DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

# Memorandum

Date MAY - 4 2001

From Michael F. Mangano
Acting Inspector General

Subject Review of Alabama State Medicaid Agency Enhanced Payments to Public Hospitals for Fiscal Years 1997 to 2000 (A-04-00-02171)

To Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

This is to alert you to the issuance on Friday, May 4, 2001, of our final report entitled, "Review of Alabama State Medicaid Agency Enhanced Payments to Public Hospitals for Fiscal Years 1997 to 2000." A copy is attached.

The Health Care Financing Administration (HCFA) expressed concern regarding Alabama's enhanced payments to hospital providers. To address HCFA's concern, the objective of this review was to determine the reasonableness of Medicaid inpatient hospital enhanced payments totaling approximately $432 million made to State-owned and local government-owned hospitals for the period October 1, 1996 to July 31, 2000. This report includes only information on Medicaid enhanced payment transactions resulting from the upper payment limit calculations. These enhanced payments are separate and in addition to the basic payment rates for Medicaid providers. The basic Medicaid payments were not included as part of our review.

We found that the State of Alabama did not compute its inpatient hospital enhanced payments in accordance with the approved State plan amendment (SPA). In Fiscal Year (FY) 1998, the State made two revisions to its funding pool calculations. First, the State began using Medicare prospective payment system (PPS) principles in computing the Medicare upper payment limit instead of using Medicare cost principles as required by the SPA. Second, the State began including privately-owned facilities in computing the enhanced payments, contrary to the SPA which stated that the payments would be based on public facilities. We were not provided any support indicating that HCFA had approved these revisions, thus we believe the State's actions were not authorized.

As a result of these two revisions, the State made excessive enhanced payments over 4 years totaling $240,424,456, of which the Federal share was $168,297,119. We consider the Federal share to be unallowable, since the payments were not in accordance with the approved SPA. Therefore, we recommended that the State reimburse HCFA $168,297,119,

representing the Federal share of the inpatient hospital enhanced payments which were not in accordance with the SPA.

In addition, the State informed us after the conclusion of our on-site audit work that it made retroactive payments totaling $98,123,442 (Federal share of $68,686,409) relating to our audit period. The State informed us that it made these payments in order to use more up-to-date information for the calculations using Medicare PPS principles. We believe that, since the State still used Medicare PPS principles in its calculation of the retroactive enhanced payments, the additional payments were also not in accordance with the SPA. However, we did not review the calculations in order to confirm that conclusion. We recommended that the State demonstrate that the additional retroactive payments were made in accordance with the SPA, or reimburse HCFA for the Federal share of $68,686,409.

In the State's response to our draft report, the State generally disagreed with our findings. The State believed that it was justified in using Medicare PPS principles in computing the Medicare upper payment limit because the State no longer required hospitals to file a Medicaid cost report. The State also believed that it acted within the scope of the regulations by including payments related to privately-owned facilities.

Finally, the State indicated that the retroactive payments were in accordance with Federal regulations for the same reason that it believed it was proper to use Medicare PPS principles instead of using Medicare cost principles.

Any questions or comments on any aspect of this final report are welcome. Please address them to George M. Reeb, Assistant Inspector General for Health Care Financing Audits at (410) 786-7104 or Chuck Curtis, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750.

Attachment

Department of Health and Human Services

# OFFICE OF INSPECTOR GENERAL

# REVIEW OF ALABAMA STATE MEDICAID AGENCY ENHANCED PAYMENTS TO PUBLIC HOSPITALS FOR FISCAL YEAS 1997 TO 2000


MAY 2001
A-04-00-02171

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region IV
61 Forsyth Street, SW
Room 3T41
Atlanta, GA30303-8909

CIN: A-04-00-02171

Mr. Michael E. Lewis
Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36103-5624

Dear Mr. Lewis:

This report provides you with the results of our review to determine the reasonableness of the State of Alabama's enhanced payments to public hospitals and to determine whether the State followed its approved State plan amendment (SPA). An earlier review of enhanced payments to public hospitals and the use of intergovernmental transfers was issued directly to the Health Care Financing Administration (HCFA).[1]

Our review focused on Medicaid inpatient hospital enhanced payments totaling approximately $432 million made to both State-owned and local government-owned hospitals for the period October 1, 1996 to July 31, 2000.

## EXECUTIVE SUMMARY

We found that the State of Alabama did not compute its inpatient hospital enhanced payments in accordance with the approved SPA. In Fiscal Year (FY) 1998, the State made two revisions to its funding pool calculations. First, the State began using Medicare prospective payment system (PPS) principles in computing the Medicare upper payment limit instead of using Medicare cost principles as required by the SPA. Second, the State began including privately-owned facilities in computing the enhanced payments, contrary to the SPA which stated that the payments would be based on public facilities. We were not provided any support indicating that HCFA had approved these revisions, thus we believe the State's actions were not authorized.

[1]The results of the initial review were included in a draft report issued to HCFA on November 16, 2000 entitled, "Review of Medicaid Enhanced Payments to Public Hospital Providers and the Use of Intergovernmental Transfers by the Alabama State Medicaid Agency (A-04-00-02169)." We transmitted this report to the State for comment in January 2001.

As a result of these two revisions, the State made excessive enhanced payments over 4 years totaling about $240 million, of which the Federal share was about $168 million. We consider the Federal share of $168 million to be unallowable, since the payments were not in accordance with the approved SPA. In addition, after we completed our field audit work, the State informed us that it made retroactive payments totaling approximately $98 million (Federal share $68.7 million) relating to FYs 1997, 1998, and 1999. We did not review the calculations for these retroactive payments and, therefore, cannot express an opinion on them. However, based on explanations given to us by State officials, we believe these payments were also not in accordance with the SPA.

The enhanced payments were made to both State-owned and local government-owned facilities in accordance with the SPA which allowed for payments to be made to all publicly-owned facilities up to the overall Medicare upper payment limit. Under regulations in effect at the time of our review, there was a separate upper payment limit which applied to State-owned facilities, but no such limit existed for local government-owned facilities. In computing the funding pool, the State combined State facilities with local government-owned facilities. However, in so doing, the State did not exceed the upper payment limit for State-owned facilities.

In written comments to our draft report, the State noted that it believed that no reimbursement of Federal funds should be made to HCFA. The State contended that using Medicare PPS principles was the best way to measure what Medicare would have paid for the services to Medicaid beneficiaries and that payments made using this methodology were proper. The State believed that, because it no longer required hospitals to file a Medicaid cost report, using Medicare PPS principles was a reasonable alternative. The State also believed that it acted within the scope of the regulations by including payments related to privately-owned facilities. Finally, the State believed that the retroactive payments it made were proper. The full text of the State's response is attached to this report as an Appendix.

## BACKGROUND

Title XIX of the Social Security 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. Medicaid regulations at 42 CFR 440.2, specify that Federal financial participation (FFP) is available in expenditures under the State plan for the medical care and services defined in the subpart. While a State has considerable flexibility in designing its State plan and operating its Medicaid program, it must comply with broad Federal requirements. The Medicaid programs are administered by the States, but are jointly financed by the Federal and State governments. States incur expenditures for medical assistance payments to medical providers who furnish care and services to Medicaid eligible individuals. The Federal Government pays its share of medical assistance expenditures to a State according to a defined formula which yields the Federal medical assistance percentage.

State Medicaid programs have flexibility in determining payment rates for Medicaid providers within their State. The HCFA allowed State Medicaid agencies to pay different rates to the same class of providers, as long as the payments, in aggregate, did not exceed the upper payment limits (what Medicare would have paid for the services). Under Federal regulations in effect at the time of our review, the general rule regarding upper payment limits stated that aggregate payments to each group of health care facilities, such as nursing facilities or hospitals, may not exceed the amount that can be reasonably estimated would have been paid under Medicare payment principles. This aggregate payment limit applied to all facilities in the State (private, State-operated, and city/county-operated). Also, under upper payment limit regulations, there was a separate aggregate payment limit that applied only to State-operated facilities. Because there was not a separate aggregate limit that applied to local government-operated facilities at the time of our review, these types of facilities were grouped with all other facilities when calculating aggregate upper payment limits. This allowed the State Medicaid agency to make enhanced Medicaid payments to city and county-owned facilities without violating the upper payment limit regulations. These enhanced payments are separate and in addition to the basic Medicaid payments made to facilities that provide services to Medicaid eligible individuals. The FFP was not available for State expenditures that exceeded the applicable upper payment limits.

## OBJECTIVE, SCOPE, AND METHODOLOGY

During discussions with HCFA officials regarding upper payment limits in Alabama, the officials expressed concern as to the reasonableness of Alabama's enhanced payments to hospital providers. To address HCFA's concern, the objective of our review was to determine the reasonableness of the inpatient hospital enhanced payments made by the State of Alabama to publicly-owned hospitals and whether the State followed its approved SPA. Our audit covered enhanced payments made from October 1, 1996 to July 31, 2000.

To accomplish our objectives, we met with HCFA regional office staff and discussed their role and reviewed their records pertaining to Alabama's Medicaid program. We conducted a review at the State Medicaid agency, interviewed key personnel, and reviewed applicable records supporting the funding pool calculations.

Our review was conducted in accordance with government auditing standards. The review was conducted from June through October 2000. We performed field work at the State agency in Montgomery, Alabama.

# RESULTS

## ENHANCED PAYMENTS NOT IN COMPLIANCE WITH STATE PLAN AMENDMENT

We found that the enhanced payments made by the State were not in accordance with the requirements of the SPA. The State computed the Medicare upper payment limit for publicly-owned facilities using Medicare PPS principles instead of Medicare cost principles as required by the SPA. This resulted in $127 million (Federal share about $89 million) in questionable payments. In addition, the State computed enhanced payments relating to privately-owned facilities, whereas the SPA called for the payments to be based on the Medicare upper payment limit for publicly-owned facilities. This resulted in $113 million (Federal share about $79 million) in questionable payments.

The State agency received an approved SPA from HCFA, effective July 1, 1994, allowing for the creation of a funding pool to increase reimbursement to publicly-owned hospitals. The funding pool was to be calculated by computing the difference between the Medicare upper payment limit (based on Medicare cost principles) and the allowable Medicaid payments for each publicly-owned facility in the State. The combined total of the differences for all facilities in the State was to be expressed as a percentage of total Medicaid payments for the same facilities to compute an add-on percentage. This percentage was to be applied to each facility's Medicaid per diem payment rate (i.e., each facility received the same add-on percentage) in order to compute each facility's per diem enhancement. This per diem enhancement was to be applied each month to the facility's Medicaid days to compute a monthly enhanced payment.

As the following sections show, the State did not follow its own SPA.

### Medicare PPS Principles Used Instead of Cost Principles

In FY 1998, 3 years after the SPA was approved, the State altered its funding methodology. The State began using Medicare PPS principles instead of Medicare cost principles to compute its funding pool. In doing so, the State was no longer in compliance with the approved SPA. This unauthorized change generated an additional $127,323,451 in enhanced payments, of which the Federal share was $89,126,415.

Through FY 1997, the State properly used Medicare cost principles to compute the Medicare upper payment limit and its funding pool. In FY 1998, contrary to the SPA, the State began using Medicare PPS principles, which did not reflect actual costs. Under this revised methodology, in computing the Medicare upper payment limit, the State included all Medicare payments; e.g., diagnostic related group payments, outliers, capital costs, disproportionate share adjustments, direct medical education, indirect medical education, and organ acquisition costs. Using the Medicare PPS principles rather than Medicare cost principles resulted in significantly higher enhanced payments.

For FY 1997, the State recalculated the funding pool and made a retroactive adjustment to revise the payments based on the Medicare PPS methodology. By going back a year, for FY 1997, the State generated additional enhanced payments of $31,605,842. The following schedule reflects the excess enhanced payments the State generated over 4 years by altering the approved funding methodology (note: this schedule reflects only the public facilities-related enhanced payments and not the payments related to private facilities):

**Enhanced Payments to Public Facilities Under PPS Versus Cost**

| Fiscal Year | Enhancements Using Medicare PPS Principles | Enhancements Using Medicare Cost Principles | Excess Enhancements - PPS Over Cost | Federal Share of Excess Enhancements |
|---|---|---|---|---|
| 1997 | $78,685,007 | $47,079,165 | $31,605,842 | $22,124,088 |
| 1998 | $84,748,311 | $51,127,726 | $33,620,585 | $23,534,410 |
| 1999 | $77,382,696 | $45,645,537 | $31,737,159 | $22,216,011 |
| 2000 | $77,826,572 | $47,466,707 | $30,359,865 | $21,251,906 |
| Total | $318,642,586 | $191,319,135 | $127,323,451 | $89,126,415 |

Over 4 years, the State made excess enhanced payments of $127,323,451. By doing so, the State obtained additional Federal funds of $89,126,415 (Federal share is 70 percent). We consider the Federal share to be unallowable since the payments were not made in accordance with the SPA.

**Payments Related to Privately-Owned Facilities**

In FY 1998, the State made a second deviation from its approved SPA which also significantly increased its Federal funding. The State calculated an annual Medicare upper payment limit related to privately-owned facilities, resulting in a $40 million funding pool. Based on this unauthorized methodology, the State began distributing an additional $40 million per year in enhanced payments to local government-owned facilities.

In FY 1998, the State made five lump sum payments to distribute the $40 million, and in subsequent years made equal monthly payments. Through July 31, 2000, under this methodology, the State made enhanced payments of $113,101,005, of which the Federal share was $79,170,704.

The SPA stated that the enhanced payment pool would be calculated using Medicare cost principles and using data for publicly-owned hospitals. Thus, the total paid relating to privately-owned facilities was in violation of the SPA. Therefore, we consider the Federal share of these payments ($79 million) to be unallowable.

**Additional Retroactive Payments Made**

In addition to the payments previously noted, State officials informed us at the audit exit conference that they made three retroactive payments of $32,707,814 each, for a total of $98,123,442, relating to FYs 1997, 1998, and 1999. These payments were made in July, August, and September of FY 2000. The Federal share of these payments was $68,686,409.

We did not review the State's calculations of these retroactive payments. However, State officials informed us that the calculations were done in order to use more up-to-date PPS information which the State extracts from cost reports. This PPS information includes diagnostic related group payments, outliers, capital costs, disproportionate share adjustments, direct medical education, indirect medical education, and organ acquisition costs.

We believe that, since the State still used Medicare PPS principles in its calculation of the retroactive enhanced payments, the additional payments were not in accordance with the SPA. However, we did not review the calculations in order to confirm that conclusion.

## CONCLUSION AND RECOMMENDATIONS

To be in accordance with the SPA, the State's inpatient enhanced payments should have been computed using Medicare cost principles and should have been based only on publicly-owned facilities. The State agency made revisions to its funding pool calculations for what appeared to be an attempt to maximize Federal reimbursement. We were not provided any support indicating that the revisions were approved by HCFA. We consider the payments made using Medicare PPS principles (in excess of payments computed using Medicare cost principles) and payments made relating to privately-owned facilities to be unauthorized, and unallowable for Federal reimbursement.

The State made $240,424,456 in inpatient hospital enhanced payments which were not in accordance with the SPA. We consider the Federal share of these payments, totaling $168,297,119, to be unallowable. Therefore, we recommended that the State reimburse HCFA $168,297,119, representing the Federal share of the inpatient hospital enhanced payments which were not in accordance with the SPA.

We also recommended that the State demonstrate that the additional retroactive enhanced payments (Federal share $68,686,409) were made in accordance with the SPA, or reimburse HCFA for the unallowable payments.

**State Agency's Response**

The State agency disagreed with our findings.

Regarding the first finding, "Medicare PPS Principles Used Instead of Cost Principles", the State believed that it acted properly in using Medicare PPS principles instead of cost principles. The State explained that using Medicare PPS principles was the best way of determining what Medicare would have paid for the services to Medicaid beneficiaries. The State stated that initially, when the SPA was approved, the State required hospitals to file a Medicaid cost report, and the State used the costs from Medicaid cost reports to calculate the Medicare upper payment limit. However, when the State began paying for Medicaid services on a per member, per month basis, it no longer required hospitals to file a Medicaid cost report. According to the State's response, at that point the State *"...had to use the Medicare cost report and PPS principles...."* to determine the Medicare upper payment limit.

Regarding the second finding, "Payments Related to Privately-Owned Facilities", the State believed that it acted within the scope of the upper payment limit regulations by including payments for privately-owned facilities. When the SPA was approved, the State believed that it was operating in accordance with the Boren Amendment by not including upper payment limit costs of privately-owned hospitals in payments made only to publicly-owned hospitals. (Section 962 of the Omnibus Reconciliation Act of 1980 and section 2173 of the Omnibus Budget Reconciliation Act of 1981, collectively known as the "Boren Amendment", gave States flexibility to deviate from Medicare's reasonable cost payment principles in setting payment rates for hospital and long-term care services, but required States to set rates that would meet the costs incurred by efficiently and economically operated facilities.) However, when the Boren Amendment was repealed with the passage of the Balanced Budget Act of 1997, the State believed it was no longer required to exclude the privately-owned hospitals from the calculation of the Medicare upper payment limit.

Regarding the third finding, "Additional Retroactive Payments Made", the State stated that the additional retroactive payments made subsequent to the audit period were in accordance with Federal regulations for the same reason that it was proper to use Medicare PPS principles instead of using cost principles.

**Office of Inspector General's Comments**

We disagree with the State's assertion that it was obligated to use Medicare PPS principles once it no longer required hospitals to file a Medicaid cost report. The SPA stated that the calculation was to be done based on Medicare cost per day (MCPD). The SPA stated *"MCPD will then be multiplied by paid Medicaid days to determine what Medicaid would have paid using Medicare principles."* The MCPD was attainable from the Medicare cost report which hospitals still prepare, and the State could easily have obtained this information from the hospitals.

Throughout the SPA's explanation of the calculation of the Medicare upper payment limit, the language used referred to using cost as a basis for the computation.

We view the State's use of Medicare PPS principles as a way of maximizing Federal reimbursement outside of the approved methodology of the SPA. We continue to believe that the State should reimburse HCFA for the Federal share of the excessive enhanced payments ($89,126,415) made as a result of its using Medicare PPS principles instead of cost principles.

We do not disagree with the State's assertion that it acted within the scope of the regulations by including payments relating to privately-owned facilities. However, the State was in violation of its own approved SPA which stipulated that the upper payment limit would be calculated based on publicly-owned facilities. The State did not address this in its response and we continue to believe that the State should reimburse HCFA for the Federal share ($79,170,704) of the payments relating to privately-owned facilities.

In addition, we continue to believe that unless the State can demonstrate that the additional retroactive enhanced payments made after the audit period were in compliance with the SPA, it should reimburse HCFA $68,686,409, which represents the Federal share of those payments. The State's response did nothing to alleviate that concern.

In summary, we do not believe the State should be allowed to circumvent HCFA's approval process for allowing enhanced payments. Under section 1901 of the Social Security Act, Medicaid appropriated dollars may only be used for making payments under approved State plans. The State did not dispute that the methodologies discussed in this report, and on which it relied, were not approved by HCFA.

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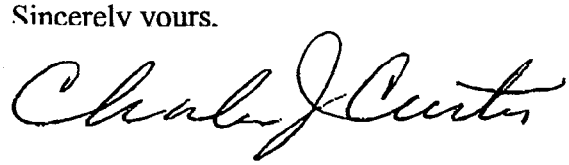
Final determination as to actions taken on all matters reported will be made by the Department of Health and Human Services (HHS) action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments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

To facilitate identification, please refer to Common Identification Number A-04-00-02171 in any correspondence related to this report.

Sincerely yours,



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

**Direct Reply to HHS Action Official:**

Mr. Eugene A. Grasser
Associate Regional Administrator
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# Alabama Medicaid Agency

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DON SIEGELMAN
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Commissioner


February 12, 2001

Mr. Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV
Department of Health and Human Services
Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

Dear Mr. Curtis:

This letter is in response to your office's report entitled *Review of Alabama State Medicaid Agency Enhanced Payments to Public Hospital for Fiscal Years 1997 to 2000* (CIN) A-04-00-02171. We disagree with the findings detailed in the Results section (pages 3-5) of this report.

In response to the first finding, "Medicare PPS Principles Used Instead of Cost Principles", we believe we used the best method available to calculate "what Medicare would have paid for these services" that you refer to in the Background section of this report. At the time our state plan amendment (SPA) was approved, the Agency required all participating hospitals to file a Medicaid specific cost report. Even though the SPA did not specify the Medicaid cost report would be used for the calculation, that is the one the Agency used in lieu of the Medicare cost report. Perhaps that was erroneous. The need for the Medicaid cost report was eliminated with the approval of the Partnership Hospital Program Waiver. This waiver allowed the Agency to pay for inpatient hospital services on a per member, per month basis. Because there was no longer a Medicaid cost report, we had to use the Medicare cost report and PPS principles because these principles more accurately reflect "what Medicare would have paid for these services".

In response to the second finding, "Payments Related to Privately Owned Facilities", we believe that the Agency is within the scope of regulations regarding upper payment limits by including privately owned facilities. When the SPA was approved, the Agency was operating in accordance with the Boren amendment by not including upper payment limit costs of privately owned hospitals in payments made only to publicly owned hospitals. The Boren amendment was repealed by the Balanced Budget Act of 1997 and so the Agency believed that we were no longer compelled to exclude the privately owned hospitals from the aggregate pool in the calculation of the upper payment limit.

In response to the third finding, "Additional Retroactive Payments Made", we believe those payments were also made in accordance with federal regulations for the same reasons stated in the previous two paragraphs.

The Alabama Medicaid Agency disputes this report's recommendation that the Agency reimburse HCFA any federal funds.

Sincerely,

Mike Lewis

Mike Lewis
Commissioner