Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

KENTUCKY DID NOT CORRECTLY CALCULATE PAYMENT RATES FOR PRIVATE FACILITIES OR REPORT COST SETTLEMENT ADJUSTMENTS TO CMS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Lori S. Pilcher
Regional Inspector General

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Office of Inspector General

https://oig.hhs.gov

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EXECUTIVE SUMMARY

Kentucky improperly calculated its payment rates for two of three private intermediate care facilities for beneficiaries with intellectual and developmental disabilities and incorrectly reported cost settlements for State-operated facilities, resulting in excess Medicaid reimbursements of $511,929 (Federal share) and $24,652 (Federal share), respectively.

WHY WE DID THIS REVIEW

Kentucky's payment rates for State-operated intermediate care facilities for beneficiaries with intellectual and developmental disabilities (ICF-IDD) from July 1, 2009, through June 30, 2012 (State fiscal years (SFYs) 2010 through 2012), were 191 percent higher than the average payment rates for privately operated facilities. In addition, Kentucky was one of the States in the southern region with the highest per capita expenditures during the same period. Previous audits in other States identified excessive payments for beneficiaries with intellectual and developmental disabilities. (See report numbers A-02-10-01027, A-02-11-01029, A-02-10-01029, and A-04-12-08016.)

The objective of our audit was to determine whether Kentucky calculated and reported its payment rates for intermediate care facilities for beneficiaries with intellectual and developmental disabilities in accordance with Federal and State requirements.

BACKGROUND

In Kentucky, the Department for Medicaid Services (State agency) within the Kentucky Cabinet for Health and Family Services is the State agency responsible for administering the State's Medicaid program. The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) is the State agency responsible for providing services and support to Kentuckians with intellectual and developmental disabilities. DBHDID oversees State-operated ICF-IDDs and privately operated facilities with 8 or more beds.

The State agency reports its Medicaid ICF-IDD expenditures on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64) to the Centers for Medicare & Medicaid Services (CMS). CMS uses the information on the CMS-64 to reimburse States for the Federal share of Medicaid expenditures.

WHAT WE FOUND

The State agency calculated its payment rates for State-operated ICF-IDDs in accordance with Federal and State requirements in SFYs 2010 through 2012. However, the State agency did not correctly calculate its payment rates for two of three private facilities. Instead of calculating its payment rates for private facilities using the most current cost reports (2010), the State agency used older (2009) cost reports to calculate 2011 payment rates for nursing costs and used projections (estimates) to calculate all other costs. These miscalculations occurred because the State agency did not follow its State plan when calculating payment rates for private facilities.

As a result of using the older cost reports, the State agency received excess Medicaid reimbursement of $511,929 (Federal share).

In addition, the State agency incorrectly reported cost settlement adjustments of $10,428,503 on the CMS-64 report for State-operated facilities, resulting in an overpayment of $24,652 (Federal share). This overpayment occurred because the State agency did not follow Federal guidelines when reporting cost settlement adjustments for State-run facilities. Specifically, it reported adjustments on the wrong line and used the wrong Federal Medical Assistance Percentage rate to determine the Federal share of payments.

WHAT WE RECOMMEND

We recommend that the State agency:

- adjust its next CMS-64 quarterly report to reimburse the Federal Government $511,929 for improperly calculated private facility payment rates;
- adjust its next CMS-64 quarterly report to reimburse the Federal Government $24,652, for improperly reported State-operated facility cost settlements;
- ensure that it calculates rates, in accordance with the State plan, using the most recent annual cost reports; and
- ensure that it reports cost settlement adjustments on the CMS-64 in accordance with Federal regulations.

STATE AGENCY COMMENTS AND OUR RESPONSE

In comments on our draft report, the State agency did not specifically address our first recommendation, although it said that it did not concur with our underlying finding that the private facility payment rates were improperly calculated. The State agency believed that it had followed the State Plan and State regulations in establishing payment rates for private facilities.

In comments on our second recommendation, the State agency said that it had made the necessary line item corrections to the March 31, 2013, CMS-64 report.

The State agency did not address our third or fourth recommendation.

To better understand the State agency's written response to our draft report, we held followup discussions with the State agency and requested additional documentation.

In response to our followup questions regarding the cost reports, the State agency said that, at the time of our audit, the desk reviewed reports were not available. Nevertheless, we continue to assert that the State agency did not calculate payment rates, as required, by using the most recent cost reports available, and, as a result, overpaid some private facilities. We also continue to recommend that the State agency reimburse the Federal Government for any identified

overpayments, and we emphasize our third recommendation that the State agency ensure that it uses the most recent cost reports to calculate payment rates.

Although the State agency indicated that it had made the necessary corrections in response to our second recommendation, we determined during our subsequent meetings that it had incorrectly applied those corrections. The State agency agreed to revisit its corrections and fix any errors. Therefore, we reiterate our second and fourth recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

Kentucky's payment rates for State-operated intermediate care facilities for beneficiaries with intellectual and developmental disabilities (ICF-IDD) from July 1, 2009, through June 30, 2012 (State fiscal years (SFYs) 2010 through 2012), were 191 percent higher than the average payment rates for privately operated facilities. In addition, Kentucky was one of the States in the southern region with the highest per capita expenditures during the same period. Previous audits in other States identified excessive payments for beneficiaries with intellectual and developmental disabilities. (See Appendix A.)

OBJECTIVE

The objective of our audit was to determine whether Kentucky calculated and reported its payment rates for intermediate care facilities for beneficiaries with intellectual and developmental disabilities in accordance with Federal and State requirements.

BACKGROUND

Kentucky's Medicaid Program

In Kentucky, the Department for Medicaid Services (State agency) within the Kentucky Cabinet for Health and Family Services is the State agency responsible for administering the State's Medicaid program. Kentucky's Medicaid program provides health care for approximately 960,000 people and operates with an annual budget of approximately $5.5 billion.

For SFYs 2010 through 2012, the State reported $414,069,420 ($317,100,068 Federal Share) in ICF-IDD expenditures for a variety of services provided to beneficiaries with intellectual and developmental disabilities. During our audit period, the State operated 10 ICF-IDDs. The State agency reported Medicaid expenditures on behalf of 494 beneficiaries, totaling $329,768,285 ($252,527,495 Federal share). In addition to the State-operated facilities, Kentucky had 3 private small residential ICF-IDD homes located in community settings. The State agency reported Medicaid expenditures on behalf of 183 beneficiaries, totaling $84,301,135 ($64,572,573 Federal share) for these facilities.

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) is the State agency responsible for providing services and support to Kentuckians with intellectual and developmental disabilities. The DBHDID oversees State-operated ICF-IDDs and privately operated facilities with 8 or more beds.

The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims. The State agency reports its Medicaid ICF-IDD expenditures on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64) to the Centers for

Medicare & Medicaid Services (CMS). CMS uses the information on the CMS-64 to reimburse States for the Federal share of Medicaid expenditures.

Kentucky's Intermediate Care Facilities for Beneficiaries With Intellectual and Developmental Disabilities

In Kentucky, the DBHDID provides leadership, in partnership with others, to prevent disability, build resilience in individuals and their communities, and facilitate recovery for people whose lives have been affected by mental illness, intellectual disability, other developmental disability, or substance abuse. Kentucky's payment rates for State-operated ICF-IDDs in SFYs 2010 through 2012 were 191 percent higher than the average payment rates for privately operated facilities. During this period, the per-patient payment rate at the 10 State-operated facilities ranged from $352 to $1,074 per day, with an average payment rate of $777 per day.

In recent years, the State has taken steps to transition from large State-run institutions to smaller, community-based homes. During this period, the per-patient payment rate at the 3 privately operated facilities ranged from $366 to $439 per day, with an average payment rate of $407 per day.

HOW WE CONDUCTED THIS REVIEW

We obtained and reviewed the ICF-IDD's cost reports for SFYs 2010 through 2012 and recalculated the Medicaid daily rates using the actual costs reported in the cost reports. We then compared the number of patients and payment rates for State-operated and privately operated ICF-IDDs. We also obtained and reviewed the State agency's MMIS data for all ICF-IDD claims paid from July 1, 2009, through June 30, 2012, and compared this information with the CMS-64s submitted for quarters ending September 30, 2009, through June 30, 2012, to determine the Medicaid reimbursement expenditures reported to CMS for ICF-IDD services.

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 contains the details of our audit scope and methodology, and Appendix C lists the Federal and State requirements related to payment rates and reporting requirements for ICF-IDDs.

FINDINGS

The State agency calculated its payment rates for State-operated ICF-IDDs in accordance with Federal and State requirements in SFYs 2010 through 2012. However, the State agency did not correctly calculate its payment rates for 2 of the 3 private facilities. Instead of calculating its payment rates for private facilities using the most current cost reports (2010), the State agency used older (2009) cost reports to calculate 2011 payment rates for nursing costs and used

projections (estimates) to calculate all other costs. These miscalculations occurred because the State agency did not follow its State plan when calculating payment rates for private facilities. As a result of using the older cost reports, the State agency received excess Medicaid reimbursement of $511,929 (Federal share).

In addition, the State agency did not follow Federal guidelines when reporting cost settlement adjustments for State-run facilities. Specifically, it incorrectly reported cost settlement adjustments of $10,428,503 on the CMS-64 report for State-operated facilities, resulting in an overpayment of $24,652 (Federal share). The overpayment occurred because the State agency reported adjustments on the wrong line and used the wrong FMAP rate to determine the Federal share of payments.

KENTUCKY DID NOT CORRECTLY CALCULATE PRIVATE FACILITY PAYMENT RATES

The State plan (Attachment 4.19-D) requires that the actual expenditures from the most recent available cost reports be used to calculate payment rates, even if those cost reports are unaudited. According to the State plan, all ICF-IDD payment rates should be calculated in the same manner, regardless of whether the facility is State or privately operated.

The State agency did not correctly calculate its payment rates for two of three private facilities because it did not follow its State plan when calculating payment rates for these facilities. Instead of calculating its payment rates for private facilities using the most current cost reports (2010), the State agency used older (2009) cost reports to calculate 2011 payment rates for nursing costs and used projections (estimates) to calculate all other costs.

These miscalculations occurred because the State agency did not follow its State plan when calculating payment rates for private facilities. As a result of using older cost reports to calculate payment rates for the private facilities, the State agency received excess Medicaid reimbursement of $511,929 (Federal share).

KENTUCKY DID NOT CORRECTLY REPORT STATE-OPERATED FACILITY COST SETTLEMENT ADJUSTMENTS

The State Medicaid Manual (CMS Publication #45, chapter 2, 2500.1, Lines 7 and 8) requires the total computable amount and the Federal share of adjustments that increase expenditures in prior periods to be reported on line 7 of the CMS-64 with an attached Form CMS-64.9 (Medical Assistance Payments). Also, adjustments to Federal funds, that are the result of increasing audit adjustments, Federal Medical Assistance Percentage (FMAP) rate changes, or corrections of amounts previously reported, must be reported on line 8.

The State agency did not follow Federal regulations when reporting cost settlement adjustments for State-run facilities. When the State agency submitted its CMS-64 report for the quarter ending June 30, 2012, it incorrectly reported cost settlement adjustments of $10,428,503 for the 2006 and 2007 cost reports for State-operated facilities. Specifically, for the period ending June 30, 2006, the State agency incorrectly reported $8,887,778 for cost settlement

reimbursement on line 7 of the CMS-64 report as a prior-period adjustment to line 3a on the CMS-64 (the category for nursing facility – regular) instead of to line 4a (the category for ICF-IDD – Public).

Also, for the period ending June 30, 2007, the State agency reported $1,540,725 on line 4a of the CMS-64 (the category for ICF-IDD – Public) as a current expenditure instead of reporting it on line 7 of the CMS-64 report as a prior-period adjustment for line 4a (the category for ICF-IDD – Public).

As a result, the State agency received an overpayment of $24,652 (Federal share). The overpayment occurred because the State agency reported adjustments on the wrong line and used the wrong FMAP rate to determine the Federal share of payments. The adjustments were necessary because the State agency did not finalize cost settlements for Federal fiscal years 2005 through 2007 until SFYs 2010 through 2012.

RECOMMENDATIONS

We recommend that the State agency:

- adjust its next CMS-64 quarterly report to reimburse the Federal Government $511,929 for improperly calculated private facility payment rates;
- adjust its next CMS-64 quarterly report to reimburse the Federal Government $24,652, for improperly reported State-operated facility cost settlements;
- ensure that it calculates payment rates, in accordance with the State plan, using the most recent annual cost reports; and
- ensure that it reports cost settlement adjustments on the CMS-64 in accordance with Federal regulations.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

State Agency Comments

In comments on our draft report, the State agency did not specifically address our first recommendation, although it said that it did not concur with our underlying finding that the private facility payment rates were improperly calculated. The State agency believed that it had followed the State Plan and State regulations in establishing payment rates for private facilities.

In comments on our second recommendation, the State agency said that it had made the necessary line item corrections to the March 31, 2013, CMS-64 report.

The State agency did not address our third or fourth recommendation.

The State Agency comments are included in their entirety as Appendix D.

Office of Inspector General Response

To better understand the State agency's written response to our draft report, we held followup discussions with the State agency and requested additional documentation.

We based our first recommendation on, among other items, our review of cost report information for the private facility, Cedar Lake Lodge, which revealed that the facility's rates resulted in an overpayment during our audit period. In response to our followup questions regarding the cost reports, the State agency said that, at the time of our audit, the desk reviewed reports were not available. Nevertheless, we continue to assert that the State agency did not calculate payment rates, as required, by using the most recent cost reports available, and, as a result, overpaid some private facilities. We also continue to recommend that the State agency reimburse the Federal Government for any identified overpayments, and we emphasize our third recommendation that the State agency ensure that it uses the most recent cost reports to calculate payment rates.

Although the State agency indicated that it had made the necessary corrections in response to our second recommendation, we determined during our subsequent meetings that it had incorrectly applied those corrections. The State agency agreed to revisit its corrections and fix any errors. Therefore, we reiterate our second and fourth recommendations.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
New York Claimed Some Unallowable Costs for Services by New York City Providers Under the State's Developmental Disabilities Program Waiver	A-02-10-01027	8/14/12
Medicaid Rates for New York State-Operated Developmental Centers May Be Excessive	A-02-11-01029	2/8/12
Review of Medicaid Payments for Services Under New Jersey's Section 1915(c) Community Care Waiver Program From January 1, 2005, Through December 31, 2007	A-02-10-01029	4/20/12
Tennessee Incorrectly Reported Costs for Individuals With Intellectual and Developmental Disabilities	A-04-12-08016	4/18/2013

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered payment rates for Medicaid beneficiaries residing in intermediate care facilities for beneficiaries with intellectual and developmental disabilities for SFYs 2010 through 2012. The State agency reported Medicaid expenditures on behalf of 677 beneficiaries, totaling $414,069,420 ($317,100,068 Federal Share).

During our audit, we did not review the overall internal control structure of the State agency, DBHDID, or the Medicaid program. Instead, we limited our internal control review to those controls related to the objective of our audit. While we examined selected expenditures from facility cost reports, we did not verify the accuracy of all cost information provided by the State.

We performed fieldwork at the Department of Medicaid Services in Frankfort, Kentucky, in August and September 2012.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations and the Medicaid State plan;
- held discussions with officials from CMS, Myers and Stauffer CPAs, the State agency, the Division of Administration and Financial Management, and the Division of Healthcare Facilities Management to gain an understanding of the State's rate-setting methodology;
- obtained MMIS data from the State agency for all ICF-IDD claims paid from July 1, 2009, through June 30, 2012;
- obtained CMS-64 reports from CMS for quarters ending September 30, 2009, through June 30, 2012, to determine the Medicaid expenditures reported to CMS for ICF-IDD services;
- reviewed the MMIS data files, calculated total dollars spent for State-operated and privately operated facilities during our audit period and matched then to the expenditures reported on the CMS-64s;
- traced costs used to calculate payment rates back to the appropriate annual cost reports and recalculated the payment rates to verify that the State agency calculated them correctly, per Federal guidelines;
- visited and interviewed officials from two of the State's ICF-IDDs (Oakwood and Hazelwood) to understand how the State managed its ICF-IDDs;

- visited, and interviewed officials from, a privately operated ICF-IDD (Cedar Lake Lodge and Cedar Lake Lodge Park Place) to understand the facility's operations;

- recalculated the SFY 2010 through 2012 Medicaid daily payment rates for ICF-IDDs using the actual costs reported in the SFY 2010 through 2012 cost reports provided by the State;

- compared the State-operated ICF-IDD payment rates with privately operated ICF-IDDs payment rates to determine the difference between the rates; and

- compared the number of patients at the State-operated ICF-IDDs with those at the privately operated ICF-IDDs.

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 C: FEDERAL REQUIREMENTS

INTERMEDIATE CARE FACILITY PER DIEM CALCULATION METHODOLOGY

Social Security Act

Section 1902(a)(30)(A) of the Social Security Act requires that payment for services be consistent with efficiency, economy, and quality of care and be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

The State Medicaid Manual, CMS Publication #45, Chapter 2, 2500.1

Line 7 - Adjustments Increasing Claims for Prior Quarters. Enter the total computable amount and Federal share of adjustments increasing claims for expenditures in prior periods, and attach Form HCFA-64.9p (Medical Assistance Payments) and/or Form HCFA-64.10p (State and Local Administration). Where more than one form is used, enter on the Summary Sheet the sum of all amounts shown on the referenced lines on each.

Line 8 - Other Expenditures. Enter the amounts, other than those reported on Lines 6 and 7, as an adjustment to Federal funds. Examples include increasing audit adjustments, FMAP rate changes, and corrections of amounts previously reported.

State Reporting Requirements

The *Medicaid Program Integrity Manual*, Chapter 11, section 11000, states:

> [T]he Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS 64) is a quarterly statement of actual program costs and administrative expenditures for which States are entitled to Federal reimbursement under the authority of Title XIX of the Act. Form CMS 64 is also the vehicle for adjustments made to correct overpayments and underpayments. Spending reported on Form CMS 64 is a tabulation of actual, documented Medicaid expenditures, drawn from source documents such as invoices, cost reports and eligibility records. If a State is unable to document a claim for expenditures made in the current quarter, the claim must be withheld until it can be supported. The State then reports the amount on a future Form CMS 64 as a prior period adjustment. Spending therefore reflects all expenditures made during the quarter, not all services used.

Kentucky State Plan

The Kentucky Medicaid program pays providers the amount determined for services furnished at an intermediate care facility in accordance with the requirements of the Kentucky State plan.

Cost Reports for Cost-Based Facilities

Facilities shall use a uniform cost reporting form for submission at the facility's fiscal year end. The single State agency shall set a uniform rate year for cost-based NF's and ICF-MRs (July 1 - June 30) by taking the latest available cost data which is available as of May 16 of each year and trending the facility costs to July 1 of the rate year.

1. If the latest available cost report period has not been audited or desk reviewed prior to rate setting, the prospective rates shall be based on cost reports which are not audited or desk reviewed subject to adjustment when the audit or desk review is completed. If desk reviews or audits are completed after May 16, but prior to universal rate setting for the rate year, the desk review or audited data shall be used (Attachment 4.19-D, *Facility Reimbursement – Methods and Procedures for January 1, 2000 and Thereafter*, p. 2).

The rate calculation in the Kentucky State plan specifies that payment rates should be calculated using the cost-based and price-based reimbursement methodologies as described in Attachment 4.19-D, Exhibit B. This Exhibit sets forth the methods and standards for establishing the rates as follows:

Section 220, "Introduction to Cost-Based Reimbursement System," states:

> B. 1. This cost-based system is designed to provide a reasonable return in relation to cost but also contains factors to encourage cost containment. Under this system, payment shall be made to State owned or operated, non-State but government owned or operated, and non-governmental ICF/MR/DDs[1] on a prospectively determined basis for routine cost of care with no year-end adjustment required other than adjustments which result from either desk reviews or field audits.
>
> B. 2. Total reimbursement to State owned or operated ICF/MR/DDs in aggregate shall be limited to the lesser of actual costs or the amount the State reasonably estimates would have been paid under Medicare Payment Principles.
>
> B. 2. Cost associated with prescription drugs should be removed from the routine cost.
>
> C. Ancillary services as defined, shall be reimbursed on a cost basis with a year-end retroactive settlement. As with routine cost, ancillary services are subject to both desk reviews and field audits that may result in retroactive adjustments.
>
> D. The basis of the prospective payment for routine care cost is the most recent annual cost report data (available as of May 16) trended to the beginning of the

[1] Although both State and Federal laws have replaced terms such as mental retardation with intellectual disability, the phrase "mentally retarded" remains in the State Plan at this time.

rate year and indexed for the prospective rate year. The routine cost is divided into two major categories: Nursing Services Cost and All Other Cost.

Section 290, "Prospective Rate Computation," states:

> E. The total Cost-Based Facility Cost for each category, after trending and indexing, shall be divided by total Certified Cost-Based Facility days in order to compute a per diem. A minimum occupancy limit of ninety (90) percent of certified bed days available, (except for State government-owned facilities shall be seventy (70) percent of certified bed days) or actual bed days used if greater, and a maximum occupancy limit of ninety-eight (98) percent computed in the same manner, shall be used in computing the per diem.

Section 340, "Payment for Ancillary Services," states:

> The reasonable, allowable, direct cost of ancillary services as defined provided as a part of total care shall be compensated through the Department for Medicaid Services on a reimbursable cost basis as an addition to the prospective rate.

Section 440, "Cost Reporting," states:

C. The cost report shall be due within sixty (60) days after the provider's fiscal year ends.

D. Providers may request in writing a thirty (30) day extension. The request shall explain in detail why the extension is necessary. There shall be no automatic extension of time for the filing of the cost report. After the extension period has elapsed, the Medicaid Program shall suspend all payments to the provider until an acceptable cost report is received.

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August 12, 2013

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Re: **Report Number: A-04-12-08018**

Dear Ms. Pilcher,

Thank you for your review of both Kentucky's Private and Public ICF-MR Facilities. The opportunity to work with your Auditors was very valuable to my staff. Herein, please find the Commonwealth of Kentucky Department for Medicaid Service's (DMS) response to your Report Number A-04-12-08018. The response has been organized to follow the report findings. All attachments are referenced within the document.

(Quoting the Report) ***What We Found:***

The State agency calculated its payment rates for State-operated ICF-IDDs in accordance with Federal and State requirements in SFYs 2010 through 2012. However, the State agency did not correctly calculate its payment rates for private facilities. Instead of calculating its payment rates for private facilities using the most current cost reports (2010), the State agency used older (2009) cost reports to calculate 2011 payment rates for nursing costs and used projections (estimates) to calculate all other costs. These miscalculations occurred because the State agency did not follow its State plan when calculating payment rates for private facilities. As a result of using the older cost reports, the State agency received excess Medicaid reimbursement of $511,929 (Federal share).

In addition, the State agency incorrectly reported cost settlement adjustments of $10,428,503 on the CMS-64 report for State-operated facilities, resulting in an overpayment of $24,652 (Federal share). The overpayment occurred because the State agency did not follow Federal guidelines when reporting cost settlement adjustments for State-run facilities. Specifically, it reported adjustments on the wrong line and used the wrong Federal Medical Assistance Percentage rate to determine the Federal share of payments.

What We Recommend:

We recommend that the State agency:

• adjust its next CMS-64 quarterly report to reimburse the Federal government $511,929 for improperly calculated private facility payment rates;

• adjust its next CMS-64 quarterly report to reimburse the Federal government $24,652, for improperly reported State-operated facility cost settlements;

• ensure that rates are calculated, in accordance with the State plan, using the most recent annual cost reports; and

• ensure that cost settlement adjustments are reported on the CMS-64 in accordance with Federal regulations.

Commonwealth of Kentucky Department of Medicaid Services - RESPONSE:

Throughout the report it is stated that "Kentucky improperly calculated its payment rates for private facilities". The report describes that Kentucky did not follow the State Plan for the calculations. It is reported that rather than using the most recently submitted cost report (2010), the State used a combination of the 2009 report and projected 2010 costs to calculate 2011 payment rates.

For the 2011 rates noted (effective 7/1/11-6/30/12) there were three (3) licensed private facilities, Wendell Foster, Cedar Lake Lodge, and Cedar Lake Lodge Park Place. Each facility's rate calculation is described below:

1. Rates established for Wendell Foster did utilize the 2010 cost report (not the 2009 with 2010 projections). Therefore, this audit comment does not apply to all private facilities and rates set.

2. Cedar Lake Lodge Park Place is a new facility that was licensed with Kentucky Medicaid effective 10/29/10. Therefore, the 2010 cost report submitted only included 2 months of actual costs. Per the Kentucky State Plan, Attachment 4.19-D page 2:

   "Partial year or budgeted cost data may be used if a full year's data is unavailable Unaudited reports shall be subject to adjustment to the audited amount".

   In accordance with the State Plan and Kentucky state regulations, for a new facility a projected cost report will be relied upon to establish the interim rate for a facility until the first full year cost report is received. Therefore, in compliance with the State Plan and regulations, the 7/1/11 interim rate for Cedar Lake Park Place was based on a projected cost report. The final rate for 7/1/11 will be based on the 12/31/11 cost report, which is the first full year cost report. Therefore, this provider's rate was set in full compliance and in accordance with regulations and the State Plan.

3. Cedar Lake transitioned beds to Cedar Lake Park Place to open the new facility. This transition of beds created a significant staffing ratio change. Per the Kentucky State Plan Attachment 4.19-D page 3,

   "Interim rates are established on July 1 of each year. Interim rates will be adjusted to include the cost of staffing ratio increases, level of service increases, to accommodate changes of circumstances affecting resident patient care, to correct errors in the rates (whether due to action or inaction of the state or the facilities), or to address displacement of residents. Rates shall-be adjusted to an audited cost base if an unaudited cost report has been used due to new construction or other specified reasons which requires using an unaudited cost report."

In addition to the State Plan, per the Kentucky state regulation, interim rates may be amended due to a staffing ratio change. The provider requested a rate increase to reflect the change in services and the Department for Medicaid Services approved this rate revision. The provider requested that the increase become effective 12/1/10. Therefore the 2010 cost report, which included the Park Place beds, if utilized would not represent a cost per day for services that would actually be provided by Cedar Lake for 7/1/11-6/30/12. Therefore, in compliance with the State Plan and regulations, DMS established a reasonable rate utilizing the 2009 Nursing Services Costs, and 2010 projected Other Costs and Days to establish the rate.

Note: The total costs utilized to establish the 7/1/11 rate for Cedar Lake are actually less than the costs that would have been used with the 2010 cost report. (The variance in the per diem paid and what the 2010 per diem would have been is due to the change in total days, due to the re-licensing of beds.) In summary, the rates calculated for the private ICF facilities during the period of the HHS OIG review were calculated in conformance with the Kentucky State Plan.

Please also note that the necessary line item corrections to the CMS64 were made during the QE3.31.13 submission of the report.

This response should be inclusive of all items outlined in your report, **Report Number: A-04-12-08018**. Should you or your team require anything further, please contact Paul Cooper at any time. He can be reached at 502-564-4321.

Most Sincerely,

Lawrence Kissner, Commissioner
Kentucky Department for Medicaid Services

Enclosures

c. A nursing facility designed as an institution for mental disease;

d. A dually-licensed pediatric nursing facility;

e. An intermediate care facility for the mentally retarded and developmentally disabled; and

Cost Reports for Cost-Based Facilities

Facilities shall use a uniform cost reporting form for submission at the facility's fiscal year end. The single state agency shall set a uniform rate year for cost-based NF's and ICF-MRs (July 1-June 30) by taking the lates available cost data which is available as of May 16 of each year and trending the facility costs to July 1 of the rate year.

1. If the latest available cost report period has not been audited or desk reviewed prior top rate setting, the prospective rates shall be based on cost reports which are not audited or desk reviewed subject to adjustment when the audit or desk review is completed. If desk reviews or audits are completed after May 16, but prior to universal rate setting for the next rate year, the desk review or audited data shall be used.

2. Partial year or budgeted cost data may be used if a full year's data is unavailable. Unaudited reports shall be subject to adjustment to the audited amount.

3. Facilities paid on the basis of partial year or budgeted cost reports shall have their reimbursement settled back to allowable cost.

Allowable Cost

Allowable costs are cost found necessary and reasonable by the single state agency using Medicare Title XVIII-A principles except as otherwise stated. Bad debts, charity and courtesy allowances for non-Title XIX patients are not included in allowable costs. A return on equity is not allowed.

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