

**Memorandum**

JUN 22 2001

Date

From

Michael Mangano
Michael F. Mangano
Acting Inspector General

Subject

Review of Medicaid Enhanced Payments to Hospitals and the Use of Intergovernmental Transfers in North Carolina (A-04-00-00140)

To

Thomas Scully
Administrator
Centers for Medicare and Medicaid Services

Attached are two copies of a final report that presents the results of an Office of Inspector General review of Medicaid enhanced payments to hospitals and the use of intergovernmental transfers (IGT) in the State of North Carolina. The objectives of our review were to analyze the use of enhanced payments and evaluate the financial impact of IGTs on the Medicaid program.

Under upper payment limit (UPL) rules, States are permitted to establish payment methodologies that allow for enhanced payments to certain providers, such as hospitals. In North Carolina, these enhanced payments are called supplemental payments. The supplemental payments, which trigger a Federal matching payment, are in addition to regular Medicaid payments and disproportionate share hospital (DSH) payments made to hospitals. The regular Medicaid payments were not included as part of our review.

We found that Medicaid supplemental payments to public and private hospitals in North Carolina were based on their Medicaid deficits. The Medicaid deficits were calculated without consideration of DSH payments or the State/local governments' payments for indigent care. For Fiscal Years (FY) 1996 through 1999, North Carolina made supplemental payments to hospitals totaling about \$647 million, generating about \$412 million in Federal financial participation. The hospitals retained the supplemental payments and used the funds to pay facility expenses.

In FYs 1996 and 1997, North Carolina relied on public hospitals to have "Certified Public Expenditures" (CPE) to cover the entire State/local share of the total supplemental payments (the State/local share was approximately 37 percent of the total payment and the Federal share was approximately 63 percent). In FYs 1998 and 1999, the 37 percent State/local share consisted of CPEs (33 percent) and State funds (4 percent). The State agency's records showed that the State's portion, 4 percent totaling \$4.5 million in FY 1999, was paid from a trust fund that consisted of DSH payments. The public hospitals returned 90 percent of the DSH payments to the State through IGTs, totaling \$145 million in FY 1999. As a

result, the State agency used Federal funds to match other Federal funds. However, based on the cash outlays from this trust fund, the supplemental payments were used to fund Medicaid deficits for inpatient and outpatient hospital costs.

The return of 90 percent of DSH payments by public hospitals to the State agency raises the question as to whether supplemental payments would be needed if the total DSH payments were retained by the hospitals. We believe the return of DSH payments to the State contradicts the purpose of assisting these hospitals and we plan to perform additional work in this area.

We also noted that there is no clearly defined methodology for computing the Medicare UPL. Based on reviews in other States, we noticed that payment amounts can vary significantly, depending on the creativity of a State's funding pool methodology.

In our draft report, we recommended that in order to better protect the fiscal integrity of the Medicaid program, the Centers for Medicare and Medicaid Services (CMS) should: (1) provide States with definitive guidance on how to calculate the Medicare UPL and review the calculation of this limit each year, (2) require that cost report data be the basis of the UPL calculation, which North Carolina is already utilizing, and (3) require State plans to contain assurances that supplemental payments will be retained by the hospitals and used to provide services to Medicaid eligible individuals.

In written comments to the draft report, CMS advised us of the changes that had been made to the UPL regulations. We commend CMS for taking action. The CMS concurred with our recommendation to issue additional guidance to States and said it intends to issue a revised State Medicaid Manual to provide guidance regarding the States' calculation of the Medicare UPL. However, CMS did not concur with our recommendation to review the calculation of the UPL each year. Rather, CMS plans to conduct selective financial reviews, as appropriate.

In addition, CMS disagreed with our recommendation to require cost report data to be the basis of the UPL calculation. Instead, CMS intends to offer several methods for States to use, depending on which method is suitable for a State's reimbursement system. Finally, CMS contended that it does not have the authority to prescribe how facilities use the Medicaid payments they receive from State Medicaid agencies. However, we strongly believe that Medicaid payments should only be used to provide Medicaid services. The full text of CMS' response is attached as Appendix B.

Please note that the attached report was fully processed before the name change was made from the Health Care Financing Administration (HCFA) to the Centers for Medicare and Medicaid Services (CMS). Thus, references are made to HCFA.

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

To facilitate identification, please refer to Common Identification Number A-04-00-00140 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICAID ENHANCED
PAYMENTS TO HOSPITALS AND THE
USE OF INTERGOVERNMENTAL
TRANSFERS IN NORTH CAROLINA**



**JUNE 2001
A-04-00-00140**

**Memorandum**

JUN 22 2001

Date *Michael Mangano*

From Michael F. Mangano
Acting Inspector General

Subject Review of Medicaid Enhanced Payments to Hospitals and the Use of Intergovernmental Transfers in North Carolina (A-04-00-00140)

To Thomas Scully
Administrator
Health Care Financing Administration

This final report provides the results of our review of Medicaid enhanced payments to hospitals and the use of intergovernmental transfers (IGT) in the State of North Carolina. The objectives of our review were to analyze the use of enhanced payments and evaluate the financial impact of IGTs on the Medicaid program. This report only includes information on Medicaid enhanced payment transactions resulting from the upper payment limit (UPL) calculations.

Under UPL rules, States are permitted to establish payment methodologies that allow for enhanced payments to certain providers, such as hospitals. In North Carolina, these enhanced payments are called supplemental payments. The supplemental payments, which trigger a Federal matching payment, are in addition to regular Medicaid payments and disproportionate share hospital (DSH) payments made to hospitals. The regular Medicaid payments were not included as part of our review.

We found that Medicaid supplemental payments to public and private hospitals in North Carolina were based on their Medicaid deficits. The Medicaid deficits were calculated without consideration of DSH payments or the State/local governments' payments for indigent care. For Fiscal Years (FY) 1996 through 1999, North Carolina made supplemental payments to hospitals totaling about \$647 million, generating about \$412 million in Federal financial participation (FFP). The hospitals retained the supplemental payments. While we were unable to determine the specific use of the payments, we did determine that the payments were deposited into the hospitals' general funds and used to pay facility expenses.

In FYs 1996 and 1997, North Carolina relied on public hospitals to have "Certified Public Expenditures" (CPE) to cover the entire State/local share of the total supplemental payments (the State/local share was approximately 37 percent of the total payment and the Federal share was approximately 63 percent). In FYs 1998 and 1999, the 37 percent State/local share consisted of CPEs (33 percent) and State funds (4 percent). The State agency's records showed that the State's portion, 4 percent totaling \$4.5 million in FY 1999, was paid from a trust fund that consisted of DSH payments. The public hospitals returned 90 percent of the DSH payments to the State through IGTs, totaling \$145 million in FY 1999. As a

result, the State agency used Federal funds to match other Federal funds. However, based on the cash outlays from this trust fund, the supplemental payments were used to fund Medicaid deficits for inpatient and outpatient hospital costs.

The return of 90 percent of DSH payments by public hospitals to the State agency raises the question as to whether supplemental payments would be needed if the total DSH payments were retained by the hospitals. We believe the return of DSH payments to the State contradicts the purpose of assisting these hospitals and we plan to perform additional work in this area.

In North Carolina, private hospitals do not receive DSH payments, but do receive supplemental payments. In accordance with the State plan, the total amount of the supplemental payments were approximately 67 percent of the cost deficits for private hospitals. The supplemental payments for private hospitals consisted of 63 percent Federal and 37 percent State funds.

Supplemental payments were based on inpatient and outpatient deficits at both public and private hospitals with "pools" being calculated for public and private hospitals separately. Therefore, a regulation change to include a separate aggregate upper limit applicable to payments made to local government-owned facilities would not significantly change the funds available to North Carolina for supplemental payments to public providers.

Finally, we noted that there is no clearly defined methodology for computing the Medicare UPL. Based on reviews in other States, we noticed that payment amounts can vary significantly, depending on the creativity of a State's funding pool methodology.

In our draft report, we recommended that in order to better protect the fiscal integrity of the Medicaid program, HCFA should: (1) provide States with definitive guidance on how to calculate the Medicare UPL and review the calculation of this limit each year, (2) require that cost report data be the basis of the UPL calculation, which North Carolina is already utilizing, and (3) require State plans to contain assurances that supplemental payments will be retained by the hospitals and used to provide services to Medicaid eligible individuals.

In written comments to the draft report, HCFA advised us that changes had been made in the UPL regulations. We commend HCFA for taking action.

The HCFA concurred with our recommendation to issue additional guidance to States and said it intends to issue a revised State Medicaid Manual to provide guidance regarding the States' calculation of the Medicare UPL. However, HCFA did not concur with our recommendation to review the calculation of the UPL each year. Rather, HCFA plans to conduct selective financial reviews, as appropriate.

In addition, HCFA disagreed with our recommendation to require cost report data to be the basis of the UPL calculation. Instead, HCFA intends to offer several methods for States to use, depending on which method is suitable for a State's reimbursement system.

Finally, HCFA contended that it does not have the authority to prescribe how facilities use the Medicaid payments they receive from State Medicaid agencies. However, we strongly believe that Medicaid payments should only be used to provide Medicaid services. The full text of HCFA's response is included as Appendix B.

We also provided a copy of our draft report to the State agency and offered the State agency the opportunity to provide written comments concerning the facts presented in the report. The State agency agreed in general that the report accurately described the method by which North Carolina made supplemental payments to hospitals.

INTRODUCTION

BACKGROUND

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

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

Also, there was a separate aggregate payment limit that applied only to inpatient services provided by State-operated facilities. Because there was no separate aggregate limit that applied to local government-operated facilities, these types of facilities were grouped with

all other facilities when calculating aggregate UPLs. This allowed the State Medicaid agencies to make supplemental Medicaid payments to city and county-owned facilities without violating the UPL regulations. These supplemental payments are in addition to the regular Medicaid payments made to facilities that provide services to Medicaid eligible individuals. The FFP is not available for State expenditures that exceed the applicable UPLs.

The DSH payments are provided to hospitals which serve a disproportionate number of low-income patients with special needs. In North Carolina, DSH payments were made to public hospitals based on "Net Unreimbursed Uninsured Patient Care Charges." Also, DSH payments were paid to State mental facilities based on interim cost report data and patient days.

The Form HCFA-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, was used to report both supplemental and DSH expenditures to HCFA. The DSH payments described in the above paragraph were included on the HCFA-64 report as Medicaid expenditures.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of our review were to analyze the use of Medicaid supplemental payments to hospitals and evaluate the financial impact of IGTs on the Medicaid program. Our review covered supplemental payments made to hospitals in North Carolina from 1996 to 1999. We reviewed the funding pool calculations prepared by the State Medicaid agency. We also tracked the dollars that were transferred between the State and three hospitals during FYs 1998 and 1999. Supplemental payments to these three hospitals comprised about 23 percent of the total supplemental payments.

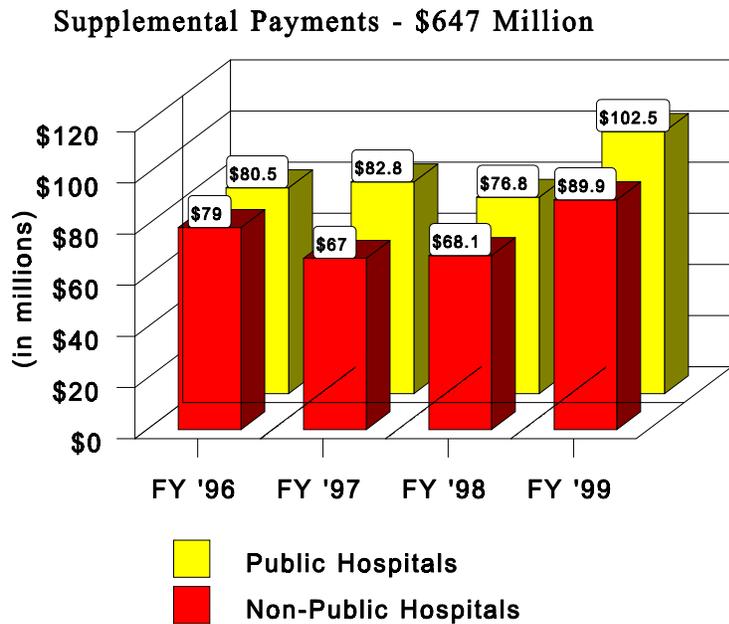
To accomplish our objectives, we held discussions with HCFA regional office staff to determine its role pertaining to North Carolina's Medicaid program. We conducted a review at the State Medicaid agency; interviewed key personnel; and reviewed applicable records supporting the funding pool calculations, supplemental payments, and IGTs. We also visited two county-owned hospitals and one private hospital that received supplemental payments to determine how the supplemental payments were used. At these hospitals, we interviewed key personnel and reviewed financial statements supporting their source and application of funds.

Our review was conducted in accordance with generally accepted government auditing standards. The review was conducted from July to October 2000. We performed field work at the State agency in Raleigh, North Carolina and at hospitals in Raleigh, Fayetteville, and Charlotte, North Carolina.

On January 25, 2001, we issued a draft report to HCFA for comment. On February 1, 2001, we provided the State agency a copy of the draft report for comment. We received written comments from HCFA on May 7, 2001 and the State agency on March 27, 2001.

RESULTS

For FYs 1996 through 1999, North Carolina made Medicaid supplemental payments to hospitals totaling \$647 million of which \$412 million were Federal matching funds. During FY 1999, supplemental payments totaled \$193 million (\$103 million to 41 public hospitals and \$90 million to 76 private hospitals). Except for bank fees, the hospitals retained the supplemental payments and used the funds to pay for facility expenses.



HISTORY OF NORTH CAROLINA'S SUPPLEMENTAL PAYMENT PROGRAM

In 1995, North Carolina implemented two supplemental payment programs (inpatient and outpatient) which made payments on at least an annual basis to hospitals that met specific eligibility requirements. According to the State Plan Amendments (SPA), supplemental payments were to cover hospital Medicaid deficits.

Each year, North Carolina submitted new SPAs providing for supplemental payments which updated the FMAP rate. For FY ending September 30, 1999, SPAs 99-17 (inpatient) and 99-18 (outpatient) were filed with HCFA.

North Carolina SPA 99-17 was approved by HCFA on December 22, 1999 with an effective date of September 16, 1999. This SPA provided a lump-sum payment for the unreimbursed [Medicaid] inpatient hospital services. On November 23, 1999, North Carolina SPA 99-18 was approved by HCFA with an effective date of September 16, 1999. This SPA provided an additional payment for [Medicaid] outpatient hospital services.

Both the inpatient and outpatient supplemental payments were made to public and private hospitals that had deficits and met certain payment criteria.

FUNDING METHODOLOGY

North Carolina calculated its supplemental payment pool based on estimated hospital Medicaid cost deficits.¹ These estimated Medicaid cost deficits were based on the hospitals' prior years' cost reports plus inflation factors. Hospitals were grouped by public and private facilities to compute the supplemental payments.

Medicaid inpatient costs were increased by an inflation factor and then reduced by Medicaid payments, excluding DSH payments. The difference was the "Inpatient Cost Deficit." Medicaid outpatient costs were multiplied by the 20 percent not already paid by Medicaid (basic Medicaid payments were based on 80 percent of costs) and increased by an inflation factor. This resulted in the "Outpatient Cost Deficit."

The inpatient and outpatient cost deficits were combined for the total Medicaid cost deficit (see Appendix A for details). For public hospitals, this was the total amount of the supplemental payment pool.

The public hospitals only received approximately 67 percent (63 percent Federal and 4 percent State funds) of the total supplemental payment because about 33 percent of the State match consisted of CPEs² of the hospitals. The 33 percent of the State/local match was considered met by the CPEs of the public hospitals.

Supplemental payments to public hospitals in 1999 consisted of about 63 percent Federal funds, 4 percent State funds, and 33 percent Certified Public Expenditures of the hospitals.

¹The Medicaid cost deficit is the reasonable cost of hospital Medicaid services, plus the reasonable direct and indirect costs attributable to Medicaid services of operating Medicare approved graduate medical education programs, less Medicaid payments received or to be received for these services (excluding Medicaid DSH payments).

²CPEs consisted of a hospital's Medicaid cost deficit less the Federal and State portion of the supplemental payment; i.e., the Medicaid deficit funded by other hospital sources.

Private hospitals' supplemental payments were approximately 67 percent of their cost deficits. The supplemental payments for private hospitals consisted of 63 percent Federal and 37 percent State funds.

However, based on our review of the State agency's documentation, the State's portion of each of the supplemental payments came from a trust fund at the State's Division of Medical Assistance that was funded by the 90 percent of DSH payments the public hospitals returned to the State agency.

The only funding pools for the Medicaid supplemental payments were the public and private pools created by Medicaid inpatient and outpatient hospital deficits. Deficits were calculated by individual hospitals. Hospitals that did not have a Medicaid deficit did not receive a supplemental payment. The total of all inpatient/outpatient deficits was considered to be the "upper limit" by the State agency. There was no other "calculation" of an "upper limit" and as noted earlier, there were no other funding pools.

To assure the UPL was not exceeded, North Carolina's supplemental payments were based on estimates calculated from the prior year's Medicare/Medicaid cost reports which were prepared using Medicare payment principles. These payments were then cost settled as required by the SPAs. The settlement amount was determined by using data submitted by the hospitals on the Medicaid cost reports and claims payment information supplied by the fiscal agent as well as additional DSH payment information provided by the North Carolina Division of Medical Assistance. According to the SPAs, "Hospitals that receive payments in excess of unreimbursed reasonable costs...shall promptly refund their proportionate share of any payments that exceed the state aggregate upper limits as specified by 42 CFR 447.272 [(inpatient) and 447.321 (outpatient)]. No additional payment shall be made in connection with the cost settlement."

However, for both of the SPAs, the payments were supposed to be cost settled within 12 months of receipt of the completed cost report. The latest year cost settled was 1996.

USE OF SUPPLEMENTAL PAYMENTS

Except for bank fees paid to a business agent that disbursed some of the supplemental payments, all supplemental payments made to hospitals under these SPAs were retained by the hospitals and used to pay facility expenses.

To determine the use of the funds at the local level, we visited two county-owned hospitals and one private hospital that received supplemental payments.³ In all three cases, the supplemental payments were deposited into the hospitals' general funds that were used to pay facility expenses. Because the funds were not accounted for separately from other funds, we were unable to determine specifically how the funds were used.

IMPACT OF REVISIONS TO THE UPPER PAYMENT LIMIT REGULATIONS

The FYs 1996 through 1999 funding pools were calculated in accordance with the requirements of the SPAs and were based on the prior years' Medicare/Medicaid cost reports. According to the SPAs, the Medicare UPL was based on the cost reports for years ending 1995 through 1998 and the limit was not to be exceeded in the aggregate.

Supplemental payments were based on inpatient and outpatient deficits at both public and private hospitals with "pools" being calculated for public and private hospitals separately. Therefore, the new change to the regulations to include a separate aggregate upper limit applicable to payments made to local government-owned facilities will not reduce the funds available to North Carolina for supplemental payments to public providers. While many States will see a dramatic decrease in the funds available for enhanced payments, North Carolina would have an increase under the higher payment limit of 150 percent for public hospitals.

We believe North Carolina's supplemental payments and IGTs had less negative impact on the Medicaid program than in other States. However, the following are observations for HCFA's consideration relative to any actions being contemplated to provide improved fiscal integrity to the Medicaid program.

- Through supplemental payments and IGTs, the State agency developed a mechanism to receive additional Federal Medicaid funds without committing its share of required matching funds. This was done by using previous DSH payments, 90 percent of which were returned to the State from public hospitals, as the source of the State match for supplemental payments, thus effectively reducing the State's share.
- The State initially received approximately 63 percent of Federal matching dollars when it made the DSH payments (as part of the Medicaid DSH payment process which is supposed to be separate and distinct from the

³All three hospitals visited received Medicaid supplemental payments and the two county-owned hospitals also received Medicaid DSH payments, of which 90 percent was subsequently returned to the State. Our review showed that all three hospitals were profitable from their total hospital operations. In fact, these three hospitals had profits ranging from \$9 million to \$65 million for their 12-month operating period ending during Calendar Year 1998. These facts bring into question the hospitals' need for Medicaid supplemental and/or DSH payments.

Medicaid supplemental payment process) to the public hospitals and reported them to HCFA as program expenses. But as we noted, 90 percent of these DSH payments were actually returned to the State from public hospitals and transferred into a trust fund. Then, when supplemental payments and additional DSH payments were made, the State used transfers from this trust fund as the State match to draw down these additional Federal funds. This recycling of the funds had the effect of using Federal funds to generate additional Federal funds, thus increasing the overall Federal share for Medicaid expenses in North Carolina.

We believe the return of DSH payments to the State contradicts the purpose of assisting these hospitals and we plan to perform additional work in this area. This recycling effect could be greatly reduced if the State agency was required to report the amounts returned by the hospitals under the DSH program as a refund or other collection on the Form HCFA-64 report, thus offsetting an amount equal to expenditures previously reported. The potential for the use of such a transaction will be pursued as part of our overall DSH program review.

SUMMARY AND RECOMMENDATIONS

In FYs 1996 and 1997, North Carolina relied on public hospitals to have CPEs to cover the entire State/local share of the total supplemental payments (the State/local share was approximately 37 percent of the total payment and the Federal share was approximately 63 percent). In FYs 1998 and 1999, the 37 percent State/local share consisted of CPEs (33 percent) and State funds (4 percent). The State agency's records showed that the State's portion, 4 percent totaling \$4.5 million in FY 1999, was paid from a trust fund that consisted of DSH payments. The public hospitals returned 90 percent of the DSH payments to the State through IGTs, totaling \$145 million in FY 1999. As a result, the State agency used Federal funds to match other Federal funds.

The State allowed the hospitals to keep all of the supplemental payments. While we were unable to determine the specific use of the supplemental payments, we did determine that they were deposited into the hospitals' general funds and used to pay facility expenses.

The broad range of potential funding pool calculations available to North Carolina and other States indicated that clarification was needed to ensure the fiscal integrity of the Medicaid program.

We recommended that HCFA:

- provide States with definitive guidance on how to calculate the Medicare UPL and review the calculation of this limit each year;

- require that cost report data be the basis of the UPL calculation, which North Carolina is already utilizing; and
- require State Plans to contain assurances that supplemental payments will be retained by the hospitals and used to provide services to Medicaid eligible individuals.

HCFA'S COMMENTS

In written comments to the draft report, HCFA advised us of the changes that had been made in the UPL regulations. We commend HCFA for taking action.

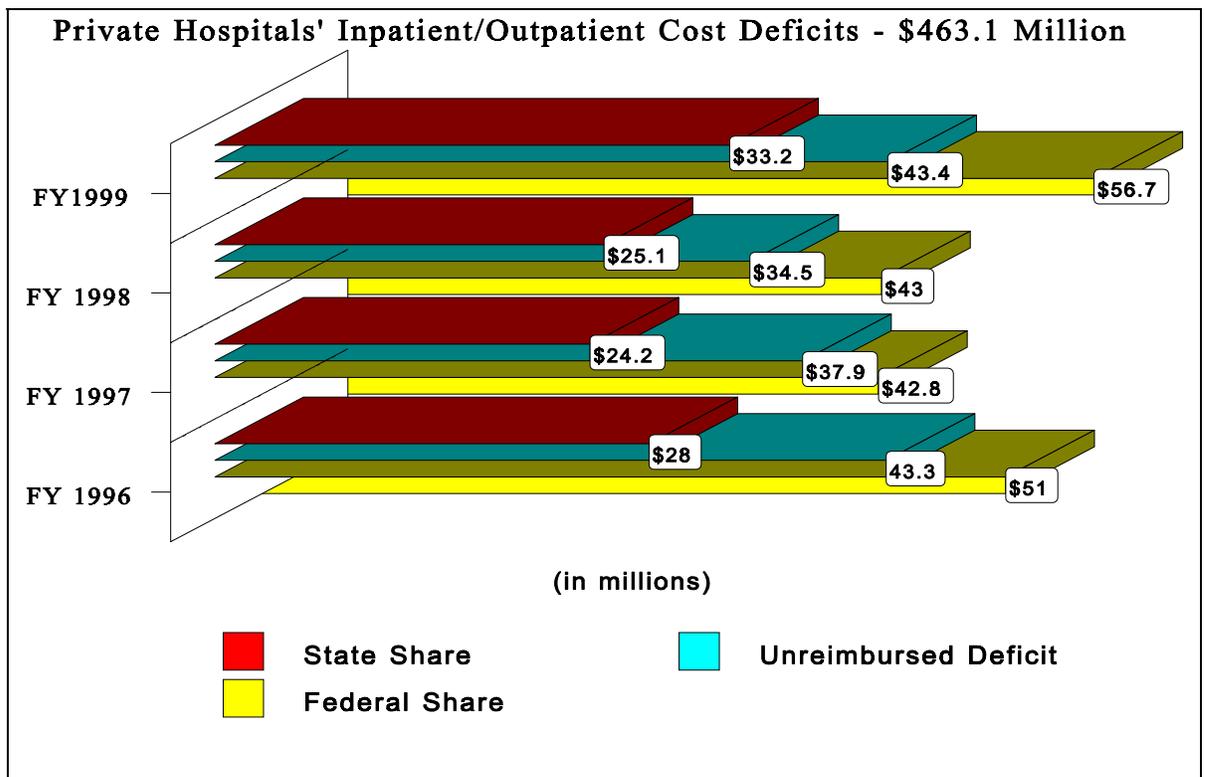
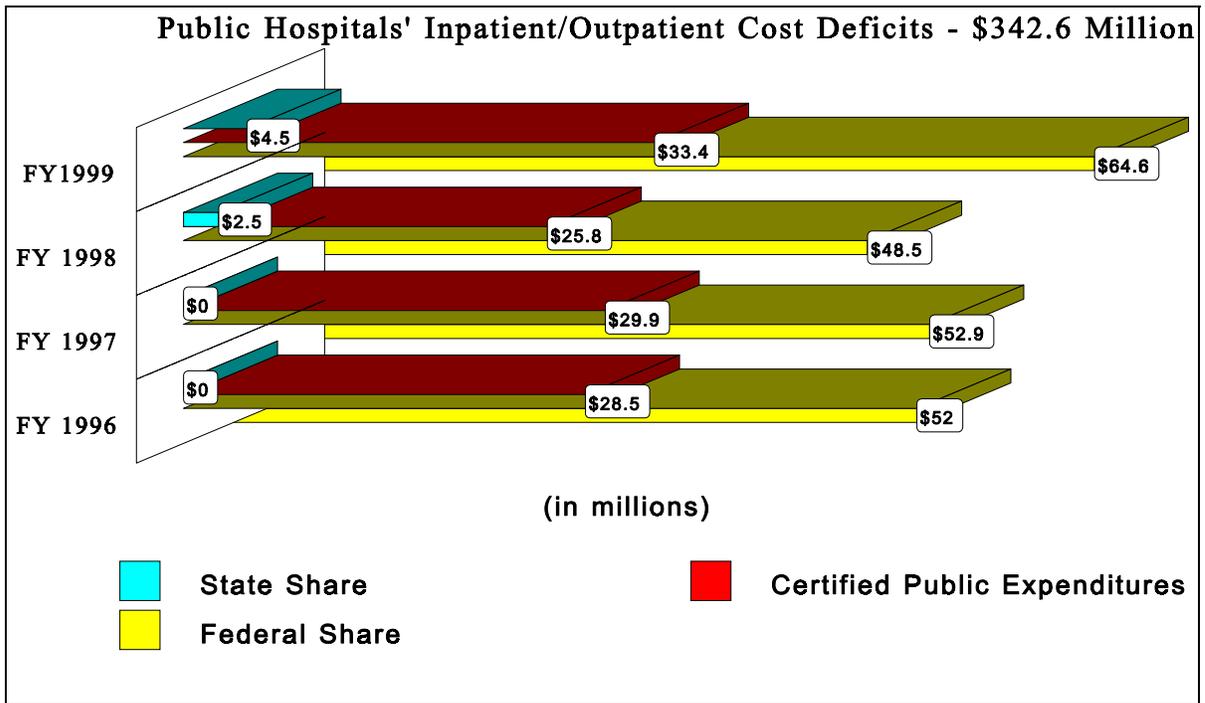
The HCFA concurred with our recommendation to issue additional guidance to States and said it intends to issue a revised State Medicaid Manual to provide guidance regarding the States' calculation of the Medicare UPL. However, HCFA did not concur with our recommendation to review the calculation of the UPL each year. Rather, HCFA plans to conduct selective financial reviews, as appropriate.

In addition, HCFA disagreed with our recommendation to require cost report data to be the basis of the UPL calculation. Instead, HCFA intends to offer several methods for States to use, depending on which method is suitable for a particular State's reimbursement system.

Finally, HCFA contended that it does not have the authority to prescribe how facilities use the Medicaid payments they receive from State Medicaid agencies. The complete text of HCFA's comments is included as Appendix B.

OIG'S RESPONSE

We commend HCFA for its efforts to control excessive enhanced payments. However, we continue to believe that HCFA should (1) review State UPL calculations each year, (2) require that cost report data be used as the basis of the UPL calculation, and (3) require that State plans contain assurances that supplemental payments are retained by hospitals and used to provide services to Medicaid eligible individuals.





DATE: MAY - 2 2001

TO: Michael F. Mangano
Acting Inspector General

FROM: Michael McMullan 
Acting Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *Review of Medicaid Enhanced Payments to Hospitals and the Use of Intergovernmental Transfers in North Carolina (A-04-00-00140)*

Thank you for the opportunity to review and comment on the above-referenced draft report regarding the use of Medicaid upper payment limits (UPLs). The information that OIG has provided in the related draft reports is very useful to the Health Care Financing Administration (HCFA) as we develop new Medicaid payment policies.

In the report, reference is made to the current UPL regulations that include a separate aggregate UPL requirement for state-operated facilities. This limit is reported to apply to inpatient services furnished by hospitals, nursing facilities, and institutional care facilities for the mentally retarded. We suggest that the language be clarified to show that this limit applies to inpatient services furnished by hospitals and does not apply to outpatient services furnished by hospitals.

In addition, a final UPL regulation was published in the *Federal Register* on January 12, and the regulation took effect as scheduled on March 13. On March 29, the Department of Health and Human Services issued a proposed regulation that would limit the transition period for the new UPL requirements to a single year for states that had plan amendments pending as of January 22 – the first working day of the new Administration. Although those plans will be considered under the rules in effect at the time that they were submitted, this proposed rule would create a new, 1-year transition period for the plans. The rule estimates \$600 million in potential savings when compared to the cost if the affected plans had received a full, 2-year transition.

We appreciate the effort that went into this report and the opportunity to comment on the issues it raises. Our detailed comments on the OIG recommendations follow.

OIG Recommendation

HCFA should provide states with definitive guidance on how to calculate the Medicare UPL and review the calculation of this limit each year.

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HCFA Response

We concur with the recommendation to issue guidance to states. We intend to issue a revised State Medicaid Manual that will provide guidance regarding the states' calculation of the Medicare UPL.

However, we do not concur with the recommendation that we review the calculation of this limit each year for all states. Instead, we intend to enforce the reporting requirements in the final UPL regulation, effective March 13, which affect states that are eligible for a transition period in the rule and make payments that exceed the new UPL. These states must report to HCFA the total Medicaid payments made to each facility, as well as a reasonable estimate of the amount that would be paid for the services furnished under Medicare payment principles. We will also conduct selective financial reviews, as appropriate.

OIG Recommendation

HCFA should require that cost report data be the basis of the UPL calculation, which North Carolina is already utilizing.

HCFA Response

We do not concur. While cost report data may be useful in a state such as North Carolina, the data may not be as useful nationwide. For example, a state may use a diagnosis-related group payment methodology, which does not rely on cost report data. The reporting requirements in the final rule provide that states must report a reasonable estimate of what Medicare would have paid for Medicaid services. It is not our intention to prescribe one method for determining what Medicare would have paid. Rather, we intend to offer several methods for states to use, depending on which method is suitable for their reimbursement system.

OIG Recommendation

HCFA should require state plans to contain assurances that supplemental payments will be retained by the hospitals and used to provide services to Medicaid eligible individuals.

HCFA Response

We do not concur. HCFA does not have the authority to prescribe how facilities are to use the Medicaid payments they receive from state Medicaid agencies.