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**Medicaid Eligibility Status for Adult Civil  
Patients at the Colorado Mental Health Institutes**

**Department of Health Care Policy and Financing  
Department of Human Services**

**Performance Audit  
May 2012**

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May 11, 2012

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of Medicaid eligibility status for adult civil patients at the Colorado Mental Health Institutes. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government. The report presents our findings, conclusions, and recommendations, and the responses of the Department of Health Care Policy and Financing and the Department of Human Services.

A handwritten signature in black ink, appearing to read "Dianne E. Ray".



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## *Glossary of Terms and Abbreviations*

**BHO** – Behavioral Health Organization

**CDHS** – Colorado Department of Human Services

**CMHC** – Community Mental Health Center

**CMS** – Federal Centers for Medicare and Medicaid Services

**HCPF** – Colorado Department of Health Care Policy and Financing

**IMD** – Institution for Mental Diseases

**MMIS** – Medicaid Management Information System

**SSI** – Supplemental Security Income



# MEDICAID ELIGIBILITY STATUS FOR ADULT CIVIL PATIENTS AT THE COLORADO MENTAL HEALTH INSTITUTES

## Performance Audit, May 2012 Report Highlights



Dianne E. Ray, CPA  
State Auditor

Department of Health Care Policy and Financing  
Department of Human Services

### PURPOSE

The purpose of this audit was to determine whether eligible adult civil patients have access to Medicaid as soon as possible when they are discharged from the State's mental health institutes into the community.

### BACKGROUND

- Colorado's public mental health system serves Medicaid- and non-Medicaid-eligible individuals in community and institutional settings. Individuals diagnosed with serious mental illness often move between the community and institutional settings as the need for more or less intensive services dictates.
- The Colorado Mental Health Institutes at Fort Logan and Pueblo provide inpatient hospitalization for those individuals diagnosed with the most serious mental illnesses and emotional disorders.
- Federal law prohibits federal matching funds from being used to cover the cost of care for Medicaid clients aged 21 through 64 who are patients in an institution for mental diseases (IMD), which includes the Fort Logan and Pueblo Institutes.
- For IMD-excluded patients, the cost of care is primarily paid for by state general funds appropriated to the Institutes.

### OUR RECOMMENDATIONS

The Department of Health Care Policy and Financing and the Department of Human Services should develop controls to ensure that Medicaid does not pay any claims for Fort Logan or Pueblo Institute patients who fall under the federal IMD exclusion.

The Department of Health Care Policy and Financing and the Department of Human Services agreed with our recommendation.

### EVALUATION CONCERN

We did not find significant or systemic problems related to gaps in Medicaid eligibility for discharged adult civil patients. However, the State is not fully complying with a provision of federal law and related State Medicaid Rules which exclude Institute patients aged 21 through 64 from eligibility for medical assistance.

### KEY FACTS AND FINDINGS

- **Medicaid Eligibility Status**
  - We matched admission and discharge data with Medicaid eligibility data for all adult civil patients (i.e., patients aged 21 through 64) who were discharged from the Fort Logan and Pueblo Institutes in Fiscal Year 2011.
  - Only four out of the 497 patients (less than 1 percent) who were Medicaid eligible as of their admission date subsequently lost Medicaid eligibility during their Institute stay and experienced a delay in reestablishing Medicaid eligibility after their discharge.
  - The four patients regained Medicaid eligibility within an average of 4 months (minimum of 1 month and maximum of 11 months) after their discharge.
- **Institution for Mental Diseases (IMD) Exclusion**
  - We analyzed Medicaid claims data for the 41 Medicaid patients aged 21 through 64 who were discharged from the Institutes in Fiscal Year 2011 and who had a length of stay of at least 90 days.
  - We identified a total of about \$76,300 in questioned costs for 288 Medicaid claims that the State inappropriately paid for 36 of the 41 patients we reviewed.
  - All of the claims we identified were for dates of service that fell during the time the patients were inpatients at the Fort Logan or Pueblo Institutes. None of the claims were related to care provided by the Institutes.
  - Questionable claims included about \$64,000 for monthly capitation payments paid to managed care organizations, \$10,200 in claims from alternative care facilities, and \$2,100 in claims from pharmacies.

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# Medicaid Eligibility Status for Adult Civil Patients at the Colorado Mental Health Institutes

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## Overview

Colorado's public mental health system is composed of a number of agencies and organizations that work in conjunction to ensure that individuals diagnosed with mental illnesses receive appropriate treatment and services. Ideally, those needing mental health services are able to receive these services in the community. However, the severity of a mental illness may require that a person be admitted to one of Colorado's two State-run mental health institutes for some period of time. Often, the full continuum of care for those diagnosed with serious mental illness involves moving between the community and institutional settings as the need for more or less intensive services dictates.

- The **Colorado Mental Health Institutes** (the Institutes) are located in Pueblo and at Fort Logan in Denver. The Institutes provide inpatient hospitalization for adolescents, adults, and geriatric adults diagnosed with the most serious mental illnesses or emotional disorders. Civil patients are individuals who have sought treatment voluntarily or who have been committed involuntarily by a court. The Pueblo Institute also serves forensic patients, who are individuals referred by the courts for evaluation of competency to stand trial, or found by the courts to be Not Guilty by Reason of Insanity or Incompetent to Proceed (i.e., defendants unable to assist in their defense).
- The **Behavioral Health Organizations** (BHO) are managed care organizations that arrange for or provide mental health services under Colorado's Medicaid program. The five BHOs operate under contracts with the Colorado Department of Health Care Policy and Financing. Medicaid clients are automatically assigned to a BHO based on where they live. The BHOs are contractually obligated to ensure that Medicaid clients in their assigned service areas receive all medically necessary mental health care services. The BHOs coordinate the delivery of mental health services for Medicaid clients through a network of community providers and the Institutes.

- The **Community Mental Health Centers (CMHC)** are nonprofit or publicly operated clinics that provide mental health services in the community. Specifically, the BHOs contract with the 17 CMHCs to provide mental health services to Medicaid clients in their assigned service area. The Colorado Department of Human Services also contracts with the CMHCs to provide mental health services to indigent persons (i.e., non-Medicaid-eligible individuals). When necessary, the CMHCs refer individuals to the Institutes for treatment.

The administration of Colorado's public mental health system is complex; there are different service settings, providers, and funding sources. Additionally, depending on the service setting and the funding source being utilized, there are different state agencies responsible for oversight.

- The **Colorado Department of Health Care Policy and Financing (HCPF)** is the State's Medicaid agency and is responsible for overseeing the delivery of mental health services under Colorado's Medicaid program. Specifically, HCPF oversees the Medicaid Community Mental Health Services Program, which provides mental health services to Medicaid clients under a managed care model approved by the federal Centers for Medicare and Medicaid Services (CMS). As discussed previously, HCPF contracts with the BHOs to arrange for or provide all medically necessary mental health services to Medicaid clients living in each BHO's geographic service area. In Fiscal Year 2011, the caseload for the Medicaid Community Mental Health Services Program totaled approximately 540,400 individuals.

Funding for the Medicaid Community Mental Health Services Program comprises state general funds, cash funds, and federal matching funds. Under the managed care model, HCPF pays each BHO a contracted monthly amount, also known as a "capitation payment," for each enrolled Medicaid client. Capitation payments are made regardless of whether the client seeks mental health services. In Fiscal Year 2011, expenditures for capitation payments totaled approximately \$249 million.

- The **Colorado Department of Human Services (CDHS)** is responsible for overseeing the State's two mental health institutes. Specifically, CDHS's Mental Health Institutes Division directly oversees services, operations, finance and budgeting, information management, quality management, contract management, and regulatory compliance at the Fort Logan and Pueblo Institutes. In Fiscal Year 2011, the Institutes admitted approximately 1,900 patients and had expenditures totaling approximately \$102 million.

Additionally, CDHS's Division of Behavioral Health serves as the State's Mental Health Authority and provides programmatic oversight of the community mental health system, including developing state rules, regulations, and other policies and standards for community mental health treatment. As mentioned previously, the Division of Behavioral Health contracts with the CMHCs to provide mental health services to "medically indigent" individuals. Unlike Medicaid, indigent mental health services are not an entitlement, and services are more limited. To be considered "medically indigent," the individual must (1) not be Medicaid eligible or have other insurance coverage, (2) be diagnosed with a serious mental illness (adults) or a severe emotional disturbance (children), and (3) have an income that is at or below 300 percent of the federal poverty level. Funding for indigent community mental health services comprises state general funds, cash funds, and federal funds (e.g., mental health block grant). In Fiscal Year 2011, approximately 18,700 adult indigent mental health patients were served through CDHS's contracts with the CMHCs at a total cost of approximately \$36 million.

## **Audit Scope and Methodology**

We conducted this performance audit in response to a legislative request. Audit work was performed from August 2011 through May 2012. We contracted with PHBV Partners LLP, based in Austin, Texas, to assist our in-house audit staff with conducting the planned audit work and developing related findings and recommendations. We acknowledge the cooperation and assistance provided by management and staff at the Department of Health Care Policy and Financing and the Department of Human Services.

The overall objective of this audit was to determine whether the State has adequate controls in place to ensure that eligible adult civil patients have access to Medicaid as soon as possible when they are discharged from the Institutes into the community mental health care system. Our audit did not include forensic patients, patients under the age of 21 or over the age of 64, or patients who were not discharged from one of the Institutes during Fiscal Year 2011.

To accomplish our audit objective, we:

- Researched applicable federal and state laws and regulations.
- Interviewed management and staff at the Fort Logan and Pueblo Institutes, CDHS, HCPF, the CMHCs, and the BHOs about applicable policies, procedures, and processes.

- Analyzed admission and discharge data and Medicaid eligibility data for all adult civil patients who were discharged from the Institutes during Fiscal Year 2011.
- Conducted site visits at the Fort Logan and Pueblo Institutes to review patient documentation for those discharged patients who had a length of stay greater than 90 days.

Based on the results of our audit work and additional risks we identified related to noncompliance with provisions of federal law, we performed additional audit procedures to review Medicaid claims data for a subgroup of Institute patients. Specifically, we analyzed Medicaid claims data for all discharged adult civil patients who had a length of stay greater than 90 days to determine whether the claims were allowable.

We did not rely on sampling techniques to support our audit work.

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 the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## Medicaid Eligibility Status

Colorado is one of many states where Medicaid eligibility for the aged, blind, and disabled is directly tied to eligibility for Supplemental Security Income (SSI) benefits, which are administered through the U.S. Social Security Administration. That is, under Colorado's Medicaid program, disabled adults through the age of 64 automatically qualify for Medicaid if they are eligible for or are receiving SSI benefits.

### What was the purpose of the audit work?

The impetus for this audit was the potential effect that two provisions of federal law can have on individuals' Medicaid eligibility status once they are admitted to the Institutes.

- **Institution for Mental Diseases Exclusion.** Federal law (42 USC 1396d) bars federal matching funds from being used to cover the cost of care for Medicaid clients aged 21 through 64 who are patients in an institution for mental diseases (IMD). We refer to this provision in federal law as the

“IMD exclusion.” An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. The IMD exclusion was designed to ensure that states, rather than the federal government, have principal responsibility for funding inpatient psychiatric services. According to the State Medicaid Manual issued by CMS, the IMD exclusion also extends to care an IMD patient receives outside of the facility.

The Fort Logan and Pueblo Institutes both qualify as an IMD, which means that the cost of care for Medicaid patients aged 21 through 64 must be paid entirely by the State from the date of admission through the date of discharge. (Twenty-one-year-olds who were admitted to the institution prior to turning 21 do not fall under the IMD exclusion until the age of 22.) For IMD-excluded patients, the cost of care is primarily paid for by state general funds appropriated to the Institutes. The Institutes also bill the cost of care to other payer sources (e.g., the patient, third-party insurers, Medicare), where applicable.

- **SSI Eligibility.** Under federal law [42 USC 1382(e)] and regulations [20 C.F.R. 416.1325], an individual aged 18 or over is ineligible to receive SSI benefits starting with the first full calendar month in which he or she is a resident of a public institution *and* where Medicaid pays for less than half of the cost of the individual’s care. The Fort Logan and Pueblo Institutes qualify as public institutions, and, as discussed previously, none of the cost of medical care for Medicaid patients aged 21 through 64 is paid for through Medicaid due to the IMD exclusion. Thus, SSI-eligible individuals who are in this age range can lose their SSI eligibility status beginning with the first full calendar month during which they are patients at the Institutes. This ineligibility continues through the date of discharge. Because Colorado ties Medicaid eligibility to SSI eligibility for some clients, when SSI eligibility is suspended or terminated, the client’s Medicaid eligibility automatically terminates and must be reestablished upon discharge from the Institutes.

The fact that an individual can experience a change in his or her Medicaid eligibility status when moving from a community treatment setting into one of the Institutes and back into the community creates the potential for gaps in Medicaid eligibility to occur. When gaps in Medicaid eligibility occur, the risk increases that funds earmarked for the mental health care of indigent clients (i.e., those not eligible for Medicaid) will be used to cover community mental health services for discharged patients. Using indigent funding for individuals who could otherwise be covered through Medicaid is not cost-effective, since federal matching funds

are available under Medicaid and the covered services are more comprehensive. The purpose of our audit work was to determine whether Institute patients are losing Medicaid eligibility while being treated at the Institutes and experiencing delays in reestablishing Medicaid eligibility after their discharge from the Institutes.

### **What audit work was performed and how were the results measured?**

We obtained admission and discharge data from CDHS and Medicaid eligibility data from HCPF for all 877 adult civil patients (i.e., patients aged 21 through 64) who were discharged from the Fort Logan and Pueblo Institutes during Fiscal Year 2011. These patients had a total of 1,056 stays, as some patients were admitted and discharged multiple times during the year. We matched the admission and discharge data with the Medicaid eligibility data and determined that 497 patients were Medicaid eligible as of their admission date. We performed further analysis to determine whether any of these patients subsequently (1) had their Medicaid eligibility terminated during their length of stay at the Institutes and (2) experienced delays in reestablishing Medicaid eligibility after being discharged.

Our contractor performed onsite review of Institute documentation for all 41 adult civil Medicaid patients who were discharged in Fiscal Year 2011 and who had a length of stay of at least 90 days. We considered this subgroup of patients to be at greater risk of experiencing gaps in Medicaid eligibility because of their longer lengths of stay. We used a 90-day threshold because of a provision in federal regulations that allows Institute patients in certain circumstances to continue to receive SSI benefits and, therefore, remain eligible for Medicaid for up to 90 days during their stay.

### **What problem did the audit work identify?**

Overall, we found that significant or systemic problems related to gaps in Medicaid eligibility for discharged patients do not exist. Our analysis showed that the vast majority of adult civil patients who were eligible for Medicaid when they were admitted to the Institutes remained eligible for Medicaid as of their discharge dates. Specifically, we found that only four out of the 497 patients (less than 1 percent) who were Medicaid eligible as of their admission date subsequently lost Medicaid eligibility during their Institute stay and experienced a delay in reestablishing Medicaid eligibility after their discharge. These four patients regained Medicaid eligibility within an average of 4 months (minimum of 1 month and maximum of 11 months) after their discharge.

Our interviews with staff at the Institutes, CMHCs, and BHOs confirmed that case managers work throughout the discharge planning process to ensure that the patient has as smooth of a transition to the community as possible, including ensuring that Medicaid and other benefits for which the patient is eligible will continue or are reinstated upon discharge.

## **Medicaid Claims and the Institution for Mental Diseases (IMD) Exclusion**

Although we did not find gaps in Medicaid eligibility for a significant number of adult civil patients, during the course of performing our audit testwork, we identified anomalies in the Medicaid claims data for a subgroup of patients that raised concerns about the State's compliance with the federal IMD exclusion.

### **What audit work was performed and how were the results measured?**

We analyzed Medicaid claims data for the subgroup of 41 adult civil Medicaid patients who were discharged from the Institutes in Fiscal Year 2011 and who had a length of stay of at least 90 days. As mentioned previously, when a Medicaid-eligible individual aged 21 through 64 is a patient in an IMD (i.e., the Institutes), federal matching funds are not available for Medicaid-covered services regardless of whether the services are provided inside or outside the IMD. The cost of care must be paid entirely by the State from the date of admission to the IMD through the date of discharge. Consistent with this federal requirement, State Medicaid Rules specifically exclude IMD patients aged 21 through 64 from eligibility for medical assistance. State Medicaid Rules further exclude such patients from enrollment in a BHO or other managed care organization under Medicaid. Therefore, due to the IMD exclusion, we should not see any Medicaid claims, including capitation payments for managed care programs, being paid for adult civil patients aged 21 through 64 while they are inpatients at the Institutes.

### **What problem did the audit work identify?**

Overall, we found that the State is not fully complying with the federal IMD exclusion, having paid Medicaid claims for most of the patients in the subgroup we reviewed. Specifically, we identified questioned costs totaling \$76,318 for 288 Medicaid claims that HCPF paid for 36 of the 41 patients in the subgroup. All of these 288 claims were for dates of service that fell during the time the patients were admitted inpatients at one of the two Institutes. The Medicaid claims we identified fall broadly into four categories, as shown in the following table:

<b>Medicaid Claims Paid for 36 Adult Civil Patients Who Were Discharged From a State Mental Health Institute in Fiscal Year 2011</b>			
<b>Claim Type</b>	<b>Number of Claims</b>	<b>Number of Patients<sup>1</sup></b>	<b>Total Amount</b>
Monthly Capitation Payments to Behavioral Health Organizations for Enrollment in the Community Mental Health Services Program <sup>2</sup>	192	36	\$27,801
Monthly Capitation Payments to Other Medicaid Managed Care Organizations <sup>2</sup>	56	10	36,218
Alternative Care Facilities (i.e., assisted living)	22	3	10,201
Pharmacies	18	5	2,098
<b>Total</b>	<b>288</b>	<b>36</b>	<b>\$76,318</b>

**Source:** Office of the State Auditor's analysis of Medicaid claims data provided by the Department of Health Care Policy and Financing (HCPF).

<sup>1</sup>The total for this column is an unduplicated count of patients with claims. Some patients had claims within more than one claim type.

<sup>2</sup>Capitation payments are fixed amounts that HCPF pays automatically on a monthly basis for each Medicaid client who is enrolled in a managed care program.

We question all of the claims we identified for these 36 Institute patients on the basis of the federal IMD exclusion and related State Medicaid Rules. We acknowledge that there may be reasons why service providers would submit claims for individuals while they are inpatients at an Institute. For example, State Medicaid Rules allow alternative care facilities to bill Medicaid for up to 42 days in a calendar year for a resident who is on programmatic leave from the facility for therapeutic and/or rehabilitative purposes. However, such claims are not allowable for the patients in our subgroup due to the patients' age and status as IMD patients.

It should be noted that none of the claims we identified were for care that the patients received from the Institutes. We confirmed with accounting staff at the Institutes that they do not bill Medicaid or any BHO for Medicaid patients who fall within the IMD exclusion (i.e., are between the ages of 21 and 64). The Institutes bill other available payer sources, including third-party insurers and Medicare, where applicable. In addition, state law (Section 27-92-101, et seq., C.R.S.) requires the Institutes to evaluate each patient's own resources and bill the patient based on his or her ability to pay. Any remaining costs that the Institutes cannot bill and that might otherwise have been paid by Medicaid are covered by State general funds appropriated to the Institutes. For the 41 patients in the subgroup we reviewed, Institute staff estimate that the cost of care provided by

the Institutes, inclusive of both mental health services and medical care, totaled about \$5.4 million, none of which was billed to Medicaid. Of this amount, about \$5.1 million was covered by the State's General Fund.

### **Why did the problem occur?**

As the State Medicaid Agency, HCPF is responsible for ensuring that Colorado abides by the federal IMD exclusion. HCPF is also responsible for analyzing claims data in an effort to reduce the possibility of improper payments for claims that are medically unnecessary, duplicative, erroneous, or potentially fraudulent.

In general, HCPF does not adequately screen or review claims for Institute patients to accomplish either of these two goals. First, as we explain in greater detail below, HCPF lacks controls to prevent its claims processing system, known as the Medicaid Management Information System (MMIS), from paying claims for patients who fall under the IMD exclusion. Second, HCPF does not have a process or procedure for checking whether it has paid claims for IMD-excluded patients.

- **Payment Controls in MMIS.** MMIS currently lacks functionality to globally suppress payments on claims for specific clients during a specified time span without changing the client's eligibility status. However, HCPF is currently conducting a procurement process to replace MMIS and has an opportunity to add this functionality to the new system.

While a global suppression of payments is not currently possible, HCPF staff report that they have the capability to halt Medicaid capitation payments for a period of time by entering "exclusion spans" into MMIS. Exclusion spans represent a period of time for which capitation payments should not be made. HCPF currently uses exclusion spans to stop capitation payments for forensic patients at the Institutes who have been deemed by a court to be Incompetent to Proceed or Not Guilty by Reason of Insanity in a criminal proceeding. Thus, in a similar manner, HCPF could use exclusion spans to stop capitation payments for all Institute patients enrolled in Medicaid and who fall under the IMD exclusion. However, regardless of the specific process used, HCPF first needs to routinely receive reliable data on admission and discharge dates from CDHS for Medicaid patients being treated as inpatients by the Institutes. HCPF does not currently receive such data.

- **Compliance Monitoring.** One of HCPF's functions is to monitor Medicaid providers for compliance with federal and state statutes and regulations. To this end, HCPF has established a Program Integrity Section to engage in a variety of monitoring activities, including data

mining, onsite reviews, desk audits, and claims reviews. All of these activities are aimed at detecting noncompliance and preventing fraud and abuse. However, the Program Integrity Unit does not currently obtain or use patient information from the Institutes to monitor providers who submit claims for patients with a date of service falling during the patient's Institute stay. In addition to monitoring for compliance with the IMD exclusion, the Program Integrity Unit could use such information for Institute patients of all ages to identify and investigate claims that may be inconsistent with their inpatient status. We forwarded the list of questionable claims we identified during our audit to the Program Integrity Unit for further investigation and follow up.

### **Why does this problem matter?**

In total, we identified more than \$76,300 in questioned costs stemming from Medicaid claims for dates of service that fell during the time the patients were receiving inpatient care at the Institutes. As discussed previously, these claims are not allowable because of the federal IMD exclusion. Of these questioned costs, about \$51,100 was paid during Fiscal Year 2011 (the remaining amount was paid in prior fiscal years). However, it is likely that the total amount of questionable claims in a given year is higher. This is because the 41 patients we reviewed represent only a small subset of all Medicaid patients within the IMD-excluded age range whom the Institutes served. For example, the Institutes report that, in Fiscal Year 2011, they served about 509 inpatients between the ages of 21 and 64 who were Medicaid eligible on the date of admission. These patients had a combined total of 632 stays during the year. Given the lack of controls for ensuring compliance with the federal IMD exclusion, HCPF could potentially have paid claims for any of these patients during their stays.

In addition to ensuring compliance with federal requirements, it is important that action be taken to address the issue we identified because these controls will prevent the State from paying duplicative costs. For example, a large portion of the questioned costs we identified, about \$64,000, consisted of automatic capitation payments to BHOs and other Medicaid managed care organizations. However, the State already pays for the full range of care for IMD-excluded patients through the Institutes' General Fund appropriations. Therefore, additional money paid to managed care organizations for patients whose cost of care cannot be paid for by Medicaid is duplicative and a waste of state matching funds.

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### **Recommendation No. 1:**

The Department of Health Care Policy and Financing (HCPF) should develop controls to ensure that Medicaid does not pay any claims for Fort Logan or Pueblo

Institute patients who fall under the federal institution for mental diseases (IMD) exclusion. Specifically, HCPF should:

- a. Work with the Department of Human Services (CDHS) to develop a process for receiving data on the dates of admission and discharge for Medicaid-eligible clients, regardless of age, who are inpatients at the Fort Logan and Pueblo Institutes.
- b. Use the patient information obtained through part a to develop a process for identifying and denying, or flagging for further investigation, all Medicaid claims, including capitation payments, for IMD-excluded patients. Additionally, HCPF should pursue a long-term solution as part of the Medicaid Management Information System (MMIS) reprocurement.
- c. Use the patient information obtained through part a to develop a routine process for identifying and reviewing for appropriateness all claims paid for Medicaid clients, regardless of age, who were inpatients at the Fort Logan or Pueblo Institute on the date of service.
- d. Investigate the claims questioned in this audit and recoup payments as appropriate.

### **Department of Health Care Policy and Financing Response:**

- a. Agree. Implementation date: July 1, 2012.

The Department agrees to work with the Department of Human Services to develop a process for receiving timely data on admission and discharge dates for Medicaid-eligible clients, regardless of age, who are inpatients at the Pueblo and Fort Logan Mental Health Institutes. HCPF and CDHS staff held a phone conference on May 9, 2012, to discuss how to operationalize this process. The Department is confident that a reliable process will be in place no later than July 1, 2012. This process will provide the data necessary to support implementation of parts b, c, and d.

- b. Agree. Implementation date: Interim Process – August 1, 2012.  
Reprocured MMIS – March 2016.

The Department agrees that identifying and denying claims for IMD-excluded clients are important.

Provided that a process or link is implemented allowing the regular receipt of adequate client data from the IMDs, the Department will ensure that the capability to systematically identify, deny, or flag claims for further investigation for IMD-excluded clients is implemented in its reproced MMIS. The reproced MMIS is expected to be operational by March 2016.

In the interim, provided that a process or link is implemented allowing the regular receipt of adequate client data from the IMDs, the managed care eligibility spans of clients admitted or discharged from the IMDs will be updated monthly in the current MMIS to prevent the payment of capitation amounts for clients in the IMDs. Medicaid payments for other types of services will be identified post-adjudication as discussed in the response to part c.

- c. Agree. Implementation date: July 1, 2012.

The Department agrees with this recommendation. The Department's Program Integrity Section will conduct monthly data monitoring for fee-for-service claims paid when clients of any age are institutionalized in the mental health institutes. Using data provided by CDHS, together, Program Integrity and Department policy staff will analyze any paid claims for proper recovery actions.

The Program Integrity Section's data team is currently establishing its work plan and will prioritize conducting monthly monitoring to identify fee-for-service claims paid when clients of any age are institutionalized in the mental health institutes. By partnering with CDHS, Program Integrity and Department policy staff will analyze any paid claims for proper recovery actions.

- d. Agree. Implementation date: Implemented and Ongoing.

The Department agrees with this recommendation and has already begun investigating claims reviewed by the Office of the State Auditor. The Department agrees that the capitation payments identified by the OSA were made in error and will begin its process of recovering those questioned costs and will continue to review the alternative care facility and pharmacy claims to identify any appropriate recoveries.

As part of the Department's Program Integrity (PI) annual work plan, the PI Section has already expanded its scope of review of alternative care facilities that started in January 2012 (currently underway) to identify and determine proper recovery actions involving claims

during IMD stays. Should the Department identify any erroneous payments that contain Federal Financial Participation (FFP) funds, the Department will record such reimbursements to the federal government on the CMS-64 in the quarter for which the recovery occurred, return these funds to the federal government, and report these recoveries on the CMS-64.

## **Recommendation No. 2:**

The Department of Human Services should work with the Department of Health Care Policy and Financing to develop a process for sending data on the dates of admission and discharge for Medicaid-eligible clients, regardless of age, who are inpatients at the Fort Logan and Pueblo Institutes.

### **Department of Human Services Response:**

Agree. Implementation date: July 1, 2012.

The Colorado Department of Human Services will work with the Department of Health Care Policy and Financing to develop a process and send data about the dates of admission and discharge for Medicaid-eligible clients, regardless of age, who are inpatients at the Pueblo and Fort Logan Institutes.

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