DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date MAY - 4 2001

From Michael F. Mangano
Acting Inspector General

Subject Review of Medicaid Enhanced Payments to Public Hospital Providers and the Use of Intergovernmental Transfers by the Alabama State Medicaid Agency (A-04-00-02169)

To Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "Review of Medicaid Enhanced Payments to Public Hospital Providers and the Use of Intergovernmental Transfers by the Alabama State Medicaid Agency." This is one in a series of reports on enhanced payments made in six States. The objectives of our review were to analyze the use of enhanced payments and to evaluate the financial impact of intergovernmental transfers on the Medicaid program.

We found that the State of Alabama made inpatient hospital enhanced payments to both State-owned and local government-owned facilities totaling approximately $465 million for the period October 1, 1996 through July 31, 2000. We audited about $432 million of this total, of which the Federal share was about $302 million. Of the Federal share, the hospitals retained about $216 million, and about $86 million (about 28.5 percent of the $302 million) was returned to the State agency.

Contrary to the spirit of the State-Federal matching requirements of the Medicaid program, the State agency developed a mechanism to receive additional Federal funds without committing its share of required matching funds. We found that the facilities receiving the enhanced payments were required to provide the State's share of the payments in advance. This amount was returned to the facilities, along with the Federal share, as part of the enhanced payment. Once the State made the payments, the facilities returned approximately 28.5 percent of the Federal share of the payments to the State. Because 28.5 percent of the Federal funds was returned to the State, it did not appear that the State actually incurred an expense related to these enhanced payments. This condition drew into question whether the amounts paid back to the State agency constituted a refund required to be reported as other collections and consequently offset against expenditures on the Health Care Financing Administration (HCFA) Form 64.

The enhanced payments were made based on State Plan Amendment (SPA) 94-17, approved effective July 1, 1994, which allowed for public facilities (State and local government-

owned facilities) to be paid enhanced payments up to the overall Medicare upper payment limit. Through the years, the State changed its methodology for calculating the funding pool and the changes were not always in accordance with the SPA. We are taking exception to these changes and will issue a separate report to the State on these matters. In addition, in 1995 the State developed a plan by which Alabama hospitals were paid for inpatient hospital services through the State's Partnership Hospital Program. We understand that HCFA is currently reviewing this arrangement because of concern that it may represent a managed care environment. We, too, are concerned with the use of enhanced payments in a managed care environment and will discuss this further with HCFA officials.

We also noted that there is no clearly defined methodology for computing the upper payment limit. Payment amounts can vary significantly, depending on the creativity of a State's funding pool methodology. We believe HCFA needs to define and develop clear and consistent guidelines for calculating a reasonable Medicare upper payment limit pursuant to the economy and efficiency provisions at section 1902 (a)(30) of the Social Security Act.

In a related matter, with the implementation of enhanced payments, we believe that the State reduced the amount of the disproportionate share hospital (DSH) payments that the hospitals were allowed to retain. During our audit period, the State reduced its net DSH outlay to facilities by approximately $70 million per year. Comparatively, the facilities retained about $56 million in enhanced payments.

On January 12, 2001, HCFA issued revisions to the upper payment limit regulations. In a written reply to our draft report, HCFA indicated that they also plan to issue revisions to the State Medicaid Manual which will address the method of calculating the Medicare upper payment limit. We commend HCFA for taking this action.

In Alabama, we estimate savings to the Federal Government of about $18.8 million during the transition period of the new regulations. Once the regulatory changes are fully implemented (i.e., the transition period is completed), we estimate savings to the Federal Government of about $12.6 million annually, totaling a savings of about $63 million over 5 years. Therefore, we recommend that HCFA take action to ensure that Alabama complies with the phase-in of the revised regulations.

Please advise us within 60 days on actions taken or planned on our recommendations. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at 410-786-7104.

To facilitate identification, please refer to Common Identification Number A-04-00-02169 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID ENHANCED PAYMENTS TO PUBLIC HOSPITAL PROVIDERS AND THE USE OF INTERGOVERNMENTAL TRANSFERS BY THE ALABAMA STATE MEDICAID AGENCY

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From Michael F. Mangano
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Subject Review of Medicaid Enhanced Payments to Public Hospital Providers and the Use of Intergovernmental Transfers by the Alabama State Medicaid Agency (A-04-00-02169)

To Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

This final report provides the results of our review of Medicaid enhanced payments to publicly-owned hospitals and the use of intergovernmental transfers (IGT) by the State of Alabama and local governments within Alabama. This is one in a series of reports on enhanced payments made in six States. The objectives of our review were to analyze the use of enhanced payments and to evaluate the financial impact of IGTs on the Medicaid program. This report includes only information on Medicaid enhanced payment transactions resulting from the upper payment limit calculations relating to publicly-owned hospitals. These enhanced payments are separate and in addition to the basic payment rates for Medicaid providers. The basic Medicaid payments were not included as part of our review.

We found that the State of Alabama made inpatient hospital enhanced payments to both State-owned and local government-owned facilities totaling approximately $465 million for the period October 1, 1996 through July 31, 2000. We audited about $432 million of this total, of which the Federal share was about $302 million. Of the Federal share, the hospitals retained about $216 million, and about $86 million (about 28.5 percent of $302 million) was returned to the State agency.

Contrary to the spirit of the State-Federal matching requirements of the Medicaid program, the State agency developed a mechanism to receive additional Federal funds without committing its share of required matching funds. We found that the facilities receiving the enhanced payments were required to provide the State's share of the payments in advance. This amount was returned to the facilities, along with the Federal share, as part of the enhanced payment. Once the State made the payments, the facilities returned approximately 28.5 percent of the Federal share of the payments to the State. Because 28.5 percent of the Federal funds was returned to the State, it did not appear that the State actually incurred an expense related to these enhanced payments. This condition drew into question whether the amounts paid back to the State agency constituted a refund required to be reported as other collections and consequently offset against expenditures on the Health Care Financing Administration (HCFA) Form 64.

The enhanced payments were made based on State Plan Amendment (SPA) 94-17, approved effective July 1, 1994, which allowed for public facilities (State and local government-owned facilities) to be paid enhanced payments up to the overall Medicare upper payment limit. Under regulations in effect at the time of our audit, there was a separate upper payment limit which applied to State-owned facilities, but no such limit existed for local government-owned facilities. In computing the funding pool, the State combined State facilities with local government-owned facilities. However, in so doing, the State did not exceed the upper payment limit for State-owned facilities.

Through the years, the State changed its methodology for calculating the funding pool and the changes were not always in accordance with the SPA. We are taking exception to these changes and will issue a separate report to the State on these matters. In addition, in 1995 the State developed a plan by which Alabama hospitals were paid for inpatient hospital services through the State's Partnership Hospital Program. We understand that HCFA is currently reviewing this arrangement because of concern that it may represent a managed care environment. We, too, are concerned with the use of enhanced payments in a managed care environment and will discuss this further with HCFA officials.

We found that if regulations were changed to include a separate aggregate upper payment limit for local government-owned facilities, the amount of funds available to Alabama for enhanced payments to public providers would be significantly reduced. Thus, the amount of Federal Medicaid funds that public providers are able to transfer to the State for other uses would be limited. A change in regulations (which as noted later was made in January 2001) would have reduced the enhanced payments during the audit period by approximately $42 million.

Finally, we noted that there is no clearly defined methodology for computing the Medicare upper payment limit. We noticed that payment amounts can vary significantly, depending on the creativity of a State's funding pool methodology. As a result, we believe controls are needed to protect the fiscal integrity of the Medicaid program. More specifically, we believe HCFA needs to define and develop clear and consistent guidelines for calculating a reasonable Medicare upper payment limit pursuant to the economy and efficiency provisions at section 1902 (a)(30) of the Social Security Act (the Act).

In a related matter, with the implementation of enhanced payments, we believe that the State reduced the amount of the disproportionate share hospital (DSH) payments that the hospitals were allowed to retain. Medicaid DSH payments are intended to help hospitals that provide care to a large number of Medicaid beneficiaries and uninsured patients. During our audit period, the State reduced its net DSH outlay to facilities by approximately $70 million per year. Comparatively, the facilities were retaining about $56 million in enhanced payments.

In our draft report, we noted that HCFA issued a Notice of Proposed Rulemaking (NPRM) on October 10, 2000 that, when implemented, would help to limit the present manipulation

of upper payment limit requirements. We also recommended that HCFA provide guidance that would address the method of calculation of the Medicare upper payment limit.

In a written reply to our draft report, HCFA generally concurred with our recommendations and believed that the recently published upper payment limit revisions will significantly eliminate excessive enhanced payments. The HCFA also indicated that they plan to issue revisions to the State Medicaid Manual which will address the method of calculating the Medicare upper payment limit. The HCFA's response is included as **APPENDIX B** to this report.

We commend HCFA for taking action to change the upper payment limit regulations. On January 12, 2001, HCFA issued revisions to the upper payment limit regulations. The regulations included several transition periods, one of which applied to Alabama. During the transition period applicable to Alabama, the financial impact of the new regulations will be gradually phased-in and become fully effective on October 1, 2005. In essence, the transition period allows the State of Alabama to claim the full upper payment limit calculated under the old regulations for the years 2001 and 2002, and gradually reduces the State's claim from 2003 through 2005, after which time the allowable payments will be as calculated under the new regulations.

In Alabama, we estimate savings to the Federal Government of about $18.8 million during the transition period. Once the regulatory changes are fully implemented (i.e., the transition period is completed), we estimate savings to the Federal Government of about $12.6 million annually, totaling a savings of about $63 million over 5 years (see **APPENDIX A** for additional details). Therefore, we recommend that HCFA take action to ensure that Alabama complies with the phase-in of the revised regulations.

We also provided a copy of our draft report to the State agency and offered the State agency the opportunity to provide written comments to the facts presented in the report. The State agency did not provide any comments to the report.

BACKGROUND

Title XIX of the Act authorizes Federal grants to States for Medicaid programs that provide medical assistance to needy persons. Each State Medicaid program is administered by the State in accordance with an approved State plan. While the State has considerable flexibility in designing its State plan and operating its Medicaid program, it must comply with broad Federal requirements. The Medicaid programs are administered by the States, but are jointly financed by the Federal and State governments. States incur expenditures for medical assistance payments to medical providers who furnish care and services to Medicaid-eligible individuals. The Federal Government pays its share of medical assistance expenditures to a

State according to a defined formula which yields the Federal medical assistance percentage (FMAP). The FMAP rate for the State of Alabama is 70 percent.

State Medicaid programs have flexibility in determining payment rates for Medicaid providers within their State. The HCFA allows State Medicaid agencies to pay different rates to the same class of providers, as long as the payments, in aggregate, do not exceed the upper payment limits (what Medicare would have paid for the services). Under Federal regulations in effect during our review, the general rule regarding upper payment limits states that aggregate payments to each group of health care facilities, such as nursing facilities or hospitals, may not exceed the amount that can be reasonably estimated would have been paid under Medicare payment principles. This aggregate payment limit applied to all facilities in the State (private, State-operated, and city/county-operated).

Also, as previously mentioned, there was a separate aggregate payment limit that applied only to State-operated facilities. Because there was not a separate aggregate limit that applied to local government-operated facilities, these types of facilities were grouped with all other facilities when calculating aggregate upper payment limits. This allowed the State Medicaid agency to make enhanced Medicaid payments to city and county-owned facilities without violating the upper payment limit regulations. These enhanced payments are separate and in addition to the basic Medicaid payments made to facilities that provide services to Medicaid-eligible individuals. Federal financial participation is not available for State expenditures that exceed the applicable upper payment limits.

The upper payment limit regulations at 42 CFR 447.272, as discussed in this report, are applicable to Federal financial participation in payments made by a State agency for inpatient hospital services under the traditional fee-for-service Medicaid program. Managed care payments are subject to separate upper payment limit regulations contained at 42 CFR 447.361. If a State makes payments to a managed care organization to assume the risk of caring for Medicaid patients, those payments cannot be included in calculating enhanced payments available under the fee-for-service upper payment limit regulations. The prohibition against making direct payments (regular or enhanced) to providers for services for which a State is already paying a managed care organization is contained in 42 CFR 434.57.

Since October 1995, Alabama hospitals have been paid for inpatient hospital services through the State's Partnership Hospital Program. Under this arrangement, each Alabama Medicaid beneficiary is enrolled in one of eight different prepaid health plans (PHP). The PHPs pay hospitals a per diem payment for inpatient services rendered to Medicaid patients. Currently, within HCFA, there is a question whether the situation in Alabama represents a managed care environment or if the PHPs are merely serving as a payment agent for the State to pay hospitals for inpatient services in a traditional fee-for-service manner.

SCOPE

The objectives of our review were to analyze the use of Medicaid enhanced payments to public hospitals and to evaluate the financial impact of IGTs on the Medicaid program. Our audit covered enhanced payments made to public hospitals in the State of Alabama beginning with October 1, 1996 through July 31, 2000. We attempted to determine the accuracy of the funding pool calculated by the State Medicaid agency for distribution to public hospitals and attempted to track the dollars that were transferred between State and local governments.

To accomplish our objectives, we met with HCFA regional office staff and discussed their role and reviewed their records pertaining to Alabama's Medicaid program. We conducted a review at the State Medicaid agency, interviewed key personnel, and reviewed applicable records supporting the funding pool calculations, enhanced payments, and IGTs. We also selected one State-owned and one county-owned facility that received enhanced payments to determine how the enhanced payments were used. We surveyed key personnel about the transfer and use of funds.

While the State made approximately $465 million in enhanced payments during the audit period, we were able to review only $432 million in enhanced payments. The remaining $33 million was made in a retroactive payment in July 2000 and was disclosed to auditors after the completion of the field audit work. Also, we did not review Alabama's financial arrangement through its Partnership Hospital Program. We plan to discuss this arrangement further with HCFA personnel to determine if it represents a managed care environment.

Our review was conducted in accordance with generally accepted government auditing standards. We performed field work at the State agency in Montgomery, Alabama.

RESULTS

We found that the State of Alabama made inpatient hospital enhanced payments to public hospitals totaling approximately $465 million for the period October 1, 1996 through July 31, 2000. We audited about $432 million of this total, of which the Federal share was about $302 million. Of the Federal share, the hospitals retained about $216 million, and about $86 million was returned to the State agency.

Contrary to the spirit of the State-Federal matching requirements of the Medicaid program, the State agency developed a mechanism to receive additional Federal Medicaid funds without committing its share of required matching funds. The facilities were required to provide the State's share of enhanced payments in advance. This amount was returned to the facilities, along with the Federal share, as part of the enhanced payments. Subsequent to

receiving the enhanced payments, the facilities returned about 28.5 percent of the Federal share of the payments to the State.

The enhanced payments were made based on the SPA 94-17, approved effective July 1, 1994, which allowed for public facilities to be paid enhanced payments up to the overall Medicare upper payment limit. Under regulations in effect during our audit, there was a separate upper payment limit which applied to State-owned facilities, but no such limit existed for local government-owned facilities. In computing the funding pool, the State combined State facilities with local government-owned facilities. However, in so doing, the State did not exceed the upper payment limit for State-owned facilities. Through the years, the State changed its methodology for calculating the funding pool and the changes were not always in accordance with the SPA. We are taking exception to these changes and will issue a separate report to the State on these matters. In addition, in 1995 the State developed a plan by which Alabama hospitals were paid for inpatient hospital services through the State's Partnership Hospital Program. We understand that HCFA is currently reviewing this arrangement because of concern that it may represent a managed care environment. We, too, are concerned with the use of enhanced payments in a managed care environment and will discuss this further with HCFA officials.

The State computed the Medicare upper payment limit using Medicare prospective payment system (PPS) principles. In Fiscal Year (FY) 1997, the payments were based on a Medicare upper payment limit calculation relating to publicly-owned facilities only. Beginning in FY 1998, and for the remainder of the audit period, the State made payments based on two separate Medicare upper payment limit calculations - one for publicly-owned facilities and one for privately-owned facilities. Of the $432 million in payments that we reviewed, the total payments made resulting from the public facilities funding pool was $319 million and the total resulting from the private facilities funding pool was $113 million.

We found that if regulations were changed to include a separate aggregate upper payment limit for local government-owned facilities, the amount of funds available to Alabama for enhanced payments to public providers would be significantly reduced. Thus, the amount of Federal Medicaid funds that public providers are able to transfer to the State for other uses would be limited. As previously stated, we reviewed a total of $432 million in enhanced payments made during our audit period. Had the new regulations been in effect during the audit period, the enhanced payments would have been reduced from $432 million to approximately $390 million--a difference of $42 million.

Finally, we noted that there was no clearly defined methodology for computing the Medicare upper payment limit. We noticed that payment amounts can vary significantly, depending on the creativity of a State's funding pool methodology. We believe controls are needed to protect the fiscal integrity of the Medicaid program. More specifically, we believe HCFA needs to define and develop clear and consistent guidelines for calculating a reasonable

Medicare upper payment limit pursuant to the economy and efficiency provisions at section 1902 (a)(30) of the Act.

In a related matter, it appears that the State used the enhanced payments to partially replace State DSH payments. In FY 1994, the year prior to the first full year of enhanced payments, the facilities had been returning 68 percent of their total DSH payments to the State. According to State officials, this percentage was increased to 86 percent by FY 1996. During our audit period, the State reduced its share of DSH payments to facilities by approximately $70 million per year. Comparatively, the facilities were receiving about $56 million in enhanced payments. On one hand, the State provided new funds to the facilities through enhanced payments, but on the other hand, the State reduced the amount of DSH funds the facilities were receiving. The effect of this was to put more funds in the State's general revenue account.

The following sections provide more details on the results of our review.

FUNDING POOL METHODOLOGY

The State agency received an approved SPA from HCFA, effective July 1, 1994, allowing for the creation of a funding pool to increase reimbursement to publicly-owned hospitals. The funding pool was to be calculated by computing the difference between the Medicare upper payment limit and the allowable Medicaid payments for each publicly-owned facility in the State. The combined total of the differences for all facilities in the State was to be expressed as a percentage of total Medicaid payments for the same facilities to compute an add-on percentage to be applied to each facility's Medicaid per diem payment rate (i.e., each facility received the same add-on percentage) to compute a per diem enhancement for each facility. This per diem enhancement was applied each month to each facility's Medicaid days to compute a monthly enhanced payment.

We found that the State computed the Medicare upper payment limit for publicly-owned facilities using Medicare PPS principles. Using this methodology, the State included all Medicare payments; e.g., diagnosis related group payments, outliers, capital costs, disproportionate share adjustment, direct medical education, indirect medical education, and organ acquisition costs. Of the $432 million in payments which we reviewed, the total payments relating to the publicly-owned facilities funding pool was about $319 million. We also noted that in FY 1998, the State began performing a Medicare upper payment limit computation relating to private facilities which it distributed to the publicly-owned facilities. This computation was also done using Medicare PPS principles. The total paid relating to the private facilities funding pool was about $113 million.

In addition to the $432 million in payments that we reviewed, State officials informed us at the audit exit conference that they made three retroactive payments of $32,707,814 each, for a total of $98,123,442, relating to FYs 1997, 1998, and 1999. These payments were made in

July, August, and September of FY 2000. The Federal share of these payments was approximately $68,686,409. We did not review the State's calculations of these retroactive payments; however, State officials informed us that the calculations were done in order to use more up-to-date cost report information in computing the enhanced payments using Medicare PPS principles.

Through the years, the State changed its methodology for calculating the funding pool, and the changes were not always in accordance with the SPA. We are taking exception to these changes and will issue a report to the State on these matters. These issues were not within the scope of this review, and will be disclosed in a later report (Common Identification Number A-04-00-02171). In addition, in 1995 the State developed a plan by which Alabama hospitals were paid for inpatient hospital services through the State's Partnership Hospital Program. We understand that HCFA is currently reviewing this arrangement because of concern that it may represent a managed care environment. We, too, are concerned with the use of enhanced payments in a managed care environment and will discuss this further with HCFA officials.

FINANCIAL IMPACT AND USE OF THE FUNDS

The State developed a funding mechanism to obtain additional Federal funding without expending its share of required matching funds. Moreover, once the State made the enhanced payments to the facilities, the funds lost their identity in the accounting records. Consequently, we could not determine the specific use of the funds, although at the State agency, the funds were deposited into a Medicaid special revenue account which was used to cover Medicaid program expenditures. The following sections provide more details on the source of the State matching funds, the distribution of the State and Federal funds, the use of the enhanced payments, and the potential financial impact of enhanced payments on the Medicaid program.

Facilities Provide State's Share of Matching Funds

The State included the budgeted enhanced payments in its budget request to HCFA (HCFA Form 37) and, accordingly, received the Federal share of the enhanced payments along with the Federal share of all other Medicaid expenditures. On the HCFA 37, the State certified that it had or would have the State's portion of the budgeted expenditures on hand.

The State required the facilities to provide the State's share of the enhanced payments. Subsequently, when the State made enhanced payments to the facilities, the payment included the State and Federal share. In so doing, the State effectively incurred no expense.

Distribution of Funds Between State and Facilities

The distribution of enhanced payments to public hospitals by the State varied depending on the source of the payments. If the payments were based on the public facilities funding pool, the facilities retained most of the payments. However, if the payments were based on the private facilities funding pool, the State retained most of the payments.

For Alabama, the State matching share was approximately 30 percent. As the SPA was initially implemented, the State required the facilities to provide 35 percent of the funding pool (the State's share plus 5 percent). The State then claimed the Federal share of 70 percent and paid 100 percent of the funding pool to the facilities. In effect, the net gain to the hospitals was 65 percent (100 percent of the funding pool less the 35 percent originally provided to the State) and the net gain to the State was the remaining 5 percent. This was how the cash flowed when the payments were strictly based on the public facilities' funding pool. Through this process, the Federal Government provided the only outlay of funds. The following schedule shows the Federal share of the payments relating to the public facilities and the portion retained by the State and the facilities.

Facilities' and State's Share of Public Facilities Related Enhancements

Fiscal Year	Total Payments Relating to Public Facilities	State Share	Federal Share	Federal Share Retained by State	Federal Share Retained by Facilities
1997	$78,685,007	$23,605,502	$55,079,505	$3,934,250	$51,145,255
1998	$84,748,311	$25,424,493	$59,323,818	$2,963,580	$56,360,238
1999	$77,382,696	$23,214,809	$54,167,887	-	$54,167,887
2000	$77,826,572	$23,347,972	$54,478,600	-	$54,478,600
Total	$318,642,586	$95,592,776	$223,049,810	$6,897,830	$216,151,980

After the State began including private hospitals in the funding pool calculation, the distribution of funds changed. The State no longer required the facilities to put up 35 percent of the payments. Instead, it required the public hospitals that were included in the distribution of the funding pool to put up only the State share of 30 percent. However, upon receiving the enhanced payments, the public hospitals were required to return to the State 100 percent of the Federal share of the payment relating to the private facilities' funding pool calculation. Thus, by changing funding pool methodologies to include private facilities, the State created a windfall for itself. This windfall was also created without the State being required to outlay any money. The following schedule shows how the State benefitted from these payments:

Facilities' Share and State's Share of Private Facilities Related Enhancements

Fiscal Year	Total Payments Relating to Private Facilities	State Share	Federal Share	Federal Share Retained by State	Federal Share Retained by Facilities
1997	-	-	-	-	-
1998	$39,929,822	$11,978,947	$27,950,875	$27,950,875	-
1999	$39,929,820	$11,978,946	$27,950,874	$27,950,874	-
2000	$33,241,363	$9,972,409	$23,268,954	$23,268,954	-
Total	$113,101,005	$33,930,302	$79,170,703	$79,170,703	-

Use of Funds

To determine the use of the funds at the local level, we questioned key personnel at two hospitals receiving enhanced payments. In both cases, the personnel indicated that the enhanced payments were deposited into general funds used to pay facility expenses. The funds were not accounted for separately from other funds. We were unable to determine specifically how the funds were used.

We also tried to determine the use of the enhanced payments at the State agency. State officials stated that the State portion of the enhanced payments was deposited into a special revenue fund. This was the main fund of three funds used by the State to pay Medicaid expenses. Upon deposit, the enhanced payment funds lost their identity. Under the circumstances, we were unable to determine exactly how the State spent the enhanced payments. However, based on the cash outlays from this fund, it appears the enhanced payment funds were spent on Medicaid expenditures which in effect drew down additional Federal funds.

We also asked State agency officials how the funds were used. They were unable to tell us because the payments were commingled with other Medicaid funds.

Effect of Revising the Medicare Upper Payment Limit Regulations

The new change to the regulations to include a separate aggregate upper payment limit applicable to payments made to local government-owned facilities will significantly limit the amount of funds available to Alabama for enhanced payments to public providers. This regulatory revision creates a separate aggregate limit for local government-owned providers thereby excluding privately-owned facilities from the funding pool calculation. We believe such an exclusion is a more equitable and reasonable methodology for calculating enhanced payment funding pools.

During the audit period, Alabama paid publicly-owned facilities approximately $40 million per year relating to privately-owned facilities. The facilities receiving these payments returned 100 percent of the Federal share to the State Medicaid agency. This grossly inflated the funding pool in relation to the benefitting providers (i.e, none of the private facilities benefitted), and resulted in excessive Federal matching outlays.

To demonstrate the effect for the audit period, we computed a separate aggregate upper limit for local government-owned facilities and noted that the funding pools for Alabama would have been reduced from about $432 million to about $390 million. This would have resulted in a combined 4-year reduction of about $42 million (Federal share about $29.4 million), as shown in the following schedule.

Potential Payment Reductions
Using Separate Aggregate Limits for Government Providers
FYs 1997 Through 2000

Fiscal Year	Actual Enhanced Payments	Revised Payments	Potential Payment Reduction	Federal Share of Payment Reductions
1997	$78,685,007	$96,190,789	$(17,505,782)	$(12,254,047)
1998	$124,678,133	$103,550,148	$21,127,985	$14,789,590
1999	$117,312,516	$93,892,379	$23,420,137	$16,394,096
2000	$111,067,935	$96,168,395	$14,899,540	$10,429,678
Total	$431,743,591	$389,801,711	$41,941,880	$29,359,317

OTHER MATTERS

Enhanced Payments Used to Replace Disproportionate Share Hospital Payments

Medicaid DSH payments are intended to help hospitals that provide care to a large number of Medicaid beneficiaries and uninsured patients. The State appeared to be using enhanced payments to replace a portion of the DSH payments that hospitals received, thus leaving more disposable funds at the State level. State officials told us that in FY 1994, the year prior to the first full year of enhanced payments, facilities returned 68 percent of their DSH payments to the State. With the implementation of enhanced payments, this percentage incrementally increased to 86 percent by FY 1996. The facilities retained less of their DSH payments. During our audit period, annual DSH payments averaged about $389 million per year. Using the escalating percentages, during this period, we estimate that approximately $335 million of these annual payments were returned to the State.

In effect, the facilities were retaining approximately $70 million per year less in DSH payments. On the other hand, the facilities were retaining between $51 million and $56 million per year in enhanced payments. Thus, the facilities actually incurred a net loss of revenue through the replacement of DSH funds with the enhanced payments. While it may appear that the facilities have benefitted from the enhanced payment plan in the State of Alabama, the primary beneficiary of this plan was the State.

CONCLUSION AND RECOMMENDATIONS

Enhanced payments and IGTs have become a financial windfall for Alabama's State agency, and the magnitude of that windfall seems to have unlimited growth potential. We are concerned with the financial impact this program aspect has on Federal funds. Under guidelines in effect at the time of our review, we questioned whether sound fiscal controls, including future financial planning and budgeting could exist. We believe HCFA needed such controls to ensure the fiscal integrity of the Medicaid program.

In our draft report, we noted that HCFA had issued an NPRM on October 10, 2000 that, when implemented, would help to limit the present manipulation of upper payment limit requirements. On January 12, 2001, HCFA issued revisions to the upper payment limit regulations. The regulations included several transition periods, one of which applied to Alabama. By adding a transition period, the financial impact of the new regulations will be gradually phased-in and become fully effective on October 1, 2005. In addition, the final regulation includes a provision to allow non-State acute care public hospitals 150 percent of the Medicare payment as the upper payment limit.

As a result of HCFA's actions, in Alabama, we estimate savings to the Federal Government of about $18.8 million during the transition period. Once the regulatory changes are fully implemented (i.e., the transition period is completed), we estimate savings to the Federal Government of about $12.6 million annually, totaling a savings of about $63 million over 5 years (see **APPENDIX A** for additional details). Therefore, we recommend that HCFA take action to ensure that Alabama complies with the phase-in of the revised regulations.

We also recommended that HCFA issue guidance that would address the method of calculation of the Medicare upper payment limit. Currently, there is no clearly defined methodology for computing the Medicare upper payment limit and States are free to use various means to increase the enhanced payments, and consequently the Federal funding of their Medicaid program.

HCFA's Comments

The HCFA noted that on January 12, 2001, it published the final upper payment limit regulation which prevented States from aggregating upper payment limits across private and public facilities, and created a separate aggregate upper payment limit for local government-owned providers. The HCFA believed that these changes will significantly reduce the amount of excessive payments which States were making under the previous upper payment limit regulations. The final regulation also included a gradual transition policy in order to help States that relied on upper payment limit financing arrangements, and to ensure that public hospitals have adequate reimbursement rates. Also, HCFA stated that it planned to revise the State Medicaid Manual and provide guidance regarding the States' calculation of the Medicare upper payment limit.

OIG's Response

We commend HCFA for its efforts to control the excessive payments currently being made. We are pleased that HCFA intends to make changes to the State Medicaid Manual to provide guidance to States regarding the calculation of the Medicare upper payment limit. With the transition phase-in period, we estimate that the reduction in payments over the 5-year transition period will be about $26.9 million (Federal share about $18.8 million).

We are also aware that HCFA is reviewing Alabama's financial arrangement through the State's Partnership Hospital Program. We plan to discuss this arrangement further with HCFA personnel to determine if it represents a managed care environment.

APPENDIX A

SCHEDULE OF FEDERAL SAVINGS IN ALABAMA BASED ON IMPLEMENTATION OF REVISED UPPER PAYMENT LIMIT REGULATIONS (INCLUDING TRANSITION PERIOD)

Fiscal Period	Federal Savings (Millions)
10/01/00 - 09/30/01	$ 0
10/01/01 - 09/30/02	0
10/01/02 - 09/30/03	3.1
10/01/03 - 09/30/04	6.3
10/01/04 - 09/30/05	9.4
Savings during transition	$ 18.8
10/01/05 - 09/30/06	$ 12.6
10/01/06 - 09/30/07	12.6
10/01/07 - 09/30/08	12.6
10/01/08 - 09/30/09	12.6
10/01/09 - 09/30/10	12.6
5-year savings after transition	$ 63.0

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: JAN 26 2001

TO: Michael F. Mangano
Acting Inspector General

FROM: Michael McMullan
Acting Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Medicaid Enhanced Payments to Public Hospital Providers and the Use of Intergovernmental Transfers by the Alabama Medicaid Agency," (A-04-00-02169)

Thank you for the opportunity to comment on the use of Medicaid upper payment limits (UPL). The information you have provided in the related draft reports is very useful to us as we develop new Medicaid payment policies. We look forward to receiving the audit reports regarding the remaining states and your summary report and recommendations.

In your memorandum and throughout the report, reference is made to the previous UPL regulations, which included a separate aggregate UPL requirement for state-operated facilities. This limit is applied to inpatient services furnished by hospitals, nursing facilities, and institutional care facilities for the mentally retarded. The language should be clarified to show that this limit is applied to inpatient services furnished by hospitals, and does not apply to outpatient services furnished by hospitals.

Also, throughout the report, there are references made to October 5, 2000, the date HCFA issued a Notice of Proposed Rulemaking (NPRM) on the issue. The proposed rule was actually published in the Federal Register on October 10, 2000, and the final regulation was published on January 12, 2001. You may want to reference these dates instead when making future references.

OIG Recommendation

A separate UPL requirement is also needed for local government-operated facilities.

HCFA Response

We concur. In July, we issued a letter to State Medicaid Directors outlining our concerns about excessive payments to public providers and setting forth our intent to propose new rules to address the issue. HCFA published an NPRM on the subject on October 10, 2000, followed by the publication of the final rule on January 12, 2001. The final rule precludes States from aggregating payments across private and public facilities to

calculate UPLs. We further created a new payment limit for local governmental providers, and in the case of outpatient hospital and clinic services, an additional UPL for state-operated facilities. These changes will significantly reduce the amount of excessive payments that were paid under the previous UPL regulations.

To help states that have relied on UPL financing arrangements, we have instituted a gradual transition policy. In addition, recognizing the need to preserve access by Medicaid beneficiaries to public hospitals, we have included provisions that would ensure adequate payment rates for such facilities.

1/ OFFICE OF AUDIT SERVICES NOTE: These comments related to issues included in the draft report which have been eliminated from the final report.

OIG Recommendation

We also recommend that HCFA issue guidance that would address the method of calculation of the Medicare upper payment limit.

HCFA Response

We intend to issue revisions to the State Medicaid Manual to provide guidance regarding the states' calculation of the Medicare UPL.