DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

FEB 2 7 2007

Report Number: A-04-05-00015

Carmen Hooker Odom, Secretary
North Carolina Department of Health
and Human Services
Adams Building, 101 Blair Drive
Raleigh, North Carolina 27699

Dear Secretary Odom:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of the Medicaid Program's Use of Consultants on a Contingency Fee Basis." A copy of this report will be forwarded to the action official noted on the next page for his 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 HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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 members of 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.)

If you have any questions or comments about this report, please do not hesitate to contact me at (404) 562-7750 or at Peter.Barbera@oig.hhs.gov or Andrew Funtal, Audit Manager, at (404) 562-7762 or at Andrew.Funtal@oig.hhs.gov. Please refer to report number A-04-05-00015 in all correspondence.

Sincerely,

Peter J Barbera

Peter J. Barbera
Regional Inspector General
for Audit Services, Region IV

Enclosures

Direct Reply to HHS Action Official:

Roger Perez, Regional Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Atlanta, Georgia 30303-8909

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE MEDICAID PROGRAM'S USE OF CONSULTANTS ON A CONTINGENCY FEE BASIS

Daniel R. Levinson
Inspector General

February 2007
A-04-05-00015

Office of Inspector General

http://oig.hhs.gov

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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 HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Congress established Medicaid in 1965 as a jointly funded State and Federal program that provides medical assistance to eligible recipients. The Medicaid program is funded by a combination of Federal and State dollars allocated through a matching structure. The Federal Government matches State spending using a calculation called the Federal medical assistance percentage (FMAP). The FMAP is determined annually for every State using a formula based on income levels. The Centers for Medicare & Medicaid Services (CMS) administers the program at the Federal level. The North Carolina Department of Health and Human Services (the State agency) is the State agency responsible for administering North Carolina's Medicaid program.

Title XIX of the Social Security Act (the Act) makes family planning services a mandatory Medicaid service for eligible recipients of childbearing age. The Act also provides for 90 percent Federal matching for family planning services, which, as an enhanced rate, is higher than the FMAP allowed for most Medicaid services.

As long as they stay within Federal and State regulations, States make every attempt to ensure they receive the maximum allowable Federal share for expenditures they incur for Medicaid services. States regularly contract with consultants to help them identify and implement ways to maximize Federal funds.

OBJECTIVE

Our objective was to determine the reasonableness and allowability of Medicaid costs claimed for reimbursement by the State agency as a result of contingency fee arrangements with consultants.

SUMMARY OF FINDINGS

For the most part, the costs claimed for reimbursement by the State agency were reasonable and allowable. However, the State agency overstated its claims for reimbursement by $125,361 (Federal share) for Medicare/Medicaid cost report adjustments due to the use of misclassified expense data during computation of the claim. This occurred because the consultant inappropriately claimed non-allowable costs for reimbursement.

RECOMMENDATIONS

The State agency should refund $125,361 erroneously received under the Medicare/Medicaid Cost Report project.

State Agency Response

In written comments to the draft report, the State agency agreed that the $125,361 was erroneously received for the Medicare/Medicaid cost report project and said that the amount has been refunded to CMS. This amount also impacted the State's disproportionate share reimbursement. The State is resolving this with CMS.

The State agency did not agree with our recommendation for the family planning service project and provided additional information in response to our draft finding.

The State's comments are included in their entirety as Appendix B.

Office of Inspector General Comments

We have revised our final report to remove our draft finding on the family planning service project based on the State's response. The State provided us with information that we had not previously considered.

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INTRODUCTION

BACKGROUND

Medicaid Program

Title XIX of the Social Security Act (the Act) authorizes Federal grants to States for Medicaid programs that provide medical assistance to persons with limited income and resources. The Centers for Medicare & Medicaid Services (CMS) administers the program at the Federal level. The North Carolina Department of Health and Human Services (the State agency) is the State agency responsible for administering North Carolina's Medicaid program.

The Medicaid program is funded by a combination of Federal and State dollars allocated through a matching structure. The Federal Government matches State spending using a calculation called the Federal medical assistance percentage (FMAP). The FMAP is determined annually for every State using a formula based on income levels.

The Act was amended in 1972 to include the availability and provision of family planning services in the States. The Act makes family planning services a mandatory Medicaid service for eligible recipients of childbearing age, and provides for 90 percent Federal matching for family planning services. This match, an enhanced rate, is higher than the FMAP typically allowed for most Medicaid services.

States' Use of Consultants

Fiscally, it is in the States' best interest to use all available mechanisms to maximize Federal matching funds. Contracting consultants on a contingency fee basis is one available mechanism that a growing number of States are using to maximize Federal Medicaid reimbursements. States employ these consultants to help them identify and implement ways to obtain additional Federal funds. With the consultant's assistance, States can design their Medicaid programs to ensure they receive the maximum allowable Federal share of expenditures, as long as the programs adhere to Federal law, Federal regulations, and CMS policy.

North Carolina's Consultant Contract

In January 2002, North Carolina contracted with a consultant in an effort to increase State and Federal revenues. The consultant initiated 11 different projects, and the State agency submitted claims for increased Federal reimbursement based on 4 of the 11 projects:

- The Disproportionate Share Hospital Payments for State Hospitals project ($6,826,435): This project represented a one-time retroactive claim for DSH payments not previously claimed by two State-owned hospitals.

- The Medicare/Medicaid Cost Report project ($4,434,270): This project was to analyze State-owned facility cost reports to identify any costs not previously claimed for Federal reimbursement by the State.

- The Family Planning Services project ($2,531,897): This project was to claim family planning services costs not previously claimed for Federal reimbursement at the enhanced reimbursement rate.

- The Department of Public Health project ($4,072,709): This project had two tasks: one was to claim administrative costs not previously claimed and one was to claim medical services not previously claimed for Federal reimbursement.

These projects generated an additional $17.8 million in Federal funding to the State. (Refer to Appendix A for more details on these projects.) The consultant fee for these projects totaled about $1.6 million, based on fees that ranged from 6 to 10 percent of the Federal revenue generated. The consultants negotiated different contingency fees for each project.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine the reasonableness and allowability of Medicaid costs claimed for reimbursement by the State agency as a result of contingency fee arrangements with consultants.

Scope

Our review covered claims for Federal reimbursement from January 2002 through December 2004. We conducted our fieldwork at the State agency offices in Raleigh, North Carolina.

Methodology

To accomplish our audit objectives, we:

- reviewed sections 1905 and 1902 of the Social Security Act, Federal regulations, OMB Circular A-87, CMS's State Medicaid Manual and policy letters, and North Carolina's consulting contract;

- interviewed State agency officials regarding payments made to consultants;

- interviewed officials from the consulting firm to obtain an understanding of the work performed on each project;

- reviewed the consultant's invoices supporting the Medicaid reimbursement;

- examined Medicaid cost reports pertaining to the adjustments made on disproportionate share hospital (DSH) payments;

- obtained and tested supporting documentation pertaining to one State Hospital's Medicaid utilization rate to ensure that DSH requirements were met;

- analyzed Medicaid cost reports and retroactive cost report adjustments in the Medicare/Medicaid Cost Report project;

- examined the consultant's methodology used in the Family Planning Services project;

- tested a judgmental sample of fee-for-service family planning claims to ensure the claims were eligible for Federal funding;

- performed an in-depth review of a random moment time study (RMTS) claim within the Department of Public Health project including salary, benefits, cost factors, and programs and activities selected by the time study participants;

- visited a local health department to observe an employee in the process of entering data into a database as an RMTS participant; and

- interviewed CMS officials regarding the State's RMTS, specifically the cost factors and internal controls.

We reviewed certain internal controls relating to the State agency's claims for revenue generated by the consultant. However, we did not review the overall internal control structure of the State agency because we accomplished our objectives through substantive testing.

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

FINDINGS AND RECOMMENDATIONS

For the most part, the costs claimed for reimbursement by the State agency were reasonable and allowable. However, the State agency overstated its claims for reimbursement by $125,361 for Medicare/Medicaid cost report adjustments due to the use of misclassified expense data during computation of the claim. This occurred because the consultant inappropriately claimed non-allowable costs for reimbursement.

MEDICARE/MEDICAID COST REPORT PROJECT

Pursuant to OMB Circular A-87, Attachment A, C.1.a., costs must be necessary and reasonable for proper and efficient performance and administration of Federal Awards.

During our analysis of retroactive adjustments made by the consultants to a facility's 1999 cost report, we found a revenue item from vending operations misclassified as a Medicaid expense. This misclassification by the consultant resulted in the State agency improperly receiving $125,361 in Federal reimbursement. We brought the misclassification and resulting claim to the State agency's attention. The State agency acknowledged the error and informed us that it would return the $125,361 to the Federal Government.

RECOMMENDATIONS

The State agency should refund $125,361 erroneously received under the Medicare/Medicaid Cost Report project.

STATE RESPONSE

In written comments to the draft report, the State agency agreed that the $125,361 was erroneously received for the Medicare/Medicaid cost report project and said that the amount has been refunded to CMS. This amount also impacted the State's disproportionate share reimbursement. The State is resolving this with CMS.

The State agency did not agree with our recommendation for the family planning service project and provided additional information in response to our draft finding.

The State's comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL COMMENTS

We have revised our final report to remove our draft finding on the family planning service project based on the State's response. The State provided us with information that we had not previously considered.

APPENDIXES

REVENUE EARNED BY THE STATE ON FEDERAL MAXIMIZATION PROJECTS

Project Name	Federal Revenue to State	Recovery of State Funds	Total Project Revenue to State
DSH Payments for State Hospitals *(see Note 1)*	$ 6,826,435	$ 3,995,742	$ 10,822,177
Medicare/Medicaid Cost Reporting *(see Note 2)*	$ 4,434,270	$ 2,614,922	$ 7,049,192
Family Planning Services *(see Note 3)*			
Managed Care	$ 938,170	$ 0	$ 938,170 **
Fee-for-Service	$ 1,593,727	$ 0	$ 1,593,727 **
Sub-Total	$ 2,531,897	$ 0	$ 2,531,897
Department of Public Health *(see Note 4)*			
Fee-for-Service	$ 1,282,210	$ 767,358	$ 2,049,568
Administrative Claiming	$ 2,790,499	$ 0	$ 2,790,499**
Sub-Total	$ 4,072,709	$ 767,358	$ 4,840,067
Grand Totals	$ 17,865,311	$ 7,378,022	$ 25,243,333

****** These projects were for Federal revenue recovery only, otherwise the project total includes increased State and Federal revenue.

Note 1
DSH Payments for State Hospitals

This project was specifically for Alcohol and Drug Abuse Treatment Centers. The consultant determined that the State had not previously claimed DSH payments for two State-owned Alcohol and Drug Abuse Treatment Centers. The consultant quantified the amount owed to the State and filed a one-time retroactive claim for Federal reimbursement. ($6,826,435)

Note 2
Medicare/Medicaid Cost Reporting

This project was open to any cost report reimbursement issue. The consultant analyzed State-owned facility cost reports to identify any costs not previously claimed for Federal reimbursement by the State. The State retroactively claimed Federal reimbursement for any costs identified by the consultant. For example, the State had not included certain costs in the uncompensated care cost calculation for an Institution for Mental Disease. These were allowable costs that should have been included in the calculation. ($4,434,270)

Note 3
Family Planning Services

This project was to claim family planning services costs for Federal reimbursement at the enhanced reimbursement rate. The consultant analyzed the State's claims for family planning services and determined that the State had not used the enhanced rate allowed for Federal reimbursement. The consultant calculated the amount of family planning services that should have been claimed at the enhanced rate, and the State agency filed for additional Federal reimbursement. ($2,531,897)

Note 4
Department of Public Health

This project had two tasks: one was to claim administrative costs not previously claimed and one was to claim medical services not previously claimed for Federal reimbursement. The consultant initiated the first task because the State had not claimed administrative costs incurred by public health facilities. The consultant calculated the administrative costs associated with providing public health services and assisted the State in filing a claim for Federal reimbursement.

The consultant initiated the second task to claim reimbursement for Medicaid services rendered. The State provided these services to individuals who were not known to be Medicaid eligible, and therefore, no Medicaid claims were filed. The consultants performed Medicaid eligibility determinations, identified Medicaid eligible patients, and retroactively filed claims for Federal reimbursement. ($4,072,709)

North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

January 24, 2007

Report Number: A-04-05-00015

Mr. Peter J. Barbera
Regional Inspector General for Audit Services
US DHHS Office of Inspector General
61 Forsyth Street, SW
Suite 3 T41
Atlanta, Georgia 30303

Dear Mr. Barbera:

We have received your December 26, 2006 letter and the draft report entitled "*Review of the North Carolina Medicaid Program's Use of Consultants on a Contingency Fee Basis*" [Audit# A-04-05-00015]. Our response to the findings is indicated in the following narrative.

NC DHHS Response

As stated on page one of the draft report, Title XIX of the Social Security Act makes family planning services a mandatory Medicaid service for eligible recipients of childbearing age. The Act also provides for 90 percent Federal matching for family planning services, which, as an enhanced rate, is higher than the FMAP allowed for most Medicaid services. We agree with the report that for the most part, the costs claimed by the Department for reimbursement were reasonable and allowable. However, the audit report does not fairly present key facts and as a result, the audit report has misstatements of fact, incorrect conclusions and inappropriate recommendations.

In general, we believe that the OIG audit report is based upon flawed assumptions.

OIG Audit Recommendation #1: North Carolina should return excessive reimbursements of $508,347 which resulted from "incomplete cost data used in the calculations" which arose because DHHS did not "adequately review work performed by its consultants".

***NC Response**: The Department disagrees with this audit finding/recommendation.*

First, the statement "incomplete cost data used in the calculations", which is first stated at page i of the report and then repeated at pages ii, 3 and 4 of the report, is factually incorrect. The statement that the Department did not "adequately review work performed by its consultants" is based largely on this flawed assumption and is, therefore, also incorrect.

The "cost data used in the calculations" was prepared under contract by William M. Mercer, Inc., and published in May 2001. The claim filed by the Department was based upon data in SFY 1998. The report published in May 2001 contained complete data for the SFY 1998. However, under the same contract, Mercer also published a report on June 14, 1999, which covered a different time period, i.e. July 1994 through March 1998. For SFY 1998, only the first three quarters of data were included in the study published in June, 1999. The audit report statement that the Department received excessive reimbursements resulting from "incomplete cost data used in the calculations" is false. Had the Department based their claim on the data in June, 1999 rate study, there may have been some merit to this statement. However, the Department did not base their reimbursement claim on the report dated June, 1999. Instead, the Department based their claim on the study which was published in May, 2001. The study published in May 2001 contained complete cost data for SFY 1998. Therefore, the Department believes that the statement in the audit report, first made on page i of the report and then repeated three times at pages ii, 3 and 4, is invalid. Further, the report states "These conditions demonstrate that the State agency did not adequately review work performed by its consultants before submitting claims". However, the condition cited ("incomplete cost data") did not exist. The report goes on to state "the State agency continued to use incomplete cost data".

A. *Regarding the first instance claimed, in the amount of $125,361, the Department determined this situation arose as a result of a misclassification of expense, and the Department has already corrected this error by netting the claim submitted to CMS on the form CMS-64 for the quarter ending March 31, 2006.*

Specifically for this project, provider cost reports for the four state psychiatric facilities that were prepared by the Department and submitted to the Medicare Fiscal Intermediary were reviewed. As part of the review, the non-allowable expenditures reported were reviewed to determine the appropriateness of these expenses. The review concluded that certain costs should be reclassified as patient care expenditures. One such cost center was Vending Operations. This cost center is a special revenue account whereby, revenues earned from vending operations are deposited to the account. Revenues earned from this account are reviewed by a committee to determine how these funds should be spent. The expenditures are for reimbursable activities and should be included in the overall hospital reimbursement. However, during the OIG review it was revealed that when expenditures are approved from this account, they are transferred to the hospital and paid out of the hospital general expenditure accounts.

Based on the new information, it was determined that the hospital had inappropriately claimed these costs twice – once as an allowable cost and once as a non-allowable cost. And as a result, the Department adjusted the Medicaid claim to remove these expenditures, resulting in a net reduction of federal financial participation (FFP) of $125,361. Therefore, this amount has already been refunded to CMS.

Of the $125,361 associated with Vending Operations that was disallowed, net FFP of $16,385.62 was returned to CMS and reflected in the quarter ending 3/31/06 CMS-64. This amount reflected the additional Medicaid receipts due the inclusion of Vending Operations. As for the Disproportionate Share (DSH) portion, the remaining $108,975 of the disallowance has not been returned to CMS. This amount is part of the DSH settlement that DMA plans to execute this SFY. The overall settlement for SFY 1999 due to the IMDs stands at net FFP of $14,771,897. Broughton's share is $743,759. Thus, the disallowance will be deducted from the DSH settlement.

B. *The second amount, totaling $382,986, arises from the auditors' calculations and is based upon amounts which are irrelevant. More specifically, the auditors' calculations are based upon amounts which are from a data source different than the source used by the Department to compute the family planning factors. As described by the Department and its consultants, the data source for computing the family planning factors was the document titled "State of North Carolina Statewide Data Book" dated May 2001 and prepared by William M. Mercer, Incorporated. This data book contained fee for service cost information from several calendar years. The data book compiles and reports fee for service expenditures for designated state fiscal years for the purpose of assisting DHHS in establishing managed care payment rates. As previously stated, Mercer published another rate study in June, 1999 for the period July 1994 through March 1998.*

In the June 1999 report, data for the final quarter in SFY 1998 was not available. As a result, Mercer was required to project or estimate the value of claims not actually provided to Mercer by the Department. The absence of complete data is in fact the situation noted by the OIG. However, this Book is irrelevant because the Department used the data book issued May 21, 2001. The May 21, 2001 data book did in fact contain a complete set of all adjudicated and paid claims for the SFY 1998. As stated in the data book section 3-1 (attachment "A") the data for SFY 1998 was assumed to be 100 percent complete. This assumption is based on Mercer having all SFY 1998 claims which had been paid as of October 31, 2000. Any incomplete data could only have arisen from a valid claim for dates of service prior to July 1, 1999 and ***still unpaid more than 16 months later****. Although it is theoretically possible that a valid claim can remain unpaid after more than 16 months, such claims have historically been quite rare. The amount of any such claims, expressed as a percentage of the total, would be insignificant. Thus, for all practical purposes, the data set used was in fact complete. As a result, the audit report statements on pages i, ii, 3 and 4 regarding "incomplete data" are incorrect.*

The consultant received claims data provided by the Department for SFY 1997, SFY 1998, SFY 1999 and FFY 2000 which had been paid between July 1, 1997 and October 31, 2000, where the dates of service were within SFY 1998. These amounts totaled $4,043,615,468 and were termed "raw data" by the consultant. The consultant then applied various adjustments to the data, including completion factors, pharmacy rebates, etc. This data was then termed "adjusted data" by the consultant. The "raw data" for SFY 1998 FFS was $1,250,777,660 and the "adjusted data" was $885,624,567. The data source for the adjusted amount is page 10-1 of the StateWide Data Book dated May 2001. The data source for the $1,250,777,660 is the applicable components of covered populations provided by Mercer in their overall analysis of the claims population. (Family planning services of $11,859,975 plus other covered services $1,238,917,684 = denominator used by the auditors in the amount of $1,250,777,660).

The auditors' methodology to compute the amount of family planning services eligible for FFP is identical with that of the Department. However, the data used, (i.e. total fee for service and family planning fee for service costs) differs significantly. *Thus, the auditors' finding of excess reimbursements of $382,986 is based entirely on different costs used in their computation. As described in the documents provided to CMS and OIG, the basic calculation of the family planning Managed Care Organization (MCO) factors or ratios is straightforward and simple. The numerator is the total fee for service family planning costs incurred by Medicaid recipients that are eligible to enroll in the managed care program. The numerator is also limited to services for those individuals that would be covered by the MCO plans. The denominator is the total fee for service costs for the same recipient populations that are eligible for enrollment in the MCO program. This denominator includes both the family planning costs and all other fee for service costs that are to be provided by the MCO plans. The Mercer data books report two major categories of total fee for service costs. These categories are: (1) Raw Unadjusted Claims costs and (2) Adjusted claims costs. The raw unadjusted claims costs represent the entire universe of paid claims available from the states data warehouse. The adjusted claims costs represent the elimination of costs from the managed care rate setting process by the actuaries as these costs represent services that are not included in the managed care program. Additionally, Mercer makes numerous additional adjustments to assure that only services for individuals that are to be enrolled in the managed care plans are included in the rate setting process. The Department used the adjusted cost database in developing the family planning factors. Since the purpose of the family planning factor is to determine what portion of the managed care rates relate to family planning, it would be inappropriate to include costs that are not contained in the managed care rates when identifying the family planning portion of these costs. The auditors base their analysis on a total fee for service of $1,250,777,660, whereas the Department used an amount of $885,624,567. (There was also a difference in family planning fee for service costs of $11,859,975 vs. $10,773,535 which also had a contributory effect on the difference).*

The Department's reimbursement claim is based upon the "adjusted data" published by the consultants on May 7, 2001 in their rate book on pages 10-16 through 10-22. This data was attached to the claim as Appendix D. The data used by the auditors was not the "adjusted data", but instead the "raw data" produced by the consultant, unadjusted for any completion factors, pharmacy rebates, etc.

The Department firmly believes that its use of the adjusted claims figure of $885,624,567 for the denominator is appropriate for this calculation as it includes the appropriate adjustments to the raw claims figure of $1,250,777,660 used by the auditors as noted above. The Department contacted Mercer directly who confirmed this position and validated the Department's determination that using the $1,250,888,660 is inappropriate and, as such, stands by the figures used to determine the family planning factor.

For all of these reasons, and also those in attachment B, the Department believes that the basis for the claim is appropriate, and therefore no adjustment or reimbursement is necessary.

OIG Audit Recommendation #2: The State continued to use the consultant's calculations after December 30, 2004 in subsequent claims for Federal reimbursement. Therefore, the State agency may have continued to overstate family planning services claims beyond the audit period.

***NC Response**: The Department disagrees with this audit finding/recommendation.*

*First, unless there is evidence or other reason to believe that the nature of the program has changed materially, there is no requirement that the Department is aware of, that the factors need to be recomputed. Nevertheless, the Department did perform a preliminary analysis to determine if the Family Planning portion had changed materially and would thus necessitate a complete review and revision of the Family Planning factors used. That preliminary analysis indicated that the Family Planning factor would have increased somewhat, and thus the factor used on claims for calendar years subsequent to December 31, 2004 would be **conservative**, i.e. if claims were revised to reflect currently available data, the amount of the claim for reimbursement would be larger than what has been submitted. However, the Department felt that a **conservative approach** was the most appropriate, and therefore did not perform a full-fledged study. If the OIG and CMS determine that such a study is necessary, then the Department will proceed with the study and revise their reimbursement claims accordingly.*

We trust that the foregoing responses address the report recommendations. If additional information is needed, please contact Dan Stewart, Deputy DHHS Secretary at (919) 733-4534 or Dan.Stewart@ncmail.net. Lastly, even though we disagree on a couple of basic issues, we

would like to state that the OIG staff were very professional to deal with and appreciate the review. We are always interested in studying various options to improve our Medicaid Program.

Sincerely,

Carmen Hooker Odom

CHO:ds

Cc: Dan Stewart, CPA
L. Allen Dobson Jr., M.D.
Mark Benton
Eddie Berryman, CPA
Laketha Miller, CPA
Honorable Les Merritt, CPA

Attachments A and B

Attachment A

Data Adjustments

This section summarizes the adjustments made to the base period data. The adjustments were developed using actual State experience except where noted. These adjustments are reflected in the total dollars and service units columns of the data sets where applicable:

Completion Factors

The data sets contain dates of service from July 1996 through September 2000 and dates of payment through October 2000. Because of the claim lag, the delay in time between the date of service and the date of payment, Mercer applied completion factors to capture the claims that have not been reported.

SFY1997 and SFY1998 were assumed to be 100 percent complete and, therefore, are not listed in the chart below. The completion factors were applied to net paid and utilization amounts to estimate a fully incurred claim and unit level. Mercer applied the completion factors to the claims and the units in order to ensure accurate unit cost and utilization calculations. Completion factors for child therapy procedures, CA physician coordination fees, and other coordination fees were applied to the appropriate COS before those services were separately identified. ICF/MR, ventilator care, and TBI COS were consolidated with the NF COS after the completion factors were applied.

The following are the completion factors that were applied for the following COA: ***AFDC, MPW, MIC, and Other Children***

COS	FFY1999 Completion Factor	FFY2000 Completion Factor
Covered Services		
Inpatient	1.007	1.205
NF	1.010	1.504
Outpatient	1.002	1.112
ER	1.001	1.110
Primary Care	1.003	1.108
Specialist	1.003	1.108
Family Planning	1.005	1.212
Home Health	1.007	1.221
Lab & X-Ray	1.000	1.347

Attachment B

Attachment B – Basis for use of the Methodology

Claim Development Methodology

In order to compute the amount of claimed Family Planning cost portion of the Managed Care premiums, the Department had to develop a methodology. This methodology resulted computing such costs by multiplying the Gross MCO Payments reported to CMS on the CMS-64 form by a fraction. The fraction consisted of a numerator and a denominator. The numerator was the adjusted amount of family planning fee for service costs as computed by the consultant using a methodology which had been reviewed and approved by CMS. The denominator was the adjusted amount of total fee for service costs, using the same methodology reviewed and approved by CMS.

For administrative cost allocations to the Medicaid program, State governments must allocate such costs in accordance with a plan approved by DHHS Division of Cost Allocation (DCA) after CMS review and comments on the fairness of the allocation methodology, Federal regulations (45 CFR § 95.507) require that cost allocation plans conform to the accounting principles and standards in Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments" (A-87).

The cost allocation methodology used by the consultant (and approved by CMS) to transform the "raw unadjusted data" to the "adjusted data" took into account a number of reductions and credits, for example prescription drug rebates, Medical educations, etc. This is in accordance with the principles set out in section D-1 of Circular A-87 at page 10, which states "Total cost. The total cost of Federal awards is comprised of the allowable direct cost of the program, plus its allocable portion of allowable indirect costs, *less applicable credits*." (emphasis added). The auditors cite OMB Circular A-87 at page 5 of the report as the basis for disallowance of a $125,361 claim reimbursement.

CMS' Federal Audit Guide

The CMS Federal Audit Guide provides general guidance for evaluating "multiple service claims", that is when a claim contains services that are both family planning and non family planning. Medicaid managed care capitation claims are "multiple service claims". The guide instructs States to "develop a reasonable method" for allocating costs between family planning and non family planning activities.

The State fully disclosed their methodology, which was in accordance with the methodology that CMS had reviewed and approved for the development of the rate books. Thus, CMS was clearly on notice that the reimbursement claims submitted used data developed using a methodology that CMS had reviewed and approved.

Attachment B

Nevertheless, the audit report states at pages i, ii, 3 and 4 that "incomplete cost data" was used, with excluded costs of $365,153,093 ($1,250,777,660 - $885,624,567), and that "excluded costs were considered family planning costs".

The effect of the auditors recommendation would require the Department to now disavow their prior understanding and agreement with CMS as to the proper methodology and put forth a new proposal. Such an action might also necessitate development of revised MCO rates which might also require the review and approval of CMS. Such a methodology is also in apparent conflict with Circular A-87, as previously discussed.

Reliance on CMS Approval

Both the consultant and the Department relied upon the review and approval by CMS of the methodology used to compute the adjusted fee for service amounts. To submit a reimbursement claim to CMS which ignored the methodology which had been approved would have required substantial justification and would also have put the claim at risk of denial.