DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Memorandum

Date JUL 25 2002

From Dennis J. Duquette
Deputy Inspector General
for Audit Services

Subject Review of Medical and Ancillary Claims Made to Medicaid for Aged 21 to 64 Year Old Residents of State Operated Psychiatric Hospitals within New York State (A-02-01-01014)

To Neil Donovan
Director, Audit Liaison Staff
Centers for Medicare & Medicaid Services

As part of the Office of Inspector General's self-initiated audit work, we are alerting you to the issuance within 5 business days of our final report entitled, "Review of Medical and Ancillary Claims Made to Medicaid for Aged 21 to 64 Year Old Residents of State Operated Psychiatric Hospitals within New York State." A copy of the report is attached. This report is one of a series of reports involving our multi-State review of patients in institutions for mental diseases (IMD). We suggest you share this report with components of the Centers for Medicare & Medicaid Services (CMS) involved with program integrity, provider issues, and State Medicaid agency oversight, particularly the Center for Medicaid and State Operations.

The objective of the review was to determine if controls were in place to effectively preclude New York State (NYS) from claiming Federal financial participation (FFP) under the Medicaid program for all medical and ancillary services (except inpatient acute care hospital services) made on behalf of 21 to 64 year old residents of State operated psychiatric hospitals (SOPH) that are IMDs. Examples of the types of claims included in this review would be physician, clinic, pharmacy, laboratory, and inpatient psychiatric services. Our audit period was July 1, 1997 through September 30, 2000.

Our audit found that NYS had implemented controls that were generally adequate to prevent FFP from being claimed for medical and ancillary services provided to residents of SOPHs between the ages of 21 to 64. However, in testing these controls, we identified a small number of medical and ancillary services that were incorrectly claimed for FFP.

Since controls were generally adequate, our report did not make any procedural recommendations. However, we recommended a financial adjustment of $84,077 for FFP that was improperly claimed for medical and ancillary services for residents of SOPHs between the ages of 21 to 64 years old.

State officials did not concur with a portion of our recommended financial adjustment that related to four claims for patients who were temporarily released from the IMDs to acute care hospitals for medical treatment. The four claims amounted to $11,096 of the $84,077 of FFP questioned by our audit. Officials contended that: (1) these patients were physically in acute care hospitals and not the IMDs, (2) CMS's issuance of a 1991 State Operations Letter and section 4390 of the State Medicaid Manual amounted to improper rule making, (3) the denial of medical benefits to individuals because of their status as transferees from the IMDs constituted impermissible discrimination on the basis of handicap, and (4) the disallowance was contrary to a CMS transmittal related to inmates of public institutions.

We disagreed with NYS officials. Similar arguments were raised by NYS officials before the Department of Health and Human Service's Departmental Appeals Board (DAB) in two related disallowance cases. In its decisions, the DAB rejected New York's arguments and upheld the disallowances in their entirety. The DAB, as well as the U.S. District Court and CMS, have continuously upheld that individuals residing in IMDs retain their IMD status when they are temporarily released to acute care hospitals for medical treatment and that the exclusion of FFP for 21 to 64 year olds would apply. Therefore, we continue to recommend that NYS refund the $84,077 to the Federal Government.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for the Centers for Medicare and Medicaid Audits, at (410) 786-7104 or Timothy J. Horgan, Regional Inspector General for Audit Services, Region II, at (212) 264-4620.

Attachment

Office Of Inspector General
Office Of Audit Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

Common Identification Number: A-02-01-01014

Dr. Antonia C. Novello, M.D.
Commissioner
New York State Department of Health
Empire State Plaza
14th Floor, Room 1408
Corning Tower
Albany, New York 12237

JUL 30 2002

Dear Dr. Novello:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OIG/OAS) final report entitled, "Review of Medical and Ancillary Claims Made to Medicaid for Aged 21 to 64 Year Old Residents of State Operated Psychiatric Hospitals Within New York State." Our audit covered the period July 1, 1997 through September 30, 2000. A copy of this report will be forwarded to the HHS action official noted below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, OIG/OAS reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR part 5). As such, within 10 business days after the final report is issued, it will be posted on the world wide web at http://oig.hhs.gov/.

To facilitate identification, please refer to Common Identification Number A-02-01-01014 in all correspondence relating to this report.

Sincerely yours,

Timothy J. Horgan
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Mr. Peter Reisman
Associate Regional Administrator
Division of Financial Management
Centers for Medicare & Medicaid Services, Region II
Department of Health and Human Services
26 Federal Plaza, Room 38-130
New York, New York 10278

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAL AND ANCILLARY CLAIMS MADE TO MEDICAID FOR AGED 21 TO 64 YEAR OLD RESIDENTS OF STATE OPERATED PSYCHIATRIC HOSPITALS WITHIN NEW YORK STATE

JANET REHNQUIST
INSPECTOR GENERAL

JULY 2002
A-02-01-01014

EXECUTIVE SUMMARY

Background

Federal law and regulations prohibit Federal financial participation (FFP) for all services provided to residents of institutions for mental diseases (IMD) who are between the ages of 22 to 64, and in certain instances those who are 21 years old. The basis for the IMD exclusion of FFP was established in the 1950 amendments to the Social Security Act (Act). Those amendments excluded all Federal assistance payments for patients of IMDs. The creation of the Medicaid program in 1965 permitted FFP for the first time for residents of IMDs in certain situations. Specifically, FFP was allowed for inpatient care provided to IMD residents age 65 and over. The 1972 amendments to the Act extended FFP for inpatient psychiatric care to individuals under the age of 21. Therefore, since the beginning of the Medicaid program, Federal medical assistance has never been available for residents of IMDs between the ages of 22 to 64, and in certain instances those who are age 21, for any type of service.

Objective

The objective of the review was to determine if controls were in place to effectively preclude New York State (NYS) from claiming FFP under the Medicaid program for all medical and ancillary services (except inpatient acute care hospital services) made on behalf of 21 to 64 year old residents of State operated psychiatric hospitals (SOPH) that are IMDs. Examples of the types of claims included in this review would be physician, clinic, pharmacy, laboratory, and inpatient psychiatric services. Our audit period was July 1, 1997 through September 30, 2000.

Summary of Findings

Our audit found that NYS had implemented controls that were generally adequate to prevent FFP from being claimed for medical and ancillary services provided to residents of SOPHs between the ages of 21 to 64. However, in testing these controls, we identified a small number of medical and ancillary services that were incorrectly claimed for FFP.

Conclusion and Recommendation

Our review determined that controls were generally adequate. As a result, we did not make any procedural recommendations. However, we recommended a financial adjustment of $84,077 for FFP that was improperly claimed for medical and ancillary services for residents of SOPHs between the ages of 21 to 64.

Auditee's Comments

State Officials did not concur with a portion of our recommended financial adjustment that related to four claims for patients who were temporarily released from the IMDs to acute care hospitals for medical treatment. The four claims amounted to $11,096 of the $84,077 of FFP questioned by our audit. Officials contended that: (1) these patients were physically in acute care hospitals and not the IMDs, (2) CMS's issuance of a 1991 State Operations Letter and section 4390 of the State Medicaid Manual amounted to improper rule making, (3) the denial of medical benefits to individuals because of their status as transferees from the IMDs constitutes impermissible discrimination on the basis of handicap, and (4) the disallowance is contrary to a CMS transmittal related to inmates of public institutions. The State's response is included in its entirety as an Appendix to this report.

OIG's Response

We disagreed with NYS officials. Similar arguments were raised by NYS officials before the Department of Health and Human Service's Departmental Appeals Board (DAB) in two related disallowance cases. In its decisions, the DAB rejected New York's arguments and upheld the disallowances in their entirety. The DAB, as well as the U.S. District Court and CMS, have continuously upheld that individuals residing in IMDs retain their IMD status when they are temporarily released to acute care hospitals for medical treatment, and that the exclusion of FFP for 21 to 64 year olds would apply. Therefore, we continue to recommend that NYS refund the $84,077 to the Federal Government.

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INTRODUCTION

Background

Federal Law And Regulations

Federal law and regulations prohibit Federal financial participation (FFP) for all services provided to residents of institutions for mental diseases (IMD) who are between the ages of 22 to 64, and in certain instances those who are 21 years old. The basis for the IMD exclusion of FFP was established in the 1950 amendments to the Social Security Act (Act). Those amendments excluded all Federal assistance payments for patients of IMDs. The creation of the Medicaid program in 1965 permitted FFP for the first time for residents of IMDs in certain situations. Specifically, FFP was allowed for inpatient care provided to IMD residents age 65 and over. The 1972 amendments to the Act extended FFP for inpatient psychiatric care to individuals under the age of 21. Therefore, since the beginning of the Medicaid program, Federal medical assistance has never been available for residents of IMDs between the ages of 22 to 64, and in certain instances those who are age 21, for any type of service.

The regulations implementing the IMD exclusion are found at 42 CFR 441.13 and 42 CFR 435.1008. These regulations preclude FFP for any services to residents under the age of 65 who are in an IMD, except for inpatient psychiatric services provided to individuals under the age of 21, and in some instances for those who are under the age of 22. This 21 to 64 year old exclusion of FFP was designed to assure that States, rather than the Federal Government, continue to have principal responsibility for funding inpatients in IMDs. Under this broad exclusion, no FFP payments can be made for services provided either in or outside the facility for IMD patients in this age group.

The Act defines an IMD 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. Psychiatric hospitals (including State operated psychiatric hospitals) with more than 16 beds are always IMDs.

Centers For Medicare & Medicaid Services Guidance

The Centers for Medicare & Medicaid Services (CMS) has consistently provided guidance to States (including New York) that FFP is not permitted for IMD residents between the ages of 21 to 64. Specifically, the CMS State Medicaid Manual issued to all States provides the necessary guidance regarding the prohibition of FFP for IMD residents within this age group.

The CMS issued Transmittal Number 65 of the State Medicaid Manual in March 1994 and Transmittal Number 69 of the State Medicaid Manual in May 1996. Section 4390 A.2. of the Manual entitled, “IMD Exclusion,” states that:

> ". . . The IMD exclusion is in 1905(a) of the Act in paragraph (B) following the list of Medicaid services. This paragraph states that FFP is not available for any medical assistance under title XIX for services provided to any individual who is under age 65 and who is a patient in an IMD unless the payment is for inpatient psychiatric services for individuals under age 21. This exclusion was designed to assure that States, rather than the Federal government, continue to have principal responsibility for funding inpatient psychiatric services. Under this broad exclusion, no Medicaid payment can be made for services provided either in or outside the facility for IMD patients in this age group."

The CMS has also consistently provided guidance to States that FFP is not permitted for IMD residents between the ages of 21 to 64 when these patients are temporarily released to acute care hospitals for medical treatment. Specifically, section 4390.1 of both Transmittal Number 65 and 69 entitled, "Periods of Absence From IMDs," states in part that:

> " . . . If a patient is temporarily transferred from an IMD for the purpose of obtaining medical treatment . . . the patient is still considered an IMD patient."

In summary, the Act and implementing regulations, as well as transmittals to the State Medicaid Manual, make it clear that FFP is not available for any services provided to residents of IMDs who are between the ages of 22 to 64, and in certain instances for those who are 21 years old.

New York's Medicaid Program

In New York State (NYS), the Department of Health (DOH) is the single State agency responsible for operating the State's title XIX Medicaid program. Within the NYS DOH, the Office of Medicaid Management is responsible for administering the Medicaid program. The DOH uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims. Additionally, within NYS, the Office of Mental Health (OMH) sets mental health policy. The State operated psychiatric hospitals (SOPH) within NYS are under the OMH's jurisdiction.

Objective, Scope, and Methodology

The objective of the review was to determine if controls were in place to effectively preclude NYS from claiming FFP under the Medicaid program for all medical and ancillary services (except inpatient acute care hospital services) made on behalf of 21 to 64 year old residents of SOPHs that are IMDs. A review of inpatient acute care hospital claims made on behalf of 21 to 64 year old Medicaid beneficiaries in SOPHs using recipient county code 97 and charge indicator 04 was included in a separate audit performed under Common Identification Number (CIN) A-02-99-01031. However, a review of inpatient acute care hospital claims made with community Medicaid identification numbers was included in this review. Examples of the types of claims included in our audit would be physician, clinic, pharmacy, laboratory, and inpatient psychiatric services.

Our review was conducted in accordance with generally accepted government auditing standards. Our audit period was July 1, 1997 through September 30, 2000. During our audit, we did not review the overall internal control structure of the State or the Medicaid program. Rather, our internal control review was limited to obtaining an understanding of the State's controls to prevent FFP from being claimed under the Medicaid program for 21 to 64 year old residents of SOPHs that were IMDs.

In order to accomplish our audit objective we:

- Held discussions with State agency officials to ascertain policies and procedures for claiming FFP under the Medicaid program for 21 to 64 year old residents of SOPHs in NYS.

- Obtained an understanding of computer edits and controls established by NYS regarding the claiming of FFP for medical and ancillary services provided to aged 21 to 64 year old residents of SOPHs.

- Obtained a listing of SOPHs within the State.

- Ran a computer programming application to identify if NYS claimed FFP under the Medicaid program for inpatient psychiatric services for residents of the SOPHs between the ages of 21 to 64.

- Performed a review of the inpatient psychiatric claims identified for 21 to 64 year old residents of the SOPHs to determine if they were allowable.

- Ran a computer programming application against the 8 types of files at the MMIS fiscal agent for the purpose of identifying all FFP medical and ancillary claims (except inpatient acute care hospital claims) with recipient county code 97 and charge indicator 04. Recipient county code 97 in combination with charge indicator 04 denotes a beneficiary in a SOPH.

- Performed site visits to 22 judgmentally selected medical providers to review the 97/04 claims identified by our computer programming application.

- Requested that OMH officials review the 97/04 claims from the practitioner and clinic files (2 largest files) to verify that the 21 to 64 year old beneficiaries were residents of SOPHs during the service dates claimed.

- Obtained a listing of 296 Medicaid eligible beneficiaries between the ages of 21 to 64 from the NYS OMH whose community Medicaid identification numbers remained open for short periods after their admissions to 6 SOPHs.

- Matched the 296 beneficiaries' inpatient IMD stays against the 8 types of files at the MMIS fiscal agent for the purpose of identifying all FFP medical and ancillary claims made with these community Medicaid numbers.

- Performed a review of the inpatient claims identified by our match against the community Medicaid numbers.

Audit field work was performed at the NYS DOH, the NYS OMH, the MMIS fiscal agent, medical service providers, and at our Albany field office from February 2001 to December 2001.

FINDINGS AND RECOMMENDATIONS

Our review determined that NYS had adequate controls to prevent FFP from being claimed for medical and ancillary services provided to residents of SOPHs between the ages of 21 to 64. Specifically, we noted four major controls as follows:

- The NYS paid medical and ancillary services out of State funds and Medicaid reimbursement and FFP would not have been claimed.

- Effective September 1, 1998, when a 21 to 64 year old Medicaid beneficiary of a SOPH required an overnight stay in an outside hospital, NYS OMH opened the beneficiary's Medicaid case number as federally non-participating (FNP). All types of claims (including practitioner and clinic) using the beneficiary's Medicaid number on or after this date would be FNP.

- The NYS had an edit within its MMIS to prevent FFP from being claimed for inpatient psychiatric services provided to 21 to 64 year old residents of the SOPHs.

- During our audit period, it was NYS's policy to cancel a 21 to 64 year old beneficiary's community Medicaid identification number within 90 days of admission to a SOPH.

We will briefly discuss these controls and our testing of these controls below.

State Funds Paid For Services

Our review noted that NYS paid medical and ancillary services using State funds. With the exception of a few medical and ancillary services noted below, Medicaid reimbursement and FFP was not claimed. We noted that central office OMH officials sent directives and instructions to their local resource offices (these offices process the billing for the SOPHs) that indicated medical and ancillary services should be paid with State funds and not Medicaid. The medical providers were instructed to use NYS vouchers for payment. Officials at OMH stated that when a SOPH beneficiary goes for services to an outside medical provider, they notified the provider to bill NYS and not Medicaid.

The NYS officials provided us with correspondence that the local OMH resource offices sent to providers of medical and ancillary services. This correspondence states in part: "It is the responsibility of the Office of Mental Health (OMH) to process payment for all ancillary medical services for all inpatients of our psychiatric hospitals." The correspondence goes on to state: "The outside medical provider cannot bill ancillary services directly to Medicare or Medicaid."

Medicaid Cases Opened By OMH

Officials at the NYS OMH stated that the only time they would open a Medicaid identification number for a 21 to 64 year old beneficiary in a SOPH was when the beneficiary required an overnight stay in an acute care hospital. Officials indicated that they would open the beneficiary's Medicaid identification number using recipient county code 97 and charge indicator 04. We determined, and OMH officials verified, that recipient county code 97 in combination with charge indicator 04 denotes a beneficiary in a SOPH.

Our review noted that effective September 1, 1998, these 97/04 Medicaid cases were opened by OMH as FNP. All types of claims (such as physician and clinic services) with this 97/04 combination on or after this date should be FNP. Prior to this date, NYS claimed FFP for beneficiaries whose Medicaid identification numbers had the 97/04 combination.

As part of our audit, we ran a computer programming application against the 8 files at the MMIS fiscal agent to identify all FFP medical and ancillary claims for 21 to 64 year olds with recipient county code 97 and charge indicator 04. This application did not include inpatient acute care hospital claims that were reviewed and included in a separate report under CIN A-02-99-01031, nor did it include inpatient psychiatric claims, which we reviewed separately under this audit (see below). However, it did include other types of claims on the inpatient file such as nursing home and intermediate care facility for the mentally retarded claims. Our computer programming application identified 8,523 FFP claims totaling $441,352 (Federal share $220,831) with recipient county code 97 and charge indicator 04 as shown below.

MMIS File	Total Medicaid	FFP	Number of Claims
Clinic	$162,811	$81,539	1,359
Practitioner	119,749	59,880	6,146
Home Health	104,026	52,013	427
Pharmacy	36,723	18,378	465
Inpatient	16,129	8,064	12
DME [1]	1,161	581	7
Laboratory	534	267	95
Dental	219	109	12
Total Claims	$441,352	$220,831	8,523

1 Durable Medical Equipment (DME)

To test these claims, we performed survey site visits to 22 judgmentally selected medical providers to review 137 judgmentally selected claims with the 97/04 combination identified by our computer programming application. The purpose of our testing was to determine if improper FFP claims had been made.

Our site visits determined that 67 of the 137 FFP claims reviewed (including all 33 home health agency claims) were allowable because the beneficiaries were not residents of the SOPHs (IMDs) on the service dates claimed, even though they had a Medicaid identification number with 97 and 04. We found that 58 of the 137 FFP claims were improper because the beneficiaries were IMD residents on the service dates claimed. For 12 of the 137 FFP claims, we could not determine their propriety. Based on these survey results, we requested that OMH officials review all the 97/04 claims for only 2 files identified by our match (practitioner and clinic) to determine whether the claims were made on behalf of residents of the SOPHs. These 2 files represented 7,505 of the 8,523 claims (or 88 percent) identified by our computer programming application and totaled $141,419 of FFP.

Based on OMH officials' determinations and additional audit analysis of the practitioner and clinic claims, we found that $50,090 of the $141,419 reviewed related to dates when residents of the SOPHs were temporarily released to outside hospitals and $7,801 related to dates when they were residents of the SOPHs. Individuals residing in IMDs retain their IMD status when they are temporarily released to outside hospitals for medical treatment and as such, the FFP exclusion for all types of medical services (including practitioner and clinic) would apply to the 21 to 64 year old population.

Of the $57,891 ($50,090 plus $7,801) combined FFP total, we noted that only $363 occurred after September 1, 1998, the date OMH made these 97/04 cases FNP. Since the $363 amount was immaterial, we did not determine why this occurred. As part of our audit, we will question the $57,891 of improper FFP.

Inpatient Psychiatric Edit

Our review determined that NYS had a rate code driven edit (edit number 00856) within its MMIS which prevents psychiatric hospitals from receiving Medicaid reimbursement for inpatient psychiatric services provided to beneficiaries between the ages of 21 to 64 years old. Since NYS's Medicaid program did not pay for these services, FFP was not claimed.

To test this edit, we ran a computer programming application to determine if NYS claimed FFP under the Medicaid program for inpatient psychiatric services for residents of the SOPHs between the ages of 21 to 64. Our programming application identified 788 FFP claims for 122 beneficiaries totaling $11,146,341 (Federal share $5,571,499). All 122 beneficiaries identified were 21, 22, or 65 years old (none were between the ages of 23 to 64).

Our review determined that 782 of the 788 FFP claims for inpatient psychiatric services were allowable because the beneficiaries either turned 65 years old or were admitted to the SOPHs prior to their 21st birthday. If a beneficiary is admitted to an IMD prior to their 21st birthday,

Federal regulations allow FFP for inpatient psychiatric services to be claimed up until the date of discharge or age 22, whichever occurs first. However, we found that NYS improperly continued to claim FFP for six beneficiaries after they turned age 22. The improper FFP claimed for these six beneficiaries was $15,090. We will question this amount as part of our audit.

Residents With Community Medicaid Numbers

During our audit period, it was NYS's policy to cancel a 21 to 64 year old beneficiary's community Medicaid identification number within 90 days of admission to a SOPH. These community Medicaid numbers are separate and distinct from the 97/04 Medicaid numbers discussed above. However, a beneficiary's community Medicaid identification number remained open and active up until the date it was cancelled. Officials at OMH indicated that if a beneficiary was expected to be a long term resident of a SOPH, they notified the beneficiary's county to cancel the community Medicaid number within 30 to 60 days of admission. For Supplemental Security Income beneficiaries, OMH officials stated that their community numbers must remain open for a period of at least 90 days.

As part of our audit, we tested to determine if improper FFP claims were being made for 21 to 64 year old beneficiaries of SOPHs during periods when their community Medicaid identification numbers remained active. To do this, we requested that OMH officials identify and provide us with those Medicaid beneficiaries between the ages of 21 to 64 whose community Medicaid identification numbers remained open upon admission to a SOPH.

For testing purposes, OMH provided us with 296 beneficiaries' community Medicaid numbers from 6 of the 21 adult SOPHs it operated. According to OMH officials, the 296 represented a 20 percent sample of the Medicaid admissions to the 6 facilities during our audit period. For these 296 beneficiaries, OMH also supplied us with their admission and discharge dates to the SOPHs.

We matched the 296 beneficiaries' inpatient IMD stays against the 8 types of files at the MMIS fiscal agent for the purpose of identifying all FFP medical and ancillary claims made with these community Medicaid numbers. Our match identified 612 FFP claims totaling $1,204,376 (Federal share $602,198). As shown by the schedule below, only 6 of the 8 MMIS files matched these 296 Medicaid numbers. The two with no matches were the dental and DME files.

MMIS File	Total Medicaid	FFP	Number of Claims
Inpatient	$1,154,426	$577,213	87
Clinic	17,944	8,972	113
Home Health	16,076	8,038	50
Practitioner	10,286	5,143	254
Pharmacy	5,618	2,819	103
Laboratory	26	13	5
Total Claims	$1,204,376	$602,198	612

Since the inpatient FFP amount of $577,213 was over 95 percent of the total FFP amount identified by our match, we reviewed all 87 claims. The remaining claims totaling $24,985 of FFP were not reviewed since we considered them immaterial.

Our review determined that only 4 of the 87 inpatient claims with community Medicaid numbers totaling $11,096 of FFP were improper. We determined that the four improper claims were made during periods when the IMD residents were temporarily released to acute care hospitals for medical treatment. Individuals residing in IMDs retain their IMD status when they are temporarily released to acute care hospitals for medical treatment and as such, the FFP exclusion for 21 to 64 year olds would apply. The $11,096 of improper FFP will be questioned by our audit.

Conclusion and Recommendation

Our review determined that NYS had adequate controls to prevent FFP from being claimed for medical and ancillary services provided to residents of SOPHs between the ages of 21 to 64. However, we found $84,077 of improper FFP claimed during our July 1, 1997 through September 30, 2000 audit period. Of this amount, $57,891 related to beneficiaries with recipient county code 97 and charge indicator 04, $15,090 related to 6 improper FFP claims for inpatient psychiatric services after the beneficiaries turned age 22, and $11,096 related to 4 inpatient acute care hospital claims for beneficiaries whose community Medicaid number remained open after their admissions to the SOPHs. We recommended that NYS refund the improper FFP amount of $84,077 to the Federal Government.

Auditee's Comments

State Officials did not concur with a portion of our recommended financial adjustment that related to the four claims for patients with community Medicaid numbers who were temporarily released from the IMDs to acute care hospitals for medical treatment. The four claims amounted to $11,096 of the $84,077 of FFP questioned by our audit.

Officials contended that medical services provided in a general hospital, to persons physically located in that hospital, are not in an IMD within the meaning of the laws and regulations as properly construed. They also stated that CMS's issuance of a 1991 State Operations Letter and section 4390 of the State Medicaid Manual amounted to improper rule making. Additionally, State officials contended that the denial of medical benefits to individuals because of their status as transferees from an IMD constitutes impermissible discrimination on the basis of handicap.

Finally, State officials noted that CMS issued a transmittal clarifying Medicaid coverage policy for inmates of public institutions. They indicated that the transmittal distinguished between medical care provided to inmates in an outside hospital, and those provided on the premises of a prison, jail, or other penal setting. State officials noted that the transmittal states that FFP is available for services in an outside hospital, but not for services provided on the grounds of the public institution. They believe that the language of the IMD exclusion is legally

indistinguishable from the public institutions exclusion, and should be similarly interpreted and implemented. The State's response is included in its entirety as an Appendix to this report.

OIG's Response

We disagreed with NYS officials. These arguments were raised by NYS officials before the Department of Health and Human Service's Departmental Appeals Board (DAB) in two similar cases involving CMS' disallowances of FFP for aged 21 to 64 year old residents of SOPHs (IMDs) who were temporarily released to acute care hospitals for medical treatment. The disallowances were identified in two Office of Audit Services' audit reports. One disallowance was for over $19.6 million of FFP (CIN A-02-99-01031) and the other involved $291,981 of improper FFP (CIN A-02-93-01036). In both cases, the DAB rejected New York's arguments in their entirety and upheld the disallowances.

In Decision Number 1809, dated January 17, 2002, which related to the over $19.6 million of improper FFP, the Board noted that: (1) institutional status, not physical location, is determinative of whether the general IMD exclusion applies, (2) CMS' policy on funding for medical services to inmates of a public institution is not inconsistent with CMS' interpretation of the general IMD exclusion, and (3) the general IMD exclusion does not discriminate against individuals on the basis of disability.

In Decision Number 1577, dated May 21, 1996, related to the $291,981 of improper FFP, the Board indicated that: (1) the institutional status of the individual, not the individual's location, is determinative of whether the general IMD exclusion applies, (2) CMS' reading of the Social Security Act and regulations as prohibiting Federal funding for medical services provided to patients temporarily transferred out of IMDs to receive medical services did not represent a change in CMS policy which required publication pursuant to notice and comment rulemaking, and (3) CMS' determination did not deny the individuals in question access to medical services based on a disability or handicap.

In addition to these two New York DAB cases, there was a similar DAB case involving New Jersey. In New Jersey, CMS disallowed over $1.0 million of FFP for IMD residents between the ages of 22 to 64 who were temporarily released from IMDs to acute care hospitals for medical treatment. In DAB Decision Number 1549, issued on November 20, 1995, the DAB upheld CMS's disallowance in its entirety and indicated that the IMD exclusion would apply. New Jersey officials sought judicial relief of DAB Decision Number 1549. On February 5, 1997, the U.S. District Court for the District of New Jersey upheld the DAB decision.

In addition to the three DAB decisions and the U.S. District Court decision, CMS continuously provided guidance to NYS that FFP is not permitted for IMD residents between the ages of 21 to 64 when these patients are temporarily released to acute care hospitals for medical treatment. Specifically, three transmittals to the State Medicaid Manual and a 1991 Medicaid State Operations Letter made it clear to NYS officials that FFP is not available for IMD residents between the ages of 21 to 64 years old when these patients are temporarily released to acute care hospitals for medical treatment.

In summary, the DAB, the U.S. District Court, and CMS have continuously upheld that individuals residing in IMDs retain their IMD status when they are temporarily released to acute care hospitals for medical treatment and that the exclusion of FFP for 21 to 64 year olds would apply. Therefore, we continue to recommend that NYS refund the $84,077 to the Federal Government.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

May 14, 2002

Timothy J. Horgan
Regional Inspector General for
Audit Services
DHHS OIG Office of Audit Services
26 Federal Plaza
Room 3900A
New York, New York 10278

Dear Mr. Horgan:

Enclosed are the Department of Health's comments on the DHHS - OIG's draft audit report A-02-01-01014 entitled "Review of Medical and Ancillary Claims Made to Medicaid for Aged 21 to 64 Year Old Residents of State Operated Psychiatric Hospitals Within New York State."

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Department of Health and Office of Mental Health Comments on the Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) Draft Audit Report A-02-01-01014 "Review of Medical and Ancillary Claims Made to Medicaid For Aged 21 to 64 Year Old Residents of State Operated Psychiatric Hospitals With New York State"

The following are the Department of Health's (DOH) and Office of Mental Health's (OMH) comments in response to the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) Draft Audit Report of Review of Medical and Ancillary Claims Made to Medicaid For Aged 21 to 64 Year Old Residents of State Operated Psychiatric Hospitals With New York State", number A-02-01-01014.

RECOMMENDATION 1:

Our review determined that controls were generally adequate. As a result, we are not making any procedural recommendations. However, we are recommending a financial adjustment of $84,077 for FFP that was improperly claimed for medical and ancillary services for residents of SOPH's (State Operated Psychiatric Hospitals) between the age of 21 to 64.

DEPARTMENT OF HEALTH RESPONSE:

A financial adjustment will be made after the final report is issued and after the basis of the overpayments are reviewed by the Department and OMH.

OFFICE OF MENTAL HEALTH RESPONSE:

Although the amounts questioned as a result of this audit are not material, we wish to respond to one issue to ensure that the State is on record as not agreeing with certain DHHS/OIG statements, conclusions and exceptions. Of the total amount DHHS/OIG recommends that the State refund ($84,077), OMH disagrees with $11,096 of this amount. However, OMH appreciates DHHS/OIG's recognition of the adequacy of controls New York has in place to prevent Federal Financial Participation (FFP) from being claimed for medical and ancillary services provide to residents of SOPH's aged 21 to 64, as reflected on page 4 of the draft report.

OFFICE OF MENTAL HEALTH RESPONSE: (cont'd):

Residents With Community Medicaid Numbers. Page 8 Para. 2 of Draft Report - Regarding the $11,096 of FFP DHHS/OIG requested the State to refund in their recommendation, New York State continues to disagree with DHHS/OIG's position on this matter (four inpatient claims for patients temporarily released to acute care hospitals for medical treatment). The State disagrees with this proposed disallowance, based upon its contention that medical services provided in a general hospital to persons physically located in that hospital are not "in" an Institution for Mental Diseases (IMD) within the meaning of the laws and regulations as properly construed. It is the State's further contention that the issuance and enforcement of the 1991 State Operations Letter and Section 4390 of the Manual amounted to improper rule making, in violation of the Federal Administrative Procedures Act. 5 U.S.C. §553. The State also contends that the denial of medical benefits to individuals because of their status as transferees from an IMD constitutes impermissible discrimination on the basis of handicap, in violation of Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794, as confirmed by the Supreme Court in Olmstead v. L.C., 527 U.S. 58 I.

The Centers for Medicare and Medicaid Services (CMS, formerly HCFA) also issued a Medicaid transmittal clarifying Medicaid coverage policy for inmates of public institutions. In that transmittal, CMS distinguished between medical care provided to inmates in an outside hospital, and those provided on the premises of a prison, jail, or other penal setting. As explained in the transmittal, FFP is available for services in an outside hospital, but not for services provided on the grounds of the public institution. The State believes that the language of the IMD exclusion is legally indistinguishable from the public institutions exclusion, and should properly be similarly interpreted and implemented.