New Jersey State Legislature
Office of Legislative Services
Office of the State Auditor

Department of Human Services
Division of Mental Health Services
Community Services Grants-in-Aid

July 1, 2005 to December 15, 2006

Richard L. Fair
State Auditor
The Honorable Jon S. Corzine  
Governor of New Jersey

The Honorable Richard J. Codey  
President of the Senate

The Honorable Joseph J. Roberts, Jr.  
Speaker of the General Assembly

Mr. Albert Porroni  
Executive Director  
Office of Legislative Services

Enclosed is our report on the audit of the Department of Human Services, Division of Mental Health Services, Community Services, Grant-In-Aid for the period of July 1, 2005 to December 15, 2006. If you would like a personal briefing, please call me at (609) 292-3700.

Richard L. Fair  
State Auditor  
April 19, 2007
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Department of Human Services
Division of Mental Health Services
Community Services Grants-in-Aid

Scope

We have completed an audit of the Department of Human Services (DHS), Division of Mental Health Services (DMHS), Community Services, Grants-in-Aid for the period July 1, 2005 to December 15, 2006. The audit included expenditure activities accounted for in the state’s General Fund. We did not review the Community Mental Health Center-University of Medicine and Dentistry of New Jersey line item appropriations or state aid funding. The prime responsibility of the division is to develop a comprehensive range of accessible, coordinated mental health services for all citizens of the state, with emphasis on the development of local mental health programs, as well as to provide leadership and management for the state psychiatric hospitals. Total expenditures of these grants-in-aids programs during fiscal year 2006 were $237.3 million. The major component of expenditures was community care.

Objectives

The objectives of our audit were to determine whether expenditure transactions were related to the division’s programs, were reasonable, and were recorded properly in the accounting systems. We also tested for resolution of significant conditions noted in our prior audit dated October 29, 2001.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section 1, Paragraph 6 of the State Constitution and Title 52 of the New Jersey Statutes.

Methodology

Our audit was conducted in accordance with Government Auditing Standards, issued by the Comptroller General of the United States. In preparation for our testing, we studied legislation, administrative code, circular letters promulgated by the Office of Management and Budget, and policies of the division. Provisions that we considered significant were documented and
compliance with those requirements was verified by interview, observation, and through our samples of expenditure transactions. We also read the budget message, reviewed financial trends, and interviewed division personnel to obtain an understanding of the programs and internal controls.

A nonstatistical sampling approach was used. Our samples of expenditure transactions were designed to provide conclusions about the validity of transactions as well as internal control and compliance attributes. Transactions were judgmentally selected for testing.

To ascertain the status of findings included in our prior report, we identified corrective action taken by the division and walked through the system to determine if the corrective action was effective.

Conclusions

We found that the expenditure transactions included in our testing were related to the division’s programs, were reasonable, and were recorded properly in the accounting systems. In making this determination, we noted internal control weaknesses meriting management’s attention. We also found that the division has resolved the significant issues noted in our prior report.
Medicaid Billing

The Division of Mental Health Services (DMHS) contracts with more than 120 community-based organizations to provide mental health services. The division is responsible for establishing a system which effectively provides for reasonable, equitable, and efficient reimbursement for services delivered under such contracts. Contracts include various mental health programs administered by community care providers; several are eligible for Medicaid reimbursement. We reviewed Medicaid billings for two of these programs.

Programs of Assertive Community Treatment (PACT) is a multi-disciplinary service delivery team which makes certain that comprehensive rehabilitation, treatment, and support services are integrated into a treatment plan for individuals with the most serious and persistent mental illnesses. The PACT team provides a minimum of two hours of face-to-face contact per month with or on behalf of a beneficiary in order to submit a claim for reimbursement from Medicaid. The fiscal year 2006 PACT rate was $1,323.66 per month.

The Residential Program provides housing such as group homes, supervised apartments, and family care homes where individuals can both live and receive psychiatric care and treatment. The Residential Program Medicaid rates vary depending on the care level the residence provides. We only reviewed residences with the highest level of care (A+). The fiscal year 2006 billing rates were $172.29 per day per client in these facilities.

We selected five contract providers and reviewed their Medicaid billing documentation to determine if revenue was being maximized. The sampled providers all had PACT programs and four provided A+ residential services. We tested
PACT team client populations in September 2005 to determine if all eligible clients were billed to Medicaid. In cases where we identified an unbilled client, we expanded our test to determine the extent of that client's unbilled activity. Our review disclosed that all five of the sampled PACT program providers had unbilled activity (13 percent error rate). We tested the sampled A+ residential programs based on the number of beds licensed by the department's Bureau of Licensing. We obtained client occupancy data and verified Medicaid eligibility and billings. We found that three of the four sampled providers had additional clients that could have been billed to Medicaid. Since Medicaid has a timely filing deadline of one year, only a portion of the identified amount is still collectible. However, the department can seek a waiver of this filing deadline from Medicaid which if granted would allow the providers to bill for costs beyond the one year deadline. For the five sampled PACT programs we identified $220,000 that may be back billed and $322,000 that is uncollectible unless the one year filing deadline is waived. For the A+ residential program we discovered $51,000 that should be back billed and $20,000 that is no longer collectible unless the deadline is waived. Given that there are other Medicaid eligible programs that were not part of our review and that our review was based on a sampled month, there may be additional unbilled activity that could result in Medicaid reimbursements.

It is the responsibility of the contracted provider to verify client eligibility and to bill Medicaid for the services provided. Providers verify eligibility using several methods. The New Jersey Medicaid Management Information System (NJMMIS) maintained by Unisys currently provides beneficiary eligibility information through its Recipient Eligibility Verification System (REVS) and web-based Medicaid Eligibility Verification System (eMEVS). In addition, eligibility can be verified through a private contracted Medicaid Eligibility Verification System (MEVS). REVS is
a "voice" system that requires the use of a touch tone phone. Providers enter a client recipient identification number (if available) or social security number and date of birth. Providers can also log onto eMEVS via the NJMMIS website and access beneficiary eligibility data. We noted instances where REVS & eMEVS eligibility queries resulted in inconsistent data as to the Medicaid eligibility of the client thus resulting in unbilled services. In addition, some providers were unaware of the existence of eMEVS. We also noted instances of provider error resulting in unbilled activity.

The division relies on providers to properly bill Medicaid to maximize the recovery of revenue. Currently, the division does not routinely review the billing process of contracted providers. The division has program analysts that perform field reviews of the contracted programs; however, these reviews are program oriented and are not designed to assess eligibility issues.

**Recommendation**

We recommend that DMHS take an active role in the review of the provider Medicaid billings to maximize revenue collections. Communications should be drafted to inform providers of all eligibility verification systems available. The department should apply for the Medicaid waiver. The division should verify that the providers have back billed all eligible services.

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**Contract Closeout**

The Division of Mental Health Services contracts with provider agencies to render services to the division's clients living in the community. Contracts have a term of one year and are typically renewed for subsequent years.

The Department of Human Services Policy
Circular P7.01 Contract Closeout requires the provider agency to submit all financial, audit, performance, and other reports required by the terms and conditions of the contracts within 120 days after contract expiration or termination. The division is responsible to reconcile the amount of funding paid to the provider against the Final Report of Expenditures, to calculate any over/underpayment, and to make financial settlement. Final contract closeout should occur as promptly as feasible after contract expiration or termination according to the policy circular.

We reviewed the division’s Closeout Review Schedule for fiscal years 2002 to 2005 as of December 2006 to verify timely final contract closeout. The division has completed the final closeout for 127 of the 128 fiscal year 2002 contracts resulting in recoveries of $252,000. For fiscal year 2003, 142 or 80 percent of the 177 contracts have been closed resulting in recoveries of $306,000. For fiscal years 2004 and 2005, only seven of 186 and two of the 177 contracts, respectively, have been closed out. This resulted from the division’s allocation of resources. A risk based approach could reduce the volume of work and identify additional recoveries. The division does perform a preliminary contract closeout which identifies a major portion of the dollars to be recovered.

**Recommendation**

Final contract closeouts need to be performed timely. A risk based approach could be utilized to select providers for final closeout.
April 10, 2007

Richard L. Fair
State Auditor
Office of Legislative Services
PO Box 067
Trenton, New Jersey 08625-0067

Dear Mr. Fair:

Enclosed is our formal response to the OLS Audit Report of the Division of Mental Health Services' Community Services Grants-in-Aid for the period July 1, 2005 to December 15, 2006. We would like to extend our sincere thanks to your office and the audit team members who performed this review and for bringing the two observations to our attention. We have already taken significant steps to improve our controls in the areas noted and expect to make even greater progress in the coming months.

The enclosed comments follow the sequence of observations as they appear in the Report, and we would greatly appreciate your incorporating these comments into the final report that is scheduled for release shortly.

Again, I wish to extend our sincere thanks to your Office and staff for the information and recommendations contained in the Audit Report.

Sincerely,

[Signature]

Jennifer Velez
Acting Commissioner

JV:kb
Enclosure
c: Thomas R. Meseroll
    Kevin Martone
    William Cutti
bc:  Diane Zompa
Response to “Medicaid Billing” Observations / Recommendations (Pages 3 – 5)

The division agrees with the observations and recommendations in the audit report with respect to “Medicaid Billing”. While the observation that “Currently, the division does not routinely review the billing process of contracted providers.” is accurate, the division did have a limited number of “Agreed-Upon Procedures Reviews” conducted at provider agencies on the Integrated Case Management Services program in Fiscal Year’s 2003 and 2004, which included a review of billing procedures. Moreover, as a result of these reviews, certain billing issues came to light and to address these concerns the division conducted provider agency training sessions in each of the three regions, in order to improve billing and related offsetting revenues. In addition, the division had also undertaken a number of activities to increase overall Medicaid revenues collected by millions of dollars, by moving to establish certain services and costs such as Adult Residential Rehabilitation, PACT and administrative costs as Medicaid eligible thus drawing Medicaid FFP revenues instead of having these costs continue to be funded 100% by state funds.

Regarding the unbilled Medicaid activity cited in this Report, the division has already taken the following actions;

1) provider agencies have been contacted and directed to bill as soon as possible for any identified unbilled activity going back one year. As of this writing, $188,450 has been billed for PACT programs and $33,757 for residential programs.

2) with respect to billing activity that was beyond the one-year timely filing deadline, the division has already requested a waiver. However, this request has been denied by the Division of Medical Assistance and Health Services (DMAHS) as it is their policy, which has been supported by a recent court opinion, not to grant such a waiver if the delay is due to actions or omissions on the part of the provider agency.

3) regarding the issue of different eligibility verification systems and the inconsistent data sometimes obtained from them, the division has discussed this matter with DMAHS and will be working with the providers and DMAHS to report and eliminate such inconsistencies. Furthermore, the division has recently sent a formal communication to all provider agencies outlining each of the ways eligibility can be verified, strongly encouraging use of the on-line verification system eMEVS, and further stressing that any inconclusive or questionable responses from any of the verification systems, should be followed-up by utilizing the toll-free number to call Unisys’ Provider Services for a final determination. (See attached)

In addition, in the future, procedures will be implemented whereby division staff will periodically analyze provider Medicaid revenue levels per budgets and expenditure reports, versus payments data from the Medical Assistance database, to identify billing and collection trends that are atypical, and require additional follow-up. DMHS will also continue its previous practice of requesting “Agreed Upon Procedures Reviews” each year through DHS regional audit staff, specifically targeted at identification of Medicaid
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eligible consumers, billing and collection procedures, and follow-up activities to maximize revenue collection.

The division is confident that the actions already taken and those proposed will serve to improve our contracted providers' efforts to properly and timely bill for all eligible Medicaid services provided and to properly reflect such revenues in the required quarterly contract expenditure reports.

Response to "Contract Closeout" Observations / Recommendations (Pages 5 – 6)

Although we concur with the finding and related recommendation regarding "Contract Closeout", some additional clarification is warranted. While the number of contracts "closed" for FY '04 and '05 was very small at the time of the review, in actuality for a significant number contracts, staff had completed the initial close-out analyses, but this work had not yet been reviewed by the supervisor. Such work constitutes 85% - 90% of the effort involved in such close-outs and thus DMHS is far closer to completing the close-outs for contracts for these fiscal years than one might conclude from an initial reading of the report observation. In fact, at present, the initial close-out work has been completed for 159 of the remaining 179 FY '04 contracts or almost 90% and for 89 contracts or over 50% of the remaining FY '05 contracts.

While division staff strive to complete the contract closeouts on a timely basis, there are several factors - some beyond the division's control, that result in significant delays in completing such work. Such factors include; agency requests for extensions needed by their auditors to complete annual audit reports and related Final Reports of Expenditures (ROE's), lengthy delays in the disposition process when agencies disagree with closeout conclusions and seek to provide additional information or formally appeal the initial decisions, and some agencies' failure to submit audit and / or Final ROE's in a timely basis. It should be noted however, that unless agencies are able to provide a reasonable explanation / justification for such delays, DMHS suspends further contract payments to such providers until the required reports are received.

However, the factor which has contributed the most to these delays has been the division's continuing need to re-direct its limited fiscal staff resources away from completing such contract close-out reviews which yield only a few hundred thousand dollars in recoveries each year, to other activities which have yielded millions of dollars in additional Medicaid revenues. Examples of these other more cost effective priorities include:

- Coordinating and completing the Children's and Adult Residential Rehabilitation Services retroactive Medicaid claims during FY's 2003 and 2004 which resulted in the State receiving $4.192 million in additional Medicaid FFP revenue.
- Conducting required quality control review activities throughout the year beginning in FY '06, to assure the accuracy of the division's quarterly Medicaid Administrative Cost (MAC) claims, that now generate annual increased Medicaid (FFP) of nearly $13 million. This increased funding has enabled significant program expansion at participating provider agencies, as well as served to be able
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to reduce the required Direct State Services funding otherwise required for DMHS administrative salaries.

- Billing, collection and reconciliation of the annual DMHS License Fee revenue which is appropriated to help offset the costs of conducting such license reviews and yields approximately $325,000 annually.

Lastly, due to revisions made to the Department of Human Services Policy Circular P1.10 - Contract Modification effective July 1, 2004, and the recently implemented DMHS policy on Operational Incentives, provider agencies have additional contract budget flexibility and the ability to retain some surplus contract funds that previously would have been recoverable by the state. Based on early results under these new policies, our expectations are that close-out reviews will yield an even lower amount of contract recoveries and therefore the division will definitely be re-examining how to better prioritize which contracts are closed-out first to maximize recoveries related to the time available to complete such activities.
MEMORANDUM

TO: Executive Directors of DMHS Contract Community Provider Agencies

FROM: Stephen Adams, Chief Financial Officer
Division of Mental Health Services

DATE: February 9, 2007

SUBJECT: Medicaid/Familycare Eligibility Verification and Billing

It has recently come to the attention of the Division of Mental Health Services through the Office of Legislative Services audit team, that a significant amount of Medicaid revenue is not being realized for services delivered by community agencies and hospital providers. The issue centers upon verification of Medicaid/Familycare eligibility.

First, most mental health program elements require that as part of enrollment, efforts are made to maximize entitlement benefits on behalf of consumers. Applying for Medicaid/Familycare eligibility should be a part of this process for all consumers who appear to be eligible and whose status is unknown.

As you know, prior to submitting Medicaid/Familycare claims, eligibility needs to be verified. There are currently several ways to verify eligibility for your consumers.

➢ Through outside vendors who charge a per transaction fee;
➢ Through the Recipient Eligibility Verification System (REVS) which is the telephone-based voice response system for which there is no fee and which is accessed via a toll free number;
➢ Through the Medicaid Eligibility Verification System (MEVS) which has per transaction fees, and;
➢ The electronic Medicaid Eligibility Verification System (eMEVS) for which there is no fee.
The DMHS does not believe it appropriate to use contract funds to support fee based verification systems now that the eMEVS system is available. The eMEVS system is felt to be preferable to the REV system. For these reasons if you are not currently using eMEVS we would request that you begin to use this system.

The “eMEVS” is reportedly the most reliable source of eligibility data available. The system can be accessed via link on the homepage www.njmmis.com. In order to use the online system for free, you will first need to submit an on-line provider registration application to receive a UserName and Password. You will need to obtain a unique UserName and Password for each provider number under which you submit claims for Medicaid reimbursement. The primary reason for this is that by verifying eligibility online under the provider number for which you plan to submit a claim, your agency is guaranteed Medicaid reimbursement for that date of service for a recipient shown to be eligible, even if eligibility is terminated retroactively for that consumer at a later time. On the NJMMIS homepage, on the left, you will see a link labeled “Provider Registration”. Click once on it and follow the instructions. Again, you need to submit a registration application separately for each provider number that you maintain for service delivery and subsequent billing.

Use of the recipient identification number or card control number (CCN) if available, are the most efficient on-line search methods to verify current eligibility in eMEVS. Use of Social Security Number should be secondary, and only used where you do not have access to the recipient ID number or the CCN. The eMEVS system has multiple user-friendly search options. If any one or all of those return a message such as “Duplicate Patient ID” or “Patient not found”, as can be the case, you should then contact Unisys Provider Services by calling 1(800)776-6334. This may take some time or several tries, depending on call volume at Unisys provider services. However, speaking to a representative at Unisys is the crucial last step that you should take after all other options have been exhausted. These representatives will determine whether or not the consumer has any active Medicaid/Familycare eligibility.

It is critical to the overall mental health system that consumers properly receive entitlements and that provider agencies generate the maximum appropriate amount of reimbursement from Medicaid/Familycare as possible. It is not appropriate to use State contract dollars to support a service when Medicaid/Familycare should legitimately have paid for the service.

Thank you for your prompt attention to this matter. Should you have any questions or concerns, please do not hesitate to contact Joel Boehmler directly at (609)777-0765.

C: DMHS Executive Staff
   Dave Salewski
   Pete Revesz