DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date JUN 25 2002

From Dennis J. Duquette
Deputy Inspector General
for Audit Services

Subject Review of Medical and Ancillary Medicaid Claims for 21 to 64 Year Old Residents of State Psychiatric Hospitals in Texas that are Institutions for Mental Diseases (A-06-01-00054)

To

Neil Donovan
Director, Audit Liaison Staff
Centers for Medicare & Medicaid Services

As part of the Office of Inspector General's self-initiated audit work, we are alerting you to the issuance of the subject final audit report within 5 business days. A copy of the report is attached. This report is one of a series of reports involving our multi-State review of Federal reimbursement for medical care provided to residents of institutions for mental diseases (IMD). We suggest you share this report with components of the Centers for Medicare & Medicaid Services involved with program integrity, provider issues, and State Medicaid agency oversight, particularly the Center for Medicaid and State Operations.

The objective of our review was to determine if controls were in place to effectively preclude the Texas Department of Health (TDH) from claiming Federal financial participation (FFP) under the Medicaid program for 21 to 64 year old residents of State-operated psychiatric hospitals that are IMDs. Our review focused on fee-for-service reimbursement for individuals who received medical and ancillary services (except inpatient acute care hospital services which were reviewed in a prior audit under Common Identification Number A-06-00-00074). Examples of the types of claims included in this review are physician, clinic, pharmacy, transportation, and laboratory services.

Our review found that for the period September 1, 1997 through August 31, 2000, TDH improperly claimed FFP for medical and ancillary services for IMD clients between the ages of 22 to 64, and for those aged 21 at admission. As a result, FFP totaling $462,551 was improperly claimed at the nine State hospitals included in our audit. While State officials stated that it would recover payments for the claims that were improperly paid, our review focused on the improper claiming of FFP by the State Medicaid agency, not on inappropriate payments received by providers. Therefore, the improperly claimed FFP associated with this audit, as well as any identified subsequently, should be refunded to the Federal Government irrespective of whether or not payments are recouped from providers.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General, Centers for Medicare and Medicaid Audits, at (410) 786-7104 or Gordon L. Sato, Regional Inspector General for Audit Services, Region VI, at (214) 767-8414.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of **Inspector General**

Office of Audit Services
1100 Commerce, Room 686
Dallas, TX 75242

JUN 2 a 2002

Common Identification Number: A-06-0 1-00054

Mr. Don A. Gilbert
Coinmissioner
Texas Health and Human Services Commission
P.O. Box 13247
Austin. Texas 78711-3247

Dear Mr. Gilbert:

Enclosed are two copies of the Department of Health and Human Services (HHS). Office of Inspector General (OIG). Office of Audit Services' **(OAS),** final report entitled, "Review of Medical and Ancillary Medicaid Claims for 21 to 64 Year Old Residents of State Psychiatric Hospitals in Texas that are Institutions for Mental Diseases." A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. Wc 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), OIG/OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR part 5.) As such, within 10 business days after the final report is issued, it will be posted on the world wide web at http://oig.hhs.gov.

To facilitate identification, please refer to Common Identification Number A-06-0 1-00054 in all correspondence relating to this report.

Sincerely yours.

Gordon L. Sato
Regional Inspector General for
Audit Services

Enclosure- as stated

Direct Reply to HHS Action Official:

Regional Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
1301 Young Street, Room 714
Dallas, Texas 75202

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAL AND ANCILLARY MEDICAID CLAIMS FOR 21 TO 64 YEAR OLD RESIDENTS OF STATE PSYCHIATRIC HOSPITALS IN TEXAS THAT ARE INSTITUTIONS FOR MENTAL DISEASES

JANET REHNQUIST
Inspector General

JUNE 2002
A-06-01-00054

EXECUTIVE SUMMARY

Background

Federal law and regulations prohibit Federal financial participation (FFP) claims to Medicaid for residents of institutions for mental diseases (IMD) between the ages of 22 to 64, and those 21 at admission. Prior to the Social Security Act Amendments of 1965 (Public Law 89-97), FFP was not available for payments made on behalf of individuals who were receiving care in IMDs. Until that time, such care had been solely the responsibility of the States. The Amendments of 1965 provided, for the first time, an option for States to include medical assistance on behalf of individuals 65 years of age or older who were patients in IMDs. Additionally, the Social Security Act Amendments of 1972 (Public Law 92-603) provided for inpatient psychiatric hospital services, under certain circumstances, for individuals under age 21 or, in specific circumstances, under age 22. In clarifying guidance, the Centers for Medicare & Medicaid Services made it clear that FFP is not available for any services provided to residents of IMDs who are between the ages of 21 to 64.

Objective

The objective of our review was to determine if controls were in place to effectively preclude the Texas Department of Health (TDH) from claiming FFP under the Medicaid program for 21 to 64 year old residents of State-operated psychiatric hospitals (State hospital) that are IMDs. Our review focused on fee-for-service reimbursement for individuals who received medical and ancillary services (except inpatient acute care hospital services which were reviewed in a prior audit under Common Identification Number A-06-00-00074). Examples of the types of claims included in this review are physician, clinic, pharmacy, transportation, and laboratory services.

Summary of Findings

The TDH improperly claimed FFP for medical and ancillary services for 21 to 64 year old residents of State hospitals that the Texas Department of Mental Health and Mental Retardation (MHMR) identified as IMDs.

The TDH officials stated that there were neither edits nor mechanisms within National Heritage Insurance Company's (NHIC) Medicaid Management Information System (MMIS) to detect and prevent FFP from being claimed for IMD clients between the ages of 21 to 64. However, as a result of our prior audit, the Texas Health and Human Services Commission (HHSC) is working on ways to prevent improper FFP from being claimed in the future.

For the period September 1, 1997 through August 31, 2000, TDH improperly claimed FFP for medical and ancillary services for IMD clients between the ages of 22 to 64, and for those aged 21 at admission. As a result, FFP totaling $462,551 was improperly claimed. **Appendix B** of our report provides a summary of total Medicaid amounts claimed and FFP amounts improperly claimed at each of the nine State hospitals included in our audit.

Recommendations

We recommended that HHSC ensure that TDH:

1. Refund $462,551 to the Federal Government for the FFP improperly claimed during the period September 1, 1997 through August 31, 2000.

2. Identify and return any improper FFP claimed subsequent to August 31, 2000.

3. Cease claiming FFP for clients between the ages of 22 to 64, and for those aged 21 at admission, when these clients receive medical and ancillary services.

4. Develop controls or edits within its MMIS to detect and prevent claims for FFP for clients between the ages of 22 to 64, and for those aged 21 at admission, who receive medical and ancillary services.

Auditee's Comments

In response to our draft report, HHSC stated that it has taken action to address the recommendations in our report. The HHSC directed NHIC to initiate a recoupment process for the claims that were inappropriately paid during the period September 1, 1997 through August 31, 2000. In addition, HHSC developed a system in collaboration with MHMR and NHIC to detect and identify on a quarterly basis inappropriate claims for clients between the ages of 22 to 64, and for those aged 21 at admission, who received medical and ancillary services.

OIG's Response

While HHSC officials stated that it would recover payments for the claims that were improperly paid for medical and ancillary services provided to 21 to 64 year old IMD residents during the period September 1, 1997 through August 31, 2000, our review focused on the improper claiming of FFP by the State Medicaid agency, not on inappropriate payments received by providers. Therefore, the improperly claimed FFP associated with this audit, as well as any identified subsequently, should be refunded to the Federal Government irrespective of whether or not payments are recouped from providers. The full text of HHSC's comments is included as **Appendix C.**

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INTRODUCTION

BACKGROUND

Medicaid, authorized by title XIX of the Social Security Act, as amended, provides grants to States for furnishing medical assistance to eligible low-income persons. The States arrange with medical service providers such as physicians, pharmacies, hospitals, nursing homes, and other organizations to provide the needed medical assistance.

To be eligible for Federal financial participation (FFP) under the Medicaid program, each State must submit an acceptable plan (hereafter referred to as the State Plan) to the Centers for Medicare & Medicaid Services (CMS). The State Plan specifies the amount, duration, and scope of all medical and remedial care services offered to Medicaid recipients. The State Plan is the basis of operation for the Medicaid program in the State. The CMS is responsible for monitoring the activities of the State agency and its implementation of the Medicaid program under the State Plan.

Prior to the Social Security Act Amendments of 1965 (Public Law 89-97), FFP was not available for payments made on behalf of individuals who were receiving care in institutions for mental diseases (IMD). Until that time, such care had been solely the responsibility of the States. The Amendments of 1965 provided, for the first time, an option for States to include medical assistance on behalf of individuals 65 years of age or older who were patients in IMDs. Additionally, the Social Security Act Amendments of 1972 (Public Law 92-603) extended FFP for inpatient psychiatric hospital services, under certain circumstances, for individuals under age 21 or, in specific circumstances, under age 22.

Texas began participating in the Medicaid program in September 1967. The Texas Health and Human Services Commission (HHSC) has been the single State agency for Medicaid since January 1993 with the State Medicaid Director administering the program. The Texas Department of Mental Heath and Mental Retardation (MHMR) is mandated to serve those individuals with mental illness and mental retardation in greatest need of services. The Texas Department of Health (TDH) is the Medicaid operating agency that provides assistance with claims processing to certain other operating agencies through a contract with the National Heritage Insurance Company (NHIC). The NHIC is the Medicaid Management Information System (MMIS) fiscal agent for the Medicaid program and has administered the program since 1977.

Federal regulations prohibit FFP claims to Medicaid for IMD clients between the ages of 22 to 64, and for those aged 21 at admission. The regulations at 42 CFR 435.1008, which are found under a subcaption entitled, “LIMITATIONS ON FFP”, were amended on May 3, 1985 and state that:

"(a) FFP is not available in expenditures for services provided to- . . .
(2) Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under Section 440.160 of this subchapter."

Subpart (c) of 42 CFR 435.1008 defines an exception when an IMD patient is not considered to be a resident of an IMD as follows:

> "An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution..."

In November 1990, CMS issued Transmittal No. 51 of the State Medicaid Manual, part 4, to all States. Section 4390.1 of this manual states in part that:

> "If a patient is temporarily released from an IMD for the purpose of obtaining medical treatment, however, this is not considered a conditional release and the patient is still considered an IMD patient."

In December 1992, CMS issued a report to the Congress entitled, "Medicaid and Institutions for Mental Diseases." This report states in part that:

> "If a patient is temporarily released from an IMD for the purpose of obtaining medical treatment (e.g. surgery in a general hospital), this is not considered to be either of these categories of release and the patient is considered to remain in the IMD. In such a situation, medical assistance is not available during the absence."

Finally, in March 1994, CMS issued Transmittal No. 65 of the State Medicaid Manual, part 4. Section 4390 A.2 of this manual, entitled <u>IMD Exclusion</u>, states that:

> " …The IMD exclusion is in Section 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. This exclusion was designed to assure that States, rather than the Federal government, continue to have principal responsibility for funding inpatient psychiatric services. Under this broad exclusion, no Medicaid payment can be made for services provided either in or outside the facility for IMD patients in this age group."

Additionally, part 4390.1 of Transmittal No. 65, entitled <u>Periods of Absence From IMDs,</u> again reemphasized that when a patient is temporarily released from an IMD for the purpose of obtaining medical treatment, the patient still retains his IMD status and as such, the FFP exclusion for patients within the 21 to 64 year old age group would still apply.

In summary, the Social Security Act and implementing regulations, as well as transmittals to the State Medicaid Manual and CMS's report to the Congress, make it clear that FFP is not available for any services provided to residents of IMDs who are between the ages of 22 and 64, and those who are aged 21 at admission.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of our review was to determine if controls were in place to effectively preclude TDH from claiming FFP under the Medicaid program for 21 to 64 year old residents of State-operated psychiatric hospitals (State hospital) that are IMDs. Our review focused on fee-for-service reimbursement for individuals who received medical and ancillary services (except inpatient acute care hospital services which were reviewed in a prior audit under Common Identification Number A-06-00-00074). Examples of the types of claims included in this review are physician, clinic, pharmacy, transportation, and laboratory services.

The audit period was September 1, 1997 through August 31, 2000. The review focused on nine State hospitals that MHMR identified as IMDs and was limited to medical and ancillary services. (See **Appendix A** for a list of the nine State hospitals.)

Our review was performed in accordance with generally accepted government auditing standards. It included tests and procedures that we considered necessary in the circumstances. During our audit, we interviewed and obtained information from officials of TDH, MHMR, and NHIC. In addition, we reviewed applicable policies and procedures relevant to our audit.

Audit field work was performed at TDH, our Austin field office, and our Dallas regional office during the period August 2001 through February 2002.

FINDINGS AND RECOMMENDATIONS

For the period September 1, 1997 through August 31, 2000, TDH improperly claimed FFP for IMD clients between the ages of 22 to 64, and for those aged 21 at admission. The claiming of FFP for these clients was contrary to Federal law and regulations and clarifying guidance issued by CMS. As a result, FFP totaling $462,551 was improperly claimed. (See **Appendix B** for a summary of the total Medicaid amounts claimed and FFP amounts improperly claimed at each of the nine State hospitals).

Analysis of Medicaid Eligible Individuals at All Nine State Hospitals

During our prior audit, MHMR provided a complete listing of Medicaid eligible individuals for the 21 to 64 year old age group residing in State hospitals during our audit period. This listing contained both admission and discharge dates and was again used as the universe of beneficiaries for this audit. From this listing, NHIC extracted Medicaid payments for medical services and TDH extracted Medicaid payments for pharmacy and transportation claims on behalf of

individuals residing in an IMD during our 3-year audit period. We then used computer programming to extract only those payments for services that occurred during the time when the individual was a resident of the IMD.

We obtained a patient movement file from MHMR. The patient movement file was used to verify that the residents under review were residents of the State hospitals during the time the medical and ancillary services were paid by Medicaid. In addition, this file showed when IMD patients were on conditional or convalescent leave. Through the use of computer programming, we then removed any payments from our universe of questioned costs for individuals that were on either of these two types of leave at the time medical or ancillary services were provided.

The resulting universe of questioned costs included only those payments for individuals who were residents of the IMD, and not on approved leave, at the time medical and ancillary services were provided. We then calculated the improper FFP that had been claimed for medical and ancillary services during the period September 1, 1997 through August 31, 2000.

Lack of System Edits

The TDH officials stated that there were neither edits nor mechanisms within NHIC's MMIS to detect and prevent FFP from being claimed for medical and ancillary services provided to IMD residents between the ages of 21 to 64. However, MHMR had some controls in place to preclude FFP from being claimed for this population. The MHMR officials informed us that they distributed regulations regarding the IMD exclusion to each of the State hospitals. In addition, our limited testing revealed that one of the IMDs, upon requesting medical care for one of its residents, would send a form that requested the medical care and instructed the provider to bill the IMD for the medical services. Even though these controls were in place, they were not always effective. However, as a result of our prior audit, the HHSC is working on ways to prevent FFP from being claimed in the future.

CONCLUSION

For the period September 1, 1997 through August 31, 2000, TDH improperly claimed FFP for clients between the ages of 22 to 64, and for those aged 21 at admission, who received medical and ancillary services, other than inpatient services at an acute care hospital. As a result, FFP totaling $462,551 was improperly claimed.

RECOMMENDATIONS

We recommended that HHSC ensure that TDH:

1. Refund $462,551 to the Federal Government for the FFP improperly claimed during the period September 1, 1997 through August 31, 2000.

2. Identify and return any improper FFP claimed subsequent to August 31, 2000.

3. Cease claiming FFP for clients between the ages of 22 to 64, and for those aged 21 at admission, when these clients receive medical and ancillary services.

4. Develop controls or edits within its MMIS to detect and prevent claims for FFP for clients between the ages of 22 to 64, and for those aged 21 at admission, who receive medical and ancillary services.

AUDITEE'S COMMENTS

In response to our draft report, HHSC stated that it has taken action to address the recommendations in our report. The HHSC directed NHIC to initiate a recoupment process for the claims that were inappropriately paid during the period September 1, 1997 through August 31, 2000. In addition, HHSC developed a system in collaboration with MHMR and NHIC to detect and identify on a quarterly basis inappropriate claims for clients between the ages of 22 to 64, and for those aged 21 at admission, who received medical and ancillary services.

OIG'S RESPONSE

While HHSC stated that it would recover payments for the claims that were improperly paid for medical and ancillary services provided to 21 to 64 year old IMD residents during the period September 1, 1997 through August 31, 2000, our review focused on the improper claiming of FFP by the State Medicaid agency, not on inappropriate payments received by providers. Therefore, the improperly claimed FFP associated with this audit, as well as any identified subsequently, should be refunded to the Federal Government irrespective of whether or not payments are recouped from providers. The full text of HHSC's comments is included as **Appendix C.**

Appendix A

LIST OF THE NINE STATE HOSPITALS INCLUDED IN OUR AUDIT

Austin State Hospital

Big Spring State Hospital

Kerrville State Hospital

North Texas State Hospital

Rusk State Hospital

San Antonio State Hospital

Terrell State Hospital

Rio Grande State Center

El Paso State Center

SUMMARY OF TOTAL MEDICAID AMOUNTS CLAIMED AND FFP AMOUNTS IMPROPERLY CLAIMED AT THE NINE STATE HOSPITALS FOR THE PERIOD SEPTEMBER 1, 1997 THROUGH AUGUST 31, 2000

State Hospital	Total Medicaid Claimed	FFP Improperly Claimed
Austin	$ 78,783	$ 48,896
Big Spring	47,564	29,525
Kerrville	25,327	15,723
North Texas	65,410	40,578
Rusk	133,136	82,715
San Antonio	234,994	145,960
Terrell	104,299	64,795
Rio Grande	45,772	28,459
El Paso	9,468	5,900
Totals:	$744,753	$462,551

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

Don A.Gilbert, M.B.A.
COMMISSIONER

May 23, 2002

Gordon L. Sato
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Services
1100 Commerce, Room 6B6
Dallas, Texas 75242

Re: Common Identification Number A-06-01-00054

Dear Mr. Sato:

This is in response to your letter dated April 17, 2002, transmitting a draft of the U.S. Department of Health and Human Services, Office of Inspector General's report entitled "Review of Medical and Ancillary Medicaid Claims for 21 to 64 Year Old Residents of State Psychiatric Hospitals in Texas that are Institutions for Mental Diseases".

As indicated in previous responses to earlier letters from your office, HHSC has taken action to address the recommendations in the report. In addition to the actions cited in our earlier letters, the Health and Human Services Commission (HHSC) has:

- Directed the National Heritage Insurance Company (NHIC) to initiate the recoupment process for the claims that were improperly paid for the IMD population during the period September 1, 1997 through August 21, 2000.
- Developed a system in collaboration with Texas Department for Mental Health and Mental Retardation and NHIC to routinely audit on a quarterly basis to detect and identify inappropriate claims for clients between the ages of 22 to 64 and for those aged 21 at admission who receive medical and ancillary services.

Should you need additional information please contact Mr. Arnulfo Gómez, Health and Human Services Commission, Medicaid/Chip Benefits, at 512/338-6511 or in writing at the following address:

Health & Human Services Commission, Y-927
Benefits, Attention: Arnulfo Gomez
1100 West 49th Street
Austin, Texas 78756

Sincerely,

Don A. Gilbert

DAG:rg