DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUL 14 2004

TO: Wynethea Walker
Acting Director, Audit Liaison Staff
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Seven States' Medicaid Claims for Medical and Ancillary Services Made on Behalf of 21- to 64-Year-Old Residents of State-Operated Institutions for Mental Diseases (A-02-03-01030)

Attached is a copy of our final report consolidating the results of our seven-State review of Medicaid claims for medical and ancillary services (except inpatient acute care hospital services, which were included in our June 2004 report[1]) made on behalf of 21- to 64-year-old residents of State-operated institutions for mental diseases (IMD). We conducted these audits pursuant to our longstanding concern that States were not complying with the Centers for Medicare & Medicaid Services (CMS) general prohibition on Federal Medicaid funding for IMD residents under the age of 65. We suggest you share this report with the Center for Medicaid and State Operations and any other component of CMS involved with Medicaid program integrity and provider issues.

A common objective of our audits was to determine if controls were in place to preclude States from claiming Federal Medicaid funds for medical and ancillary services (except inpatient acute care hospital services) provided to 21- to 64-year-old residents of State-operated IMDs.

Federal regulations define an IMD as a hospital, nursing facility, or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. Section 1905(a) of the Social Security Act, implementing Federal regulations, and CMS guidance preclude Federal funding for services to IMD residents under age 65, except for inpatient psychiatric services provided to individuals under the age of 21 and, in some instances, under the age of 22.[2]

Three States (Maryland, Texas, and Virginia) had no controls to prevent Federal funding from being claimed, one State (New Jersey) had ineffective controls, two States (New York and Florida) had generally adequate controls, and one State (California) had effective controls and

[1] "Seven States' Medicaid Claims for 21- to 64-Year-Old Residents of Institutions for Mental Diseases Who Were Temporarily Released to Acute Care Hospitals" (A-02-03-01002, June 9, 2004).

[2] If an individual was receiving inpatient psychiatric services immediately before he or she reached age 21, services may continue to be provided until the earlier of (1) the date the individual no longer requires the services or (2) the date the individual reaches the age of 22.

made no improper claims. The remaining six of the seven States improperly claimed a total of $2,466,190 in Federal Medicaid funds during various audit periods.

This report does not contain any recommendations because the recommendations in our June 2004 report relating to reinforcing guidance and developing and implementing controls would also apply to medical and ancillary claims for the excluded age group. Our prior report noted that controls in the seven States reviewed (the same seven States included in our current audit) were generally not adequate to prevent Federal Medicaid claims for 21- to 64-year-old IMD residents who were temporarily released to acute care hospitals for inpatient medical treatment. Our prior report recommended that CMS:

- reinforce to States that Federal Medicaid funds may not be claimed for 21- to 64-year-old IMD residents, including those temporarily released to acute care hospitals for medical treatment

- instruct States to develop and implement controls, where cost effective, to prevent Federal Medicaid claims for 21- to 64-year-old IMD residents who are temporarily released to acute care hospitals for inpatient medical treatment

- advise States not included in our review of our audit findings and encourage them to review their controls to prevent improper claims

CMS concurred with those recommendations.

If you have any questions or comments about this report, please do not hesitate to call me or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Timothy J. Horgan, Regional Inspector General for Audit Services, Region II, at (212) 264-4620. Please refer to report number A-02-03-01030.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

SEVEN STATES' MEDICAID CLAIMS FOR MEDICAL AND ANCILLARY SERVICES MADE ON BEHALF OF 21- TO 64-YEAR-OLD RESIDENTS OF STATE-OPERATED INSTITUTIONS FOR MENTAL DISEASES

JULY 2004
A-02-03-01030

Office of Inspector General

http://oig.hhs.gov

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The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

This report summarizes the results of our seven-State review of Medicaid claims for medical and ancillary services (except inpatient acute care hospital services, which were included in our June 2004 report[1]) made on behalf of 21- to 64-year-old residents of State-operated institutions for mental diseases (IMD). We conducted audits in California, Florida, Maryland, New Jersey, New York, Texas, and Virginia.

Section 1905(a) of the Social Security Act, implementing Federal regulations, and guidance from the Centers for Medicare & Medicaid Services (CMS) preclude Federal funding for services to IMD residents under age 65, except for inpatient psychiatric services provided to individuals under the age of 21 and, in some instances, under the age of 22.[2] This report refers to these individuals as "the excluded age group."

OBJECTIVE

A common objective of our audits was to determine if controls were in place to preclude States from claiming Federal Medicaid funds for medical and ancillary services (except inpatient acute care hospital services) provided to 21- to 64-year-old residents of State-operated IMDs.

SUMMARY OF FINDINGS

Three States (Maryland, Texas, and Virginia) had no controls to prevent Federal funding from being claimed, one State (New Jersey) had ineffective controls, two States (New York and Florida) had generally adequate controls, and one State (California) had effective controls and made no improper claims. The remaining six of the seven States improperly claimed a total of $2,466,190 in Federal Medicaid funds.

RECOMMENDATIONS

This report does not contain any recommendations because the recommendations in our June 2004 report relating to reinforcing guidance and developing and implementing controls would also apply to medical and ancillary claims for the excluded age group. Our prior report noted that controls in the seven States reviewed (the same seven States included in our current audit) were generally not adequate to prevent Federal Medicaid claims for 21- to 64-year-old IMD residents who were temporarily released to acute care hospitals for inpatient medical treatment.

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[1] "Seven States' Medicaid Claims for 21- to 64-Year-Old Residents of Institutions for Mental Diseases Who Were Temporarily Released to Acute Care Hospitals" (A-02-03-01002, June 9, 2004).

[2] If an individual was receiving inpatient psychiatric services immediately before he or she reached age 21, services may continue to be provided until the earlier of (1) the date the individual no longer requires the services or (2) the date the individual reaches the age of 22.

Our prior report recommended that CMS:

- reinforce to States that Federal Medicaid funds may not be claimed for 21- to 64-year-old IMD residents, including those temporarily released to acute care hospitals for medical treatment

- instruct States to develop and implement controls, where cost effective, to prevent Federal Medicaid claims for 21- to 64-year-old IMD residents who are temporarily released to acute care hospitals for inpatient medical treatment

- advise States not included in our review of our audit findings and encourage them to review their controls to prevent improper claims

CMS concurred with those recommendations.

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INTRODUCTION

BACKGROUND

Section 1905(i) of the Social Security Act (the Act) and 42 CFR § 435.1009 define an IMD as a hospital, nursing facility, or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. Psychiatric hospitals (including State-operated psychiatric hospitals) with more than 16 beds are IMDs.

Regulations found at 42 CFR §§ 435.1008 and 441.13 preclude Federal Medicaid funding for services to IMD residents under the age of 65, except for inpatient psychiatric services provided to individuals under the age of 21 and, in some instances, under the age of 22.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

A common objective of these audits was to determine if controls were in place to preclude States from claiming Federal Medicaid funds for medical and ancillary services (except inpatient acute care hospital services) provided to 21- to 64-year-old residents of State-operated IMDs.

Scope and Methodology

This report summarizes the results of our audits in seven States: California, Florida, Maryland, New Jersey, New York, Texas, and Virginia. The audit periods for the seven States varied. (See table on page 3.)

We did not review the overall internal control structure of the States or their Medicaid programs; our internal control reviews were limited to obtaining an understanding of the States' controls to prevent Federal Medicaid claims for medical and ancillary services provided to IMD residents in the excluded age group. For each of the seven States, we also determined the amount of any improperly claimed Federal funds for medical and ancillary services.

We conducted our review in accordance with generally accepted government auditing standards. However, because this report does not contain any recommendations, we did not issue a draft to CMS for comment.

FINDINGS AND RECOMMENDATIONS

FEDERAL STATUTES, REGULATIONS, AND GUIDANCE

Statutory and Regulatory Requirements

According to section 1905(a) of the Act, "medical assistance" includes inpatient hospital services and nursing facility services for IMD residents 65 years of age or older but excludes

care or services for IMD residents who are under 65, except "inpatient psychiatric hospital services for individuals under the age of 21."

Federal regulations prohibit Federal Medicaid funding for "any individual who is under age 65 and is in an institution for mental diseases, except an individual who is under age 22 and receiving inpatient psychiatric services under subpart D of this part." (42 CFR § 441.13.)

Centers for Medicare & Medicaid Services Guidance

CMS guidance to States specifies that Federal Medicaid funds are not available for IMD residents under the age of 65 unless the payments are for inpatient psychiatric services for individuals under the age of 21 and, in certain instances, under the age of 22. Specifically, CMS issued Transmittal 65 of the State Medicaid Manual in March 1994 and Transmittal 69 of the State Medicaid Manual in May 1996. Section 4390 of the State Medicaid Manual provides in subsection A.2:

> The IMD exclusion is in 1905(a) of the Act in paragraph (B) following the list of Medicaid services. This paragraph states that FFP [Federal financial participation] 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.

ASSESSMENT OF STATE CONTROLS

Controls in the seven States reviewed had varying levels of effectiveness in preventing Federal Medicaid claims for medical and ancillary services provided to IMD residents in the excluded age group. Three States (Maryland, Texas, and Virginia) had no controls, and one State (New Jersey) had ineffective controls. Two States (New York and Florida) had generally adequate controls but still submitted some improper Federal Medicaid claims. One State (California) had effective controls that prevented Federal funds from being claimed throughout the audit period.

New York had established four controls: (1) medical and ancillary services were paid with State funds, (2) effective September 1, 1998, New York made coding changes in the way it opened Medicaid cases for residents of State-operated IMDs in the excluded age group, (3) an edit within New York's Medicaid Management Information System prevented Federal funds from being claimed, and (4) New York canceled each 21- to 64-year-old beneficiary's Medicaid number within 90 days of admission to a State-operated IMD. In Florida, IMDs were diligent in initiating Medicaid disenrollment when Medicaid-eligible patients entered their facilities. Finally, California's main control was to use State funds to pay for care provided to the excluded age group.

As shown in the table below, six States improperly claimed a total of $2,466,190 in Federal Medicaid funds.

Audits in Seven States

State	Audit Period		Federal Funds Improperly Claimed
	Start Date	End Date	
Maryland	07/01/97	06/30/00	$1,184,496
Texas	09/01/97	08/31/00	462,551
Virginia	07/01/97	12/31/00	331,951
New Jersey	07/01/97	06/30/01	331,709
New York	07/01/97	09/30/00	84,077
Florida	07/01/97	01/31/01	71,406
California	07/01/97	02/28/01	0
Total			**$2,466,190**

The appendix to this report provides a brief summary of the results of the seven audits. All seven reports are available on the Internet at http://oig.hhs.gov.

RECOMMENDATIONS

This report does not contain any recommendations because the recommendations in our June 2004 report relating to reinforcing guidance and developing and implementing controls would also apply to medical and ancillary claims for the excluded age group. Our prior report noted that controls in the seven States reviewed (the same seven States included in our current audit) were generally not adequate to prevent Federal Medicaid claims for 21- to 64-year-old IMD residents who were temporarily released to acute care hospitals for inpatient medical treatment. Our prior report recommended that CMS:

- reinforce to States that Federal Medicaid funds may not be claimed for 21- to 64-year-old IMD residents, including those temporarily released to acute care hospitals for medical treatment

- instruct States to develop and implement controls, where cost effective, to prevent Federal Medicaid claims for 21- to 64-year-old IMD residents who are temporarily released to acute care hospitals for inpatient medical treatment

- advise States not included in our review of our audit findings and encourage them to review their controls to prevent improper claims

CMS concurred with those recommendations.

APPENDIX

SUMMARY OF RESULTS IN THE SEVEN STATES

MARYLAND

In our March 25, 2003 report (A-03-00-00214), we noted that Maryland did not have controls to preclude Federal claims for IMD residents in the excluded age group. For the period January 1, 1997 to December 31, 2000, we identified improper Federal payments totaling $2,093,729. Of this amount, $1,184,496 related to medical and ancillary services provided to residents of State-operated IMDs from July 1, 1997 to June 30, 2000. The remainder of the improper claims related to other types of services.

We recommended that Maryland refund $2,093,729 (including $1,184,496 related to medical and ancillary services) and, among other things, establish controls to prevent unallowable Federal claims. Maryland officials generally disagreed with our findings and recommendations on improperly claimed medical and ancillary services.

TEXAS

Our June 28, 2002 report (A-06-01-00054) noted that Texas did not have controls to prevent improper Federal claims. For the period September 1, 1997 through August 31, 2000, the State improperly claimed $462,551 of Federal funds for medical and ancillary services provided to residents of State-operated IMDs in the excluded age group.

We recommended that the State (1) refund $462,551, (2) identify and return improper Federal funds claimed subsequent to our August 31, 2000 cutoff date, (3) cease claiming Federal funds for medical and ancillary services provided to residents of State-operated IMDs in the excluded age group, and (4) develop controls or edits in the Medicaid Management Information System to detect and prevent such claims. State officials generally agreed with our recommendations.

VIRGINIA

In our October 30, 2001 report (A-03-00-00212), we noted that Virginia did not have controls to preclude Federal claims for IMD residents in the excluded age group. For the period July 1, 1997 through December 31, 2000, we identified $1,382,079 of improper Federal claims. Of this amount, $331,951 related to medical and ancillary services provided to residents of State-operated IMDs. The remainder of the improper claims related to other types of services.

We recommended that Virginia refund $1,382,079 (including $331,951 related to medical and ancillary services) and establish controls to prevent unallowable Federal claims. State officials generally agreed.

NEW JERSEY

Our July 5, 2002 report (A-02-01-01008) noted weaknesses in New Jersey's controls. Although it was State policy not to claim Federal funds for IMD residents in the excluded age group who received medical services outside the State-operated IMDs, we found that from July 1, 1997 through June 30, 2001, New Jersey improperly claimed $331,709 in Federal Medicaid funds for medical and ancillary services.

We recommended that New Jersey (1) refund $331,709, (2) identify and return Federal funds improperly claimed after June 30, 2001, and (3) strengthen procedures to prevent Federal claims for IMD residents in the excluded age group who receive medical and ancillary services outside the IMDs. State officials agreed with all of our recommendations.

NEW YORK

In our July 30, 2002 report (A-02-01-01014), we noted that New York had implemented controls that were generally adequate to prevent Federal funds from being claimed for medical and ancillary services provided to residents of State-operated IMDs in the excluded age group. However, in testing these controls, we identified $84,077 of improper Federal claims for medical and ancillary services from July 1, 1997 through September 30, 2000.

Our report did not contain any procedural recommendations; however, we did recommend a financial adjustment of $84,077. New York officials did not concur with $11,096 of the $84,077 questioned by our audit but did concur with the remaining portion.

FLORIDA

Our July 18, 2002 report (A-04-01-02008) noted that for the period July 1, 1997 through January 31, 2001, Florida had generally adequate controls to prevent Federal claims for IMD residents in the excluded age group. Nevertheless, we found that $71,406 in Federal funds was improperly claimed for medical and ancillary services.

Florida officials disagreed with our recommendation to refund the $71,406 because the claims in question were for Supplemental Security Income recipients. In response, our report stated that because these individuals were residents of IMDs in the excluded age group, Federal Medicaid funding on their behalf was prohibited.

CALIFORNIA

In our December 5, 2002 report (A-09-01-00107), we noted that from July 1, 1997 through February 28, 2001, California had effective controls that prevented Federal funds from being claimed for medical and ancillary services rendered to residents of State-

operated IMDs in the excluded age group. Our report did not identify any improper Federal claims, and it contained no recommendations.

ACKNOWLEDGMENTS

This report was prepared under the direction of Timothy J. Horgan, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

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