Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

HAWAII DID NOT COMPLY WITH SOME PROVISIONS OF THE QUEST EXPANDED MEDICAID DEMONSTRATION PROJECT WHEN DETERMINING ELIGIBILITY FOR FEDERAL REIMBURSEMENT OF UNCOMPENSATED CARE COSTS

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

Lori A. Ahlstrand
Regional Inspector General

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Office of Inspector General

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EXECUTIVE SUMMARY

For State fiscal years 2011 and 2012, Hawaii did not comply with some provisions of the special terms and conditions of the QUEST Expanded Medicaid demonstration project when determining whether governmentally operated hospitals' uncompensated care costs were eligible for Federal reimbursement.

WHY WE DID THIS REVIEW

The Hawaii Department of Human Services (State agency) entered into an agreement with the Centers for Medicare & Medicaid Services (CMS) to provide medical, dental, and behavioral health services under the QUEST Expanded Medicaid demonstration project (the demonstration). According to the demonstration's special terms and conditions, the State agency is permitted to make payments to governmentally operated facilities to cover their uncompensated care costs for hospital services provided to the uninsured or underinsured. The State agency reported to CMS $74.7 million in uncompensated care costs for State fiscal years (SFYs) 2011 and 2012. If uncompensated care costs are overstated, the claim for Federal reimbursement will also be overstated.

Our objective was to evaluate whether the State agency complied with the demonstration's special terms and conditions when determining whether governmentally operated hospitals' uncompensated care costs were eligible for Federal reimbursement.

BACKGROUND

Payments to governmentally operated hospitals to cover their uncompensated care costs are funded with certified public expenditures (CPEs). The State agency is allowed to claim for Federal reimbursement the CPEs for uncompensated care costs. The demonstration's special terms and conditions state that uncompensated care costs included as CPEs must not include inpatient Medicaid fee-for-service shortfalls, the cost of providing nonemergency care to certain aliens, and the cost of providing drugs to individuals eligible for Medicare Part D.

The State agency's process to determine the CPEs for claiming Federal reimbursement for the hospitals' uncompensated care costs has three phases:

- The interim quarterly expenditure payment for each hospital is the basis of the State agency's initial claim for drawing down Federal funds, which is based on the cost-to-charge ratios calculated from the hospital's prior-period Medicare cost report.

- The annual reconciliation payment for each hospital is calculated by reconciling the interim quarterly expenditure payments with its filed Medicare cost report. The annual reconciliation should be completed within 12 months after the filing of the Medicare cost report.

- The final reconciliation payment for each hospital is reconciled with the finalized Medicare cost report for the respective cost-reporting period. The final reconciliation is

completed within 6 months after the issuance of the hospital's finalized Medicare cost report.

WHAT WE FOUND

For SFYs 2011 and 2012, the State agency did not comply with some provisions of the demonstration's special terms and conditions when determining whether governmentally operated hospitals' uncompensated care costs were eligible for Federal reimbursement:

- To calculate the interim quarterly expenditure payments for the two SFYs, the State agency (1) did not use the hospitals' filed Medicare cost reports and (2) included in the uncompensated care costs the inpatient Medicaid fee-for-service shortfalls and the cost of providing nonemergency care to certain aliens, which were unallowable for Federal reimbursement.

- To determine the annual reconciliation payment for SFY 2011, the State agency did not reconcile the interim quarterly expenditure payments with the filed Medicare cost report for each hospital within 12 months after filing the cost report.

The financial effect of the State agency's noncompliance with the demonstration's special terms and conditions could not be determined because the hospitals' Medicare cost reports had not been finalized for the two SFYs.

WHAT WE RECOMMEND

We recommend that the State agency:

- for interim quarterly expenditure payments, use the hospitals' filed Medicare cost reports and exclude unallowable costs from the CPEs used for claiming Federal reimbursement and

- for annual reconciliation payments, perform annual reconciliations within 12 months after filing the Medicare cost reports.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings and described actions that it planned to take to address our recommendations.

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WHY WE DID THIS REVIEW

The Hawaii Department of Human Services (State agency) entered into an agreement with the Centers for Medicare & Medicaid Services (CMS) to provide medical, dental, and behavioral health services under the QUEST Expanded Medicaid demonstration project (the demonstration). According to the demonstration's special terms and conditions, the State agency is permitted to make payments to governmentally operated facilities[1] to cover their uncompensated care costs for hospital services provided to the uninsured or underinsured. The State agency reported to CMS $74.7 million in uncompensated care costs for State fiscal years (SFYs) 2011 and 2012. If uncompensated care costs are overstated, the claim for Federal reimbursement will also be overstated.

OBJECTIVE

Our objective was to evaluate whether the State agency complied with the demonstration's special terms and conditions when determining whether governmentally operated hospitals' uncompensated care costs were eligible for Federal reimbursement.

BACKGROUND

Administration of the Medicaid Program and Authorization of Section 1115 Demonstration Projects

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

Section 1115 of the Social Security Act (the Act) provides the Secretary of Health and Human Services with broad authority to authorize demonstration projects to assist in promoting the objectives of the Medicaid program. Under section 1115, the Secretary may waive compliance with any of the requirements of section 1902 of the Act to enable States to carry out these projects and receive Federal funds. In addition, the Secretary may also authorize expenditures under section 1115 that cannot otherwise be claimed for Federal reimbursement under section 1903 of the Act.

Hawaii QUEST Expanded Medicaid Demonstration Project

In Hawaii, the State agency administers the Medicaid program. On August 1, 1994, the State agency implemented QUEST Expanded Medicaid, a section 1115 demonstration project, to provide medical, dental, and behavioral health services. The State agency entered into an agreement with CMS under the demonstration's special terms and conditions, which describe the

[1] Governmentally operated facilities include hospitals and freestanding nursing facilities.

extent of Federal involvement in the demonstration and the State agency's obligations to CMS during the period of the demonstration.

Special Terms and Conditions of the QUEST Expanded Medicaid Demonstration Project

According to the demonstration's special terms and conditions, the State agency is permitted to make payments to governmentally operated facilities to cover uncompensated care costs for hospital services. These costs include the costs of providing hospital services to the uninsured or underinsured. Payments to governmentally operated hospitals to cover their uncompensated care costs are funded with certified public expenditures (CPEs). The State agency is allowed to claim for Federal reimbursement the CPEs for uncompensated care costs.

The Hawaii Health Systems Corporation (the Corporation) oversees governmentally operated facilities and receives appropriations from the State of Hawaii's general fund to cover some of the cost of these facilities' operations. The Corporation uses these appropriations to operate and certifies how much was spent on uncompensated care, to be submitted to the State agency for claiming the uncompensated care costs under the special terms and conditions.

In the special terms and conditions, CMS approved the CPE/Governmentally Owned Hospital Uncompensated Care Cost Protocol (the protocol). The protocol establishes the procedures and methods that the State agency uses to determine the hospitals' uncompensated care costs that are eligible for Federal reimbursement. According to the protocol, expenditures are certified according to costs reported on each hospital's Medicare cost report. The Corporation compiles the cost report for each hospital. Cost-to-charge ratios for each hospital are calculated using the total costs from the hospital's filed Medicare cost report.

The special terms and conditions of the demonstration state that uncompensated care costs included as CPEs must not include inpatient Medicaid fee-for-service shortfalls,[2] the cost of providing nonemergency care to certain aliens,[3] and the cost of providing drugs to individuals eligible for Medicare Part D.

The State agency's process to determine the CPEs for claiming Federal reimbursement for the hospitals' uncompensated care costs has three phases:

- The interim quarterly expenditure payment for each hospital is the basis of the State agency's initial claim for drawing down Federal funds, which is based on the cost-to-charge ratios calculated from the hospital's prior-period Medicare cost report.

[2] A "shortfall" is the cost of providing a service less the payment received for the service, either in accordance with the State plan or the demonstration, and is net of any profit earned on a fee-for-service or managed-care reimbursement (Attachment 4.19-A, § VIII(A)(4), of the State plan).

[3] Certain aliens are those considered unqualified aliens, qualified aliens subject to a 5-year ban, and those from countries that have entered into a Compact of Free Association with the United States. Unqualified aliens are individuals whose alien status makes them ineligible for Federal medical assistance. Qualified aliens subject to a 5-year ban are aliens prohibited from medical assistance for 5 years from the date of entry into the United States.

- The annual reconciliation payment for each hospital is calculated by reconciling the interim quarterly expenditure payments with its filed Medicare cost report. The annual reconciliation should be completed within 12 months after the filing of the Medicare cost report.

- The final reconciliation payment for each hospital is reconciled with the finalized Medicare cost report for the respective cost-reporting period. The final reconciliation is completed within 6 months after the issuance of the hospital's finalized Medicare cost report.

HOW WE CONDUCTED THIS REVIEW

Our audit covered SFYs 2011 and 2012.[4] We reviewed the special terms and conditions of the demonstration. We limited our review of the State agency's internal controls to those controls over ensuring compliance with the special terms and conditions of the demonstration for governmentally operated hospitals. We did not review freestanding nursing facilities.

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 the details of our audit scope and methodology.

FINDINGS

For SFYs 2011 and 2012, the State agency did not comply with some provisions of the demonstration's special terms and conditions when determining whether governmentally operated hospitals' uncompensated care costs were eligible for Federal reimbursement:

- To calculate the interim quarterly expenditure payments for the two SFYs, the State agency (1) did not use the hospitals' filed Medicare cost reports and (2) included in the uncompensated care costs the inpatient Medicaid fee-for-service shortfalls and the cost of providing nonemergency care to certain aliens, which were unallowable for Federal reimbursement.

- To determine the annual reconciliation payment for SFY 2011, the State agency did not reconcile the interim quarterly expenditure payments with the filed Medicare cost report for each hospital within 12 months after filing the cost report.

The financial effect of the State agency's noncompliance with the demonstration's special terms and conditions could not be determined because the hospitals' Medicare cost reports had not been finalized for the two SFYs.

[4] The State agency's fiscal year ends on June 30.

CALCULATION OF INTERIM QUARTERLY EXPENDITURE PAYMENTS

To calculate the interim quarterly expenditure payments to governmentally operated hospitals for SFYs 2011 and 2012, the State agency did not use the filed Medicare cost report for each hospital and included certain costs that were unallowable for Federal reimbursement.

State Agency Did Not Use the Filed Medicare Cost Reports To Calculate Cost-to-Charge Ratios

According to the protocol, the interim quarterly expenditure payment for each hospital is the basis of the State agency's initial claim for drawing down Federal funds. This payment is based on the cost-to-charge ratios calculated from the hospital's prior-period Medicare cost report.

To calculate the interim quarterly expenditure payments, the State agency did not use the prior-period Medicare cost report for each hospital to calculate the cost-to-charge ratios. Instead, the State agency used the Medicaid final settlement cost report.

State Agency Included in the Uncompensated Care Costs Certain Unallowable Costs

According to the demonstration's special terms and conditions, uncompensated care costs for governmentally operated hospitals must not include (1) inpatient Medicaid fee-for-service shortfalls; (2) the cost of providing nonemergency care to certain aliens; and (3) the cost of providing drugs to individuals eligible for Medicare Part D.

To calculate the interim quarterly expenditure payments, the State agency properly excluded from the uncompensated care costs the cost of providing drugs to individuals eligible for Medicare Part D. However, the State agency included in the uncompensated care costs the inpatient Medicaid fee-for-service shortfalls and the cost of providing nonemergency care to certain aliens:

- The State agency did not adjust the governmentally operated hospitals' uncompensated care costs to exclude the costs for inpatient Medicaid fee-for-service shortfalls. The State agency reported these costs on the incorrect CMS form for claiming Federal reimbursement.

- The State agency did not adjust the governmentally operated hospitals' uncompensated care costs to exclude the cost of providing nonemergency care to certain aliens.

CALCULATION OF ANNUAL RECONCILIATION PAYMENT

According to the protocol, the annual reconciliation payment for each hospital is calculated by reconciling the interim quarterly payments with its filed Medicare cost report. The annual reconciliation should be performed and completed within 12 months after the filing of the hospital's Medicare cost report.

To calculate the annual reconciliation payment for SFY 2011, the State agency did not reconcile the interim quarterly expenditure payments with each hospital's filed Medicare cost report. The State agency files the Medicare cost report within 5 months after the end of the SFY. Therefore, the annual reconciliation should have been completed by November 30, 2012. The initial claim for Federal reimbursement is based on interim quarterly payments using the prior-period cost report. Once the Medicare cost report is filed, the payments should be adjusted to coincide with the actual costs for the period. By not performing the reconciliation, the State agency claimed costs based on estimates.

For SFY 2012, the State agency is in the process of completing the annual reconciliation for each hospital within 12 months after filing the Medicare cost report. The reconciliation is due on November 30, 2013.

RECOMMENDATIONS

We recommend that the State agency:

- for interim quarterly expenditure payments, use the hospitals' filed Medicare cost reports and exclude unallowable costs from the CPEs used for claiming Federal reimbursement and

- for annual reconciliation payments, perform annual reconciliations within 12 months after filing the Medicare cost reports.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings and described actions that it planned to take to address our recommendations. The State agency's comments are included in their entirety as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered SFYs 2011 and 2012. We did not review the State agency's overall internal control structure because our objectives did not require us to do so. We limited our review of the State agency's internal controls to those controls over ensuring compliance with the special terms and conditions of the demonstration for governmentally operated hospitals. We did not review freestanding nursing facilities.

We conducted fieldwork from November 2012 to March 2013 at the State agency's offices in Honolulu, Hawaii.

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal laws and regulations and the State plan,
- reviewed the special terms and conditions of the demonstration,
- held discussions with CMS and State agency officials to gain an understanding of the special terms and conditions,
- evaluated the methods used to determine whether the hospitals' uncompensated care costs were eligible for Federal reimbursement,
- judgmentally selected two governmentally operated hospitals for SFY 2012 to review the calculation of the cost-to-charge ratios,
- reviewed the CPEs to determine whether the State agency excluded unallowable costs, and
- discussed the results of our review with the State agency.

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

NEIL ABERCROMBIE
GOVERNOR

PATRICIA MCMANAMAN
DIRECTOR

BARBARA A. YAMASHITA
DEPUTY DIRECTOR

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November 5, 2013

Ms. Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Audit Services, Region IX
90-7th Street, Suite 3-650
San Francisco, California 94103

Dear Ms. Ahlstrand:

Enclosed is the Department of Human Services' responses and corrective action plan related to your draft audit entitled *Hawaii Did Not Comply with Some Provision of the QUEST Expanded Medicaid Demonstration Project When Determining Eligibility for Federal Reimbursement of Uncompensated Costs*, audit number A-09-12-02084 dated September 2013.

We appreciate the opportunity to comment on the audit report.

Sincerely,

Barbara Yamashita
for Patricia McManaman
Director

Enclosure

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Findings and Recommendation

For SFYs 2011 and 2012, the State agency did not comply with some provisions of the demonstration's special terms and conditions when determining whether governmentally operated hospitals' uncompensated care costs were eligible for Federal reimbursement:

- To calculate the interim quarterly expenditure payments for the two SFYs, the State agency (1) did not use the hospitals' filed Medicare cost reports and (2) included in the uncompensated care costs the inpatient Medicaid fee-for-service shortfalls and the cost of providing nonemergency care to certain aliens, which were unallowable for Federal reimbursement.

- To determine the annual reconciliation payment for SFY 2011, the State agency did not reconcile the interim quarterly expenditure payments with the filed Medicare cost report for each hospital within 12 months after filing the cost report.

The financial effect of the State agency's noncompliance with the demonstration's special terms and conditions could not be determined because the hospitals' Medicare cost reports had not been finalized for the two SFYs.

Auditor's Recommendation

We recommend that the State Agency:

- For interim quarterly expenditure payments, use the hospitals' filed Medicare cost reports and exclude unallowable costs from the CPEs used for claiming Federal reimbursement; and

- For annual reconciliation payments, perform annual reconciliations within 12 months after filing the Medicare cost reports.

Concurrence/Corrective Action Taken or Planned

We concur with the auditor's findings. The Department will work with the Hawaii Health System Corporation (HHSC) and our fiscal agent to reconcile the interim quarterly payments to the as file cost reports. In addition, we will work with HHSC to conduct a data match of cost for state only participants serviced by HHSC. We will also work with HHSC to ensure that HHSC has the sufficient staffing levels to conduct the interim reconciliation to the as file cost reports.

Also, as noted in your audit report the final reconciliation to the final cost report could not be completed until Medicare has completed their review and will adjust the CMS-64 as needed.

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