Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION DID NOT PROPERLY SETTLE MISSOURI MEDICARE DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

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

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A-07-16-04229

Office of Inspector General

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Report in Brief
Date: June 2017
Report No. A-07-16-04229

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Wisconsin Physicians Service Insurance Corporation Did Not Properly Settle Missouri Medicare Disproportionate Share Hospital Payments

Why OIG Did This Review

During fiscal years (FYs) 2010 through 2012, Medicare paid $35.7 billion in disproportionate share hospital (DSH) payments to hospitals that have a large share of low-income patients. These payments are at risk of overpayment.

Providers verify Medicaid eligibility for each patient day with the State. Providers submit Medicaid patient days on the Medicare cost report for Medicare DSH payments. The cost reports for inpatient hospitals in Missouri (Missouri providers) are reviewed by the Medicare contractor, Wisconsin Physicians Service Insurance Corporation (WPS).

Our objective was to determine whether, with respect to Medicaid patient days, WPS properly settled FYs 2010 through 2012 Medicare cost reports submitted by Missouri providers for Medicare DSH payments in accordance with Federal requirements.

How OIG Did This Review

For FYs 2010 through 2012, we obtained Medicaid eligibility data from Missouri for 10 selected Missouri providers (with 20 associated cost reports) and compared the data to the Medicaid eligibility information filed by the providers on the Medicare cost report. Medicare DSH payments to these 10 providers represented 31.3 percent of all DSH payments made to Missouri providers for FYs 2010 through 2012. We reviewed $204 million in Medicare DSH payments.

What OIG Found

With respect to Medicaid patient days, WPS did not properly settle FYs 2010 through 2012 Medicare cost reports submitted by Missouri providers for Medicare DSH payments in accordance with Federal requirements. The 10 selected providers (with 20 cost reports) improperly claimed 7,132 Medicaid patient days on their Medicare cost reports, resulting in DSH overpayments totaling almost $3.0 million. These improper claims included both unallowable and unsupported patient days and involved patients in a variety of categories that, under Federal requirements and guidelines, are not considered to be Medicaid programs for purposes of Medicare DSH payments.

These errors occurred because the selected Missouri providers did not properly claim Medicaid patient days in accordance with Federal requirements when they prepared and submitted their cost reports to WPS. 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.

What OIG Recommends and WPS Comments

We recommend that WPS recover the nearly $3.0 million in Medicare DSH overpayments from the selected Missouri providers, reopen and revise settled cost reports (from Missouri providers) that we did not review, and refund overpayments to the Federal Government. We also recommend that WPS communicate annually with the Missouri State Medicaid agency to obtain updated eligibility information and furnish education to providers regarding the categories that are not considered to be Medicaid programs for purposes of Medicare DSH payments.

WPS concurred with our first recommendation but did not concur with our recommendation to reopen and revise settled cost reports (from Missouri providers) that we did not review. WPS stated that its limited resources did not permit it to conduct the detailed auditing that, it said, our second recommendation would require. WPS agreed with our remaining recommendations. We maintain that all of our findings and recommendations remain valid. Coordination with the Missouri State Medicaid agency to obtain information necessary to address our second recommendation would involve a relatively straightforward process. Corrective actions that used this process would, we believe, yield more accurate results and a potentially significant recovery of Medicare funds that could justify the investment of resources.

The full report can be found at https://oig.hhs.gov/oas/reports/region7/71604229.asp.

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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 in part 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 years (FYs) 2010 through 2012, Medicare made $35.7 billion in DSH payments.

Federal requirements identify certain programs and other categories of services as excluded (excluded categories) from the calculation of Medicaid patient days used to determine a provider's Medicare DSH payment adjustment. This report conveys the results of one of a series of reviews involving the calculations of Medicaid patient days that figure into the amounts of Medicare DSH payments made by Medicare contractors to providers. A recent Office of Inspector General review found that inpatient hospitals in the State of Indiana did not properly claim Medicaid patient days on their Medicare cost reports, and Wisconsin Physicians Service Insurance Corporation (WPS), a Medicare contractor, did not properly settle cost reports submitted by these providers for Medicare DSH payments for FYs 2008 through 2010.[1]

WPS is the Medicare contractor for Jurisdiction 5, which comprises the States of Iowa, Kansas, Missouri, and Nebraska. This review focused on Medicare DSH payments made to Missouri providers and, in particular, on the calculations that these providers made when claiming Medicaid patient days on their Medicare cost reports.

OBJECTIVE

Our objective was to determine whether, with respect to Medicaid patient days, WPS properly settled FYs 2010 through 2012 Medicare cost reports submitted by inpatient hospitals in the State of Missouri (Missouri providers) for Medicare DSH payments in accordance with Federal requirements.

[1] *Wisconsin Physicians Service Insurance Corporation Did Not Properly Settle Indiana Medicare Disproportionate Share Hospital Cost Report Payments* (A-07-15-04219), Nov. 1, 2016.

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.

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)).

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)).

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).[2]

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.[3]

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.[4]

Limitations on Programs Qualifying for Disproportionate Share Hospital Payments

CMS guidelines regarding excluded categories appear in the *Medicare Claims Processing Manual* (the Manual), which clarifies that State-only health programs and certain other programs and categories of services are not considered to be Medicaid programs for purposes of Medicare DSH payments (the Manual, chapter 3, §§ 20.3.1.1 and 20.3.1.2). For purposes of the Medicare DSH calculation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State plan.

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

[3] Under 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, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State Medicaid plan (State plan). Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

[4] 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.

Under these guidelines, excluded categories include family planning and family planning-related services programs; the Children's Health Insurance Program (CHIP);[5] temporary prenatal care services; State-only programs; individuals who have not met designated spenddown requirements that, if met, would allow those individuals to become eligible for Medicaid;[6] and services involving dual eligibles (footnote 4). Additional information about these excluded categories within the State of Missouri appears below.

Missouri Medicaid Program and Excluded Categories Within It

In Missouri, the Department of Social Services, MO HealthNet Division (State agency), administers the State's Medicaid program. Another subordinate entity of the Department of Social Services, the Family Support Division, maintains an eligibility verification system and makes eligibility determinations.

The provisions of the Manual regarding excluded categories apply to several programs and other categories of services in the State of Missouri:

- *Family planning and family planning-related services*. The Missouri Women's Health Services Program provides outpatient family planning and family planning-related services to low-income women aged 18 through 55. Some of the furnished services are approved methods of birth control, family planning counseling, Pap tests, and pelvic exams.

- *CHIP*. Missouri provides separate health care coverage under the CHIP to uninsured children in families whose incomes are too high to qualify for Medicaid but too low to afford private health coverage.

- *Temporary prenatal care services*. Missouri provides temporary ambulatory prenatal care services to pregnant women while they await formal determinations of Medicaid eligibility. These services include physician, clinic, x-ray, and outpatient hospital services.

- *State-only services*. Missouri provides State funds for individuals who receive a blind pension check, children who receive a State-only adoption subsidy payment, and

[5] The Balanced Budget Act of 1997 expanded the Social Security Act and created Title XXI, the State Children's Health Insurance Program (SCHIP). SCHIP 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. On February 4, 2009, this program was renamed the CHIP.

[6] The term "spenddown requirements" refers to programs under which individuals whose income is too high to qualify for Medicaid may become eligible for Medicaid by incurring medical expenses or making payments to the State agency that are subtracted (or spent down) from their income to qualify for Medicaid. Such programs are referred to as "spenddown programs;" for this report, we refer to individuals who meet these requirements and qualify for these programs as "spenddown recipients."

individuals under age 21 living in foster homes. These funds are not matched by any Federal funds under an approved State Medicaid plan.

- *Spenddown programs*. In the Missouri Aged, Blind, and Disabled Program, some individuals become eligible for Medicaid after having met a periodic spenddown requirement. Individuals may meet their spenddown requirement (and become "spenddown recipients") by submitting incurred medical expenses or by paying the designated monthly spenddown amount.

- *Dual eligibles* (footnote 4). After WPS pays a Medicare Part A claim for a dual eligible and assesses the Part A deductibles and coinsurance, it forwards the claim information to the State agency. The State agency determines, on the basis of the requirements established in its State plan, whether to pay part or all of the Medicare Part A deductibles and coinsurance and then pays the provider through the usual Medicaid payment system.

Eligibility Verification System

Missouri providers must verify eligibility with the Family Support Division by using the Internet or interactive voice response system. The State agency uses Managed Care eligibility codes (ME codes) to identify eligible participants. Each eligibility group or category of assistance, which is designated by one or more ME codes and which can include the excluded categories discussed just above, has its own eligibility determination criteria that must be met.

We focused on Medicaid patient days for this review of Medicare DSH payments to Missouri providers because the calculation of those patient days was directly affected by the inclusion (in the numerator of the Medicaid fraction) of any patient days associated with the excluded categories that did not qualify for Medicare DSH payments. In turn, the inclusion of such patient days affected each provider's determination of its Medicaid fraction, WPS's calculation of the disproportionate patient percentage for that provider, and ultimately the amount of Medicare DSH payments to Missouri providers.

HOW WE CONDUCTED THIS REVIEW

Of 63 providers we identified in the State of Missouri, we judgmentally selected 10 providers (with 20 associated Medicare cost reports) that received Medicare DSH payments totaling $203,899,507 for FYs 2010 through 2012 (which at the time of our audit work was the most recent period that had settled cost reports). We selected these 10 providers because the amounts of their total Medicare DSH payments were significantly higher than those for other Missouri providers for this timeframe. Medicare DSH payments to these 10 providers represented 31.3 percent of all DSH payments made to Missouri providers for this timeframe.

We reviewed the 20 Medicare cost reports submitted by these 10 providers for FYs 2010 through 2012. In particular, we focused on the calculation of Medicaid patient days insofar as

those calculations affected the amounts of Medicare DSH payments made to Missouri providers, and evaluated whether these providers had properly calculated their Medicaid patient days. When the providers had not properly calculated their Medicaid patient days, we recalculated the Medicaid patient days in accordance with Federal requirements,[7] and on the basis of those recalculations, we determined the Medicare DSH overpayments.

The Missouri providers had submitted the 20 Medicare cost reports (which reflected 612,517 Medicaid patient days) that we reviewed to WPS; in turn, WPS brought the cost reports to final settlement. Prior to the final settlement and before the start of our audit, WPS audited DSH payments for 6 of the 20 cost reports selected for review.

We evaluated provider information supporting the cost reports' calculated Medicaid patient days. We also gave the providers the opportunity to review and comment on our preliminary findings and recalculations. In addition, to determine whether the Medicare DSH payments were proper, we contacted the State agency to verify the Medicaid eligibility of the individuals who received services that figured into the Medicaid patient days claimed by providers on their cost reports.

Appendix A contains details of our audit scope and methodology.

FINDINGS

With respect to Medicaid patient days, WPS did not properly settle FYs 2010 through 2012 Medicare cost reports submitted by Missouri providers for Medicare DSH payments in accordance with Federal requirements. The 20 settled Medicare cost reports that Missouri providers submitted for FYs 2010 through 2012 reflected 612,517 Medicaid patient days. The 10 selected providers (with those 20 associated cost reports) improperly claimed a total of 7,132 Medicaid patient days on their cost reports, resulting in DSH overpayments totaling $2,992,094. These improper claims included both unallowable and unsupported Medicaid patient days and involved patients in the excluded categories of family planning and family planning-related services, CHIP, temporary prenatal care services, State-only programs, patients who did not meet the designated spenddown requirements to qualify for spenddown programs, and dual eligibility.

The table on the following page summarizes these findings in the context of patient days improperly claimed on the Medicare cost reports that we reviewed.

[7] To recalculate these patient days, we identified ME codes associated with excluded categories (described earlier) that do not qualify for Medicare DSH payments. We then removed the patient days associated with those ME codes from the numerators of the relevant providers' Medicaid fractions.

Table: Unallowable, Unsupported, and Dual-Eligible Patient Days[8]

Unallowable Patient Days	3,645
Unsupported Patient Days	621
Dual Eligible Patient Days	2,866
Total Unallowable Patient Days	**7,132**

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 WPS. Providers did so because they were not sufficiently educated on the excluded categories that did not qualify for Medicare DSH payments.

Prior to the final settlement of the cost reports and before the start of our audit, WPS audited DSH payments for 6 of the 20 cost reports that we selected for review. 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. Had WPS communicated with State agency officials annually to identify and obtain updated listings of Missouri ME codes as well as other State-level guidance affecting programs and other categories of services that figure into Medicare DSH cost report payments, the errors we identified could have been prevented.

MEDICAID PATIENT DAYS WERE UNALLOWABLE AND UNSUPPORTED

Federal Requirements and Guidelines and State Agency Policy

The Act and implementing regulations (42 CFR § 412.106(b)) explain the two computations that make up the disproportionate share 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. The Medicare contractor or fiscal intermediary determines the second computation, which reflects the hospital's patient days of service for patients eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For the second computation, a patient is eligible for Medicaid on a given day only if that individual is eligible for inpatient hospital services under an approved State Medicaid plan.

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)).

[8] Although we are able to determine the Medicare DSH overpayments in the aggregate, the need to compute the financial effect based on the specific details of each cost report means that it is not possible to break out the overpayments for each category of unallowable patient days.

Providers must furnish adequate cost information obtained from records to support payments made for services furnished to beneficiaries. The data should be accurate and in sufficient detail to accomplish the purpose for which it is intended (42 CFR § 413.24(c)).

CMS guidelines elaborate upon Medicaid eligibility guidelines. The Manual, chapter 3, § 20.3.1.1, explains 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 that is not included in the Title XIX State plan. A chart in the 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 *Hospital Manual*[9] provides specific information, in the context of State medical assistance programs, regarding the Medicaid eligibility of individuals receiving services under the excluded categories that do not qualify for Medicare DSH payments.

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

Unallowable Medicaid Patient Days

Missouri providers claimed and WPS settled a total of 3,645 unallowable patient days, consisting of the following excluded categories:

- 1,407 unallowable family planning and family planning-related patient days (Missouri ME codes 80 or 89). Family planning and family planning-related outpatient services are not considered Medicaid patient days. Accordingly, patient days associated with recipients eligible for family planning and family planning-related services are not considered Medicaid patient days.

- 1,350 unallowable CHIP patient days (Missouri ME codes 73, 74, or 75). CHIP is funded under Title XXI of the Act and recipients of the program are eligible under Title XXI. Accordingly, patient days associated with CHIP recipients are not considered Medicaid patient days.

- 454 unallowable temporary prenatal care patient days (Missouri ME codes 58 or 59). Temporary prenatal care patient days do not qualify as inpatient services under Medicaid. Accordingly, patient days associated with prenatal care services are not considered Medicaid patient days.

- 284 unallowable State-only patient days (Missouri ME codes 2, 8, 52, 57, 64, or 65). The State-only program is funded solely by the State of Missouri and does not involve or

[9] The Missouri *Hospital Manual* may be found at http://manuals.momed.com/manuals/ (accessed Dec. 20, 2016).

provide for eligibility for Medicaid. Accordingly, patient days associated with State-only recipients are not considered Medicaid patient days.

- 150 unallowable spenddown patient days (Missouri ME codes (with a Financial Grant Indicator (FGI) of 4 added) 11, 12, or 13).[10] Patients who have not met their spenddown requirements by incurring a certain level of medical expenses or making payments to the State agency are not eligible for Medicaid (footnote 6). Accordingly, patient days associated with individuals who do not qualify as spenddown recipients are not considered Medicaid patient days.

  Missouri requires some aged, blind, and disabled patients to spend down their income by incurring medical expenses to qualify for Medicaid. Providers did not verify with Missouri whether a patient was in a spenddown status. Providers claimed unallowable days for patients that had not met their spenddown requirements.

Missouri providers claimed these unallowable Medicaid patient days on the cost reports that they prepared and submitted to WPS. In turn, WPS brought all of the cost reports to final settlement. Because these cost reports included 3,645 improperly claimed Medicaid patient days, the cost reports were not properly settled, and the Missouri providers received Medicare DSH overpayments as a result.

Unsupported Medicaid Patient Days

Missouri providers claimed and WPS settled a total of 621 patient days that lacked data to support the recipients' Medicaid eligibility. One Missouri provider claimed 399 patient days that did not have documentation supporting that the patients were eligible for Medicaid. Another Missouri provider claimed 222 patient days that were duplicated—in each case, the same patient day, for the same recipient, was claimed twice.

Missouri providers claimed these unsupported Medicaid patient days on the cost reports that they prepared and submitted to WPS. In turn, WPS brought all of the cost reports to final settlement. Because these cost reports included 621 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

[10] FGIs are subsets of the ME codes and are used by the State agency to designate the financial status of Medicaid recipients. FGI 4 reveals that the individual has not met his or her spenddown requirements to qualify for Medicaid.

service. Patient days associated with dual eligibles therefore cannot, by definition,[11] 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 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, most providers did not fully identify Medicare Part A entitlement information for each patient day on their cost reports. As a result, Missouri providers claimed and WPS settled 2,866 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 WPS. In turn, WPS brought all of the cost reports to final settlement. Because these cost reports included 2,866 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 Federal requirements—including requirements governing the determination of dual-eligibility status—when the providers prepared and submitted their cost reports to WPS. Providers did so because they were not sufficiently educated on the excluded categories that did not qualify for Medicare DSH payments.

WPS audited DSH payments for 6 of the 20 cost reports that we selected for review. 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. These cost reports can be reopened and the Medicare DSH overpayments can be recovered and refunded to the Federal Government.

We determined that WPS was using an outdated Missouri ME code listing that incorrectly reflected Medicaid eligibility for Medicare DSH payments. Had WPS communicated with State agency officials annually to identify and obtain updated listings as well as other State-level guidance affecting programs and other categories of services that figure into Medicare DSH cost report payments, the errors we identified could have been prevented.

[11] See footnote 4.

EFFECT OF INCORRECTLY CLAIMED AND SETTLED MEDICAID PATIENT DAYS

The 10 selected providers improperly claimed a total of 7,132 Medicaid patient days on their Medicare cost reports, resulting in DSH overpayments totaling $2,992,094. Appendix C contains details on the unallowable and unsupported Medicaid patient days as well as the overpayments for each provider cost report.

RECOMMENDATIONS

We recommend that WPS:

- reopen and revise the 20 finalized Medicare cost report settlements to recover $2,992,094 in Medicare DSH overpayments from the 10 selected Missouri providers and refund that amount to the Federal Government;

- reopen and revise final cost report settlements for those Medicare cost reports (from Missouri providers) that we did not review, recover any additional Medicare DSH overpayments made to Missouri providers, and refund those recovered amounts to the Federal Government;

- communicate with State agency officials annually to identify and obtain updated listings of Missouri ME codes as well as other State-level guidance affecting programs and other categories of services that figure into Medicare DSH cost report payments; and

- furnish education to providers regarding excluded categories that do not qualify for Medicare DSH payments (family planning and family planning related services, CHIP, temporary prenatal care services, State-only, individuals who do not qualify as spenddown recipients, and dual eligibles) of Missouri patient days for Medicare DSH to ensure that patient days associated with those categories are not claimed on the providers' cost reports.

AUDITEE COMMENTS

In written comments on our draft report, WPS concurred with our first recommendation and, for our third and fourth recommendations, said that it agreed as to the value and importance of State agency guidance and provider education. For these three recommendations, WPS described corrective actions that it had taken or planned to take.

WPS did not concur with our second recommendation. WPS stated that the errors we identified could be found only through a detailed review of a provider's reported Medicaid patient days. WPS added that due to limited audit resources, a WPS auditor would typically perform a random sample and extrapolate any findings. Furthermore, WPS stated that our findings "were largely due to a 100% review of all Medicaid patient days. This level of effort is not currently funded in our normal workload. Complying with this recommendation would

require substantial additional funding with no assurance that similar results could be obtained." WPS added that it would work with CMS to determine the costs and benefits of additional action on these 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. 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. With respect to the Medicare cost reports covered by our second recommendation—that is, the Missouri providers' cost reports that we did not review—we note that our methodology (Appendix A) involved obtaining Medicaid eligibility information directly from the State agency to determine the unallowable ME codes for patient days claimed on the cost reports. We also coordinated with the State agency to obtain information about Medicare Part A entitlement for each associated patient day, from which we determined unallowable dual-eligible patient days.

These determinations involved a relatively straightforward process. Corrective actions that used this process to comply with our second recommendation would, we believe, yield more accurate results than would be achieved through sampling patient days on a random basis. If, by using this process, the error rate on the cost reports that we did not review was similar to the error rate in the cost reports that we did review (which is a reasonable expectation), reopening these cost reports could justify the investment of resources as we estimate a potential recovery of approximately $6.6 million for the Medicare Trust Fund.

If, on the other hand, WPS were to use random sampling to address and resolve our second recommendation, it could create a sample frame that included only those Medicaid patient days with potentially unallowable ME codes in its review. Such an approach would not, however, identify and take into account all dual-eligible Medicare Part A information as identified by the State agency.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $203,899,507 in Medicare DSH payments made to 10 judgmentally selected Missouri providers (out of 63 providers we identified in that State) for FYs 2010 through 2012 (which at the time of our audit work was the most recent period that had settled cost reports). We selected these 10 providers (with 20 associated Medicare cost reports) because the amounts of their Medicare DSH payments were significantly higher than those for other Missouri providers for this timeframe. Medicare DSH payments to these 10 providers represented 31.3 percent of all DSH payments made to Missouri providers for this timeframe.

We reviewed the 20 Medicare cost reports submitted by these 10 providers for FYs 2010 through 2012. In particular, we focused on the calculation of Medicaid patient days insofar as those calculations affected the Medicare DSH payments made to Missouri providers. The Missouri providers had submitted the 20 Medicare cost reports (which reflected 612,517 Medicaid patient days) that we reviewed to WPS; in turn, WPS brought the cost reports to final settlement. Prior to the final settlement and before the start of our audit, WPS audited DSH payments for 6 of the 20 cost reports selected for review.

We conducted our audit work from February through November 2016.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, guidance, and State agency policy;
- extracted inpatient acute care hospital cost report data from the Healthcare Cost Report Information System for our FYs 2010 through 2012 audit period;
- judgmentally selected 10 providers in Missouri whose Medicare DSH payments were significantly higher than those for other Missouri providers for our audit period;
- obtained and reviewed the 20 Medicare cost reports that these 10 providers submitted to WPS for our audit period;
- evaluated the information and procedures that the selected providers used to calculate Medicaid patient days on their cost reports;
- contacted the State agency to verify the Medicaid eligibility of the patient days claimed by providers on their cost report;

- contacted the State agency to verify Medicare Part A entitlement information for each patient day and incorporated the results of these inquiries into our identification of dual-eligible recipients;

- recalculated Medicaid patient days in accordance with Federal requirements (footnote 7) for all cases in which we determined that providers had not properly calculated those patient days;

- discussed the findings we were developing with provider officials throughout the audit; and

- discussed the results of our review with WPS officials on November 30, 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 (42 CFR § 412.106(b)) state:

> (1) A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage ….
>
> (4) ***Second computation***. The fiscal intermediary determines … the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation …
>
> (i) a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan …. [Emphasis in original.]

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 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 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 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 Missouri State plan, Attachment 2.2-A, "Mandatory Coverage—Categorically Needy and Other Required Special Groups," provides for Medicaid coverage for the aged, blind, and disabled. The State agency deducts from income incurred expenses for necessary medical and remedial services recognized under State law to determine Medicaid eligibility.

The State agency's *Hospital Manual* explains (pages 24 and 37) that the Women's Health Services Program provides family planning and family planning-related services to low-income women aged 18 through 55 who are not otherwise eligible for Medicaid, CHIP, Medicare, or health insurance that provides family planning services.

The State agency's *Hospital Manual* explains (pages 22 and 37—39) that pregnant women who qualify under the presumptive eligibility temporary prenatal program receive limited coverage for ambulatory prenatal care while they await the formal determination for Medicaid eligibility. Inpatient services, including miscarriage and delivery, are not covered for temporary prenatal program participants.

The State agency's *Hospital Manual* explains (page 50) that in the State's Aged, Blind, and Disabled Program, some individuals are eligible for Medicaid benefits only after having met a periodic spenddown requirement. The individual may choose to meet his or spenddown requirement by submitting incurred medical expenses to the Family Support Division or by paying the designated monthly spenddown amount.

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

Provider Cost Report	Number of Days in Error	Dollar Effect
1	269	$140,862
2	149	72,237
3	1,036	436,319
4	1,428	612,403
5	599	110,147
6	326	61,576
7	119	63,342
8	540	289,331
9	289	76,726
10	389	92,713
11	459	208,237
12	356	160,555
13	399	218,920
14	81	28,612
15	327	195,029
16	0	0
17	86	49,076
18	67	34,953
19	107	72,872
20	106	68,184
Totals	**7,132**	**$2,992,094**

WPS GOVERNMENT HEALTH ADMINISTRATORS

Wisconsin Physicians Service Insurance Corporation
A CMS Medicare Contractor
1717 W. Broadway | P.O. Box 1787 | Madison, WI 53701-1787

April 11, 2017

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-07-16-04229

Dear Mr. Cogley,

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

OIG performed a review of Medicaid eligible days used to compute Disproportionate Share Hospital (DSH) payments for 10 Missouri providers for FYs beginning in 2010 through 2012; a total of 20 cost reports. OIG found these providers incorrectly reported 7,132 Medicaid eligible days resulting in $2,992,094 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.

OIG indicates 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 WPS. As noted in the regulations, the provider has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed and verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

The errors located by 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 for all cost reports. Further, due to limited audit resources, where an audit of Medicaid days is performed the auditor will typically perform a random sample of the total universe of claims and extrapolate any findings. As noted in IOM 100-06, Chapter 8, Section 60.6 (below), sampling is a normal part of any Medicare audit and CMS expects that less than 100 percent of the items under review will be tested.

> *Sampling is the application of an audit procedure to less than 100 percent of the items within an account balance, class of transactions, or statistics (e.g., count of interns/residents) to evaluate some characteristic of the such balance, class, or statistics.*
>
> *On the basis of facts known to you, decide if all transactions, balances, or statistics that pertain to the issue/area being tested need to be reviewed in order to obtain sufficient evidence. In most cases, an auditor will test at a level less than 100 percent.*

OIG, on the other hand, performed a 100% review of all the Medicaid days claimed in all 20 cost reports reviewed. Of the 20 cost reports reviewed by OIG, 6 were settled as desk reviews by WPS, without any detailed audit work performed. Of the 14 cost reports that were audited by

WPS, 6 were audited for DSH, but only 4 included a detailed audit of Medicaid days. Therefore, only these 4 cost reports were audited at a level that would have located the types of errors found by OIG:

Cost Report 2
The WPS auditor performed a random sample of 60 patients totaling 449 days, out of a total of 72,371 reported in the cost report, and found no errors. None of the patients sampled by WPS had one of the non-allowable Medicaid codes identified by OIG, although some were in a spend down category with no evidence the Financial Grant Indicator was checked. The WPS auditor also performed a dual eligible review by checking each patient in their sample over age 65 in CWF. During its review, OIG found 149 days were incorrect. This is not statistically significant and it was unlikely the WPS auditor would have reviewed the same days; moreover, none of the days included in the WPS auditor's sample were found to be nonallowable by OIG. Using the same sample, OIG would have likewise found no errors.

Cost Report 3
The WPS auditor did a random sample of 46 patients totaling 2,110 days, out of a total of 39,142 reported in the cost report, and found no errors. During its review OIG found 1,036 days were incorrect. There was some crossover of claims sampled by the WPS auditor and those disallowed by OIG. One of these claims had a non-allowable Medicaid eligibility code and 4 of these claims were disallowed by OIG as Medicare/Medicaid dual eligible. These 4 Medicare beneficiaries were enrolled under a HIC that was different from their SSN.

Cost Report 16
The WPS auditor did a random sample of 48 patients totaling 826 days, out of a total of 20,545 reported in the cost report. Based on the random sample the WPS auditor disallowed 335 days, as it was found that one patient stay was only partially covered by Medicaid. 26 days were disallowed by WPS for that patient, which was extrapolated into a total of 335 days disallowed. OIG found no days were incorrect.

Cost Report 19
The WPS auditor did a random sample of 93 patients totaling 1,280 days, out of a total of 12,013 reported on the cost report, and found no errors. None of the patients sampled by WPS had one of the non-allowable Medicaid codes identified by OIG, although some were in a spend down category with no evidence the Financial Grant Indicator was checked. The WPS auditor also performed a dual eligible review by checking each patient in their sample in CWF. During its review, OIG found 107 days were incorrect. This is not statistically significant and it was unlikely the WPS auditor would have reviewed the same days; moreover, none of the days included in the WPS auditor's sample were found to be nonallowable by OIG. Using the same sample, OIG would have likewise found no errors.

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

- *reopen and revise the 20 finalized Medicare cost report settlements to recover $2,992,094 in Medicare DSH overpayments from the 10 selected Missouri 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.

- *reopen and revise final cost report settlements for those Medicare cost reports (from Missouri providers) that we did not review, recover any additional Medicare DSH overpayments made to Missouri providers, and refund those recovered amounts to the Federal Government;*

WPS Response:
WPS does not concur with this recommendation. As noted previously, the results obtained by OIG were largely due to a 100% review of all Medicaid patient days. This level of effort is not currently funded in our normal audit workload. Complying with this recommendation would require substantial additional funding with no assurance that similar results could be obtained. We will work with our CMS Contracting Officer's Representative to determine the cost/benefit of additional action on these cost reports.

- *communicate with State agency officials annually to identify and obtain updated listings of Missouri ME codes as well as other State-level guidance affecting programs and other categories of services that figure into Medicare DSH cost report payments; and*

WPS Response:
WPS agrees that State agency guidance is valuable. WPS has initiated, and in some cases completed, efforts to contact the State agency in all of the states located in our J5 and J8 service areas in order to obtain the most current listing of state codes. Our intention is to repeat this effort on an annual basis.

- *furnish education to providers regarding excluded categories that do not qualify for Medicare DSH payments (family planning and family planning related services, CHIP, temporary prenatal care services, State-only, individuals who do not qualify as spenddown recipients, and dual eligibles) of Missouri patient days for Medicare DSH to ensure that patient days associated with those categories are not claimed on the providers' cost reports.*

WPS Response:
WPS agrees that provider education is important. We intend on posting the listings we obtain from the State agencies to our Medicare website.

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

Sincerely,

Mark DeFoil

Mark DeFoil
Director, Contract Coordination