

**Memorandum**Date
From
SubjectDEC 10 2001
Thomas D. Roslewicz
Thomas D. Roslewicz
Deputy Inspector General
for Audit ServicesTo
Review of Texas-Medicaid Claims for 21 to 64 Year Old Residents of Institutions for
Mental Diseases Who Were Temporarily Released to Acute Care Hospitals
(A-06-00-00074)Neil Donovan
Director, Audit Liaison Staff
Centers for Medicare & Medicaid Services

This memorandum is to alert you to the issuance on **December 13, 2001**, of the subject audit report. A copy of the report is attached. 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. This report is one of a series of reports in our nationwide initiative focusing on Federal reimbursement for medical care provided to residents of institutions for mental diseases (IMD).

The objective of our review was to determine if controls were in place to effectively preclude the Texas Department of Health (State Agency) from claiming Federal financial participation (FFP) under the Medicaid program for 21 to 64 year old residents at nine State-operated psychiatric hospitals (State hospitals) that are IMDs. The review focused on fee-for-service reimbursement for individuals who were temporarily released to acute care hospitals for medical treatment.

Our review found that, for the period September 1, 1997 through August 31, 2000, the State Agency improperly claimed FFP of \$424,838 for IMD residents between the ages of 21 to 64 who were temporarily released from State hospitals to general acute care hospitals for medical treatment. We recommended that the State Agency: (1) refund \$424,838 to the Federal Government for the FFP improperly claimed; (2) cease claiming FFP for clients between the ages of 22 to 64 and for those aged 21 at admission when these clients are temporarily released from State hospitals to general acute care hospitals for medical treatment; and (3) develop controls or edits within its Medicaid Management Information System to detect and prevent claims for FFP for clients between the ages of 22 to 64 and for those aged 21 at admission who are temporarily released from State hospitals to general acute care hospitals for medical treatment.

Page 2 – Neil Donovan

The State Agency agreed with our recommendations and has begun efforts to detect and prevent FFP from being claimed for IMD clients between the ages of 21 to 64 who are temporarily released to acute care facilities for medical care.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for Health Care Financing 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 and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF TEXAS MEDICAID CLAIMS
FOR 21 TO 64 YEAR OLD RESIDENTS OF
INSTITUTIONS FOR MENTAL DISEASES
WHO WERE TEMPORARILY RELEASED
TO ACUTE CARE HOSPITALS**



**JANET REHNQUIST
INSPECTOR GENERAL**

DECEMBER 2001

A-06-00-00074



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 6B6
Dallas, TX 75242

Common Identification Number: A-06-00-00074

Mr. Don A. Gilbert
Commissioner
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 Texas Medicaid Claims for 21 to 64 Year Old Residents of Institutions for Mental Diseases Who Were Temporarily Released to Acute Care Hospitals." 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. 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, 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://www.oig.hhs.gov>.

To facilitate identification, please refer to common identification number A-06-00-00074 in all correspondence relating to this report.

Sincerely,

A handwritten signature in black ink that reads "Gordon L. Sato".

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures - as stated

Page 2 – Mr. Don A. Gilbert

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

EXECUTIVE SUMMARY

Background

Federal 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 during a temporary release to an acute care facility for medical treatment, the clients retain their IMD status and, as such, FFP claims for aged 21 to 64 year old clients would not be allowable.

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 were temporarily released to acute care hospitals for medical treatment.

Summary of Findings

The TDH improperly claimed FFP for clients between the ages of 21 to 64 who were temporarily released from State hospitals, which the Texas Department of Mental Health and Mental Retardation (MHMR) identified as IMDs, to acute care hospitals for medical treatment.

The TDH officials disclosed 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 who were temporarily released to acute care facilities for medical care. The NHIC is the MMIS fiscal agent for the Medicaid program and has administered the program since 1977. While MHMR had some controls in place to preclude claiming FFP on behalf of 21 to 64 year old residents of IMDs, they were not always effective.

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 were temporarily released from State hospitals to general acute care hospitals for medical treatment. As a result,

FFP totaling \$424,838 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 the Texas Health and Human Services Commission (HHSC) ensure that TDH:

1. Refund \$424,838 to the Federal Government for the FFP improperly claimed during the period September 1, 1997 through August 31, 2000.
2. Cease claiming FFP for clients between the ages of 22 to 64 and for those aged 21 at admission when these clients are temporarily released from State hospitals to general acute care hospitals for medical treatment.
3. 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 are temporarily released from State hospitals to general acute care hospitals for medical treatment.

Auditee's Comments

In response to our draft report, the HHSC stated that it had begun efforts to detect and prevent FFP from being claimed for IMD clients between the ages of 21 and 64 who are temporarily released to acute care facilities for medical care. The HHSC will be working with TDH to explore methods of establishing an identifier on the enrollment data file to tag these individual's living arrangement. The HHSC will also be working with MHMR in looking at all avenues for reporting IMD admissions, temporary releases, and discharges of individuals aged 21 to 64. The HHSC indicated that it will instruct NHIC to deny claims for medical services for individuals who are on temporary release as they are identified. Lastly, HHSC will undertake a recoupment process to recover funds.

OIG's Response

The HHSC generally agreed with our recommendations and stated that it would recover payments made for services provided to 21 to 64 year old IMD residents temporarily released to acute care hospitals. 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 should be refunded to the Federal Government irrespective of whether or not payments are recouped from providers. The full text of the HHSC's comments is included as **Appendix D**.

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Appendix A-

LIST OF THE NINE STATE HOSPITALS INCLUDED IN OUR AUDIT

Appendix B

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.

Appendix C

THREE EXAMPLES THAT DEMONSTRATE IMPROPER CLAIMING OF FEDERAL FINANCIAL PARTICIPATON

Appendix D-

AUDITEE'S COMMENTS TO DRAFT REPORT

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) provided 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 Health 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. In clarifying guidance, CMS made it clear that during a temporary release to an acute care facility for medical treatment, the clients retain their IMD status and, as such, FFP claims for aged 21 to 64 year old clients would not be allowable.

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 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 . . .”

The CMS’s consistent interpretation has been that the release of patients to acute care hospitals does not qualify as either conditional release or convalescent leave. In addition to these regulations, our research identified the following documents which provide specific clarifications concerning the propriety of a State claiming FFP when an IMD client between the ages of 21 to 64 years old is temporarily transferred to an acute care facility for medical treatment. These documents show that CMS clarified its applicable regulations to all States in November 1990. Further notifications on this issue were also distributed by CMS.

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 IMD Exclusion, 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 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.

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 that were temporarily released to acute care hospitals for medical treatment.

The audit period was from September 1, 1997 through August 31, 2000. The review focused on nine State hospitals that MHMR identified as IMDs and was limited to inpatient acute care hospital 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, one State hospital, and CMS. In addition, we reviewed applicable policies and procedures relevant to our audit.

Audit field work was performed at MHMR, TDH, and at one of the nine State hospitals during the period September 2000 through March 2001.

FINDINGS AND RECOMMENDATIONS

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 were temporarily released from State hospitals to general acute care hospitals for medical treatment. The claiming of FFP for these clients was contrary to Federal regulations and clarifying guidance issued by CMS. As a result, FFP totaling \$424,838 was improperly claimed. (See **Appendix B** for a summary of the total Medicaid amounts claimed and FFP amounts improperly claimed at the nine State hospitals.)

On-Site Visit

As part of our review, we conducted a site visit to one of the nine State hospitals to determine whether TDH was claiming FFP for 21 to 64 year old residents who were temporarily released to general acute care hospitals for medical treatment. During our visit, we obtained information that showed every patient admitted to that IMD during our audit period. In addition, hospital officials identified whether those patients were Medicaid eligible upon admission to the IMD, if they ever received treatment outside of the IMD at any time during their stay, and who was responsible for the payment of the services received. When a resident was in need of medical services unavailable at the IMD, an internal *Request For Authorization For Medical, Diagnostic, or Surgical Services* form was completed and sent with the resident to the outside provider. This authorization form specifically stated who was responsible for the payment of the services received by the resident. During our visit, we chose a judgmental sample of 10 residents who had received outside medical treatment during their stay at the IMD, reviewed their case files, and had TDH run a Medicaid payment history during the time they were a resident of the IMD. From this sample, Medicaid was billed for the inpatient services received by two residents. The authorization form for the two residents stated that either Medicare or the IMD itself was responsible for payment, however, in both instances, Medicaid was billed for the services.

Analysis of Medicaid Eligible Individuals At All Nine State Hospitals

Since we had evidence to support that TDH had billed Medicaid for 21 to 64 year old residents of an IMD, we requested and obtained from MHMR a complete listing of Medicaid eligible individuals for this age group residing in State hospitals during our audit period. This listing contained both admission and discharge dates from the IMDs. From this listing, HHSC extracted Medicaid payments for inpatient acute care on behalf of individuals residing in an IMD at the time of the inpatient claim.

After receiving the payment history from HHSC, we obtained a patient movement file from MHMR. The patient movement files were used to verify that the residents under review were residents of the State hospitals prior to and after their acute care hospital stays and to verify their inpatient medical stays at the acute care hospitals. In addition, this file showed when IMD patients were on conditional or convalescent leave. We then removed any individuals from our universe of questioned costs that were on either of these two types of leave at the time of their acute care hospital stay.

After verifying that each individual in our universe was an IMD resident both prior to and after their acute care hospital stay, we calculated the improper FFP that had been claimed for inpatient acute care services during the period September 1, 1997 through August 31, 2000. At 8 of the 9 IMDs in our review, we determined that FFP totaling \$424,838 had been improperly claimed for 112 individuals. **Appendix B** of our report provides a summary of the total Medicaid amounts claimed and the Federal share amounts improperly claimed at each of the State hospitals.

Lack of System Edits

The TDH officials disclosed that there were neither edits nor mechanisms within NHIC's MMIS to detect and prevent FFP from being claimed for IMD clients between the ages of 21 to 64 who were temporarily released to acute care facilities for medical care.

However, MHMR had some controls in place to preclude FFP from being claimed for this population. The MHMR officials informed us that they had 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 at an acute care hospital, would send a form that requested the medical care and instructed the acute care hospital to bill the IMD for the medical services. However, even though these controls were in place, they were not always effective.

We developed the following two examples which provide details on the claiming of FFP for ineligible clients. Additional examples are included in **Appendix C**.

Example 1

We reviewed the patient movement file and Medicaid payments for a client in his late 40's at Austin State Hospital (ASH). The records showed that he was temporarily transferred to Brackenridge Hospital for treatment of abnormally low blood pressure. The authorization for medical services outside of the State hospital clearly stated that ASH was to be billed for all services. The temporary release occurred December 29, 1998 through January 2, 1999. The client was not discharged from ASH prior to the acute care stay and he returned to the IMD once his inpatient hospital stay was over. This client would still be considered a resident of ASH and, therefore, the related medical services rendered by the acute care facility would not be eligible for Federal reimbursement. Below is the hospital claim for which TDH claimed FFP.

SERVICE DATES	CLIENT TEMPORARILY	
<u>CLAIMED FOR FFP</u>	<u>RELEASED TO:</u>	<u>FFP PAID</u>
12/29/98-01/02/99	Brackenridge Hospital	\$4,892

Example 2

A resident of San Antonio State Hospital (SASH) in her 50's was transferred to Baptist Medical Center on three separate occasions beginning August 13, 1998 through September 4, 1998 for medical treatment. The client was not discharged from SASH prior to being released for medical treatment and she returned to the IMD after each of her acute care stays were over. This client would still be considered a resident of SASH and, therefore, the related medical services would not be eligible for Federal reimbursement. Below are the hospital claims for which TDH claimed FFP.

<u>SERVICE DATES</u> <u>CLAIMED FOR FFP</u>	<u>CLIENT TEMPORARILY</u> <u>RELEASED TO:</u>	<u>FFP PAID</u>
8/13/98-8/15/98	Baptist Medical Center	\$ 7,910
8/16/98-8/21/98	Baptist Medical Center	3,326
9/1/98-9/4/98	Baptist Medical Center	<u>10,437</u>
	TOTAL	<u>\$21,673</u>

We believe that the two examples above and the examples in **Appendix C** provide evidence that TDH did not have edits or mechanisms within their MMIS system to detect and prevent FFP from being claimed on inpatient acute care hospital claims for IMD clients aged 22 to 64 and those aged 21 at admission who were temporarily transferred from an IMD.

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 were temporarily released from State hospitals to general acute care hospitals for medical treatment. As a result, FFP totaling \$424,838 was improperly claimed.

RECOMMENDATIONS

We recommended that HHSC ensure that TDH:

1. Refund \$424,838 to the Federal Government for the FFP improperly claimed during the period September 1, 1997 through August 31, 2000.
2. Cease claiming FFP for clients between the ages of 22 to 64 and for those aged 21 at admission when these clients are temporarily released from State hospitals to general acute care hospitals for medical treatment.
3. 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 are temporarily released from State hospitals to general acute care hospitals for medical treatment.

AUDITEE'S COMMENTS

In response to our draft report, the HHSC stated that it had begun efforts to detect and prevent FFP from being claimed for IMD clients between the ages of 21 and 64 who are temporarily released to acute care facilities for medical care. The HHSC will be working with TDH to explore methods of establishing an identifier on the enrollment data file to tag these individual's living arrangement. The HHSC will also be working with MHMR

in looking at all avenues for reporting IMD admissions, temporary releases, and discharges of individuals aged 21 to 64. The HHSC indicated that it will instruct NHIC to deny claims for medical services for individuals who are on temporary release as they are identified. Lastly, HHSC will undertake a recoupment process to recover funds.

OIG'S RESPONSE

The HHSC generally agreed with our recommendations and stated that it would recover payments made for services provided to 21 to 64 year old IMD residents temporarily released to acute care hospitals. The objective of 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 should be refunded to the Federal Government irrespective of whether or not payments are recouped from providers. The full text of the HHSC's comments is included as **Appendix D**.

**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

Appendix B

**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**

<u>State Hospital</u>	<u>Number of Recipients</u>	<u>Total Medicaid Claimed</u>	<u>FFP Improperly Claimed</u>
Austin	16	\$ 78,440	\$ 48,685
Big Spring	13	122, 512	76,446
Kerrville	3	18,394	11,317
North Texas	0	0	0
Rusk	33	167,190	103,902
San Antonio	22	173,567	107,816
Terrell	22	107,813	66,704
Rio Grande	2	10,967	6,830
El Paso	<u>1</u>	<u>5,039</u>	<u>3,138</u>
Totals:	<u>112</u>	<u>\$683,922</u>	<u>\$424,838</u>

**THREE EXAMPLES THAT DEMONSTRATE IMPROPER
CLAIMING OF FEDERAL FINANCIAL PARTICIPATION**

Example 1

We reviewed the patient movement file and Medicaid payments for a client in his 30's who was a resident of San Antonio State Hospital (SASH). During August 1998, he was transferred to Baptist Medical Center for treatment of acute respiratory failure. The client was not discharged from SASH prior to the acute care stay and he returned to the IMD once his inpatient hospital stay was over. This client would still be considered a resident of SASH and, therefore, the related medical services would not be eligible for Federal reimbursement. Below is the hospital claim for which TDH claimed FFP.

SERVICE DATES	CLIENT TEMPORARILY	
<u>CLAIMED FOR FFP</u>	<u>RELEASED TO:</u>	<u>FFP PAID</u>
8/20/98-8/24/98	Baptist Medical Center	\$ 14,713

Example 2

A client at Austin State Hospital (ASH) in her 40's was transferred to Brackenridge Hospital for treatment of pneumonia from April 23, 2000 through April 27, 2000. The authorization for medical services outside of the State hospital clearly states that ASH is to be billed for all services. The client was not discharged prior to being temporarily released for medical treatment and returned to the IMD once her inpatient hospital stay was over. This client would still be considered a resident of ASH and, therefore, the related medical service would not be eligible for Federal reimbursement. Below is the hospital claim for which TDH claimed FFP.

SERVICE DATES	CLIENT TEMPORARILY	
<u>CLAIMED FOR FFP</u>	<u>RELEASED TO:</u>	<u>FFP PAID</u>
4/23/00-4/27/00	Brackenridge Hospital	\$5,709

Example 3

We reviewed the patient movement file and Medicaid payments for a client in her 20's who was a resident of ASH. She was transferred to St. David's Hospital from 01/29/98 through 02/04/98. The client was not discharged from ASH prior to her acute care stay and she returned to the IMD once her inpatient hospital stay was over. This client would still be considered a resident of ASH and, therefore, the related medical service would not be eligible for Federal reimbursement. Below is the hospital claim for which TDH claimed FFP.

SERVICE DATES
CLAIMED FOR FFP
01/29/98-02/04/98

CLIENT TEMPORARILY
RELEASED TO:
St. David's Hospital

FFP PAID
\$ 5,842



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

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

September 21, 2001

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

Dear Mr. Sato:

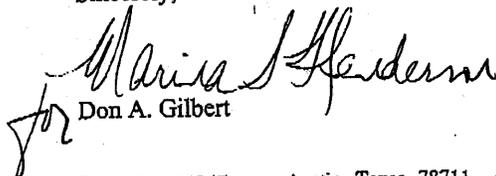
This is in response to your letter dated August 17, 2001 regarding U.S. Department of Health and Human Services, Office of Inspector General's draft letter report entitled "Review of Medicaid Claims Made for Aged 21 to 64 Year Old Residents of Institutions for Mental Diseases".

Through our participation in this review we became aware of this issue and have begun efforts to detect and prevent FFP from being claimed for IMD clients between the ages of 21 and 64 who are temporarily released to acute care facilities for medical care. As the Texas Department of Human Services determines eligibility, we will be working with them to explore methods of establishing an identifier on the enrollment data file that can tag these individual's living arrangement. We will also be working with the Texas Department of Mental Health and Mental Retardation (TDMHMR) in looking at all possible avenues for reporting of IMD admissions, temporary releases, and discharges of individuals aged 21 to 64. As that work is undertaken, we will instruct the Texas claims administrator for the Texas Medicaid program, National Heritage Insurance Company (NHIC) to deny claims for medical services to these individuals who are on temporary release, as they are identified.

As the directives to the medical facilities by TDMHMR did not prove to be adequate to prevent FFP from being claimed and thus paid to medical facilities, the Texas Health and Human Service Commission (HHSC) will undertake a recoupment process to recover these funds.

If you have any questions please contact Ron Gemsbacher, Benefits Manager, HHSC, at (512) 338-6509.

Sincerely,


Don A. Gilbert