



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

April 20, 2011

Report Number: A-05-09-00095

Ms. Olga Dazzo
Director
Michigan Department of Community Health
Capitol View Building
201 Townsend Street
Lansing, MI 48913

Dear Ms. Dazzo:

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 Michigan From January 1, 2007, Through March 31, 2009*. 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-05-09-00095 in all correspondence.

Sincerely,

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

Enclosure

Direct Reply to HHS Action Official:

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

Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICAID
HIGH-DOLLAR PAYMENTS FOR
INPATIENT SERVICES IN MICHIGAN
FROM JANUARY 1, 2007,
THROUGH MARCH 31, 2009**



Daniel R. Levinson
Inspector General

April 2011
A-05-09-00095

Office of Inspector General

<http://oig.hhs.gov>

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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 Community Health (the State agency) administers the Medicaid program in Michigan. 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 for expenditures that constitute payment for part or all of the cost of services furnished as medical assistance under the State plan.

The State plan requires the State agency to pay hospital costs according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned. The State plan also provides for outlier payments to hospitals, in addition to DRG payments, for cases incurring extraordinarily high costs. Payments for certain DRGs specified in the State plan are equal to the amount of hospital's charges adjusted by the hospital's cost-to-charge ratio (percent-of-charge payments).

During the audit period of January 1, 2007, through March 31, 2009, the State agency processed and paid approximately 271,000 inpatient claims, 204 of which resulted in payments of \$200,000 or more (high-dollar payments) to hospitals for services.

OBJECTIVE

Our objective was to determine whether the 204 high-dollar Medicaid payments that the State agency made to hospitals for inpatient services were based on accurate charges and adequate documentation.

SUMMARY OF FINDINGS

Twenty-five percent of the high-dollar Medicaid payments that the State agency made to hospitals for inpatient services were based on inaccurate charges or inadequate documentation. Of the 204 high-dollar Medicaid payments that the State agency made to hospitals for inpatient services, 151 were based on accurate charges and adequate documentation. However, the State agency made 53 payments that were not based on accurate charges or adequate documentation. These inaccurate payments consisted of 52 overpayments totaling \$641,184 (\$381,596 Federal share) and one underpayment of \$682,537 (\$384,814 Federal share).

The 52 overpayments were based on hospitals' reporting:

- incorrect charges that resulted in 43 erroneous outlier payments;
- incorrect charges that resulted in 6 erroneous percent-of-charge payments; and
- incorrect diagnosis codes, procedure codes, and charges that resulted in a combination of 3 erroneous DRGs and outlier payments.

For the underpayment, a hospital reported incorrect charges, diagnosis, and procedure codes that resulted in an incorrect DRG and outlier payment and consequently a lower percent-of-charge payment than should have been received.

Hospital officials attributed the incorrect charges, diagnosis codes, and procedure codes primarily to data entry errors.

Although the State agency reported these 53 adjustments on the CMS-64 form during our fieldwork, it is possible these inaccurate payments will continue, without adequate monitoring.

RECOMMENDATIONS

We recommend that the State agency increase its monitoring of Medicaid expenditures by:

- using the results of this audit in its provider education activities related to data entry procedures and proper documentation, and
- periodically reviewing high-dollar Medicaid payments to hospitals.

STATE AGENCY COMMENTS

In written comments to our draft report, the State agency concurred with our recommendations.

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 for expenditures that constitute payment for part or all of the cost of services furnished as medical assistance under the State plan. To receive Federal reimbursement, State Medicaid agencies report expenditures on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64), that they submit to CMS. The State must refund the Federal reimbursement for unallowable overpayments made to Medicaid providers (42 CFR § 433.312(a)). In order to refund the Federal reimbursement for unallowable overpayments, State Medicaid agencies report unallowable overpayment amounts as adjustments decreasing Medical assistance payments on its CMS-64.

Michigan's Medical Assistance Payments for Inpatient Hospital Services

The Department of Community Health (the State agency) administers the Medicaid program in Michigan. 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 (A)(1) of the State plan requires the State agency to pay hospital costs 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 operating costs associated with the beneficiary's stay. One of these exceptions is outlier payments.² In addition, payments for DRGs that are specified in Attachment 4.19-A,

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 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 III, section (A)(15)(c)(2)).

chapter III, section (C)(7)³ of the State plan are equal to the amount of the hospital's charges adjusted by the hospital's cost-to-charge ratio (percent-of-charge payments).

During the audit period, the State agency processed a total of approximately 271,000 inpatient claims, 204 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 the 204 high-dollar Medicaid payments that the State agency made to hospitals for inpatient services were based on accurate charges and adequate documentation.

Scope

We reviewed 204 high-dollar payments for inpatient claims that the State agency processed from January 1, 2007, through March 31, 2009.

We limited our review of the State agency's internal controls to those applicable to the 204 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 the State agency's Medicaid Management Information System, but we did not assess the completeness of the data.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- reviewed the CMS-approved Michigan State plan, including Attachment 4.19-A;
- obtained all high-dollar payments⁴ for inpatient hospital services in Michigan from the State agency's Medicaid Management Information System file;

³ Attachment 4.19-A, chapter III, section (C)(7) of the State plan, that was in effect until December 2007, states "The payment amount for claims that fall into DRGs 103, 468, 480, 481, 495, 512 or 513 is total hospital charges times the hospital's...cost to charge ratio...." This section as amended effective from January 2008, states "The payment amount for claims that fall into DRGs 1, 2, 5, 6, 7, 8, 9, 981, 982, or 983 is total hospital charges times the hospital's...cost to charge ratio...."

⁴ Payments of \$200,000 or more were considered high-dollar payments for the purpose of this review.

- contacted officials of the 22 hospitals that received the 204 high-dollar payments to determine whether the information originally reported on the claims was correct and, if not: why the claims were incorrect, whether the hospitals agreed that refunds were appropriate, and whether the hospitals submitted replacement claims⁵ to the State agency; and
- verified with the State agency that: inappropriate payments occurred, refunds and an additional payment were appropriate, and refunds and additional payment were reported on the CMS-64s.

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

Twenty-five percent of the high-dollar Medicaid payments that the State agency made to hospitals for inpatient services were based on inaccurate charges or inadequate documentation. Of the 204 high-dollar Medicaid payments that the State agency made to hospitals for inpatient services, 151 were based on accurate charges and adequate documentation. However, the State agency made 53 payments that were not based on accurate charges or adequate documentation. These inaccurate payments consisted of 52 overpayments totaling \$641,184 (\$381,596 Federal share) and one underpayment of \$682,537 (\$384,814 Federal share).

FEDERAL REQUIREMENTS

Pursuant to section 1903(a)(1) of the Act, Federal reimbursement is available for expenditures that constitute payment for part or all of the cost of services furnished as medical assistance under the State plan. The State must refund the Federal share of unallowable overpayments made to Medicaid providers (42 CFR § 433.312(a)). Sections 2500.1 and 2500.4 of CMS's *State Medicaid Manual* provide that the Federal share of the overpayments can be refunded and underpayments can be claimed as adjustments on the current CMS-64.

⁵ The State agency's *Medicaid Provider Manual*, chapter titled "Billing & Reimbursement for Institutional Providers", section 3.1, dated January 2009, states "Replacement claims are submitted when all or a portion of the claim was paid incorrectly....All money paid on the first claim will be recouped and payment will be based on information reported on the replacement claim...."

STATE PLAN REQUIREMENTS

Attachment 4.19-A, chapter I, section (A)(1) of the State plan requires the State agency to pay hospital costs according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned.

Attachment 4.19-A, chapter III, section (A)(15)(c)(2) of the State plan provides for outlier payments to hospitals, in addition to DRG payments, for cases incurring extraordinarily high costs. This section further states that the 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 III, section (C)(7) of the State plan provides for percent-of-charge payments for claims that fall into DRGs listed in the section (C)(7).

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

The State agency made 52 overpayments totaling \$641,184 (\$381,596 Federal share) and one underpayment of \$682,537 (\$384,814 Federal share).

The 52 overpayments were based on hospitals' reporting:

- incorrect charges that resulted in 43 erroneous outlier payments;
- incorrect charges that resulted in 6 erroneous percent-of-charge payments; and
- incorrect diagnosis codes, procedure codes, and charges that resulted in a combination of 3 erroneous DRGs and outlier payments.

For the underpayment, a hospital reported incorrect charges, diagnosis, and procedure codes that resulted in an incorrect DRG and outlier payment and consequently a lower percent-of-charge payment than should have been received.

Hospital officials attributed the incorrect charges, and diagnosis and procedure codes primarily to data entry errors.

The State agency has recovered \$641,184 (\$381,596 Federal share) from the overpaid hospitals, and paid \$682,537 (\$384,814 Federal share) to the underpaid hospital.

Although the State agency reported these 53 adjustments on the Form CMS-64 during our fieldwork, it is possible these inaccurate payments will continue without adequate monitoring.

RECOMMENDATIONS

We recommend that the State agency increase its monitoring of Medicaid expenditures by:

- using the results of this audit in its provider education activities related to data entry procedures and proper documentation and
- periodically reviewing high-dollar Medicaid payments to hospitals.

STATE AGENCY COMMENTS

In written comments to our draft report, the State agency concurred with our recommendations.

The State agency's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: STATE AGENCY COMMENTS



RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

OLGA DAZZO
DIRECTOR

March 25, 2011

Mr. James C. Cox
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region V
233 North Michigan Avenue
Suite 1360
Chicago, Illinois 60601

Re: Report Number A-05-09-00095

Dear Mr. Cox:

Enclosed is the Michigan Department of Community Health's response to the draft report entitled "Review of Medicaid High-Dollar Payments for Inpatient Services in Michigan from January 1, 2007, through March 31, 2009."

We appreciate the opportunity to review and comment on the report before it is released. If you have any questions regarding this response, please refer them to Pam Myers at Myerspa@Michigan.gov or (517) 373-1508.

Sincerely,

Olga Dazzo

Olga Dazzo
Director

OD:kk

Enclosure

cc: Steve Fitton
Nick Lyon
Pam Myers

Review of Medicaid High-Dollar Payments for Inpatient Services in Michigan
from January 1, 2007 Through March 31, 2009
A-05-09-00095

Summary of Findings

Twenty-five percent of the high-dollar Medicaid payments that the State agency made to hospitals for inpatient services were based on inaccurate charges or inadequate documentation. Of the 204 high-dollar Medicaid payments that the State agency made to hospitals for inpatient services, 151 were based on accurate charges and adequate documentation. However, the State agency made 53 payments that were not based on accurate charges or adequate documentation. These inaccurate payments consisted of 52 overpayments totaling \$641,184 (\$381,596 Federal share) and one underpayment of \$682,537 (\$384,814 Federal share).

- The 52 overpayments were based on hospitals' reporting:
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For the underpayment, a hospital reported incorrect charges, diagnosis, and procedure codes that resulted in an incorrect DRG and outlier payment and consequently a lower percent-of-charge payment than should have been received.

Hospital officials attributed the incorrect charges, diagnosis codes, and procedure codes primarily to data entry errors.

Although the State agency reported these 53 adjustments on the CMS-64 form during our fieldwork, it is possible these inaccurate payments will continue, without adequate monitoring.

Recommendations

We recommend that the State agency increase its monitoring of Medicaid expenditures by:

- using the results of this audit in its provider education activities related to data entry procedures and proper documentation, and
- periodically reviewing high-dollar Medicaid payments to hospitals.

Department of Community Health (DCH) Response:

While DCH acknowledges that 53 payments were made based upon inaccurate information reported by hospitals, DCH disagrees with the report's use of the terms "inaccurate payments" and "inadequate documentation." These terms imply that DCH did something inappropriate when, in fact, the payments were appropriate based on the claims submitted. In every case, DCH paid the correct amount based on the information submitted by the hospital on the claim.

DCH:

- Concurs with the recommendation and will use the results of this audit in its provider education activities related to data entry procedures and proper documentation.
- Concurs with the recommendation and, upon determining an appropriate dollar threshold, will periodically review high-dollar Medicaid payments to hospitals. This will be in addition to any other hospital audits DCH currently conducts.