



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

NOV - 3 2003

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

Report Number: A-04-03-02023

Mr. Michael Nesbit
Vice President – Corporate Finance
Methodist Healthcare - Memphis
1211 Union Avenue, Suite 600
Memphis, Tennessee 38104

Dear Mr. Nesbit:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled, ***Review of Medicare Disproportionate Share Hospital Payments for Methodist Hospital – Memphis for Fiscal Year 1999***. A copy of this report will be forwarded to the HHS 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 United States Code 552, as amended by the Public Law 104-231, OIG reports are made available to members of the press and the general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise (see 45 Code of Federal Regulations, part 5). As such, within 10 business days after the final report is issued, it will be posted on the World Wide Web at <http://oig.hhs.gov>.

To facilitate identification, please refer to the report number A-04-03-02023 in all correspondence relating to this report. If you have any questions, please contact me or have your staff contact Peter Barbera at (404) 562-7758.

Sincerely,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures – as stated

Direct Reply To HHS Action Official:

Mr. Dale Kendrick
Associate Regional Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Sam Nunn Federal Building
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303-8909

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE DISPROPORTIONATE
SHARE HOSPITAL PAYMENTS FOR METHODIST
HOSPITAL – MEMPHIS FOR FISCAL YEAR 1999**



**NOVEMBER 2003
A-04-03-02023**

Notices

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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 information contained therein 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 awarding agency will make final determination on these matters.





November 3, 2003

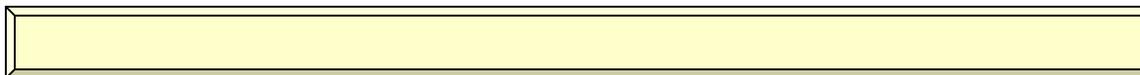
Report Number: A-04-03-02023

Mr. Michael Nesbit
Vice President – Corporate Finance
Methodist Healthcare - Memphis
1211 Union Avenue, Suite 600
Memphis, Tennessee 38104

Dear Mr. Nesbit:

This report provides you with the results of our review of the Medicare disproportionate share hospital (DSH) reimbursement claimed by Methodist Healthcare - Memphis (hospital) for fiscal year (FY) ending December 31, 1999. The objective of our review was to determine if the hospital's claim for Medicare DSH reimbursement was in compliance with Medicare reimbursement criteria.

The hospital claimed \$22,059,968 in Medicare DSH reimbursement, which was comprised of a Medicare DSH adjustment of \$21,217,380 and Medicare capital DSH of \$842,588. Our review focused on the 67,068 Medicaid eligible days and the Supplemental Security Income (SSI) ratio of 15.62 percent used by the hospital to support its claim on the FY 1999 amended cost report.



The hospital's Medicare DSH claim included \$3,057,727 that was unsupported and/or otherwise unallowable. The unallowable claim occurred because the hospital overstated the Medicaid eligible days and the SSI ratio used in its revised DSH calculation. We found 9,522 of the 67,068 Medicaid eligible days included in the hospital's claim to be either unsupported or non-allowable. The hospital's SSI ratio was incorrect because the hospital improperly combined two SSI ratios in its DSH calculation. The hospital used a blended SSI ratio of 15.62 percent, while the correct ratio for FY 1999 was 15.335 percent.

We are recommending that the hospital coordinate with its Medicare fiscal intermediary (FI) to revise its FY 1999 Medicare DSH claim by revising the Medicaid eligible days total and the SSI ratio, thus reducing the amount claimed for Medicare DSH by \$3,057,727. This reduction includes \$2,988,177 to the \$21,217,380 Medicare DSH adjustment and \$69,550 to the \$842,588 of Medicare capital DSH included in total Medicare capital.

We also recommend that the hospital improve its procedures for verifying Medicaid eligibility to assure that only allowable Medicaid eligible days are included in its future DSH adjustment calculations.

In written comments to our draft report the hospital disagreed with our conclusion regarding the number of days considered unsupported or unallowable. The hospital believes that, on whole, its procedures were sufficient and reasonable, but plans to further refine its procedures to avoid the types of errors noted in the report. The hospital's specific comments are incorporated into the body of this report and included as an Appendix.

BACKGROUND

The origin of the DSH adjustment is rooted in legislation passed in 1982. However, an explicit adjustment to the Medicare Prospective Payment System (PPS) was not adopted until May 1986, two years after prospective payment began. In the Tax Equity and Fiscal Responsibility Act of 1982, Congress directed the Secretary of Health and Human Services to study the extent which the Tax Equity and Fiscal Responsibility Act of 1982 hospital rates should be adjusted for the extra costs incurred by hospitals in treating low-income patients. With the Deficit Reduction Act of 1984, Congress directed the Secretary to define and identify DSH hospitals.

A study by the Congressional Budget Office in late 1984 showed that certain groups of hospitals with relatively large shares of Medicaid patients would be affected more adversely, on average, under the Medicare PPS than would other hospitals. The effect would be concentrated in big city areas and especially in hospitals with more than 100 beds. In April 1986, with the passage of the Consolidated Omnibus Reconciliation Act of 1985 (Public Law (P.L.) 99-272), Congress mandated an explicit adjustment for hospitals that serve a large share of low-income patients.

The DSH adjustment has been modified repeatedly. Each time, Congress has added money to the adjustment for specific categories of hospitals. Legislation passed in 1990 (P.L. 101-8) added the most money to the adjustment, about \$1 billion over a 5-year period, through changes in the DSH calculations. Congress also repealed the sunset provision for the adjustment, making it a permanent part of the PPS. In recent years, DSH payments have grown rapidly, from \$1.1 billion in 1989 to \$4.5 billion in 1997. DSH payments accounted for about 6 percent of total PPS operating payments to all hospitals in 1997. The Balanced Budget Act of 1997 (P.L. 105-33) reduced DSH payments by 5 percent, with the reduction to be implemented in 1-percentage point increments between FYs 1998 and 2002.

DSH Payment Methodology

The DSH payment is calculated as a percentage add-on to the basic Diagnosis Related Group (DRG) payment. The amount of DSH payment a hospital receives is determined by a complex formula and each hospital's DSH percentage. The hospital's DSH percentage is derived as the sum of two ratios: the proportion of all Medicare days that are attributable to beneficiaries of SSI, a cash benefit program for aged and disabled people, and the proportion of all patient days for which Medicaid is the primary payer. Other considerations in the calculation include a hospital's location, urban or rural, and hospital size.

A hospital must have a minimum DSH percentage, which differs across hospital groups, to qualify for DSH payments. After a specified DSH percentage threshold is exceeded, a more generous formula is applied, targeting payments to hospitals that are at the high end of service to low-income poor.

Initially the DSH calculation was based on Medicaid paid days. In February 1997, the Centers for Medicare & Medicaid Services (CMS) issued a ruling clarifying the issue of what could be counted as a Medicaid day pursuant to the Medicare DSH calculation. This ruling, HCFAR 97-2, stated that “the Medicare disproportionate share adjustment under the hospital inpatient PPS will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a State Medicaid Plan, whether or not the hospital received payment for those inpatient services.” Thus, Medicaid eligible but unpaid days could be counted as a Medicaid day for the Medicare DSH calculation. HCFAR 97-2 also states that the hospital “must verify with the State that a patient was eligible for Medicaid.”

The FY 1999 Cost Report Settlement Process

The hospital filed its original 1999 FY Medicare cost report on June 1, 2000 and included 61,234 Medicaid eligible days and an SSI ratio of 15.62 percent in calculating its Medicare DSH adjustment. The Medicare FI performed a tentative settlement on the original Medicare cost report on July 26, 2000. The hospital then filed an amended Medicare cost report dated November 1, 2002. The DSH calculation supporting the amended Medicare cost report included 67,068 Medicaid eligible days and an SSI ratio amount of 15.62 percent. The FI performed an initial tentative settlement on the amended Medicare cost report. This settlement resulted in an additional payment to the hospital of \$1,243,062, the majority of which represented DSH reimbursement. The increased DSH payment was due to the increase of 5,834 (67,068 – 61,234) Medicaid days.

In a letter dated January 21, 2003, the hospital informed the FI that the \$1,243,062 tentative settlement it received was related in large part to the inclusion of Medicaid waiver days on its amended Medicare cost report. Thus, the 67,068 Medicaid days included waiver days¹ not disclosed to the FI until January 21, 2003. Based on this information, the FI completed another tentative settlement taking back an overpayment of \$1,243,204 (\$1,243,062 + \$142), thus removing the waiver days in the settlement calculations. Therefore, the FI did not allow for the reimbursement of waiver days.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of our review was to determine if the hospital’s FY 1999 claim for Medicare DSH reimbursement was in compliance with Medicare reimbursement criteria. We reviewed the hospital’s most recent DSH claim, which was requested in an amended Medicare cost report submitted on November 1, 2002. Our review focused on the 67,068 Medicaid eligible days and the SSI ratio of 15.62 percent used in calculating the Medicare DSH adjustment (\$21,217,380) and Medicare capital DSH (\$842,588) totaling \$22,059,968. The FY 1999 cost report covered the period from January 1, 1999 through December 31, 1999.

Our review was conducted in accordance with generally accepted government auditing standards. In planning and performing our audit, we considered those control procedures that we

¹ Waiver days in Tennessee (TennCare) are called Uninsured and Uninsurable days under a managed care program.

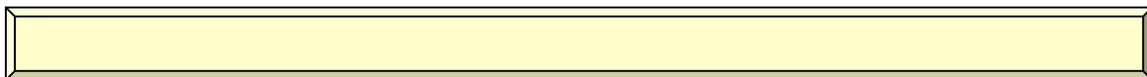
believe were an important part of the management controls for compiling Medicaid eligible day data and determining Medicare DSH reimbursement.

To accomplish our objective, we met with staff from the hospital's FI in Jackson, Mississippi. We discussed the FI's role in the Medicare cost report settlement process and reviewed Medicare cost reports, settlement information, audit work papers, and permanent files pertaining to the Medicare DSH reimbursement claimed for the period January 1, 1999 through December 31, 1999.

We also met with hospital staff to review the procedures used in preparing the list of Medicaid eligible days and calculating the SSI ratio used in calculating the \$21,217,380 Medicare DSH adjustment and the \$842,588 Medicare capital DSH component of Medicare capital. At the hospital we reconciled the FY 1999 SSI ratio to the FY 1999 CMS published amount. We also reconciled the Medicaid eligible day count used in the Medicare DSH calculation to a summary detail of State Medicaid eligible days provided by the hospital. Since the summary detail of Medicaid eligible days included FY 1999 Medicaid history and claim data from Tennessee, Arkansas, Missouri, and Mississippi, and a list of data from all other States titled "Other States," we reviewed and tested supporting documentation for the eligible days pertaining to each State.

We did not review the process by which the hospital's FY 1999 cost report was filed or settled as described in the background section of this report. Consequently, we do not express an opinion on such matters. Nor did we review other aspects of the Medicare DSH calculation except for the Medicaid eligible days count and SSI ratio. In particular, because DRG data affects DSH reimbursement and is subject to updating before final cost report settlement by the FI, our recommended reduction to Medicare DSH reimbursement of \$3,057,727 is based on the DRG data included in the amended cost report and excludes any impact of FI adjustments to reported DRG amounts.

We performed our fieldwork at FI offices in Jackson, Mississippi and at the hospital in Memphis, Tennessee between October 2002 and May 2003.



We found that \$3,057,727 of the \$22,059,968 Medicare DSH reimbursement claimed did not comply with Medicare guidelines and was therefore unallowable. The \$3,057,727 was attributable to an overstatement of Medicaid eligible days and an overstatement of the SSI ratio. The hospital's claim of 67,068 Medicaid eligible days was overstated by 9,522 days, and included, for example, unsupported days, duplicated days, and days not applicable to FY 1999. The SSI ratio was incorrect because the hospital blended two ratios together instead of using the proper ratio for FY 1999. The hospital used a calculated ratio of 15.62 percent, while the proper rate was 15.335 percent. The results of our review are more fully explained below.

MEDICAID ELIGIBLE DAYS WERE OVERSTATED

The hospital included 67,068 eligible days in its DSH calculation. However, the hospital's procedures for compiling this total were not adequate to assure that only allowable, eligible days

were included. We found that this total included 9,522 unsupported and otherwise unallowable days. The 9,522 days considered unallowable included days that were questioned for a number of reasons, as explained in the following sections.

State Medicaid Records Do Not Support Some Days

The hospital did not verify its Medicaid eligible days with State Medicaid agency records. As a result, our review found that some of the days claimed were unsupported and therefore unallowable for Medicare reimbursement.

Federal guidelines at HCFAR-97-2 state that a hospital “must verify with the State that a patient was eligible for Medicaid.”

The hospital used internal financial statistical data to obtain its Medicaid eligible day count of 67,068 days. The hospital did not perform a reconciliation of its data to the States’ data.

We obtained a summary report of State verified eligible days from the hospital and compared this report to the hospital’s Medicaid eligible day count used in its FY 1999 Medicare DSH calculation. We identified 5,691 days in the hospital’s DSH calculation day count that were not verified by State records and therefore were considered unsupported and unallowable for Medicare DSH reimbursement.

Auditee’s Comments

The hospital asserts that the 5,691 days represent Section 1115 waiver days that the hospital can justifiably include in the DSH calculation, and it intends to pursue this claim through the appeals process. The hospital states that the days are associated with patients who, according to the report received from the State, are eligible for Medicaid through a Section 1115 waiver. The hospital cites Medicare regulations and court cases supporting their conclusion that Medicaid waiver days should be included in their Medicare DSH calculation. And finally, the auditee takes exception to the OIG’s draft report that refers to the waiver days as being undisclosed.

OIG’s Response

We disallowed the 5,691 days on the basis that the days were unsupported. The hospital’s response indicates that according to a report from the State, these days are eligible for Medicaid. However, the hospital’s response does not provide any documentation or other records to support that the 5,691 days were verified by the State as eligible for Medicaid. Therefore, we still consider the days to be unallowable.

If the hospital can claim any waiver days on the cost report is another issue. Per Health Care Financing Administration’s Program Memorandum Rev. A-01-13, dated January 25, 2001, if a hospital did not receive any payment based on the erroneous inclusion of waiver days for cost reports that were settled before October 15, 1999, and the hospital never filed a jurisdictionally proper appeal to the Provider Reimbursement Review Board on this issue, the FI is not to pay the hospital based on the inclusion of these types of days for any open cost report periods beginning before January 1, 2000. The hospital did not provide us any evidence that it met either of these

conditions. In our opinion the hospital, as indicated in its response, needs to pursue these matters through the appeals process.

FY 2000 Discharge Days Incorrectly Included in the FY 1999 Report

The hospital incorrectly included patient days in FY 1999 that related to FY 2000 discharges. As a result, FY 1999 Medicaid eligible days were overstated by 3,952 days.

The hospital's procedures were not adequate to properly account for the days applicable to patients who were admitted in one cost report period and discharged in a subsequent cost report period. Basically, the patient-listing database provided to TennCare in support of the total days claimed, included patient admissions in FY 1998 with discharges in FY 1999 as well as patient admissions in FY 1999 with discharges in FY 2000. Patients days related to an admission in FY 1998 with a discharge in FY 1999 were allowable as eligible days in FY 1999. However, patient days related to admissions in FY 1999 with a discharge in FY 2000 were not allowable as eligible days in FY 1999.

DRG and Medicare day amounts on the FY 1999 Medicare cost report relate to days associated with discharges in FY 1999. To ensure a proper Medicaid eligible day count for FY 1999, allowed Medicaid eligible days should include only those days associated with a FY 1999 discharge in the Medicaid day count.

Auditee's Comments

The hospital concurred that it "... erroneously included days associated with discharges during its fiscal year 2000 in its number of Medicaid eligible days for fiscal year 1999." The hospital notes that this is a timing issue, since the days in question are Medicaid eligible days and can be included in the DSH calculation for fiscal year 2000. In the future the hospital will ensure that it includes on the database it sends to the State only days associated with discharges in that cost reporting year.

Dual Eligible Beneficiaries Incorrectly Included

The Medicaid eligible days used in the revised Medicare DSH calculation were overstated by 159 days applicable to dual eligible beneficiaries. The days applicable to dual eligible beneficiaries are already included in the Medicare component of the DSH calculations. Thus, also including them in the Medicaid eligible day count resulted in duplication.

The hospital's procedures for determining eligible days were not adequate to identify all dual eligible beneficiaries. The hospital relied mainly on removing hospital patients with a Medicare financial class code. This step identified some but not all of the dual eligible patients. We reviewed the files of all patients over 65 who were included in the hospital's claim, including their payment history and/or the Common Working File to verify Medicare eligibility. We found an additional 159 dual eligible days that were improperly included in the Medicaid eligible day total.

Auditee's Comments

The hospital agrees with this finding. The hospital believes it has reasonable procedures for identifying dual eligible beneficiaries, but will adopt procedures to further verify the Medicare eligibility of its patients who are over 65 years of age.

TennCare Baby Days Understated

The hospital initially claimed 4,000 Medicaid eligible baby days based on an estimate of what it thought eventually would be verified by the State agency as allowable TennCare baby days. We reviewed this estimate and found that 1,070 days were verified by the State agency and allowable. Subsequently, the hospital provided additional documentation to support an additional 3,473 TennCare baby days. This information was provided to the FI and we confirmed with the FI that 3,473 additional days were supported and allowable. Therefore, 4,543 (1,070 + 3,473) TennCare baby days should be included in the Medicaid eligible day count.

Other Ineligible Days Included

The hospital's claim included 263 days that were unallowable for other reasons.

- 38 days were included twice in the total.
- 130 days included on the "Other States" log of Medicaid eligible days were not supported by the Medicaid remittance advice. The remittance advices indicated the days were denied, not covered, or otherwise not supported.
- 88 days included on the Mississippi paid claims listing were applicable to Mississippi subprovider patients that were not in "PPS beds." These patients were in a non-PPS psychiatric unit. Title 42 Code of Federal Regulation Part 412 states that only patient days "that are subject to the prospective system ..." are to be included.
- 7 days were erroneously included on the Missouri paid claims listing as the result of a transposition error.

Auditee's Comments

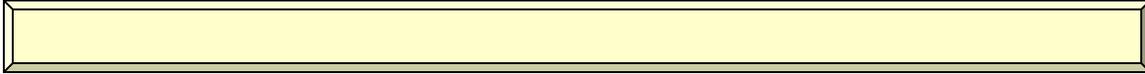
The hospital concurred with our finding and will use its best efforts to avoid these kinds of errors in future cost reports.

MEDICARE SSI RATIO WAS INCORRECT

The hospital used an incorrect SSI ratio in its DSH calculation. The hospital combined 9 months of the FY 1998 ratio and 3 months of the FY 1999 ratio to create a single rate for its FY 1999 Medicare DSH calculation. The rate used by the hospital was 15.62 percent. The ratio published by CMS that should have been used for FY 1999 was 15.335 percent.

Auditee's Comments

The hospital concurred with our finding. The hospital explained that they used a blended rate for two reasons: (1) its cost reporting year is not consistent with the Federal FY, and (2) the FI approved the use of a blended rate in prior FYs. However, the hospital is now using the published rates in filing the 2001 cost report and will continue to do so in the future.



We found that the \$22,059,968 Medicare DSH adjustment claimed for reimbursement was overstated by \$3,057,727. This overstatement was attributable to overstated Medicaid eligible days included in the hospital's revised DSH calculation and an overstated SSI ratio amount. The hospital's settlement request included 67,068 Medicaid eligible days. Our review considered only 57,546 of these to be allowable. The settlement request included an SSI ratio of 15.62 percent. Our review only considered 15.335 percent to be allowable.

We are recommending that the hospital coordinate with its FI to revise its FY 1999 Medicare DSH claim by revising the Medicaid eligible days total and the SSI ratio, thus reducing the amount claimed for Medicare DSH by \$3,057,727. This reduction includes \$2,988,177 to the \$21,217,380 Medicare DSH adjustment and \$69,550 to the \$842,588 of Medicare capital DSH included in total Medicare capital.

We also recommend that the hospital improve its procedures for verifying Medicaid eligibility to assure that only allowable Medicaid eligible days are included in its future DSH adjustment calculations.

APPENDIX



October 3, 2003

Mr. Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV
U.S. Department of Health and Human Services
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

Re: Methodist Healthcare-Memphis Hospitals
Disproportionate Share Hospital Payment Audit
Comments on Draft Report No. A-04-03-02023

Dear Mr. Curtis:

Methodist Healthcare-Memphis Hospitals ("MHMH" or "the hospital") hereby responds to the draft report of the U.S. Department of Health and Human Services, Office of the Inspector General ("OIG"), Office of Audit Services, entitled "Review of Medicare Disproportionate Share Hospital Payments for Methodist Hospital-Memphis for Fiscal Year 1999" ("Draft Report"). MHMH appreciates the opportunity to comment on the OIG's Draft Report on its audit of the number of Medicaid eligible days and the Supplemental Security Income ("SSI") ratio used for purposes of calculating the disproportionate share hospital ("DSH") adjustment. Below are MHMH's comments on the Draft Report, which are generally divided by section of the Draft Report to which the comments apply.

I. Executive Summary

The Draft Report concludes that 12,995 of the 67,068 Medicaid eligible days reported by MHMH were "either unsupported or non-allowable." Draft Report at 1. MHMH strongly disputes this conclusion. In fact, a close examination of the OIG's findings reveals that only 422 of the reported 67,068 days could be accurately characterized as "unsupported or non-allowable."

As discussed in further detail below, of the 12,995 days identified by the OIG, 5,691 are Section 1115 waiver days that the hospital can justifiably include in the DSH calculation under the governing statutes and regulations, and that MHMH intends to pursue through the administrative appeal process. The 3,952 days cited by the OIG as being associated with fiscal year 2000 (rather than fiscal year 1999) discharges are supported and allowable for MHMH's fiscal year 2000, and therefore, their inclusion in the DSH calculation is simply a matter of timing of payment. With respect to the estimated TennCare baby days included by the hospital, a subsequent audit by MHMH's fiscal intermediary ("FI") showed that the hospital had, in fact,

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underestimated the actual number of such days (by 543 days), and the OIG's exclusion of 2,930 of the estimated TennCare days is improper.

MHMH agrees that certain days identified by the OIG (relating to dual eligible beneficiaries, days counted twice, and days attributable to non-Tennessee Medicaid programs) should not have been included in the DSH calculation. The total number of these non-allowable days, however, is only 422 days, representing an error rate with respect to MHMH's Medicaid eligible days of only six-tenths of one percent. The amount of DSH payment resulting from the inclusion of 422 non-allowable days, along with the payment attributable to the error in the SSI ratio used by the hospital, is approximately \$384,000, an amount that is less than ten percent of the \$4,017,564 asserted by the OIG to be "unsupported and/or otherwise unallowable." Draft Report at 1.

A. Procedures for Verifying Medicaid Eligibility

MHMH disputes the OIG's finding that the hospital needs to "establish procedures" for assuring that only Medicaid eligible days are included in its DSH calculations. Draft Report at 1. MHMH has well-established procedures in place for verifying the Medicaid eligibility of the patients whose days are listed as Medicaid eligible days for purposes of DSH.

Upon admission, the hospital determines whether the patient is enrolled in any of the Tennessee Medicaid (TennCare) managed care organizations. As acknowledged on page 5 of the Draft Report ("patient-listing database provided to TennCare in support of total days claimed"), MHMH also submits to the State of Tennessee a report derived from its claims management system with information on its non-Medicare patients in order to verify their Medicaid eligibility, and then receives a report of Medicaid days back from the State.¹ The hospital also performs manual verifications of Medicaid eligibility for Tennessee patients without social security numbers (mainly newborns). For Arkansas, Mississippi, and Missouri, MHMH derives its data on eligible days from State reports on Medicaid paid days. For other States, the hospital relies on the remittance advice log of paid Medicaid claims.²

¹ While the hospital requests State reports prior to filing its cost report, it does not always receive them prior to cost report submission. In light of the OIG audit findings, MHMH will make additional efforts to obtain the reports more quickly.

² When reporting the number of Medicaid days for all States other than Tennessee, the hospital does not include days for which patients were Medicaid eligible but for which Medicaid did not make payment. Thus, the number of Medicaid days reported for these other States is understated.

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B. DSH Background

With respect to the background on DSH, we note that the Medicaid fraction used to compute DSH payments does not represent the "proportion of all patient days for which Medicaid is the primary payer." Draft Report at 2. Instead, it represents the proportion of all inpatient days for which the patient is eligible for Medicaid and not entitled to Medicare Part A. Section 1886(d)(5)(F)(vi)(II) of the Social Security Act. Thus, the Medicaid fraction is not limited to days for which Medicaid has made payment and includes, for example, days for which Medicaid is the secondary payer. See "Clarification of Allowable Medicaid Days in the Medicare Disproportionate Share Hospital (DSH) Adjustment Calculation," Health Care Financing Administration Program Memorandum A-99-62 (Dec. 1, 1999) (PM A-99-62).

C. Section 1115 Waiver Days and the Settlement Process

The largest number of days the OIG proposes to disallow is 5,691 days attributable to patients who qualify for Medicaid by virtue of a Section 1115 waiver. As discussed further below, MHMH included these 5,691 days consistent with its view that the federal statutes governing the DSH adjustment require the inclusion of all Section 1115 waiver days in the number of Medicaid eligible days, not just days for patients who would have been eligible for Medicaid absent the waiver. MHMH first notified its FI of its position with respect to Section 1115 waiver days during the FI's audit of MHMH's cost report for fiscal year 1998 (Attachment 1). MHMH reiterated its position as to its fiscal year 1999 by letter dated January 21, 2003 (Attachment 2), after which the FI revised the tentative settlement that had reflected the inclusion of the Section 1115 waiver days. Accordingly, MHMH's inclusion of these days can in no way be considered "undisclosed." Draft Report at 3.

II. Results of Review

A. Medicaid Eligible Days

As described above, the hospital believes it had adequate and reasonable procedures for verifying Medicaid eligibility to ensure the proper number of Medicaid eligible days on its cost report, including verification of Medicaid eligible days with State Medicaid agency records. As a result of the OIG's audit findings, however, the hospital will make certain adjustments to those procedures to further ensure that only Medicaid eligible days are reported.

For the reasons detailed below, of the 12,995 days identified by OIG as "unsupported or non-unallowable," MHMH believes that only 422 are days that should not be included in calculating the hospital's DSH adjustment. This number represents only six-tenths of one percent of the total number of Medicaid eligible days claimed on the amended cost report.

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1. Section 1115 Waiver Days

As explained above, the 5,691 days identified by the OIG as unsupported in Medicaid records are days associated with patients who, according to the report received from the State, are eligible for Medicaid through a Section 1115 waiver.

As previously expressed to the FI, MHMH disagrees with the policy of excluding from Medicaid eligible days the days attributable to patients who qualify for Medicaid through a Section 1115 waiver. MHMH's view is supported by the plain language of the governing statutes and the applicable regulations.³ See Sections 1115(a) and 1886(d)(5)(F)(vi)(II) of the Social Security Act; 42 C.F.R. § 412.106. Furthermore, a recent district court decision and a recent PRRB decision interpreting the regulations and statutes lend support to MHMH's position. See Portland Adventist Medical Center v. Thompson, No. 02-289-JE, Findings and Recommendations of Magistrate Judge (Feb. 11, 2003), adopted in their entirety by Order dated April 4, 2003, at 15-16 (concluding "that the Secretary's previous exclusion of those made eligible for medical assistance solely by a § 1115 waiver was contrary to the clear language and meaning of the relevant statutes, and that the Secretary did not have discretion to exclude 'expansion populations' from the DSH formula") (Attachment 3)⁴; Castle Medical Center v. Blue Cross and Blue Shield Association/United Government Services, LLC-CA, PRRB Decision No. 2003-D36, Case No. 98-1973 at 15 (July 16, 2003) ("the plain language of the governing Medicare statutory provisions requires all [Section] 1115 waiver days" to be included in the Medicaid proxy for purposes of calculating the Provider's DSH payment") (Attachment 4).⁵

³ The current Medicare regulations, amended in early 2000, require the inclusion of Section 1115 waiver days in the number of Medicaid eligible days. 42 C.F.R. § 412.106(b)(4)(ii) (2003). The Medicare regulations effective for cost reporting periods prior to 2000 did not address Section 1115 days, and certainly did not prohibit their inclusion. See 42 C.F.R. § 412.106 (1999). Accordingly, prior to that time, many hospitals were allowed to include in the DSH calculation days attributable to Section 1115 expansion populations. See 65 Fed. Reg. 3136 (prior to January 2000, "because [HCFA's] prior guidance on certain aspects of [the] Medicare DSH policy was insufficiently clear, many hospitals in States with approved Section 1115 expansion waivers [had] been receiving Medicare DSH payments reflecting the inclusion of expansion population days"); see also PM A-99-62 (instructing the intermediaries, within certain parameters, to continue to allow the inclusion of ineligible waiver or demonstration population days to the extent that they had previously allowed their inclusion).

⁴ This case is now on appeal to the U.S. Court of Appeals for the Ninth Circuit.

⁵ The CMS Administrator has rejected the Board's reasoning with respect to the waiver days. Castle Medical Center v. Blue Cross and Blue Shield Association/United Government Services, LLC-CA, Centers for Medicare and Medicaid Services, Decision of the Administrator

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MHMH plans to appeal the adjustment for these days, as it previously has done for a similar adjustment to the cost report for its fiscal year 1998, to the Provider Reimbursement Review Board ("PRRB") of the U.S. Department of Health and Human Services.

2. Discharges in Fiscal Year 2000

The OIG correctly found that MHMH erroneously included days associated with discharges during its fiscal year 2000 in its number of Medicaid eligible days for fiscal year 1999. This error occurred as MHMH was adjusting to new procedures for determining the total number of Medicaid eligible days. In preparing its list of Medicaid eligible days, MHMH was moving from relying on remittance advices to submitting data to the State for electronic verification of Medicaid days.

However, MHMH disagrees with the OIG's characterization of these fiscal year 2000 discharge days as "multiple year duplicates." Draft Report at 4, 5. The hospital claimed these days prematurely, but has not claimed them twice. The hospital has not claimed fiscal year 1999 days associated with fiscal year 2000 discharges in its total of Medicaid eligible days for fiscal year 2000. Furthermore, the 3,952 days in question are indisputably Medicaid eligible days and can be included in the calculation of MHMH's DSH payment for fiscal year 2000. As the OIG acknowledged during the audit, the hospital may be reimbursed for these days in the Fiscal year 2000 cost report. Thus, it is simply a question of when the hospital will be reimbursed for these days, and not whether these days are allowable.

In verifying Medicaid eligibility for future cost reporting years, MHMH will ensure that it includes on the database it sends to the State only days associated with discharges in that cost reporting year.

3. Dual Eligible Beneficiaries

MHMH agrees with the OIG's conclusion that 159 days attributable to dual eligible beneficiaries were included in its number of Medicaid eligible days. The hospital removed from the Medicaid eligible day's total the days for patients with a financial class code indicating the availability of Medicare coverage. It appears that the hospital's procedures did not identify the days of patients who, for example, gained Medicare coverage following admission. While MHMH believes its procedures for identifying dual eligible beneficiaries were reasonable, it will adopt procedures to further verify the Medicare eligibility of its patients who are over 65 years of age.

(Sept. 12, 2003). MHMH disagrees with the Administrator's decision and believes the Board's decision is correct and will ultimately be upheld by the courts.

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4. TennCare Baby Days

Based on information from its claims management system, MHMH developed an estimate of 4,000 baby days for which there would be Medicaid eligibility; this represented an estimate of days for Medicaid newborns that did not yet have social security numbers. In fact, that estimate of Medicaid baby days was understated. At the time the OIG concluded its audit, 1,070 of those days had been verified. Since that time, consistent with the OIG's determination that the FI should complete the audit of the baby days, the FI has verified another 3,473 days. Attachment 5. Accordingly, rather than exclude 2,930 days from the total number of Medicaid eligible days, 543 days should be added to that number to account for all eligible baby days. See Attachment 5.

5. Other Days

MHMH agrees with the OIG's finding that 45 (38 + 7) days were erroneously included in the Medicaid eligible days total as a result of clerical error. With respect to the 130 days on the "Other States" log, the hospital acknowledges that these days should be removed. As for the 88 days associated with Mississippi patients who received services in a psychiatric unit, MHMH agrees that they should not have been included in the total number of Medicaid eligible days. The hospital will use its best efforts to avoid these kinds of errors in future cost reports.

B. Medicare SSI Ratio

MHMH's cost reporting year, which ends December 31, does not correspond to the federal fiscal year, which ends September 30. The hospital used different SSI ratios for different parts of its fiscal year to account for this difference in fiscal year end date. For fiscal year 1999, MHMH used the federal fiscal year 1997 published ratio for the first ninth months and the federal fiscal year 1998 published ratio for the last three months when it filed its cost report. The hospital used these earlier year figures because the fiscal year 1999 published ratio was not available when it filed its cost report.

MHMH notes that the FI approved this "blended" approach to the SSI ratio for prior fiscal years. However, consistent with the OIG's finding, MHMH realizes that it should have used its published SSI ratio in its DSH calculations.

During 2001, the FI instructed MHMH that it should no longer use the "blended approach" it had used in the past. Per the FI's instructions, MHMH began using the latest published rate in filing the 2001 cost report and will continue to use this method in the future.

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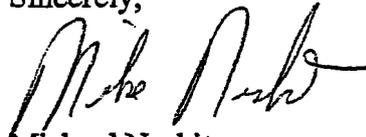
III. Conclusion and Recommendations

As noted at the outset of our comments, of the 12,995 days identified by the OIG, only 422 days (out of the 67,068 total Medicaid days reported by the hospital) should actually be considered "unsupported or non-allowable;" this represents a minimal error rate of only six-tenths of one percent. The inclusion of the 422 non-allowable Medicaid days and the hospital's use of an incorrect SSI ratio impact the amount of the hospital's DSH adjustment by approximately \$384,000, which is less than two percent of MHMH's total DSH payment claim.

While MHMH plans to further refine its procedures to avoid the types of errors identified by the OIG for fiscal year 1999, the hospital believes that, on the whole, its procedures were sufficient and reasonable.

If you have any questions or need additional information, please feel free to call me at (901) 516-0721.

Sincerely,



Michael Nesbit
Vice President-Corporate Finance

Attachments

Cc: Wanda Mathis, Trispan



This report was prepared under the direction of Charles J. Curtis, Regional Inspector General for Audit Services, Region IV. Other principal Office of Audit Services staff who contributed include:

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