Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

COLORADO CLAIMED UNALLOWABLE MEDICAID NURSING FACILITY SUPPLEMENTAL PAYMENTS

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

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Deputy Inspector General
for Audit Services

September 2014
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Office of Inspector General

http://oig.hhs.gov/

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

Colorado claimed $2.5 million in unallowable Medicaid nursing facility supplemental payments during State fiscal years 2010 and 2011.

WHY WE DID THIS REVIEW

During our audit period (State fiscal years (FYs) 2010 through 2012) (July 1, 2009, through June 30, 2012), Colorado received more than $128 million in Federal reimbursement for its Medicaid nursing facility (nursing facility) supplemental payment program. A previous Office of Inspector General review found that the Colorado Department of Health Care Policy and Financing (State agency) did not always make Medicaid inpatient hospital supplemental payments in accordance with Federal and State requirements.

The objective of this review was to determine whether the nursing facility supplemental payments that the State agency made to nursing facilities during FYs 2010 through 2012 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). Colorado's State plan provides a framework within which the State agency can make supplemental payments to nursing facilities, in addition to regular Medicaid payments, to help offset the costs of care provided to Medicaid beneficiaries. As specified in the State plan, the State agency calculates the supplemental payments on a prospective basis for the start of an FY and pays facilities in installments throughout the FY. Furthermore, supplemental payments to institutional providers for Medicaid services are limited by upper payment limit (UPLs). A UPL is the ceiling on Federal matching funds paid for all Medicaid payments, including supplemental payments, and is based on an estimate of what Medicare would pay for comparable services.

Supplemental payments may include Certified Public Expenditure (CPE) supplemental payments. A CPE is a statutorily recognized Medicaid financing approach by which a State or non-State governmental entity, including a governmental provider (e.g., State or county nursing facility), incurs an expenditure eligible for Federal financial participation (FFP) under the State plan. The governmental entity certifies that the funds represent expenditures eligible for FFP. On the basis of this certification, the State agency claims FFP. A State Medicaid agency may use this financing approach so long as the CPE supplemental payment totals do not exceed applicable UPLs.

Federal UPL regulations classify institutional providers that furnish inpatient Medicaid services into three categories: (1) State government-owned or -operated facilities, (2) non-State government-owned or -operated facilities, and (3) privately owned and operated facilities. The

first two categories may use CPEs in their financing, subject to the conditions set forth in the previous paragraph.

The State agency claimed Federal reimbursement for supplemental payments to nursing facilities totaling $228,134,342 ($128,384,674 Federal share) during FYs 2010 through 2012. We reviewed all of the supplemental payments to nursing facilities for which the State agency claimed Federal reimbursement during this period.

WHAT WE FOUND

The State agency made nursing facility supplemental payments for FY 2012 in accordance with Federal and State requirements. However, not all of the nursing facility supplemental payments that the State agency made to nursing facilities for FYs 2010 and 2011 were allowable. Some payments were unallowable for the following reasons:

- The State agency made supplemental payments to nursing facilities that exceeded the calculated prospective payment amounts, resulting in overpayments totaling $1,202,995 ($740,906 Federal share).

- The State agency made CPE supplemental payments to nursing facilities that exceeded the applicable UPLs, resulting in overpayments totaling $2,933,689 ($1,729,544 Federal share).

- The State agency incorrectly included both State government-owned or -operated nursing facilities and non-State government-owned or -operated nursing facilities in its UPL calculations for privately owned and operated nursing facilities. Because the combined payments remained below the UPL for privately owned and operated nursing facilities, this error did not result in any overpayments during our audit period. However, the potential exists for overpayments in subsequent periods.

On the basis of the results of our review, we determined that under Colorado's nursing facility supplemental payment program, the State agency made overpayments to nursing facilities totaling $4,136,684 ($2,470,450 Federal share) and incorrectly claimed these costs for Federal reimbursement.

The State agency was not able to able to identify the exact cause of the overpayment, nor was the overpayment identified when it was made. We believe that the State agency could correct these types of deficiencies by adjusting its accounting system to capture greater facility-level payment detail. In addition, the State agency did not follow its State plan methodology so that CPE supplemental payments did not exceed the UPLs. Further, the State agency did not accurately identify nursing facilities by category. Therefore, the State agency did not correctly calculate the privately owned and operated nursing facility UPLs.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $2,470,450 to the Federal Government,
- improve policies and procedures to ensure that its accounting system captures sufficient facility-level detail to ensure that actual payments do not exceed prospective payments,
- strengthen internal controls to ensure that it follows its State plan methodology so that CPE supplemental payments made to nursing facilities are equal to or below the applicable UPLs in accordance with Federal requirements, and
- strengthen internal controls to ensure that it calculates UPLs for the three categories of nursing facilities in accordance with Federal and State requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with all of our recommendations and described corrective actions that it had taken or planned to take.

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INTRODUCTION

WHY WE DID THIS REVIEW

During our audit period (State fiscal years (FYs) 2010 through 2012) (July 1, 2009, through June 30, 2012), Colorado received more than $128 million in Federal reimbursement for its Medicaid nursing facility (nursing facility) supplemental payment program. A previous Office of Inspector General review found that the Colorado Department of Health Care Policy and Financing (State agency) did not always make Medicaid inpatient hospital supplemental payments in accordance with Federal and State requirements.[1]

OBJECTIVE

Our objective was to determine whether the nursing facility supplemental payments that the State agency made to nursing facilities during FYs 2010 through 2012 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. CMS uses the CMS-64 reports to reimburse States for the Federal share of Medicaid expenditures. The amounts that States report on the CMS-64 report and its attachments must be actual expenditures with supporting 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 (FFP) 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 our audit period (FYs 2010 through 2012).

[1] *Colorado Claimed Unallowable Medicaid Inpatient Supplemental Payments* (A-07-13-04206), issued April 7, 2014.

Medicaid Nursing Facility Supplemental Payments

Federal regulations state that Medicaid coverage of nursing facility services is available only for services provided in nursing homes that the relevant State survey agency has licensed and certified as Medicaid nursing facilities. Furthermore, CMS program information states that Medicaid nursing facility services are available only when other payment options are unavailable and the individual is eligible for the Medicaid program.[2]

Colorado's State plan provides a framework within which the State agency can make supplemental payments to nursing facilities, in addition to regular Medicaid payments, to help offset the costs of care provided to Medicaid beneficiaries. As specified in the State plan, the State agency calculates the supplemental payments on a prospective basis for the start of an FY and pays facilities in installments throughout the FY.[3] Furthermore, Medicaid payments, which include supplemental payments, to institutional providers for Medicaid services are limited by upper payment limits (UPLs). A UPL is the ceiling on Federal matching funds paid for all Medicaid payments, including supplemental payments, and is based on an estimate of what Medicare would pay for comparable services (42 CFR §§ 447.272).

Supplemental payments may include Certified Public Expenditure (CPE) supplemental payments. A CPE is a statutorily recognized Medicaid financing approach by which a State or non-State governmental entity, including a governmental provider (e.g., State or county nursing facility), incurs an expenditure eligible for FFP under the State plan.[4] The governmental entity certifies that the funds represent expenditures eligible for FFP. On the basis of this certification, the State agency claims FFP. A State Medicaid agency may use this financing approach so long as the CPE supplemental payment totals do not exceed applicable UPLs (section 1903(w)(6)(A) of the Act and 42 CFR §447.272(b)(2)).

Federal UPL regulations classify institutional providers that furnish inpatient Medicaid services into three categories: (1) State government-owned or -operated facilities, (2) non-State government-owned or -operated facilities, and (3) privately owned and operated facilities. The first two categories may use CPEs in their financing, subject to the conditions set forth in the previous paragraph.

HOW WE CONDUCTED THIS REVIEW

The State agency claimed Federal reimbursement for supplemental payments to nursing facilities totaling $228,134,342 ($128,384,674 Federal share) during FYs 2010 through 2012. We

[2] These requirements appear in 42 CFR § 440.155(a)(2). The CMS program information appears on the CMS Web site: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Nursing-Facilities-NF.html (accessed April 25, 2014).

[3] Prospective payment amounts have an FMAP associated with them, such that the Federal share can be determined.

[4] Section 1903(w)(6) of the Social Security Act (the Act) provides the statutory basis for this Medicaid financing approach.

reviewed all of the supplemental payments to nursing facilities for which the State agency claimed Federal reimbursement during this 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.

FINDINGS

The State agency made nursing facility supplemental payments for FY 2012 in accordance with Federal and State requirements. However, not all of the nursing facility supplemental payments that the State agency made to nursing facilities for FYs 2010 and 2011 were allowable. Some payments were unallowable for the following reasons:

- The State agency made supplemental payments to nursing facilities that exceeded the calculated prospective payment amounts, resulting in overpayments totaling $1,202,995 ($740,906 Federal share).

- The State agency made CPE supplemental payments to nursing facilities that exceeded the applicable UPLs, resulting in overpayments totaling $2,933,689 ($1,729,544 Federal share).

- The State agency incorrectly included both State government-owned or -operated nursing facilities and non-State government-owned or -operated nursing facilities in its UPL calculations for privately owned and operated nursing facilities. Because the combined payments remained below the UPL for privately owned and operated nursing facilities, this error did not result in any overpayments during our audit period. However, the potential exists for overpayments in subsequent periods.

On the basis of the results of our review, we determined that under Colorado's nursing facility supplemental payment program, the State agency made overpayments to nursing facilities totaling $4,136,684 ($2,470,450 Federal share) and incorrectly claimed these costs for Federal reimbursement.

The State agency was not able to able to identify the exact cause of the overpayment, nor was the overpayment identified when it was made. We believe that the State agency could correct these types of deficiencies by adjusting its accounting system to capture greater facility-level payment detail. In addition, the State agency did not follow its State plan methodology so that CPE supplemental payments did not exceed the UPLs. Further, the State agency did not accurately identify nursing facilities by category. Therefore, the State agency did not correctly calculate the privately owned and operated nursing facility UPLs.

SUPPLEMENTAL PAYMENTS EXCEEDED PROSPECTIVE SUPPLEMENTAL PAYMENT AMOUNTS

Section 1903(a)(1) of the Act authorizes payments 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. For details on these Federal requirements, see Appendix B.

In FYs 2010 and 2011, the State agency's actual supplemental payment amounts to nursing facilities exceeded the State agency's calculated prospective payment amounts, resulting in overpayments totaling $1,202,995 ($740,906 Federal share). State agency officials agreed with us that the difference between the actual supplemental payments and the calculated prospective payment amounts constituted overpayments and that the overpayments consequently did not conform to State plan requirements (Colorado State plan, Attachment 4.19D, pages 34 through 39a). For this reason, the overpaid amounts for FYs 2010 and 2011 were not eligible for FFP and did not meet the requirements of section 1903(a)(1) of the Act. The State agency's total calculated prospective payment amounts for nursing facilities for these 2 FYs totaled $119,607,392. However, the State agency actually paid $120,810,387 in supplemental payments to these facilities, resulting in overpayments totaling $1,202,995 ($740,906 Federal share).

The State agency was not able to able to identify the exact cause of the overpayment, nor was the overpayment identified when it was made. We believe that the State agency could correct these types of deficiencies by adjusting its accounting system to capture greater facility-level payment detail.

UPPER PAYMENT LIMITS EXCEEDED

Medicaid payments, which include supplemental payments, to institutional providers for Medicaid services are limited by UPLs. A UPL is the ceiling on Federal matching funds paid for supplemental payments and is based on an estimate of what Medicare would pay for comparable services (42 CFR §§ 447.272).

Under Federal UPL regulations, institutional providers that furnish inpatient Medicaid services are classified into three categories: (1) State government-owned or -operated facilities, (2) non-State government-owned or -operated facilities, and (3) privately owned and operated facilities (42 CFR § 447.272).[5] Each of those categories has its own UPL. The State agency's total supplemental payments to a group of facilities within each category may not exceed the UPL for that respective category (42 CFR § 447.272).

The State plan, Attachment 4.19D, page 50, echoes the language of 42 CFR § 447.272 and specifies that payments to State government-owned or -operated facilities and to non-State government-owned or -operated facilities may not exceed the UPLs for their respective categories.

For details on these Federal and State requirements, see Appendix B.

[5] As stated in "Background," the first two categories qualify for the use of CPEs in their financing.

In FYs 2010 and 2011, total CPE supplemental payments to State government-owned or -operated nursing facilities and non-State government-owned or -operated nursing facilities exceeded their applicable UPLs, resulting in overpayments totaling $2,933,689 ($1,729,544 Federal share). Specifically:

- In FYs 2010 and 2011, the State agency's total CPE supplemental payments to State government-owned or -operated nursing facilities were $9,202,594, while the total UPLs for these facilities were $8,278,046. Therefore, supplemental payments to State government-owned or -operated nursing facilities exceeded the UPLs by $924,548 ($506,228 Federal share).

- In FY 2011, the State agency's total CPE supplemental payments to non-State government-owned or -operated nursing facilities were $2,606,393, while the UPL for these facilities was $597,252. Therefore, CPE supplemental payments to non-State government-owned or -operated nursing facilities exceeded the UPL by $2,009,141 ($1,223,316 Federal share).

These overpayments occurred because the State agency did not follow its State plan methodology so that CPE supplemental payments did not exceed the UPLs.[6]

UPPER PAYMENT LIMITS INCORRECTLY CALCULATED

Under Federal UPL regulations, institutional providers that furnish inpatient Medicaid services are classified into the three categories mentioned above (42 CFR § 447.272). Each of these categories has its own UPL; the State agency's total supplemental payments to a group of facilities within each category may not exceed the UPL for that respective category (42 CFR § 447.272). For details on these Federal requirements, see Appendix B.

State agency officials stated that the State agency had incorrectly included some facilities in the UPL calculations for State government-owned or -operated nursing facilities, as well as non-State government-owned or -operated nursing facilities in the UPL calculations for privately owned and operated nursing facilities. Over the course of our 3-year audit period, the State agency's UPL calculations for privately owned and operated nursing facilities totaled $2,567,286,750. This amount represented an overstatement because it incorrectly included $21,235,740 associated with State government-owned or -operated nursing facilities and non-State government-owned or -operated nursing facilities. Thus, the State agency's UPL calculations for privately owned and operated nursing facilities over the course of our 3-year audit period should have totaled $2,546,051,010 ($2,567,286,750 minus $21,235,740).

[6] According to State agency officials, and under the State plan methodology, the State agency must calculate the UPLs on a calendar-year basis rather than an FY basis (State Plan, Attachment 419D, section 7A, page 51). The State agency did not perform this conversion, and our own calculations (see "Methodology" in Appendix A) determined that the State agency's CPE supplemental payments exceeded the UPLs.

This error occurred because the State agency did not accurately identify nursing facilities by category. Therefore, the State agency did not correctly calculate the privately owned and operated nursing facility UPLs.

RECOMMENDATIONS

We recommend that the State agency:

- refund $2,470,450 to the Federal Government,
- improve policies and procedures to ensure that its accounting system captures sufficient facility-level detail to ensure that actual payments do not exceed prospective payments,
- strengthen internal controls to ensure that it follows its State plan methodology so that CPE supplemental payments made to nursing facilities are equal to or below the applicable UPLs in accordance with Federal requirements, and
- strengthen internal controls to ensure that it calculates UPLs for the three categories of nursing facilities in accordance with Federal and State requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with all of our recommendations and described corrective actions that it had taken or planned to take. The State agency's comments appear in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

The State agency claimed Federal reimbursement for supplemental payments to nursing facilities totaling $228,134,342 ($128,384,674 Federal share) during FYs 2010 through 2012. We reviewed all of the supplemental payments to nursing facilities for which the State agency claimed Federal reimbursement during this period.

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, from September 2013 to March 2014.

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 nursing facility supplemental payment program;
- reconciled nursing facility supplemental payments reported on the State agency's CMS-64 reports for FYs 2010 through 2012 to the State agency's supporting documentation;
- reviewed the State agency's UPL calculations and the State agency's supplemental payments calculations;
- determined whether the totals of the State agency's actual nursing facility supplemental payments exceeded the totals of the UPLs that the State agency calculated and that we adjusted (as necessary) for its nursing facility supplemental payments;
- reviewed all Colorado nursing facility supplemental payments to determine whether the State agency made the payments correctly in accordance with prospective payment calculations;
- determined the total overpayments made by the State agency and the Federal share of these overpayments; and
- discussed the results of our review with State agency officials on April 17, 2014.

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: FEDERAL AND STATE PLAN REQUIREMENTS RELATED TO MEDICAID SUPPLEMENTAL PAYMENTS

FEDERAL REQUIREMENTS

Section 1903(a)(1) of the Act states:

> From the sums appropriated therefor, the Secretary [of Health and Human Services] (except as otherwise provided in this section) shall pay to each State which has a [State] plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—
>
> > (1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g) and (j) of this section and subsection 1923(f)) of the total amount expended during such quarter as medical assistance under the State plan ….

Section 1903(w)(6)(A) of the Act states:

> Notwithstanding the provisions of this subsection, the Secretary [of Health and Human Services] may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

Federal regulations (42 CFR § 433.51) state:

> (a) Public Funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.
>
> (b) The public funds are appropriated directly to the State or local Medicaid agency, or are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.
>
> (c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

Federal regulations (42 CFR § 447.272) state:

> (a) *Scope*. This section applies to rates set by the [State Medicaid] agency to pay for inpatient services furnished by hospitals [and nursing facilities] … within one of the following categories:
>
> > (1) State government-owned or operated facilities (that is, all facilities that are either owned or operated by the State).
> >
> > (2) Non-State government-owned or operated facilities (that is, all government facilities that are neither owned nor operated by the State).
> >
> > (3) Privately-owned and operated facilities.
>
> (b) *General rules*.
>
> > (1) Upper payment limit refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of this chapter.
> >
> > (2) Except as provided for in paragraph (c) of this section, aggregate Medicaid payments to a group of facilities within one of the categories described in paragraph (a) of this section may not exceed the upper payment limit described in paragraph (b)(1) of this section.

STATE PLAN REQUIREMENTS

With respect to nursing facility reimbursement, the State plan, Attachment 4.19D, includes information regarding the calculation of supplemental payments that providers can receive (pages 34 through 39a).

The State plan, Attachment 4.19D, states (page 50):

> Effective July 1, 2008, public nursing facilities will receive supplemental Medicaid payments to provide reimbursement to public providers for uncompensated care related to nursing facility services for Medicaid clients, such that total payments will not exceed the Medicare Upper Payment Limit for nursing facility services by provider class (state-owned and non-state owned Government nursing facilities). The nursing facilities Medicare Upper Payment Limit will be equal to a reasonable estimate of the amount that would be paid for nursing facility services using Medicare cost principles.

The State plan, Attachment 4.19D, section 7A, states (page 51): "Uncompensated costs for nursing facilities with State fiscal year reporting periods (i.e. July l through June 30) must be calculated and approximated for the calendar year Payment …."

APPENDIX C: STATE AGENCY COMMENTS

COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax • (303) 866-3883 TTY

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

August 15, 2014

Patrick J. Cogley, Regional Inspector General for Audit Services
Office of the Inspector General
Office of Audit Services, Region VII
601 E. 12th St., Room 0429
Kansas City, MO 64106

Mr. Cogley:

Please see the enclosed document that contains the Department of Health Care Policy and Financing's submission of responses to the draft report entitled *Colorado Claimed Unallowable Medicaid and Nursing Facility Supplemental Payments* (Report Number A-07-14-04215).

If you have any questions or comments, please contact Delora Hughes-Wise, Audit Coordinator at 303-866-4155 or Delora.hughes-wise@state.co.us

Sincerely,

Susan E. Birch MBA, BSN, RN
Executive Director

SB:dhw

Enclosure

Department of HealthCare Policy and Financing's Response to the
Department of Health and Human Services
Office of Inspector General
Colorado Claimed Unallowable Medicaid Nursing Facility Supplemental Payments
A-07-14-04215

Office of the Inspector General's Recommendation:

We recommend that the State agency

- *refund $2,470,450 to the Federal Government*

The Department of Health Care Policy and Financing agrees to refund $2,470,450 to the federal government by July 2015.

Department of HealthCare Policy and Financing's Response to the
Department of Health and Human Services
Office of Inspector General
Colorado Claimed Unallowable Medicaid Nursing Facility Supplemental Payments
A-07-14-04215

Office of the Inspector General's Recommendation: **1b**

We recommend that the State agency

- *improve policies and procedures to ensure that its accounting system captures sufficient facility-level detail to ensure that actual payments do not exceed prospective payments,*

The Department agrees to add codes to its accounting system for each supplemental payment type to capture greater facility-level payment detail and this will be implemented by January, 2015.

Department of HealthCare Policy and Financing's Response to the
Department of Health and Human Services
Office of Inspector General
Colorado Claimed Unallowable Medicaid Nursing Facility Supplemental Payments
A-07-14-04215

Office of the Inspector General's Recommendation **1c**

We recommend that the State agency

- *strengthen internal controls to ensure that it follows its State plan methodology so that CPE supplemental payments made to nursing facilities are equal to or below the applicable UPLs in accordance with Federal requirements*

The Department has developed and documented its internal processes to ensure that payments are made according to the approved Medicaid State Plan and within the calculated upper payment limits (UPLs).

Department of HealthCare Policy and Financing's Response to the
Department of Health and Human Services
Office of Inspector General
Colorado Claimed Unallowable Medicaid Nursing Facility Supplemental Payments
A-07-14-04215

Office of the Inspector General's Recommendation **1d**

We recommend that the State agency

- *strengthen internal controls to ensure that it calculates UPLs for the three categories of nursing facilities in accordance with Federal and State requirements.*

The Department agrees to improve its internal review processes to ensure that upper payment limits (UPLs) are calculated such that state government-owned, non-state government-owned, and private-owned nursing facilities are included in the correct UPL category. This will be implemented by January, 2015.