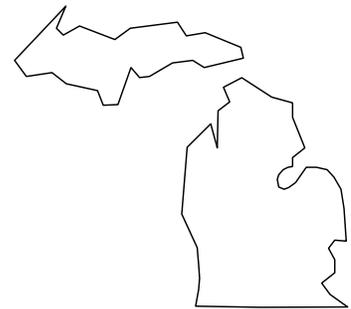


**DEPARTMENT OF COMMUNITY HEALTH**

**FOLLOW-UP REVIEW OF THE  
CENTER FOR FORENSIC PSYCHIATRY AND  
RELATED BUREAUWIDE REIMBURSEMENT ACTIVITIES**

Office of Audit  
Special Audits, Review and Compliance Section  
February 2008





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February 8, 2008

Ms. Janet D. Olszewski, Director  
Michigan Department of Community Health  
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201 Townsend Street  
Lansing, Michigan 48933

Dear Ms. Olszewski:

This is our report on the results of our follow-up review of the findings and recommendations contained in the Office of the Auditor General's Performance Audit of the Center for Forensic Psychiatry and Related Bureauwide Reimbursement Activities.

This report contains an introduction; background information; review scope and methodology; and follow-up conclusions.

We appreciate the courtesy and cooperation extended to us during this audit.

Sincerely,



Pam Myers, Acting Director  
Office of Audit

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## **INTRODUCTION**

This special report contains the results of our follow-up review of the findings and recommendations reported in the Office of the Auditor General (OAG) Performance Audit of the Center for Forensic Psychiatry and Related Bureauwide Reimbursement Activities for the period October 1, 2000 through August 27, 2004. The OAG audit report contained 5 findings and 7 corresponding recommendations. DCH's preliminary responses indicated that it concurred with all of the findings.

## **PURPOSE OF REVIEW**

The purpose of this follow-up review was to determine whether DCH has taken appropriate steps to comply with OAG audit recommendations.

## **BACKGROUND**

The Center for Forensic Psychiatry (CFP) was created by Act 266, P.A. 1966, and operates under the jurisdiction of the Bureau of Hospitals, Centers, and Forensic Mental Health Services, Department of Community Health. CFP's mission is to provide quality forensic mental health services to individuals and the Michigan court system.

To fulfill its mission, CFP conducts diagnostic evaluations for all of the State's district and circuit criminal courts on issues related to competency to stand trial, criminal responsibility, competency to be sentenced, juvenile waiver, sentencing and pre-sentencing recommendations, dangerousness, and other issues. CFP also provides inpatient psychiatric treatment for criminal defendants adjudicated incompetent to stand trial and/or acquitted by reason of insanity. A complement of psychiatrists, psychologists, social workers, nurses, forensic security aides, and occupational, recreational, and music therapists provides this treatment in CFP's seven inpatient units.

CFP, like other DCH facilities, is responsible for seeking reimbursement from patients, insurers, and federal entitlement programs, as applicable, to recover its treatment delivery costs.

On November 1, 2000, CFP earned its first accreditation from the Joint Commission on Accreditation of Healthcare Organizations. CFP was reaccredited on June 18, 2007.

## **REVIEW SCOPE AND METHODOLOGY**

Our review procedures were of limited scope; therefore they should not be considered an audit in accordance with Government Auditing Standards issued by the Comptroller General of the United States.

Our review procedures were performed July of 2006 through September 2006, and included an examination of updates made to the databases as well as interviews with applicable DCH staff.

## **FOLLOW-UP REVIEW RESULTS**

### **1. Reimbursement for Medicare Bad Debt**

DCH's CMS-certified facilities did not seek reimbursement from Medicare for bad debt resulting from the unpaid deductibles and coinsurances of Medicare enrolled patients.

#### **Recommendation**

DCH's CMS-certified facilities seek reimbursement from Medicare for bad debt resulting from the unpaid deductibles and coinsurances of Medicare enrolled patients.

DCH facilities request to reopen past cost settlements and seek reimbursement from Medicare for eligible Medicare bad debt.

### **DCH Preliminary Response**

DCH agreed with the finding and both recommendations. DCH stated that procedures were implemented to identify and include reimbursable bad debt expense on all current and future cost reports. DCH also agreed that cost reports can be reopened as far back as fiscal year 1998-99 and indicated they are currently working to gather the necessary information and will seek reimbursement for those previous years.

### **Follow-up Review Conclusion**

DCH has not complied with these recommendations.

DCH's State Facility and CMHSP Reimbursement Section (Section) has implemented a process to quantify and report bad debt written off and referred to treasury, as well as, any subsequent reimbursement for any bad debts. Bad debt resulting from unpaid deductibles and coinsurance will be included in FY 2007 cost reports. Written internal policies/procedures have been drafted with expected finalization by December 31, 2007. In addition, the Section is researching whether additional bad debt can be reported for unpaid deductibles and coinsurance for Medicaid/Medicare patients that have no ability to pay.

The Section, due to staffing limitations, did not reopen the cost reports mentioned in the audit and has since lost the ability to do so because of the three year limitation.

## **2. CMS Certification**

CFP had not conducted a comprehensive analysis to determine if it would be cost-effective to obtain CMS certification. As a result, CFP may be forgoing Medicare and Medicaid reimbursements that would significantly exceed the costs it would incur to generate them.

### **Recommendation**

CFP conduct a comprehensive analysis to determine if it would be cost-effective to obtain CMS certification.

### **DCH Preliminary Response**

DCH agreed with the finding and recommendation. DCH indicated it will conduct a more thorough analysis to determine if it should pursue certification and will maintain documentation supporting the results of the analysis. If the analysis demonstrates that it is cost-effective, DCH will pursue certification subject to any statutory or budgetary approvals that may be required.

### **Follow-up Review Conclusion**

DCH has complied with this recommendation.

DCH contracted with Health Management Associates (HMA) to conduct a study to assess the feasibility of CFP obtaining Medicare certification and the financial impact of such an action. In addition, DCH management, in consultation with HMA, conducted a study to quantify the costs and benefits of this certification for CFP. Information obtained during these processes indicated that CFP CMS certification would have an adverse effect upon aggregate DCH Medicare revenues.

The DCH analysis concluded that the patients for whom CFP might bill were not guilty by reason of insanity probates. These patients are routinely transferred to other DCH facilities where billing already takes place. Thus, while they estimate that CFP could generate \$625,000 in Medicare Part A and B revenue annually, other DCH facilities would lose approximately \$1,900,000 annually. The HMA study concluded that the reimbursement obtained by DCH would drop from approximately \$1,750,000 to approximately \$550,000. In order to obtain CMS certification it is expected that additional staffing, particularly nursing, would be needed at CFP. The HMA study estimates the cost of hiring the additional registered nurses needed would be

\$2,400,000. The DCH Budget Office estimates that it would cost CFP an additional \$8,000,000 to staff CFP at levels similar to DCH facilities that are certified.

### **3. Medicare Part B Benefits**

CFP and other DCH facilities did not ensure that eligible patients retained enrollment in Medicare Part B after the discontinuance of their Social Security benefits.

#### **Recommendation**

DCH facilities ensure that eligible patients retain enrollment in Medicare Part B after the discontinuance of their Social Security benefits.

#### **DCH Preliminary Response**

DCH agreed with the finding and recommendation. DCH stated it will expand the system used at the Caro Center to its other certified hospitals and centers to ensure that eligible patients retain their enrollment in Medicare Part B after discontinuance of their Social Security benefits. CFP will participate in Part B should it seek and obtain CMS certification. If it is determined that CMS certification is not feasible, CFP will explore whether it is cost-effective to enhance the documentation of the covered services that would be required to participate in Part B.

#### **Follow-up Review Conclusion**

DCH has not complied with this recommendation.

Medicaid pays the premium for Medicare Part B if the beneficiary is Medicaid eligible. Only one DCH facility, Caro Center, continues to use general fund dollars to reimburse for Medicare Part B premiums for non-Medicaid eligible beneficiaries. The Walter Reuther Psychiatric Hospital cannot use Medicaid funding to pay for Medicare Part B premiums because their local Department of Human Services office refuses to do Medicaid eligibility determinations for beneficiaries residing in their hospital, if they are between the ages of 21 and 65. The Kalamazoo Psychiatric Hospital is not paying for premiums for at least three beneficiaries because they

refuse to provide the necessary verifications to KPH that are required by DHS for Medicaid eligibility approval, therefore they are charged full cost.

#### **4. County Cost Reimbursement**

CFP and other DCH facilities did not charge counties for their full share of the facilities' costs to deliver services to county residents. As a result, DCH facilities did not obtain all applicable county cost reimbursements.

#### **Recommendation**

DCH facilities charge counties for their full share of the facilities' costs to deliver services to county residents.

DCH facilities charge counties for their 10% share of the uncollectible accounts previously referred to the Department of Treasury, as determined to be economically feasible.

#### **DCH Preliminary Response**

DCH agreed that counties are financially liable, with some limited exceptions, for 10% of the net cost of services provided by DCH facilities. DCH also agreed that it did not separately bill the counties for any first and third party reimbursements that proved to be uncollectible. DCH indicated that it is in the process of analyzing and making changes to its billing system in response to changes in Medicare. As a result of these changes and issues raised by the audit, DCH intends to completely review its procedures relating to how it calculates the net cost of providing services to determine the cost-benefit of any changes necessary to ensure that first and third party payers and the counties meet their financial obligation.

#### **Follow-up Review Conclusion**

DCH has not complied with this recommendation.

DCH State Facility and CMHSP Reimbursement Section stated that the current billing system would not be able to bill the counties for their portion of the charges that are forwarded to the Department of Treasury. If DCH were to bill the counties for 10% of uncollectible accounts forwarded to Treasury there is not a mechanism in place to return these additional 10% payments in the event that Treasury subsequently obtains payment for the forwarded accounts. For example, a patient owed \$1,000 that was determined to be uncollectible by DCH and the account is turned over to Treasury for collection. DCH bills the appropriate county 10% for his care, \$100, and later Treasury is able to collect the \$1,000 owed by the patient. The Section indicated that it is currently unable to track these payments to ensure that the \$100 is then returned to the county.

**5. Reimbursement Office Staffing**

DCH did not provide CFP with the staffing needed to complete its reimbursement responsibilities in a timely manner. As a result, CFP did not timely bill patients, counties, and other responsible parties for its patients' cost of care. Timely billing is important because it increases the likelihood of collection and improves the State's cash flow.

**Recommendation**

DCH provide CFP with the staffing needed to complete its reimbursement responsibilities in a timely manner.

**DCH Preliminary Response**

DCH agreed with the finding and corresponding recommendation. DCH stated that for a period of time its billing functions were not being performed in a timely manner. DCH indicated it has now centralized its billing responsibilities for all of its hospitals and centers. DCH stated that the backlog of financial liability determinations has been caught up and the determinations are now current. In addition, DCH has and will continue to make progress to improve its timeliness regarding its billing responsibilities.

**Follow-up Review Conclusion**

DCH has not complied with this recommendation.

DCH centralized its billing responsibilities in July 2004. At the time of our review billings were not current. We were informed that the billings are not up-to-date because of a system change, which took effect October 1, 2005. In addition, we were informed that in February 2007 there were four vacancies in the reimbursement unit. All hospital billings are expected to be current by October 2007.

## GLOSSARY OF ACRONYMS AND TERMS

bad debt	The Medicare deductible and coinsurance amounts that are deemed uncollectible from Medicare beneficiaries after reasonable collection efforts have been made.
Centers for Medicare and Medicaid Services (CMS)	An agency within the federal Department of Health and Human Services that administers Medicare. In addition, the agency works with individual states to administer Medicaid.
certification	The designation given to a health care provider that has demonstrated, through inspection, that it meets the participation requirements of Medicare and Medicaid. Medicare and Medicaid cover only care delivered by certified providers.
CFP	Center for Forensic Psychiatry
coinsurance	A fixed percentage of the total amount paid for a health care service that can be charged to a beneficiary on a per service basis.
DCH	Department of Community Health
deductible	The amount a beneficiary must pay for health care before Medicare begins to pay, either for each benefit period for Part A or for each year for Part B.
Medicaid	A federal and state-funded health care entitlement program for certain individuals and families with low incomes and limited resources.
Medicare	A federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease.
Medicare Part A	Hospital insurance that provides coverage for inpatient care.
Medicare Part B	Medical insurance that provides coverage for doctor's services and outpatient hospital care, including physical and occupational therapists and some home health care.
mission	The agency's main purpose or the reason that the agency was established.

## GLOSSARY OF ACRONYMS AND TERMS

performance audit	An economy and efficiency audit or a program audit that is designed to provide an independent assessment of the performance of a governmental entity, program, activity, or function to improve public accountability and to facilitate decision making by parties responsible for overseeing or initiating corrective action.
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