDANCE	4
PENNSYLVANIA STATE PLAN	5
UNALLOWABLE INPATIENT DAYS USED TO CALCULATE MEDICAID INPATIENT UTILIZATION RATE	5
LOW-INCOME UTILIZATION RATE CALCULATION	6
NONCOMPLIANCE WITH FEDERAL REGULATIONS	7
RECOMMENDATION	7
STATE AGENCY COMMENTS	7
OFFICE OF INSPECTOR GENERAL RESPONSE	7
APPENDIXES	
A - LOW-INCOME UTILIZATION RATE CALCULATIONS FOR STATE-OPERATED INSTITUTIONS FOR MENTAL DISEASES	
B - STATE AGENCY COMMENTS	

INTRODUCTION

BACKGROUND

Medicaid Disproportionate Share Hospital Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. Within broad Federal guidelines, each State determines eligible groups, types and ranges of services, payment levels for services, and administrative operating procedures. The Pennsylvania Department of Public Welfare (the State agency) administers Pennsylvania's Medicaid program.

The Omnibus Budget Reconciliation Act of 1981 established the Medicaid Disproportionate Share Hospital program. Section 1902 of the Act requires State Medicaid programs to “. . . take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs” when determining payment rates for inpatient hospital care. This requirement is referred to as the Medicaid disproportionate share hospital (DSH) payment adjustment. Medicaid DSH payments are made to those hospitals that provide services to a disproportionate number of low-income and uninsured patients.

Institutions for Mental Diseases

Section 1905(i) of the Act defines an Institution for Mental Disease (IMD) as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Psychiatric hospitals (including State-operated and private psychiatric hospitals) and inpatient psychiatric residential treatment facilities with more than 16 beds are IMDs. Conversely, not all facilities that provide inpatient psychiatric care are classified as IMDs. Specifically, facilities that have 16 beds or less are not IMDs, and those facilities that are not primarily engaged in providing care to persons with mental diseases are not IMDs. The State agency operates eight IMDs for persons with serious mental illness.¹

Section 1905(a) of the Act precludes Federal funding for any Medicaid services to IMD residents under age 65, except for inpatient psychiatric services provided to individuals under the age of 21. However, 42 CFR § 435.1009(a)(2) permits Medicaid services in some instances for those

¹Three of the State-operated IMDs provided services through forensic units as well as psychiatric units. Forensic units serve individuals who require treatment in highly secure buildings.

under the age of 22.² Additionally, CMS clarified that individuals who are inmates of correctional facilities are also unallowable.

Section 1923(d)(3) of the Act and Attachment 4.19-A of the approved State plan require that IMDs have a Medicaid inpatient utilization rate (MIUR) of not less than 1 percent to be deemed a Medicaid DSH. IMDs that have an MIUR of at least 1 percent are eligible for DSH payments to recoup the unreimbursed costs of providing inpatient care to patients who are either Medicaid eligible or uninsured. Medicaid days associated with unallowable inpatients cannot be included in the MIUR calculation. In addition, the State plan requires State-operated IMDs to have a low-income utilization rate (LIUR) in excess of 25 percent to be eligible for a DSH payment. The State plan defines the LIUR as the “services provided during the year to persons who were eligible for Medicaid under the State plan or who received uncompensated or publically funded care.”

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

Our objective was to determine whether the State agency complied with the State plan and Federal requirements in determining whether State-operated IMDs were eligible for Medicaid DSH payments.

Scope

We reviewed Medicaid DSH eligibility determinations for eight State-operated IMDs for State fiscal year (FY) 2008–09.³ Because the State determines eligibility based on the second prior year’s patient census information, we reviewed State-operated IMDs’ inpatient data for State FY 2006–07.

Our objective did not require an understanding or assessment of the State’s overall internal control structure. Our review was limited to controls over the State’s determination of DSH eligibility for State-operated IMDs. In addition, we did not review the State’s methodology for determining the allocation of DSH funds to State-operated IMDs.

We performed this audit in conjunction with our audit of whether DSH payments made to the eight IMDs for State FY 2006–07 fell within hospital-specific limits.

We performed our fieldwork during March and April 2008 at the offices of the State agency in Harrisburg, Pennsylvania.

²If the individual was receiving the services immediately before he or she reached age 21, the State agency may continue to claim Medicaid payment for services provided until the earlier of (1) the date the individual no longer requires the services or (2) the date the individual attains the age of 22.

³This is one of two audits that review the State agency’s DSH program for IMDs. The other was “Review of Disproportionate Share Hospital Payments Made by Pennsylvania to State-Operated Institutions for Mental Diseases,” (A-03-08-00202).

Methodology

To accomplish our objective, we:

- reviewed Federal regulations concerning the establishment of the Medicaid DSH program and DSH eligibility,
- reviewed the State plan to ensure consistency with Federal DSH eligibility requirements,
- interviewed State agency officials to gain an understanding of the State agency's DSH program and of its interpretation and implementation of the program and of the State plan itself,
- determined whether State-owned IMDs had a valid Medicare participation agreement for State FY 2006–07,
- reviewed inpatient census data to determine whether inpatient days included in MIUR calculations for State-owned IMDs were in accordance with Federal regulations,
- compiled inpatient cost data for State-operated IMDs as the basis for calculating the LIUR in accordance with Federal regulations,
- recomputed the MIUR and LIUR calculations for all State-operated IMDs based on allowable Medicaid or low-income inpatient days and costs and redetermined their DSH eligibility for State FY 2008–09, and
- shared our results with CMS regional staff and State agency officials.

We conducted this performance audit 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 objective.

FINDINGS AND RECOMMENDATION

The State agency did not fully comply with the State plan and Federal requirements in determining whether State-operated IMDs were eligible for Medicaid DSH payments in State FY 2008–09. The State agency included in its calculations of the MIUR percentage some inpatient days related to unallowable age groups and inmates held in the IMDs by the State's criminal justice system. Also, the State agency did not compute an LIUR.

Our correction of the errors in the MIUR calculation did not cause the MIUR to fall below the 1 percent minimum allowable DSH eligibility threshold at any facility. Our calculation of the LIUR showed that none of the IMDs fell below the 25 percent minimum allowable DSH

eligibility threshold at any facility. Thus, the eight State-operated IMDs were eligible for DSH payments for State FY 2008–09. However, we are concerned that the State may in the future overstate the MIUR or the LIUR and, consequently, incorrectly classify one or more IMDs as DSH eligible.

FEDERAL REQUIREMENTS AND GUIDANCE

Section 1923(d)(3) of the Act states, “No hospital may be defined or deemed a disproportionate share hospital under a State plan under this title . . . unless the hospital has a medicaid [sic] inpatient utilization rate . . . of not less than 1 percent.” Section 1923(b)(1) of the Act states that, for hospitals deemed eligible for DSH payments, the MIUR must be at least one standard deviation above the mean MIUR for hospitals receiving Medicaid payments in the State, or the hospital’s LIUR must be greater than 25 percent. Section 1923(b)(2) of the Act states that the MIUR is a fraction, “the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance . . . and the denominator of which is the total number of the hospital's inpatient days in that period.”

Section 1905(a)(28) of the Act excludes Medicaid payment for all services to “(A) . . . any individual who is an inmate of a public institution (except as a patient in a medical institution; or (B) . . . any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.” Section 1905(a)(xiii)(16) of the Act modifies this exception to allow for payment of inpatient psychiatric hospital services for individuals under the age of 21.

Additionally, 42 CFR § 435.1009(a)(1) states that Federal funding is not available for services to “individuals who are inmates of public institutions as defined in Sec. 435.1010.” Pursuant to 42 CFR § 435.1010, “[i]nmate of a public institution means a person who is living in a public institution. An individual is not considered an inmate if . . . (b) He is in a public institution for a temporary period pending other arrangements appropriate to his needs.” In a letter to Associate Regional Administrators dated December 12, 1997, CMS clarified its policy: “It is important to note that the exception to inmate status – based on ‘while other living arrangements appropriate to the individual’s needs are being made’ does not apply when the individual is involuntarily residing in a public institution awaiting criminal proceedings, penal dispositions, or other involuntary detainment determinations.” CMS clarified that inmates of correctional facilities are wards of the State, which is responsible for their medical coverage and therefore, the State agency cannot make DSH payments to cover the cost of their care (SMDL 02-013, August 16, 2002).

In a letter to State Medicaid Directors issued August 17, 1994, CMS also provided guidance that: “It is important to note that the numerator of the MUR formula does not include days attributable to Medicaid patients between 21 and 65 years of age in Institution for Mental Disease (IMDs).⁴ These patients . . . may not be counted as Medicaid days in computing the Medicaid utilization rate.”

⁴The Medicaid Utilization Rate (MUR) discussed in the August 1994 CMS letter to State Medicaid Directors is presently known as the Medicaid Inpatient Utilization Rate (MIUR).

42 CFR § 430.10 requires States to include assurances that the State Plan is in compliance with Federal law, regulations, and official guidance issued by the U.S. Department of Health and Human Services.

PENNSYLVANIA STATE PLAN

Attachment 4.19-A, page 15a, of the Pennsylvania State Medicaid plan states: “At least 1 percent (1%) of the hospital’s total days must be Medicaid days to be eligible for disproportionate share hospital payment adjustments.” In addition, “A State operated psychiatric hospital is eligible for a disproportionate share payment if its low-income utilization rate [LIUR] exceeds 25 percent.” The State plan defines the LIUR as “. . . services provided during the year to persons who were eligible for Medicaid under the State plan or who received uncompensated or publically funded care.”

The State plan also provides that “Medical assistance recipients 21 years of age or older but under 65 years of age who receive services in Institutions for Mental Diseases (IMD), . . . who are not otherwise eligible for Federal Financial participation for the IMD services, also qualify as low-income individuals subject to the provisions of the Federal disproportionate share statute . . .” (Attachment 4.19A, page 25).

UNALLOWABLE INPATIENT DAYS USED TO CALCULATE MEDICAID INPATIENT UTILIZATION RATE

Using State FY 2006–07 census data, the State correctly determined the eight State-operated IMDs to be eligible for DSH payments for State FY 2008–09. However, the State incorrectly computed the MIURs for its eight State-operated IMDs by including unallowable inpatient days for groups excluded under section 1905(a)(28) of the Act. The State included in its calculation 86,305 days related to Medicaid beneficiaries between the ages of 22 and 64 and 551 days related to individuals being held involuntarily by the State’s criminal justice system. Pursuant to section 1923(b)(2) of the Act, ineligible beneficiaries may not be included in the calculation of the MIUR. Table 1 below identifies the unallowable days noted for each State-operated IMD:

Table 1: Unallowable Days Used in MIUR Calculation

Facility Name	Unallowable Age Groups	Incarcerated Individuals⁵	Total Unallowable Days
Allentown State Hospital	11,998	0	11,998
Clarks Summit State Hospital	8,243	0	8,243
Danville State Hospital	14,509	27	14,536
Mayview State Hospital	15,145	57	15,202

⁵Patient days for incarcerated individuals between the ages of 22 and 64 were included only in the “Unallowable Age Groups” column.

Facility Name	Unallowable Age Groups	Incarcerated Individuals	Total Unallowable Days
Norristown State Hospital	9,602	442	10,044
Torrance State Hospital	14,367	0	14,367
Warren State Hospital	6,269	25	6,294
Wernersville State Hospital	6,172	0	6,172
Total	86,305	551	86,856

As shown in Table 2, the State’s inclusion of unallowable days in the MIUR did not disqualify any IMD from meeting the 1 percent threshold.

Table 2: MIUR Calculation

Facility Name	Medicaid Days		Total Patient Days⁷	MIUR Percentage	
	State	OIG⁶		State	OIG
Allentown State Hospital	5,944	4,534	60,694	9.8	7.5
Clarks Summit State Hospital	9,475	6,118	78,355	12.1	7.8
Danville State Hospital	8,759	7,313	62,798	13.9	11.7
Mayview State Hospital	10,309	4,944	110,546	9.3	4.5
Norristown State Hospital	13,188	11,277	142,527	9.3	7.9
Torrance State Hospital	7,393	4,003	77,715	9.5	5.2
Warren State Hospital	6,799	3,456	66,037	10.3	5.2
Wernersville State Hospital	12,706	8,757	76,515	16.6	11.4

LOW-INCOME UTILIZATION RATE CALCULATION

The State agency did not compute a LIUR as required by the State plan. We therefore calculated the LIUR for each State-operated IMD in accordance with the State plan, by dividing the IMDs’ low-income service costs by the total hospital costs (see Appendix). As defined by the State plan, low-income service costs represented “services provided during the year to persons who were eligible for Medicaid under the State plan or who received uncompensated or publicly funded care.” State IMD records identify uncompensated care as “self-pay” services for which full compensation was not received. “Publicly funded care” represents services provided to General Assistance patients. General Assistance is a State-administered program that provides financial and medical benefits to low-income families not eligible for cash.

⁶OIG denotes Office of Inspector General.

⁷Total includes all patient days for both psychiatric and forensic units.

As shown in Appendix A, the LIUR for each of the eight State-operated IMDs exceeded the 25 percent threshold, thus allowing for State FY 2008–09 DSH payments.

NONCOMPLIANCE WITH FEDERAL REGULATIONS

The State plan did not fully comply with Federal DSH regulations concerning the exclusion of unallowable age groups and individuals under the control of the State’s criminal justice system from the MIUR calculation for State-operated IMDs. As a result, the State agency included unallowable inpatient days in its determination of DSH eligibility. The State agency said that it did not compute the LIUR because the DSH days reported by the IMDs far exceed the 25 percent threshold required by the State plan.

This leads us to express our concern that the State may in the future overstate allowable Medicaid inpatient days for some IMDs with low MIURs and, consequently, incorrectly classify one or more IMDs as DSH eligible.

RECOMMENDATION

We recommend the State agency amend its State plan to comply with Federal requirements concerning the exclusion of unallowable inpatient days and costs from its MIUR and LIUR calculations.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency said that it believes its current MIUR methodology meets Federal requirement and needs no further modifications. Although the State agency said that the State plan does not require a LIUR calculation, it provided a LIUR calculation for data collected during State FY 2006–07 and agreed to calculate the LIUR for all subsequent State fiscal years.

The State agency said that OIG’s MIUR and LIUR calculations incorrectly excluded patient days for Medicaid beneficiaries between 22 and 64 and incarcerated individuals. The State agency said that Medicaid beneficiaries between 22 and 64 qualify as “low income/indigent” patients in the calculation of DSH eligibility and agreed to work with CMS to resolve the status of the incarcerated individuals. The State agency also called to our attention a technical issue with the patient payment income data used in our report. The State agency’s comments are presented in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

We revised Appendix A to clarify patient payment income as noted by the State agency. However, nothing in the State agency’s comments has given us cause to modify our recommendation.

APPENDIXES

**LOW-INCOME UTILIZATION RATE CALCULATIONS FOR
STATE-OPERATED INSTITUTIONS FOR MENTAL DISEASES**

The first line of each Institute for Mental Diseases low-income utilization rate calculation represents patient days and costs for services provided in psychiatric units of the facility. The calculations for Mayview, Norristown, and Warren State Hospitals include a second line representing forensic unit costs.

Allentown State Hospital					
Patient Days by Payer Type			Total	Per Diem	Patient Costs
Medicaid	Self-Pay	GA¹			
4,534	40,090	1,969	46,593	\$609.83	\$28,413,809
				Medicaid Payments	-288,064
				Patient Payments	-848,927
				Low-income Service Costs	\$27,276,818
				Total Hospital Costs	\$37,012,989
				Low-Income Utilization Rate Percentage	73.7

Clarks Summit State Hospital					
Patient Days by Payer Type			Total	Per Diem	Patient Costs
Medicaid	Self-Pay	GA			
6,118	54,605	4,546	65,269	\$589.80	\$38,495,656
				Medicaid Payments	-273,657
				Patient Payments	-1,032,790
				Low-income Service Costs	\$37,189,209
				Total Hospital Costs	\$46,213,974
				Low-Income Utilization Rate Percentage	80.5

Danville State Hospital					
Patient Days by Payer Type			Total	Per Diem	Patient Costs
Medicaid	Self-Pay	GA			
7,313	35,939	1,158	44,410	\$588.88	\$26,152,161
				Medicaid Payments	-380,565
				Patient Payments	-907,682
				Low-income Service Costs	\$24,863,914
				Total Hospital Costs	\$36,980,606
				Low-Income Utilization Rate Percentage	67.2

¹GA denotes General Assistance.

Mayview State Hospital					
Patient Days by Payer Type			Total	Per Diem	Patient Costs
Medicaid	Self-Pay	GA			
4,944	55,773	14,425	75,142	\$564.04	\$42,383,094
0	10,183	3,200	13,383	\$750.67	\$10,046,217
				Medicaid Payments	-455,741
				Patient Payments	-948,225
				Low-income Service Costs	\$51,025,345
				Total Hospital Costs	\$65,927,816
				Low-Income Utilization Rate Percentage	77.4

Norristown State Hospital					
Patient Days by Payer Type			Total	Per Diem	Patient Costs
Medicaid	Self-Pay	GA			
11,277	70,298	9,636	91,211	\$534.27	\$48,731,301
0	19,497	5,292	24,789	\$733.58	\$18,184,715
				Medicaid Payments	-710,193
				Patient Payments	-1,248,530
				Low-income Service Costs	\$64,957,293
				Total Hospital Costs	\$83,320,929
				Low-Income Utilization Rate Percentage	78.0

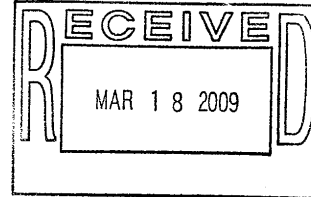
Torrance State Hospital					
Patient Days by Payer Type			Total	Per Diem	Patient Costs
Medicaid	Self-Pay	GA			
4,003	49,720	3,991	57,714	\$555.42	\$32,055,510
				Medicaid Payments	-220,100
				Patient Payments	-1,011,113
				Low-income Service Costs	\$30,824,297
				Total Hospital Costs	\$43,164,305
				Low-Income Utilization Rate Percentage	71.4

Warren State Hospital					
Patient Days by Payer Type			Total	Per Diem	Patient Costs
Medicaid	Self-Pay	GA			
3,117	38,780	3,614	45,511	\$647.91	\$29,487,032
339	5,242	195	5,776	\$784.16	\$4,529,308
				Medicaid Payments	-293,614
				Patient Payments	-713,245
				Low-income Service Costs	\$33,009,481
				Total Hospital Costs	\$44,015,188
				Low-Income Utilization Rate Percentage	75.0

Wernersville State Hospital					
Patient Days by Payer Type			Total	Per Diem	Patient Costs
Medicaid	Self-Pay	GA			
8,757	53,202	2,767	64,726	\$581.49	\$37,637,522
				Medicaid Payments	-868,650
				Patient Payments	-1,225,183
				Low-income Service Costs	\$35,543,689
				Total Hospital Costs	\$44,492,469
				Low-Income Utilization Rate Percentage	79.9



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
P.O. BOX 2675
HARRISBURG, PENNSYLVANIA 17105-2675



MAR 18 2009

Theodore Dallas
Executive Deputy Secretary

(717) 787-2600
Email: tdallas@state.pa.us

Mr. Stephen Virbitsky
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General
Office of Audit Services, Region III
150 South Independence Mall West, Suite 316
Philadelphia, Pennsylvania 19106-3499

Dear Mr. Virbitsky:

Thank you for your January 28 letter that transmitted the draft report entitled "Review of Pennsylvania's Determination of Medicaid Disproportionate Share Hospital Eligibility for the State-Operated Institutions for Mental Diseases" for the period July 1, 2008 through June 30, 2009.

This audit determined that the eight State-Operated Institutions for Mental Diseases (IMDs) met the eligibility requirements set forth by Social Security Act Section 1923, which requires that hospitals meet a Medicaid Inpatient Utilization Rate (MIUR) of at least one percent and a Low-Income Inpatient Utilization Rate (LIUR) of at least twenty-five percent to receive Disproportionate Share Hospital (DSH) payments.

Office of Inspector General (OIG) Recommendation: We recommend that the State agency amend its State plan to comply with Federal requirements concerning the exclusion of unallowable inpatient days and costs from its MIUR and LIUR calculations.

Department of Public (DPW) Response: The DSH claims made on behalf of the State-Operated IMDs are calculated based on methods stated within the State Plan on page 15a. When determining the DSH payment based on both the MIUR and LIUR eligibility, the State Plan follows the requirements set forth by the Social Security Act, which requires the MIUR to be at least 1 percent and the LIUR to be at least 25 percent. Therefore, the DPW believes the current MIUR methodology in Attachment 4.19A, page 15a meets the Federal directive regarding the State-Operated IMDs' eligibility to claim DSH payments, and it is unclear how further amendment to the State Plan would modify this calculation requirement.

The Office of Inspector General (OIG) cited a portion of the State Plan within the report that does not apply to the State-Operated IMDs, specifically page 25 titled "Additional Disproportionate Share Payment", which allows for additional DSH payments to Private Inpatient Hospitals. The DPW does not claim for additional DSH Payments to State-Operated IMDs. The only DSH claim made for State-Operated IMDs is the Disproportionate Share Payment Adjustment described on page 15a.

Mr. Stephen Virbitsky

-2-

The DPW is aware that the Social Security Act Section 1905(a) does not allow the State-Operated IMDs to charge Medical Assistance (MA) for days that a patient is committed to the State-Operated IMD, if that patient is between the ages of 22 and 64; however, the DPW is unaware of any other requirement restricting DSH payments for patients ages 22-64. Therefore, the DPW uses the low-income (indigent) days recorded for patients ages 22-64 when determining the total uncompensated care costs.

Pennsylvania's State Plan does not require the DPW to calculate the LIUR. However, as recommended, the DPW has completed the LIUR calculation for census data collected during State Fiscal Year (SFY) 2006-07 (Enclosure A) and plans to calculate the LIUR for all subsequent state-fiscal years. The percentages are significantly different from the OIG's calculation due to the OIG's usage of monthly patient pay totals instead of the Year-to-Date (YTD) totals used in all other categories. Also, the DPW has included in the Indigent Days uncompensated care costs for low-income patients between the ages of 22 to 64. The DPW notified the OIG of this discrepancy regarding monthly totals and was told YTD Patient Pay figures are to be used in the final report. Based on the DPW's calculation, all of the State-Operated IMDs had percentages over 90 percent for the SFY 2006-07.

The DPW will utilize the following calculation when determining each State-Operated IMD's percentage:

- MA days + Patient Pay Days + Indigent Days = Total Inpatient Days
- Total Days x Per Diem Amount = Patient Costs
- Patient Costs – MA Payments – Patient Payments = Low-Income Service Costs

$$\frac{\text{Low Income Service Costs}}{\text{Total Hospital Costs}} = \text{LIUR}$$

During the course of this audit, the DPW, Office of Income Maintenance (OIM) provided the OIG with a Client Information System (CIS) data dump showing State-Operated IMDs patients' MA eligibility. The OIG had OIM supply data for all patients admitted to the State-Operated IMDs during SFYs 2004-05 and 2006-07, including individuals between the ages of 22 and 64.

As the Bureau of Financial Operations, Reimbursement Operations Section (ROS) has no data entry capabilities within CIS, the OIG incorrectly applied the data contained within CIS to the data used to bill MA for patients residing in the State-Operated IMDs. The OIG calculated the eligible MA days by reviewing the eligibility dates within the CIS data and determined there was a significant difference between MA days calculated by DPW and those calculated by the OIG. As per DPW policy, ROS contacts the County Assistance Office (CAO) to apply for MA benefits for clients under 22 and over 64. Upon approval of eligibility, ROS bills MA directly and

Mr. Stephen Virbitsky

-3-

records billing dates on the MA Charge Reconciliation Sheets provide to the OIG during this audit.

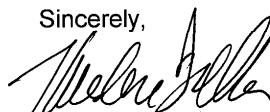
The DPW has reviewed the data used by the OIG to determine ineligible MA days for individuals between the ages of 22 to 64, and also the MA days calculated for patients under age 22 and over 64. Based on the CIS data, the DPW noted that for patients under age 22 and over 64, there were several instances where CIS did not show the patient as having updated MA eligibility; however, ROS billed MA and received payment for these individuals during SFY 2006-07. Based on these billings and receipts, ROS includes these patient days as MA days within the census data.

Also, for the MA eligibility for patients between the ages of 22 to 64, the MA eligibility dates should have been compared to the dates the client was a patient committed to the State-Operated IMD. ROS has a policy in place to notify the CAO of the MA client's admission to the State-Operated IMD if their age is between 22 and 64. ROS does not charge MA for these patients during their commitment to the State-Operated IMD. It is possible that the client would again be eligible for MA benefits upon discharge from the State-Operated IMD. This may result in numerous eligibility periods during a given fiscal year. The OIG did not compare the eligibility days within CIS to the dates these clients were committed to the State-Operated IMDs, and also did not compare the MA charges for clients 22-64 to the MA Charge Recon Sheets provided by ROS. If this had been done, the OIG would have noted that there were no MA charges for clients 22-64, as they are deemed by MA to be ineligible while institutionalized.

The DPW is aware of the clarifications sent by CMS to the MA Program Administrators regarding the determination of inmates; however, the DPW has always viewed the State-Operated IMDs as medical facilities providing active treatment. Therefore, the DPW will work with CMS to secure a determination on both the State-Operated IMDs medical facility status and a more detailed determination regarding MA eligibility for incarcerated patients, specifically juvenile offenders.

Thank you for the opportunity to respond to this report. If you need any further information, please contact Maranatha E. Earling, Bureau of Financial Operations, Audit Resolution Section, at (717) 772-4911, or via e-mail at mearling@state.pa.us.

Sincerely,



Theodore Dallas

Enclosure

Low-Income Utilization Rate (LIUR) Calculations for State-Operated Institutions for Mental Diseases

	Patient Days by Payer Type			Total Days	Per Diem	Patient Costs	Medicaid Payments	Patient Payments	Low Income Service Costs	Total Hospital Costs	LIUR
	Medicaid	Indigent	Patient Pay								
Allentown	5,944	19,856	33,187	58,987	\$609.83	\$35,972,042	288,064	848,927	34,835,051	37,012,989	94%
Clarks Summit	9,474	19,882	45,986	75,342	\$589.81	\$44,437,465	273,657	1,032,790	43,131,018	46,213,974	93%
Danville	8,759	18,276	33,197	60,232	\$588.88	\$35,469,420	380,565	907,682	34,181,173	36,980,606	92%
Mayview Psychiatric	10,309	33,569	44,826	88,704	\$564.04	\$50,032,604	453,437	872,509	48,706,658	51,547,141	
Mayview Forensics	1,053	14,231	4,926	20,210	\$750.67	\$15,171,041	2,304	75,716	15,093,021	14,380,675	
Mayview Total						\$65,203,645	455,741	948,225	63,799,679	65,927,816	97%
Norristown Psychiatric	13,188	41,584	47,759	102,531	\$534.27	\$54,779,237	710,080	1,174,448	52,894,709	56,921,441	
Norristown Forensics	778	18,899	17,028	36,705	\$733.58	\$26,926,054	113	74,082	26,851,859	26,399,488	
Norristown Total						\$81,705,291	710,193	1,248,530	79,746,568	83,320,929	96%
Torrance State Hospital	7,393	24,990	40,398	72,781	\$555.87	\$40,456,774	220,100	1,011,113	39,225,561	43,199,619	91%
Warren Psychiatric	6,799	19,295	27,274	53,368	\$647.91	\$34,577,661	293,579	643,199	33,640,883	36,939,744	
Warren Forensics	110	5,401	3,439	8,950	\$784.16	\$7,018,232	36	70,046	6,948,150	7,075,444	
Warren Total						\$41,595,893	293,615	713,245	40,589,033	44,015,188	92%
Wernersville	12,706	16,942	43,309	72,957	\$581.49	\$42,423,766	868,651	1,225,183	40,329,932	44,492,469	91%