December 1, 2009

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

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

SUBJECT: Review of Medicaid Supplemental Rate Payments to UMass Memorial Health Care, Inc., for Fiscal Years 2004 and 2005 (A-01-07-00013)

Attached is an advance copy of our final report on Medicaid supplemental rate payments made to UMass Memorial Health Care, Inc. (UMMHC), for Federal fiscal years (FY) 2004 and 2005. We will issue this report to the Massachusetts Executive Office of Health and Human Services (the State agency) within 5 business days.

In addition to standard Medicaid payments, the State agency provides Medicaid supplemental rate payments (supplemental payments) to UMMHC. For the period October 1, 1999, through January 20, 2001, UMMHC received supplemental payments for its unreimbursed costs. Effective January 20, 2001, the State plan was amended to change the methodology for calculating supplemental payments from a cost basis to a charge basis. Under this methodology, UMMHC is reimbursed in full for its Medicaid charges.

During the 2-year period that ended September 30, 2005, UMMHC received supplemental payments totaling $349,727,197: $125,000,000 in FY 2004 and $224,727,197 in FY 2005. These supplemental payments were in addition to the $141 million that UMMHC received in Medicaid fee-for-service payments during this period. During our audit, the State agency reduced its claim for supplemental payments by $12,516,047. As a result of this adjustment, the State agency claimed a total of $337,211,150 in supplemental payments during FYs 2004 and 2005.

Our objective was to determine whether the State agency's claims for Federal reimbursement of supplemental payments to UMMHC during FYs 2004 and 2005 were in accordance with certain Federal and State plan requirements.

Of the $337,211,150 that the State agency claimed in supplemental payments to UMMHC during FYs 2004 and 2005, $320,148,713 was claimed in accordance with Federal and State plan requirements. However, the State agency's claim included $12.7 million for hospital and

physician services provided in FYs 2000 through 2003 that were not eligible for supplemental payments. In addition, the State agency understated its claim for unreimbursed charges for inpatient and outpatient services in FY 2005 by $1.2 million. We have adjusted our total finding from $12.7 million to $11.5 million to reflect the $1.2 million understatement.

We also identified an additional $5.6 million ($2.8 million Federal share) included in the supplemental payment calculations for FYs 2000 and 2001 that represented payments to the University of Massachusetts Medical School (Medical School) on which we were unable to express an opinion.

These excessive supplemental Medicaid payments occurred because UMMHC did not follow procedures set forth in the State plan to calculate these payments and the State agency believed that the procedures that UMMHC used were in accordance with the State plan.

We recommend that the State agency:

- make a financial adjustment of $11.5 million ($5.75 million Federal share),

- work with the Centers for Medicare & Medicaid Services (CMS) to determine the appropriateness of $5.6 million ($2.8 million Federal share) in supplemental payments representing UMMHC payments to the Medical School, and

- follow State plan requirements when submitting claims for supplemental payments.

In written comments on our draft report, the State agency respectfully disagreed with $8.5 million of our $11.5 million finding and stated that the supplemental payments were in accordance with the State plan in effect at the time. The State agency agreed to work with CMS in resolving our finding related to payments to the Medical School.

We based our findings on the applicable Medicaid requirements in effect during our audit period. Therefore, we maintain that our findings and recommendations, as originally stated, are valid.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at George.Reeb@oig.hhs.gov, or Michael J. Armstrong, Regional Inspector General for Audit Services, Region I, at (617) 565-2689 or through email at Michael.Armstrong@oig.hhs.gov. Please refer to report number A-01-07-00013 in all correspondence.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services
Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203
(617) 565-2684

December 7, 2009

Report Number: A-01-07-00013

JudyAnn Bigby, M.D.
Secretary
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, Massachusetts 02108

Dear Dr. Bigby:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Medicaid Supplemental Rate Payments to UMass Memorial Health Care, Inc., for Fiscal Years 2004 and 2005." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Curtis Roy, Audit Manager, at (617) 565-9281 or through email at Curtis.Roy@oig.hhs.gov. Please refer to report number A-01-07-00013 in all correspondence.

Sincerely,

/Michael J. Armstrong/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID SUPPLEMENTAL RATE PAYMENTS TO UMASS MEMORIAL HEALTH CARE, INC., FOR FISCAL YEARS 2004 AND 2005

Daniel R. Levinson
Inspector General

December 2009
A-01-07-00013

Office of Inspector General

http://oig.hhs.gov

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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

In Massachusetts, the Executive Office of Health and Human Services (the State agency) administers the Medicaid Program. Services covered under Medicaid and eligible for Federal reimbursement are set forth in the Massachusetts Medicaid State plan. Subsequent changes to the State plan are negotiated with the Centers for Medicare & Medicaid Services (CMS) and incorporated through State plan amendments.

UMass Memorial Health Care, Inc. (UMMHC), is the controlling company for one large teaching hospital, four small community hospitals, and a physician practice group (UMass Memorial Medical Group). Its teaching hospital, UMass Memorial Medical Center, is affiliated with the University of Massachusetts Medical School (the Medical School) and shares facilities with it. However, the Medical School is a legally separate entity.

The State agency reimburses acute-care hospitals for an array of inpatient and outpatient services. In addition, it provides Medicaid supplemental rate payments (supplemental payments) to selected hospitals. For the period October 1, 1999, through January 20, 2001, UMMHC received supplemental payments for its unreimbursed costs. Effective January 20, 2001, the State plan was amended to change the methodology for calculating supplemental payments from a cost basis to a charge basis. Under this methodology, UMMHC is reimbursed in full for its Medicaid charges.

During the 2-year period that ended September 30, 2005, UMMHC received supplemental payments totaling $349,727,197: $125,000,000 in Federal fiscal year (FY) 2004 and $224,727,197 in FY 2005. These supplemental payments were in addition to the $141 million that UMMHC received in Medicaid fee-for-service payments during this period. During our audit, the State agency reduced its claim for supplemental payments by $12,516,047. As a result of this adjustment, the State agency claimed a total of $337,211,150 in supplemental payments during FYs 2004 and 2005.

OBJECTIVE

Our objective was to determine whether the State agency's claims for Federal reimbursement of supplemental payments to UMMHC during FYs 2004 and 2005 were in accordance with certain Federal and State plan requirements.

SUMMARY OF FINDINGS

Of the $337,211,150 that the State agency claimed in supplemental payments to UMMHC during FYs 2004 and 2005, $320,148,713 was claimed in accordance with Federal and State plan requirements. However, the State agency's claim included $12.7 million for hospital and physician services provided in FYs 2000 through 2003 that were not eligible for supplemental payments. In addition, the State agency understated its claim for unreimbursed charges for

inpatient and outpatient services in FY 2005 by $1.2 million. We have adjusted our total finding from $12.7 million to $11.5 million to reflect the $1.2 million understatement.

We also identified an additional $5.6 million ($2.8 million Federal share) included in the supplemental payment calculations for FYs 2000 and 2001 that represented payments to the Medical School on which we were unable to express an opinion.

These excessive supplemental Medicaid payments occurred because UMMHC did not follow procedures set forth in the State plan to calculate these payments and the State agency believed that the procedures that UMMHC used were in accordance with the State plan.

RECOMMENDATIONS

We recommend that the State agency:

- make a financial adjustment of $11.5 million ($5.75 million Federal share),
- work with CMS to determine the appropriateness of $5.6 million ($2.8 million Federal share) in supplemental payments representing UMMHC payments to the Medical School, and
- follow State plan requirements when submitting claims for supplemental payments.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency respectfully disagreed with $8.5 million of our $11.5 million finding. The State agency believed that these supplemental payments were appropriate under a reasonable reading of the supplemental payment methodologies of the State plan in effect during 2000 and 2001, parts of which it attached with its comments. In addressing our finding related to payments to the Medical School, the State agency said that it would be happy to work with CMS on this issue. However, it maintained that the inclusion of medical education costs for FYs 2000 and 2001 in the supplemental payment calculations was in accordance with the State plan in effect at the time.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

We based our findings on the applicable Medicaid requirements in effect during our audit period. The State Plan amendments that the State agency attached with its comments were an intrinsic part of our evaluation and contain no material that we did not consider during our review. Therefore, we maintain that our findings and recommendations, as originally stated, are valid.

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INTRODUCTION

BACKGROUND

The Medicaid Program

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

In Massachusetts, the Executive Office of Health and Human Services (the State agency) administers the Medicaid program. Services covered under Medicaid and eligible for Federal reimbursement are set forth in the Massachusetts Medicaid State plan. Subsequent changes to the State plan are negotiated with CMS and incorporated through State plan amendments (SPA).

UMass Memorial Health Care, Inc.

UMass Memorial Health Care, Inc. (UMMHC), is a Massachusetts not-for-profit corporation formed in 1998 through a series of mergers of several private and State entities. UMMHC is the controlling company for one large teaching hospital, four small community hospitals, and a physician practice group (UMass Memorial Medical Group). Its teaching hospital, UMass Memorial Medical Center (the Medical Center), is affiliated with the University of Massachusetts Medical School (the Medical School) and shares facilities with it. However, the Medical School is legally separate from UMMHC.

Medicaid Supplemental Rate Payments

The State agency reimburses acute-care hospitals for an array of inpatient and outpatient services. In addition, it provides Medicaid supplemental rate payments (supplemental payments) to selected hospitals. The State plan currently designates certain hospitals that are eligible for supplemental payments as "Essential MassHealth Hospitals." UMMHC is one of two entities in Massachusetts whose hospitals have this designation.

For the period October 1, 1999, through January 20, 2001, UMMHC received supplemental payments for its unreimbursed costs. These costs represented the difference between the standard Medicaid payments that UMMHC received and its actual Medicaid costs, as calculated using specific cost data on UMMHC's Division of Health Care Finance and Policy-403 Hospital Statement of Costs, Revenues and Statistics (DHCFP-403 cost reports).

Effective January 20, 2001, the State plan was amended to change the methodology for calculating supplemental payments from a cost basis to a charge basis. Under this methodology,

UMMHC began receiving supplemental payments that represented the difference between UMMHC's total standard Medicaid payments and total Medicaid charges, as calculated using data from its financial and cost reports.

During the 2-year period that ended September 30, 2005, UMMHC received supplemental payments totaling $349,727,197: $125,000,000 in Federal fiscal year (FY) 2004 and $224,727,197 in FY 2005 (Appendix A). These supplemental payments were in addition to the $141 million that UMMHC received in Medicaid fee-for-service payments during this period. During our audit, the State agency reduced its claim for supplemental payments by $12,516,047 (Appendix B). After this adjustment, the State agency's claim totaled $337,211,150 in supplemental payments made during FYs 2004 and 2005.

Upper Payment Limits

The upper payment limit (UPL) is an estimate of the amount that Medicare would have paid for the Medicaid services. Medicaid allows State Medicaid agencies to pay different amounts to providers in the same category as long as the payments, in aggregate, do not exceed that category's UPL. Medicaid regulation (42 CFR § 447.272) specifies that States must calculate a separate UPL for each of three categories: private facilities; State-owned facilities; and non-State, government-owned facilities. The State agency categorizes UMMHC's five hospitals as private facilities. According to the State's most recent UPL calculations available, the private pool had sufficient funds to allow for the amount of the supplemental payments that UMMHC received. We did not review these UPL calculations as part of this audit.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency's claims for Federal reimbursement of supplemental payments to UMMHC during FYs 2004 and 2005 were in accordance with certain Federal and State plan requirements.

Scope

Our audit covered the $349,727,197 that the State agency claimed for supplemental payments made to UMMHC during FYs 2004 and 2005. During our audit, the State agency made an adjustment that reduced the audited amount to $337,211,150. We limited our review of internal controls to obtaining an overall understanding of the policies and procedures for calculating supplemental payments. We did not review the State agency's process for determining Medicaid eligibility or the medical necessity of the services provided.

We performed our fieldwork at UMMHC in Worcester, Massachusetts, and at the State agency in Boston, Massachusetts, during the period July 2005 to May 2009.

Methodology

To accomplish our objective, we:

- reviewed the State plan and Federal regulations as they pertain to supplemental payments;
- interviewed personnel from the State agency, UMMHC, and the Medical School;
- consulted with CMS regional staff who monitor the supplemental payments and the State plan;
- determined the amount of supplemental payments that UMMHC received by examining the State agency's Form CMS-64, "Quarterly Statement of Expenditures for the Medical Assistance Program";
- analyzed financial and cost report data that UMMHC and the State agency used to calculate supplemental payments;
- reviewed UMMHC's detailed claim files and data from the Medicaid Management Information System;
- analyzed the Medical Group's detailed claim files related to the supplemental payments;
- recalculated eligible supplemental payments using the State plan methodologies; and
- reviewed invoices and related documentation pertaining to UMMHC's payments to the Medical School.

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

FINDINGS AND RECOMMENDATIONS

Of the $337,211,150 that the State agency claimed in supplemental payments to UMMHC during FYs 2004 and 2005, $320,148,713 was claimed in accordance with Federal and State plan requirements. However, the State agency's claim included $12.7 million for hospital and physician services provided in FYs 2000 through 2003 that were not eligible for supplemental payments. In addition, the State agency understated its claim for unreimbursed charges for inpatient and outpatient services in FY 2005 by $1.2 million. We have adjusted our total finding from $12.7 million to $11.5 million to reflect the $1.2 million understatement.

We also identified an additional $5.6 million ($2.8 million Federal share) included in the supplemental payment calculations for FYs 2000 and 2001 that represented payments to the Medical School on which we were unable to express an opinion.

These excessive supplemental Medicaid payments occurred because UMMHC did not follow procedures set forth in the State plan to calculate these payments and the State agency believed that the procedures that UMMHC used were in accordance with the State plan.

FEDERAL AND STATE PLAN REQUIREMENTS

Federal Requirements

Section 1903(a)(1) of the Act provides for Federal matching funds only for those expenditures made by a State under an approved State plan. Federal regulations (42 CFR § 430.10) require that the State plan describe "the nature and scope of its Medicaid program." In addition, the State plan should contain "all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation . . . ."

The State Plan

Requirements for Fiscal Years 2001 Through 2005

Effective January 20, 2001, the Massachusetts Medicaid SPA TN 01-004, section IV.C.5 (and similar subsequent revisions), defines the inpatient reimbursement methodology for supplemental payments to Essential MassHealth Hospitals as follows:

> Subject to specific legislative authorization and appropriation and compliance with federal upper payment limit and other applicable regulations at 42 CFR part 447, the [State agency] will make a supplemental payment in addition to the standard reimbursement made under the [State agency's] Acute Hospital Contract, to Essential MassHealth Hospitals . . . . The payment amount will be (i) determined by the [State agency] using data filed by each qualifying hospital in its financial and cost reports, and (ii) a percentage of the difference between the qualifying hospital's total Medicaid charges and total Medicaid payments for such charges from any source, which percentage shall in no event exceed 100 percent.

SPA TN 01-005, section IV.B.3, and subsequent revisions, defines the outpatient supplemental payment methodology in a similar manner.

Requirements for Fiscal Years 2000 and 2001

The Massachusetts Medicaid SPA TN 99-012, section IV.C.4.b, which was in effect before January 20, 2001, defines the inpatient reimbursement methodology for supplemental payments to be equal to the hospital's cost per discharge calculated as follows:

> The data used for this payment will be from the most recent submission of the hospital's or predecessor hospital's DHCFP-403 report(s). Total hospital-specific

> inpatient non-psychiatric charges are multiplied by the hospital's inpatient non-psychiatric cost-to-charge ratio (calculated using DHCFP-403, schedule II, column 10, line 100 minus column 10, line 82 for the total cost numerator and schedule II, column 11, line 100 minus column 11, line 82 for the total charges denominator) to compute that facility's total inpatient non-psychiatric cost. The total inpatient non-psychiatric cost is then multiplied by the ratio of the hospital-specific non-psychiatric Medicaid discharges to the total hospital non-psychiatric discharges to yield the Medicaid inpatient non-psychiatric cost. The Medicaid inpatient non-psychiatric cost is then divided by the number of Medicaid non-psychiatric discharges to calculate the Medicaid cost per discharge . . . .

SPA TN 99-013, section IV.B.a, defines the outpatient supplemental Medicaid payment methodology in a similar manner.

Hospital-Based Physicians

The Massachusetts Medicaid State plan allows for hospitals to be reimbursed for services provided by hospital-based physicians. The Massachusetts Medicaid SPAs TN 99-012, section II, and TN 99-013, section II, define a hospital-based physician as any physician, excluding interns, residents, fellows, and house officers, who contracts with a hospital or hospital-based entity to provide inpatient or outpatient services to MassHealth members at a site for which the hospital is otherwise eligible to receive reimbursement. The same sections of these SPAs also define inpatient services as "medical services provided to a [Medicaid recipient] admitted to an acute inpatient hospital" and outpatient services as "medical services provided to a [Medicaid recipient] in a hospital outpatient department . . . ." Accordingly, inpatient and outpatient hospital physician services may be included in supplemental payment calculations so long as they meet these definitions.

RETROACTIVE CLAIMS FOR FISCAL YEARS 2000 THROUGH 2003

During FYs 2004 and 2005, the State agency retroactively claimed $52.3 million[1] for previously unreimbursed supplemental payments for FYs 2000 through 2003. However, we found that the State agency had already received $12.7 million in excessive supplemental payments for FYs 2000 through 2003. These excessive payments consisted of:

- $8.5 million for supplemental payments based on hospital services provided in FYs 2000 and 2001 and

- $4.2 million for supplemental payments based on physician services of the UMass Memorial Medical Group provided outside of the hospital setting in FYs 2000 through 2003.

As a result, the State agency was eligible to claim only $39.6 million in unreimbursed supplemental payments for these FYs.

[1]The State agency retroactively claimed $13.5 million in FY 2004 and $38.8 million in FY 2005.

Appendix C shows the supplemental payments that we recalculated for FYs 2000 through 2003 and the resulting effects on retroactive supplemental payments that the State agency claimed during FYs 2004 and 2005.

Retroactive Claims for Supplemental Payments Based on Hospital Services Provided in Fiscal Years 2000 and 2001

In determining the amount available to be retroactively claimed in FYs 2004 and 2005, UMMHC did not always use the methodology set forth in the State plan that was in effect when the services were provided. The State plan in effect before January 20, 2001, required that calculations of supplemental payments use cost data from specific line items on the DHCFP-403 cost reports. At our request, UMMHC officials recalculated the amount available for supplemental payments using the method required by the State plan. Our comparison of UMMHC's recalculation with UMMHC's calculation on which the State agency had based its claim indicated that the original calculation for the period before January 20, 2001, had included costs that were not part of the formula that the State plan set forth for calculating supplemental payments. These costs were for items such as free care assessments, provisions for bad debts, and payments from the UMass Memorial Medical Group to the Medical School that did not correspond to specified line items on the cost reports.

In contrast, for the period January 20 through September 30, 2001, the State agency did not claim all of the amounts for which UMMHC was eligible.

We reviewed UMMHC's recalculations and verified that:

- For the period before January 20, 2001, the State agency overclaimed the amounts available for retroactive claims for supplemental payments based on hospital services by $17.3 million.

- For the period January 20 through September 30, 2001, the State agency underclaimed the amounts available for retroactive claims for supplemental payments by $8.8 million.

As a result, the State agency overstated the total amount available from FYs 2000 through 2001 for retroactive claims during FYs 2004 and 2005 by a total of $8.5 million.

Retroactive Claims for Supplemental Payments Based on Physician Services Performed Outside the Hospital Setting in Fiscal Years 2000 Through 2003

For FYs 2000 through 2003, UMMHC's supplemental payment calculations included claims for physician services from the UMass Memorial Medical Group that were not provided at a site for which the hospital was otherwise eligible to receive reimbursement, pursuant to the Massachusetts Medicaid SPAs TN 99-012, section II, and TN 99-013, section II. Instead, these services were provided in nonhospital settings such as physician's offices and nursing homes. State agency officials agreed that these nonhospital-based physician services provided by the UMass Memorial Medical Group should not have been included in the supplemental payment calculations.

In recalculating the amount of supplemental payments based on physician services performed in FYs 2000 through 2003 that were available for the State agency to retroactively claim in FY 2005, we allowed for claims for physician services that were performed in accordance with the State plan. However, we removed claims for physician services performed outside the hospital setting, thereby reducing the amount of supplemental payments available to be claimed in FY 2005 by $4.2 million.

PAYMENTS TO UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL

In determining UMMHC's supplemental payments eligible under the State plan before January 20, 2001, we found that UMMHC had included costs of $4.3 million in FY 2000 and $1.3 million from October 1, 2000, to January 20, 2001, for payments that the Medical Center made to the Medical School and reported on its DHCFP-403 cost reports. UMMHC described these costs as "medical education costs" representing the direct and indirect undergraduate classroom instruction expenses of the Medical School.

The State plan does not clearly allow Medical School costs to be included in supplemental payment calculations. The State plan only references payments to the Medical School under the sections dealing with disproportionate share hospital payments. As a result, we are unable to express an opinion on the $5.6 million ($2.8 million Federal share) in medical education costs representing UMMHC payments to the Medical School.

CONCLUSION

The State agency overstated its supplemental payment claims during FYs 2004 and 2005 by approximately $12.7 million in retroactively claimed costs from FYs 2000 through 2003. The State agency understated its claim for unreimbursed charges for inpatient and outpatient services in FY 2005 by $1.2 million. We have adjusted our total finding from $12.7 million to $11.5 million ($5.75 million Federal share) to reflect the $1.2 million understatement.

These excessive supplemental Medicaid payments occurred because UMMHC did not follow procedures set forth in the State plan to calculate these payments and the State agency believed that the procedures that UMMHC used were in accordance with the State plan.

RECOMMENDATIONS

We recommend that the State agency:

- make a financial adjustment of $11.5 million ($5.75 million Federal share),
- work with CMS to determine the appropriateness of $5.6 million ($2.8 million Federal share) in supplemental payments representing UMMHC payments to the Medical School, and
- follow State plan requirements when submitting claims for supplemental payments.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency respectfully disagreed with $8.5 million of our $11.5 million finding. The State agency believed that these supplemental payments were appropriate under a reasonable reading of the supplemental payment methodologies of the State plan in effect during 2000 and 2001, parts of which it attached with its comments. In addressing our finding related to payments to the Medical School, the State agency said that it would be happy to work with CMS on this issue. However, it maintained that the inclusion of medical education costs for FYs 2000 and 2001 in the supplemental payment calculations was in accordance with the State plan in effect at the time.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

We based our findings on the applicable Medicaid requirements in effect during our audit period. The SPAs that the State agency attached with its comments were an intrinsic part of our evaluation and contain no material that we did not consider during our review. Therefore, we maintain that our findings and recommendations, as originally stated, are valid.

APPENDIXES

APPENDIX A: SUPPLEMENTAL PAYMENTS MADE TO UMASS MEMORIAL HEALTH CARE, INC., DURING FISCAL YEARS 2004 AND 2005[1,2]

Fiscal Year (FY) 2004 Payment	For Services Provided in FY 2000	For Services Provided in FY 2001	For Services Provided in FY 2002	For Services Provided in FY 2003	For Services Provided in FY 2004	For Services Provided in FY 2005	Total
Total Costs or Charges, Actual	$95,859,359				$199,578,141		
Total Fee for Service Payments, Actual	62,927,183				87,025,511		
Unreimbursed Costs or Charges Before Supplemental Payments	32,932,176				112,552,630		
Supplemental Payments Made Before FY 2004	30,262,245						
Unreimbursed Charges (or Costs) Before FY 2004 Supplemental Payments	2,669,931						
Supplemental Payments Made in FY 2004	13,526,924				111,473,076		**$125,000,000**
Net Remaining Costs or Charges	(10,856,993)				1,079,554		
FY 2005 Payment	**FY 2000**	**FY 2001**	**FY 2002**	**FY 2003**	**FY 2004**	**FY 2005**	
Total Costs or Charges (or Costs), Actual	$95,859,359	$151,837,376	$189,213,133	$199,344,270	$199,578,141	$267,075,744	
Total Fee for Service Payments, Actual	62,927,183	69,061,931	68,164,620	67,453,711	87,025,511	93,545,724	
Unreimbursed Cost or Charges (or Costs) Before Supplemental Payments	32,932,176	82,775,445	121,048,513	131,890,559	112,552,630	173,530,020	
Supplemental Payments Made Before FY 2005	43,789,169	53,710,664	120,000,000	125,000,000	111,473,076	-	
Unreimbursed Costs or Charges (or Costs) Before FY 2005 Supplemental Payments	(10,856,993)	29,064,781	1,048,513	6,890,559	1,079,554	173,530,020	
Supplemental Payments Made in FY 2005	10,792,270	17,416,830	2,424,979	8,146,587	13,595,598	172,350,933	**$224,727,197**
Net Remaining Costs or Charges	(21,649,263)	11,647,951	(1,376,466)	(1,256,028)	(12,516,044)	1,179,087	
Combined Fiscal Years 2004 and 2005 Supplemental Payments							
Supplemental Payments Made in FYs 2004 and 2005	$24,319,194	$17,416,830	$2,424,979	$8,146,587	$125,068,674	$172,350,933	**$349,727,197[3]**

[1]The information in this Appendix was provided by the Massachusetts Executive Office of Health and Human Services (the State agency) and was adjusted for the effects of our audit findings. The totals do not include the $5,607,721 in Medicaid supplemental rate payments (supplemental payments) on which we express no opinion or the State agency's $12,516,047 adjustment made in January 2006.

[2]The supplemental payments made during FYs 2004 and 2005 represent unreimbursed costs and charges that were incurred not only in FYs 2004 and 2005 but also in prior years.

[3]Does not include the State agency's $12,516,047 adjustment made in January 2006, which reduces the total supplemental payments during FYs 2004 and 2005 to $337,211,150.

APPENDIX B: SUPPLEMENTAL PAYMENTS MADE TO UMASS MEMORIAL HEALTH CARE, INC., DURING FISCAL YEARS 2004 AND 2005 FOR FISCAL YEARS 2004 AND 2005

	FY 2004	FY 2005	Total FYs 2004 and 2005
Eligible Supplemental Payments Per Audit	$112,552,630	$173,530,020	**$286,082,650**
Total Supplemental Payments Claimed	125,068,674	172,350,933	**297,419,607**
Total (Overclaimed) or Underclaimed Supplemental Payments	**($12,516,044)**[1]	**$1,179,087**	**($11,336,957)**

[1]During our audit, the State agency refunded $12,516,047 to account for these overclaimed supplemental payments. There was a $3 discrepancy between the amount that the State agency overclaimed and the amount that it refunded.

APPENDIX C: RETROACTIVE SUPPLEMENTAL PAYMENTS MADE TO UMASS MEMORIAL HEALTH CARE, INC., DURING FISCAL YEARS 2004 AND 2005 FOR FISCAL YEARS 2000 THROUGH 2003

	FY 2000	FY 2001	FY 2002	FY 2003	Total FYs 2000–2003
Eligible Supplemental Payments per Audit	$32,932,176	$82,775,445	$121,048,513	$131,890,559	**$368,646,693**
Amounts Claimed Before FYs 2004 and 2005	30,262,245	53,710,664	120,000,000	125,000,000	**328,972,909**
Amounts Remaining for Retroactive Payments in FYs 2004 and 2005	2,669,931	29,064,781	1,048,513	6,890,559	**39,673,784**[1]
Retroactive Payments Claimed in FYs 2004 and 2005	24,319,194	17,416,830	2,424,979	8,146,587	**52,307,590**
(Overclaimed) or Underclaimed Hospital Costs and Charges	(21,129,188)	12,640,016	$0	$0	**(8,489,172)**
(Overclaimed) Physician Services	(520,075)	(992,065)	(1,376,466)	(1,256,028)	**(4,144,634)**
Total (Overclaimed) or Underclaimed Supplemental Payments	**($21,649,263)**	**$11,647,951**	**($1,376,466)**	**($1,256,028)**	**($12,633,806)**

[1]On page 5 of the report, we rounded this number down to $39.6 million to account for a discrepancy in total dollar amounts remaining for retroactive payments in FYs 2004 and 2005 that was caused by rounding.

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Office of Medicaid
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Medicaid Director

September 16, 2009

Michael Armstrong
Regional Inspector General
U.S. Department of Health and Human Services
JFK Federal Building Room 2425
Boston, MA 02203

Re: Audit Report No: A-01-07-00013
Response to Office of the Inspector General's Draft Audit Report of Review of Medicaid Supplemental Rate Payments to UMass Memorial Health Care, Inc., for Fiscal Years 2004 and 2005

Dear Mr. Armstrong,

Thank you for the opportunity to review and comment on Draft Audit Report No: A-01-07-00013 "Review of Medicaid Supplemental Rate Payments to UMass Memorial Health Care, Inc., for Fiscal Years 2004 and 2005."

We wish to thank you and your team for your time and effort, and for the input we have received over the course of this engagement. Much has changed in the ten-year period since the first services covered under the scope of this audit were delivered. The methodologies and specific State Plan language EOHHS relied on to pay hospitals during the audit period have been substantially revised and some State Plan provisions at issue in the Draft Audit Report are no longer in effect. Moreover, EOHHS has adopted additional internal procedures over the last several years to monitor program payments. Nevertheless, we wish to comment specifically on two issues, which are discussed below.

Supplemental payments based on hospital services provided in fiscal years 2000 and 2001

The Draft Audit Report recommends a financial adjustment of $11.5 million relating to supplemental payments for hospital services. EOHHS respectfully disagrees with $8.5 million of the OIG's finding. We believe that these supplemental payment amounts were appropriate under a reasonable reading of supplemental payment methodologies of the State Plan in effect during 2000 and 2001. In both Massachusetts Medicaid SPA TN-99-12 and SPA TN-99-13, which described the Commonwealth's reimbursement methodologies for acute inpatient and acute outpatient hospital services, respectively, Sections IV.C.4 (Inpatient, Attachment 1) and IV.B. (Outpatient, Attachment 2) should be considered in their entirety when evaluating whether supplemental payments were made in accordance with the State Plan. The full text of these sections describes additional conditions under which these supplemental payments were permitted.

Inclusion of medical education costs for fiscal years 2000 and 2001

The Draft Audit Report also recommended that EOHHS work with CMS to determine the appropriateness of the portion of the supplemental payments representing payment amounts for medical education costs, but made no specific monetary findings. EOHHS is of course happy to work with CMS on these issues, and believes that the inclusion of medical education costs for fiscal years 2000 and 2001 in supplemental payment calculations was in accordance with the State Plan in effect at the time. EOHHS looks forward to resolving any outstanding questions CMS may have on this aspect of the calculation.

* * * *

In conclusion, we appreciate the OIG's collaboration and communication during this review. We believe that our current practices comply with all federal requirements, and will work with CMS to resolve the issues noted in your report as to our past practices. Please feel free to contact Kate Moriarty, EOHHS Director of Compliance, at 617-348-5380 if you have any questions or concerns.

Sincerely,

Thomas Dehner
Medicaid Director

Attachment 1: Inpatient State Plan (TN-99-12)

by 3.16% to reflect inflation between RY95 and RY96, 2.38% to reflect inflation between RY96 and RY97, 2.14% to reflect inflation between RY97 and RY98, 1.9% to reflect inflation between RY98 and RY99, and 1.43% to reflect inflation between RY99 and RY00.

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days.

Acute hospitals which receive payment as public service hospital providers shall be determined by the Division.

4. ~~Non-Profit Teaching Hospitals Affiliated with a Commonwealth-Owned Medical School~~

a. Subject to Section IV.C.4.b, the inpatient payment amount for non-psychiatric admissions at non-profit acute care teaching hospitals affiliated with a state-owned university medical school shall be equal to the hospital's cost per discharge calculated as follows:

The data used for this payment will be from the most recent submission of the hospital's or predecessor hospitals' DHCFP-403 report(s). Total hospital-specific inpatient non-psychiatric charges are multiplied by the hospital's inpatient non-psychiatric cost-to-charge ratio (calculated using DHCFP-403, schedule II, column 10, line 100 minus column 10, line 82 for the total cost numerator and schedule II, column 11, line 100 minus column 11, line 82 for the total charges denominator) to compute that facility's total inpatient non-psychiatric cost. The total inpatient non-psychiatric cost is then multiplied by the ratio of the hospital-specific non-psychiatric Medicaid discharges to the total hospital non-psychiatric discharges to yield the Medicaid inpatient non-psychiatric cost. The Medicaid inpatient non-psychiatric cost is then divided by the number of Medicaid non-psychiatric discharges to calculate the Medicaid cost per discharge. This Medicaid cost per discharge is multiplied by the inflation rates for those years between the year of the cost report and the current rate year, as set forth in Section IV.B.2.a.

b. Any payment amount in excess of amounts which would otherwise be due any state-owned teaching hospital pursuant to Section IV.B is subject to specific legislative appropriation and intergovernmental transfer.

Attachment 2: Outpatient State Plan (TN-99-13)

B. Reimbursement for Unique Circumstances
Non-Profit Acute Teaching Hospitals Affiliated with a State-Owned University Medical School

a. Subject to section IV.C.2.b, the payment amount for outpatient, emergency department, and hospital-licensed health center services at non-profit acute care teaching hospitals affiliated with a state-owned university medical school shall be as follows. The data used for this payment will be from the most recent submission of the hospitals' or predecessor hospitals' DHCFP-403 report(s).

The hospital's total outpatient charges are multiplied by the hospital's overall outpatient cost to charge ratio (the hospital's outpatient cost to charge ratio is calculated using the DHCFP-403 total outpatient costs located on schedule II, column 10, line 114 as the numerator and total outpatient charges located on schedule II, column 11, line 114 as the denominator) in order to compute the total outpatient costs. The total outpatient costs are then multiplied by the Medicaid outpatient utilization factor (this factor is calculated by dividing the total Medicaid outpatient charges by the total hospital outpatient charges) in order to calculate Medicaid outpatient costs. Medicaid outpatient costs are then multiplied by the inflation rates for those years between the year of the cost report and the current rate year.

b. Any payment amount in excess of amounts which would otherwise be due any non-profit teaching hospital affiliated with a state-owned university medical school pursuant to sections IV.A and IV.B is subject to specific legislative appropriation and intergovernmental funds transfer.

C. Upper Limit Review and Federal Approval

Payment adjustments may be made for reasons relating to the Upper Limit, if the number of hospitals that apply and qualify changes, if updated information necessitates a change, or as otherwise required by the Health Care Financing Administration (HCFA). If any portion of the reimbursement methodology is not approved by HCFA, the Division may recover any payment made to a hospital in excess of the approved methodology.

D. Future Rate Years

Adjustments may be made each rate year to update rates and shall be made in accordance with the hospital contract in effect on that date.