DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

AUG 3 1994

Memorandum

Date

From Michael Mangano for June Gibbs Brown
Inspector General

Subject Rate Increases for State-Owned Intermediate Care Facilities for the Mentally Retarded - Indiana (A-05-93-00060)

To

Bruce C. Vladeck
Administrator
Health Care Financing Administration

This memorandum alerts you to the issuance on August 5, 1994 of our final audit report. A copy is attached.

Indiana needs to make a financial adjustment of $3.9 million (Federal share - $2.5 million) for computation errors made in 1991 when setting reimbursement rates for eight State-owned Intermediate Care Facilities for the Mentally Retarded (ICF/MR). In addition, Indiana needs to amend the section of its State Plan which permits special rate increases to accommodate changes in Federal/State laws and regulations. We believe that as written, the section is too vague to be consistently applied.

Our audit started because of a case referral to us by Indiana's Medicaid Fraud Control Unit (MFCU). The MFCU staff told us that their preliminary review disclosed there were millions in duplicated payments made to the ICF/MR facilities while Indiana was implementing the rate increases. The purpose of our audit was to determine (i) if the duplicate payments occurred and whether the funds had been returned to the Medicaid program and (ii) whether the rate increases were computed and implemented in accordance with Indiana's State Plan for Medicaid.

We found that duplicate payments totaling $40.6 million were made because of miscommunication between State employees and its fiscal contractor. The duplicate payments, however, were quickly "netted" against incoming claims from the facilities. We are not making a recommendation in this area because the duplicate payments were the results of human error rather than a systemic problem, and the duplicate payments have been returned to the Medicaid program.

The rate increases, however, were not accurately computed. Computation errors resulted in excessive reimbursement to the ICF/MR facilities totaling $3.9 million.

We are recommending that Indiana make a financial adjustment for the $3.9 million (Federal share - $2.5 million). In its written response to our report, Indiana concurred with our recommendation.

We also noted that computations for the 1991 rate increases were inconsistent with computations for similar increases, to the same facilities, in 1987. Both rate increases were granted ostensibly because of increased costs incurred due to changes in Federal regulations on active treatment. Section 6(d) of Indiana's State Plan permits special rate increases to recover costs incurred because of changes to Federal/State laws or regulations. The 1987 rate increases included only active treatment costs in the raise computations. Recovery of increases in non-active treatment costs, such as administrative and maintenance costs, was capped under Indiana's normal rate setting procedures. Conversely, the 1991 rate increases were computed based on all the facilities' cost increases instead of only those increases incurred for Federal mandates on active treatments.

The inconsistent interpretation of section 6(d) provisions was due to the provisions being too vague to be consistently applied. We are recommending that Indiana amend its State Plan to clarify when rate setting caps and limitation factors can be waived, and when (or if) cost increases other than those specifically caused by changes in Federal/State laws or regulations can be incorporated into section 6(d) raises.

Indiana concurred with our recommendation, indicating a willingness to work with the Health Care Financing Administration (HCFA) to determine if section 6(d) of the State Plan needs clarification. However, Indiana officials felt that the 1987 and 1991 rate increases were based on different Federal regulations and that, therefore, the computations for rate increases were not inconsistent. We don't agree because the regulations that Indiana used in 1987 were proposed regulations that were not formally adopted until October 3, 1988. These same regulations were in effect when the 1991 rate increases were computed.

The HCFA regional office also concurred with our findings and recommendations.

For further information contact:

Martin D. Stanton
Regional Inspector General
for Audit Services, Region V
(312) 353-2618

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

RATE INCREASES FOR STATE-OWNED INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION

INDIANAPOLIS, INDIANA

JUNE GIBBS BROWN
Inspector General

AUGUST 1994
A-05-93-00060

DEPARTMENT OF HEALTH AND HUMAN SERVICES

REGION V
105 W ADAMS ST
CHICAGO, ILLINOIS 60603-6201

OFFICE OF
INSPECTOR GENERAL

Common Identification No. A-05-93-00060

Mr. James M. Verdier
Assistant Secretary, Medicaid Policy and Planning
Indiana Family and Social Services Administration
402 W. Washington Street, Room W382
Indianapolis, Indiana 46204

Dear Mr. Verdier:

Enclosed for your information and use are two copies of an Office of Inspector General report entitled "Rate Increases For State-Owned ICF/MR Facilities". Your attention is invited to the audit findings and recommendations contained in the report. The Health Care Financing Administration action official will contact you to resolve the issues presented in the report. Any additional comments or information which you believe will affect resolution of the audit may be presented at that time.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), Office of Inspector General reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public, to the extent information contained therein is not subject to exemptions in the Act, which the Department chooses to exercise (see 45 CFR Part 5).

Please refer to Common Identification Number A-05-93-00060 in all correspondence relating to this report.

Sincerely,

Martin D. Stanton

Martin D. Stanton
Regional Inspector General
for Audit Services

Enclosures

SUMMARY

In 1991, Indiana granted rate increases to eight State-owned Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) that totalled almost $112 million for fiscal years 1990 through 1992. Duplicate payments of $40.6 million were made by Indiana in implementing the rate increases, but the duplicate payments were quickly recovered and credited back to the Medicaid program. The rate increases however were overstated by $3.9 million because they were not accurately computed. In addition, the rate setting standard Indiana used to grant the rate increases is too vague to be consistently applied. We are recommending that Indiana make a financial adjustment for the $3.9 million (Federal share - $2.5 million) overstatement, and amend the State Plan to clarify the rate setting standard.

Our review was performed because of a case referral to us by Indiana's Medicaid Fraud Control Unit (MFCU). The MFCU staff told us their preliminary review disclosed that millions in duplicate payments were made to ICF/MR facilities while the State was implementing retroactive rate increases. After conducting initial interviews with State officials and other parties concerned, the MFCU decided the situation was outside their usual scope of activities and referred the matter to us, sending a copy of their investigative file for our information.

Based on examination of the MFCU file and our own initial contacts with State officials, our first objective was to verify that duplicate payments occurred and, if so, why they occurred and whether the funds involved had been returned to the Medicaid program. Also, because the file contained information that raised questions regarding the appropriateness of the rate increases, our second objective was to determine whether the rate increases were computed and implemented in accordance with Indiana's State Plan for Medicaid. Our review was limited to State-owned ICF/MR facilities because privately owned facilities were not included in the rate increases.

We found that duplicate payments totaling $40.6 million did occur but that these payments were properly recovered by the State. Indiana issued manually prepared checks to State-owned ICF/MR facilities to quickly implement reimbursement rate increases retroactively. These checks were issued outside of Indiana's Medicaid Management Information System (MMIS) which, in Indiana, is controlled by a contractor referred to as the fiscal agent. Miscommunication between State employees and those of the fiscal agent caused the fiscal agent to duplicate the State's retroactive payments by issuing checks to the facilities through the MMIS. As a result, Medicaid payments of $40.6 million were duplicated. Indiana decided to correct the duplicate payments by "netting" them against future claims from the facilities. We determined that all of the duplicate payments were "netted" by January 12, 1993. Because our review showed the duplicate

payments were the result of human error rather than a systemic problem and because we found the amounts owed Medicaid by the ICF/MRs were liquidated in a timely manner, we are not making recommendations in this area.

Indiana granted the rate increases because of increased costs due to changes in Federal regulations on active treatment. A special rate review was performed under section 6(d) of the State Plan which is used when additional costs are the result of changes in Federal/State laws or regulations. The rate increases that were granted, however, were computed based on all of the facilities' cost increases instead of only those costs incurred for Federal active treatment changes. The rate increases permitted the State-owned facilities to recover all of their non-active treatment costs such as administrative and maintenance costs that are normally capped or limited under rate setting standards prescribed in Indiana's State Plan.

In 1987, Indiana granted a similar rate increase for the same State-owned ICF/MR facilities under section 6(d) for increased active treatment costs. Under this rate increase only active treatment cost increases were included in rate computations, the non-active treatment costs were restricted or capped because of Indiana's normal rate setting procedures.

The inconsistent application of section 6(d) was due to the section being too vague to be consistently applied. We are recommending that Indiana amend the State Plan to clarify when the normal rate setting caps and limitation factors can be waived, and when costs other than those specifically affected by changes in State/Federal laws or regulations can be incorporated into 6(d) raises.

Indiana concurred with our recommendation by stating it was willing to work with HCFA to determine if the State Plan needs clarification. Indiana, however, expressed the view that the 1987 and 1991 rate increases were based on different Federal regulations, and therefore, the rate increases were not inconsistently applied. We do not agree because the regulations that Indiana refers to for 1987 were proposed regulations that were not formally adopted until October 3, 1988--the same regulations on which Indiana based the 1991 rate increases.

We also found that the rate increases for FYs 1990 and 1991 were not accurately computed. The computation errors were (i) $2.4 million due to using incorrect rates, and (ii) $1.5 million due to using incorrect service days. We are recommending that Indiana make a financial adjustment for the $3.9 million (Federal share - $2.5 million). Indiana concurred in our findings and recommendation. The State's response is in Appendix C.

The HCFA regional office also concurred in our findings and recommendations.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

The Medicaid program in Indiana is administered by the Office of Medicaid Policy and Planning (State agency), a division of Indiana's Family and Social Services Administration.

Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) provide medical services under the Medicaid program. Indiana has eight State-owned ICF/MR facilities, and numerous privately owned facilities. All of the ICF/MR facilities are administered by the Indiana Department of Mental Health, another division of Indiana's Family and Social Services Administration.

The eight State-owned ICF/MR facilities are:

1) Central State Hospital -- Indianapolis
2) Evansville State Hospital -- Evansville
3) Fort Wayne Development Center -- Fort Wayne
4) Logansport State Hospital -- Logansport
5) Madison State Hospital -- Madison
6) Muscatatuck State Hospital -- Butlerville
7) New Castle State Development Center -- New Castle
8) Northern Indiana Development Center -- South Bend

ICF/MR reimbursement rates are set according to standards in Indiana's State Plan that also establish rates for Nursing Facilities, and Community Residential Facilities for the Developmentally Disabled. The standards were established in Indiana Law, Title 470 IAC, section 5-4.1. The standards have five cost containment provisions to ensure that the rate of increase in Medicaid costs is controlled. The cost containment provisions were designed to reimburse providers for:

> *...reasonable, allowable costs incurred by a prudent businessman, and allow incentives for efficiently managed providers...*

The ICF/MR reimbursement rates are computed by an outside rate-setting contractor, a CPA firm with headquarters in Kansas and an office in Indiana. The rates are set on a prospective basis, and are expressed as daily per diem amounts.

Normally the rates are reviewed once each year unless a provider files what is commonly referred to as a "6(d) exception". The 6(d) exception provides for:

> *...Any increase mandated by changes in federal or state law or regulation during a calendar year will be addressed separately by the department, and will not be considered as an additional rate review...*

On April 11, 1991, the Indiana Department of Mental Health requested a rate increase from the State agency, under the 6(d) exception criteria, for the eight State-owned ICF/MR facilities. The request was made because of increased active treatment costs caused by new Federal regulations. Private ICF/MR facilities were not covered by the Department of Mental Health's request.

On November 21, 1991, the State agency granted the 6(d) exception request and instructed the rate-setting contractor to establish new rates for each of the state owned facilities for the fiscal year ending (FYE) 9/30/92. The rate-setting contractor was told to set new rates that incorporated both active treatment costs and non-active treatment costs without applying the "Maximum Annual Limitation" and the "Market Area Limitation", two of the cost limitation factors prescribed by the State Plan. On December 12, 1991, the rate-setting contractor was also instructed to set new rates, retroactively, for the FYE 9/30/90 and 9/30/91.

Medicaid costs were increased by $111.9 million overall (Federal Share- $71.2 million) as a result of the rate increases:

Period	Total Increase	Federal Share
FY 1990	$ 25,149,828	$16,035,530
FY 1991	37,003,647	23,401,106
FY 1992	49,778,314	31,783,453
Total	$111,931,789	$71,220,089

The State agency issued manually prepared checks to each of the State-owned facilities for the retroactive rate increases. The checks were processed outside of the State agency's Medicaid Management Information System (MMIS). The State agency's fiscal contractor also issued checks, for a portion of the retroactive raises, to the same state owned facilities. As a result, payments of $40.6 million were duplicated.

SCOPE OF AUDIT

Our review was conducted in accordance with generally accepted government auditing standards. A referral from Indiana's Medicaid Fraud Control Unit (MFCU) prompted our initial involvement. The MFCU had performed some preliminary interviews with State officials concerning alleged duplicate payments under Medicaid and had tried to determine why there were such significant increases in the ICF/MR reimbursement rates. The MFCU then referred the case to us, after deciding the situation was outside the scope of its normal activities, and sent us a copy of their investigative file.

Our first objective was to determine if the alleged duplicate payments had occurred and, if so, whether the funds had been returned to the Medicaid program. Later our objectives broadened to include a determination of whether rate increases granted to state-owned facilities were (i) implemented in accordance with the State Plan rate setting standards, and (ii) properly computed for each facility. We did not review any of the private ICF/MR facilities because they were not included in the rate increases.

To accomplish our objectives, we first reviewed (i) the State agency's rate setting criteria for ICF/MR facilities contained in Indiana's state plan, established in Indiana law by Title 470, Section 5-4.1; (ii) the Federal conditions of participation for ICF/MR facilities contained in 42 CFR, Part 483, Subpart D; (iii) cost reports from each of the eight State-owned ICF/MR facilities; and (iv) accounting records maintained by each of the eight state owned ICF/MR facilities.

We examined paid claim records produced by the MMIS for the period October 1, 1989 to June 30, 1993 to establish the amount of the rate increases for dates of service from October 1, 1989 to September 30, 1992. Also, we made a site visit to one State-owned facility, Central States, to test the accuracy of Medicaid service days used in the retroactive raise calculations.

We held several meetings with the State agency's rate setting contractor to gain an understanding of Indiana's rate setting process for ICF/MR facilities. We also reviewed the methodology used by the State agency in 1987 for a similar 6(d) rate increase for state owned ICF/MR facilities. This increase was exclusively for active treatment costs and was based on a consultant's report commonly referred to as the "Ernst & Whinney Study".

Our evaluation of internal controls was limited to reviewing State controls over the rate setting process. We performed our review between March and November 1993.

RESULTS OF REVIEW

Indiana made about $40.6 million in duplicate payments to State-owned ICF/MRs because of miscommunication between State and contractor employees. The $40.6 million was "netted" against subsequent Medicaid claims made by the ICF/MRs, accordingly, we are not making any recommendations in this area.

The rate setting standard Indiana used to grant the rate increases (Section 6(d)), is too vague to be consistently applied. We found for instance, that Indiana applied the standard differently under similar circumstances in an earlier rate increase for the same ICF/MRs. We are recommending that Indiana amend the State Plan to clarify the standard so that it can be consistently applied in the future.

In addition, the rate increases for FYs 1990 and 1991 were not accurately computed. In some instances, the State agency used incorrect rates and/or service days. We are recommending that the rate increases be recomputed using the correct rates and service days. Implementing this recommendation will reduce Medicaid costs by $3.9 million (Federal share $2.5 million) for the period October 1, 1989 through June 30, 1993.

DUPLICATE PAYMENTS

When the new rates were established, the State agency issued manually prepared checks to the ICF/MR facilities for the retroactive portion of the raises. Later, the rate-setting contractor notified the State's fiscal agent of the new retroactive and prospective reimbursement rates. On May 29, 1992, the fiscal agent applied the retroactive rates to claims that the State agency had already paid. Computer generated checks, totaling $40.6 million, were issued through the MMIS to the facilities. Since the State agency had already fully reimbursed the facilities, these checks were duplicate payments. Apparently, there was incomplete or miscommunication between the State, the rate-setting contractor and the fiscal agent which caused the duplicate payments.

State officials quickly realized what had happened and took steps to reverse the duplicate payments by netting them against incoming Medicaid claims from the ICF/MR facilities. The fiscal agent was told to establish credit balances in the MMIS to accomplish the netting process.

We reviewed the paid claim records produced by the MMIS to ensure that the duplicate payments were appropriately netted against the ICF/MR facilities' subsequent claims. A summary of the duplicate payments and the date they were completely liquidated is shown below:

Facility	Duplicate Payment Amount	Date Completely Liquidated
Muscatatuck	$22,997,732	January 12, 1993
Ft. Wayne	10,101,150	October 20, 1992
New Castle	3,821,365	September 8, 1992
NISDC	1,441,479	September 29, 1992
Central State	869,036	November 17, 1992
Evansville	688,802	October 6, 1992
Logansport	684,734	September 8, 1992
Madison	None	N/A
	$40,604,298	

Recommendation

Since all of the duplicate payment amounts were liquidated in a timely manner and were part of a unique situation, apart from Indiana's normal claims processing procedures, we believe that there is low risk of similar occurrences. Accordingly, we are making no recommendations in this area.

RATE SETTING STANDARD NEEDS CLARIFICATION

The Section 6(d) rate increases provided to the state owned facilities in January 1992 were granted because Federal requirements for active treatment had increased costs. The April 11, 1991 Department of Mental Health request for the rate increases for instance stated:

> *...Changes in HCFA regulations have caused the cost per client to rise significantly. As of October 1988, conditions of participation in the ICF/MR medical program include active treatment. Refer to 42 CFR Chapter IV (10-1-89 Edition) subpart D: Conditions of Participation for ICF/MR, Sections 483.400 and others. Facility staffing requirements of participation increased particularly in the area of direct-care staff. A broad array of health care therapists and professionals are required in order to implement the active treatment program defined by each client's individual program plan....*

The rate increases however included not only the active treatment costs such as the "direct-care staff" costs cited in the April 11th request, but also all of the facilities' non-active treatment costs such as administrative and maintenance costs. The rate increases allowed the facilities to recover all of the costs that had previously been capped or limited under Indiana's rate setting standards. State officials told us this was an appropriate application of Section 6(d) because all of the costs involved were otherwise allowable Medicaid costs and facilities should be able to recover all of their allowable costs under the Medicaid program.

Section 6(d) however is not specific enough to support this interpretation of its intent. Section 6(d) should be amended by Indiana in its State Plan to clarify (i) under what circumstances Indiana's rate setting caps and limitation factors can be waived, and (ii) whether costs other than those specifically affected by changes in State/Federal laws or regulations can be incorporated into the 6(d) raises. This clarification is needed because the current application of Section 6(d) is inconsistent with how Indiana granted a similar 6(d) rate increase to the same State-owned facilities in 1987.

In 1987, the CPA firm of Ernst & Whinney was hired to calculate the 6(d) rate increases. The report issued by Ernst & Whinney stated that the Indiana legislature had mandated the state to close the gap between the costs it took to run the state owned ICF/MR facilities and the Federal Medicaid reimbursement they were receiving for the facilities. The report concluded however that only active treatment costs could be included in the 6(d) exception rate increase:

...This mandate cannot be completely carried out because the Indiana Medicaid reimbursement system, Title 470, does not allow for the increase of daily rates for other than changes in federal or state laws or regulations effecting ICF/MR providers...federal regulations pertaining to active treatment have "in fact" changed and therefore the rule allows for the calculation of interim rates addressed in this Report. Increases in other allowable expenses can not be recognized at this time under the current Title 470 reimbursement system...

Ernst & Whinney separated the state-owned facilities' costs into active treatment and non-active treatment categories. All of the active treatment costs were incorporated into the rate increases, but the non-active treatment costs were restricted because of Indiana's rate setting cost limitation factors.

Also, indirectly related to the inconsistent application of the Section 6(d) standard, Indiana recently vigorously defended its use of rate-setting cost limitation factors in a lawsuit initiated by Indiana's nursing facility industry association. One of the key points in the lawsuit was whether Indiana could apply the cost limitation factors to the nursing facility costs. On October 29, 1993, the Indiana Supreme Court held that Indiana was acting within its authority to limit Medicaid costs by the cost limitation factors.

Recommendation

We recommend that Indiana, after consulting with HCFA, amend its State plan to make Section 6(d) more specific regarding (i) when standard rate caps and other rate limitation factors contained in the State plan may be waived and (ii) whether the 6 (d) exception can be used to permit recovery of higher costs that are not specifically mandated by changes in Federal or State laws and regulations.

State Agency Comments

The full text of the State Agency comments can be found at APPENDIX C. A synopis of the State Agency comments follows.

Indiana concurred with our recommendation by stating that it is willing to work with HCFA to evaluate if the 6(d) exception policy needs amending. Indiana, however, feels that the rate increases granted in 1987 and 1991 were two distinctly different situations that were not handled inconsistently. Indiana states that the 1987 rate increases were necessary because of Federal regulations in effect in 1987 that only affected the active treatment area, and therefore, Indiana only increased the ICF/MR's active treatment costs. The 1991 rate increases however were necessary because of changes in Federal policy effective

October 3, 1988 that increased both active and non-active treatment costs.

Indiana also stated that the 1991 rate increase described on page 2 of our report did not include waiving all five of the caps and limitation factors prescribed by the State Plan. Only the "Maximum Annual Limitation" and the "Market Area Limitation" was waived.

OIG Response

The rate increases granted in 1987 and 1991 were not distinctly different situations. The two situations were very similar because they were both based on the same issues and the same Federal regulations, therefore, the 6(d) exception policy was inconsistently applied.

The 1987 rate increases were based on proposed regulations that were "in fact" being applied before formal adoption. The proposed regulations were not formally adopted until October 3, 1988, the same regulations the State Agency based the 1991 rate increases on.

Concerning the State Agency's comments about the number of caps and limitation factors waived in the 1991 rate increases, we have corrected our narrative on page 2.

ACCURACY OF THE RETROACTIVE RAISE COMPUTATIONS

The retroactive raises for FYs 1990 and 1991 were not accurately computed. Incorrect rates were used and the number of service days did not represent the actual service days paid by the Medicaid program. The computation errors increased Medicaid costs by $3.9 million (Federal share - $2.5 million.)

Incorrect Rates Used

In the FY 1990 calculation, the "old" rates for two of the facilities were actually the rates paid in FY 1989 not FY 1990. This error increased the retroactive calculation by $709,211 (Federal share - $452,193). Details are presented in the attached APPENDIX A.

Also in FY 1990, the "new" rates used for seven of the facilities were higher than the actual new rates approved by the rate-setting contractor. State Officials advised us that because of time limitations involved in filing HCFA-64 reports the new rates used in the retroactive calculations were the rates requested by the facilities not the final rates approved by the rate-setting contractor. The rates approved by the rate setting contractor were lower because the contractor eliminated unallowable Medicaid costs from the requested rates. Using the higher new rates

caused the retroactive calculation to increase by $1.7 million (Federal Share - $1.1 million). Details are presented in the attached APPENDIX A.

Incorrect Service Days Used

The number of service days used in both of the retroactive calculations were the service days reported in each facilities' cost report. The actual service days paid by the Medicaid program were significantly lower than the cost report figures: 80 days lower for FY 1990, and 17,142.5 days lower for FY 1991.

The service days reported in the cost reports are compiled from daily patient census data. We made a field visit to the Central State facility to determine the reliability of the service days contained on the cost reports. We found that the service days were not an accurate reflection of Medicaid service days. For example, the daily patient census data used for the cost report figures included both Medicaid and non-Medicaid clients in the reported statistics. In addition, the accountant who assembled the number of service days to be reported on the cost reports was counting half days of service as whole days of service.

Using the service days contained on the cost reports, instead of actual service days paid by the Medicaid program, increased the retroactive calculation by $1.5 million (Federal share $1.0 million). Details are presented in the attached APPENDIX B.

Recommendation

We are recommending that the State agency make a financial adjustment of $3.9 million (Federal share - $2.5 million) for the computation errors in the retroactive rate increases.

State Agency Comments

The State Agency concurred with our recommendation.

APPENDIX A

INCORRECT RATES USED

Incorrect "Old" Rates

	Actual 1990 Rate	"Old" 1989 Rate	Difference	Medicaid Days Paid	Increased Medicaid Costs
Logansport	$91.88	$88.60	$3.28	19,677	$ 64,541
Muscatatuck	93.62	90.28	3.34	193,015	644,670
				Total	$709,211
				Federal Share	$452,193

Incorrect "New" Rates

	Rate Used By The State	Actual "New" Rate	Difference	Medicaid Days Paid	Increased Medicaid Costs
Central State	$242.53	$213.80	$28.73	12,492	$ 358,895
Evansville	143.00	137.29	5.71	21,302	121,634
Ft. Wayne	135.00	135.00	00	215,309	0
Logansport	140.00	134.26	5.74	19,677	112,946
Madison	177.63	141.92	35.71	6,626	236,614
Muscatatuck	155.64	153.86	1.78	193,015	343,567
New Castle	180.38	173.41	6.97	67,956	473,654
NISDC	199.65	199.27	.38	17,555	6,671
				Total	$1,653,980
				Federal Share	$1,054,576

APPENDIX B

INCORRECT SERVICE DAYS USED

	Days Used By The State	Actual Medicaid Days Paid	Difference	State's Increase In Rate	Increased Medicaid Costs
FY 1990:					
Central State	12,492.0	8,320.0	4,172.0	$92.61	$386,369
Evansville	21,302.0	15,263.0	6,039.0	44.55	269,037
Ft. Wayne	215,309.0	218,604.5	-3,295.5	21.02	-69,271
Logansport	19,677.0	19,049.5	627.5	42.38	26,593
Madison	6,626.0	11,191.0	-4,565.0	41.84	-191,000
Muscatatuck	193,015.0	192,715.5	299.5	60.24	18,042
New Castle	67,956.0	69,825.5	-1,869.5	33.25	-62,161
NISDC	17,555.0	18,883.0	-1,328.0	65.91	-55,808
Totals	553,932.0	553,852.0	80.0		$290,081
			Federal Share		$184,956
FY 1991:					
Central State	13,496.0	11,924.0	1,572.0	$123.39	$ 193,969
Evansville	17,790.0	15,620.0	2,170.0	77.03	167,155
Ft. Wayne	211,823.0	209,949.5	1,873.5	54.26	101,656
Logansport	20,103.0	19,438.5	664.5	44.42	29,517
Madison	14,133.0	13,426.5	706.5	37.97	26,826
Muscatatuck	196,372.0	184,129.5	12,242.5	73.67	901,905
New Castle	71,148.0	72,490.5	-1,342.5	66.77	-89,639
NISDC	18,939.0	19,683.0	-744.0	96.50	-71,796
Totals	563,804.0	546,661.5	17,142.5		$1,259,593
			Federal Share		$ 796,567

APPENDIX C

Evan Bayh, Governor
State of Indiana

Indiana Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

Cheryl Sullivan, Secretary

Office of Medicaid Policy and Planning
James M. Verdier, Assistant Secretary

"People helping people help themselves"

June 16, 1994

Mr. Rick Pound, Senior Auditor
Indianapolis Field Office
HHS/OIG, Office of Audit Services
575 N. Pennsylvania Street, Room 680
Indianapolis, IN 46204

Dear Mr. Pound:

This letter constitutes Indiana's written response to your office regarding the recommendations set out in the draft OIG report entitled "Rate Increases for State-Owned ICF/MR Facilities" which was received by our office on May 20, 1992, and issued under Common Identification Number A-05-93-00060.

Our comments on the two specific OIG recommendations outlined in the draft report are as follows:

1. **Recommendation: We recommend that Indiana, after consulting with HCFA, amend its State plan to make Section 6(d) more specific regarding (i) when standard rate caps and other limitation factors contained in the State plan may be waived and (ii) whether 6(d) exception can be used to permit recovery of higher costs that are not specifically mandated by changes in Federal or State laws and regulations.**

Your report noted state officials advised the OIG auditors that the inclusion of the facilities' non-active treatment costs in the rate increases was an appropriate application of Section 6(d) because all of the costs involved were otherwise allowable Medicaid costs and facilities should be able to recover all of their allowable costs under the Medicaid program. As we noted in our June 28, 1993 memo to you and Tom Grissmer, the increased costs incurred by the state-owned ICF/MR facilities were not limited solely to active treatment costs. These costs were related to HCFA's revised survey standards that were implemented effective October 3, 1988.

It is important to note that the revised Conditions of Participation represented a shift from prescriptive standards of compliance to standards which focused more on client and staff performance. As such, HCFA focused more attention on quality of care by placing more emphasis on active treatment and consolidating this treatment in an individual program plan. The revised standards emphasized staff performance rather than compliance with processes and paper work requirements. Requirements in the areas of active treatment, physician services, nursing personnel, dental services and physical environment represented a potential fiscal impact on all ICF/MR facilities. The impact to Medicaid was not uniform across all ICFs/MR, since a portion of the active treatment costs for some facilities were paid with state-only dollars. For the other requirements, the fiscal impact would have varied by facility depending upon whether the facility had previously met the intent of the new standards.

As your report noted, the 1987 6(d) rate increases, that were calculated by the CPA firm of Ernst & Whinney, included only those costs that were related to active treatment. The non-active treatment costs were restricted because of Indiana's rate setting cost limitation factors. At the time of the 1987 rate increases, federal policy pertaining to active treatment costs had changed. Since the changes were limited solely to active treatment, the 6(d) rate increases were similarly limited to the costs associated with active treatment.

The 6(d) rate increases granted in 1991 included both active treatment and non-active treatment costs since the federally established Conditions of Participation, which were implemented subsequent to the 1987 6(d) rate increases, contained provisions that resulted in cost increases in both these areas. Thus, the 6(d) exception was appropriately applied in both the 1987 and 1991 rate increases that were granted to state-owned ICF/MR facilities. The 6(d) standard was not inconsistently applied in these two situations.

On page 2 of the audit report, OIG asserts that on November 21, 1991, Myers and Stauffer was instructed to set new rates without applying any of the caps and limitation factors prescribed by the State Plan. We would like to point out that the November 21, 1991 letter only instructed Myers and Stauffer to not apply the maximum annual limitation found at 470 IAC 5-4.1-9(c)(3) (see Attachment A). In addition to waiving the maximum annual limitation, the market area limitation was also waived (see Attachment B). All other caps and limitation factors, as set out in 470 IAC 5-4.1-9(c)(2), (4) and (5) were not waived.

While we disagree with the basis for OIG's recommendation, Indiana is agreeable to working with HCFA in further evaluating the 6(d) exception policy to determine if amendments to the policy are necessary.

2. **<u>Recommendation:</u> We are recommending that the State agency make a financial adjustment of $3.9 million (Federal share - $2.5 million) for the computation errors in the retroactive rate increases.**

We concur that incorrect rates were used in the retroactive calculations for fiscal year 1990 and that incorrect service days were used in the retroactive calculations for fiscal years 1990 and 1991. We agree that the Federal share associated with the recommended adjustment should be returned to HCFA.

Thank you for the opportunity to comment on the draft audit report.

Sincerely,

James M. Verdier

JMV/PN:jb

Attachments

State of Indiana • Family and Social Services Administration
402 West Washington Street, Room W382, Indianapolis 46204
Evan Bayh, Governor
Christine W. Lotta, Secretary

November 21, 1991

Myers and Stauffer
8555 North River Road, Suite 360
Indianapolis, Indiana 46240-4305
Attn: Keenan Buoy

RE: State ICF/MR Request for 470 5-4.1-6(d) Exception

Dear Mr. Buoy:

The Office of Medicaid Policy, Family of Social Services Administration, has received a request from Jerry Thaden of the Department of Mental Health, dated April 11, 1991, requesting a 6(d) exception for the State-operated ICF/MR facilities. This request was made primarily because of the assertion that the rates currently paid these facilities do not fully reflect the costs of active treatment as required and specified as conditions of participation in 42 CFR Chapter IV (10-1-89) Subpart D: 483.400 et al. The letter further claims that enhanced federal requirements for "qualified mental retardation professionals" and programs tailored to the "client's individual program plan" have dramatically increased the cost of operating these ICF/MR's, and the application of the current rate setting methodology has not allowed for payment of these additional costs.

We have reviewed the financial and personnel records of these facilities and found that significant additional costs have been incurred by the State-operated facilities in order to meet active treatment requirements. Because these additional costs were mandated by "changes in federal law", we have determined that the standard mandated by 470 IAC 5-4.1-6(d) has been met. As part of our analysis of the facilitys' cost, it has also been determined that certain patient-related costs have previously been omitted from the cost reports. Accordingly, we are instructing you to set new rates for these facilities with rate effective dates of 10-1-91. The rates are to be established using the recently submitted budgeted cost reports and without the application of the maximum annual limitation found at 470 IAC 5-4.1-9(c)(3). *

"A"-1

If you have any questions about this letter or require any additional supporting documentation, please do not hesitate to call me at 232-6865.

Sincerely,

Gary Kyzr-Sheeley
Director, Medicaid Policy,
Planning and LTC

CC/Jim Verdier, Medicaid
Jerry Thaden,Division of Mental Health
LaDonna Johnson, Division of Mental Health
Leo Dillon, Division of Mental Health
Bill Leep, State Budget Agency
Jay Keesling, Medicaid
Tom Quarto. Division of Family and Children

State of Indiana • Family and Social Services Administration
402 West Washington Street, Room W382, Indianapolis 46204
Evan Bayh, Governor
Christine W. Latta, Secretary

December 12, 1991

RECEIVED
DEC 13 1991
EXECUTIVE

Myers and Stauffer
8555 North River Road, Suite 360
Indianapolis, Indiana 46240-4305
Attn: Keenan Buoy

RE: State ICF/MR Request for 470 5-4.1-6(d) Exception---Memo of December 5, 1991

Dear Mr. Buoy:

I am in receipt of your memorandum of December 5, 1991 regarding State ICF/MR rates effective 10/1/91. After reviewing the summary and rate information regarding the eight state-operated ICF/MR providers I have determined that the Market Area Limitation(MAL), found at 470 IAC 5-4.1-9 (c)(1), should not be applied in the calculation of the new rates for these facilities. The current MAL was based on previously submitted budgeted cost reports and therefore the factors which shaped the MAL used in your rate calculations no longer apply. Accordingly, please set new rates for the eight state-operated ICF/MR facilities, based on my letter of November 21, 1991, without application of the MAL. For the purpose of future rate cases, please construct new MAL's based on the most recently submitted cost report information.

Leo Dillon of the Division of Mental Health has also informed me that the cost report submitted for Muscatatuck State Hospital incorrectly recorded the private pay rate. Please calculate the new rate for Muscatatuck after Leo has advised you of the correct private pay rate.

If you have any questions about this letter or require any additional supporting documentation, please do not hesitate to call me at 232-6865.

B-1

Gary Kyzr-Sheeley
Director, Medicaid Policy,
Planning and LTC

CC/Jim Verdier
Leo Dillon

MEMORANDUM

Myers and Stauffer
Certified Public Accountants

TO: Gary Kyzr-Sheeley

FROM: Keenan Buoy

DATE: December 5, 1991

SUBJECT: State ICFs/MR Rates Effective 10/1/91

Attached please find a summary of cost and rate information regarding the eight state-operated ICR/MR providers. The table reflects the following columns.

Allowable cost - Budgeted allowable cost, determined in accordance with 470 IAC 5-4.1. Note that since 470 IAC 5-4.1-25(d) precludes any add-on incentive in Medicaid rates of state-operated providers, these amounts also represent calculated rates.

MAL - Market Area Limitation; computed in accordance with 470 IAC 5-4.1-9(c)(1). Note that this rate limitation was based on average allowable cost for these providers, based on the rate reviews effective 10/1/90. We also observe that if this limitation were not applied, Central State, New Castle and Northern Indiana approved rates would increase to the lesser of their allowable cost or the DMH Requested rate amount.

DMH Requested - These rates represent amounts contained in Table V of the materials prepared by the Department of Mental Health; except for Evansville and Central State. These two facilities requested Medicaid rates higher than those contained in Table V, and the higher amounts are reflected in the attached summary.

Approved - These rates represent the rates approved, based on the application of rate setting criteria 470 IAC 5-4.1, including the MAL, but not including the maximum annual limitation. This procedure is consistent with the Department's November 21, 1991 letter of instruction to us.

Difference - These amounts represent the difference between the DMH Requested rates, and the Approved rates.

ERS-STAUFFER INDIANA TEL:

After reviewing this information, please advise us as to what additional steps are necessary to finalize these rate reviews. We will not release these to the providers and DMH until we hear from you. Please let us know if you have any questions.

MYERS-STAUFFER INDIANA TEL: Jan 27.95 10:58 No.004 P.04

SUMMARY OF STATE ICFs/MR 10/01/91 RATES

Facility	Allowable Cost	MAL	DMH Requested	Approved	Difference
Central State	$303.23	$224.97	$292.19	$224.97	$67.22
Evansville	130.79	224.97	217.00	130.79	86.21
Fort Wayne	199.36	224.97	202.45	199.36	3.09
Logansport	162.16	224.97	167.00	162.16	4.84
Madison	145.72	224.97	183.00	145.72	37.28
Muscatatuck	224.82	224.97	229.92	222.00(1)	7.92
New Castle	231.24	224.97	234.92	224.97	9.95
Northern Ind.	258.20	224.97	258.61	224.97	33.64

(1) Limited by reported private pay rate

State of Indiana • Family and Social Services Administration
402 West Washington Street, Room W382, Indianapolis 46204
Evan Bayh, Governor
Christine W. Letts, Secretary

December 12, 1991

Myers and Stauffer
8555 North River Road, Suite 360
Indianapolis, Indiana 46240-4305
Attn: Keenan Buoy

RE: State ICF/MR Request for 470 5-4.1-6(d) Exception

Dear Mr. Buoy:

As you know, the Office of Medicaid Policy and Planning, Family and Social Services Administration, has received a request from Jerry Thaden of the Department of Mental Health, dated April 11, 1991, requesting a 6(d) exception for the State-operated ICF/MR facilities. This request was made primarily because of the assertion that the rates paid these facilities since 1989 do not fully reflect the costs of active treatment as required and specified as conditions of participation in 42 CFR Chapter IV (10-1-89) Subpart D: 483.400 et al. The letter further claims that enhanced federal requirements for "qualified mental retardation professionals" and programs tailored to the "client's individual program plan" have dramatically increased the cost of operating these ICF/MR's, and the application of the current rate setting methodology has not allowed for payment of these additional costs.

We have reviewed the financial and personnel records of these facilities and found that significant additional costs have been incurred by the State-operated facilities in order to meet active treatment requirements. Because these additional costs were mandated by "changes in federal law", we have determined that the standard mandated by 470 IAC 5-4.1-6(d) has been met. As part of our analysis of the facilitys' cost, it has also been determined that certain patient-related costs have previously been omitted from the cost reports.

These additional costs have occurred over an extended period of time, including federal fiscal years 1990 and 1991. Accordingly, we are instructing you to retroactively adjust the rates for these facilities with rate effective dates of 10-1-89 and 10-1-90. The rates are to be established using the recently submitted corrected historical cost reports, in place of the normal budgeted cost reports, and without the application of the maximum annual limitation found at 470 IAC 5-4.1-9(c)(3) and the Market Area *

Limitation found at 470 IAC 5-4.1-9(c)(2).

If you have any questions about this letter or require any additional supporting documentation, please do not hesitate to call me at 232-6865.

Sincerely,

Gary Ayzr-Sheeley
Director, Medicaid Policy,
Planning and LTC

CC/Jim Verdier, Medicaid
Jerry Thaden,Division of Mental Health
LaDonna Johnson, Division of Mental Health
Leo Dillon, Division of Mental Health
Bill Leep, State Budget Agency
Jay Keesling, Medicaid
Tom Quarto. Division of Family and Children