



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601
March 12, 2004

REGION V
OFFICE OF
INSPECTOR GENERAL

Report Number: A-05-01-00087

Mr. Kenneth B. Marshall
Chief Inspector
Office of the Chief Inspector
Ohio Department of Job & Family Services
30 East Broad Street
Columbus, Ohio 43215

Dear Mr. Marshall:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final audit report entitled "Review of Medicaid Disproportionate Share Hospital Payment Limits for St. Vincent Charity Hospital and St. Luke's Medical Center, Cleveland, Ohio." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

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

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

Please refer to report number A-05-01-00087 in all correspondence.

Sincerely,

A handwritten signature in cursive script that reads "Paul Swanson".

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures – as stated

Page 2 – Mr. Kenneth B. Marshall

Direct Reply to HHS Action Official:

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

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICAID
DISPROPORTIONATE SHARE
HOSPITAL PAYMENT LIMITS FOR
ST. VINCENT CHARITY HOSPITAL
AND ST. LUKE'S MEDICAL CENTER,
CLEVELAND, OHIO**

**OHIO DEPARTMENT OF JOB
AND FAMILY SERVICES
COLUMBUS, OHIO**



**March 2004
A-05-01-00087**

Office of Inspector General

<http://oig.hhs.gov>

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

OAS FINDINGS AND OPINIONS

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



EXECUTIVE SUMMARY

OBJECTIVE

The objective of our review was to confirm that disproportionate share hospital (DSH) payments to St. Vincent Charity Hospital and St. Luke's Medical Center (collectively, the Provider) during Federal fiscal year 2000 did not exceed the DSH payment limits imposed by the Omnibus Budget Reconciliation Act of 1993.

SUMMARY OF RESULTS

The Ohio Department of Job & Family Services calculated the Provider's DSH limit in accordance with the State plan. However, we found that the Provider's DSH payments exceeded the hospital specific limits imposed by the Omnibus Budget Reconciliation Act of 1993. We found that the Provider included patient charges totaling \$849,596 that did not qualify as uncompensated care in its Medicaid cost reports. The charges included:

- unsupported charges totaling \$652,560,
- duplicate charges of \$109,768,
- charges for patient bad debt recoveries totaling \$38,160,
- overstated charges due to an accounting error of \$24,619,
- inflated charges for billing adjustments totaling \$17,609, and
- charges for unallowable items and services totaling \$6,880.

The costs associated with the unallowable charges were included in the calculated DSH limits and resulted in DSH overpayments to the Provider. Approximately \$407,000 of the \$849,596 had been allocated into the "non-Medicaid uninsured" cost reporting categories. Ohio calculated the costs of uncompensated care by converting the reported charges to costs through the application of cost-to-charge ratios. When converted from a charge basis to a cost basis, the \$407,000 reflects DSH overpayments of about \$197,000 (\$115,000 Federal share).

RECOMENDATIONS

We recommend that the Ohio Department of Job & Family Services recalculate and recover the DSH overpayment to the Provider of about \$197,000 (\$115,000 Federal share) and redistribute this amount through its payment distribution formula to other hospitals that may have been underpaid as the result of this overpayment.

OHIO COMMENTS

In written comments to the draft report, the Ohio Department of Job & Family Services requested details showing where charges were reported on Schedule F of the Provider's cost report, itemized by location (inpatient or outpatient), and by eligibility type (disability assistance, uncompensated care above 100 percent of the Federal poverty level, or uncompensated care equal to or below 100 percent of the Federal poverty level). Ohio indicated that it would then work with the Provider to recalculate and recover any DSH overpayments.

OFFICE OF INSPECTOR GENERAL RESPONSE

We have attached a schedule to the report, as Appendix A, that shows the necessary adjustments, by location and eligibility type, to Schedule F of the Provider's cost report.

TABLE OF CONTENTS

	Page
INTRODUCTION	1
BACKGROUND	1
Disproportionate Share - General Program Overview	1
Ohio DSH Program – General Hospitals	1
Hospitals Selected for Review	2
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective	2
Scope	2
Methodology	2
RESULTS OF REVIEW	3
COMPLIANCE WITH HOSPITAL SPECIFIC LIMITS	3
<i>Criteria – Federal Requirements and CMS Policy</i>	3
<i>Condition – DSH Payments Exceeded the DSH Limits</i>	4
Unsupported Charges	4
Duplicated Charges	4
Charges for Patient Bad Debt Recoveries	5
Overstated Charges Due to Accounting Errors	5
Inflated Charges for Billing Adjustments	5
Charges for Unallowable Items and Services	6
<i>Cause – Provider DSH Limits Were Overstated Due to Unallowable Reported Charges</i>	6
<i>Effect – Provider DSH Overpayment</i>	6
STATE PLAN CONSIDERATIONS	6
RECOMMENDATION	7
OHIO COMMENTS	7
OFFICE OF INSPECTOR GENERAL RESPONSE	7
APPENDICES	
A – Unallowable Charges and Costs Included on Schedule F of Provider’s Cost Report	
B – Ohio Department of Job & Family Services Written Comments	

INTRODUCTION

BACKGROUND

Disproportionate Share - General Program Overview

In 1965, Medicaid was established as a jointly funded Federal and State program providing medical assistance to qualified low-income people. At the Federal level, the program is administered by the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services. Within a broad legal framework, each State designs and administers its own Medicaid program. Each State prepares a State plan that defines how a State will operate its Medicaid program and is required to submit the plan for CMS approval.

The Omnibus Budget Reconciliation Act of 1981 established the DSH program by adding section 1923 to the Social Security Act. Section 1923 required State Medicaid agencies to make additional payments to hospitals serving disproportionate numbers of low-income patients with special needs. States had considerable flexibility to define DSH under sections 1923(a) and (b) of the Act.

States receive allotments of DSH funds as set forth by Federal statute. The Federal Government cost-shares Medicaid DSH expenditures based upon the applicable Federal medical assistance percentage. States report DSH expenditures on CMS Form-64, the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program.

Ohio DSH Program – General Hospitals

During the Federal fiscal year 2000 funding period, Ohio made DSH payments exceeding \$526 million to over 180 general hospitals and fully expended its Federal DSH allotment of \$363 million. The Federal financial participation rate was 58.7 percent of the total expenditures. The aggregate hospital-specific DSH limits calculated by the Ohio Department of Job & Family Services for the review period exceeded the total DSH payments by over \$200 million. As a result, some hospitals were paid at levels below their hospital-specific DSH limits.

The DSH program for general hospitals in Ohio was established in 1989 and is referred to as the Hospital Care Assurance Program. The program provides funds to qualified hospitals and helps to offset the costs incurred by these facilities in furnishing services to a disproportionate share of the indigent population. The program is primarily funded at the State level through a tax assessed on participating general hospitals. The assessments are combined with Federal funding to make DSH payments to the qualified facilities.

Hospitals may receive DSH payments up to the amount of their calculated hospital-specific DSH limits. For the review period, this DSH limit was the net of the Medicaid shortfall plus the reported uncompensated care costs for uninsured persons based on the hospital cost reporting periods ended during State fiscal year 1999. Uncompensated care charges were reported by general hospitals on Schedule F of the Ohio Medicaid cost report.

Hospitals Selected for Review

During the review period, St. Vincent Charity Hospital and St. Luke's Medical Center, jointly referred to as the Provider, participated together in the Ohio DSH program as a single reporting entity. Both hospitals, located in downtown Cleveland, were among the holdings of the Caritas Healthcare Partnership and provided medical services to individuals residing in some of the lowest income neighborhoods in the metropolitan area.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to confirm that Medicaid DSH payments made to the Provider during Federal fiscal year 2000 did not exceed the DSH payment limits imposed by the Omnibus Budget Reconciliation Act of 1993.

Scope

The audit was conducted in accordance with generally accepted government auditing standards and included:

- Confirmation that the Provider met the general eligibility requirements for program participation.
- Verification that Ohio appropriately calculated the hospital-specific DSH limits, and that DSH payments made to the Provider were appropriately calculated and distributed.
- Confirmation that the DSH limit calculations and DSH payments were based on accurate information, as reported on Schedule F of the Provider's Medicaid cost reports.

Our review of management controls was limited to discussions with State officials and representatives of the Provider. These discussions were intended to facilitate our overall understanding of the DSH program, cost report preparation, and the general control procedures that have been implemented to ensure program compliance with applicable Federal and State requirements. We also completed a review of Ohio's overall DSH program oversight, including the review of a selected State-owned institution for mental disease. The results of this review will be reported separately.

Fieldwork was completed at the Provider, located in Cleveland, Ohio and at the offices of the Ohio Department of Job & Family Services, located in Columbus, Ohio.

Methodology

At the State, we evaluated the accuracy and appropriateness of the DSH limit and payments through an analysis of various schedules prepared by Ohio, and an examination of the Provider's cost reports, and other State accounting records.

Our review at the Provider included an evaluation of detailed account listings, a reconciliation of these listings to Schedule F of the Medicaid cost reports for the Provider's reporting period ended September 30, 1998, and a general evaluation of the hospital's DSH eligibility. We also selected and reviewed detailed patient records supporting the reported uncompensated care charges. These records supported the selected inpatient admission and outpatient visit transactions. We also reviewed selected transactions with large dollar amounts or the appearance of potential reporting duplications.

RESULTS OF REVIEW

The Ohio Department of Job & Family Services calculated the Provider's DSH limit in accordance with the State plan. However, we found that the Provider's DSH payments exceeded the hospital specific limits imposed by the Omnibus Budget Reconciliation Act of 1993. We found that the Provider included patient charges totaling \$849,596 that did not qualify as uncompensated care in its Medicaid cost reports. The charges included:

- unsupported charges totaling \$652,560,
- duplicate charges of \$109,768,
- charges for patient bad debt recoveries totaling \$38,160,
- overstated charges due to an accounting error of \$24,619,
- inflated charges for billing adjustments totaling \$17,609, and
- charges for unallowable items and services totaling \$6,880.

The costs associated with the unallowable charges were included in the calculated DSH limits and resulted in DSH overpayments to the Provider. Approximately \$407,000 of the \$849,596 had been allocated into the "non-Medicaid uninsured" cost reporting categories. Ohio calculated the costs of uncompensated care by converting the reported charges to costs through the application of cost-to-charge ratios. When converted from a charge basis to a cost basis, the \$407,000 reflects DSH overpayments of about \$197,000 (\$115,000 Federal share).

COMPLIANCE WITH HOSPITAL SPECIFIC LIMITS

Criteria – Federal Requirements and CMS Policy

Section 13621 of the Omnibus Budget Reconciliation Act of 1993 amended section 1923 of the Social Security Act to limit DSH payments to a hospital's incurred uncompensated care costs. Under section 1923(g) of the Act, the uncompensated care was limited to costs of medical services provided to Medicaid and uninsured patients less payments received for those patients excluding Medicaid DSH payments. The specific language contained in the Act, as amended, is as follows:

Section 1923...

(g) Limit on Amount of Payment to Hospital.---

(1) Amount of adjustment subject to uncompensated costs.---

(A) IN GENERAL.---A payment adjustment during a fiscal year shall not be considered to be consistent with . . . respect to a hospital if the payment

adjustment exceeds the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year.

In a subsequent letter to State Medicaid Directors dated August 17, 1994, CMS provided further guidance in calculating hospital-specific DSH limits, stating that total DSH payments to a specific hospital may not exceed the sum of the hospital's Medicaid shortfall plus the cost of uncompensated care provided to uninsured patients. The letter further stated that both inpatient and outpatient costs may be included in the DSH limit calculation, and provided a degree of flexibility by allowing the States to generally define the composition of appropriate costs as long as the appropriate Medicare upper payment limits were not exceeded.

Condition – DSH Payments Exceeded the DSH Limits

The Provider's DSH payments exceeded the hospital specific limits imposed by section 13621 of the Omnibus Budget Reconciliation Act of 1993. The patient charges totaling \$849,596 that did not qualify as uncompensated care for DSH funding purposes were reported by the Provider on Schedule F of its Medicaid hospital cost reports. The unallowable charges were, as follows:

Unsupported Charges. We identified total charges of \$652,560 pertaining to missing patient records covering a 1 month time period and unavailable records relating to a single large account. The Ohio Provider agreement for all providers, except long-term care facilities, states that a provider must:

Maintain all records necessary and in such form as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer

Although the Provider agreed that the missing records were unavailable, it believed that the accounting systems data, made available to us during the review, was sufficiently reliable to document a significant portion of the reported charges. We disagree. The Provider is responsible for maintaining and furnishing patient specific records to document and support its reported patient specific charges. The unsupported charges should be removed from the Provider's cost report.

Duplicated Charges. We identified \$109,768 of charges for three transactions that were mistakenly compiled twice in the transaction logs and duplicated on Schedule F. The Provider agreed that the duplicated amounts were reported in error. The duplicate charges should be removed from the Provider's cost report.

Charges for Patient Bad Debt Recoveries. The Provider recovered \$38,160 from patient accounts that were previously written off as uncollectable bad debts. All recoveries should have been offset against the reported uncompensated care amounts as a reduction to the reported charges. The Provider made aggregate adjustments to the transaction logs to reflect the total amounts that it believed were recovered against the uncollectable patient accounts. These adjustments were appropriately carried forward and reported through Schedule F. However, the Provider was unable to furnish any specific account or transaction data to support its adjustments. Consequently, we could not confirm which, if any, of the selected recovery amounts were actually included in the Provider's aggregate adjustments. The identified amounts should be removed from the cost reports.

The Provider agreed that it was unable to furnish individual detail for the bad debt recovery, but believed that all recovered bad debt amounts had been appropriately included in its aggregate patient log adjustments. As previously cited, the Ohio Provider Agreement requires the Provider to retain all necessary records to disclose its significant business transactions. Since the reported charges were compiled based on the uncompensated care associated with specific visit and admission transactions, we believe that the amounts used to offset these charges should also be supported on a specific, or transaction oriented basis. The disclosure of only a total write-off amount fails to provide reasonable assurance that any specifically identified account recoveries were included in the aggregate adjustments. As a result, the identified amounts should be removed from the cost reports.

Overstated Charges Due to Accounting Errors. We identified \$24,619 of overstated charges attributable to an error in adjusting an account balance and an accounting reconciliation error between the Provider's accounting records and the Schedule F.

The Provider agreed that it incorrectly made an adjustment to an account balance of \$20,520, but believed that the reconciliation error of \$4,099 was based partially on an estimate and was not material. We disagree, noting that the Provider clearly designated the \$4,099 as an "accounting error" in the account reconciliation support that was provided to us as part of the review. The identified amounts should be removed from the Provider's cost report.

Inflated Charges for Billing Adjustments. The Provider increased the amounts of initially billed charges by \$17,609 to inflate its billed amounts to the expected rate of Medicaid reimbursement for the same services. The Ohio Provider Agreement states that a provider must "... bill the Ohio Department of Human Services for no more than the usual and customary fee charged other patients for the same service." The Provider believed that the upward adjustments to the charged amounts were appropriate, contending that the Omnibus Budget Reconciliation Act of 1993 payment limit is based on Medicaid reimbursement rates and that it is appropriate to increase its billed charges up to the Medicaid rate in order to determine the uncompensated care write-off.

We disagree, noting that CMS grants the States a certain level of flexibility in defining allowable costs, as long as these costs do not exceed the Medicare principles of cost reimbursement. Although the discretion to determine allowable cost or charge amounts resides with the State, it should not be interpreted to extend to the level of the individual provider. Accordingly, based on

the requirements of the Ohio Provider Agreement, the charge increases are not allowable and should be removed from the Provider's cost report.

Charges for Unallowable Items and Services. We identified \$6,880 of charges for unallowable drugs, medical transportation, durable medical equipment, take-home supplies, and recreational therapy services. These charges were unallowable under Ohio's Hospital Care Assurance Program pursuant to Ohio Code section 5101:3-2-02. The Provider agreed that the identified amounts were unallowable. The reported charges should be removed from the cost reports.

Cause – Provider DSH Limits Were Overstated Due to Unallowable Reported Charges

A hospital's total DSH payments may not exceed its hospital-specific DSH limit, calculated to be the sum of the hospital's Medicaid shortfall plus the costs of uncompensated care provided to uninsured patients. The Provider received DSH payments equal to 100 percent of its calculated limit. The costs associated with the charges that did not qualify as uncompensated care for DSH funding were included in both the limit and the payments to the Provider, resulting in an overstated DSH limit and a corresponding overpayment.

During the review period, Ohio calculated the costs of uncompensated care by converting reported charges to costs through the application of hospital-specific inpatient and outpatient cost-to-charge ratios developed by Ohio from the Provider's cost report data. The DSH limit and payment calculations were based on current data that was not subject to inflationary adjustment.

Effect – Provider DSH Overpayment

Based on the Provider's cost allocation process, about \$407,000 of the \$849,596 in identified charges was allocated to the "non-Medicaid uninsured" charge categories. Using the applicable cost-to-charge ratios, the \$407,000 of inappropriately allocated charges converted to \$197,000 in costs that did not qualify for DSH payment. The Federal share was about \$115,000.

STATE PLAN CONSIDERATIONS

The Ohio Medicaid State plan requires that:

If an audit . . . identifies amounts that . . . a hospital . . . should not have received, but did receive . . . the Department shall:

- (a) Make payments to any hospital that the audit reveals paid amounts that it should not have been required to pay but did pay or did not receive amounts it should have received.
- (b) Take action to recover from a hospital any amounts that the audit reveals it should have been required to pay but did not pay or that it should not have received but did receive

In accordance with the State plan, we concluded that a redistribution of the DSH overpayments is appropriate.

RECOMMENDATION

We recommend that the Ohio Department of Job & Family Services recalculate and recover the identified DSH overpayments made to the Provider of about \$197,000 (\$115,000 Federal share) and redistribute this amount to any hospitals that were underpaid as the result of this overpayment.

OHIO COMMENTS

In written comments to the draft report, the Ohio Department of Job & Family Services requested confirmation of its understanding that the overpayments were attributable to hospital charges for persons without insurance. It also requested details showing where charges were reported on Schedule F of the Provider's cost report, itemized by location (inpatient or outpatient) and by eligibility type (disability assistance, uncompensated care above 100 percent of the Federal poverty level, or uncompensated care equal to or below 100 percent of the Federal poverty level). Ohio indicated that it would then work with the provider to recalculate and recover any DSH overpayments.

Ohio's written comments are presented in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

Ohio is correct that the charges reported by the Provider resulted from services provided to patients without insurance (uninsured). We have attached, as Appendix A, a schedule of necessary adjustments to Schedule F of the Provider's cost report, itemized by location and eligibility type.

APPENDICES

Appendix A

Unallowable Charges and Costs Included on Schedule F of Provider's Cost Report

<i>Category on Schedule F of Cost Report</i>	<i>Insured Charges</i>	<i>Uninsured Charges</i>	<i>Cost/Charge Ratio</i>	<i>Uninsured Costs</i>
Inpatient:				
Disability Assistance – St. Luke's	\$ -	\$ -	0.617464	\$ -
Disability Assistance – St. Vincent	-	-	0.403411	-
Uncompensated < 100% Poverty Level – St. Luke's	-	10.00	0.617464	6.17
Uncompensated < 100% Poverty Level – St. Vincent's	-	58,778.53	0.403411	23,711.90
Uncompensated > 100% Poverty Level – St. Luke's	137,318.84	85,131.89	0.617464	52,565.88
Uncompensated > 100% Poverty Level – St. Vincent's	22,242.07	30,816.30	0.403411	12,431.63
Total Inpatient	\$159,560.91	\$174,736.72		\$ 88,715.58
Outpatient:				
Disability Assistance – St. Luke's	\$ -	\$ -	0.534130	\$ -
Disability Assistance – St. Vincent	-	-	0.371131	-
Uncompensated < 100% Poverty Level – St. Luke's	-	-	0.534130	-
Uncompensated < 100% Poverty Level – St. Vincent's	-	61,150.39	0.371131	22,694.81
Uncompensated > 100% Poverty Level – St. Luke's	220,584.51	137,161.76	0.534130	73,262.21
Uncompensated > 100% Poverty Level – St. Vincent's	62,179.74	34,222.89	0.371131	12,701.17
Total Outpatient	\$282,764.25	\$232,535.04		\$108,658.19
Total Unallowable Costs (Inpatient and Outpatient)				<u>\$197,373.77</u>

Bob Taft
Governor



Tom Hayes
Director

30 East Broad Street • Columbus, Ohio 43215
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July 11, 2003

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

Dear Mr. Swanson:

This letter is being sent in response to your letter dated June 11, 2003, and the draft report entitled, "Review of Medicaid Hospital-Specific Disproportionate Share Hospital Payment Limits, St. Vincent Charity Hospital and St. Luke's Medical Center Cleveland, Ohio", audit report number A-05-01-00087. Thank you for the opportunity to respond.

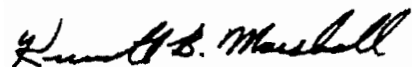
ODJFS was pleased to learn that the audit found that given the information furnished in the Provider's Medicaid hospital cost reports, ODJFS calculated the DSH limit in accordance with the approved state plan. However, the audit found that the cost reports included inaccurate data, which caused uncompensated care costs to be overstated and payments to be made above the DSH limit by about \$197,000. The report recommends that ODJFS recalculate and recover the DSH overpayment from the provider of about \$197,000 and redistribute this amount through its payment distribution formula to other hospitals that may have been underpaid as a result of this overpayment.

In order to implement the findings of the audit, ODJFS will need further information from the findings of the investigation. Because the charges affected the DSH limit, ODJFS believes these charges were reported as resulting from services provided to patients without insurance. Please let ODJFS know where on the Schedule F these charges were reported by itemizing charges by location (inpatient or outpatient) and by eligibility type (disability assistance, uncompensated care above 100% of the federal poverty level, or uncompensated care equal to or below 100% of the federal poverty level). In addition, please confirm that the charges identified are for persons without insurance. Upon receipt of this information from you, ODJFS will work with the provider to recalculate and recover any DSH overpayments.

Mr. Paul Swanson
July 11, 2003
Page 2

Again, thank you for the opportunity to respond to the draft report. Please contact Dick Starks, Office of the Chief Inspector, at 614-466-3015, if you have any questions or comments.

Sincerely,

A handwritten signature in cursive script that reads "Kenneth B. Marshall".

Kenneth B. Marshall
Chief Inspector
Office of the Chief Inspector