Memorandum

Date JUL - 1 2002

From Dennis J. Duquette
Deputy Inspector General
for Audit Services

Subject Review of Medical and Ancillary Claims to Medicaid for Patients Between the Ages of 21 to 64 in New Jersey's State Operated Institutions for Mental Diseases (A-02-01-01008)

To 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 report entitled, "Review of Medical and Ancillary Claims to Medicaid for Patients Between the Ages of 21 to 64 in New Jersey's State Operated Institutions for Mental Diseases." A copy of the report is attached. This report is one of a series of reports involving our multi-State review of patients in institutions for mental diseases (IMD). We suggest you share this report with components of the Centers for Medicare & Medicaid Services (CMS) 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 New Jersey from claiming Federal financial participation (FFP) under the Medicaid program for all medical and ancillary services (except inpatient acute care hospital services) made on behalf of 21 to 64 year old residents of State operated psychiatric hospitals that were IMDs. Examples of the types of claims included in this review would be physician, pharmacy, and laboratory services.

Our review found that improvements were needed in controls established by the State to preclude claiming FFP under the Medicaid program for medical and ancillary services provided to 21 to 64 year old residents of State operated IMDs. Although it was State policy not to claim FFP for 21 to 64 year old residents of IMDs who receive medical services provided outside of the psychiatric hospitals, we found that for the period July 1, 1997 through June 30, 2001, the State improperly claimed at least $331,709 of FFP under the Medicaid program for medical and ancillary services.

We recommended that the State: (1) refund $331,709 to the Federal Government for the improper FFP claimed during the period July 1, 1997 through June 30, 2001; (2) identify and return the improper FFP claimed subsequent to June 30, 2001; and (3) strengthen procedures to ensure that medical and ancillary services provided to 21 to 64 year old residents of IMDs are not claimed for FFP.

New Jersey officials agreed with all of our recommendations and plan to begin efforts to identify and prevent FFP from being claimed for IMD residents between the ages of 21 to 64 who receive medical and ancillary services. In their response, State officials cited the significant analytical work the auditors performed to provide an accurate and reasonable report.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for the Centers for Medicare and Medicaid Audits, at (410) 786-7104 or Timothy J. Horgan, Regional Inspector General for Audit Services, Region II, at (212) 264-4620.

Attachment

Office Of Inspector General
Office Of Audit Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Common Identification Number: A-02-01-01008

JUL - 5 2002

Ms. Kathryn A. Plant
Acting Director
New Jersey Division of Medical Assistance
and Health Services
Post Office Box 712
Trenton, New Jersey 08625

Dear Ms. Plant:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OIG/OAS) final report entitled, "Review of Medical and Ancillary Claims to Medicaid for Patients Between the Ages of 21 to 64 in New Jersey's State Operated Institutions for Mental Diseases." Our audit covered the period July 1, 1997 through June 30, 2001. A copy of this report will be forwarded to the HHS action official noted below for his 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 Public Law 104-231, OIG/OAS reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act 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-02-01-01008 in all correspondence relating to this report.

Sincerely yours,

Timothy J. Horgan
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:

Mr. Peter Reisman
Associate Regional Administrator
Division of Financial Management
Centers for Medicare & Medicaid Services, Region II
Department of Health and Human Services
26 Federal Plaza, Room 38-130
New York, New York 10278

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAL AND ANCILLARY CLAIMS TO MEDICAID FOR PATIENTS BETWEEN THE AGES OF 21 TO 64 IN NEW JERSEY'S STATE OPERATED INSTITUTIONS FOR MENTAL DISEASES

JANET REHNQUIST
INSPECTOR GENERAL

JULY 2002
A-02-01-01008

EXECUTIVE SUMMARY

Background

Federal law and regulations prohibit Federal financial participation (FFP) for all services, including medical and ancillary services, provided to residents of institutions for mental diseases (IMD) who are between the ages of 22 to 64, and in certain instances for those who are 21 years old. The basis for the IMD exclusion of FFP was established in the 1950 amendments to the Social Security Act. Those amendments excluded all Federal assistance payments for patients of IMDs. The creation of the Medicaid program in 1965 permitted FFP for the first time for residents of IMDs in certain situations. Specifically, FFP was allowed for inpatient care provided to IMD residents age 65 and over. The 1972 amendments to the Social Security Act extended FFP for inpatient psychiatric care to individuals under the age of 21. Therefore, since the beginning of the Medicaid program, Federal medical assistance has never been available for residents of IMDs between the ages of 21 to 64 for any type of service.

Objective

The objective of the review was to determine if controls were in place to effectively preclude New Jersey from claiming FFP under the Medicaid program for all medical and ancillary services (except inpatient acute care hospital services) made on behalf of 21 to 64 year old residents of State operated psychiatric hospitals that are IMDs. Examples of the types of claims included in this review would be physician, pharmacy, and laboratory services.

Summary of Findings

Our review showed that improvements were needed in controls established by the State to preclude claiming FFP under the Medicaid program for medical and ancillary services provided to 21 to 64 year old residents of State operated IMDs. Although it was State policy not to claim FFP for these services, we estimate that for the period July 1, 1997 through June 30, 2001, the State improperly claimed at least $331,709 of FFP under the Medicaid program for medical and ancillary services.

The preventative control to preclude claiming FFP was that upon admission to a State operated psychiatric hospital, New Jersey officials would enroll aged 21 to 64 year old patients into their Medicaid program using a unique institutional identification number. When an outside provider submitted a claim using the patient's institutional number, the claims processing system would classify and pay the claim with only State funds and no FFP. However, during our review, we determined that some patients also had county issued Medicaid identification numbers prior to being admitted to the psychiatric hospitals. We noted that the State did not cancel these county numbers, which resulted in the beneficiary having two active Medicaid identification numbers. If outside providers billed using the active county number, the claim was categorized and paid

with FFP. The current system did not have the capability to match these two numbers and correctly classify the payment as State funds only with no FFP.

We discussed this issue with State officials who agreed with our findings. In order to quantify the extent of the improper FFP claimed for the 21 to 64 year old residents of the IMDs, State officials ran a computer application that identified potentially improper FFP claims for both inpatient acute care and medical and ancillary services made for patients whose county numbers rather than institutional numbers were billed by outside providers. This application covered the period July 1, 1997 through June 30, 2001. Based on our review of claims statistically selected from the computer match application, we estimate that the State improperly claimed at least $331,709 of FFP under the Medicaid program for 21 to 64 year old residents of IMDs who received medical and ancillary services.

Conclusions and Recommendations

As a result of the outside providers using county Medicaid identification numbers versus the institutional numbers for 21 to 64 year old residents of the State operated IMDs, we estimate that New Jersey improperly claimed at least $331,709 of FFP for medical and ancillary services.

We recommended that New Jersey:

1. Refund $331,709 to the Federal Government for the improper FFP claimed during the period July 1, 1997 through June 30, 2001.

2. Identify and return the improper FFP claimed subsequent to June 30, 2001.

3. Strengthen procedures to ensure that medical and ancillary services provided to 21 to 64 year old residents of IMDs are not claimed for FFP.

Auditee's Comments

In comments dated May 8, 2002, State officials agreed with all of our recommendations. The State's response is included in its entirety as APPENDIX D to this report.

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INTRODUCTION

Background

State Administration

In New Jersey, the Department of Human Services (NJDHS) is the single State agency responsible for operating the State's title XIX Medicaid program. Within NJDHS, the Division of Medical Assistance and Health Services is responsible for administering the Medicaid program. Also, within NJDHS, the Division of Mental Health Services sets mental health policy and operates six psychiatric hospitals throughout the State. These include: Ancora Psychiatric Hospital, Greystone Park Psychiatric Hospital, Trenton Psychiatric Hospital, Arthur Brisbane Child Treatment Center, Ann Klein Forensic Center, and Senator Garrett W. Hagedorn Gero-Psychiatric Hospital. Another psychiatric hospital, Marlboro, was closed during 1998.

Regulatory Background

Federal law and regulations prohibit Federal financial participation (FFP) for all services, including medical and ancillary services, provided to residents of institutions for mental diseases (IMD) who are between the ages of 22 to 64, and in certain instances for those who are 21 years old. The basis for the IMD exclusion of FFP was established in the 1950 amendments to the Social Security Act (Act). Those amendments excluded all Federal assistance payments for patients of IMDs. The creation of the Medicaid program in 1965 permitted FFP for the first time for residents of IMDs in certain situations. Specifically, FFP was allowed for inpatient care provided to IMD residents age 65 and over. The 1972 amendments to the Act extended FFP for inpatient psychiatric care to individuals under the age of 21. Therefore, since the beginning of the Medicaid program, Federal medical assistance has never been available for residents of IMDs between the ages of 21 to 64 for any type of service.

The Act defines an IMD as a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. State operated mental hospitals with more than 16 beds are always IMDs.

Previous New Jersey IMD Reviews

On June 3, 1994, the Region II Centers for Medicare & Medicaid Services (CMS)[1] issued a report to New Jersey entitled, "Special Review of Patients Aged 22 to 64 in Institutions for Mental Diseases Serviced by the New Jersey Department of Human Services' Division of Medical Assistance and Health Services under Title XIX of the Social Security Act for the

[1] Formerly known as the Health Care Financing Administration (HCFA)

Period January 1, 1990 – June 30, 1991." In its report, Region II CMS determined that New Jersey improperly claimed over $1 million of FFP for IMD patients between the ages of 22 to 64 who were temporarily transferred to acute care facilities for medical treatment and disallowed this amount.

New Jersey appealed CMS's disallowance before the Departmental Appeals Board (DAB). In DAB decision number 1549, issued on November 20,1995, the DAB upheld CMS's findings and indicated that the IMD exclusion of FFP would apply. New Jersey sought judicial relief of DAB decision number 1549. On February 5, 1997, the U.S. District Court for the District of New Jersey upheld the DAB decision. In its decision, the U.S. District Court stated: "The Act exempts payments for care or services for IMD patients between the ages of 22 and 64."

Objective, Scope, and Methodology

The objective of the review was to determine if controls were in place to effectively preclude New Jersey from claiming FFP under the Medicaid program for all medical and ancillary services (except inpatient acute care hospital services) made on behalf of 21 to 64 year old residents of State operated psychiatric hospitals that are IMDs. A review of inpatient acute care hospital claims made on behalf of 21 to 64 year old Medicaid beneficiaries in New Jersey's State operated psychiatric hospitals was included in a separate audit performed under Common Identification Number A-02-00-01027. Examples of the types of claims included in this review would be physician, pharmacy, and laboratory services. Our audit period was July 1, 1997 through June 30, 2001.

Our review was conducted in accordance with generally accepted government auditing standards. Audit field work was performed at the Division of Medical Assistance and Health Services office in Mercerville, New Jersey, and at five State operated psychiatric hospitals: Ancora Psychiatric Hospital, Greystone Park Psychiatric Hospital, Trenton Psychiatric Hospital, Ann Klein Forensic Center, and Senator Garrett W. Hagedorn Gero-Psychiatric Hospital.

During our audit, we did not review the overall internal control structure of the State agency or of the Medicaid program. Rather, our internal control review was limited to obtaining an understanding of the State agency's controls in place to preclude claiming FFP under the Medicaid program for 21 to 64 year old residents of State operated psychiatric hospitals that are IMDs.

In order to accomplish our audit objective we:

- Held discussions with CMS Regional Office program managers and obtained an understanding of CMS's reviews and the guidance provided to New Jersey officials regarding IMD issues. Additionally, we obtained a listing of State owned and private psychiatric hospitals in New Jersey from CMS.

- Held discussions with State agency officials to ascertain State policies and procedures for claiming FFP under the Medicaid program for 21 to 64 year old residents of State operated psychiatric hospitals in New Jersey who receive medical and ancillary services.

- Obtained an understanding of computer edits and controls regarding the claiming of FFP for services to aged 21 to 64 year old residents of State operated psychiatric hospitals who receive medical and ancillary services.

- Obtained a universe of all residents between the ages of 21 to 64 for each State operated psychiatric hospital.

- Requested and received from the State, a computer generated Exception Report that identified $7,454,241 of Medicaid claims for medical and ancillary services made on behalf of 21 to 64 year old residents of State operated psychiatric hospitals whose county numbers rather than institutional numbers were billed by outside providers.

- Did not assess the completeness of the universe files. However, we did perform limited testing to obtain reasonable assurance that the Exception Report provided was reliable. First, we worked with the State in the overall design and specifications of the application. Next, we performed various analytical and verification tests to assure the accuracy and completeness of the Exception Report. Finally, we verified the accuracy of the statistically selected claims to the patients' IMD medical records. We believe that the aforementioned steps provided us with reasonable assurance that the Exception Report was reliable for audit purposes.

- Reviewed and removed $470,852 from the Exception Report for claims that were paid with only State funds (no FFP) and for claims that were after our June 30, 2001 audit period. Upon completing this step, the revised Exception Report contained 92,443 claims totaling $6,983,389 ($3,494,150 FFP).

- Used stratified random sampling techniques to select a sample of 100 claims from a universe of 92,443 FFP claims. APPENDIX A to our report contains the details of our sampling methodology.

- Performed on-site reviews at five State operated psychiatric hospitals. For the 100 claims selected for review, we verified the patients' admission and discharge dates to the IMD records. From the patients' IMD medical records, we verified that an outside provider rendered the medical and ancillary services.

- Used a variables appraisal program to estimate the dollar impact of the improper FFP claims in the total population of 92,443 medical and ancillary claims.

- Discussed the audit results with New Jersey officials.

FINDING AND RECOMMENDATIONS

Preventative Controls Not Always Effective

Our review showed that improvements were needed in controls established by the State to preclude claiming FFP under the Medicaid program for medical and ancillary services provided to 21 to 64 year old residents of State operated IMDs. Although it was State policy not to claim FFP for these services, we estimate that from July 1, 1997 to June 30, 2001, the State improperly claimed at least $331,709 of FFP under the Medicaid program for medical and ancillary services.

Section 1905 (a) of the Act and 42 CFR 441.13 and 42 CFR 435.1008 preclude FFP for any services provided to residents under the age of 65 who are in an IMD except for inpatient psychiatric services provided to individuals under the age of 21, and in some instances for those who are under the age of 22. This exclusion of FFP was designed to assure that States, rather than the Federal Government, continue to have principal responsibility for funding care provided to 21 to 64 year old inpatients in IMDs. Under this broad exclusion, no FFP payments should be made for services provided either in or outside the facility for IMD patients in this age group.

At the entrance conference, we were advised that the State does not claim FFP for residents of IMDs between the ages of 21 to 64 who receive either inpatient acute care or medical and ancillary services. The preventative control to preclude claiming FFP was that upon admission to a State operated psychiatric hospital, New Jersey officials would enroll aged 21 to 64 year old patients into their Medicaid program using a unique institutional identification number. When an outside provider submitted a claim using the patient's institutional number, the claims processing system would classify the claim as federally non-participating. However, during our review, we determined that some patients also had county Medicaid identification numbers prior to their admission to the psychiatric hospitals. We noted that the State did not cancel these county numbers, which resulted in the beneficiary having two active Medicaid identification numbers. If an outside provider billed using an active county number, the claim was categorized and paid with FFP. Our review determined that the current system did not have the capability to match these two numbers and correctly classify the payment using only State funds.

We discussed this issue with State officials who agreed with our finding. In order to quantify the extent of the improper FFP claimed for the 21 to 64 year old residents of the IMDs, State officials ran a computer application (Exception Report) that identified potentially improper FFP claims for both inpatient acute care and medical and ancillary services made for patients whose county numbers rather than institutional numbers were billed by the outside providers. This application covered the period July 1, 1997 through June 30, 2001.

The State's computer application identified $7,454,241 of claims made for medical and ancillary care services for IMD residents between the ages of 21 to 64 whose county numbers rather than institutional numbers were billed by outside providers. We reviewed and removed $470,852

from the Exception Report for claims that were paid with only State funds (no FFP) and for claims that were made after our June 30, 2001 audit period. Upon completing this step, the revised Exception Report contained 92,443 claims totaling $6,983,389 ($3,494,150 FFP). The 92,443 claims were made on behalf of 1,563 beneficiaries. APPENDIX B to our report shows the types of services for the 92,443 claims.

Stratified random sampling techniques were used to select a sample of 100 claims totaling $84,603 (Federal share $42,753) from the universe of 92,443 Medicaid FFP claims. The sampling plan consisted of 3 strata, 33 claims totaling $858 (Federal share $429), 33 claims totaling $8,123 (Federal share $4,061), and 34 claims totaling $75,623 (Federal share $38,263).

The determination as to whether an FFP sample claim was improper and unallowable was based on applicable Federal laws and regulations. Specifically, if the following four characteristics were met, the FFP claim under review was considered improper and unallowable:

(i) The beneficiary was a resident of an IMD on the service date of the FFP claim under review.

(ii) The beneficiary was between the ages of 22 to 64 or aged 21 at admission to the IMD.

(iii) The service date of the FFP claim under review was during the period that the beneficiary was an IMD resident.

(iv) The provider who rendered the service was paid and the State claimed FFP for the service rendered.

To evaluate the 100 sample claims against the 4 criteria above, we performed on-site reviews at 5 State operated psychiatric hospitals where we verified the patients' admission and discharge dates to the IMD records. From the IMD medical records, we verified that an outside provider rendered the medical and ancillary services.

Our review showed that 29 of the 100 FFP claims were improper. Specifically, we found that: 18 of the 33 FFP claims in stratum 1, 6 of the 33 FFP claims in stratum 2, and 5 of the 34 FFP claims in stratum 3 were improperly claimed for FFP.

An example of an unallowable claim in our sample was for a 50 year old Medicaid beneficiary who was admitted to Ancora State Hospital on October 5, 1999 and discharged on March 4, 2000. A State contracted pharmacy billed for drugs prescribed and issued on December 1, 1999. Since the pharmacy billed under the beneficiary's county number rather than the institutional number, Medicaid paid $219.19 and the State improperly claimed $109.60 of FFP for the service.

Extrapolating the results of the statistical sample, we estimate that the State improperly claimed between $331,709 and $835,855 of FFP during our July 1, 1997 through June 30, 2001 audit period. The midpoint of the confidence interval amounted to $583,782 of FFP. The range shown has a 90 percent level of confidence with a sampling precision as a percentage of the midpoint of 43.55 percent. The details of our sample appraisal are shown in APPENDIX C of our report.

Conclusion and Recommendations

As a result of the outside providers using county Medicaid identification numbers versus the institutional numbers for 21 to 64 year old residents of the State operated IMDs, we estimate that New Jersey improperly claimed at least $331,709 of FFP under the Medicaid program for individuals that received medical and ancillary services.

We recommended that New Jersey:

1. Refund $331,709 to the Federal Government for the improper FFP claimed during the period July 1, 1997 through June 30, 2001.

2. Identify and return the improper FFP claimed subsequent to June 30, 2001.

3. Strengthen procedures to ensure that medical and ancillary services provided to 21 to 64 year old residents of IMDs are not claimed for FFP.

Auditee's Comments

In comments dated May 8, 2002, State officials agreed with all of our recommendations. The State's response is included in its entirety as APPENDIX D to this report.

With respect to recommendation number one, New Jersey officials noted that a review of available documentation indicated that this amount was improperly claimed for the audit period. Officials stated that a decreasing adjustment will be included on the Quarterly Statement of Medicaid Expenditures for this amount upon issuance of the final audit report.

For recommendation number two, State officials replied that they will develop an automated reporting process similar to the procedures used by the auditors to identify improper FFP claimed. Additionally, officials stated that decreasing adjustments will be included on the Quarterly Statement of Medicaid Expenditures when this automated process is implemented.

Finally, for recommendation number three, officials stated that they intend to implement improvements in the maintenance of the automated eligibility records to preclude the use of county issued Medicaid identification numbers for reimbursement of services to IMD patients between the ages of 21 to 64. In the interim, officials at the Division of Mental Health Services

will be requested to advise medical providers of the appropriate Medicaid identification number to be used for claiming reimbursement.

SAMPLING METHODOLOGY

Audit Objective:

The objective of our review was to determine if controls were in place to effectively preclude New Jersey from claiming FFP under the Medicaid program for all medical and ancillary services (except inpatient acute care hospital services which were reviewed under a separate audit) provided to 21 to 64 year old residents of six State operated psychiatric hospitals that are IMDs.

Population:

The population was medical and ancillary claims (except inpatient acute care hospital claims) for FFP made on behalf of Medicaid beneficiaries between the ages of 21 to 64 who were residents of State operated psychiatric hospitals (IMDs) during our July 1, 1997 through June 30, 2001 audit period.

Sampling Frame:

The sampling frame was a computer file containing 92,443 detailed FFP claims for 1,563 Medicaid beneficiaries between the ages of 21 to 64 years old who were residents of State operated psychiatric hospitals during our review period. The total Medicaid reimbursement for the 92,443 claims was $6,983,389 of which the Federal share was $3,494,150. The claims were extracted by New Jersey officials from paid claims' files maintained at the Medicaid Management Information System fiscal agent. The sampling frame was the same as the target population.

Sampling Unit:

The sampling unit was an individual Medicaid FFP claim.

Sample Design:

A stratified random sample was used to evaluate the population of Medicaid FFP claims. We separated the sampling frame into 3 strata as follows:

- Stratum 1 --- $0.01 to $99.99 --- 78,341 items,
- Stratum 2 --- $100.00 to $499.99 --- 12,747 items,
- Stratum 3 --- $500.00 to $12,749.99 --- 1,355 items.

Sample Size:

A sample size of 100 claims was selected as follows:

- 33 items from the first stratum,
- 33 items from the second stratum,
- 34 items from the third stratum.

Source of the Random Numbers:

The source of the random numbers was the Office of Audit Services (OAS) Statistical Sampling Software, dated October 1998. We used the Random Number Generator for our stratified sample.

Method for Selecting Sample Items:

The claims in our sampling frame were numbered sequentially. Three sets of random numbers were selected for the 3 strata (33 claims from the first strata, 33 claims from the second strata, and 34 claims from the third strata). The random numbers were correlated to the sequential numbers assigned to each claim in the sampling frame. A list of sample items was then created.

Characteristics to be Measured:

The determination as to whether an FFP claim was improper and unallowable was based on applicable Federal laws and regulations. Specifically, if the following four characteristics were met, the FFP claim under review was considered improper and unallowable:

- The beneficiary was a resident of an IMD on the service date of the FFP claim under review.
- The beneficiary was between the ages of 22 to 64 or aged 21 at admission to the IMD.
- The service date of the FFP claim under review was during the period that the beneficiary was an IMD resident.
- The provider who rendered the service was paid and New Jersey claimed FFP for the service rendered.

Estimation Methodology:

We used the Department of Health and Human Services, Office of Inspector General, OAS' Variables Appraisal Program in RAT-STATS to appraise the sample results. We used the lower limit at the 90 percent confidence level to estimate the cost recoveries associated with the improper claiming of FFP under the Medicaid program for medical and ancillary services for 21 to 64 year old residents of State operated psychiatric hospitals that are IMDs.

TYPES OF MEDICAL AND ANCILLARY SERVICES IDENTIFIED BY OUR AUDIT

Type of Service	Number of Claims	Total Medicaid Payments	Federal Financial Participation
Nursing Home	262	$1,108,570	$554,285
Outpatient Hospital	10,656	1,763,943	882,675
Physician	4,246	103,546	51,867
Chiropractor	29	174	87
Home Health	57	14,383	7,191
Transportation	3,278	150,541	75,271
Vision	303	3,449	1,724
Supplies	97	11,938	5,969
Pharmacy	47,156	2,152,347	1,077,576
Podiatry	163	3,179	1,589
Dental	790	19,950	9,975
Institutional Cross-Overs	647	50,675	25,337
Professional Cross-Overs	889	15,258	7,629
Lab	3,893	38,401	19,203
Prosthetic & Orthotics	48	7,035	3,518
Independent Clinic	19,475	1,507,338	753,923
Psychology	73	2,690	1,345
Optometrists	43	900	450
Mid Level Practitioner	26	352	176
Hearing Aid	8	1,199	600
Capitation	304	27,521	13,760
Total	**92,443**	**$6,983,389**	**$3,494,150**

SAMPLE RESULTS AND PROJECTION

Results of Sample:

The results of our review of the 100 FFP Medicaid claims are as follows:

Sample Results						
Stratum Number	**Claims in Universe**	**FFP Value of Universe**	**Sample Size**	**FFP Value of Sample**	**Improper FFP Claims**	**FFP Value of Improper Claims**
1. $0.01 to $99.99	78,341	$1,008,681	33	$429	18	$176
2. $100.00 to $499.99	12,747	$1,408,934	33	$4,061	6	$418
3. $500.00 to $12,749.99	1,355	$1,076,535	34	$38,263	5	$4,932
Total	92,443	$3,494,150	100	$42,753	29	$5,526

ESTIMATE OF IMPROPERLY CLAIMED FFP
PROJECTION OF SAMPLE RESULTS
(Precision at the 90 Percent Confidence Level)

Point Estimate:	$583,782
Lower Limit:	$331,709
Upper Limit:	$835,855
Precision Percent:	43.55%

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O. Box 712
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Telephone 1-800-356-1561

JAMES E. McGREEVEY
Governor

GWENDOLYN L. HARRIS
Commissioner

KATHRYN A. PLANT
Acting Director

May 8,2002

Timothy J. Horgan
Regional Inspector General
for Audit Services
Office of the Inspector General
Office of Audit Services
'Jacob K. Javits Federal Building
26 Federal Plaza
New York, New York 10278

Re: CIN A-02-01-01008

Dear Mr. Horgan:

This is in response to your correspondence of April 19, 2002 to Deborah C. Bradley concerning the draft audit report titled "Review of Medical and Ancillary Claims to Medicaid for Patients Between the Ages of 21 to 64 in New Jersey's State Operated Institutions for Mental Diseases". Your letter provides an opportunity to comment on the audit report.

The draft report contains one finding and three recommendations. The report indicated that New Jersey improperly claimed at least $331,079 federal financial participation (FFP) for medical and ancillary services for patients of State operated psychiatric hospitals between the ages of 21 to 64. Federal financial participation is not available for these services in accordance with the regulation at 42 CFR 436.1004 (a) (2). This amount reflects the federal share of medical and ancillary claims processed by the New Jersey Medicaid Management Information System (MMIS) using county issued Medicaid identification numbers. The use of these county issued Medicaid identification numbers thwarted the controls in place to preclude claiming of FFP for these expenditures. The existing controls are based on the use of a hospital specific Medicaid identification number.

Based on this finding it appears that improvements are needed in the controls established to implement our policy to not claim FFP for these services. The recommendations contained in the report and our responses are provided below:

1. New Jersey should refund $331,709 to the Federal government for improper FFP claimed during the period July 1, 1997 through June 30, 2001.

A review of the available documentation indicates that this amount was improperly claimed for the period indicated. A decreasing adjustment will be included on the Quarterly Statement of Medicaid Expenditures (form CMS-64) for this amount upon issuance of the final audit report.

2. New Jersey should identify and return the improper FFP claimed subsequent to June 30,2001.

The Division of Medical Assistance and Health Services will develop an automated reporting process similar to the procedures used by the auditors to identify any improperly claimed FFP. Decreasing adjustments will be included on the Quarterly Statement of Medicaid Expenditures (form CMS-64) when this automated reporting 'process is implemented.

3. New Jersey should strengthen procedures to ensure that medical and ancillary services provided to 21 to 64 year old residents of IMD's are not claimed for FFP.

The Division of Medical Assistance and Health Services intends to implement improvements in the maintenance of the automated eligibility records to preclude the use of county issued Medicaid identification numbers for reimbursement of services to IMD patients between the ages of 21-64. In the interim, the Division of Mental Health Services has been requested to advise medical providers of the appropriate Medicaid identification number to be used for claiming reimbursement.

Please be advised that the extensive and professional efforts of the auditors responsible for this report are greatly appreciated. Your staff performed significant analytical work to provide an accurate and reasonable report.

If you have any questions or require additional information please contact me or David Lowenthal at (609) 588-2820.

Sincerely,

John B Judd for KAP

Kathryn A. Plant
Acting Director

KAP:L
c: Gwendolyn L. Harris