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

August 11, 2008

Report Number: A-02-06-01020

Jennifer Velez, Esq.
Commissioner
New Jersey Department of Human Services
222 South Warren Street
P.O. Box 700
Trenton, New Jersey 08625-0700

Dear Ms. Velez:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Inpatient Hospital Claims Billed as Family Planning Under New Jersey's Medicaid Program." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this 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.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact John Berbach, Audit Manager, at (518) 437-9390, extension 228, or through e-mail at John.Berbach@oig.hhs.gov. Please refer to report number A-02-06-01020 in all correspondence

Sincerely,

James P. Edert

James P. Edert
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner, Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF INPATIENT HOSPITAL CLAIMS BILLED AS FAMILY PLANNING UNDER NEW JERSEY'S MEDICAID PROGRAM

Daniel R. Levinson
Inspector General

August 2008
A-02-06-01020

Office of Inspector General

http://oig.hhs.gov

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF INPATIENT HOSPITAL CLAIMS BILLED AS FAMILY PLANNING UNDER NEW JERSEY'S MEDICAID PROGRAM

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Federal share of the Medicaid program is referred to as Federal financial participation (FFP). The Federal share of a State's Medicaid program is determined by the Federal medical assistance percentage (FMAP). During our audit period (February 1, 2001, through January 31, 2005), the FMAP in New Jersey was 50 or 52.95 percent. Section 1903(a)(5) of the Social Security Act and 42 CFR §§ 433.10 and 433.15 provide enhanced 90-percent FFP for family planning services. Pursuant to section 4270 of the CMS "State Medicaid Manual," family planning services prevent or delay pregnancy or otherwise control family size. According to the manual, 90-percent Federal funding is available for the cost of sterilization if a properly completed sterilization consent form is submitted in accordance with Federal regulations.

CMS "Financial Management Review Guide Number 20" states that inpatient hospital costs must be allocated when multiple procedures are performed and at least one of those procedures is related to family planning. To comply with these requirements, New Jersey developed a blended rate methodology to determine the Federal share of inpatient hospital family planning for claims containing multiple procedures performed during the same inpatient hospital stay.

OBJECTIVE

Our objective was to determine whether inpatient Medicaid claims, for which New Jersey received Federal reimbursement at the blended rate or the enhanced 90-percent rate, qualified as family planning services.

SUMMARY OF FINDINGS

The State improperly received Federal Medicaid reimbursement for 111 of the 161 claims in our statistical sample. The remaining 50 claims were properly reimbursed. Specifically, the State properly received Federal reimbursement for all 47 inpatient hospital claims in our sample paid at the blended rate and 3 claims in our sample paid at the enhanced 90-percent rate. However, the State improperly received Federal reimbursement for 111 claims in our sample paid at the enhanced 90-percent rate. As a result, the State improperly received $162,548 in Federal Medicaid funds.

The overpayment occurred because: (1) the State's Medicaid Management Information System (MMIS) did not have edits or controls to identify all claims for which a family planning service

was performed with a non-family planning procedure during a single inpatient hospital stay, and (2) some hospitals did not properly complete sterilization consent forms.

RECOMMENDATIONS

We recommend that the State:

- refund $162,548 to the Federal Government;
- develop edits and controls in its MMIS to identify all claims for which a family planning service was performed with a non-family planning procedure during a single inpatient hospital stay;
- reinforce guidance to hospitals that a properly completed sterilization consent form must be prepared and submitted in accordance with Federal requirements for all Medicaid sterilizations; and
- determine the amount of Federal Medicaid funds improperly reimbursed at the 90-percent rate for inpatient hospital services subsequent to our audit period and refund that amount to the Federal Government.

STATE COMMENTS

In its comments on our draft report, the State generally agreed with our first two recommendations and fully agreed with our remaining two recommendations. The State's comments are included in their entirety as Appendix B.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

New Jersey's Medicaid Program

In New Jersey, the Department of Human Services operates the Medicaid program. Within the Department of Human Services, the Division of Medical Assistance and Health Services administers the program. The Department of Human Services uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims.

The Federal share of a State's Medicaid program is determined by the Federal medical assistance percentage (FMAP). During our audit period (February 1, 2001, through January 31, 2005), the FMAP in New Jersey was 50 or 52.95 percent.[1] To comply with CMS requirements regarding family planning services provided along with non-family planning services, the State developed a blended rate methodology to determine the Federal share of inpatient hospital claims containing multiple procedures (e.g., delivery and sterilization) performed during the same inpatient hospital stay.[2] The methodology multiplies the regular FMAP rate by two-thirds of the Medicaid payment amount, and the enhanced 90-percent rate by one-third of the Medicaid payment amount. Using this methodology, the State's blended rates were 63.73 or 65.67-percent during our audit period.

To identify procedures related to inpatient hospital family planning, the State relies on family planning related diagnosis-related group (DRG) codes. When providers submit inpatient hospital claims to the MMIS for payment as family planning, the claims are paid at either the blended rate or the enhanced 90-percent rate. The MMIS also utilizes a variety of indicators on the Medicaid claim form to identify family planning services.

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[1]The FMAP was 50 percent from February 1, 2001, through March 31, 2003; 52.95 percent from April 1, 2003, through June 30, 2004; and 50 percent from July 1, 2004, through January 31, 2005.

[2]CMS "Financial Management Review Guide Number 20" states that inpatient hospital costs must be allocated when multiple procedures are performed and at least one of those procedures is related to family planning. CMS determined the State's methodology to be reasonable.

Medicaid Coverage of Family Planning Services

Section 1905(a)(4)(C) of the Act requires States to furnish family planning services and supplies to individuals of childbearing age who are eligible under the State plan and who desire such services and supplies. Section 1902(a)(10)(A) of the Act specifies that family planning services be available to "categorically needy" Medicaid recipients, while section 1902(a)(10)(C) specifies that the services may be provided to "medically needy" Medicaid recipients at the State's option. Section 1903(a)(5) of the Act and both 42 CFR §§ 433.10 and 433.15 authorize 90-percent Federal funding for family planning services.

According to section 4270 of the CMS "State Medicaid Manual," family planning services prevent or delay pregnancy, or otherwise control family size. The manual indicates that 90-percent Federal funding is available for the cost of a sterilization if a properly completed sterilization consent form is submitted in accordance with Federal regulations (42 CFR § 441, Subpart F). These regulations state that Federal Medicaid reimbursement is not available for any sterilization or hysterectomy unless the Medicaid agency, before making payment, obtains documentation showing that Federal requirements were met (42 CFR § 441.256(a)). Pursuant to 42 CFR § 441.253, Federal reimbursement is available if the Medicaid beneficiary has consented to a sterilization at least 30 days, but not more than 180 days, before the procedure, except in the case of premature delivery or emergency abdominal surgery.[3] Further, pursuant to 42 CFR § 441.258(b)(4), the sterilization consent form must be signed and dated by the physician who performed the sterilization procedure.

CMS "Financial Management Review Guide Number 20," states that only items and procedures clearly provided or performed for family planning purposes may be matched at the 90-percent rate. The guide further states that inpatient hospital costs must be allocated when multiple procedures are performed and at least one of those procedures is related to family planning.[4]

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether inpatient Medicaid claims, for which New Jersey received Federal reimbursement at the blended rate or the enhanced 90-percent rate, qualified as family planning services.

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[3]In the case of premature delivery or emergency abdominal surgery performed within 30 days of consent, the physician must certify that the sterilization was performed less than 30 days, but not less than 72 hours after informed consent was obtained because of premature delivery or emergency abdominal surgery and (i) in the case of premature delivery, must state the expected date of delivery; or (ii) in the case of abdominal surgery, must describe the emergency.

[4]The guide, issued January 30, 1991, via Medicaid State Operations Letter 91-9, included a 1980 memorandum regarding CMS policy for allocating inpatient hospital costs when multiple procedures involving a family planning procedure are performed. The memorandum states that when multiple procedures are performed during a single inpatient stay as a single claim, the claim for Federal Medicaid reimbursement must distinguish between costs attributable to family planning and costs reimbursed at the regular FMAP.

Scope

Our audit period covered February 1, 2001, through January 31, 2005. We did not review the overall internal control structure of the State or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective. We did not review the claims in our sample for compliance with Medicaid requirements other than those related to whether the claims qualified for blended or enhanced 90-percent funding as family planning services.

We performed fieldwork at the Division of Medical Assistance and Health Services in Mercerville, New Jersey, and at hospitals throughout the State.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance, as well as the New Jersey Medicaid State plan;
- held discussions with CMS officials and acquired an understanding of CMS's guidance to State officials on Medicaid family planning claims;
- held discussions with State officials to ascertain State policies and procedures for claiming Medicaid reimbursement for family planning services;
- extracted all 565 Medicaid claims, totaling $2,075,822 ($1,336,872 Federal share), from the State's MMIS reimbursed at the blended rate for the period February 1, 2001, through January 31, 2005;
- extracted all 114 Medicaid claims, totaling $633,751 ($570,375 Federal share), from the State's MMIS reimbursed at the enhanced 90-percent rate for the period February 1, 2001, through January 31, 2005;
- used stratified random sampling to select 161 family planning claims from the population of Medicaid claims;
- obtained and reviewed medical records for each sample claim to determine whether the inpatient services were properly reimbursed at either the blended rate or the enhanced 90-percent rate; and
- calculated the unallowable Federal funding, if any, paid for each sample claim.[5]

Appendix A contains the details of our sample design and methodology.

[5]Claims improperly paid at the enhanced Federal rate of 90-percent were eligible for reimbursement only at the enhanced blended rate or the applicable FMAP.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

The State improperly received Federal Medicaid reimbursement for 111 of the 161 claims in our sample. The remaining 50 claims were properly reimbursed. Specifically, the State properly received Federal reimbursement for all 47 inpatient hospital claims in our sample paid at the blended rate and 3 claims in our sample paid at the enhanced 90-percent rate. However, the State improperly received Federal reimbursement for 111 claims in our sample paid at the enhanced 90-percent rate.

Of the 111 claims improperly paid at the enhanced 90-percent rate: 103 claims should have been reimbursed at the blended rate because the services were provided along with non-family planning services, 1 claim should have been reimbursed at the regular FMAP because the service was not related to family planning, and 7 claims involving a cesarean delivery and sterilization, which were billed to Medicaid using a cesarean delivery diagnosis related group (DRG), should have been reimbursed at the regular FMAP because a properly completed sterilization consent form was not provided with each claim. As a result, the State improperly received $162,548 in Federal Medicaid funds.

The overpayment occurred because: (1) the State's MMIS did not have edits or controls to identify all claims for which a family planning service was performed with a non-family planning procedure during a single inpatient hospital stay, and (2) some hospitals did not properly complete sterilization consent forms.

SERVICES PROPERLY REIMBURSED AT THE BLENDED RATE

To comply with CMS requirements regarding family planning services provided along with non-family planning services, the State developed a blended rate methodology to determine the Federal share of inpatient hospital claims containing multiple procedures (e.g., delivery and sterilization) performed during the same inpatient stay. The methodology multiplies the regular FMAP rate (50 or 52.95-percent) by two-thirds of the Medicaid payment amount, and the enhanced 90-percent rate by one-third of the Medicaid amount. Using this methodology, the State's blended rates were 63.73 or 65.67-percent.

All of the 47 claims in our sample for which the State received Medicaid reimbursement at the blended rate were properly reimbursed. Each claim was submitted as a single inpatient hospital claim for a vaginal delivery and sterilization. Therefore, the State properly claimed these services using the approved blended rate methodology.

SERVICES IMPROPERLY REIMBURSED AT THE 90-PERCENT RATE

CMS "Financial Management Guide Number 20" states that only items and procedures clearly provided or performed for family planning purposes may be matched at the 90-percent rate. Section 4270 of the CMS "State Medicaid Manual" states that 90-percent funding is available for the cost of a sterilization if a properly completed sterilization consent form is submitted in accordance with federal regulations (42 CFR § 441, Subpart F). Further, pursuant to 42 CFR § 441.258(b)(4), the sterilization consent form must be signed and dated by the physician who performed the sterilization procedure.

For 111 of the 114 inpatient hospital claims in our sample paid at the 90-percent rate, the State improperly received Federal Medicaid reimbursement. The remaining three claims paid at the 90-percent rate were properly reimbursed.

Of the 111 claims improperly paid at the enhanced 90-percent rate: 103 claims should have been reimbursed at the blended rate because the services were provided along with non-family planning services, 1 claim should have been reimbursed at the regular FMAP because the service was not related to family planning, and 7 claims involving a cesarean delivery and sterilization, which were billed to Medicaid using a cesarean delivery DRG, should have been reimbursed at the regular FMAP because a properly completed sterilization consent form was not provided with each claim.[6] As a result, the State improperly received $162,548 in Federal Medicaid funds.

CAUSES OF THE OVERPAYMENT

As discussed below, we identified two causes for the overpayment.

Insufficient State Controls

Overpayments occurred because the State's MMIS did not have edit routines to identify all claims that should have been paid at the blended rate. The State's MMIS edit failed to identify all instances for which a family planning service and a non-family planning procedure was performed during an inpatient hospital stay and submitted as a single inpatient claim. Specifically, claims containing a cesarean section with sterilization, and claims containing other operating room procedures with sterilization, were not included in the State's MMIS edit. State agency officials advised that this edit only considered vaginal deliveries and sterilizations. Without an edit identifying the cesarean section with sterilization, and claims containing additional operating room procedures with sterilization, the MMIS was unable to properly allocate the costs.

[6]Of the seven claims for which a properly completed consent form was not provided, three consent forms were signed by the patient less than the 72 hours before sterilization, three forms were signed by a provider representative instead of the physician, and, for one claim, no form could be located by the hospital or the State.

Improperly Submitted Sterilization Consent Forms

Some hospitals did not comply with Federal requirements for submitting sterilization consent forms for seven claims in our sample. These seven claims involved a cesarean delivery and sterilization performed during the same inpatient hospital stay. For three claims, consent forms were signed by patients less than the 72 hours before sterilization. In three other cases, a provider representative signed the consent forms instead of the physician. Finally, for one claim, the hospital and the State could not locate a sterilization consent form.

CALCULATION OF THE UNALLOWABLE AMOUNT

Of the 161 claims in our sample, 111 were improperly reimbursed. All 111 claims were from the third stratum of our stratified sample for which we conducted a 100-percent review and calculated the exact amount of error for each unallowable claim. We reduced 103 claims from the 90-percent enhanced rate to the lower blended rate and 8 claims from 90-percent to the appropriate FMAP rate, resulting in a total unallowable amount of $162,548.

RECOMMENDATIONS

We recommend that the State:

- refund $162,548 to the Federal Government;
- develop edits and controls in its MMIS to identify all claims for which a family planning service was performed with a non-family planning procedure during a single inpatient hospital stay;
- reinforce guidance to hospitals that a properly completed sterilization consent form must be prepared and submitted in accordance with Federal requirements for all Medicaid sterilizations; and
- determine the amount of Federal Medicaid funds improperly reimbursed at the 90-percent rate for inpatient hospital services subsequent to our audit period and refund that amount to the Federal Government.

STATE COMMENTS

In its comments on our draft report, the State generally agreed with our first two recommendations and fully agreed with our remaining two recommendations. The State's comments are included in their entirety as Appendix B.

APPENDIXES

SAMPLE DESIGN AND METHODOLOGY

AUDIT OBJECTIVE

Our objective was to determine whether New Jersey's inpatient hospital family planning claims were properly reimbursed at either the enhanced blended rate or the enhanced 90-percent rate.

POPULATION

The population was Medicaid claims billed by New Jersey at the 90-percent enhanced rate, or an enhanced blended rate, for inpatient hospital services during our February 1, 2001, through January 31, 2005 audit period.

SAMPLING FRAME

The sampling frame consisted of two computer files:

The first file contained 565 Medicaid claims for inpatient hospital services billed at an enhanced blended rate. The total Medicaid reimbursement for the 565 claims was $2,075,822 of which the Federal share was $1,336,872.

The second file contained 114 Medicaid claims for inpatient hospital services billed as family planning at the enhanced 90-percent rate. The total Medicaid reimbursement for the 114 claims was $633,751 of which the Federal share was $570,375.

The Medicaid claims were extracted from New Jersey's Medicaid payment files provided by the staff of the State's Medicaid Management Information System fiscal agent.

SAMPLING UNIT

The sampling unit was an individual Medicaid claim for an inpatient hospital service billed as family planning at the enhanced Federal funding rate of 90-percent, or the enhanced blended rate.

SAMPLE DESIGN

We used a stratified random sample to evaluate the population of Medicaid inpatient hospital paid claims. To accomplish this, we separated the sampling frame into three strata as follows:

- Stratum 1: Claims with a Federal share payment amount from $0.01 to $4,500.00 that were reimbursed at the enhanced blended rate for inpatient hospital services - 558 claims.

- Stratum 2: Claims with a Federal share payment amount greater than $4,500.00 that were reimbursed at the enhanced blended rate for inpatient hospital services - 7 claims.

- Stratum 3: Claims with a Federal share payment amount reimbursed at the enhanced 90-percent rate for inpatient hospital services - 114 claims.

SAMPLE SIZE

We selected a sample size of 161 claims:

- Stratum 1, a random sample of 40 claims,
- Stratum 2, all seven claims, and
- Stratum 3, all 114 claims.

SOURCE OF THE RANDOM NUMBERS

The source of the random numbers was the OIG-OAS statistical software, RAT-STATS. We used the Random Number Generator for our sample.

METHOD FOR SELECTING SAMPLE ITEMS

We sequentially numbered the 558 claims in stratum 1. We selected 40 random numbers for stratum 1 and selected the corresponding frame items. We also selected each of the claims from strata two and three. We then created a list of 161 sample items.

CHARACTERISTICS TO BE MEASURED

We determined whether a claim was improper and unallowable based on applicable Federal laws and regulations, Federal guidance, a review of all information contained on the claim form, and a review of documentation from the provider that submitted the claim. If a claim did not meet the criteria for reimbursement at the 90-percent Federal funding rate, or the enhanced blended rate, we considered the claim unallowable.

Specifically, if a sample claim was determined to be in error, but allowable for Federal Medicaid funding, we disallowed the portion of the claim between 90-percent, or the enhanced blended rate, and New Jersey's regular Federal medical assistance percentage for non-family planning services. If we determined that a sample claim was in error and did not qualify for reimbursement at the 90-percent rate, but did qualify for the enhanced blended rate, we disallowed the portion of the claim between the 90-percent rate and the enhanced blended rate. If a sample claim was determined to be in error, and unallowable for Federal funding, we disallowed the entire Federal funding amount of the claim.

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July 8, 2008

James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services
Region II
Jacob K. Javits Federal Building – Room 3900
New York, NY 10278

Report Number A-02-06-01020

Dear Mr. Edert:

This is in response to your correspondence of May 15, 2008 concerning the Department of Health and Human Services, Office of the Inspector General's (OIG) draft audit report entitled "Review of Inpatient Hospital Claims Billed as Family Planning Under New Jersey's Medicaid Program." Your letter provides an opportunity to comment on the draft audit report.

The draft audit report contains one finding and four recommendations. The report makes the finding that New Jersey improperly received Federal Medicaid reimbursement for 111 of the 161 claims in the statistical sample. The remaining 50 claims were properly reimbursed. Specifically, New Jersey properly received Federal reimbursement for all 47 inpatient hospital claims in the sample paid at the blended rate and 3 claims in the sample paid at the enhanced 90-percent rate. However, the State improperly received Federal reimbursement for 111 claims in our sample paid at the enhanced 90-percent rate. As a result, New Jersey improperly received $162,548 in Federal Medicaid funds.

In summary, the recommendations contained in the report and our responses are provided below:

1. New Jersey should refund $162,548 to the Federal Government.

Staff of the Division of Medical Assistance and Health Services is reviewing the details of the specific claims identified by the auditor and will take appropriate action based on the results of this review. Any claims not appropriately classified as family planning will be adjusted on the Quarterly Statement of Medicaid Expenditures (Form CMS-64).

2. New Jersey should develop edits and controls in its MMIS to identify all claims for which a family planning service was performed with a non-family planning procedure during a single inpatient hospital stay.

New Jersey agrees to review the possibility of developing edits to suspend an inpatient claim where there is both a family planning service and non-family planning procedure billed for a single inpatient hospital stay. These claims would be reviewed by clinical staff; clinical staff would determine the appropriate rate at which the claim should be billed for federal reimbursement.

3. New Jersey should reinforce guidance to hospitals that a properly completed sterilization consent form must be prepared and submitted in accordance with Federal requirements for all Medicaid sterilizations.

New Jersey will issue a Newsletter to all hospitals which render family planning services and/or perform family planning procedures reminding these hospitals to complete all appropriate consent documentation. Similarly, a Newsletter will be issued to other providers of family planning services reminding them of the importance of being compliant with appropriate consent documentation.

4. New Jersey should determine the amount of Federal Medicaid funds improperly reimbursed at the 90-percent rate for inpatient hospital services subsequent to our audit period and refund that amount to the Federal Government.

New Jersey will review inpatient hospital claims billed as a family planning service subsequent to the audit period (January 31, 2005) and refund the Federal Government in accordance with the appropriate matching rate.

The opportunity to review and comment on this draft report is greatly appreciated. If you have any questions or require additional information, please contact me or David Lowenthal at 609-588-7933.

Sincerely,

John R. Guhl
Director

JRG: C
c: Jennifer Velez
David Lowenthal
Kaye Morrow