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Washington, D.C. 20201

Dennis J. Duquette
Deputy Inspector General
for Audit Services

John Green for

Audit of Medical and Ancillary Medicaid Claims for 21 to 64 Year Old Residents of State Psychiatric Hospitals that are Institutions for Mental Diseases in Florida (A-04-01-02008)

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

As part of the Office of Inspector General's self-initiated audit work, we are alerting you to the issuance within 5 business days of our final audit report entitled, "Audit of Medical and Ancillary Medicaid Claims for 21 to 64 Year Old Residents of State Psychiatric Hospitals that are Institutions for Mental Diseases in Florida." 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 care provided to residents of institutions for mental diseases (IMD). We suggest you share this report with components of the Centers for Medicare & Medicaid Services involved with program integrity, provider issues, and State Medicaid agency oversight, particularly the Center for Medicaid and State Operations.

The objective of our review was to determine if controls were in place to effectively preclude the Florida Agency for Health Care Administration (State agency) from claiming Federal financial participation (FFP) under the Medicaid program when 21 to 64 year old residents of State operated IMDs received physician services, laboratory and clinic services, or hospital outpatient treatment.

Our review found that, for the period July 1, 1997 through January 31, 2001, the State agency appeared to have some controls in place at the IMDs to prevent improper FFP claims for medical and ancillary services provided to IMD residents. We reviewed 262,796 claims totaling over \$16 million in Medicaid payments, and found 5,745 claims that were not eligible for Federal reimbursement, yet FFP was claimed. These claims represented \$71,406 in FFP. We did not have any procedural recommendations, but we recommended the State reimburse the Federal Government for the FFP share of the unallowable claims.

In responding to our draft report, the State agency did not believe there was an overpayment because the claims in question pertained to Supplemental Security Income (SSI) recipients. The State is allowed up to 4 months to process Medicaid eligibility terminations for these recipients. In Florida, Medicaid pays for SSI recipients during the redetermination process. Contrary to the State's position, we believe that the Social Security Act and implementing Federal regulations are clear in that while a 21 to 64 year old person is a resident of an IMD, his/her Medicaid costs are not eligible for Federal matching.

Page 2 – Neil Donovan

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General, Centers for Medicare and Medicaid Audits, at (410) 786-7104 or Charles J. Curtis, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Common Identification Number: A-04-01-02008

Region IV
61 Forsyth Street, SW
Room 3T41
Atlanta, GA 30303-8909

JUL 18 2002

Mr. Robert Sharpe
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Building 3, Room 2427
Tallahassee, Florida 32308

Dear Mr. Sharpe:

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

Final determination as to actions 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.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by the Public Law 104-231, OIG/OAS reports issued to the Department's grantees and contractors are made available to members of the press and the general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (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://oig.hhs.gov/>

To facilitate identification, please refer to Common Identification Number A-04-01-02008 in all correspondence relating to this report. If you have any questions, please contact me or have your staff contact Peter Barbera at (404) 562-7758.

Sincerely yours,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures – as stated

Direct Reply to HHS Action Official:

Eugene A. Grasser
Associate Regional Administrator
Division of Medicaid and State Operations, Region IV
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**AUDIT OF MEDICAL AND ANCILLARY
MEDICAID CLAIMS FOR 21 TO 64
YEAR OLD RESIDENTS OF STATE
PYSCHIATRIC HOSPITALS THAT ARE
INSTITUTIONS FOR MENTAL
DISEASES IN FLORIDA**



**JANET REHNQUIST
INSPECTOR GENERAL**

**JULY 2002
A-04-01-02008**



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
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JUL 18 2002

Region IV
61 Forsyth Street, SW
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Common Identification Number: A-04-01-02008

Mr. Robert Sharpe
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Building 3, Room 2427
Tallahassee, Florida 32308

Dear Mr. Sharpe:

This final report by the Office of Inspector General (OIG), Office of Audit Services, provides you with the results of our *Audit of Medical and Ancillary Medicaid Claims for 21 to 64 Year Old Residents of State Psychiatric Hospitals that are Institutions for Mental Diseases in Florida*. This audit is part of our ongoing review into the area of institutions for mental diseases (IMD). We previously issued a final report to you on our review of inpatient acute care hospital claims for residents of State IMDs (A-04-01-02003, issued March 18, 2002).

The objective of this audit was to determine if the State of Florida had adequate controls to preclude claiming Federal financial participation (FFP) under the Medicaid program when 21 to 64 year old residents of State operated IMDs received physician services, laboratory and clinic services, or hospital outpatient treatment. Our review covered Medicaid payments for the period July 1, 1997 through January 31, 2001.

Our audit showed that the State of Florida appeared to have some controls in place at the IMDs to prevent improper FFP claims for medical and ancillary services provided to IMD residents. The IMDs were diligent in initiating Medicaid disenrollment when a Medicaid eligible patient entered their facility and, consequently, averted most FFP claims. We reviewed 262,796 claims totaling over \$16 million in Medicaid payments and found 5,745 claims that were not eligible for Federal reimbursement, yet FFP was claimed. These claims represented \$71,406 in FFP. We do not have any procedural recommendations, but we recommended that the State reimburse the Federal Government for the FFP share of the unallowable claims.

In responding to our draft report, State agency officials did not believe there was an overpayment because the claims in question pertained to Supplemental Security Income (SSI) recipients. The State is allowed up to 4 months to process Medicaid eligibility terminations for these recipients. In Florida, Medicaid pays for SSI recipients during the redetermination process. The State's complete response is included as an Enclosure. Contrary to the State's position, we believe that the Social Security Act and implementing Federal regulations are clear in that while a 21 to 64 year old person is a resident of an IMD, his/her Medicaid costs are not eligible for matching Federal payments.

BACKGROUND

Title XIX of the Social Security Act authorizes Federal grants to States for Medicaid programs that provide medical assistance to persons whose incomes are insufficient to meet the cost of medical services. Florida's Medicaid program is administered by the Agency for Health Care Administration (State agency). The Federal Government pays its share of medical assistance expenditures to the State agency according to a defined formula yielding the FFP rate. In Florida, this rate was between 55.65 and 56.62 percent during the period 1997 through 2001.

Federal criteria found in section 1905(a) of the Social Security Act and 42 CFR 441.13 and 435.1008 prohibit FFP for any services provided to IMD residents between the ages of 21 to 64. This exclusion from FFP was designed to assure that States, rather than the Federal Government, continued to have principal responsibility for funding medical services for IMD residents. The Department of Children and Families (DCF) is responsible for the administration of State psychiatric hospitals that are IMDs in Florida.

Public Law 100-360 of 1988 defines an IMD as a hospital or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care to persons with mental diseases. If the institution is licensed as a psychiatric facility, the Centers for Medicare & Medicaid Services (CMS), considers the institution an IMD. At the time of our audit, the three largest IMDs in Florida were Northeast Florida State Hospital, Florida State Hospital, and G. Pierce Wood Memorial Hospital. These hospitals comprised 92 percent of the State's IMD licensed beds between 1997 and 2000.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of this audit was to determine if the State agency improperly claimed FFP when 21 to 64 year old residents of State psychiatric hospitals received physician services, laboratory and clinic services, or hospital outpatient treatment between July 1, 1997 and January 31, 2001.

Our review included Medicaid payments for medical and ancillary services as well as Medicaid payments for Medicare deductibles for qualified beneficiaries covered by both Medicare and Medicaid (crossover payments).

This audit is a continuation of our multi-State review of Medicaid payments for services to IMD residents. We previously reviewed the State's controls over hospital inpatient claims for residents of State IMDs.

From the State's IMDs, we obtained resident lists and identified individuals between 21 to 64 years old during our audit period. We requested Medicaid eligibility status for these residents and payment information for physician, laboratory and clinic, and hospital outpatient treatment claims. We compared the dates of services on the Medicaid payments to the dates of the

patients' admissions and discharges from the IMD to determine if the payments should have been excluded from FFP. We interviewed State agency program officials and reviewed information provided by the State agency and the IMDs.

Our review of the State agency's and the IMDs' internal controls were limited to those considered necessary to achieve our objectives. Our review allowed us to establish a reasonable assurance regarding the accuracy of Medicaid eligibility and payment data. However, our audit was not directed toward assessing the completeness of their eligibility and payment files.

We conducted our audit in accordance with generally accepted government auditing standards. Our fieldwork was performed at the Agency for Health Care Administration and DCF offices in Tallahassee, Florida; our regional office in Atlanta, Georgia; and our field office in Miami, Florida from July to November 2001.

RESULTS OF REVIEW

Our audit showed that the State of Florida appeared to have some controls in place at the IMDs to prevent improper FFP claims for medical and ancillary services provided to IMD residents. The results of this audit were similar to the results of our previous review of inpatient acute care hospital claims for residents at State IMDs. The IMDs were diligent in initiating Medicaid disenrollment when a Medicaid eligible patient entered their facility and, consequently, averted most FFP claims.

Although there were some controls in place, FFP was erroneously paid for some claims. We reviewed 262,796 claims totaling over \$16 million in Medicaid payments. These were claims applicable to individuals who at one time were IMD residents during our audit period. We found 5,745 claims that should have been excluded from FFP because the dates of service were during the period of IMD residency. The remaining claims had dates of service when the individuals were not IMD residents, and, therefore, were not questioned by our audit. The 5,745 claims represented \$71,406 in FFP, which, on a per claim basis, was immaterial.

The \$71,406 was comprised of the following types of claims:

- Outpatient claims totaling \$39,874, representing medical services provided to IMD residents transferred but not admitted into a hospital.
- Capitation claims totaling \$4,277, representing monthly fees paid to physicians for every Medicaid recipient. The fee was payable whether the recipient received medical services or not.

- Practitioner claims totaling \$17,185, representing Medicaid claims filed by practitioners for professional services provided to IMD residents in our review. The payments were based on a Medicaid fee schedule.
- Medicare Part B crossover claims totaling \$1,721, applicable to IMD residents who were covered by Medicare and Medicaid. The Medicare carrier forwards the claims to the Medicaid agency since Medicaid is responsible for the deductible in these cases.
- Mental health, drug, and alcohol claims totaling \$8,349, representing services provided to the IMD residents when they were transferred to these type facilities for outpatient services.

We did not consider the errors we found to be significant. Because of the nature of our findings, we did not consider it necessary to fully develop the cause of these errors or to address specific recommendations to the State. We believe a lack of communication between the IMDs and the outpatient healthcare providers and medical professionals, coupled with the delay in terminating SSI recipients, probably were contributing factors to the improper FFP claims. In our first IMD review of inpatient hospital claims, we found similar circumstances when SSI recipients were involved. The fact that the SSI recipients remained IMD residents during the periods of outpatient services made such claims ineligible for FFP reimbursement.

CONCLUSION AND RECOMMENDATION

Although the State of Florida appeared to have some controls in place at the IMDs to prevent FFP claims for medical and ancillary services provided to IMD residents, these controls did not prevent improper FFP claims in all instances. Therefore, we recommended that the State agency reimburse the Federal Government for the \$71,406 in FFP that should not have been claimed during the period July 1, 1997 through January 31, 2001.

State Agency's Comments

State agency officials did not believe there was an overpayment because the claims in question pertained to SSI recipients. According to the State agency, the Social Security Administration (SSA) determines Medicaid eligibility for SSI recipients residing in Florida, and SSA should notify the State when a recipient is no longer eligible for SSI. At that time, the State determines if the individual is eligible under any other eligibility group prior to terminating the individual's Medicaid eligibility. The State is allowed up to 4 months to process Medicaid eligibility terminations for these recipients. In Florida, Medicaid pays for SSI recipients during this redetermination process.

OIG's Response

For the most part, the State agency was correct in the treatment of SSI recipients. However, as the Federal criteria cited in the **Background** section of this report indicates, while 21 to 64 year old recipients remain residents of an IMD, they are not eligible for Federal matching of Medicaid payments. The recipients in our review were transferred from the IMDs to other care settings, such as outpatient acute care settings, other outpatient facilities, and physician offices. However, these residents were not discharged from the IMDs. Thus, they remained IMD residents and, therefore, FFP was prohibited.

Sincerely yours,

A handwritten signature in black ink, reading "Charles J. Curtis". The signature is written in a cursive style with a large, prominent initial "C".

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV



ENCLOSURE

JEB BUSH, GOVERNOR

RHONDA J. EDOWS, MD, FAAP, SECRETARY

Mr. Eugene Grasser
Associate Regional Administrator
Department of Health and Human Services, Region IV
Division of Medicaid and State Operations
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

Subject: Common Identifier Number A-04-01-02008

Dear Mr. Grasser:

This is to acknowledge receipt of two copies of the Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services report entitled, "Audit of Medical Claims for 21 to 64 Year Old Residents of State Psychiatric Hospitals that are Institutions for Mental Diseases in Florida."

Florida is a designated 1634 state; therefore the Social Security Administration (SSA) determines Medicaid eligibility for SSI recipients residing in Florida. It is the responsibility of SSA to notify the state when a recipient is no longer eligible for SSI, at which point federal regulations require the state to determine that the individual is not eligible under any other eligibility group prior to terminating the Medicaid recipient's eligibility [reference: 42 CFR 435.930(b)]. Florida is allowed up to 4 months to process Medicaid eligibility terminations for these recipients.

Again, the questionable claims pertained to SSI recipients. In Florida, Medicaid pays for SSI recipients during the re-determination process. Thus we do not believe there is any overpayment for these recipients by Medicaid.

Sincerely,


for Bob Sharpe
Deputy Secretary for Medicaid

