



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF AUDIT SERVICES  
233 NORTH MICHIGAN AVENUE  
CHICAGO, ILLINOIS 60601

REGION V  
OFFICE OF  
INSPECTOR GENERAL

January 20, 2004

Report Number A-05-03-00065

Janet Olszewski, Director  
Michigan Department of Community Health  
Lewis Cass Building  
300 South Walnut Street  
Lansing, MI 48913

Dear Ms. Olszewski:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General report entitled: "*Review of Medicaid Upper Payment Limit Requirements for Michigan.*" A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

The audit objective was to determine whether Michigan's Medicaid upper payment limit (UPL) and the related payments are reasonable and calculated in accordance with the revised Federal regulations and the approved State plan. An additional audit objective was to determine whether the UPL was properly included by Michigan when calculating disproportionate share hospital specific payment limits. At the request of the Centers for Medicare & Medicaid Services (CMS), our audit covered Michigan's methodology and calculations for the upper payment limit and related payments. Our audit period covered the implementation of the new upper payment limit regulations for State Fiscal year 2003.

On October 1, 2001, CMS modified 42 CFR 447, which are the requirements for calculating the Medicaid upper payment limit and related payments. Prior to October 1, 2001, the regulations allowed enhanced Medicaid payments using a total aggregated limit for all facilities between the estimated amount that Medicare would have paid (the upper payment limit) and the aggregated amount actually paid using the State plan for reimbursing Medicaid services. The new regulation required all Medicaid payments and the upper payment limits to be aggregated by three ownership-categories.<sup>1</sup> The new regulation also provided a transition period for the States to meet the new requirements using the effective date of the State plan. Michigan was allowed a transition period of five years.

Our review disclosed that the Michigan UPL and the related payments were reasonable and calculated in accordance with the revised Federal regulations and the approved State plan. In addition, the UPL payments were properly included by Michigan when calculating disproportionate share hospital specific payment limits.

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<sup>1</sup> The categories of ownership include: state-owned or operated, non-state government owned or operated, or privately owned or operated. However, there are no state-owned or operated nursing facilities in Michigan.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG 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 exemptions in the Act, which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Report Number A-05-03-00065 in all correspondence relating to this report.

Sincerely,

A handwritten signature in black ink that reads "Paul Swanson". The signature is written in a cursive, slightly slanted style.

Paul Swanson  
Regional Inspector General  
for Audit Services

Enclosures - As stated

**Direct Reply to HHS Action Official:**

Cheryl Harris, Associate Regional Administrator  
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U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
233 North Michigan Avenue Suite 600  
Chicago, Illinois 60601-5519

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MEDICAID UPPER  
PAYMENT LIMIT REQUIREMENTS  
FOR MICHIGAN**

**MICHIGAN DEPARTMENT OF  
COMMUNITY HEALTH  
LANSING, MICHIGAN**



**January 2004  
A-05-03-00065**

# *Office of Inspector General*

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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 awarding agency will make final determination on these matters.



## **EXECUTIVE SUMMARY**

### **OBJECTIVES**

The audit objective was to determine whether Michigan's Medicaid upper payment limit (UPL) and the related payments are reasonable and calculated in accordance with the revised Federal regulations and the approved State plan. An additional audit objective was to determine whether the UPL was properly included by Michigan when calculating disproportionate share hospital specific payment limits.

### **CRITERIA**

The 42 CFR 447 sets forth the requirements for calculating the Medicaid UPL and related payments. Prior to October 1, 2002, the regulations allowed for enhanced Medicaid payments using a total aggregated limit for all facilities between the estimated amount that Medicare would have paid (the UPL) and the aggregated amount actually paid using the State plan for reimbursing Medicaid services. On October 1, 2002, 42 CFR 447 was modified. The new regulation required all Medicaid payments and the upper payment limits to be aggregated by three ownership categories. Michigan initiated two State Plan Amendments (SPA); 97-06, Long Term Care, effective March 25, 1997 and 99-16, Outpatient Hospital, effective November 1, 1999. The modified 42 CFR 447 also provided a transition period based on the effective date of the State Plans. Michigan was allowed a transition period of five years, which began on State fiscal year ended September 30, 2003.

### **RESULTS**

The Michigan UPL and the related payments were reasonable and calculated in accordance with the revised Federal regulations and the approved State plan. In addition, the UPL payments were properly included by Michigan when calculating disproportionate share hospital specific payment limits.

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## INTRODUCTION

### BACKGROUND

Using an established financing formula, Title XIX of the Social Security Act (Act) authorizes Federal payments to States for Medicaid programs that provide medical assistance to low-income families, elderly individuals, and persons with disabilities. Each State administers its Medicaid program in accordance with a CMS approved State plan. The Act requires the State plan to meet certain requirements, which includes Medicaid payments for care and services to be consistent with efficiency, economy, and quality of care. The Federal Government pays its share of medical assistance expenditures to a State according to a defined formula that yields the Federal medical assistance percentage.

State Medicaid programs have flexibility in determining Medicaid payment rates; however, the State must not exceed the aggregate upper payment limit for institutional services. The upper payment limit is the amount that Medicare would have paid for the Medicaid services provided under the approved State plan. The 42 CFR 447 sets forth the requirements for calculating the Medicaid UPL and related payments. Formerly, the regulations provided that the aggregated upper payment limit was for all facilities. As of October 1, 2002, CMS modified the requirements for calculating the Medicaid UPL and related payments. The new regulations established three separate aggregated payment limits based on the type of ownership. The difference between the aggregated upper payment limit and the actual regular Medicaid payments allowed the State to make enhanced Medicaid payments to the facilities. Using the new regulations, the three aggregated upper payment limits and the inter-governmental transfer rule causes less enhanced payments.

#### *State Plan Amendments*

Michigan submitted two State Plan Amendments (SPA) described, as follows:

**SPA 97-06; Long Term Care.** The SPA, which became effective March 25, 1997, addresses the methods and standards for establishing prospective payment rates for long term care. In determining the long term care UPL, the Medicaid recipients within the public nursing facilities are categorized into 44 Resource Utilization Groups (RUGs) established by CMS for the purpose of determining Medicare reimbursement. Based on the RUGs categorization of Medicaid recipients, a weighted average Medicare rate (which reflects the applicable rural wage index adjustment for the Prospective Payment System) is calculated for each public facility. The weighted average Medicare rate is adjusted to remove ancillary services that are not included in the applicable Michigan Medicaid reimbursement rate for each long term care facility.

**SPA 99-16; Outpatient Hospital.** The SPA, which became effective November 1, 1999, addresses the methods and standards for establishing prospective payment



rates for outpatient hospital services. The UPL for outpatient hospitals is calculated based on each hospital's inflated outpatient charges multiplied by a Medicare payment to charge ratio of 54.9%. Payments are calculated based on each hospital's inflated Title XIX payments, plus the outpatient fee for service share of graduate medical education. Payments are subtracted from the UPL to derive the outpatient UPL gap. The outpatient Quality Assurance Assessment Program pool payment is subtracted from the UPL gap to determine the amount that the State is below the UPL.

It is imperative that the State properly includes UPL payments when calculating disproportionate share hospital specific payment limits. Disproportionate share hospitals (DSHs) have a large number of uninsured and uncompensated costs that receive supplemental payments, or intergovernmental transfers (IGTs). Once the UPL is identified for a given category, certain amounts, such as paid claims, are subtracted from the UPL to determine how much payment room is left under the UPL. That difference is then used to determine available funding for special financing transactions such as intergovernmental transfers (IGTs). Any direct benefit received by a given hospital in conjunction with an IGT will impact either how revenue is counted against that hospital's DSH limit or on how it calculates its DSH ceiling. The DSH ceiling for a given hospital can be split between inpatient and outpatient services, or it can be combined into a single limit. The hospitals select the approach that yields the highest ceiling.

Because this is a prospective payment system, the charge and payment data is based on historical data.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### ***Objective***

The audit objective was to determine whether Michigan's Medicaid upper payment limit (UPL) and the related payments are reasonable and calculated in accordance with the revised Federal regulations and the approved State plan. An additional audit objective was to determine whether the UPL was properly included by Michigan when calculating disproportionate share hospital specific payment limits.

### ***Scope***

The scope of our review was limited to the evaluation of whether Michigan's Medicaid upper payment limits for fiscal year 2003 Medicaid payments met the Federal requirements of Title 42 Part 447, and Michigan's Medicaid State Plan Amendments; 97-06, Long Term Care, and 99-16, Outpatient Hospitals. We did not complete an internal controls review at the State.

## ***Methodology***

The support for the UPL payments was obtained through interviews and documentation provided by officials from Michigan's Department of Community Health officials, CMS regional officials, and CMS's National Institutional Reimbursement Team. The documentation supporting the historical data used in the calculation was obtained from various sources including, but not limited to audit contractors, State consultants, various providers, and Medicaid Management Information System (MMIS).

Michigan's UPL calculations per SPAs; 97-06, Long Term Care, effective March 25, 1997, and 99-16, Outpatient Hospital, effective November 1, 1999; were analyzed to determine the reasonableness of the calculations and compliance with recently revised Federal regulations (Title 42, Chapter IV, Part 447, Subpart C, Sections 447.272 and 447.321) and to assure reasonableness of related payments, including intergovernmental transfer payments to the State's disproportionate share hospitals.

Our review was performed in accordance with generally accepted government auditing standards. The review was conducted June 2003 through October 2003 at the Michigan Department of Community Health and the OIG Lansing Field Office, Lansing, Michigan.

## **RESULTS**

The Michigan upper payment limit and the related payments were reasonable and calculated in accordance with the revised Federal regulations and the approved State plan. In addition, the upper payment limit payments were properly included by Michigan when calculating disproportionate share hospital specific payment limits.

## ACKNOWLEDGMENTS

This report was prepared under the direction of Paul Swanson, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff that contributed include:

Stephen Slamar, Audit Manager  
Denise R. Novak, Senior Auditor  
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For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.