



MAY 2 2003

REGION IV  
Room 3T41  
61 Forsyth Street, S.W.  
Atlanta, Georgia 30303-8909

Report Number: A-04-02-02021

Mr. Thomas Y. McBride, III.  
Sr. Vice President and C.F.O.  
Promina Gwinnett Medical Center  
1000 Medical Center Boulevard  
Lawrenceville, Georgia 30045

Dear Mr. McBride:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) final report entitled, *Review of Gwinnett Medical Center's Claim for Medicare Disproportionate Share Hospital Payments for Fiscal Year 1999*. A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS action 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.

In accordance with the principles of the Freedom of Information Act, 5 United States Code 552, as amended by the Public Law 104-231, OIG/OAS reports are made available to members of the press and the general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 Code of Federal Regulations, Part 5). As such, within 10 business days after the final report is issued, it will be posted on the World Wide Web at <http://oig.hhs.gov>.

To facilitate identification, please refer to report number A-04-02-02021 in all correspondence relating to this report. If you have any questions, please contact me or have your staff contact Peter Barbera at (404) 562-7758.

Sincerely,

Charles J. Curtis  
Regional Inspector General  
for Audit Services, Region IV

Enclosures – as stated

Page 2 – Mr. Thomas Y. McBride, III.

**Direct Reply To HHS Action Official:**

Mr. Dale Kendrick  
Associate Regional Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
Sam Nunn Federal Building  
61 Forsyth Street, SW, Suite 4T20  
Atlanta, Georgia 30303-8909

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF GWINNETT MEDICAL  
CENTER'S CLAIM FOR MEDICARE  
DISPROPORTIONATE SHARE  
HOSPITAL PAYMENTS FOR  
FISCAL YEAR 1999**



**JANET REHNQUIST**  
Inspector General

**MAY 2003**  
**A-04-02-02021**

# *Notices*

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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.





May 2, 2003

Report Number: A-04-02-02021

Mr. Thomas Y. McBride, III.  
Sr. Vice President and C.F.O.  
Promina Gwinnett Medical Center  
1000 Medical Center Boulevard  
Lawrenceville, Georgia 30045

Dear Mr. McBride:

This report provides you with the results of our review of the revised Medicare disproportionate share hospital (DSH) adjustment submitted by Promina Gwinnett Medical Center (PGMC) for fiscal year (FY) ended June 30, 1999. The objective of our review was to determine if the Medicare DSH reimbursement claimed by PGMC was in compliance with Medicare reimbursement criteria.

We reviewed the hospital's FY 1999-revised DSH adjustment of \$2,386,024, focusing on the 13,830 Medicaid eligible days used by PGMC to support this amount.

## EXECUTIVE SUMMARY

We found that the Medicare DSH adjustment of \$2,386,024 was overstated by a net amount of \$288,564. This overstatement occurred because the Medicaid eligible days used in PGMC's revised DSH calculation were overstated. Medicaid eligible days were overstated due to the incorrect inclusion of days related to dual eligible beneficiaries and duplicated days for some beneficiaries. The hospital's settlement request included 13,830 Medicaid eligible days, including 4,503 Medicaid eligible but unpaid days that previously were neither claimed by PGMC nor included in the fiscal intermediary's (FI) final settlement dated September 14, 2001. Our review found only 12,577 of these days to be allowable.

We are recommending that the hospital revise its settlement request and supporting documentation to reflect the audited Medicaid eligible days count, thus reducing the revised DSH adjustment and amount requested for settlement claimed by \$288,564. We also recommend that PGMC establish procedures to assure only allowable days are included in its future DSH adjustment calculations.

In written comments to our draft report, the hospital generally agreed with our findings and recommendations. The hospital and its consultants have established procedures to assure only allowable days are included in future DSH adjustment calculations. The hospital revised its Medicaid eligible day count and submitted a revised claim for Medicare DSH reimbursement.

## **BACKGROUND**

The origin of the DSH adjustment is rooted in legislation passed in 1982. However, an explicit adjustment to the Medicare Prospective Payment System (PPS) was not adopted until May 1986, 2 years after prospective payment began. In the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Congress directed the Secretary of Health and Human Services to study the extent to which the TEFRA hospital rates should be adjusted for the extra costs incurred by hospitals in treating low-income patients. With the Deficit Reduction Act of 1984, Congress directed the Secretary to define and identify DSH hospitals.

A study by the Congressional Budget Office in late 1984 showed that certain groups of hospitals with relatively large shares of Medicaid patients would be affected more adversely, on average, under the Medicare PPS than would other hospitals. The effect would be concentrated in big city areas and especially in hospitals with more than 100 beds. In April 1986, with the passage of the Consolidated Omnibus Reconciliation Act of 1985 (Public Law (P.L.) 99-272), Congress mandated an explicit adjustment for hospitals that serve a large share of low-income patients.

The DSH adjustment has been modified repeatedly. Each time, Congress has added money to the adjustment for specific categories of hospitals. Legislation passed in 1990 (P.L. 101-8) added the most money to the adjustment, about \$1 billion over a 5-year period, through changes in the DSH calculations. Congress also repealed the sunset provision for the adjustment, making it a permanent part of the PPS. In recent years, DSH payments have grown rapidly, from \$1.1 billion in 1989 to \$4.5 billion in 1997. The DSH payments accounted for about 6 percent of total PPS operating payments to all hospitals in 1997. The Balanced Budget Act of 1997 (P.L. 105-33) reduced DSH payments by 5 percent, with the reduction to be implemented in 1 percentage point increments between FYs 1998 and 2002.

### **DSH Payment Methodology**

The DSH payment is calculated as a percentage add-on to the basic DRG payment. The amount of DSH payment a hospital receives is determined by a complex formula and each hospital's DSH percentage. The hospital's DSH percentage is derived as the sum of two ratios: the proportion of all Medicare days that are attributable to beneficiaries of Supplemental Security Income (SSI), a cash benefit program for aged and disabled people, and the proportion of all patient days for which Medicaid is the primary payer. Other considerations in the calculation include a hospital's location, urban or rural, and hospital size.

A hospital must have a minimum DSH percentage, which differs across hospital groups, to qualify for DSH payments. After a specified DSH percentage threshold is exceeded, a more generous formula is applied, targeting payments to hospitals that are at the high end of service to low-income poor.

In February 1997, CMS issued a ruling clarifying the issue of what could be counted as a Medicaid day pursuant to the Medicare DSH calculation. This ruling, HCFAR 97-2, stated that "all inpatient hospital days of service for patients who were eligible on that day for medical

assistance under a state Medicaid plan, whether or not the hospital received payment for those inpatient services.” could be counted as a Medicaid day for the Medicare DSH calculation. Prior to HCFAR 97-2, Medicaid paid days was to be used in the calculation.

### **PGMC FY 1999 Cost Report Settlement Process**

The PGMC filed its 1999 cost report and did not include approximately 4,500 Medicaid eligible but unpaid days in the submitted total Medicaid days used in calculating its Medicare DSH adjustment. The FI settled PGMC’s FY 1999 Medicare cost report by decreasing Medicaid eligible days and reducing the Medicare DSH adjustment to \$1,346,949 as communicated in a Notice of Program Reimbursement (NPR) dated September 14, 2001. The FI’s DSH adjustment and resulting calculation were based on Medicaid paid days; Medicaid eligible but unpaid days were excluded.

The Medicaid eligible but unpaid days were allowed by CMS to be included in calculating the Medicare DSH adjustment (per HCFA 97-2 effective February 27, 1997).

In PRRB case number 02-0781, PGMC appealed the FI’s adjustment to decrease Medicaid eligible days, which decreased the allowable DSH adjustment. On June 27, 2002, PGMC submitted a preliminary position paper to the FI and PRRB relating to this appeal. The PGMC’s cover letter submitted with the preliminary position paper proposed that the FI review the issues and determine if settlement was possible prior to a final appeal position paper due on October 1, 2002. Essentially, PGMC requested the FI administratively settle the Medicare DSH adjustment under appeal to include approximately 4,500 Medicaid eligible but unpaid days that were not included on PGMC’s filed cost report. The settlement proposed by PGMC requested additional DSH reimbursement of \$1,039,075.

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

The objective of our review was to determine if the revised Medicare DSH reimbursement claimed by PGMC was in compliance with Medicare reimbursement criteria. This revised amount was requested by PGMC in a preliminary position paper submitted on June 27, 2002, along with a revised Medicare DSH adjustment. We specifically audited 13,830 Medicaid eligible days used in calculating the Medicare DSH adjustment of \$2,386,024 as included in PGMC’s preliminary position paper. Our audit covered PGMC’s Medicare cost report for FY 1999 (July 1, 1998 through June 30, 1999).

We did not review for compliance the process by which PGMC’s FY 1999 cost report was filed, settled, or appealed, as described in the background section of this report. Consequently, we do not express an opinion as to whether this is a jurisdictionally proper appeal.

To accomplish our objective we met with staff of PGMC’s FI, Blue Cross of Georgia in Columbus, Georgia. We discussed the FI’s role in the Medicare cost report settlement process and reviewed Medicare cost reports, settlement information, audit work papers, and permanent files pertaining to Medicare DSH adjustments claimed for several hospitals. We also met with

PGMC staff and its consultant to review the procedures used in preparing the list of Medicaid eligible days used in calculating the \$2,386,024 Medicare DSH adjustment. A consulting group assisted PGMC in preparing the DSH calculations. Specifically, the consultants worked with an authorized vendor contracted by the State of Georgia Medicaid agency to procure data directly from the Medicaid agency's database in matching the hospital patient database for FY 1999 to the state's Medicaid database to obtain Medicaid eligible but unpaid days previously not included in the FI's NPR dated September 14, 2001.

At the hospital we:

- identified dual eligible days by electronically reconciling the Medicaid eligible day listing to the Medicare provider statistical and reimbursement (PS&R) report;
- determined Medicare coverage by comparing the remaining Medicaid eligible days to the Medicare common working file;
- identified dual eligible days not previously identified by reviewing primary payer data and financial class information for Medicare HMO enrollees;
- identified current year duplicate days by electronically matching the FY 1999 Medicaid eligible but not paid listing to the FY 1999 Medicaid paid listing; and
- Identified multiple year duplicate days by electronically matching the FY 1998 Medicaid eligible day listing to the FY 1999 Medicaid eligible day listing.

Our review was conducted in accordance with generally accepted government auditing standards. We performed our fieldwork at FI offices in Columbus, Georgia and at PGMC in Lawrenceville, Georgia between August 2002 and November 2002.

## RESULTS

We found that \$288,564 of the Medicare DSH adjustment of \$2,386,024 claimed for reimbursement did not comply with Medicare guidelines and was therefore unallowable. The \$288,564 was attributable to an overstatement of Medicaid eligible days and the overstatement of PGMC's reduction for Medicaid sub-provider days. The PGMC claimed 13,830 days (15,348 Medicaid eligible days less 1,518 sub-provider days) in the calculation of Medicare DSH. Our review found that the 15,348 Medicaid eligible days were overstated by 1,390 days. The Medicaid eligible days total incorrectly included:

- 1) 554 days relating to dual eligible beneficiaries incorrectly included in total Medicaid days;



- 2) 196 days that were included in both the Medicaid paid claims listing and the Medicaid eligible but not paid claims listing; and
- 3) 640 days that were included in the current year yet were related to FY 1998 admissions.

Incorporating the above adjustments to the total eligible days automatically adjusts the total for sub-provider days from 1,518 to 1,381. Sub-provider days are an offset to the total for Medicaid eligible days. Thus, in summary, we believe the proper total for Medicaid eligible days should be 12,577 (15,348 – 1,390 – 1,381).

The errors in Medicaid eligible days occurred because neither PGMC nor its consultant had adequate procedures for accurately determining Medicaid eligible days. The following sections provide more details on the results of our review.

### **Dual Eligible Beneficiaries Incorrectly Included**

The Medicaid eligible days used in the revised Medicare DSH calculation were overstated by 554 days applicable to dual eligible beneficiaries. The days applicable to dual eligible beneficiaries were included in the Medicare component of the DSH calculations. Thus, also including them in the Medicaid eligible day count resulted in duplication.

The PGMC's procedures for determining eligible days were not adequate to identify all dual eligible beneficiaries. The PGMC relied mainly on the consultant's reconciliation of hospital beneficiary data to the state Medicaid agency's database in determining Medicaid eligible days. This step identified some, but not all, dual eligible beneficiaries who should have been excluded from the Medicaid days count. The reconciliation was inaccurate because the state agency did not maintain current Medicare data in its database. We found that additional steps were needed to identify all dual eligible beneficiaries. By comparing PGMC's data to a PS&R report prepared by the FI, which summarized all Medicare payments to PGMC's patients, we identified 480 days applicable to dual eligible beneficiaries that were not identified as such in the Medicaid database.

Additionally, we compared PGMC's data on patients to the Medicare common working file, and to PGMC's records of patients who were listed as Medicare HMO enrollees. These steps identified 20 days and 54 days respectively, applicable to dual eligible Medicare beneficiaries.

### **Current Year Duplicates Incorrectly Included**

The PGMC incorrectly included certain patient days twice in its FY 1999 Medicaid eligible days. As a result, total Medicaid eligible days were overstated by 196 days.

The PGMC's Medicaid eligible days total was comprised of several categories, including (1) patients on a Medicaid paid claims list and (2) patients on a Medicaid eligible but not paid list. Neither PGMC nor its consultant reconciled these two lists, which would have identified

duplicate entries. We performed reconciliation and identified 196 days that were counted twice in PGMC's records.

### **Multiple Year Duplicates Incorrectly Included**

The PGMC incorrectly included some patient days in FY 1999 that related to FY 1998 admissions. As a result, FY 1999 Medicaid eligible days were overstated by 640 days.

The PGMC's procedures were not adequate to properly account for the days applicable to patients who were admitted in one cost report period and discharged in a subsequent cost report period. Basically, these periods of admission straddled PGMC's FY end date. For these patient stays, PGMC included the days in its FY 1998 cost report under the category of Medicaid paid days. In FY 1999, PGMC again included these days under the category of Medicaid eligible but not paid days. By doing so, 640 days were incorrectly included in the FY 1999 total.

### **Reduction for Sub-Provider Medicaid Days**

The initial total for sub-provider days submitted by PGMC had to be revised to reflect our audit results. The PGMC's submission reported 1,518 sub-provider days, a figure that is the outcome of a formula based on total Medicaid days. Since our review adjusted total Medicaid eligible days, the formula for computing sub-provider days results in a new total of 1,381.

Using a methodology consistent with an FI audit adjustment, PGMC's revised calculation of its Medicare DSH adjustment included a reduction attributable to excludable Medicaid eligible days related to its sub-provider. Applying our audit results to this methodology, the submitted reduction for sub-provider Medicaid eligible days was overstated by 137 days (1,518 – 1,381).

## **CONCLUSION AND RECOMMENDATIONS**

We found that the \$2,386,024 Medicare DSH adjustment claimed for reimbursement was overstated by \$288,564. This overstatement was attributable to overstated Medicaid eligible days included in PGMC's revised DSH calculation. The hospital's settlement request included 13,830 Medicaid eligible days. Our review considered only 12,577 of these to be allowable.

We recommend that PGMC revise its settlement request to reflect the audited Medicaid eligible days, thus reducing its Medicare DSH adjustment claimed and reimbursement claimed by \$288,564. We also recommend that PGMC establish procedures to assure only allowable days are included in its future DSH payment calculations.

### **Auditee's Comments**

In written comments to our draft report, the hospital generally agreed with our findings and recommendations addressing the Medicaid eligible day count issues and have implemented procedural changes, which were outlined in the response. The hospital also revised its settlement request based on the audit findings.

In addition, the auditee:

- 1) noted three additional days over and above what the Office of Inspector General (OIG) recommended for removal, representing multiple year duplicates (643 days compared to 640 days in the draft report). This brings the revised total of Medicaid eligible days to 12,574.
- 2) offered an explanation why its June 30, 1999 cost report did not include any Medicaid eligible days. Basically, the information was not available from the State of Georgia's Medicaid program.
- 3) noted that the hospital's consultants met with the OIG and discussed the processes, procedures, and actions taken by the consultants to identify the Medicaid eligible patients, and that the OIG concurred that these actions covered the issues in the report.

### **OIG's Response**

The documentation provided by the hospital indicates that the Medicaid eligible days total included 643 multiple year duplicate days rather than 640 days. However, we considered the variance immaterial, and have not revised the figures in our final report. This information will be provided to the hospital's FI for use in settling the hospital's cost report.

We did meet with the consultants and suggested procedural changes to their methods to better identify Medicaid eligible days. Subsequently, the consultants informed us of their revised procedures based on the results of our review. We concurred that the consultant's revised procedures were adequate to accurately identify Medicaid eligible days at this hospital. This in no way implies that these same procedures would be all inclusive or adequate in other settings.

Sincerely,



Charles J. Curtis  
Regional Inspector General  
for Audit Services, Region IV



**GWINNETT HEALTH SYSTEM**  
 **PROMINA®**

April 14, 2003

**VIA: Federal Express**

Mr. Charles J. Curtis  
Regional Inspector General for Audit Services  
Office of Inspector General  
Office of Audit Services, Region IV  
Room 3T41  
61 Forsyth Street, S.W.  
Atlanta, Georgia 30308-8909

Re: Gwinnett Hospital System  
Medicare Disproportionate Share (DSH) Review  
FYE June 30, 1999  
Report Number A-04-02-02021

Dear Mr. Curtis:

We have reviewed the contents of your draft report presenting the results of your *Review of Gwinnett Medical Center's Claim for Medicare Disproportionate Share Hospital Payments for Fiscal Year 1999*. We have prepared responses to your audit findings and action plans in accordance with your recommendations.

Based on our review of the draft report, Gwinnett Hospital System (GHS) accepts and generally agrees with the findings disclosed herein. However, we feel it is important to comment on several key points:

- Page 3 of the draft report states that upon filing the June 30, 1999 Medicare cost report, GHS not include any Medicaid eligible days, even though the HCFA 97-2 ruling, effective February 27, 1997, allowed the provider to do so. Our response is that at the time of filing the cost report, no vendor application was available from the State of Georgia's Medicaid program. It should also be noted that the process in place by the State at the time of filing the June 30, 1999 cost report was a manual process that produced incomplete Medicaid eligibility data. Since State verification of eligibility information is and was required by Medicare Blue Cross and Blue Shield of Georgia, our Fiscal Intermediary (FI), GHS opted to file the more reliable paid day's summary report from the State.

Charles J. Curtis  
April 14, 2003  
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- Page 4 of the draft report states that “the consultants worked with the State of Georgia Medicaid in matching the hospital patient database for FY 99 to the State’s database to obtain Medicaid eligible but unpaid days”. The consultants actually worked with an authorized vendor contracted by the State of Georgia to procure data directly from the State of Georgia’s Medicaid database. These consultants reviewed with Office of Inspector General (OIG) staff the process, procedures, and actions taken thus far in the identification of Medicaid XIX eligible patients. After explaining the current process, identification and actions taken, the OIG concurred that the processes and procedures discussed, covered the issues.
- Page 5 of the draft report states that there were 640 days that were included in the current year yet were related to FY 98 admissions. This amount should be changed to 643. Subsequent review identified 3 additional days with a patient that had a name change. The total Medicaid days would be revised to 12,574, for a DSH adjustment of \$2,096,089. This adjustment is \$289,935 less than appeal filing and \$1,371 more than the reduction in your draft report.
- Page 6 of the draft report’s heading is “Reduction for Sub-Provider Medicaid Days **Overstated**”. We believe it should read “Reduction for Sub-Provider Medicaid Days **Adjusted**”. Since this is a formula-based computation required by the FI, Medicaid days are naturally reduced, as the Sub-Provider Medicaid eligible days would be reduced.

#### ACTIONS TAKEN ON THE RECOMMENDATIONS:

As recommended by OIG, GHS has revised its settlement request and supporting documentation to reflect the audited Medicaid eligible days count, thus a revised DSH adjustment in the amount of \$2,096,089. The Medicaid eligible days count was revised to 12,574. The detail support information for this revision is appended with this response letter.

GHS and its consultants have established and instituted procedures to assure only allowable days are included in its future DSH adjustment calculations. Procedures include the following:

- Identification of Dual eligible patients – the Medicare PS&R are reconciled with all patient lists submitted to the FI. All inpatients (excluding newborns and mothers of newborns) are processed and screened through the Medicare Common Working file. All Medicare HMO patients are identified by financial class.

Charles J. Curtis  
April 14, 2003  
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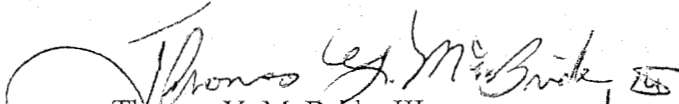
Medicare HMO patients are to be excluded from the filing of Medicaid Title XIX days.

- Current Year Medicaid patients – all Medicaid patients, paid and eligible, are processed through a program that queries and identifies any duplication. All true duplicates are removed, and not included in the Medicaid day count.
- Multiple Year Medicaid patients – all Medicaid patients that have an admit date in a different year will be identified. If a paid claims exist for the year of admit and the patient was paid on the service dates in the admit year, the patient's dates of service in the previous year will be excluded from any current year filings.

The above processes and procedures were used on the revised June 30, 1999 GHS filing.

Gwinnett Hospital System is committed to compliance with all Medicare rules and regulations relating to Medicare Disproportionate Share payments. We would like to thank you and your staff for your cooperative efforts in this review. If you have any questions, please feel free to contact me at (678) 442-4308 or Robert Cross at (678) 842-7435.

Sincerely,



Thomas Y. McBride, III  
Sr. Vice President & CFO  
Gwinnett Hospital System, Inc.

cc: Robert Cross- PROMINA Health System

## ACKNOWLEDGMENTS □

This report was prepared under the direction of Charles J. Curtis, Regional Inspector General for Audit Services, Region IV. Other principal Office of Audit Services staff who contributed include:

Pete Barbera, *Audit Manager*

Eric Bowen, *Senior Auditor*

Dicky Sanford, *Auditor*

For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.