MAY 12 2009

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of the Long-Term Care, Managed Care Program Costs Claimed by the Utah Department of Health (A-07-08-02719)

Attached is an advance copy of our final report on Medicaid payments for Long-Term Care, Managed Care (LTC-MC) services. We will issue this report to the Utah Department of Health (State agency) within 5 business days. This review was requested by the Region VIII office of the Centers for Medicare & Medicaid Services (CMS).

The State agency created the LTC-MC program to allow Medicaid beneficiaries living in nursing facilities the option of moving into home- or community-based settings. The LTC-MC program consists of two components: (1) primary- and acute-care services and (2) long-term-care (LTC) services. The primary- and acute-care component consists of all non-LTC medical services that are covered under the State plan.

The LTC-MC program was developed using nonrisk contracts. Under a nonrisk contract, the contractor (1) is not at financial risk for changes in utilization or for service costs incurred that are equal to or less than upper payment limits specified in Federal regulations and (2) may be reimbursed by the State agency for the incurred costs, subject to specified limits.

For the period July 1, 2000, through December 31, 2005, the State agency received a total of $30,363,335 in Federal reimbursement for both LTC and primary- and acute-care service costs for the LTC-MC program. Of this total, $27,432,527 was for LTC services.

Our objective was to determine whether the State agency ensured that payments for LTC services under the nonrisk contracts were equal to or less than the upper payment limits.

The State agency did not ensure that payments made under the nonrisk contracts for LTC services were equal to or less than the upper payment limits. The State agency lacked policies and procedures to ensure that the LTC payments made to the contractors were equal to or less than the upper payment limits.

Because the State agency could not ensure that the costs claimed for LTC services were equal to or less than the upper payment limits, we are unable to express an opinion on the $27,432,527 of Federal reimbursement the State agency received for the costs of LTC services for the period July 1, 2000, through December 31, 2005. Therefore, we are setting aside these costs for adjudication by CMS.

We recommend that the State agency work with CMS to (1) resolve the allowability of $27,432,527 in Federal reimbursement for LTC services that we set aside and (2) review claims subsequent to our audit period through the end of the program in 2007 and return to CMS any overpayments identified subject to the upper payment limits.

In written comments on our draft report, the State agency did not concur with our findings or recommendations. The State agency said that it had complied with Federal regulations governing nonrisk contract reimbursement because "in all cases, the comprehensive daily rate paid for the LTC-MC program was less than the fee-for-service alternative, which was the comprehensive daily rate for nursing facility services."

Also, the State agency said that the LTC-MC program was converted to a fee-for-service 1915(c) Home and Community Based Waiver in 2007 and so "the upper payment limit test is no longer required."

After reviewing the State agency's written comments, we slightly modified our second recommendation, and we are no longer recommending that the State agency develop new procedures for the LTC-MC program because the State agency converted the LTC-MC program to fee-for-service.

However, the State agency did not provide information that caused us to change our findings or remaining recommendation. The State agency said that it met the upper payment limit requirements because the LTC-MC program paid less than it would have paid if the participants had been served in nursing facilities. Federal regulations, though, require the State agency to demonstrate that payments to nonrisk contractors not exceed what Medicaid would have paid, on a fee-for-service basis, for the services actually furnished to the recipients. Services actually furnished under the LTC-MC program included adult day care, home health services, and assisted living. By basing its upper payment limit test on nursing home facility costs that were avoided, and not on actual services provided under the LTC-MC program, the State agency did not comply with Federal regulations.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at george.reeb@oig.hhs.gov or Patrick Cogley, Regional Inspector General, at (816) 426-3591 or through e-mail at patrick.cogley@oig.hhs.gov. Please refer to report number A-07-08-02719.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region VII
601 East 12th Street
Room 0429
Kansas City, Missouri 64106

MAY 19 2009

Report Number: A-07-08-02719

Mr. Michael Hales
Director
Division of Health Care Financing
Utah Department of Health
P.O. Box 144102
Salt Lake City, Utah 84114

Dear Mr. Hales:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of the Long-Term Care, Managed Care Program Costs Claimed by the Utah Department of Health." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this 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.

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, OIG reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, or contact James Korn, Audit Manager, at (303) 844-7153 or through e-mail at james.korn@oig.hhs.gov. Please refer to report number A-07-08-02719 in all correspondence.

Sincerely,

Patrick J. Cogley
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE LONG-TERM CARE, MANAGED CARE PROGRAM COSTS CLAIMED BY THE UTAH DEPARTMENT OF HEALTH

Daniel R. Levinson
Inspector General

May 2009
A-07-08-02719

Office of Inspector General

http://oig.hhs.gov

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THIS REPORT IS AVAILABLE TO THE PUBLIC
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Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Utah Department of Health (State agency) created the Long-Term Care, Managed Care (LTC-MC) program to allow Medicaid beneficiaries living in nursing facilities the option of moving into home- or community-based settings. The LTC-MC program consists of two components: (1) primary- and acute-care services and (2) long-term-care (LTC) services. The primary- and acute-care component consists of all non-LTC medical services that are covered under the State plan.

The LTC component is the focus of our review and consists of a broad array of institutional and home- and community-based LTC services. These services may include 24-hour supported living alternatives, home health services, physical environment modifications, and adult day care. Beneficiaries of these services may stay in nursing facilities or move to a home- or community-based setting.

The LTC-MC program was developed using nonrisk contracts. Under a nonrisk contract, the contractor (1) is not at financial risk for changes in utilization or for service costs incurred that are equal to or less than upper payment limits specified in Federal regulations and (2) may be reimbursed by the State agency for the incurred costs, subject to specified limits.

For the period July 1, 2000, through December 31, 2005, the State agency received a total of $30,363,335 in Federal reimbursement for both LTC and primary- and acute-care service costs for the LTC-MC program. Of this total, $27,432,527 was for LTC services.

OBJECTIVE

Our objective was to determine whether the State agency ensured that payments for LTC services under the nonrisk contracts were equal to or less than the upper payment limits.

SUMMARY OF FINDINGS

The State agency did not ensure that payments made under the nonrisk contracts for LTC services were equal to or less than the upper payment limits. The State agency lacked policies and procedures to ensure that the LTC payments made to the contractors were equal to or less than the upper payment limits.

Because the State agency could not ensure that the costs claimed for LTC services were equal to or less than the upper payment limits, we are unable to express an opinion on the $27,432,527 of Federal reimbursement the State agency received for the costs of LTC services for the period July 1, 2000, through December 31, 2005. Therefore, we are setting aside these costs for adjudication by CMS.

RECOMMENDATIONS

We recommend that the State agency:

- work with CMS to resolve the allowability of $27,432,527 in Federal reimbursement for LTC services that we set aside and

- review claims subsequent to our audit period through the end of the program in 2007 and return to CMS any overpayments identified subject to the upper payment limits.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not concur with our findings or recommendations. The State agency said that it had complied with Federal regulations governing non-risk contract reimbursement because "in all cases, the comprehensive daily rate paid for the LTC-MC program was less than the fee-for-service alternative, which was the comprehensive daily rate for nursing facility services."

Also, the State agency said that the LTC-MC program was converted to a fee-for-service 1915(c) Home and Community Based Waiver in 2007 and so "the upper payment limit test is no longer required."

The State agency's written comments (except for personally identifiable information that has been redacted) are included as the appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's written comments on our draft report, we slightly modified our second recommendation, and we are no longer recommending that the State agency develop new procedures for the LTC-MC program. The State agency converted the LTC-MC program to fee-for-service.

However, the State agency did not provide information that caused us to change our findings or remaining recommendation. The State agency said that it met the upper payment limit requirements because the LTC-MC program paid less than it would have paid if the participants had been served in nursing facilities. Federal regulations, though, require the State agency to demonstrate that payments to nonrisk contractors not exceed what Medicaid would have paid, on a fee-for-service basis, for the services actually furnished to the recipients. Services actually furnished under the LTC-MC program included adult day care, home health services, and assisted living. By basing its upper payment limit test on nursing home facility costs that were

avoided, and not on actual services provided under the LTC-MC program, the State agency did not comply with Federal regulations.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

States' Authority To Contract for Services

States are authorized by Federal statute (section 1915(a) of the Act) to contract with an organization (contractor) to provide care and services to beneficiaries in addition to those services offered under the State plan.

Utah's Medicaid Long-Term Care, Managed Care Program

The Utah Department of Health (State agency) created the Long-Term Care, Managed Care (LTC-MC) program to allow Medicaid beneficiaries living in nursing facilities the option of moving into home- or community-based settings instead of remaining in nursing facilities. CMS approved the implementation of the LTC-MC program under section 1915(a) of the Act.

To become eligible for the program, a beneficiary must have lived in a nursing facility for at least 90 days. The LTC-MC program has two components: (1) primary- and acute-care services and (2) long-term-care (LTC) services. The primary- and acute-care component consists of all non-LTC medical services that are covered under the State plan. The State agency uses contractors to furnish LTC services to Medicaid beneficiaries.

The LTC-MC contracts describe the LTC component as a ". . . broad array of institutional and home and community-based long term care services." These services may include 24-hour supported living alternatives, home health services, physical environment modifications, and adult day care. Beneficiaries of these services may stay in nursing facilities or move to a home- or community-based setting.

The LTC-MC program was developed using nonrisk contracts. Pursuant to Federal regulations at 42 CFR § 438.2, a nonrisk contract is a contract under which the contractor (1) is not at financial risk for changes in utilization or for service costs incurred that do not exceed the upper payment limits[1] "specified in 42 CFR § 447.362" and (2) may be reimbursed by the State agency for the incurred costs, subject to specified limits.

[1]Upper payment limits are defined more fully later in this section.

CMS approved the implementation of the LTC-MC program under section 1915(a) of the Act, which allows the State agency to use contractors to provide care and services to beneficiaries. In 1999, the State agency submitted a contract with a managed care contractor—a contract that incorporated one LTC service—to CMS for approval. Although CMS approved that contract, the State agency modified the LTC-MC program and executed contracts with other contractors. According to CMS officials, CMS withheld approval of those other contracts because of a lack of compliance with the regulations.

CMS requires that the contracts between the State agency and contractors include language directing the contractors to submit information to the State agency that the State agency uses both in its semiannual reports to CMS and in its annual evaluations of the LTC-MC program.

Long-Term Care, Managed Care Program Payments

Capitation payments are lump-sum payments made each month in advance for all services that will be provided to beneficiaries during that month. Fee-for-service (FFS) payments are after-the-fact reimbursements from the State agency to the contractors for each individual service provided. In its contracts, the State agency uses capitation payments to pay for all LTC and primary- and acute-care services to beneficiaries enrolled in the LTC-MC program. The contractors receive two monthly capitation payments for each enrolled beneficiary: (1) one for LTC services and (2) one for primary- and acute-care services. Risk is mitigated through additional payments and adjustments.

Pursuant to Federal regulations at 42 CFR § 447.362, capitation payments made under nonrisk contracts may not exceed (a) what Medicaid would have paid, on an FFS basis, for the services actually provided to beneficiaries plus (b) the net savings of administrative costs the State agency achieves by contracting for the services instead of purchasing them on an FFS basis. In this report, we refer to the calculated amounts described in this regulation as the upper payment limits.

The State agency claimed Federal reimbursement on the Form CMS-64, "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program," for the amount of the payments made to the contractors. The costs claimed for these payments must be equal to or less than the upper payment limits.

For the period July 1, 2000, through December 31, 2005, the State agency received a total of $30,363,335 in Federal reimbursement for both LTC and primary- and acute-care service costs for the LTC-MC program. Of this total, $27,432,527 was for LTC services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency ensured that payments for LTC services under the nonrisk contracts were equal to or less than the upper payment limits.

Scope

The State agency claimed $41,981,698 ($30,363,335 Federal share) in costs on its Forms CMS-64 for LTC and for primary- and acute-care services for the period July 1, 2000, through December 31, 2005. We reviewed the $27,432,527 (Federal share) claimed for LTC services. We did not review $2,930,808 (Federal share) of claimed costs for primary- and acute-care services.

We did not review the overall internal control structure of the State agency's operations or financial management because our objective did not require us to do so. Rather, we gained an understanding of the State agency's controls with respect to the identification, accumulation, and reporting of costs related to the LTC-MC program.

We performed our fieldwork at the State agency's offices in Salt Lake City, Utah.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal Medicaid laws and regulations and the State Medicaid plan;
- interviewed CMS officials to obtain an understanding of their roles in the oversight of the LTC-MC program, to review the CMS approval of the LTC-MC program, and to obtain additional CMS documentation pertaining to this program;
- interviewed State agency officials to obtain an understanding of the LTC-MC program and its payment, reimbursement, and cost settlement mechanisms;
- reviewed the LTC-MC contracts between the State agency and the contractors;
- identified those beneficiaries enrolled in the LTC-MC program, identified the contractors who provided the beneficiaries' care, and verified where the beneficiaries resided while enrolled in the program;
- determined the dollar amounts of LTC and primary- and acute-care payments made to the contractors;
- requested documentation from the State agency to support that payments were equal to or less than what Medicaid would have paid on an FFS basis; and
- identified the total dollar amounts of payments made under the nonrisk contracts, per year, for the LTC-MC program on the Forms CMS-64 and then attempted to reconcile these amounts both to the amounts the State agency reported in its Forms CMS-64 and to the State agency's supporting schedules for its Forms CMS-64.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

The State agency did not ensure that payments made under the nonrisk contracts for LTC services were equal to or less than the upper payment limits. The State agency lacked policies and procedures to ensure that the LTC payments made to the contractors were equal to or less than the upper payment limits.

Because the State agency did not ensure that the costs claimed for LTC services were equal to or less than the upper payment limits, we are unable to express an opinion on the $27,432,527 of Federal reimbursement the State agency received for the costs of LTC services for the period July 1, 2000, through December 31, 2005. Therefore, we are setting aside these costs for adjudication by CMS.

PAYMENT FOR LONG-TERM-CARE SERVICES AND THE UPPER PAYMENT LIMITS

Requirements for Payment of Long-Term-Care Services Under Nonrisk Contracts

Federal regulations (42 CFR § 447.362) mandate that "under a non risk contract, Medicaid payments to the contractor may not exceed (a) what Medicaid would have paid, on a fee-for-service basis, for the services actually furnished to the recipients: plus (b) the net savings of administrative costs the Medicaid agency achieves by contracting with the plan instead of purchasing the services on a fee-for-service basis."

Long-Term-Care Payments Not Equal To or Less Than the Upper Payment Limits

The State agency did not follow Federal regulations governing nonrisk contract reimbursement when claiming costs for LTC services for the LTC-MC program. Specifically, the State agency did not provide documentation to support that payments were equal to or less than what Medicaid would have paid on an FFS basis for the services provided to beneficiaries, plus the net savings of administrative costs the State agency achieved by contracting for the services instead of purchasing them on an FFS basis.

We asked State agency officials to provide documentation to support that the amounts claimed on the Forms CMS-64 were equal to or less than the upper payment limits. The State agency was not able to provide supporting documentation for this comparison of the upper payment limits with the Form CMS-64 claim amounts.

State agency officials were also unable to provide us with or explain the policies and procedures used to calculate the upper payment limits.

NO POLICIES AND PROCEDURES

These potentially unallowable claims occurred because the State agency did not have policies and procedures to ensure that the State agency could support that it was paying equal to or less than the upper payment limits, pursuant to 42 CFR § 447.362.

FEDERAL REIMBURSEMENT FOR POTENTIALLY UNALLOWABLE CLAIMS

Because the State agency could not ensure that its payments to contractors were equal to or less than the upper payment limits, we cannot express an opinion on the State agency claims for $27,432,527 (Federal share) in nonrisk contract costs for LTC services. As a result, we are setting aside these costs for adjudication by CMS.

RECOMMENDATIONS

We recommend that the State agency:

- work with CMS to resolve the allowability of $27,432,527 in Federal reimbursement for LTC services that we set aside and

- review claims subsequent to our audit period through the end of the program in 2007 and return to CMS any overpayments identified subject to the upper payment limits.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not concur with our findings or recommendations. The State agency said that "in all cases, the comprehensive daily rate paid for the LTC-MC program was less than the fee-for-service alternative, which was the comprehensive daily rate for nursing facility services." The State agency added that, accordingly, it "believes it has clearly demonstrated compliance with Federal regulations governing non-risk contract reimbursement . . . ."

Also, the State agency said that the LTC-MC program was converted to an FFS 1915(c) Home and Community Based Waiver in 2007 and so "the upper payment limit test is no longer required."

The State agency's comments (except for personally identifiable information that has been redacted) are included as the appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's written comments on our draft report, we slightly modified our second recommendation, and we are no longer recommending that the State agency develop new procedures for the LTC-MC program. The State agency converted the LTC-MC program to FFS.

However, the State agency did not provide information that caused us to change our findings or remaining recommendation. The State agency said that it met the upper payment limit requirements because the LTC-MC program paid less than it would have paid if the participants had been served in nursing facilities. Federal regulations, though, require the State agency to demonstrate that payments to nonrisk contractors not exceed what Medicaid would have paid, on an FFS basis, for the services actually furnished to the recipients. Services actually furnished under the LTC-MC program included adult day care, home health services, and assisted living. By basing its upper payment limit test on nursing home facility costs that were avoided, and not on actual services provided under the LTC-MC program, the State agency did not comply with Federal regulations.

APPENDIX

State of Utah
JON M. HUNTSMAN, JR.
Governor

GARY R. HERBERT
Lieutenant Governor

Utah Department of Health
Executive Director's Office

David N. Sundwall, M.D.
Executive Director

A. Richard Melton, Dr. P.H.
Deputy Director

Allen Korhonen
Deputy Director

Health Care Financing

Michael T. Hales
Division Director

MHC-121-08

November 26, 2008

Re: Report Number: A-07-08-02719

Mr. Patrick J. Cogley
Regional Inspector General
Offices of Audit Services
Region VII
601 East 12th Street
Kansas City, Missouri 64106

Dear Mr. Cogley:

The Utah Department of Health, Division of Health Care Financing appreciates the opportunity to respond to the draft report entitled "Review of the Long-Term Care, Managed Care Program Costs Claimed by the Utah Department of Health."

As per instructions in the cover letter that accompanied the draft report, the Utah Department of Health (Department) has provided a statement of concurrence or non-concurrence with each recommendation.

The Department is providing an additional attachment which exhibits, by fiscal year, the daily rates paid for the long term care portion of the Long-Term Care Managed Care Program and the daily rates paid for nursing facility services.

If you have any questions, please do not hesitate to call me at (801)538-6689

Sincerely,

Michael Hales, Director
Division of Health Care Financing

Attachments

Utah Department of Health, Division of Health Care Financing
Response to
Draft Report, "Review of the Long-Term Care Managed Care Program Costs Claimed by the Utah Department of Health"

Utah Department of Health (Department) Response:
The Department believes some additional background information may be helpful to allow for a more thorough understanding of the Long-Term Care Managed Care (LTC-MC) Program. Better understanding the program will lead to improved understanding of what the fee-for-service alternative to the program is.

The LTC-MC program was developed specifically as a deinstitutionalization program. Eligibility for the program required that individuals reside in a nursing facility for at least 90 days immediately prior to admission into the LTC-MC program.

Because LTC-MC program participants were residents in nursing facilities immediately prior to coming onto the LTC-MC program, the State established that the FFS alternative to the LTC-MC program was service received in a nursing facility. The payment for nursing facility services is paid through a daily rate.

It must be acknowledged that the State was paying the nursing facility daily rate for these individuals immediately prior to their admission into the LTC-MC program. As such, the State clearly established that services received in the nursing home (paid to the nursing facility providers as a daily rate) was the fee-for-service comparison upon which the upper payment limit was to be tested.

In plain terms, if the participants in the LTC-MC program where not in the program, where would they go to receive needed services? The answer is they would go back to the place they were before they entered the LTC-MC program – the nursing facility.

If the OIG's position is that a UPL test needed to be conducted using the individual services offered under the LTC-MC daily rate and compared to individual services that would have been provided under the nursing facility daily rate, the Department and the OIG have a fundamental disagreement on the UPL test methodology.

Nursing facilities do not break down the individual cost of services provided on a resident-by-resident basis in the same way that the LTC-MC program did not break down the individual cost of services on a participant by participant basis. Rather, we confirmed that in all cases, the comprehensive daily rate paid for the LTC-MC program was less than the fee-for-service alternative, which was the comprehensive daily rate for nursing facility services.

The Department feels that during the on-site portion of the audit, its staff described these points to the OIG auditors verbally and in writing (written response to the OARS and verbal discussion during the exit conference).

At the conclusion of the exit conference with OIG in December 2006, it was the impression of the Department that the auditors were willing to accept the premise that the UPL test was between the LTC-

MC daily rate and the average daily nursing facility rate, rather than individual services in the LTC-MC program and individual service costs within nursing facilities. As stated above, nursing facilities also do not collect that level of encounter data on an individual client basis.

The Department's recollection was that the OIG auditors requested a list of the nursing facility daily rates paid during the audit period in order to provide evidence that the daily rate paid for the LTC-MC program remained less than the daily rate paid to the nursing facilities. We believe this information was sent to Redacted

Until receiving the OIG draft report in September 2008, the State was not aware that this issue remained unresolved.

Excerpts from Page 4 of draft report, "FINDINGS AND RECOMMENDATIONS" section:

"Long –Term-Care Payments Not Equal to or Less Than the Upper Payment Limits

The State agency did not follow Federal regulations governing nonrisk contract reimbursement when claiming costs for the LTC services for the LTC-MC program. Specifically, the State agency did not provide documentation to support that payments were equal to or less than what Medicaid would have paid on an FFS basis for the services provided to beneficiaries, plus the net savings of administrative costs the State agency achieved by contracting for the services instead of purchasing them on an FFS basis.

We asked State agency officials to provide documentation to support that the amounts claimed on the Forms CMS-64 were equal to or less than the upper payment limits. The State agency was not able to provide supporting documentation for this comparison of the upper payment limits with the Form CMS-64 claim amounts.

State agency officials were unable to provide us with or explain the policies and procedures used to calculate the upper payment limits."

Utah Department of Health Response:

The Department does not concur that it did not follow Federal regulations governing non-risk contract reimbursement. The Department does not concur that it did not provide documentation to support that the amounts claimed on the Forms CMS-64 were equal to or less than the upper payment limits. The Department does not concur that it was unable to provide or explain policies and procedures used to calculate upper payment limits.

In the fall of 2006, the OIG auditors sent the Department copies of documents called "Object Attributes Recap Sheet" (OARS). The Department submitted its responses to the OARS in the fall of 2006.

The Department provided the following explanation in its response to the OARS in 2006:

"This LTC-MC program was developed as an alternative to fee-for-service nursing facility care. As such, the fee-for-service comparison by which the program was evaluated for cost effectiveness was

the average daily rate Medicaid paid for nursing facility services. From the inception of the LTC-MC program through June 2004 Medicaid paid the same average daily rate to the LTC-MC program as it did to nursing facilities. Beginning July 2004, a nursing facility assessment was implemented within the nursing facility industry which increased the average nursing facility rate to approximately $135.00 per day. The LTC-MC program rates did not reflect this increase and the rate stayed at a rate of $105.00 per day.

By comparing fee-for-service nursing facility costs to the costs of the LTC-MC program, the LTC-MC program has remained cost neutral to or has cost Medicaid less than the cost of the fee-for-service equivalent throughout the life of the program."

Upon providing this response, the Department of Health concluded that sufficient explanation had been provided to answer the questions presented in the OARS documents.

The attached spreadsheet exhibits the following by fiscal year:

- Daily rates paid for the long term care portion of the LTC-MC program.
- Daily rates that were paid for nursing facility services (Fee-For-Service Comparison)

Based upon the original information provided in response to the OARS in 2006 and the additional detail provided in the spreadsheet, the Department believes it has clearly demonstrated compliance with Federal regulations governing non-risk contract reimbursement by assuring that payments for long term care services in the LTC-MC program were less than the rate paid to the fee-for-service nursing facilities.

Excerpts from Page 5 of draft report, "RECOMMENDATIONS", section:

"We recommend the State agency:

- Work with CMS to resolve the allowability of $27,432,527 in Federal reimbursement for LTC services that we set aside:"

Utah Department of Health Response:
The Department does not concur that $27,432,527 should be set aside. The fee-for-service comparison for the LTC-MC program is nursing facility care. By clearly showing that the LTC-MC program paid less than what would have been paid if the participants had been served in nursing facilities, the Department has demonstrated that it met the Federal regulations governing nonrisk contract reimbursement, specifically, the amounts claimed on the Forms CMS-64 were equal to or less than the upper payment limits.

"We recommend the State agency:

- Review claims subsequent to our audit period, based on the resolution it reaches with CMS, and return to CMS an overpayments identified for time periods subject to the upper payment limits;"

Utah Department of Health Response:
The Department does not concur that any funds should be set aside from the OIG audit period, nor any time after the audit period. During the audit period and continuously thereafter, the Department has demonstrated that the LTC-MC services claimed were less than nursing facility services, the fee-for-

service alternative. Therefore, no overpayments have been made. Please see attached spreadsheet for a demonstration of cost neutrality through the end of the program in 2007.

"We recommend the State agency:

- Develop policies and procedures for the LTC-MC program to ensure that the State agency complies with all Federal reimbursement requirements."

Utah Department of Health Response:
The Department had procedures in place to assure that the LTC-MC program did not pay more for services provided in the program than would have been spent on the client had he/she continued to reside in the nursing facility. Please see attached spreadsheet for a demonstration of cost neutrality through the end of the program in 2007.

The program was converted to a fee-for-service 1915(c) Home and Community-Based Waiver in 2007. Because the program now operates under the fee-for-service method, the upper payment limit test is no longer required.

Long-Term Care Demonstration Project SUMMARY / HISTORY

PROGRAM	CONTRACTOR	TIME PERIOD	Contract TYPE	AUDITOR	Contract Component	Costs	Patient Days	Costs Per Day/Rate Paid	Medicaid NF Nursing Home Revenue Per Patient Day (Per NF FCP Database)	Base Rates from Other Sources: (Does not include any add on's)	<Source	BC Add	SRS Add
FLEXCARE	UHC	SFY 2001	Non Risk		LTC	1,509,819.46	17,297	$ 87.29	$ 93.41			na	na
FLEXCARE	UHC &Healthy U /VHM	SFY 2002	Non Risk		LTC	3,993,075.00	44,572	$ 89.59	$ 102.79	98.70		na	na
FLEXCARE	Healthy U / VMH	July 2002 thru Mar 2003	Non Risk		LTC	3,579,386.00	37,312	$ 95.93	$ 109.60	103.38		na	na
FLEXCARE	Healthy U / VMH	April 2003 thru Jun 2003	RISK		LTC	na	na	$ 100.72	$ 109.60	103.38		na	na
FLEXCARE	Healthy U / VMH	SFY 2004	Non Risk		LTC	10,694,267.00	108,128	$ 98.90	$ 122.72	103.78		na	na
FLEXCARE	Healthy U / VMH	SFY 2005	Non Risk		LTC	14,407,751.00	135,963	$ 105.97	$ 135.20	131.82		7.00	20.38
FLEXCARE	Healthy U / VMH	SFY 2006	Non Risk		LTC	17,977,793.00	164,210	$ 109.48	$ 137.71	132.97		7.07	20.58
FLEXCARE	Healthy U / VMH	SFY 2007	Non Risk		LTC	17,099,512.00	157,733	$ 108.41		138.46		7.21	20.99
FLEXCARE	Healthy U / VMH	July 2007 thru Dec. 2007	Non Risk	Redacted	LTC	1,416,590.00	12,201	$ 116.10		150.11	Redacted	7.39	21.58
WEBER MACS	Weber Human Services	SFY 2004	Non Risk		LTC	na	na	$ 100.72	$ 122.72	103.78		na	na
WEBER MACS	Weber Human Services	SFY 2005	Non Risk		LTC	na	na	$ 95.00	$ 135.20	131.82		7.00	20.38
WEBER MACS	Weber Human Services	SFY 2006	Non Risk		LTC	na	na	$ 95.00	$ 137.71	132.97		7.07	20.58
WEBER MACS	Weber Human Services	SFY 2007	Non Risk		LTC	na	na	$ 95.00		138.46		7.21	20.99
M.I.C.	South	SFY 2004	Non Risk		LTC	na	na	$ 100.72	$ 122.72	103.78		na	na
M.I.C.	South	SFY 2005	Non Risk		LTC	na	na	$ 95.00	$ 135.20	131.82		7.00	20.38
M.I.C.	South	SFY 2006	Non Risk		LTC	na	na	$ 95.00	$ 137.71	132.97		7.07	20.58
M.I.C.	South	SFY 2007	Non Risk		LTC	na	na	$ 95.00		138.46		7.21	20.99

NOTES:

There was one time period (April 2003 thu June 2003) that was "at Risk". The other periods marked "na" had no cost settlement requirement.

The July 2007 thru December 2007 period for FLEXCARE has not been settled yet.

The base rate for FY2001, was unavailable from Redacted *but the actual rate PAID (which includes add on's) for this period is still lower than the FCP reported revenue per day which should also include add on's*

A total UPL rate (including the base plus add on's) was not calculated because the actual amounts paid (which include the actual add on's) was already lower than just the base portion of the rate.

In other words, no room was needed to pass the UPL test. Comparing the actual rates paid to rates that included a portion of clients with higher daily rates was not necessary.