DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

DEC 26 2007

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

FROM: Daniel R. Levinson Daniel R. Levinson
Inspector General

SUBJECT: Review of Hurricane Katrina Uncompensated Care Costs Claimed by Mississippi for the University of Mississippi Medical Center (A-04-07-06004)

Attached is an advance copy of our final report on Hurricane Katrina uncompensated care costs claimed by Mississippi for the University of Mississippi Medical Center (the Medical Center) in Jackson. We will issue this report to the Mississippi Division of Medicaid (the State agency) within 5 business days.

In response to Hurricane Katrina, section 6201 of the Deficit Reduction Act of 2005 authorized Federal funding for the total costs of medically necessary uncompensated care furnished to evacuees and affected individuals without other coverage in eligible States, i.e., States that provided care to such individuals under section 1115 projects. Mississippi was one of those States. As of December 5, 2006, the State agency reported $63.5 million in uncompensated care reimbursement to 772 health care providers. The Medical Center received $17.9 million of this reimbursement.

Our objective was to determine whether the State agency claimed reimbursement for services provided by the Medical Center in accordance with the approved section 1115 demonstration and uncompensated care pool plan.

We found that the State agency generally claimed reimbursement for services provided by the Medical Center in accordance with the approved section 1115 demonstration and uncompensated care pool plan. Of the 200 sampled claims, 196 claims were allowable. The remaining four claims totaling $22,379 were improper because the individuals who received the services had health care coverage under other programs. The improper payments occurred because the State agency did not have adequate procedures to verify the Medical Center's attestations that individuals did not have other health care coverage.

We recommend that the State agency:

- refund to the Centers for Medicare & Medicaid Services (CMS) the $22,379 paid to the Medical Center for improper uncompensated care claims and

- consider reviewing the Medical Center's claims that were not included in our sample to ensure that no other health care coverage was available and make refunds to CMS if appropriate.

In its comments on the draft report, the State agency did not fully agree with our recommendations but said that it would make the proper adjustments in cooperation with CMS. The State agency also provided detailed explanations of the seven claims questioned in our draft report. After reviewing the State agency's comments, we allowed three of the seven claims and revised our recommended refund accordingly.

This audit was conducted in conjunction with the President's Council on Integrity and Efficiency (PCIE) as part of its examination of relief efforts provided by the Federal Government in the aftermath of Hurricanes Katrina and Rita. As such, a copy of the report has been forwarded to the PCIE Homeland Security Working Group, which is coordinating Inspectors General reviews of this important subject.

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 or Peter J. Barbera, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750 or through e-mail at Peter.Barbera@oig.hhs.gov. Please refer to report number A-04-07-06004.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

DEC 31 2007

Report Number: A-04-07-06004

Dr. Robert L. Robinson
Executive Director
Mississippi Division of Medicaid
239 North Lamar Street
Jackson, Mississippi 39201-1399

Dear Dr. Robinson:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Hurricane Katrina Uncompensated Care Costs Claimed by Mississippi for the University of Mississippi Medical Center." 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.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG 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, within 10 business days after this report is issued, it will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me at (404) 562-7750. Please refer to report number A-04-07-06004 in all correspondence.

Sincerely,

Peter J. Barbera

Peter J. Barbera
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Childrens Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HURRICANE KATRINA UNCOMPENSATED CARE COSTS CLAIMED BY MISSISSIPPI FOR THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

Daniel R. Levinson
Inspector General

December 2007
A-04-07-06004

Office of Inspector General

http://oig.hhs.gov

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR part 5.)

OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

In response to Hurricane Katrina, section 6201 of the Deficit Reduction Act of 2005 authorized Federal funding for the total costs of medically necessary uncompensated care furnished to evacuees and affected individuals without other coverage in eligible States, i.e., States that provided care to such individuals under section 1115 projects.

Under section 1115 of the Social Security Act, the Centers for Medicare & Medicaid Services (CMS) approved Mississippi's request for demonstration authority related to Hurricane Katrina and allowed the State to reimburse providers that incurred uncompensated care costs for medically necessary services and supplies for evacuees who did not have other coverage. In accordance with the State's uncompensated care pool plan, CMS authorized reimbursement from the pool for services provided from August 24, 2005, through January 31, 2006, to Katrina evacuees and affected individuals who did not have coverage under Medicare, Medicaid, the State Children's Health Insurance Program, private insurance, State-funded health insurance programs, or public or private hurricane relief efforts. The pool was 100 percent federally funded.

As of December 5, 2006, the Mississippi Division of Medicaid (the State agency) reported $63.5 million in uncompensated care reimbursement to 772 health care providers. The University of Mississippi Medical Center (the Medical Center) received $17.9 million of this reimbursement.

OBJECTIVE

Our objective was to determine whether the State agency claimed reimbursement for services provided by the Medical Center in accordance with the approved section 1115 demonstration and uncompensated care pool plan.

SUMMARY OF FINDINGS

The State agency generally claimed reimbursement for services provided by the Medical Center in accordance with the approved section 1115 demonstration and uncompensated care pool plan. Of the 200 sampled claims, 196 claims were allowable. The remaining four claims totaling $22,379 were improper because the individuals who received the services had health care coverage under other programs. The improper payments occurred because the State agency did not have adequate procedures to verify the Medical Center's attestations that individuals did not have other health care coverage.

RECOMMENDATIONS

We recommend that the State agency:

- refund to CMS the $22,379 paid to the Medical Center for improper uncompensated care claims and

- consider reviewing the Medical Center's claims that were not included in our sample to ensure that no other health care coverage was available and make refunds to CMS if appropriate.

Because authority for the uncompensated care pool has expired, we are not making procedural recommendations.

STATE AGENCY'S COMMENTS

In its comments on the draft report, the State agency did not fully agree with our recommendations but said that it would make the proper adjustments in cooperation with CMS. The State agency also provided detailed explanations of the seven claims questioned in our draft report. The State agency's comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

After reviewing the State agency's comments, we allowed three of the seven claims originally questioned and revised our recommended refund accordingly. We maintain that the remaining four claims were improper because the individuals had other sources of health care coverage. Furthermore, the approved uncompensated care pool plan specifically provides for retrospective reviews and recoupment of inappropriate payments.

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INTRODUCTION

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 applicable Federal requirements.

Section 1115 Hurricane-Related Demonstration Projects

Section 1115 of the Act permits the Secretary to authorize demonstration projects to promote the objectives of the Medicaid program. Under section 1115, CMS may waive compliance with any of the requirements of section 1902 of the Act and provide Federal matching funds for demonstration expenditures that would not otherwise be included as expenditures under the Medicaid State plan.

In response to Hurricane Katrina, CMS announced that States could apply for section 1115 demonstration projects to ensure the continuity of health care services for hurricane victims. A State with an approved hurricane-related section 1115 demonstration project was eligible under section 6201 of the Deficit Reduction Act of 2005 for Federal payment of the total costs of uncompensated care incurred for medically necessary services and supplies furnished to evacuees and affected individuals who did not have other coverage for such assistance.

Mississippi's Approved Uncompensated Care Pool Plan

In a September 22, 2005, letter, CMS approved Mississippi's request for section 1115 demonstration authority related to Hurricane Katrina. In a March 24, 2006, letter, CMS approved Mississippi's uncompensated care pool plan and authorized reimbursement from the pool for services provided from August 24, 2005, through January 31, 2006. Specifically, the March letter authorized Mississippi to reimburse providers that incurred uncompensated care costs for medically necessary services and supplies for Katrina evacuees and affected individuals who did not have coverage under Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), private insurance, State-funded health insurance programs, or public or private hurricane relief efforts.

The State's uncompensated care pool plan stated that reimbursement for uncompensated care would be limited to services covered through the Mississippi Medicaid program and that providers would be paid according to the Mississippi Medicaid rate for each procedure. Only Medicaid providers were eligible for reimbursement, and all claims were to be submitted manually. Providers were required to attest that all services were medically necessary and that they were unaware of any other source of payment. The plan limited reimbursement for dental and eye care and durable medical equipment to medical emergencies. The plan also limited

reimbursement for prescription drugs to those that exceeded the State's Medicaid benefit limits and to the period August 26 through September 30, 2005.

The Mississippi Division of Medicaid (the State agency) administered the uncompensated care pool, which was 100 percent federally funded. As of December 5, 2006, the State agency reported $63.5 million in uncompensated care reimbursement to 772 health care providers. The University of Mississippi Medical Center (the Medical Center), located in Jackson, received $17.9 million of this reimbursement.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed reimbursement for services provided by the Medical Center in accordance with the approved section 1115 demonstration and uncompensated care pool plan.

Scope

Our review covered the $17.9 million in uncompensated care claims that the State agency paid to the Medical Center and claimed for Federal reimbursement as of December 5, 2006. These claims had dates of service from August 26, 2005, through January 31, 2006.

We did not assess the State agency's overall internal controls. We limited our review to gaining an understanding of those controls related to uncompensated care claims paid under the section 1115 waiver.

We conducted our fieldwork in February 2007 at the Medical Center and the State agency in Jackson, Mississippi.

Methodology

To accomplish our objective, we:

- reviewed Federal laws, approval letters, and the State's approved uncompensated care pool plan;
- interviewed State agency and Medical Center officials;
- obtained the State agency's database of uncompensated care claims paid to providers as of December 5, 2006, which consisted of 209,327 claims totaling $63.5 million;
- verified that all paid uncompensated care claims were included on the "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program" (Form CMS-64) for our audit period;

- extracted from the State agency's database a population of 31,593 claims totaling $17.9 million paid to the Medical Center;

- selected, as detailed in Appendix A, a statistical sample of 200 of these claims totaling $1,081,574; and

- reviewed supporting documentation for each sampled claim to verify that:

    - the patient did not have health insurance coverage for the service under Medicare, Medicaid, SCHIP, private insurance, or a State-funded health insurance program by using the Medical Center's access to an online insurance verification program (Envision) maintained by the State and a private insurance verification system;

    - the patient did not receive the service or item from a public or private hurricane relief effort by checking the Federal Emergency Management Agency's disaster relief database;

    - the patient's home address was within one of the individual assistance designation counties listed in an attachment to the uncompensated care pool plan;

    - the date of service was between August 26, 2005, and January 31, 2006 (between August 26 and September 30, 2005, for prescription drug claims);

    - the service was covered by the State plan and the claim was paid at the appropriate rate based on the State's Medicaid fee schedule or per diem rates;

    - dental and eye care and durable medical equipment were related to a medical emergency; and

    - prescription drug services exceeded the State's Medicaid benefit limits.

We performed our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The State agency generally claimed reimbursement for services provided by the Medical Center in accordance with the approved section 1115 demonstration and uncompensated care pool plan. Of the 200 sampled claims, 196 claims were allowable. The remaining four claims totaling $22,379 were improper because the individuals who received the services had health care coverage under other programs. The improper payments occurred because the State agency did not have adequate procedures to verify the Medical Center's attestations that individuals did not have other health care coverage.

UNCOMPENSATED CARE POOL PLAN REQUIREMENTS

Mississippi's approved uncompensated care pool plan limited Federal reimbursement to Hurricane Katrina evacuees and affected individuals who did not have coverage under Medicare, Medicaid, SCHIP, private insurance, State-funded health insurance programs, or public or private hurricane relief efforts. Allowable services were restricted to those services covered under the State's Medicaid program and provided between August 26, 2005, and January 31, 2006.

IMPROPER CLAIMS

Of the 200 claims in our sample, 4 claims totaling $22,379 were improper because the individuals who received the services from the Medical Center had other health care coverage:

- One individual, with a claim of $14,835, was covered by Medicare Part A.[1]
- One individual, with a claim of $6,181, was covered by the Civilian Health and Medical Program of the Uniformed Services.
- One individual, with a claim of $1,268, was covered by Medicaid.
- One individual, with a claim of $95, was covered by SCHIP.

We did not identify a sufficient number of improper payments in our sample to allow us to make a reliable estimate of the improper payments in the population.

INADEQUATE PROCEDURES FOR ELIGIBILITY VERIFICATION

The State agency was responsible for ensuring that only allowable claims were paid from the uncompensated care pool. CMS's September 22, 2005, letter approving section 1115 demonstration authority and allowing the State to reimburse providers for uncompensated care costs required the State to "establish mechanisms to prevent payments from the pool on behalf of individuals who have coverage for services, or for whom other options are available." However, the State agency paid the four improper claims because it was unaware that the individuals who received the services from the Medical Center had health care coverage under other programs. The Medical Center submitted attestations that it was not aware of any other source of payment. The State agency relied on those attestations and did not have adequate procedures to verify that the individuals did not have other health insurance coverage.

[1]Subsequent to our review, the Medical Center refunded this money to the State and billed Medicare Part A for the service.

RECOMMENDATIONS

We recommend that the State agency:

- refund to CMS the $22,379 paid to the Medical Center for improper uncompensated care claims and

- consider reviewing the Medical Center's claims that were not included in our sample to ensure that no other health care coverage was available and make refunds to CMS if appropriate.

Because authority for the uncompensated care pool has expired, we are not making procedural recommendations.

STATE AGENCY'S COMMENTS

In its comments on the draft report, the State agency did not fully agree with our recommendations but said that it would make the proper adjustments in cooperation with CMS. The State agency also said that procedures were in place to verify that the uncompensated care pool was used only to pay for allowable services. Disputing the seven claims questioned in our draft report, the State agency provided the following explanations:

- Three claims questioned because of Medicaid eligibility were for individuals covered under Medicaid's family planning category of eligibility. According to the State agency, these claims were not related to family planning services and therefore would not have been covered by Medicaid.

- For three claims, information contradicting eligibility was not available when the claims were approved. However, the State agency subsequently acknowledged that one of these claims was improper because of Medicare eligibility and received a refund from the Medical Center.

- For one claim questioned because of SCHIP coverage, the State agency's further review found no indication that the individual would have been covered by SCHIP.

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

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We agree that three claims questioned in our draft report because of Medicaid eligibility were allowable, and we have revised our findings and recommended refund accordingly. With respect to the remaining four claims, we maintain that our findings and recommendations are valid for the following reasons:

- The approved uncompensated care pool plan states that "Medicaid will perform retrospective reviews and recoup payments for inappropriate claims." Therefore, even if

the three claims were appropriately paid based on information available when the claims were approved, the State agency was responsible for later recovery of payments made for individuals with other sources of health care coverage. Moreover, although the Medical Center subsequently refunded one of the three payments, the State agency had not refunded the money to the Federal Government as of February 2007.

- For the fourth claim, data obtained through the Medical Center's private insurance verification system showed that the individual was covered under SCHIP.

APPENDIXES

SAMPLING METHODOLOGY

OBJECTIVE

Our objective was to determine whether the State agency claimed reimbursement for services provided by the Medical Center in accordance with the approved section 1115 demonstration and uncompensated care pool plan.

POPULATION

The population consisted of 31,593 uncompensated care claims paid as of December 5, 2006, with dates of service from August 26, 2005, through January 31, 2006.

SAMPLE UNIT

The sample unit was a paid claim.

SAMPLE DESIGN

We used a stratified sample design with four strata, as follows:

Stratum	Boundaries	Number of Items
1	$1.00 to $599.99	27,529
2	$600.00 to $5,599.99	3,482
3	$5,600.00 to $39,999.99	578
4	$40,000.00 to $84,999.99	4
Total		**31,593**

SAMPLE SIZE

We selected a sample of 200 paid claims, as follows:

Stratum	Sample Size
1	66
2	65
3	65
4	4
Total	**200**

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

DR. ROBERT L. ROBINSON
EXECUTIVE DIRECTOR

October 10, 2007

Department of Health and Human Services
Office of Inspector General
Office of Audit Services
Attn: Mr. Peter J. Barbera
61 Forsyth Street, Suite 3T41
Atlanta, GA 30303

Dear Mr. Barbera:

The attached document is in response to recommendations contained in the draft report A-04-07-06004, "Hurricane Katrina Uncompensated Care – University of Mississippi Medical Center". While we do not fully agree with the recommendations in the report, we would like to express our appreciation of the review performed by your staff.

Sincerely,

Robert L. Robinson
Executive Director

Enclosures

cc: Ms. Phyllis Williams, Deputy Administrator, DOM
Mrs. Janet Mann, Deputy Administrator, DOM
Mr. Brian Smith, Bureau Director, DOM

AGENCY RESPONSE TO "HURRICAN KATRINA UNCOMPENSATED CARE – UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

1. IMPROPER CLAIMS

Of the 200 claims in our sample, 7 claims totaling $22,569 were improper because the individuals who received the services from the Medical Center had other health care coverage:

- One individual, with a claim of $14,835, was covered by Medicare Part A. (UMC refunded this claim prior to the OIG review)
- One individual, with a claim of $6,181, was covered by the Civilian Health and Medical Program of the Uniformed Services.
- Four individuals, with claims totaling $1,458 were covered by Medicaid.
- One individual, with a claim of $95, was covered by SCHIP.

We did not identify a sufficient number of improper payments in our sample to allow us to make a reliable estimate of the improper payments in the population.

The agency has reviewed the seven claims and we are disputing that these claims are improper. We feel that the agency exercised our due diligence in devising a claims processing and payment system. The following steps were performed for each claim:

- **A search of the agency's eligibility system was conducted utilizing the patient information listed on the claim form to determine if the patient was in a Medicaid covered category.**
- **If the claim document indicated an employer or other pertinent information, a search of potential third-party payors was conducted.**
- **Each procedure code billed was reviewed and the proper pricing amount was written on the claim.**
- **Once the claim had been priced, and it was determined to the best of our ability that there was no other payors available; the claim was batched for payment.**

Each of these steps was performed by different staff members and over a period of several weeks from start to finish.

Factors such as retroactive eligibility after the claim was processed or lack of indicators to check third party payors contributed to some of the exceptions which were beyond our control. Other exceptions may have been due to a misunderstanding on the part of the reviewer. A detailed explanation for each exception is listed below.

- The reviewer indicated that one recipient, with a claim of $14,835 was covered under Medicare Part A. At the time of the claim, this recipient was 58 years old. While we do not dispute this claim was covered under Medicare Part A, given the age of the recipient, the staff member verifying eligibility for this claim would have had no reason to anticipate if Medicare coverage was available.

  The agency has received a refund for this claim.

- The reviewer indicated that one recipient, with a claim of $6,181 was covered by Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). During the timeframe in which this claim was submitted, the agency did not have any information regarding this recipient in our eligibility system until August 25, 2006. In addition, the claim documentation submitted by the medical provider did not contain information which gave any indication that third party coverage was available through CHAMPUS. Therefore, it is our opinion that at the time this claim was processed, it was a valid claim for UCC.

- The reviewer indicated that four claims totaling $1,458 were improper because the recipient had Medicaid coverage. Three of these four claims totaling $190 were for recipients that were covered under the Family Planning category of eligibility. While the procedure code utilized to bill these claims is a valid procedure code for family planning services, further review of the diagnosis code revealed that the claim was not related to family planning services. Based on the diagnosis code, payment for these claims would have denied if the provider had originally billed Medicaid for these services. Therefore, it is our opinion that these were valid claims for UCC.

  In addition, the reviewer indicated that one claim totaling $1,268 was improper because Envision indicated that the recipient had Medicaid coverage at the time of the claim. After further review, the eligibility span which covers this claim was not entered into the Envision system until December 8, 2006. At the time eligibility was verified for this claim, this recipient was not eligible in our system. It is our opinion that this claim should not be included as an exception.

- **The reviewer indicated that one claim totaling $95 was improper because the recipient had coverage under SCHIP. However, upon further review of the claim, and the information that was available in the Envision system, there were no indicators that this child would have been covered under SCHIP.**

The agency will pursue recovery of the claims that were eligible for other payor sources at the time of the audit. In addition, the agency will make the proper adjustments in cooperation with CMS.

2. LACK OF PROCEDURES FOR ELIGIBILITY VERIFICATION

The State agency was responsible for ensuring that only allowable claims were paid from the uncompensated care pool. CMS's September 22, 2005, letter approving section 1115 demonstration authority and allowing the State to reimburse providers for uncompensated care costs required the State to "establish mechanisms to prevent payments from the pool on behalf of individuals who have coverage for services, or for whom other options are available." However, the State agency paid the seven improper claims because it was unaware that the individuals who received the services from the Medical Center had health care coverage under other programs. The Medical Center submitted attestations that it was not aware of any other source of payment. The State agency relied on those attestations and did not have procedures to verify that the individuals did not have other health insurance coverage.

The agency does not agree with the statement that there were no procedures to verify that the individuals did not have other health insurance coverage. As we have indicated above, every UCC claim was checked to determine if the recipient had Medicaid eligibility and where sufficient information was provided, a search of potential third party payors was conducted. At any time during the process, it is highly probable that recipient eligibility information could have changed, especially if retroactive eligibility was granted. Since the claims were paid outside of the normal Medicaid claims process, it was not possible to perform a final eligibility or third party payor check at the time payment was made.

It is the agency's opinion that sufficient controls were in place and that these claims properly paid based on the information that was available when the claim was approved for payment.