DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Memorandum

Date OCT 26 2001

From Thomas D. Roslewicz
Deputy Inspector General
for Audit Services

Subject Review of Medicaid Claims Made for 21 to 64 Year Old Residents of Institutions for Mental Diseases in Virginia (A-03-00-00212)

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

This memorandum is to alert you to the issuance on October 30, 2001 of our final report entitled, "Review of Medicaid Claims Made for 21 to 64 Year Old Residents of Institutions for Mental Diseases in Virginia." A copy of the report is attached. We suggest you share this report with the Centers for Medicare & Medicaid Services components 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 the Virginia Department of Medical Assistance Services (DMAS) from claiming Federal financial participation (FFP) under the Medicaid program for 21 to 64 year old residents of psychiatric hospitals that are institutions for mental diseases (IMD). We found that adequate controls were not in place to preclude DMAS from inappropriately claiming FFP under the Medicaid program. As a result, from July 1, 1997 through December 31, 2000, DMAS paid Medicaid claims of $2,680,670 including $1,382,079 FFP for 21 to 64 year old residents of IMDs:

- The Medicaid Management Information System (MMIS) did not deny Medicaid crossover payments for Medicare deductibles for 21 to 64 year old residents of private IMDs. As a result, DMAS inappropriately paid crossover claims of $1,705,635 including $879,917 FFP directly to private IMDs for inpatient psychiatric services for 21 to 64 year old residents.

- The Department of Social Services (DSS)--which makes eligibility decisions--did not have a method to (i) systematically identify Medicaid recipients who entered an IMD, and (ii) suspend their Medicaid eligibility. As a result, DMAS inappropriately made Medicaid payments of $975,035 including $502,162 FFP for medical and ancillary claims for 21 to 64 year old residents of State IMDs.

We recommended that DMAS: (i) refund $1,382,079 of improperly claimed FFP for 21 to 64 year old residents of IMDs; (ii) change the MMIS to deny crossover payments to private IMDs; (iii) establish procedures to require State IMDs to report IMD admissions to DSS organizations responsible for determining Medicaid eligibility; and (iv) require DSS to suspend Medicaid eligibility for all IMD residents upon entering an IMD. We recommended that, once these controls are in place, DMAS review claims paid after January 20, 2001 for State IMDs, and January 19, 2001 for private IMDs, to the date controls are established, and make the appropriate refund of FFP. We also recommended that DMAS perform the review for claims paid from July 1997 for private IMDs, take the necessary action to establish controls, and make the appropriate refund of FFP. The DMAS generally agreed with our findings and recommendations.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104 or David M. Long, Regional Inspector General for Audit Services, Region III, at (215) 861-4470.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID CLAIMS MADE FOR 21 TO 64 YEAR OLD RESIDENTS OF INSTITUTIONS FOR MENTAL DISEASES IN VIRGINIA

JANET REHNQUIST
Inspector General

OCTOBER 2001
A-03-00-00212

DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF AUDIT SERVICES
150 S. INDEPENDENCE MALL WEST
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Common Identification Number: A-03-00-00212

Eric S. Bell, Director
Department of Medical Assistance Services
Suite 1300
600 E. Broad Street
Richmond, Virginia 23219

Dear Mr. Bell:

Enclosed for your information and use are two copies of an Office of Inspector General final audit report entitled, **"REVIEW OF MEDICAID CLAIMS MADE FOR 21 TO 64 YEAR OLD RESIDENTS OF INSTITUTIONS FOR MENTAL DISEASES IN VIRGINIA."** Your attention is invited to the audit findings and recommendations contained in the report.

Final determination as to the actions to be taken on all matters reported will be made by the Department of Health and Human Services (HHS) action official named below. 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. Should you have any questions, please direct them to the HHS action official named below.

In accordance with the principals of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information contained therein is not subject to exemptions in the Act. (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://www.hhs.gov/progorg/oig.

To facilitate identification, please refer to the above common identification number in all correspondence pertaining to this report.

Sincerely yours,

David M. Long

David M. Long
Regional Inspector General
for Audit Services

Enclosures

Reply directly to HHS Action Official:

Acting Regional Administrator
Centers for Medicare & Medicaid Services, Region III
U.S. Department of Health and Human Services
Suite 216, Public Ledger Building
150 S. Independence Mall West
Philadelphia, Pennsylvania 19106-3499

EXECUTIVE SUMMARY

This audit presents the results of an Office of Inspector General (OIG) **REVIEW OF MEDICAID CLAIMS MADE FOR 21 TO 64 YEAR OLD RESIDENTS OF INSTITUTIONS FOR MENTAL DISEASES IN VIRGINIA.**

Background

The basis for the exclusion of Federal financial participation (FFP) for institutions for mental diseases (IMD) was established in the 1950 amendments to the Social Security 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 Social Security Act extended FFP for inpatient psychiatric care to individuals under the age of 21. If inpatient psychiatric services begins prior to age 21, and continues, the patient may be eligible for Medicaid assistance until age 22. Therefore, since the beginning of the Medicaid program, Federal medical assistance has never been available for residents of IMDs between the ages of 21 to 64 for any type of service provided either in or outside the IMD.

Objective

The objective of the review was to determine if controls were in place to effectively preclude the Virginia Department of Medical Assistance Services (DMAS) from claiming FFP under the Medicaid program for 21 to 64 year old residents of psychiatric hospitals that are IMDs. We conducted our review in accordance with generally accepted government auditing standards.

To accomplish our audit objective, we conducted audit work at DMAS, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and contacted responsible personnel in the Department of Social Services (DSS). We visited the seven State IMDs who served 21 to 64 years old residents.

Summary of Findings

Our review showed that controls were not in place to effectively preclude DMAS from claiming FFP under the Medicaid program for 21 to 64 year old residents of IMDs. From July 1, 1997 through December 31, 2000, DMAS inappropriately paid Medicaid claims of $2,680,670 including $1,382,079 FFP for 21 to 64 year old residents of IMDs:

- The Medicaid Management Information System (MMIS) did not deny Medicaid crossover payments for Medicare deductibles for 21 to 64 year old residents of private IMDs. As a result, DMAS inappropriately paid crossover claims of $1,705,635 including $879,917 FFP directly to private IMDs for inpatient psychiatric services for 21 to 64 year old residents.

- The DSS--which makes eligibility decisions--did not have a method to (i) systematically identify Medicaid recipients who entered an IMD, and (ii) suspend their Medicaid eligibility. As a result, DMAS inappropriately made Medicaid payments of $975,035 including $502,162 FFP for medical and ancillary claims for 21 to 64 year old residents of State IMDs. The DMAS inappropriately made Medicaid payments of:

    - $289,057 including $149,227 FFP for inpatient acute care hospital costs for residents of State IMDs.

    - $645,192 including $331,951 FFP for other medical and ancillary claims for residents of State IMDs.

    - $40,786 including $20,984 FFP for an individual resident of a State IMD who was released for medical attention, then readmitted.

Recommendations

We recommended that DMAS (i) refund $1,382,079 of improperly claimed FFP for 21 to 64 year old residents of IMDs, (ii) change the MMIS to deny crossover payments to private IMDs, (iii) establish procedures to require State IMDs to report IMD admissions to DSS organizations responsible for determining Medicaid eligibility, and (iv) require DSS to suspend Medicaid eligibility for all IMD residents upon entering an IMD. Once these controls are in place, we recommended DMAS review claims paid after January 20, 2001 for State IMDs, and January 19, 2001 for private IMDs, to the date controls are established, and make the appropriate refund of FFP.

We did not include in our review inpatient and other medical and ancillary claims made for residents of private IMDs. We recommended that DMAS perform the review for claims paid from July 1997, take the necessary action to establish controls, and make the appropriate refund of FFP.

By letter dated August 3, 2001, DMAS responded to a draft of this report. The DMAS generally agreed with our findings and recommendations. However, DMAS stated that for the recommended reviews DMAS will conduct, FFP would be refunded only after erroneous Medicaid payments were recovered from the providers. The reviews that DMAS agreed to conduct will determine if DMAS' improperly claimed FFP, not if providers received inappropriate payments. When the reviews are completed, any improper claims identified must be refunded. We have reviewed DMAS' response and included it as **Appendix C** to this report. We have also presented a summary of their response after the **CONCLUSIONS AND RECOMMENDATIONS** section in this report.

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INTRODUCTION

Background

Code of Federal Regulations (CFR): The institutions for mental disease (IMD) criteria found at section 1905(a) of the Social Security Act (the Act), 42 CFR 441.13, and 42 CFR 435.1008, preclude Federal financial participation (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 cases 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.

State Medicaid Manual: The Centers for Medicare & Medicaid Services (CMS) – formerly the Health Care Financing Administration – provided guidance to States 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 to States regarding the prohibition of FFP for IMD residents between the ages of 21 to 64. 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. . . . 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."

Section 4390.1 of both transmittals entitled, "Periods of Absence From IMDs," states that:

> "42 CFR 435.1008(c) states that an individual on conditional release or convalescent leave from an IMD is not considered to be a patient in that institution. These periods of absence relate to the course of treatment of the individual's mental disorder. If a patient is sent home for a trial visit, this is convalescent leave. If a patient is released from the institution on the condition that the patient receive outpatient treatment or on other comparable conditions, the patient is on conditional release. . . . If an emergency or other need to obtain medical treatment arises during the course of convalescent leave or conditional release, these services may be covered under Medicaid because the individual is not considered to be an IMD patient during these periods. If a patient is temporarily transferred from an IMD for the purpose of obtaining medical treatment, however, this is not considered a conditional release, and the patient is still considered an IMD patient."

Virginia IMDs: In Virginia, there were 16 IMDs that served 21 to 64 year old residents. The 16 IMDs consisted of 9 private IMDs and 7 State IMDs:

Private IMDs	State IMDs
Carilion Saint Albans Hospital	Catawba Hospital
Charter Hospital of Charlottesville	Central State Hospital
Charter Westbrook Hospital	Eastern State Hospital
Dominion Hospital	Northern VA Mental Health Institute
Piedmont Behavioral	Southern VA Mental Health Institute
Poplar Spring Hospital	Southwestern VA Mental Health Institute
Virginia Beach Psychiatric Hospital	Western State Hospital
Virginia Psychiatric	
West End Behavioral Health Care System	

Objective, Scope, and Methodology

The objective of the review was to determine if controls were in place to effectively preclude DMAS from claiming FFP under the Medicaid program for inpatient, and other medical and ancillary services for 21 to 64 year old residents of psychiatric hospitals that are IMDs. We conducted our review in accordance with generally accepted government auditing standards. To accomplish our audit objective, we conducted audit work at Department of Medical Assistance Services (DMAS), Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), and contacted responsible personnel in Department of Social Services (DSS). We also visited the seven State IMDs which served 21 to 64 year old residents.

Upon our request, DMAS provided a listing identifying Medicaid payments made directly to private IMDs. The listing included paid claims from July 1, 1997 through December 31, 2000, with a claim paid date prior to January 20, 2001. From this data, we were able to identify all Medicaid payments that were for inpatient psychiatric services. The DMHMRSAS was not able to identify the residents of private IMDs, and DMAS was not able to provide us with medical and ancillary claims made by third parties.

The DMAS also provided a listing identifying 1,651 individuals with paid Medicaid claims, who were 21 to 64 year old residents of State IMDs from July 1, 1997 through November 30, 2000. The claims for these IMD residents totaled $1,678,316. This listing was based on (i) names, (ii) social security numbers, and (iii) State IMD admission and discharge dates provided by DMHMRSAS. We identified and removed from the listing $283,989 ($146,591 FFP) of Medicaid payments made to acute care hospitals for inpatient care. These inpatient claims were for 46 individuals, and we reviewed these claims in their entirety. We also removed from the

listing 319 individual IMD residents whose total claims were less than $100 each, which accounted for only $12,797 ($6,584 FFP). We did not review these claims. We sampled from the remaining 1,332 individuals.

Breakdown of Listing Provided by DMAS

	Individual IMD Residents	Value of Claims
Total Listing	1,651	$ 1,678,316
Less Amounts Not Sampled		
Inpatient Acute Care	-	283,989
Individuals With Total Claims Under $100	319	12,797
Total Not Sampled	319	$ 296,786
Universe Sampled	**1,332**	**$ 1,381,530**

- There were 46 individual IMD residents with inpatient acute care costs. Four of the 46 individuals had total paid claims under $100 after acute care costs were removed from the listing. The 4 individuals are included in the 319 with claims under $100, which we removed from the listing. The remaining 42 individuals had total claims of $100 or more after the acute care claims were removed from the listing. The 42 individuals remain included in the 1,332 individuals, from which we sampled.

We selected a stratified random sample of 149 individuals from the remaining 1,332 individuals with Medicaid claims of $100 or more, totaling $1,381,530 ($710,797 FFP). **Appendix A** explains our methodology to develop our sample. **Appendix B** details the projection of the sample results.

We reviewed: (i) claims histories for IMD residents we selected during our visits to State IMDs to confirm the accuracy of claims listings provided by DMAS, (ii) State policies and procedures to determine what controls were in place to prevent inappropriate payments, (iii) claims histories from July 1, 1997 through November 30, 2000 with a claim payment date prior to January 21, 2001, and (iv) medical histories to determine if Medicaid payments for 21 to 64 year old residents of IMDs were appropriate. We performed other auditing procedures we considered necessary under the circumstances. Our audit work was accomplished in Richmond, Virginia, and at the seven State IMDs throughout Virginia from September 2000 through April 2001.

By letter dated August 3, 2001, DMAS responded to a draft of this report. We have reviewed DMAS' response and included it as **Appendix C** to this report. We have also summarized their response, and included it after the **Conclusions and Recommendations** section of this report.

RESULTS OF REVIEW

Controls were not in place to effectively preclude DMAS from claiming FFP under the Medicaid program for 21 to 64 year old residents of IMDs. From July 1, 1997 through December 31, 2000, DMAS inappropriately paid Medicaid claims of $2,680,670 including $1,382,079 FFP for 21 to 64 year old residents of IMDs.

The Medicaid Management Information System (MMIS) did not have an edit to deny Medicaid crossover payments for Medicare deductibles for 21 to 64 year old residents of private IMDs. Additionally, there was no method in place for DSS to: (i) systematically identify Medicaid recipients who entered a State IMD, and (ii) suspend their Medicaid eligibility. As a result, DMAS:

- Paid crossover claims of $1,705,635 including $879,917 FFP directly to private IMDs for inpatient psychiatric services for 21 to 64 year old residents.

- Made Medicaid payments of $975,035 including $502,162 FFP for medical and ancillary claims for 21 to 64 year old residents of State IMDs.

Claims Paid Directly to Private IMDs: The DMAS improperly paid crossover claims of $1,705,635 including $879,917 FFP directly to private IMDs for inpatient psychiatric services for 21 to 64 year old residents.

- A crossover claim can be a single claim for Medicare covered services submitted to and processed by the Medicare intermediary.

- Providers do not have to submit a separate crossover claim to be paid for the Medicare co-insurance or deductible amount if their Medicare provider number is identified in the MMIS.

- $875,376 of the $879,917 FFP in improper payments were submitted to and processed by the Medicare intermediary. The remaining $4,541 FFP in crossover claims were made directly from the provider.

The DMAS provided us a listing of Medicaid payments made directly to private IMDs. This listing showed that the payments made by DMAS to private IMDs were limited to crossover payments. From this listing, we identified 2,013 crossover payments for Medicare deductibles for inpatient psychiatric services for 21 to 64 year old residents of private IMDs. The claims for inpatient psychiatric services were made by private IMDs to the Medicare intermediary. The intermediary passed the deductible portion of the claim to DMAS for payments of $1,696,831 including $875,376 FFP. The remaining $8,804 including $4,541 FFP in crossover claims were made directly from the provider. The private IMDs that received the improper crossover payments, and the amount of the crossover payments received are identified in the following table:

Listing of Medicaid Crossover Payments Made Directly to Private IMDs

Provider	Direct Payments	FFP
Carilion Saint Albans Hospital	$ 216,763	$ 111,844
Charter Hospital of Charlottesville	111,474	57,474
Charter Westbrook Hospital	299,522	154,360
Dominion Hospital	4,224	2,181
Piedmont Behavioral	4,840	2,494
Poplar Spring Hospital	249,238	128,656
Virginia Beach Psychiatric Hospital	439,675	226,912
Virginia Psychiatric	369,983	190,888
West End Behavioral Health Care System	9,916	5,108
Value of Improper Payments	**$ 1,705,635**	**$ 879,917**

The Director of DMAS Program Operations Division informed us that the MMIS had edits to deny claims made by an IMD for inpatient psychiatric services for 21 to 64 year old residents. However, the MMIS had no edit for crossover claims for the same services.

Claims Paid for Residents of State IMDs: Medicaid eligibility should have been suspended for all residents of State IMDs by DSS. However, DSS was not always aware of the IMD admissions, and eligibility was not suspended in a timely manner. As a result, DMAS made Medicaid payments of $975,035 including $502,162 FFP for medical and ancillary claims for 21 to 64 year old residents of State IMDs. The DMAS made Medicaid payments of:

- $289,057 including $149,227 FFP for inpatient acute care hospital costs for residents of State IMDs.

- At least $645,192 including $331,951 FFP for other medical and ancillary claims for residents of State IMDs.

  - Using statistically valid sampling techniques, we estimate that DMAS improperly paid at least $630,677 of Medicaid claims including $324,483 FFP.

  - We also identified two individuals who were not identified by DMAS, and who had Medicaid claims paid while they were IMD residents. The DMAS improperly paid Medicaid claims of $14,515 including $7,468 FFP for these individuals.

- $40,786 including $20,984 FFP for an individual resident of a State IMD who was released for medical attention, then readmitted.

Suspending Medicaid Eligibility in State IMDs: The DSS had no method to systematically identify Medicaid recipients who entered State IMDs and to suspend their Medicaid eligibility. Several months could pass before DSS determined that a Medicaid recipient was an IMD resident and suspended his or her Medicaid eligibility. In some cases, IMD residents would remain Medicaid eligible throughout their IMD stays. A number of factors contributed to the delay in suspending Medicaid eligibility for IMD residents:

- The DSS/DMHMRSAS procedures stated that if a patient is expected to remain in an IMD for less than 30 days, the hospitalization is considered a temporary absence from the home, and Medicaid eligibility continues.

- The DSS eligibility workers and DMAS eligibility managers incorrectly believed that they were required to provide a Medicaid suspension notice with an appeal period to allow the Medicaid recipient to challenge the suspension.

- The DSS eligibility workers incorrectly believed that, except for the death of a Medicaid recipient, the MMIS would not allow immediate suspension of Medicaid eligibility.

In July 1994, DSS and DMHMRSAS agreed on procedures DSS workers would use when an individual entered an IMD. The procedure clearly states that an IMD resident between the ages of 21 and 64 cannot be Medicaid eligible. However, the procedure also states that if a patient is expected to remain in the facility for less than 30 days, the hospitalization is considered a temporary absence from the home, and Medicaid eligibility continues. A DMHMRSAS representative explained that they agreed to the 30-day criteria because establishing Medicaid eligibility was a time consuming task, and there was no need to suspend eligibility if it were to be reestablished within 30 days. He noted that neither DSS nor DMHMRSAS foresaw Medicaid claims being made on behalf of IMD residents.

The DSS eligibility workers were inappropriately providing IMD residents with suspension notices. The notices included a period for the Medicaid recipient to challenge the suspension. Both DMAS and DSS believed the advance notice of suspension was a Federal requirement. However, 42 CFR 431.213 (c) provides for an exemption from the requirement for advance notice. It states that:

> "The agency may mail a notice no later than the date of action if -- the recipient has been admitted to an institution where he is ineligible under the plan for further services."

The DSS eligibility workers also believed that the MMIS would only allow for an immediate suspension of eligibility for a deceased Medicaid recipient. Suspensions for other Medicaid recipients could only occur at the end of the month the suspension was decided. If the eligibility worker missed the cutoff date, the suspension would not take place until the end of the following month. The Director of the Program Operations Division informed us that although the MMIS was actually set up to allow for full-month eligibility with the exception of deceased recipients, the MMIS could be overridden to suspend Medicaid eligibility on the day a Medicaid recipient

enters an IMD. Clearly, DMAS, DMHMRSAS, and DSS need to develop a policy whereby DSS is notified the same day a patient enters an IMD, so that Medicaid eligibility can be suspended at that time.

Claims Paid to Acute Care Hospitals: The DMAS made Medicaid payments of $289,057 including $149,227 FFP for inpatient acute care hospital costs for residents of State IMDs. These patients were temporarily released – but not discharged – from an IMD to receive medical attention. However, their Medicaid eligibility was not suspended, and claims submitted by acute care hospitals were paid.

Data provided by DMAS showed acute care hospitals made 63 claims for 46 IMD residents during our audit period. We reviewed medical records and claims histories for all 46 IMD residents and determined that 8 of the claims were appropriate because the IMD residents were on convalescent leave at the time of the service. However, DMAS should not have paid 55 of the claims. We also identified 1 additional inappropriately paid claim for 1 of the 46 IMD residents that was not included in the data provided by DMAS. One of the 55 claims was adjusted to a lower payment by DMAS after they provided the file.

Review of Inpatient Acute Care Claims

	Claims	Payments	FFP
Total Reviewed	63	$ 283,989	$ 146,591
Convalescent Leave	(8)	(15,872)	(8,182)
DMAS Adjustment		(1,229)	(637)
Questioned	55	$ 266,888	$ 137,772
Additional Claim	1	22,169	11,455
Total Questioned	**56**	**$289,057**	**$149,227**

For example, 1 of the 46 IMD residents was detained while at an acute care hospital because he refused to accept medical attention for uncontrolled hypertension, glaucoma, anemia, and renal insufficiency. The patient was admitted to Northern Virginia Mental Health Institute (NVMHI) on October 6, 1997 by court order. The NVMHI sent him to Fairfax Hospital on the same day he was admitted to NVMHI to receive the medical treatment he previously refused. This NVMHI resident was admitted to Fairfax Hospital on two additional occasions before his discharge from NVMHI on June 22, 1998. In total, his acute care hospitalization while a resident of NVMHI resulted in Medicaid payments of $50,572 including $26,111 FFP.

Claims Paid for Medical and Ancillary Services: The DMAS made unallowable Medicaid payments of at least $645,192 including $331,951 FFP for other medical and ancillary claims for residents of State IMDs. These claims were made for IMD residents and included claims for outpatient hospital, practitioner, pharmacy, laboratory, x-ray, crossover payments, and other ancillary claims.

The DMAS provided a file of Medicaid claims paid for residents of State IMDs. The file contained 1,332 IMD residents with other medical and ancillary Medicaid claims totaling $100 or more and included $1,381,530 ($710,797 FFP). To determine if these claims paid on behalf of IMD residents were appropriate, we selected a stratified random sample of 149 individuals from the 1,332 individual residents. Paid claims for the 149 individuals selected for review were $191,971.

We reviewed medical records and claims histories and determined that DMAS improperly paid Medicaid claims of $111,171 ($57,197 FFP) for 120 of the 149 IMD residents. These patients were residents of an IMD and were not on conditional release or convalescent leave at the time of the service. However, DSS had not suspended their Medicaid eligibility at the time of the service. We projected the results of our sample. Based on the inappropriately paid claims of $111,171, and using statistically valid sampling techniques, we estimate with 95 percent confidence that DMAS improperly paid at least $630,677 of Medicaid claims including $324,483 FFP. Two examples of improperly paid claims follow.

One 57-year-old patient entered Eastern State Hospital on October 27, 1998 suffering from severe dementia, and remained in Eastern State Hospital throughout our audit period. The patient was Medicaid eligible prior to entering Eastern State Hospital, and did not have his eligibility suspended until July 1999. During that time, DMAS paid Medicaid crossover payments of $15,569 including $8,011 in FFP.

Another patient, a 52-year-old man, was admitted to Southwestern Virginia Mental Health Institute on June 4, 1998, and he remained there until October 4, 1999. The patient was Medicaid eligible until he entered Southwestern. However, DSS did not suspend his Medicaid eligibility until September 1998. From June 4, 1998 through August 7, 1998, DMAS paid Medicaid claims of $2,089 including $1,075 in FFP.

In addition to the IMD residents we sampled, we identified two individuals during our survey who were not identified on the DMAS listing of Medicaid claims paid for IMD residents. While these patients were residents of Eastern State Hospital and Southern Virginia Mental Health Institute respectively, DMAS improperly paid Medicaid claims of $14,515 including $7,468 FFP. In all, DMAS made inappropriate Medicaid payments of $645,192 including $331,951 FFP for other medical and ancillary claims for residents of State IMDs:

	Inappropriately Paid Claims	FFP
Projected On The Basis Of The Sample	$ 630,677	$ 324,483
Identified During The Survey, But Not In Claims Listing	14,515	7,468
Total Payments	$ 645,192	$ 331,951

Claims Paid for an IMD Resident Discharged for Medical Attention: The DMAS made Medicaid payments of $40,786 including $20,984 FFP for an individual resident of a State IMD who was discharged from the IMD for medical attention, then readmitted to the IMD. A 45-year-old woman was admitted to Central State Hospital in January 1996 on a detention order due to her loud and angry behavior. On January 16, 2000, she was sent out on special hospitalization status for numerous physical problems including Chronic Obstructive Pulmonary Disease (COPD). On March 10, 2000, after about 3 months on special hospitalization status, the patient was discharged from Central State Hospital and transferred to Hiram Davis Medical Center. Hiram Davis Medical Center is a State Medical Surgical Unit on the Central State Hospital Campus. The March 10, 2000 discharge plan indicated that:

> "Ms. . . .has numerous physical problems and has had several local hospital (Southside Regional Medical Center) and Hiram Davis Medical Center hospitalizations. Currently, she has been on special hospitalization status at SRMC & HDMC since 1/16/00. Due to her health status and medical needs, she is being transferred to Hiram Davis Medical Center as of 3/10/00"

The patient remained at Hiram Davis Medical Center until September 7, 2000, when she was readmitted to Central State Hospital. The September 19, 2000 Comprehensive Psychiatric Assessment stated:

> "Ms. . . .has been virtually continuously psychotic since 1984, and possibly before. She was last admitted to Central State Hospital on account of her psychotic illness on 01/11/96. In addition to her psychotic illness, she was known to suffer from Chronic Hypertension and COPD, complicated by COR Pulmonale. Both conditions have been serious and she suffered a number of exacerbations between 1996 and the year 2000. These required special hospitalization. An exacerbation of her COPD in January 2000 was particularly severe. She was then admitted to Southside Regional Medical Center where she was given ventilatory support. After her initial recovery, she still needed to be on oxygen, and it appeared that adequate recovery to permit her return to Central State Hospital was likely. Subsequently, on 03/10/2000, she was discharged to Hiram Davis Medical Center in order to be provided with more intensive treatment of her respiratory insufficiency. Over a period of six months, she made a very good recovery, no longer needing to be on oxygen, with clear lungs, and no peripheral edema. On the other hand,

her moderately, severe psychotic symptoms persisted. Therefore, it was decided that she should be readmitted to Central State Hospital for further treatment of her psychotic illness."

This patient was only readmitted to Central State Hospital when her COPD was under control. Clearly, this patient was discharged for a medical condition, which could not be treated while residing in an IMD. This patient would not have been discharged from Central State in March 2000 because her psychotic symptoms were persistent.

CONCLUSIONS AND RECOMMENDATIONS

Controls were not in place to effectively preclude DMAS from claiming FFP under the Medicaid program for 21 to 64 year old residents of IMDs. From July 1, 1997 through December 31, 2000, DMAS inappropriately paid Medicaid claims of $2,680,670 including $1,382,079 FFP for 21 to 64 year old residents of IMDs.

The DMAS paid crossover claims of $1,705,635 including $879,917 FFP directly to private IMDs for inpatient psychiatric services and made payments of at least $975,035 including $502,162 FFP for medical and ancillary claims for residents of State hospitals. We recommended that DMAS:

1. Refund to the Federal Government $1,382,079 FFP associated with unallowable claims for 21 to 64 year old residents of IMDs.

2. Change the MMIS to ensure that FFP is not claimed for crossover payments to private IMDs.

3. Establish procedures to require State IMDs to report IMD admissions to DSS organizations responsible for determining Medicaid eligibility.

4. Require DSS to suspend Medicaid eligibility for all IMD residents between the ages of 21 and 64 when they enter an IMD.

5. Review claims for IMD residents paid after January 20, 2001 for State IMDs--after January 19, 2001 for private IMDs--to the date controls specified in recommendations two through four are established, and make the appropriate refund of FFP.

6. Review inpatient and other medical and ancillary claims made for residents of private IMDs from July 1997. Take the necessary action to establish controls and make the appropriate refund of FFP.

DMAS' Comments

The DMAS agreed to refund $1,382,079 FFP associated with unallowable claims for 21 to 64 year old residents of IMDs. The DMAS also stated:

- As of June 1, 2001, DMAS completed enhancements to the MMIS to prevent the payment of Medicaid crossover claims for 21 to 64 year old residents of IMDs.

- The DMAS is working with representatives of DMHMRSAS and DSS to develop a process for on-site eligibility workers to review all admissions and make referrals for prompt closure for 21 to 64 year old residents of State IMDs. In addition, DMHMRSAS will provide DMAS with a monthly IMD patient list that will be matched against Medicaid enrollment in the MMIS. Matches for 21 to 64 year old residents will be referred to DSS for closure.

- The DMAS will review claims for IMD residents paid after January 20, 2001 for State IMDs, and after January 19, 2001 for private IMDs through the date controls were established. However, DMAS will refund FFP only after DMAS recovers improper payments from providers.

- The DMAS will conduct a review of inpatient and other medical and ancillary claims made for 21 to 64 year old residents of private IMDs from July 1997. However, DMAS will refund FFP only after DMAS recovers improper payments from providers.

OIG's Response

The DMAS generally agreed with all of our recommendations. As part of their comments, DMAS stated that it will conduct reviews of claims for IMD residents paid after January 20, 2001 for State facilities and from July 1997 for residents in private IMDs. The DMAS stated that it would refund FFP only after improper payments are recovered from providers. The reviews that will be conducted will determine if DMAS improperly claimed FFP, not if providers received inappropriate payments. When the reviews are completed, any improper claims identified must be refunded in accordance with CMS instructions.

SAMPLING METHODOLOGY

Review Objective:

The objective of the review was to determine if controls were in place to effectively preclude DMAS from claiming FFP under the Medicaid program for 21 to 64 year old residents of psychiatric hospitals that are IMDs.

Population:

The population of IMD residents we statistically sampled totaled 1,332. Medical and ancillary claims of $1,381,530 including $710,797 FFP had been paid for these IMD residents.

Sampling Frame:

We sampled the 1,332 people with claims for medical and ancillary services while they were residents of IMDs.

Sample Unit:

Our sampling unit was an individual resident of an IMD who had claims for medical and ancillary services while a resident of an IMD.

Sample Design:

The population of interest included 1,332 people with medical and ancillary claims while they were residents of IMDs. The data was provided by DMAS in a file it prepared at our request. The file contained Medicaid claims paid for medical and ancillary services on behalf of individuals who were residents of IMDs at the time of the medical service. We sampled the data in three strata:

From $100.00 to $499.99.
From $500.00 to $999.99.
More than $999.99.

Sample Size:

We selected a sample size of 149 IMD residents identified by DMAS with paid medical and ancillary Medicaid claims:

From $100.00 to $499.99	50 IMD Residents.
From $500.00 to $999.99	50 IMD Residents.
More than $999.99	49 IMD Residents.

Source of Random Numbers:

The random numbers for selecting the sample items were generated using an approved Department of Health and Human Services, OIG, Office of Audit Services statistical software package that has been validated using the National Bureau of Standards methodology. The numbers were generated for each of the three strata independently.

Method of Selecting Sample Items:

The DMAS provided a listing of Medicaid claims paid for residents of IMDs from July 1, 1997 through November 2000. The listing contained 1,651 IMD residents with $1,678,316 in paid Medicaid claims. We removed from the listing $283,989 in claims paid for inpatient acute care because we reviewed acute care costs in their entirety. We also removed 319 of the IMD residents from the listing because the total of the claims for each resident was less than $100. The paid claims for these 319 IMD residents amounted to $12,797. We sorted the remaining individuals with claims by the value of the total claims for each individual and placed them in three strata:

- 734 individuals with total claims for each IMD resident from $100 to $499.99. All claims in this strata totaled $191,592.

- 254 individuals with total claims for each IMD resident from $500 to $999.99. All claims in this strata totaled $180,648.

- 344 individuals with total claims for each IMD resident from $1,000 and over. All claims in this strata totaled $1,009,290.

Residents within each stratum were numbered sequentially and independently. Three sets of random numbers were drawn, and the random numbers were correlated to the numbered sample items in the database.

Our sample was drawn from a sample of 1,336 IMD residents due to the inclusion of acute care claims in the original sample frame. Costs associated with acute care were removed from the population, resulting in 1,332 IMD residents subject to review. The adjustment in the amounts claimed resulted in 16 IMD residents being reviewed in the strata of "more than $999.99" that should have been classified in the "from $100.00 to $499.99" strata (6 IMD residents) or the

"from "$500.00 to $999.99" strata (10 IMD residents). Because 1 of the sampled IMD residents was 1 of the 4 with acute care claims only, the sample size for the "more than $999.99" strata was reduced from 50 to 49 IMD residents. These adjustments did not affect the statistical validity of the sample.

Appendix B

SAMPLE PROJECTION

Results of Sample:

The results of our review of 149 individuals with Medicaid claims follow:

Sample Results					
Stratum Number	**IMD Residents in the Universe**	**Value of Universe**	**Sample Size**	**IMD Residents with Improper Claims**	**Value of Improper Claims**
1. $100 to $499.99	734	$191,592	50	43	$10,634
2. $500 TO $999.99	254	180,648	50	41	25,506
3. $1,000 and Over	344	1,009,290	49	36	75,031
Total	1,332	$1,381,530	149	120	$111,171

Variable Projection (90 percent confidence level):

		Value of Errors	
	Errors	Paid Claims	FFP
Number of claims with errors identified In the sample:	120		
Value of errors identified in the sample:		$ 111,171	$ 57,198
Point estimate:		812,433	417,997
Upper limit:		994,188	511,510
Lower limit:		630,667	324,483
Standard Error		$ 110,500	$ 56,852

Using statistically valid sampling techniques, we estimate with 95 percent confidence that DMAS improperly paid claims of at least $630,667 of the $1,381,530 total paid claims for residents of IMDs. The inappropriate payments included at least $324,483 FFP. Our point estimate was $812,433 ($417,997 FFP) with a precision of plus or minus $181,755 ($93,513 FFP).

COMMONWEALTH of VIRGINIA

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August 3, 2001

Mr. James Maiorano
Regional Inspector General for Audit Services
OIG/OAG
150 South Independence Mall West, Suite 316
Philadelphia, PA 19106-3499

Re: A-03-00-00212

Dear Mr. Maiorano:

The purpose of this letter is to respond to the draft report entitled "Review of Medicaid Claims Made for 21 to 64 Year Old Residents of Institutions for Mental Diseases in Virginia." The Department of Medical Assistance Services (DMAS) appreciates the work of your staff involved in the audit, and especially in identifying erroneous payments made to Institutions for Mental Diseases (IMD).

At the time preliminary findings were presented to DMAS, staff from Program Operations validated the accuracy of the audit findings. A sample of the claims were reviewed to verify the accuracy of the audit findings, as well as validate that the recipients were residents of an IMD at the time the claims in question were incurred. Based on our review we found that the auditors' calculations were accurate in all cases sampled.

In your letter you request that we indicate any action taken or contemplated by DMAS to address the recommendations on page 10 of the draft report. I will respond in the same order as listed in the report.

(1.) The Department of Medical Assistance Services agrees to refund to the Federal Government $1,382,079 FFP associated with unallowable claims for IMD residents ages 21 to 64. This refund will be generated upon receipt of the final report from the United States Department of Health and Human Services, Office of Inspector General (OIG).

(2.) Enhancements to the Medicaid Management Information System (MMIS) have been completed to prevent the payment of Medicare crossover claims for 21 to 64 year old residents of an IMD. This change was effective for claims received on and after June 1, 2001.

(3.) DMAS is working with representatives form the Department of Mental Health Mental Retardation and Substance Abuse Services (DMHMRSAS) and the Department of Social Services (DSS), to develop a process for on-site eligibility workers at the State IMDs to review all admissions and make referral for prompt closure to DSS for residents ages 21 to 64. In addition to reviewing IMD admissions, DMAS will also implement ongoing monitoring. On a monthly basis, DMHMRSAS will provide DMAS with an IMD patient list, which will be matched against Medicaid enrollment on the MMIS. All matches for residents 21 to 64 years old will be referred to DSS for closure.

(4.) As noted in number 3 above, DSS will be requested to cancel Medicaid eligibility for all IMD residents ages 21 to 64.

(5.) DMAS will review claims for IMD residents paid after January 20, 2001 for State IMDs and after January 19, 2001 for private IMDs based on controls established in items 2 through 4. However, since DMAS will be conducting the review, refund of FFP will be made when the provider refunds to DMAS any erroneous payments.

(6.) DMAS will conduct a thorough review of acute care hospital and other medical and ancillary claims incurred from July 1997 for residents ages 21 to 64 of private IMDs. However, since DMAS will be required to expend system programming and personnel resources to accomplish this audit, FFP will be refunded only when erroneous payments are collected from providers.

Thank you for the opportunity to respond to the draft report, we look forward to the final OIG report.

Sincerely,

Eric S. Bell

ESB:jpc