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DRAFT REPORT

REVIEW OF THERAPEUTIC RESIDENTIAL INTERVENTION
SERVICES

FOR THE CMS-64 REVIEW PERIOD OF
MARCH 2005 – SEPTEMBER 2005

State Medicaid Agency: Georgia Department of Community Health (DCH)

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I. INTRODUCTION

Both Branches (Financial and Program Operations Branch (FPOB) Medicaid and SCHIP Policy (MSPB)) of the Atlanta Regional Office (RO) of the Centers for Medicare and Medicaid services (CMS), Division of Medicaid and Children's Health (DMCH), completed a Financial Management Review (FMR) of the Georgia Department of Community Health's (DCH) program referred to as Therapeutic Intervention Residential Services (TRIS). Regional staff began the review in April 2005 and performed on-site visits to four TRIS facilities, with further on-site work performed during the month of July 2005 at the Georgia Department of Human Resources (DHR) and the Department of Juvenile Justice (DJJ). Additional review work was conducted at the CMS RO in Atlanta, Georgia throughout that period as well during the month of September 2005.

II. BACKGROUND**A. Statutory Guidelines**

Title XIX (Medicaid) of the Social Security Act (the Act) was enacted in 1965 to provide grants to states for medical assistance programs. Medicaid is a matching entitlement program that provides necessary medical services to low income families, elderly individuals, and persons with disabilities. This program is jointly funded by the Federal and State governments and is administered by each individual State. For each State dollar spent, the Federal government contributes the Federal share in matching payments.

All states are required to describe the nature and scope of their Medicaid programs in a comprehensive written plan submitted to CMS. This plan is commonly referred to as the State Plan. Each state is required to operate its Medicaid program in accordance with its approved State Plan. While a State has considerable flexibility in designing its State Plan, it must comply with Federal requirements specified in the Medicaid statute, regulations, and program guidance. Additionally, a State must adhere to its approved State Plan. Any deviation from the State Plan can jeopardize Federal Financial Participation (FFP).

CMS is responsible for Federal oversight of the Medicaid program. CMS approves each State Plan and all State Plan Amendments and reviews the state's claims for FFP to ensure funds are spent in accordance with Federal requirements.

Section 1902(a)(30)(A) of the Act requires a State Plan to meet certain requirements providing services and in setting payment amounts for covered Medicaid services. One of these requirements is that payment for care and services under an approved plan are consistent with efficiency, economy, and quality of care. Medicaid is generally regarded as the payer of last resort unless otherwise specified in Federal law or regulation.

B. Overview of TRIS

The General Accounting Office (GAO) completed a review in June 2005 entitled Medicaid Financing – States’ Use of Contingency Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight, which recommended that CMS improve oversight of contingency fee contracts to which TRIS is included. The report can be reviewed in its entirety at <http://www.gao.gov/new.items/d05748.pdf>.

TRIS services are for emotionally disturbed children in the custody or under the supervision of the state. These are generally adolescents who display a wide variety of psychiatric, behavioral and/or substance abuse disorders that make them unable to live in the community. Services are based on an intervention services assessment of the medical, psychological, social, educational and other needs of the child. These “Child and Adolescent Mental Health Services” are listed in the Georgia Medicaid State Plan on page 1 of “Supplement 2 to Attachment 4.19-B, Methods for Establishing Payment Rates for Medically Necessary Services for EPSDT Recipients when such services are not normally covered under the Plan.” The services were being erroneously billed to CMS on the 64 as Targeted Case Management (TCM) services at the start of our review.

Section 601 in the Policy and Procedures Manual for Providers (July 2004) published by the Georgia DHC, Division of Medical Assistance defines TRIS services as follows:

The Department of Human Resources (DHR) and the Department of Juvenile Justice (DJJ) purchase Therapeutic Residential Intervention Services through a Level of Care (LOC) system for children and adolescents. Therapeutic Residential Intervention Services (TRIS) provide mental health treatment and intervention for all levels of emotionally disturbed eligible Medicaid members with dysfunctional behaviors and psychiatric conditions which prevent or jeopardize residency with the family or in a setting less restrictive than therapeutic out-of-home care.

Therapeutic Residential Intervention Services emphasize coordination with the local education system, intensive involvement with family or other caretakers, development of recreational skills and appropriate peer interactions, and strengthening of age appropriate functioning for family and community living.

Section 903 of this manual indicates that the “types of Therapeutic Residential Intervention Services purchased are: Basic Institutional Foster Care, Therapeutic Foster Care, and Residential Treatment and Therapeutic Camps.” The next section (904) indicates that non-covered services are:

- Services provided in an institution in which the recipient is a resident or inmate as defined in 42 CFR 435.1008 and 435.1009;
- Vocational services; and
- Room, board and watchful oversight.

Provisions of the Interagency Agreement for EPSDT Therapeutic Services include:

- DCH is the single state agency for the State of Georgia responsible for administration of the Medical Assistance Program under Title XIX of the Social Security Act (SSA), and
- DHR, Division of Public Health is responsible for administration of Maternal and Child Health Services under Title V of the SSA, and
- DHR and DJJ provide therapeutic services to children in the custody of, under the supervision of, or at risk of being in the custody of the respective Departments.
- DCH, DHR, and DJJ collaborate in the provision of certain medically necessary therapeutic services to Medicaid eligible recipients under twenty-one (21) years of age who are in need of mental health treatment services for behaviors and psychiatric conditions which prevent residency with the family, and
- 42 CFR 431.615 sets forth the collaborative arrangements and agreements between the State Title V Agency, the State Title XIX Agency, and sister agencies.

III. PURPOSE AND SCOPE OF REVIEW

This report serves as a follow-up to the GAO investigation. Thus, the purpose of this review is to determine if the TRIS claims being submitted to CMS for reimbursement are allowable and consistent with Federal regulations and the State's approved Medicaid plan.

The period and scope of this review was limited to the review of the CMS-64 TRIS expenditures for the quarters ended 3/31/2005, 6/30/2005, and 9/30/2005.

IV. FINDINGS AND RECOMMENDATIONS

We found that TRIS services are claimed as EPSDT rehabilitation services provided in non-federally recognized residential settings and erroneously claimed on the CMS-64 as Targeted Case Management services. These therapeutic services are based on an intervention services assessment of the medical, psychological, social, educational and other needs of the children. The assessment itself would be a coverable service under EPSDT. However, the other services cannot be billed as a bundled rate except through an institutional payment or a managed care waiver. Based on the two deferral letters issued by CMS, on March 15, 2006 the DCH requested a proposed resolution and transitional period to restructure the entire TRIS program and eliminate the bundled rate. Our review also disclosed that a public notice was issued by the State on January 14, 2004, which included a significant change to TRIS reimbursement payment methodology; however, a State Plan Amendment (SPA) was never submitted to reflect this change which violates the requirements of Federal Statute, §1902 of the Social Security Act, Federal Regulations at 42 CFR 430 Sub-Part B, and State Medicaid

Manual, section 5340(a). We also determined, based on our limited review of claims, the actual date of service is not used; instead DHR and DJJ uses one CMS 1500 to cover an entire treatment period for a child, which violates State Medicaid Manual 5320.2(b).

In April 2005, we visited four (4) TRIS facilities over the course of four (4) days and the main office of the Department of Juvenile Justice. The facilities had been identified as operations that are currently billing Medicaid for services. The facilities were chosen based on location, type of site, and current reimbursement. CMS staff visited both neighborhood "group home" type settings and inpatient residential treatment settings. The purpose of the facility reviews was to gain an understanding of the funding, services provided, and the settings where TRIS services are provided.

CMS staff followed the same protocol at each facility. Each facility was visited without prior notification. After explaining why we were there, we requested a list of the current Medicaid and non-Medicaid residents. We reviewed the list and selected a random sample from each of the various programs of the facility. Ten (10) records or more were sampled (dependent upon the number of reviewers present and the amount of time available). Each record was examined to determine if there was a plan of care, what services were ordered and provided and what documentation existed in the record. (Please refer to **EXHIBIT 1** for the details of each facility visited).

Findings:

1. Lack of State Medicaid Agency Oversight: Section 1902(a)(5) of the Act provides for the designation or establishment of a single State Agency responsible for the administration of the Medicaid plan. Regulations at 42 CFR 431.10 sets forth rules for the Medicaid agency's administration of the plan. Section 431.10(e) specifies responsibilities that may not be delegated by the Medicaid agency to any, other than its own employees. We did not find any Medicaid oversight of the program, rather Medicaid paid what DHR and DJJ asked, with no requirement for Department of Community Health approval of or review of the services. In fact, we find the 2/3/06 letter from DCH responding to CMS's deferral GA/2005/2/E/01/MAP, confirms this finding. In response to the request of CMS in item #5 for the protocols used by DCH to monitor the quality, efficiency, and effectiveness of the TRIS program, the State indicated that:
 - (a) All TRIS providers have signed a contract with DHR or DJJ (not DCH);
 - (b) TRIS services are prior authorized by DHR or DJJ. We find it most remarkable that the State would consider the prior approval of the provider (DHR and DJJ, are the enrolled providers, who in turn sub-contract with the individual facilities) as sufficient. Section 1902(a)(5) of the Act provides for the designation or establishment of a **single** State agency responsible for the administration of the Medicaid plan. Regulations at 42 CFR 431.10 sets forth rules for the Medicaid agency's administration of the plan. Section 431.10(e) specifies responsibilities that may not be

- delegated by the Medicaid agency to any, other than its own employees for the Medicaid State Agency.
- (c) Semi-annual utilization reviews are conducted by practitioners of the healing arts and the "services are reauthorized by DHR or DJJ," again, not the Medicaid State Agency.
 - (d) The letter does not indicate what agency conducts the site inspections of providers seeking to enroll or the periodic re-reviews.
 - (e) The letter indicates that DCH "requires" DHR and/or DJJ to also screen the providers. Given that facilities are contracting with DHR or DJJ, not DCH, it appears that this is more a requirement of the "contracting" agencies, not DCH. Where is the DCH requirement for DHR/DJJ facility screening?
 - (f) It is not clear on which agency (DCH or DHR) conducts the annual review of the cost report and time studies.

In addition, the Agency Supplement "Q" to the Interagency Master Agreement between the Georgia Department of Community Health, the Georgia Department of Human Resources and the Department of Juvenile Justice (July 1, 2003) clearly delineates that DHR has the regulatory responsibility and that main function of DCH is to pay for the services contracts for by DHR and DJJ.

Recommendation: DCH must exercise its administrative oversight and review what it is being asked to pay for by its sister agencies.

2. Non-Medicaid Costs Charged to Medicaid: Federal statute and regulations require that Medicaid pay for "medical assistance" provided by Medicaid enrolled providers to Medicaid eligible recipients, not programs for which other programs are responsible. We found that the TRIS program shifts the program costs of the foster care program, managed by the Department of Human Resources (DHR), and aspects of the Juvenile Justice program, managed by the Department of Juvenile Justice (DJJ), to Medicaid. Section 471 of the Act [42 U.S.C. 671] mandates: "(a) In order for a State to be eligible for payments under this part, it shall have a plan approved by the Secretary which - (1) provides for foster care maintenance payments in accordance with section 472." Section 475(4)(A) of the Social Security Act indicates what the responsibilities are a part of the State Agency managing the foster care program:

The term "foster care maintenance payments" means payments to cover the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel to the child's home for visitation. In the case of institutional care, such term shall include the reasonable costs of administration and operation of such institution as are necessarily required to provide the items described in the preceding sentence.

The TRIS provider manual (Section 903, quoted above) indicates that what is being purchased are four different levels of foster care. In the review of case records at the facilities CMS staff visited, we did not find documentation of medical services being provided. We find that TRIS services are more correctly viewed as foster care and not **medical** treatment (and the responsibility of the foster care agency) although the majority of the costs were claimed as Medicaid costs. We found that the services of licensed mental health professionals provided to residents of these facilities are separately billed. A major component of the treatment provided in the two higher-level foster care facilities, "Residential Treatment and Therapeutic Camps" is "Milieu therapy." "Milieu therapy" is considered to be custodial care by most private health insurance companies and is **not** a Medicaid covered service.

We reviewed the copies of annual cost reports for the two facilities we were given (United Methodist Children's Home [UMCH] and the Bridge). We found that the United Methodist Children's home cost reports did not establish claimable TRIS rates, or the degree in which these facilities are also supported by other state, local, or private funds. Using other revenues including private funds collected by the abovementioned facility to offset cost as per the attached worksheets (Exhibits 3 and 4 respectively), it appears that more than 93.5 percent of the remaining costs for the UMCH and 95.07 percent for the Bridge shifted to Medicaid.

Recommendation: The program costs should be assigned to the correct agency. Medicaid should be paying for medical assistance costs for Medicaid eligible children only. The incorrectly claimed costs spent should be recouped and the program re-vamped. According to 1905(a) of the Social Security Act (the Act), Therapeutic Residential Intervention Services (TRIS) is not a Medicaid coverable service in and of itself. After a thorough review of the types of services provided through TRIS, only one service is found to be a 1905(a) service, and that is psychiatric nursing services which would be delivered under the benefit for nursing services under 21. We believe that the State should add Inpatient Psychiatric Services for the <21 year olds (also known as Psychiatric Residential Treatment Facilities or PRTFs), which is an optional service, not provided in the current Georgia State Plan. PRTFs are recognized under Medicaid statutes for the provision of intermediate psychiatric care (including the costs of room and board) for children who do not need inpatient hospital level of care, but who need more care than can be provided in a community setting. Crisis intervention is also listed as a TRIS service. This is also seen as an integral part of any service that a PRTF or other facility/program would provide. It does not appear that there would be a way to separate this function from other types of services provided (e.g., how to provide documentation such as length of time).

3. Inaccurate Time Study and Methodology Used for the Development of the Medicaid Payment: A time study can be used to develop a rate, but the cost base

must be established in accordance with reasonable criteria, and be supported / *adjusted* by the ratio of Medicaid eligible individuals to total population served by facility (the Medicaid discount rate as described in the final Medicaid Administrative Claiming Guide), the total number of full time employee (FTEs) on staff, and the number of FTE's who are **licensed** to provide mental health rehabilitation. The time study in use did not meet any of these criteria. We examine the four codes claimed as Medicaid coverable below:

- Code E- the activities listed appear to be ones that are the responsibility of the DHR as foster care activities.
- Code F- "Life Skills Development," we question whether this is a medical service. If these services are "medical" and provided to individuals with a mental health diagnosis, then it would seem these facilities are Institutions for Mental Disease (IMDs). Some of the facilities reviewed appear to have more than 16 beds. If a facility has more than 16 beds, and is providing services to primarily persons with a mental health diagnosis, it is considered an institution for mental disease (IMD) and is not eligible for FFP.
- Code G- Counseling, Therapy, Consultation, Assessments- What assessment? None is mentioned in the examples given. Again we question whether these are medical services - are house parents "licensed practitioners of the healing arts?" Are these facilities IMDs?
- Code H - Medical treatment not billed to Medicaid (as a separate service, I assume, but added to the rate).

We found the codes to be biased towards Medicaid. These appear to be the ones the staff who are identified as generally included in the time study: "child care workers, house parents, social workers, therapists (include consultants), nurses, interns who are assigned direct-service caseload responsibility, and other staff who routinely engage in providing direct services to children" (page 3 of the SFY 2006 Time Study Instructions) would be expected to perform. Only some of the staff include would be likely to have medical credentials necessary to perform a billable medical service. Are the costs of some of the other codes prorated to Medicaid (for example, Code B, General Administration, or Code D "Room and Board"? At one of our meetings with DHR, I remember being told that a portion of room and board costs was include in the rate, for the was a "therapeutic" component to "room and board."

These residential facilities are paid a "per diem" payment, which we find not acceptable for a variety of reasons:

- Medicaid pays only for services in the approved State plan.
- To be approved outside the waiver context, a service must be found in section 1905(a) of the Social Security Act, or fall into the category of "any other medical care, and any other type of remedial care recognized under state law, specified by the Secretary." The facilities reviewed are

not recognized as a provider solely because of the setting or because they have been accredited as a provider within the state to deliver services to DJJ or DHR children. The Medicaid program considers the following facilities as providers of care: nursing homes, hospitals, federally qualified health clinics (FQHC's), intermediate care facilities for the mentally retarded (ICF/MR), and psychiatric residential treatment facilities (PRTF's). For Institutions for Mental Diseases (IMDs), payment is excluded for services furnished to residents under age 65.

- Individuals have free choice of qualified Medicaid providers who undertake to provide a service.
- An individual may not be compelled to receive a Medicaid service, either alone, or as a pre-condition for receiving another Medicaid service, as this would violate that person's right to choice.
- Within a juvenile institution, it is generally claimed that individuals receive multiple Medicaid services. In a fee-for-service environment, however, it cannot be assumed that each individual would receive each (or any specified number or portion or frequency of) service in a "bundle."
- Time studies, cost-finding methodologies, etc. that are used to establish a bundled rate are based on one of two assumptions:
 - each individual would receive each service at specified frequencies; or
 - some individuals would receive more, some fewer, services at varying frequencies, but on the average the math would be correct.

These assumptions cannot be used as the basis for Medicaid Federal Financial Participation (FFP). The first is flawed because Medicaid can only pay if the individual actually does receive a service - not because the individual is presumed to receive one; the second because it does not reflect actual utilization of Medicaid services on a per-eligible basis. Moreover, neither assumption is consistent with freedom of choice requirements.

During our limited review, it did not appear that the facilities would meet the conditions of participation for psychiatric residential treatment facilities (PRTFs) contained in §1905(h) of the Social Security Act and 42 CFR of the Code of Federal Regulations (440.160, 441, Subpart D and 483, Subpart G). Unless the TRIS facilities qualify as PRTFs, there is no specific regulatory or statutory authority for the provision of these services under Medicaid. Thus, we find that TRIS facilities do not provide services for which FFP can be claimed for eligible beneficiaries. PRTFs meeting the requirements in Part 441, Subpart D, and Part 483, Subpart G, are the only recognized institutions for mental disease (IMD) facilities where individuals under 21 years of age can receive inpatient psychiatric services and room and board costs can be included.

Recommendation: An accurate time study with only appropriate Medicaid providers should be developed (assuming there is any part of the services being

provided in these facilities are eligible for Medicaid reimbursement). Per diem payments are only appropriate for services provided in an institutional setting.

If the State wants to provide services to children in an institutional setting, it must provide these services in a setting that meets provider qualifications. We recommend that the State add Inpatient Psychiatric Services for the <21 year olds (also known as Psychiatric Residential Treatment Facilities or PRTFs), which is an optional service and not provided in the current Georgia State Plan.

4. Unallowable Documentation Used for Medicaid Claims: Actual services must be documented with clinical records to support the claim, not a two-week time study was used to establish statewide rates and to serve as a proxy for services rendered for an entire year. Facilities maintain a plan of care but not documentation that supports what service has actually been provided. This methodology does not comply with Federal requirements to Medicaid claiming – the why, who, what, when, how long, to whom. It does not support who was performing what Medicaid service for whom when time was allocated to the medical service category during the two week time study. It is also quite presumptuous to assume that the rest of the year would be identical in nature to the sampled two weeks.

Recommendation: Any Medicaid service must be correctly documented and provided by an enrolled Medicaid provider to an eligible Medicaid individual child. We find the TRIS program is not in compliance with Federal requirements, so the incorrectly claimed Federal share should be recouped and the program re-vamped.

5. Ineligible Children Included: It is longstanding Federal policy that when a juvenile is participating in a program sanctioned under the terms of his/her sentence, whether made voluntarily or involuntarily, **FFP is not available** (42 CFR 435.1008 and 1009). Although, allowing for a choice to participate in a special program, the terms of the sentence are still basically involuntary participation mandated by the sentence from DJJ. The “Juvenile Justice Terms/Definitions / Definitions of terms used in the Department of Juvenile Justice” found on the Georgia Department of Juvenile Justice web site (<http://www.djj.state.ga.us/djgglossary>) indicates that:

Specialized Residential Services – This program provides residential treatment services for delinquent and unruly youth that need more specialized care than the Department of Juvenile Justice programs currently provide. These youth require either long-term residential placement or specialized treatment services emphasizing mental health care. **Services are purchased from the private sector** (added emphasis).

Recommendation: Medicaid should not be billed for services provided to children who are the responsibility of the DJJ.

6. Duplication of TCM Services: We note that the requirements for service found in Section 7 of the TRIS Provider Manual are the same as found in the many county specific Targeted Case Management Services in the current Georgia State Plan, for example: "All Medicaid members from birth to age twenty-one (21) that are in the custody of, at risk of being in the custody of, or are under the supervision of either DHR or DJJ and ... Need for assistance from multiple community service agencies; Substantial need for care to augment or replace insufficient or unavailable; and natural support from a family or family equivalent unit." The activities listed under Code E of the Time Study sound like typical TCM services – "identifying the child's medical, social educational and other needs... development of a Plan of Care, coordination and advocacy, facilitating the child's access to the services..." We believe the billing of TRIS services as TCM services is indicative of both the confusion within the two agencies involved in TRIS services (DHR and DJJ) of these services and the differences in the services and the duplication of the services provided. We find similar problems with both services (DJJ probation officers as TCM providers does not afford clients freedom of choice of provider, for example). The "Juvenile Justice Terms/Definitions" referenced above indicates that: "Counseling/Case Management – Involves developing a plan that the Juvenile Probation Parole Specialist (JPPS) pursues to rehabilitate the youth and prevent further involvement with the court. The worker provides counseling, supervision and may network with other resource providers in the community for appropriate program referrals." We question why the JPPS services are being billed as a Medicaid service, for surely "case management" is a required part of the job for a juvenile probation officer.

The Department of Community Health provided some Medicaid claim histories for 2004 for 25 children whose records CMS reviewed in TRIS facilities. We noted that 21 children also had claims paid for targeted case management services. Two children who received inpatient TRIS services every day of the year (AL, last 4 numbers of Medicaid identification number are 9955, and DF, 4687) also received TCM services. The claims history for DF indicates that DCYS provided a service on 1/1/04 (\$173.16 paid, the basic TCM rate), while Inner Harbour received payment for 31 days of in-patient services that month. DF also had \$1,687.50 in "CPS case management" services in 2004. While it is the policy of CMS to permit limited TCM services for institutionalized individuals for a limited period of time (30 days prior to the expected discharge), since the claims history indicated that TRIS facilities received payment for services on every day of 2004 and these 2 children were still in TRIS Facilities in 2005, we believe these are duplicative services.

Recommendation: Section 1905(a)(19) and 1915(g)(2) of the Act define case management as "services which will assist an individual eligible under the State plan in gaining access to needed medical, social, educational and other services." Activities commonly understood to be allowable include: (1) assessment of the eligible individual to determine service needs, (2) development of a specific care

plan, (3) referral and related activities to help the individual obtain needed services, and (4) monitoring and follow-up.

- a. Any services outside of the above definition may not be billed as case management.
- b. Medicaid case management services also do not include payment for the provision of direct services (medical, educational, or social) to which the Medicaid eligible individual has been referred.
- c. In the review, it appears that case management is billed separately for each of the facilities/programs. However, the majority of the children residing in these facilities/programs are in custody of the DJJ and DHR. The State must provide that case management services will not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.
- d. If the state chooses to add PRTF's to their state plan, they would not be able to bill TCM as a separate service.

The Deficit Reduction Act (DRA), section 6052, supports CMS' longstanding policy related to case management. Through this statute, Congress recognized that implementing case management services has led to problematic claiming. The statute reiterates the definition of case management and targeted case management contained in section 1915(g), as well as, examples of activities that are not reimbursable.

7. Lack of Freedom of Choice of Providers. Section 1902(a)(23) of the Act provides that "any individual eligible for medical assistance... may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required... who undertakes to provide him such services." Where is the freedom of choice of provider for these children in the custody of the two public agencies that determine the children's placement?
8. Violation of Comparability: Section 1902(a)(10)(B) of the Act and regulations at 42 CFR 440.240 establish requirements for comparability of services. Comparability means that (with certain exceptions) the services available to any categorically needy recipient are not less in amount, duration and scope than those services available to a medically needy recipient, and that services are equal for any individual within a group. If access to these facilities is controlled by DHR and DJJ, how are other children in need of residential psychiatric treatment assured access (given the requirements of §1905(r) EPSDT for any medically necessary §1905(a) coverable service to be provided)? It is not clear how other children could be provided the "services" that children in TRIS facilities receive.

Recommendation for Items 7 & 8: The TRIS program needs to be revised to comply with Federal requirements. If Medicaid requirements cannot be met, the program should be funded with all State funds.

9. State Plan Concerns: For services, Federal regulations at 42 CFR 430.10 require that the State plan "contains all information necessary for CMS to determine

whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.” For payment of services, Federal regulations at 42 CFR 447.201 require that the plan “describe the policy and methods to be used in setting the payment rates for each service in the State plan” and at 42 CFR 447.205, “must provide public notice of any significant proposed change in its methods and standards in setting payment rates for services.” We find that the State failed to meet these requirements with TRIS services. TRIS services are described on page 1 of Supplement 2 to Attachment 4.19-B of the current Georgia Title XIX State plan. The brief description provided does not appear to accurately describe the services provided (for example, while the description indicates that child and adolescent mental health services are provided in “home, school, therapeutic foster care, child caring institutions (IMDs excluded),” we did NOT find any services are provided in any setting other than the facilities contracted with DHR or DJJ). In addition, we question whether it is correct that “IMDs are excluded,” given the Federal definition of an IMD at 42 CFR 435.1009 as an Institution for mental diseases means 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. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

The payment methodology for TRIS services does not provide the detail CMS expects to see an SP to adequately describe how the services are actually paid. We did not see any “adjustment for inflation” in the payment computation provided as examples for the two facilities we were given. We question why DCH issued public notice in January 2004, if the Agency did not feel the change was “significant.”

We also found a lack of clarity in the current Georgia State Plan for there are several services that appear as possible duplicates of some of the “treatment components” of TRIS. DCH provides similar services under the rehabilitation option, 42 CFR 440.130(d), “Community Mental Health Rehabilitative Services” as “Psychosocial Rehabilitation Services” and “Residential Rehabilitation Supports,” as well as “Child and Adolescent Mental Health Services (TRIS),” described in Supplement 2 to Attachment 4.19-B, page 1. In both instances, the providers must meet the provider qualifications as defined by the national accreditation of Joint Commission on Accreditation for Healthcare Organizations (JCAHO), Commission on Accreditation for Rehabilitation Facilities (CARF), Council on Accreditation for Services for Children and Families, Inc., Council on Quality Leadership, and/or State certification.

Recommendation: The Georgia State plan must be revised to comply with Federal requirements that it be a comprehensive and complete description of its Medicaid program and in compliance with all Federal mandates.

10. Eligibility:

1. It appears that there is some type of MATCH program and DJJ will pay "half" of the payment to the facility/program. Medicaid is always the payer of last resort. Additional questions arise in the following areas:
 - a. Under what guidance does DCH allow a provider to bill a parent \$700 a month for the provision of services to their children?
 - b. What if children are dually involved in DHR and DJJ? Who is billed first, how do they compute the payment, and when is Medicaid being billed?
 - c. How do facilities/programs bill for non-Medicaid eligible children?
2. For children under the supervision of the DJJ, how did the children become Medicaid eligible given that Medicaid does not cover the provision of services for inmates regardless of age?
3. A possible duplication of payments exists because DCH, the single state agency for the State of Georgia, responsible for administration of the Medical Assistance Program, provides TRIS services under the rehabilitation option (42 CFR 440.130(d)), "Community Mental Health Rehabilitative Services" as "Psychosocial Rehabilitative Services" and "Residential Rehabilitation Supports," as well as "Child and Adolescent Mental Health Services." It appears that the state plan should be reviewed for consistency and accuracy to avoid duplication of both the number of times a service is rendered and/or billed.

V. OVERALL RECOMMENDATIONS

Programmatic Issues: Given the systemic failure to comply with Federal Medicaid statutory and regulatory requirements for services, we find the TRIS Program as it exists today must be completely revised. We realize that this will be a massive task. CMS staff is willing to work with DCH to revise the TRIS Program so that any services which could be covered by Medicaid are provided in a manner in compliance with Federal requirements. One place to begin is the serious consideration of adding of Psychiatric Residential Treatment Facilities services in the State Plan. Other overall Medicaid considerations should include:

Provider Qualifications:

There is no documentation mentioned that specifies if these facilities/programs hire individuals that meet the State's qualified provider criteria, including state licensure and certification requirements.

Provider Enrollment:

The facilities reviewed were accredited by the Council on Services for Families and Children as "child care facilities" but were not otherwise

licensed. How do these facilities meet the requirements to be a Medicaid enrolled provider?

Financial Issues:

Improper Medicaid documentation:

Improper documentation is directly linked to inappropriate billing procedures.

- DHR and DJJ use one CMS 1500 to cover an entire treatment period for a child, violating the State Medicaid Manual at 5320.2(b).
- DHR pays for children based on number of clients at a facility instead of the actual services rendered.

Case records must document, for each individual receiving case management, the name of the individual; the dates of case management services; the name of the provider agency (if relevant) and person chosen by the individual to provide the case management services; the nature, content, and units of case management services; whether the individual requests that the assessment and care plan be limited; timelines for providing services and reassessment; and the need for coordination with other Medicaid case managers or case managers of other programs. If the State pursues developing a PRTF service, facilities would still be required to follow all Medicaid documentation requirements.

Based on the lack of documentation to support that allowable rehabilitation services were rendered and rates paid were reasonable, we are recommending the following:

Financial Recommendations:

We recommend that this issue be resolved by granting Georgia their proposed 12 month transition starting April 28, 2006 to provide sufficient time to replace the Therapeutic Residential Intervention Services (TRIS) Program with an allowable medically necessary behavioral health care program for the eligible children through an appropriate outpatient and inpatient facilities. However, the return of the outstanding deferral amounts is contingent upon CMS receiving an acceptable timeline and action plan that comports with CMS guidelines.

D R A F T

CMS FMR #04-FM-2005-GA-006-D

Exhibit 1

DEFERRED FEDERAL FINANCIAL PARTICIPATION (FFP):

For the quarter ended 3/31/2005, we have issued a deferral for \$144,016.

For the quarter ended 6/30/2005, we have issued a deferral for \$40,098,369.

Total outstanding deferrals relating to TRIS equal \$40,242,385.

Exhibit 2

**Eckerd Youth Facility doing business as Camp E-Ma-Laku
Suches, GA**

Licensed as a child care facility by the Council on Accreditation of Services for Families and Children, Inc. (COA)

General Information

This is an *outdoor therapeutic camp*. It has been in operation for nine years. The camp treats at-risk, behavioral, emotional problems and ADHD. Group therapy is used with 2 psychologists and 1 psychiatrist. 60% to 65% are on medication.

This is a boys only camp, ages 10 to 17. Average stay is nine months; the longest stay was 18 months.

Camp census was approximately 41 at the time of visit.

<u>Custody</u>	<u>Number of Children</u>
DHR	7 to 8
DJJ	30
Private Pay	2-3

Each child has an *individual treatment plan*. Family conferences are every 9-10 weeks. Home visits are every 5 weeks. 25% are in foster care.

CHRIS Homes

Atlanta, GA

Licensed as a child care provider by the Council on Accreditation of Services for Families and Children.

General Information

CHRIS Homes operates six foster care homes in residential neighborhoods in DeKalb, Fulton, Gwinnett, Douglas, and Clayton counties. The home-like settings provide 24 hour supervision for children who are in Department of Family and Children Services (DFACS) or DJJ custody and have a history of failed or difficult placements. The children attend their neighborhood schools and receive therapy as needed as a part of their individual service plan. The police are contacted to support intervention as needed (i.e., the child commits an illegal act or runs away). Children with repeated problems may be transferred to a more restrictive environment. In 2003, 110 children were served.

The Bridge

Atlanta, GA

Licensed as a child care provider by the Council on Accreditation of Services for Families and Children

General Information

An inpatient setting with two units and three (3) outlying cottages. One of the cottages is for assessment and two of the other units focus more on transitions to independent living. The children residing in these cottages may attend public schools and/or have jobs. The billing process for DHR works by a pre bill being submitted by DHR to the facility. Children are added or subtracted as appropriate and the facility is reimbursed.

Custody

80% of the children served come from DJJ, or DHR.

Concerns Identified

The documentation in the charts reviewed was not consistent with The Bridge's policies. Progress reviews conducted six (6) months after the designated time, psychiatric visits with lags of over four weeks rather than the designated weekly visits, and service plan reviews not updated appropriately. One child was noted to have eloped and the recommendation was that he be placed in a DJJ boot camp.

Devereux Center (Specialty Hospital)

Kennesaw, GA

Devereux has licensure and approval from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

General Information

The facility consists of several treatment programs which are housed in small dorm like facilities. There is a separate foster care facility. The treatment program appears comprehensive. The campus is locked and surrounded by a large tall fence (eight (8) feet topped with barbed wire).

Custody

Most of the children are DHS or DJJ custody.

Concerns Identified

There were numerous questions regarding payment. Some of the records reviewed indicated that the payment was being made by DJJ and DHR. Some of the patient charts indicated "DJJ is willing to pay half the costs".

In some cases it was noted that the parents were required to pay \$700 per month toward the TRIS program. The other question that arises is what happens to the foster parent stipend when the child is in a residential program.

D R A F T

CMS FMR #04-FM-2005-GA-006-D

Department of Juvenile Justice
Decatur, GA

General Information

Many of the children come to DJJ after being removed from their foster care environment. DHR bills Medicaid for both TRIS 1- therapeutic residential and TRIS 2 - basic care. DJJ uses probation officers as case management employee and bills Medicaid with respect to their services provided to the children. Medicaid is reimbursing DCH for children adjudicated and in DJJ custody, paying probation officers for targeted case management, and possibly paying for the same services multiple times.

Custody

Children are in DJJ custody, or could have shared custody with the GA Department of Children and Family Services.