DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF AUDIT SERVICES
150 S. INDEPENDENCE MALL WEST
SUITE 316
PHILADELPHIA, PENNSYLVANIA 19106-3499

JUL 5 2005

Report Number: A-03-01-00228

Mr. Michael L. Stauffer
Deputy Secretary for Administration
Office of Administration
Department of Public Welfare
Health and Welfare Buildings, Room 234
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

Dear Mr. Stauffer:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General final report entitled "Review of Medicaid Claims Made for Beneficiaries Under the Age of 21/22 Who Reside in Institutions for Mental Diseases in the Commonwealth of Pennsylvania." A copy of this report will be forwarded to the HHS action official noted below for her review and any action deemed necessary.

The HHS action official named below will make a final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 552, as amended by Public Law 104-231), Office of Inspector General reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5).

If you have any questions or comments about this report, please do not hesitate to contact me at (215) 861-4470 or through e-mail at Stephen.Virbitsky@oig.hhs.gov or your staff may contact Mr. James Maiorano, Audit Manager, at (215) 861-4476 or through e-mail at James.Maiorano@oig.hhs.gov. Please refer to report number A-03-01-00228 in all correspondence.

Sincerely,

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosure

Direct replay to HHS Action Official:
Nancy B. O'Connor
Regional Administrator
Centers for Medicare & Medicaid Services, Region III
Public Ledger Building, Suite 216
150 South Independence Mall West
Philadelphia, Pennsylvania 19106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID CLAIMS MADE FOR BENEFICIARIES UNDER THE AGE OF 21/22 WHO RESIDE IN INSTITUTIONS FOR MENTAL DISEASES IN THE COMMONWEALTH OF PENNSYLVANIA

Daniel R. Levinson
Inspector General

JULY 2005
A-03-01-00228

Office of Inspector General

http://oig.hhs.gov

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

Office of Audit Services

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

Office of Evaluation and Inspections

OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to HHS, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. OEI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Investigations

OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information contained therein is not subject to exemptions in the act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

This report is part of a nationwide audit focusing on States' Medicaid claims made for beneficiaries under the age of 21 who reside in institutions for mental diseases (IMD).

Regulations found at 42 CFR § § 435.1008 and 441.13 preclude Federal financial participation (FFP) for any services to IMD residents under the age of 65, except for inpatient psychiatric services provided to individuals under the age of 21 and in some instances those under the age of 22[1].

Centers for Medicare & Medicaid Services (CMS) guidance to States has also established that FFP is not permitted for IMD residents who are temporarily released to acute care hospitals for medical treatment. Specifically, section 4390.1 of the State Medicaid Manual, entitled "Periods of Absence From IMDs," states in part that, "If a patient is temporarily transferred from an IMD for the purpose of obtaining medical treatment . . . the patient is still considered an IMD patient."

In the Commonwealth of Pennsylvania (Commonwealth), the Department of Public Welfare (Department) operates the Medicaid program, sets mental health policies and procedures, and processes claims. The Department used the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims. In March 2004 MMIS was replaced with a new claims processing system called PROMISe.

OBJECTIVE

The objective of our review was to determine if controls were in place to preclude the Commonwealth from claiming FFP under the Medicaid program for all medical services, except inpatient psychiatric services, provided to residents of IMDs under the age of 21/22.

FINDINGS

Our review of Medicaid claims, for the period July 1, 1998 through June 30, 2001, determined that the Commonwealth did not have adequate controls to preclude it from claiming FFP under the Medicaid program for medical services provided to residents of IMDs who were under the age of 21/22. As a result, the Commonwealth made 69,801 improper Medicaid claims totaling $1,694,148 FFP.

[1]If the individual was receiving the inpatient psychiatric services immediately before he or she reached age 21, services may continue to be provided until the earlier of (1) the date the individual no longer requires the services or (2) the date the individual reaches the age of 22.

RECOMMENDATIONS

We recommend that the Commonwealth:

1. refund $1,694,148 to the Federal Government,

2. implement controls to prevent FFP from being claimed for medical services, other than inpatient psychiatric services, provided to IMD residents under the age of 21/22,

3. issue written guidance to medical providers and IMDs advising that all medical services provided to IMD residents should be billed directly to the IMDs,

4. establish procedures to identify all Medicaid recipients under the age of 21/22 who are admitted to an IMD, and

5. identify and refund to the Federal Government any improper FFP claimed for the period subsequent to our June 30, 2001 audit cutoff date.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

Auditee Comments

The Commonwealth generally disagreed with our findings and recommendations. The Commonwealth stated that, in addition to the per diem for inpatient psychiatric services, the Pennsylvania State plan authorizes payment for physician services during the inpatient period and for case management, family-based mental health services, mobile therapy, behavior specialists, discharge planning, and other services, including drug treatments, on the date of admission or discharge or within 30 days of discharge, as specified. The Commonwealth also asserted that capitation payments for managed care should continue during the inpatient period.

Office of Inspector General Comments

The State Plan can determine the method of payment for covered services, but it cannot include services specifically excluded by statute. The Commonwealth did not provide documentation to support that physician services met the requirements of statute, Federal regulations, or the State Plan. Other services claimed by the Commonwealth are not covered under the statute. Based on statute, Federal regulation and comment from CMS, we continue to recommend that the Commonwealth refund $1,694,148 to the Federal Government and implement our four remaining recommendations.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Definition of an Institution for Mental Diseases

Section 1905(i) of the Social Security Act and 42 CFR § 435.1009 define an institution for mental diseases (IMD) as a hospital, nursing facility, or other institution of more than 16 beds primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Psychiatric hospitals (including State-operated and private psychiatric hospitals) and inpatient psychiatric residential treatment facilities with more than 16 beds are IMDs.

Medicaid Exclusion

Regulations found at 42 CFR § § 435.1008 and 441.13 preclude paying Federal financial participation (FFP) for any services to IMD residents under the age of 65, except for inpatient psychiatric services provided to individuals under the age of 21/22.

Centers for Medicare & Medicaid Services (CMS) guidance to States specifies that FFP is only available for inpatient psychiatric services under the Medicaid program for individuals under the age of 21 and in certain instances those under the age of 22. Specifically, CMS issued Transmittal Number 65 of the State Medicaid Manual in March 1994 and Transmittal Number 69 of the State Medicaid Manual in May 1996. Section 4390 of the State Medicaid Manual, entitled "Institutions for Mental Diseases," provides in subsection A.2. ("IMD Exclusion"):

> The IMD exclusion is in 1905(a) of the Act in paragraph (B) following the list of Medicaid services. This paragraph states that FFP is not available for any medical assistance under title XIX for services provided to any individual who is under age 65 and who is a patient in an IMD unless the payment is for inpatient psychiatric services for individuals under age 21.

CMS guidance to States has also established that FFP is not permitted for IMD residents who are temporarily released to acute care hospitals for medical treatment. Specifically, section 4390.1 of the State Medicaid Manual, entitled "Periods of Absence From IMDs," states in part that, "If a patient is temporarily transferred from an IMD for the purpose of obtaining medical treatment . . . the patient is still considered an IMD patient."

In summary, based on the Act, the implementing Federal regulations, and CMS's guidance, FFP may not be claimed for any medical services, except inpatient psychiatric services, for IMD residents under the age of 21/22.

Commonwealth of Pennsylvania's Medicaid Program

In the Commonwealth of Pennsylvania (Commonwealth), the Department of Public Welfare (Department) operates the Medicaid program, sets mental health policies and procedures, and processes claims. The Department used the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims. In March 2004 MMIS was replaced with a new claims processing system called PROMISe.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to determine if controls were in place to preclude the Commonwealth from claiming FFP under the Medicaid program for all medical services, except inpatient psychiatric services, provided to residents of IMDs under the age of 21/22.

Scope

Our review of medical services provided to residents of IMDs under the age of 21/22 focused on 27 private and State-operated IMDs for the period July 1, 1998 through June 30, 2001.

The objective of our audit did not require an understanding or assessment of the overall internal control structure of the Department. Rather, our internal control review was limited to reviewing the controls that were in place to prevent the Commonwealth from claiming FFP under the Medicaid program for all medical services, except inpatient psychiatric services, provided to IMD residents under the age of 21/22.

We performed our audit at several Commonwealth and privately managed IMDs in Pennsylvania.

Methodology

To accomplish our audit objective we:

- reviewed Federal criteria, including section 1905(i) of the Act, 42 CFR § 435.1008, and applicable sections of the State Medicaid Manual;

- held discussions with Department officials to ascertain policies and procedures for claiming FFP under the Medicaid program for individuals under the age of 21/22 who were residents of the IMDs;

- obtained an understanding of computer controls and edits established by the Department regarding the claiming of FFP for medical services provided to IMD residents under the age of 21/22;

- obtained a listing of State-operated psychiatric hospitals and private psychiatric hospitals within the Commonwealth;

- obtained a list of Medicaid patients who were under the age of 21/22 who were residents of the 27 identified IMDs during our audit period;

- compared the Commonwealth's list of Medicaid eligible IMD patients under the age of 21/22 with the IMDs' lists of Medicaid eligible patients to determine whether the Commonwealth's list was accurate and complete;

- verified with the Commonwealth all Medicaid patients identified at the IMD facilities but not on the Commonwealth Medicaid eligible list;

- verified Medicaid patient records that contained no Medicaid paid claims per the Commonwealth through the paid claims files to assure the information was accurate;

- used the paid claims to identify Medicaid patients who were under the age of 21/22 and were residents of the 27 IMDs; using these parameters, identified 92,727 claims that were submitted for Medicaid reimbursement for services provided to IMD residents; and

- performed a review of the identified 92,727 Medicaid paid claims for medical services from various medical providers for IMD residents included in our audit to determine whether these claims were eligible for FFP.

Our review was conducted in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Our review of Medicaid claims, for the period July 1, 1998, through June 30, 2001, determined that the Commonwealth did not have adequate controls to preclude it from claiming FFP under the Medicaid program for medical services provided to residents of IMDs who were under the age of 21/22. As a result, the Commonwealth made 69,801 improper Medicaid claims totaling $1,694,148 FFP.

IMPROPERLY CLAIMED FFP

Condition – The Commonwealth made 69,801 improper Medicaid claims totaling $1,694,148 FFP for patients who were under the age of 21/22 and were residents of IMDs.

During the period July 1, 1998, through June 30, 2001, the Commonwealth received FFP for 92,727 Medicaid claims totaling over $2.58 million for IMD residents who were under the age of 21/22. Of the 92,727 claims reviewed, 69,801 claims were improper.

The following table shows the type of service, number of claims, and the FFP amounts questioned:

Type of Service	Number of Claims	FFP
Physician Services	50,278	$668,341
Family Rehabilitation	10,131	493,145
EPSDT	2,285	291,521
Managed Care Organizations	1,177	104,600
Prescription Drug	2,892	70,496
Other	3,038	66,045
Total	**69,801**	**$1,694,148**

Criteria – 42 CFR § 441.13 prohibits States from claiming FFP for services provided to any individual who is under age 65 and who is a patient of an IMD unless the payment is for inpatient psychiatric services for individuals under age 21/22.

CMS guidance to States has also established that FFP is not permitted for IMD residents who are temporarily released to acute care hospitals for medical treatment. Specifically, section 4390.1 of the State Medicaid Manual, entitled "Periods of Absence From IMDs," states in part that, "If a patient is temporarily transferred from an IMD for the purpose of obtaining medical treatment . . . the patient is still considered an IMD patient."

Cause – The Commonwealth did not have a procedure to identify Medicaid recipients who were in an IMD. We found that the Commonwealth did not maintain a complete list of Medicaid eligible individuals who were under the age of 21/22 and were admitted to an IMD. The Commonwealth's eligibility file identified 11,066 Medicaid recipients who were under the age of 21/22 and in 27 IMDs. However, records maintained by the individual IMDs identified 12,458 Medicaid eligible recipients. As a result, the Commonwealth's eligibility files did not identify 1,392 Medicaid eligible recipients in IMDs. We notified the Commonwealth of this discrepancy, and the Commonwealth agreed that 1,300 of the 1,392 individuals were Medicaid patients that were omitted from its Medicaid eligible file. The Commonwealth could not determine the status of the other 92 individuals, but concluded that they received no Medicaid benefits.

The Department did not have adequate controls in place to preclude it from claiming FFP for services provided to IMD residents who were under the age of 21/22. Medical services provided to residents of an IMD were billed directly to the Department instead of the IMDs. The Department processed and paid claims through its MMIS and submitted the claims for FFP without further editing to determine whether the claims were eligible for FFP.

Effect – We identified 69,801 improper Medicaid claims, totaling $1,694,148 FFP for medical services provided to IMD residents who were under the age of 21/22**.**

RECOMMENDATIONS

We recommend that the Commonwealth:

1. refund $1,694,148 to the Federal Government,

2. implement controls to prevent FFP from being claimed for medical services, other than inpatient psychiatric services, provided to IMD residents under the age of 21/22,

3. issue written guidance to medical providers and IMDs advising that all medical services provided to IMD residents should be billed directly to the IMDs,

4. establish procedures to identify all Medicaid recipients under the age of 21/22 who are admitted to an IMD, and

5. identify and refund to the Federal Government any improper FFP claimed for the period subsequent to our June 30, 2001 audit cutoff date.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

Auditee Comments

The Commonwealth generally disagreed with our findings and recommendations.

Physician Services – 50,278 claims - $668,341

The Commonwealth stated that The Pennsylvania State plan, Attachment 4.19A Page 22, authorizes payment for physician services in addition to the inpatient psychiatric services as indicated: "All compensable services provided to an inpatient are covered by the prospective per diem rate except for direct care services provided by salaried practitioners who bill the Medical Assistance Program directly."

Office of Inspector General Comments

The Office of Inspector General (OIG) allowed physician services on the date of admission only if the physician services were performed before the patient was admitted to an IMD.

For other physician services, the State Plan can determine the method of payment for covered services, but it cannot include services specifically excluded by statute. To be eligible to claim FFP for practitioner services under the State Plan, therefore, the physician must:

1. Provide psychiatric services only,
2. Provide the services on the premises of the IMD, and
3. Provide those services as a salaried practitioner.

There was no evidence that the physician services met all three requirements for claimed physician costs; we continue to disallow those claims.

Auditee Comments:

Family Rehabilitation; Early, Periodic, Screening, Diagnostic, Treatment; and Other Services Including Drug Claims

The Commonwealth argued that the Pennsylvania state plan and the Omnibus Budget Reconciliation Act of 1998 (OBRA 89) allow FFP for services to persons under 21 in IMDs for case management, family-based mental health services, mobile therapy, behavior specialist, discharge planning, and other services, including drug treatments on the date of admission or discharge or within 30 days of discharge, as specified.

Office of Inspector General Comments:

Of the 92,727 Medicaid claims obtained, a total of 22,926 claims were allowable for services provided on the date of admission or on the date of discharge. Under the statute, implementing Federal regulations, and CMS's guidance, however, the only exception to the IMD exclusion for individuals under the age of 21 is for inpatient psychiatric services. No other services may be claimed for FFP.

As part of the definition of "medical assistance." in section 1905(a) of the Act, subsection (a)(4)(B) states the medical assistance includes EPSDT [Early, Periodic, Screening, Diagnostic, and Treatment] services (as defined in subsection(r)) for individuals who are eligible the plan are under the age of 21. However, section 1905(a) also provides, in the material following subsection (a)(27):

> Except as otherwise provided in paragraph (16), such term does not include-
>
> (A) any such payments with respect to care or services for individual who is an inmate of public institution (except as a patient in medical institution); or
> (B) any such payments with respect to care or services for an individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

Section 1905(a) thus provides, notwithstanding the general allowability of payments for EPSDT and other services, that "such payments" are **not** eligible for FFP if made with respect to care or services for those under 65 who are patients in an IMD. The only exception to this exclusion from coverage for IMD patients is contained in paragraph 16, which authorizes payments for "inpatient psychiatric hospital services for individuals

under age 21, as defined in subsection (h) (which further provides in part that certain 22 year-olds may qualify for payment)." Therefore, unless the EPSDT services at issue are also within the scope of "inpatient psychiatric hospital services for individuals under age 21," they are subject to the statute's exclusion from coverage for IMD patients under 65.

Auditee Comments:

Managed Care Organization – 1,177 claims - $104,600

The Commonwealth stated that the HealthChoices waiver approved by CMS includes inpatient psychiatric hospital services. Persons who are admitted to private inpatient psychiatric hospitals are not disenrolled from HealthChoices but remain the responsibility of the managed care contractor for any needed health care and therefore properly receives a capitation payment for maintaining that responsibility. Because the monthly per member capitation payments to the department's behavioral health managed cared contractors include inpatient psychiatric services, claims associated with those payments are proper.

Office of Inspector General Comments:

OIG disagrees. Pursuant to statute and Federal regulations, services provided to residents of IMDs under the age of 21 are not eligible for FFP except for inpatient psychiatric services. If the State claims FFP for inpatient psychiatric services, a further claim for monthly capitation payments would constitute a duplicate claim.

Furthermore, payments to managed care organizations were usually made prospectively, one month in advance, which would therefore include the first month of inpatient care. Any capitation payments for members who incurred claims for inpatient psychiatric services should have been returned. Therefore we continue to disallow these claims.

Auditee Comments:

Remaining Claims – 5,176 Claims - $125,188

Without the audit work papers, the Commonwealth is unable to dispute the remaining claims. However, they do not concede that the claims are improper.

Office of Inspector General Comments

The OIG has made the electronic work papers available to the Commonwealth for many months. The Commonwealth, however, did not avail itself of the opportunity to copy the records in a timely manner. We therefore continue to disallow these claims.

Response to Recommendations

Auditee: For the reasons specified above, the Commonwealth did not concur with our recommendations to refund to the Federal Government $1,694,148 for the audit period and any additional improper FFP claimed subsequent to June 20, 2001. The Commonwealth likewise did not concur with the recommendations to improve controls, issue written guidance to providers, or establish procedures to identify all Medicaid recipients under the age of 21/22 who are admitted to an IMD.

Office of Inspector General: Based on statute, Federal regulation and comment from CMS, we continue to believe that our findings and recommendations are valid and we continue to recommend that The Commonwealth refund $1,694,148 to the Federal Government and implement our four remaining recommendations.

Pennsylvania's response in its entirety is included as an Appendix to this report.

APPENDIX

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
P.O. Box 2675
Harrisburg, PA 17105-2675

Michael Stauffer
Deputy Secretary for Administration

(717) 787-3422
Email: mistauffer@state.pa.us

February 11, 2005

Mr. Steven Virbitsky, Regional Inspector
General for Audit Services
Office of Audit Services
Office of Inspector General
Department of Health & Human Services
Suite 316
150 South Independence Mall West
Philadelphia, Pennsylvania 19106-3499

Dear Mr. Virbitsky:

Thank you for the October 14, 2004, letter in which you transmitted the draft report entitled, "Review of Medicaid Claims Made for Beneficiaries Under the Age of 21/22 Who Reside in Institutions for Mental Diseases in the Commonwealth of Pennsylvania," Report Number: A-03-01-00228.

We appreciate the opportunity to review the draft report as well as the extensions that you granted for submitting a response. We requested the extensions in part to have an opportunity to review the audit work papers, but your new proprietary working paper system has made it impossible for us to obtain a copy of your work papers, despite the cooperation of your staff and our efforts to do so. The lack of access to your work papers is a serious problem, and I will be corresponding with you under separate cover to seek a mutually acceptable resolution.

Because we have been unable to review your work papers, we cannot evaluate all of the issues that might be associated with your audit, and we cannot be completely responsive to it. Of necessity, therefore, our response is limited to and based on an analysis of the financial data previously provided by the auditors, which were also quite difficult to decipher.

Our response to the Findings and Recommendations in the draft report is set forth below.

Response to Findings

> **OIG Findings:** Our review of Medicaid claims, for the period July 1, 1998 through June 30, 2001, determined that the Commonwealth did not have adequate controls to preclude it from claiming FFP under the Medicaid program for medical services provided to residents of IMDs who were under the age of 21/22. As a result, the Commonwealth made 69,801 improper Medicaid claims totaling $1,694,148 FFP.

The Department of Public Welfare (Department) does not concur with this finding, even leaving aside the validity of the premise on which the audit was conducted. After reviewing the draft report and the data previously provided by the auditors, we believe that the vast majority of claims included in the draft report are not improper. Having analyzed the data extensively and in detail, we identified several categories of proper claims. In order to demonstrate why the claims in each category are proper, we classified the claims by justification, with the result that some of the categories overlap the groupings identified in the draft report. We are providing the following analysis of disputed claims, along with supporting justification, to quantify the approximate number of those claims and associated dollar amounts:

Physician Services - 50,278 claims - $668,341

Consistent with federal regulations at 42 C.F.R. Subpart D, which specify that physicians are a critical component of the inpatient treatment team and participants in active treatment, the Pennsylvania State Plan, approved by the Centers for Medicare & Medicaid Services (CMS), explicitly authorizes payment for physician services in addition to the per diem for inpatient psychiatric services. See Pennsylvania State Plan, Attachment 4.19A at p. 22. Pennsylvania has relied on the approved State Plan to claim federal financial participation (FFP) for physician services provided to inpatient psychiatric patients. Payments for physician services in addition to the per diem are not only consistent with the approved State Plan but are also common practice within the health care industry. Under these circumstances, excluding physician payments from FFP is clearly improper and at a practical level would result in an upward rate adjustment to the inpatient per diem to incorporate these appropriate costs for federally required services. Without your work papers and additional investigation, we cannot identify those physician payments that might fall outside the scope of the State Plan.

Family Rehabilitation; EPSDT; Other

Mobile Therapy, Behavior Specialist Consultant, and Therapeutic Staff Support Provided on the Date of Admission or Discharge - 811 claims - $117,937

These services are provided under the mandate of the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101-239, § 6403(a) (42 U.S.C. § 1396d(r)(5)) (OBRA 89) as rehabilitation services under section 1905(a)(13) of Title XIX (42 U.S.C. § 1396d(a)(13)). As services designed for the "maximum reduction of . . . mental disability and restoration of an individual to the best possible functional level," the primary purpose of these services is to avoid institutionalization and to promote successful return to and ongoing functioning in the community. As such, these services are appropriately provided on either the date of admission or the date of discharge, or both.

In addition, it was our understanding based on discussions with the auditors during the course of the audit that these payments were to be excluded from the calculations because it could not be determined whether the services were delivered before admission on the day of admission or after discharge on the day of discharge, in which case the claims would be proper.

Other Services Provided on the Date of Admission or Discharge - 1,022 claims - $32,630

As noted, it was our understanding based on discussions with the auditors during the course of the audit that these payments were to be excluded from the calculations because it could not be determined whether the services were delivered before admission on the day of admission or after discharge on the day of discharge, in which case the claims would be proper.

Case Management and Family-Based Mental Health Services Provided within 30 days of Discharge - 9,167 claims - $448,852

Discharge planning is a federally required part of an inpatient psychiatric service. See 42 C.F.R § 441.155(b)(5). Consistent with federal regulations, the Pennsylvania State Plan, approved by CMS, authorizes payment for case management and family-based mental health services in addition to the per diem within 30 days of discharge, in order to facilitate discharge planning and enhance the likelihood of successful reintegration into the community. See Pennsylvania State Plan, Attachment 3.1-A at pp. 6b, 10b, Supplement 2 at pp. 6-7. The State Plan provisions allow the community-based agencies to prepare the recipient for discharge before discharge takes place, ensuring continuity of care and compliance with aftercare services, with the ultimate result of lower overall costs to the system. Absent these provisions, inpatient stays would be longer and readmissions more likely. As with physician charges, Pennsylvania has relied on

the approved State Plan to claim FFP for payments for these services, and excluding these payments from FFP is clearly improper.

Mobile Therapy, Behavior Specialist Consultant, and Therapeutic Staff Support Provided within 30 days of Discharge - 1570 claims - $178,517

As noted, these services are provided under the mandate of OBRA 89 to provide medically necessary services to Medical Assistance recipients under the age of 21 "whether or not such services are covered under the State plan." 42 U.S.C. § 1396d(r)(5). Given the nature of the services, payments for these services within 30 days of discharge are appropriately claimed for the same reasons that case management and family-based mental health services are needed during the same time period.

Managed Care Organizations – 1,177 claims - $104,600 (Behavioral Health – 312 claims - $20,142; Physical Health – 865 claims, $84,506)

The HealthChoices waiver approved by CMS has from the outset of the HealthChoices program identified private inpatient psychiatric hospital services as an in-plan service. Because the monthly per member capitation payments to the Department's behavioral health managed care contractors appropriately include inpatient psychiatric services, the claims associated with those payments are entirely proper. Moreover, consistent with well-accepted managed care principles, the Department's behavioral health and physical health managed care contractors receive a monthly per member capitation payment regardless of whether or not a member receives services during the month and regardless of whether a member becomes ineligible during the month. In accordance with the approved waiver, persons who are admitted to private inpatient psychiatric hospitals are not disenrolled from HealthChoices. The managed care contractors remain responsible for any needed health care and therefore properly receive a capitation payment for maintaining that responsibility. Actuarial analysis used in rate development, and approved by CMS, proceeds from the premise that some members will be heavy users of services while others will be light users, regardless of the reason. To withhold capitation payments for members admitted to private inpatient psychiatric hospitals would undermine the premise on which managed care is based as well as the methodology by which capitation rates are developed.

Drug Claims Provided on Date of Admission or Discharge - 600 claims - $18,083

As noted above, it was our understanding based on discussions with the auditors during the course of the audit that these payments were to be excluded from the calculations because it could not be determined whether the services were delivered before admission on the day of admission or after discharge on the day of discharge, in which case the claims would be proper.

Remaining Claims - 5176 claims - $125,188

Without the audit work papers, the Department is unable to dispute the remaining claims. We do not thereby concede that the claims are improper.

Response to Recommendations

OIG Recommendations: We recommend that the Commonwealth:

1. refund $1,694,148 to the Federal Government;
   Response: For all of the reasons explained above, the Department does not concur in this recommendation.

2. implement controls to prevent FFP from being claimed for medical services, other than inpatient psychiatric services, provided to IMD residents under the age of 21/22;
   Response: The Department does not concur in this recommendation because it believes that the vast majority of questioned claims are proper. The Department will continue to take necessary steps to ensure that FFP is claimed appropriately.

3. issue written guidance to medical providers and IMDs advising that all medical services provided to IMD residents should be billed directly to the IMDs;
   Response: The Department does not concur in this recommendation because it believes that the vast majority of questioned claims are proper. If a review of the audit work papers reveals that certain types of claims are being submitted improperly, then the Department will issue such guidance as necessary to insure proper submission of claims.

4. establish procedures to identify all Medicaid recipients under the age of 21/22 who are admitted to an IMD;
   Response: The Department does not concur in this recommendation, since the procedures currently in place identified close to 90% of eligible recipients. The Department is aware of no requirement that imposes a duty to confirm Medicaid eligibility upon admission to an inpatient psychiatric hospital, whether or not a claim is ultimately submitted for payment. The Department's current procedures require that eligibility be confirmed before a payment is made. If a review of the audit work papers reveals that some modifications to current procedures are needed, the Department will make those modifications.

5. identify and refund to the Federal Government any improper FFP claimed for the period subsequent to our June 30, 2001 audit cutoff date.

Response: The Department does not concur in this recommendation. For all of the reasons explained above, the Department believes it would be a wasteful use of resources to conduct a systematic review only to identify the comparatively few payments for which claimed FFP might be improper.

Thank you for the opportunity to respond to the draft report. Please contact Linda Swick, Bureau of Financial Operations, Audit Resolution Section, at (717) 783-7218 if you have any questions or require additional information.

Sincerely,

Michael Stauffer

ACKNOWLEDGMENTS

This report was prepared under the direction of Stephen Virbitsky, Regional Inspector General for Audit Services. Other principal Office of Audit Service staff that contributed includes:

James Maiorano, *Audit Manager*
Patty B. Wong, *CPA, Senior Auditor*
Arthur Livingston, *Advanced Audit Techniques Staff*
Michael Romano, *Auditor*
Michael Anyanwu, *Auditor*
Maritza Cruz, *Auditor*

For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.