

**Memorandum**

Date - APR 6 1995

From June Gibbs Brown *June G Brown*
Inspector General

Subject Review Of Medical Assistance Claims For State-Operated Psychiatric Center Clients
Between The Ages Of 21 To 64 Who Were Temporarily Released To Acute Care
Facilities For Medical Treatment (A-02-93-01036)

To

Bruce C. Vladeck
Administrator
Health Care Financing Administration

This memorandum alerts you to the issuance on April 10, 1995 of our final audit report. A copy is attached.

The purpose of our audit was to determine if the New York State (NYS) Department of Social Services (DSS) improperly claimed Federal financial participation (FFP) for clients between the ages of 21 to 64 at 25 State-operated adult psychiatric centers (PC) when these clients were temporarily released to acute care facilities for inpatient medical treatment. The NYS identified the 25 State-operated PCs as Institutions for Mental Diseases (IMD). Our audit period was limited to January 1, 1991 to December 31, 1993. The audit start date is after the Health Care Financing Administration (HCFA) issued clarifications of the applicable regulations to States regarding temporary absences from IMDs.

We determined that NYS DSS has and is continuing to improperly claim FFP for clients between the ages of 21 to 64 who are temporarily released from State-operated adult PCs to acute care hospitals for medical treatment. Federal regulations prohibit FFP claims to Medicaid for IMD clients between the ages of 22 to 64 and those aged 21 at admission. In clarifying guidance, HCFA has made it clear that during a temporary release to an acute care facility for medical treatment, the clients retain their IMD status and, as such, FFP claims for aged 21 to 64-year-old clients would not be allowable. Despite the Federal regulations and clarifying guidance, NYS has continued to improperly claim FFP.

The NYS Office of Mental Health operated the 25 adult PCs. Eight of the 25 PCs had medical surgical units (MSU) located on the grounds of their PCs. The MSUs were separately certified by HCFA as acute care hospitals.

Around April 1, 1991, the eight PCs phased out their MSUs as acute care facilities. Prior to the MSU phase-outs, the PCs would send their clients to either the MSUs or general acute care hospitals for medical treatment. Beginning April 1, 1991, all PCs sent their clients to general acute care hospitals when they needed medical care.

We performed a 100 percent review of the FFP claims for clients between the ages of 21 to 64 who were temporarily released from the State-operated PCs to the MSUs. From January 1, 1991 to March 31, 1991, we determined that NYS improperly claimed \$583,963 (Federal share \$291,981) for clients between the ages of 21 to 64 who were temporarily released from the PCs to the MSUs for inpatient medical treatment. We did not perform a detailed claims audit for the releases to the general acute care hospitals. Rather, we gathered evidence that clearly showed that NYS has and is continuing to improperly claim FFP when clients between the ages of 21 to 64 are temporarily released from their PCs to general acute care hospitals for inpatient medical treatment. Our report includes examples which clearly document this condition.

For the temporary releases to general acute care hospitals, we believe the potential amount of improperly claimed FFP is significant as our computer applications have identified an unaudited FFP adjustment of approximately \$9.2 million for the period January 1, 1991 to December 31, 1993. Furthermore, the improper claiming of FFP is still occurring.

We recommend that NYS refund the identified \$291,981 in improperly claimed FFP for the eight PCs which operated MSUs during the first 3 months of 1991. In addition, NYS should immediately implement procedures to cease claiming FFP for IMD clients between the ages of 21 to 64 who are temporarily released to general acute care hospitals for inpatient medical treatment, and establish appropriate edits in its Medicaid Management Information System to prevent these improper claims from being made in the future. Also, we recommended that NYS voluntarily compute and process an FFP adjustment on stays by IMD clients between the ages of 21 to 64 who were temporarily released to general acute care hospitals for inpatient medical treatment during the period January 1, 1991 to the present.

In their response, NYS did not agree with the findings and recommendations of our report. In summary, NYS indicated that the Medicaid law only restricted FFP for services rendered "in" an IMD, stated that certain cited regulations do not require exclusion of these costs, and indicated that HCFA incorrectly interpreted its law and regulations. We disagree with the States comments and believe HCFA's guidance was clear. Both regional and central office officials of the HCFA concurred with the findings and recommendations contained in our report.

In addition to the above discussed audit in NYS, we understand that this same issue is being examined by HCFA in New Jersey. The existence of this condition in two States significantly increases the risk that a more systematic problem may exist.

Further, our research and development work to date has identified several potential weaknesses in the propriety of NYS's claiming of FFP on claims for medical care rendered to various aged IMD patients residing in several IMD settings. For example, we have obtained examples of FFP being improperly claimed by NYS for certain physician and ancillary services to PC clients aged 21 to 64. This same condition was identified by HCFA in California where substantial disallowances were imposed by HCFA and sustained by the Departmental Appeals Board. We are also concerned about the possibility of FFP being improperly claimed by NYS for medical care to patients under the age of 21 years old who reside in various IMD settings and to various aged patients who reside in community residences with 16 or more beds and as such meet the definition of an IMD. The HCFA in a response to us and in Medicaid State Operation Letter 91-36 has provided guidance on FFP limitations related to these areas.

As both our organizations have uncovered significant FFP claiming issues in the IMD area by State governments, I believe a meeting between our respective staffs to further discuss these issues would be most beneficial.

For further information, contact:
John Tournour
Regional Inspector General
for Audit Services, Region II
(212) 264-4620

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF
MEDICAL ASSISTANCE CLAIMS
FOR STATE-OPERATED PSYCHIATRIC CENTER
CLIENTS BETWEEN THE AGES OF 21 TO 64 WHO
WERE TEMPORARILY RELEASED TO ACUTE CARE
FACILITIES FOR MEDICAL TREATMENT**

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

JANUARY 1, 1991 TO DECEMBER 31, 1993



**JUNE GIBBS BROWN
Inspector General**

**APRIL 1995
A-02-93-01036**



DEPARTMENT OF HEALTH & HUMAN SERVICES

**Office of Inspector General
Office of Audit Services**

**Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278**

Our Reference: Common Identification No. A-02-93-01036

Ms. Mary Glass
Acting Commissioner
New York State Department
of Social Services
40 North Pearl Street
Albany, New York 12243

Dear Ms. Glass:

Enclosed for your information and use are two copies of a Department of Health and Human Services (HHS)/Office of Inspector General Office of Audit Services (OAS) report entitled, "Review of Medical Assistance Claims For State-Operated Psychiatric Center Clients Between The Ages Of 21 To 64 Who Were Temporarily Released To Acute Care Facilities For Medical Treatment." Our audit covered the period January 1, 1991 to December 31, 1993.

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

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG/OAS reports issued to the Department's grantees and contractors are available, if requested, 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).

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

Page 2 - Mary Glass

If you have any questions or comments on the enclosed report, please contact Mr. Timothy Horgan, Audit Manager, at (212) 264-2875.

Sincerely yours,

A handwritten signature in black ink, appearing to read "John Tournour", with a long, sweeping underline.

John Tournour
Regional Inspector General
for Audit Services

(2) Enclosures

Direct Reply to HHS Action Official:

Mr. Arthur J. O'Leary
Associate Regional Administrator
Division of Medicaid, HCFA, Region II
26 Federal Plaza, Room 38-130
New York, NY 10278

S U M M A R Y

We determined that the New York State (NYS) Department of Social Services (DSS) has and is continuing to improperly claim Federal financial participation (FFP) for clients between the ages of 21 to 64 who are temporarily released from State-operated adult psychiatric centers (PCs) to acute care hospitals for medical treatment. This practice is in direct contradiction to guidance issued by the Health Care Financing Administration (HCFA).

Included within our review were 25 PCs which the State identified as Institutions for Mental Diseases (IMD). Federal regulations prohibit FFP claims to Medicaid for IMD clients between the ages of 22 to 64 and those aged 21 at admission. In clarifying guidance, HCFA has made it clear that during a temporary release to an acute care facility for medical treatment, the clients retain their IMD status and, as such, FFP claims for aged 21 to 64 year old clients would not be allowable. Despite the Federal regulations and clarifying guidance, NYS has continued to improperly claim FFP.

During our review, we requested from NYS clarification why it had not revised its claiming practices. In a March 10, 1994 reply, State officials advised us that since the services in question were inpatient hospital services that were not rendered in an IMD, they believe that Medicaid law and regulations would permit these types of claims. We disagree with the State's contention as it directly contradicts the Federal reimbursement restrictions that exist on aged 21 to 64 IMD patients temporarily transferred from an IMD to an acute care facility for medical treatment.

During the period of our audit, January 1, 1991 through December 31, 1993, the NYS Office of Mental Health (OMH) operated 25 adult PCs. Eight of the 25 PCs had medical surgical units (MSUs) located on the grounds of their PCs. The MSUs were separately certified by HCFA as acute care hospitals. We found that clients at the PCs were temporarily released to either the MSUs or general acute care hospitals for medical treatment. During their medical stays at the MSUs, we found that NYS improperly claimed FFP for the PC clients who were between the ages of 22 to 64 and for those aged 21 at admission. Around April 1, 1991, the eight PCs phased out their MSUs as acute care facilities. As such, the last service date for which FFP was claimed for MSU services was March 31, 1991. We performed a 100 percent review of the FFP claims for clients between the ages of 21 to 64 who were temporarily released from the

State-operated PCs to the MSUs. From January 1, 1991 to March 31, 1991, we determined that NYS improperly claimed \$583,963 (Federal share \$291,981) for clients between the ages of 21 to 64 who were temporarily released from the PCs to the MSUs for medical treatment. Appendix B of our report provides a summary of the Federal share amounts improperly claimed at each of the eight PCs that had MSUs.

Prior to the MSU phase-out, the PCs would send their clients to either the MSUs or general acute care hospitals for medical treatment. Beginning April 1, 1991, all PCs sent their clients to general acute care hospitals when they needed medical care. We did not perform a detailed claims audit for the releases to the general acute care hospitals. Rather, we gathered evidence that clearly showed that NYS has and is continuing to improperly claim FFP when clients between the ages of 21 to 64 are temporarily released from their PCs to general acute care hospitals for medical treatment. Our report includes examples which clearly document this condition. We are requesting that NYS voluntarily compute the unallowable FFP amount and make the necessary financial adjustments from January 1, 1991 to the present.

For the temporary releases to general acute care hospitals, we believe the potential amount of improperly claimed FFP is significant as our computer applications have identified an unaudited FFP adjustment of approximately \$9.2 million for the period January 1, 1991 to December 31, 1993. We recognize that an audit calculated amount will be different because it will have to reflect both positive and negative adjustments. Increases will be necessary to reflect additional claims during our 3-year audit period that were submitted after our computer applications were run. In addition, upward adjustments will be needed to reflect FFP on inpatient claims for all or a significant portion of Calendar Year (CY) 1994. Decreases will also be necessary based on audit verification work and could include adjustments for instances when a client may not have been a resident of the IMD immediately prior to his release to the acute care hospital (i.e. family care client). We believe the positive adjustments will be greater than the negative adjustments and accordingly, we believe the calculated adjustment will be significant.

Based on our audit, we recommend that NYS refund the identified \$291,981 in improperly claimed FFP for the eight PCs which operated MSUs during the first 3 months of 1991. In addition, NYS should immediately implement procedures to cease claiming FFP for IMD clients between the ages of 21 to 64 who are temporarily released to general

acute care hospitals for medical treatment, and establish appropriate edits in its Medicaid Management Information System (MMIS) to prevent these improper claims from being made in the future. We further recommend that NYS voluntarily compute and process an FFP adjustment on stays by IMD clients between the ages of 21 to 64 who were temporarily released to general acute care hospitals for medical treatment during the period January 1, 1991 to the present. We would be willing to provide technical assistance to the State in computing the FFP adjustment and we will monitor their progress in implementing our recommendations.

In their comments dated November 4, 1994, NYS officials did not concur with the findings and recommendations contained within our report. In summary, NYS indicated that the Medicaid law only restricted FFP for services rendered "in" an IMD, stated that certain cited regulations do not require exclusion of these costs, and indicated that HCFA incorrectly interpreted its law and regulations. We disagree with the State's comments and believe HCFA's guidance was clear and appropriate. Officials of HCFA concurred with the findings and recommendations contained in our draft audit report.

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INTRODUCTION

Background

Medicaid, authorized by title XIX of the Social Security Act, as amended, provides grants to States for furnishing medical assistance to eligible low-income persons. The States arrange with medical service providers such as physicians, pharmacies, hospitals, nursing homes, and other organizations to provide the needed medical assistance.

To be eligible for FFP under the Medicaid program, each State must submit an acceptable plan, hereafter referred to as the State Plan, to HCFA. The State Plan specifies the amount, duration, and scope of all medical and remedial care services offered to Medicaid recipients and becomes the basis of operation for the Medicaid program in the State. The HCFA has the responsibility for monitoring the activities of the State agency in implementing the Medicaid program under the State Plan.

Prior to the Social Security Act Amendments of 1965 (Public Law 89-97), FFP was not available for payments made on behalf of individuals who were receiving care in IMDs. Until that time, such care had been solely the responsibility of the States. The Amendments of 1965 provided for the first time an option for States to include medical assistance on behalf of individuals 65 years of age or older who were patients in IMDs. Additionally, the Social Security Act Amendments of 1972 (Public Law 92-603) provided for inpatient psychiatric hospital services, under certain circumstances, for individuals under age 21 or, in specific circumstances, under age 22.

New York initiated its Medicaid program on May 1, 1966. The NYS DSS is the Single State Agency for Medicaid. The DSS delegates certain of its responsibilities to other State agencies. One such agency is the OMH. In general, OMH is responsible for the overall administration of inpatient and outpatient psychiatric services. Under its Medicaid State Plan, NYS has opted to cover inpatient hospital services for individuals age 65 or older in IMDs and inpatient psychiatric facility services for individuals under age 22.

Our review included 25 State-operated adult PCs that were identified as IMDs by NYS. For the most part, clients receiving inpatient psychiatric services at the PCs who were age 65 and older and those under age 22 were claimed for Medicaid reimbursement through the State's MMIS while at the PCs. Appendix A of our report provides a list of the 25 PCs included in our review.

When clients at the 25 State-operated adult PCs required medical treatment, NYS would temporarily transfer the clients to either a general acute care hospital or a MSU located on the PC's grounds. For the most part, after their medical stays the clients would return to the PCs. During the period January 1, 1991 through December 31, 1993, 8 of the 25 PCs had MSUs on their grounds. The MSUs were separately certified by HCFA as acute care hospitals.

The eight PCs phased out their MSUs as medical acute care units by April 1, 1991. On or after April 1, 1991, all 25 PCs had to send their clients (including those aged 21 to 64) to general acute care hospitals for medical treatment. The last FFP claims to Medicaid for clients in the MSUs were made as of March 31, 1991. The eight PCs that had MSUs during our review period were: Rochester, Willard, Middletown, Binghamton, Buffalo, Gowanda, Hudson River, and St. Lawrence.

Scope of Review

The purpose of our audit was to determine if NYS DSS improperly claimed FFP for clients between the ages of 21 to 64 (also referred to in this report as the audited age group) at the 25 State-operated adult PCs included in our review during periods that these clients were temporarily released to acute care facilities for medical treatment. Although our review determined that from at least July 1, 1985, NYS has claimed FFP for State-operated PC clients within the audited age group who were temporarily released to acute care facilities for medical treatment, we found that HCFA did not clarify its regulations to all States (including NYS) until around November 1990. Because of this, we decided to use January 1, 1991 as our audit start date for determining the propriety of the State's FFP claims. Our audit period is January 1, 1991 to December 31, 1993. As part of our review, we evaluated the State's claiming practices both before and after the issuance of HCFA's guidance regarding temporary transfers of IMD patients for medical treatment. Our review was limited to inpatient services and accordingly, we did not review other possible types of services that were claimed for FFP by NYS.

Our review was made in accordance with standards for governmental auditing. It included such tests and other auditing procedures that we considered necessary in the circumstances. During our audit, we interviewed and obtained information from NYS, PC, and HCFA officials and reviewed applicable policies and procedures relevant to our audit. We also documented our understanding of OMH's client movement history system and performed tests of the movement histories at selected PCs. Our review

and tests determined that the movement histories were reliable for audit purposes in that they accurately showed the temporary transfers of PC clients to and from acute care facilities.

However, while acquiring an understanding of the internal control structure, it became apparent that there were no edits or mechanisms within New York's MMIS to prevent FFP from being claimed for PC clients between the ages of 21 to 64 who were temporarily released to acute care facilities for medical care. As a result, we assessed control risk at the maximum level and decided to perform substantive testing of the audited age group who were temporarily released from PCs to acute care facilities. As part of our audit, we did not perform a facility-wide review of the electronic data processing general and application controls within the MMIS.

We performed various computer programming applications at the MMIS fiscal agent using the paid claims inpatient files (tapes). Our applications identified inpatient claims for clients between the ages of 21 to 64 who were temporarily released from a State-operated PC to either an MSU or a general acute care hospital for medical treatment. We performed a 100 percent review of the claims for clients in the audited age group who were temporarily released from a State-operated PC to an MSU during the period January 1, 1991 to March 31, 1991 (the last date of MSU claims). No sampling techniques of the MSU claims were used. Our review of the MSU claims was limited to extracting claims information from the MMIS, examining supporting documentation in the form of client case records for 46 judgementally selected clients at the 8 PCs that had MSUs, reviewing client movement histories and billing information supplied by Central Office OMH, and determining the amount of improperly claimed FFP. The client movement histories obtained from OMH were used to verify that the clients under review were residents of the PCs prior to and after their MSU stays and to verify their inpatient medical stays at the MSUs. We established the reliability of the client movement histories through testing and site visits to the PCs for the 46 clients that were tested.

Our computer programming applications at the MMIS fiscal agent also identified inpatient claims for clients between the ages of 21 to 64 who were temporarily released from the 25 State-operated adult PCs included in our review to general acute care hospitals for medical treatment. For these claims, we reviewed a judgementally selected sample of 41 cases at 10 PCs. The purpose of this review was to obtain examples which demonstrated that the State was and is continuing to claim FFP for the medical care of PC clients within the 21 to 64 year old age group when these clients were and are temporarily released to general acute care hospitals. Additionally, as part of this phase of our audit, we reviewed client movement histories and billing

information obtained from Central Office OMH related to the clients identified by our programming applications. However, we did not calculate the amount of improperly claimed FFP for PC clients within the 21 to 64 year old age group who were temporarily released to general acute care hospitals. Rather, as part of our audit, we are requesting that NYS voluntarily compute the unallowable FFP amount and make the necessary financial adjustments from January 1, 1991 to the present.

Audit field work was performed at DSS, OMH, and the MMIS fiscal agent in Albany, New York and at 14 of the 25 PCs included in our review during the period July 1993 through May 1994.

FINDINGS

During the period January 1, 1991 through December 31, 1993, we determined that when clients between the ages of 22 to 64 years old and those aged 21 at admission, who were inpatients of the 25 State-operated PCs, were temporarily released (not discharged) to either an MSU or to a general acute care hospital for medical treatment, NYS would claim FFP for the inpatient acute care hospital services. The claiming of the FFP on these claims was improper and contrary to Federal regulations and clarifying guidance issued by HCFA. Subsequent to our audit period, NYS has continued to improperly claim FFP.

The statutory requirements with respect to IMDs are found at section 1905(a) of the Social Security Act. Medicaid regulations implementing the IMD exclusion in section 1905(a) of the Act are found at 42 CFR part 441.13 and 42 CFR part 435.1008. Specifically, 42 CFR part 441.13, entitled Prohibitions on FFP: Institutionalized Individuals, states that:

"(a) FFP is not available in expenditures for . . .

(2) 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."

Part 441.151 of Subpart D states:

"Inpatient psychiatric services for recipients under age 21 must be provided -- . . . Before the recipient reaches age 21 or, if the recipient was receiving the services immediately before he reached age 21, before the earlier of the following -

- (1) The date he no longer requires the services; or
- (2) The date he reaches age 22."

The regulations at 42 CFR part 435.1008, which are contained under a subcaption entitled Limitations on FFP, were amended on May 3, 1985 and state that:

"(a) FFP is not available in expenditures for services provided to -- . . .

- (2) Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under 440.160 of this subchapter."

Subpart (c) of 42 CFR part 435.1008 defines an exception when an IMD patient is not considered to be a resident of an IMD as follows:

"An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution"

The HCFA's consistent interpretation has been that the release of patients to MSUs or to acute care hospitals do not qualify as either "conditional release" or "convalescent leave." In addition to these regulations, our research identified the following documents which provide specific clarifications concerning the propriety of a State claiming FFP when an IMD client between the ages of 21 to 64 years old is temporarily transferred to an acute care facility for medical treatment. These documents show that HCFA clarified its applicable regulations to all States in November 1990. Further notifications on this issue were also distributed by HCFA. Despite this information, NYS has not revised its claiming procedures.

In November 1990, HCFA issued Transmittal No. 51 of the State Medicaid Manual, part 4 to all States. Section 4390.1 of this manual states in part that:

"If a patient is temporarily released 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."

On January 4, 1991 Medicaid State Operations Letter 91-1 was issued by the HCFA Region II Associate Regional Administrator, Division of Medicaid, to State agencies (including NYS) administering the Medicaid program. This letter states in part that:

"Regulations at 42 CFR 435.1008 provide that individuals who are inmates of public institutions and individuals who are inpatients of IMDs and are between the ages of 22 and 65 may not have Federal financial participation (FFP) paid on their behalf for medical services they receive. A patient who is temporarily

released from an IMD for the purpose of obtaining treatment is not considered to be conditionally released under 42 CFR 435.1008(c) and thus is still an inpatient of the IMD."

The January 4, 1991 Medicaid State Operations Letter goes on to state that if:

". . . a patient is temporarily released from an IMD for other purposes, such as to obtain medical treatment, either at a hospital on the institutional grounds or in the community, this would not be considered a conditional release or convalescent leave and the patient would still be considered to be an IMD patient, subject to IMD payment restrictions."

On December 3, 1991, a final audit report (CIN A-05-91-00023) was issued by the Region V Office of Inspector (OIG)/Office of Audit Services (OAS) Regional Inspector General for Audit Services to the Director of the Illinois Department of Public Aid. In that report, which NYS officials acknowledged that it had obtained, the Region V auditors identified unallowable claims for clients between the ages of 22 to 64 who were temporarily released from four Illinois State-operated psychiatric hospitals that were IMDs to MSUs located on the grounds of those IMDs. The Region V audit covered the period January 1, 1983 through September 30, 1990. The auditors determined that from January 1, 1983 to April 30, 1988, Illinois improperly claimed \$3,126,442 of FFP for clients between the ages of 22 to 64 who were temporarily transferred from the State-operated IMDs to the MSUs for medical treatment. During the period under review, our Region V auditors also found that Illinois began phasing out these MSUs as early as April 1983 and that the State ceased claiming FFP for the aged 22 to 64 clients by April 30, 1988. The Region V report recommended that Illinois refund \$3,126,442 to the Federal Government for the improper aged 22 to 64 claims. Both the State and HCFA concurred with the findings and recommendations in that report in their entirety.

In December 1992, HCFA issued a report to the Congress entitled Medicaid and Institutions for Mental Diseases. This report states in part that:

"If a patient is temporarily released from an IMD for the purpose of obtaining medical treatment (e.g. surgery in a general hospital), this is not considered to be either of these categories of release and the patient is considered to remain in the IMD. In such a situation, medical assistance is not available during the absence."

Finally, in March 1994, HCFA issued Transmittal No. 65 of the State Medicaid Manual, part 4. Section 4390 A.2. of this manual, entitled IMD Exclusion, states that:

"--The IMD exclusion is in §1905(a) of the Act in paragraph (B) following the list of Medicaid services. This paragraph states that FFP is not available for any medical assistance under title XIX for services provided to any individual who is under age 65 and who is a patient in an IMD unless the payment is for *inpatient psychiatric services for individuals under age 21*. 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."

Additionally, part 4390.1 of Transmittal No. 65 again reemphasizes that when a patient is temporarily released from an IMD for the purpose of obtaining medical treatment, the patient still retains his IMD status and as such the IMD payment exclusion for patients within the 21 to 64 year old age group would still apply.

Based on all of the above, HCFA has made it very clear that FFP is not available to IMD clients who are between the ages of 22 to 64 and those who are aged 21 at admission, when these clients are temporarily released to an acute care facility for medical treatment.

In NYS, we found that the improper claiming was occurring at both MSUs and at acute care hospitals. Our findings with respect to each area are discussed below.

Medical Surgical Units

We determined that NYS DSS improperly claimed FFP from January 1, 1991 to March 31, 1991 for clients between the ages of 22 to 64 and for those aged 21 at admission who were temporarily released from State-operated PCs to eight MSUs located on the PCs' grounds for the purpose of obtaining medical treatment. As a result, the Medicaid program was overcharged \$583,963 (Federal share \$291,981). Appendix B of our report provides a summary of the Federal share amounts improperly claimed at each of the eight PCs that had MSUs.

During the period of our review, 8 of the 25 PCs had MSUs located on the institutions' grounds. The MSUs were certified by HCFA as acute care hospitals. The eight MSUs were phased out as medical acute care units around April 1, 1991 with the last FFP claims on March 31, 1991. We performed various computer programming applications at the MMIS fiscal agent using the paid claims inpatient files (tapes). Our applications identified inpatient claims for clients in the audited age group who were temporarily released from a State-operated PC to the eight MSUs.

We performed a 100 percent review of the claims for clients in the audited age group who were temporarily released from a State-operated PC to an MSU during the period January 1, 1991 through March 31, 1991 (the last date of MSU claims). No sampling techniques of the MSU claims were used. We conducted site visits to the eight PCs during September 1993. During our visits, we determined that the buildings that originally housed the MSU wards were still part of the PCs' campus under the jurisdiction of OMH. Our review of the MSU claims was limited to extracting claims information from the MMIS, examining supporting documentation in the form of client case records for 46 judgementally selected clients at the 8 PCs that had MSUs, reviewing client movement histories and billing information supplied by Central Office OMH, and determining the amount of improperly claimed FFP.

The client movement histories obtained from OMH were used to verify that the clients under review were residents of the PCs prior to and after their MSU stays and to verify their inpatient medical stays at the MSUs. We established the reliability of the client movement histories through testing and site visits to the PCs for the 46 clients that were tested. Based on our review, we calculated the improper FFP that had been claimed for MSU services during the period January 1, 1991 through March 31, 1991. In summary, NYS improperly claimed \$583,963 (Federal share \$291,981) for clients between the ages of 21 to 64 who were temporarily released from the PCs to the MSUs for medical treatment.

General Acute Care Hospitals

Our review determined that NYS has and is improperly continuing to claim FFP for clients between the ages of 22 to 64 and for those aged 21 at admission who were and are temporarily released from State-operated PCs to general acute hospitals for medical treatment.

As part of our audit, we conducted site visits to 10 judgementally selected State-operated PCs to obtain evidence demonstrating that the State was and is continuing to claim FFP for PC clients in the audited age group who were temporarily released to general acute care hospitals for medical treatment.

During our site visits, we obtained information on the temporary transfers to acute care hospitals as evidenced in the case records. This was done to demonstrate that before and after the November 1990 clarifications by HCFA, NYS' claiming practices were the same. As discussed in the scope of audit section, we did not compute the improperly claimed FFP for periods after December 31, 1990. Rather, we are recommending that the State voluntarily compute and make the necessary financial adjustment.

The following two examples clearly document the improper claiming of FFP. An additional three examples are included in Appendix C.

At Buffalo PC, we reviewed the case records of a client, during his late 40's and early 50's. These records showed that he had numerous temporary transfers to both the MSU at Buffalo PC and to Erie County Medical Center for treatment of urinary tract infections and infected ulcers. These temporary releases, for which NYS claimed FFP, occurred during the period July 1985 through September 1993. For these transfer periods, the client was not discharged from Buffalo PC prior to the acute care stays and he returned to the PC after his medical stays were over. As such, during our audit period, this client would still be considered a resident of Buffalo PC and therefore the related medical services rendered by the acute care facilities would not be eligible for Federal reimbursement. Below are the hospital and MSU claims for which NYS claimed FFP.

<u>SERVICE DATES CLAIMED FOR FFP</u>	<u>CLIENT TEMPORARILY RELEASED TO:</u>	<u>FFP PAID</u>
<u>Prior to HCFA Clarification and Our Audit Period</u>		
7/18/85 to 7/31/85	Erie County Medical Center	\$ 250
7/31/85 to 12/11/85	Medical Surgical Unit	11,320
4/1/86 to 4/11/86	Medical Surgical Unit	1,306
12/7/87 to 12/31/87	Medical Surgical Unit	3,444
1/2/88 to 2/16/88	Erie County Medical Center	6,075
2/16/88 to 2/18/88	Medical Surgical Unit	274
10/25/88 to 11/23/88	Erie County Medical Center	270
12/3/88 to 12/20/88	Erie County Medical Center	540
1/1/89 to 1/12/89	Medical Surgical Unit	9
9/18/89 to 9/21/89	Erie County Medical Center	<u>280</u>
	TOTAL	<u>\$23,768</u>

After HCFA Guidance and During Our Audit Period

4/26/93 to 5/11/93	Erie County Medical Center	\$ 2,535
8/31/93 to 9/7/93	Erie County Medical Center	<u>338</u>
TOTAL		<u>\$ 2,873</u>

As the above example illustrates, NYS did not revise its procedures for claiming FFP and continued to claim FFP long after the November 1990 guidance was issued by HCFA.

Another example involves a male client at Binghamton PC in his 30's who was sent to both the MSU and general acute care hospitals for medical treatment during the period December 1990 through September 1993. The client was not discharged prior to being temporarily released for medical treatment and returned to the PC after his treatment was over. As such, during our audit period, this client would still be considered a resident of Binghamton PC and therefore the related medical services would not be eligible for Federal reimbursement. Below are the FFP hospital and MSU claims for this example.

<u>SERVICE DATES</u> <u>CLAIMED FOR FFP</u>	<u>CLIENT TEMPORARILY</u> <u>RELEASED TO:</u>	<u>FFP PAID</u>
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Prior to Our Audit Period but After HCFA Guidance

12/1/90 to 12/11/90	Our Lady of Lourdes	\$ 795
12/11/90 to 12/31/90	Medical Surgical Unit	<u>6,843</u>
TOTAL		<u>\$ 7,638</u>

After HCFA Guidance and During Our Audit Period

1/1/91 to 3/31/91	Medical Surgical Unit	\$29,329
8/30/93 to 9/7/93	United Health Services	<u>1,544</u>
TOTAL		<u>\$30,873</u>

The two examples above plus the three examples in Appendix C document that NYS did not revise its claiming procedures regarding FFP as a result of the clarifications issued by HCFA. Rather, NYS is continuing to improperly

claim FFP on inpatient acute care hospital claims for IMD clients aged 22 to 64 and those aged 21 at admission who are temporarily transferred from an IMD.

Although we did not calculate the improperly claimed FFP for PC clients aged 21 to 64 that were temporarily transferred to acute care hospitals, we believe the amount involved is significant. Our computer applications have identified an unaudited FFP adjustment of approximately \$9.2 million for the period January 1, 1991 to December 31, 1993. We recognize that an audit calculated amount will be different because it will have to reflect both positive and negative adjustments. Increases will be necessary to reflect additional claims during our 3-year audit period that were submitted after our computer applications were run. In addition, upward adjustments will be needed to reflect FFP on inpatient claims for all or a significant portion of CY 1994. Decreases will also be necessary based on audit verification work and could include adjustments for instances when a client may not have been a resident of the IMD immediately prior to being released to the acute care hospital (i.e. family care client). We believe the positive adjustments will be greater than the negative adjustments and accordingly we believe the calculated adjustment will be significant.

On February 16, 1994, we sent a letter to cognizant NYS officials stating that Federal regulations prohibit claims for FFP for clients between the ages of 22 to 64 and for those aged 21 at the time of admission who are temporarily released from IMDs to acute care hospitals for medical treatment. Our letter noted that HCFA had clarified these IMD payment restrictions in the State Medicaid Manual Part 4 Transmittal No. 51, dated November 1990 and in Medicaid State Operations Letter 91-1, dated January 4, 1991. In those documents, HCFA indicated that clients who are temporarily released from an IMD to receive medical services are still considered to be IMD patients, subject to IMD payment restrictions. Our February 16, 1994 letter requested that State officials explain why, after receiving these clarifications from HCFA, they continued to claim FFP for clients between the ages of 22 to 64 and for those aged 21 at admission when these clients were temporarily released from State-operated PCs to the MSUs or to general acute care hospitals to obtain medical treatment.

The State response, dated March 10, 1994, states in part that:

"It is the State's belief that such claiming is consistent with Medicaid law and regulations, which provide for coverage of inpatient hospital services other than those rendered in an

institution for mental diseases. The services in question clearly were not rendered in an institution for mental disease, and were therefore properly reimbursed by Medicaid."

We do not agree with the State's contention as it is inconsistent with the guidance issued by HCFA, of which the State had notice.

The State provided additional comments on its position of disagreement with the findings and recommendations in a written response to our draft audit report. The State's November 4, 1994 comments appear in their entirety in Appendix D and are summarized under the caption State Agency Comments in this report. In finalizing this report, we considered their comments, rebutted them in the OIG Response section of the report and continue to believe the claims in question are unallowable.

Recommendations

We recommend that NYS:

1. Refund \$291,981 to the Federal Government for the improper MSU claims for the period January 1, 1991 to March 31, 1991.
2. Cease claiming FFP for clients between the ages of 22 to 64 and for those aged 21 at admission when these clients are temporarily released from their PCs which are IMDs to general acute care hospitals for medical treatment.
3. Develop controls or edits within its MMIS to prevent claims for FFP for clients between the ages of 22 to 64 and for those aged 21 at admission who are temporarily released from the PCs to general acute care hospitals for medical treatment.
4. Identify the unallowable FFP claims for clients between the ages of 22 to 64 and for those aged 21 at admission who were temporarily released from their State-operated PCs to general acute care hospitals for medical treatment during the period January 1, 1991 to the present and voluntarily return the Federal share of these claims. In this regard, we are willing to provide technical assistance to the State in computing the FFP adjustment and we will monitor their progress in implementing our recommendations.

State Agency Comments

In their comments dated November 4, 1994, DSS officials stated that they shared our report with officials from the OMH, whose comments have been incorporated into the State's response. In their comments, State officials disagreed with the findings and recommendations contained within our report and suggested that the report be withdrawn.

State officials indicated that HCFA incorrectly interpreted the Medicaid law and regulations related to the IMD exclusion. In addition, State officials suggested that HCFA exceeded the scope of its statutory authority by issuing regulations and guidance that were inconsistent with relevant law. The NYS interprets the IMD exclusion to mean that the Federal Government will not pay for medical services that are provided in an IMD. The State concludes that since the services in question were provided outside of an IMD, they would not be affected by the IMD exclusion.

In addition, State officials indicated that the regulations related to the IMD exclusion do not specifically require that the costs in question be excluded from FFP eligibility.

State officials also indicated that HCFA's interpretation of the laws and regulations related to the IMD exclusion is contrary to congressional intent, and would deny access to medical services for individuals with mental illness based solely on their disability.

The State's comments are provided in their entirety in Appendix D of this report.

OIG Response

We disagree with the State's position and believe that the claims in question are unallowable. The HCFA has repeatedly provided consistent guidance emphasizing that when a patient is temporarily released from an IMD for the purpose of obtaining medical treatment, the patient still retains his IMD status and as such the IMD payment exclusion for patients within the 21 to 64 year old age group would apply. Despite receiving this guidance as early as November 1990, NYS has not revised its improper claiming practices.

In the body of our report, we cite various documents issued by HCFA to NYS which provide guidance on the IMD payment restrictions in question. Specifically, Transmittal No. 51 of the State Medicaid Manual issued in November 1990, Medicaid State Operations Letter 91-1 issued on January 4, 1991, and Transmittal No. 65 of the State Medicaid Manual issued in March 1994, all provided guidance to NYS which indicated that clients within the 21 to 64 year old age group, who are temporarily released from an IMD to an acute care hospital to obtain medical treatment, retain their IMD status and as such are not eligible for FFP. Additionally, during our review, the State acknowledged that it had received a December 3, 1991 final audit report issued by the Region V OIG/OAS which identified an improper claiming problem found in Illinois that was similar to the aged 21 to 64 year old IMD claims in question made by NYS. Both Illinois and HCFA officials concurred with the findings and recommendations in the Region V report in their entirety. Finally, in December 1992, HCFA issued a report to the Congress which also delineated the IMD payment restrictions under discussion.

Based on all of the above guidance, HCFA has made it very clear that FFP is not available to IMD clients who are between the ages of 22 to 64 and those who are aged 21 at admission, when these clients are temporarily released to an acute care facility for medical treatment. It is important to note that NYS did not choose to challenge HCFA's interpretation of the applicability of the

IMD exclusion, but rather ignored HCFA's guidance and continued to claim FFP in direct contradiction of the instructions and clarifications it received.

Furthermore, contrary to the State's assertions, we believe that section 1905(a) of the Social Security Act (the Act) supports HCFA's implementing regulations and guidance. Section 1905(a) of the Act defines the term medical assistance and contains the IMD exclusion. In their comments, State officials quote section 1905 (a)(1) of the Act which states that the term medical assistance includes:

"inpatient hospital services (other than services in an institution for mental diseases);".

Based on this section of the Act, State officials concluded that since the medical services in question were not rendered in an IMD, but rather were provided in an acute care facility, the IMD exclusion of FFP would not apply. However, we believe that the State has ignored other plain language within section 1905 (a) of the Act which supports HCFA's position that the FFP exclusion would apply to the claims in question. Specifically, sections 1905 (a)(14) of the Act defines the term medical assistance to include:

"inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases;".

Section 1905 (a)(16) of the Act further defines the term medical assistance to include:

"effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21"

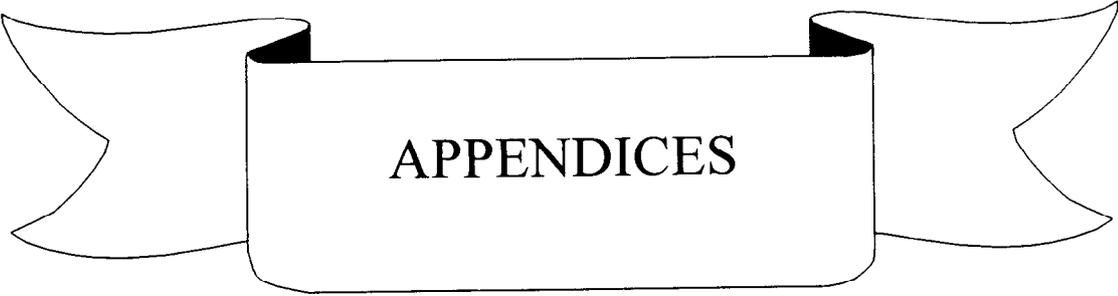
Clear, concise language contained within the paragraph immediately after section 1905 (a)(25) of the Act states that the term medical assistance does not include (with the exception of section 1905 (a)(16) of the Act quoted above):

". . . (B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases."

Apparently, in their comments, State officials have ignored these latter sections of the Act which show that the focus of the IMD exclusion is on the institutional status and age of the client, and not the location where the services were rendered. In our opinion, the language in the Act clearly

supports HCFA's implementing regulations and guidance that temporary releases from an IMD to an acute care hospital for medical treatment do not affect the fact that the patient is still considered a resident of the IMD and as such the aged 21 to 64 year old payment exclusions of FFP would apply.

Based on all the above, we believe our recommendations are appropriate and we urge NYS to reverse its position and take all necessary action to fully implement the audit recommendations. If requested by either NYS or HCFA, OAS would help in computing the unallowable FFP.



APPENDICES

STATE-OPERATED PSYCHIATRIC CENTER CLIENTS BETWEEN THE
AGES OF 21-64 WHO WERE TEMPORARILY RELEASED TO
ACUTE CARE FACILITIES FOR MEDICAL TREATMENT

Common Identification No. A-02-93-01036

Schedule of the 25 State-Operated
Psychiatric Centers Included in Our Audit

Psychiatric Center Name

Binghamton PC
Kingsboro PC
Buffalo PC
Central Islip PC
Creedmore PC
Gowanda PC
Harlem Valley PC
Hudson River PC
Kings Park PC
Middletown PC
Pilgrim PC
New York PC
Rochester PC
Rockland PC
St. Lawrence PC
Hutchings PC
Willard PC
Bronx PC
Capital District PC
Manhattan PC
Elmira PC
South Beach PC
Mid Hudson PC
Mohawk Valley PC
Kirby Forensic¹

¹ Kirby Forensic was included in our review because they temporarily transferred age 21 to 64 year old clients to general acute care hospitals for medical treatment. NYS claimed Federal Medicaid reimbursement for the medical services provided at the general acute care hospitals.

STATE-OPERATED PSYCHIATRIC CENTER CLIENTS BETWEEN THE
AGES OF 21-64 WHO WERE TEMPORARILY RELEASED
TO ACUTE CARE FACILITIES FOR MEDICAL TREATMENT

Common Identification No. A-02-93-01036

Summary of the Amounts Questioned At the Eight
MSUs For the Period 1/1/91 To 3/31/91

<u>MSU Location</u>	<u>Number of Recipients</u>	<u>Total Amounts Questioned</u>	<u>FFP Amounts Questioned</u>
Rochester PC	7	\$ 55,999	\$ 27,999
Willard PC	5	23,547	11,774
Middletown PC	5	2,303	1,152
Binghamton PC	12	138,744	69,372
Buffalo PC	17	138,718	69,359
Gowanda PC	1	58,656	29,328
Hudson River PC	15	77,585	38,792
St. Lawrence PC	<u>13</u>	<u>88,411</u>	<u>44,205</u>
Totals:	<u>75</u>	<u>\$583,963</u>	<u>\$291,981</u>

STATE-OPERATED PSYCHIATRIC CENTER CLIENTS BETWEEN THE
AGES OF 21-64 WHO WERE TEMPORARILY RELEASED TO
ACUTE CARE FACILITIES FOR MEDICAL TREATMENT

Common Identification Number A-02-93-01036

Three Additional Examples Demonstrating Improper
Claiming of Federal Financial Participation

Example 1

At Capital District PC, we reviewed the records of a male client in his 50's who was sent to Albany Medical Center nine times between April 1990 and November 1993 for treatment of pneumonia and respiratory problems. Capital District PC did not have an MSU. The client was not discharged prior to being temporarily released for medical treatment to Albany Medical Center and he returned to Capital District PC after his treatment was over. Thus, this client would still be considered a resident of Capital District PC and therefore the related medical services, during our audit period, would not be eligible for FFP. As a result, the Federal Government was overcharged. Below are the acute care claims for which FFP was claimed by NYS.

<u>SERVICE DATES CLAIMED FOR FFP</u>	<u>CLIENT TEMPORARILY RELEASED TO:</u>	<u>FFP PAID</u>
<u>Prior to HCFA Clarification and Our Audit Period</u>		
4/10/90 to 4/13/90	Albany Medical Center	\$ 1,209
<u>Prior to Our Audit Period but After HCFA Guidance</u>		
12/5/90 to 12/14/90	Albany Medical Center	\$ 7,636
12/19/90 to 12/21/90	Albany Medical Center	1,798
12/25/90 to 12/31/90	Albany Medical Center	<u>2,210</u>
	TOTAL	<u>\$11,644</u>
<u>After HCFA Guidance and During Our Audit Period</u>		
6/6/91 to 6/11/91	Albany Medical Center	\$ 2,406
8/19/91 to 8/21/91	Albany Medical Center	2,208
5/18/92 to 5/21/92	Albany Medical Center	2,643
1/14/93 to 1/29/93	Albany Medical Center	8,210
11/19/93 to 11/22/93	Albany Medical Center	<u>8,548</u>
	TOTAL	<u>\$24,015</u>

Example 2

We reviewed the case records of a female client in her 50's who was a resident of Hutchings PC. During the period April 1991 through August 1993, she was transferred to University Hospital-SUNY for treatment of a breast abscess and related complications. Hutchings PC did not have an MSU. The client was not discharged from Hutchings PC prior to being temporarily released for medical treatment and she returned to the PC after her acute care stays were over. This client would still be considered a resident of Hutchings PC and therefore the related services would not be eligible for Federal reimbursement. Below are the hospital claims for which NYS improperly claimed FFP.

<u>SERVICE DATES</u> <u>CLAIMED FOR FFP</u>	<u>CLIENT TEMPORARILY</u> <u>RELEASED TO:</u>	<u>FFP PAID</u>
<u>After HCFA Guidance and During Our Audit Period</u>		
4/23/91 5/6/91	University Hospital-SUNY	\$ 8,150
6/5/91 to 6/8/91	University Hospital-SUNY	1,124
2/26/92 to 3/3/92	University Hospital-SUNY	1,657
3/12/92 to 3/18/92	University Hospital-SUNY	1,583
5/22/93 to 6/1/93	University Hospital-SUNY	4,280
8/18/93 to 8/20/93	University Hospital-SUNY	<u>1,253</u>
	TOTAL	<u>\$18,047</u>

Example 3

At St. Lawrence PC, we reviewed the case records for a male client in his 50's who was admitted to both the MSU and to A Barton Hepburn Hospital for treatment of bronchitis and pneumonia during the period February 1990 through February 1993. The client was not discharged from St. Lawrence PC prior to being temporarily released for medical treatment and returned to the PC after his medical stays. As such, the client would still be considered a resident of St. Lawrence PC and therefore the related medical services would not be eligible for Federal reimbursement. As a result, the Federal Government was overcharged. Below are the hospital and MSU claims for which FFP was claimed by NYS.

<u>SERVICE DATES CLAIMED FOR FFP</u>	<u>CLIENT TEMPORARILY RELEASED TO:</u>	<u>FFP PAID</u>
<u>Prior to HCFA Clarification and Our Audit Period</u>		
2/22/90 to 4/13/90	Medical Surgical Unit	\$15,351
7/4/90 to 7/12/90	A Barton Hepburn Hospital	1,749
7/18/90 to 7/25/90	Medical Surgical Unit	2,281
8/10/90 to 8/13/90	A Barton Hepburn Hospital	1,313
8/16/90 to 8/28/90	A Barton Hepburn Hospital	2,542
10/7/90 to 10/9/90	A Barton Hepburn Hospital	1,442
10/10/90 to 10/31/90	Medical Surgical Unit	<u>6,843</u>
	TOTAL	<u>\$31,521</u>
<u>Prior to Our Audit Period but After HCFA Guidance</u>		
12/17/90 to 12/26/90	Medical Surgical Unit	\$ 2,932
<u>After HCFA Guidance and During Our Audit Period</u>		
5/17/91 to 5/24/91	A Barton Hepburn Hospital	\$ 3,486
5/30/92 to 6/2/92	A Barton Hepburn Hospital	1,902
2/15/93 to 2/20/93	A Barton Hepburn Hospital	<u>1,865</u>
	TOTAL	<u>\$ 7,253</u>

NEW YORK STATE

DEPARTMENT OF SOCIAL SERVICES

40 NORTH PEARL STREET, ALBANY, NEW YORK 12243-0001

MICHAEL J. DOWLING
Commissioner

OFFICE OF SOCIAL SERVICES
NEW YORK REGIONAL OFFICE

NOV 10 1994



APPENDIX D
Page 1 of 4

RECEIVED

November 4, 1994

Mr. John Tournour
Regional Inspector General
for Audit Services
Office of the Inspector General
Office of Audit Services
Region II - Federal Building
26 Federal Plaza
New York, NY 10278

Re: HHS/OIG Draft Report: Review of
Medical Assistance Claims for
State-Operated Psychiatric
Center Clients Between Ages of
21 to 64 who were Temporarily
Released to Acute Care
Facilities for Medical Treatment
A-02-93-01036 (94-022)

Dear Mr. Tournour:

The issues raised in the referenced report are under the jurisdiction of the Office of Mental Health (OMH). We shared the report with that agency and have attached their comments for your consideration. This Department supports OMH's position.

Thank you for the opportunity to comment on the report.

Sincerely,

A handwritten signature in black ink, appearing to read 'Nelson M. Weinstock', written over a horizontal line.

Nelson M. Weinstock

Attachment

**OMH RESPONSE TO DRAFT AUDIT REPORT
REVIEW OF MEDICAL ASSISTANCE CLAIMS
FOR STATE-OPERATED PSYCHIATRIC CENTER CLIENTS
BETWEEN THE AGES OF 21 TO 64 WHO WERE
TEMPORARILY RELEASED TO ACUTE CARE FACILITIES
FOR MEDICAL TREATMENT**

The New York State Office of Mental Health (OMH) strongly disagrees with the findings and recommendations of the Department of Health and Human Services' Office of Inspector General (OIG). It is the contention of OIG that the provisions of Medicaid law and regulations that exclude Federal Financial Participation (FFP) for the costs of providing psychiatric care to persons between the ages of 21 and 64 who are in an Institution for Mental Diseases (IMD) should be extended to prohibit FFP for the costs of providing medical care to psychiatric patients when they are being treated outside of an IMD setting.

For the following reasons, such an application of the so-called "IMD exclusion" is contradicted by the clear wording of Medicaid law, is contrary to the intent of the IMD exclusion, and is not required by the relevant Medicaid regulations. Further, such an interpretation of the exclusion would serve to deny access to all medical services to individuals based solely upon their disability, in contravention of the Equal Protection Clause of the United States Constitution, as well as the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973.

It should first be noted that the OIG report distinguishes between the cost of care provided in the Medical Surgical Units of State-operated psychiatric centers, and the costs of care or services provided by general acute care hospitals. In the former case, the draft report recommends a disallowance of \$291,981; in the latter the report recommends that the State compute the "unallowable" FFP amount and adjust its future claiming in order to permit the Federal government to recoup those payments. Because the OMH Medical Surgical Units were separately certified by the HHS Health Care Financing Administration (HCFA) as general acute care hospitals, the analysis that follows applies equally to both.

I. The OIG Report Directly Contradicts the Clear Wording of the Medicaid Statute

It is perhaps instructive that the OIG draft report does not specifically refer to the Medicaid law to support its findings and recommendations. Rather, the report refers to HHS regulations and guidelines. A regulatory agency, however, may not exceed the scope of its statutory authority in its rulemaking, or issue regulations that are inconsistent with relevant law. Thus, in order to apply regulations, reference must be made to the enabling law.

In the instant case, the basis for the so-called IMD exclusion is found in Section 1905(a) of the Social Security Act (the Act), which provides for FFP for "inpatient hospital services (other than services in an institution for mental diseases)." (emphasis added). Further, a statute must be construed in such a way as to be consistent with plain language (i.e., laws mean what they say). In this case, the plain, unambiguous meaning of the IMD exclusion is that the Federal government will not pay for services that are provided in an institution for mental diseases. The services in question in this case, however, were all furnished outside of an IMD, either by virtue of being located in a separately certified Medical Surgical Unit or in an acute care general hospital. It is apparent, therefore, from the plain language of the law, that these services were not within the ambit of the IMD exclusion and, as a matter of law, should be eligible for FFP.

Such an interpretation is consistent with Congress' intent in creating the IMD exclusion, as well as the longstanding practice of HCFA in implementing it. As the draft report notes, the purpose of the IMD exclusion was to prevent the Federal government from taking over the traditional responsibility of the states to pay for the costs of long-term psychiatric care. The intent clearly was not, however, to relegate individuals with mental illness to second class status by affording general medical coverage under the Act to all but those suffering from a severe psychiatric disability.

HCFA did not apply the exclusion to services provided outside of the IMD until at least 20 years after the law was enacted. The earliest manifestation of this interpretation that OIG can cite was a 1985 letter issued by HCFA's Region V to the State of Illinois. It was not until 1990 that the Administration actually adopted this view. Prior to that time, these claims were paid by HCFA without question. Thus, HCFA's current interpretation represents a departure from its longstanding policy.

Although administrative agencies are given broad discretion to interpret the statutes they administer, this discretion is not unlimited. The agency may not construe a statute to contradict its plain meaning. Further, an agency is given less deference when its interpretation is recent and contravenes longstanding practice and precedent. In this case, both of those circumstances exist.

II. The Regulations Do Not Require Exclusion of These Costs

The draft report cites 42CFR Sections 441.13 and 435.1008 in support of its recommendations. Section 441.13 prohibits FFP for services for any individual who is under age 65 and in an IMD, unless he or she is under age 22 and receiving inpatient psychiatric services. Section 435.1008 contains a similar restriction, but adds that an "individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution."

Thus, OIG infers from these regulations that a person who is neither on conditional release nor convalescent leave should be considered to be a patient in an IMD. That inference, however, is logically fallacious. The regulation resolves the status of only two classes of individuals for whom some ambiguity was thought to exist. In no way does the regulation indicate that all other classes of individuals are "in" an IMD (i.e., those persons who may also be inpatients in a general acute care hospital).

III. HCFA Transmittal No. 51 Incorrectly Interprets the Law and Regulations

As previously stated, both the relevant law and regulations exclude FFP solely for services provided in an IMD, and thus do not pertain to the services in question here. HCFA Transmittal No. 51, issued in November 1990, states that a patient temporarily released from an IMD for the purpose of obtaining medical treatment is not on conditional release, and (therefore) is still considered an IMD patient. As has been demonstrated, such an interpretation runs counter to the clear meaning of both the statute and regulations, as well as HCFA's longstanding practice in implementing the IMD exclusion. Thus, the interpretation should not be afforded the usual deference given to agency interpretations.

In conclusion, OMH disagrees with the findings and recommendations of the OIG draft report and suggests that the report be withdrawn.