December 20, 2010

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /Joe Green/ for
George M. Reeb
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of Medicaid High-Dollar Payments for Inpatient Services in Illinois From January 1, 2006, Through September 30, 2007—Hospitals With Five or More High-Dollar Payments (A-05-09-00049)

Attached, for your information, is an advance copy of our final report on Medicaid high-dollar payments for inpatient services in Illinois from January 1, 2006, through September 30, 2007, for hospitals with five or more high-dollar payments. We will issue this report to the Illinois Department of Healthcare and Family Services within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Robert A. Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Robert.Vito@oig.hhs.gov or James C. Cox, Regional Inspector General for Audit Services, Region V, at (312) 353-2621 or through email at James.Cox@oig.hhs.gov. Please refer to report number A-05-09-00049.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region V
233 North Michigan Avenue
Suite 1360
Chicago, IL 60601

December 22, 2010

Report Number: A-05-09-00049

Ms. Julie Hamos
Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Springfield, IL 62763-00002

Dear Ms. Hamos:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicaid High-Dollar Payments for Inpatient Services in Illinois From January 1, 2006, Through September 30, 2007—Hospitals With Five or More High-Dollar Payments.* We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Stephen Slamar, Audit Manager, at (312) 353-7905 or through email at Stephen.Slamar@oig.hhs.gov. Please refer to report number A-05-09-00049 in all correspondence.

Sincerely,

/James C. Cox/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID HIGH-DOLLAR PAYMENTS FOR INPATIENT SERVICES IN ILLINOIS FROM JANUARY 1, 2006, THROUGH SEPTEMBER 30, 2007—HOSPITALS WITH FIVE OR MORE HIGH-DOLLAR PAYMENTS

Daniel R. Levinson
Inspector General

December 2010
A-05-09-00049

Office of Inspector General

http://oig.hhs.gov

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

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

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

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Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

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

The Department of Healthcare and Family Services (the State agency) administers the Medicaid program in Illinois. The State agency uses its Medicaid Management Information System to process claims.

Pursuant to section 1903(a)(1) of the Act, Federal reimbursement is available only for expenditures that constitute payment for part or all of the cost of services furnished as medical assistance under the State plan. Pursuant to 42 CFR § 433.312(a), the State must refund the Federal share of unallowable overpayments made to Medicaid providers.

During the audit period of January 1, 2006, through September 30, 2007, the State agency processed and paid approximately 1.5 million inpatient claims, 286 of which resulted in payments of $200,000 or more (high-dollar payments) to hospitals for services. We reviewed 224 high-dollar payments totaling $69,748,844 that were made to hospitals that each received 5 or more such payments during our audit period.

OBJECTIVE

Our objective was to determine whether selected high-dollar Medicaid payments that the State agency made to hospitals for inpatient services were allowable.

SUMMARY OF FINDING

Not all the selected high-dollar Medicaid payments that the State agency made to hospitals for inpatient services were allowable. Of the 224 high-dollar Medicaid payments that the State agency made to hospitals for inpatient services, 75 were allowable. The remaining 149 payments included overpayments totaling $2,173,482 ($1,124,978 Federal share). For 110 of the 149 payments, hospitals reported incorrect charges that resulted in unallowable outlier payments; for 39 payments, hospitals reported incorrect charges that resulted in unallowable payments for transplant procedures. Hospital officials attributed the incorrect charges primarily to data entry errors.

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,124,978 to the Federal Government and

- consider using the results of this audit in its provider education activities related to data entry procedures and proper documentation.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings. However, it said that repayment of the Federal share would not be required because all claims had been resubmitted via the voiding process. The State agency drafted a provider notice reminding hospitals of their responsibility to ensure the accuracy of claims that they submit. The State agency's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Medicaid Program

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

Pursuant to section 1903(a)(1) of the Act, Federal reimbursement is available only for expenditures that constitute payment for part or all of the cost of services furnished as medical assistance under the State plan. Pursuant to 42 CFR § 433.312(a), the State must refund the Federal share of unallowable overpayments made to Medicaid providers.

Illinois' Medical Assistance Payments for Inpatient Hospital Services

The Department of Healthcare and Family Services (the State agency) administers the Medicaid program in Illinois. The State agency uses its Medicaid Management Information System to process hospital inpatient claims.[1]

Attachment 4.19-A of the State plan describes the methods and standards that the State agency must use to determine medical assistance amounts for inpatient hospital services. Attachment 4.19-A, chapter I, section (C)(1), of the State plan requires the State agency to use a prospective payment system (PPS) for inpatient hospital services. Under the PPS, the State agency pays hospital costs at predetermined rates for patient discharges unless Attachment 4.19-A of the State plan specifically excludes the cost from the PPS.[2] The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned. The DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. One of these exceptions is outlier payments.[3]

[1] The Medicaid Management Information System is a mechanized claims processing and information retrieval system that States are required to use to record Title XIX program and administrative costs, report services to recipients, and report selected data to CMS.

[2] Attachment 4.19-A, chapter I, section (C)(4), of the State plan excludes hospital costs for transplant procedures, psychiatric services, and certain rehabilitation services from the PPS.

[3] Outlier payments occur when a hospital's charges for a particular Medicaid beneficiary's inpatient stay substantially exceed the DRG payment (State plan, Attachment 4.19-A, chapter V, (C)(1) & (C)(2)).

During the audit period, the State agency processed a total of approximately 1.5 million inpatient claims, 286 of which resulted in payments of $200,000 or more (high-dollar payments) to hospitals for services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether selected high-dollar Medicaid payments that the State agency made to hospitals for inpatient services were allowable.

Scope

We reviewed 224 of the 286 high-dollar payments for inpatient claims that the State agency processed from January 1, 2006, through September 30, 2007. The 224 high-dollar payments, which totaled $69,748,844, were made to hospitals that each received 5 or more such payments during the period. We previously conducted a separate review of the remaining 62 high-dollar payments, totaling $17,237,356, made to hospitals that each received fewer than 5 such payments (A-05-09-00048).

We limited our review of the State agency's internal controls to those applicable to the 224 claims because our objective did not require an understanding of all internal controls over the submission and processing of claims. This review allowed us to establish a reasonable assurance of the authenticity and accuracy of the data obtained from CMS's Medicaid Statistical Information System, but we did not assess the completeness of the data.[4]

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- reviewed the CMS-approved Illinois State plan, including Attachment 4.19-A;
- extracted all high-dollar payments[5] for inpatient hospital services in Illinois from CMS's Medicaid Statistical Information System file (286 claims from 49 hospitals);
- contacted the State agency to determine whether the 286 high-dollar payments had been canceled or superseded by revised claims, whether payments remained outstanding at the time of our fieldwork, and whether the State agency received Federal reimbursements to match high-dollar payments;

[4] The Balanced Budget Act of 1997 (P.L. No. 105-33) requires that all State Medicaid programs submit claims and eligibility data to CMS. CMS's Medicaid Statistical Information System is the repository for this data.

[5] Payments of $200,000 or more were considered high-dollar payments for the purpose of this review.

- separated hospitals that received 5 or more high-dollar payments from hospitals that did not (15 hospitals with 224 high-dollar payments totaling $69,748,844);

- contacted officials from the 15 hospitals that received the 224 high-dollar payments to determine whether the information originally reported on the claims was correct and, if not, why the claims were incorrect and whether the hospitals agreed that refunds were appropriate;

- submitted to the State agency the corrected claims and related correspondence that we received from the hospitals; and

- verified with the State agency that inappropriate payments occurred and that refunds were appropriate.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

Not all the selected high-dollar Medicaid payments that the State agency made to hospitals for inpatient services were allowable. Of the 224 high-dollar Medicaid payments that the State agency made to hospitals for inpatient services, 75 were allowable. The remaining 149 payments included overpayments totaling $2,173,482 ($1,124,978 Federal share). For 110 of the 149 payments, hospitals reported incorrect charges that resulted in unallowable outlier payments; for 39 payments, hospitals reported incorrect charges that resulted in unallowable payments for transplant procedures. Hospital officials attributed the incorrect charges primarily to data entry errors.

FEDERAL REQUIREMENTS

Pursuant to section 1903(a)(1) of the Act, Federal reimbursement is available only for expenditures that constitute payment for part or all of the cost of services furnished as medical assistance under the State plan. Pursuant to 42 CFR § 433.312(a), the State must refund the Federal share of unallowable overpayments made to Medicaid providers.

STATE PLAN REQUIREMENTS

Attachment 4.19-A, chapter I, section (C)(5), of the State plan provides for outlier payments to hospitals, in addition to prospective payments, for cases incurring extraordinarily high costs. Pursuant to Attachment 4.19-A, chapter V, section (C)(2), of the State plan, outlier payments are made to hospitals for covered inpatient services furnished to a Medicaid beneficiary if the hospital's charges, as adjusted by the hospital-specific cost-to-charge ratio, exceed the DRG payment for the case.

Attachment 4.19-A, chapter X, section (A), of the State plan requires the State agency to pay hospital costs for transplant procedures at an all-inclusive rate, which is limited to a maximum of 60 percent of the hospital's usual and customary charges to the general public.[6]

UNALLOWABLE HIGH-DOLLAR PAYMENTS

The State agency made 149 unallowable payments totaling $2,173,482 ($1,124,978 Federal share), which hospitals had not refunded before the start of our audit. For 110 of the 149 payments, hospitals reported incorrect charges that resulted in unallowable outlier payments. For the remaining 39 payments, hospitals reported incorrect charges that resulted in unallowable payments for transplant procedures. Hospital officials attributed the incorrect charges primarily to data entry errors.

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,124,978 to the Federal Government and

- consider using the results of this audit in its provider education activities related to data entry procedures and proper documentation.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings. However, it said that repayment of the Federal share would not be required because all claims had been resubmitted via the voiding process. The State agency drafted a provider notice reminding hospitals of their responsibility to ensure the accuracy of claims that they submit. The State agency's comments are included in their entirety as the Appendix.

[6] The State agency's *Handbook for Hospital Services*, chapter H-200, dated March 2010, defines "all-inclusive rate" as "a specified rate that includes all services provided in an inpatient or outpatient setting for each day a patient is treated."

APPENDIX

APPENDIX: STATE AGENCY COMMENTS

ILLINOIS DEPARTMENT OF Healthcare and Family Services

Pat Quinn, Governor
Julie Hamos, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
TTY: (800) 526-5812

October 29, 2010

Department of Health and Human Services
Office of Audit Services, Region V
Attn: James C. Cox, Regional Inspector General for Audit Services
233 North Michigan Avenue, Suite 1360
Chicago, Illinois 60601

Re: Draft Audit Report Number A-05-09-00049

Dear Mr. Cox:

Thank you for providing the opportunity to comment on your draft audit report entitled "*Review of Medicaid High-Dollar Payments for Inpatient Services in Illinois From January 1, 2006 Through September 30, 2007 – Hospitals With Five or More High Dollar Payments*".

The Department concurs with the findings. Repayment of the federal share will not be required, as all claims have been resubmitted via the voiding process. In addition, a provider notice has been drafted reminding hospitals of their responsibility to ensure the accuracy of the claims they submit to the Department for payment. We appreciate the work done by your audit team and will use the report to consider changes in procedures to prevent such overpayments in the future.

If you have any questions or comments about our response to the audit, please contact Peggy Edwards, External Audit Liaison, at (217) 785-9764 or through email at peggy.edwards@illinois.gov.

Sincerely,

Julie Hamos
Director