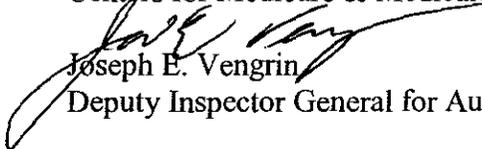




JUN - 9 2004

TO: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

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

SUBJECT: Seven States' Medicaid Claims for 21- to 64-Year-Old Residents of Institutions for Mental Diseases Who Were Temporarily Released to Acute Care Hospitals (A-02-03-01002)

Attached is a copy of our final report consolidating the results of our seven-State review of Medicaid claims for 21- to 64-year-old residents of institutions for mental diseases (IMD) who were temporarily released to acute care hospitals for inpatient medical treatment. We conducted these audits pursuant to our longstanding concern that States were not complying with Federal statute and regulations which generally preclude Federal Medicaid funding for IMD residents under the age of 65.

A common objective of these audits was to determine if controls were in place to preclude States from claiming Federal Medicaid funds when 21- to 64-year-old IMD residents were temporarily released to acute care hospitals for inpatient medical treatment.

Federal regulations define an IMD as a hospital, nursing facility, or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. Section 1905(a) of the Social Security Act and implementing Federal regulations preclude Federal funding for services to IMD residents under age 65, except for inpatient psychiatric services provided to individuals under the age of 21 and, in some instances, those under the age of 22.¹ CMS guidance to States stipulates that individuals residing in IMDs retain their IMD status when they are temporarily released to acute care hospitals for medical treatment. Therefore, Federal funding is not permitted for such treatment.

We determined that four States (California, Maryland, Texas, and Virginia) had no controls to prevent Federal funding from being claimed, one State (New Jersey) had ineffective controls, and one State (New York) implemented controls as a result of our prior audit efforts. One other State (Florida) had generally adequate controls during the audit period. The seven States improperly claimed a total of \$21,105,151 in Federal Medicaid funds during various audit periods.

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

We recommend that CMS:

- reinforce to States that Federal Medicaid funds may not be claimed for 21- to 64-year-old IMD residents, including those temporarily released to acute care hospitals for inpatient medical treatment
- instruct States to develop and implement controls, where cost effective, to prevent Federal Medicaid claims for 21- to 64-year-old IMD residents who are temporarily released to acute care hospitals for inpatient medical treatment
- advise States not included in our review of our audit findings and encourage them to review their controls to prevent improper claims

CMS concurred with our recommendations.

We would appreciate your views and information on the status of any action taken or contemplated on the recommendations within the next 60 days. If you have any questions or comments about this report, please do not hesitate to call me or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Timothy J. Horgan, Regional Inspector General for Audit Services, Region II, at (212) 264-4620.

Please refer to report number A-02-03-01002 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**SEVEN STATES' MEDICAID CLAIMS
FOR 21- TO 64-YEAR-OLD
RESIDENTS OF INSTITUTIONS FOR
MENTAL DISEASES WHO WERE
TEMPORARILY RELEASED TO ACUTE
CARE HOSPITALS**



**JUNE 2004
A-02-03-01002**

EXECUTIVE SUMMARY

BACKGROUND

This report summarizes the results of our seven-State review of Medicaid claims for 21- to 64-year-old residents of institutions for mental diseases (IMD) who were temporarily released to acute care hospitals for inpatient medical treatment. We conducted audits in California, Florida, Maryland, New Jersey, New York, Texas, and Virginia.

Section 1905(a) of the Social Security Act and implementing Federal regulations preclude Federal funding for services to IMD residents under age 65, except for inpatient psychiatric services provided to individuals under the age of 21 and, in some instances, those under the age of 22.¹ This report refers to these individuals as “the excluded age group.” Residents retain their IMD status when they are temporarily released to acute care hospitals; as such, Federal funding is not permitted for the inpatient hospital care of residents in the excluded age group.

OBJECTIVE

A common objective of our audits was to determine if controls were in place to preclude States from claiming Federal Medicaid funds when 21- to 64-year-old IMD residents were temporarily released to acute care hospitals for inpatient medical treatment.

SUMMARY OF FINDINGS

Four States (California, Maryland, Texas, and Virginia) had no controls to prevent Federal funds from being claimed, one State (New Jersey) had ineffective controls, and one State (New York) implemented controls as a result of our prior audit efforts. One other State (Florida) had generally adequate controls during the audit period. The seven States improperly claimed a total of \$21,105,151 in Federal Medicaid funds.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services (CMS):

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

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

- instruct States to develop and implement controls, where cost effective, to prevent Federal Medicaid claims for 21- to 64-year-old IMD residents who are temporarily released to acute care hospitals for inpatient medical treatment
- advise States not included in our review of our audit findings and encourage them to review their controls to prevent improper claims

CMS COMMENTS

In comments dated June 26, 2003, CMS officials concurred with our recommendations. CMS's comments are included in their entirety as Appendix B.

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INTRODUCTION

BACKGROUND

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

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

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

A common objective of our audits was to determine if controls were in place to preclude States from claiming Federal Medicaid funds when 21- to 64-year-old IMD residents were temporarily released to acute care hospitals for inpatient medical treatment.

Scope and Methodology

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

We did not review the overall internal control structure of the States or their Medicaid programs; our internal control reviews were limited to obtaining an understanding of the States' controls to prevent Federal Medicaid claims for IMD residents in the excluded age group who were temporarily released to acute care hospitals. For each of the seven States, we also determined the amount of improperly claimed Federal funds for these temporary releases.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

FEDERAL STATUTES, REGULATIONS, AND GUIDANCE

Statutory and Regulatory Requirements

According to section 1905(a) of the Act, "medical assistance" includes inpatient hospital services and nursing facility services for IMD residents 65 years of age or older but excludes care or services for IMD residents who are under 65, except "inpatient psychiatric hospital services for individuals under the age of 21."

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

Centers for Medicare & Medicaid Services Guidance

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

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

CMS guidance to States has also established that Federal funds are not permitted for IMD residents who are temporarily released to acute care hospitals for inpatient medical treatment. Section 4390.1 of the State Medicaid Manual states that “If a patient is temporarily transferred from an IMD for the purpose of obtaining medical treatment . . . the patient is still considered an IMD patient.”

Departmental Appeals Board and U.S. District Court Decisions

Three Departmental Appeals Board (DAB) decisions and a U.S. district court decision affirmed that Federal funds should not be claimed when IMD residents in the excluded age group are temporarily released to acute care hospitals for inpatient medical treatment. The three DAB decisions were DAB No. 1809 (2002), DAB No. 1577 (1996), and DAB No. 1549 (1995) (affirmed by U.S. District Court for the District of New Jersey).

STATE CONTROLS GENERALLY INADEQUATE

Controls in six States were generally not adequate to prevent Federal Medicaid claims for IMD residents in the excluded age group who were temporarily released to acute care hospitals for inpatient medical treatment. Four States (California, Maryland, Texas, and Virginia) had no controls to prevent Federal funds from being claimed, one State (New Jersey) had ineffective controls, and one State (New York) implemented controls as a result of our prior audit efforts. Effective September 1, 1998, New York made coding changes in the way it opened Medicaid

cases for 21- to 64-year-old residents of State-operated IMDs who were temporarily released to acute care hospitals. Those changes prevent Federal funds from being claimed.

Only one State (Florida) had generally adequate controls throughout the audit period. When individuals in the excluded age group entered Florida’s IMDs, the IMDs disenrolled the individuals from the Medicaid program and instructed acute care hospitals that the IMDs would be responsible for these residents’ bills during temporary release periods. Despite these controls, Florida still submitted a small number of improper claims.

As shown in the table below, the seven States improperly claimed a total of \$21,105,151 in Federal Medicaid funds.

Audits in Seven States

State	Audit Period		Federal Funds Improperly Claimed
	Start Date	End Date	
New York	01/01/91	12/31/99	\$19,601,451
California	07/01/97	02/28/01	551,394
Texas	09/01/97	08/31/00	424,838
New Jersey	07/01/97	06/30/01	190,848
Virginia	07/01/97	12/31/00	149,227
Maryland	07/01/97	06/30/00	108,513
Florida	07/01/97	01/31/01	78,880
Total			\$21,105,151

Appendix A provides a brief summary of the results of the seven audits. All seven reports are available on the Internet at <http://oig.hhs.gov>.

RECOMMENDATIONS

We recommend that CMS:

- reinforce to States that Federal Medicaid funds may not be claimed for 21- to 64-year-old IMD residents, including those temporarily released to acute care hospitals for inpatient medical treatment
- instruct States to develop and implement controls, where cost effective, to prevent Federal Medicaid claims for 21- to 64-year-old IMD residents who are temporarily released to acute care hospitals for inpatient medical treatment
- advise States not included in our review of our audit findings and encourage them to review their controls to prevent improper claims

CMS COMMENTS

In comments dated June 26, 2003, CMS officials concurred with the recommendations in our draft report. Additionally, in a technical comment, they suggested that our report include brief example(s) of the controls that States used to avoid improper claims. CMS's response is included in its entirety as Appendix B.

In response to CMS's technical comment, we revised our final report to include examples of controls in New York and Florida.

APPENDICES

SUMMARY OF RESULTS IN THE SEVEN STATES**NEW YORK**

In our April 6, 1995 report (A-02-93-01036), we noted that New York lacked controls to preclude Federal claims for IMD residents in the excluded age group who were temporarily released from State-operated psychiatric hospitals to acute care hospitals (which were located on the grounds of the IMDs) for inpatient medical treatment. As a result, from January 1, 1991 through December 31, 1993, the State improperly claimed \$291,981 in Federal Medicaid funds.

We recommended that the State (1) refund \$291,981, (2) cease claiming Federal Medicaid funds for patients in the excluded age group who were temporarily released from State-operated IMDs to acute care hospitals for medical treatment, (3) develop controls or edits in its Medicaid Management Information System to prevent these improper claims from being made in the future, and (4) identify unallowable Federal Medicaid claims for IMD residents in the excluded age group who were temporarily released from State-operated psychiatric hospitals to acute care hospitals for the period January 1, 1991 to the present and refund the Federal share of these claims.

On January 4, 2001, we issued a followup report (A-02-99-01031) concerning CMS's resolution of the findings in our prior report. We verified that on September 1, 1998, New York implemented appropriate edits and controls, which, if maintained, would prevent the improper claiming of Federal funds when patients in the excluded age group were temporarily released from State-operated IMDs to acute care hospitals for inpatient medical treatment. In addition, New York officials identified and quantified unallowable Federal claims for the period January 1, 1991 through December 31, 1999. At CMS's request, we validated the State's computations and identified \$19,601,451 in unallowable Federal payments during this period.

Based on our followup audit and to resolve the recommendations in our prior report, we recommended that CMS instruct the State to refund the \$19,601,451 and to compute and refund unallowable payments for claims after December 31, 1999. As a result of our followup audit, CMS recouped over \$19.6 million of improperly claimed Federal funds.

CALIFORNIA

Our report (A-09-01-00055), issued on March 27, 2002, determined that controls were not in place to preclude California from inappropriately claiming Federal funds for IMD residents in the excluded age group who were temporarily released to acute care hospitals for inpatient medical treatment. As a result, from July 1, 1997 through February 28, 2001, the State improperly claimed \$551,394 in Federal funds.

We recommended that the State refund \$551,394 and establish controls to prevent unallowable Federal claims. State officials disagreed with our finding and recommendations.

TEXAS

Our December 13, 2001 report (A-06-00-00074) noted that Texas did not have controls to prevent improper Federal claims. For the period September 1, 1997 through August 31, 2000, the State improperly claimed \$424,838 of Federal funds for IMD residents in the excluded age group who were temporarily released from State-operated psychiatric hospitals to acute care hospitals for inpatient medical treatment.

We recommended that the State (1) refund \$424,838, (2) cease claiming Federal funds for individuals in the excluded age group who are temporarily released from State-operated psychiatric hospitals to acute care hospitals for inpatient medical treatment, and (3) develop controls or edits in the Medicaid Management Information System to detect and prevent such claims. State officials agreed with our recommendations and began efforts to detect and prevent improper claims.

NEW JERSEY

Our March 25, 2002 report (A-02-00-01027) noted weaknesses in New Jersey's controls. Although it was State policy not to claim Federal funds for IMD residents in the excluded age group who received medical services outside the IMDs, we found that from July 1, 1997 through June 30, 2001, New Jersey improperly claimed \$190,848 in Federal Medicaid funds for inpatient acute care hospital services.

We recommended that New Jersey (1) refund \$190,848, (2) identify and return Federal funds improperly claimed after June 30, 2001, and (3) strengthen procedures to prevent Federal claims for IMD residents in the excluded age group who receive medical services, including inpatient acute care hospital services, outside the IMDs. State officials agreed with all of our recommendations.

VIRGINIA

In our October 30, 2001 report (A-03-00-00212), we noted that Virginia did not have controls to preclude Federal claims for IMD residents in the excluded age group. For the period July 1, 1997 through December 31, 2000, we identified \$1,382,079 of improper Federal claims. Of this amount, \$149,227 related to residents of State-operated IMDs who were temporarily released to acute care hospitals for inpatient medical treatment. The remainder of the improper claims related to other types of services.

We recommended that Virginia refund \$1,382,079 (including \$149,227 related to temporary acute care releases) and establish controls to prevent unallowable Federal claims. State officials generally agreed.

MARYLAND

Our report (A-03-00-00214), issued on March 25, 2003, noted that Maryland did not have controls to preclude Federal claims for IMD residents in the excluded age group. For the period January 1, 1997 to December 31, 2000, we identified improper Federal

payments totaling \$2,093,729 for medical and ancillary services made on behalf of residents of State-operated and private IMDs. Of this amount, \$108,513 related to IMD residents in the excluded age group who were temporarily released to acute care hospitals for inpatient medical treatment from July 1, 1997 to June 30, 2000.

We recommended that Maryland refund \$2,093,729 (including \$108,513 related to temporary acute care releases) and, among other things, establish controls to prevent unallowable Federal claims. Maryland officials generally disagreed with our findings and recommendations on improperly claimed medical and ancillary services.

FLORIDA

In our March 18, 2002 report (A-04-01-02003), we determined that for the period July 1, 1997 through January 31, 2001, Florida had generally adequate controls to prevent Federal claims for IMD residents in the excluded age group who were temporarily transferred to acute care hospitals for inpatient medical treatment. We found only 47 acute care claims for which \$78,880 in Federal funds was improperly claimed.

Florida officials disagreed with our recommendation to refund the \$78,880 because the claims in question were for Supplemental Security Income recipients. In response, our report stated that because these individuals remained IMD residents, Federal Medicaid funding on their behalf was prohibited.



DEPARTMENT OF HEALTH & HUMAN SERVICES

APPENDIX B

Page 1 of 3

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUN 26 2003

TO: Dara Corrigan
Acting Inspector General

FROM: Thomas A. Scully *Tom Scully*
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *Roll-Up Report on OIG's Seven State Review of Institutions for Mental Diseases (IMD) Residents Between the Ages of 21 to 64 Who Were Temporarily Released to Acute Care Hospitals for Medical Treatment (A-02-03-01002)*

Thank you for the opportunity to review and comment on the above-referenced draft report concerning IMD residents. We appreciate the effort that went into this report and the opportunity to review and comment on the issues it raises. We look forward to working with OIG on this and other issues pertinent to IMD residents. Our responses to the recommendations are discussed below.

OIG Recommendation

The Centers for Medicare & Medicaid Services (CMS) should reinforce its guidance to states that federal financial participation (FFP) should not be claimed under the Medicaid program when IMD residents between the ages of 22 to 64, and in some instances for those aged 21, are temporarily released to acute care hospitals for medical treatment.

CMS Response

We concur. The regional offices (ROs) will work with states to apply coverage and payment policy and will recommend that they develop controls to prevent inappropriate claiming of IMD services.

OIG Recommendation

The CMS should instruct the states to develop and implement controls, where cost effective, to prevent FFP from being claimed for IMD residents between the ages of 21 to 64 who are temporarily released to acute care hospitals for medical treatment.

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CMS Response

We concur. The ROs will work with states to apply coverage and payment policy and will recommend that they develop controls to prevent inappropriate claiming of IMD services.

OIG Recommendation

The CMS should consider having officials in those states not included in the seven state review determine if controls are in place to prevent FFP from being claimed for IMD residents between the ages of 21 to 64 who are temporarily released to acute care hospitals for medical treatment, and if they are not in place, instruct the states to identify and return any improper FFP claimed to the Federal Government from July 1, 1997 to the present.

CMS Response

We agree to advise states of the audit findings, remind them of the IMD exclusion law, and encourage them to look to their own program controls to ensure proper claiming of FFP to avoid repayment of improper payments.

Attachment

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Technical Comment

- **We suggest the OIG report include brief example(s) of the controls states use to avoid improper claiming. For example, did the one state with controls “disenroll” Medicaid recipients, or were edits made to the Medicaid Management Information System to catch improper claiming? What types of controls were effective and ineffective?**