

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**WISCONSIN PHYSICIANS SERVICE
INSURANCE CORPORATION
DID NOT PROPERLY SETTLE
INDIANA MEDICARE
DISPROPORTIONATE SHARE
HOSPITAL COST REPORT PAYMENTS**

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EXECUTIVE SUMMARY

Inpatient hospitals in Indiana did not properly claim Medicaid patient days on their Medicare cost reports, and Wisconsin Physicians Service Insurance Corporation did not properly settle cost reports submitted by these providers for Medicare disproportionate share hospital payments for Federal fiscal years 2008 through 2010. The resulting disproportionate share hospital overpayments totaled \$6.1 million.

WHY WE DID THIS REVIEW

The Medicare program, like the Medicaid program, includes provisions under which Medicare-participating hospitals (providers) that serve a disproportionate share of low-income patients may receive disproportionate share hospital (DSH) payments. Because these payments are the result of calculations to which a number of sometimes-complex factors and variables (one of which is referred to as “Medicaid patient days”) contribute, they are at risk of overpayment. In Medicare, DSH payments to providers are based on Medicaid patient days that the providers furnish. Providers report these Medicaid patient days on Medicare cost reports that Medicare administrative contractors review and settle. During Federal fiscal year (FY) 2010, Medicare made \$10.8 billion in DSH payments.

This review involved updated State Medicaid agency guidance regarding the eligibility of certain categories of Medicaid recipients. This updated guidance also affected the calculation of Medicare DSH payments to providers. Specifically, the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (State agency), notified inpatient hospitals in Indiana (Indiana providers) that effective June 29, 2011, the State agency had updated its eligibility verification system (EVS) so that providers could more readily differentiate certain DSH-eligible beneficiaries from non-DSH-eligible beneficiaries. Federal requirements exclude separate Children’s Health Insurance Program (S-CHIP, which allows States to provide health care coverage to uninsured children in families whose incomes are too high to qualify for Medicaid but too low to afford private health care coverage) and Aid to Residents in County Homes (ARCH, a State-level program that provides case review services to certain residents of county nursing homes) recipients from the calculation of Medicaid patient days used to determine a provider’s Medicare DSH payment adjustment. Prior to June 29, 2011, the EVS did not differentiate between S-CHIP and CHIP administered through a Medicaid expansion program, whose recipients receive full Medicaid benefits and are eligible for inclusion. Accordingly, cost reports submitted before the update may have included ineligible patient populations, which may have resulted in Medicare DSH overpayments.

National Government Services, Inc. (NGS), had been since FY 2009 the Medicare administrative contractor (Medicare contractor) for Jurisdiction 8, which comprises the States of Indiana and Michigan. In July 2012, NGS’s responsibilities transferred to Wisconsin Physicians Service Insurance Corporation (WPS); accordingly, we are addressing our recommendations to WPS.

The objective of this review was to determine whether, with respect to Medicaid patient days, WPS properly settled FYs 2008 through 2010 Medicare cost reports submitted by Indiana providers for Medicare DSH payments in accordance with Federal requirements.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) administers Medicare Part A and uses a prospective payment system (PPS) to pay providers for inpatient hospital services delivered to Medicare beneficiaries. CMS uses Medicare contractors to, among other things, process and pay Medicare claims submitted for medical services.

Providers submit cost reports to their Medicare contractors annually. The cost reports are based on the providers' financial and statistical records, and providers attest to the accuracy of the data when submitting their cost reports. After acceptance of each cost report, the Medicare contractor performs a tentative settlement, then reviews the cost report and, if necessary, conducts an audit. Final settlement of the cost report constitutes the Medicare contractor's determination as to whether payment is owed to the provider or to the Medicare program.

Under the Medicare inpatient PPS, CMS pays provider costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the provider for all inpatient costs associated with the beneficiary's stay.

One of those exceptions is the "DSH adjustment," which is statutorily mandated for providers that serve a large share of low-income patients. The Medicare DSH adjustment is a percentage add-on payment applied to the DRG payment rate.

A provider must have a minimum DSH adjustment, which differs across provider groups, to qualify for DSH payments. A provider must have a "disproportionate patient percentage" that equals or exceeds the threshold level established for its geographic location. The provider's "disproportionate patient percentage" is derived as the sum of two fractions: the Medicare fraction and the Medicaid fraction.

- CMS determines the *Medicare fraction* for each provider by identifying the total number of days of inpatient hospital status for that provider's patients who were entitled to both Medicare Part A and Supplemental Security Income (numerator), and then dividing that number by the total number of Medicare Part A patient days for that provider (denominator). (A "Medicare Part A patient day" represents 1 day of inpatient hospital status for an individual who is entitled to Part A benefits.)
- Each provider determines and reports its own *Medicaid fraction* by identifying the total number of days of inpatient hospital status for its patients who were eligible for Medicaid but not entitled to Medicare Part A (that is, the total number of "Medicaid patient days"), and then dividing that number by the total number of patient days in the same period.

We focused on Medicaid patient days for this review of Medicare DSH payments to Indiana providers because the addition of recipient and population information for the S-CHIP and the ARCH program to the State agency's updated EVS data directly affected the calculation of Medicaid patient days. In turn, the change affected each provider's determination of its

Medicaid fraction, CMS's calculation of the disproportionate patient percentage for that provider, and ultimately the amount of Medicare DSH payments to Indiana providers.

We also reviewed 590 Program recipients and dual eligibles. The 590 Program is funded solely by Indiana and provides certain health care services to individuals between the ages of 21 and 64 who are residents of State-owned facilities. Its recipients are excluded from the calculation of Medicaid patient days used in Medicare cost reports. In the context of Medicare DSH payments, "dual eligibles" refers to individuals who are entitled to Medicare Part A and eligible for inpatient hospital Medicaid benefits.

We judgmentally selected 48 of the 74 Indiana providers that received Medicare DSH payments totaling \$457,152,975 for FYs 2008 through 2010, before the update to the EVS made data on S-CHIP and ARCH recipients more accessible to providers. We selected these 48 providers because their total Medicare DSH payments represented the vast majority (82 percent) of all Medicare DSH payments to all providers in Indiana for this timeframe. We reviewed the Medicare cost reports submitted by these 48 providers for FYs 2008 through 2010. The cost reports were submitted to NGS, which conducted the initial review. WPS brought the cost reports to final settlement by updating the Medicare fraction and incorporating the review of NGS.

WHAT WE FOUND

With respect to Medicaid patient days, WPS did not properly settle Medicare cost reports submitted by Indiana providers for Medicare DSH payments in accordance with Federal requirements. The 48 selected providers improperly claimed a total of 14,325 Medicaid patient days on their Medicare cost reports, resulting in DSH overpayments totaling \$6,110,557. These improper claims included both unallowable and unsupported patient days and involved S-CHIP recipients, ARCH recipients, 590 Program recipients, and dual eligibles.

These errors occurred because the selected providers did not properly claim Medicaid patient days in accordance with Federal requirements when they prepared and submitted their cost reports to NGS. Specifically, the providers included in their calculations S-CHIP and ARCH recipients whose ineligibility was subsequently revealed by the June 2011 updated EVS data. The providers did not amend their submitted cost reports to take the updated eligibility data into account (that is, they did not revise their calculations of the Medicaid patient days to remove S-CHIP and ARCH recipients from the numerator of the Medicaid fraction). Moreover, the providers included unallowable patient days associated with 590 Program recipients and dual eligibles in their calculations of the Medicaid fraction.

Further, neither the State agency nor the providers notified the Medicare contractor (NGS, later WPS) of the update to the State agency's EVS data. Absent such notification, the Medicare contractors had no reason or basis to review the Medicare cost reports to identify the improperly claimed Medicaid patient days and, consequently, the Medicare DSH overpayments. Moreover, relevant Federal guidelines do not require Medicare contractors to perform detailed reviews of all submitted cost reports. Nevertheless, WPS did not ensure that the providers' cost reports' claims for Medicare DSH payments were in accordance with Federal requirements before

bringing those cost reports to final settlement. If Indiana had sent WPS the newsletter (NL201106) published in June 2011, the WPS staff could have used the information to ensure the cost reports were accurate. These cost reports were reopened by WPS, and the Medicare DSH overpayments can be recovered and refunded to the Federal Government.

WHAT WE RECOMMEND

We recommend that WPS:

- revise the finalized Medicare cost report settlements to recover \$6,110,557 in Medicare DSH overpayments from the 48 selected Indiana providers and refund that amount to the Federal Government;
- revise final cost report settlements for those FYs 2008 through 2010 Medicare cost reports that were submitted before the June 2011 EVS update but that we did not review, recover any additional Medicare DSH overpayments made to Indiana providers, and refund those recovered amounts to the Federal Government; and
- communicate with State agency officials annually to identify and obtain any State-level guidance affecting recipient categories that figure into Medicare DSH cost report payments.

AUDITEE COMMENTS AND OUR RESPONSE

In written comments on our draft report, WPS concurred with our first recommendation and described corrective action that it planned to take. Regarding our third recommendation, WPS said that it agreed that “State agency guidance is valuable” and added that it would continue its current approach, under which its auditors can contact States “on an ad hoc basis whenever they run into a situation during an audit where they believe there has been a significant change in the state’s policies or reporting procedures.”

WPS did not concur with our second recommendation. WPS stated that “virtually all of the 2008 and 2009 cost reports for the remaining providers are closed and beyond the three year reopening period.” (WPS was referring to Federal regulations under which a settled cost report may be reopened by the Medicare contractor no more than 3 years after the date of the final settlement of that cost report.) WPS said that, for this reason, it could not reopen and review the cost reports covered by our second recommendation. WPS also stated that, in its view, the FY 2010 Medicare cost reports that could be reopened would not yield a significant return, but added that it would work with CMS to determine the cost and benefit of additional action on those cost reports.

After reviewing WPS’s comments, we maintain that all of our findings and recommendations remain valid. With respect to the Medicare cost reports covered by our second recommendation—that is, the FYs 2008 through 2010 cost reports for the 26 Indiana providers that we did not review—CMS regulations allow for cost reports to be reopened beyond 3 years if there is evidence of “similar fault.” Accordingly, we maintain that the State agency’s June 2011

newsletter notifying Indiana providers that it had modified the EVS constitutes a sufficient basis for our second recommendation.

We also maintain that a review of the cost reports covered by our second recommendation would yield a significant return on investment. The Medicare program made \$101 million in DSH payments that were associated with these cost reports. If the error rate in these cost reports is similar to the error rate in the cost reports that we reviewed (which is a reasonable expectation), reopening these cost reports could yield a recovery of approximately \$1.3 million.

Finally, we maintain that cost report information would be more accurate if WPS auditors communicate with the applicable State agency officials annually, rather than on an ad hoc basis, to identify any State-level guidance affecting recipient categories that figure into Medicare DSH payments.

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INTRODUCTION

WHY WE DID THIS REVIEW

The Medicare program, like the Medicaid program, includes provisions under which Medicare-participating hospitals (providers) that serve a disproportionate share of low-income patients may receive disproportionate share hospital (DSH) payments. Because these payments are the result of calculations to which a number of sometimes-complex factors and variables (one of which is referred to as “Medicaid patient days”) contribute, they are at risk of overpayment. In Medicare, DSH payments to providers are based on Medicaid patient days that the providers furnish. Providers report these Medicaid patient days on Medicare cost reports that Medicare administrative contractors review and settle. During Federal fiscal year (FY) 2010, Medicare made \$10.8 billion in DSH payments.

This review involved updated State Medicaid agency guidance regarding the eligibility of certain categories of Medicaid recipients. Specifically, the Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (State agency), notified inpatient hospitals in Indiana (Indiana providers) that effective June 29, 2011, the State agency had updated its eligibility verification system (EVS) so that providers could more readily differentiate certain DSH-eligible beneficiaries from non-DSH-eligible beneficiaries.¹ Federal requirements exclude separate Children’s Health Insurance Program (S-CHIP)² and Aid to Residents in County Homes (ARCH)³ recipients from the calculation of Medicaid patient days used to determine a provider’s Medicare DSH payment adjustment. Prior to June 29, 2011, the EVS did not differentiate between S-CHIP and CHIP administered through a Medicaid expansion program (M-CHIP), whose recipients receive full Medicaid benefits and are eligible for inclusion. In addition, the EVS had not previously identified ARCH recipients as ineligible for inclusion. Accordingly, cost reports submitted before the update may have included ineligible patient populations, which may have resulted in Medicare DSH overpayments.

National Government Services, Inc. (NGS), had been since FY 2009 the Medicare administrative contractor (Medicare contractor) for Jurisdiction 8, which comprises the States of Indiana and Michigan. In July 2012, NGS’s responsibilities transferred to Wisconsin Physicians Service Insurance Corporation (WPS); accordingly, we are addressing our recommendations to WPS.

OBJECTIVE

Our objective was to determine whether, with respect to Medicaid patient days, WPS properly settled FYs 2008 through 2010 Medicare cost reports submitted by Indiana providers for Medicare DSH payments in accordance with Federal requirements.

¹ Provider news, Indiana Health Coverage Programs, NL201106, June 2011.

² CHIP allows States to provide health care coverage to uninsured children in families whose incomes are too high to qualify for Medicaid but too low to afford private health coverage.

³ The ARCH program provides case review services to certain residents of county nursing homes.

BACKGROUND

Medicare Cost Reports

Under Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program and uses a prospective payment system (PPS) to pay providers for inpatient hospital services delivered to Medicare beneficiaries under Medicare Part A. CMS uses Medicare contractors to, among other things, process and pay Medicare claims submitted for medical services.⁴

Providers submit cost reports to their Medicare contractors annually. The cost reports are based on the providers' financial and statistical records, and providers attest to the accuracy of the data when submitting their cost reports. After acceptance of each cost report, the Medicare contractor performs a tentative settlement. The Medicare contractor then reviews the cost report and conducts an audit, if necessary, before final settlement. The Medicare contractor then issues a notice of program reimbursement. As the final settlement document, this notice shows whether payment is owed to the provider or to the Medicare program.

A settled cost report may be reopened by the Medicare contractor no more than 3 years after the date of the final settlement of that cost report (42 CFR § 405.1885(b)). We refer to this as the 3-year reopening limit. If a matter is reopened, it may result in a revision of the final settlement of the cost report (42 CFR § 405.1885(a)). During our audit, WPS reopened the selected cost reports within the 3-year reopening limit.⁵

Medicare Disproportionate Share Hospital Adjustment

Under the Medicare inpatient PPS, CMS pays provider costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The DRG payment is, with certain exceptions, intended to be payment in full to the provider for all inpatient costs associated with the beneficiary's stay.

One of those exceptions is the "DSH adjustment" for providers that serve a large share of low-income patients (the Act § 1886(d)(5)(F)). The Medicare DSH adjustment is a percentage add-on payment applied to the DRG payment rate. A provider must have a "disproportionate patient percentage" that equals or exceeds the threshold level established for its geographic location (the Act § 1886(d)(5)(F)(v)). The provider's "disproportionate patient percentage" is derived as the sum of two fractions: the Medicare fraction and the Medicaid fraction (the Act § 1886(d)(5)(F)(vi)).

⁴ Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare contractors between October 2005 and October 2011. In this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or Medicare contractor, whichever is applicable.

⁵ See "How We Conducted This Review" and Appendix A.

Medicare Fraction

The Medicare fraction is also known as the Supplemental Security Income (SSI) percentage. CMS determines the Medicare fraction for each provider by identifying the total number of days of inpatient hospital status for that provider's patients who were entitled to both Medicare Part A and SSI (numerator) and then dividing that number by the total number of Medicare Part A patient days for that provider (denominator).⁶

Medicaid Fraction

Each provider determines and reports its own Medicaid fraction by identifying the total number of days of inpatient hospital status for its patients who were eligible for Medicaid but not entitled to Medicare Part A (that is, the total number of "Medicaid patient days") and then dividing that number by the total number of patient days in the same period.⁷

In calculating the number of patient Medicaid days, a provider must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX of the Act, and not entitled to Medicare Part A, on the date of service.⁸ State-only health programs (*e.g.*, ARCH) and S-CHIP are not considered to be Medicaid programs for purposes of Medicare DSH payments.⁹ For purposes of the Medicare DSH calculation, Medicaid patient days include all days during which a patient is eligible for Medicaid benefits, even if Medicaid did not make payment for any services.

Medicare Cost Reports on Hold

In accordance with instructions from CMS, Medicare contractors either (1) withheld settlement of cost reports that used or needed to use FYs 2006-2009 SSI ratios for DSH payments or (2) reopened those cost reports that had been brought to settlement using those SSI ratios. The Medicare contractors did not settle those cost reports until CMS notified them (in calendar year 2012) that the FYs 2006-2009 SSI ratios had been updated and that settlement should commence.

NGS had been since FY 2009 the Medicare contractor for Jurisdiction 8, which comprises the States of Indiana and Michigan. In July 2012, NGS's responsibilities transferred to WPS.

⁶ A "Medicare Part A patient day" represents 1 day of inpatient hospital status for an individual who is entitled to Part A benefits.

⁷ Pursuant to Title XIX of 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 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 applicable Federal requirements.

⁸ Individuals who are entitled to Medicare Part A and eligible for inpatient hospital Medicaid benefits are referred to as "dual eligibles." A finding that involves dual eligibles appears later in this report.

⁹ CMS, *Medicare Claims Processing Manual*, chapter 3, §§ 20.3.1.1 and 20.3.1.2.

Because of the cost report settlement hold and transfer of Medicare contractor responsibilities from NGS to WPS, the selected FYs 2008 through 2010 Medicare cost reports were settled by WPS in FY 2013 and later, which allowed the cost reports to be reopened within the 3-year reopening window.

Eligibility Verification System

The State agency administers Indiana's Medicaid program; it established and uses the EVS to make eligibility determinations.

In a newsletter (NL201106) published in June 2011, the State agency notified Indiana providers that effective June 29, 2011, the EVS would be updated to differentiate certain DSH-eligible beneficiaries from non-DSH-eligible beneficiaries. This State agency notified Indiana providers in order to exclude S-CHIP and ARCH recipients from the calculation of Medicaid patient days used to determine a provider's DSH payment adjustment. See footnotes 2 and 3.

We focused on Medicaid patient days for this review of Medicare DSH payments to Indiana providers because the addition of recipient and population information for the S-CHIP and the ARCH programs to the State agency's updated EVS data directly affected the calculation of Medicaid patient days. In turn, the change affected each provider's determination of its Medicaid fraction, CMS's calculation of the disproportionate patient percentage for that provider, and ultimately the amount of Medicare DSH payments to Indiana providers.

HOW WE CONDUCTED THIS REVIEW

We judgmentally selected 48 of the 74 Indiana providers that received Medicare DSH payments totaling \$457,152,975 for FYs 2008 through 2010, which is the timeframe before the update to the EVS made data on S-CHIP and ARCH recipients more accessible to providers. We selected these 48 providers because their total Medicare DSH payments represented the vast majority (82 percent) of all Medicare DSH payments to all providers in Indiana for this timeframe.

We reviewed the Medicare cost reports submitted by these 48 providers for FYs 2008 through 2010. In particular, we focused on the calculation of Medicaid patient days insofar as those calculations affected the amounts of Medicare DSH payments made to Indiana providers. We evaluated whether these providers had (1) revised their calculations of the Medicaid patient days (by removing S-CHIP and ARCH recipients from the numerator of the Medicaid fraction) and (2) amended their submitted cost reports to take these updated eligibility data into account. Where these revisions had not been undertaken, we recalculated the Medicaid patient days in accordance with Federal requirements and using the updated EVS data, and on the basis of those recalculations, we determined the Medicare DSH overpayments.

The providers had submitted the Medicare cost reports that we reviewed to NGS, which conducted the initial review. WPS brought the cost reports to final settlement by updating the Medicare fraction and incorporating the review of NGS.

We also requested that Indiana providers conduct their own reviews of the Medicare DSH payments that they had received to determine whether the payments were proper by obtaining updated eligibility data from the State agency's EVS.

Appendix A contains details of our audit scope and methodology.

FINDINGS

With respect to Medicaid patient days, WPS did not properly settle Medicare cost reports submitted by Indiana providers for Medicare DSH payments in accordance with Federal requirements. The 48 selected providers improperly claimed a total of 14,325 Medicaid patient days on their Medicare cost reports, resulting in DSH overpayments totaling \$6,110,557. These improper claims included both unallowable and unsupported patient days and involved S-CHIP recipients, ARCH recipients, 590 Program recipients,¹⁰ and dual eligibles.

These errors occurred because the selected providers did not properly claim Medicaid patient days in accordance with Federal requirements when they prepared and submitted their cost reports to NGS. Specifically, the providers included in their calculations S-CHIP and ARCH recipients whose ineligibility was subsequently revealed by the June 2011 updated EVS data. The providers did not amend their submitted cost reports to take the updated eligibility data into account (that is, they did not revise their calculations of the Medicaid patient days to remove S-CHIP and ARCH recipients from the numerator of the Medicaid fraction). Moreover, the providers included unallowable patient days associated with 590 Program recipients and dual eligibles in their calculations of the Medicaid fraction.

Further, neither the State agency nor the providers notified the Medicare contractor (NGS, later WPS) of the update to the State agency's EVS data.¹¹ Absent such notification, the Medicare contractors had no reason or basis to review the Medicare cost reports to identify the improperly claimed Medicaid patient days and, consequently, the Medicare DSH overpayments. Moreover, relevant Federal guidelines do not require Medicare contractors to perform detailed reviews of all submitted cost reports. Nevertheless, WPS did not ensure that the providers' cost reports' claims for Medicare DSH payments were in accordance with Federal requirements before bringing those cost reports to final settlement. If Indiana had sent WPS the newsletter (NL201106) published in June 2011, the WPS staff could have used the information to ensure the cost reports were accurate. These cost reports were reopened by WPS, and the Medicare DSH overpayments can be recovered and refunded to the Federal Government.

¹⁰ Like the ARCH program, the 590 Program is funded solely by Indiana. Its recipients cannot be included in the calculation of Medicaid patient days used in Medicare cost reports submitted by Indiana providers for Medicare DSH payments.

¹¹ We did not identify any criteria requiring the State agency to notify the contractor of any changes to its EVS data. Consequently, the contractor would not expect to be notified of such changes.

MEDICAID PATIENT DAYS WERE UNALLOWABLE AND UNSUPPORTED

Federal Requirements and Guidelines and State Agency Policy

The Act and implementing Federal regulations (42 CFR § 412.106(b)) explain the two computations that make up the disproportionate patient percentage and specify that the Medicaid fraction includes patient days associated with beneficiaries who were eligible for Medicaid under a State plan approved under Title XIX of the Act but who were not entitled to Medicare Part A.

Federal regulations state that health care providers have “... the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed..., and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day” (42 CFR § 412.106(b)(4)(iii)).

With respect to documentation and supportability, Federal regulations state: “Adequate cost information must be obtained from the provider’s records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended” (42 CFR § 413.24(c)).

CMS guidelines elaborate on these requirements. The *Medicare Claims Processing Manual*, chapter 3, § 20.3.1.1., states that “the focus is on eligibility for medical assistance under an approved Title XIX State plan, not medical assistance under a State-only program or other program” (emphasis in original). A chart in the *Medicare Claims Processing Manual*, chapter 3, § 20.3.1.2., identifies several categories of individuals receiving services who “are not Medicaid-eligible under the State plan.”

The State agency’s *Medical Policy Manual* provides specific information, in the context of State medical assistance programs, on these categories of Medicaid-ineligible individuals. These programs include the ARCH program and the 590 Program.

Details on these Federal requirements and guidelines, and on State agency policy, appear in Appendix B.

Unallowable Medicaid Patient Days

Indiana providers claimed and WPS settled a total of 8,538 unallowable patient days, consisting of the following categories:

- 8,425 unallowable S-CHIP patient days. S-CHIP is funded under Title XXI of the Act and recipients of the program are eligible under Title XXI. Accordingly, patient days associated with S-CHIP recipients are not allowable Medicaid patient days.
- 98 unallowable ARCH patient days. The ARCH program is funded solely by Indiana, and as a State-only program does not involve or provide for eligibility for Medicaid.

Accordingly, patient days associated with ARCH recipients are not allowable Medicaid patient days.

- 15 unallowable 590 Program patient days. Like the ARCH program, the 590 Program is a State-only program, funded solely by Indiana. Accordingly, patient days associated with 590 Program recipients are not allowable Medicaid patient days.

Indiana providers claimed these unallowable Medicaid patient days on the cost reports that they prepared and submitted to NGS. In turn, WPS brought all of the cost reports to final settlement. Because these cost reports included 8,538 improperly claimed Medicaid patient days, the cost reports were not properly settled, and the Indiana providers received Medicare DSH overpayments as a result.

Unsupported Medicaid Patient Days

Indiana providers claimed and WPS settled a total of 5,019 unsupported patient days, consisting of the following categories:

- 4,163 patient days that lacked data to support the beneficiaries' Medicaid eligibility. For example, one Indiana provider claimed 1,403 patient days that did not have documentation supporting that the patients were eligible for Medicaid. Another Indiana provider claimed 565 patient days that were duplicated—in each case, the same patient day, for the same beneficiary, was claimed twice.
- 812 patient days that were claimed based on providers' estimates of the Medicaid-eligible days rather than on verification with the State of the Medicaid eligibility for each patient day.
- 44 patient days that were claimed on the cost reports but involved individuals whose Medicaid eligibility was not supported by the EVS.

Indiana providers claimed these unsupported Medicaid patient days on the cost reports that they prepared and submitted to NGS. In turn, WPS brought all of the cost reports to final settlement. Because these cost reports included 5,019 improperly claimed Medicaid patient days, the cost reports were not properly settled, and the providers received Medicare DSH overpayments as a result.

Unallowable Dual-Eligible Patient Days

As stated earlier, the numerator of the Medicaid fraction consists of patient days associated with patients who are eligible for Medicaid but not entitled to Medicare Part A on the day of service. Patient days associated with dual eligibles therefore cannot, by definition,¹² be counted in the numerator when a provider is determining its Medicaid fraction (the Act § 1886(d)(5)(F)(vi)(II)). Accordingly, once a provider has verified a patient's eligibility for Medicaid under a State plan

¹² See footnote 8.

approved under Title XIX of the Act, the provider must then determine whether the patient had dual-eligible status on any days of service and, if so, subtract those days from the other Medicaid patient days when calculating the Medicaid fraction.

Contrary to these requirements, Indiana providers claimed and WPS settled 768 unallowable dual-eligible patient days. These unallowable patient days remained in the numerators of the Medicaid fractions that these providers used when preparing and submitting their cost reports to NGS. In turn, WPS brought all of the cost reports to final settlement. Because these cost reports included 768 improperly claimed Medicaid patient days, the cost reports were not properly settled, and the providers received Medicare DSH overpayments as a result.

COST REPORTS WERE NOT PROPERLY PREPARED AT THE PROVIDER LEVEL AND WERE NOT CORRECTLY REVIEWED AND SETTLED AT THE MEDICARE CONTRACTOR LEVEL

The Medicare DSH overpayments that resulted from the inclusion of unallowable and unsupported patient days occurred because the selected providers did not properly claim Medicaid patient days in accordance with Medicare requirements when the providers prepared and submitted their cost reports to NGS. Specifically, the providers included in their calculations S-CHIP and ARCH recipients whose ineligibility was subsequently revealed by the June 2011 updated EVS data. The providers did not amend their submitted cost reports to take the updated eligibility data into account (that is, they did not revise their calculations of the Medicaid patient days to remove S-CHIP and ARCH recipients from the numerator of the Medicaid fraction) after the State notified providers of the updated EVS. Moreover, the providers included unallowable patient days associated with 590 Program recipients and dual eligibles in their calculations of the Medicaid fraction.

Further, neither the State agency nor the Indiana providers notified the Medicare contractor (NGS, later WPS) of the update to the State agency's EVS data. Consequently, the Medicare contractors had no reason or basis to review the Medicare cost reports to identify the improperly claimed Medicaid patient days and, consequently, the Medicare DSH overpayments. Moreover, relevant Federal guidelines do not require Medicare contractors to perform detailed reviews of all submitted cost reports. Nevertheless, WPS did not ensure that the providers' cost reports' claims for Medicare DSH payments were in accordance with Federal requirements before bringing those cost reports to final settlement. If Indiana had sent WPS the newsletter (NL201106) published in June 2011, the WPS staff could have used the information to ensure the cost reports were accurate. These cost reports can be reopened and the Medicare DSH overpayments can be recovered and refunded to the Federal Government.

EFFECT OF INCORRECTLY CLAIMED AND SETTLED MEDICAID PATIENT DAYS

The 48 selected providers improperly claimed a total of 14,325 Medicaid patient days on their Medicare cost reports, resulting in DSH overpayments totaling \$6,110,557. Appendix C contains details on the unallowable and unsupported Medicaid patient days as well as the overpayments by provider.

RECOMMENDATIONS

We recommend that WPS:

- revise the finalized Medicare cost report settlements to recover \$6,110,557 in Medicare DSH overpayments from the 48 selected Indiana providers and refund that amount to the Federal Government;
- revise final cost report settlements for those FYs 2008 through 2010 Medicare cost reports that were submitted before the June 2011 EVS update but that we did not review, recover any additional Medicare DSH overpayments made to Indiana providers, and refund those recovered amounts to the Federal Government; and
- communicate with State agency officials annually to identify and obtain any State-level guidance affecting recipient categories that figure into Medicare DSH cost report payments.

AUDITEE COMMENTS

In written comments on our draft report, WPS concurred with our first recommendation and described corrective action that it planned to take. Regarding our third recommendation, WPS said that it agreed that “State agency guidance is valuable” and added that it would continue its current approach, under which its auditors can contact States “on an ad hoc basis whenever they run into a situation during an audit where they believe there has been a significant change in the state’s policies or reporting procedures.”

WPS did not concur with our second recommendation. WPS stated that “virtually all of the 2008 and 2009 cost reports for the remaining providers are closed and beyond the three year reopening period; thus, it is no longer possible for WPS to reopen and review these cost reports.” WPS said that, for this reason, it could not reopen and review the cost reports covered by our second recommendation. WPS also stated that, in its view, the FY 2010 Medicare cost reports that could be reopened would not yield a significant return but added that it would work with the CMS Contractor Officer Representative to determine the cost and benefit of additional action on those cost reports.

WPS’s comments appear in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing WPS’s comments, we maintain that all of our findings and recommendations remain valid. With respect to the Medicare cost reports covered by our second recommendation—that is, the FYs 2008 through 2010 cost reports for the 26 Indiana providers that we did not review—CMS regulations allow for cost reports to be reopened beyond 3 years if there is evidence of “similar fault.” These regulations state that a Medicare payment contractor (*e.g.*, WPS) may reopen an initial determination at any time if the determination was procured by fraud or similar fault (42 CFR § 405.1885(b)(3)).

For example, a Medicare payment contractor may reopen a cost report after finding that a provider received money that it knew or reasonably should have known it was not entitled to retain (73 Fed. Reg. 30190, 30233 (May 23, 2008)). The State agency notified Indiana providers in a June 2011 provider newsletter that it had modified the EVS so that it could differentiate among M-CHIP, S-CHIP, and ARCH recipients (which the EVS did not do previously). Given that notification, providers knew or should have known that the Medicaid patient days used to calculate their DSH claims in their FYs 2008 through 2010 cost reports likely were erroneous, and they knew or should have known this before WPS brought those cost reports to final settlement in and around FY 2013. With these considerations in mind, we maintain that the State agency's June 2011 newsletter notifying Indiana providers that it had modified the EVS constitutes a sufficient basis for our second recommendation.

We also maintain that a review of these cost reports covered by our second recommendation would yield a significant return on investment. The Medicare program made \$101 million in DSH payments that were associated with these cost reports. If the error rate in these cost reports is similar to the error rate in the cost reports that we reviewed (which is a reasonable expectation), reopening these cost reports could yield a recovery of approximately \$1.3 million for the Medicare Trust Fund. Accordingly, we continue to recommend that WPS determine whether the providers associated with the cost reports we did not review recover any additional Medicare DSH overpayments made to Indiana providers and refund those recovered amounts to the Federal Government.

Finally, we maintain that cost report information would be more accurate if WPS auditors communicate with the applicable State agency officials annually, rather than on an ad hoc basis, to identify any State-level guidance affecting recipient categories that figure into Medicare DSH payments.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$457,152,975 in Medicare DSH payments made to 48 judgmentally selected Indiana providers (out of 74 providers we identified in Indiana) for FYs 2008 through 2010. This audit period is the timeframe before the update to the EVS made data on S-CHIP and ARCH recipients more accessible to providers. We selected these 48 providers because their total Medicare DSH payments represented the vast majority (82 percent) of all Medicare DSH payments made to all Indiana providers for this timeframe.

We reviewed the Medicare cost reports submitted by these 48 providers for FYs 2008 through 2010. In particular, we focused on the calculation of Medicaid patient days insofar as those calculations affected the Medicare DSH payments made to these providers. The Medicare cost reports that we reviewed were submitted to NGS but brought to final settlement by WPS.

We conducted our audit work from February through December 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance, State agency policy, State agency communications to providers, and information associated with the EVS update;
- extracted inpatient acute-care hospital and rehabilitation facility cost report data from the Healthcare Cost Report Information System for our FYs 2008 through 2010 audit period;
- judgmentally selected 48 providers in Indiana that, among them, received 82 percent of all Medicare DSH payments to all providers in the State for our audit period;
- obtained and reviewed the Medicare cost reports that these 48 providers submitted to NGS for our audit period;
- evaluated the information and procedures that the selected providers used to calculate Medicaid patient days on their cost reports;
- evaluated whether these providers had revised their calculations of the Medicaid patient days (by removing S-CHIP and ARCH recipients from the numerator of the Medicaid fraction) after the EVS update, and whether they had then amended their submitted cost reports to take these updated eligibility data into account;
- used the updated EVS data to recalculate the Medicaid patient days in accordance with Federal requirements and used those recalculations to determine any Medicare DSH overpayments to the selected providers;

- requested that providers obtain updated eligibility data from the State agency's EVS and conduct their own reviews of the Medicare DSH payments that they had received to determine whether the payments were proper;
- discussed the findings we were developing with provider officials throughout the audit; and
- discussed the results of our review with WPS officials on February 1, 2016.

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 objectives.

APPENDIX B: FEDERAL REQUIREMENTS AND GUIDELINES AND STATE AGENCY POLICY

FEDERAL REQUIREMENTS AND GUIDELINES

The Act explains the two computations that make up the Medicare DSH “disproportionate share percentage” (§ 1886(d)(5)(F)(vi)(II)). The second of these two computations (the Medicaid fraction) is “the fraction (expressed as a percentage), the numerator of which is the number of hospital’s patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, but who were not entitled to benefits under Part A of this title, and the denominator of which is the total number of the hospital’s patient days for such period.”

Federal regulations state that health care providers have “... the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed ... and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day” (42 CFR § 412.106(b)(4)(iii)).

Federal regulations state: “Adequate cost information must be obtained from the provider’s records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended” (42 CFR § 413.24(c)).

CMS guidelines elaborate upon Medicaid eligibility requirements. The *Medicare Claims Processing Manual*, chapter 3, § 20.3.1.1., states that “the focus is on eligibility for medical assistance under an approved Title XIX State plan, not medical assistance under a State-only program or other program” (emphasis in original).

A chart in the *Medicare Claims Processing Manual*, chapter 3, § 20.3.1.2., provides specific guidance regarding patient days for individuals “... covered under a State-only (or county-only) general assistance program (whether or not any payment is available for health care services under the program). These patients are not Medicaid-eligible under the State plan.” The same guideline applies to patient days associated with the S-CHIP: “... patients who are eligible for benefits under a non-Medicaid State program furnishing child health assistance to targeted low-income children. These children are, by definition, not Medicaid-eligible under a State plan.”

STATE AGENCY POLICY

The State agency’s *Medical Policy Manual* states (page 26) that ARCH provides services to certain residents of county-owned facilities.

Indiana’s 590 Program “provides coverage for certain healthcare services provided to members who are residents of state-owned facilities” (the State agency’s *Medical Policy Manual*, page 26).¹³

¹³ The State agency explained that “[t]he 590 Program exists due to a federal mandate prohibiting federal financial participation (FFP) for individuals between the ages of 21 and 64” That mandate appears in 42 CFR § 435.1009. Individuals in this age group are the eligible population for the 590 Program.

**APPENDIX C: EFFECT OF INCORRECTLY CLAIMED AND SETTLED
MEDICAID PATIENT DAYS**

Provider	Number of Days in Error	Dollar Effect
1	350	\$179,287
2	172	112,650
3	79	47,391
4	108	41,800
5	73	42,059
6	167	107,196
7	182	118,482
8	58	36,458
9	541	238,248
10	158	153,391
11	786	475,356
12	385	239,299
13	145	(59,264)
14	67	31,773
15	157	82,655
16	43	26,669
17	1,453	541,760
18	80	0
19	128	69,953
20	4,522	1,456,557
21	1,721	690,572
22	221	114,702
23	663	339,980
24	225	116,473
25	889	569,468
26	163	92,629
27	319	19,742
28	95	62,907
29	165	112,969
30	95	21,159
31	0	(2)
32	0	(2)
33	0	0
34	0	0
35	0	1
36	2	920
37	0	0
38	23	4,185
39	12	515
40	0	4

Provider	Number of Days in Error	Dollar Effect
41	0	0
42	12	4,190
43	65	18,429
44	0	0
45	0	0
46	0	(2)
47	0	(1)
48	0	(1)
Totals	14,325	\$6,110,557



September 2, 2016

Mr. Patrick J. Cogley
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

RE: Office of Inspector General (OIG) Draft Report – A-07-15-04219

Dear Mr. Cogley,

This letter is in response to the OIG draft report titled *Wisconsin Physicians Service Insurance Corporation Did Not Properly Settle Indiana Medicare Disproportionate Share Hospital Cost Report Payments*.

The OIG performed a review of Medicaid eligible days used to compute Disproportionate Share Hospital (DSH) payments for 48 Indiana providers (comprised of 30 hospitals and 18 hospital sub-providers) for FYs beginning in 2008 through 2010. The OIG found these providers incorrectly reported 14,325 Medicaid eligible days resulting in \$6.1 million in overpayments. The days were found to be incorrect because they were either not a Medicaid eligible day or the provider could not provide adequate support.

We note that the OIG has largely placed responsibility for these incorrectly reported days and resulting overpayments on the providers. Specifically the OIG has noted:

- *The situation that triggered the OIG review was a change in the State of Indiana's eligibility validation system (EVS) that separately identified days that are not eligible for Medicare DSH payments. These days were previously reported as eligible. Because MACs were not notified by the State or providers of the update to the EVS data, and the potential for incorrectly reported days, MACs had no reason to review DSH days in detail for this particular issue.*
- *The errors located by the OIG can only be found through a detailed review of the provider's reported Medicaid eligible days, including an examination of additional supporting documentation sufficient to support the provider's claim. The Centers for Medicare & Medicaid Services does not require this level of review of all cost reports.*

The review work for these cost reports was all completed prior to the transition of these J8 providers to WPS. NGS, the prior MAC, performed all of the desk review and audit work and was responsible for any audit findings, including any findings pertaining to DSH Medicaid eligible days. Final settlement of these cost reports was delayed pending release of SSI ratios for these reporting periods by CMS; consequently it was left to WPS to issue the final settlements by updating the SSI ratio and incorporating the audit work performed by NGS.

The OIG Recommendations to WPS and WPS' response to the Recommendations:

- *revise the finalized Medicare cost report settlements to recover \$6,110,557 in Medicare DSH overpayments from the 48 selected Indiana providers and refund that amount to the Federal Government;*

WPS Response:

WPS concurs with this recommendation. We note that all of the relevant cost reports have had reopening letters issued and WPS will process a revised settlement in order to recoup the funds identified by OIG.

- *revise final cost report settlements for those FYs 2008 through 2010 Medicare cost reports that were submitted before the June 2011 EVS update but that we did not review, recover any additional Medicare DSH overpayments made to Indiana providers, and refund those recovered amounts to the Federal Government; and*

WPS Response:

WPS does not concur with this recommendation. Virtually all of the 2008 and 2009 cost reports for the remaining providers are closed and beyond the allowable three year reopening period; thus, it is no longer possible for WPS to reopen and review these cost reports. We also believe that the remaining 2010 Medicare cost reports that could be reopened would not yield a significant return. We will work with our CMS Contracting Officer Representative to determine the cost/benefit of additional action on these cost reports.

- *Communicate with State agency officials annually to identify and obtain any State-level guidance affecting recipient categories that figure into Medicare DSH cost report payments.*

WPS Response:

WPS agrees that State agency guidance is valuable. WPS will continue our current approach which allows individual auditors to contact States on an ad hoc basis whenever they run into a situation during an audit where they believe there has been a significant change in the state's policies or reporting procedures. The auditors will obtain the updated information from the state and will communicate any findings to the audit staff.

If you have any questions or need additional information, please contact me at 402-995-0443.

Sincerely,



Mark DeFoil
Director, Contract Coordination

CC: Ronda Jones, CMS
Wanda Jones, CMS
Robert Bernal, CMS
Linda Tran, CMS
Debra Keasling, OIG