OHIO DEPARTMENT OF HUMAN SERVICES

HOSPITAL CARE ASSURANCE PROGRAM

PROGRAM YEAR 1995

OCTOBER 1995 THROUGH APRIL 1996

HOSPITAL CARE ASSURANCE PROGRAM

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December 14, 1996

Mr. Arnold R. Tompkins, Director
Ohio Department of Human Services
30 East Broad Street, 32nd Floor
Columbus, Ohio 43266-0423

Dear Director Tompkins:

This report presents the results of our work on the Hospital Care Assurance Program (HCAP) for Program Year 1995 (PY)[1]. This work was performed pursuant to Section 5112.20 of the Ohio Revised Code (ORC) which requires the Auditor of State to "determine the amounts that, due to errors by the department of human services, a hospital should not have been required to pay but did pay, should have been required to pay but did not pay, should not have received but did receive, or should have received but did not receive."

The requirements of ORC Section 5112.20 are more consistent with that of a program audit than a financial audit. Accordingly, this work was performed as a program audit. A program audit is a type of performance audit designed to determine (1) the extent to which the desired results or benefits established by a legislature or other authorizing body are being achieved, (2) the effectiveness of organizations, programs, activities, or functions, and (3) whether an entity has complied with significant laws and regulations applicable to a program. Therefore, this work did not include a review of Ohio Department of Human Services (ODHS)' financial statements nor was it intended to express an opinion on the financial statements.

The scope of our work was limited due to the complexity of the issues identified, a lack of supporting documentation for fund distribution decisions, a number of significant errors and control weaknesses, and resource constraints. Consequently, we did not evaluate all 193 hospitals or all the cost data for the 26 hospitals included in this review. These limitations, in turn, prevented us from being able to quantify the full impact of errors identified on assessments and distributions. We performed our field work between October 1995 and April 1996.

HCAP is a federal program through which Ohio provides additional funds to help offset expenses of hospitals that serve a disproportionate share of the indigent population. The State's funding

[1]PY 1995 is the same as the Federal Fiscal Year (October 1994 through September 1995).

for HCAP is obtained through a tax assessed against each participating hospital[2] and intergovernmental transfers from governmental hospitals[3]. For PY 1995, the hospitals collectively provided $211 million (about 40 percent) of the program's total funding of $536 million. The Federal Government provided $325 million (60 percent).

The ODHS, pursuant to ORC Section 5112.03, is responsible for administration of HCAP. Among other things, the Department acts as a facilitator between the hospitals and the State and between the State and the Federal Government. ODHS writes the State Plan, obtains the U.S. Health Care Financing Administration's (HCFA) approval, receives hospital cost reports, and collects and distributes program funds.

As program administrator, ODHS has certain responsibilities, including ensuring a fair and equitable distribution of HCAP funds. To achieve this basic objective, we believe it is crucial for ODHS to have processes and procedures in place to ensure that funding decisions are made based on (1) reasonably complete and accurate data, (2) properly documented management decisions, and (3) mechanisms, processes, and procedures that result in accurate allocations.

During the course of this audit, we found several problem areas which if not rectified, will constrain program achievement. For example, the rationale used to develop the fund allocation factors and certain management decisions made relative to the distribution process were not documented. This is significant since these two items substantially influenced the funding distributed to the individual hospitals. Further, use of a questionable approach for determining group averages possibly resulted in six of the 193 hospitals being placed in the wrong funding group. In addition, we found that 16 of 26 hospitals included in this review, provided ODHS erroneous information on the cost of uncompensated care. Further, a $524,204 overstatement by one of the 16 caused 12 other hospitals in the same group to receive lower distributions ranging from $11,007 to $98,935.

In addition to the above, we observed that cost figures, as used in the fund distribution model for three hospitals, were not supported by available hospital cost reports. When asked to clarify these discrepancies, ODHS internal audit officials provided documents that only confirmed the existence of the discrepancies. Finally, ODHS officials could not provide documentation showing the disposition of questions, corrections, and revisions by individual hospitals concerning their reports during the course of this audit. Corrective action has been taken for this latter issue, according to ODHS officials.

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[2]Non-governmental participating hospitals included general medical, surgical, and pediatric hospitals. Psychiatric hospitals, health maintenance organizations, and hospitals that do not charge patients for medical services, if any, are excluded from participation.

[3]Governmental hospitals are those county or State-owned and operated hospitals with more than 500 registered beds.

The details of our review are discussed in ***Exhibit A***. While ODHS has recently taken action to improve the accuracy of data received and has a corrective action plan in place to deal with other issues, we recommend that ODHS continue making changes to correct issues we identified in its program administration procedures and processes. These corrections should initially focus on getting accurate data from the participating hospitals and on developing a process which ensures proper data control and input. We also recommend development of a fully documented and properly validated fund distribution model prior to the PY 1997 fund distribution. To the extent that ODHS relies on others to develop all or part of this model, we further recommend a written agreement be used to define the tasks to be performed. In addition, we recommend that the specific dollar adjustments relating to over and/or under payments as identified in this report be made during the PY 1997 distribution process.

A copy of this draft report was provided to your staff on October 8, 1996. Your written comments, dated November 22, 1996, were incorporated into the body of this report as appropriate, and included in full in Exhibit B. This report is a matter of public record and copies will also be made available to other parties upon request.

JIM PETRO
Auditor of State

Attachment

Background

HCAP was established as Ohio's Indigent Care Program in 1989. It provides for the redistribution of funds between hospitals to help offset expenses incurred by those that provide a disproportionate share of medical care to Ohio's indigent population.

HCAP is an extension of Ohio's Medicaid Program and is jointly funded by the Federal Government and the State. Ohio pays approximately 40 percent of the program's total expenditures as documented in the State Plan[4] and the Federal Government provides a 60 percent funding match. The State's financial contributions are derived from assessments paid and funds transferred from HCAP participating hospitals.

During PY 1995, 193 hospitals participated in HCAP including three State-owned and operated (governmental) hospitals. These hospitals paid assessments totaling $131.5 million (based upon 1.165 percent of total facility costs reported on their Fiscal Year 1994 cost reports, excluding skilled nursing services). The three governmental hospitals also provided additional funds (intergovernmental transfers) of $79.9 million.

ODHS is responsible for administering HCAP. In this regard, ORC Chapter 5112 requires the Director of ODHS to perform the following functions;

-- establish the methodology for distributing HCAP funds,

-- define disproportionate share hospitals,

-- prescribe the form for submitting cost reports,

-- set the HCAP assessment rates, and

-- establish schedules for hospitals to pay their assessments and procedures for adjusting scheduled payments if necessary.

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[4]The U.S. Health Care Financing Administration (HCFA) requires state plans of all states that receive Federal funds under Title XIX of the Social Security Act (49 Stat. 620 [1935], 42 U.S.C.A. 301, as amended). According to Section 433.53 of the Code of Federal Regulation, these plans must stipulate that state funds will be used to pay at least 40 percent of the non-Federal share of total expenditures and should (1) include information on the nature and scope of the Medicaid Program, and (2) provide assurance that the state will administer its Medicaid Program in conformance with Title XIX, 42 CFR (Chapter IV) and other applicable guidance issued by the U.S. Department of Health and Human Services.

Section 5112.17 of the ORC also states that ODHS will adopt rules specifying medical services to be provided. Additionally, Section 5101:3-2-24 of the Ohio Administrative Code (OAC) requires ODHS to audit hospitals to verify the costs and charges utilized in the determination of the hospitals' assessments and distributions under HCAP.

Besides ODHS, other organizations have responsibilities relating to HCAP. For example, the Ohio Hospital Association (OHA) has historically played a major role in developing the HCAP fund distribution methodology. According to its mission statement, OHA works on behalf of its member hospitals through leadership in the:

-- development of public policy,

-- representation and advocacy of hospital interests, and

-- provision of services which assists hospitals in meeting the health care needs of their communities.

The HCFA also has a significant role in the administration of HCAP. The 60 percent Federal funding is provided through HCFA. This organization also approves the State plan and the HCAP fund distribution methodology developed by OHA.

Applicable Legal Authority

Section 5112.17 of the ORC requires hospitals that receive HCAP funds to provide basic, medically necessary, hospital level services to Ohio residents at or below the Federal poverty guidelines. In this regard, OAC Section 5101:3-2-0717:

-- defines "basic, medically necessary hospital level services" as inpatient and outpatient services covered by the Medicaid Program excluding transplantation and related services;

-- defines a resident as one (1) voluntarily living in Ohio with the intent to remain, (2) who is not a recipient of the Medicaid Program but who may be a recipient of General or Disability Assistance under ORC Chapters 5113 and 5115, and, (3) who is not receiving public assistance from another state; and

-- clarifies income eligibility requirements by stating that the individual or family income must be at or below the current Federal poverty guidelines. The determination of the level of income should be made by either multiplying the income for the three months preceding the date of service by four; or, using the income for the preceding 12 months.

OAC Section 5101:3-2-0717 also requires each HCAP hospital to post in appropriate areas--such as emergency rooms, admission areas, and business offices--clearly worded notices in English and any other language common to the population of the area serviced that inform individuals with incomes at or below the Federal poverty levels of their rights to receive free HCAP services. If it is believed that a person is unable to read the notice, hospital personnel must make reasonable effort to inform the individuals of this right.

Furthermore, OAC Section 5101:3-2-0717 requires hospitals to collect and report to ODHS such information as the number of individuals served by indigent care category. This information, which is provided annually, should be documented on ODHS Form 2929, "Service Summary Sheet." Additionally, the participating hospitals must maintain and make available to ODHS the records necessary to document compliance with Section 5101:3-2-0717. These records include:

-- the documentation supporting information reported on the ODHS Form 2929, including the medical records of the population served;

-- accounts which clearly segregate the services rendered under HCAP from other accounts;

-- documentation supporting program eligibility determinations; and,

-- a copy of the general assistance and the disability assistance cards for recipients of those programs that received HCAP services.

In addition to program identification and reporting requirements, OAC Section 5101:3-2-0717 also sets billing requirements for third-party payers and others. First, the OAC states that hospitals may bill any third-party payer[5] that has a legal liability to pay for services. Second, hospitals may bill individuals for services provided that the hospitals have a system for (1) determining the individual's income, (2) providing the individual a written notification with the initial bill explaining the HCAP eligibility requirements, and (3) subsequently canceling the billed charges if the individual is found to qualify for HCAP services.

HCAP Funding

As previously noted, State funding for HCAP is provided through assessments and fund transfers from participating hospitals. **Table I** identifies this funding by hospital group.

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[5]OAC Section 5101:3-2-0717 defines a third-party payer as any private or public entity or program that may be liable by law or contract to make payment to or on behalf of an individual for health care services.

HCAP Distribution Model

ORC Section 5112.08 states that the ODHS Director, in establishing the methodology (model) for distributing HCAP funds, will:

-- classify similar hospitals into groups,

-- establish a method of allocating funds to each group taking into consideration the relative amount of indigent care provided by each group,

-- distribute funds to hospitals in each group in a manner that first provides for an additional payment to the individual hospitals that provide a high proportion of indigent care in relation to the total care provided by the hospital or in relation to other hospitals, and

-- establish a formula to distribute the remainder of the funds allocated to respective groups to all hospitals in the groups.

For PY 1995, the hospitals were classified into 10 groups based upon their size (total facility costs) and the ratio of Medicaid to total facility costs. According to ODHS officials, this grouping was established at the request of the hospitals and OHA to ensure fairness between the different types of institutions.

The methodology for allocating funds among and within the 10 hospital groups was more involved. In order to allocate program funds, a matrix relationship was used considering the 10 groups and five funding pools. Separate factors were assigned to each group and each pool, and these factors were used to allocate funds to and within the hospital groups. See **Table II** for the funds distributed by hospital group and **Table III** for the specific factors used as a basis for fund allocation.

Objectives, Scope and Methodology

The principal objectives of this program audit were to determine whether the desired program results established by the Ohio Legislature were being achieved and, in accordance with ORC 5112.20, to determine whether errors by ODHS resulted in hospitals paying or receiving inaccurate assessments and distributions. This required us to review the planning and implementation of decisions and procedures used by ODHS that caused, allowed, or contributed to erroneous payments. This audit focused on the PY 1995 HCAP program.

To accomplish the audit objectives, we (1) reviewed statutory provisions that delineated program requirements; (2) interviewed ODHS, OHA, HCFA, and hospital officials to identify relevant policies and procedures; (3) reviewed the Ohio State Plan to identify changes in HCAP since its inception; (4) visited 10 hospitals to determine compliance with HCAP eligibility, notification, and reporting requirements; (5) analyzed ODHS' assessment and fund distribution methodologies (see below for more details); (6) coordinated work performed with that performed for the "Single Audit" of ODHS; and (7) performed other procedures necessary to complete the review.

To test the accuracy of assessments and disbursements, we:

-- reviewed ODHS' methodology and controls for imposing assessments on and allocating funds to hospitals;

-- traced financial data reported by 26 randomly selected hospitals[6] (such as the number of patients served and the cost of providing the patient service) from the hospitals' supporting records to input into the HCAP distribution model;

-- analyzed the data file ODHS provided as support for the PY 1995 assessments and distributions for compliance with state and federal guidance and for errors in formulas, logic, and data;

-- assessed the existence and adequacy of ODHS controls to ensure use of accurate data in funding decisions; and

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[6]The 26 hospitals were randomly selected based on their total reported facility costs. The selection included 12 (out of 117) with total facility costs below $50 million; 5 (out of 43) with total facility costs between $50 and $100 million; 2 (of 13) with total facility costs between $100 and $150 million; 2 (of 11) with total facility costs between $150 and $200 million; and 5 (of 9) with total facility costs in excess of $200 million.

-- assessed the impact, in part, of errors identified in hospital supporting cost data on the distributions to HCAP participating hospitals.

The scope of this program audit was limited due to the complexity of review issues, a lack of documentation supporting decisions that affected fund distribution, a number of significant errors and control weaknesses, and resource constraints. Therefore, this audit did not evaluate all cost information for any of the 193 participating hospitals. Our review was performed between October 1995 and April 1996 in accordance with generally accepted government auditing standards.

Accountability Concerns

During the course of this audit, we identified a number of issues that potentially affected the distribution of PY 1995 HCAP funds. ODHS officials maintain, however, that the funds were equitably distributed to all participating hospitals. According to them, equity was ensured because:

-- ODHS reviewed the recommended distributions by OHA and ensured compliance with existing State and Federal regulations;

-- the specific fund distribution methodology was deemed reasonable by a consensus of the hospital industry;

-- the individual hospitals and the legislature via the Joint Committee on Agency Rule Review, saw, reviewed, and had opportunity to comment on the assessment and distribution methodologies through public forums;

-- no comments were received from interested parties in any public hearing on the proposed assessment and distribution methodologies; and,

-- HCFA had reviewed and approved the State Plan which included the specific allocation factors to be used.

However, we found reasons to question the accuracy of program distributions because (1) a lack of documentation existed for key factors and decisions that drove distributions to individual hospitals, (2) up to six hospitals may have been placed in the incorrect funding group, (3) significant errors existed in data reported by some hospitals, (4) the erroneous data, in some cases, impacted distributions to other hospitals, and (5) other problems were observed. Details on the issues are discussed below.

Lack of Documentation

ODHS' fund distribution methodology involved the placement of the 193 hospitals into 10 similar groups and the allocation of funds available to and within these groups. While ODHS identified these funding groups in the OAC (Section 5101:3-2-09) and allocated funds to and within the groups based on the allocation factors it had established in that OAC Section (see Table III), ODHS officials could not explain and did not have documentation showing how the allocation factors were derived (computed). Although ODHS officials stated that the factors were derived from the hospitals' Medicaid and uncompensated care costs, the lack of documentation showing specifically how the factors were computed is a significant issue since the factors were one of the major components used to determine distributions to individual hospitals.

We talked to OHA officials about the rationale and documentation for the HCAP fund allocation factors[7]. OHA, like ODHS, did not have specific documentation showing how the allocation factors were derived. According to OHA officials, when they developed the original fund distribution methodology in 1989, the rationale, assumptions, and decisions made to formulate the methodology were not documented. Nor were any changes documented that have been made to update the formula.

Although not documented, one OHA official said that after input and processing of the hospital reported data into the fund distribution model, OHA management normally reviews the result to ensure amounts to be distributed to each hospital appear to be appropriate. If anomalies are observed, OHA management may then revise amounts to ensure a more equitable distribution. In these cases, amounts determined by management would be manually input into the fund distribution model (hard coded) to override formulas previously used. As indicated, however, documentation to reflect specific rationale for a decision like this does not exist.

Questionable Methodology

An analysis of the PY 1995 HCAP assessments and distributions data disk provided by ODHS showed a questionable methodology was used as a basis for placing the hospitals into funding groups. This resulted in six of the 193 hospitals possibly being placed in the incorrect funding group (two from Group 4, one from Group 8, and three from Group 10). The specific methodology required by OAC Section 5101:3-2-9 and that used by ODHS is discussed below using Group 3 and Group 4 hospitals as an example.

According to OAC Section 5101:3-2-9, Hospital Group 3 and Group 4 both should have included hospitals with adjusted total facility costs in excess of $100 million. To be a Group 3 hospital, the hospitals also should have had a total Medicaid to adjusted facility cost ratio that was greater than or equal to the average such ratio for all the hospitals with adjusted total facility costs in excess of $100 million. Hospitals in Group 4 were defined similarly except that the ratio was to be less than (instead of greater than or equal to) the group average.

The adjusted total facility costs for the 27 hospitals with reported facility costs in excess of $100 million amounted to $4,876,232,719 whereas the total Medicaid costs reported for this group amounted to $486,923,865. These amounts yield an average Medicaid to adjusted total facility cost ratio of 9.9857 percent (Medicaid cost divided by adjusted total facility costs) for the group of 27 hospitals. However, ODHS computed a Medicaid to adjusted facility cost ratio of 10.5548

[7]As stated previously, OHA has historically played a major role in developing the HCAP fund distribution model. However, ODHS does not have a formal (written) agreement with OHA detailing the tasks to be performed and the documentation required to ensure accomplishment of HCAP goals.

percent by summing the total ratios determined for the individual hospitals and dividing that aggregate number by the 27 hospitals with facility costs in excess of $100 million. ODHS then placed the hospitals with individual ratios in excess of 10.558 into Hospital Group 3 and those with ratios below 10.5548 into Hospital Group 4.

ODHS' methodology for determining the average ratio for the group of 27 hospitals is questionable, in our opinion, since any average derived from a set of averages, ratios, or percentages will produce mathematically invalid results unless all members of the set are exactly the same size[8]. This is significant since use of the more commonly used weighted average methodology would likely have placed six hospitals in different funding groups which in turn would have impacted fund distributions.

ODHS disagreed with our conclusions and requested an evaluation of the proposed and utilized methodologies from a consultant, The Lewin Group. The Consultant said it really wasn't clear, based on the information provided, as to whether ODHS should use an unweighted or a weighted average approach. It said that if ODHS was more concerned with the average Medicaid burden faced by individual hospitals as opposed to the overall average burden faced by all hospitals of a certain size, the unweighted mean ratio should be used. As a whole, however, the consultant concluded that whether the unweighted or weighted approach should be used is as much dependent on the policy as it is on a statistical decision.

After giving consideration to the consultant's views, we concluded that the methodology ODHS used to place hospitals into groups was still questionable in view of the ORC 5112.08 criteria which stated that ODHS was to first allocate funds within each group to the hospitals that provided the greatest proportion of indigent care in relation to the total care provided by those hospitals or in relation to other hospitals (underlining added). First, the OAC did not specify which approach to use (weighted, unweighted or other approaches) Second, OHA officials said the use of the unweighted approach was an oversight in that they did not intentionally use that method to determine the average group ratio. Finally, the unweighted approach does not ensure total compliance with OAC in that at least one Group 4 hospital clearly provided a greater proportion of indigent care in relation to indigent care provided by other hospitals.

Hospital Data Accuracy

Of the 26 randomly selected hospitals included in the scope of this audit, we found that 16 (61.5 percent) submitted inaccurate data. These discrepancies were of two types, program eligibility and financial reporting, as shown by the following examples.

[8]Facility costs for the 27 hospitals ranged from $101.8 million to $438.1 million.

- A review of selected patient records maintained by one hospital to support data reported on its ODHS Form 2929 (Service Summary Sheet) showed seven *(7)* instances where the patients' income exceeded the Federal poverty guidelines. Although these patients' income generally met the more lenient income guidelines established by that hospital for its other charity programs, ORC Section 5112.17 specifically states that HCAP is designed for participants at or below the Federal poverty level. (Eligibility error)

- At one hospital, a review of medical and billing records for 60 randomly selected patients whose medical services were designated as provided by HCAP showed that 18 either were on Medicaid (12) or belonged to a health maintenance organization (6). Since the involved costs had been rejected by the health maintenance organization and/or Medicaid, the services provided may not have been medically necessary or, the costs may have been excessive. (Eligibility error)

- Sixteen of the 26 hospitals (61.5 percent) included in our review reported incorrect amounts for uncompensated care on their annual ODHS Form 2929, "Service Summary Sheet." Of these, 11 hospitals understated program costs by approximately $1.6 million and four overstated program costs by $526,628. We could not determine the amount understated or overstated by one other hospital because it could not provide us sufficient supporting records necessary to make this determination. (Financial reporting error)

While we did not attempt to quantify the impact of some errors and could not quantify the impact of others, we tested one such error to determine the potential impact on other hospitals. In this case, one hospital included $524,204 for outpatient pharmacy charges relating to care for patients below the federal poverty level in its HCAP costs. This error violated provisions of OAC Section 5101:3-2-02 and also resulted in that hospital receiving $467,371 more as a distribution than it should have. It also resulted in 12 other hospitals in the same hospital group receiving a lower distribution. Lower distributions to these hospitals ranged from $11,007 to $98,935.

Concerning the hospital data reporting errors, ODHS officials acknowledged that the inclusion of Medicaid and HMO patients by some hospitals has been a problem. In this regard, they said that ODHS is trying to prevent future problems by better educating hospitals on reporting requirements. ODHS, in conjunction with OHA, held its first set of conferences to clarify PY 1996 HCAP reporting requirements during the spring of 1996.

ODHS also confirmed that under reporting of uncompensated care costs on the ODHS Form 2929 has been a problem area. This, in their opinion, may have resulted from hospitals' difficulty in determining patients' eligibility for HCAP instead of the hospitals' inability to reconcile reported amounts to supporting records.

ODHS Data Issues

During this review, we found that ODHS did not have a process to document the resolution of hospitals' requests for reconsideration of their annual assessments. That is, ODHS did not maintain documentation showing how petitions for adjustments by 19 hospitals were resolved. Nor did ODHS maintain documentation showing that the hospitals were informed of decisions made on their reconsideration requests. The lack of a formal process could result in hospitals paying incorrect assessments if they are notified to pay assessments based on the incomplete resolution of a petition.

We also found that ODHS did not have a process to ensure that the correct cost reports were used for HCAP funding decisions. For example, ODHS recorded data in the fund distribution model for three hospitals which did not match the data on the cost report (ODHS Form 2930). Although ODHS internal review officials provided information which they believed would resolve this discrepancy, the documentation provided merely confirmed the discrepancy.

Conclusions and Recommendations

HCAP, is a jointly funded Federal and State program designed to help offset the cost by hospitals that provide a disproportionate share of medical care to Ohio's indigent population. The State contributes approximately 40 percent of the Program's funding and the Federal Government provides approximately 60 percent.

The ORC, (Section 5112) requires ODHS to manage the HCAP program. Specific responsibilities mandated by these criteria are identified on pages 6 through 7 of this report. OAC Section 5101:3-2-24 also requires ODHS to audit hospitals participating in the program to verify costs and charges reported by the hospitals and in turn used by ODHS to determine assessments and fund distributions under the HCAP program. ORC Section 5112.20 also requires the Auditor of State to determine whether errors by ODHS resulted in participating hospitals being levied inaccurate assessments and receiving inaccurate distributions from the program.

Our audit of the PY 1995 HCAP program disclosed a number of obstacles ODHS faced in administering the program. These, in some cases, impacted the accuracy of distributions to the participating hospitals as shown by the examples below.

- ODHS officials could not explain and did not have documentation showing how the specific factors used to allocate funds to and within hospital groups were computed.

- Use of a questionable methodology as a basis for placing the hospitals into funding groups resulted in six of the 193 hospitals possibly being placed in the incorrect funding group.

- Sixteen of the 26 hospitals (61 percent) included in this audit provided ODHS erroneous totals as the value of medical services provided on an uncompensated basis.

- One of the 16 hospitals included $524,204 for unallowable outpatient pharmacy charges. This, in turn, caused 12 other hospitals to receive lower distributions.

- Cost figures, as used in the fund distribution model for three hospitals, were not supported by available hospital cost reports.

- Officials could not provide documentation showing the disposition of questions, corrections, and revisions by individual hospitals concerning their reports.

ODHS has developed a corrective action plan to deal with many of the issues identified in this report. We commend ODHS for quickly taking action to correct and minimize future problems. We are making the following recommendations to help ensure accomplishment of HCAP program directives and objectives.

Recommendations

We recommend that ODHS develop a fully documented fund distribution model with explainable assumptions and rationale. To the extent that ODHS relies on OHA or another entity to develop this revised model, we also recommend that ODHS specify in a formal, written agreement:

-- the specific tasks to be performed, and

-- the specific documentation to be maintained to support the reasonableness and propriety of assumptions, rational, and decisions that affect fund distributions.

Moreover, we recommend that ODHS revise its methodology for computing the ratio used to place hospitals into their respective funding groups. Specifically, we recommend that ODHS compute ratios by using a weighted average approach instead of computing the ratio from the averages determined for the individual hospitals. If ODHS still prefers to use the unweighted approach for placing hospitals into funding groups, we recommend, at a minimum, that ODHS revise criteria in the OAC to reflect the method to be used and to instruct all external organizations that may play a future role in model development to use the same method.

To ensure the data reported by hospitals is reasonably accurate, we recommend that in addition to ODHS' plan to continue holding conferences to clarify reporting requirements, that ODHS also perform analytical procedures on hospital furnished data to help identify significant fluctuations and other anomalies that may indicate inherit control risks. Examples of the analytical procedures we are recommending include comparisons of (1) costs reported on the ODHS Forms 2929 and 2930 to costs reported in audited financial statements to the extent possible, (2) current-year amounts to prior-year amounts reported, (3) data reported for specific costs to costs reported by similar hospitals. In addition, we recommended that ODHS periodically conduct desk and field audits to identify systemic control weaknesses hospitals may be experiencing and to comply with requirements of OAC Section 5101:3-2-24. These audits should use random sampling techniques to ensure projectable results, minimize audit time required, and maximize use of limited audit resources. Such audits may be conducted on a cyclical basis.

Finally, we recommend that ODHS adjust the PY 1997 distributions by the amounts we computed for each of the 13 affected hospitals as shown in the scheduled submitted to ODHS under separate cover. These adjustments should also reflect interest as required by ORC Section 5112.20.

Table I: HCAP Assessments/Intergovernmental Transfers by Hospital Group				
Type of Hospital	**Group Number**	**Number of Hospitals In Group**	**Funding by Hospitals (in million)**	**Per-centage**
Children	1	9	$ 7.2	3.4
Government	2	3	89.4	42.0
Hospitals with facility costs and a Medicaid to facility cost ratio of $100 million or more	3	12	21.9	10.4
Hospitals with facility costs of $100 million or more but with a Medicaid to facility cost ratio less than the average for this group	4	15	34.8	16.5
Hospitals with facility costs and a Medicaid to facility cost ratio of $50 to $99.9 million or more	5	22	16.4	7.8
Hospitals with facility costs of $50 to $99.9 million or more but with a Medicaid to facility cost ratio less than the group average	6	19	15.0	7.2
Hospitals with facility costs and a Medicaid to facility cost ratio of $25 to $49.9 million or more	7	18	7.1	3.4
Hospitals with facility costs of $25 to $49.9 million or more but with a Medicaid to facility cost ratio less than the group average	8	23	9.0	4.3
Hospitals with facility costs and a Medicaid to facility cost ratio of $25 to $49.9 million or more	9	27	3.5	1.7
Hospitals with facility costs of $25 to $49.9 million or more but with Medicaid to facility cost ratio less than the group average	10	45	6.7	3.2
Total		193	211.0	99.9

Table II: Fiscal Year 1995 HCAP Fund Distribution By Hospital Groups

Group Number	Number in Group	Total Distributions	Percentage of Total	Average Distribution to each Hospital	Range of Distribution
1	9	$ 49,699,568	9.3	5,522,174	$ 634,003 to $11,553,039
2	3	151,585,346	28.3	50,528,449	$20,647,594 to $69,905,350
3	12	92,886,657	17.3	7,740,555	$ 4,061,009 to $15,728,824
4	15	77,317,653	14.4	5,154,510	$ 1,505,741 to $13,343,794
5	22	60,181,017	11.2	2,735,501	$1,718,420 to $6,643,660
6	19	24,127,666	4.5	1,269,877	$ 536,637 to $2,665,479
7	18	25,912,575	4.8	1,439,588	$ 701,611 to $2,307,190
8	23	22,855,643	4.3	993,724	$ 395,643 to $1,840,869
9	27	15,386,061	2.9	569,854	$ 103,125 to $1,502,383
10	45	16,540,056	3.1	367,557	$ 82,865 to $855,363
Total	193	536,492,240	100.0		

Table III: Matrix Showing Factors Used by ODHS To Distribute PY 1995 HCAP Funds to Participating Hospitals					
Allocation Factor by Hospital Group	Federal High Disprop. Share	Medicaid Indigent Care	GA/DA and Uncomp. Care Below Poverty	Children Indigent Care	Low Indigent Care
Group 1: .092638	0.113316	0.535533	0.115407	0.235744	See note below
Group 2: .282549	0.069376	0.306341	0.624283		
Group 3: .173137	0.010105	0.346730	0.643165		
Group 4: .144117		0.387547	0.612453		
Group 5: .112175		0.360415	0.639585		
Group 6: .044973		0.323801	0.676199		
Group 7: .048300		0.391788	0.608212		
Group 8: .042602		0.268878	0.731122		
Group 9: .028679	0.10004	0.382974	0.607022		
Group 10: .030830		0.296300	0.703700		

Note: ODHS established specific allocation factors each of the low indigent care hospitals based on their overall indigent care rank. For example, the hospital with an overall rank of 593 was given a 0.01043 allocation factor whereas the hospital with a 624 rank was given an allocation factor of 0.1037.

George V. Voinovich
Governor

Arnold R. Tompkins
Director

Ohio Department of Human Services

30 East Broad Street, Columbus, Ohio 43266-0423

November 22, 1996

Jim Petro, Auditor of State
State of Ohio
Office of the Auditor
88 East Broad Street
P.O. Box 1140
Columbus, Ohio 43215

Dear Auditor Petro:

On October 8, 1996, the Ohio Department of Human Services received a draft copy of the Hospital Care Assurance Program (HCAP) audit from the State Auditor's Office, Fraud, Waste, and Abuse Prevention Division. The department accepts the report with the technical modifications described in the attached comments. In addition to the technical comments, the department has prepared a corrective action plan that incorporates suggestions for improving HCAP which is also described in detail in the attached comments. We request that the attached document be incorporated into the final report on the fiscal year 1995 HCAP.

We appreciate the opportunity to comment on the draft report and hope that our comments and clarifications will give you reason to revisit some of your original conclusions. The HCAP has afforded Ohio an opportunity to provide care to Ohio's uninsured in a uniquely funded manner, unlike other state funded programs. It is the product of delicate collaboration in a public forum among the federal government, state government, hospital providers and the community.

In closing, we reiterate our position that the department discharged its duty in both assessing and distributing HCAP funds based on Ohio Administrative Code in an accountable manner and would hope that the Auditor would revisit conclusions and recommendations in light of the clarifications presented.

Sincerely,

Arnold R. Tompkins
Director

cc: William T. Ryan, Deputy Director

DLC,G:\CLEMENT\AUDRESP.LTR, November 18, 1996

AUDIT OF PROGRAM YEAR 1995 HCAP: REVIEW AND COMMENTS ON DRAFT REPORT

On October 8, 1996, ODHS received a draft copy of the Hospital Care Assurance Program (HCAP) audit from the State Auditor's Office, Fraud, Waste, and Abuse Prevention Division. The Ohio Department of Human Services accepts the report with the following modifications.

Requested Modifications to October 8 Draft Report

- **References to the funding of HCAP**

Pages 4 and 6 of the October 8 draft states that "The State's funding for HCAP is obtained through a tax assessed against non-governmental participating hospitals and intergovernmental transfers from governmental hospitals." This is incorrect because the State's portion of funding for HCAP is obtained through a tax assessed against each participating hospital (this includes governmental hospitals) and intergovernmental transfers (IGT) made by governmental hospitals (please refer to paragraph (D) through (E) of rule 5101:3-2-08 and paragraph (E) of rule 5101:3-2-09 of the OAC). The total State portion for FY 1995 HCAP was made up of assessments totaling $131,528,005 (which includes assessments dollars from hospitals classified as governmental hospitals) and IGT totaling $79,917,268.

- **References to methodology used to group hospitals**

Pages 4 and 12 through 14 of the October 8 draft indicates that the department used inappropriate mathematical methodology to group hospitals. The audit report suggests that a weighted mean ratio of Medicaid costs to total facility costs less skilled nursing facility costs would be the most mathematically correct method to group hospitals into hospital care assurance groups three and four. This would be correct if the department were not interested in treating all hospitals within the group equally. Using the weighted mean gives more consideration to larger hospitals than smaller hospitals within the group. Using an unweighted mean allowed the department to treat all hospitals with total facility costs greater than $100 million dollars equally by recognizing the burden Medicaid places on each hospital.

Because of the questions raised in the October 8 draft, we asked a member of The Lewin Group, a nationally recognized consulting group, to review our grouping methodology. The reviewer determined that our methodology was correct in light of the fact that the department wanted to ensure equal treatment within each hospital care assurance group.

While on the surface the use of unweighted means may appear to be incorrect, it is a recognized method for determining qualification for disproportionate share payments. As described in the attached copy of Section 1923(b) of the Social Security Act, the mean medicaid inpatient utilization rate, i.e., an unweighted mean, is the methodology used to determine disproportionate share status.

- **References to development of the distribution formula.**

Pages 4, 7, 13 contain statements indicating that ODHS delegates the function of establishing a methodology for disbursing the HCAP funds to the Ohio Hospital Association and that the audit staff were instructed to contact OHA for an explanation of the distribution formula. Again, the department maintains that these statements are simply not true. What was communicated to the Auditor of State staff is that OHA has prepared potential distribution models for HCAP for FFY 1992 to present, which have had the consensus of the hospital industry as being a fair and equitable method to distribute HCAP funds. In addition to OHA, other hospital provider representative groups have at times prepared potential distribution formulas, or provided suggested changes to OHA's proposed distribution formulas. Each potential distribution model has always been reviewed by the department to determine the impact upon hospitals and to ensure compliance with existing state and federal regulations.

It is important to understand that the Hospital Association, individual hospitals, any interested party and the legislature via the Joint Committee on Agency Rule Review, all saw, reviewed and had the opportunity through public forums to comment on both the assessment and distribution methodologies that were described in exacting detail in rules that have the force and effect of law. The Auditor's staff were also informed that no comments were received from any interested parties in any public hearing on the proposed assessment and distribution formula. Additionally, they were informed that the Health Care Financing Administration had received the same materials as part of a State Plan requirement and had approved our program.

All information, including the administrative code and the rationale for distribution factors, was shared with the Auditor's staff. Regardless of our understanding of the scope of the audit, the department and department staff have fully cooperated with audit reviewers in a timely manner. Department staff have released information, documentation, rules, and electronic data, spoken with Audit reviewers explaining the complexities and specifics of the program, responded to all requests in a timely manner, and have asked to see a draft reports in order to help the audit reviewers prepare a report which fully accounts for the complexities of the HCAP program.

- **References to documentation problems.**

The data discrepancies regarding the three hospitals (Samaritan Hospital of Ashland, University of Cincinnati, and Memorial Hospital of Geneva) surfaced at a meeting between the Auditor's staff and Medicaid staff on April 18, 1996. Supporting documentation regarding these discrepancies was given to the Auditor's staff via the Internal Audits Section of the department, and was verified against the data used in the HCAP distribution formula. No further questions or clarification has been requested by the Auditor's staff. The department continues to maintain that this should no longer be an issue for the final report.

- **Identification and recommendation of how to resolve errors in data reported by hospitals.**

Pages 4, 14, 15, 17 through 19 of the audit identified problems related to hospital errors in financial reporting. Most of the Service Summary Sheet errors were for understatement of uncompensated care. Although this is a problem, this may be due to problems hospitals have in identifying the eligibility of patients within the reporting period.

The one measurable error of overstating uncompensated care charges related to a hospital's submission of $524,204 in pharmacy charges which should not be reported. However, the other overstated errors amounted to $330, $287, and $1,807 in charges for three hospitals. All other errors amounting to $1.6 million were for under reporting. Given that the hospital program is $1.2 billion a year, these do not appear to be significant errors. However, we do share the concern that the program be implemented on the best information available and we have tried to correct this type of problem through better education of hospitals by conducting HCAP data reporting seminars.

Although an error of $524,204 in charges appears to be a large error, it is important to note that this translates into approximately $ 422,299 in costs. The $422,299 in over reported costs is approximately 0.6% of statewide costs of uncompensated care provided during SFY 1995. If any of this amount was for people above the poverty level, then the portion of those costs to serve that population would only effect the calculation of one indigent care factor and would not effect the distribution formula since uncompensated care costs for persons above the poverty level are not used to distribute funds in any of the distribution pools.

The existence of potential data problems which cannot always be caught before their use is one reason that the model has more than one pool for distribution and bases indigent care rankings on more than one data source. While we share the Auditor's concerns that the program be implemented using the most correct data available, federal requirements to use the most current data available to make disproportionate share adjustments within each federal fiscal year, places real constraints upon the department from validating 100 % of all data elements used.

- **References to audit requirements.**

Pages 7 and 17 contain a reference to OAC Rule 5101:3-2-24. This rule presently applies only to audits of the non-disproportionate share payment portion of the Medicaid program. This means that the rule is applicable to audits of the Medicaid cost report not the ODHS 2929. The reference to audits used to verify hospitals costs and charges utilized in the determination of the hospital's contribution to and reimbursement from the hospital care assurance fund and disproportionate share fund as described in rule 5101:3-2-0715 of the OAC refers to an old DSH program in effect from FFY 1990 through FFY 1991. The HCAP described in OAC 5101:3-2-0715 was replaced by the HCAP for FFY 1992 through FFY 1993 as described in rule 5101:3-2-0716. Rule 5101:3-2-24 does not reference the current HCAP as described in rules 5101:3-2-08 and 5101:3-2-09, and therefore is not applicable.

Corrective Action Plan.

- **HCAP data seminars.**

In an effort to clarify federal requirements related to uncompensated care and reporting issues related to uncompensated care as reported on the ODHS 2929, ODHS and Ohio Hospital Association staff conducted seminars for the 1996 HCAP program. The department will continue to provide instruction to hospitals on how to comply with the complex federal regulations that govern disproportionate share payments.

- **Documentation of the disposition of hospital requested data changes.**

Comments related to the documentation of the resolution of hospitals' requests for reconsideration of their preliminary assessments and tentative data to be used in HCAP calculations have resulted in letters being written to each hospital that requested reconsideration explaining the action taken on their requests for PY 1996. This is in addition to the existing practice of resolving provider issues while the caller waits on the telephone, and letters being sent to all providers informing them of the data (sometimes revised as above) to be used in the final calculation and the "revised" amount of their assessment. Beginning with the 1997 HCAP program, we will print and save the cost report for each hospital that has not been interim settled at the time of extracting data for HCAP.

- **Cost reports.**

Based on federal requirements to use the most current data available, data is checked for reasonableness, each hospital's Medicaid cost report information is reconciled with Medicare cost reports, and hospitals are requested to verify the data we are using is accurate. Any requests made on behalf of the hospital is assessed for accuracy and allowableness by departmental staff. The existence of potential data problems which cannot always be caught before their use is one reason that the model has more than one pool for distribution and bases indigent care rankings on more than one data source.

While we share the Auditor's concerns that the program be implemented using the most correct data available, federal requirements to use the most current data available to make disproportionate share adjustments within each federal fiscal year, places real constraints on the department from validating 100 % of all data elements used. Based upon the Auditor's findings, we will modify the Medicaid cost report to incorporate uncompensated care data so that it can become part of the normal Medicaid cost report review process.

The cost report modification would be proposed for the ODHS 2930 used for hospital fiscal year end occurring in state fiscal year 1997, which would be used for FFY 1998 HCAP. To improve the accuracy of data incorporated into the FFY 1997 HCAP, the department will conduct an audit of uncompensated care data used in the distribution of program funds prior to implementation of .

the FFY 1997 HCAP. We believe that this is a proactive approach to the issues raised in the audit report that does not involve the complexities, as well as legal issues with using old data to adjust a prospective program.

Conclusion

The HCAP program is very complex and requires understanding both the political context of the hospital industry and the minutia of federal regulation as it relates to the structure of assessments and payments to hospitals for the care of indigent patients. We believe that the department has always maintained a proactive posture in the oversight and management of the HCAP program, most importantly as it relates to the political nature of the hospital industry and federal regulations governing disproportionate share payments.

We appreciate the opportunity to comment on the draft report and hope that our comments and clarifications will give you reason to revisit some of your original conclusions. The Hospital Care Assurance Program (HCAP) has afforded Ohio an opportunity to provide care to Ohio's uninsured in a uniquely funded manner, unlike other state funded programs. It is the product of delicate collaboration in a public forum among the federal government, state government, hospital providers and the community. We would hope that you agree that this process, regardless of personal thoughts, represents a consensus position that should not be the subject of this audit. In closing, we reiterate our position that the department discharged its duty in both assessing and distributing HCAP funds based on Ohio Administrative Code in an accountable manner and would hope that the Auditor would revisit conclusions and recommendations in light of the clarifications presented.

THE LEWIN GROUP

October 29, 1996

Ms. Debbie Clement
Ohio Department of Human Services
Bureau of Medicaid Policy
30 East Broad Street, 31st Floor
Columbus, OH 43266-0423

Dear Debbie:

I have reviewed the regulations and cost data in the fax you sent me on October 26, 1996. The regulations indicate how the cost data can be used to define hospital care assurance groups. In turn, the regulations then specify the payment factors for each of the 10 hospital care assurance groups, where the payment factors indicate how the disproportionate share pool is split among hospitals in the state.

The private hospital care assurance groups consist of pairs of groups defined by size and then by the hospitals' Medicaid shares. For example, Groups 3 and 4 include all private hospitals in the state with adjusted total costs of $100 million or more. The cost data included in the fax revealed that there are 27 hospitals in Groups 3 and 4.

Medicaid shares are then calculated, where the Medicaid share is equal to the ratio of adjusted Medicaid costs to adjusted total costs. The unweighted average of these ratios is then calculated for hospitals of a given size range. Hospitals with Medicaid cost ratios greater than the unweighted mean of all the ratios are assigned to one group (Group 3), while hospitals with ratios below the unweighted mean are assigned to the other group (Group 4).

For the purposes of payment policy, the important difference between each pair of hospital groups is that the payment factors differ. For instance, hospitals in Group 3 receive a payment factor of 0.173137, while those in Group 4 have a lower payment factor of 0.144117. Thus, hospitals in Group 3 would receive relatively larger disproportionate share payments than would their counterpart hospitals in Group 4.

For hospitals of a given size range, there is another way to calculate the mean ratio of adjusted Medicaid costs to total adjusted costs. This second method would first sum up the adjusted Medicaid costs and the total adjusted costs for all hospitals of a certain size. Next, the ratio of the sum of adjusted Medicaid costs to the sum of total adjusted costs would be calculated for hospitals of a given size. This second approach yields a mean ratio *weighted* to adjust for differences in the size (as measured by adjusted total costs) of each hospitals.

It is not clear whether policy-makers should use an unweighted or weighted mean ratio when dividing hospitals of a certain size into two groups. The unweighted approach treats all hospitals of a certain size equally in the calculations, while weighting gives more consideration to larger hospitals and less consideration to smaller hospitals. Thus, if Medicaid policy-makers are more concerned with the average Medicaid burden

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faced by individual hospitals as opposed to the overall average burden faced by all hospitals of a certain size, the unweighted mean ratio should be used.

In the case of Groups 3 and 4, there is a difference between the unweighted and weighted means. According to our calculations, the weighted mean is slightly lower than the unweighted mean for these two groups. This difference is largely due to the relatively low Medicaid ratios of two large very large hospitals. If the weighted mean ratio were used, two hospitals would be reclassified from Group 4 to Group 3.

The choice between using an unweighted and weighted ratio is as much a policy as it is a statistical decision. Basing the groupings and hospital care assurance payment factors on an unweighted average recognizes the burden Medicaid places on each hospital.

Sincerely,

Allen Dobson
Vice President

STATE OF OHIO
OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

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Columbus, Ohio 43216-1140
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HOSPITAL CARE ASSURANCE PROGRAM

CLERK'S CERTIFICATION

This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

By: Jill M. Burch
Clerk of the Bureau

Date: DEC 24 1996