

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**FLORIDA MEDICAID PAID
HUNDREDS OF MILLIONS IN
UNALLOWABLE PAYMENTS TO
JACKSON MEMORIAL HOSPITAL
UNDER ITS LOW INCOME POOL
PROGRAM**

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Office of Inspector General

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Report in Brief

Date: August 2019

Report No. A-04-17-04058

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

As part of its Research and Demonstration Waiver for Medicaid reform (the waiver), Florida established the Low Income Pool (LIP) program to compensate hospitals for providing care to low-income patients. During State fiscal years (SFYs) 2010 through 2014, hospitals received a total of \$5.1 billion in LIP funds. Jackson Memorial Hospital (the Hospital) received \$1.8 billion of this total.

The Centers for Medicare & Medicaid Services (CMS) performed reviews of the LIP program covering SFYs 2007 through 2009 and found that Florida did not provide adequate oversight and guidance. As a result, the hospitals claimed unallowable costs and inconsistently documented, calculated, and reported costs. Florida also had not refunded \$146.1 million of Federal funds related to hospital-reported LIP overpayments disallowed by CMS.

Our objective was to determine whether Florida made LIP payments to the Hospital in accordance with the waiver and applicable Federal regulations.

How OIG Did This Review

Our audit covered SFYs 2010 through 2014, the most recent SFY for which supporting calculations were available. We reviewed the cost-limit calculations and supporting LIP data for unallowable items and clerical errors, and we recalculated the Hospital's cost limits for caring for low-income patients.

Florida Medicaid Paid Hundreds of Millions in Unallowable Payments to Jackson Memorial Hospital Under Its Low Income Pool Program

What OIG Found

Florida paid hundreds of millions to the Hospital under the LIP program that were not in accordance with the waiver and applicable Federal regulations. Of the \$1.8 billion in LIP payments made to the Hospital during our audit period, Florida claimed Medicaid reimbursement of \$686 million (\$412 million Federal share) in excess of the Hospital's allowable costs, including \$132 million (\$64 million Federal share) of net Hospital-reported overpayments and \$554 million (\$348 million Federal share) of unallowable costs identified during this audit.

What OIG Recommends and Hospital and Florida Comments

We recommend that Florida (1) refund \$412 million to the Federal Government, including \$64 million of hospital-reported net overpayments and \$348 million of unallowable costs identified during this audit; (2) instruct hospitals to establish procedures to return the Federal share of any overpayments in their LIP cost-limit calculations; (3) establish procedures to ensure that it returns to the Federal Government the Federal share of overpayments reported by hospitals; and (4) improve its oversight of the LIP program. We also made other procedural recommendations.

The Hospital disagreed with most of our findings. Most significantly, the Hospital contended that we incorrectly determined that it should offset Medicare and commercial insurance payments against costs for dual-eligible patients. After reviewing the Hospital's comments, we maintain that our findings and recommendations are correct, with one exception related to nonmedical assistance costs.

Florida disagreed with our findings. Like the Hospital, Florida argued that we incorrectly determined that the Hospital should offset Medicare and commercial insurance payments against costs for dual-eligible patients. Florida also argued that we did not properly consider the intersection of the LIP and disproportionate share hospital programs, contending that we should not have offset DSH payments that it had identified as overpayments. Florida also said that we should reduce Medicaid payments by the overpayment that it identified in its preliminary analysis of Medicaid rate settlements. After reviewing Florida's comments, we maintain that our findings and recommendations are correct but reduced the recommended refund from \$436 million to \$412 million based on additional information that Florida provided.

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INTRODUCTION

WHY WE DID THIS REVIEW

In 2005, the Centers for Medicare & Medicaid Services (CMS) approved Florida's Research and Demonstration Waiver (the waiver) for Medicaid reform. As a part of the waiver, the Florida Agency for Health Care Administration (State agency) established the Low Income Pool (LIP) program to compensate providers for the cost of care given to low-income patients. During State fiscal years¹ (SFYs) 2010 through 2014, 289 providers received \$5.1 billion in LIP funds. Jackson Memorial Hospital (the Hospital) received \$1.8 billion, which was more than 35 percent of total LIP funds paid in Florida and 3.6 times greater than the LIP funds paid to the recipient of the next highest amount. Beyond our audit period, the State agency paid LIP funds for SFYs 2015 through 2018 totaling \$4.6 billion, of which the Hospital received \$970 million, or approximately 21 percent. The amount that the Hospital received was about 3.4 times greater than the LIP funds paid to the recipient of the next highest amount.

CMS conducted two Financial Management Reviews of the LIP program covering SFYs 2007 through 2009 and found that the State agency did not provide hospitals with adequate oversight and guidance. As a result, the hospitals claimed unallowable costs and inconsistently documented, calculated, and reported costs. Additionally, for SFYs 2007 through 2014, CMS disallowed \$146.1 million of Federal funds related to hospital-reported LIP overpayments that the State agency had not refunded.² On the basis of the risks that CMS identified and the Federal funds at stake, we conducted this review of LIP funds paid to the Hospital.

OBJECTIVE

Our objective was to determine whether the State agency made payments to the Hospital under the LIP program for SFYs 2010 through 2014³ in accordance with the waiver and applicable Federal regulations.

¹ Florida's fiscal year is July 1 through June 30.

² The State agency has appealed CMS's disallowance.

³ The audit period begins the first SFY after the period covered by CMS's Financial Management Reviews (SFYs 2007 through 2009). SFY 2014 was the most recent year for which cost-limit calculations were available when we began our audit.

BACKGROUND

Medicaid Program

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, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. The State plan establishes which services the Medicaid program will cover. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Federal Government pays its share of a State's medical assistance costs on the basis of the Federal medical assistance percentage, which varies depending on the State's relative per capita income. In Florida, the State agency administers the Medicaid program.

The Waiver

The State agency operates the waiver, which was approved by CMS under Title XIX, section 1115, of the Social Security Act (the Act). Section 1115 of the Act gives CMS authority to approve experimental, pilot, or demonstration projects that it considers likely to assist in promoting the objectives of the Medicaid program. The purpose of these projects, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate State-specific policy approaches to better serve Medicaid populations.

To implement a State demonstration project, States must comply with the special terms and conditions (STCs) of the agreement between CMS and the State.⁴

Special Terms and Conditions

The STCs provide in detail the nature, character, and extent of Federal involvement in the waiver and the State's obligations to CMS during the life of the waiver.

Authorizations of the Low Income Pool Program

The waiver's STCs authorized the State agency to create the LIP program, which was to "be established and maintained by the [S]tate." The LIP program was to provide direct payments and distributions to safety-net providers in the State for providing healthcare

⁴ Two versions of the STCs were in effect during the audit period: one effective July 1, 2009, through December 15, 2011 (STC-a) and the other effective for the remainder of the audit period (STC-b). CMS amended STC-b on June 14, 2013. The amended version did not materially change the requirements or provisions of the STCs cited in this report; however, it did change the item numbers. We have cited the amended version of STC-b.

services to Medicaid, underinsured, and uninsured populations. The initial authorization allowed for annual State-wide total LIP payments of up to \$1 billion per year for SFYs 2007 through 2011. CMS has extended the LIP program several times, most recently through SFY 2022.

General Guidelines for Allowable Costs

The uncompensated costs of medical services for low-income patients, such as uninsured and Medicaid patients, are permissible LIP expenditures. Hospitals are to determine such incurred costs by using hospital Medicare cost report⁵ methodologies (STC-a and STC-b, items 97 and 80, respectively). Also, the State may claim other costs, as agreed upon by the State and CMS (STC-a and STC-b, items 97 and 80, respectively). In addition, the STCs required the State agency to submit for CMS approval a Reimbursement and Funding Methodology Document (RFMD) that defined permissible LIP expenditures (STC-a, item 93).⁶

Reimbursement and Funding Methodology Document

The RFMD, along with the STCs, provides the primary governing guidance for the LIP program. In June 2009, the State agency submitted its RFMD; in December 2009, CMS approved it effective retroactive to July 1, 2006.⁷ The RFMD defines the expenditures and entities, including certain hospitals, eligible to receive Federal matching. The RFMD provides instruction for calculating a hospital's cost limit, which is the portion of total allowable expenditures related to low-income patients, less any reimbursements received related to those patients. In addition to the RFMD, the State agency provided to hospitals a template (cost-limit calculation template⁸) and an instruction manual (LIP instruction manual) that reiterated the RFMD instructions for the cost-limit calculations.

⁵ The Medicare cost report (Form CMS 2552) is a form that all hospitals must submit to CMS to determine program payments and support Federal program management.

⁶ The STCs also discuss prescribed milestones that are not within the scope of this audit.

⁷ The first RFMD (RFMD-a) ended June 30, 2011. During SFYs 2012 through 2014, two updated versions of the RFMD were in effect (RFMD-b and RFMD-c).

⁸ The cost-limit calculation template is a Microsoft Excel spreadsheet that provides hospitals with the format for calculating the cost-limits and specific instructions regarding which Medicare cost report data to use in the calculations.

Distribution and Reimbursement Methodology

Distribution of Low Income Pool Funds

In 2005, the Florida Legislature established the LIP Council to, among other things, make recommendations on the financing of the LIP and the disproportionate share hospital (DSH)⁹ programs and the distribution of those funds. During the audit period, the LIP Council consisted of 24 members from a variety of healthcare-related occupations. According to the RFMD, the LIP Council is responsible for making recommendations annually to the Florida Legislature regarding the distribution of LIP funds. Upon review and action by the Florida Legislature, the distribution methodology becomes part of the annual General Appropriations Act. Each year, the State agency may begin distributions in July, and the distributions are generally made monthly or quarterly.

Intergovernmental Transfers

For the audit period, 97 percent of the State share of LIP payments came from intergovernmental transfers (IGTs) from local governments.¹⁰ The State agency entered into contracts with local governments to enforce its IGT agreements and assured local governments that the providers on whose behalf they sent IGTs would receive as much as or more in LIP payments than the amount of the IGTs.

Cost-Limit Calculations

To receive LIP distributions, hospitals are required to submit their LIP cost-limit calculations to the State agency annually. The LIP cost-limit calculations are due by March 1 of the second SFY after the SFY for which the calculation is being performed (e.g., a hospital's calculation for the SFY ended June 30, 2012, was due March 1, 2014). The State agency is required to submit these calculations to CMS 3 months later, by May 31.

Hospital Cost Portion of Calculations

The RFMD instructs hospitals to calculate the allowable costs for three types of low-income patients: Medicaid fee-for-service, Medicaid managed care, and uninsured or underinsured patients (all RFMDs, section IV (A)(1)(2)&(3)). Additionally, the State agency included Medicare dual-eligible¹¹ patients as a category of low-income patients on its CMS-approved cost-limit calculation template for hospitals to calculate costs.

⁹ Federal law requires that States make DSH payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals (the Act §§ 1902(a)(13)(A)(iv) and 1923).

¹⁰ The remaining 3 percent of the State share came from the State general revenue funds.

¹¹ Dual-eligible patients are patients who are entitled to Medicare and are also eligible for some form of Medicaid benefit.

To calculate inpatient routine costs, as well as inpatient and outpatient ancillary costs for each category of low-income patients, the RFMD instructs hospitals to perform the following steps:

determine the total hospital costs per day by inpatient routine cost center and the total cost-to-charge ratio by ancillary cost center;¹²

- multiply each inpatient routine cost center's low-income patient days¹³ by the costs per day for the cost center; and
- multiply each ancillary cost center's inpatient and outpatient low-income charges by the cost-to-charge ratio for the cost center.

Additionally, the RFMD allows for hospitals to calculate organ acquisition costs for each category of low-income patient.

Hospital Provider Additional Medicaid Costs (Section 6 Costs)

Hospitals may include additional costs not included in the hospital LIP inpatient routine and ancillary costs (RFMD-a, section IV(A)(4), RFMDs b and c, section IV(A)(5)&(6)). In section 6 of its LIP cost-limit calculation template, the State agency included a separate section for these costs entitled "Hospital Provider Additional Medicaid Costs" (section 6 costs). These section 6 costs may include, for example, outpatient clinical laboratory services, patient and community education programs, and services contracted to other providers.

Payments Portion of Cost-Limit Calculations

Hospitals should reduce calculated costs by payments from the uninsured, Medicaid managed care organizations (MCOs), Medicaid, and other non-State payers. Also, Medicaid DSH and LIP payments should be included in the Medicaid payments that are being offset against costs (RFMD-a, section IV(A)(5), RFMDs b and c, section IV(A)(7)). In addition, the LIP cost-limit calculations "may also include costs for Medicaid services that exceed Medicaid payments (after all other title XIX payments are made, including disproportionate share hospital payments)" (STC-a, and STC-b, items 94 and 77, respectively).

Reconciliation to the Finalized Medicare Cost Report

¹² According to the RFMD, cost, days, and ancillary charges are to be taken from the Medicare cost report worksheets B part I, S-3, and C part I, respectively (all RFMDs, section IV (A)(1),(2),&(3)). The data on these cost report worksheets are broken down into cost centers based on the hospital services to which they relate. Examples of inpatient routine service cost centers are the adult and pediatrics, intensive care, and coronary care units. Examples of ancillary cost centers are the operating room, recovery room, and radiology.

¹³ Low-income patient days are the total of the days of service for all low-income patients during which those patients were inpatients in the hospital.

Ultimately, the State agency is required to reconcile the low-income costs calculated by the hospital to the costs calculated based on the finalized Medicare cost report for the payment year (RFMDs b and c, section IV(A)(9)).

Refund of Overpayments

The State agreed that it would not receive Federal financial participation (FFP) for payments to hospitals in excess of costs (STC-a, and STC-b, items 97 and 80, respectively, and all RFMDs, section IV). Additionally, the State must return to the Federal Government the Federal share of any overpayments made to the hospitals (RFMD-a, section IV(A)(7), RFMDs b and c, section IV(A)(9)).

Jackson Memorial Hospital

The Hospital is the largest teaching hospital in Florida and the only public hospital in Miami-Dade County. With about 1,500 beds, the Hospital is the largest facility operated and managed by the Public Health Trust of Miami-Dade County, Florida (PHT). PHT was created by the Board of County Commissioners pursuant to Florida statute and county ordinance and receives part of its funding from a healthcare surtax.¹⁴ PHT's patients are primarily Medicaid or other publicly funded residents, and its facilities treat the uninsured and underinsured, as it operates the only safety-net hospital in the county.

HOW WE CONDUCTED THIS REVIEW

Our audit covered SFYs 2010 through 2014 (audit period). We focused our review on the Hospital, which received the largest amount of LIP payments, \$1.8 billion, or approximately 35 percent of the State-wide total, with the second-ranking hospital receiving only about 10 percent of LIP funds. We reviewed the cost-limit calculations and the supporting LIP data to identify any unallowable items or clerical errors, and we recalculated the Hospital's cost limits to determine the amount the State agency paid the Hospital in excess of its costs of caring for low-income patients.

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 objectives.

¹⁴ Florida Statute, Title XIV, chapter 212, section 212.055, Discretionary Sales Surtaxes, authorizes the imposition of a discretionary sales surtax. Under § (5), County Public Hospital Surtax, a 0.5-percent sales surtax was voted on and approved for the administration of the county public general hospital and the public health trust that operates it.

See Appendix A for the details of our scope and methodology and Appendix C for applicable Federal requirements.

FINDINGS

The State agency paid hundreds of millions to the Hospital under the LIP program that were not in accordance with the waiver and applicable Federal regulations. Of the \$1,798,392,602 in LIP payments made to the Hospital during our audit period, \$1,112,047,198 was allowable. However, the remaining \$686,345,404 (\$411,932,576 Federal share) that the State agency claimed for Medicaid reimbursement was for payments in excess of the Hospital's allowable costs as follows:

- \$131,983,013 (\$64,382,543 Federal share) of net Hospital-reported overpayments for the audit period, consisting of \$245,783,531 (\$141,036,263 Federal share) of overpayments for SFYs 2012, 2013, and 2014¹⁵ that the State agency did not refund and \$113,800,518 (\$76,653,720 Federal share) of underpayments for SFYs 2010 and 2011;
- \$222,650,251 (\$141,527,826 Federal share) related to omitted and underreported payments:
 - Medicaid payments of \$134,108,689 (\$87,390,030 Federal share) and
 - Medicare payments of \$88,541,562 (\$54,137,796 Federal share) for dual-eligible patients;
- \$142,311,325 (\$88,075,549 Federal share) related to caring for patients for whom Federal funding was not available:
 - costs of \$136,736,903 (\$84,538,219 Federal share) related to the non-emergency care of undocumented aliens and
 - costs of \$5,574,422 (\$3,537,330 Federal share) related to the outpatient care of prisoners;
- \$67,905,785 (\$39,008,490 Federal share) of unallowable costs that were not calculated in accordance with RFMD guidance:
 - \$37,320,247 (\$21,390,528 Federal share) related to excluded low-income cost data,
 - \$14,083,369 (\$5,627,904 Federal share) related to incorrectly distributed low-income data,

¹⁵ As of December 10, 2018, the State agency had not yet returned the Federal share of these hospital-reported overpayments.

- \$11,411,642 (\$7,396,731 Federal share) related to incorrectly calculated observation bed costs, and
- \$5,090,527 (\$4,593,327 Federal share¹⁶) related to incorrectly calculated organ acquisition costs;
- \$51,889,200 (\$31,955,859 Federal share) of unallowable section 6 costs:
 - incorrectly included costs totaling \$36,262,973 (\$22,864,006 Federal share) for nonmedical assistance,
 - incorrectly included costs totaling \$14,310,216 (\$8,256,930 Federal share) for caring for prisoners in a prison facility, and
 - incorrectly included costs totaling \$1,316,011 (\$834,923 Federal share) for other than low-income patients;
- \$48,044,340 (\$31,898,767 Federal share) related to clerical errors in reporting LIP data, including \$42,427,589 of overstated low-income ancillary charges for SFY 2010; and
- \$21,561,490 (\$15,083,542 Federal share) of costs that the State agency did not reconcile to the Hospital's finalized Medicare cost reports.

See Appendix B for a summary of these findings by year and total.

The State agency did not return the Federal share of overpayments reported by hospitals because it did not have a procedure in place to do so. Also, the State agency claimed excessive reimbursement because it had not established policies for the oversight of the LIP program to ensure that it could identify and correct instances in which hospitals overstated their cost limits. Finally, the Hospital did not have adequate policies and procedures for preparing and reviewing cost-limit calculations and did not have any procedures to ensure that it returned to the State agency the Federal share of any overpayments that the Hospital identified.

THE STATE AGENCY DID NOT RETURN THE FEDERAL SHARE OF THE HOSPITAL'S SELF-REPORTED OVERPAYMENTS

The State agency agreed that it would not receive FFP for Medicaid and LIP payments to hospitals in excess of costs (STC-a and STC-b, items 97 and 80, respectively). CMS may reduce funds available through the LIP to recoup payments made to providers that it determines were

¹⁶ The Federal share percentage is higher in this instance because a substantial portion of the overpayment was in 2010, a year in which there was a significantly enhanced Federal share percentage.

made in excess of allowable costs and may recoup funds through a reduction of FFP claimed against LIP payments or through disallowance (STC-b, item 75). Additionally, the State agency must ensure that the total costs claimed in a State plan rate year do not exceed the costs justified in the underlying hospital cost reports for the applicable years (RFMD-a, section IV(A)(7), RFMDs b and c, section IV(A)(9)).

For SFYs 2012 through 2014, the Hospital self-reported overpayments (payments in excess of allowable costs) totaling \$245,783,531 (\$141,036,263 Federal share). In September 2016, CMS issued a demand letter for the Federal share of State-wide hospital-reported overpayments for SFYs 2007 through 2014.¹⁷ As of December 10, 2018, the State agency had not yet paid the amount demanded by CMS.

The Hospital also reported underpayments for SFYs 2010 and 2011 totaling \$113,800,518 (\$76,653,720 Federal share). In its demand letter, CMS did not offset the self-reported overpayments with these underpayments because neither the STCs nor the RFMD has a provision for settlement payments to hospitals for years in which they are underpaid. However, we determined that the Hospital now has net overpayments for all SFYs in the audit period, including SFYs 2010 and 2011 which had previously been underpayments. Therefore, the \$76,653,720 Federal share of self-reported underpayments should be netted against the \$141,036,263 Federal share of self-reported overpayments, resulting in a net self-reported overpayment of \$64,382,543.

The State agency did not have procedures to ensure that it returned the Federal share of overpayments reported by hospitals. Additionally, the Hospital did not have procedures to ensure that it returned to the State agency the Federal share of any calculated overpayments that the Hospital identifies.

THE HOSPITAL OMITTED AND UNDERREPORTED MEDICAID AND MEDICARE PAYMENTS

The Hospital incorrectly omitted and underreported Medicaid and Medicare payments totaling \$222,650,251 (\$141,527,826 Federal share) in its cost-limit calculations.

Medicaid Payments

Hospitals must include all Title XIX payments, including DSH payments, as offsetting payments against calculated low-income costs (STC-a, and STC-b, items 94 and 77, respectively). Additionally, hospitals must offset LIP payments received during the year for which the LIP cost-limit calculation is being performed (RFMD-a, section IV(A)(5), RFMDs b and c, section IV(A)(7)).

In its cost-limit calculations, the Hospital did not offset \$134,108,689 it received in Medicaid payments against low-income costs. Specifically, the Hospital received \$83,256,130 in Medicaid

¹⁷ In total, CMS demanded \$146,113,363, which included \$141,036,263 related to the Hospital. The State agency has appealed CMS's disallowance.

DSH payments in SFY 2010 that it did not offset, understated LIP payments by \$21,393,680 from SFYs 2010 through 2014, and received \$29,458,879 for the care of Medicaid patients not identified with specific claims in SFYs 2010 and 2014 that it did not offset (Table 1).

Table 1: Omitted and Underreported Payments in the Hospital’s Cost-Limit Calculations

Payment Type	Amount	State Fiscal Year(s)
Diagnosis-related group transitional ¹⁸	\$17,487,543	
Additional funding of inpatient and outpatient rates ¹⁹	9,373,381	
Organ acquisition costs	2,597,955	
Subtotal—Medicaid payments not for specific claims	\$29,458,879	2010–2014
Medicaid DSH	83,256,130	2010
LIP	21,393,680	2010–2014
Total Medicaid Payments Not Offset	\$134,108,689	

As a result of the Hospital overstating its cost-limits by \$134,108,689, the State agency received an overpayment of \$87,390,030 from the Federal Government.

The State agency received the overpayment for the omitted DSH payments and the underreported LIP payments because it did not provide proper oversight by testing or verifying the accuracy of the LIP data the Hospital used in its cost-limit calculations. The State agency should have been able to readily identify the Hospital’s omission of DSH payments and understatement of the LIP payments if it had reviewed the data the Hospital used.

The State agency claimed the unallowable reimbursements related to the non-claim-specific Medicaid payments because it did not instruct hospitals to include these payments in the LIP cost-limit calculations. Additionally, although the State agency included a section in its cost-limit calculation template for hospitals to include DSH and LIP payments, it neither included a section to record other non-claim-specific Medicaid payments nor reviewed the cost-limit calculations to verify that the Hospital included such payments.

Also, contrary to the instructions in the STCs, the Hospital did not consider all Medicaid payments when it was calculating its cost limits. Hospital personnel said that for SFY 2010 they omitted the Medicaid DSH payments because they assumed that the State would automatically include the payments. However, for SFYs 2011 through 2014, they correctly reported the Medicaid DSH payments.

¹⁸ In SFY 2014, the State agency changed its claims reimbursement methodology from per diem payments to payments based on diagnosis-related groups. These transitional payments made in SFY 2014 were designed to aid hospitals that experienced a decrease in reimbursement due to the change in methodology.

¹⁹ This payment represented a one-time adjustment to increase the rates paid to the Hospital for inpatient and outpatient services.

Medicare Payments for Dual-Eligible Patients

The RFMD instructs hospitals to calculate allowable costs for three types of low-income patients: Medicaid fee-for-service, Medicaid managed care, and uninsured or underinsured patients (all RFMDs, section IV(A)(1)(2)&(3)). In its CMS-approved cost-limit calculation template, the State agency also allowed hospitals to include Medicare dual-eligible patients as a category of low-income patients.

To calculate allowable costs, hospitals should offset costs for these patients with payments from the uninsured, Medicaid MCOs, Medicaid, and payments from other non-State payers (RFMD-a, section IV(A)(5), RFMDs b and c, section IV(A)(7)). Similarly, hospitals should use the portion of payments attributable to Medicare dual-eligible patients to offset their uncompensated care costs. Medicare makes payments to hospitals for (1) individual Medicare patients, including Medicare dual-eligible patients; (2) tentative and final settlement of their Medicare cost reports; and (3) separate payments for direct graduate medical education, Medicare bad debts, and organ acquisition costs.

For our audit period, the Hospital did not offset against its low-income costs \$88,541,562 for the Medicare dual-eligible patients' portion of Medicare payments for tentative and final cost report settlements, direct graduate medical education, Medicare bad debts, and organ acquisition costs. As a result of understating payments received, the Hospital overstated its LIP cost limits by \$88,541,562, and the State agency received an overpayment of \$54,137,796 from the Federal Government.

The State agency received this overpayment because it did not instruct hospitals to include in their LIP cost-limit calculations some payments associated with Medicare dual-eligible patients. Also, the State agency neither included in its cost-limit calculation template a section in which hospitals could report these payments nor reviewed the calculations to verify that the Hospital included such payments.

THE HOSPITAL CLAIMED COSTS FOR PATIENTS FOR WHOM FEDERAL FUNDING WAS NOT ALLOWABLE

The Hospital incorrectly claimed a total of \$142,311,325 (\$88,075,549 Federal share) for categories of patients for which Federal funding is not allowable. These patients were undocumented aliens or prisoners being treated on an outpatient basis.

Care Provided to Undocumented Aliens

The Act § 1903(v)(1) prohibits payments to States for medical assistance to an alien who is not lawfully admitted for permanent residence to the United States or otherwise permanently residing in the United States under color of law (i.e., "undocumented aliens"). However,

§ 1903(v)(2) provides an exception to this rule for the cost of emergency care provided to undocumented aliens. LIP funds cannot be used for costs associated with the provision of healthcare to non-qualified aliens (STC-a and STC-b, items 95 and 78, respectively).

For each of the 5 years in our audit period, the Hospital included the unallowable costs of non-emergency care²⁰ for undocumented aliens in its cost-limit calculations. The Hospital identified these patients as undocumented aliens when assigning them to a financial class in the Hospital's accounting records.

As a result of improperly including in its cost-limit calculations the unallowable costs of non-emergency care for undocumented aliens, the Hospital overstated its cost limits by \$136,736,903, and the State agency received an overpayment of \$84,538,219 from the Federal Government.

The State agency received this overpayment because it did not instruct hospitals to exclude the costs of non-emergency care for undocumented aliens. Also, the State agency did not provide proper oversight by checking the Hospital's documents, which clearly identified the "undocumented aliens" financial class for many claims used in the cost-limit calculation.

Outpatient Care Provided to Prisoners

The cost of inpatient care provided to prisoners is allowed, but hospitals should not include in their cost-limit calculations the costs of care for prisoners in other than an inpatient setting (STC-a and STC-b, items 94 and 77, respectively; the Act § 1905(a)(29)(A); and December 12, 1997, CMS Director letter ("Clarification of Medicaid Coverage Policy for Inmates of a Public Institution")).

For our audit period, the Hospital included, in its low-income data, claims for outpatient care provided to prisoners. The Hospital separately identified these patients as prisoners when assigning them to a financial class in the Hospital's accounting records. The Hospital also included in its section 6 costs for SFYs 2012 through 2014 the costs related to the care of prisoners provided at prison facilities. (See "The Hospital Claimed Unallowable Section 6 Costs" below.)

As a result of including the unallowable costs of providing care to prisoners in outpatient settings, the Hospital overstated its LIP cost-limit calculations by \$5,574,422,²¹ and the State agency received an overpayment of \$3,537,330 from the Federal Government.

²⁰ The Hospital also included the costs of emergency care for undocumented aliens, which was allowable.

²¹ This figure does not include the cost of caring for prisoners in a prison facility, which we have addressed in another finding. (See page 17.)

The State agency received this overpayment because it did not instruct hospitals to exclude the costs of caring for prisoners in outpatient settings. Also, the State agency did not provide proper oversight by testing or verifying that the Hospital was not including unallowable costs of caring for prisoners in its LIP cost-limit calculation. Hospital personnel stated that nobody at the Hospital reviewed the low-income data to determine whether claims for outpatient care provided to prisoners were included. If the State agency had reviewed the Hospital's supporting list of low-income claims, it would have identified the errors because the Hospital identified the financial classes for each line item on the list.

THE HOSPITAL DID NOT FOLLOW SOME REIMBURSEMENT AND FUNDING METHODOLOGY DOCUMENT INSTRUCTIONS

The Hospital did not follow RFMD instructions regarding (1) calculating costs for all low-income patients, (2) distributing low-income data consistent with the Medicare cost report methodology, (3) calculating organ acquisition costs, or (4) calculating low-income observation bed costs. As a result, the Hospital overstated its cost-limit calculations by \$67,905,785 (\$39,008,490 Federal share).

Excluded Some Low-Income Patient Data

The RFMD instructs hospitals to calculate the cost shortfall (i.e., costs in excess of payments) for Medicaid fee-for-service, Medicaid managed care, and uninsured or underinsured patients (all RFMDs, section IV(A)(1), (2), and (3); also RFMD-a, section IV(A)(5), RFMDs b and c, section IV(A)(7)). In its CMS-approved LIP cost-limit calculation template, the State agency also allowed for hospitals to include Medicare dual-eligible patients as a category of low-income patients.

For SFYs 2011, 2012, and 2013, rather than including in its cost-limit calculations the data for all patients from the four low-income categories, the Hospital excluded certain low-income patient accounts for which it estimated payments exceeded costs. This omission distorted the amount by which the Hospital's overall costs exceeded payments (i.e., its LIP cost limit) for the applicable categories of low-income patients. As indicated in Table 2 below, if the Hospital had correctly included these accounts, it would have increased its allowable costs by \$127,365,471, but this cost would have been offset by payments totaling \$164,685,718, resulting in a net decrease to the Hospital's cost limits of \$37,320,247.

Table 2: Patient Data Excluded From Hospital Calculations

Low-Income Category	Costs for Excluded Accounts*	Payments Received	Payments > Costs
SFY 2011			
Dual-eligibles	\$14,938,567	\$21,220,700	\$6,282,133
Medicaid MCO	9,997,498	7,993,754	(2,003,744) [†]
Total SFY 2011	\$24,936,065	\$29,214,454	\$4,278,389
SFY 2012			
Dual-eligibles	\$63,388,150	\$80,214,938	\$16,826,788
Out-of-State Medicaid	750,720	1,028,754	278,034
Medicaid MCO	29,204,664	38,622,898	9,418,234
Total SFY 2012	\$93,343,534	\$119,866,590	\$26,523,056
SFY 2013			
Uninsured	\$9,085,872	\$15,604,674	\$6,518,802
Total All Years	\$127,365,471	\$164,685,718	\$37,320,247
<p>* The costs represent the increase in total low-income costs when we added the patient days and ancillary charges for the excluded accounts to the cost-limit calculations.</p> <p>† The Hospital excluded these accounts for which it estimated the payments exceeded costs. However, for these particular accounts, the actual costs exceeded payments.</p>			

As a result of improperly excluding certain low-income patients from its data, the Hospital overstated its LIP cost limit by \$37,320,247, and the State agency received an overpayment of \$21,390,528 from the Federal Government.

The State agency received this overpayment because it did not provide proper oversight by testing or verifying the completeness of data being used by the Hospital in its LIP cost-limit calculations. Additionally, Hospital personnel said that, because the excluded patient data involved significant payments, they did not think it was proper to include the patient data in the LIP cost-limit calculations.

Incorrectly Allocated Low-Income Data Used To Calculate Costs

The RFMD instructs hospitals to calculate low-income costs by multiplying low-income patient days and ancillary charges by specified cost factors derived from the Medicare cost report (all RFMDs, section IV(A)(1),(2), and (3)). Additionally, the STCs state that permissible expenditures are to be derived utilizing methodologies from the Medicare cost report. This instruction is

repeated in the RFMD. To calculate its low-income costs consistent with the Medicare cost report, the Hospital should have allocated low-income patient days and ancillary charges in its cost-limit calculations to cost centers in the same manner as it distributed those patient days and ancillary charges within the total patient days and total ancillary charges on its Medicare cost reports. Otherwise, low-income costs may exceed total hospital costs for certain cost centers.

In its cost-limit calculations for each SFY in our audit period, the Hospital distributed more low-income patient days and ancillary charges to certain cost centers than there were total hospital patient days and ancillary charges for those cost centers. This distribution resulted in calculated low-income costs that exceeded total hospital costs for those cost centers.

As a result of its incorrect distribution of the low-income patient data, the Hospital overstated its cost-limit calculations by \$14,083,369, and the State agency received an overpayment of \$5,627,904 from the Federal Government.

The State agency received this overpayment because it did not provide adequate oversight by testing or verifying the accuracy of the Hospital's LIP cost-limit calculations. Specifically, even a cursory review by the State agency would have revealed that the low-income costs exceeded total costs in certain cost centers.

In addition, the State agency did not have basic electronic edits in place to detect low-income costs exceeding total costs.

Hospital personnel stated that low-income costs exceeded total costs for certain cost centers because they used the Medicaid low-income data allocation percentages to distribute the low-income data for the Medicaid managed care, uninsured, and Medicare dual-eligible patients.

Incorrectly Calculated Low-Income Observation Bed Costs

The RFMD instructed hospitals to include observation bed-days²² in the total inpatient day count for purposes of calculating the total inpatient routine cost per day and to include low-income observation charges in the calculation of low-income ancillary costs (all RFMDs, section IV(A)(1),(2), and (3)).

The Hospital did not include observation bed-days in its calculation of the inpatient routine costs per diem in any of its cost-limit calculations in our audit period. In addition, for certain years, the Hospital did not include the observation cost center in its calculation of low-income ancillary costs.

²² Observation services are hospital outpatient services a patient receives while the patient's doctor decides whether to admit the patient.

As a result of not including observation bed-days in the routine costs per diem calculation and not including the observation cost center in the low-income ancillary cost calculation, the Hospital overstated its LIP cost limit by \$11,411,642, and the State agency received an overpayment of \$7,396,731 from the Federal Government.

The State agency received this overpayment because it did not check or verify that the Hospital properly incorporated observation days and charges into its cost-limit calculations, as the RFMD required.

Incorrectly Calculated Organ Acquisition Costs

The RFMD instructs hospitals to identify the ratio of usable organs for low-income patients (from hospital records) to total usable organs (from the Medicare cost report). The RFMD then instructs the hospitals to multiply that ratio by total organ acquisition costs from the Medicare cost report to arrive at the allowable low-income patient organ acquisition costs (all RFMDs, section IV(A)(1),(2),and (3)).

For SFYs 2010 and 2011, the Hospital did not follow the methodology prescribed by the RFMD and instead incorrectly calculated its low-income organ acquisition costs by multiplying low-income charges by the cost-to-charge ratio for the specific organ acquisition cost centers. In addition, for SFY 2010, the Hospital incorrectly claimed that all of its organ acquisition costs were for low-income patients.

The Hospital used the correct methodology to calculate organ acquisition costs for the other 3 years in the audit period; however, the figures it used in the calculations did not agree with the finalized Medicare cost reports.

As a result of the Hospital overstating its LIP organ acquisition costs by \$5,090,527 on its LIP cost-limit calculations, the State agency received an overpayment of \$4,593,327 from the Federal Government.

The State agency received this overpayment for improperly calculated organ acquisition costs because it did not ensure that the Hospital used the RFMD-prescribed method for calculating low-income organ acquisition costs. Additionally, the State agency had no procedures in place to review the calculations and did not verify the organ counts data and organ acquisition costs used by the Hospital for the years that the Hospital calculated the costs using the proper methodology.

THE HOSPITAL CLAIMED UNALLOWABLE SECTION 6 COSTS

The Hospital included costs in its section 6 costs that were not in compliance with the RFMD. Specifically, it included costs that were (1) not for medical assistance, (2) for caring for prisoners in prison facilities, (3) not reduced by payments received, and (4) not for low-income patients.

In total, the hospital claimed \$51,889,200 of unallowable section 6 costs (\$31,955,859 Federal share).

Nonmedical Assistance Costs

In defining permissible expenditures, the STCs say that LIP funds may be used for healthcare costs (medical care costs or premiums) within the definition of medical assistance in § 1905(a) of the Act.

As noted in Table 3, for our audit period, the Hospital made errors in its cost-limit calculations by including a total of \$36,262,973 in costs that did not qualify as “medical assistance,”²³ as defined in section 1905(a) of the Act.

Table 3: Nonmedical Assistance Costs in Cost-Limit Calculations

Cost Item	Total Cost
Jackson International*	\$25,129,748
Toddler shelter day care	6,839,245
Jail rapid transit	2,278,116
Jail diversion	1,853,014
Forensic evaluation	162,850
Total	\$36,262,973
* Jackson International is a program designed to lead international patients to providers who can treat their complex medical conditions.	

As a result of these errors in the Hospital’s cost-limit calculations, the State agency claimed unallowable Federal reimbursement totaling \$22,864,006.

The State agency received this overpayment for section 6 costs that were not for medical assistance because it did not evaluate the nature of the section 6 costs that the Hospital claimed.

Costs of Caring for Prisoners in a Prison Facility

The cost of inpatient care provided to prisoners is allowed, but hospitals should not include in the cost-limit calculations the costs of care for prisoners in other than an inpatient setting (STC-a and STC-b, items 94 and 77, respectively; the Act § 1905(a)(29)(A); and December 12,

²³ Medical assistance under a State’s Medicaid State Plan for which it may receive Federal payments includes inpatient and outpatient services, as well as other medical services for Medicaid beneficiaries.

1997, CMS Director letter (“Clarification of Medicaid Coverage Policy for Inmates of a Public Institution”).

For 3 years in our audit period, the Hospital included in the section 6 part of its cost-limit calculations costs totaling \$14,310,216 that were for caring for prisoners in a prison facility instead of a hospital inpatient setting. As a result of the Hospital incorrectly including these costs, the State agency received an overpayment of \$8,256,930 from the Federal Government.

The State agency received this overpayment for section 6 costs that were for caring for prisoners at a prison facility because it did not evaluate the nature of the section 6 costs that the Hospital claimed.

Medical Assistance for Other Than Low-Income Patients

The STCs require LIP funds to be used for the provision of care to low-income patients (STC-a and STC-b, items 94 and 77, respectively).

For our audit period, the Hospital’s cost-limit calculations included in its section 6 costs the costs of a physician’s private office that did not service primarily low-income patients. The total of such costs that the Hospital claimed was \$1,316,011. As a result of the Hospital incorrectly including these costs, the State agency claimed unallowable Federal reimbursement totaling \$834,923.

The State agency received this overpayment because it did not instruct hospitals to review section 6 costs for allowability based on the RFMD, and it did not review the Hospital’s section 6 costs.

THE HOSPITAL MADE SEVERAL CLERICAL ERRORS

The RFMD instructs hospitals to calculate low-income costs by multiplying low-income patient days and ancillary charges by cost factors derived from the Medicare cost report (all RFMDs, section IV(A)(1), (2), and (3)).

The Hospital made several clerical errors in its LIP cost-limit calculations for SFYs 2010, 2011, 2013, and 2014. The most significant of these errors was related to its calculation of low-income ancillary charges for SFY 2010, which caused the Hospital’s SFY 2010 cost-limit calculation to be overstated by \$42,427,589. Hospital personnel said that they used an incorrect formula to obtain the low-income inpatient routine charges. They incorrectly obtained only 1 day’s per diem inpatient routine charge for each line of low-income data, rather than obtaining the total inpatient routine charges for the entire hospital stay. The Hospital then subtracted inpatient routine charges from total charges to calculate ancillary charges. This calculation caused the gross overstatement of low-income ancillary charges.

The Hospital's other clerical errors caused its cost limits for SFYs 2011, 2013, and 2014 to be overstated by another \$5,616,751. In total, the Hospital overstated its cost-limit calculations by \$48,044,340 because of clerical errors. As a result, the State agency received an overpayment of \$31,898,767 from the Federal Government.

The State agency received this overpayment because it did not provide adequate oversight by testing or verifying the accuracy of the low-income patient data, including patient days, ancillary charges, and payments, that the Hospital used in its LIP cost-limit calculations. Specifically, for SFY 2010, if the State agency had checked the amounts of low-income ancillary charges, it would have recognized that the Hospital had a noticeable error in its cost-limit calculations.

THE STATE AGENCY DID NOT RECONCILE THE HOSPITAL'S COST-LIMIT CALCULATIONS TO FINALIZED MEDICARE COST REPORTS

The State agency must reconcile the hospital cost limits to the finalized Medicare cost report for the payment year (RFMDs b and c, section IV(A)(9)).

The State agency did not reconcile (i.e., update) the Hospital's cost-limit calculations based on the finalized Medicare cost reports, causing its cost-limit calculations to be overstated by \$21,561,490. As a result, the State agency received an overpayment of \$15,083,542 from the Federal Government.

The State agency received this overpayment because it did not perform the required reconciliations and because it did not have controls in place to ensure adherence to the requirements of the RFMD. Additionally, the State agency explained that, because its share of the LIP funds is provided almost entirely through IGTs, it has no risk and no incentive to identify overpayments after LIP payments are made.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$411,932,576 to the Federal Government, consisting of:
 - \$64,382,543, representing the Federal share of net Hospital self-reported LIP overpayments for the audit period and
 - \$347,550,033, representing the Federal share of LIP cost limits calculated by the Hospital that did not comply with Federal and State requirements as identified in this audit;

- instruct hospitals²⁴ to establish procedures to return to the State agency the Federal share of any overpayments identified in their LIP cost-limit calculations;
- establish procedures to ensure that it returns to the Federal Government the Federal share of overpayments reported by hospitals;
- update the cost-limit calculation template for hospitals to include a section to report Medicaid payments (other than DSH and LIP) that are not related to specific claims and the dual-eligible patient portion of payments for Medicare cost report settlements, direct graduate medical education, Medicare bad debts, and organ acquisition costs and review the cost-limit calculations to verify that hospitals have included these payments;
- revise its LIP instruction manual to instruct participant hospitals to perform the following steps when preparing the LIP cost-limit calculations:
 - exclude the cost of non-emergency care for undocumented aliens;
 - exclude the cost of caring for prisoners in other than an inpatient setting;
 - review section 6 costs for allowability based on the RFMD;
 - distribute low-income patient days and ancillary charges to cost centers consistent with the Medicare cost report;
 - review the calculations for clerical errors and ensure that they exclude noncompliant items; and
 - reduce calculated costs by all payments received including:
 - Medicaid payments that do not relate to specific claims;
 - the portion of Medicare cost report settlements, direct graduate medical education, bad debts, and organ acquisition cost payments that relate to Medicare dual-eligible patients; and
- improve its oversight of the LIP program by establishing policies and procedures for:
 - providing additional training to its staff members on the RFMD and STCs for the waiver;

²⁴ Although this report specifically cites the nonreturn of self-reported overpayments for the Hospital, the State agency's instructions go to all hospitals. Additionally, CMS's Financial Management Reviews noted that the State agency had not returned the Federal share of self-reported overpayments for multiple hospitals.

- providing training to participating hospital personnel on LIP program compliance and preparing the cost-limit calculations; and
- monitoring hospital LIP calculations to verify that they comply with the RFMD and STCs including:
 - reconciling hospital cost-limit calculations to the finalized Medicare cost reports;
 - reviewing hospital low-income data to verify that it does not include data for undocumented aliens;
 - reviewing hospital low-income data to verify that it does not include data for prisoners in other than an inpatient setting;
 - testing or verifying the accuracy and completeness of the data being used by hospitals in their LIP cost-limit calculations;
 - reviewing hospital cost-limit calculations to verify that the hospitals properly incorporate observation days and charges into the calculations, as prescribed by the RFMD;
 - reviewing organ acquisition costs to verify that hospitals use the RFMD-required methodology and to verify the accuracy of the data used in the calculations;
 - establishing electronic edits in the cost-limit calculation template to detect distribution errors in which low-income costs exceed total costs for individual cost centers; and
 - reviewing section 6 costs claimed by hospitals to verify allowability based on the RFMD.

HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Hospital disagreed with most of our findings. Most significantly, the Hospital contended that we incorrectly determined that it should offset Medicare and commercial insurance payments against costs for dual-eligible patients and that removing this offset would virtually eliminate the overpayment cited in the report. In addition, the Hospital strongly urged us to remove our refund recommendations from the report, noting that the Hospital is a significant provider of care to Medicaid, underinsured, uninsured, and indigent patients in South Florida. The Hospital did not specifically address our finding that the State agency had not refunded net Hospital-reported overpayments for the audit period.

After reviewing the Hospital's comments, we maintain that the State agency made payments to the Hospital in excess of allowable costs and that the State agency should refund the Federal share of the overpayments. However, after considering the Hospital's comments, we removed from our findings \$1,125,000 (\$756,708 Federal share) related to the fire rescue helicopter included in section 6 costs, and we reflect this removal in this final report. For reasons more fully explained below, we maintain that Medicare and commercial insurance payments for dual-eligible patients should be offset against the related costs and that we correctly recommended refunding the overpayment. In addition, we understand the importance of the Hospital's role in providing healthcare to low-income patients in South Florida. However, our objective was to assess the allowability of LIP payments that the State agency made to the Hospital. We used criteria to evaluate the allowability of LIP payments that were negotiated and established by CMS and the State agency. In particular, the STC and RFMD establish payment requirements specific to the State agency's LIP program. If the State agency and CMS had agreed to other payment requirements specific to the Hospital because of its role in providing healthcare to low-income patients, we would have used that criteria.

Below, we have addressed each of the Hospital's specific comments on our findings. The Hospital's comments are included in their entirety as Appendix D.

OVERSTATED LOW INCOME POOL PAYMENTS

Hospital Comments

The Hospital said that we overstated by \$60 million the LIP payments that the Hospital received for SFY 2011 because we relied on an outdated report. The Hospital said that the State agency had reallocated LIP payments among State hospitals for that year.

Office of Inspector General Response

We used the LIP figures that the State agency had provided to us. Upon receiving the Hospital's comments on our report, we confirmed with the State agency that we had used the correct figures.

PAYMENTS FOR DUAL-ELIGIBLE PATIENTS

Hospital Comments

The Hospital stated that it "vehemently disagrees" with our finding regarding reducing unreimbursed costs by certain payments related to dual-eligible patients. The Hospital argued that Medicare and commercial insurance payments related to dual-eligible patients should not be offset against costs because the STCs say that "the Medicaid shortfall should be calculated as Medicaid costs less 'Title XIX payments'" (and do not mention Medicare or commercial insurance payments). The Hospital took issue with our citing of the RFMD language as

authority for offsetting the Medicare and insurance payments, stating that the RFMD language is ambiguous and that the RFMD cannot supersede the STCs that authorized the RFMD.

The Hospital likened our calculation of the Medicaid shortfall for LIP to CMS's position on the Medicaid shortfall calculation for Medicaid DSH, noting that CMS has lost several lawsuits preventing it from enforcing a similar interpretation. The Hospital asserted that, when the Medicare and commercial insurance payments are properly excluded from the Medicaid shortfall calculation, the total overpayment we cited would be "almost entirely eliminated."

Office of Inspector General Response

The STCs specifically state that LIP-permissible expenditures are defined in the RFMD (STC-a, items 93 and 97, and STC-b, items 76 and 80). As stated in the report, the RFMD requires all payments from non-State payers to be offset against computed costs (RFMD-a, section IV(A)(5), RFMDs b and c, section IV(A)(7)). Accordingly, the STCs and RFMD require Medicare and commercial insurance payments to be offset against costs.

CMS's approval of the cost-limit calculation template, which included dual-eligible patients in section 5 of the template, further clarifies that these payments must be offset against costs. The instructions in the payments section of the template included the following unambiguous language identifying which payments should be offset: "All payments made by or on behalf of the patients in sections 2-6 above adjusted to reflect the State Fiscal Year. Exclude only payments from State and local tax sources. Include retrospective adjustments received during the year as well as gross LIP and DSH Medicaid payments." These instructions say exactly what may be excluded—namely, payments from State and local tax sources—thus precluding the exclusion of Medicare and commercial insurance payments for dual-eligible patients.

Although the Hospital asserted that the \$728 million overpayment would be nearly eliminated if we excluded Medicare and commercial insurance payments from the Medicaid shortfall calculation, the Hospital had correctly offset Medicare and commercial insurance claims payments in its cost-limit calculations. Eliminating the entire \$728 million overpayment (\$436 million Federal share) from the Medicaid shortfall calculation would also require inappropriately removing those payments from the cost-limit calculations. Besides, our two findings regarding dual-eligible patients totaled only about \$111.6 million: (1) the Hospital did not offset the Medicare dual-eligible patients' portion of various payments not related to specific claims (\$88.5 million) and (2) the Hospital incorrectly excluded certain dual-eligible patients from its calculations (\$6.3 million for SFY 2011 and \$16.8 million for SFY 2012). Even if we agreed with the Hospital's assertions (which we do not), removing these two findings would not come close to eliminating the entire \$728 million overpayment.

Finally, the Hospital's argument regarding CMS's position on Medicaid DSH is not relevant to our report on the LIP program.

NON-QUALIFIED ALIENS COSTS

Hospital Comments

The Hospital agreed that costs of caring for undocumented aliens are not allowable for the LIP program. However, the Hospital contended that the costs we identified were not related to caring for undocumented aliens. The Hospital stated that we made that assumption because we lacked documentation.

Office of Inspector General Response

As we noted in our report, the Hospital identified these patients as undocumented aliens when assigning them to a financial class in its accounting records. Missing documentation was not an issue. We believe our finding regarding undocumented aliens is appropriate.

COSTS OF OUTPATIENT CARE FOR PRISONERS

Hospital Comments

The Hospital argued that it was not clear that the criteria we cited regarding the allowability of the costs of outpatient care provided to prisoners was applicable in the context of the LIP program. The Hospital acknowledged that CMS had stated in the context of Medicaid DSH that such costs are not allowable, but the Hospital believes that is not necessarily true for the LIP program. It noted that the STCs, in general, and the sections that we cited, in particular, did not address the costs of caring for prisoners. It argued that the CMS State Medicaid Director letter that we cited concerned the costs of caring for prisoners under the Medicaid program but not the costs of caring for prisoners that have no source of coverage.

Office of Inspector General Response

The STC sections that we cited say that LIP funds may be used for healthcare expenditures that would be within the definition of medical assistance in section 1905(a) of the Act. The CMS State Medicaid Director letter concerns the exclusion of FFP for medical care provided to inmates of a public institution under section 1905(a)(A) of the Act and clarifies that the exclusion applies only to the costs of outpatient care provided to prisoners (and not inpatient care). The State receives Federal matching funds (i.e., FFP) for its LIP expenditures. As a result, we maintain that the costs of outpatient care provided to prisoners, which is not allowable for FFP, is not an allowable LIP expenditure.

EXCLUDED ACCOUNTS

Hospital Comments

The Hospital said that it believed that the LIP cost limit did not require the inclusion of all low-income patient costs. The Hospital specifically said that it believed that it was appropriate to exclude certain patients who received no Medicaid benefit but were Medicaid eligible and for whom there was no payment shortfall (i.e., payments exceeded estimated costs). Furthermore, it speculated that we included such patients in our cost-limit calculations for the sole purpose of reducing the allowable LIP cost limit.

Office of Inspector General Response

We maintain that it is inappropriate to exclude low-income patients from certain categories from the cost-limit calculations because payments for those patients exceeded estimated costs. Excluding low-income patients distorts the amount by which the Hospital's costs exceeded payments for the applicable categories of patients. For example, approximately \$23.1 million of the total \$37.3 million finding on "excluded accounts" related to patients who were in the dual-eligible category. To identify the amount by which the Hospital's costs of caring for dual-eligible patients exceeded payments received, the Hospital had to include all dual-eligible patients. It is no more appropriate to exclude patients from this category than it would be to selectively exclude certain Medicaid fee-for-service or Medicaid managed-care patients for whom the Hospital estimated that the Medicaid or Medicaid MCO payments exceeded costs. We maintain that the Hospital overstated its allowable costs by \$37.3 million (\$21.4 million Federal share) related to improperly excluded accounts.

DISTRIBUTION OF LOW-INCOME DATA

Hospital Comments

The Hospital said that it believed that its method of allocating low-income data was permissible under the STCs and RFMD. It further contended that our allocation method was flawed and inappropriate.

Office of Inspector General Response

The Hospital did not cite in its comments a specific problem with our method for correcting the allocation of low-income data. We continue to believe that our method, which correctly allocated low-income patient data to the same cost centers where the data were included on the Medicare cost report, was correct and complied with the STC requirement that costs be calculated using methodologies from the Medicare cost report (a requirement that is reiterated in the RFMD).

ORGAN ACQUISITION COSTS

Hospital Comments

The Hospital agreed with our update of its organ acquisition cost calculations based on data from the finalized Medicare cost reports. However, the Hospital maintained that the method it had used to calculate those costs was permissible under the STCs and RFMD.

Office of Inspector General Response

The Hospital used two completely different methods for calculating organ acquisition costs during the audit period (one method for SFYs 2010 and 2011 and another for SFYs 2012 through 2014). Only the method that the Hospital used for SFYs 2012 through 2014 was consistent with the instructions in the RFMD. We adjusted the SFYs 2012 through 2014 calculations based on updated data from the finalized Medicare cost reports, as required by the RFMD. We adjusted the SFYs 2010 and 2011 calculations using the specific methodology prescribed by the RFMD and using finalized Medicare cost report data for those years. We maintain that our finding regarding organ acquisition costs is valid.

UNALLOWABLE SECTION 6 COSTS

Hospital Comments

The Hospital stated that it believed that a majority of the additional costs (i.e., section 6 costs) that we identified as unallowable were, in fact, allowable. However, it offered an argument for only one such cost: the fire rescue helicopter costs of \$1,125,000. The Hospital noted that, according to 42 CFR section 440.170, transportation expenses deemed necessary to secure medical examinations and treatment for a beneficiary are allowable. The Hospital also cited Florida Statute section 409.905, which requires the State Medicaid agency to ensure that transportation is available to Medicaid recipients in need of care.

The Hospital did not make an argument in favor of the remaining identified, unallowable section 6 costs, which totaled \$56,185,874 and included, among other things, costs such as a program for international patients (\$25.1 million), costs of treating prisoners at a prison facility (\$14.3 million), and day care costs (\$6.8 million).

Office of Inspector General Response

After reviewing the information that the Hospital provided regarding the fire rescue helicopter, we agree that these costs are allowable and have removed this part of the finding. We continue to believe the remaining identified unallowable additional costs should be removed from the calculations.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with all of our findings. As its overarching concern, the State agency contended that we had not considered the interrelationship of the DSH and the LIP programs. The State agency said that because the DSH examination reports for SFYs 2012 through 2014 indicated that all \$221 million in DSH payments were overpayments, we should not include those payments in the LIP cost-limit calculations. Also, the State agency said that because its preliminary analysis of rate settlements based on Medicaid cost report reviews for SFYs 2011 through 2014 indicated expected State agency recoupments of \$83 million, we should reduce Medicaid payments by \$83 million, resulting in an increase in the LIP cost limits.

The State agency furthermore cited its appeal of the LIP overpayments identified by CMS in a disallowance letter,²⁵ noting that the appeal involves LIP overpayments that overlap with the audit years. It said that it believes the overpayments are grossly overstated because they were calculated based on the same methodology as the DSH guidance that CMS was forced to withdraw (i.e., third-party payments were offset against costs). The State agency argued that our report is misleading in stating that we have identified hundreds of millions of dollars in additional overpayments (i.e., in addition to the Hospital-reported overpayments).

We agree with the State agency that the LIP and DSH programs intersect, with each program's payments being considered in the other program's calculations. We also acknowledge that the State agency's argument that the Medicaid claims payments for the period in question are still in the process of cost settlement. However, we reviewed the LIP payments based on the DSH and Medicaid claims payments as they were during our audit fieldwork, not as they might be after any possible future adjustments have been made. As we more fully discuss below, the State agency may account for any action that CMS takes on our recommendations in its final DSH settlements for the years in our audit period and in future LIP calculations.

We disagree that we were misleading in our report regarding the overpayments we identified. We were careful to point out that \$132 million of the total findings resulted from \$246 million in Hospital-reported overpayments offset by \$114 million in Hospital-reported underpayments and that we identified an additional \$554 million (i.e., "hundreds of millions in additional overpayments").

After reviewing the State agency's comments, we maintain that the State agency made payments to the Hospital in excess of allowable costs and that the State agency should refund the Federal share of the overpayments. However, after considering the comments and additional documentation provided by the State agency, we (1) reduced LIP payments by the amount that the Hospital reallocated to other hospitals, (2) reclassified the assignment of LIP payments between years, (3) revised the allocation of the LIP data based on the allocation

²⁵ These were self-reported overpayments calculated by the Hospital.

percentages for total days and total ancillary charges from the finalized Medicare cost reports as requested by the State agency, (4) reduced payments by the pro rata share of payments related to ancillary charges that we assigned to non-reimbursable cost centers, (5) increased organ acquisition costs to correct the organ counts that the Hospital had incorrectly input into its cost-limit calculations, and (6) removed the offset of revenues related to certain section 6 costs. Because of these six changes, we reduced the overpayment by \$41,445,429 (\$23,885,063 Federal share), and we reflect this reduction in this final report.

Below, we have addressed each of the State agency's specific comments on our findings. The State agency's comments are included in their entirety as Appendix E.

THE STATE AGENCY DID NOT RETURN THE FEDERAL SHARE OF THE HOSPITAL'S SELF-REPORTED OVERPAYMENTS

State Agency Comments

The State agency said that it had not returned the Federal share of the Hospital's self-reported overpayments because it disputes how CMS determined the alleged overpayments. It said that the Hospital-reported overpayments are not valid because the calculations reduced costs by some third-party payments provided to dual-eligible patients. The State agency argued that, because courts have directed CMS not to offset Medicare and commercial insurance payments for dual-eligible patients against costs in the DSH calculations, then those payments should not be offset against costs in the LIP cost-limit calculations. The State agency further argued that "CMS cannot enter into negotiations with the State of Florida asserting that LIP limits will be based on DSH limits, conduct audits where LIP limits have always been based on DSH limits, and then fail to modify the LIP limits when the courts mandate that DSH limits be changed." The State agency argued that, by removing the payments in question, the cited overpayment would be either eliminated entirely or at least substantially reduced.

The State agency also said that because it has appealed the disallowance identified in the letter in which CMS sought recovery of the hospital-reported overpayments, we should not repeat the CMS finding in our audit.

Office of Inspector General Response

Although there is an inter-relationship of the DSH and LIP programs, the rules for each program are separately defined. The LIP program rules are defined in the STCs, RFMDs, and the cost-limit calculation template. As we noted in our response to the Hospital's comments, the STCs specifically state that LIP-permissible expenditures are defined in the RFMD (STC-a, items 93 and 97, and STC-b, items 76 and 80). Also, the RFMD requires all payments from non-State payers to be offset against computed costs (RFMD-a, section IV(A)(5), RFMDs b and c, section IV(A)(7)). Accordingly, the STCs and RFMD require Medicare and commercial insurance payments to be offset against costs. As we also noted in our response to the Hospital, the LIP

cost-limit calculation template approved by CMS contained unambiguous language requiring the Hospital to offset Medicare and commercial insurance payments.²⁶

Based on the cited RFMD requirements and the unambiguous language in the CMS-approved cost-limit calculation template, we conclude that the Hospital was obligated to offset those payments.

It was necessary for us to include in our report the Hospital-reported overpayments identified as a disallowance in CMS's demand letter (as well as the Hospital-reported underpayments) to accurately report the net overpayment or underpayment for each year.

THE HOSPITAL OMITTED AND UNDERREPORTED MEDICAID AND MEDICARE PAYMENTS

State Agency Comments

The State agency reiterated its argument that third-party payments related to dual-eligible patients should not be offset against costs in the LIP cost-limit calculations.

The State agency said that DSH examination reports for SFYs 2012 through 2014, for which the Hospital received \$221,079,238 in DSH payments, show that the Hospital was 100 percent overpaid for those years. Also, it said that the preliminary analysis of rate settlements, based on its Medicaid cost report reviews for SFYs 2011 through 2014, indicate that there will be recoupments of \$82,783,027. The State agency argued that removing the DSH payments for SFYs 2012 through 2014 and adjusting for the rate settlements would increase the Hospital's cost limits by \$303,862,265. In particular, the State agency said that the \$221 million in DSH payments for SFYs 2012 through 2014 should be removed from our calculations to prevent collecting these payments from the Hospital twice.

The State agency also noted, as did the Hospital, that it had reallocated \$60 million in LIP payments to other hospitals for SFY 2011. The State agency said that the Hospital provided interlocal agreements and documentation that the redistribution was allowable and occurred during June 2013. It contended that accounting for this redistribution would result in an increase of \$60 million to the Hospital's allowable costs.

The State agency also said that we had incorrectly identified LIP payments based on the SFY in which the payments were made to the Hospital rather than the SFY to which the payments relate.

²⁶ Although we maintain that the LIP rules require hospitals to offset the third-party payments (regardless of the DSH-related court rulings cited by the State agency), we also note that the DC Circuit recently reversed the lower court's decision, which had vacated CMS's 2017 rule requiring Medicare and other third-party payments to be offset against costs in hospital-specific DSH-limit calculations, and thus reinstated the rule. (See *Children's Hosp. Ass'n of Tex. v. Azar*, 2019 U.S. App. LEXIS 24026 (DC Cir. 2019).)

Office of Inspector General Response

As previously stated, based on the cited RFMD requirements and the unambiguous language in the cost-limit calculation template, we disagree with the State agency's argument that the third-party payments for dual-eligible patients should not be offset against costs.

We audited the LIP cost-limit calculations based on what had actually occurred. Even though the DSH examination reports for SFYs 2012 through 2014 show 100-percent overpayment, the State agency has not refunded those DSH payments. During our audit fieldwork, the State agency confirmed the amount of DSH payments for the audit period (including the \$221 million for SFYs 2012 through 2014) and did not contend that the payments should be reduced by \$221 million. The STCs and the RFMD instruct the State agency to include DSH payments in the offsetting payments section of the cost-limit calculation (STC-a, and STC-b, items 94 and 77, respectively, and RFMD-a, section IV(A)(5), RFMDs b and c, section IV(A)(7)). Therefore, we do not agree that we should reduce the DSH payments by \$221 million.

After refunding the LIP overpayments as recommended in our report, the State agency may work with CMS to reduce the Hospital's LIP payments included in its final DSH examination to reflect the amount of the LIP overpayment refund and prevent the Hospital from refunding the overpayments twice. Alternatively, the State agency may work with CMS to refund the identified DSH overpayments (i.e., the \$221 million for SFYs 2012 through 2014) before finalizing the DSH audit and then reduce the LIP overpayment to reflect the amount of the DSH overpayment refund. Regardless of the order in which the State agency handles the refunds, we properly reported that the State agency overpaid the Hospital, including the \$221 million in DSH payments for SFYs 2012 through 2014.

Regarding the State agency's preliminary analysis of rate settlements that it said projected \$83 million in recoupments, we properly did not reduce payments as this is only a projected amount and the State agency had not actually recouped funds in the audit period. If the State agency makes recoupment based on rate settlements, it should reflect the amount recouped as a reduction of payments in the year in which the recoupment is made. The LIP cost-limit calculation template instructions for the payments section of the calculations say to "Include retrospective rate adjustments received during the year" Any future recoupments relating to years in our audit period would be considered retrospective adjustments, because they would be done after the SFYs to which they are applicable. Thus, it is appropriate to reflect the amount ultimately recouped as a reduction of payments for the year in which the State agency recoups the money.

After providing its comments on the draft report, the State agency provided us with the agreements detailing the Hospital's reallocation of \$60 million of its SFY 2011 LIP funds to other hospitals. The agreements appear to require the Hospital to first send \$60 million to the receiving hospitals and then for the receiving hospitals to return \$57 million to the Hospital, resulting in a net loss to the Hospital of only \$3 million. Both the Hospital and the receiving

hospitals used wire transfers to transfer the \$60 million and the \$57 million on the same day. Despite the stated intent of these transactions to reallocate \$60 million of the Hospital's SFY 2011 LIP payments to other hospitals, the substance of the transactions appears to show that the Hospital reallocated only \$3 million in LIP funds. Despite our request for clarification, the State agency did not provide any further explanation or documentation to support a reduction of \$60 million in LIP payments to the Hospital. Accordingly, we have reduced the Hospital's LIP payments used in the SFY 2011 cost-limit calculation by only \$3 million (\$1,972,650 Federal share).

For our audit, we used the LIP payment amounts by year that the State agency provided to us. The State agency confirmed the LIP payment amounts before our issuing the draft report and later again confirmed the payments to be correct after we received the Hospital's comments on our draft report. Now that the State agency has corrected the SFY assignment of the LIP payments, we have revised the LIP payments by SFY to reflect the changes that the State agency communicated in its comments. This revision resulted in no change to the overall LIP payments or the total computable overpayment. However, because the Federal share percentage is different for each SFY, the reclassification of LIP payments between SFYs resulted in an increase in the Federal share of the overpayment of \$587,776.

THE HOSPITAL CLAIMED COSTS FOR PATIENTS FOR WHOM FEDERAL FUNDING WAS NOT ALLOWABLE

State Agency Comments

The State agency contended that the DSH payments related to undocumented aliens for SFYs 2010 and 2011 should be removed from the calculation. (It had also previously said that all DSH payments for SFYs 2012 through 2014 should be removed.)

Office of Inspector General Response

Federal law prohibits payments for non-emergency care provided to undocumented aliens, and the STCs further stipulate that LIP funds cannot be used for costs associated with the provision of healthcare to undocumented aliens. The Hospital included unallowable costs for undocumented aliens in its LIP cost-limit calculation. To correct the Hospital's error, we removed costs as well as the individual claims payments for non-emergency care related to undocumented aliens. DSH payments are not patient-specific; they are lump-sum payments to hospitals to help offset hospitals' uncompensated care costs incurred in providing services to Medicaid and uninsured individuals. The STCs and the RFMD (STC-a, and STC-b, items 94 and 77, respectively and RFMD-a, section IV(A)(5), RFMDs b and c, section IV(A)(7)) require that hospitals offset all DSH payments against allowable LIP costs. It would be inappropriate for us to reduce the amount of DSH payments included in the LIP cost-limit calculations.

THE HOSPITAL DID NOT FOLLOW SOME REIMBURSEMENT AND FUNDING METHODOLOGY DOCUMENT INSTRUCTIONS

State Agency Comments

The State agency said that, even after our reallocation of LIP data, some cost centers still had more low-income patient days or ancillary charges than total patient days or ancillary charges. The State agency said that we seemed satisfied with that because it resulted in a reduction of allowable costs. Also, it contended that allocating patient days and ancillary charges based on the Hospital's finalized Medicare cost reports would result in an increase in allowable costs and would not have cost centers for which low-income patient days or ancillary charges exceeded total patient days or ancillary charges.

In addition, the State agency said that we had allocated some ancillary charges to non-reimbursable cost centers, which resulted in a reduction of allowable costs and that we should have removed the payments associated with those charges.

Office of Inspector General Response

As part of our audit, we reallocated the Hospital's LIP data (low-income patient days and ancillary charges) because the cost-limit calculations contained numerous cost centers for which low-income costs exceeded total costs by about \$226 million. There would not have been excess cost amounts if the hospital had followed the RFMD instructions and allocated the LIP data in the same way they were distributed in the Medicare cost report. We materially corrected this problem by assigning the LIP data to the same cost centers to which the data were assigned in the Medicare cost reports, reducing the excesses from about \$226 million down to about \$7 million (3 percent of the original total). At that point, we decided not to expend additional limited audit resources on this issue.

In its comments, the State agency suggested that we allocate low-income data based on the allocation percentages of total patient days and ancillary charges in the finalized Medicare cost reports. Recognizing that our proposed reallocation in the draft report resulted in some excesses (albeit a significantly reduced amount) of low-income costs over total costs, we agreed to reallocate the Hospital's low-income data, which did not result in any cost centers with low-income costs exceeding total costs. As a result, we reduced the overpayment by \$9,785,031 (\$5,391,761 Federal share).

The State agency made a valid point regarding the need to reduce payments by the portion of payments related to the ancillary charges that were allocated to non-reimbursable cost centers. Accordingly, we have reduced payments in each year's calculation with a total reduction of \$4,027,966 (\$2,360,650 Federal share). Our figures do not agree with the State agency's because we made minor corrections to the State agency's calculations.

We revised the “Incorrectly allocated low-income patient data” line of Appendix B to reflect the changes resulting from the revised allocation of LIP data and the reduction of payments, reducing the original total of \$27,896,366 by \$13,812,997 to \$14,083,369 (\$5,627,904 Federal share).

MISSING ORGAN ACQUISITION COSTS

State Agency Comments

The State agency said that we did not include all organ acquisition costs for low-income patients in the LIP cost-limit calculations. The State agency said that for multiple low-income patients, we included the patient days, ancillary charges, and payments but did not include the patients’ organ acquisition costs. The State agency further said that we knew the organ counts were not correct. The State agency contended that properly including these costs would increase the Hospital’s cost limits by \$21,613,956.

Office of Inspector General Response

We did not revise the organ counts provided to us by the Hospital in calculating the organ acquisition costs, and, contrary to the State agency’s assertion, neither the Hospital nor the State agency informed us at any time during our audit that the Hospital had understated the organ counts. Furthermore, we did not include any low-income patient days or ancillary charges and payments in the LIP data. Rather, the Hospital compiled these data. However, after providing its comments, the State agency has provided us with the low-income organ counts that the Hospital had compiled for the DSH reviews but incorrectly input into its LIP cost-limit calculations. Accordingly, we have revised our organ acquisition cost calculations based on the organ counts that the Hospital had used for the DSH calculation, resulting in an increase in the cost limits of \$20,335,758 (\$12,129,939 Federal share).

THE HOSPITAL CLAIMED UNALLOWABLE SECTION 6 COSTS

State Agency Comments

The State agency said that we should not have offset other revenue against section 6 costs because the revenue in question was derived from a State or local government tax source.

Office of Inspector General Response

The revenue that we offset related to the costs of operating the Miami Hope Clinic and the costs of providing family-based care for medically complex and fragile children. We concede the point that the contracts for the services in question provide for the Florida Department of Health to make payment to the Hospital. In accordance with the cost-limit template instructions, payments from State or local tax sources should be excluded from offsetting

payments in the cost-limit calculations. Thus, we have removed our offset of the revenue, resulting in an increase of the Hospital's allowable costs of \$4,296,674 (\$2,617,839 Federal share).

THE HOSPITAL MADE SEVERAL CLERICAL ERRORS

State Agency Comments

The State agency said that the data we used were incomplete and that the Hospital had offered more appropriate data to calculate a more accurate cost limit.

Office of Inspector General Response

At the exit conference in July 2018, the Hospital indicated that it was working on producing revised LIP data for all 5 years in the audit period to, among other things, include claims that it had previously omitted. We told the Hospital that 45 CFR section 95.7 specifies a 2-year filing limit that would preclude the Hospital from claiming additional costs. Under 45 CFR section 95.7, a State agency must file a claim for expenditures within 2 years after the calendar quarter in which the State agency made the expenditure. Thus, for the Hospital to revise its data to include previously omitted claims—in effect, increasing the amount claimed by the State agency—it would need to have done so within 2 years of the calendar quarter in which the State agency made its claims. The Hospital notified us of its plan to refile the data in July 2018, well beyond 2 years from the last calendar quarter of the audit period (June 30, 2014).

THE STATE AGENCY DID NOT RECONCILE THE HOSPITAL'S COST-LIMIT CALCULATIONS TO FINALIZED MEDICARE COST REPORTS

State Agency Comments

The State agency said that the organ acquisition costs that we calculated did not include costs for interns and residents and, as a result, were understated by \$3,662,528.

Office of Inspector General Response

We calculated the organ acquisition costs in accordance with the RFMD instructions prepared by the State agency and approved by CMS, which require that low-income organ acquisition costs be calculated using the organ acquisition costs on schedule D-6 of the Medicare cost report (schedule D-4 after the Hospital fiscal year ended September 30, 2010). Revising the calculations as the State agency requested would not be appropriate.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered SFYs 2010 through 2014 (audit period).²⁷ For this period, the State agency made payments to the Hospital for the LIP program totaling \$1.8 billion.

In planning and performing our audit, we limited our review of the State agency's and the Hospital's internal controls to those controls related to verifying that the LIP cost-limit calculations conformed to Federal regulations and the waiver, as further defined in the STCs and the RFMD.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable laws and regulations;
- reviewed the governing documents for the LIP program, including the STCs and the RFMD;
- obtained from the State agency a schedule of total LIP payments by provider for each SFY in our audit period;
- obtained from the State agency the cost-limit calculations that the Hospital submitted to the State agency for the audit period;
- obtained from the Hospital detailed low-income patient data supporting the cost-limit calculations and compared the supporting data with the calculations;
- reviewed the low-income patient data used in the Hospital's cost-limit calculations to identify any:
 - data for undocumented aliens and outpatient prisoners,
 - low-income data that was improperly excluded, and
 - clerical errors that the Hospital made in accumulating the data;
- compared the DSH payments on the Hospital's LIP cost-limit calculations to the DSH payments published by CMS;

²⁷ The audit period begins the first SFY after the period covered by CMS's Financial Management Reviews (SFYs 2007 through 2009). SFY 2014 was the most recent year for which cost-limit calculations were available when we began our audit.

- compared the LIP payments on the Hospital's LIP cost-limit calculations to the LIP payments provided to us by the State agency;
- obtained from the Hospital's Medicare administrative contractor (MAC) the Medicare payments for direct graduate medical education, bad debts, and organ acquisition costs for the audit period;
- obtained from the Hospital's MAC the Hospital's finalized Medicare cost reports for the audit period and identified the cost report settlement payments;
- calculated the portion of the payments for direct graduate medical education, bad debts, organ acquisition, and cost report settlements that related to Medicare dual-eligible patients;
- obtained from the State agency all non-claim-specific Medicaid payments made during the audit period;
- obtained from the Hospital its mapping of general ledger departments to Medicare cost report lines;
- obtained from the Hospital the low-income data for each year broken down by general ledger department;
- identified the correct distribution of low-income data for each year by moving the low-income data to the correct cost report lines based on the general ledger department assignment;
- reviewed the Hospital's section 6 costs and supporting documentation for each year;
- reviewed the Hospital's cost-limit calculations for compliance with the RFMD and the STCs;
- recalculated the Hospital's organ-acquisition costs in compliance with the instructions in the RFMD;
- recalculated the cost-limit calculations for each unallowable cost that we identified to determine the effect;
- adjusted, for each year, the cost report data to agree with the finalized Medicare cost reports provided by the Hospital's MAC; and
- discussed the results of our audit with State agency and Hospital officials.

We conducted our review 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 objectives.

**APPENDIX B: UNALLOWABLE COSTS INCLUDED IN COST LIMIT CALCULATIONS
FOR STATE FISCAL YEARS 2010—2014**

Unallowable Costs Claimed (Total Computable)	2010	2011	2012	2013	2014	Total
(1) Net Hospital Self-Reported Overpayments	(\$96,773,962)	(\$17,026,556)	\$78,364,371	\$85,187,891	\$82,231,269	\$131,983,013
Hospital self-reported overpayments	-	-	78,364,371	85,187,891	82,231,269	245,783,531
Hospital self-reported underpayments	(96,773,962)	(17,026,556)	-	-	-	(113,800,518)
(2) Omitted and Underreported Payments	69,629,047	75,771,339	16,592,621	21,051,662	39,605,582	222,650,251
Medicaid payments not offset	52,296,960	56,836,120	(1,337)	(470,995)	25,447,941	134,108,689
Medicare dual-eligible patients' payments not offset	17,332,087	18,935,219	16,593,958	21,522,657	14,157,641	88,541,562
(3) Cost of Care for Patients Ineligible for Federal Funding	39,812,971	27,907,039	24,839,848	23,828,141	25,923,326	142,311,325
Cost of caring for undocumented aliens	39,159,133	24,621,462	24,111,833	23,456,559	25,387,916	136,736,903
Cost of caring for outpatient prisoners	653,838	3,285,577	728,015	371,582	535,410	5,574,422
(4) Costs Not Calculated in Accordance With RFMD Instructions	5,200,072	(3,088,613)	29,383,023	23,251,869	13,159,434	67,905,785
Excluded low-income patient data	-	4,278,389	26,523,056	6,518,802	-	37,320,247
Incorrectly allocated low-income patient data	(22,028,419)	(5,942,473)	2,384,706	14,272,287	25,397,268	14,083,369
Incorrectly calculated low-income observation bed costs	3,957,003	5,293,439	1,086,493	(223,762)	1,298,469	11,411,642
Incorrectly calculated organ acquisition costs	23,271,488	(6,717,968)	(611,232)	2,684,542	(13,536,303)	5,090,527
(5) Unallowable Section 6 Costs	12,513,084	10,166,320	8,159,383	8,778,050	12,272,363	51,889,200
Nonmedical assistance costs	12,089,109	9,682,916	4,449,843	5,039,788	5,001,317	36,262,973
Care of prisoners at prison facilities	-	-	3,406,550	3,643,796	7,259,870	14,310,216
Not low-income	423,975	483,404	302,990	94,466	11,176	1,316,011
(6) Clerical Errors in Reporting LIP Data	42,427,589	654,750	-	13,250,569	(8,288,568)	48,044,340
(7) Costs Not Reconciled to Finalized Medicare Cost Reports	15,512,159	10,525,066	(13,006,620)	5,762,922	2,767,963	21,561,490
Total Unallowable Costs Claimed by the State Agency	\$88,320,960	\$104,909,345	\$144,332,626	\$181,111,104	\$167,671,369	\$686,345,404
Total Unallowable Costs Excluding Hospital Self-Reported	\$185,094,922	\$121,935,901	\$65,968,255	\$95,923,213	\$85,440,100	\$554,362,391

Unallowable Costs Claimed (Federal Share)	2010	2011	2012	2013	2014	Total
FMAP RATES	67.64%	65.76%	55.89%	57.57%	58.61%	
(1) Net Hospital Self-Reported Overpayments	(\$65,457,908)	(\$11,195,812)	\$43,797,847	\$49,042,669	\$48,195,747	\$64,382,543
Hospital self-reported overpayments	-	-	43,797,847	49,042,669	48,195,747	141,036,263
Hospital self-reported underpayments	(65,457,908)	(11,195,812)	-	-	-	(76,653,720)
(2) Omitted and Underreported Payments	47,097,088	49,823,444	9,274,031	12,119,442	23,213,821	141,527,826
Medicaid payments not offset	35,373,664	37,372,591	(747)	(271,152)	14,915,674	87,390,030
Medicare dual-eligible patients' payments not offset	11,723,424	12,450,853	9,274,778	12,390,594	8,298,147	54,137,796
(3) Cost of Care for Patients Ineligible for Federal Funding	26,929,494	18,350,273	13,883,612	13,717,861	15,194,309	88,075,549
Cost of caring for undocumented aliens	26,487,238	16,189,842	13,476,706	13,503,941	14,880,492	84,538,219
Cost of caring for outpatient prisoners	442,256	2,160,431	406,906	213,920	313,817	3,537,330
(4) Costs Not Calculated in Accordance With RFMD Instructions	3,517,329	(2,030,917)	16,422,906	13,386,100	7,713,072	39,008,490
Excluded low-income patient data	-	2,813,255	14,824,399	3,752,874	-	21,390,528
Incorrectly allocated low-income patient data	(14,900,023)	(3,907,473)	1,332,872	8,216,555	14,885,973	5,627,904
Incorrectly calculated low-income observation bed costs	2,676,517	3,480,701	607,268	(128,820)	761,065	7,396,731
Incorrectly calculated organ acquisition costs	15,740,835	(4,417,400)	(341,633)	1,545,491	(7,933,966)	4,593,327
(5) Unallowable Section 6 Costs	8,463,850	6,684,864	4,560,483	5,053,523	7,193,139	31,955,859
Nonmedical assistance costs	8,177,073	6,367,002	2,487,128	2,901,406	2,931,397	22,864,006
Care of prisoners at prison facilities	-	-	1,904,006	2,097,733	4,255,191	8,256,930
Not low-income	286,777	317,862	169,349	54,384	6,551	834,923
(6) Clerical Errors in Reporting LIP Data	28,698,021	430,531	-	7,628,352	(4,858,137)	31,898,767
(7) Costs Not Reconciled to Finalized Medicare Cost Reports	10,492,424	6,920,757	(7,269,725)	3,317,714	1,622,372	15,083,542
Total Unallowable Costs Claimed by the State Agency	\$59,740,298	\$68,983,140	\$80,669,154	\$104,265,661	\$98,274,323	\$411,932,576
Total Unallowable Costs Excluding Hospital Self-Reported	\$125,198,206	\$80,178,952	\$36,871,307	\$55,222,992	\$50,078,576	\$347,550,033

APPENDIX C: FEDERAL REQUIREMENTS

SOCIAL SECURITY ACT

Social Security Act § 1903(v)

Section 1903(v)(1) prohibits payments to States “for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.”

Section 1903(v)(2) provides an exception to this rule for the cost of emergency care provided to undocumented aliens.

Social Security Act § 1905(a)

Medical assistance includes inpatient and outpatient services as well as other medical and remedial services for Medicaid beneficiaries.

Social Security Act § 1905(a)(29)(A)

States may not receive FFP for medical care for inmates except for care provided in a medical institution. The CMS Director clarified in a December 12, 1997, letter to CMS Regional Administrators that the medical institution exception is for inpatient care only; there is no exception for outpatient care.

CODE OF FEDERAL REGULATIONS

45 CFR § 95.7

CMS will reimburse a State for an expenditure only if the State files a claim for that expenditure within 2 years after the calendar quarter in which it made the expenditure.

FLORIDA MEDICAID REFORM SECTION 1115 DEMONSTRATION WAIVER

The waiver does not provide any specifics on the operation of the LIP program. It states only that the State agency will maintain the LIP program.

CMS SPECIAL TERMS AND CONDITIONS FOR THE WAIVER

STC-a, Item 94, and STC-b, Item 77

LIP funds may be used for healthcare costs within the definition of “medical assistance” per section 1905(a) of the Act.

All Medicaid payments must be used to reduce the costs of caring for Medicaid patients.

Costs funded by the LIP must be for the provision of care to low-income patients.

STC-a, Item 95, and STC-b, Item 78

The State may not use LIP funds to provide non-emergency healthcare to undocumented aliens.

STC-a, Item 97, and STC-b, Item 80

Hospitals should determine expenditures using Medicare cost report methodologies.

The State agrees that it will not receive FFP for payments to hospitals in excess of their costs.

STC-b, Item 75

The State must refund the Federal share of any overpayments made to specific hospitals. CMS may recoup overpayments through a reduction of FFP claimed against LIP payments or through disallowance.

REIMBURSEMENT AND FUNDING METHODOLOGY DOCUMENT

RFMDs a, b, and c, Section IV(A)(1), (2), and (3)

Hospitals are required to calculate the inpatient routine as well as inpatient and outpatient ancillary costs for Medicaid, Medicaid managed care, and uninsured or underinsured patients (as explained in the “Hospital Cost Portion of Calculations” part of the background, the CMS approved cost-limit calculation template added a fourth category of patient, Medicare dual-eligible patients), as follows:

- determine the total hospital costs per day by inpatient routine cost center and the total cost-to-charge ratio by ancillary cost center,
- multiply each inpatient routine cost center’s low-income patient days by the cost per day for the cost center, and

- multiply each ancillary cost center’s inpatient and outpatient low-income charges by the cost-to-charge ratio for the cost center.

Although this section of the RFMD does not mention Medicare dual-eligible patients, the State added this category on its CMS-approved cost-limit calculation template.

Hospitals must include observation bed-days in the total inpatient day count for purposes of calculating the total inpatient routine cost per day while including low-income observation charges in the calculation of low-income ancillary costs.

Hospitals should calculate allowable organ acquisition costs for low-income patients by:

- identifying the ratio of usable organs for low-income patients, as taken from hospital records, to total usable organs, as taken from the Medicare cost report and
- multiplying that ratio by the total organ acquisition costs from the Medicare cost report.

RFMD-a, Section IV(A)(4), and RFMDs b and c, Sections IV(A)(5) and (6)

The State may include additional hospital cost items not included in the hospital LIP inpatient routine and ancillary costs. In its CMS-approved cost-limit calculation template, the State agency included a separate section for these costs entitled “Hospital Provider Additional Medicaid Costs” (section 6 costs).

RFMD-a, Section IV(A)(5), and RFMDs b and c, Section IV(A)(7)

In calculating its LIP cost limit, a hospital should offset allowable costs with its payments and recoveries from the following:

- Medicaid MCOs;
- Medicaid behavioral health organizations;
- Medicaid enrollees;
- the uninsured;
- supplemental payments (e.g., LIP);
- graduate medical education funds received that exceeded the hospital’s Medicaid graduate medical education expenditures;
- DSH payments; and

- other sources, including any related patient copayments or payments from other non-State payers.

RFMDs b and c, Section IV(A)(9)

The State agency is required to reconcile the hospital cost limits to the finalized Medicare cost report for the payment year. The reconciliation process involves recomputing the cost limits using the same methodology that hospitals use for filing the cost-limit calculations but using the inpatient routine cost per day and ancillary cost-to-charge ratios calculated using the finalized Medicare cost report for the payment year.

This same section requires the State agency to refund hospital overpayments: “If, at the end of the reconciliation process, it is determined that a provider received an overpayment, the overpayment will be properly credited to the Federal [G]overnment”

RFMD-a, Section IV(A)(7), and RFMDs b and c, Section IV (A)(9)

The State agency is required to ensure that the total costs claimed in a particular year do not exceed the costs justified in the underlying hospital cost reports for the applicable years.

APPENDIX D: HOSPITAL COMMENTS



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February 26, 2019

Lori S. Pilcher
Regional Inspector General for Audit Services
Department of Health and Human Services Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW Suite 3T41
Atlanta, GA 30303

Re: OIG Draft Report No. A-04-17-04058

Dear Ms. Pilcher:

Jackson Memorial Hospital (the "Hospital") appreciates the opportunity to respond to the draft audit report entitled *Florida Medicaid Paid Hundreds of Millions in Unallowable Payments to Jackson Memorial Hospital Under Its Low Income Pool Program, A-04-17-04058* ("Draft Report"), which reviews Florida's Low Income Pool ("LIP") Program payments to the Hospital. The LIP program provides direct payments and distributions to safety-net providers in the state, including Jackson Memorial Hospital, for providing health care services to Medicaid, underinsured, and uninsured populations.

The Hospital strongly disagrees with a number of the findings in the Draft Report. For the reasons discussed below, the Hospital disagrees with the OIG's findings that that the Hospital claimed federal reimbursement for Medicaid supplemental payments that were not in accordance with State and Federal requirements, and that federal financial participation is not allowable. The OIG's findings on this issue are largely inaccurate, are based on erroneous assumptions, and misconstrue or mischaracterize documentation provided in the course of the audit.

For example, in 2011, the OIG overstated the Hospital's LIP payments by \$60 million, which negatively impacts calculations showing the Hospital as over its cost limit that year. More importantly, the OIG incorrectly determined that the calculation of the Hospital's Medicaid shortfall for Medicaid patients that also have Medicare or private insurance should include payments from Medicare or private insurance. That conclusion is contrary to the Special Terms and Conditions which governed Florida's LIP program during the pertinent years at issue. Eliminating Medicare and commercial payments as an offset in the LIP calculation eliminates virtually the entire LIP overpayment claimed by the OIG in the draft report (the Hospital estimates any remaining overpayment under \$10 million), even assuming the validity of the OIG's other arguments (which the Hospital does not).

The Hospital also strongly disagrees with the OIG's recommendation that Florida refund \$436 million to the Federal government, as it would result in massive recoupments from the Hospital and not serve any purpose in improving administration of the Florida waiver. The OIG, with the clear benefit of

hindsight, places blame on the State Medicaid agency and the Hospital for allegedly not having adequate procedures to identify and police what OIG now sees as clear cost limits. However, as is made clear by numerous ongoing disputes with respect to these same or similar issues, including two Financial Management reviews by the Centers for Medicare & Medicaid Services (“CMS”), and two disallowances with pending appeals before the U.S. Department of Health and Human Services Departmental Appeals Board (“DAB”), these limits were by no means clear at the time.

In retrospect, it may be easy to identify that numerous prior CMS and State Medicaid agency leadership should have more precisely defined and identified cost limits and restrictions regarding the LIP Program. However, these limits and restrictions were not precisely defined and identified in real time. Massive refunds and recoupments based on years of uncertainty will only harm the State of Florida, the citizens and Miami-Dade County, the Hospital, and, most importantly, the Medicaid and uninsured patients that rely on the Jackson Health System, of which the Hospital is a part.

Regardless, the Hospital maintains that, as is elucidated by the arguments set forth herein, when its LIP cost limits are correctly calculated, the Hospital’s potential federal overpayment is less than 2% of the OIG’s alleged overpayment of \$436 million. Lastly, the Hospital objects to including Jackson Memorial Hospital in the title of the report, since it is clear that the OIG examined Jackson Memorial Hospital because of the substantial amount of funds paid to the Hospital as the largest safety net provider in the State and not because the OIG had any reason to believe that the Hospital’s processes were any different than any other provider in the State.

1. Background

a. Jackson Memorial Hospital

The Jackson Health System is a public, non-profit, tertiary care teaching hospital and health system in Miami-Dade County, Florida, and is governed and operated by the Public Health Trust of Miami-Dade County pursuant to county ordinance and Florida law.¹ Jackson Health operates the third-largest public hospital in the United States with approximately 1,500 beds and is also the major teaching hospital for the University of Miami Miller School of Medicine and is the third-largest teaching hospital in the country. Further, Jackson Health is a safety-net hospital system in Miami-Dade County and, as such, provides care to all patients regardless of payment status or source.

Jackson Health is owned and supported by the taxpayers of Miami-Dade County. As a public hospital and health system, Jackson Health receives funding from Miami-Dade County to build the health of the community by providing a single, high standard of quality care for the residents of Miami-Dade County regardless of ability to pay for services. The funding Jackson Health receives is used to provide care for the underinsured and uninsured population in Miami-Dade County. As a public hospital, Jackson Health receives safety-net funding from Miami-Dade County on an annual basis in addition to payments from various federal and Florida government sources, including the Medicaid program.

¹ Under the authority of Chapter 73-102, Laws of Florida 1973, the Dade County Board of County Commissioners enacted an ordinance on October 1, 1973, to create the Public Health Trust of Miami-Dade County, Florida to serve as an independent governing body as an agency of Miami-Dade County responsible for the operation, governance, and maintenance of Jackson Memorial Hospital and all its related facilities and property. The Public Health Trust is an instrumentality of Miami-Dade County whose purpose is to promote, protect, maintain, and improve the health and safety of all residents and visitors of Miami-Dade County.

b. The LIP Program

In 2005, the Florida Legislature authorized the Florida Medicaid agency to seek a demonstration waiver under section 1115 of the Social Security Act to transition Florida's Medicaid program from a fee-for-service program to a capitated managed care program. The waiver authority also included the creation of the LIP program and the termination of prior supplemental payments made under regulatory upper payment limits. The waiver, including the LIP program, was approved in 2005 to begin in 2006. The Special Terms and Conditions ("STCs") were the governing agreement between the State Medicaid agency (i.e., the Agency for Health Care Administration ("AHCA")) and CMS which set forth the respective obligations under the demonstration waiver. The state submitted a Reimbursement and Funding Mechanism Document ("RFMD") relevant to LIP in June 2006. Although CMS did not formally approve this document, CMS allowed payments to begin. Discussions continued regarding the RFMD, and CMS and AHCA finally agreed on a RFMD in June 2009. The 2009 RFMD was intended to resolve issues moving both forward and backward, but clearly did not, since CMS issued two disallowances in 2016 which are currently pending before the DAB with respect to state fiscal years 2006 through 2013. This is largely the same time period as the Draft Report, which covers state fiscal years 2010 through 2014.

c. Summary of OIG Findings

The Draft Report incorrectly states that Florida paid hundreds of millions to the Hospital under the LIP program not in accordance with the waiver and applicable Federal regulations. Of the \$1.8 billion in LIP payments made to the Hospital during the audit period, the OIG alleges that Florida claimed Medicaid reimbursement of \$729 million (\$436 million Federal share) in excess of the limits under the waiver, including \$132 million (\$64 million Federal share) of net Hospital-related overpayments and \$597 million (\$372 million Federal share) of unallowable costs. The OIG identifies a number of alleged errors and oversights on the part of the Hospital and the State which it says contributed to these unallowable costs. For example, the OIG concludes that the Hospital omitted and underreported Medicaid and Medicare payments; the Hospital did not follow some RFMD instructions; the Hospital claimed unallowable Section 6 costs; and the Hospital made several clerical errors. The Hospital disagrees.

2. OIG's findings in the Draft Report are largely inaccurate, are based on erroneous assumptions, and/or misconstrue or mischaracterize documentation provided in the course of the audit.

As discussed below, the Hospital largely disagrees with the OIG's findings in the Draft Report. In most cases, the Hospital believes that its actions were proper and consistent with the guidance provided by the State Medicaid agency and in the RFMD. There are some situations where the Hospital agrees that the recalculations suggested in the Draft Report would make the cost limit calculation more accurate. Further, the Hospital believes that these calculation issues must be assessed in the context of the ongoing discussions at the time between CMS and the State Medicaid agency. The Hospital is happy to continue to provide information to the OIG as necessary.

One important mistake in the Draft Report is the fact that the Draft Report overstates the payments made to the Hospital. Particularly for 2011, the OIG appears to have relied on an older report of payments by hospital before the State Medicaid agency reallocated LIP payments amongst the

hospitals. The Hospital's LIP payments are overstated by \$60 million, which impacts calculations that show that payments were over LIP cost limits.

a. The Hospital Disagrees with the Major Portion OIG's Finding that the Hospital Omitted and Underreported Medicaid and Medicare Payments.

The OIG Draft Report points to two categories of payments where the Hospital allegedly omitted and underreported. One category consists of Medicaid payments, including LIP payments and Medicaid disproportionate share hospital ("DSH") payments. The Hospital does not disagree with the OIG regarding these omissions. The LIP limit calculation should include all payments. As noted in the Draft Report, the Hospital generally assumed that the State Medicaid agency was taking these payments into account.

The second and more substantial category concerns the treatment of payments related to dual eligible patients. The Hospital vehemently disagrees with the OIG's finding in this regard. If payments from Medicare and commercial insurance are excluded, as the Hospital believes they must be under the governing documents, the Hospital has – at most – a relatively small overpayment that equates to less than 2% of the amount alleged by the OIG.

The OIG argues that the Medicaid shortfall for Medicaid patients that also have Medicare (or private insurance) coverage should include payments from Medicare or private insurance. This is contrary to the waiver's governing agreement between CMS and AHCA, the Special Terms and Conditions. The STCs clearly state that the Medicaid shortfall should be calculated as Medicaid costs less "Title XIX payments." For example, the 2005 Special Terms and Conditions regarding LIP state that LIP can be used to compensate for "expenditures ... incurred ... by hospitals ... for uncompensated medical care costs of medical services for ... Medicaid shortfall (after all other Title XIX payments are made)".² The 2011 special terms and conditions similarly state that "[t]hese health care costs may also include costs for Medicaid services that exceed Medicaid payments (after all other title XIX payments are made, including disproportionate share hospital payments)."³ The OIG cites more ambiguous language in the RFMD, but this language cannot supersede the Special Terms and Conditions that authorized the RFMD.

The OIG's mischaracterization of the calculation of the Medicaid shortfall for purposes of LIP is similar to CMS' mischaracterization of the analogous Medicaid shortfall calculated in the context of the hospital-specific limit used for the Medicaid DSH program.⁴ The fact that the limits are analogous is not surprising, since the LIP and DSH programs have similar purposes: to reimburse hospitals for the costs of providing care to Medicaid and uninsured patients. CMS has lost numerous federal lawsuits regarding its interpretation of the Medicaid shortfall in the Medicaid DSH context, similarly requiring that Medicare and private insurance revenues be included despite underlying authority that does not permit such

² CMS, Special Terms and Conditions for the Florida Agency for Health Care Administration ¶ 94 (2005), https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/federal_authorities/federal_waivers/Archive/waiver/pdfs/cms_special_terms_and_conditions.pdf ("2005 STCs").

³ CMS, Special Terms and Conditions for the Florida Agency for Health Care Administration ¶ 54 (2011), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/Managed-Medical-Assistance-MMA/fl-medicaid-reform-stc-12162011-06302014.pdf> ("2011 STCs").

⁴ Social Security Act § 1923(g)(1)(A), 42 U.S.C. § 1396r-4(g)(1)(A).

inclusion.⁵ CMS is currently enjoined from enforcing this interpretation in the context of DSH payments.⁶ The OIG's Draft Report is making the same faulty interpretation in the LIP context that CMS is enjoined from doing in the DSH context.

Thus, even assuming the validity of the OIG's other findings – which the Hospital does not – the Hospital's purported overpayment under the OIG's Draft Report is almost entirely eliminated once the dual eligibility payment issue is addressed and Medicare and commercial payments are properly excluded from the Medicaid shortfall portion of the LIP cost limit calculation.

b. Regarding Costs that OIG Says Concerned Patients For Whom Federal Funding Was Not Allowable, the Hospital Believes OIG has in Some Instances Jumped to Conclusions and in Others Guidance Was Not Clear.

The Draft Report identifies two categories of costs where the OIG indicates that federal funding was not allowed: (1) care provided to undocumented aliens and (2) outpatient care provided to prisoners. The Hospital believes that guidance regarding the treatment of these costs specifically in LIP was not clear.

With respect to undocumented aliens, the Hospital recognizes that the original Special Terms and Conditions state that "LIP funds cannot be used for costs associated with the provisions of health care to non-qualified aliens."⁷ However, the Hospital disagrees that the costs identified by the OIG were related to non-qualified aliens. The OIG's auditors appear to have assumed that if certain accounts were lacking documentation, then the accounts related to undocumented non-qualified aliens. The Hospital disputes that conclusion. The OIG should not be permitted to assume that patient accounts are in a not allowable class simply because of missing documentation.

With respect to outpatient care for prisoners, the Hospital does not believe applicable guidance was clear in the context of LIP. The Hospital acknowledges that in the Medicaid DSH context, CMS has stated that inmates of correctional facilities are not uninsured and thus not includable in the hospital-specific DSH limit.⁸ However, it is not clear that costs associated with these patients are excluded from reimbursement under LIP. Notably, the Special Terms and Conditions do not directly address this issue, and the STC provisions cited in the Draft Report more generally indicate the scope of permissible expenditures and do not specifically exclude care to prisoners. The State Medicaid Director letter cited in the Draft Report concerns the scope of permitted coverage for Medicaid-eligible prisoners under the Medicaid program, not with respect to prisoners that have no source of coverage (including Medicaid).

c. The Hospital Disagrees with Most of Draft Report Sections Indicating that the Hospital Did Not Follow RFMD Instructions.

The Draft Report identifies four areas where the OIG indicates that the Hospital did not follow RFMD instructions: (1) including costs for all low-income patients, (2) distributing low-income data, (3)

⁵ See *Children's Hosp. Ass'n of Texas v. Azar*, 300 F. Supp. 3d 190, 205 (D.D.C. 2018); *Missouri Hosp. Ass'n v. Hargan*, No. 2:17-cv-04052, 2018 WL 814589, at *12 (W.D. Mo. Feb. 9, 2018); *Baptist Mem'l Hosp.-Golden Triangle, Inc. v. Azar*, No. 3:17-cv-491, 2018 WL 3118703, at *2 (S.D. Miss. June 25, 2018); *Tennessee Hosp. Ass'n v. Price*, No. 3:16-cv-3263, 2017 WL 2703540, at *8 (M.D. Tenn. June 21, 2017).

⁶ *Children's Hosp. Ass'n of Texas v. Azar*, 300 F. Supp. 3d at 205

⁷ 2005 STCs ¶ 95; 2011 STCs ¶ 55.

⁸ 73 Fed. Reg. 77904, 77915 (Dec. 19, 2008); State Medicaid Director Letter #02-013, Aug. 16, 2002.

calculating organ acquisition costs, and (4) calculating low-income observation bed costs. The Hospital believes that its interpretation was permissible for many of these issues. In others, the Hospital agrees with the Draft Report.

With respect to omitted costs for certain low income patients, the LIP cost limit has never required the inclusion of all low-income patient costs. The Draft Report seems to be concerned with the omission of costs and payments related to certain patients that received no Medicaid benefits and had no payment shortfall, despite being Medicaid eligible. The Hospital believes it was permissible to treat these patients as not being Medicaid patients, given that these patients received no Medicaid benefits. The OIG wants to include these patient accounts, solely for the purpose of decreasing the LIP Limit. The Hospital disagrees.

With respect to the distribution of low-income data to calculate costs, the Draft Report is prescribing one proxy for allocating charges while the Hospital used another. The Hospital believes its method was permissible under the Special Terms and Conditions and the RFMD. Although a different proxy for allocating charges also may be acceptable, the Hospital believes that the OIG's proxy has flaws that were identified for the OIG auditor when on site and the OIG refused to correct these flaws. Thus, the Hospital believes that the calculation prescribed in the Draft Report is inappropriate.

With respect to the method for calculating organ acquisition costs, while the Hospital agrees that certain data corrections are appropriate, it similarly believes that the method it used to compute costs was permissible under the under the Special Terms and Conditions and the RFMD.

With respect to low-income observation beds, the Hospital does not object to the Draft Report findings.

d. The Hospital Disagrees with the Draft Report's Findings Regarding Unallowable Additional Costs

The Draft Report includes a number of findings regarding additional costs claimed under Section 6 of the RFMD. The scope of allowable costs under Section 6 was not clear, particularly in the earlier years of the waiver, and is the subject of current litigation between AHCA and CMS before the DAB. The Hospital believes that the majority of the costs identified in the Draft Report as not allowable were in fact allowable under the RFMD.

As one mere example, one issue before the DAB is whether amounts paid by the Hospital to the Miami-Dade County Fire-Air Ambulance Rescue unit in order to pay for transportation of uninsured patients to and from the Hospital in critical emergency situations can be included as an allowed contracted additional service under the RFMD. It appears these are the same costs challenged by the OIG in the Draft Report, which lists "Fire rescue helicopter" in a list of services that "did not qualify as 'medical assistance' as defined in section 1905(a) of the [Social Security] Act." However, the conclusion in the Draft Report is incorrect. Transportation services are clearly permitted medical assistance services under CMS regulations⁹ and Florida law.¹⁰ The Draft Report does not provide any legal basis for its finding that these services did not qualify as medical assistance.

⁹ See, e.g., 42 C.F.R. § 440.170 (permitting transportation "determined to be necessary by the agency to secure medical examinations and treatment for a beneficiary").

In any event, the Hospital believes that any determination by the OIG that certain costs were unallowable prior to conclusion of the litigation between CMS and AHCA is premature. The DAB could determine that certain categories of costs were allowable.

e. The Hospital Agrees that Clerical Errors Should be Updated and that Updated Cost Report Factors Should be Used.

The Draft Report points out clerical errors that were made in the Hospital's initial submission. The Hospital agrees that clerical errors should be corrected. The Draft Report also suggests updating hospital report factors based on finalized Medicare cost reports. The Hospital has no objection to updating the calculations to use finalized cost report factors.

3. OIG Should Reverse Its Refund Recommendation Because the Hospital is Not Primarily Responsible and the Refund Will Cripple The Hospital and the Community It Serves.

Jackson Health and the Hospital is the centerpiece of the Public Health Trust and a vital safety-net provider for the Miami-Dade community. Jackson Health is required by law to provide health care services to indigent, underinsured, and uninsured residents of Miami-Dade County. Not surprisingly, Jackson Health has been one of the most significant providers of care, particularly in South Florida, to Medicaid, underinsured, uninsured and indigent patients, and is a much-needed resource in the community for patients who have challenges related to accessing health care services. Jackson Health is the largest provider of care in Florida for the homeless, uninsured, and people who simply do not pay for services. The Draft Report notes the admittedly substantial amount and high percentage of LIP payments received by the Hospital during the audit period. However, this merely reflects the substantial responsibility the Hospital shoulders and the substantial amount of care that the Hospital provides.

Because of the Hospital's high levels of Medicaid and uncompensated care, the Hospital relies heavily on the Medicaid payments provided through programs such as the Medicaid DSH and LIP programs to cover its substantial uncompensated care costs. The Hospital depends upon these payments to carry out its critical mission to provide health care to those most in need, and Jackson Health has appropriately operated based on an expectation that CMS and the State Medicaid agency would accurately calculate and distribute LIP payments.

As OIG relates in the Draft Report, CMS' Financial Management Reviews found that "the State agency did not provide hospitals with adequate oversight and guidance." The Draft Report refocuses more attention on the Hospital. However, assuming the truth of the CMS Financial Management Review, it is difficult to understand how the Hospital could be primarily to blame given the absence of adequate oversight and guidance. In this context, the Hospital is extremely concerned that the refunds recommended in the Draft Report will harm the Hospital most of all, since the State Medicaid agency will seek to recoup funds from the Hospital. This result will only harm the Hospital, the safety net in Miami-Dade County and all of South Florida, and the patients that rely on the Jackson Health System. We hope that the OIG would not consider this to be a favorable result.

¹⁰ Fl. Stat. § 409.905 (requiring State Medicaid agency to "ensure that appropriate transportation services are available for a Medicaid recipient in need of transport to a qualified Medicaid provider for medically necessary and Medicaid-compensable services").

The Hospital respectfully and strongly suggests that the OIG remove the refund recommendations from its report. There was simply no way that the State Agency or Hospital could tell in real time that there were overpayments. The STCs and RFMD were too vague and lend themselves to competing post-implementation interpretation. This is particularly true in light of the fact that the issues surrounding the LIP have been essentially resolved – switching to DRG reimbursement and Medicaid Managed Care – completely redesigning the LIP with much clearer, hospital specific caps. Moreover, implementation of the Draft Report’s recommendations would have no effect other than to level a devastating impact on the safety net that the Hospital is committed to providing.

Thank you for your time and consideration of the comments above. The Hospital would welcome the opportunity to discuss the OIG findings and Hospital concerns in greater detail before OIG finalizes the Draft Report. Please do not hesitate to contact me directly with any questions or requests for additional information.

Regards,



Mark T. Knight
Executive Vice President and Chief Financial Officer

MTK:hv

APPENDIX E: STATE AGENCY COMMENTS



RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

June 28, 2019

Lori S. Pilcher
Regional Inspector General for Audit Services
Department of Health and Human Services Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW Suite 3T41
Atlanta, GA 30303

Re: Response to DHHS, OIG Draft Report No. A-04-17-04058

Dear Ms. Pilcher:

The State of Florida appreciates the opportunity to review and respond to the Office of Inspector General ("OIG") draft report A-04-17-04058 ("Draft Report") on Medicaid overpayments issued in May of 2019. After careful review, we have concluded that conclusions of the report are misguided, that the title is extremely misleading, and that Florida assuredly has not, as alleged, paid "hundreds of millions in unallowable payments" to Jackson Memorial Hospital. While the Agency for Health Care Administration ("AHCA" or "Agency") is prepared to work with the Centers for Medicare & Medicaid Services ("CMS") and Jackson Memorial ("Jackson" or "Hospital") to resolve the issues identified, it believes that it would be reckless and irresponsible for the OIG to finalize the report in its current form.

The State's primary and overarching concern is that the OIG has used incomplete data when more appropriate data was readily available. Low Income Pool ("LIP") payments and LIP cost limits were investigated in isolation, without taking account of the intersection between LIP and Medicaid payments, including Medicaid disproportionate share hospital ("DSH") payments. The LIP cost limit depends in large part on payments received, or not received, through these other funding sources. Changes in one necessarily affect the other.

Virtually all of the OIG's calculations are in error as both DSH and Medicaid payments and costs for the years in question are not included in the LIP cost limit calculation. The Medicaid payments and costs for the years in question are still in the process of cost settlement. Thus even if the OIG is correct that Jackson made some errors in how it reported certain payments and costs for LIP purposes, the fundamental question of whether Jackson *actually* was paid in excess of its LIP cost limit depends on the incorporation of the DSH examinations and Medicaid cost settlements, a fact which is completely ignored in the draft audit.

Relatedly, the audit completely fails to take account of the ongoing administrative appeal that AHCA has pending before the Departmental Appeals Board within the Department of Health and Human Services ("DAB"). That appeal involves LIP "overpayments" that largely overlap with the years at issue in the audit, and which AHCA believes are grossly overstated because they were calculated using the same flawed methodology as the DSH guidance that CMS was

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forced to withdraw. Instead of recognizing AHCA's pending appeal and argument, the Draft Report leaves the misleading impression that it has identified hundreds of millions in *additional* overpayments, which is not the case.

The State recognizes that cost reporting data must be reported accurately, and it has been working diligently with Jackson to ensure that costs are correctly calculated and counted. But that obligation also applies to the OIG. In many instances, the OIG used inaccurate data when accurate, more appropriate data was readily available, or attempted to recalculate Jackson's uncompensated costs using cost apportionment methodologies that suffer from the same defects for which it criticized the Hospital.

As set forth more fully below, the State disagrees with every finding in the draft report. Finalizing it in its current form needlessly puts one of the largest public health systems in the nation at risk. The threat of massive refunds and recoupments based on errors, miscalculations, faulty assumptions, and lack of care by the OIG in this investigation will only harm the State of Florida and the Medicaid and uninsured patients that rely on Jackson for life-saving care.

Issue: Finding #1 The State Agency did not return the federal share of the Hospital's self-reported overpayments.

Florida agrees that it has not returned the federal share of the hospital's self-reported overpayments. That is because Florida disputes how CMS determined the alleged overpayments.

Specifically, in calculating its LIP limits, Jackson deducted some third-party payments for services provided to Medicaid enrollees who also had Medicare or private insurance coverage. Federal courts have repeatedly rejected CMS's failure to make similar deductions in the context of DSH, which was the basis for the LIP cost-limit calculations. See, e.g., *Tex. Children's Hosp. v. Burwell*, 76 F. Supp. 3d 224 (D.D.C.2014); *Children's Hosp. of the King's Daughters v. Price*, 258 F. Supp. 3d 672, 682 (E.D. Va. 2017) (vacated in part by *Children's Hospital of the King's Daughters, Inc. v. Azar*, 4th Cir.(Va.), July 23, 2018); *N.H. Hosp. Ass'n v. Burwell*, 2016 WL 1048023 (D.N.H. 2016), *aff'd*, 2017 WL 822094 (1st Cir. 2017); *Tenn. Hosp. Ass'n v. Price*, 2017 WL 2703540 (M.D. Tenn. 2017); *Children's Health Care v. CMS*, 2017 WL 3668758 (D. Minn. 2017). If these third party payments are not included, Jackson's overpayments will be eliminated entirely, or at least substantially reduced.

There is no doubt that the LIP limits were patterned after the DSH limits, given that CMS was negotiating the LIP limit with the State at the same time it was issuing guidance regarding the DSH limit. However, CMS has been forced by the court decisions listed above to specifically withdraw its 2010 DSH limit guidance. See <https://www.medicaid.gov/medicaid/finance/dsh/index.html>. A court mandate currently prohibits CMS from enforcing a 2017 rule containing the same requirements. *Id.* Given that the Waiver's Special Terms and Conditions require compliance with changes in federal law, the OIG's efforts to impose on the Florida LIP program CMS' discredited and disavowed DSH guidance and rule is a plain violation of court orders.

Imposing an additional disallowance based on this flawed analysis may further raise concerns under the U.S. Constitution. It is well-established that the Medicaid program, as a program implemented under Congress' spending power, "is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions. The legitimacy of [the federal government's] power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.'" *Pennhurst State School and Hosp. v. Halderman*, 451 U.S. 1, 17 (1981).

The contract analogy, if anything, is even stronger in the context of a Section 1115 waiver, where the Federal and State governments negotiate the terms. Accordingly, if the Federal government "intends to impose a condition on the grant of federal moneys, it must do so unambiguously." Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 583 (2012) (quoting Pennhurst, 451 U.S. at 17). CMS cannot enter into negotiations with the State of Florida asserting that LIP limits will be based on DSH limits, conduct audits where LIP limits have always been based on DSH limits, and then fail to modify the LIP limits when the courts mandate that the DSH limits be changed. This is an unconstitutional ambush.

As the audit notes, in November 2016, CMS issued a disallowance letter seeking recovery of the federal share of LIP self-reported overpayments, including the federal share of alleged overpayments to Jackson Memorial for 2012 and 2013. Florida has appealed the disallowance to the DAB, DAB Docket No. A-17-64, on the ground that the calculation should not have included offsetting payments from third-parties. That case is still currently pending before the DAB.

The pending CMS disallowance and amount at issue before the DAB encompasses the entire first finding in the OIG audit; the finding therefore should **not** be repeated in the audit finding.

Issue: Finding #2 The Hospital omitted and underreported Medicaid and Medicare payments.

The audit takes the position that Jackson incorrectly omitted and underreported Medicare payments in its LIP cost-limit calculations.

Yet again, this involves the same issue that Florida is currently litigating before the DAB in Docket No. A-17-64. In addition, Jackson has brought suit against HHS and CMS in the Southern District of Florida, Case No. 1:19-cv-21206, seeking to enjoin application of a policy that would require it to count these revenues as an offset in the LIP cost-limit calculation, in accordance with the cases that have struck down a similar policy in the context of DSH payments. The audit should **not** include this calculation and the audit amounts that are in dispute.

Additionally, the OIG's review of the LIP cost-limits for the period indicates that the Hospital did not include the DSH payment received during SFY 2010 as noted in the final DSH examination report submitted to CMS. The DSH examination reports submitted to CMS for SFYs 2012-2014, however, show the Hospital as 100% overpaid for DSH payment purposes. As a result, those DSH payments should be removed from the LIP cost-limit in order to prevent the collection of these payments from the Hospital twice. Removing these payments for SFYs 2012-2014 results in an increase to allowable cost for the period of \$221,079,238. While the results of the finalized DSH audits submitted to CMS showing these overpayments were available for the OIG to include in their report, the OIG chose not to.

Furthermore, while Medicaid cost report reviews for the cost report years included in the period are not complete, a preliminary analysis of rate settlements for SFYs 2011-2014 reflects agency recoupments, and therefore an increase in the LIP cost-limits of \$82,783,027. Had the OIG inquired about the current status of Medicaid cost reports in question, preliminary data could have been supplied but the OIG failed to investigate this area and its impact on the Hospital's overall uncompensated cost.

Removing DSH payments and adjusting for rate settlements will immediately increase the LIP cost-limit by \$303,862,265, which reduces the total Federal overpayment to \$261,040,873.

The OIG also disallowed a claimed redistribution of LIP payments from the Hospital to other providers for SFY 2011 due to a lack of supporting documentation. Upon request, the Hospital was able to provide interlocal agreements to the Agency, as well as documentation that the redistribution was allowable and occurred during June 2013. Furthermore, review of agency records shows this redistribution was approved and communicated to the Hospital. The result of this redistribution is an increase in allowable cost of \$60,000,000.

Finally, review of OIG support shows that the OIG adjusted LIP payments were reported based on the state year the LIP payment was submitted to the Hospital, rather than the state year for which the payment was related. The following table shows the impact of correctly reporting LIP payments based on the state year for which the payment relates to. This further serves to highlight that the OIG did not correctly report the LIP cost-limits by year.

	State Year 2010 (DY 4)	State Year 2011 (DY 5)	State Year 2012 (DY 6)	State Year 2013 (DY 7)	State Year 2014 (DY 8)
Cost Impact	(\$77,609,677)	\$77,609,677	(\$32,745,755)	\$1,488,603	\$31,257,152

Source: 2010-2014 LIP Cost-limit, 2010-2014 DSH Examinations Submitted to CMS, 2011-2014 Preliminary Medicaid Rate Settlements, 2010-2014 LIP Payment Schedule, AHCA Table 10 2010-2011, Hospital Interlocal Agreements, Hospital Bank Records

Issue: Finding #3 The Hospital claimed costs for patients for whom federal funding was not allowable.

The OIG report identified and removed costs related to undocumented aliens originally reported in the LIP cost-limit during the period. However, the OIG failed to remove payments received related to these costs resulting in an understatement of the LIP cost-limit. The DSH payment program in Florida is designed to cover the State's large, undocumented alien population and \$137,073,693 of uncompensated care costs related to undocumented aliens were specifically covered by DSH payments for the period. The OIG has included 100% of all DSH payments paid to the Hospital during SFYs 2010 and 2011 (2012-2014 DSH payments should be removed per the above **Issue: The Hospital omitted and underreported Medicaid and Medicare payments**). The reported DSH payments for these years should be decreased to account for the portion of the DSH payment applicable to undocumented aliens which for 2010 and 2011 totals to \$60,946,508. The OIG should remove DSH payments related to undocumented aliens from the LIP cost-limit overpayment totals and increase total allowable cost for the period by \$60,946,508. Again, the fact that the OIG did not consider the intertwining relationship between costs included in both DSH and LIP showcases that the report is fundamentally incorrect.

Source: 2010-2014 LIP Cost-limit, 2010-2014 Hospital Patient Detail Data

Issue: Finding #4 The Hospital did not follow some reimbursement and funding methodology document instructions.

The OIG report noted that the Hospital's original allocation of routine days and ancillary charges in the LIP cost-limit resulted in more low-income patient days or ancillary charges allocated to certain cost centers than there were total hospital patient days or ancillary charges. The OIG's attempt to allocate cost based on departmental mappings provided by the Hospital results in a reduction of allowable cost so the OIG was satisfied with the result. This allocation methodology, however, still

results in more low-income patient days or ancillary charges allocated to certain cost centers than there were total hospital patient days or ancillary charges. The OIG seems satisfied to leave the exact errors they were trying to correct only because their revised methodology reduced the allowable LIP cost-limit. Allocating allowable low-income patient days and ancillary charges based on the Hospital's finalized Medicare cost reports, which does not result in improper allocations as noted by the OIG, results in an increase to allowable cost for the period of \$9,785,031, and is commonly accepted by Medicaid and Medicare auditors nationally.

Additionally, the OIG allocated a portion of the Hospital's ancillary charges to non-reimbursable cost centers in the LIP cost-limit. These non-reimbursable cost centers are not included in total low-income patient cost in the LIP cost-limit. Therefore, a portion of payments related to these charges should be removed from the LIP cost-limit to prevent the matching of a payment without associated cost. Removing payments related to non-reimbursable cost centers results in an increase to allowable cost for the period of \$3,989,872. Both of the above issues speak to a complete and lack of understanding on behalf of the OIG as it concerns the Medicare cost report, cost apportionment methodologies, and the matching of allowable costs and payments.

Source: 2010-2014 LIP Cost-limit, 2009-2014 Finalized Medicare Cost Reports, 2010-2014 OIG Day and Charge Allocation Mappings.

Issue: Finding #4 Missing Organ Acquisition Costs.

The OIG did not include all organ acquisition costs for low-income patients in the LIP cost-limit. Review of the OIG work papers indicates that for multiple low-income patients, the OIG has included the patient's routine days, ancillary charges and payments, but has not included the patient's organ acquisition cost. A review of the Hospital's provided patient detail for the period indicates that additional low-income patient organ costs should be included in the calculation of the LIP cost-limit. Adding these missing organ counts to the organ acquisition cost calculation results in an increase to allowable cost for the period of \$21,613,956. Despite the OIG's acknowledgment from the Hospital that the data as-submitted for the LIP cost-limit was incorrect regarding patient organ counts, the OIG did not investigate the potential for missing patient organ costs even as they included days, charges, and payments for those patients in the LIP cost-limit.

Source: 2010-2014 LIP Cost Limit, 2009-2014 Finalized Medicare Cost Reports, 2010-2014 Hospital Patient Detail Data

Issue: Finding #5 The Hospital claimed unallowable section 6 costs.

Instructions in Section 7 of the LIP cost-limit specifically state to report payments paid on behalf of low-income patients other than to "[e]xclude... payments from State and local tax sources." The OIG report reduced allowable Section 6 costs by payments received for Section 6 services not originally reported on the LIP cost-limits for the period. Review of the Hospital's working trial balance for the period indicates these payments are for program grants from state or local tax sources. Removing this adjustment results in an increase to allowable cost for the period of \$4,296,674. As previously stated, the OIG yet again failed to adequately investigate data and supporting documentation before making their adjustments.

Source: 2010-2014 LIP Cost-limit, 2009-2014 Hospital Working Trial Balance

Issue: Finding #6 The Hospital made several clerical errors.

The underlying data used by the OIG to arrive at the dollar value overpayment was known to have been incomplete or based on erroneous data queries and could have been superseded by more appropriate data that was offered to be made available and supplied by the Hospital during the audit to calculate a more accurate LIP cost-limit to determine any possible overpayment. The OIG had the option to use this more accurate data to determine allowable cost, but intentionally opted to use the incomplete data as submitted with the Hospital's original LIP cost-limits.

Issue: Finding #7 The State agency did not reconcile the Hospital's cost-limit calculations to finalized Medicare cost reports.

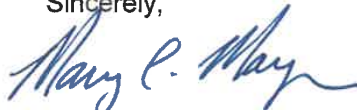
The OIG report claims that the Hospital's original allocation of organ acquisition cost did not follow LIP guidelines, and re-calculated all organ acquisition cost following their interpretation of LIP guidelines and using finalized Medicare cost reports for the period. This resulted in a decrease of allowable cost for the period. The OIG's calculations, however, did not take into account intern and resident cost excluded from Medicare calculated cost totals on the finalized Medicare cost report that should be allocated to organ acquisition costs (the OIG did take these costs into consideration for routine days and ancillary charges, however). Allocating intern and resident cost to organ acquisition cost calculations results in an increase to allowable cost for the period of \$3,662,528. Again, the failure of the OIG to correctly account for Medicare cost report issues belies a lack of understanding of the Hospital cost environment.

Source: 2010-2014 LIP Cost Limit, 2009-2014 Finalized Medicare Cost Reports, 2010-2014 Hospital Patient Detail Data

In December 2018, the OIG conducted an audit of CMS and issued a report titled, *The Centers for Medicare & Medicaid Services Had Not Recovered More Than a Billion Dollars in Medicaid Overpayments Identified by OIG Audits*. In her response to the draft report, Administrator Verma points out that "In instances where the states do not agree to refund the overpayments, CMS works with state officials to obtain documentation to make a determination on the allowability of the audit findings."

The State again suggests that the burden of obtaining documentation and accurate data to determine allowability must lie with the OIG in the first instance, particularly when the allegations are so clearly erroneous and inflammatory. If the OIG appreciated the intimate relationship between LIP and DSH in the Draft Report and took the time to gather accurate data, then CMS would not have to go through the costly and labor-intensive steps of re-plowing ground where the OIG already performed an audit in order to determine if the amounts claimed by the OIG were even allowable. The net result is an erroneous Draft Report that must be corrected or completely thrown out.

Sincerely,



Mary C. Mayhew
Secretary