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

October 20, 2004

Report Number: A-02-03-01028

Mr. James M. Davy
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 Made by New Jersey for Residents of Institutions for Mental Diseases Who Were Under the Age of 22." 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-02-03-01028 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 MADE BY NEW JERSEY FOR RESIDENTS OF INSTITUTIONS FOR MENTAL DISEASES WHO WERE UNDER THE AGE OF 22

OCTOBER 2004
A-02-03-01028

Office of Inspector General

http://oig.hhs.gov/

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Section 1905(i) of the Social Security Act (the Act) and 42 CFR § 435.1009 define an institution for mental diseases (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 (including State, private, and county-operated psychiatric hospitals) with more than 16 beds are IMDs.

Regulations at 42 CFR §§ 435.1008 and 441.13 preclude Federal Medicaid funding for any services 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, under the age of 22.[1]

OBJECTIVE

Our objective was to determine if controls were in place to preclude New Jersey from claiming Federal Medicaid funds for all medical services, except inpatient psychiatric services, provided to IMD residents under the age of 21 and, in certain instances, under the age of 22. This report refers to these individuals as "the excluded age group." Examples of the types of medical claims included in our review were inpatient acute care hospital, physician, clinic, pharmacy, laboratory, and dental services.

SUMMARY OF FINDINGS

New Jersey's controls did not prevent improper Federal claims for medical services provided to IMD residents in the excluded age group:

- New Jersey did not have controls to prevent such claims for residents of private and county-operated psychiatric hospitals.

- New Jersey's controls were not always effective in precluding such claims for residents of State-operated psychiatric hospitals.

Of the 100 claims in our statistically valid sample, 81 did not meet Federal requirements. As a result, we estimate that New Jersey improperly claimed $848,374 in Federal Medicaid funds during our July 1, 1997 through June 30, 2001 audit period.

[1] If the individual is receiving inpatient psychiatric services immediately before he or she reaches age 21, services may continue until the earlier of (1) the date the individual no longer requires the services or (2) the date the individual reaches the age of 22.

RECOMMENDATIONS

We recommend that New Jersey:

- refund $848,374 to the Federal Government
- implement controls to prevent Federal claims for medical services provided to under-22-year-old IMD residents of private and county-operated psychiatric hospitals
- strengthen its procedures to prevent Federal claims for medical services provided to under-22-year-old IMD residents of State-operated psychiatric hospitals
- identify and refund to the Federal Government any improper funds claimed for periods after our audit period.

AUDITEE'S COMMENTS

In comments dated September 28, 2004, New Jersey Officials concurred with our findings and recommendations. The State's response is included in its entirety as Appendix D to this report.

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INTRODUCTION

BACKGROUND

Definition of an Institution for Mental Diseases

Section 1905(i) of the 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 (including State, private, and county-operated psychiatric hospitals) with more than 16 beds are IMDs.

Medicaid Exclusion

Regulations at 42 CFR §§ 435.1008 and 441.13 preclude Federal Medicaid funding for any services 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, under the age of 22.

New Jersey's Medicaid Program

In New Jersey, the Department of Human Services is the 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 administers the Medicaid program. Additionally, within the Department of Human Services, the Division of Mental Health Services sets State mental health policy for State, private, and county-operated psychiatric hospitals.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine if controls were in place to preclude New Jersey from claiming Federal Medicaid funds for all medical services, except inpatient psychiatric services, provided to IMD residents under the age of 21 and, in certain instances, under the age of 22. Examples of the types of medical claims included in our review were inpatient acute care hospital, physician, clinic, pharmacy, laboratory, and dental services.

Scope

Our audit period covered July 1, 1997 through June 30, 2001. We did not review the overall internal control structure of the State or the Medicaid program. Our internal control review was limited to obtaining an understanding of the State's controls to prevent Federal Medicaid funds from being claimed for all medical services, except inpatient psychiatric services, provided to IMD residents in the excluded age group. We performed fieldwork at the New Jersey Division of Medical Assistance and Health Services office in Mercerville, NJ.

Methodology

To accomplish our audit objective, we took the following steps:

- We held discussions with State agency officials to ascertain the policies and procedures for claiming Federal Medicaid funding for individuals in the excluded age group who were residents of State, private, or county-operated psychiatric hospitals.

- We obtained an understanding of New Jersey's computer controls and edits for claiming Federal Medicaid funding for medical services, other than inpatient psychiatric services, provided to IMD residents in the excluded age group.

- We obtained a listing of State, private, and county-operated psychiatric hospitals. Appendix A contains a listing of the IMDs included in our audit.

- We requested and received from the State a computer-generated exception report that identified $14,507,885 ($7,397,756 Federal share) of potentially unallowable Federal Medicaid claims made on behalf of individuals in the excluded age group who were residents of State, private, or county-operated IMDs.

- We removed the following from the exception report: claims paid with State funds only, zero-pay claims, claims for which the first day of an acute care hospital admission corresponded 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, claims made on behalf of beneficiaries who were older than 21 at the time of admission to the IMDs, and claims made by school health providers that were reviewed in other audits. The revised exception report contained 60,838 claims totaling $4,474,180 ($2,247,409 Federal share).

- We performed limited testing of the exception report to obtain reasonable assurance that it was reliable. We consulted with State officials on the overall design and specifications of the computer programming application that generated the report. We also performed analytical and verification tests to ensure the report's accuracy and completeness. Finally, we verified the accuracy of statistically selected claims against the patients' medical records. We were satisfied that the exception report was reliable.

- We used stratified random sampling techniques to select a statistically valid sample of 100 claims from a universe of 60,838 Federal Medicaid claims. Appendix B contains the details of our sampling methodology and design.

- We issued letters to medical providers and IMDs requesting documentation to support the sampled claims, and we reviewed the documentation to determine whether the claims were allowable.

- We used a variable appraisal program to estimate the dollar impact of the improper Federal Medicaid claims on the total population of 60,838 claims.

- We discussed the audit results with State officials.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

New Jersey's controls did not prevent improper Federal claims for medical services provided to IMD residents in the excluded age group:

- New Jersey did not have controls to prevent such claims for residents of private and county-operated psychiatric hospitals.

- New Jersey's controls were not always effective in precluding such claims for residents of State-operated psychiatric hospitals.

Of the 100 claims in our statistically valid sample, 81 did not meet Federal requirements. The improper claims included inpatient acute care hospital, physician, clinic, pharmacy, laboratory, and dental services provided to IMD residents in the excluded age group. As a result, we estimate that New Jersey improperly claimed $848,374 in Federal Medicaid funds during our July 1, 1997 through June 30, 2001 audit period.

FEDERAL REGULATIONS AND GUIDANCE

Legislative and Regulatory Background

Section 1905(a) of the Act defines the term "medical assistance." Medical assistance includes inpatient hospital services and nursing facility services for IMD residents 65 years of age or over but excludes care or services for IMD residents who are under 65, except "inpatient psychiatric hospital services for individuals under the age of 21."

Federal regulations prohibit payment of Federal Medicaid funds for "any individual who is under age 65 and is in an institution for mental diseases, except an individual who is under age 22 and receiving inpatient psychiatric services under subpart D of this part." (See 42 CFR § 441.13.)

Centers for Medicare & Medicaid Services Guidance

The Centers for Medicare & Medicaid Services (CMS) guidance to States specifies that Federal Medicaid funds are only available for inpatient psychiatric services for individuals under the age of 21 and, in certain instances, under the age of 22. 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 the State Medicaid Manual, entitled "Institutions for Mental Diseases," provides in subsection A.2 ("IMD Exclusion"):

> The IMD exclusion is in 1905(a) of the Act in paragraph (B) following the list of Medicaid services. This paragraph states that FFP [Federal financial participation] 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.

CMS guidance to States has also established that Federal Medicaid funding is not permitted for IMD residents who are temporarily released to acute care hospitals for medical treatment. Section 4390.1 of the State Medicaid Manual, 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."

In summary, according to the Act, the implementing Federal regulations, and CMS's guidance, Federal Medicaid funding may not be claimed for any medical services, except inpatient psychiatric services, for IMD residents in the excluded age group.

CONTROLS TO PREVENT IMPROPER CLAIMS

No Controls for Residents of Private and County-Operated Psychiatric Hospitals

New Jersey had no controls to prevent claiming Federal Medicaid funds for medical services provided to IMD residents of private and county-operated psychiatric hospitals who were in the excluded age group. New Jersey officials stated that outside medical providers should not claim Medicaid reimbursement for medical services provided to IMD residents within this age group. However, the officials stated that they had no way of knowing whether a Medicaid beneficiary was an inpatient at a private or county-operated IMD or when an outside provider submitted a Medicaid claim for an IMD patient.

Ineffective Control for Residents of State-Operated Psychiatric Hospitals

New Jersey had a control to prevent claiming Federal Medicaid funding for medical services provided to residents of State-operated psychiatric hospitals who were in the excluded age group but the control could be circumvented. Upon a patient's admission to a State-operated psychiatric hospital, New Jersey officials would enroll the patient in

the Medicaid program using a unique institutional identification number. When an outside medical provider submitted a claim using the patient's institutional number, the claims processing system would classify the claim as federally nonparticipating (no Federal funding claimed).

However, some patients also had a county Medicaid identification number before their admission to State-operated psychiatric hospitals. Because the State did not cancel these county numbers, some beneficiaries had two active Medicaid identification numbers. If the outside medical provider billed using the county number, the claim was submitted for Federal reimbursement. New Jersey's system did not have the capability to match these two numbers and correctly classify the claim as State-reimbursable only.

CLAIMS REVIEW

We used stratified random sampling techniques to select a sample of 100 claims from the universe of 60,838 claims totaling $4,474,180 ($2,247,409 Federal share). The sample of 100 claims consisted of 3 strata. Additional data is provided in Appendix B.

The determination as to whether a claim was improper and unallowable was based on Federal law and regulation. Specifically, if the following three criteria were met, the claim under review was considered improper and unallowable:

- The service date of the claim was during a period in which the beneficiary was a resident of an IMD.

- The beneficiary was under the age of 21 at the time of admission to the IMD, and the service date of the claim was before the beneficiary reached the age of 22.

- The medical provider who rendered the service was paid and the State claimed Federal Medicaid funding for the service.

To evaluate the 100 sample claims against the 3 criteria above, we issued letters requesting supporting documentation from the medical providers who submitted the 100 claims. We also requested documentation from the IMDs where the beneficiaries resided. We reviewed the submitted documentation to determine if the sample claims were allowable.

Of the 100 claims in our statistical sample, 81 met the criteria above and were improper. The remaining 19 were found allowable because the service was rendered on the date of admission or the date of discharge at the IMD and we did not consider these dates as being a resident of the IMD.

An example of an unallowable claim is as follows:

- An 18 year-old Medicaid beneficiary was admitted to Trenton Psychiatric Hospital (Trenton), an IMD, on April 28, 1998. On July 18, 1998, the patient was temporarily released to Capital Health System (Capital), an inpatient acute care hospital, for chest pains. On July 21, 1998, the beneficiary was discharged back to Trenton where he continued to reside until August 11, 1998. For this inpatient hospital claim, Medicaid paid Capital $3,058.44 and the State improperly claimed the Federal share amount of $1,529.22.

Extrapolating the results of the statistical sample, we estimated that New Jersey improperly claimed $848,374 in Federal Medicaid funding during the audit period. The details of our sample projection are shown in Appendix C.

RECOMMENDATIONS

We recommend that New Jersey:

- refund $848,374 to the Federal Government
- implement controls to prevent Federal claims for medical services provided to under-22-year-old IMD residents of private and county-operated psychiatric hospitals
- strengthen its procedures to prevent Federal claims for medical services provided to under-22-year-old IMD residents of State-operated psychiatric hospitals
- identify and refund to the Federal Government any improper funds claimed for periods after our audit period.

AUDITEE'S COMMENTS

In comments dated September 28, 2004, New Jersey officials concurred with our findings and 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 stated that a decreasing adjustment for the improperly claimed Federal Medicaid funds of $848,374 will be included on the Quarterly Statement of Medicaid Expenditures upon issuance of the final audit report.

For recommendations two and three, officials stated that their current payment system cannot determine if a Medicaid recipient is in an IMD when receiving services outside the IMD and billed for by another provider. Officials stated that they will put together a work group to evaluate this problem to make the necessary system changes. Until a system is implemented to prevent the inappropriate Federal claims, officials stated that they will perform a quarterly review of recipients in IMDs to determine if there are

improper claims and where appropriate, exclude these amounts from the Quarterly Statement of Medicaid Expenditures.

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

APPENDICES

APPENDIX A

IMDs INCLUDED IN OUR AUDIT

	Provider Type
1. Ancora Psychiatric Hospital	State
2. Arthur Brisbane Psychiatric Hospital	State
3. Forensic Psychiatric Hospital	State
4. Greystone Park Psychiatric Hospital	State
5. Marlboro Psychiatric Hospital	State
6. Senator Hagedorn Psychiatric Hospital	State
7. Trenton Psychiatric Hospital	State
8. Buttonwood Psychiatric Hospital	County
9. Camden County Mental Health Care	County
10. Essex County Hospital Center	County
11. Hudson County Meadowview Psychiatric Hospital	County
12. Carrier Clinic Foundation	Private
13. Charter Behavioral Health System (Summit Hospital)	Private
14. Delaware Valley Foundation	Private
15. Devereux Children's Hospital	Private
16. Hampton Hospital	Private
17. Mapleton Psychiatric Hospital	Private
18. National Hospital for Kids/Crisis	Private
19. Poplar Springs Hospital	Private
20. Ramapo Ridge Psychiatric Hospital	Private
21. St. Barnabas Behavioral Health Center (Shoreline)	Private
22. University Behavioral Health Care	Private
23. Western Psychiatric Institute/Clinic	Private

SAMPLING METHODOLOGY

AUDIT OBJECTIVE

Our objective was to determine if controls were in place to preclude New Jersey from claiming Federal Medicaid funds for all medical services, except inpatient psychiatric services, provided to IMD residents under the age of 21 and, in certain instances, under the age of 22.

POPULATION

The population consisted of all medical claims, except inpatient psychiatric claims, for Federal funding made on behalf of Medicaid beneficiaries in the excluded age group who were residents of State, private, or county-operated psychiatric hospitals (the three types of IMDs included in our audit) during our July 1, 1997 through June 30, 2001 audit period.

SAMPLING FRAME

The sampling frame was a computer file containing 60,838 detailed Federal claims for 2,134 Medicaid beneficiaries in the excluded age group who were residents of State, private, or county-operated IMDs during our audit period. The total Medicaid reimbursement for the 60,838 claims was $4,474,180, of which the Federal share was $2,247,409. The Medicaid claims were extracted by New Jersey officials from the paid claims files 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 Federal Medicaid medical claim.

SAMPLE DESIGN

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

- Stratum 1: less than $50.00—50,822 claims totaling $654,360 ($331,103 Federal share)

- Stratum 2: $50.00 to $2,699.99—9,675 claims totaling $1,608,994 ($810,893 Federal share)

- Stratum 3: $2,700.00 and greater—341 claims totaling $2,210,826 ($1,105,413

Federal share)

SAMPLE SIZE

A sample 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 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 33, 33, and 34 random numbers were selected for the 3 strata. The random numbers were correlated to the sequential numbers assigned to each claim in the sampling frame. A list of 100 sample items was created.

CHARACTERISTICS TO BE MEASURED

Applicable Federal laws and regulations were used to determine whether a Federal Medicaid claim was improper. Specifically, if the following three criteria were met, the claim was considered improper:

- The service date of the claim was during a period in which the beneficiary was an IMD resident.
- The beneficiary was under the age of 21 at the time of admission to the IMD, and the service date of the claim was before the beneficiary reached the age of 22.
- The medical provider who rendered the service was paid and the State claimed Federal Medicaid funding for the service 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 Federal Medicaid funds for all medical services, except inpatient psychiatric services, for IMD residents in the excluded age group.

APPENDIX C

SAMPLE RESULTS AND PROJECTION

RESULTS OF SAMPLE

The results of our review of the 100 Federal Medicaid claims were as follows:

Stratum	Claims in Universe	Federal Value of Universe	Sample Size	Federal Value of Sample	Improper Federal Claims	Federal Value of Improper Claims
1. <$50.00	50,822	$ 331,103	33	$ 173.27	29	$ 141.03
2. $50.00 to $2,699.99	9,675	810,893	33	2,195.60	24	1,110.26
3. =Or>$2,700.00	341	1,105,413	34	111,175.03	28	50,286.45
Total	**60,838**	**$2,247,409**	**100**	**$113,543.90**	**81**	**$ 51,537.73**

PROJECTION OF SAMPLE RESULTS

Precision at the 90-Percent Confidence Level

Point Estimate:	$1,047,045
Lower Limit:	$ 848,374
Upper Limit:	$1,245,715
Precision Percent:	18.97 %

State of New Jersey
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JAMES E. MCGREEVEY
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JAMES M. DAVY
Commissioner

ANN CLEMENCY KOHLER
Director

September 28, 2004

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

Re: CIN A-02-03-01028

Dear Mr. Horgan:

I am writing in response to your correspondence of August 17, 2004 concerning the draft audit report entitled "Review of Medicaid Claims Made by New Jersey for Residents of Institutions for Mental Diseases Who Were Under the Age of 22." 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 four (4) recommendations. Our responses to the 4 recommendations are as follows:

- Refund $848,374 to the Federal Government

  A decreasing adjustment for the improperly claimed FFP of $848,374 will be included on the Quarterly Statement of Medicaid Expenditures (form CMS-64) upon issuance of the final audit report.

- Implement controls to prevent Federal claims for medical services provided to under 22 year old IMD residents of private and county-operated psychiatric hospitals

- Strengthen its procedures to prevent Federal claims for medical services provided to under 22 year old IMD residents of State-operated psychiatric hospitals

  The current Unisys claims payment system can not determine if a Medicaid recipient is in an Institution for Mental Diseases (IMD) when receiving services outside the IMD and billed for by another provider.

The Division will put together a work group from our systems, eligibility and fiscal offices to evaluate this problem to make the necessary system changes.

Until such time that a prospective system can be implemented to prevent inappropriate Federal claims, the Division will do a quarterly review of recipients in IMD's to see if there are claims being paid incorrectly and where appropriate, exclude these amounts from the quarterly CMS-64.

- Identify and refund to the Federal Government any improper funds claimed for periods after our audit period

As outlined in the previous response, DMAHS will identify and refund to the federal government any improper FFP claimed for periods subsequent to the June 30, 2001 audit cutoff date.

If you have questions or require additional information, please contact Michael Keevey in the Office of Reimbursement, DMAHS, at (609) 588-2668.

Sincerely,

Ann Clemency Kohler
Director

ACK:Cb
c: David Lowenthal