

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**COLORADO CLAIMED  
UNALLOWABLE MEDICAID  
INPATIENT SUPPLEMENTAL  
PAYMENTS**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



**Gloria L. Jarmon  
Deputy Inspector General**

**April 2014  
A-07-13-04206**

# *Office of Inspector General*

<https://oig.hhs.gov/>

---

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## *Office of Audit Services*

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

## *Office of Evaluation and Inspections*

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

## *Office of Investigations*

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

## *Office of Counsel to the Inspector General*

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

# *Notices*

---

**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
at <https://oig.hhs.gov>

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

*Colorado claimed \$2.7 million in unallowable Medicaid inpatient supplemental payments during Federal fiscal year 2012.*

### WHY WE DID THIS REVIEW

Supplemental Medicaid payments to institutional providers for Medicaid services are based on upper payment limits. During our audit period (Federal fiscal years (FYs) 2010 through 2012), Colorado received almost \$900 million in Federal reimbursement for its inpatient supplemental payment programs. The amount of these payments, combined with the fact that Colorado had 13 different inpatient supplemental payment programs with varying and complex calculation methods, made these potentially high-risk payments.

The objective of this review was to determine whether Medicaid inpatient supplemental payments that the Colorado Department of Health Care Policy and Financing (State agency) made to Colorado Medicaid hospitals (providers) during FYs 2010 through 2012 and for which it claimed Federal reimbursement were in accordance with Federal and State requirements.

### BACKGROUND

In Colorado, the State agency is responsible for administering the Medicaid program. It does so in accordance with a Centers for Medicare & Medicaid Services (CMS)-approved State Medicaid plan (State plan). A CMS-approved State plan describes the supplemental payments established by the State and specifies which providers are eligible to receive supplemental payments and what categories of service are covered. Any material changes a State makes in its State plan must be submitted to CMS for review and approval as a State plan amendment before the State can implement those changes. Supplemental payments can be made to providers on an inpatient basis.

The State agency uses “Medicaid days” as part of its calculation of supplemental payments. Essentially, a Medicaid day is a day of inpatient services provided to a Medicaid recipient.

The State agency claimed \$1,585,003,459 (\$877,749,215 Federal share) of Federal reimbursement for 13 different Medicaid inpatient supplemental programs during FYs 2010 through 2012. We judgmentally selected and reviewed the five Medicaid inpatient supplemental payment programs with the largest payment totals during this time period. For these five programs, the Medicaid inpatient supplemental payments to providers for which the State agency claimed Federal reimbursement during FYs 2010 through 2012 totaled \$1,457,319,962 (\$807,923,956 Federal share).

## **WHAT WE FOUND**

During our audit period, the payments for four of the five Medicaid inpatient supplemental payment programs reviewed were in accordance with Federal and State requirements. However, for FY 2012, the Medicaid inpatient supplemental payments that the State agency made to Colorado Medicaid providers for one of the five programs (called the Metropolitan Statistical Area Medicaid inpatient supplemental payment program (the program)) were not always in accordance with Federal and State requirements. Colorado's CMS-approved State plan specified the supplemental payments for the program, effective as of October 1, 2010, as \$600 per Medicaid day; however, beginning October 1, 2011, the State agency made payments of \$650 per Medicaid day, which CMS had not approved, for 106,382 Medicaid days. As a result, the State agency made overpayments to providers totaling \$5,319,100 (\$2,659,550 Federal share).

The payment amounts for the program for FYs 2010 and 2011 had been specified in the CMS-approved State plan. No discrepancies regarding the payments and reimbursements during these 2 FYs came to our attention during this review.

The error for FY 2012 occurred because the State agency did not ensure that the payment amounts authorized in the State plan for the Medicaid inpatient supplemental payments program were the actual amounts used to make payments.

## **WHAT WE RECOMMEND**

We recommend that the State agency:

- refund \$2,659,550 to the Federal Government,
- determine the amount that the State agency incorrectly paid after our audit period in program funds at \$650 per Medicaid day and refund that amount to the Federal Government, and
- ensure that the payment amounts specified in its CMS-approved State plan are the amounts used to make payments.

## **STATE AGENCY COMMENTS**

In written comments on our draft report, the State agency concurred with all of our recommendations and described corrective actions that it had taken or planned to take. Additionally, the State agency said that it had calculated an overpayment of \$5,409,000 (\$2,704,500 Federal share) for the FY subsequent to our audit period and would refund the Federal share within 1 year of the issuance of our final report. We verified that the State agency correctly calculated this overpayment.

## TABLE OF CONTENTS

INTRODUCTION .....	1
Why We Did This Review .....	1
Objective .....	1
Background .....	1
Medicaid Program .....	1
Colorado Medicaid Program .....	1
Medicaid Inpatient Supplemental Payments .....	2
How We Conducted This Review .....	2
FINDING .....	2
RECOMMENDATIONS .....	3
STATE AGENCY COMMENTS .....	4
APPENDIXES	
A: Audit Scope and Methodology .....	5
B: State Agency Comments .....	7

## **INTRODUCTION**

### **WHY WE DID THIS REVIEW**

Supplemental Medicaid payments to institutional providers for Medicaid services are based on upper payment limits (UPLs) (42 CFR §§ 447.272 and 447.321). During our audit period (Federal fiscal years (FYs) 2010 through 2012), Colorado received almost \$900 million in Federal reimbursement for its inpatient supplemental payment programs. The amount of these payments, combined with the fact that Colorado had 13 different inpatient supplemental payment programs with varying and complex calculation methods, made these potentially high-risk payments.

### **OBJECTIVE**

Our objective was to determine whether Medicaid inpatient supplemental payments that the Colorado Department of Health Care Policy and Financing (State agency) made to Colorado Medicaid hospitals (providers) during FYs 2010 through 2012 and for which it claimed Federal reimbursement were in accordance with Federal and State requirements.

### **BACKGROUND**

#### **Medicaid Program**

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 Medicaid plan (State plan). Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

States use the standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), to report actual Medicaid expenditures for each quarter, and CMS uses it to reimburse States for the Federal share of Medicaid expenditures. The amounts reported on the CMS-64 report and its attachments must be actual expenditures and be supported by documentation.

#### **Colorado Medicaid Program**

In Colorado, the State agency is responsible for administering the Medicaid program. The amount that the Federal Government reimburses to the State agency, known as Federal financial participation or Federal share, is determined by the Federal medical assistance percentage (FMAP), which varies based on a State's relative per capita income. The State agency's FMAP rates ranged from 50.00 to 61.59 percent during FYs 2010 through 2012.

The State agency uses “Medicaid days” as part of its calculation of supplemental payments. The State agency defines Medicaid days as including “... Medicaid fee for service days, Medicaid managed-care days, and days where Medicaid is the secondary payer (Medicare/Medicaid dually eligible days and Medicaid and other third party coverage days)” (Colorado State Plan, Attachment 4.19A, page 55, section 4.b). Essentially, a Medicaid day is a day of inpatient services provided to a Medicaid recipient.

### **Medicaid Inpatient Supplemental Payments**

Supplemental payments can be made to providers on an inpatient basis.

A CMS-approved State plan describes the supplemental payments established by the State and specifies which providers are eligible to receive supplemental payments and what categories of service are covered. Any material changes a State makes in its State plan must be submitted to CMS for review and approval as a State plan amendment before the State can implement those changes (42 CFR § 430.12(c)(1)(ii)).

### **HOW WE CONDUCTED THIS REVIEW**

The State agency claimed \$1,585,003,459 (\$877,749,215 Federal share) of Federal reimbursement for 13 different Medicaid inpatient supplemental programs during FYs 2010 through 2012. We judgmentally selected and reviewed the five Medicaid inpatient supplemental payment programs with the largest payment totals during this time period. For these five programs, the Medicaid inpatient supplemental payments to providers for which the State agency claimed Federal reimbursement during FYs 2010 through 2012 totaled \$1,457,319,962 (\$807,923,956 Federal share).

We reviewed the State agency’s calculation of overpayments identified in its review of Medicaid inpatient supplemental payments for reporting periods after our audit period.

We conducted this performance 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 objectives.

Appendix A contains details of our audit scope and methodology.

### **FINDING**

During our audit period, the payments for four of the five Medicaid inpatient supplemental payment programs reviewed were in accordance with Federal and State requirements. However, for FY 2012, the Medicaid inpatient supplemental payments that the State agency made to Colorado Medicaid providers for one of the five programs (called the Metropolitan Statistical Area Medicaid inpatient supplemental payment program (the program)) were not always in accordance with Federal and State requirements.

Section 1903(a)(1) of the Social Security Act authorizes payment to the States of an amount equal to the FMAP of the total amount expended during the quarter as medical assistance under an approved State plan.

The Colorado State plan, Attachment 4.19A, page 54, section 3, states:

The Metropolitan Statistical Area Supplemental Medicaid payment is a prospective payment calculated using historical data, with no reconciliation to actual data for the payment period. For each hospital, this payment shall be calculated on a per Medicaid day basis as follows.... b. Effective October 1, 2010, qualified hospitals [providers] shall receive \$600 per Medicaid day.

Contrary to Colorado's CMS-approved State plan, beginning October 1, 2011, the State agency made payments of \$650 per Medicaid day, not \$600 per Medicaid day, for 106,382 Medicaid days. As a result, the State agency made overpayments to providers totaling \$5,319,100 (\$2,659,550 Federal share).

The payment amounts for the program for FYs 2010 and 2011 had been specified in the CMS-approved State plan. No discrepancies regarding the payments and reimbursements during these 2 FYs came to our attention during this review.

The error for FY 2012 occurred because the State agency did not ensure that the payment amounts authorized in the State plan for the Medicaid inpatient supplemental payments program were the actual amounts used to make payments.

## **RECOMMENDATIONS**

We recommend that the State agency:

- refund \$2,659,550 to the Federal Government,
- determine the amount that the State agency incorrectly paid after our audit period in program funds at \$650 per Medicaid day and refund that amount to the Federal Government, and
- ensure that the payment amounts specified in its CMS-approved State plan are the amounts used to make payments.

## STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with all of our recommendations and described corrective actions that it had taken or planned to take. Additionally, the State agency said that it had calculated an overpayment of \$5,409,000 (\$2,704,500 Federal share) for the FY subsequent to our audit period and would refund the Federal share within 1 year of the issuance of our final report. We verified that the State agency correctly calculated this overpayment. The State agency's comments are included in their entirety as Appendix B.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

The State agency claimed Federal reimbursement for Medicaid inpatient supplemental payments to providers totaling \$1,585,003,459 (\$877,749,215 Federal share) during FYs 2010 through 2012. Of Colorado's 13 Medicaid inpatient supplemental payment programs, we judgmentally selected the 5 programs with the largest payment totals during this time period. Accordingly, we reviewed Medicaid inpatient supplemental payments to providers totaling \$1,457,319,962 (\$807,923,956 Federal share) for which the State agency claimed Federal reimbursement during FYs 2010 through 2012. The \$1,457,319,962 constituted approximately 92 percent of the \$1,585,003,459 claimed.

We did not review the overall internal control structure of the State agency or the Medicaid program. We reviewed only the internal controls that pertained directly to our objective.

We performed fieldwork at the State agency in Denver, Colorado, in July 2013.

### METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal laws, Federal and State regulations, and the relevant portions of the CMS-approved Colorado State plan;
- held discussions with officials from CMS and the State agency to gain an understanding of Colorado's inpatient supplemental payment programs;
- reconciled inpatient supplemental payments reported on the State agency's CMS-64 reports for FYs 2010 through 2012 to the State agency's supporting documentation;
- verified the State agency's UPL<sup>1</sup> calculations and the State agency's inpatient supplemental payments calculations;
- verified whether the totals of the State agency's inpatient supplemental payments exceeded the totals of the State agency's UPLs for the five supplemental payment programs we selected for review;
- reviewed five judgmentally selected Colorado inpatient supplemental payment programs to determine whether the State agency correctly made payments under those programs;
- determined the total overpayments made by the State agency and the Federal share of these overpayments;

---

<sup>1</sup> A UPL is the ceiling on Federal matching funds for Medicaid payments and is based on an estimate of what Medicare would pay for comparable services (42 CFR §§ 447.272 and 447.321).

- discussed the results of our review with State agency officials on September 23, 2013; and
- reviewed the State agency's calculation of overpayments identified in its review of Medicaid inpatient supplemental payments for reporting periods after our audit period.

We conducted this performance 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 objectives.

## APPENDIX B: STATE AGENCY COMMENTS



### COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 ♦ (303) 866-2993 ♦ (303) 866-4411 Fax

John W. Hickenlooper, Governor ♦ Susan E. Birch MBA, BSN, RN, Executive Director

February 28, 2014

Mr. Patrick J. Cogley  
Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office of Inspector General  
Office of Audit Services  
Region VII  
601 East 12<sup>th</sup> Street, Room 0429  
Kansas City, MO 64106

RE: Report Number A-07-13-04206

Dear Mr. Cogley:

Enclosed is the Department of Health Care Policy and Financing's (the Department's) response to the report entitled *Colorado Claimed Unallowable Medicaid Inpatient Supplemental Payments* for the review conducted by the Office of Inspector General (OIG) for federal fiscal years (FFYs) 2009-10, 2010-11, and 2011-12. The OIG reviewed five inpatient supplemental payment programs totaling \$1,457,319,962 in total funds or \$807,923,956 federal share.

The report includes a recommendation that the Department refund \$2,659,550 to the federal government for overpayments identified in FFY 2011-12 and determine and refund any amount paid incorrectly after the audit period. The Department concurs with the OIG's recommendations and has taken action to ensure that payments are made in accordance with the Department's approved Medicaid State Plan.

Sincerely,

A handwritten signature in black ink, appearing to read 'Susan Birch', is written over a circular stamp.

Susan E. Birch, MBA, BSN, RN  
Executive Director

*FOR SUSAN BIRCH*

SEB:nad

Enclosure

"The mission of the Department of Health Care Policy & Financing is improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources."  
colorado.gov/hcpf

Department of Health Care Policy and Financing Response  
to Review of Colorado Claimed Unallowable Medicaid Inpatient Supplemental Payments

**Recommendation 1:** Refund \$2,659,550 to the Federal Government.

Department Response: The Department of Health Care Policy and Financing (the Department) agrees. The Department made overpayments in Federal Fiscal Year (FFY) 2011-12 totaling \$5,319,100 (\$2,659,550 federal share) to providers under the Metropolitan Statistical Area Medicaid Inpatient Supplemental Payment. The Department will recover the overpayment made to providers and refund \$2,659,550 to the federal government within one (1) year after the Office of Inspector General's (OIG's) final audit report is published.

**Recommendation 2:** Determine the amount the State agency incorrectly paid after our audit period in program funds at \$650 per Medicaid day and refund that amount to the Federal Government.

Department Response: The Department agrees. The Department reviewed the Metropolitan Statistical Area Medicaid Inpatient Supplemental Payments made to providers in FFY 2012-13 and found that those payments were also calculated at \$650 per Medicaid day although the approved Medicaid State Plan indicated the payments should be calculated at \$600 per Medicaid day. (The Department has a proposed State Plan Amendment for this payment for FFY 2013-14 which is currently under review with the Centers for Medicare and Medicaid Services.)

The Department has determined that overpayments in FFY 2012-13 totaling \$5,409,000 (\$2,704,500 federal share) were made to providers. The Department will recover the overpayment made to providers and refund \$2,704,500 to the federal government within one (1) year after the OIG's final audit report is published.

**Recommendation 3:** Ensure that the payment amounts specified in its CMS-approved State Plan are the amounts used to make payments.

Department Response: The Department agrees. The Department has implemented additional levels of review during the State Plan Amendment submission and the payment calculation finalization processes to ensure that all payments are made in accordance with the approved State Plan.