Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

WISCONSIN 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

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A-05-11-00037

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

Wisconsin claimed approximately $1.1 million in Federal reimbursement for unallowable high-dollar payments that it made to hospitals for inpatient services.

WHY WE DID THIS REVIEW

The Wisconsin Department of Health Services (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 Wisconsin, 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 providers 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 386 inpatient claims with payments of $200,000 or more, totaling $138,735,373 ($80,906,872 Federal share), for services provided from 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 386 high-dollar Medicaid payments that the State agency made to hospitals for inpatient service claims, 302 were allowable. The remaining 84 payments (22 percent) were unallowable. The State agency recalculated the payment amounts for the claims that we determined had erroneous charges, resulting in overpayments totaling $1,879,836 ($1,106,872 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 $1,106,872 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 said that it agreed with the recommendations outlined in our draft report. It has implemented procedures to recover the overpayments by reducing future claim payments to the providers that received overpayments. It will also use the report results to provide education activities regarding proper data entry to improve claim accuracy.

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INTRODUCTION

WHY WE DID THIS REVIEW

The Wisconsin Department of Health Services (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 (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 Wisconsin'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

[1] In Wisconsin, there are two types of outlier payments: (1) cost outlier payments and (2) length-of-stay 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.

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 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.

Wisconsin's Medicaid Program: How It Is Administered

The State agency's Medicaid program provides certain medical services, including inpatient hospital services. Wisconsin 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 $1,694,697,337 for inpatient service claims. We reviewed all 386 Medicaid inpatient service claims with payments of $200,000[4] or more, which totaled $138,735,373 ($80,906,872 Federal share). We tested the charges associated with the 386 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.

[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 beneficiaries, and report selected data to CMS.

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

FINDING

The State agency claimed Federal Medicaid reimbursement for high-dollar claims that were unallowable. Of the 386 high-dollar Medicaid payments that the State agency made during CYs 2006 through 2009 to hospitals for inpatient services, 302 were allowable. The remaining 84 payments (22 percent) were unallowable. The State agency recalculated the payment amounts for the claims that we determined had erroneous charges, resulting in overpayments totaling $1,879,836 ($1,106,872 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 $28,848 because of a pharmacy charge error that was entered manually for a medication that the patient did not receive. The erroneous charges led to a $15,180 overpayment ($9,014 Federal share).

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,106,872 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 said that it agreed with the recommendations outlined in our draft report. It has implemented procedures to recover the overpayments by reducing future claim payments to the providers that received overpayments. It will also use the report results to provide education activities regarding proper data entry to improve claim accuracy.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We selected and reviewed 386 inpatient claims with payments of $200,000 or more, totaling $138,735,373 ($80,906,872 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]

We conducted fieldwork at the State agency's offices in Madison, Wisconsin, and contacted the 24 hospitals in Wisconsin 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 Wisconsin's Medicaid Statistical Information System file (386 claims from 24 hospitals);

- contacted the State agency to determine whether the 386 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 24 hospitals that received payments for the 386 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;

[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.

- reviewed supporting documentation received from the hospitals to verify the hospitals' assessment of the selected claims;

- 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 we determined had erroneous charges; and

- provided the results of our review to State agency officials on September 25, 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 §§ 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 § 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, § 1000, provides an overview of reimbursement to hospitals for Medicaid inpatient services. A hospital may be paid a DRG payment amount plus an additional length-of-stay[6] or cost outlier payment. Attachment 4.19-A, § 5200, of the State plan provides for outlier payments to hospitals, in addition to DRG payments, for cases incurring extremely high costs. Pursuant to Attachment 4.19-A, § 5221, of the State plan, outlier payments are made to hospitals for covered inpatient services furnished to a Medicaid beneficiary if the hospital's charges, as adjusted by the hospital-specific cost-to-charge ratio, exceed the DRG payment by the amount of the trimpoint applicable to the hospital. The applicable trimpoints are defined by the type of hospital and number of beds within the hospital as follows:

Trimpoint Amount[7] by Type and Bed Size of Hospital

Type of Hospital / Bed Size	Less Than 100 Beds	100 Beds or Greater
General medical and surgical hospital	$5,235	$31,410
Critical access hospital[8]	$300	not applicable

[6] A length-of-stay 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.

[7] The trimpoint amount changes by the current rate year. The amounts listed in the table are for State fiscal year 2010.

[8] Critical access hospitals operate primarily in rural areas and are limited to 25 beds.

APPENDIX C: AUDITEE COMMENTS

State of Wisconsin
Department of Health Services

Scott Walker, Governor
Kitty Rhoades, Secretary

May 3, 2013

TO: Ms, Sheri Fulcher
Regional Inspector General for Audit Services, Region V

FROM: Kitty Rhoades, Secretary
Department of Health Services

SUBJECT: Wisconsin Claimed Medicaid Reimbursement for High-Dollar Inpatient Services Audit finding (A-05-11-00037)

Department staff has reviewed the audit report titled Wisconsin Claimed Medicaid Reimbursement for High-Dollar Inpatient Services (A-05-11-00037). This memo is the DHS response to the recommendations made in the report.

BACKGROUND

DHS claims Federal Medicaid reimbursement for high-dollar inpatient services. For the audit period January 1, 2006, through December 31, 2009, HHS/OIG selected and reviewed all 386 Medicaid inpatient service claims with payments of $200,000 or more that totaled $138,735,373 ($80,906,872 Federal share).

Of the 386 high-dollar Medicaid payments that DHS made to hospitals for inpatient service claims, 302 were allowable. The remaining 84 (22 percent) were unallowable. DHS recalculated the payment amounts for the claims that were determined to have erroneous charges resulting in overpayments totaling $1,879,836 ($1,106,872 Federal share). The overpayments occurred because hospitals reported incorrect charges. Hospital Officials attributed the incorrect charges primarily to data entry errors.

☑ ***Recommendation:***

HHS/OIG: *We recommend that the State agency:*

- *refund $1,106,872 to the Federal Government*
- *use the results of this audit in its provider education activities related to data entry procedures.*

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WIDHS Response: The Department of Health Services (DHS) agrees with the recommendation

- Procedures were implemented to recover the overpayments by reducing the providers future claim payments, which in effect returned the recouped money to the Federal Government.
- DHS will use the results of this audit in its provider education activities to improve claim accuracy related to data entry.

M K. Rhoades

Kitty Rhoades, Secretary

cc: Cheryl Johnson, DES - Deputy Administrator
Curtis Cunningham, DHCAA – Director - Bureau of Fiscal Management
Alan White, DHS – Office of Inspector General
Lori Thornton, DHS - Office of Inspector General
Amy McDowell, DES – Director – Bureau of Fiscal Services
Dale Crapp, DES – BFS