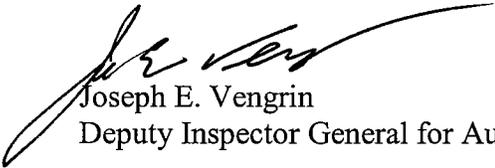




OCT 28 2008

TO: Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: 
Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Allowable Medicare Capital Disproportionate Share Payments for the Period October 1, 2000, Through September 30, 2006 (A-07-08-02735)

The attached final report provides the results of our review of allowable Medicare disproportionate share payments for the period October 1, 2000, through September 30, 2006.

Section 1886(g) of the Social Security Act provides for Federal reimbursement of capital-related costs of inpatient hospital services. This provision has created a category of Medicare payment, known as the capital disproportionate share hospital (DSH) payment, for hospitals that are classified as urban and have 100 or more beds. For qualifying hospitals, the amount of this payment varies based on a statutory formula.

Our objective was to determine whether the hospitals that received capital DSH payments were eligible based on their geographic classification and number of beds.

We found that a number of rural hospitals and hospitals with fewer than 100 beds claimed Medicare capital DSH payments even though those facilities were, according to Federal requirements, ineligible for these payments. Of 2,396 acute-care hospitals that claimed \$1,621,679,111 in capital DSH payments on submitted cost reports, 397 hospitals in rural areas or with fewer than 100 beds claimed \$21,915,658 in unallowable capital DSH payments. The remaining \$1,599,763,453 was claimed by hospitals that were classified as urban and had 100 or more beds.

We recommend that the Centers for Medicare & Medicaid Services (CMS):

- direct the fiscal intermediaries to recover \$21,915,658 in capital DSH payments made to ineligible hospitals, in accordance with CMS policies and procedures;

- determine whether capital DSH payments were made to ineligible hospitals for the period subsequent to the end of our review (fiscal year 2006) and direct fiscal intermediaries to recover any unallowable payments; and
- conduct reviews on a recurring basis to determine whether capital DSH payments are being made to ineligible hospitals.

In its written comments on our draft report, CMS agreed with our recommendations.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at <http://oig.hhs.gov>.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov. Please refer to report number A-07-08-02735 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF ALLOWABLE
MEDICARE CAPITAL
DISPROPORTIONATE SHARE
PAYMENTS FOR THE PERIOD
OCTOBER 1, 2000, THROUGH
SEPTEMBER 30, 2006**



Daniel R. Levinson
Inspector General

October 2008
A-07-08-02735

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

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 XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant). The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare providers, including hospitals, submit cost reports to their Medicare fiscal intermediaries annually. The cost report is 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 the cost report, the fiscal intermediary performs a tentative settlement. The fiscal intermediary reviews the cost report and conducts an audit, if necessary, before final settlement. The fiscal intermediary 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.

The Medicare cost report is used to report various Medicare payments, including an operating disproportionate share hospital (DSH) payment if a hospital is deemed eligible for reimbursement of operating costs because it treats a disproportionate share of low-income patients. In addition to this category of Medicare payments, section 1886(g) of the Act also provides for Federal reimbursement of capital-related costs of inpatient hospital services "in accordance with a prospective payment system" established by the U.S. Department of Health and Human Services. This provision has created an additional category of Medicare payment, known as the capital DSH payment, for hospitals that are categorized as urban hospitals and have 100 or more beds. For qualifying hospitals, the amount of this payment varies based on a statutory formula.

OBJECTIVE

Our objective was to determine whether the hospitals that received capital DSH payments were eligible based on their geographic classification and number of beds.

SUMMARY OF FINDINGS

A number of rural hospitals and hospitals with fewer than 100 beds claimed Medicare capital DSH payments even though those facilities were, according to Federal requirements, ineligible for these payments. Of 2,396 acute-care hospitals that claimed \$1,621,679,111 in capital DSH payments on submitted cost reports, 397 hospitals in rural areas or with fewer than 100 beds claimed \$21,915,658 in unallowable capital DSH payments. The remaining \$1,599,763,453 was claimed by hospitals that were classified as urban and had 100 or more beds.

These errors occurred because CMS did not ensure that only eligible hospitals received capital DSH payments. Specifically, although the fiscal intermediaries may have reviewed the cost reports to ensure their proper completion, CMS did not have adequate procedures in place to

ensure that the fiscal intermediaries verified during the settlement process that the hospitals were eligible for capital DSH payments.

RECOMMENDATIONS

We recommend that CMS:

- direct the fiscal intermediaries to recover \$21,915,658 in capital DSH payments made to ineligible hospitals, in accordance with CMS policies and procedures;
- determine whether capital DSH payments were made to ineligible hospitals for the period subsequent to our review (Federal fiscal year 2006) and direct fiscal intermediaries to recover any unallowable payments; and
- conduct reviews on a recurring basis to determine whether capital DSH payments are being made to ineligible hospitals.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS agreed with our recommendations and described corrective actions it was undertaking. CMS's comments appear in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant). The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare providers, including hospitals, submit cost reports to their Medicare fiscal intermediaries¹ annually. The cost report is 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 the cost report, the fiscal intermediary performs a tentative settlement. The fiscal intermediary reviews the cost report and conducts an audit, if necessary, before final settlement. The fiscal intermediary 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.

The Medicare cost report is used to report various Medicare payments, including an operating disproportionate share hospital (DSH) payment if a hospital is deemed eligible for reimbursement of operating costs because it treats a disproportionate share of low-income patients. In addition to this category of Medicare payments, section 1886(g) of the Act also provides for Federal reimbursement of capital-related costs of inpatient hospital services "in accordance with a prospective payment system" established by the U.S. Department of Health and Human Services. This provision has created an additional category of Medicare payment, known as the capital DSH payment, for hospitals that are categorized as urban hospitals and have 100 or more beds. For qualifying hospitals, the amount of this payment varies based on a statutory formula.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the hospitals that received capital DSH payments were eligible based on their geographic classification and number of beds.

Scope

The audit scope included \$1,621,679,111 in capital DSH payments claimed on the cost reports for 2,396 acute-care hospitals for Federal fiscal years (FY) 2000 through 2006. We limited our

¹Medicare fiscal intermediaries are private insurance companies that serve as the Federal Government's agents in the administration of the Medicare program and are responsible for determining costs and reimbursement amounts, providing payment to the providers, and establishing controls to safeguard against fraud and abuse.

internal control review to the fiscal intermediaries' procedures for determining whether hospitals were eligible for capital DSH payments.

We did not verify the accuracy of either the geographic determination listed on each impact file² or the information used to calculate the number of beds, which was certified as accurate by each hospital on its cost report.

We conducted fieldwork in March 2008 at CMS's offices in Baltimore, Maryland.

Methodology

To accomplish our objective:

- We reviewed applicable Federal laws and regulations.
- We interviewed CMS and fiscal intermediary officials to gain an understanding of the capital DSH program.
- We reviewed the audit steps used by the fiscal intermediaries to ensure that only urban hospitals with 100 or more beds received capital DSH payments.
- We obtained and analyzed all cost reports for acute care inpatient hospitals for FYs 2000 through 2006 as of March 31, 2007, to identify whether any hospitals received capital DSH payments while being categorized as rural or having fewer than 100 beds as defined by 42 CFR § 412.105(b). Specifically, we used the historical impact files, which CMS compiles, to identify whether particular hospitals were classified as rural or urban for the respective time period. If a particular hospital was not included on the impact file, we used information from the cost report. To determine the number of beds in each hospital, we used information contained in the cost reports.
- We provided a list of the hospitals that we determined were ineligible for capital DSH payments to CMS on April 14, 2008.

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.

²CMS compiles the impact files from the provider-specific files maintained by the fiscal intermediaries. The impact files, as used by CMS to estimate the payment effects of policy changes, serve as references and identify the urban or rural classification of the hospitals.

FINDINGS AND RECOMMENDATIONS

A number of rural hospitals and hospitals with fewer than 100 beds claimed Medicare capital DSH payments even though those facilities were, according to Federal requirements, ineligible for these payments. Of 2,396 acute-care hospitals that claimed \$1,621,679,111 in capital DSH payments on submitted cost reports, 397 hospitals in rural areas or with fewer than 100 beds claimed \$21,915,658 in unallowable capital DSH payments. The remaining \$1,599,763,453 was claimed by hospitals that were classified as urban and had 100 or more beds.

FEDERAL REQUIREMENTS

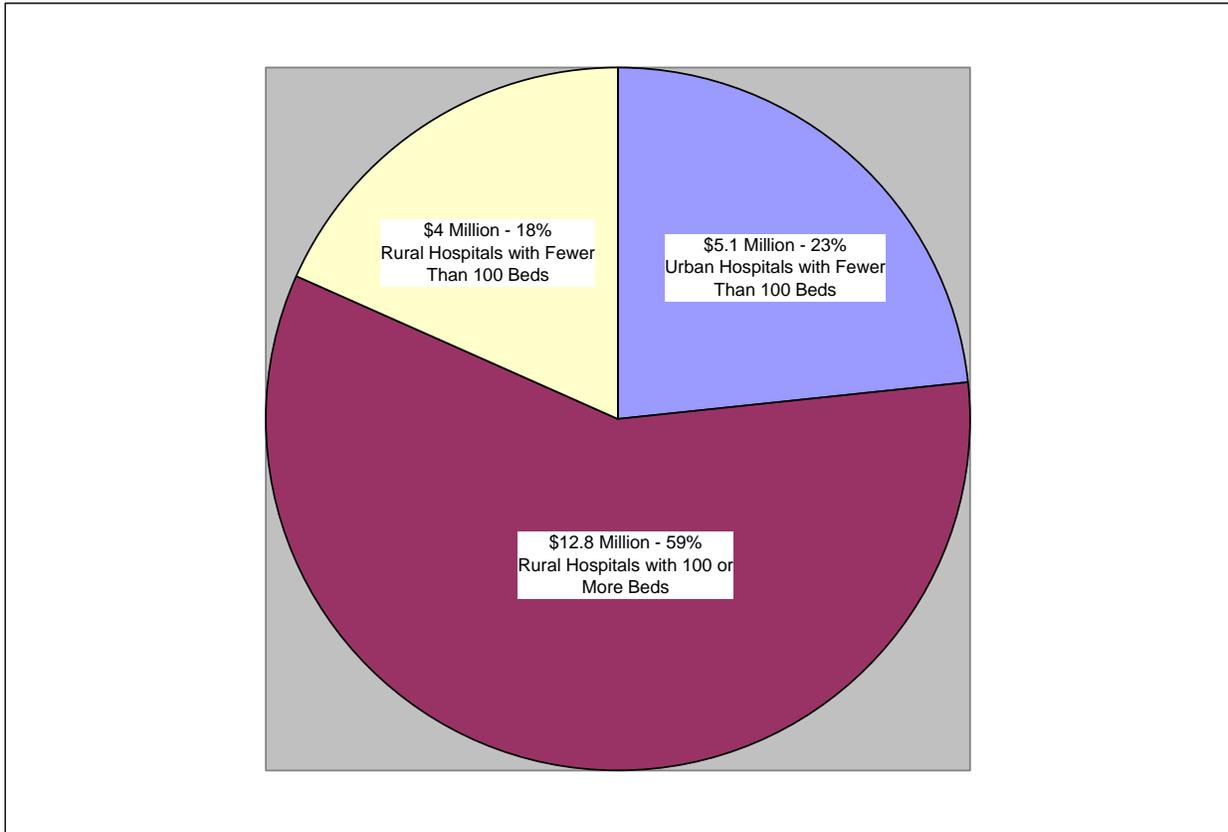
Pursuant to 42 CFR § 412.320, a hospital must be located in an urban area and have 100 or more beds to be eligible to receive capital DSH payments.

INELIGIBLE HOSPITALS RECEIVED UNALLOWABLE PAYMENTS

A number of rural hospitals and hospitals with fewer than 100 beds claimed Medicare capital DSH payments even though these facilities were ineligible for these payments.

Our review of the Medicare cost reports and the historical impact files indicated that of the \$1,621,679,111 in capital DSH payments claimed on submitted cost reports during our audit period, 397 hospitals—ineligible for capital DSH payments because they were either rural or had fewer than 100 beds—claimed a total of \$21,915,658 in unallowable capital DSH payments. The chart shows the total unallowable capital DSH payments for hospitals that were rural, had fewer than 100 beds, or both.

Capital DSH Payments to Ineligible Hospitals, Fiscal Years 2000–2006



INADEQUATE PROCEDURES

CMS did not ensure that only eligible hospitals received capital DSH payments. Specifically, although the fiscal intermediaries may have reviewed the cost reports to ensure their proper completion, CMS did not have adequate procedures in place to ensure that fiscal intermediaries verified during the settlement process that the hospitals were eligible for capital DSH payments.

RECOMMENDATIONS

We recommend that CMS:

- direct the fiscal intermediaries to recover \$21,915,658 in capital DSH payments made to ineligible hospitals, in accordance with CMS policies and procedures;
- determine whether capital DSH payments were made to ineligible hospitals for the period subsequent to our review (FY 2006) and direct fiscal intermediaries to recover any unallowable payments; and
- conduct reviews on a recurring basis to determine whether capital DSH payments are being made to ineligible hospitals.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS agreed with our recommendations and described corrective actions it was undertaking.

Specifically, CMS stated that it had directed Medicare administrative contractors and fiscal intermediaries to reopen cost reports for each hospital that we had identified as being ineligible to receive capital DSH payments (as long as the cost report was within the 3-year reopening period).³ CMS further stated that for all cost reports that are reopened, all payments that we had identified as erroneous would be reviewed and overpayments would be collected. CMS also said that it has directed the contractors to immediately begin reviewing capital DSH eligibility as a part of their review process. CMS also said that it “will include a review of capital DSH when we review contractors’ audit performance” and that it intends to add an edit to the cost report software to prevent ineligible hospitals from claiming capital DSH payments on their cost reports.

CMS’s comments appear in their entirety as the Appendix.

³The Medicare Modernization Act of 2003, P.L. No. 108-173, which became effective on October 1, 2005, amended certain sections of the Act, including section 1842(a), to require that Medicare administrative contractors replace fiscal intermediaries by October 2011.

APPENDIX



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: OCT 9 2008

TO: Daniel R. Levinson
Inspector General

FROM: Kerry Waerns
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Allowable Medicare Capital Disproportionate Share Payments for the Period October 1, 2000 through September 30, 2006" (A-07-08-02735)

Thank you for the opportunity to review and comment on the OIG's draft report entitled, "Review of Allowable Medicare Capital Disproportionate Share Payments for the Period October 1, 2000 through September 30, 2006." We appreciate the OIG's efforts to ensure Medicare's payments to hospitals for Medicare capital DSH are reasonable and necessary.

Medicare reimburses hospitals located in an urban area having 100 or more beds and serving low-income patients a payment adjustment known as the capital disproportionate share hospital (DSH) payment. (See 42 CFR section 412.320.) The OIG's draft report estimated that \$21,915,658 of the \$1,621,679,111 (or 1.35%) in capital DSH payments reviewed were made to hospitals in rural areas or with fewer than 100 beds.

Although we agree with the recommendations in the draft report, the Centers for Medicare & Medicaid Services (CMS) recommends that the OIG delete the last sentence in the last bullet in the Methodology section on page 2 of this report. This bullet states:

"We provided a list of the hospitals that we determined were ineligible for capital DSH payment to CMS on April 14, 2008. As of May 31, 2008 we have not received a response from CMS."

When CMS received the list of hospitals from OIG, CMS reviewed the list, negotiated workload with the Fiscal Intermediaries (FIs) and Medicare Administrative Contractors (MACs), and issued a joint signature memorandum (JSM)/technical direction letter (TDL) to the FIs/MACs on June 18, 2008, more than 2 months before the OIG issued its draft report. This JSM/TDL directed the FIs/MACs to reopen the cost reports for each hospital that the OIG identified as being ineligible to receive capital DSH payments so long as the cost report was within the 3-year reopening period.

Below are CMS's responses to the OIG recommendations.

Page 2 – Daniel R. Levinson

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services (CMS) direct the fiscal intermediaries to recover \$21,915,658 in capital DSH payments made to ineligible hospitals, in accordance with CMS policies and procedures.

CMS Response

The CMS issued a JSM/TDL on June 18, 2008, directing each FI/MAC to review the list of hospitals the OIG determined received capital DSH payments in error and issue reopening notices for all cost reports that were within the 3-year reopening period. For all cost reports that are reopened, the FIs/MACs were instructed to review the capital DSH payments, issue a revised Notice of Program Reimbursement within 180 days of the reopening letter, and collect any overpayments.

OIG Recommendation

The OIG recommends that CMS determine whether capital DSH payments were made to ineligible hospitals for the period subsequent to the end of our review (Federal fiscal year 2006) and direct fiscal intermediaries to recover any unallowable payments.

CMS Response

At the audit conference on May 6, 2008, in Columbia, Maryland, CMS notified contractors that they should immediately begin reviewing the eligibility for capital DSH as part of the Hospital Desk Review Process. CMS will include a review of capital DSH when we review contractors' audit performance.

OIG Recommendation

The OIG recommends that CMS conduct reviews on a recurring basis to determine whether capital DSH payments are being made to ineligible hospitals.

CMS Response

The CMS plans to add an edit to the cost report software to prevent ineligible hospitals from claiming a capital DSH payment on their cost report. Adding such an edit will eliminate the need for contractors to manually review the appropriateness of the capital DSH payment. Until such an edit is in place, we have instructed contractors that they should review the eligibility for capital DSH as part of the Hospital Desk Review Process, and we will include a review of capital DSH when we review contractors' audit performance.

The CMS thanks OIG for its efforts on this report. These findings provide us with invaluable information to help us take action towards our commitment to improve our reviews/audits of Medicare cost reports. We look forward to working together with you in the future as we address the recommendations in this report.