DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

Report Number: A-06-06-00064 June 21, 2007

Mr. John Selig
Director
Arkansas Department of Health and Human Services
Donaghey Plaza South, Slot S201
P.O. Box 1437
Little Rock, Arkansas 72203-1437

Dear Mr. Selig,

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Arkansas Physician Supplemental Payment Program." A copy of this report will be forwarded to the HHS action official noted on the next 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 the action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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 are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-06-06-00064 in all correspondence.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Dr. James R. Farris
Regional Administrator, Region VI
Centers for Medicare & Medicaid Services
1301 Young Street, Suite 714
Dallas, Texas 75202

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ARKANSAS PHYSICIAN SUPPLEMENTAL PAYMENT PROGRAM

Daniel R. Levinson
Inspector General

JUNE 2007
A-06-06-00064

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. Specifically, these evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness in departmental programs. To promote impact, the reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

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 are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR part 5.)

OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

At the request of the Centers for Medicare & Medicaid Services (CMS), we reviewed the Medicaid supplemental payment to the University of Arkansas for Medical Sciences (the University) for the period October 2002 through May 2004. The Arkansas Department of Health and Human Services (the State) proposed the supplemental payment in a State plan amendment that was approved by CMS with an effective date of October 1, 2002. The State plan provides for the State to make supplemental payments to eligible physicians and other health care professionals affiliated with the University.

According to the State plan, a supplemental payment is based on the average commercial payment rate, which is the ratio of total commercial payments (both the commercial insurance payments and amounts payable from patients) to total commercial charges. The average commercial rate is applied to paid Medicaid charges, and that amount is reduced by Medicaid payments to determine the supplemental payment.

The University received a supplemental payment of approximately $43.8 million for the 20-month period October 2002 through May 2004. The payment amount was based on a fiscal year 2002 average commercial payment rate of approximately 67.2 percent multiplied by Medicaid charges of approximately $144.6 million. This amount was then reduced by Medicaid payments of approximately $53.4 million.

OBJECTIVE

Our objective was to determine whether the calculation of the supplemental payment for provider services was in accordance with the approved State plan and was adequately supported.

SUMMARY OF FINDINGS

With one exception, the University's formula to calculate the supplemental payment was in accordance with the approved State plan. The University did not follow the State plan when it determined commercial payments. The University determined commercial payments by subtracting disallowances (reductions in charges that commercial payers negotiated with the University) from commercial charges.[1] However, we do not believe that the University's method of determining commercial payments would produce results that are materially different from the State plan method.

Although the formula used to calculate the supplemental payment was generally in accordance with the State plan, the supplemental payment was not adequately supported. Specifically, the average commercial payment rate included noncommercial charges and duplicate commercial charges and did not include some disallowances. The Medicaid charges and payments used to determine the supplemental payment included ineligible charges and payments. As a result, the

[1]This was the revised supplemental payment method used by the University. For more details on the initial and revised methods, see the body of this report.

University overstated the average commercial payment rate, and the State overstated Medicaid charges and understated Medicaid payments. We were unable to determine the amount by which the University overstated the average commercial payment rate. The State overstated Medicaid charges used to calculate the supplemental payment by approximately $19.2 million and understated Medicaid payments by approximately $1.9 million.

The University included noncommercial and duplicate commercial charges in the average commercial payment rate calculation because its accounts receivable system could not properly account for misclassified charges. The University did not include some disallowances because its data was created before commercial payers could process and report some of the disallowances. The ineligible Medicaid charges and payments were included due to an oversight by the State.

RECOMMENDATION

We recommend that the State work with CMS to address the weaknesses noted in this report related to the calculation of the supplemental payment, which may require amending the State plan. We also recommend that any change in the average commercial payment rate be applied to the correct Medicaid charges and payments for the audit period and that any excess payment be refunded to the Federal Government.

STATE'S COMMENTS

In its written comments on our draft report, the State confirmed that it was in negotiations with CMS regarding the University's supplemental payment. The State's comments are included as Appendix B.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

At the request of the Centers for Medicare & Medicaid Services (CMS), we reviewed the Medicaid supplemental payment to the University of Arkansas for Medical Sciences (the University) for the period October 2002 through May 2004. The University is the sole academic medical center in Arkansas. Along with the medical center, the University's outreach efforts include seven Area Health Education Centers (AHEC) throughout Arkansas. In addition, physicians and other health care professionals employed by the University perform services at Arkansas Children's Hospital (ACH), an affiliate of the University.

Medicaid Supplemental Payment

The supplemental payment mechanism is a funding arrangement between the Arkansas Department of Health and Human Services (the State) and the Federal Government. In its State plan submission, the State cited 42 CFR § 447.325, which states that the Medicaid "agency may pay the customary charges of the provider but must not pay more than the prevailing [average] charges in the locality for comparable services under comparable circumstances."

The State proposed the supplemental payment in a State plan amendment that was approved by CMS with an effective date of October 1, 2002. The State plan provides for the State to make supplemental payments to eligible physicians and other health care professionals affiliated with the University. According to the State plan, a supplemental payment is based on the average commercial payment rate, which is the ratio of total commercial payments (both the commercial insurance payments and amounts payable from patients) to total commercial charges. The average commercial rate is applied to paid Medicaid charges, and that amount is reduced by Medicaid payments to determine the supplemental payment.

The University received a supplemental payment of approximately $43.8 million for the 20-month period October 2002 through May 2004. The payment amount was based on a fiscal year 2002 average commercial payment rate of approximately 67.2 percent multiplied by Medicaid charges of approximately $144.6 million. This amount was then reduced by Medicaid payments of approximately $53.4 million.

Initial Average Commercial Payment Rate

The University initially calculated the average commercial payment rate of 67.2 percent by adding commercial insurance payments to patient copayments and deductibles, which the University called transfers, to calculate total commercial payments and then dividing total commercial payments by commercial insurance charges. (See Table 1 below.)

Table 1 – Initial State Fiscal Year 2002 Average Commercial Payment Rate Calculation

	A	B	C (A + B)	D	E (C/D)
	Commercial Insurance Payments	**Transfers**	**Total Commercial Payments**	**Commercial Insurance Charges**	**Commercial Payment Rate**
PPO[1]	$17,860,411	$3,220,340	$21,080,751	$35,364,124	59.61%
Blue Shield	6,744,813	1,028,909	7,773,722	13,120,220	59.25%
Commercial	10,510,408	2,675,711	13,186,119	14,952,479	88.19%
ACH	5,635,368		5,635,368	8,286,972	68.00%
AHECs	5,047,985		5,047,985	6,729,613	75.01%
Total	**$45,798,985**	**$6,924,960**	**$52,723,945**	**$78,453,408**	**67.20%**

CMS reviewed the supplemental payment calculation and expressed concern that (1) ACH's amounts were estimates, (2) AHEC amounts were unverified, and (3) transfers included transfers to other payers.

This average commercial payment rate calculation was the initial focus of our review. We performed limited testing and determined that transfers included more than patient copayments and deductibles. Additionally, the accounts receivable system could break down the amounts into individual transactions only when the summary report was created. The University did not save transaction data at the time the summary report was created; thus, detailed information was not available at the time of our audit. This precluded us from testing and verifying individual transactions for our audit.

Revised Average Commercial Payment Rate

The University addressed CMS's concerns and our audit issues by proposing a new methodology to calculate the average commercial payment rate. The University excluded ACH and AHEC data from the calculation for the reasons noted above. Rather than using transfers to identify patient copayments and deductibles, the University backed into total commercial payments by reducing commercial charges by their disallowances, which were the reductions in charges that commercial payers negotiated with the University. Table 2 shows the revised methodology.

[1]Preferred provider organization.

Table 2 – Revised State Fiscal Year 2002 Average Commercial Payment Rate Calculation

	A	B	C (A – B)	D (C/A)
	Commercial Insurance Charges	**Disallowances**	**Total Commercial Payments**	**Commercial Payment Rate**
PPO	$42,052,257	$12,483,330	$29,568,927	70.31%
Blue Shield	17,002,869	4,901,396	12,101,473	71.17%
Commercial	20,200,579	2,109,864	18,090,715	89.56%
ACH	-	-	-	-
AHECs	-	-	-	-
Total	**$79,255,705**	**$19,494,590**	**$59,761,115**	**75.40%**

Because the new methodology relied on a different report to identify charges, the University was able to provide a list of the individual charges that made up total charges. With CMS's approval, we changed the focus of our review to the revised methodology.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the calculation of the supplemental payment for provider services was in accordance with the approved State plan and was adequately supported.

Scope

Our audit focused on (1) the University's revised method of calculating the average commercial payment rate and (2) the State's identification of Medicaid charges and payments for the 20-month period ending May 31, 2004.[2] We did not review the overall internal controls of the University's accounts receivable system or the State's Medicaid claims processing system because our objective did not require us to do so.

The University's accounts receivable system purges claims with a zero balance after one year. The purged data is then aggregated with the total patient history and stored on microfiche. The process to obtain data stored on microfiche is cumbersome and time consuming. Because our review started after much of the data had been stored on microfiche, it was impractical to test and verify 2002 data in a reasonable amount of time. Therefore, we used 2005 data to test the University's accounts receivable system. Specifically, we tested whether the University's accounts receivable system could accurately record and report commercial charges and disallowances. We performed our fieldwork at the University and the State Medicaid office, both of which are in Little Rock, Arkansas.

[2]The State plan amendment was approved June 4, 2004, with an effective date of October 1, 2002. Therefore, the supplemental payment was for the period October 2002 through May 2004.

Methodology

To accomplish our objective, we:

- reviewed the applicable portions of the Code of Federal Regulations and the Social Security Act,
- reviewed the approved State plan amendment regarding the supplemental payment for the University,
- interviewed CMS officials to obtain information related to their review of the supplemental payment calculation,
- interviewed State officials to gain an understanding of the processes used to create the initial and revised Medicaid charges and payments reports used in the supplemental payment calculation,
- interviewed University officials to gain an understanding of the accounts receivable system's procedures and controls,
- analyzed Medicaid charges and payments, and
- reviewed and tested a nonstatistical sample of 200 charges from four clinics for March and December 2005.

We performed our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

With one exception, the University's revised formula to calculate the supplemental payment was in accordance with the approved State plan. The University did not follow the State plan when it determined commercial payments. The University determined commercial payments by subtracting disallowances (reductions in charges that commercial payers negotiated with the University) from commercial charges. However, we do not believe that the University's method of determining commercial payments would produce results that are materially different from the State plan method.

Although the revised formula used by the University to calculate the supplemental payment was generally in accordance with the State plan, the supplemental payment was not adequately supported. Specifically, the average commercial payment rate included noncommercial charges and duplicate commercial charges and did not include some disallowances. The Medicaid charges and payments used to determine the supplemental payment included ineligible charges and payments. As a result, the University overstated the average commercial payment rate, and the State overstated Medicaid charges and understated Medicaid payments. We were unable to determine the amount by which the University overstated the average commercial payment rate.

The State overstated Medicaid charges used to calculate the supplemental payment by approximately $19.2 million and understated Medicaid payments by approximately $1.9 million.

The University included noncommercial and duplicate commercial charges in the average commercial payment rate calculation because its accounts receivable system could not properly account for misclassified charges. The University did not include some disallowances because its data was created before commercial payers could process and report some of the disallowances. The ineligible Medicaid charges and payments were included due to an oversight by the State.

COMMERCIAL PAYMENTS

According to the State plan, commercial payments are determined by adding all payments from commercial payers to amounts payable by the patients (copayments and deductibles) insured by those commercial payers. However, in the revised method, the University determined commercial payments by subtracting disallowances from commercial charges. The University used this methodology because its accounts receivable system could not effectively identify patient copayments and deductibles.

The University initially computed commercial payments by adding commercial insurance payments to patient transfers. As previously noted, patient copayments and deductibles were identified as transfers in the University's accounts receivable system. However, the University's accounts receivable system could not separate amounts that were transferred to a patient's responsibility (copayments and deductibles) from amounts that were transferred to another payer; consequently, transfers included more than patient copayments and deductibles. We do not believe that the University's revised method of determining commercial payments would produce results that are materially different from the State plan method.

NONCOMMERCIAL AND DUPLICATE CHARGES

The State plan requires that the average commercial payment rate be based on commercial charges. In calculating the average commercial payment rate, the University included some noncommercial charges and some commercial charges more than once. This occurred because the University could not properly account for charges that were misclassified and subsequently transferred. The University's accounts receivable system could not identify transferred charges in a manner that would allow the removal of misclassified charges from the rate calculation. When a charge was assigned to a commercial payer and then transferred to a noncommercial payer, the charge remained as a commercial charge in the rate calculation. Additionally, when a charge was transferred from one commercial payer to another commercial payer, the charge was included in the rate calculation for both payers.

The noncommercial charges did not have any disallowances associated with them; thus, they were included in the rate calculation as charges that were paid at 100 percent. Including commercial charges more than once had a similar effect because at least one charge would be included with no disallowances and would appear to be paid at 100 percent.

For example, from our testing of 2005 charges, we noted that one charge for $1,124 was initially assigned to a commercial payer and then transferred to another commercial payer. The second commercial payer disallowed $360. The University rate calculation methodology would have resulted in charges of $2,248 ($1,124+$1,124) and a disallowance of $360 for a commercial payment rate of 84 percent (($2,248-$360)÷$2,248). The commercial payment rate for the charge should have been 68 percent (($1,124-$360)÷$1,124).

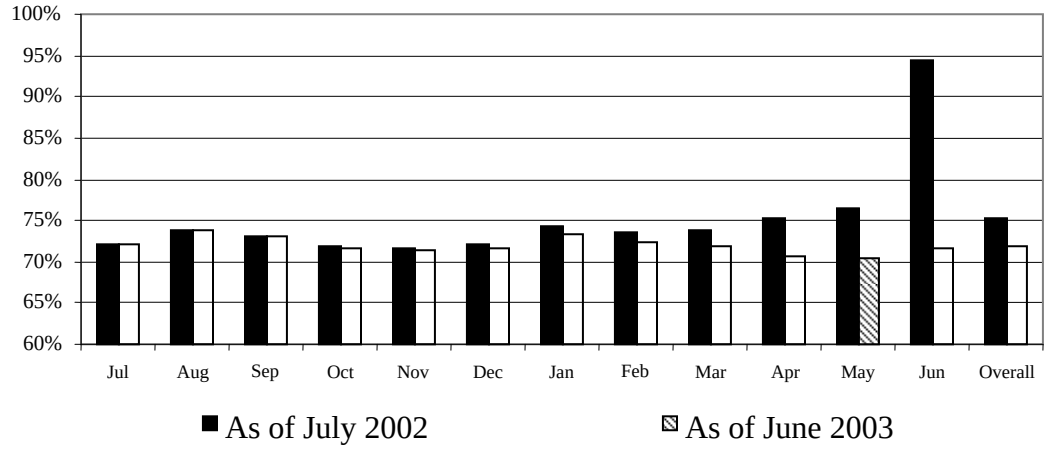
We did not determine the amount by which the average commercial payment rate was overstated because (1) the University's accounts receivable system could not identify transferred charges in a manner that would allow the removal of misclassified charges from the rate calculation, and (2) it was impractical to sample and test 2002 data because the data was stored on microfiche.

UNPROCESSED DISALLOWANCES

Because the University determined commercial payments by subtracting disallowances from commercial charges, to accurately determine the commercial payment rate all disallowances must be included in the calculation. Any charge without a disallowance would be included in the rate calculation as 100-percent paid. However, some disallowances were not included in determining commercial payments because the University used a report created before commercial payers had processed all of the reported charges and identified the disallowances. This report was created in July 2002 for the State fiscal year ended June 30, 2002.

By not accounting for all of the disallowances, the University overstated commercial payments, resulting in an overstatement of the average commercial payment rate. The following chart shows the effect of not including the disallowances on commercial payment rate determinations. The solid bars represent the monthly payment rates calculated using the July 2002 report. The striped bars represent the monthly payment rates calculated from using information available 11 months later. The chart shows a significant difference in the payment rates for the last 3 months of the report. Overall, when using disallowance data from the updated report, the average commercial payment rate dropped from 75.4 percent to 71.9 percent.

Monthly Commercial Payment Rates - State Fiscal Year 2002



MEDICAID CHARGES AND PAYMENTS

The State plan requires that the supplemental payment be based on paid Medicaid charges. The State included ineligible charges and payments in the Medicaid charges and payments used to calculate the supplemental payment. Specifically, the State (1) included charges that Medicaid ultimately denied, (2) associated charges and payments in an inconsistent manner, and (3) included the commercial portion of charges for which Medicaid was a secondary payer.

During our audit, the State identified and reported the inclusion of the denied charges and the inconsistent association of charges and payments. The State attributed all of these errors to an oversight. As a result of the errors, the State overstated Medicaid charges by $19.2 million and understated Medicaid payments by $1.9 million. (See Appendix A.)

RECOMMENDATIONS

We recommend that the State work with CMS to address the weaknesses noted in this report related to the calculation of the supplemental payment, which may require amending the State plan. We also recommend that any change in the average commercial payment rate be applied to the correct Medicaid charges and payments for the audit period and that any excess payment be refunded to the Federal Government.

STATE'S COMMENTS

In its written comments on our draft report, the State confirmed that it was in negotiations with CMS regarding the University's supplemental payment. The State's comments are included as Appendix B.

APPENDIXES

APPENDIX A

MEDICAID CHARGES AND PAYMENTS

	Charges	Payments
Amounts Reported by the State	$144,612,382.56	$53,412,689.98
Adjustments	(19,169,234.29)	1,928,441.50
Supported Amount	**$125,443,148.27**	**$55,341,131.48**

Arkansas Department of Health and Human Services

Division of Medical Services

P.O. Box 1437, Slot S-401
Little Rock, AR 72203-1437

Fax: 501-682-1197 **TDD: 501-682-6789** **Internet Website: www.medicaid.state.ar.us**

May 22, 2007

Forrest Duvall
HHS/OIG/OAS
11300 N. Rodney Parham, Suite 205
Little Rock, AR 72212

Dear Mr. Duvall:

Per your request, this is to confirm that the Arkansas Division of Medical Services is presently in negotiations with the Centers for Medicare and Medicaid Services regarding the University of Arkansas for Medical Sciences Professional Services supplemental payments. If you require additional information, please feel free to contact us.

Roy Jeffus
Director