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

February 24, 2004

Report Number: A-02-03-01017

Mr. James M. Davy
Acting Commissioner
New Jersey Department of Human Services
Post Office Box 700
Trenton, New Jersey 08625

Dear Mr. Davy:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Medicaid Claims for Patients Between the Ages of 21 to 64 in New Jersey's Private and County-Operated Institutions for Mental Diseases." A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

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

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To facilitate identification, please refer to report number A-02-03-01017 in all correspondence.

Sincerely yours,

Timothy J. Horgan
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Ms. Sue Kelly
Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare & Medicaid Services, Region II
Department of Health and Human Services
26 Federal Plaza, Room 3811
New York. New York 10278

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID CLAIMS FOR PATIENTS BETWEEN THE AGES OF 21 TO 64 IN NEW JERSEY'S PRIVATE AND COUNTY-OPERATED INSTITUTIONS FOR MENTAL DISEASES

FEBRUARY 2004
A-02-03-01017

Office of Inspector General

http://oig.hhs.gov/

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EXECUTIVE SUMMARY

OBJECTIVE

The objective of our review was to determine if controls were in place to preclude New Jersey from claiming Federal financial participation (FFP) under the Medicaid program for all medical and ancillary services (except crossover claims to Medicaid for inpatient psychiatric services that were included in our prior report under A-02-02-01017) made on behalf of 21 to 64 year-old residents of private and county-operated psychiatric hospitals that were institutions for mental diseases (IMD). Examples of the types of claims included in our review were inpatient acute care hospital, physician, pharmacy, and laboratory services. Our audit period was July 1, 1997 through June 30, 2001.

FINDINGS

We found that New Jersey improperly claimed FFP for 68 of 110 claims in our statistical sample. The improper claiming occurred because New Jersey did not have controls in place to prevent FFP from being claimed for medical and ancillary services provided to 21 to 64 year-old residents of private and county-operated psychiatric hospitals. As a result, we estimate that New Jersey improperly claimed $170,770 of FFP during our July 1, 1997 through June 30, 2001 audit period.

RECOMMENDATIONS

We recommend that New Jersey:

- refund $170,770 to the Federal Government;
- establish controls to prevent FFP from being claimed for medical and ancillary services provided to IMD residents between the ages of 21 to 64 in private and county-operated psychiatric hospitals; and
- identify and refund to the Federal Government any improper FFP claimed for periods subsequent to our June 30, 2001 audit cutoff date.

AUDITEE'S COMMENTS

In comment's dated January 22, 2004, New Jersey officials concurred with our findings and recommendations. The state's response is included in its entirety as Appendix C to this report.

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INTRODUCTION

BACKGROUND

Definition of an Institution for Mental Diseases

Section 1905(i) of the Social Security Act and 42 CFR § 435.1009 define 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. Psychiatric hospitals with more than 16 beds (including private and county-operated psychiatric hospitals) are IMDs.

Medicaid Exclusion

Regulations found at 42 CFR § 441.13 and 435.1008 preclude FFP for any services, including medical and ancillary 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 those under the age of 22. The regulations further provide that if a resident is receiving inpatient psychiatric services immediately before reaching age 21, then these services may continue until the earlier of the date the resident no longer requires the services or the date the resident reaches the age of 22.

New Jersey's Medicaid Program

In New Jersey, the Department of Human Services is the single State agency responsible for operating the State's title XIX Medicaid program. Within the Department of Human Services, the Division of Medical Assistance and Health Services is responsible for administering the Medicaid program. Additionally, within the Department of Human Services, the Division of Mental Health Services sets State mental health policy for 11 private and county-operated psychiatric hospitals. These 11, that were included in our audit, were Carrier Clinic Foundation, Essex County Hospital Center, Hampton Behavioral Health Center, St. Barnabas Behavioral Health Care, Camden County Health Services Center, Charter Behavioral Health System, Mt. Carmel, University Behavioral Health Care, Buttonwood Hospital of Burlington County, Meadowview Psychiatric Hospital, and Ramapo Ridge Psychiatric Hospital.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to determine if controls were in place to preclude New Jersey from claiming FFP under the Medicaid program for all medical and ancillary services (except crossover claims to Medicaid for inpatient psychiatric services that were included in our prior report under A-02-02-01017) made on behalf of 21 to 64 year-old residents of private and

county-operated psychiatric hospitals that were IMDs. Examples of the types of claims included in our review were inpatient acute care hospital, physician, pharmacy, and laboratory services.

Scope

Our review period was July 1, 1997 through June 30, 2001. Our audit did not require us to review the overall internal control structure of the State or the Medicaid program. Rather, our review was limited to obtaining an understanding of the State's controls to prevent FFP from being claimed under the Medicaid program for all medical and ancillary services provided to IMD residents between the ages of 21 to 64. Audit fieldwork was performed at the Division of Medical Assistance and Health Services office in Mercerville, New Jersey and at our Trenton field office from March 2003 through October 2003.

Methodology

Our review was conducted in accordance with generally accepted government auditing standards.
To accomplish our audit objectives, we took the following steps:

- We held discussions with officials from the Centers for Medicare & Medicaid Services (CMS) regional office and obtained an understanding of CMS's guidance provided to New Jersey officials regarding IMD issues.

- We obtained a listing of private and county-operated psychiatric hospitals in New Jersey from CMS.

- We held discussions with New Jersey officials to ascertain State policies and procedures for claiming FFP under the Medicaid program for 21 to 64 year-old residents of private and county-operated psychiatric hospitals.

- We obtained an understanding of controls and edits established by New Jersey regarding the claiming of FFP for medical and ancillary services provided to 21 to 64 year-old residents of private and county-operated psychiatric hospitals.

- We obtained listings of all IMD residents between the ages of 21 to 64 from officials at each of the 11 private and county-operated psychiatric hospitals included in our audit for our review period.

- We provided State officials with the listings of IMD residents at the 11 private and county-operated psychiatric hospitals and requested that they match these residents' IMD stays against all paid claims' files at the Medicaid Management Information System (MMIS) fiscal agent for the purpose of identifying a universe of potentially unallowable Medicaid claims.

- We received a computer generated Exception Report from the State that identified 26,104 potentially improper claims totaling $4,622,959.98 for medical and ancillary services made on behalf of 21 to 64 year old residents of private and county-operated psychiatric hospitals.

- We reviewed and removed 12,489 claims totaling $3,491,704.35 from the Exception Report for the following reasons: claims that were paid with State funds (no FFP), zero pay claims, claims for the first day of an acute care hospital admission corresponding with the last day of an IMD stay, claims for the last day of an acute care hospital admission matching the first day of an IMD stay, transportation claims matching either the first or last day of an IMD stay, and inpatient psychiatric crossover and per diem claims that were identified and questioned under report number A-02-02-01017. Upon completing this step, the revised Exception Report contained 13,615 claims totaling $1,131,255.63 ($567,468.71 of FFP).

- We performed limited testing of the Exception Report provided by the State to obtain reasonable assurance that it was reliable for audit purposes. Specifically, we worked with State officials on the overall design and specifications of the computer programming application that generated the Exception Report. We performed various analytical and verification tests to assure the accuracy and completeness of the Exception Report. Finally, we verified the accuracy of 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.

- We used stratified random sampling techniques to select a sample of 110 claims. Appendix A contains the details of our sample methodology and design.

- We issued letters, as needed, to the medical providers and IMDs requesting documentation to support the claims under review.

- We reviewed documentation obtained from the medical records of both the medical providers and the IMDs for the sample claims under review to determine if they were allowable.

- We used a variable appraisal program to estimate the dollar impact of the improper FFP claims in the total population of 13,615 medical and ancillary claims.

- Finally, we discussed the audit results with State officials.

FINDINGS AND RECOMMENDATIONS

We found that New Jersey improperly claimed FFP for 68 of 110 claims in our sample. The improper claiming occurred because New Jersey did not have controls in place to prevent FFP from being claimed for medical and ancillary services provided to 21 to 64 year-old residents of private and county-operated psychiatric hospitals. As a result, we estimate that New Jersey improperly claimed $170,770 of FFP during our July 1, 1997 through June 30, 2001 audit period.

FEDERAL REGULATIONS AND GUIDANCE

The Social Security Act, implementing Federal regulations, and CMS guidance have made it clear that FFP under the Medicaid program is not available for any services, including medical and ancillary services, provided to IMD residents between the ages of 22 to 64 and in some instances those aged 21.

Legislative and Regulatory Background

Section 1905(a) of the Social Security Act defines the term "medical assistance." Section 1905(a)(14) states that medical assistance includes inpatient hospital services and nursing facility services for individuals 65 years of age or over in an IMD. Section 1905(a)(16) states that effective January 1, 1973, medical assistance includes inpatient psychiatric hospital services for individuals under the age of 21.

Regulations implementing the IMD exclusion in section 1905(a) of the Social Security Act are found at 42 CFR § 441.13 and 435.1008. Specifically, 42 CFR § 441.13, entitled "Prohibitions on FFP: Institutionalized Individuals," states that, "(a) FFP is not available in expenditures for . . . Any individual who is under the 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."

The regulations at 42 CFR § 435.1008 state that, "(a) FFP is not available in expenditures for services provided to . . . Individuals under age 65 who are patients in an institution for mental diseases unless under age 22 and are receiving inpatient psychiatric services under 440.160 of this subchapter."

Centers for Medicare & Medicaid Services Guidance

CMS provided guidance to States regarding the IMD exclusion of FFP under the Medicaid program. Specifically, CMS issued Transmittal Number 65 of the State Medicaid Manual in March 1994 and Transmittal Number 69 of the State Medicaid Manual in May 1996. Section 4390 of these manuals is entitled "Institutions for Mental Diseases." Section 4390 A.2. of the manuals, 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.

CMS guidance to States also consistently stated that FFP was not permitted for IMD residents who were temporarily released to acute care hospitals for medical treatment. Specifically, section 4390.1 of CMS Transmittal Number 65 and 69, entitled "Periods of Absence From IMDs," states in part that, "If a patient is temporarily transferred from an IMD for the purpose of obtaining medical treatment . . . the patient is still considered an IMD patient."

REVIEW OF SAMPLE CLAIMS

We used stratified random sampling techniques to select a sample of 110 claims from the universe of 13,615 claims totaling $1,131,255.63 ($567,468.71 of FFP**)**. The sample of 110 claims consisted of 3 strata. The first stratum had 30 claims and the second and third stratums had 40 claims each. The first stratum totaled $855.38 ($427.69 of FFP), the second stratum totaled $6,582.22 ($3,291.11 of FFP), and the third stratum totaled $127,380.00 ($64,362.88 of FFP).

The determination as to whether an FFP claim was improper and unallowable was based on applicable Federal laws and regulations. Specifically, if the following three criteria 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 provider who rendered the service(s) was paid and New Jersey claimed FFP for the service(s) rendered.

To evaluate the 110 sample claims against the 3 criteria above, we sent a letter to each of the medical and IMD providers requesting documentation to support the sample claims under review. We reviewed the documentation obtained from both the medical and IMD providers to determine if the sample claims were allowable.

We determined that 68 of the 110 sample claims totaling $50,830.64 ($25,516.08 of FFP) were improperly claimed for FFP. The 68 claims include: 22 pharmacy, 16 long term care reserved

bed day claims, 8 clinic, 7 inpatient acute care hospital, 6 physician, 4 outpatient hospital, 4 monthly capitation, and 1 laboratory claim.

The following are three examples of the improper FFP claims identified by our audit:

- A 37 year-old Medicaid beneficiary was admitted to Buttonwood Hospital of Burlington County (psychiatric hospital) on December 13, 1998. The patient was temporarily released to Lourdes Hospital (acute care hospital) for medical treatment on December 18, 1998, and was discharged back to Buttonwood on December 28, 1998. The beneficiary remained at Buttonwood until January 4, 1999. Lourdes Hospital received Medicaid reimbursement totaling $3,823.43 for the 10-day inpatient acute care stay and New Jersey improperly claimed $1,911.71 of FFP for the claim.

- A 39 year-old Medicaid beneficiary was admitted to St. Barnabas Behavioral Health Care (psychiatric hospital) on March 24, 1999, and was discharged on March 29, 1999. The Crystal Lake Health Care and Rehabilitation (nursing home) claimed and received Medicaid reimbursement for reserve bed days during this same period. The nursing home received Medicaid reimbursement totaling $509.31 and New Jersey improperly claimed $254.66 of FFP for the nursing home's reserved bed day claim.

- A 60 year-old Medicaid beneficiary was a resident of St. Barnabas Behavioral Health Care (psychiatric hospital) during the period November 27, 1999 through December 8, 1999. On December 2, 1999, the beneficiary received a neuro-diagnostic lab test from Kimbal Medical Center (medical provider). For this outpatient claim, Medicaid paid Kimbal Medical Center $121.62 and New Jersey improperly claimed $60.81 of FFP for the claim.

CONTROLS WERE NOT ESTABLISHED

We determined that controls were not in place to preclude the State from claiming FFP under the Medicaid program for 21 to 64 year-old residents of private and county-operated IMDs. New Jersey officials stated that outside medical providers should not be separately claiming Medicaid reimbursement for medical services provided to IMD residents between the ages of 21 to 64. However, we were advised by State officials that they have no way of knowing that a Medicaid patient is in a private or county-operated IMD or when a Medicaid claim is submitted for payment from an outside medical provider for that patient.

ESTIMATION OF THE IMPROPER CLAIMS

We found that 68 of the 110 sample claims were improperly claimed for FFP. Extrapolating the results of the statistical sample, we estimate that New Jersey improperly claimed between $170,770 and $265,985 of FFP during our July 1, 1997 through June 30, 2001 audit period. The midpoint of the confidence interval amounts to $218,378 of FFP. The range shown has a 90-percent level of confidence with a sampling precision as a percentage of the midpoint of 21.80 percent. As a result, during our July 1, 1997 through June 30, 2001 audit period, we estimate that New Jersey improperly claimed $170,770 of FFP under the Medicaid program. The details of our sample appraisal are shown in Appendix B.

RECOMMENDATIONS

We recommend that New Jersey:

- refund $170,770 to the Federal Government;

- establish controls to prevent FFP from being claimed for medical and ancillary services provided to IMD residents between the ages of 21 to 64 in private and county-operated psychiatric hospitals; and

- identify and refund to the Federal Government any improper FFP claimed for periods subsequent to our June 30, 2001 audit cutoff date.

AUDITEE'S COMMENTS

In comments dated January 22, 2004, New Jersey officials concurred with our findings and recommendations. The state's response is included in its entirety as Appendix C to this report.

With respect to recommendation number one, New Jersey officials stated that a decreasing adjustment for the improperly claimed FFP of $170,770 will be included on the Quarterly Statement of Medicaid Expenditures upon issuance of the final audit report.

For recommendation number two, officials stated that they will establish controls to prevent FFP from being claimed for medical and ancillary services provided to IMD residents between the ages of 21 to 64 in private and county-operated psychiatric hospitals.

Finally, for recommendation number three, New Jersey officials replied that they will identify and refund to the Federal Government any improper FFP claimed for periods subsequent to our June 30, 2001 audit cutoff date.

SAMPLING METHODOLOGY

Audit Objective

The objective of our review was to determine if controls were in place to preclude New Jersey from claiming FFP under the Medicaid program for all medical and ancillary services provided to 21 to 64 year-old residents of 11 private and county-operated psychiatric hospitals that are IMDs.

Population

The population consists of medical and ancillary claims for FFP made on behalf of Medicaid beneficiaries between the ages of 21 to 64 who were residents of private and county-operated psychiatric hospitals during our July 1, 1997 through June 30, 2001 audit period.

Sampling Frame

The sampling frame was a computer file containing 13,615 detailed FFP claims for 1,805 Medicaid beneficiaries between the ages of 21 to 64 years old who were residents of private and county-operated psychiatric hospitals during our review period. The total Medicaid reimbursement for the 13,615 claims was $1,131,255.63 of which the Federal share was $567,468.71. The sampling frame was the same as the target population. The Medicaid claims were extracted by New Jersey officials from the paid claims' files maintained at the MMIS fiscal agent.

Sampling Unit

The sampling unit was an individual Medicaid FFP medical and ancillary claim.

Sample Design

A stratified random sample was used to evaluate the population of Medicaid FFP claims. The first stratum consisted of 11,314 claims totaling $262,781.69 ($131,390.84 of FFP) with a value less than $100.00. The second stratum consisted of 2,191 claims totaling $477,620.59 ($238,810.30 of FFP) with a value ranging from $100.00 to $899.99. The third stratum consisted of 110 claims totaling $390,853.35 ($197,267.57 of FFP) with a value of $900.00 or greater.

Sample Size

A sample size of 110 claims was selected; 30 claims from stratum 1 and 40 claims each from stratums 2 and 3.

Source of the Random Numbers

The source of the random numbers was the Office of Audit Services Statistical Sampling software dated September 2001. 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 30, 40, and 40 random numbers were selected for each of the 3 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

Applicable Federal laws and regulations were used to determine whether an FFP claim was improper and unallowable. Specifically, if the following three criteria 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 provider who rendered the service(s) was paid and New Jersey claimed FFP for the service(s) rendered.

Estimation Methodology

We used the Department of Health and Human Services, Office of Inspector General, Office of Audit Services variable appraisal program in RAT-STATS to appraise the sample results. We used the lower limit at the 90-percent confidence level to estimate the overpayment associated with the improper claiming of FFP under the Medicaid program for all medical and ancillary services for 21 to 64 year-old residents of private and county-operated psychiatric hospitals that are IMDs.

APPENDIX B

SAMPLE RESULTS AND PROJECTION

Results of Sample

The results of our review of the 110 FFP Medicaid claims were as follows:

Stratum Number	Claims in Universe	FFP Value of Universe	Sample Size	FFP Value of Sample	Improper FFP Claims	FFP Value of Improper Claims
1. < $100.00	11,314	$131,390.84	30	$427.69	19	$226.62
2. $100.00 to $899.99	2,191	$238,810.30	40	3,291.11	22	1,217.95
3. = or > $900.00	110	$197,267.57	40	64,362.88	27	24,071.51
TOTAL	**13,615**	**$567,468.71**	**110**	**$68,081.68**	**68**	**$25,516.08**

PROJECTION OF SAMPLE RESULTS
Precision at the 90-Percent Confidence Level

Point Estimate:	$218,378
Lower Limit:	$170,770
Upper Limit:	$265,985
Precision Percent:	21.80%

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
PO BOX 700
TRENTON NJ 08625-0700

JAMES E. MCGREEVEY
Governor

GWENDOLYN L. HARRIS
Commissioner

January 22, 2004

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

Re: CIN A-02-03-01017

Dear Mr. Horgan:

I am writing in response to your correspondence of December 19, 2003, concerning the draft audit report titled "Review of Medicaid Claims for Patients Between the Ages of 21 to 64 in New Jersey's Private and County-Operated Institutions for Mental Diseases." Your letter provides an opportunity to comment on the audit report, which covered the audit period July 1, 1997, through June 30, 2001.

The draft report contains one (1) finding and three (3) recommendations. Our responses to the 3 recommendations are as follows:

1. A decreasing adjustment for the improperly claimed FFP of $170,770 will be included on the Quarterly Statement of Medicaid Expenditures (from CMS – 64) upon issuance of the final audit report.

2. The Division of Medical Assistance and Health Services (DMAHS) will establish controls to prevent FFP from being claimed for medical and ancillary services provided to IMD residents between the ages of 21 to 64 in private and county-operated psychiatric hospitals.

3. DMAHS will identify and refund to the Federal government any improper FFP claimed for periods subsequent to our June 30, 2001, audit cutoff date.

If you have questions or require additional information, please contact David Lowenthal, Chief, Bureau of Financial Reporting, DMAHS, at 609-588-2820.

Sincerely,

Gwendolyn L. Harris
Commissioner

GLH:2:11
c: David Lowenthal

ACKNOWLEDGMENTS

This report was prepared under the direction of Timothy J. Horgan, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

John Berbach, *Audit Manager*
Terence Sharkey, *Senior Auditor*
Romulo Capistrano, *Auditor*
Lloyd Canfield, *Auditor*
Benjamin Wilson, *Auditor*
John Schwartz, *Auditor*

Technical Assistance

Brenda Ryan, *Statistical Specialist*

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