JAN - 4 2001

Memorandum

Date

From Michael F. Mangano
Acting Inspector General

Subject Follow-Up Review of the Health Care Financing Administration's Resolution of Improper Medicaid Claims for Patients Residing in Institutions for Mental Diseases (A-02-99-01031)

To Robert Berenson, M.D.
Acting Deputy Administrator
Health Care Financing Administration

Attached are two copies of the Department of Health and Human Services, Office of Inspector General's final report entitled, "Follow-Up Review of the Health Care Financing Administration's Resolution of Improper Medicaid Claims for Patients Residing in Institutions for Mental Diseases." The primary objective of our follow-up review was to assess the adequacy of resolution actions taken by Region II Health Care Financing Administration (HCFA) officials in clearing and closing the four audit recommendations contained in a prior Office of Audit Services report. A related objective of our follow-up audit was to evaluate whether New York State (NYS) had implemented appropriate controls to cease the improper claiming of Federal financial participation (FFP) beyond the end of our prior audit period.

Our follow-up audit determined that Region II HCFA officials' resolution efforts were adequate with respect to one of the four recommendations in our prior report but were untimely and ineffective for the remaining three recommendations. We determined that no meaningful resolution activity took place between May 1996, the time HCFA won a Departmental Appeals Board case related to our prior audit, and June 1999. However, in July 1999, HCFA issued an appropriate follow-up letter to NYS and since that time, positive actions have occurred.

We verified that NYS implemented appropriate edits and controls which, if maintained, will prevent the improper claiming of FFP when patients between the ages of 21 and 64 are temporarily released from State-operated psychiatric centers (which are institutions for mental diseases) to acute care hospitals for medical treatment. In addition, NYS took action to identify and quantify unallowable FFP claims for State-operated psychiatric center patients between the ages of 21 and 64 who were temporarily released to acute care hospitals. At HCFA's request, we validated NYS computations and identified the amount of improper FFP that was claimed by them for the period January 1, 1991 to December 31, 1999.

Based on our follow-up audit and to resolve the recommendations in our original report, we now recommend that HCFA: (1) issue a disallowance letter to NYS and instruct them to refund the $19,601,451 of unallowable FFP identified by our validation work and (2) instruct NYS to compute the unallowable FFP amount after the December 31, 1999 cut-off date and return the unallowable FFP to the Federal Government.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you should have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-02-99-01031 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

FOLLOW-UP REVIEW OF THE HEALTH CARE FINANCING ADMINISTRATION'S RESOLUTION OF IMPROPER MEDICAID CLAIMS FOR PATIENTS RESIDING IN INSTITUTIONS FOR MENTAL DISEASES

Inspector General

JANUARY 2001
A-02-99-01031

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From Michael F. Mangano
Acting Inspector General

Subject Follow-Up Review of the Health Care Financing Administration's Resolution of Improper Medicaid Claims for Patients Residing in Institutions for Mental Diseases (A-02-99-01031)

To Robert Berenson, M.D.
Acting Deputy Administrator
Health Care Financing Administration

This final report provides the results of our follow-up review of the Health Care Financing Administration's (HCFA) resolution of improper Medicaid claims for patients residing in institutions for mental diseases (IMD). Our initial report entitled, "Review of Medical Assistance Claims for State-Operated Psychiatric Center Clients Between the Ages of 21 and 64 Who Were Temporarily Released to Acute Care Facilities for Medical Treatment" (A-02-93-01036) was issued on April 10, 1995. The primary objective of our follow-up review was to assess the adequacy of resolution actions taken by HCFA Region II officials in clearing and closing the audit recommendations contained in our prior report.

During our prior audit, we found that New York State (NYS) was not in compliance with Federal regulations that prohibit Federal financial participation (FFP) for services provided to patients of an IMD who are within specified age groups. We recommended that NYS (1) refund $291,981 for the Federal share of improper claims for IMD patients, (2) cease the improper claiming of FFP, (3) implement controls and edits to prevent the improper claiming in the future, and (4) identify all unallowable claims and voluntarily return the Federal share of the claims to the Federal Government.

During our follow-up audit, we found HCFA Region II resolution efforts were adequate with respect to recommendation number one but for recommendations two through four, we concluded that resolution actions were untimely and ineffective. We determined that no meaningful resolution activity took place between May 1996, the time HCFA won a Departmental Appeals Board (DAB) case related to our prior audit, and June 1999. However, in July 1999, HCFA issued an appropriate follow-up letter to NYS and since that time, positive actions have occurred.

We verified that NYS implemented appropriate edits and controls which, if maintained, will prevent the improper claiming of FFP when patients between the ages of 21 and 64 are temporarily released from State-operated psychiatric centers (which are IMDs) to acute care hospitals for medical treatment. These actions successfully address recommendations two and three of our original report. In addition, NYS took action to identify and quantify unallowable FFP claims for State-operated psychiatric center patients between the ages of

21 and 64 who were temporarily released to acute care hospitals. This action partially addresses the fourth recommendation from our original report. At HCFA's request, we validated NYS's computations and identified the amount of improper FFP that was claimed by them for the period January 1, 1991 to December 31, 1999.

Based on our follow-up audit and to resolve the recommendations in our original report, we now recommend that HCFA: (1) issue a disallowance letter to NYS and instruct them to refund the $19,601,451 of unallowable FFP identified by our validation work and (2) instruct NYS to compute the unallowable FFP amount after the December 31, 1999 cut-off date and return the unallowable FFP to the Federal Government.

Background

On April 10, 1995, we issued our prior audit report and distributed it to the designated HCFA action official. Our audit covered the period January 1991 through December 1993. We determined that NYS improperly claimed FFP for patients between the ages of 21 and 64 who were temporarily released from 25 State-operated adult psychiatric centers (PC) to acute care hospitals for medical treatment. The NYS identified the State-operated PCs as IMDs. The temporary releases were made to medical surgical units (MSU), which were separately certified acute care hospitals on the grounds of certain State-operated PCs, and to general acute care hospitals. The MSUs were closed by March 31, 1991 and all temporary releases after that date were made to general acute care hospitals.

Federal regulations prohibit FFP claims to Medicaid for IMD patients between the ages of 22 and 64 and those aged 21 at admission. In clarifying guidance, HCFA stated that during a temporary release to an acute care facility for medical treatment, the patients retain their IMD status and, as such, FFP claims for those between the ages of 21 and 64 would not be allowable. Various DAB decisions, including one related to our audit report, upheld the IMD exclusion. Additionally, the U.S. District Court also upheld the IMD exclusion for temporary releases to acute care hospitals.

Our prior audit report contained four recommendations. We recommended that NYS (1) refund $291,981 for the improper MSU claims identified during the period January 1, 1991 through March 31, 1991, (2) cease claiming FFP for patients between the ages of 22 and 64 and for those aged 21 at admission when the patients are temporarily released from their PCs, which are IMDs, to general acute care hospitals for medical treatment, (3) develop controls or edits within its Medicaid Management Information System (MMIS) to prevent improper claims for FFP, and (4) identify the unallowable FFP claims during the period January 1, 1991 to the present for the transfers to general acute care hospitals and voluntarily return the Federal share of the claims. In our prior report, we identified a potentially improper FFP amount of approximately $9.2 million for our 3-year audit period ending December 31, 1993. Our prior audit did not include steps to determine if the entire $9.2 million was for unallowable claims.

Objectives, Scope, and Methodology

The primary objective of our follow-up review was to determine the extent and adequacy of actions taken by HCFA officials in clearing and closing audit findings and recommendations contained in our prior report. A related objective of our follow-up audit was to evaluate whether NYS had implemented appropriate controls to cease the improper claiming of FFP beyond the end of our prior audit period.

Our follow-up audit was performed in accordance with generally accepted government auditing standards.

The Office of Management and Budget Circular A-50 also establishes procedures to ensure audit findings are resolved in a timely and efficient manner. Audit follow-up officials are responsible for ensuring: (1) systems of audit follow-up, resolution, and corrective action are documented and in place, (2) timely responses are made to all audit reports, (3) disagreements are resolved, (4) corrective actions are taken, and (5) semiannual reports to the agency head are submitted on the status of all unresolved audit reports more than 6 months old. Additionally, chapter 1-105 of the Department of Health and Human Services (HHS) Grants Administration Manual sets forth departmental policy for the resolution of audit findings.

Our audit effort included determining the extent of resolution activities undertaken by HCFA officials and assessing whether the resolution actions were appropriate and timely. To do this, we reviewed pertinent audit resolution documentation and held discussions with HCFA officials. As part of this follow-up audit, we did not perform a review of HCFA's internal control structure.

We also performed computer programming applications on New York's MMIS to determine if NYS had implemented appropriate controls to cease the improper claiming of FFP for State-operated PC patients between the ages of 21 and 64 who were temporarily released to acute care hospitals for medical treatment. We performed limited testing of the claims identified by our computer programming applications. This testing involved performing site visits to 6 judgmentally selected acute care hospitals to review medical records related to 50 potentially improper inpatient claims.

At HCFA's request, we also performed validation work to determine the accuracy of the calculations made by NYS on quantifying unallowable FFP claims made on behalf of State-operated psychiatric center (IMD) patients between the ages of 21 and 64 who were temporarily released to acute care hospitals for medical treatment. As part of our validation work, we obtained and reviewed the State's documentation supporting its computations, met with NYS officials, performed various computer programming applications using the MMIS to test the State's edits/controls, performed various tests of the State's computations, and made site visits to selected general acute care hospitals.

The follow-up review, including validation work, was conducted from January 1999 to August 2000.

RESULTS OF AUDIT

We determined that although HCFA officials concurred with all four recommendations in our prior audit report, their resolution actions were timely and appropriate for only one of the four recommendations. For the remaining recommendations, we concluded that HCFA's resolution actions were untimely and ineffective from 1996 to June 1999. However, since July 1999, when HCFA issued a cease and desist letter to NYS, positive actions occurred and resolution can be achieved when HCFA implements our recommendations.

The following sections discuss our positive findings with respect to actions taken by HCFA Region II officials on recommendation number one. We also discuss our findings with respect to the lack of timely and appropriate actions taken by HCFA on the remaining three recommendations in our original report which delayed its resolution. Finally, we discuss positive actions which have occurred as well as our recommendations to resolve these matters.

HCFA Properly Closes Recommendation Number One

We determined that HCFA Region II's actions with respect to recommendation number one in our prior report were effective and timely. We found that the regional office issued a disallowance letter to NYS on October 10, 1995 requesting a refund of $291,981 for the improper MSU claims identified during our prior audit. New York appealed the disallowance to the DAB. The DAB upheld the disallowance amount in its entirety. The HCFA Region II recovered the $291,981 from NYS by reducing their grant award by this amount.

In DAB decision number 1577, dated May 21, 1996, the Board upheld the disallowance of $291,981 related to the temporary transfers of IMD patients between the ages of 21 and 64 to the MSUs. In its decision, the Board stated that:

> "...the individuals for whom the claims were made remained patients in IMDs at the time they received medical services in the acute care facilities. The Act and regulations, considered as a whole in light of their purpose, clearly require this finding since these individuals were admitted to IMDs, had not been discharged, and were not on conditional release or convalescent leave...Accordingly, we sustain the disallowance."

In a section of the decision entitled Relevant Legal Requirements, the DAB stated that:

> "Title XIX of the Act established a cooperative federal-state program known as Medicaid, which provides medical assistance to certain economically disadvantaged

> persons. Section 1905 (a) of the Act enumerates various services for which payment qualifies as "medical assistance." Following the last of the enumerated paragraphs describing covered services is language which provides that "medical assistance" does not include payments "with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases." ...This provision, known as the general IMD exclusion, was modified on January 1, 1973 to allow for coverage of persons in IMDs who had not yet reached the age of 21, or, in some cases, the age of 22...The general IMD exclusion was based on a congressional belief that care in mental institutions was a traditional state responsibility...."

In its decision, the Board stated the following three main points to address New York's arguments:

> "The institutional status of the individual, not the individual's physical location, is determinative of whether the general IMD exclusion applies."
>
> "HCFA's reading of the 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 HCFA policy which required publication pursuant to notice and comment rulemaking."
>
> "HCFA's determination did not deny the individuals in question access to medical services based on a disability or handicap."

In its conclusion, the DAB stated that:

> "...we conclude that HCFA properly applied the general IMD exclusion in the Act and implementing regulations to preclude Medicaid reimbursement for services to the individuals in question here. Accordingly, we sustain the disallowance in full."

Based on our audit, we concluded that the resolution actions taken by HCFA Region II were reasonable, appropriate, and timely with respect to recommendation number one.

Lack of Timely Action by HCFA Region II on Recommendations Two Through Four

Despite receiving the very favorable DAB decision in May 1996, we concluded that HCFA Region II's resolutions actions for recommendations two through four were untimely and ineffective. Our review determined that from May 1996 to June 1999, HCFA Region II officials had not initiated any meaningful resolution actions.

Although HCFA had written resolution procedures and was required to report on the status of the recommendations in its monitoring system, these controls were not sufficient to ensure

that needed actions to achieve resolution were occurring. On the contrary, we found that the status reports routinely discussed actions that needed to be taken and the comments were consistently phrased in the future tense. For example, on the December 1998 quarterly audit status follow-up report, it stated that with respect to recommendations two and three that "...HCFA will instruct the State to implement any necessary safeguards to preclude such claiming...." and that "...HCFA will instruct the State to implement the necessary internal controls and/or edits...." within the MMIS. With respect to recommendation number four, HCFA stated that it "...will instruct the State to implement this recommendation." The narrative goes on to state that "...HCFA will take safeguard action by notifying the State of the Regional Office's intention to work with the auditors to review claims made during the period January 1, 1991 through the present." The quarterly status report as of June 30, 1999 contained similar wording.

From May 1996 to June 1999, the quarterly status reports clearly document inaction by HCFA. It is evident that the status reports were completed on a perfunctory basis and that the reports were not critically evaluated to determine whether effective action was being taken to address and resolve the outstanding recommendations in our report. When we discussed the lack of progress with HCFA Region II officials, we were not provided any rebuttal to the factual accuracy of our findings but were informed that the lack of resources and other priorities were responsible for their inactions.

In our opinion, HCFA's untimely and ineffective resolution actions did not insulate or absolve NYS officials from complying with the guidance they received.

HCFA's Actions in July 1999 and Positive Results

During the time of our follow-up review, HCFA Region II officials issued a July 14, 1999 letter to NYS directing them to cease and desist the practice of improperly claiming FFP for IMD patients and to voluntarily return the Federal share of the unallowable claims.

In a February 28, 2000 response to HCFA's letter, NYS officials identified what they referred to as $19,657,680 of potentially unallowable FFP. The State's computations of this amount were for the period from January 1, 1991 to December 31, 1999. In its February 28, 2000 letter, State officials indicated that they believe these funds were properly claimed and are allowable. They indicated that the State would not return the funds but rather would await a formal disallowance from HCFA and avail itself of its right to appeal.

In order to have assurance that the amount calculated by NYS was reasonable, Region II HCFA officials requested that the Office of Audit Services (OAS) review the State's computations. The OAS agreed to assist HCFA in testing and validating the reasonableness of the computations.

In summary, our validation work determined that the State's computations were reasonable. We found that there were a few errors in the calculation of the amount which caused a minor

overstatement. Additionally, for the most part, we determined that the methodology employed by the State correctly identified the unallowable FFP claims for the 21 to 64 year old residents of State-operated psychiatric centers (that were IMDs) who were temporarily released to acute care hospitals for medical treatment.

Our validation work determined that the State ran two separate computer programming applications using its MMIS to compute the unallowable FFP amount of $19,657,680. One application covered the period from January 1, 1991 to September 30, 1999 and was run by Federal fiscal year. A separate supplemental application was run for the October 1, 1999 through December 31, 1999 quarter.

Our review found that the $19,657,680 of potentially unallowable FFP was overstated by $56,229 for a revised total of $19,601,451 ($19,657,680 less $56,229). The overstatement related to the October 1, 1999 through December 31, 1999 quarter. Two reasons caused the overstatement. The first reason was that the State included 17 FFP claims twice in its computations. The 17 claims included in the October 1, 1999 through December 31, 1999 quarter were retroactive rate adjustments to prior claims. These 17 claims totaled $52,917. The State previously included these same 17 claims totaling $50,006 in its computations. Only the difference, or $2,911 ($52,917 less $50,006) should have been included in this quarter.

The second reason for the overstatement was that the State incorrectly included three FFP claims totaling $6,223 in its computations for the October 1, 1999 through December 31, 1999 quarter. In a May 2000 meeting, NYS officials indicated that these three claims would be allowable and should not have been included in their computations of potentially unallowable FFP.

During our validation work, we also learned that NYS had taken action to implement edits and controls to prevent improper FFP claims from continuing for State-operated psychiatric center patients between the ages of 21 and 64 who were temporarily released to acute care hospitals for medical treatment. State officials indicated that these edits and controls were effective for services on or after September 1, 1998. We expanded our testing to obtain reasonable assurance that the controls and edits were working.

Our testing determined that the edits and controls established by the State, for services on or after September 1, 1998, prevented the improper FFP claims from continuing. For periods on or after September 1, 1998, our Advanced Techniques Staff identified 649 inpatient hospital claims for 21 to 64 year old residents of State-operated psychiatric centers. Of the 649 claims, 638 were Federally non-participating and 11 were claimed for FFP. We reviewed the 11 FFP claims and determined that they were all allowable.

Finally, our review noted that improper FFP claims could be paid subsequent to the December 31, 1999 cut-off date of the State's computations. The FFP amounts after this

date would be for original and retroactive rate adjustment claims for service dates prior to September 1, 1998 (the implementation date of the State's edits/controls) that were paid after December 31, 1999. As part of our validation work, we did not quantify the unallowable FFP claims subsequent to December 31, 1999.

CONCLUSIONS AND RECOMMENDATIONS

During our follow-up audit, we found HCFA Region II resolution efforts were adequate with respect to recommendation number one but for recommendations two through four, we concluded that resolution actions were untimely and ineffective. We determined that no meaningful resolution activity took place between the time HCFA won the DAB case in May 1996 to June 1999. However, in July 1999, HCFA issued an appropriate follow-up letter to NYS and since that time, positive actions have occurred.

We verified that NYS implemented appropriate edits and controls which, if maintained, will prevent the improper claiming of FFP when State-operated psychiatric center (IMD) patients between the ages of 21 and 64 are temporarily released to acute care hospitals for medical treatment. These actions successfully addressed recommendations two and three with respect to services provided on or after September 1, 1998. In addition, NYS took action to identify and quantify all unallowable FFP claims which partially addresses the fourth recommendation from our original report. At HCFA's request, we validated the work of NYS and identified the amount of improper FFP that was claimed by them for the period January 1, 1991 to December 31, 1999.

Recommendations

Based on our follow-up audit and to resolve the recommendations in our original report, we now recommend that HCFA: (1) issue a disallowance letter to NYS and instruct them to refund the $19,601,451 of unallowable FFP identified by our validation work and (2) instruct NYS to compute the unallowable FFP amount after the December 31, 1999 cut-off date and return the unallowable FFP to the Federal Government.

HCFA's Comments

We issued a draft report to HCFA on March 28, 2000. In their comments dated June 16, 2000, HCFA officials concurred with the draft report's recommendations which were for HCFA to: (1) ensure that NYS officials immediately identify the total amount of unallowable claims and return the Federal share, (2) confirm that NYS was no longer submitting improper claims, and (3) certify that NYS implemented controls and edits to prevent the improper claims in the future. HCFA also agreed to disallow the $19,657,680 identified by NYS and to take appropriate actions to disallow any additional amount identified by our validation work. The complete text of HCFA's comments are shown as an appendix to this report.

OIG Comments

We are pleased that resolution of these matters is within sight. At HCFA's request, we assisted them in validating the State's computations and we verified that the State developed edits and controls to prevent improper FFP claims from occurring in the future. Once HCFA acts on the recommendations in this report, we believe that HCFA will have taken appropriate actions to address the recommendations in our original report.

The Administrator
Washington, D.C. 20201

DATE: JUN 16 2000

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: "Follow-Up Review of the Health Care Financing Administration's Resolution of Improper Medicaid Claims for Patients Residing in Institutions for Mental Diseases" (A-02-99-01031)

We appreciate the opportunity to comment on this draft report regarding the Health Care Financing Administration's (HCFA's) resolution of improper Medicaid claims for patients residing in Institutions for Mental Diseases (IMD). The OIG recommended that HCFA should: (1) ensure that New York State (NYS) officials immediately identify the total amount of unallowable claims and return the Federal share; (2) confirm that NYS is no longer submitting improper claims; and (3) certify that NYS implemented controls and edits to prevent improper claims in the future.

HCFA concurs with the OIG's recommendations. As pointed out in the OIG's report, we acted timely on the monetary recommendation contained in the prior audit report and issued a disallowance letter for the full amount of the recommendation. HCFA has also taken the following actions:

- agreed to issue a disallowance in the amount of $19,657,680;
- agreed to instruct NYS to cease submission of improper claims;
- agreed to work with the OIG Regional Office to verify the overpayment amount; and
- agreed to instruct NYS to implement controls and edits to prevent improper claims.

In addition, HCFA successfully defended the disallowance against NYS's appeal before the Departmental Appeals Board (DAB). However, despite the Board's ruling, NYS continued to assert that it had a right to claim and receive FFP payments for the services rendered to the subject class of patients. HCFA regrets that, despite the continued efforts of our Region II staff, NYS has refused to comply with two of the other three recommendations in the OIG's prior review. Specifically, NYS refused to: (1) cease claiming FFP for the disputed services; and (2) implement controls over their own processes to further prevent improper claims.

In regard to the fourth recommendation, until recently, NYS refused to perform a study to identify the unallowable FFP claims for periods subsequent to the OIG's review. However, in a letter dated February 28, 2000, NYS advised us they identified the amount of $19,657,680 in FFP for the period 1990 to 1999, and that documentation is available to support this calculation.

HCFA will immediately disallow the $19,657,680 based on the NYS study. However, we have requested your Regional Office auditors to work with our staff to verify the amount identified by NYS. If necessary, HCFA will take the appropriate actions to disallow any additional amount identified by the OIG's review.

We appreciate the efforts of your staff in assisting us to resolve the findings related to this audit. We perceive the OIG's work as invaluable in our continuous efforts to improve the oversight of the Medicaid program.

Enclosed are our comments on the specific recommendations. We look forward to continuing our work with your office to ensure the implementation of controls to eliminate the submission of improper claims.

Attachment

Comments of the Health Care Financing Administration on the OIG Draft Report: "Follow-Up Review of the Health Care Financing Administration's Resolution of Improper Medicaid Claims for Patients Residing in Institutions for Mental Diseases" (A-02-99-01031)

Specific Comments

OIG Recommendation
HCFA should ensure that NYS officials immediately identify the total amount of unallowable claims and return the Federal share.

HCFA Response
We concur. NYS identified the amount of $19,657,680 FFP for the period 1990 to 1999 and advises that documentation is available to support the calculation. HCFA agrees to disallow the amount identified by the NYS. In addition, the OIG's Regional Office auditors have agreed to work with the HCFA staff to verify the amount calculated by NYS. If necessary, HCFA will take the appropriate actions to disallow any additional amount identified by the OIG's review.

OIG Recommendation
HCFA should confirm that NYS is no longer submitting improper claims.

HCFA Response
We concur. HCFA will continue to instruct NYS to cease submission of improper claims. In addition, HCFA will notify NYS that our Regional Office staff will be working with the OIG's Regional Office auditors to review claims submitted from 1991 through 1999 to verify the $19,657,680 FFP identified by the State.

OIG Recommendation
HCFA should certify that NYS implemented controls and edits to prevent the improper claims in the future.

HCFA Response
We concur. HCFA will continue to instruct NYS to implement controls and edits to prevent improper claims. However, it should be noted that NYS continues to allege that these costs are allowable.