

**Memorandum**

MAR 15 2007  
Date *Thomas D. Roslewicz*  
Thomas D. Roslewicz  
From Deputy Inspector General  
for Audit Services

Subject Review of Florida Medicaid Claims for 21 to 64 Year Old Residents of State Psychiatric Hospitals that are Institutions for Mental Diseases (A-04-01-02003)

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

As part of self-initiated audits by the Office of Inspector General, we are alerting you to the issuance within 5 working days from the date of this memorandum of the subject final audit report. A copy of the report is attached. 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. This report is one of a series of reports in our multi-State initiative focusing on Federal reimbursement for medical care provided to residents of institutions for mental diseases (IMD).

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 were transferred to acute care hospitals for inpatient treatment.

Our review found that, for the period July 1, 1997 through January 31, 2001, the State agency appeared to have adequate controls to prevent improper FFP claims for inpatient services provided to IMD residents who were transferred to acute care hospitals. We reviewed about 3,800 claims totaling about \$19.8 million in Medicaid payments and found only 47 claims for which FFP was improperly claimed by the State agency. These claims represented \$78,880 in FFP. We did 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 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. Contrary to the State's position, we believe that the Social Security Act and implementing Federal regulations are clear in that while a person is a resident of an IMD, that individual is not eligible for Federal matching of Medicaid payments.

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

Attachment

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF FLORIDA MEDICAID  
CLAIMS FOR 21 TO 64 YEAR OLD  
RESIDENTS OF STATE PSYCHIATRIC  
HOSPITALS THAT ARE INSTITUTIONS  
FOR MENTAL DISEASES**



**JANET REHNQUIST  
Inspector General**

**MARCH 2002  
A-04-01-02003**



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General  
Office of Audit Services

CIN: A-04-01-02003

MAR 18 2002

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

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, Office of Audit Services' (OAS) report entitled, "Review of Florida Medicaid Claims Made for 21 to 64 Year Old Residents of State Psychiatric Hospitals that are Institutions for Mental Diseases." A copy will be forwarded to the action official noted below for his review and any action 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 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 this 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-04-01-02003 in all correspondence relating to this report. If you have any questions, please call me or Peter Barbera of my staff, at (404) 562-7758.

Sincerely,

A handwritten signature in cursive script that reads "Charles J. Curtis".

Charles J. Curtis  
Regional Inspector General  
For Audit Services

Enclosures - as stated

Page 2 – Mr. Robert Sharpe

**Direct Reply to HHS Action Official:**

Mr. Eugene A. 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



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General  
Office of Audit Services

CIN: A-04-01-02003

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

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, Office of Audit Services (OIG/OAS) provides you with the results of our "Review of Florida Medicaid Claims for 21 to 64 Year Old Residents of State Psychiatric Hospitals that are Institutions for Mental Diseases."

The objective of our review 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 institutions for mental diseases (IMD) were transferred to acute care hospitals for inpatient treatment. Our review covered Medicaid payments for the period July 1, 1997 through January 31, 2001.

Our audit indicated that the State of Florida appeared to have adequate controls to prevent improper FFP claims for inpatient services provided to IMD residents and, in this regard, the State complied with Federal regulations. The State's IMDs were diligent in initiating Medicaid disenrollment and assumed responsibility for residents' bills when transferred to acute care hospitals.

We reviewed about 3,800 claims totaling about \$19.8 million in Medicaid payments and found only 47 claims that were not eligible for Federal reimbursement, yet FFP was claimed. These claims represented \$78,880 in FFP. We do not have any procedural recommendations, but we are recommending the State reimburse the Federal Government for the FFP share of the unallowable claims.

In responding to our 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 person is a resident of an IMD, that individual is not eligible for Federal matching of Medicaid 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 55.79 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. Individuals residing in IMDs also retain their IMD status when they are temporarily transferred to acute care hospitals for medical treatment and, as such, the FFP exclusion would apply. 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), formerly known as the Health Care Financial Administration, 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 our audit was to determine if the State agency improperly claimed FFP when 21 to 64 year old residents of State psychiatric hospitals were temporarily transferred to acute care hospitals for inpatient treatment between July 1, 1997 and January 31, 2001. This audit is part of a review of Medicaid payments for services to IMD residents and is being performed in several States.

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

From the State's IMDs, we obtained resident lists and hospital transfer logs covering our audit period. We identified the residents between the ages of 21 to 64 and requested Medicaid eligibility status and payment information for their inpatient hospital claims. We compared the dates of inpatient 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 CMS to the State agency, the IMDs, and the acute care hospitals.

Our review of the State agency's and the IMDs' internal controls was 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 CMS Regional Office in Atlanta, Georgia; the Agency for Health Care Administration and DCF offices in Tallahassee, Florida; and at three IMDs located in MacClenny, Chattahoochee, and Arcadia, Florida from November 2000 to July 2001.

### **RESULTS OF REVIEW**

Our audit indicated that the State of Florida appeared to have adequate controls to prevent improper FFP claims for inpatient services provided to 21 to 64 year old residents of State psychiatric hospitals that are IMDs and, in this regard, complied with Federal regulations. The IMDs were diligent in initiating the Medicaid disenrollment process when a Medicaid eligible patient entered their facility. More importantly, the IMDs instructed the acute care hospitals that the IMDS would be responsible for the residents' bills at the time of the residents' transfers.

We reviewed about 3,800 claims totaling nearly \$19.8 million in Medicaid payments. These were all claims applicable to individuals who at one time were IMD residents during our audit period. We found only 47 claims that should have been excluded from FFP because the dates of service were during periods 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 47 claims represented \$78,880 in FFP. Nineteen of the claims (or \$65,356 in FFP) pertained to inpatient hospital services, while the other 28 claims (or \$13,524 in FFP) pertained to Medicare inpatient deductibles paid by Medicaid.

We discussed the results of the inpatient hospital claims with State agency and DCF officials. We explained that 14 of the 19 questionable inpatient hospital claims pertained to residents from G. Pierce Wood Memorial Hospital, 1 of the 3 psychiatric hospitals included in our review. State officials indicated that, at the time of our visit, this IMD was scheduled for closing and hospital personnel were involved in relocating its current residents. The State agency's plan to close the hospital caused a high rate of employee turnover and this may have contributed to the errors we found.

The officials also explained that, according to CMS instructions (as contained in a final rule published in the Federal Register on January 13, 1997, MB-105-FC), States have up to 120 days to process Medicaid eligibility terminations related to individuals losing their SSI benefit. The 47 questionable claims found during our audit pertained to SSI participants and, as such, their termination from Medicaid was not completed. This apparently allowed for the payment of the claims when submitted by the acute care hospitals.



## CONCLUSION AND RECOMMENDATION

Overall, the State agency had adequate controls in place to preclude claiming FFP when 21 to 64 year old residents of State operated IMDs were transferred to acute care hospitals for inpatient treatment. However, we did identify some improper FFP claims. Therefore, we recommend that the State agency reimburse the Federal Government for the \$78,880 in FFP that should not have been claimed during the period July 1, 1997 through January 31, 2001. Considering the volume of Medicaid claims, we commend the State agency for the controls in place to prevent FFP claims from being made relative to the IMD residents in our review.

### State Agency's Comments

The State agency did not believe there was an overpayment because the claims in question pertained to SSI recipients. 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 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 IMD to an acute care setting, however, they were not discharged. Thus, they remained IMD residents and, therefore, FFP was prohibited.

Sincerely yours,



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



JEB BUSH, GOVERNOR

RHONDA M. MEDOWS, MD, FAAP, SECRETARY

February 6, 2002

Charles J. Curtis  
 Regional Inspector General  
 For Audit Services, Region IV  
 Room 3T41  
 61 Forsyth Street, S.W.  
 Atlanta, Georgia 30303-8909

RE: Common Identification Number (CIN) A-04-01-02003

Dear Mr. Curtis:


In a November 29 letter, we requested information about Medicaid payment for Institutions for Mental Diseases (IMD) residents during their stay in an acute care hospital. We thank Lourdes Puntonet for sending us the data on the comparison of acute inpatient service dates and dates of residency in an IMD. However, after examining Medicaid eligibility of the residents, it was found that they were SSI recipients, and as such, Florida is expected to keep individuals on the Medicaid rolls during the redetermination period.

Florida is designated a 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.

As stated on page 3 of the audit, the questionable claims pertained to SSI recipients. In Florida, Medicaid pays for SSI recipients during the redetermination process. Thus, we do not believe there is any overpayment for these recipients by Medicaid or the federal match (FFP) of \$78,880.

Please contact me or Elsa Kellberg at 850/487-2628 should you need additional information.

Sincerely,

  
 Bob Sharpe  
 Deputy Secretary for Medicaid

BS/erk

