Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

INDIANA CLAIMED MEDICAID REIMBURSEMENT FOR HIGH-DOLLAR INPATIENT SERVICES THAT WERE UNALLOWABLE

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Gloria L. Jarmon
Deputy Inspector General

September 2013
A-05-11-00040

Office of Inspector General

https://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

Indiana claimed approximately $1 million in Federal reimbursement for unallowable high-dollar payments that it made to hospitals for inpatient services.

WHY WE DID THIS REVIEW

The Indiana Office of Medicaid Policy and Planning (State agency) uses a prospective payment system to claim Medicaid reimbursement for inpatient service costs based on the charges that a hospital submits to the State agency**.** When a hospital's charges exceed predetermined charge thresholds, the State agency makes what is known as an outlier payment. Outlier payments are intended to protect hospitals against large financial losses associated with high-cost cases. Because of these outlier payments, extraordinarily high-cost cases generally result in high-dollar Medicaid payments. Previous Office of Inspector General reviews found a high occurrence of erroneous Medicaid payments associated with high-dollar inpatient service claims reimbursed by the States.

The objective of this review was to determine the allowability of certain high-dollar Medicaid payments that the State agency made to hospitals for inpatient services.

BACKGROUND

In Indiana, the State agency administers the Medicaid program. Federal reimbursement is authorized to cover part or all of the cost of services furnished as medical assistance under a State Medicaid plan (State plan). Improper payments to hospitals are not allowable for Federal reimbursement under the State plan. Therefore, Federal reimbursements in cases of improper payments constitute overpayments and are unallowable.

HOW WE CONDUCTED THIS REVIEW

We selected 250 inpatient claims with payments of $200,000 or more, totaling $82,146,682 ($50,332,915 Federal share), for services provided during the audit period of January 1, 2006, through December 31, 2009, and reviewed the charges related to those payments.

WHAT WE FOUND

The State agency claimed Federal Medicaid reimbursement for high-dollar claims that were unallowable. Of the 250 high-dollar Medicaid payments that the State agency made to hospitals for inpatient service claims during the audit period, 20 were allowable. The remaining 230 payments (92 percent) were unallowable. The State agency recalculated the payment amounts for the claims that we determined had erroneous charges, resulting in overpayments totaling $1,556,964 ($998,466 Federal share). The overpayments occurred because hospitals reported incorrect charges. Hospital officials attributed the incorrect charges primarily to data entry errors.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $998,466 to the Federal Government and
- use the results of this audit in its provider education activities related to data entry procedures.

AUDITEE COMMENTS

In comments on our draft report, the State agency generally agreed with our recommendations. The State agency explained that it has a policy of not allowing undercharges that are identified as a result of certain audits and said that we agreed with this policy. The State agency has implemented procedures to recover the overpayments by reducing future claim payments to the providers that received overpayments, and it will publish a provider bulletin with a summary of the audit findings.

OIG RESPONSE

We continue to recommend that the State agency refund $998,466 to the Federal Government. We do not agree that "OIG agreed to the State's approach of excluding underpayments." We applied Federal requirements, which allow for netting of underpayments. We did not apply the State-specific policy regarding the exclusion of underpayments. Thus, we have no opinion on Indiana's policy of excluding underpayments.

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INTRODUCTION

WHY WE DID THIS REVIEW

The Indiana Office of Medicaid Policy and Planning (State agency) uses a prospective payment system to claim Medicaid reimbursement for inpatient service costs based on the charges that a hospital submits to the State agency**.** When a hospital's charges exceed predetermined charge thresholds, the State agency makes what is known as an outlier payment.[1] Outlier payments are intended to protect hospitals against large financial losses associated with high-cost cases. Because of these outlier payments, extraordinarily high-cost cases generally result in high-dollar Medicaid payments. Previous Office of Inspector General reviews found a high occurrence of erroneous Medicaid payments associated with high-dollar inpatient service claims reimbursed by the States.[2]

OBJECTIVE

The objective of this review was to determine the allowability of certain high-dollar Medicaid payments that the State agency made to hospitals for inpatient services.

BACKGROUND

The Medicaid Program: How It Is Administered

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 State agency is responsible for administering Indiana's Medicaid program.

Payments for High-Dollar Medicaid Claims

Attachment 4.19-A of the State plan describes the prospective payment system for inpatient hospital services. Under the prospective payment system, the State agency pays hospital 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. The DRG payment is, with certain

[1] In Indiana, there are two types of outlier payments: (1) cost outlier payments and (2) day outlier payments for certain hospital admissions for children. For this review, we use the term "outlier payment" to refer to both types.

[2] U.S. Department of Health and Human Services, Office of Inspector General, report number A-05-09-00048 entitled *Review of Medicaid High-Dollar Payments for Inpatient Services in Illinois From January 1, 2006, Through September 30, 2007 – Hospitals With Fewer Than Five High-Dollar Payments*, issued on May 21, 2010, and report number A-05-09-00049 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*, issued on December 20, 2010.

exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. One of these exceptions is an outlier payment.

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 by a predetermined threshold as defined by the State plan. Thus, for high-dollar Medicaid claims, the State agency pays the DRG payment plus an outlier payment when necessary.

Indiana's Medicaid Program: How It Is Administered

The State agency's Medicaid program provides certain medical services, including inpatient hospital services. Indiana pays for inpatient services using a prospective payment system that includes an outlier payment for high-dollar claims. The State agency processes hospital inpatient service claims through the Medicaid Management Information System.[3]

HOW WE CONDUCTED THIS REVIEW

Our review covered the State agency's claims for Medicaid reimbursement during calendar years (CYs) 2006 through 2009. During this period, the State agency claimed $1,544,668,030 for inpatient service claims. We reviewed all 250 Medicaid inpatient service claims with payments of $200,000[4] or more, which totaled $82,146,682 ($50,332,915 Federal share). We tested the charges associated with the 250 claims and presented the results of our review to the State agency. The State agency recalculated the payment amounts for the claims that we determined had erroneous charges.

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 A contains the details of our audit scope and methodology. Appendix B contains the Federal and State requirements for Medicaid inpatient services.

FINDING

The State agency claimed Federal Medicaid reimbursement for high-dollar claims that were unallowable. Of the 250 high-dollar Medicaid payments that the State agency made during

[3] 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.

[4] We considered claims with payment amounts of $200,000 or more high-dollar claims for this review.

CYs 2006 through 2009 to hospitals for inpatient services, 20 were allowable. The remaining 230 payments (92 percent) were unallowable. The State agency recalculated the payment amounts for the claims that we determined had erroneous charges, resulting in overpayments totaling $1,556,964 ($998,466 Federal share). The overpayments occurred because hospitals reported incorrect charges. Hospital officials attributed the incorrect charges primarily to data entry errors. For example, one inpatient hospital claim contained an overcharge of $81,588 because a nitric oxide charge was entered for each hour it was used, when it was actually a daily rate. The erroneous charges led to a $15,410 overpayment ($9,648 Federal share).

RECOMMENDATIONS

We recommend that the State agency:

- refund $998,466 to the Federal Government and
- use the results of this audit in its provider education activities related to data entry procedures.

AUDITEE COMMENTS

In comments on our draft report, the State agency generally agreed with our recommendations. The State agency explained that it has a policy of not allowing undercharges that are identified as a result of certain audits and said that we agreed with this policy. The State agency has implemented procedures to recover the overpayments by reducing future claim payments to the providers that received overpayments, and it will publish a provider bulletin with a summary of the audit findings.

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

OIG RESPONSE

We continue to recommend that the State agency refund $998,466 to the Federal Government. We do not agree that "OIG agreed to the State's approach of excluding underpayments." We applied Federal requirements, which allow for netting of underpayments. We did not apply the State-specific policy regarding the exclusion of underpayments. Thus, we have no opinion on Indiana's policy of excluding underpayments.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We selected and reviewed 250 inpatient claims with payments of $200,000 or more, totaling $82,146,682 ($50,332,915 Federal share), for services provided from January 1, 2006, through December 31, 2009.

We limited our review of the State agency's internal controls to those that related to our audit objective. 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.[5]

Our fieldwork was conducted from May 2011 through November 2012 and included contacting the State agency in Indianapolis, Indiana, and the 38 hospitals that received the selected Medicaid payments.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, guidance, and the CMS-approved State plan;
- interviewed State agency officials to gain an understanding of how the State agency processed and adjusted claims for inpatient services;
- requested all high-dollar claim data for inpatient hospital services provided during the audit period from Indiana's Medicaid Statistical Information System file (250 claims from 38 hospitals);
- contacted the State agency to determine whether the 250 high-dollar claims 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 for the claims;
- contacted the 38 hospitals that received payments for the 250 high-dollar claims and requested assessments as to whether the charges originally reported on each of the claims were correct and, if not, why the claims were incorrect;
- reviewed supporting documentation received from the hospitals to verify the hospitals' assessment of the selected claims;

[5] 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.

- summarized and submitted to the State agency information regarding our review of submitted charges and related correspondence that we received from the hospitals;

- requested that the State agency recalculate the payment amounts for the claims that we determined had erroneous charges; and

- provided the results of our review to State agency officials on October 16, 2012.

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 AND STATE REQUIREMENTS FOR MEDICAID INPATIENT SERVICES

FEDERAL REQUIREMENTS

Improper payments to providers are not allowable for Federal reimbursement under the State plan within the meaning of sections 1903(a)(1) and 1905(a) of the Social Security Act (the Act). Federal reimbursement is authorized to State Medicaid agencies for expenditures that constitute payment for part or all of the cost of services furnished as medical assistance under the State plan. Therefore, Federal funding in cases of improper payments constitutes overpayments that must be adjusted under section 1903(d)(2)(A) of the Act.

Federal regulations (42 CFR § 433.312(a)(2)) require a State to refund the Federal share of unallowable overpayments made to Medicaid providers.

STATE REQUIREMENTS

Attachment 4.19-A provides an overview of reimbursement to hospitals for Medicaid inpatient services. A hospital may be paid a DRG payment amount plus an additional day[6] or cost outlier payment. Attachment 4.19-A of the State plan also provides that each in-State hospital may receive an additional inpatient Medicaid outlier payment adjustment for cases incurring extremely high costs. A Medicaid stay that exceeds a predetermined threshold, defined as the greater of twice the DRG rate or the outlier threshold, is a cost outlier case. The calculation for outlier payment amounts is made by multiplying the overall facility cost-to-charge ratio by submitted charges. The outlier payment is equal to the marginal cost factor multiplied by the difference between the prospective cost per stay and the greater of the DRG rate or the outlier threshold amount.

Pursuant to Attachment 4.19-A of the State plan, each facility that submits an Indiana Medicaid cost report will receive a cost-to-charge ratio. The cost-to-charge ratio will be computed from claim data and will be used to determine applicable cost outlier payments. Facilities with less than 30 Medicaid claims annually will be given the statewide median cost-to-charge ratio. The outlier payment adjustment will be made annually after the State agency has computed the payment under this methodology.

[6] A day outlier payment is available upon a hospital's request for children under 6 years of age in disproportionate share hospitals and for children under age 1 in all hospitals (§ 1902(s) of the Act).

APPENDIX C: AUDITEE COMMENTS

Michael R. Pence, Governor
State of Indiana

Office of Medicaid Policy and Planning
MS 07, 402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

August 16, 2013

Ms. Sheri L. Fulcher
Regional Inspector General
Office of Audit Services, Region V
Department of Health and Human Services
Office of Inspector General
233 North Michigan, Suite 1360
Chicago, IL 60601

Re: OIG Report No. A-05-11-00040

Dear Ms. Fulcher,

The Indiana Office of Medicaid Policy and Planning ("OMPP") appreciates the opportunity to comment on the draft report of the Office of the Inspector General ("OIG") entitled "Indiana Claimed Medicaid Reimbursement for High-Dollar Inpatient Services That Were Unallowable", Report No. A-05-11-00040, dated July 17, 2013 and received by the State on July 19, 2013 ("Audit Report"). The OIG audit encompassed inpatient claims with payments of $200,000 or more, for services provided during the period of January 1, 2006 through December 31, 2009. The OIG found that 230 of 250 high-dollar Medicaid payments, for which the State claimed Federal Medicaid reimbursement, were paid incorrectly due to provider submitted erroneous charges.

In April 2012, the OIG provided the State with a spreadsheet containing two hundred fifty (250) claims included in OIG audit A-05-11-00040. This spreadsheet also included a column for the *net* over and/or undercharges identified by the individual providers and verified by the OIG. Given the information supplied in this spreadsheet, the State and its contractor(s) re-priced the claims based *solely* on the *net* over and/or undercharges reported (i.e., all other claim information remained constant) in order to determine any potential overpayments due from providers. Potential overpayments were identified by subtracting the re-priced Indiana Medicaid payment from the original Indiana Medicaid payment received by providers on the originally submitted claim after any and all claim adjustments or voids were taken into consideration. The resulting estimated total overpayment amount identified for all 250 claims involved in the audit was $1,556,964 (of which, $998,466 is the estimated Federal share).

Due to the State's policy of not allowing undercharges that are identified as a result of OMPP Surveillance and Utilization Review (SUR) audits to be paid to provider's beyond the claim filing limit (whereas the OIG considers both over and undercharges), it was determined that two (2) different methodologies would be required in order to estimate and report any overpayments due from providers. After discussion between the State and the OIG regarding this issue, the OIG supplied a revised spreadsheet with an additional column identifying *overcharges* only. The State and its contractor(s) subsequently re-priced the claims based *solely* on the overcharges reported (i.e., all other claim information remained constant) in order to determine any potential overpayments due from providers. Potential overpayments were again identified by subtracting the re-priced Indiana Medicaid payment from the original Indiana Medicaid payment received by providers on the originally submitted claim after any and all adjustments or voids were taken into consideration. The estimated total overpayment amount identified for all 250 claims involved in this audit is $2,421,719 (of which, $1,552,258 is the estimated Federal share). The State provided the results of both re-pricing methodologies to the OIG for review and approval. Upon further discussion, the OIG agreed to the State's approach of excluding underpayments identified as a result of OMPP Surveillance and Utilization Review (SUR) audits to be paid to provider's beyond the claim filing limit and inclusion in the calculation of overpayments due from the providers.

On October 29, 2012, based on the information supplied by the OIG and the re-pricing calculations completed by the State and its contractor(s), the OMPP sent out either a Draft Audit Findings (DAF) letter or a Final Audit Findings (FAF) letter to the thirty-eight (38) providers included within the OIG audit. In the DAF letters, providers were informed of the identified potential errors and were asked to complete certain claim adjustment request forms, as documented in the IHCP Provider Manual, and submit the completed form(s) to the OMPP SUR Department. In instances in which the provider agreed with the draft audit findings and submitted the appropriate claim adjustment information, the State and its contractor(s) have reviewed and submitted the requests to the State's fiscal agent for processing. Once these claims are fully adjudicated through the claims processing system, a Final Calculation of Overpayment (FCO) letter is issued to the provider stating that OMPP acknowledges that the provider has elected, via the claims adjustment process, to have the principle overpayment amount deducted from *future* Indiana Medicaid payments (which may already have occurred) and outlines any remaining interest that may be due (to be paid via check).

In instances in which the provider has disagreed with the draft audit findings and requested administrative reconsideration, the State is also working with these providers to finalize the audit findings. In these instances, a Response to Request for Administrative Reconsideration letter is prepared again outlining the audit findings and addressing any issues and/or concerns raised by the provider in their response to the Draft Audit Findings. Providers are again asked to submit the appropriate adjustment information in order for the claims to be adjusted to accurately reflect the correct billed charges amount. The State is continuing to work with providers on submitting the appropriate claim adjustment information in order to finalize these audits. As of July 22, 2013, the OMPP has collected $460,134.37 (with an estimated Federal share of $308,256 in overpayments, including interest, from thirteen (13) providers identified in this review). Of the remaining 25 providers identified: three (3) provider cases are

on hold by recommendation of the Indiana Medicaid Fraud Control Unit (with a total estimated overpayment of $110,199.63; six (6) provider cases resulted in no overpayments identified upon validation of provider billing; the State and its contractor(s) continues to correspond and work with the remaining 16 providers to facilitate proper claim reprocessing and repayment of the outstanding overpayments, as well as request providers to develop greater internal controls to minimize further instances of inappropriate billings and promote increased internal auditing. It is the expectation of the State that the remaining overpayments will be processed and repaid by December 31, 2013. OMPP will also publish a provider bulletin to the hospital provider community that summarizes the audit findings and the actions providers can take to minimize incorrect billings.

The State appreciates your consideration of the information provided in this letter. If you have any questions or require additional information, please contact James Waddick at 317-234-7484 or James.Waddick@fssa.in.gov.

Sincerely,

Pat Nolting
Interim Medicaid Director