Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# OKLAHOMA IMPROPERLY CLAIMED FEDERAL REIMBURSEMENT FOR MOST REVIEWED MEDICAID INPATIENT PSYCHIATRIC HOSPITAL SERVICE AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS TO CHILDREN'S RECOVERY CENTER

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


Gloria L. Jarmon
Deputy Inspector General

March 2013
A-05-12-00052

# *Office of Inspector General*

https://oig.hhs.gov

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

## *Office of Audit Services*

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

## *Office of Evaluation and Inspections*

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

## *Office of Investigations*

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

## *Office of Counsel to the Inspector General*

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

# *Notices*

## THIS REPORT IS AVAILABLE TO THE PUBLIC

at https://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

## 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

### Medicaid Program

Pursuant to Title XIX of the Social Security 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.

### Oklahoma Medicaid Program

The Oklahoma Health Care Authority (the State agency) administers the Oklahoma Medicaid program according to the CMS-approved State plan. The State agency makes Medicaid payments to eligible hospitals and claims Federal reimbursement for a portion of such payments. Children's Recovery Center of Oklahoma (CRCO), a State-owned institution for mental diseases and psychiatric hospital, provides inpatient psychiatric services primarily to adolescents and children with serious emotional disturbances. During the audit period, January 1, 2006, through December 31, 2010, CRCO participated in the Medicaid, but not the Medicare, program.

### Federal Requirements for Inpatient Psychiatric Hospital Services

For States to claim Federal reimbursement for their Medicaid inpatient psychiatric service and disproportionate share hospital (DSH) payments to a psychiatric hospital, the hospital's inpatient services must meet the Federal definition of such services. This definition requires the provider to demonstrate compliance with the basic Medicare Conditions of Participation (CoP) generally applicable to all hospitals and two special Medicare CoP applicable to psychiatric hospitals. The basic Medicare CoP address issues such as licensing, quality of care, safety, patient rights, self assessment and performance improvement, and service availability. The special Medicare CoP specify staffing and medical record requirements.

A psychiatric hospital must undergo review by qualified health care professionals to demonstrate compliance with the basic and special Medicare CoP. Such review provides CMS with reasonable assurance that participating facilities are improving the health and protecting the safety of Medicaid beneficiaries. For periods that a psychiatric hospital does not demonstrate compliance with the basic and special Medicare CoP, all Medicaid inpatient psychiatric service and DSH payments received from the State agency are ineligible for Federal reimbursement.

CMS made a technical error when it issued Medicare transplant center CoP regulations in 2007. Effective June 28, 2007, it inadvertently omitted certain Medicare psychiatric hospital CoP regulations that were relevant to this audit. CMS formally reinstated the omitted regulations

effective October 26, 2007. Despite the omission, CMS's implementing guidance remained in effect from June 28 through October 25, 2007 (the regulatory gap period).

## OBJECTIVE

Our objective was to determine whether the State agency claimed Federal reimbursement for Medicaid inpatient psychiatric service and DSH payments made to CRCO in accordance with certain Federal requirements for inpatient psychiatric hospital services.

## SUMMARY OF FINDING

Most State agency claims for Federal reimbursement for Medicaid inpatient psychiatric service and DSH payments made to CRCO were not in accordance with Federal requirements for inpatient psychiatric hospital services because CRCO did not demonstrate compliance with the basic or special Medicare CoP from January 1, 2006, through December 31, 2010. Therefore, of the $6,675,543 claimed during that period, the amount of $6,209,502 that was for claims with dates of service outside the regulatory gap period was not allowable. We have not provided an opinion on the allowability of State agency claims for the remaining $466,041, which was for claims with dates of service during the regulatory gap period. The State agency claimed the $6,675,543 because it believed that CRCO had met all requirements to be eligible for Medicaid inpatient psychiatric service and DSH payments.

## RECOMMENDATIONS

We recommend that the State agency:

- refund $6,209,502 to the Federal Government for its share of Medicaid inpatient psychiatric service and DSH payments made to CRCO for claims with dates of service outside the regulatory gap period,

- work with CMS to determine whether the State agency should refund an additional $466,041 to the Federal Government for its share of payments made to CRCO for claims with dates of service during the regulatory gap period,

- identify and refund the Federal share of any additional payments made to CRCO for claims with dates of service after the audit period if neither the State agency nor CRCO can demonstrate the hospital's compliance with Federal requirements for inpatient psychiatric hospital services, and

- ensure that Federal reimbursement for Medicaid inpatient psychiatric service and DSH payments to psychiatric hospitals is claimed only if those hospitals can demonstrate compliance with the basic and special Medicare CoP.

## STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency concurred with three of our four recommendations. The State agency agreed with our first recommendation—it will work with CMS to refund $6,209,502 for the Federal share of Medicaid inpatient psychiatric services and DSH payments made to CRCO for claims with dates of service outside the regulatory gap period. The State agency did not concur with our second recommendation that it should be responsible for refunding payments with dates of service during the regulatory gap period. As to our third recommendation, the State agency identified an additional $292,811 in DSH payments that were made after the audit period; it will work with CMS to make an adjustment for this overpayment. The State agency also agreed with our fourth recommendation—it has implemented procedures within its provider enrollment division to ensure that all hospitals have the certifications required for Medicaid reimbursement.

We maintain our second recommendation that the State agency should present its position to and work with CMS to determine whether it should refund payments made to CRCO for claims with dates of service during the regulatory gap period.

## TABLE OF CONTENTS

# INTRODUCTION

## BACKGROUND

### 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.

### Oklahoma Medicaid Program

The Oklahoma Health Care Authority (the State agency) administers the Oklahoma Medicaid program according to the CMS-approved State plan. The State agency makes Medicaid payments to eligible hospitals and claims Federal reimbursement for a portion of such payments. Children's Recovery Center of Oklahoma (CRCO), a State-owned institution for mental diseases (IMD) and psychiatric hospital, provides inpatient psychiatric services primarily to adolescents and children with serious emotional disturbances. During the audit period, January 1, 2006, through December 31, 2010, CRCO participated in the Medicaid, but not the Medicare, program.

### Federal Requirements for Inpatient Psychiatric Hospital Services

For States to claim Federal reimbursement for their Medicaid inpatient psychiatric service and disproportionate share hospital (DSH)[1] payments to a psychiatric hospital, the hospital's inpatient services must meet the Federal definition of such services. This definition requires the provider to demonstrate compliance with the basic Medicare Conditions of Participation (CoP) generally applicable to all hospitals and two special Medicare CoP applicable to psychiatric hospitals.

*Medicaid Payments*

Pursuant to section 1903(a)(1) of the Act, States can claim Federal reimbursement for a portion of their Medicaid medical assistance and DSH payments. For patients in IMDs, a category that generally includes psychiatric hospitals, medical assistance includes inpatient hospital services for individuals aged 65 or older but excludes care or services for younger individuals except for inpatient psychiatric hospital services for individuals under age 21 (section 1905(a) of the Act).[2]

[1] Pursuant to section 1923 of the Act, certain hospitals are eligible for special payments, known as DSH payments. To receive DSH payments, hospitals must serve a disproportionately large share of low-income and/or uninsured patients and meet other Federal and State requirements. The payments compensate the hospitals for their uncompensated costs of providing hospital services to such patients.

[2] Pursuant to 42 CFR § 441.151(a)(3), medical assistance also includes necessary inpatient psychiatric hospital services for individuals aged 21 if they were receiving such services immediately before reaching age 21.

In addition, if a certain percentage of a psychiatric hospital's inpatient days are attributable to Medicaid-eligible patients, the hospital may be entitled to DSH payments pursuant to section 1923 of the Act.

*Definition of Medicaid Inpatient Psychiatric Hospital Services*

The Federal definition of Medicaid inpatient psychiatric hospital services requires the hospitals providing such services to comply with Medicare CoP, including two special Medicare CoP. The basic Medicare CoP address issues such as licensing, quality of care, safety, patient rights, self assessment and performance improvement, and service availability (42 CFR §§ 482.1–482.23 and 42 CFR §§ 482.25–482.57). The special Medicare CoP specify staffing and medical record requirements (42 CFR §§ 482.61 and 482.62).

In 72 Fed. Reg. 60787 (Oct. 26, 2007), CMS corrected a technical error that it had made when it issued Medicare transplant center CoP regulations that became effective June 28, 2007. When it amended 42 CFR part 482, subpart E, in 72 Fed. Reg. 15198 (Mar. 30, 2007), CMS inadvertently omitted 42 CFR §§ 482.60–482.62, which are Medicare psychiatric hospital CoP regulations relevant to this audit. The correction reinstated the omitted regulations effective October 26, 2007. Despite the omission, CMS's implementing guidance (e.g., manuals) remained in effect from June 28 through October 25, 2007 (the regulatory gap period).

*Demonstrating Compliance With Medicare Conditions of Participation*

To demonstrate compliance with the basic and special Medicare CoP, a psychiatric hospital must undergo review by qualified health care professionals. Medicare-participating psychiatric hospitals are generally deemed to meet both the basic and special Medicare CoP for Medicaid purposes (42 CFR § 488.5(b)). During our audit period, psychiatric hospitals that did not participate in Medicare could generally demonstrate compliance with the *basic* Medicare CoP[3] by being accredited as a hospital by CMS-approved organizations, such as the Joint Commission.[4] However, during that time, such accreditation did not demonstrate compliance with the *special* Medicare CoP (42 CFR § 488.5(a)).[5] According to the CMS *State Operations Manual*, section 2718A, psychiatric hospitals had to be specially surveyed by qualified psychiatric health care professionals to demonstrate compliance with the *special* Medicare CoP. Accreditation or survey by qualified health care professionals provides CMS with reasonable assurance that participating facilities are improving the health and protecting the safety of Medicaid beneficiaries.

---

[3] One exception is the utilization review requirement in 42 CFR § 482.30; however, compliance with the utilization review requirement was outside the scope of our audit.

[4] The Joint Commission was previously known as the Joint Commission on Accreditation of Healthcare Organizations and is so referenced in 42 CFR § 488.5(a).

[5] After the audit period (January 1, 2006, through December 31, 2010), CMS granted the Joint Commission deeming authority with respect to the two special Medicare CoP (76 Fed. Reg. 10598 (Feb. 25, 2011)).

For periods that a psychiatric hospital does not demonstrate compliance with the basic and special Medicare CoP, all Medicaid inpatient psychiatric service and DSH payments received from the State agency are ineligible for Federal reimbursement.

## OBJECTIVE, SCOPE, AND METHODOLOGY

### Objective

Our objective was to determine whether the State agency claimed Federal reimbursement for Medicaid inpatient psychiatric service and DSH payments made to CRCO in accordance with certain Federal requirements for inpatient psychiatric hospital services.

### Scope

We reviewed CRCO's compliance for the period of January 1, 2006, through December 31, 2010, with certain Federal requirements for inpatient psychiatric hospital services. We identified $6,675,543 in Federal reimbursement for Medicaid inpatient psychiatric service and DSH payments made to CRCO for claims with dates of service during the audit period. We limited our review of the State agency's internal controls to those significant to the objective of our audit.

We performed our fieldwork from March through August 2012.

### Methodology

To accomplish our objective, we:

- examined Federal and State Medicaid requirements for inpatient psychiatric hospital services,
- identified periods for which neither the State agency nor CRCO could demonstrate CRCO's compliance with certain Federal requirements for inpatient psychiatric hospital services,
- held discussions with officials of the State agency and reviewed its Medicaid payment records, and
- determined the amount of Federal reimbursement for Medicaid inpatient psychiatric service and DSH payments made to CRCO for claims with dates of service during periods when it did not demonstrate compliance.

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

## FINDING AND RECOMMENDATIONS

Most State agency claims for Federal reimbursement for Medicaid inpatient psychiatric service and DSH payments made to CRCO were not in accordance with Federal requirements for inpatient psychiatric hospital services because CRCO did not demonstrate compliance with the basic or special Medicare CoP from January 1, 2006, through December 31, 2010. Therefore, of the $6,675,543 claimed during that period, the amount of $6,209,502 that was for claims with dates of service outside the regulatory gap period was not allowable. We have not provided an opinion on the allowability of State agency claims for the remaining $466,041, which was for claims with dates of service during the regulatory gap period. The State agency claimed the $6,675,543 because it believed that CRCO had met all requirements to be eligible for Medicaid inpatient psychiatric service and DSH payments.

## FEDERAL REQUIREMENTS

Pursuant to sections 1905(h)(1) and 1861(f) of the Act, if inpatient psychiatric services furnished to individuals under age 21 are provided in a psychiatric hospital, the psychiatric hospital must meet the basic and special Medicare CoP. Regulations in 42 CFR § 482.60 implement the requirements in 1861(f) and mandate that such psychiatric hospitals meet the basic Medicare CoP (42 CFR §§ 482.1–482.23 and 42 CFR §§ 482.25–482.57) applicable to all hospitals and two special Medicare CoP applicable to psychiatric hospitals (42 CFR §§ 482.61 and 482.62). Psychiatric hospitals that provide Medicaid inpatient psychiatric services must meet the same Medicare CoP for their DSH payments to be eligible for Federal reimbursement.

The Medicare CoP for psychiatric hospitals are minimum standards that provide a basis for improving quality of care and protecting the health and safety of Medicaid beneficiaries. The basic Medicare CoP address issues such as licensing, quality of care, safety, patient rights, self assessment and performance improvement, and service availability (42 CFR §§ 482.1–482.23 and 42 CFR §§ 482.25–482.57). The special staffing Medicare CoP require that psychiatric hospitals "have adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures, and engage in discharge planning" (42 CFR § 482.62). The special medical record Medicare CoP require that "medical records maintained by a psychiatric hospital … permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution" (42 CFR § 482.61).

## CHILDREN'S RECOVERY CENTER OF OKLAHOMA DID NOT DEMONSTRATE COMPLIANCE WITH MEDICARE CONDITIONS OF PARTICIPATION DURING THE AUDIT PERIOD

CRCO did not demonstrate compliance with the basic or special Medicare CoP during the audit period. CRCO did not participate in Medicare and was not accredited as a hospital by a

CMS-approved organization at any time during the audit period.[6] CRCO was also never specially surveyed to demonstrate compliance with the special Medicare CoP.

Of the $6,675,543 in Federal reimbursement claimed for Medicaid inpatient psychiatric service and DSH payments made to CRCO for claims with dates of service during the audit period, the State agency improperly claimed $6,209,502 for claims with dates of service outside the regulatory gap period. The $6,209,502 included Federal reimbursement of $3,788,794 for improperly claimed service payments and $2,420,708 for improperly claimed DSH payments. We have set aside for further review by CMS and the State agency $466,041 in Federal reimbursement for payments made to CRCO for claims with dates of service during the regulatory gap period.[7] The table below shows Federal reimbursement by payment type.

**Federal Reimbursement by Payment Type**

| Payment Type | Improperly Claimed | Set Aside | Total |
|---|---|---|---|
| **Service** | $3,788,794 | $224,240 | **$4,013,034** |
| **DSH** | 2,420,708 | 241,801 | **2,662,509** |
| **Total** | **$6,209,502** | **$466,041** | **$6,675,543** |

The State agency claimed the $6,675,543 in Federal reimbursement for claims with dates of service during the audit period because it believed that CRCO had met all requirements to be eligible for Medicaid inpatient psychiatric service and DSH payments.

## RECOMMENDATIONS

We recommend that the State agency:

- refund $6,209,502 to the Federal Government for its share of Medicaid inpatient psychiatric service and DSH payments made to CRCO for claims with dates of service outside the regulatory gap period,

[6] CRCO was accredited by the Joint Commission under the *Comprehensive Accreditation Manual for Behavioral Health Care* standards, but it was not accredited as a hospital and thus did not have deemed compliance with the basic Medicare CoP.

[7] Despite CMS's inadvertent omission of 42 CFR §§ 482.60–482.62 in 72 Fed. Reg. 15198 (Mar. 30, 2007), CMS's implementing guidance remained in effect during this period.

- work with CMS to determine whether the State agency should refund an additional $466,041 to the Federal Government for its share of payments made to CRCO for claims with dates of service during the regulatory gap period,

- identify and refund the Federal share of any additional payments made to CRCO for claims with dates of service after the audit period if neither the State agency nor CRCO can demonstrate the hospital's compliance with Federal requirements for inpatient psychiatric hospital services, and

- ensure that Federal reimbursement for Medicaid inpatient psychiatric service and DSH payments to psychiatric hospitals is claimed only if those hospitals can demonstrate compliance with the basic and special Medicare CoP.

## STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with three of our four recommendations. The State agency agreed with our first recommendation—it will work with CMS to refund $6,209,502 for the Federal share of Medicaid inpatient psychiatric services and DSH payments made to CRCO for claims with dates of service outside the regulatory gap period. The State agency did not concur with our second recommendation that it should be responsible for refunding payments with dates of service during the regulatory gap period. As to our third recommendation, the State agency identified an additional $292,811 in DSH payments that were made after the audit period; it will work with CMS to make an adjustment for this overpayment. The State agency also agreed with our fourth recommendation—it has implemented procedures within its provider enrollment division to ensure that all hospitals have the certifications required for Medicaid reimbursement.

The State agency comments are included in their entirety as the Appendix.

## OFFICE OF INSPECTOR GENERAL RESPONSE

We maintain our second recommendation that the State agency should present its position to and work with CMS to determine whether it should refund payments made to CRCO for claims with dates of service during the regulatory gap period.

# APPENDIX

# APPENDIX: STATE AGENCY COMMENTS

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

January 28, 2013

Re: Report # A-05-12-00052

Sheri L. Fulcher
Regional Inspector General for Audit Services
Office of Audit Services, Region V
233 North Michigan, Suite 1360
Chicago, IL 60601

Dear Ms. Fulcher,

This is Oklahoma's response to the audit of "Oklahoma Improperly Claimed Federal Reimbursement for Most Reviewed Medicaid Inpatient Psychiatric Hospital Service and Disproportionate Share Hospital Payments to Children's Recovery Center".

In general, we concur with the overall finding that the Children's Recovery Center was not certified during the audit period as an inpatient psychiatric hospital. Specifically, with regards to the recommendations found on page five of the report, our comments are as follows:

1. Oklahoma will work with CMS to refund the share of Medicaid inpatient psychiatric services and DSH payments made to the Children's Recovery Center with dates outside the regulatory gap period.
2. Oklahoma does not concur that the state should be responsible for refunding any payments made to the Children's Recovery Center with dates of service during the regulatory gap period.
3. The Children's Recovery Center stopped claiming for inpatient psychiatric services in May 2010, therefore no additional service claims were made post audit period. We did, however, find an additional $292,811 in DSH payments made subsequent to the end of the audit period. Oklahoma will work with CMS to make the appropriate adjustments for this overpayment.
4. We have implemented procedures within our provider enrollment division to ensure that all hospitals have the appropriate certifications for Medicaid reimbursement.

If you have any questions or comments regarding our responses, please don't hesitate to contact our offices.

Sincerely,

Carrie Evans

Carrie Evans
Chief Financial Officer
Oklahoma Health Care Authority
2401 Northwest 23rd Street, Suite 1A
Oklahoma City, Oklahoma 73107