DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

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

AUG 18 2004

Report Number: A-04-03-02029

Mr. Russ Fendley
Department for Medicaid Services, 6W-A
Cabinet for Health and Family Services
275 East Main Street
Frankfort, Kentucky 40601

Dear Mr. Fendley:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled *Review of State Fiscal 2002 Medicare Upper Payment Calculations and Payments: Kentucky Medicaid Agency*. A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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If you have any questions or comments about this report, please contact me at 404-562-7750 or have your staff contact Peter Barbera, Audit Manager at 404-562-7758. To facilitate identification, please refer to report number A-04-03-02029 in all correspondence relating to this report.

Sincerely,

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

Enclosures – as stated

Direct Reply to HHS Action Officials:

Mr. Renard L. Murray
Associate Regional Administrator
Division of Medicaid and State Operations, Region IV
61 Forsyth Street, S.W., Suite 4T20
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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF STATE FISCAL 2002 MEDICARE UPPER PAYMENT CALCULATIONS AND PAYMENTS

KENTUCKY MEDICAID AGENCY

Inspector General

AUGUST 2004
Report No. A-04-03-02029

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Title XIX of the Social Security Act (the Act) authorizes Federal grants to States for Medicaid programs that provide medical assistance to needy persons. Each State Medicaid program is administered by the State in accordance with an approved State plan amendment (SPA). While the State has considerable flexibility in designing its plan and operating its Medicaid program, it must comply with broad Federal requirements. The Federal Government pays its share of medical assistance expenditures to a State according to a defined formula that yields the Federal share.

State Medicaid programs have flexibility in determining payment rates for Medicaid providers within their State. The Centers for Medicare & Medicaid Services (CMS) allows State Medicaid agencies to pay different rates to the same category of providers as long as the payments, in aggregate, do not exceed the Medicare upper payment limit (UPL). The UPL represents an estimate of the amount that would be paid to a group of facilities for Medicaid services under Medicare payment principles. State expenditures that exceed the applicable UPL are not available for Federal financial participation.

Federal regulations at 42 CFR § 447.272 (Inpatient Hospital and Long-Term Care Facility Services) and 447.321 (Outpatient Hospital and Clinic Services) limit aggregate state Medicaid payments to a reasonable estimate of the amount that would have been paid for the furnished services under Medicare payment principles. The Federal regulations do not specify the methodology for calculating the estimated UPL; however, a state's methodology and UPL related payments must comply with a SPA approved by CMS. The Federal Government recently took steps in an attempt to limit abuses occurring in the application of UPL requirements.

Effective March 13, 2001 CMS issued revised UPL regulations at 42 CFR § 447.272 (inpatient services) and 447.321 (outpatient services) that were designed to limit abuses occurring in the application of UPL requirements. Part of this revision was to allow payment to public hospitals at 150 percent of the UPL. Effective May 15, 2002 CMS issued an additional revision that reduced the allowable UPL payments to public hospitals from the 150 percent to 100 percent.

The Commonwealth of Kentucky's SPAs authorizing UPL payments were effective starting April 2, 2001. From inception through March 31, 2003 the Commonwealth made a combined total of $81 million in Medicaid inpatient hospital, outpatient hospital, and skilled nursing facility UPL payments.

OBJECTIVE

The objective of our audit was to review the reasonableness and accuracy of the UPL calculations supporting Kentucky's UPL payments made from April 2, 2001 through March 31, 2003.

SUMMARY OF FINDINGS

Overall, the Commonwealth's inpatient hospital, outpatient hospital, and skilled nursing facility UPL payments were made within the terms of the approved SPAs. We also determined that the Commonwealth's methodologies for the UPL calculations were reasonable. However, in reviewing the calculations we found minor computational errors, some of which resulted in UPL overpayments.

The Commonwealth's **inpatient** hospital UPL calculations, supporting approximately $23 million of UPL payments, contained errors when entering data from the cost reports into the UPL calculation. These errors overstated the UPL. As a result, the Commonwealth made overpayments of $75,748 (Federal share $52,926).

The Commonwealth's **outpatient** hospital UPL calculations, supporting approximately $13 million of UPL payments, contained data input errors that also overstated the UPL. As a result, the Commonwealth made overpayments of $227,916 (Federal share $159,405). The Commonwealth discontinued these UPL payments on May 14, 2002 around the time of the regulatory change that ended reimbursement at the 150 percent level.

The Commonwealth's **skilled nursing** facility UPL calculations, supporting approximately $45 million of UPL payments also contained some errors; however, no overpayments were made. Thus, the Commonwealth's skilled nursing facility UPL payments were within the UPL and reasonable.

RECOMMENDATIONS

We recommend that Kentucky:

- improve procedures to review the UPL calculations for accuracy

- reimburse the Federal Government $212,331for the Federal share of the overpayments made for inpatient hospital and outpatient hospital services

COMMONWEALTH COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In responding to our draft report, the Commonwealth generally agreed with our findings, but questioned the overpayment amounts. Subsequently, the Commonwealth provided additional documentation to support its UPL calculations. Based on this documentation we accepted more of the UPL calculation and revised the results of our review accordingly. The full text of the Commonwealth's response to our draft report is included as an appendix.

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INTRODUCTION

BACKGROUND

Medicaid Program

Title XIX of the Act authorizes Federal grants to States for Medicaid programs that provide medical assistance to needy persons. Each State Medicaid program is administered by the State in accordance with an approved SPA. While the State has considerable flexibility in designing its plan and operating its Medicaid program, it must comply with broad Federal requirements. The Federal Government pays its share of medical assistance expenditures to a State according to a defined formula that yields the Federal share.

State Medicaid programs have flexibility in determining payment rates for Medicaid providers within their State. CMS allows State Medicaid agencies to pay different rates to the same category of providers as long as the payments, in aggregate, do not exceed the Medicare UPL. The UPL represents an estimate of the amount that would be paid to a group of facilities for Medicaid services under Medicare payment principles. State expenditures that exceed the applicable UPL are not available for Federal financial participation.

Federal regulations at 42 CFR § 447.272 (Inpatient Hospital and Long-Term Care Facility Services) and 447.321 (Outpatient Hospital and Clinic Services) limit aggregate state Medicaid payments to a reasonable estimate of the amount that would have been paid for the furnished services under Medicare payment principles. The Federal regulations do not specify the methodology for calculating the estimated UPL; however, a State's methodology and UPL related payments must comply with a SPA approved by CMS. The Federal Government recently took steps in an attempt to limit abuses occurring in the application of UPL requirements.

Effective March 13, 2001 CMS issued revised UPL regulations at 42 CFR § 447.272 (inpatient services) and 447.321 (outpatient services) that were designed to limit abuses occurring in the application of UPL requirements. Part of this revision was to allow payment to public hospitals at 150 percent of the UPL. Effective May 15, 2002 CMS issued an additional revision that reduced the allowable UPL payments to public hospitals from the 150 percent to 100 percent.

Kentucky's UPL State Plan Amendments

The Cabinet for Health Services, Department for Medicaid Services (Commonwealth agency) is responsible for making UPL payments in accordance with the SPA. Kentucky's State plan provided for estimated UPL payments to qualified public hospitals for inpatient, outpatient and skilled nursing services.

The Commonwealth of Kentucky's SPAs authorizing UPL payments were effective starting April 2, 2001. From April 2, 2001 through March 31, 2003, the Commonwealth made a total of $81 million in UPL payments for the following Medicaid services:

- $23 million for **inpatient** hospital UPL payments to non-State Government owned or operated hospitals pursuant to SPA 01-11 effective April 2, 2001

- $13 million for **outpatient** hospital UPL payments to non-State Government owned or operated hospitals pursuant to SPA 01-15 effective April 2, 2001

- $45 million for **skilled nursing** facility UPL payments pursuant to SPA 01-09 effective April 2, 2001

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our audit was to review the reasonableness and accuracy of the UPL calculations supporting Kentucky's UPL payments made from April 2, 2001 through March 31, 2003.

Scope

Our review covered UPL calculations and subsequent payments from April 2, 2001 through March 31, 2003 (State Fiscal Year 2001 through 2003). We reviewed $81 million of inpatient hospital, outpatient hospital and skilled nursing facilities UPL payments. These payments were separate and distinct from the basic Medicaid payments made to facilities that provide Medicaid services, were pursuant to various SPAs, and were subject to Medicare UPL regulations at 42 CFR § 447.272 (Inpatient Services and Long-Term Care Facility Services), and 447.321 (Outpatient Services).

Methodology

To accomplish our objective, we examined the Commonwealth's SPAs for inpatient hospitals, outpatient hospitals, and skilled nursing facilities to verify that the UPL computations and payments were done in accordance with the relevant SPA. Next, an understanding of the UPL calculation methodology was attained through discussions with Commonwealth officials. In addition, we reviewed the methodology for reasonableness, reviewed the UPL calculations and resulting payments for mathematical accuracy, and traced various components of the calculations and payments to supporting documentation. We did not review the accuracy of the Medicaid payments ad hoc reports used in the UPL calculations.

For the hospital **inpatient** payments, we reviewed and recalculated the various computations that resulted in the payments. This included UPL calculations at 150 percent (for April 2, 2001 through May 14, 2002) and calculations at 100 percent (for May 15, 2002 through March 31, 2003).

The data used in the calculations was traced to Medicare cost reports. While on site, we were provided with cost reports that did not trace to the UPL calculations. In responding to our draft report, the Commonwealth discovered that the consultants, who prepared the Commonwealth's

inpatient UPL calculation, had relied on the most recent audited version of the cost reports. The cost reports we were originally given were for the proper year; however, they had earlier preparation dates. We requested copies of the more recent audited cost reports used by the consultants and traced them to the inpatient UPL calculations.

For the hospital **outpatient** payments, we reviewed and recalculated the UPL calculations and resulting payments, which were made at 150 percent for outpatient hospital services, for April 2, 2001 through May 14, 2002. The outpatient UPL payments ceased after May 14, 2002.

For the **skilled nursing** facility payments, we reviewed and recalculated the various nursing facility UPL computations for April 2, 2001 through March 31, 2003. We traced data used in the UPL calculations to supporting ad hoc reports. We recalculated the UPL calculations and payments using the appropriate Resource Utilization Groups (RUGs) classifications identified in the Federal regulations. Under the Medicare prospective payment system for skilled nursing facilities, facilities are required to classify residents to a RUG, based on data from the resident assessment.

In addition, starting July 1, 2002 the nursing facility UPL computations included UPL calculations for crossover claims. When calculating the UPL for Medicare crossovers, the Commonwealth is calculating the UPL for patients that were covered under the Medicare and Medicaid programs. These patients have a coinsurance factor; thus, the Commonwealth is estimating the difference between the average Medicaid daily rate and the average Medicare daily rate. We recalculated the Commonwealth's UPL for crossover claims to determine its accuracy.

We relied primarily on substantive testing; therefore, an understanding of the Commonwealth Medicaid agency's internal controls was not necessary. The fieldwork was conducted from June 2003 through December 2003 at the offices of the Commonwealth Medicaid agency in Frankfort, Kentucky. We conducted an exit conference with Commonwealth officials to present our initial findings.

Our audit was conducted in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

REASONABLENESS OF UPL PAYMENTS

Hospital Inpatient UPL Payments Overstated

Federal regulations at 42 CFR § 447.272 (Inpatient Services) established the UPL as a reasonable estimate of the amount that would be paid for Medicaid services under Medicare payment principles. Additionally, the Commonwealth's inpatient SPA (SPA 01-11) states:

> *The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to the qualifying*

hospitals for services to Medicaid patients and the maximum amount allowable under applicable federal regulations in accordance with 42 CFR 447.272.

The Commonwealth made about $23 million in UPL payments to facilities for **inpatient** services and made these payments within the terms of its SPA. These payments were based on cost data from Medicare cost reports for the various hospitals included in the UPL calculations. We considered the use of cost data to be a reasonable methodology for determining the inpatient UPL. However, in reviewing the methodology we found that the calculations did not accurately quantify the UPL.

The UPL calculations contained clerical errors, which were primarily keying errors when entering the data from the cost reports into the UPL calculation. Cumulatively, the errors overstated the UPL by $498,276.

As a result of the errors in the UPL calculation, the Commonwealth made $75,748 in UPL overpayments (Federal share $52,926).

Hospital Outpatient UPL Payments Overstated

Federal regulations at 42 CFR § 447.321 (Outpatient Services) established the UPL as a reasonable estimate of the maximum amount that would be paid for Medicaid services under Medicare payment principles.

Additionally, the Commonwealth's outpatient SPA (SPA 01-15) states:

The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to the qualifying hospitals for outpatient services to Medicaid patients and the maximum amount allowable under applicable federal regulations at 42 CFR 447.321.

The Commonwealth made approximately $13 million in total UPL payments to facilities for **outpatient** services and made these payments within the terms of its SPA. These payments were based on a methodology that included the Medicaid outpatient cost to charge ratio as described in the SPA. We considered the Commonwealth's methodology to be reasonable for determining the outpatient UPL. However, in reviewing this methodology we found that the calculations did not accurately quantify the UPL.

The outpatient UPL was overstated because the Commonwealth inadvertently used inpatient hospital data instead of outpatient hospital data. Cumulatively, the errors overstated the UPL by $662,535.

We revised the outpatient UPL calculation using the proper data and determined that the Commonwealth had overstated the UPL by using the wrong data. Based on an inflated UPL, the Commonwealth made UPL overpayments of $227,916 (Federal share $159,405).

After May 14, 2002 the Commonwealth ceased making outpatient hospital UPL payments.

Skilled Nursing Home Facilities UPL Payments Reasonable

The Commonwealth made about $45 million in UPL payments to **skilled nursing facilities** and made these payments within the terms of its SPA. These payments were based on a methodology that included the use of RUG rates, which are the basis by which Medicare reimburses nursing facilities for Medicare related services. We considered the Commonwealth's methodology to be reasonable for determining the skilled nursing facility UPL.

Our review of this methodology also found errors in the calculations that impacted the accuracy of the UPL; however, these errors did not result in overpayments. Based on our analysis, the Commonwealth's skilled nursing facility UPL payments were within the UPL and are, therefore, considered reasonable.

RECOMMENDATIONS

We recommend that Kentucky:

- improve procedures to review the UPL calculations for accuracy

- reimburse the Federal Government $212,331 for the Federal share of the overpayments made for inpatient hospital and outpatient hospital services

AUDITEE COMMENTS

Regarding the recommended financial adjustment the Commonwealth agreed with our overpayment amount related to the UPL outpatient hospital payments. The Commonwealth also agreed that its inpatient UPL calculations contained some data entry errors; however, the Commonwealth did not agree with the amount we questioned as an inpatient overpayment. It believed that our calculations might have been based on inappropriate documents in a few cases. Therefore, the Commonwealth requested copies of our working papers containing these calculations. The Commonwealth noted that the nursing facility payments were under the upper payment limit.

In closing, the Commonwealth indicated that at a later date, it would outline a proposed resolution to address any remaining over- or underpayments.

Regarding the procedural recommendation, the Commonwealth offered no comments. It only mentioned that the data entry error related to the inpatient UPL calculation has been corrected.

The appendix includes the full text of the Commonwealth's comments.

OFFICE OF INSPECTOR GENERAL RESPONSE

Through further communications with the Commonwealth, we were provided additional documentation to support the Commonwealth's inpatient UPL calculation. Based on this documentation we accepted more of the inpatient UPL calculation and reduced the overpayment amount accordingly.

We believe the Commonwealth should address any proposed resolution of the issues in this report to CMS.

APPENDIX

ERNIE FLETCHER
GOVERNOR

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
COMMISSIONER'S OFFICE
275 EAST MAIN STREET, 6W-A
FRANKFORT, KENTUCKY 40621-0001
(502) 564-4321 (502) 564-0509 FAX
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JAMES W. HOLSINGER, JR., M.D.
SECRETARY

May 21, 2004

Mr. Charles J. Curtis
Regional Inspector General for
Audit Services, Region IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, GA 30303

Dear Mr. Curtis:

I am writing to respond to the Office of Inspector General's draft report entitled *Review of State Fiscal 2002 Medicare Upper Payment Calculations and Payments: Kentucky Medicaid Agency.* Overall, we agree with the finding that the Commonwealth's methodology for each program's UPL calculation is reasonable. Outlined below are specific comments related to the OIG's findings.

Outpatient

Kentucky accepts the finding of an overpayment of $227,916 (state and federal funds).

Inpatient

Your report indicates that Kentucky has made $322,590 (state and federal funds) in payments in excess of the inpatient upper payment limit (UPL) to county facilities during the period April 2, 2001 through March 31, 2003. We acknowledge the data entry error related to inpatient ancillary costs for Crittenden hospital that was included in the payment calculations for the 3rd and 4th quarters of calendar year 2002 which contributes to this finding. The majority of data entry errors referred to you in your report occurred during these quarters. As demonstrated in the most recent calculation you reviewed, these errors have been eliminated.

However, we have been unable to reconcile other corrections made in the hospital UPL calculations for 3rd and 4th quarters of calendar year 2002 to the source documents. Further, when we modify the calculations to reflect figures from our reports consistent with other corrections that OIG has made, the overpayment for July 1, 2002 through September 30, 2002 is

reduced from $503,633 to $391,146 and the overpayment for October 1, 2002 through December 31, 2002 is eliminated, reducing the total inpatient overpayment for the audit period from $322,590 to $90,653. As a result, we are requesting that you share a copy of your working papers for these two quarters prior to finalizing your report. As your report indicates that you used the oldest available cost reports to calculate the UPL payment for comparisons to the actual UPL payments made by the Commonwealth, we believe that inappropriate documents may have been used in a few limited cases. A preliminary list of the figures in the supporting documentation provided to the Commonwealth that we can not reconcile is attached (See Attachment A).

Nursing Facilities

According to the supporting documentation provided by OIG auditors, supplemental payments to county nursing facilities for the period April 2, 2001 through March 31, 2003 were under the upper payment limit by $910,044.

Upon completion of our review of the working papers for the inpatient UPL calculation, we will outline our proposed resolution to address any remaining over- or underpayments.

Sincerely,

Russ Fendley
Commissioner

RF/JM/tp

Attachment A
OIG Inputs, Unable to Reconcile

Period	Item Unable to Reconcile
7/1/02 - 9/30/02	A) Number of Adult/Peds Medicaid days for Rockcastle hospital - 527 not 510. B) Routine Swing Bed exclusion for Caldwell County does not tie to Wksht D-1. Should be $108,331. C) Routine Adult/Peds costs for Rockcastle do not tie to Wksht C, Part I Line 25. Should be $1,663,311. D) Input for calculation supporting Inpatient ancillaries for Rockcastle hospital does tie to 10/31/98 cost report: 1) 79945 entered as 19945, 2) "0.19031349306" should be "0.190316 + 49306". 3) Cost-to-charge ratios do not tie to 10/31/98 cost report. E) Nursery per diem for Muhlenberg hospital missing. Nursery costs entered in column C6 but formula to calculate per diem replaced with 0. Per diem should be 125.59.
10/1/02 - 12/31/02	A) Number of Adults/Peds Medicaid days for Rockcastle hospital - 527 not 510. C) Routine Adult/Peds costs for Rockcastle do not tie to Wksht C, Part I Line 25. Should be $1,663,311. D) Input for calculation supporting Inpatient ancillaries for Rockcastle hospital does tie to 10/31/98 cost report or 3Q02 calculation. F) Caldwell Routine Adult/Peds cost does not reconcile to Wksht C, Part I. Should be $1,897,647. G) Fleming Routine Adult/Peds cost does not reconcile to Wksht C, Part I. Should be $2,004,819. H) Taylor Routine Adult/Peds cost does not reconcile to Wksht C, Part I. Should be $6,072,255. I) Fleming ICU cost does not reconcile to Wksht C, Part I. Should be $471,224. J) Taylor ICU cost does not reconcile to Wksht C, Part I. Should

	be $1,324,797. L – M) Cost-to-charge ratios used to calculate inpatient ancillaries does not tie to cost report (Caldwell, Fleming, Rockcastle, Taylor).

ACKNOWLEDGMENTS

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

Pete Barbera, *Audit Manager*
Eric Bowen, *Senior Auditor*
Tim Romero, *Senior Auditor*
Tasha Wolford, *Senior Auditor*
Melanie Wilson, *Auditor*

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