DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

August 31, 2009

Report Number: A-06-07-00108

Mr. Albert Hawkins
Executive Commissioner
Texas Health and Human Services Commission
P.O. Box 13247
Austin, Texas 78711

Dear Mr. Hawkins:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Medicaid Payments Made for Nonemergency Services Provided to Undocumented Aliens and Legal Aliens Restricted to Emergency Services in Texas." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this 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.

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If you have any questions or comments about this report, please do not hesitate to call me at (214) 767-8414 or contact Mark Ables, Audit Manager, at (214) 767-9203 or through email at Mark.Ables@oig.hhs.gov. Please refer to report number A-06-07-00108 in all correspondence.

Sincerely,

Patricia Wheeler

Patricia Wheeler
Regional Inspector General
for Audit Services

cc:
Mr. David Griffith
Mr. Chris Traylor

Enclosure

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID PAYMENTS MADE FOR NONEMERGENCY SERVICES PROVIDED TO UNDOCUMENTED ALIENS AND LEGAL ALIENS RESTRICTED TO EMERGENCY SERVICES IN TEXAS

Daniel R. Levinson
Inspector General

August 2009
A-06-07-00108

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Section 1903(v) of the Social Security Act states that Federal Medicaid funding is available to States for medical services provided to aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only when those services are necessary to treat an emergency medical condition. Further, 42 CFR § 440.255 states that Federal Medicaid funding is available to States for medical services provided to aliens granted lawful temporary resident status or lawful permanent resident status and who meet all other requirements for Medicaid only when those services are necessary to treat an emergency medical condition.

In addition, 42 CFR § 440.255 states that Federal Medicaid funding is available to States for services provided to pregnant women if a provision is included in the approved State plan. These services include routine prenatal care, labor and delivery, and routine postpartum care.

In Texas, the Texas Health and Human Services Commission (the State agency) administers the Medicaid program. Texas Administrative Code Rule 354.2103 uses the definition of an emergency medical condition contained in Federal regulations. To receive emergency Medicaid funding in Texas, providers are required to fill out an "Emergency Medical Services Certification Form" (Form 3038) certifying that the patient had received treatment for an emergency medical condition. In addition, the State has a list of medical diagnoses, including labor and delivery, that it considers to be emergency conditions and has an edit (edit 00064) to verify whether the condition coded on a claim is one that the State considers to be an emergency. Coverage is limited to the specific dates of service of the emergency, as stated on the Form 3038, and does not include any service provided after the emergency condition has been stabilized.

During our audit period (October 1, 2004, through September 30, 2005), the State agency processed 303,266 claims totaling approximately $314.2 million ($191.2 million Federal share) for medical services and approximately $148,000 ($90,000 Federal share) for prescription drugs provided to undocumented aliens and legal aliens restricted to emergency services. Of the $314.2 million total, approximately $218.3 million (70 percent) was for labor and delivery services.

OBJECTIVE

Our objective was to determine whether the State agency had adequate internal controls to ensure that, for undocumented aliens and legal aliens restricted to emergency services, Federal reimbursement was claimed only for those conditions that it defined as emergency services.

SUMMARY OF FINDINGS

The State agency did not have adequate internal controls to ensure that, for undocumented aliens and legal aliens restricted to emergency services, Federal reimbursement was claimed only for those conditions that it defined as emergency services. We reviewed 854 medical claims and 44

prescription drug claims. For the 854 medical claims, we determined that the services contained on 629 claims totaling $679,588 met the State's definition of emergency care. However, services contained on 193 claims totaling $262,366 ($159,702 Federal share) did not meet the definition. The State agency did not have the supporting medical documentation for us to determine whether the services billed on 32 claims totaling $5,903 were for emergency care. Therefore, we are questioning 193 claims for the following reasons:

- The State agency claimed Federal reimbursement for 170 medical claims for nonemergency services totaling $165,494 ($100,736 Federal share) because edit 00064 was inadequate.

- The State agency claimed Federal reimbursement for 23 claims for nonemergency services totaling $96,872 ($58,966 Federal share). These claims were initially denied by edit 00064; however, upon appeal, the claims were paid.

The State agency claimed Federal reimbursement for 7,114 claims totaling $147,805 ($89,969 Federal share) for prescription drugs that did not meet the State's definition of emergency care.

In addition, the edit in place to prevent payment of family planning services claims for undocumented aliens and legal aliens did not always operate correctly or was manually overridden to allow services to be claimed as family planning services, which are paid at an enhanced Federal medical assistance rate of 90 percent. The State agency claimed a total of $126,178 ($113,560 Federal share) for 350 claims at the enhanced rate of 90 percent. As a result, the State agency claimed overpayments totaling at least $36,756 (Federal share).

Finally, Form 3038 was not completed for 429 of our sampled claims (48 percent) or was not a reliable indicator of whether the services provided were for emergency medical services.

RECOMMENDATIONS

We recommend that the State agency:

- adjust the "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program" (Form CMS-64) for the $159,702 (Federal share) claimed for services that did not meet the State's definition of emergency care;

- ensure that officials responsible for reviewing appealed claims for the emergency Medicaid program are familiar with Federal and State requirements and have medical backgrounds to determine whether claims are for emergency medical treatment;

- adjust the Form CMS-64 for the $89,969 (Federal share) claimed for unallowable prescription drugs and for any additional Federal funds paid for prescriptions filled prior and subsequent to our audit period;

- adjust the Form CMS-64 for the $36,756 (Federal share) for the 350 claims improperly paid at the enhanced Federal medical assistance percentage rate for family planning

services, review the claims to determine whether the services provided were for nonemergencies and make any additional adjustments as necessary;

- require medical personnel to review medical records prior to certifying on Form 3038 that emergency medical treatment was provided and ensure that the certified dates are limited to the specific dates of the emergency;

- strengthen its policies and procedures, including developing edits, to prevent Medicaid payments for nonemergency services provided to aliens; and

- periodically sample and review claims paid for emergency medical services provided to aliens and refund any payments made in error.

STATE AGENCY COMMENTS

In its comments on our draft report, the State agency said that it will take corrective action for each of the recommendations and analyze the claims identified in the report for services that reportedly did not meet the definition of emergency care and refund the Federal share. The State agency's comments are included in their entirety as the Appendix.

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STATE AGENCY COMMENTS

INTRODUCTION

BACKGROUND

The Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), 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 plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Federal Emergency Medicaid Funding for Aliens

Section 1903(v) of the Social Security Act states that Federal Medicaid funding is available to States for medical services provided to aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only when those services are necessary to treat an emergency medical condition. Further, 42 CFR § 440.255 states that Federal Medicaid funding is available to States for medical services provided to aliens granted lawful temporary resident status or lawful permanent resident status and who meet all other requirements for Medicaid only when those services are necessary to treat an emergency medical condition.

Section 1903(v) of the Act and 42 CFR § 440.255 define an emergency medical condition as one manifested by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any body part or organ. Further, 42 CFR § 440.255 specifies that there must be "sudden onset" of the condition. In addition, 42 CFR § 440.255 states that Federal Medicaid funding is available to States for services provided to pregnant women if a provision is included in the approved State plan. These services include routine prenatal care, labor and delivery, and routine postpartum care.

State Emergency Medicaid Funding for Aliens

In Texas, the Texas Health and Human Services Commission (the State agency) administers the Medicaid program. Texas's State plan authorizes payments and extends coverage to (1) aliens not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law and (2) aliens granted lawful, temporary resident status. Coverage is limited, however, to care and services necessary for the treatment of an emergency medical condition (including labor and delivery). An alien granted lawful temporary resident status is restricted to emergency services during the 5-year period beginning on the date the alien is granted such status.[1]

[1]The 5-year bar applies to legal aliens who entered the United States on or after August 22, 1996, and who are not eligible for Medicaid for a period of 5 years from the date they entered the country as legal aliens.

Texas Administrative Code Rules 358.105 and 354.2103 state that to qualify for emergency Medicaid services, undocumented aliens and legal aliens restricted to emergency services must otherwise be eligible for regular Medicaid services and require emergency medical services after the sudden onset of a medical condition. The medical condition should include acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably result in (1) placing the patient's health in serious jeopardy, (2) serious impairment of bodily functions, or (3) serious dysfunction of any body part or organ.

The "Texas Medicaid Provider Procedures Manual" states that undocumented aliens and legal aliens restricted to emergency services are eligible only for emergency services, including labor and delivery. Coverage is limited to the specific dates of service of the emergency and does not include any service provided after the emergency condition has been stabilized.

The "Texas Works Handbook" states that an application for Medicaid received from an undocumented alien or legal alien restricted to emergency services cannot be processed unless the State agency has an "Emergency Medical Services Certification Form" (Form 3038) completed by the hospital or other medical services provider certifying that the person received treatment for an emergency medical condition. The Forms 3038 are maintained in the State agency's Medicaid eligibility files for each patient.

Texas also has a list of 3,987 diagnoses that it considers to be emergency medical care. Examples of these diagnoses include abdominal pain, shortness of breath, chest pains, normal delivery, and altered mental status. The State uses this list to determine whether claims are for emergency care. The State agency has an edit (00064) that determines whether the diagnosis codes on claims match the codes on its list of emergencies and denies claims that do not have emergency diagnosis codes (ERDX).

The State agency claims Federal reimbursement for emergency medical services provided to undocumented aliens and legal aliens restricted to emergency services on the "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program" (Form CMS-64). During our audit period (October 1, 2004, through September 30, 2005), the State agency processed 303,266 claims totaling approximately $314.2 million ($191.2 million Federal share) for emergency medical services provided to undocumented aliens and approximately $148,000 ($90,000 Federal share) for drugs prescribed for them. Of the $314.2 million total, approximately $218.3 million (70 percent) was for labor and delivery services.

The State agency contracts with Texas Medicaid and Healthcare Partnership (TMHP) to process and pay its Medicaid medical service claims and with First Health Services Corporation to process and pay its Medicaid prescription drug claims.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency had adequate internal controls to ensure that, for undocumented aliens and legal aliens restricted to emergency services, Federal reimbursement was claimed only for those conditions that it defined as emergency services.

Scope

We reviewed a judgmental sample of 854 medical services claims and 44 outpatient prescription drug claims totaling $949,602. During our audit period, the Federal fiscal year ended September 30, 2005, the State agency processed 303,266 claims totaling approximately $314.2 million ($191.2 million Federal share) for medical services and approximately $148,000 ($90,000 Federal share) for prescription drugs provided to undocumented aliens and legal aliens restricted to emergency services. We limited our review to the State agency's internal controls over claims for services provided to undocumented aliens and legal aliens restricted to emergency services.

We performed our fieldwork at the State agency in Austin, Texas, and at selected medical providers.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws and regulations and the State plan;
- reviewed the State agency's policies and procedures and the program instructions related to the payment of claims for emergency medical services provided to undocumented aliens and legal aliens restricted to emergency services;
- interviewed State agency personnel, selected medical providers, State Medicaid eligibility workers, and private sector workers involved with the eligibility process;
- judgmentally selected 898 claims (854 for medical services and 44 for outpatient prescription drugs) totaling $949,602;
- reviewed the Medicaid eligibility files and medical records that supported our sample claims to determine whether aliens were restricted to emergency medical services as defined by the State and whether the files contained a completed Form 3038; and
- obtained the professional opinion of the State agency Medical Director's Office medical personnel, including a physician and registered nurse, on whether selected claims for emergency services were valid based on the supporting medical records, language in section 1903(v) of the Act, and the State agency's definition of emergency services.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

The State agency did not have adequate internal controls to ensure that, for undocumented aliens and legal aliens restricted to emergency services, Federal reimbursement was claimed only for those conditions that it defined as emergency services. For the 854 medical claims we reviewed, we determined that the services contained on 629 claims totaling $679,588 met the State's definition of emergency care. However, services contained on 193 claims totaling $262,366 ($159,702 Federal share) did not meet the definition. The State agency did not have the supporting medical documentation for us to determine whether the services billed on 32 claims totaling $5,903 were for emergency care. Therefore, we are questioning 193 claims for the following reasons:

- The State agency claimed Federal reimbursement for 170 medical claims for nonemergency services totaling $165,494 ($100,736 Federal share) because edit 00064 was inadequate.

- The State agency claimed Federal reimbursement for 23 claims for nonemergency services totaling $96,872 ($58,966 Federal share). These claims were initially denied by edit 00064; however, upon appeal, the claims were paid.

The State agency claimed Federal reimbursement for 7,114 claims totaling $147,805 ($89,969 Federal share) for prescription drugs that did not meet the State's definition of emergency care.

In addition, the edit in place to prevent payment of family planning services claims for undocumented aliens and legal aliens did not always operate correctly or was manually overridden to allow services to be claimed as family planning services, which are paid at an enhanced Federal medical assistance rate of 90 percent. The State agency claimed a total of $126,178 ($113,560 Federal share) for 350 claims at the enhanced rate of 90 percent. As a result, the State agency claimed overpayments totaling at least $36,756 (Federal share).

Finally, Form 3038 was not completed for 429 of our sampled claims (48 percent) or was not a reliable indicator of whether the services provided were for emergency medical services.

UNALLOWABLE MEDICAL SERVICES CLAIMS

The State agency claimed $262,366 ($159,702 Federal share) for nonemergency services for undocumented aliens and legal aliens restricted to emergency services. Of the total, $165,494 ($100,736 Federal share) was claimed because edit 00064 did not deny nonemergency services claims and $96,872 ($58,966 Federal share) was claimed for nonemergency services claims that were initially denied by edit 00064 but paid on appeal.

Edit To Deny Nonemergency Medical Services Claims

Edit 00064 was inadequate in preventing Medicaid payments for nonemergency medical services provided to aliens restricted to emergency services for three types of claims: (1) claims for nonemergency services that included emergency diagnoses; (2) claims in which nonemergency

services were billed on the same claims as emergency services; and (3) claims containing nonemergency ancillary services.

Nonemergency Services Claims That Included Emergency Diagnoses

The State agency claimed $140,428 ($85,479 Federal share) on 79 claims for nonemergency services that included an ERDX. Edit 00064 did not deny claims containing nonemergency services when they contained at least one ERDX. For these claims, we obtained the professional opinion of the State agency's Medical Director's Office, which agreed that the claims were billed for nonemergency medical services. The following are examples of paid claims that were billed for nonemergency medical services and that had not been adjusted at the time of our review:

- A patient with cervical cancer received chemotherapy treatments at a hospital, and the provider submitted claims with diagnosis codes for chemotherapy and convulsions. The patient had a history of a seizure disorder but was not having convulsions at the time of the treatments. The diagnosis code for chemotherapy is not an ERDX, but the diagnosis code for convulsions is an ERDX. Because the diagnosis code for convulsions is an ERDX, the claims were paid. The State agency claimed $19,102 ($11,627 Federal share) for services that the patient received during several hospital stays.

- A pregnant individual was admitted to a hospital for alcohol intoxication and was released the next day. The provider submitted a claim with a diagnosis of mental disorder-antepartum, which is treated as an emergency. However, review of the medical records did not indicate that the patient had a mental disorder. The State agency claimed $357 ($217 Federal share) for the services that the patient received.

Emergency Service Claims That Included Nonemergency Services

The State agency claimed $20,380 ($12,405 Federal share) on 19 claims for patients who received emergency medical treatment and nonemergency medical treatment during the same episode of care. (The dollar figures represent only the amounts for nonemergency services.) We obtained the professional opinion of the State agency's Medical Director's Office, which determined that the patients had been seen for both emergency and nonemergency medical treatment during the same episode of care. The following example illustrates an inpatient claim containing both emergency and nonemergency services:

- A patient who had a history of convulsions, hypertension, asthma, and circulatory disease, and who had previously had a colostomy performed, arrived at a hospital experiencing abdominal pain. She remained in the hospital for 3 days and received computed tomography (CT) scans of her abdomen and pelvis. When her abdominal pain subsided, she was discharged. The inpatient claim contained diagnoses for abdominal pain, convulsions, hypertension, and a history of circulatory disease, asthma, and colostomy status. While abdominal pain was an ERDX, the other diagnoses were not. The State agency claimed $2,323 ($1,414 Federal share) for the nonemergency medical services.

Nonemergency Ancillary Services Claims

The State agency claimed $4,686 ($2,852 Federal share) on 72 claims for nonemergency ancillary services such as laboratory and radiology tests, ambulance service, and radiation therapy. The State agency allowed claims for ancillary charges to bypass edit 00064 because ancillary service providers render a service, which may or may not be related to an emergency service, rather than diagnose a condition. The State agency did not have other controls in place to determine whether the claims submitted were for emergency care. For these claims, we obtained the professional opinion of the State agency's Medical Director's Office, which determined that the medical services were for nonemergencies. The following example illustrates these types of claims:

- A patient with no acute distress was admitted to the hospital for a repeat lymph node biopsy because the results of the first biopsy were inconclusive. The patient remained in the hospital for more than 3 weeks while he had various consultations and awaited the biopsy results. The State agency claimed more than $716 ($436 Federal share) for the patient's ancillary services, which included x-rays and tissue exams. In addition, the State agency claimed $3,299 ($2,008 Federal share) for the patient's hospitalization.

Nonemergency Medical Services Claims Paid on Appeal

The State agency claimed $96,872 ($58,966 Federal share) for 23 claims that initially were denied by edit 00064, but then paid after the providers appealed. When a provider appeals a denied claim, TMHP requests documentation to determine whether the services were for an emergency. TMHP analysts follow an adjudication process to review the documentation for emergency circumstances, conditions, or symptoms; e.g., abdominal pain, shortness of breath, chest pain, fever, vomiting, diarrhea, that may not have been referenced diagnoses in a submitted claim. If the claim indicates one of these emergency conditions, TMHP processes the claim for payment. If TMHP continues to deny the claim, the provider may appeal to the State agency's Medical Director's Office.

Regarding the 23 appealed claims, we obtained the professional opinion of the State agency's Medical Director's Office, which determined that the medical services were not for emergency conditions.

The following examples illustrate claims paid based on providers' appeals:

- A paraplegic was admitted to a hospital because his personal care home refused further care and he was out of his medications. After 1 month, the hospital was able to place the patient in a new personal care home. While in the hospital, the patient received several CT scans and other physician services. The individual's only complaint while in the hospital was occasional headaches, which were relieved with Tylenol. The State agency claimed $5,534 ($3,369 Federal share) for the inpatient hospital services.

- A patient with cervical cancer received chemotherapy and radiation treatments. The State agency's Medical Director's Office determined that the claims were for cancer

treatments, which are nonemergency services. The State agency claimed $22,389 ($13,628 Federal share) for these services.

UNALLOWABLE PRESCRIPTION DRUG CLAIMS

We identified 44 claims totaling $1,744 for nonemergency drugs prescribed by one provider. We reviewed the medical records that supported the 44 claims and determined that patients were given prescription medications after they had been treated and stabilized and/or discharged from the hospital. The State agency's Medical Director's Office said that a prescription drug could not be considered necessary for an emergency if it was provided to a patient after stabilization or upon discharge. The claims were paid because the State agency did not have controls in place to prevent nonemergency drugs from being provided to undocumented aliens and legal aliens restricted to emergency services.

Based on discussions with the State regarding the 44 prescription drug claims, we determined that all of the prescription drug claims identified during our audit period were outpatient claims and that the drugs did not meet the State's definition of emergency care because they were provided to patients after they had been treated and stabilized and/or discharged from the hospital. Drugs provided during emergency care are billed on inpatient claims. As a result, the State agency inappropriately claimed a total of $147,805 ($89,969 Federal share) for 7,114 prescription drug claims.

CLAIMS IMPROPERLY PAID AT THE ENHANCED FEDERAL RATE FOR FAMILY PLANNING SERVICES

Medicaid pays for family planning services at an enhanced Federal medical assistance rate of 90 percent rather than the standard rate of 60.87 percent. However, undocumented aliens and legal aliens are not eligible for family planning services or the enhanced rate that is paid for these services. TMHP has an edit (00008) in place to prevent the payment of family planning services claims for undocumented aliens and legal aliens. This edit did not always operate correctly or was manually overridden to allow services to be claimed as family planning services. As a result, the State agency claimed family planning services at the enhanced medical assistance rate of 90 percent and received $126,178 ($113,560 Federal share) for 350 claims.

We did not review the medical records supporting these claims to determine whether the services provided were related to family planning, and therefore not reimbursable. We also did not determine whether the services qualified as emergencies but were incorrectly coded as family planning. If these services were for nonemergencies, they were ineligible for reimbursement. At most, these services should have been claimed at the medical assistance rate of 60.87 percent, or $76,805 (Federal share). Therefore, the State claimed overpayments totaling at least $36,756 (Federal share), which is the difference between the enhanced rate of 90 percent and the applicable rate of 60.87 percent. TMHP stated that it would review its policies and procedures and make any necessary changes to prevent payment for family planning services for undocumented aliens and legal aliens.

EMERGENCY MEDICAL SERVICES CERTIFICATION FORM 3038

The State agency requires providers to submit Form 3038 for all emergency medical services provided to undocumented aliens and legal aliens restricted to emergency services prior to establishing eligibility for emergency Medicaid. The State agency requires that Form 3038 include the date(s) that emergency medical services were provided and the signature of the attending physician or other designated medical personnel, certifying that the patient was treated for an emergency condition. The "Texas Medicaid Provider Procedures Manual" states that coverage is limited to the specific dates of service of the emergency; any service provided after the emergency condition is stabilized is not payable.

Of the 898 claims in our sample, Form 3038 was not completed for 429 claims (48 percent). However, we determined that 290 were for allowable emergency services. Of the 469 claims supported by a Form 3038, 92 were for nonemergency services.

State agency eligibility personnel and medical providers said that they knew of instances in which providers presigned blank Forms 3038 and provided us with a copy of a presigned form. Additionally, the individuals who signed the Forms 3038 were not always the individuals who treated the patients and did not always review the medical records to verify that the patients had received emergency medical services. The individuals who prepared the forms sometimes verified only that the patients had received some type of care on the date certified on the forms. Therefore, the Forms 3038 were not a reliable indicator of whether the services provided were for emergency services.

Under a new policy implemented during our review, the State agency samples, on a quarterly basis, claims paid for emergency services provided to aliens to ensure that providers completed a Form 3038 and that the forms are maintained properly and can be easily accessed for review.

RECOMMENDATIONS

We recommend that the State agency:

- adjust the "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program" (Form CMS-64) for the $159,702 (Federal share) claimed for services that did not meet the State's definition of emergency care;

- ensure that officials responsible for reviewing appealed claims for the emergency Medicaid program are familiar with Federal and State requirements and have medical backgrounds to determine whether claims are for emergency medical treatment;

- adjust the Form CMS-64 for the $89,969 (Federal share) claimed for unallowable prescription drugs and for any additional Federal funds paid for prescriptions filled prior and subsequent to our audit period;

- adjust the Form CMS-64 for the $36,756 (Federal share) for the 350 claims improperly paid at the enhanced Federal medical assistance percentage rate for family planning services, review the claims to determine whether the services provided were for

nonemergencies, and make any additional adjustments as necessary;

- require medical personnel to review medical records prior to certifying on Form 3038 that emergency medical treatment was provided and ensure that the certified dates are limited to the specific dates of the emergency;

- strengthen its policies and procedures, including developing edits, to prevent Medicaid payments for nonemergency services provided to aliens; and

- periodically sample and review claims paid for emergency medical services provided to aliens and refund any payments made in error.

STATE AGENCY COMMENTS

In its comments on our draft report, the State agency said that it will take corrective action for each of the recommendations and analyze the claims identified in the report for services that reportedly did not meet the definition of emergency care and refund the Federal share. The State agency's comments are included in their entirety as the Appendix.

APPENDIX

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

August 13, 2009

Mr. Gordon L. Sato
Regional Inspector General for Audit Services
Office of Inspector General, Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

Re: Report Number A-06-07-00108

Dear Mr. Sato:

The Texas Health and Human Services Commission (HHSC) received a draft audit report entitled "Medicaid Payments Made for Nonemergency Services Provided to Undocumented Aliens and Legal Aliens Restricted to Emergency Services in Texas" from the Department of Health and Human Services Office of Inspector General. The cover letter, dated July 1, 2009, requested that HHSC provide written comments, including the status of actions taken or planned in response to the report recommendations.

The report identified recommendations for HHSC to consider regarding Medicaid services provided to undocumented and legal aliens restricted to receiving emergency services. These recommendations address:

- Refunding $286,427, representing the federal share of medical and prescription services that were not eligible for emergency Medicaid coverage.
- Strengthening policies and processes for reviewing appealed claims.
- Reviewing family planning claims to determine whether the services provided were for nonemergencies, and make adjustments as necessary.
- Requiring medical providers to review medical records prior to certifying a service as an emergency.
- Strengthening policies and procedures, including developing system edits, to prevent Medicaid payments for nonemergency services provided to aliens.
- Periodically reviewing emergency claims to ensure they are paid appropriately.

Actions HHSC has completed or planned to address the recommendations contained in the report are described in the management responses below.

DHHS/OIG Recommendation: *We recommend that the State agency adjust the "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program" (Form CMS-64) for the $159,702 (Federal share) claimed for services that did not meet the State's definition of emergency care.*

HHSC Management Response

Actions Planned:

HHSC will conduct an analysis of the claims identified in the audit for services that reportedly did not meet the definition of emergency services. Once completed, HHSC will refund the federal share of claims that did not meet the definition of an emergency service.

In addition, HHSC will direct the Medicaid claims administrator to conduct a thorough review of the claims processing edits and the provider appeals processes. Once completed, action will be taken to strengthen claims processing edits and appeal processes to prevent the payment for nonemergency services by the emergency Medicaid program.

Estimated Completion Date: August 2009 – Completion of claims analysis and refunds.
September 2009 – Implementation of appeal process changes.
November 2009 - implementation of claims processing changes.

Title of Responsible Person: Deputy Director, Medicaid-CHIP Claims Administrator Operations

DHHS/OIG Recommendation: *We recommend that the State agency ensure that officials responsible for reviewing appealed claims for emergency Medicaid program are familiar with Federal and State requirements and have medical backgrounds to determine whether claims are for emergency medical treatment.*

HHSC Management Response

Actions Planned:

HHSC will direct the Medicaid claims administrator to conduct a thorough review of the policies and procedures and staffing assigned to review provider appeals that involve denied claims that did not meet the definition of an emergency service. Once completed, HHSC will direct the Medicaid claims administrator and oversee implementation of process improvements to ensure only claims that met the definition of an emergency service are paid through the provider appeals process.

Estimated Completion Date: August 2009 – initiation of appeals process review; September 2009 – implementation of appeal process improvements.

Title of Responsible Person: Deputy Director, Medicaid-CHIP Claims Administrator Operations

DHHS/OIG Recommendation: *We recommend that the State agency adjust the Form CMS-64 for the $89,969 (Federal share) claimed for unallowable prescription drugs and for any additional Federal funds paid for prescriptions filled prior and subsequent to our audit.*

HHSC Management Response

HHSC reviewed a sample of 500 prescription drug claims provided by the auditors to understand and evaluate the types of outpatient drugs that were prescribed to patients who were eligible for services through the emergency Medicaid program. The prescription claims were predominately for drugs that would be used in association with the care of an emergency condition, including emergency labor and delivery. The review highlighted that the prescriptions were written primarily by hospital-based physicians and filled at hospital pharmacies for clients directly after their discharge from the hospital.

Although the paid pharmacy claims would be considered routine care following treatment for an emergency condition, they were not part of the emergency treatment itself. Prior to this audit these outpatient pharmacy claims were not recognized as being out of compliance with the Medicaid state plan and therefore not eligible for federal reimbursement. Accordingly, HHSC has provided no education or guidance to prescribers and pharmacies to inform them that undocumented aliens and legal aliens are not eligible for outpatient prescription drug services, at the conclusion of an emergency episode.

Actions Planned:

HHSC will work with CMS to review claims for unallowable prescription drugs and identify any additional federal funds paid for prescriptions filled prior and subsequent to the audit period.

In order to prevent future pharmacy reimbursement for outpatient pharmacy claims for emergency Medicaid recipients, HHSC will work with the pharmacy claims and rebate administrator to implement system changes to prevent the payment of outpatient pharmacy claims by the emergency Medicaid program.

HHSC will also educate hospital-based prescribers and pharmacists that outpatient prescriptions are not reimbursable through the emergency Medicaid program.

Estimated Completion Date: No later than 60 days after agreement is reached with CMS regarding any ineligible expenditures.
February 2010 – Implementation system changes.
January 2010 – Notifications to hospital-based prescribers and pharmacists.

Title of Responsible Person: Deputy Director, Medicaid-CHIP Vendor Drug Program

DHHS/OIG Recommendation: *We recommend that the State agency adjust the Form CMS-64 for the $36,756 (Federal share) for the 350 claims improperly paid at the Federal medical assistance percentage rate for family planning services, review the claims to determine whether services provided were for nonemergencies and make any additional adjustments as necessary.*

HHSC Management Response

Actions Planned:

HHSC will direct the Medicaid claims administrator to conduct an analysis and determine whether family planning services identified by the auditors were paid at the appropriate federal medical assistance percentage (FMAP) and whether the services provided were for nonemergency services. Upon completion of the analyses, and if applicable, HHSC will take steps to ensure claims are paid at the appropriate FMAP and make any necessary adjustments to the CMS-64.

Estimated Completion Date: September 2009

Title of Responsible Person: Deputy Director, Medicaid-CHIP Claims Administrator Operations

DHHS/OIG Recommendation: *We recommend that the State agency require medical personnel to review medical records prior to certifying on Form 3038 that emergency medical treatment was provided and ensure that the certified dates are limited to the specific dates of the emergency.*

HHSC Management Response

Actions Planned:

HHSC implemented changes to Form 3038 instructions in November 2008 to clarify who is required to complete the form. In addition, the Form 3038 signature attestation language will be updated to reinforce that the medical practitioner signing has reviewed the patient's medical records and the dates the patient was treated were for an emergency, as defined by the Texas Medicaid Program.

As mentioned in the report, HHSC implemented a quarterly review process to ensure Form 3038 are maintained to support eligibility determinations. As part of this review process, HHSC verifies the patients eligibility for emergency Medicaid is limited to the date the emergency condition began and ends with the date the patient's condition has stabilized as documented on the Form 3038. HHSC has completed three quarterly reviews with the results indicating the Form 3038 is available to support eligibility determinations. HHSC will continue to review Form 3038s on a quarterly basis.

Estimated Completion Date: October 2009 – Form 3038 certification language changes.

Title of Responsible Person: Director of Texas Works Policy, Office of Family Services
Director of Centralized Operations, Office of Eligibility Services

DHHS/OIG Recommendation: *We recommend that the State agency strengthen its policies and procedures, including developing edits, to prevent Medicaid payments for nonemergency services provided to aliens.*

HHSC Management Response

As previously discussed, HHSC will take steps to strengthen applicable policies and procedures, including developing and enhancing claims processing edits to prevent payments for nonemergency services by the emergency Medicaid program.

DHHS/OIG Recommendation: *We recommend that the State agency periodically sample and review claims paid for emergency medical services provided to aliens and refund any payments made in error.*

HHSC Management Response

Actions Planned:

HHSC will direct the Medicaid claims administrator to conduct quality assurance reviews by clinical staff to ensure claims paid by the emergency Medicaid program are for only emergency services. HHSC will monitor these quality assurance activities to ensure claims are paid appropriately and for only emergency services.

Estimated Completion Date: October 2009

Title of Responsible Person: Deputy Director, Medicaid-CHIP Claims Administrator Operations

Please let me know if you have questions or need additional information. Mr. David M. Griffith, HHSC Internal Audit Director, serves as the lead staff on this matter and may be reached at may be reached by telephone at (512) 424-6998 or by e-mail at David.Griffith@hhsc.state.tx.us.

Sincerely,

Albert Hawkins