Review of Alleged Improprieties in the Health Care Administration

14-004-N

Department of Human Services

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Audit Participation

The following Department of Human Services staff prepared this report:

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EXECUTIVE SUMMARY

Based upon a review of the documents and interviews provided during a limited investigation into seven concerns raised by a DHS employee, it appears that two issues should receive immediate corrective action, two issues need further internal audits or reviews, and the remaining issues were either resolved or do not appear to need immediate attention.

INTRODUCTION

A DHS employee raised seven substantive issues questioning DHS decision-making related to specific Medicaid payments and programs. As a result, DHS Director of Human Resources Connie Jones and DHS Director of Compliance Greg Gray requested a limited internal investigation be conducted by Director of Internal Audits Gary Johnson and Office of Inspector General Chief Legal Counsel Bridgid Dowdal. Following a number of interviews and review of documents, this internal auditor's report was prepared and contains the mental impressions and processes of the undersigned and is being used to provide advice and recommendations related to these issues.

BACKGROUND

A DHS employee made allegations in July 2013 that triggered a request for an internal audit into seven areas where questions were raised about whether management within the Health Care Administration ("HCA") was acting within state and federal law, DHS policy and procedures, or otherwise improper. Related, but separate from the scope of this report, the Equal Opportunity and Access Office is conducting a formal investigation into work related claims. The seven issues are outlined below.

1. Did DHS properly determine that Amplatz Children's Hospital at Fairview was exempt from the 10% rate reduction under MS 256.969?
2. Did DHS fail to rebase hospital in-patient rates in 2013 pursuant to MS 256.969, subd. 2?
3. Has DHS properly settled claims related to Community University Health Care Center ("CUHCC")?
4. Did HCMC trend costs and revenues inappropriately in an attempt to increase their DSH payment?
5. Has DHS determined how to implement the 10% reduction related to readmissions in 2013?
6. Have the issues surrounding prior authorization been resolved?
7. Does the Behavioral Health Care Provider ("BHP") bundled rate for services raise concern?

OBJECTIVE

This internal audit was conducted from approximately July 9, 2013 through September 30, 2013, in an effort to expeditiously identify facts, people and documents that can clarify DHS' process, procedures and decisions on seven specific issues and provide an initial review of those issues.

SCOPE

This review was conducted in accordance with governmental auditing standards generally accepted in the United States of America, except the scope of this review was limited to reviewing the specific issues identified above. Consequently, this review should not be considered as meeting auditing requirements for a certified audit and opinion.

SUMMARY OF FINDINGS

Of the seven issues raised, two appear to need immediate attention and corrective action (Issues 1 and 2 below), three (Issues 3, 4 and 7) appear to need greater investigation or review, and the remaining two (Issues 5 and 6) are either being addressed internally or do not appear to need additional follow-up.

1. Fairview University Medical Center ("FUMC") Amplatz Unit
2. Rebased Inpatient Hospital Relative Values
3. Community University Health Care Center ("CUHCC") Settlement
4. Hennepin County Medical Center ("HCMC") Disproportionate Share Hospital ("DSH") Payment
5. 10% Reduction Adjusted for Changes in Readmissions
6. Prior Authorization
7. Behavioral Health Care Providers ("BHP")

Issue 1: Did DHS properly determine that Amplatz Children's Hospital at Fairview was exempt from the 10% rate reduction under MS 256.969?

Short Answer: While the issue is complicated by the lack of clarity in the statutory definition of what constitutes a children's hospital, it does not appear that DHS' decision to give Amplatz retroactive exemption from the 10% rate reduction under MS 256.969 was consistent with the law or how other similarly situated children's facilities are treated (specifically Duluth St. Mary's Children's Hospital and Mayo Eugenio Litta Children's Hospital).

Analysis

Overall, the interviewees described the situation as follows. After the 2011 legislative session, Fairview approached DHS to discuss a variety of legislative changes that passed including the 10% rate reduction. During that meeting (in approximately November 2011) with Fairview, Assistant Commissioner Scott Leitz ("Leitz"), Mark Hudson ("Hudson"), and possibly Sandy Burge ("Burge"), Rachel Cell ("Cell") and Marie Zimmerman ("Zimmerman") were present with several Fairview representatives. One issue among several discussed was whether Fairview's Amplatz unit could be exempt from the 10% rate reduction under MS 256.969 based upon their status as a "children's hospital".[1]

The ultimate decision to exempt Amplatz from the 10% rate reduction appears to be handled almost exclusively by Assistant Commissioner Leitz. According to Leitz, there is a "common sense" definition approach that led him to conclude that Amplatz should be entitled to the exemption. Leitz cited to the fact that Amplatz serves only children, is a stand-alone facility, and has an emergency room as facts that convinced him to authorize the exemption. Leitz claims he was not aware of opposition to his decision. He also said no legal opinion or analysis was done to support his decision.[2] Both Golden and Leitz acknowledge that a driving factor in Amplatz getting the exemption was based upon the fact that Fairview approached DHS to discuss the issue.

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[1] DHS is currently seeking a legal opinion analyzing this issue.

[2] A number of interviewees referenced a legal opinion being provided by attorneys from Fairview to support the conclusion that Amplatz was exempt from the rate reduction. Those interviewees indicated that Leitz was given a copy of a legal opinion from Fairview. Leitz stated that no such opinion exists. A review of Mr. Leitz's computer and e-mail activity found no legal opinion related to Amplatz, but recovered e-mails that suggest Fairview may have prepared one.

However, several DHS employees working on the issue raised concerns that both the statute and previous policy by DHS would not allow for Amplatz to be exempt from the rate reduction without a legislative revision.[3] Specifically, the fact that Amplatz does not have an independent license as a Children's Hospital from the Department of Health and is licensed as a part of the University of Minnesota Medical Center ("UMMC"); that the change order required to effectuate the exemption for Amplatz required additional specification because it was connected to the Fairview license (as opposed to the other Children's Hospitals that received the exemption were simply listed with their NPI number); that at least two other Children's Hospitals could argue they are similarly situated and are not exempt; and, that no legal opinion or analysis had been requested to ascertain whether or not Amplatz is a Children's Hospital under the law or DHS policy.

Findings

The decision by DHS to allow Amplatz an exemption from the 10% rate reduction in MS 256.969 appears to be contrary to prior internal policy determinations of what constitutes a children's hospital. If DHS decides to allow for exemptions from the statutory rate reduction requirement for children's hospitals such as Amplatz, it should be equally available and applicable to all similarly situated providers or programs that primarily care for children but are not independently licensed.

Recommendations

1. The Department should obtain a formal legal opinion and proceed accordingly on this issue in a fair, open and transparent manner. If the legal opinion finds the action of providing Amplatz an exemption to the 10% inpatient rate reduction illegal or contrary to current law, the Department should immediately revoke the exemption and take back any excess amounts paid to date.

2. The Department should change the statute to clearly define the scope of what is meant by children's hospital so this issue and any similar future issues can be resolved or avoided.

Issue 2: Did DHS fail to rebase hospital in-patient rates in 2013 pursuant to MS 256.969, subd. 2?

Short Answer: Yes. The law requires that in-patient hospital rates be rebased effective January 1, 2013, and to date that has not been completed by DHS.

Analysis

According to several DHS employees familiar and responsible for the rebasing of in-patient hospital rates, it is neither unusual nor problematic to miss the January deadline for issuing rebased rates for several reasons. First, according to statements from DHS employees, often times a legislative delay for issuing rebased rates is sought and obtained. Admittedly, that did not occur here so the 2013 date was in play. However, the effective date of the law and the implementation are separate issues and presumably a retroactive rebased rate can be implemented.[4]

[3] There are some inconsistencies concerning whether or not Leitz and Golden knew about the concerns of DHS employees at the time the Amplatz decision was being made and implemented.

[4] It is unclear at this point of the investigation what the limitations are of retroactive implementation of rebased rates in terms of the federal share and whether there are any adverse consequences.

Both Leitz and Golden indicated that a "promise" had been made to the Minnesota Hospital Association ("MHA") to discuss and disclose any proposed rates prior to having DHS release the rates.

According to members of HCA familiar and responsible with the issue, there were a number of issues that came in to play with getting a rebased rate out by the January 2013 deadline. First, there were issues concerning the methodology in determining a cost-neutral rebasing of rates. Certain staff wanted to use the prior methodology based on 2002 charge date but management indicated they had talked with the hospital association and thought a cost-based methodology using more current date would be much more accurate. We found no communication or directives from management to staff that clearly provided direction on rebasing methodology. As a result, there was some confusion and ambiguity about how to determine the appropriate rate. Second, this project, according to Leitz and Golden, was a low priority in a year where managed care rate setting and other issues were much higher priorities. As a result, the rebasing appears to have been done based upon historic methodologies and, in the end, was prematurely released to the industry in December 2012 and then retracted because upper management (Leitz, Golden and Hudson) had not yet reviewed and conferred with the industry about the rates and methodology.

After rescinding the proposed rebased rates in late December 2012, DHS has yet to issue rates. It is unclear whether there were any substantive problems with the original proposed rates. According to Hudson, Leitz and Golden, the methodology that was being used to calculate the proposed rebased rates was inadequate because it was using 2002 data and was using charges, rather than costs. Mr. Golden stated that such flaws could bring in to question whether the proposed rates would be accurate enough to get federal approval. Furthermore, because Leitz had specifically promised to have a dialogue with the industry, most notably people at the Minnesota Hospital Association, releasing the rates without honoring that agreement was not acceptable. Additionally, Leitz stated that because he understood the rebased rates could be retroactively implemented, he did not see a negative impact if the rates could not be rebased by January 2013.

Findings

DHS has not complied with statutory requirements to issue rebased rates by January 2013, however, it appears there is an ongoing effort to formulate the most accurate and cost-neutral rates with input from the industry. Whether there is any adverse implication related to the federal reimbursement for failure to issue new rates remains unclear at this point. This is an issue that DHS is addressing and working to resolve.

Recommendations

1. There needs to be a legal opinion from Federal Relations concerning any negative or adverse implications of failing to comply with MS 256.969 subd. 2; specifically, not getting rebased rates issued yet. Essentially, we need to know if this will impact the Department's ability to claim a federal match for the first three quarters.

2. If the rebased rates are not going to be released in the near future, DHS should seek a legislatively approved delay.

3. The Department should take steps to improve communications within HCA between management, supervisors and staff so management's position on issues and the expectations and responsibilities of staff are clearly stated, documented and understood. With this issue, we found

no clear, documented communication between HCA management and staff that set expectations of rebasing methodology or procedures. Also, we found no documented instructions to staff outlining the process to be used to release the rebased rates.

Issue 3: Has DHS properly settled claims related to Community University Health Care Center ("CUHCC")?

Short Answer: No. This is a part of a larger problem involving settlement of past claims with FQHCs that needs further review by the Internal Auditor. The specific issue involving CUHCC focuses on an 18-month period where neither party has sufficient documentation of claims. The proposed $3.28 million that DHS has agreed to pay to settle-up on past claims over a two-year period should be finalized. The parties have not yet reached an agreement.

Analysis

This issue focuses on how DHS handles settling claims from FQHCs. A lawsuit was brought by a number of FQHCs several years ago and CUHCC did not join in that litigation because they wanted to resolve their claims directly with DHS. It appears that when FQHCs have a reason to contest the amount of reimbursement on a claim they can contest it with DHS, and there has not been an adequate system put in place to give guidance and clarity to either DHS or FQHCs on how to handle the situation. As a result, DHS has contested claims back to 1997 (as is the case with CUHCC).

After a review of CUHCC's claims, the parties agreed that $3.28 million is owed for two of the three plus years being reviewed. However, the data on the claims during an 18-month window is insufficient, so there is a disagreement at this point as to whether more money is owed to CUHCC for claims that cannot now be properly reviewed and analyzed. This illustrates one of the problems with how FQHCs are allowed to bring into question claims from years ago without any type of standard process or limits. As a result, DHS and providers get bogged down when there is an effort to re-submit claims from years ago to get an adjustment. A final agreement has not been reached as it relates to CUHCC.

Findings

There are chronic and complicated issues involving FQHCs stemming, in part, from a practice of allowing them to resubmit amended claims years after the initial adjudication or date of service. As a result, neither DHS nor the FQHCs have any level of certainty or closure concerning the payment of claims and how/when to re-file for reimbursement. This issue should be further analyzed for problems and solutions.

We also found differences of opinion and understanding over who has authority to settle the different types of disputes inherent in the rate setting process. Specifically, we found confusion over authority to settle disputes when no formal litigation is involved, but where the final negotiation of rates becomes a drawn-out process and the final settlement involves significant debate and dollars. This process of final negotiations for disputed rates is often referred to as the "settle-up" process and can involve millions of dollars. Further conversations between Senior Leadership and HCA should take place to intentionally identify and define when Senior Leadership needs to be made aware of claims that are being either resubmitted and settled by HCA, or other types of settlement or settle-up negotiations. Only four people

at DHS have authority to make and accept offers of settlement on behalf of the agency, the parameters and boundaries of that decision-making should be made clear to HCA.

Recommendations

1. The Department should conduct a review or assessment of the Federally Qualified Health Clinic program, including rate setting and claims payment. The focus of this review should be an overall assessment of the program, number and age of disputed claims, the internal controls over the processes and procedures and, if necessary, a recommendation on how to best limit claims, corrections or resubmission of claims to a reasonable period.

2. The Department should clarify policy and procedures related to the settlement or settle-up of rate setting disputes. Authority to settle such disputes should be clearly defined and communicated. Follow-up conversations between managers within HCA and Senior Leadership should clearly identify when HCA can resolve disputed claims without further input and when Compliance and the Legal Management Office should be apprised of "settlement" negotiations.

Issue 4: Did HCMC trend costs and revenues inappropriately in an attempt to increase their DSH payment?

Short Answer: Yes. This is a complicated area with a long history of difficulties in terms of how providers are reporting costs/revenues for purposes of determining the appropriate payment.

Analysis

Based upon interviews and review of documents, this issue is not a new or surprising one for DHS but continues to cause problems. In essence, providers are motivated to maximize their DSH payment by reporting exaggerated costs and minimized revenues. This is not specific to any one provider but rather appears to be a relatively standard practice within the industry to gain the largest advantage. While the specifics of this area were not within the scope of this report, there was consensus among those interviewed that it is an area that needs to be evaluated and rectified because the current system is broken.

As it relates to this report, the specific provider's negotiation on their DSH payment cap is ongoing. The purpose of this review was to determine if there had been an improper settlement. Accordingly, we are not able to form an opinion on the issue until it is formally resolved but, at this point, it does not appear that any of the negotiations have been inappropriate.

Findings

This area has long-standing issues that need timely and appropriate review, analysis and resolution. The scope of this investigation did not fully assess or address this issue.

Recommendations

1. The Department should conduct a review or assessment of the DSH program, focusing on the number and age of outstanding payments, the process and procedures used to calculate the amounts due, and the general internal controls over the accuracy and efficiency of payment limits.

Issue 5: Has DHS determined how to implement the 10% reduction related to readmissions in 2013?

Short Answer: No. According to MS 256.969, subd. 3c (C), DHS is required to develop a process for providers to receive a benefit/incentive to lower their readmissions rates, however, due to a lack of current resources to identify, review and analyze the data this provision has not yet been implemented.

Analysis

Interviews of employees on this issue were conflicting. While everyone agreed the law became effective in July 2013 that gives providers an incentive to decrease readmission rates, it was unclear based upon this limited audit to determine exactly what has transpired and what the expectations are both in terms of the law, providers and DHS. Some interviewees indicated discomfort and concern about not meeting the July 2013 date for effectuating a process for implementing the 10% reduction in applicable situations. Others indicated that because DHS does not have the technological nor resource capabilities it is a challenge to determine the appropriate reduction.

There were also concerns raised about whether the industry would be evaluating and assessing readmissions used to calculate the potential reduction. This was described by some as a conflict of interest with DHS endorsing decisions made by industry instead of an independent, objective review of the data. In the end, it appears that no decision has yet been made about how the determination will be made concerning whether providers qualify for a rate reduction based upon a reduction in readmission.

Apparently, DHS is looking at 3M software that the Department of Health currently uses, but there is also a possibility that Minnesota Community Measurement Group (an affiliation of healthcare professionals that includes providers) may be asked to perform this analysis. Understandably, some interviewees raised concerns about conflicts of interest and lack of objectivity and integrity in a process that allows the industry to determine whether they are eligible to receive these benefits.

This is another example of poor communication within the Health Care Administration. We talked with several people at all levels of management, and the only person that clearly stated we were using 3M software and doing it ourselves was Leitz. That only Leitz appears to be aware of this decision with any level of clarity illustrates a fundamental breakdown in communication.

Findings

There are two findings. First, DHS needs to better anticipate and plan for statutory deadlines to remain in compliance with state and federal requirements such as the 10% readmission reduction or, alternatively, to proactively address such deadlines and why the agency will not be able to comply (lack of resources, technology, data, etc.). Second, the scope of this investigation did not include being able to completely investigate the interests of the Minnesota Community Measurement Group, however, the statements of some interviewees suggests there is a perceived or actual conflict of interest that should be further analyzed.

Recommendations

1. DHS must ensure that any process or procedure that involves data review and analysis for purposes of determining whether a provider is entitled to the 10% reduction are based upon an independent and objective review of the underlying readmission claims data.

Issue 6: Have the issues surrounding prior authorization been resolved?

Short Answer: Yes. The prior authorization ("PA") issues stemmed from a series of issues that have been fully addressed by HCA.

Analysis

According to the statements, the PA requirement became an issue in 2011 when a combination of a government shutdown, a new vendor (Telligen), and other technological issues culminated in a complete standstill of PAs. According to statements from interviewees, Telligen was a new vendor to provide the service of processing PAs. However, they came onboard with DHS on the day that a government shutdown essentially eliminated any support or assistance. Further, Telligen encountered a variety of technical and operational challenges such as a fax machine system that would not accommodate the large volume of PAs, resulting in a significant backlog of PAs not processed. As a result of this situation, DHS made a number of decisions on how best to triage and expedite decisions to ensure that clients receive the appropriate care in a timely fashion. After Leitz conferred with the Commissioner, it was decided that DHS would suspend prior authorizations in lieu of post-claim reviews to comply with the intent of the law and also implement a more efficient process to ensure patients received the necessary treatment as quickly as possible. In the end, the RFP was re-bid and a new vendor is now providing the services to support PA requests.

Findings

This issue primarily stemmed from a number of unpredictable external circumstances that caused problems in getting prior authorizations. The problematic circumstances have been addressed or disappeared so no long-term issue appears to remain at this time.

Recommendations

1. No further follow-up necessary at this time.

Issue 7: Does the Behavioral Health Care Provider ("BHP") bundled rate for services raise concern?

Short Answer: Yes. The Health Care Administration is currently analyzing these issues and developing recommendations for better transparency and accountability.

Analysis

BHP has been allowed to bundle three different services into a single rate. The services include a client assessment by a mental health professional, developing an individualized plan for the appropriate level of care, and locating an appropriate provider to avoid the costlier inpatient care. In reviewing the 2003 rate calculation, we found the rate of $252 is warranted only when the service provided involves someone with a doctoral degree, however, it does not appear that DHS has a system in place to review or preclude unwarranted claims for the $252 amount if the service actually does not involve the properly credentialed professional. Apparently, the negotiation of the BHP bundled rate system is something that happened under a different administration and management and inherited by the current managers. However, because this system of bundling rates does not appear to be cost-effective or transparent, it is currently being reviewed by HCA.

Upon a request to review BHP claims data related to this investigation, it was determined that from 2003-2012 there is an estimated $1 million that DHS overpaid for services. However, we found no documentation or communication to the provider explaining or giving instruction on how to bill for services provided, and we do not know if the provider was ever told to bill a different rate when anyone other than a doctor performs the assessment.

Findings

BHP bundled rates do not appear to be advantageous to DHS. DHS should consider unbundling the rate for services provided by BHP so that specific claims can be evaluated and reimbursed according to the level of service provided. Our review found no indication that billing DHS for the lower rates for non-doctoral work was ever communicated to BHP.

Recommendations

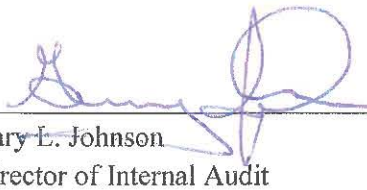
1. HCA should continue to review, analyze and develop a strategy for making BHP rates more accountable and transparent.

2. The Internal Audits Office should review documentation related to the initial rate set for BHP and determine if BHP was provided with separate rates to bill for services depending on who conducts the assessment. If BHP was expected to bill lower rates when a doctor was not involved in the assessment, the Department should identify and recover any excess amounts paid.

CONCLUSION

The issues addressed in this audit fall in to three categories: needs immediate attention and corrective action (Issues 1 and 2); needs additional review and analysis (Issues 3, 4 and 7); and is actively being addressed internally and does not need further review at this time (Issues 5 and 6).

Respectfully submitted,



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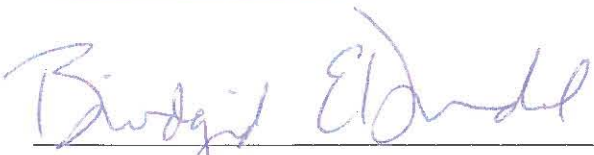

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