DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAR 24 2003

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

From: Dennis J. Duquette
Deputy Inspector General
for Audit Services

Subject: Review of Medicaid Claims Made For 21 To 64 Year Old Residents of Institutions for Mental Disease in Maryland (A-03-00-00214)

As part of the Office of Inspector General's self-initiated audit work, we are alerting you to the issuance of the subject final audit report within 5 business days. A copy of the report is attached. This report is one of a series of reports involving our multi-state review of federal reimbursement for medical services provided to residents of institutions for mental diseases (IMD). We suggest you share this report with components of the Centers for Medicare and Medicaid Services 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 state of Maryland from claiming federal financial participation (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. Our review covered the period July 1, 1997 through June 30, 2000 for acute care inpatient and other medical and ancillary services. We also reviewed IMD waiver claims from January 1, 1997 through December 31, 2000.

Our review showed that controls were not in place to effectively preclude the state from claiming FFP under the Medicaid program for 21 to 64 year old residents of IMDs. From July 1, 1997 to June 30, 2000, the state improperly claimed $1,293,009 FFP for Medicaid claims made on behalf of residents at three state IMDs. In addition, the state improperly claimed FFP for Medicaid waiver claims for residents of 12 IMDs in the amount of $800,720 from January 1, 1997 to December 31, 2000.

We recommended the state of Maryland refund $2,093,729 FFP and make other procedural changes as presented in the report. In responding to our draft report, the state generally disagreed with our findings and recommendations for improperly claimed FFP associated with inpatient acute care and other medical and ancillary claims paid on behalf of 21 to 64 year old IMD residents.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for the Centers for Medicare and Medicaid Audits, at (410) 786-7104 or Stephen Virbitsky, Regional Inspector General for Audit Services, Region III, at (215) 861-4501.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF AUDIT SERVICES
150 S. INDEPENDENCE MALL WEST
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PHILADELPHIA, PENNSYLVANIA 19106-3499

MAR 25 2003

Report Number: A-03-00-00214

Ms. Debbie Chang
Deputy Secretary
Department of Health and Mental Hygiene
201 West Preston Street
Executive Suite 5th Floor
Baltimore, Maryland 21201

Dear Ms. Chang:

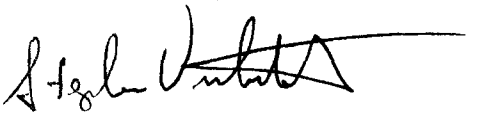
Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services (OAS) final audit report entitled, "Review of Medicaid Claims Made for 21 to 64 Year Old Residents of Institutions for Mental Diseases in Maryland." A copy of this report will also be forwarded to the HHS action official noted below for review and any action deemed necessary.

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

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

To facilitate identification, please refer to report number A-03-00-00214 in all correspondence relating to this report.

Sincerely yours,



Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosures

Reply directly to HHS Action Official:

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Regional Administrator
Centers for Medicare and Medicaid Services, Region III
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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 MARYLAND

JANET REHNQUIST
Inspector General

MARCH 2003
A-03-00-00214

Office Of Inspector General Notices

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OAS FINDINGS AND OPINIONS

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. Final determination on these matters will be made by authorized officials of the HHS divisions.

EXECUTIVE SUMMARY

Background

The basis for the institutions for mental diseases (IMD) exclusion of federal financial participation (FFP) 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. 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.

Objective

The objective of the review was to determine if controls were in place to effectively preclude the state of Maryland (state) 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.

To accomplish our audit objective, we conducted our audit work at the state Department of Health and Mental Hygiene (DHMH) and the Mental Hygiene Administration (MHA). We also visited three state IMDs (Spring Grove, Springfield, and Crownsville Hospital Centers) who served 21 to 64 year old residents.

Summary of Findings

Our review showed that controls were not in place to effectively preclude the state from claiming FFP under the Medicaid program for 21 to 64 year old residents of IMDs. From July 1, 1997 to June 30, 2000, the state improperly claimed $1,293,009 FFP for Medicaid claims submitted by various medical facilities and managed care organizations (MCO) on behalf of residents at three state IMDs. In addition, the state improperly claimed FFP for Medicaid waiver (waiver) claims for residents of 12 IMDs in the amount of $800,720 from January 1, 1997 to December 31, 2000. The total amount questioned during our audit period was $2,093,729 FFP.

Recommendations

We recommended that the state: (i) refund $1,293,009 of improperly claimed FFP for inpatient acute care and other medical and ancillary claims paid on behalf of 21 to 64 year old residents of the three state IMDs, (ii) refund $800,720 of improperly claimed FFP for payments made to IMDs for 21 to 64 year old institutionalized individuals who were covered under the waiver,

(iii) implement system edits in the Medicaid Management Information System (MMIS) to prevent claiming FFP for medical and ancillary services rendered to 21 to 64 year old residents of IMDs, (iv) implement system edits in the MMIS to prevent claiming FFP for payments made to IMDs for persons ineligible for coverage under the waiver, (v) establish procedures to require DHMH along with Maryland Health Partners to report all institutionalized Medicaid eligible adults to the local department of social services which is responsible for terminating Medical Assistance eligibility, (vi) instruct all state and private IMDs to cease the practice of forwarding purchase orders to providers that contain patients' Medical Assistance numbers, and (vii) require IMDs to adhere to Maryland Policy Alert 10-7 which instructs them to disenroll residents from MCOs after they become institutionalized.

Once these controls are in place, we recommended the state review Medicaid claims made from January 1, 1995 to June 30, 1997 and from July 1, 2000 to the date controls are established for the three reviewed state IMDs, and make the appropriate refund of FFP. The state also needs to review all Medicaid claims paid from January 1, 1995 to the date controls are established for the remaining four state IMDs and five private IMDs for 21 to 64 year old residents of the IMDs, and make the appropriate refund of FFP. Finally, the state needs to review Medicaid waiver claims made after July 1, 2001, and make the appropriate refund of FFP.

Auditee's Comments

The DHMH did not agree with all of our findings and recommendations. The DHMH's comments stated that some findings required further examination. However, MHA is currently working with Medical Assistance program officials to coordinate the Medicaid disenrollment process for individuals who have been in an IMD longer than 30 days. We have presented a summary of the DHMH's comments as well as our response after the **Conclusions and Recommendations** section of this report. The full text of DHMH's comments is included as Appendix C.

OIG's Response

The DHMH did not provide any additional information or documentation that would cause us to change our findings or recommendations.

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Introduction

Background

Institutions for Mental Diseases (IMD) Exclusion

The basis for the IMD exclusion of federal financial participation (FFP) 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. 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, and in certain instances those who are under the age of 22, for any type of service.

Federal Law and Regulations

The IMD criteria found at section 1905(a) of the Social Security Act, 42 CFR 441.13, and 42 CFR 435.1008, preclude FFP for any services to residents under the age of 65 who are in an IMD except for inpatient psychiatric services provided to individuals under the age of 21, and in some cases for those who are under the age of 22. This 21 to 64 year old exclusion of FFP was designed to assure that the 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.

Centers for Medicare and Medicaid Services Guidance

The Centers for Medicare and Medicaid Services (CMS) consistently 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 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 section 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 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 receives 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."

State's Memorandum

This memorandum, dated December 22, 1994, stated: " Effective January 1, 1995, Medicaid will no longer pay for those services provided by acute facilities to those patients entering from the state IMD whether they be on an outpatient basis or discharged from our facility and admitted on an inpatient basis. This applies only to those patients between the ages of 21 and 64 in our mental health facilities…. Payment will only be made if the patient returns to the community or a private provider after receiving the medical treatment. Any subsequent return to the state psychiatric facility will void payment to the acute facility…"

Maryland Waiver (waiver)

Beginning on January 1, 1997 and effective for 5 years, CMS allowed the state to claim expenditures for services for enrolled managed care participants residing in an IMD (excluding patients who are in an IMD at the time of implementation of the demonstration until they are discharged at which time they may be eligible for participation in the demonstration). This is limited for IMD residents age 21 to 64 to the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days. This waiver, authorized under section 1115(a)(2) of the Social Security Act, is entitled "Maryland Medicaid Section 1115 Health Care Reform Demonstration," and was approved on October 15, 1996.

Maryland Policy Alert 10-7

When a managed care organization (MCO) enrollee requires mental health services and clinical evaluation, they will be provided by the enrollee's MCO. However, Maryland Health Partners (MHP), the Administrative Services Organization, authorizes all specialty mental health services. The MCO is not responsible for payment of any specialty mental health services, including inpatient admissions to an IMD.

Maryland IMDs

There were 12 IMDs in Maryland that served 21 to 64 year old residents, and that also received Medicaid payments for their care. The 12 IMDs consisted of 5 private IMDs and 7 state IMDs:

Private IMDs	State IMDs
Brook Lane Health Services	Spring Grove Hospital Center
Charter Behavioral Health System	Springfield Hospital Center
Chestnut Lodge Hospital	Crownsville Hospital Center
Sheppard Pratt Hospital	Thomas B. Finan Hospital Center
Taylor Manor Hospital	Eastern Shore Hospital Center
	Walter P. Carter Hospital Center
	Upper Shore Hospital Center

Maryland's Medicaid Program

In Maryland, the Department of Health and Mental Hygiene (DHMH) is the single state agency responsible for operating the Medicaid program. Within DHMH, the Mental Hygiene Administration (MHA) is responsible for monitoring IMDs and setting mental health policy. The DHMH uses the Medicaid Management Information System (MMIS), a computer payment and information reporting system, to process and pay Medicaid claims.

Objective, Scope, and Methodology

The objectives of the review were to determine if (1) controls were in place to effectively preclude the state of Maryland (state) 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 and (2) Medicaid waiver claims were claimed properly.

Upon our request, MHA provided us with several listings that identified 21 to 64 year old residents of IMDs during our audit period, July 1, 1997 to June 30, 2000. The state provided us with name, date of birth, social security number, admission date, and discharge date for each admission. From those lists, we manually determined if any of those residents were Medicaid eligible during our audit period through the state MMIS.

Summary of Admissions for 21 to 64 Year Old Residents During Our Audit Period

IMD	Admissions (21 – 64)	Medicaid #'s Obtained
Spring Grove	1,856	1,766
Springfield	1,610	1,336
Crownsville	1,281	760
Totals	**4,747**	**3,862**

After obtaining 3,862 Medicaid numbers, we requested that DHMH provide us a listing of Medicaid payments for services rendered to the 21 to 64 year old residents of the 3 state IMDs. The listing consisted of Medicaid payments to IMDs and to third parties for services rendered from July 1, 1997 to June 30, 2000.

In order to determine if the information provided by DHMH was adequately completed, we judgmentally selected patient history claims from the list and compared it to the MMIS. After we found no claims discrepancies between the MMIS and the paid claims data, we merged the paid claims data with our admission and discharge data file for the residents of each IMD. By merging the two files, we were able to obtain the frequency and dollar value of Medicaid claims paid to providers while the patient was a resident of the IMD. The following were the results of the merging:

- Spring Grove Hospital - 49,601 claims with an FFP amount of $2,770,550
- Springfield Hospital - 4,321 claims with an FFP amount of $731,070
- Crownsville Hospital - 10,650 claims with an FFP amount of $646,279

The total FFP amount for the three state IMDs was $4,147,899.

We reviewed all of the inpatient history files referred to above, except for 429 residents of Spring Grove. These 429 residents had a total of 9,424 paid claims with $654,526 in FFP. These claims consisted of the following types: capitation, physician, pharmacy, community based, outpatient hospital, Medicare crossover-part B, Medicare crossover-outpatient, vision, and gross adjustment. We reviewed the 429 residents through use of a stratified sample of

50 residents from 351 residents with claims totaling less than $3,000 and 50 from the remaining 78 residents with claims ranging from $3,000 to $12,500. We reviewed all applicable medical and ancillary services for selected residents. We then utilized a stratified variable sample appraisal methodology to estimate the overpayment for these claims. Appendix A explains our sampling methodology. Appendix B details the projection of the sample results.

At the state IMDs, we reviewed: (i) IMD's policies and procedures to determine if controls were in place to prevent inappropriate claiming of FFP for Medicaid services, and (ii) patient history files to validate the patient admission and discharge date from July 1, 1997 to June 30, 2000. We also performed other auditing procedures if considered necessary under the circumstances. During our review, if we found that FFP was claimed for any medical services and MCO payments that were made while patients were residents of an IMD, we questioned those claims as improper.

In order to review payments made to IMDs under the waiver, we requested DHMH to provide us with a listing of IMD waiver payments for services rendered to the 21 to 64 year old residents of all 12 state and private IMDs from January 1, 1997 to December 31, 2000. According to the listing, the state paid 5,286 claims with an FFP amount of $9,636,489 to the 12 IMDs. Using this listing, we developed a program that identified *potential* payments that were made for IMD residents after they became institutionalized. The program selected IMD residents who had waiver payments for more than 30 consecutive days or 60 total days in a calendar year. This program identified 681 claims with an FFP amount of $1,931,366 that contained potentially unallowable payments. We questioned any payment that was made after a patient was considered institutionalized.

We conducted our review at DHMH and three state IMDs (Spring Grove, Springfield, and Crownsville Hospital Centers) from September 2000 to June 2001. Our review was conducted in accordance with generally accepted government auditing standards.

Findings

Controls were not in place to effectively preclude the state from claiming FFP under the Medicaid program for 21 to 64 year old residents of IMDs. From July 1, 1997 to June 30, 2000, the state improperly claimed $1,293,009 FFP for Medicaid claims submitted by various medical facilities and MCOs for 21 to 64 year old residents of the three state IMDs. In addition, the state improperly claimed $800,720 FFP for Medicaid waiver claims for residents of the 12 state and private IMDs from January 1, 1997 to December 31, 2000. The total amount questioned during our audit period was $2,093,729 FFP.

From July 1, 1997 to June 30, 2000, the state improperly claimed $1,293,009 in FFP for Medicaid payments made on behalf of 21 to 64 year old residents of the three state IMDs to various medical facilities and MCOs. The state's MMIS did not have edits in place to prevent

claiming FFP for Medicaid services for 21 to 64 year old residents of IMDs. The state had a mechanism in place to systematically identify a Medicaid recipient who had entered a state IMD. However, this mechanism (the Hospital Management Information System) was not used to suspend Medicaid benefits for 21 to 64 year old residents of IMDs. There was no system in place for MHA to systematically identify Medicaid recipients who had entered a state IMD and terminate their Medicaid eligibility. As a result, the state improperly claimed:

- $108,513 FFP for acute care inpatient claims for 21 to 64 year old residents of the three state IMDs;

- $1,184,496[1] FFP for medical and ancillary claims for 21 to 64 year old residents of the three state IMDs.

Because the termination process was not initiated timely when a Medicaid recipient was admitted to an IMD, at a minimum, the state improperly claimed $801,644 FFP for capitation claims submitted by MCOs for 21 to 64 year old residents of the three state IMDs. *This amount is included in the medical and ancillary claims finding referred to above.*

From January 1, 1997 to December 31, 2000, the state improperly claimed $800,720 FFP for waiver claims for 21 to 64 year old IMD residents at the 12 IMDs. The state's MMIS did not have edits in place to deny FFP claims made under the waiver for 21 to 64 year old residents of the IMDs. As a result, the state improperly claimed:

- $738,255 FFP for institutionalized individuals who had exhausted their waiver coverage;

- $62,465 FFP for individuals who were waiver ineligible.

Inpatient and Other Medical and Ancillary Claims

The state improperly claimed $1,293,009 FFP for acute care inpatient hospital services and other medical and ancillary services rendered for 21 to 64 year old residents of three state IMDs from July 1, 1997 to June 30, 2000. This amount included acute care inpatient services of $108,513 FFP as well as ancillary services of $1,184,496 FFP.

Acute Care Inpatient Services

The state improperly claimed $108,513 FFP for acute care inpatient hospital services rendered to 21 to 64 year old residents of the three state IMDs. This amount included inpatient acute care claims of $83,564 FFP as well as inpatient Medicare crossover claims of $24,949 FFP.

[1] This amount included our projection of the sample results for Spring Grove of $260,967 FFP.

We conducted on-site visits at three of the largest state operated IMDs (see chart below) to obtain evidence to determine if the state claimed FFP for IMD residents who were temporarily released to acute care hospitals for inpatient medical treatment.

Inpatient Acute Care and Medicare Crossover Claims

IMD	Claims Identified	FFP ($) Identified	Unallowable Claims	Unallowable FFP ($)
Spring Grove	87	$137,454	37	$57,975
Springfield	38	148,898	17	50,158
Crownsville	18	17,663	1	380
Totals	**143**	**$303,015**	**55**	**$108,513**

Claims Paid to Acute Care Hospitals

The state improperly claimed $83,564 FFP for inpatient acute care hospital services provided to IMD residents between the ages of 21 to 64 who were temporarily released from state IMDs to acute care hospitals for inpatient medical treatment. These patients were temporarily released – but not discharged – from an IMD to receive medical attention.

Our review showed the state paid 60 Medicaid inpatient claims on behalf of the 21 to 64 year old residents of the three state IMDs. We reviewed patient history files and claims histories and determined that FFP was inappropriately claimed for 23 of the 60 claims paid because the IMD resident was temporarily released from the IMD to receive medical attention. The IMDs should have informed the state to terminate patient Medicaid eligibility once a patient was admitted to an IMD. It was the IMD's responsibility to provide all medical services needed by the patient whether it was on an outpatient or inpatient basis.

Claims Paid to Acute Care Hospitals for Medicare Crossover

The state improperly claimed $24,949 FFP for inpatient Medicare crossover claims for residents between the ages of 21 to 64 who were temporarily released from the state IMDs to acute care hospitals for inpatient medical treatment. Medicare crossover claims are a single claim for both Medicare and Medicaid covered services. Medicare pays 80 percent of the covered services and the remaining 20 percent and the deductible is submitted to Medicaid for payment (DHMH pays 98 percent of the deductible and co-insurance). Medicaid crossover payments are made

automatically if the provider accepts assignment for Medicare Part A and Part B claims. Providers do not have to submit a separate claim to be paid for the Medicare co-insurance or deductible amount. Our review showed the state claimed 83 Medicare crossover payments for the 3 state IMDs. We reviewed patient history files and claims histories and determined that FFP was inappropriately claimed for 32 of the 83 claims paid because the IMD resident was temporarily released from the IMD to receive medical attention.

Medical and Ancillary Services

We conducted on-site visits at three of the largest state operated IMDs to obtain evidence to determine if the state claimed FFP for IMD residents who received medical and ancillary services while they were residents of the IMD.

The state improperly claimed $1,184,496 FFP for medical and ancillary services rendered to 21 to 64 year old residents of the three state IMDs. We reviewed medical and ancillary claim histories including physician, pharmacy, capitation, vision, Medicare crossover-Part B, community based services, Medicare crossover - outpatient, gross adjustment, outpatient, and long-term care services.

Claims Paid for Medical and Ancillary Services

The state improperly claimed $1,184,496 FFP for medical and ancillary services for IMD residents between the ages of 21 to 64. Once a patient is admitted to an IMD, it is the IMD's responsibility to provide all medical services needed by the patient whether it is on an outpatient or inpatient basis.

Our review showed the state paid 64,427 medical and ancillary claims in the amount of $3,843,883 FFP on behalf of the 3 state IMDs' residents. We reviewed 429 residents of Spring Grove through use of a stratified random sample. The 429 residents accounted for 9,424 paid claims totaling $654,526 in FFP. From the 429 residents, we selected a random statistical sample of 50 residents from 351 residents with claims totaling at least $3,000 and 50 from the remaining 78 residents with claims ranging from $3,000 to $12,500. The remaining residents who had claims totaling more than $12,500 were audited without sampling (see Appendices A and B). These residents accounted for 40,088 claims and $1,978,605 FFP. All residents of Springfield (4,283 claims) and Crownsville (10,632 claims) were audited without sampling. We reviewed claims histories and patient history files for residents of the three state IMDs.

Based on the results of our statistical sample at Spring Grove, we estimate that the state improperly claimed at least $260,967 in FFP. In all, the state improperly claimed $1,184,496 FFP for medical and ancillary services for 21 to 64 year old residents of the three state IMDs as shown in the following chart.

Medical and Ancillary Claims

IMD	Claims Identified	FFP ($) Identified	Unallowable FFP ($)
Spring Grove			
Audited with Sampling	3,943	$ 308,688	$ 260,967 *
Audited without Sampling	40,088	1,978,605	259,410
Springfield	4,283	582,172	486,815
Crownsville	10,632	628,615	177,304
Totals	**58,946**	**$3,498,080**	**$1,184,496**

***** Projected amount based on sample (see Appendix A and B)

The state had a mechanism in place to systematically identify a Medicaid recipient who had entered a state IMD. However, this mechanism (the Hospital Management Information System) was not used to suspend Medicaid benefits for 21 to 64 year old residents of IMDs.

During our site visits, we found all three state IMDs instructed acute care providers to recover their medical costs from a third party (including Medicaid) by including a Medical Assistance number on the purchase order that was sent with patients when they were transferred off the hospital grounds for medical treatment. Purchase orders sent to providers contained the following language:

> " . . . The Provider, in accepting this patient/resident for care, agrees to pursue the recovery of cost of care from all third party payers and any state, federal or federal-state program for which this patient/resident might be eligible before invoicing the Hospital..."

For example, when providers submitted bills for payment for services rendered to its residents, Spring Grove sent letters to the providers specifically instructing them to bill Medicaid.

Disenrolling IMD Residents After the Waiver Period

In accordance with the Maryland waiver, Medicaid beneficiaries aged 21 to 64 who were enrolled in MCOs would continue to be covered under the Medicaid program for the first 30 days in an IMD and subject to an aggregate annual limit of 60 days. After the waiver period,

patients were considered institutionalized and, therefore, should be disenrolled from the MCO. The waiver excluded patients who were already residents of IMDs at the time the waiver was implemented.

Maryland Policy Alert 10-7 clarified the appropriate action to be taken when a MCO enrolled recipient becomes institutionalized in an IMD. Non-aged adults (21 to 64) were considered institutionalized as of the 30th consecutive day of residency in an IMD, or as of the 60th cumulative day of residency in an IMD during a calendar year. Once a person was considered institutionalized, the person retained that status until they were discharged from the IMD. On the date the person was considered institutionalized, the person must be disenrolled from the MCO. For non-aged adults, being institutionalized in an IMD caused the person to become ineligible for Medical Assistance. Policy Alert 10-7 also stated that the IMD was responsible for initiating the disenrollment process.

We determined that Maryland Policy Alert 10-7 was not being followed. As a result, the state, at a minimum, improperly claimed $801,644 FFP for capitation claims to various MCOs while patients were residents of an IMD.

- $271,870 FFP for capitation claims for residents of Spring Grove Hospital.
- $397,255 FFP for capitation claims for residents of Springfield Hospital.
- $132,519 FFP for capitation claims for residents of Crownsville Hospital.

The $801,644 in erroneous FFP payments to MCOs represented 68 percent of the total improper payments for medical and ancillary services.

For example, one of the IMD residents was admitted on December 29, 1997 and remained there through the end of our audit period (June 30, 2000). Capitation claims with an FFP amount totaling $10,312 were paid to the MCO from the date of admission until April 30, 2000. In accordance to Maryland Policy Alert 10-7, the patient should have been disenrolled from the MCO on January 27, 1998. Because responsible personnel at the IMD failed to disenroll the patient from the MCO, the state inappropriately claimed $9,434 FFP.

Another patient at the state IMD was admitted on October 5, 1995 and remained there through the end of our audit period. Capitation claims with an FFP amount of $4,836 were paid to the MCO for the period November 12, 1997 until June 30, 2000. Because this patient was admitted to the IMD prior to the effective date of the waiver, he was ineligible for waiver coverage. As a result, the state inappropriately claimed $4,836 FFP.

IMD Waiver Claims

The state improperly claimed $800,720 FFP for Medicaid waiver claims for 21 to 64 year old institutionalized individuals at 12 state and private IMDs from January 1, 1997 to December 31, 2000.

Claims Paid Directly to IMDs

The state improperly claimed $800,720 FFP for waiver claims for 21 to 64 year old residents of all 12 state and private IMDs. This amount included $738,255 FFP for institutionalized individuals who had exhausted their waiver coverage and $62,465 FFP for individuals who were waiver ineligible.

Beginning January 1, 1997 and effective for 5 years, CMS allowed the state to claim expenditures for services to enroll managed care participants residing in an IMD (Maryland Waiver 1115). This was limited to beneficiaries aged 21 to 64 for the first 30 days of an IMD inpatient episode, subject to an aggregate annual limit of 60 days. The waiver excluded beneficiaries who were in an IMD on the implementation date (January 1, 1997). These individuals would become eligible for participation under the waiver once they were discharged.

We requested DHMH to provide us with a listing of IMD waiver payments for services rendered to the 21 to 64 year old residents of all 12 state and private IMDs from January 1, 1997 to December 31, 2000. According to the listing, the state paid 5,286 claims with an FFP amount of $9,636,489 to the 12 IMDs.

Claims Paid for Institutionalized Individuals

Our review showed that the state improperly claimed $738,255 FFP for claims submitted by IMDs on behalf of institutionalized individuals who had exhausted their coverage under the waiver.

For example, one of the IMD residents was admitted on July 1, 1997 and remained there until March 31, 1998. Under the waiver, the IMD was entitled to 30 consecutive days of coverage for this patient. After the 30th consecutive day (July 31, 1997), the state was responsible for the cost of treating that patient until he/she was discharged. In this case, the state continued to pay the IMD and claim FFP for this patient until the discharge date (March 31, 1998). This resulted in an overpayment of $26,578 FFP for claims submitted from July 31, 1997 to March 31, 1998.

Claims Paid for IMD Residents Admitted Prior to January 1, 1997

Our review showed that the state improperly claimed $62,465 FFP for waiver claims paid to IMDs on behalf of residents who were admitted to the IMD prior to January 1, 1997. We found

13 residents who were admitted to an IMD prior to January 1, 1997 who were not qualified for any waiver payments before being discharged.

For example, one of the IMD residents was admitted on November 13, 1996 and remained there until June 16, 2000. Under the waiver, this individual would not be eligible for waiver participation until discharged. However, the state improperly claimed waiver payments for the month of May 1999 and January 2000. This resulted in an overpayment of $10,140 FFP.

Conclusions and Recommendations

Controls were not in place to effectively preclude the state from claiming FFP under the Medicaid program for 21 to 64 year old residents of IMDs. From July 1, 1997 to June 30, 2000, the state improperly claimed $1,293,009 FFP for acute care inpatient claims and other medical and ancillary claims for 21 to 64 year old residents in three of the state IMDs. And from January 1, 1997 to December 31, 2000, the state improperly claimed $800,720 FFP for waiver payments made to the 12 state and private IMDs for 21 to 64 year old institutionalized individuals. The total unallowable FFP was $2,093,729 for our audit period.

The MHA did not have system edits in place to: (i) systematically identify Medicaid recipients who entered an IMD, and (ii) suspend their Medicaid eligibility. Therefore, we recommended that the state:

1. Refund to the Federal Government $1,293,009 of improperly claimed FFP associated with inpatient acute care and other medical and ancillary claims paid on behalf of 21 to 64 year old residents of the three state IMDs.

2. Refund to the Federal Government $800,720 of improperly claimed FFP for payments made to IMDs for 21 to 64 year old institutionalized individuals who were covered under the Maryland waiver.

3. Implement system edits in the MMIS to prevent claiming FFP for medical and ancillary services rendered to 21 to 64 year old residents of IMDs.

4. Implement system edits in the MMIS to prevent claiming FFP for payments made to IMDs for persons ineligible for coverage under the waiver.

5. Establish procedures to require DHMH along with Maryland Health Partners to report all institutionalized Medicaid eligible adults to the local department of social services, which is responsible for terminating Medical Assistance eligibility.

6. Instruct all state and private IMDs to cease the practice of forwarding purchase orders to providers that contain patients' Medical Assistance identification numbers.

7. Require IMDs to adhere to Maryland Policy Alert 10-7 which instructs them to disenroll institutionalized residents from MCOs.

8. Review Medicaid claims made from January 1, 1995 to June 30, 1997 and from July 1, 2000 to the date controls are established for the three state IMDs (Spring Grove, Springfield, and Crownsville), and make the appropriate refund of FFP.

9. Review Medicaid claims made from January 1, 1995 to the date controls are established for the remaining four state IMDs and all five private IMDs for 21 to 64 year old residents of the IMDs and make the appropriate refund of FFP.

10. Review Medicaid waiver claims from July 1, 2001 to the date controls are established for all 12 IMDs and make the appropriate refund of FFP.

Summary of Auditee's Comments

The DHMH generally disagreed with our findings and recommendations regarding improperly claimed FFP associated with inpatient acute care and other medical and ancillary claims paid on behalf of 21 to 64 year old residents of the three state IMDs. The DHMH officials stated that the problem lies in the (erroneous) presumption that the regulations governing IMDs apply to this group of individuals.

The state indicated that in 1997, CMS granted Maryland a 1115(a) (2) waiver. The approved waiver was in effect from October 15, 1996 to April 14, 2002. In its letter dated October 30, 1996, CMS waived:

> "Expenditure for services to enrolled managed care participants residing in an Institution for Mental Diseases (excluding beneficiaries who are in an IMD at the time of implementation of the demonstration until they are discharged at which time they may be eligible for participation in the demonstration). This is limited for beneficiaries 21-64 year old to the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days."

According to state officials, given this general approval, the state concluded that not only could it claim FFP for the cost of care of the individual in the IMD, but also for those ancillary medical services required outside the IMD. The state's request was consistent with its desire to have flexibility in seeking treatment for those Medicaid recipients who needed intensive inpatient mental health services, while not discriminating against them from seeking somatic services that the IMD does not perform. The state wanted to create a situation of parity for those who suffer from mental disease with those who suffer from other illnesses. Thus, this unique waiver permitted the state to treat individuals with a mental disease in a specialty hospital for that disease, while being able to seek appropriate somatic services, and claim FFP for these services. This is what would occur if the individual was treated in an acute general hospital psychiatric

unit and needed somatic services at this hospital or a different hospital. Mindful of the history of not permitting FFP for the individuals who need long term mental health care, the waiver was limited to 30 days with an aggregate annual limit of 60 days.

The state disagreed with our application of the IMD regulations to those individuals for whom the state had received a federal waiver. The state also disagreed with our findings relating to individuals who were Medicaid eligible and received somatic and ancillary services for which FFP was claimed during the first 30 days in the IMD, with an aggregate limit of 60 days. The state believed that the claiming of $1,293,009 FFP was proper.

As to individuals for whom capitation payments were made while they were in an IMD, the state noted that it will carefully examine claims totaling $801,644 FFP in payments to MCOs. This amount is part of the $1,293,009 FFP for other ancillary and medical services.

Of the $800,720 FFP of improperly claimed payments made to IMDs for 21 to 64 year old institutionalized individuals who were covered under the Maryland waiver:

- The state disagreed with our findings of $62,465 FFP for individuals who were ineligible for the waiver (patients admitted to an IMD before the waiver implementation date of January 1, 1997). The state believed that it had appropriately claimed FFP for the services in an IMD upon the approval date of the waiver, October 15, 1996. The state also was not aware of any claims for services before that date.

- The state agreed with our findings of $738,225 FFP for institutionalized individuals who had exhausted their waiver coverage in an IMD (more than 30 consecutive days of treatment or a total of more than 60 annual days). But, the state needed to further review these claims.

The state informed us that it will address immediately some of the issues raised in our report, so that no somatic or ancillary claims are made after the first 30 days in an IMD. The MHA will also instruct its providers, including its own billing facilities, to inform hospitals to bill the IMD for individuals who were in an IMD longer than 30 days. In addition, MHA is working with the Medical Assistance program officials to coordinate the disenrollment of individuals receiving treatment in an IMD longer than 30 days.

Finally, the state also asked that in light of the President's New Freedom Initiative, and the congressional studies involving the lack of parity of coverage for those with mental illness and those with other debilitating illnesses requiring long-term coverage, that "…OIG consider waiving a deficiency finding for any such wrongful claims."

Office of Inspector General's Response

Because federal law and regulations preclude FFP for any services to IMD residents between the ages of 21 to 64, we considered all acute and other medical and ancillary care claimed by the state for FFP as unallowable claims. Therefore, we questioned all FFP claims except for payments to the MCOs and IMDs during the waiver period. As a result, we continue to believe that the state improperly claimed $1,293,009 FFP associated with inpatient acute care and other medical and ancillary services. The $1,293,009 in unallowable FFP included the $801,644 FFP for payments made to the MCOs for patients who were in an IMD more than 30 consecutive days and 60 days annually.

Although the state agreed with our findings of $738,225 FFP for institutionalized individuals who had exhausted their waiver coverage in an IMD, it did not agree with our disallowance of $62,465 FFP for individuals who were waiver ineligible. Based on the conditions of the waiver, any beneficiaries who were in an IMD at the time of the implementation of the waiver were not eligible to participate until they were discharged, at which time they may be eligible for participation. Because of this exclusion, we determined that patients who were residents of an IMD prior to the implementation date of January 1, 1997 were ineligible to participate in the waiver. Consequently, we continue to recommend the disallowance of $62,465 FFP for waiver ineligible individuals, as well as the disallowance of $738,224 FFP for individuals who had exhausted their waiver coverage.

In addition, the state believed that we should use the approval date, October 15, 1996 instead of January 1, 1997, the implementation date, as the effective date to determine eligibility for the waiver. The CMS informed us that the effective date was the implementation date. The CMS also informed us that the implementation date was postponed to June 2, 1997.

Finally, with regard to the state's request to consider waiving a deficiency finding, OIG is not empowered to grant or waive audit findings.

Consequently, we continue to recommend that the state of Maryland refund to the Federal Government $2,093,729 of improperly claimed FFP paid on behalf of 21 to 64 year old IMD residents ($1,293,009 for inpatient acute and other medical and ancillary claims, and $800,720 for institutionalized individuals covered under the Maryland waiver.)

APPENDICES

SAMPLING METHODOLOGY

Review Objective:

To determine if the state inappropriately claimed FFP under the Medicaid program for residents, from the age of 21 to 64, of the Spring Grove Hospital Center.

Population:

The population was made up of residents (21 to 64 years old) of Spring Grove that had Medicaid services performed during their documented stay(s) in the IMD. The audit period for these services was July 1, 1997 through June 30, 2000.

The population audited with sampling:

The sampling population consisted of 429 IMD residents. These residents had a total of 9,424 Medicaid claims with $654,526 in FFP. These Medicaid claims consisted of the following types: capitation, physician, pharmacy, community based, outpatient hospital, Medicare crossover-Part B, Medicare crossover-outpatient, vision, and gross adjustment.

The population was divided into 2 strata:

A. Residents with services totaling less than $3,000 in FFP. There were 351 residents in this stratum, which totaled $204,146 FFP.

B. Residents with services totaling more than $2,999.99 and less than $12,500 in FFP. There were 78 residents in this stratum, which totaled $450,380 FFP.

The population audited without sampling:

A. All IMD residents with services totaling $12,500 or more from claim types referred to in the previous section. There were 40,031 of these claims with $1,897,480 in FFP for 72 residents.

B. Inpatient services with a provider type of "01" (acute care). There were 27 of these claims with $93,499 of FFP for 23 residents.

C. Inpatient services with a provide type of "05" (chronic care). There were three of these claims with $8,910 in FFP for one resident.

D. Medicare Crossover – Inpatient Hospital Services – There were 57 of these claims with $35,046 of FFP for 32 residents.

E. Long Term Care Services – There were 57 of these claims with $81,125 of FFP for 19 residents.

Sampling Unit:

The sampling unit consisted of an IMD resident. Once a resident was selected, all applicable medical and ancillary services were evaluated.

Sample Design:

A stratified random sample was used to determine the results of this review.

Sample Size:

We selected a sample size of 50 items per stratum.

Source of Random Numbers:

The random numbers for selecting the sample items were generated using an approved Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services statistical software package that has been validated using the National Bureau of Standards methodology. Numbers were independently generated for each stratum.

Method of Selecting Sample Items:

The unit in each stratum was assigned a sequential number. We generated a list of random numbers from 1 to N for each stratum. N equals the maximum universe of each stratum. An IMD resident was selected for review when the random number value equaled the assigned number of the unit, per stratum.

Characteristics to be Measured:

We validated the accuracy of the computerized admission and discharge information that the state provided with documentation that we obtained for each sampling unit.

After reviewing the documentation, an error was noted if the resident was not on convalescent leave or conditional release when the Medicaid services were performed while he/she was an IMD resident between the ages of 21 to 64.

An error was not noted for a capitation service if an individual was in an IMD for the specified time period in accordance with the IMD exclusion rule.

For each sampling unit, we determined an amount paid in error. The paid amount in error was the total of the difference from the actual paid amount to the correct paid amount for all the services evaluated for a sample item.

SAMPLE PROJECTION

Results of Sample:

The results of our review of Medicaid claims for 100 IMD residents of Spring Grove Hospital Center are as follows:

Sample Results					
Stratum Number	**IMD Residents in the Universe**	**Value of Universe (FFP)**	**Sample Size**	**IMD Residents with Improper Claims**	**Value of Improper Claims (FFP)**
1. $0 to $2,999	351	$204,146	50	29	$ 8,976
2. $3,000 to $12,500	78	450,380	50	37	150,894
Total	**429**	**$654,526**	**100**	**66**	**$159,870**

Variable Projection:

	Errors	**FFP**
Errors identified in the sample	66	$159,870
Point estimate		$298,405
Upper limit		$335,842
Lower limit		**$260,967**

Using statistically valid sampling techniques, we estimate with 95 percent confidence that DHMH improperly claimed at least $260,967 of the $654,526 FFP for residents of Spring Grove. The improper payments included at least $260,967 FFP. Our point estimate was $298,405 FFP with a precision of plus or minus $37,437 FFP.

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Parris N. Glendening, Governor - Georges C. Benjamin, M.D., Secretary

August 27, 2002

David M. Long
Office of the Inspector General, Region III
U.S. Department of Health and Human Services
150 South Independence Mall West, Suite 316
Philadelphia, Penn 19106-3499

Response to Draft OIG Report
State of Maryland Department of Health and Mental Hygiene
Review of Medicaid Claims Made for 21 to 64 Year Old Residents
Of Institutions for Mental Diseases ("IMDs") in Maryland

Dear Mr. Long:

Thank you for permitting the Department of Health and Mental Hygiene to review your report issued as a result of your review of the above referenced matter.[1] In this letter we will set forth the reasons that the State disagrees with your report. We believe that the problem lies in the presumption that the regulations governing IMDs apply to this group of individuals. We believe that they do not.

As you correctly note, in 1997, the Health Care Financing Administration ("HCFA"), currently Centers for Medicare and Medicaid Services - ("CMS"), granted Maryland a 1115(a) (2) waiver, page 160-161 of the Waiver. As part of this waiver, relevant hereto, the State requested that

> 3.1.5 Expenditures be allowed to enable the state to maintain the eligibility of Waiver eligibles who are aged 22 to 64 even if they are placed in institutions for mental diseases (IMD) for up to 30 consecutive dates. This will provide more flexibility in managing the care of Waiver eligibles who require specialty mental health services in an institution.
>
> 3.1.7 Expenditures to enable the state to pay for non-IMD services up to 30 day consecutive days for Waiver eligible aged 22 to 64 who reside in IMDs.

[1]Additionally, the State has had an opportunity to examine Maryland Policy Alert 10-7, and refine it.

3.1.8 Expenditures to enable the state to pay for IMD services of Waiver eligibles aged 22 to 64 who reside in IMDs for up to 30 consecutive days.

In approving the waiver effective October 15, 1996 to April 14, 2002, in its letter dated October 30, 1996, HCFA waived

> Expenditures for services to enrolled managed care participants residing in an Institution for Mental Diseases (excluding beneficiaries who are in an IMD at the time of implementation of the demonstration until they are discharged at which time they may be eligible for participation in the demonstration). This is limited for beneficiaries 21-64 to the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days.

Given this general approval, the State concluded that not only could it claim federal financial participation("FFP") for the cost of care of the individual in the IMD but also for those ancillary medical services required outside the IMD.[2] The State's request was consistent with its desire to have flexibility in seeking treatment for those Medicaid recipients who needed intensive inpatient mental health services, while not discriminating against them from seeking somatic services that the IMD does not perform. Maryland wanted to create a situation of parity for those who suffer from mental diseases with those who suffer from other illnesses. Thus, this unique waiver permitted the State to treat individuals with a mental disease in a specialty hospital for that disease, while being able to seek appropriate somatic services, and claim FFP for these services. This is what would occur if the individual was treated in an acute general hospital psychiatric unit and needed somatic services at that hospital or a different hospital.[3] Mindful of the history of not permitting FFP for the individuals who need long term mental health care, the waiver was limited to 30 days with an aggregate annual limit of 60 days.

With this history in mind, the State disagrees with your application of the IMD regulations to these individuals for whom the State has received a federal waiver. Thus, the State disagrees with your findings relating to individuals who were Medicaid eligible and received somatic and ancillary services for which FFP was claimed during the first 30 days in the IMD, with an aggregate limit of 60 day. The State believes its claims for $1,293,009.00 are proper.

The State believes that it appropriately claimed FFP for services in an IMD upon the approval date of the Waiver, October 15, 1996. You cite examples of residents admitted on July 1, 1997, and November 13, 1996. Therefore, the State disagrees that it owes $62,465.00 for this category of individual. We are not aware of any examples of claims for services before October 15, 1996.

As to individuals for whom FFP was claimed for more than 30 consecutive days of treatment, for

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[2]See similar request for modification of the Waiver for inpatient substance abuse services for individuals 21 years and younger.

[3]As the State stated in its July 5, 1996, response to HCFA, the IMD waiver will allow IMDs to compete with the acute psychiatric units of general hospitals.

a total of more than 60 annual days, the State agrees that this may have been improper but will need to review all these claims given the clarifications above. The amount claimed is approximately $738,225.00 The State also asks that in light of the President's New Freedom Initiative, and the congressional studies involving the lack parity of coverage for those with mental illness and those with other debilitating illnesses requiring long term coverage, that OIG consider waiving a deficiency finding for any such wrongful claims. As the National Association of State Mental Health Program Directors, ("NASMHPD") noted in its testimony on July 18, 2002, to the President's New Freedom Commission on Mental Health

> *Medicaid has been used more effectively to serve many other disability groups through home and community based waivers, which permit states to tailor service packages to meet the unique needs of specific, priority populations. However, states are effectively barred from obtaining these waivers to support people with mental illness in community settings because Medicaid's discriminatory exclusion of services provided in institutions for mental disease - known as the IMD exclusion - makes it impossible for states to demonstrate the cost-neutrality that is a precondition to obtaining a waiver.* Robert W. Glover, Ph.D., Executive Director, NASMHPD

We hope that by waiving any deficiency you can indicate your support not only for parity in the treatment of mental illness, but also for permitting Maryland to continue to craft its service delivery system to make community placement its priority.

As to individuals for whom capitation payments were made while they were in the IMD, the claim for $801,644 in payments made to MCOs will be carefully examined.

Some of the issues raised in your report will be addressed immediately, so that no somatic or ancillary claims are made, after 30 days in an IMD. MHA will instruct its providers, including its own billing facilities, that they must inform any hospital to which they refer an individual whom they have been treating for longer than 30 days to bill the IMD.

Additionally, MHA is working with the Medical Assistance program to coordinate the dis-enrollment of an individual who has been receiving treatment in an IMD longer than 30 days.

I hope this letter has addressed your concerns. If you would like to discuss this further, please contact Kenneth Smoot of my staff on (410) 767-5186. Thank you.

Sincerely,

Debbie I. Chang

Debbie I. Chang, MPH
Deputy Secretary
Health Care Financing