# Memorandum

Date JUL 25 2001

From Michael F. Mangano
Acting Inspector General

Subject Review of Medicaid Claims for Proportionate Share Payments to Public Providers by the State of Nebraska (A-07-00-02083)

To Thomas Scully
Administrator
Centers for Medicare and Medicaid Services

This memorandum is to alert you to the issuance on Friday, July 27, 2001, of our final audit report which recommends that the Nebraska Department of Health and Human Services (NDHHS) refund $44.3 million to the Medicaid program for an overpayment related to proportionate share payments (referred to as intergovernmental transfers (IGT) on the Federal claim). A copy is attached and copies of the report have been distributed to your staff for adjudication of the finding.

Under Medicaid regulations in effect at the time of our review, States were permitted to establish payment methodologies that allowed for enhanced payments to non-State-owned government providers, such as city and county-owned nursing facilities (public providers). These payments were allowable to the extent that the aggregate payments to all nursing facilities did not exceed the amounts that would have been paid under Medicare payment principles. The IGT payments were in addition to the regular Medicaid payments made to nursing facilities.

We found IGT payments for Fiscal Years (FY) 1998 and 1999 were not computed correctly. The approved State plan required IGT payments to be computed based on the difference between allowable *Medicare* payment rates and actual *Medicaid* payment rates to nursing facilities. The allowable Medicare payment rate for each facility included a wage index factor. Because the State did not use the wage index in their calculations of the allowable Medicare payment rates, the IGT claims were overstated by about $72 million (Federal share about $44 million). We recommended that Nebraska refund $44 million in Federal funds on overstated IGTs for FYs 1998 and 1999 and that NDHHS use the wage index factor in the calculation of all future proportionate share funding pools.

In response to our draft report, NDHHS did not disagree with our assertion that the wage index factor should have been used in the computation of the 1998 and 1999 proportionate share payments. The NDHHS also indicated that they had contracted with a consulting firm to identify differences, corrections, or errors in our report. The State's comments, along with the consultant's report, are attached to our report as an Appendix.

If you need additional information about this report, please contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at (410) 786-7104 or James P. Aasmundstad, Regional Inspector General for Audit Services, Region VII, at (816) 426-3591.

To facilitate identification, please refer to Common Identification Number A-07-00-02083 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

# OFFICE OF INSPECTOR GENERAL

# REVIEW OF MEDICAID CLAIMS FOR PROPORTIONATE SHARE PAYMENTS TO PUBLIC PROVIDERS BY THE STATE OF NEBRASKA


JULY 2001
A-07-00-02083

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

JUL 27 2001

CIN A-07-00-02083

Mr. Ron Ross
Director, Nebraska Health and Human Services System
301 Centennial Mall South - 5th Floor
P.O. Box 95026
Lincoln, Nebraska 68509

Dear Mr. Ross:

This report provides the results of our review of Medicaid claims for proportionate share payments to public providers by the State of Nebraska. The purpose of our review was to determine whether Nebraska's claims for Federal financial participation (FFP) in proportionate share payments were in accordance with its approved Medicaid State plan. In Nebraska, these payments were called proportionate share payments in the State plan, and intergovernmental transfers (IGT) on the Federal claim. An IGT represents a transfer of funds from one level of government to another. This is the second of two reports covering IGTs.[1]

Under regulations in effect at the time of our review, States were permitted to establish payment methodologies that allowed for enhanced payments to non-State-owned government providers, such as city and county-owned nursing facilities (public providers). These payments were allowable to the extent that the aggregate payments to all nursing facilities did not exceed the amounts that would have been paid under Medicare payment principles. The IGT payments were in addition to the regular Medicaid payments made to nursing facilities.

We found IGT payments for Fiscal Years (FY) 1998 and 1999 were not computed correctly. The approved State plan required IGT payments to be computed based on the difference between allowable *Medicare* payment rates and actual *Medicaid* payment rates to nursing facilities. The allowable Medicare payment rate for each facility included a wage index factor. Because the State did not use the wage index in their calculations of the allowable Medicare payment rates, the IGT claims were overstated by $72 million (Federal share $44 million). We recommended that Nebraska refund $44 million in Federal funds on overstated IGTs for FYs 1998 and 1999 and that the Nebraska Department of Health and Human Services (NDHHS) use the wage index in the calculation of all future proportionate share funding pools.

[1] Our first report, *Review of Medicaid Enhanced Payments to Public Providers and the Use of Intergovernmental Transfers by the State of Nebraska* (A-07-00-02076), analyzed Nebraska's use of IGTs to finance enhanced payments to public providers and evaluated the financial impact of these transfers on the Medicaid program. The final report was issued to the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) on February 22, 2001.

In response to our draft report, the NDHHS did not disagree with our finding that the wage index factor should have been used in the computation of the 1998 and 1999 proportionate share payments. The NDHHS also stated that they had contracted with a consulting firm to identify differences, corrections, or errors in our report. The consultant's report showed that a settlement of at least $39.7 million was due NDHHS rather than the $44 million refund recommended in our report. The consultant's report stated that the difference was due to adjustments that the State could have included in their original funding pool computation, but did not.

## 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 in accordance with an approved State plan. In Nebraska, NDHHS administers the Medicaid program.

The Federal Government and the States share in the cost of the program. States incur expenditures for medical assistance payments to medical providers who furnish care and services to Medicaid beneficiaries. The Federal Government pays its share of medical assistance expenditures to a State according to a defined formula. The Federal share of medical cost, referred to as FFP, is about 62 percent in Nebraska. States report Medicaid expenditures and claim FFP on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form HCFA-64).

State Medicaid programs have flexibility in determining payment rates for their Medicaid providers. Regulations in effect at the time of our review allowed States to pay different rates to the same class of providers, as long as the payments, in aggregate, did not exceed the upper payment limit--defined as a reasonable estimate of what Medicare would have paid for the services. This allowed States to make enhanced Medicaid payments to public providers without violating the upper payment limit regulations. These enhanced payments are in addition to the basic Medicaid payments made to facilities that provide services to Medicaid eligible individuals. States are not required to justify to the Centers for Medicare and Medicaid Services (CMS)[2] the details of why these enhanced payments are needed.

The NDHHS began a limited IGT program in the early 1990s. Effective September 1, 1992, Nebraska made IGT payments to public providers who met specific eligibility requirements. These payments were always made after the cost report was finalized. On March 9, 1998, CMS approved State Plan Amendment (SPA) 97-10, which greatly expanded the IGT program. Nebraska established a proportionate share funding pool for enhanced payments to public nursing facilities. This funding pool was equal to the total estimated amount that would have been paid under Medicare payment rates for all nursing facilities (public and private) less the total estimated Medicaid payments to nursing facilities. The difference (both Federal and State share) was then transferred (paid) to public nursing facilities. The facilities were required to

[2] Formerly known as the Health Care Financing Administration.

transfer those funds back to the State on the same day, except for a provider participation fee. The State share was restored to the State General Fund. The net gain to the State was the Federal share, less a provider participation fee. Through the enhanced payment process, the State obtained Federal funding without a net increase in State expenditures. For FYs 1998 through 2000, Nebraska made enhanced payments totaling $227 million. The Federal share of those payments was about $139 million.

On December 29, 1999, Nebraska amended its State plan to revise the methodology used to calculate the enhanced payment funding pool. This amendment, SPA 99-08, revised the calculation of the IGT pool, effective October 1, 1999. The change was necessary due to Medicare=s implementation of a case-mix payment methodology for skilled nursing facility (SNF) services.

**SCOPE OF REVIEW**

Our audit was conducted in accordance with government auditing standards. The objective of our review was to determine whether Nebraska=s claims for Federal participation in IGTs were in accordance with its approved State plan. Specifically, this required us to determine whether (i) the allowable Medicare payments shown in the pool calculations were in accordance with Federal criteria referenced in the State plan; and (ii) the actual Medicaid payments in the pool calculation were supported by adequate documentation.

We evaluated enhanced payments totaling $226,919,676, (FFP $138,805,345) which were made to providers for State FYs 1998 through 2000 as a result of the March 1998 and December 1999 amendments to the State plan. These enhanced payments were in addition to the basic payment rates for Medicaid providers. The basic Medicaid payments were not included as a part of our review.

We reviewed the Medicare SNF payment regulations and implementing Federal Register announcements related to calculations of Medicare rates for SNFs. We relied on calculations by Mutual of Omaha, the fiscal intermediary for Nebraska, for the FY 1998 and 1999 Medicare SNF routine cost limits (RCL) and prospective payment system (PPS) rates applicable to Nebraska nursing facilities.

We obtained the computations of the estimated funding pools and evaluated them with respect to the provisions included in the approved State plan and related Federal regulations. During the period of our field work, NDHHS revised the FY 1998 and 1999 pools to reflect actual Medicaid payments and dates of service. We traced the revised data to summary documentation maintained by the State and used the revised data to determine the allowable IGT pools. However, we did not evaluate the accuracy of the potential refund amount, because NDHHS had not revised their Medicaid claim as of the closing date of our field work.

The enhanced payments made in FY 2000 were based on estimates. While we were able to trace the amounts transferred back to NDHHS records, we were not able to evaluate the assumptions underlying the estimates. The pool calculation was dependant, in part, on comparing Medicare levels of care to Medicaid levels of care, and involved making clinical judgements.

We discussed our proposed findings with NDHHS officials and CMS regional officials. Our field work was conducted during May through June 2000 at NDHHS offices in Lincoln, Nebraska.

## RESULTS OF REVIEW AND RECOMMENDATIONS

Under the State plan, IGT payments were to be computed based on the difference between the *Medicare* RCL or PPS rates, and actual *Medicaid* payments to nursing facilities. This computation required use of a wage index component for the Medicare payment rate calculation. For 1998 and 1999, the wage index was not used in the calculation of Medicare payment rates. Consequently, IGT payments were overstated by $72 million (Federal share $44 million). We recommend NDHHS refund $44 million in Federal funds for 1998 and 1999.

### FY 1998 AND 1999 IGT POOLS

The purpose of the IGT pool was to increase reimbursement to public providers. For each nursing facility provider in the State, NDHHS computed the difference between the NDHHS estimated Medicare SNF rate and the Medicaid rate. The SPA 97-10 provided the specific methodology for the calculation of the IGT pools. It stated:

> *"*Section 1888(a) of the Social Security Act requires that the [SIC] Secretary of the Health Care Financing Administration (HCFA) update the per diem cost limits for Skilled Nursing Facility (SNF) routine service costs for cost reporting periods beginning on or after October 1, 1995 and every two years thereafter. Rates are published in the CFR. The Fiscal Intermediary for the Medicare Program (Mutual of Omaha Companies for the State of Nebraska) also publishes the SNF revised cost limits and prospective payment rates for the State. There are four rates - by provider type (freestanding and hospital based) and location (in a Metropolitan Statistical Area or not). By each individual Nebraska facility, their applicable rate is compared to the average Medicaid per diem allowable under Section 12-011 Rates for Nursing Facilities during a Report Period. The difference between the upper payment limit and the average per diem is multiplied by the number of Medicaid days in that facility for the Report Period, and that product is summed for all Nebraska facilities. This total is the maximum pool which can be paid for each Report Period."

The Code of Federal Regulations requires RCL and PPS rates to be modified by the wage index in the calculation of Medicare SNF rates. For Nebraska, the wage index was less than the national average, which had the effect of lowering the labor component of the SNF rate.

We found that Nebraska used Medicare RCL rates which did not include the wage index modifier. For each facility, the Medicare rate was compared to the Medicaid payment rate and the difference was multiplied by the estimate of the facility=s inpatient Medicaid days to determine the dollars included in the pool. The total estimated pool was then distributed to only the public providers, based on their proportionate share of Medicaid patient days.

When the 1998 SPA was filed, NDHHS provided CMS with supporting worksheets for its calculation of the estimated payments. Nebraska determined the funding pool for a full year was $90.6 million. Because the amendment was effective January 1, 1998, midway through the State FY, the initial funding pool was prorated. The distribution of $45.3 million was made in April 1998 for one half of the year. The NDHHS estimated its FY 1999 funding pool on the same calculation, and made a full year distribution of $90.6 million in October 1998.

The SPA required an after the fact reconciliation of the funding pool using actual Medicaid payments based on finalized cost reports and claims payment activity. The State performed this reconciliation for 1998 and 1999, but had not submitted a revised claim with CMS. We determined that NDHHS did not adjust for the wage index applicable to Nebraska facilities when making the reconciliation.

Because most SNFs can elect to be paid the higher of the RCL or PPS rate, we recalculated the IGT pools using the higher of the RCL or PPS rate for each facility, adjusted for wage index. We also applied the actual Medicaid payments and days provided us by NDHHS. The IGT pools were overstated by $72,197,824 (FFP $44,303,191) as follows:

| | FY 1998 | FY 1999 |
|---|---|---|
| Medicare upper cost limit [1/2 for FY 1998] | $153,661,149 | $318,863,234 |
| Less: Total Medicaid payment [1/2 for FY 1998] | 132,372,221 | 276,492,137 |
| Allowable IGT pool | $ 21,288,928 | $ 42,371,097 |
| | | |
| IGT pool estimated, distributed, and claimed for FFP by NDHHS | $ 45,285,950 | $ 90,571,899 |
| Less: Allowable IGT pool | 21,288,928 | 42,371,097 |
| Unallowable costs included in estimated IGT pool | $ 23,997,022 | $ 48,200,802 |
| FFP Rate | 61.17% | 61.46% |
| Unallowable FFP | $ 14,678,978 | $29,624,213 |
| Two Year Total | | $44,303,191 |

**Recommendations**

We recommend that: i) Nebraska refund $44,303,191 in FFP for over claimed IGT payments for FYs 1998 and 1999; and ii) NDHHS use the wage index factor in the calculation of all future proportionate share funding pools.

**NDHHS' Comments**

The NDHHS stated that they did not agree that we had used the higher of the RCL or PPS rate for each facility, as stated in our report. They believed, based on their review, that we had used the lower of the two rates where applicable. The NDHHS also stated they had contracted with a consulting firm to identify differences, corrections, or errors in our report. The consultant=s report is attached to NDHHS= comments.

The consultant=s report showed that a settlement of at least $39.7 million was due NDHHS rather than the $44.3 million refund recommended in our draft audit report. Their report stated the re-calculation differed from the one we used because they 1) added a capital related component for hospital-based facilities, 2) inflated the Medicare upper limit to include a factor for overhead allocated to ancillary departments such as physical therapy, occupational therapy, etc., and 3) substituted the exception to the Medicare routine cost limitation for the actual limitation for several facilities. The NDHHS believed the three items listed above could be included in their funding pool calculation, even though the items were not mentioned in their approved SPA.

We subsequently asked NDHHS for certain clarifications related to the consultant's report. Specifically, we asked for 1) the rationale for adding a capital component to the routine cost limit, 2) why the consultant did not accept the (upper limit) rates calculated by the intermediary, and 3) why the comparison of the higher of the Medicare RCL, or PPS rate, to the Medicaid paid rate was not equitable and what provision of the applicable SPA permitted a deviation from this comparison.

The NDHHS responded that, as to the capital component, they had confirmation from both Medicare intermediaries located in Nebraska that a capital related component must be added to all routine operating cost limits. As to the second point, NDHHS maintained that the consultant did accept the rates calculated by the intermediary. Finally, NDHHS stated that the consultant added an ancillary services overhead factor to the upper limit as a matter of equity because the wording in the SPA for determining the upper limit was Athe amount that can reasonably be estimated would have been paid for those services under Medicare payment principles.@

The Appendix to this report contains a copy of the NDHHS= original response, the text of the consultant=s report, and a copy of NDHHS= response to our request for clarification.

**OIG's Response**

The NDHHS did not disagree with our assertion that the wage index factor should have been used in the computation of the 1998 and 1999 proportionate share payments, and they did use the factor in the re-computations supporting their response. The NDHHS stated the difference between the calculation included in the our draft report and the calculation included in their comments is due to additional adjustments they made to the IGT pools for 1) a capital related component, 2) overhead costs allocated to Medicare ancillary services departments, and 3) use of the exception to the Medicare RCL for certain qualifying providers. The NDHHS is not due the

relief sought in their response on any of these three issues. The State Agency has an obligation to compute the proportionate share payments in accordance with the approved Medicaid State plan, and these proposed changes in the method of computation are not part of the SPA that was approved by CMS.

The capital cost component is an integral part of the PPS rate, but not the RCL. In our computation of the allowable pool, we used the higher of the RCL or the PPS rate. The NDHHS took exception to those instances when the RCL was higher than the PPS rate, and we did not add a capital component to the RCL. The actual payment rate to a facility reimbursed by the RCL does include the RCL, plus capital costs. However, by definition, the RCL is a *routine cost limit*, and does not include capital costs. Further, the State Plan required the use of either the RCL or PPS rate to calculate the pools, not actual rates paid to facilities. Our calculations provided the maximum pool available to the State under the requirements of the approved State plan. If we had applied the same methodology to the calculation of the IGT pools as was originally used by NDHHS, modified to include the wage index, the recommended refund by NDHHS to the Federal Government would have been substantially higher.

We do not believe that the RCL should be adjusted for overhead allocated to Medicare ancillary services departments. The Medicaid rate is an all inclusive rate, and the Medicare daily rate does not necessarily include the ancillary services. However, the comparison of un-matched rates is still required, by the Medicaid State plan, in that manner. If the comparison was to be made to a Medicare rate modified as per the NDHHS response, the difference is so significant that it would have to be so specified in the State plan. It was not so specified in the State plan, and it should not be a matter of interpretation.

In like manner, we do not believe the NDHHS can substitute the exception to the RCL, for the RCL, when the intermediary permits the provider to use the exception. Facilities that have a higher acuity and, therefore, a higher cost of providing care to their residents may file for an exception to the RCL if certain criteria are met. If the State plan intent was to allow the exception to the RCL, rather than the RCL itself, it would need to specify that the exception is permissible. It does not so specify.

As to NDHHS= comment that we had not used the higher of the RCL or the PPS rate for each facility, we re-checked our methodology and can provide assurance that we did use the higher rate.

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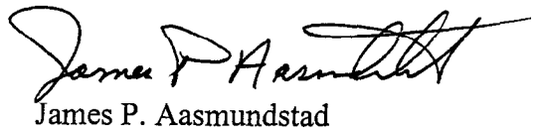
Final determination as to actions to be taken on all matters reported will be made by the Department of Health & Human Services (HHS) action official identified below. We request that you respond to the HHS action official within 30 days from the date of this report. Your response should present any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

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to the exemptions in the Act which the Department chooses to exercise (see 45 CFR part 5).

To facilitate identification, please refer to Common Identification Number A-07-00-02083 in all correspondence relating to this report.

Sincerely,



James P. Aasmundstad
Regional Inspector General
for Audit Services

**Direct Reply to HHS Action Official**:

Mr. Joe L. Tilghman
Regional Administrator, Region VII
Centers for Medicare and Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

DEPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE
DEPARTMENT OF FINANCE AND SUPPORT

STATE OF NEBRASKA
MIKE JOHANNS, GOVERNOR

December 12, 2000

Barbara A. Bennett
Regional Inspector General for Audit Services
Department of Health and Human Services
Region VII
601 East 12th Street, Room 284A
Kansas City, MO 64106

RE: CIN A-07-00-02083

Dear Ms. Bennett:

The Department has received and reviewed your October 23, 2000 correspondence. This correspondence related to a review of Medicaid claims for proportionate share payments to public nursing facility providers by the State of Nebraska.

On Page 5 of your correspondence, you identified that the Nebraska Department of Health and Human Services (NDHHS) is required to refund $44,303,191 in Federal financial participation. A table has been placed on this page identifying the computation of the aforementioned amount. I have not received, nor have I reviewed, the detail that supports the information included in this table. However, I do believe the Department has been able to materially recreate the first line item in this table titled "Medicare Upper Cost Limit". This is the amount computed by your staff to determine the Medicare upper cost limit for the applicable year for the State of Nebraska Medicaid Program.

The third paragraph on Page 5 indicates that you have recalculated the Intergovemmental Transfer (IGT) pools using the higher of the Routine Cost Limit (RCL) or Prospective Payment System (PPS) rate for each facility, adjusting for the wage index. I do not believe that is what you have done to compute the upper cost limit; rather, based on the information provided to my Department, I believe that your staff has used the lower of the two rates where applicable. You may want to provide clarity to this paragraph in your report.

In anticipation of this piece of correspondence, the Department contracted with Mr. Roger E. Thompson, CPA, FHFMA, of Seim, Johnson, Sestak & Quist, LLP and Mr. Robert J. Dick, Jr., CPA, CVA, of Koski Professional Group, P.C. to identify any potential differences, corrections or errors in the OIG computed estimation of Medicare upper payment limits. To that end, they have created a project report that has been included with this correspondence. I ask that you carefully review this report in conjunction with your draft correspondence. After you have had ample time to review this documentation, I recommend a joint meeting between you and your staff, HCFA representatives, and Department staff and its contracted CPA agents, for discussion and resolution. If you concur with this approach, please contact my office at (402) 471-8553, so arrangements may be made.

I look forward to successfully resolving this issue in the near future.

Sincerely,

Stephen B. Curtiss, Director
Department of Health and Human Services Finance and Support

J0342J

Enclosures

cc: Bob Seiffert, Medicaid Administrator
Terry Eddleman, Audit Manager, OIG
Jim Flack, OIG
Tom Lenz, HCFA

# PROJECT REPORT

October 11, 2000

Mr. Bob Sieffert
Nebraska Department of Health & Human Services
Finance and Support / Medicaid Division
PO Box 95026
Lincoln NE 68509-5026

Dear Mr. Sieffert:

At your request, we have completed the following project objectives to determine the appropriateness of computations done by the Office Of Inspector General (OIG) relative to the Nebraska Department of Health and Human Services (NDHHS) upper payment limits described in Section 12-011.07J of the Nebraska HHS Finance and Support Manual. The project objectives were as follows:

## *Project Objectives*

1. Compare computations compiled by the OIG to information found in the Federal Register.
2. Test the accuracy of the compiled computations being placed on the worksheet titled "OIG Computation of Routine Upper Limit Period Ended 6/30/99 and Period Ended 6/30/98."
3. Review consistency between upper payment limits and the computation of rates used by NDHHS in individuals facilities' rate notifications. Compute differences on a test basis, if any.
4. Update the template created by NDHHS staff to illustrate corrected information.
5. Prepare a report identifying any findings or recommendations.

It is our understanding that the project objectives were created to identify any potential differences, corrections or errors in the OIG computed estimation of Medicare upper payment limits. Our Firms, Seim, Johnson, Sestak & Quist, LLP, and Koski Professional Group, PC were selected by you due to our respective Firms' expertise in the healthcare (particularly long-term care) reimbursement issues. The individual resumes of the individual's performing the project objectives are attached to this correspondence.

## *Work Performed*

The following describes the work we performed:

1. Met with representatives of NDHHS on August 27, 2000 at Koski Professional Group, PC offices to discuss project and receive the following information:
   a. A nine-page worksheet titled "Departments Computation of the Maximum FYE 6/30/99." The worksheet contained State of Nebraska nursing facility providers, the city in which they were located and NDHHS' computation of the Medicare upper cost limit (upper payment limit).

b. A nine-page worksheet titled "Departments Computation of the Maximum FPE 6/30/98." The worksheet contained State of Nebraska nursing facility providers, the city in which they were located and NDHHS' computation of the Medicare upper cost limit (upper payment limit).

c. A nine-page worksheet titled "OIG Computation of Routine Upper Limit Year End 6/30/99." The worksheet contained State of Nebraska nursing facility providers, the city in which they were located and the OIG's computation of the Medicare upper cost limit (upper payment limit).

d. A seven-page worksheet titled "OIG Computation of Routine Upper Limit Period Ended 6/30/98." The worksheet contained State of Nebraska nursing facility providers, the city in which they were located and the OIG's computation of the Medicare upper cost limit (upper payment limit).

e. A 34-page fax received by Mr. Dale Shallenberger of NDHHS from Mr. Jim Flack of the OIG, Office of Audit Services. This fax contained computations of cost limits and PPS rates for years ended 6/30/99 and 6/30/98 for nursing facilities located in the State of Nebraska. Information contained in this fax was utilized to complete Medicare upper cost limit information placed on items c. and d. above.

f. NDHHS exhibits A and B and attachment A. Information contained on these documents were utilized to compute NDHHS' Medicare upper cost limit included on items a. and b. above.

At this meeting, discussion took place relative to differences in the development of the upper payment limits and the computation of Medicaid rates by NDHHS for individual nursing facilities.

2. Subsequent to the aforementioned meeting, via email, we received from Mr. Dale Shallenberger of NDHHS a spreadsheet for the years ended 6/30/99 and 6/30/98. Exhibits 1.0 and 2.0 have been compiled from the received spreadsheet. The following columns and descriptions were included on the received spreadsheet:

| Column Number | Description |
|---|---|
| 1 | Identifies the city in which nursing facility is located |
| 2 | Provider name |
| 3 | Medicaid days for the year ended June 30 |
| 4 | Upper payment limit computed by NDHHS |
| 5 | Column 3 x Column 4 |
| 6 | Upper payment limit computed by the OIG |
| 7 | Column 3 x Column 6 |

3. Applicable sections of the September 3, 1996 and the October 1, 1997 Federal Register were obtained to test the OIG computations of the upper payment limits. Several tests were made tying the following data elements to the appropriate Federal Registers.

| | Cost Limit | PPS Rate |
|---|---|---|
| Labor related component | x | x |
| Wage index | x | x |
| Non-labor component | x | x |
| Year-end adjustments factor | x | x |
| Capital related component | x | x |

No exceptions were noted during the tests. However, on several of the computations included in 1(e), we noted that a capital related component was not added to the cost limit for hospital-based facilities. Therefore, the rate used by the OIG for hospital-based facilities had no capital component.

Exhibits 1.0 and 2.0 include column 8 which corrects the OIG upper payment limit for the aforementioned issue.

4. Exhibits 1.1 and 2.1 were created to illustrate corrected Medicare cost limits and PPS rates used to arrive at the upper payment limits in Column 8 on Exhibits 1.0 and 2.0.

5. The following clients of our Firms were selected to compare the consistency of the NDHHS payment rate to the upper payment limit computation:

6.

| Exhibit | Facility Name | Firm |
|---|---|---|
| 1.2 and 2.2 | Florence Home | SJSQ |
| 3 | Centennial Park Retirement Village | SJSQ |
| 4 | Good Shepherd Lutheran Home | SJSQ |
| 5 | Rose Blumkin Jewish Home | SJSQ |
| 6 | The Lutheran Home | SJSQ |
| 7 | Faith Regional Health Services/St. Joseph Nursing Home | SJSQ |
| 8 | Tabitha, Inc. | SJSQ |
| 9 | AJ Merrick Manor | SJSQ |
| 10 | Lindenwood Nursing Home | KPG |
| 11 | The Ambassador - Omaha | KPG |
| 12 | Holmes Lake Manor | KPG |
| 13 | The Ambassador - Lincoln | KPG |
| 14 | The Ambassador - Nebraska City | KPG |
| 15 | Belle Terrace | KPG |
| 16 | Regency Square | KPG |
| 17 | Wakefield Health Care Center | KPG |
| 18 | Hillcrest Care Center | KPG |

Based on our review of the above clients, it was confirmed that there are indeed differences in how certain overhead amounts are allocated on the Medicare cost report vs. the Medicaid cost report. The Medicare cost report requires the allocation of certain overhead items to ancillary departments. These ancillary departments include physical therapy, occupational therapy, speech therapy, supplies, pharmaceuticals, etc. The allocation of overhead to these departments does not always take place on the Medicaid cost report. The cost limit utilized to determine the upper payment limits does not include overhead costs associated with ancillary departments. Medicare paid its fair share of fully allocated ancillary costs on a cost reimbursement basis prior to the implementation of Medicare's new PPS system (RUGs). To get a true comparison between the rates developed by NDHHS and the Medicare upper payment limits, overhead allocated to ancillary departments on the Medicare cost reports must be determined and allocated to Medicare resident days. This computation was completed on the enclosed exhibits 1.2 through 1.18 and 2.2 through 2.18. Please note that several facilities did not have a difference in the way in which their Medicaid rate and the Medicare cost limits are computed.

To the extent that there was an additional cost per day related to ancillary overhead, this amount would be found on Line 9 of the aforementioned exhibits. This amount was placed in Column 10 on Exhibits 1.0 and 2.0. Column 11 of Exhibits 1.0 and 2.0 was computed taking the amount placed in Column 10 times the facility's Medicaid days found in Column 3. For facilities that had a December 31 year end, we utilized their Medicare cost report information for that period for both years ended 6/30/99 and 6/30/98. Effective January 1, 1999, these nursing facilities would have moved to Medicare's new prospective payment system for skilled nursing facilities (RUGs).

In addition to the above, several of the clients that were selected have historically filed for what is called an *Exception to the Medicare Routine Cost Limitation.* Facilities that have a higher acuity and, therefore, a higher cost to providing care to their residents may file for an exception to the routine cost limits if certain criteria is met. Typically exception requests can be filed within 180 days of Medicare issuing a notice of program reimbursement for a specific facility year end. These exceptions are granted by HCFA. If a facility had historically filed and received an exception request, we have included appropriate amounts on Exhibits 1.2 through 1.18 and Exhibits 2.2 through 2.18. This data can be found on Line 10 of the aforementioned exhibits. This amount was then transferred to Column 12 of Exhibits 1.0 and 2.0. Column 13 represents the amount included on Column 12 times a facility's Medicaid days located in Column 3.

In your August 24, 2000 memorandum given to us, you have stated that HCFA applies an upper payment limit whereby "aggregate payments . . . may not exceed the amount that can reasonably be estimated would have been paid for these services under Medicare payment principles." Medicare does indeed pay overhead costs associated with ancillary departments and additional routine amounts if exception requests are approved. The above represents an inconsistency between Medicare payment principles and NDHHS payments to nursing facilities.

7. Columns 5, 7, 9, 11 and 13 of Exhibits 1.0 and 2.0 were totaled. Totals for Exhibits 1.0 and 2.0 can be found on Line 319.

## *Findings*

Based on data provided to us, the difference between NDHHS and the OIG's computations of the upper payment limit is as follows:

| Exhibit | Period | Column | Line | | Amount |
|---|---|---|---|---|---|
| 1.0 | 7-1-98 to 6-30-99 | 7 | 321 | $ | 42,948,026 |
| 2.0 | 1-1-98 to 6-30-98 | 7 | 333 | | 24,729,767 |
| | | | | $ | 67,677,793 |

However, with the changes identified in Columns 8, 10 and 12 of Exhibits 1.0 and 2.0, the estimated difference may be eliminated. The following illustrates amounts related to corrections and comparability discussed above:

| Exhibit | Period | Column | Line | Amount |
|---|---|---|---|---|
| 1.0 | 7-1-98 to 6-30-99 | 9 | 321 | $ (39,274,918) |
| 1.0 | 7-1-98 to 6-30-99 | 11 | 323 | 5,042,155 |
| 1.0 | 7-1-98 to 6-30-99 | 13 | 323 | 14,332,084 |
| 1.0 | 7-1-98 to 6-30-99 | 11 | 331 | 44,659,005 |
| 2.0 | 1-1-98 to 6-30-98 | 9 | 333 | (23,016,917) |
| 2.0 | 1-1-98 to 6-30-98 | 11 | 333 | 30,756,652 |
| 2.0 | 1-1-98 to 6-30-98 | 13 | 333 | 7,204,248 |
| Potential settlement (to) from Federal Government | | | | $ 39,702,309 |

On Exhibits 1.0 and 2.0, Column 11, we have computed the average additional cost per day of ancillary overhead paid by Medicare by rural and urban areas. You may want to consider multiplying appropriate Medicaid days by the cost per day by area to refine the calculation. For example, if Nebraska nursing facility days for the year ended June 30, 1999 were as follows:

| | |
|---|---|
| Rural | $ 2,080,290 |
| Urban | 1,000,000 |
| | $ 3,080,290 |

The addition amount allowed for this issue would be as follows:

| | Rural | Urban | Total |
|---|---|---|---|
| Medicaid days | 2,080,290 | 1,000,000 | 3,080,290 |
| Cost per day | 5.37 | 20.73 | |
| | $ 11,171,157 | 20,730,000 | 31,901,157 |

The above estimation would replace the following two numbers identified above in the potential settlement table:

| |
|---|
| $ 5,042,155 |
| 44,659,005 |
| $ 49,701,160 |

## *Recommendations*

We recommend that the above data and this correspondence be shared with Mr. Jim Flack of the OIG to arrive at a resolution to any settlement between NDHHS and the Federal Government.

PAGES OMITTED

A total of 52 pages of schedules and exhibits attached to the response at this point have been omitted for the sake of brevity. The omission does not, in our opinion, alter or diminish the points made in the NDHHS' response.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
DEPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE
DEPARTMENT OF FINANCE AND SUPPORT

STATE OF NEBRASKA
MIKE JOHANNS, GOVERNOR

February 6, 2001

James P. Aasmundstad
Regional Inspector General For Audit Services
Office of Inspector General
Region VII
601 East 12th Street, Room 284A
Kansas City, MO 64106

Dear Mr. Aamundstad:

The Nebraska Health and Human Services System (HHSS) has received your January 23, 2001 letter requesting additional information on your draft report "Review of Medicaid Claims for Proportionate Share Payments to Public Providers by the State of Nebraska."

First I would like to clarify that Nebraska was not purporting any type of negotiation or settlement in its request for a meeting, it was just for further understanding and explanation. HHSS would still request that meeting.

In your second paragraph you have asked us why our consultants did not accept rates calculated by Mutual of Omaha. With this correspondence we have included the workpaper Mutual of Omaha created to compute the revised cost limit for a hospital-based skilled nursing facility located in Douglas County, Nebraska. Please note that the third sentence from the bottom of the page clearly indicates that the above inpatient routine service cost is exclusive of capital related costs. Also please note that the routine service cost does not apply to ancillary service costs. We have also enclosed a copy of a provider letter from Blue Cross Blue Shield of Nebraska, a Federal Medicare Intermediary that clearly shows the capital related cost portion needs to be added to the computation of a total rate for hospital-based facilities. Finally, we have enclosed a copy of a portion of the October 1, 1997 Federal Register that discusses schedule of limits and prospectively determined payment rates for skilled nursing facility inpatient routine service costs. Information contained in this Federal Register was traced to computations made by Mutual of Omaha. Page 11 of the enclosed portion of the Federal Register under the subcaption entitled *Comparison Provider's Prospective Payment Rate With Providers Cost Limit,* clearly indicates that a capital related component must be added back to the SNF's specific cost limit or its

adjusted routine operating portion of the rate to arrive at a provider's actual prospective determined payment rate.

We believe our consultants indeed accepted rates calculated by Mutual of Omaha. The application of these rates was not consistently followed by the OIG when computing rates for hospital-based facilities. A capital related component must be added back to all routine operating costs limits. This has been confirmed by both Medicare intermediaries located in the State of Nebraska.

Our consultants have further determined that a comparison of the higher of the Medicare routine cost limit, or prospective payment rate, to the paid Medicaid rate was not equitable for all Nebraska facilities. In their Project Report to us dated October 11, 2000 and previously sent to you with our December 12, 2000 correspondence, they determined that the cost limit utilized to determine the upper payment limits did not include overhead costs associated with ancillary departments (physical therapy, occupational therapy, speech therapy, supplies, pharmaceuticals, etc.). In most cases, the State of Nebraska Medicaid rate indeed includes these overhead costs in our paid Medicaid rate. This not only has been confirmed by our consultants but it has also been confirmed by our internal audit staff.

In addition to the above, the consultants point out in their October 11, 2000 report that a number of facilities that have a higher acuity and, therefore a higher cost to providing care to their residents may file for exception to the Medicare routine cost limits if certain criteria is met. Nebraska has a number of facilities that have qualified for this exception. The consultants identified and compiled information relative to facilities for which only they serve. Such additional cost exceeding "the Medicare routine cost limitations should be included in computing the upper payment limits as these costs are included in the State of Nebraska Medicaid rates.

State Plan Amendment MS-97-10 states that a pool is created subject to the availability of funds and subject to the payment limits of 42 CFR 447.272. We have enclosed a copy of that code section. This section states that aggregate payments made by an agency to a group of healthcare facilities may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. The aforementioned inequities identified in our consultants report should be included in the upper payment limit tests since these are payments that would have reasonably been paid by Medicare.

The State Plan Amendment MS-97-10 identifies that there are published SNF revised cost limits and prospective payment rates for the State of Nebraska. The plan indicates that each individual Nebraska facility and their applicable rate is to be compared to their average Medicaid per diem allowed under §12-011 Rates for Nursing Facility Services during our report period. There is no discussion relative to the inequities discussed in our consultants report. Nor does State Plan Amendment MS-97-10 clearly indicate that the SNF revised cost limits and prospective payment rates are to represent the total upper payment limits. In order to fairly compare the State of Nebraska nursing facility Medicaid rates to the Medicare upper payment limits, it has always been

our intent to compile a comparison based on consistent reimbursement principles. By simply stating that we were going to compare our average Medicaid per diem to the upper payment limit was indication that we would try to compute as accurate an upper payment limit as information was available to us.

We do want to point out that our State Plan Amendment MS-97-10 and documentation including information furnished by our staff to the Health Care Financing Administration (HCFA), was approved by HCFA effective January 1, 1998.

Based on the information provided in our consultants report, it appears that the State of Nebraska may be due a potential settlement from the Federal government. It is not our intent to pursue this settlement. We would like to have an opportunity to discuss the calculations with you and/or your staff so that you are fully aware of how the computations were made and the source of that information.

Sincerely,

Stephen B. Curtiss, Director
Department of Health and Human Services Finance and Support

# MUTUAL OF OMAHA MEDICARE
# ROUTINE OPERATING COST LIMIT
# SKILLED NURSING FACILITIES

PROVIDER NAME:
CITY, STATE: Omaha, NE

PROVIDER NO: 28-xxxx
County: Douglas

| | | | |
|---|---|---|---|
| HOSP BASE SNF | X | FREESTANDING SNF | |
| SMSA-URBAN AREA | X | NONSMSA-RURAL AREA | |

COST REPORT PERIOD: **07/01/98 - 06/30/99**

| | |
|---|---|
| 1. LABOR-RELATED COMPONENT | 128.68 |
| 2. A & G HOSPITAL-BASED LABOR "ADD-ON" | |
| 3. ADJUSTED LABOR RELATED COMPONENT | 128.68 |
| 4. WAGE INDEX | 0.9480 |
| 5. ADJUSTED LABOR RELATED COMPONENT | 121.99 |
| 6. NONLABOR COMPONENT | 27.28 |
| 7. A & G NONLABOR "ADD-ON" | |
| 8. OSHA PER DIEM "ADD-ON" | 2.27 |
| 9. ADJUSTED COST LIMIT | 151.54 |
| 10. COST REPORTING YEAR ADJUSTMENT FACTOR | 1.02630 |
| 11. REVISED COST LIMIT | **155.53** |

PER FEDERAL REGISTER OF OCTOBER 7, 1992, FOR FISCAL YEARS BEGINNING ON OR AFTER OCTOBER 1, 1992.

* FOR COST REPORTING PERIODS 10/1/92-9/30/93 OR AFTER 10/1/95, THE PER DIEM ADD-ON IS $1.95.
* FOR COST REPORTING PERIODS UNDER FREEZE (10/1/93-9/30/95), THE PER DIEM ADD-ON IS $1.98.

SUBJECT TO CHANGE IF THE ACTUAL RATE OF INCREASE IN SNF COST EXCEEDS THE MARKET BASKET ESTIMATE BY MORE THAN 3/10 OF ONE PERCENTAGE POINT.

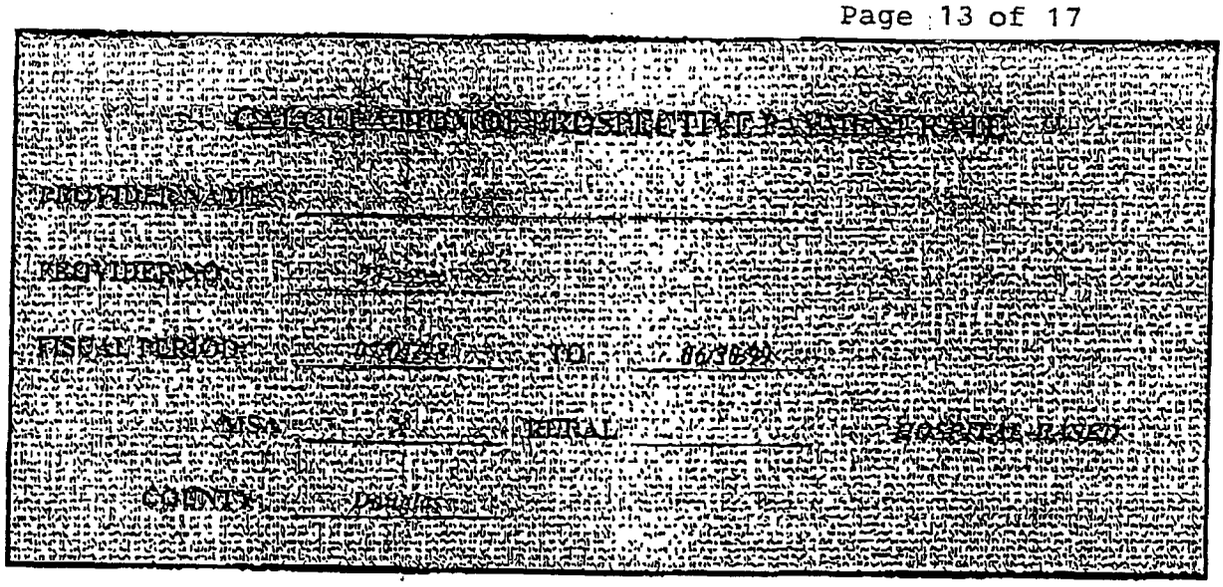
APPLICABLE TO INPATIENT ROUTINE SERVICE COSTS EXCLUSIVE OF CAPITAL RELATED COST. DOES NOT APPLY TO ANCILLARY SERVICE COSTS.

ADD-ONS ELIMINATED PER FEDERAL REGISTER DATED 1/6/94, VOL. 59 NO. 4, EFFECTIVE 10/1/93

TABLE I AND TABLE IV MODIFIED PER HCFA MEMORANDUM DATED 5/3/96.

/pr

07/08/2000



CALCULATION OF PROSPECTIVE PAYMENT RATE

PROVIDER NAME:

PROVIDER NO:

FISCAL PERIOD: TO

MSA: RURAL

COUNTY:

| | | COST LIMIT | PPS RATE |
|---|---|---|---|
| 1. LABOR RELATED COMPONENT | | 128.68 | 105.87 |
| 2. WAGE INDEX | | 0.9480 | 0.9480 |
| 3. ADJUSTED LABOR COMPONENT | | 121.99 | 100.36 |
| 4. NON-LABOR COMPONENT | | 27.28 | 17.59 |
| 5. OBRA/OSHA ADD-ON | | 2.27 | 2.13 |
| 6. ADJUSTED LIMIT/RATE | | 151.54 | 120.08 |
| 7. COST REPORT YEAR END ADJUSTMENT FACTOR | x | 1.02630 | 1.02630 |
| 8. REVISED LIMIT/RATE | | 155.53 | 123.24 |
| 9. CAPITAL RELATED COMPONENT | 10.23 | | 10.23 |
| 10. PROSPECTIVE PAYMENT RATE | | | 133.47 |

BlueCross BlueShield of Nebraska

P.O. Box 24563
Omaha, Nebraska 68124-0563

Telephone 402/390-1850
Fax 402-398-3640



Federal Medicare
Intermediary

October 4, 1996

This letter was sent provider specific to all hospital based and free standing SNF's serviced by this intermediary.

**PROVIDER LETTER NO. C-96-4**

RE: SCHEDULE OF ROUTINE COST LIMITS AND PPS RATES FOR HOSPITAL-BASED AND FREE-STANDING SKILLED NURSING FACILITIES. THESE LIMITS AND RATES WERE PUBLISHED IN A HCFA MEMORANDUM DATED 5-3-96 AND THE 9-3-96 FEDERAL REGISTER.

THE ROUTINE COST LIMITS EFFECTIVE FOR COST REPORTING PERIODS BEGINNING IN FEDERAL FISCAL YEAR 1996 ( 10-1-95 AND AFTER) ARE AS FOLLOWS:

| HOSPITAL-BASED | OMAHA | LINCOLN | RURAL |
|---|---|---|---|
| COST LIMIT | $124.44 | $124.08 | $ 89.43 |
| FREE-STANDING | | | |
| COST LIMIT | $ 89.01 | $ 88.75 | $ 70.88 |

THESE COST LIMITS WILL NEED TO BE UP-DATED BY THE APPLICABLE COST REPORT ADJUSTMENT FACTORS LISTED IN TABLE I.

THE ROUTINE COST LIMITS EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON 10-1-96 ARE AS FOLLOWS:

| HOSPITAL-BASED | OMAHA | LINCOLN | RURAL |
|---|---|---|---|
| COST LIMIT | $140.80 | $140.39 | $101.17 |
| FREE-STANDING | | | |
| COST LIMIT | $100.70 | $100.41 | $ 80.18 |

THESE COST LIMITS WILL NEED TO BE UP-DATED BY THE APPLICABLE COST REPORT ADJUSTMENT FACTORS LISTED IN TABLE II.

COST REPORT ADJUSTMENT FACTORS

TABLE I

| IF A SNF COST REPORTING PERIOD BEGINS: | | ADJUSTMENT FACTOR |
|---|---|---|
| OCTOBER 1, 1995 | | 1.09691 |
| NOVEMBER 1, 1995 | | 1.09957 |
| DECEMBER 1, 1995 | | 1.10215 |
| JANUARY 1, 1996 | | 1.10482 |
| FEBRUARY 1, 1996 | | 1.10778 |
| MARCH 1, 1996 | | 1.11056 |
| APRIL 1, 1996 | | 1.11353 |
| MAY 1, 1996 | | 1.11642 |
| JUNE 1, 1996 | | 1.11941 |
| JULY 1, 1996 | | 1.12231 |
| AUGUST 1, 1996 | | 1.12532 |
| SEPTEMBER 1, 1996 | | 1.12833 |

✓(2)

==========

TABLE II

| IF A SNF COST REPORTING PERIOD BEGINS: | | ADJUSTMENT FACTOR |
|---|---|---|
| NOVEMBER 1, 1996 | | 1.00268 |
| DECEMBER 1, 1996 | | 1.00528 |
| JANUARY 1, 1997 | | 1.00796 |
| FEBRUARY 1, 1997 | | 1.01083 |
| MARCH 1, 1997 | | 1.01343 |
| APRIL 1, 1997 | | 1.01631 |
| MAY 1, 1997 | | 1.01910 |
| JUNE 1, 1997 | | 1.02200 |
| JULY 1, 1997 | | 1.02481 |
| AUGUST 1, 1997 | | 1.02773 |
| SEPTEMBER 1, 1997 | | 1.03066 |

(2)

SNF PPS RATES (RURAL NEBRASKA)
RATES EFFECTIVE 10-1-95 ( FOR A SNF WITH A 12-31 YEAR END)

| | | HOSPITAL-BASED | | FREE-STANDING |
|---|---|---|---|---|
| LABOR COM. | | 95.48 | | 79.39 |
| TIMES: WAGE IND. | X | .6995 | X | .6995 |
| ADJUSTED LABOR | | 66.79 | | 55.53 |
| NON-LABOR | | 12.71 | | 13.40 |
| OSHA ADD-ON | | 1.82 | | 1.95 |
| ADJ. RATE/LIMIT | | 81.32 | | 70.88 |
| ADJ. FACTOR | X | 1.10482 | X | 1.10482 |
| REVISED | | 89.84 | | 78.31 |
| CAPITAL COM. | | 6.66 | | 6.66 |
| **PPS RATE** | | **$96.50** | | **$84.97** |

THESE ARE THE PPS RATES FOR A 12-31-96 FISCAL YEAR END.

RATES EFFECTIVE 10-1-96 (FOR A SNF WITH A 12-31 YEAR END)

| | | HOSPITAL-BASED | | FREE-STANDING |
|---|---|---|---|---|
| LABOR COM. | | 108.01 | | 89.81 |
| TIMES: WAGE IND. | X | .6995 | X | .6995 |
| ADJUSTED LABOR | | 75.55 | | 62.82 |
| NON-LABOR | | 14.37 | | 15.16 |
| OSHA ADD-ON | | 2.06 | | 2.20 |
| ADJ. RATE/LIMIT | | 91.98 (1) | | 80.18 |
| ADJ. FACTOR | X | 1.00796 | X | 1.00796 |
| REVISED | | 92.72 | | 80.82 |
| CAPITAL COM. | | 6.66 | | 6.66 |
| **PPS RATE** | | **$99.38** | | **$87.48** |

THESE ARE THE PPS RATES FOR A 12-31-97 FISCAL YEAR END.

SKILLED NURSING FACILITIES MUST MAKE THE PPS ELECTION IN ACCORDANCE WITH THE REGULATIONS AT 42 CFR 413.308.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT US.

SINCERELY,

WILLIAM D. GAUGHAN, DIRECTOR
AUDIT & REIMBURSEMENT

(1) 91.98
1.02481

94.26 + 6.66 = 100.92

PAGES OMITTED

A total of 37 pages attached to the response at this point have been omitted for the sake of brevity. The information omitted consisted of Federal Register Volume 62, No. 162, dated 10/01/97 and titled "Medicare Program; Schedules of Limits and Prospectively Determined Payment rates for Skille Nursing Facility Inpatient Routine Service Costs." The pages omitted are a matter of public record. The omission does not, in our opinion, alter or diminish the points made in the NDHHS' response.