



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

May 21, 2010

Report Number: A-05-09-00048

Julie Hamos  
Director  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue East  
Springfield, IL 62763

Dear Ms. Hamos:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicaid High-Dollar Payments for Inpatient Services in Illinois From January 1, 2006, Through September 30, 2007— Hospitals With Fewer Than Five High-Dollar Payments*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Stephen Slamar, Audit Manager, at (312) 353-7905 or through email at [Stephen.Slamar@oig.hhs.gov](mailto:Stephen.Slamar@oig.hhs.gov). Please refer to report number A-05-09-00048 in all correspondence.

Sincerely,

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

Enclosure

**Direct Reply to HHS Action Official:**

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

**OFFICE OF  
INSPECTOR GENERAL**

**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**



Daniel R. Levinson  
Inspector General

May 2010  
A-05-09-00048

# *Office of Inspector General*

<http://oig.hhs.gov>

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## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements.

The Department of Healthcare and Family Services (the State agency) administers the Medicaid program in Illinois. The State agency uses its Medicaid Management Information System to process claims.

Pursuant to section 1903(a)(1) of the Act, Federal reimbursement is available only for expenditures that constitute payment for part or all of the cost of services furnished as medical assistance under the State plan. Pursuant to 42 CFR § 433.312, the State must refund the Federal share of unallowable overpayments made to Medicaid providers.

Attachment 4.19-A, chapter I, section (C)(1) of the State plan requires the State agency to use a prospective payment system for medical assistance payments for inpatient hospital services. Under the prospective payment system (PPS), the State agency pays hospital costs at predetermined rates for patient discharges based on the diagnosis-related group to which a beneficiary's stay is assigned. The diagnosis-related group payment is, with certain exceptions, payment in full to the hospital for all inpatient services.

Attachment 4.19-A, chapter I, section (C)(5) of the State plan provides for an additional medical assistance payment, known as an outlier payment, to hospitals for cases incurring extraordinarily high costs.

Pursuant to Attachment 4.19-A, chapter VII, section (E)(2) of the State plan, the State agency must reduce medical assistance payments to the extent that the beneficiary's hospital stay is covered by third parties, such as workers compensation insurance.

During the audit period of January 1, 2006, through September 30, 2007, the State agency processed and paid approximately 1.5 million inpatient claims, 286 of which resulted in payments of \$200,000 or more (high-dollar payments) to hospitals for services. We reviewed 62 high-dollar payments, totaling \$17,237,356 that were made to hospitals that each received fewer than 5 such payments during our audit period.

### **OBJECTIVE**

Our objective was to determine whether selected high-dollar Medicaid payments that the State agency made to hospitals for inpatient services were appropriate.

## **SUMMARY OF FINDING**

Seventeen of the 62 high-dollar Medicaid payments that the State agency made to hospitals for inpatient services for the period January 1, 2006, through September 30, 2007, were appropriate. The 45 remaining payments included overpayments totaling \$635,141 (\$318,385 Federal share). For 44 of the payments, hospitals reported incorrect charges that resulted in inappropriate outlier payments to hospitals, and for one payment, a hospital submitted a claim for services that should have been paid by workers compensation insurance. Hospital officials attributed the incorrect charges to data entry errors and a lack of documentation to support the higher charges. The one workers compensation insurance claim was adjudicated during our field work.

## **RECOMMENDATIONS**

We recommend that the State agency:

- refund \$318,385 to the Federal Government and
- consider using the results of this audit in its provider education activities related to data entry procedures and proper documentation.

## **STATE AGENCY COMMENTS**

In written comments on our draft report, the State agency concurred with our findings and described corrective actions that it planned to take. The State agency's comments are included in their entirety as the Appendix.

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## INTRODUCTION

### BACKGROUND

#### Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements.

Pursuant to section 1903(a)(1) of the Act, Federal reimbursement is available only for expenditures that constitute payment for part or all of the cost of services furnished as medical assistance under the State plan. Pursuant to 42 CFR § 433.312, the State must refund the Federal share of unallowable overpayments made to Medicaid providers.

#### Illinois' Medical Assistance Payments for Inpatient Hospital Services

The Department of Healthcare and Family Services (the State agency) administers the Medicaid program in Illinois. The State agency uses its Medicaid Management Information System to process hospital inpatient claims.<sup>1</sup>

Attachment 4.19-A of the State plan describes the methods and standards that the State agency must use to determine medical assistance amounts for inpatient hospital services. Attachment 4.19-A, chapter I, section (C)(1) of the State plan requires the State agency to use a prospective payment system (PPS) for inpatient hospital services. Under the PPS, 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 exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

Attachment 4.19-A, chapter I, section (C)(5) of the State plan provides for an additional medical assistance payment, known as outlier payments, to hospitals for inpatient services incurring extraordinarily high costs.<sup>2</sup> The State agency determines outlier payments for inpatient services

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<sup>1</sup> 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.

<sup>2</sup> Outlier payments occur when a hospital's charges for a particular Medicaid beneficiary's inpatient stay substantially exceed the DRG payment.

by comparing the estimated costs of an inpatient service against a DRG specific fixed-loss threshold.<sup>3</sup> To estimate the cost of an inpatient service, the State agency uses Medicaid charges that the hospital reports on its claim and the hospital-specific cost-to-charge ratio. Inaccurately reporting charges could lead to excessive outlier payments.

Attachment 4.19-A, chapter VII, section (E)(2) of the State plan requires the State agency to reduce medical assistance payments to the extent that the beneficiary's hospital stay is covered by third parties, such as workers compensation insurance.

During the audit period of January 1, 2006, through September 30, 2007, the State agency processed approximately 1.5 million inpatient claims, 286 of which resulted in payments of \$200,000 or more (high-dollar payments) to hospitals for services.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether selected high-dollar Medicaid payments that the State agency made to hospitals for inpatient services were appropriate.

### **Scope**

We reviewed 62 of the 286 high-dollar payments for inpatient claims that the State agency processed during the period January 1, 2006, through September 30, 2007. The 62 high-dollar payments, which totaled \$17,237,356, were made to hospitals that each received fewer than 5 such payments during the period. We are conducting a separate review of the 224 remaining high-dollar payments, totaling \$69,748,844, made to hospitals that each received 5 or more such payments.

We limited our review of the State agency's internal controls to those applicable to the 62 claims because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our 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 file.<sup>4</sup> We conducted our fieldwork from December 2008 through November 2009.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations and guidance;

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<sup>3</sup> A DRG-specific fixed-loss threshold is a dollar amount by which the costs of a case must exceed payments to qualify for an outlier payment.

<sup>4</sup> The Balance Budget Act of 1997 (P.L. No. 105-33) required 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 the CMS-approved Illinois State plan, including its Attachment 4.19-A;
- extracted all high-dollar payments<sup>5</sup> for inpatient hospital services in Illinois from CMS's Medicaid Statistical Information System file. The resulting database included 286 claims from 49 hospitals;
- contacted the State agency to determine whether the 286 high dollar payments had been cancelled or superseded by revised claims, whether payments remained outstanding at the time of our field work, and whether the State agency received Federal reimbursements to match high-dollar payments;
- separated hospitals that had fewer than 5 high-dollar payments from hospitals that received 5 or more high-dollar payments. The resulting database had 34 hospitals with 62 high-dollar payments totaling \$17,237,356;
- contacted officials from the 34 hospitals that received the 62 high-dollar payments to determine whether the information originally reported on the claims was correct and, if not, why the claims were incorrect and whether the hospitals agreed that refunds were appropriate;
- submitted corrected claims and correspondences that we received from the hospitals to the State agency; and
- validated with the State agency that inappropriate payments occurred and that refunds were appropriate.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

## **FINDINGS AND RECOMMENDATIONS**

Seventeen of the 62 high-dollar Medicaid payments that the State agency made to hospitals for inpatient services for the period January 1, 2006, through September 30, 2007, were appropriate. The 45 remaining payments included overpayments totaling \$635,141 (\$318,385 Federal share). For 44 of the payments, hospitals reported incorrect charges that resulted in inappropriate outlier payments to hospitals, and for one payment, a hospital submitted a claim for services that should have been paid by workers compensation insurance. Hospital officials attributed the incorrect charges to data entry errors and a lack of documentation to support the higher charges. The one workers compensation insurance claim was adjudicated during our field work.

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<sup>5</sup> Payments of \$200,000 or more were considered high-dollar payments for the purpose of this review.

## **FEDERAL REQUIREMENTS**

Pursuant to section 1903(a)(1) of the Act, Federal reimbursement is available only for expenditures that constitute payment for part or all of the cost of services furnished as medical assistance under the State plan. Pursuant to 42 CFR § 433.312, the State must refund the Federal share of unallowable overpayments made to Medicaid providers.

## **STATE PLAN REQUIREMENTS**

Attachment 4.19-A, chapter I, section (C) (5) of the State plan provides for outlier payments to hospitals, in addition to prospective payments, for cases incurring extraordinarily high costs. Pursuant to Attachment 4.19-A, chapter V, section (C)(2) 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 for the case.

Attachment 4.19-A, chapter VII, section (E) (2) of the State plan requires the State agency to reduce the Medical assistance payments to the extent that the beneficiary's hospital stay is covered by third parties such as workers compensation insurance.

## **INAPPROPRIATE HIGH-DOLLAR PAYMENTS**

The State agency made 45 inappropriate payments totaling \$635,141 (\$318,385 Federal share), which hospitals had not refunded prior to the start of our audit. For 44 of the 45 inappropriate payments, hospitals submitted claims with incorrect charges, and 1 claim should have been paid by workers compensation insurance.

The hospitals attributed the incorrect charges on 44 claims to data entry errors, and a lack of documentation to support the higher charges. The one workers compensation insurance claim was adjudicated during our audit.

## **RECOMMENDATIONS**

We recommend that the State agency:

- refund \$318,385 to the Federal Government and
- consider using the results of this audit in its provider education activities related to data entry procedures and proper documentation.

## **STATE AGENCY COMMENTS**

In written comments on our draft report, the State agency concurred with our findings and described corrective actions that it planned to take. The State agency's comments are included in their entirety as the Appendix.

# **APPENDIX**

## APPENDIX: STATE AGENCY COMMENTS



Pat Quinn, Governor  
Julie Hamos, Director

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May 12, 2010

Department of Health and Human Services  
Office of Audit Services, Region V  
Attn: James C. Cox, Regional Inspector General for Audit Services  
233 North Michigan Avenue, Suite 1360  
Chicago, Illinois 60601

Re: Draft Audit Report Number A-05-09-00048

Dear Mr. Cox:

Thank you for providing the opportunity to comment on your draft audit report 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".

The Department concurs with the findings and will recoup the identified overpayments from the hospitals. The Department will also adjust the quarterly claim to credit CMS for federal funds previously received as a result of such hospital payments. We appreciate the work done by your audit team and will use the report to consider changes in procedures to prevent such overpayments in the future.

If you have any questions or comments about our response to the audit, please contact Peggy Edwards, External Audit Liaison, at (217) 785-9764 or through email at [peggy.edwards@illinois.gov](mailto:peggy.edwards@illinois.gov).

Sincerely,

Julie Hamos  
Director

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