CURRENT AUDIT FINDING AND RECOMMENDATIONS

Federal Compliance Audit Finding:

Finding No. 2018-004: Inadequate controls over the calculation of Diagnosis Related Group (DRG) reimbursement rates
Type of Finding: Significant Deficiency and Noncompliance

CFDA Titles: Medical Assistance Program (Medicaid), Children's Health Insurance Program, Refugee and Entrant Assistance State/Replacement Designee Administered Programs
CFDA Numbers: 93.778, 93.767, 93.566
Federal Award Numbers: 1805SDMAP, 1805SD5021, 1801SDRCMA
Federal Award Year: FFY18
Federal Agency: Department of Health and Human Services
Category of Finding: Allowable Costs/Cost Principles.
Questioned Costs: Total questioned costs - $4,188,510.38

CFDA 93.778, Federal Award Number – 1805SDMAP	= $ 3,730,187.07
CFDA 93.767, Federal Award Number – 1805SD5021	= $ 445,256.31
CFDA 93.566, Federal Award Number – 1801SDRCMA	= $ 13,067.00

Criteria:
The Medicaid State Plan, Attachment 4.19A outlines the method of reimbursement for inpatient services provided by hospitals to eligible recipients. Under the Medicaid State Plan, the Department of Social Services (DSS) reimburses hospitals for inpatient services, with a few limited exceptions, using a prospective Diagnosis Related Group (DRG) methodology. Under the DRG methodology, hospitals are reimbursed for services provided based on the charges to treat eligible patients, including both labor and non-labor resources. All the services provided to an eligible patient during their hospital stay are bundled into groups, referred to as DRGs. DRGs are based on several factors, including but not limited to, the reason for the hospitalization, procedures performed, any complicating factors, and patient demographics. DRG payment rates cover most routine operating costs attributable to patient care, including routine nursing services, room and board, and diagnostic and ancillary services.

DRG reimbursement rates are updated annually on October 1st (the beginning of the federal fiscal year) using complex statistical calculations based on the latest three years of claim data for inpatient hospital stays. Certain claims known as "outliers" have extremely high charge amounts compared to the average claim and are excluded from the calculations. Through these calculations, each DRG is assigned a "weight" based on historical charges, excluding any outliers, associated with that DRG. The weight assigned to each DRG is then used in the calculation of the amounts paid to reimburse hospitals for inpatient claims.

Cause:
The controls in place over the calculation of DRG weights for inpatient hospitals were inadequate to ensure the proper calculation of Medicaid reimbursement rates or to identify and correct errors to prevent the improper payment of Medicaid claims. Manual processes were used by a single individual to perform extremely complex calculations without further verification or adequate oversight.

Condition:
DRG weights are calculated by a single individual at DSS using Microsoft Excel spreadsheets with imbedded formulas. During the audit, DSS informed us that they had been notified of an error in the original DRG weight calculations and had revised the spreadsheets to correct the error. We obtained the revised spreadsheets and reviewed them as part of our audit procedures. Using the revised spreadsheets, we reviewed DSS' methodology and recalculated the determinations of the South Dakota specific DRG weights.

The following errors were noted:

1. Outlier claims were not properly removed from the population of claims used in the calculations to set the DRG weights. The inclusion of outlier claims affects the calculation of all DRG weights and can have a substantial effect, especially on DRGs that have a small number of claims.
2. The wrong claim dates were used in one calculation. DSS included 14,776 claims in the spreadsheet used to calculate the adjustment factor, but according to DSS policy, which states that the 'thru date' of claims should be used, only 13,412 claims should have been included in this calculation. The 'thru date' on the Medicaid Management Information System (MMIS) is the day of discharge from the hospital.
3. There were two formulas on the spreadsheet used to calculate the adjustment factor that did not properly include all the cells that should have been included.
4. The target amount factor in the payment rate for one hospital was not properly adjusted in the MMIS system by the inflationary factor of 0.50% approved by the SD Legislature.

These errors were communicated to DSS for review. DSS concurred with the errors noted, made corrections, and reperformed the DRG weight calculations. We obtained the revised spreadsheets and the methodology and DRG weight calculations were reviewed. Errors in the DRG weight calculations were again noted as identified below.

5. Inpatient claims from one hospital were improperly excluded from the population of claims used in the calculations of DRG weights.
6. The calculations for the adjustment factor were not reperformed or corrected for the errors shown above in #'s 2 and 3. The same improper number was used again as the adjustment factor.

These errors were communicated to DSS for review. DSS concurred with the errors noted and reperformed the DRG weight calculations after making corrections to the spreadsheets. DSS also performed procedures to identify the dollar amounts of these errors and to determine their effect on inpatient claims paid in FY2018. We obtained the revised spreadsheets from DSS and the methodology and DRG weight calculations were reviewed. After we determined the propriety of the revised DRG weight calculations, the spreadsheets used by DSS to calculate the dollar amount of these errors were also obtained from DSS and reviewed.

In order to calculate the impact of these errors on the claims paid to inpatient hospitals during FY18, we first had to determine the amount that should have been reimbursed using proper DRG calculations, and the amount that was reimbursed based on the errors noted. The difference between these two amounts, multiplied by the Federal Medical Assistance Percentage (FMAP) rate in effect for FFY18, was considered questioned costs.

All DRG reimbursed inpatient claims with a thru date greater than or equal to October 1, 2017 that were paid during State FY2018 were downloaded from the MMIS system by DSS and Bureau of Information Technology (BIT) personnel. These claims were then used by BIT personnel to run a program using the final corrected DRG weights to determine what the proper payment amounts should have been. This data was placed into a spreadsheet by DSS personnel and the original paid claim amounts were compared to the corrected paid claim amounts to determine the total amount of overpayments to the hospitals. We multiplied this amount by the SD FMAP rate for FFY 2018 to determine the federal share of the payments, which we consider questioned costs.

We performed audit procedures to verify the accuracy of the data used to calculate questioned costs provided by DSS and BIT personnel. To verify that the paid claims data downloaded by DSS personnel off the MMIS system was complete, we compared it to the amount of inpatient hospital claim expenditures recorded on the State's accounting system during the same time period. No material variances were noted. We also judgmentally selected three inpatient providers and traced all paid inpatient claims for these providers from the MMIS system to data that DSS provided to BIT for the time period without variance.

To verify that final paid claim amounts were properly corrected on the DSS spreadsheet used to calculate questioned costs, we selected a sample of 40 claims from the final claim calculations performed by DSS personnel. These claims were then recalculated with the final revised DRG weights to determine that the DSS updated paid claim amounts were proper. During this review, we discovered that payment rates at the two DRG-reimbursed psychiatric hospitals were also improperly calculated. For these two providers, claims with a discharge date on or after October 1, 2017 were overpaid until a 0.50% inflationary rate increase was approved and programmed into the MMIS system in April 2018. With the exception of the two psychiatric hospitals, we determined that the DSS calculation of the overpayment amount to providers was accurate. The amount calculated by DSS also included some additional amounts related to MMIS programming errors that were noted by DSS personnel when reviewing the DRG payment methodology and errors noted during our audit. These amounts were also reviewed and determined to be proper. Because the spreadsheets provided by DSS included all claims paid with DRG calculation errors and we were able to verify the accuracy of these spreadsheets, the total amount of the variances from the spreadsheets were determined to include all questioned costs and there are no questioned costs to be projected.

Effect:
Several errors were made in the calculation of inpatient hospital reimbursement rates for FFY 2018, resulting in inpatient hospitals reimbursed under the DRG methodology being overpaid a total of $6,734,217 during State Fiscal Year 2018. Of this amount, $4,188,510 was paid from federal funds.

Recommendations:
1. We recommend that DSS implement stronger controls over the calculations of DRG weights in order to prevent and detect errors and to ensure that the proper populations are being used in the calculations.
2. We recommend that DSS recover the overpayments from the providers.

Views of Responsible Officials:
The Department of Social Services concurs with the finding.